ASSESSMENT AND TREATMENT OF SUICIDAL CHILDREN AND ADOLESCENTS: THE SWEDISH NATIONAL GUIDELINES

Swedish Association for Child and Adolescent Psychiatry
Swedish Research Council’s planning group for research in child and adolescent psychiatry and social paediatrics
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Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health – NASP
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FOREWORD

Assessment and Treatment of Suicidal Children and Adolescents: the Swedish National Guidelines were drawn up jointly by the Swedish Association for Child and Adolescent Psychiatry, the Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) and the Swedish Research Council’s planning group for research in child and adolescent psychiatry and social paediatrics. Work on the guidelines began in 1999 with the building of a consensus among Swedish child psychiatrists in clinical practice and the Swedish Association for Suicide Prevention and Support to Survivors of Suicide (SPES).

The purpose of these guidelines is to assemble current knowledge to assure suicidal children and adolescents, and their families, of the best care possible. The guidelines are based on the findings of the WHO/EURO Multicentre Study on Suicidal Behaviour and those obtained on various other knowledge fronts. They are founded on ethical and sociopolitical priorities, and the basic regulatory framework of Swedish healthcare. They also take into account the General Assembly’s Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) and the ethical rules contained in the Declaration of Hawaii.

The target groups for these guidelines are professionals in child and adolescent psychiatry, doctors, psychologists, social workers, care staff, representatives of clinical management, and political decision-makers. The guidelines have been distributed to all child and adolescent psychiatric units in Sweden.

While the guidelines should be seen as a form of support in the clinical decision-making process, they may also be used in various training courses and clinics’ development work, for example to draw up local care programmes. The guidelines can also serve as ‘road signs’ to help politicians and healthcare administrators set priorities for care. Further, the guidelines may also be of value to staff in the social services, education and primary care.

Knowledge is expanding rapidly in child and adolescent psychiatry and in suicidology alike. The governing board of the Swedish Association for Child and Adolescent Psychiatry and the management of NASP will therefore ensure that the guidelines are updated at regular intervals.

The guidelines were drawn up by a task force comprising Professor Danuta Wasserman (psychiatry and suicidology), Professor Per Anders Rydelius (child and adolescent psychiatry), Professor Anne-Liis von Knorring (child and adolescent psychiatry), Senior Consultant Gunilla Ljungman, the chairman of the Swedish Association for Child and Adolescent Psychiatry and other specialists in child and adolescent psychiatry, Dr Agnes Hultén, Dr Tord Ivarsson, Dr Gunilla Olsson and psychologist Annelie Törnblom.
SCALE OF THE PROBLEM

Youth suicide and attempted suicide in Sweden

For parents, siblings, friends, schoolmates and other intimates, a young person’s suicide is a grave psychological loss.

The number of suicides in Sweden has fallen steadily since the early 1980s, except in the youngest age group (up to 17 years). Every year, 30 to 40 Swedish adolescents aged 15-19 take their own lives. In the 20-24 age group some 70 young people die annually as a result of suicide. The latest available data, from the year 2001, indicate 27 suicides among adolescents in their upper teens and 83 in the 20-24 age group that year.

A number of Swedish studies report that 7-8 per cent of girls and 3-4 per cent of boys have at some time tried to take their own lives. Overall, some 5-6 per cent of Sweden’s school pupils report that they have attempted to take their own lives at one time or another. Since experience to date shows that suicide attempts are frequently repeated and that previous attempted suicide is among the most common risk factors for completed suicide, this is alarming. It is therefore imperative to detect and treat suicidal adolescents at the earliest possible stage.

Relatives, friends and acquaintances of young people who commit suicidal acts often find these acts unexpected and shocking. Afterwards, however, it often emerges that many of these adolescents have had a long history of troubles. They may have suffered from anxiety or depression, or abused alcohol and/or drugs. Acting-out behaviour, such as fighting, theft and truancy, often contributes to adverse social consequences, with concomitant chronic stress. These types of behaviour are often observable long before the suicidal act. Psychoses, such as schizophrenia and manic-depressive disorder, and personality disturbances may also underlie teenage suicide and attempted suicide.

Vulnerability and stress

Adolescents who attempt or commit suicide often exhibit marked vulnerability and susceptibility to stress. This may be explained in terms both of innate genetic characteristics in the individuals concerned and of acquired characteristics stemming from adverse experiences and difficult life circumstances. These factors – combined with stress – have a major bearing on the course of the suicidal process, from the foetal stage right up to adulthood.

Suicidal behaviour has proved relatively common in certain families and under specific circumstances. Suicidal adolescents have been exposed to emotional traumas and adult conflicts to a higher degree than either adolescents who are depressed or adolescents in general. Other ordeals, such as bullying, violence and incest, have also occurred more frequently
among this group. Chronic mental ill-health and domestic violence severely impair children’s resilience and capacity to cope with stress in later life.

Suicide attempts are often precipitated by external events, such as quarrels with parents or a boyfriend/girlfriend, or failures at school. Failures are often perceived as more traumatic by vulnerable adolescents than by the average young person; in the former, such events may also arouse pronounced feelings of shame and anger. When young people suffer blows to their self-esteem, they may experience both bottomless despair and intense rage. If no help is available, suicide may appear to be the only way out.

Communication
Suicidal adolescents’ ability to communicate with adults – and sometimes also with peers – is frequently poor. Although the young person is desperately crying for help, unclear communication can make this difficult for others to grasp.

Among professionals, family members and friends, there is a fear of openly talking about suicide-related issues with children and adolescents. There is misplaced anxiety that such discussions may actually provoke suicidal acts. In fact, venturing to discuss these issues openly is usually a liberating relief for all concerned.

In clinical situations and assessments, listening to and heeding what children and adolescents relate – with the heart as well as the head – are essential. One should also be prepared to answer the difficult questions that arise. To induce them to participate in treatment, effective communication with suicidal young people is paramount. In their situation, they need all the help they can get to gain the feeling that life is worth living.

*Being available and conveying hope* are keynotes in helping suicidal children and adolescents.

Care organisation
In all social groups, subcultures emerge that derive from, and are dependent on, the members of the groups concerned. Group members’ knowledge, values and attitudes shape group activities, with their potential and limitations. Care subcultures – from healthcare management to executive management, individual wards, departments and teams – arise in a corresponding fashion.

To offer effective help in response to suicide attempts and develop preventive programmes to reduce the number of completed suicides, an appropriate care organisation is required. This must incorporate a culture of care that is imbued with ample knowledge, humanitarian values and
empathy. It is the responsibility of management to ensure that such a culture develops and is maintained at every level of care.

Help is available
To muster the courage to live, feel that their lives have meaning and learn personal coping strategies, suicidal young people need help.

Prevention of suicidal acts requires:

• An appropriate care organisation with a good care culture and well-trained staff.
• Effective treatment routines, especially for conditions like depression, bipolar disorders, schizophrenia and other types of psychoses, and alcohol and drug abuse.
• Functioning social networks in which relatives and friends can provide emotional and cognitive support.
• Vigorous preventive programmes in which schools, in particular, perform a crucial role in initiating suicide-preventive strategies.
RESPONDING TO THE SUICIDAL ADOLESCENT

A personalised response based on openness, knowledge and respect enables young people and their parents and/or guardians to discuss their problems. Teenagers’ perceptions and appraisals of themselves and their own situation, and their impressions of how other people appraise them, often determine the outcome of the first meeting and whether they are able and willing to accept help.

The initial premise should always be that young people who have attempted suicide are disappointed in themselves and others. Adolescents who feel constantly misunderstood by others may feel unfairly treated or outraged in situations of all kinds. As a result, care staff who receive teenagers must be on their guard to avoid reinforcing such feelings or provoking counter-reactions, especially those involving aggression or threats.

Individual and joint consultations

Suicidal adolescents – and other family members as well – may, for various reasons, wish to hide their problems, entirely or partially, from the rest of the family, at least in the initial phase. In principle, they should always be offered individual consultations first. Since many families have had no experience of discussing emotional distress, it may also be necessary to arrange for the family members to have separate consultations with therapists before the joint family session takes place. If individual consultations are offered, bear in mind that the adolescent should be given priority.

Consultations with suicidal adolescents

Adolescents should be asked to explain their own suicide attempts and say whether they have any idea how their problems can be solved. It is also important to ask what kind of help they want and from whom. Consultations with teenagers should be open-ended, yet follow an overall structure, in order to clarify every aspect with a bearing on assessment and management.

The therapist should not be provoked if the teenager behaves aggressively or is dismissive or openly critical. This kind of behaviour may stem from the young person’s fear of being misunderstood, not being taken seriously or treated in a prejudiced manner. A real, imminent threat of another suicidal act may also exist. The adolescent’s worst fears should be explored. It is vital, for example, to consider teenagers’ thoughts about being ‘sick’ or ‘crazy’.

Therapists should be humble, avoid engaging in a power struggle and admit that perhaps they alone cannot solve every problem confronting the young person. Showing consideration, warmth, openness and respect in
the consultation is essential. You should summarise what has been said, to assure the adolescent of your genuine understanding and thus your ability to provide support in further consultations with parents and other significant persons.

Consultations with parents

It is also important for the parents not to misconstrue the situation and feel offended. They should be shown respect and meet the same generous and professional attitude on the part of the therapist as did the adolescent. They must be given the time and opportunity to talk about their difficulties, the suicide attempt in question and the family members’ circumstances. Ask for their views on what elicited the suicide attempt. This information can later be compared with what the teenager has related, and form the basis for an assessment of the parents’ contact with their child. During the consultation with the parents, the therapist should remember that they may be at once fearful, anxious, guilt-ridden, angry and disappointed.

Family consultations

Initial individual consultations should always be followed by a joint family consultation. In simplified terms, the purpose of this family consultation may be defined as providing all parties – face to face – with an opportunity to express their thoughts and feelings. It should focus on the feelings and problems that the patient indicates as most important. At the same time, the problems that the parents view as acute should also be addressed, to attain balance in the family consultations.

Differences between boys and girls

Boys have a tendency to attribute their problems to others, and are often sceptical of the chances of getting help in solving them. Unless they obtain a prompt response when they seek help, boys easily give up. The first consultation may be the only chance we get to offer help.

In general, girls find it easier than boys to describe their situation, and have more faith in their chances of obtaining help from others. But in general they tend more than boys to blame themselves for their problems, with the risk of being caught up in self-reproaches that may result in a subsequent repetition of a suicide attempt.

Care under the Compulsory Mental Care Act

If the situation demands compulsory psychiatric care (see page XX), the patient’s right to self-determination and the parents’ right to make decisions concerning their children are temporarily waived and the healthcare authority takes over. Both the patient and the parents may find this offensive. In the urgent and often emotionally upsetting situation that arises from a compulsory-care decision, it may be difficult for patients and their parents to cope with and express all the feelings and thoughts that
result. Staff must therefore provide opportunities as soon as possible – and by the time the care certificate is issued – for a detailed discussion of the situation, to create the best possible external conditions for a mutual understanding and acceptance between parent(s) and child.
CARE IN THE ACUTE CRISIS

Attempted suicide

Children and adolescents who attempt suicide or have plans for suicide must receive prompt attention and treatment. These are the urgent ’blue-light’ ambulance cases of child and adolescent psychiatry, requiring the same high level of preparedness and priority as heart attacks in somatic care. The purpose of emergency treatment measures is to protect the young person from further suicidal behaviour and completed suicide. The basis of sound clinical assessment and treatment is a response that shows respect and empathy.

Young suicidal patients

Young people at risk come to child and adolescent psychiatric clinics under a variety of circumstances:

• Immediately after a suicide attempt – either direct to a psychiatric unit or referred from a medical department.
• After revealing suicidal ideation or plans during an emergency consultation.
• After booking an appointment for outpatient care at a child and adolescent psychiatric clinic, regardless of the reason given.
• After revealing suicide plans during a series of sessions at a child and adolescent psychiatric clinic.

First encounter

The first care professional to meet the young patient at a child and adolescent psychiatric clinic should consider the following points regarding the assessment interview:

• Introduce yourself, and describe your occupation and role.
• Be ready to listen but do not engage in too deep or detailed a discussion until a person in charge of assessment is present – teenagers cannot be bothered to tell their stories twice.
• Explain that a child psychiatrist will come to assess the patient’s situation and help needs.
• Make it clear that you will be present during the consultation with the psychiatrist.
• Make available a quiet, secluded room with good safety features with respect to suicide attempts.
• Do not leave the teenager alone, but minimise the number of persons who have contact with the patient.
• Convey quiet assurance to reduce the patient’s experience of chaos, i.e. provide good psychiatric care.
Like the patient, parents need reassurance and information about what is going to happen.

Suicide-risk assessment

Suicidal patients who present for care – regardless of the circumstances – must be assessed for suicide risk by a qualified clinician as soon as possible. This assessment should be performed in a structured and systematic fashion and be based on in-depth discussions with the patient. Sessions should also be conducted with the patient’s parents or other guardians, or intimates. In addition, the social services and the pupil-welfare unit at the patient’s school may be able to provide important information. (For a checklist for emergency assessment, see Annex 3.)

As noted above, the consultation should take place in a quiet, secluded place designed to discourage further suicide attempts or other violent acts. Windows, for example, should require a key for opening, and mobile items that patients might use to harm themselves or others should be removed. Turn off the telephone and put your pager aside. Make sure you have plenty of time and listen actively. It is important to try to convey hope and relieve the young person’s sense of guilt. Being flexible is helpful, but take care not to promise more than can reasonably be delivered. Sustainable limits and routines create stability for adolescents and their families in an otherwise chaotic life situation.

The assessor should have special training in and knowledge of suicidal behaviour. Suicide risk should be assessed in terms of:

1. The seriousness of the suicidal act (plans, thoughts) in question.
2. The acute mental state, if any.
3. The underlying psychiatric diagnosis.
4. The patient’s life circumstances.

The emergency assessment should clarify the kinds of protection the patient needs, as well as indicating the level of care required. The patient, parents and physician in charge need to agree on a preliminary treatment plan, and this plan should be entered in the patient’s records.

The assessment of the seriousness of a suicide attempt can be structured by means of a psychometric tool, such as Beck’s Suicide Intent Scale. However, self-evaluation or parental-evaluation questionnaires must never supersede the acute-phase assessment carried out during in-depth sessions with the patient and family concerned.

The diagnosis is an important factor in the emergency risk assessment, and a necessary component of further care planning. In-depth diagnosis and drawing-up of a plan for continued treatment are tasks performed once the
acute crisis is under control (see the sections on ‘Diagnostics’ and ‘Treatment and care planning’).

Acute cases
When an adolescent presents at a medical department after a suicide attempt, a psychiatric assessment should be performed before the patient leaves the hospital. Whether clear-cut or indeterminate, persistent suicide risk should entail inpatient admission for psychiatric care. The suicide-risk assessment should be thoroughly documented in the patient’s records. In the event of acute suicide risk combined with refusal to receive care, the provisions of the Compulsory Mental Care Act may apply (see also the section on ‘Treatment’).

A patient admitted to psychiatric inpatient care must not be left alone until the risk of suicide is deemed to have subsided to a level at which the patient can cope with solitude. Surveillance should be entrusted to experienced, permanent staff members, and organised by the nurse in charge. Staff continuity is imperative; individualisation and flexibility are also important. As mentioned above, a response that the patient interprets as negative or offensive will make subsequent treatment more difficult. It is thus vital for care staff to do their utmost to establish and maintain the best possible working relationship with the patient.

If possible, parents or other responsible caregivers should take part in the supportive measures provided for the teenager. Note, however, that an exception to this rule should be made when, for example, a parent is guilty of mental, physical or sexual mistreatment of the child. In these cases, the perpetrator should not be allowed near the patient. This situation then demands other forms of cooperation and investigation.

If the teenager nonetheless leaves the hospital before an assessment is feasible, an appointment at the clinic or a home visit at the earliest possible opportunity should be offered. The purpose is to establish a relationship that may enhance the teenager’s motivation to accept help. In normal cases (with the above-mentioned exception), parental participation is necessary. If no rapport with the teenager can be established despite all efforts, the social services must be informed as soon as possible.

If the staff member on duty judges that treatment can be provided on an outpatient basis, the patient should be offered an appointment within the ensuing week. This guideline should also apply when a patient is discharged from a ward after treatment for a suicide attempt or suicide plans. The risk of repeated suicidal acts is highest in the immediate aftermath of a suicide attempt, and it increases in conjunction with discharge. It is therefore desirable for patients, at the time of transfer from inpatient to outpatient care, both to meet therapists in the ward they are leaving and to see those who are to bear primary responsibility for their outpatient care. (See also the section on ‘Continuity’.)
It is essential to assess the parents’ attitude to the situation and their ability to provide protection and security for their child in the days immediately after the suicide attempt. Medicines, weapons and other dangerous objects and substances must be kept inaccessible. The adolescent should also be prevented from drinking alcohol or taking drugs, since these may exacerbate the risk of impulsive behaviour. It should also be possible, during this critical phase, to contact staff at the child and adolescent psychiatric clinic around the clock.

Suicide risk should be reassessed on each return visit until the teenager’s situation has stabilised. In addition, the therapist should assess the results of ongoing treatment and the patient’s current need for psychotherapy and pharmacotherapy at each consultation. The risk of new suicide attempts remains high in the subsequent year, so it is important to maintain contact with the teenager throughout this time.

Suicide assessment on planned visits

Adolescents who present for care without having carried out suicidal acts should also be assessed in terms of suicidality. They may be in the throes of an acute crisis and unable to cope, or suffering from a depressive or manic-depressive disorder, or some other psychotic state; or they may have been abusing alcohol or drugs. Exploration of the patient’s suicidality should begin with general queries and become progressively more specific and personal. For the ‘step model’, a useful graduated set of questions, see Annex 2.

If there is an evident risk of suicidal acts, the teenager should be hospitalised. In less serious cases, the teenager may be treated on an outpatient basis but with frequent visits. One should recognise the need for support from parents and/or other caregivers and activate it in normal cases (see the exception above). To obtain social-insurance benefit when they take temporary parental leave from work to care for their teenage children at home, so as to avoid leaving them alone, parents may need a medical certificate. Treatment must be designed to meet the patient’s specific need for protection, and with reference to the underlying mental problems. Decisions regarding both psychotherapy and pharmacotherapy should also be made at this stage.

In sessions with teenagers, therapists should always be receptive to indications of hopelessness and thoughts about death and ready, where appropriate, to proceed to ask questions that are more specific. If suicide plans are revealed in the course of treatment, a risk assessment must be conducted in the same way as for acute cases (see above). The previous treatment plan must be reviewed and probably also revised. This applies to the need for hospitalisation, family support, psychotherapy and pharmacotherapy alike.
Assessment of a specific suicide attempt

To assess the seriousness of a suicide attempt, one must investigate a range of factors. One useful tool for this kind of assessment is the Suicide Intent Scale (SIS). The assessment must investigate circumstances surrounding the suicide attempt as well as the individual’s own perception of what happened.

1. The following circumstances are relevant to assessment of a suicide attempt:
   - A suicide attempt in an out-of-the-way place where there is little risk of discovery is more serious than one occurring in, for example, a flat without the door locked.
   - The chances of detection are smaller on certain occasions, such as at night when everyone is asleep or when the rest of the family are away from home. This type of suicide attempt must be deemed highly serious.
   - If the individual takes measures to prevent detection, the attempt is intended seriously.
   - If the individual seeks help after the suicide attempt, this is a sign that a certain ‘will to live’ persists.
   - If, before attempting suicide, young people hint that they will soon be dead – for example, by putting their ‘affairs’ in order and ‘tidying up after themselves’ – this points to a premeditated decision and the attempt should therefore be judged as serious.
   - Preparing for a suicide by, for example, acquiring pills, weapons, rope and the like indicates that the decision is well thought-out and therefore serious.
   - Writing a suicide note to the family is a serious indication that the individual intends to die.
   - An adolescent’s communication of suicidal intent should be taken seriously. The individual may have talked with friends or warned a family member.

2. It is vital to take note of the following elements in a person’s own description of a suicide attempt:
   - A stated intention to die.
   - Attitude towards having survived the suicide attempt.
   - Perception of the effectiveness of the suicide method chosen. What children and adolescents think they know about the lethality of various methods may diverge from their actual medical risks.
   - Attitude towards death. Religious beliefs may provide a safeguard, but imagining a reunion with a deceased intimate may imply a longing for death.
• Understanding of death. A child’s or an adolescent’s notion of the finality of death may diverge from an adult’s.

• Hopes of possible survival or revival.

• Suicidal intentions that involve a carefully thought-out plan are more serious than impulsive, ‘haphazard’ suicide attempts.

Assessors should note in the patient’s records how reliable they deem the assessment to be. The slightest degree of uncertainty regarding the persistence of suicidal intent should call for the patient’s hospitalisation.

Assessment of underlying mental disturbance and other factors

Most teenagers who take their own lives have a history of underlying mental disorders that often extends far back in time. Depression, bipolar disorder, psychoses, anxiety states, conduct disorders and alcohol and drug abuse can all be symptoms of serious risk. It is also common for young patients to suffer from more than one of these disorders, in which case the suicide risk increases further.

For an adolescent, a psychotic state characterised by delusions, hallucinations, agitation and threats of violence spells a severe risk. Mixed affective states, such as mania and depression, or swings between the two – common initial forms of youth bipolar disorder – are also important to recognise since they involve a high risk of suicidal acts. Teenagers often attempt suicide in the course of a prolonged period of depression, when their social adjustment falters.

Poor parent-child communication, domestic violence and alcohol and drug abuse in the family are common factors underlying attempted suicide. Children who have been subjected to mental, physical or sexual abuse in the family are an acute risk group. These children sometimes suffer from post-traumatic stress disorder (PTSD) and exhibit a type of behaviour similar to those of children exposed to war trauma. Among adolescents with PTSD, it is common for aggressive – including suicidal – acts to occur suddenly and unexpectedly. These adolescents may also exhibit self-destructive behaviour without suicidal intent, but this should not mislead an assessor into believing that this behaviour excludes a risk of suicide.

Risk factors in boys and girls

Completed suicide is rare before puberty. In the teens, however, the suicide rate rises steadily with age. More boys than girls (2:1) die from suicide, although suicide attempts are markedly more frequent among girls (3:1).

Follow-up studies have shown a difference between child and adolescent psychiatric patients, on the one hand, and adult psychiatric patients on the other in terms of the prognostic significance of previous suicide attempts. In the youth group, psychoses and personality disorders combined with aggression, impulsiveness and adverse psychosocial factors appear
relatively common. Previous suicide attempts must always be considered, especially in boys. The suicide-mortality risk appears to be highest of all for vulnerable boys in their late teens with a history of one or more suicide attempts.

Experience of a suicide or suicide attempt in the family or a patient’s circle of friends also involves an elevated risk for suicidal acts. This phenomenon can also extend beyond the family and close friends; a young person’s suicide can have a powerful impact on other vulnerable teenagers with suicidal ideation and, at worst, trigger suicidal acts among the latter as well (see the section on ‘Support for survivors following a suicide’).

Precipitating factors
Stressful events often precede a suicide or suicide attempt. Adolescents with mental disorders may be incapable of coping with major psychosocial stressors, such as a death in the family. Minor stressors may also accumulate to the point that they are overpowering. Among vulnerable teenagers – in particular those who are impulsive – a quarrel with parents, separation from a boyfriend or a girlfriend, failure, detection of a criminal offence and a conviction for the same may all trigger a suicide attempt. The risk of committing impulsive suicidal acts is especially great when adolescents are under the influence of alcohol or drugs, since these impair resilience.
DIAGNOSTICS

After the acute phase, further diagnosis of suicidality should be seen as a team responsibility, with people in different occupational categories contributing various pieces of the diagnostic puzzle. Family members, therapists, psychologists, social workers, physicians and school staff all have access to different and complementary information sources, and should collaborate for the best possible diagnostics.

The clinical physician’s special responsibility in the care process is to weigh up all the information to produce a final suicide assessment and decide on the care requirement according to the Compulsory Mental Care Act.

In diagnostics, the clinician’s approach must be based on systematically applied knowledge, and also on intuitive empathy and communication with the patient.

Since the topic of suicidality is fraught with emotion, it is easier to achieve an objective assessment of adolescent suicide risk through teamwork. This gives the staff the chance to reflect on and work through their experiences as a group, thereby attaining a more reliable assessment in each individual case.

Every suicide assessment must be considered a ‘perishable’ item, with a very limited ‘sell-by date’. Suicide assessment is an ongoing process from the patient’s arrival until the team has reached a more complete diagnostic assessment.

Diagnostic process

One essential component of the diagnosis is consideration of the mental illnesses associated with a high risk of completed suicide or another suicide attempt. Other background factors that involve documented elevated risk of suicidality must also be systematically considered.
Key factors in the patient’s history

1. **Suicidal ideation**

While suicidal thoughts may arise without being a feature of mental illness, they are a more serious risk factor when they are a manifestation of mental illness. Questions about suicidal ideation must be direct as well as clear and unequivocal. If the therapist uses euphemistic expressions that gloss over reality, patients become unsure of their responses and may even get a feeling that the topic is too unpleasant for the therapist to discuss.

Basic requirements: data collection through interview according to the ‘step model’ (see Annex 2) and a psychometric scale, e.g. Beck Depression Inventory or YSR (Youth Self-Report), ‘Self-destructive/Identity problems’ (see Annex 4).

Options: questions about suicidal ideation in KSADS (see Annex 4).

2. **Previous suicide attempts**

According to follow-up studies, a previous suicide attempt is one of the most significant predictors of persistent suicidality. A stronger predictor for boys than for girls, it is especially serious when it coincides with mental illness. Terms like ‘suicidal gesture’ or ‘cry for help’, which are often used by clinicians to describe relatively minor suicide attempts, are misleading and should be avoided. Questions about a suicide attempt in the clinical interview must be direct, clear and unequivocal. See the above section on suicidal ideation.

Basic requirements: systematic completion of the Suicide Intent Scale (SIS) questionnaire (see the above section on ‘Care in the acute crisis’).

Options: questions about previous suicide attempts in KSADS (see above).
3. **Precipitating psychosocial stressors**

See the section above on ‘Care in the acute crisis’.

Basic requirements: included in the psychiatric history.

4. **Psychiatric disorder**

   - Depression
   - Bipolar disorder
   - Alcohol and drug abuse (especially in the late teens)
   - Psychosis, schizophrenia
   - Conduct disorder
   - Anxiety disorder, PTSD
   - Personality disorder, especially antisocial and borderline.

More than 90 per cent of adolescents who exhibit suicidal behaviour have underlying psychopathology: mainly affective and conduct disorders, alcohol and drug abuse, post-traumatic stress syndrome (PTSD), anxiety disorders or personality disorders. Comorbidity exacerbates suicide risk, as does chronicity. Mental states characterised by lability and agitation, such as bipolar disorder and chronic depression with simultaneous alcohol and drug abuse and irritability, entail elevated suicide risk. Composite states with elements of mania and depression and day-to-day mood swings are particularly difficult to detect.

### Key aspects in assessment

The therapist should:

1. Talk to the young person in private – and not only with the parents present. Adolescents find it difficult to talk about suicidality and severe internalising symptoms when their parents are present, out of concern that it will upset or anger them.

2. Be aware of comorbidity – it tends to be the rule rather than the exception.

3. Consider mental disturbances, e.g. alcohol and drug abuse and conduct disorder, other than those commonly associated with the suicide process.

4. Draw on a variety of information sources. Besides parents, school staff, school nurses and the social services can provide key information.

Basic requirements: included in the psychiatric history, supplemented with parental-evaluation scales. Depressive symptoms: BDI, DSRS or CDI.
Overall screening for mental symptoms: YSR and CBCL or the parent/child version of SDQ (see Annex 4).

Options: KSADS or DICA (see Annex 4).

5. Lifestyle and general state of health

Sleeping and dietary habits are important indicators of a patient’s general state of health, and are also affected by mental illnesses. Other indicators of a high-risk lifestyle include membership of subcultures in youth groups, including antisocial gangs with a propensity for violence; use of tobacco, alcohol and other drugs; risky sexual habits (unprotected sex/promiscuity, etc.); truancy and poor school attendance; and shortcomings in everyday self-care routines (eating breakfast, wearing a bicycle helmet, etc).

Basic requirements: included in the psychiatric history.

Options: KSADS.

6. Trauma/assault

Several studies have shown that adolescents exposed to trauma or assault – sexual as well as physical, owing either to war experiences or to domestic violence – run a high risk of developing various forms of self-destructive behaviour, including suicidality. Some vulnerable adolescents also exhibit symptoms of post-traumatic stress syndrome (PTSD).

Basic requirements: included in the psychiatric history.

Options: section on aggression/PTSD in KSADS; DICA (see Annex 4).

7. Survey of family situation

The family situation includes factors that affect the parents’ functional and caring ability, the home environment and lasting psychosocial stressors in the family. Examples include poor finances and housing, adverse life events, losses/deaths, mental illness in one or both parents, alcohol and drug abuse, violence and cruelty, immigrant or refugee status, children adopted from abroad, the parents’ work capacity and social adjustment, suicidality in the family, family conflicts, separation, neglect, hostility between parents and children, and single-parent status. Note that these factors must be distinguished from the acute factors that triggered the suicide attempt.

The social services may need to be notified in cases where the parents are unable to provide adequate care and protection for the suicidal adolescent.

Basic requirements: included in the psychiatric history.

Options: the home environment can be assessed by means of psychometric scales such as ‘Family environment, Questions about family members’ or
‘Five-Minute Speech Sample (Expressed Emotion)’. KSADS (see Annex 4) includes a section on mental illness in parents/family members. In addition, a questionnaire on life events can be used.

8. **Social network**

A survey of the network resources available to the patient may be highly relevant.

Basic requirements: included in the psychiatric history.

Options: the networks may be surveyed by means of ’My Social Network’ (Aresik-Ram/Elf).

9. **Survey of genetic risk factors**

Parents’ own psychiatric illness, especially depression and bipolar disorder, as well as parental criminality and alcohol and drug abuse, is both a genetic risk factor and a circumstance that boosts the incidence of adverse life events (see above) for the patient. Nature and nurture are independently associated with an elevated risk of future suicidality. The therapist should investigate whether anyone in the family (or a close friend) has died from suicide, or threatened and/or performed suicidal acts.

Basic requirements: included in the psychiatric history.

Options: KSADS includes a section on mental illness in parents/family members.

10. **Personality**

Therapists also need to consider the history of personality traits that may be associated with elevated suicide risk. Examples of these traits are impulsiveness, aggression, hostility and hopelessness. These traits may be of significance even if they are not salient enough to constitute a component of a mental disorder.

Basic requirements: included in the psychiatric history. Aggression and impulsiveness can be charted with YSR/CBCL or SDQ. Hopelessness can be assessed with the Beck Hopelessness Scale (BHS; see Annex 4).

11. **Protective/health-promoting factors**

Therapists must explore the patient’s skills and assets. These include, for example, intelligence and special talents, stability of lifestyle, relationship patterns characterised by secure bonding and family integration, positive adjustment to school and education with a realistic view of the future, and good relations with friends. Cooperativeness and a positive attitude towards getting help are other salutogenic factors. Useful resources on the parents’ part include understanding, the ability to provide support for their
children, a positive attitude towards receiving help, and support from private and professional networks.

Basic requirements: included in the psychiatric history. SDQ-B and SDQ-F.

**12. Functioning**

Deficient functioning may – whether associated with or independent of a psychiatric disorder – entail an elevated risk of suicidal behaviour.

Basic requirements: functioning can be investigated by means of CGAS or GAF, two concise scales for global assessment of function in children and adolescents (see Annex 4).

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<tr>
<th>STATUS</th>
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<tbody>
<tr>
<td>1. Psychiatric status</td>
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<tr>
<td>2. Personality/the teenager’s attitude towards the therapist</td>
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<tr>
<td>3. Somatic status</td>
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**STATUS**

1. **Psychiatric status**

Therapists must always carry out an examination of their patients’ psychiatric state, noting symptoms that indicate depression, bipolarity and psychosis.

2. **Personality/the teenager’s attitude towards the therapist**

Hostility or aggression directed at the therapist may be a risk factor as such, as well as a clear sign of personality traits associated with elevated suicide risk. Moreover, it is important to note whether a lack of cooperation in a patient’s assessment and treatment may be expected.

Although personality disorders are not, as a rule, diagnosed in children and adolescents, it is nevertheless important to consider such personality traits as impulsiveness, aggression, hostility and hopelessness.

3. **Somatic status**

The patient’s somatic status, including neurological status, must always be checked. Laboratory samples should be taken to determine blood status, including blood-sugar level. The need for alcohol and drug screening, with testing for possible intoxication with methanol and paracetamol, should be borne in mind.
Since both old-fashioned and present-day drugs may have adverse cardiac effects, an ECG should also be considered.

Summary

Effective treatment demands a broad, all-round psychiatric and somatic assessment of patients and their overall life situation. Diagnostics must be multifaceted, consistent and based on factors that research has shown may predict persistent acute suicidality. It is therefore worth using a checklist to ensure that the diagnostics touches on all the key areas.

A realistic and sufficiently long-term care plan must be based on good diagnostics.

Basic requirements: checklist (see Annex 3).
TREATMENT AND CARE PLANNING

The primary goal of emergency treatment inputs is to protect the patient from further suicidal behaviour. These inputs should then form the basis of a longer-term treatment plan aimed at:

- preventing repetition of suicidal acts, self-destructive behaviour and future suicide
- treating any underlying mental illness
- helping the patient and family concerned to function better.

As yet, while effective methods for treating suicidal adults are available, few evidence-based methods have been tested on adolescents to date. For now, we must therefore offer the treatment methods and procedures that best fulfil the aims listed above, while differentiating them and adapting them to the patient’s and family’s needs and resources. Treatment begins at the very first meeting with the patient and the parents (see sections on ‘Response’ and ‘Care in the acute crisis’). A committed and respectful response to all parties involved leads to fewer treatments ending prematurely. The importance of continuity in dealing with suicidal adolescents and their families is discussed in the section on ‘Active follow-up’.

The clinician needs to inform the family about the findings of the assessment and explain them in a clear, simple instructive style. If possible, the teenager’s and family’s own words should be used to describe the clinical picture. Based on this description, treatment can be planned in several stages, for both the short and the long term.

A-Z of treatment

| Draw up a multimodal care plan for the short and long term, and document it. Treatment should be based on available evidence-based methods that reduce suicidality and underlying mental ill-health, and can be offered to patients and their families and social network. It is vital for measures to be taken promptly and combined with active follow-up. |
| Therapists should remember that this patient group is very heterogeneous and that, in terms of problems, there are marked differences between individuals who act out and those whose problems are directed inward. According to the nature of their problems, different categories of patients in child and adolescent psychiatry may require quite different kinds of help. |
| Many adolescents also need practical knowledge and training in various skills. These include learning how to cope with stress, resolve conflicts and communicate better with others, so that their well-being, functional level and social adjustment can improve. Therapists should seek to promote a parental-care system that is as supportive as possible. |
Form of care

If suicide risk is deemed low and the family appears capable of taking responsibility for the young person’s supervision and support, treatment can start in child and adolescent psychiatric outpatient care. On the other hand, admission to inpatient care immediately after the emergency assessment is recommended if suicide risk is high or difficult to assess (see section on ‘Care in the acute crisis’). The purpose of inpatient care is to ensure that patients are supervised and to allow time for supplementary clinical assessment.

If inpatient care is required it should, if possible, be provided under the Health and Medical Services Act. It is important to inform patients and their parents of the findings of the clinical assessment, the seriousness of the suicide attempt and the purpose of hospitalisation. If there are no contraindications, such as suspected parental violence or cruelty, it is helpful to involve the parents as much as possible at the time of admission. Offering the parents overnight accommodation (in their own room) in the department can encourage a close relationship among the family members while making support and information more easily accessible to them.

Psychiatric inpatient care calls for special attention to monitoring and security. The risk of further suicidal acts must be continuously assessed and appropriate surveillance measures taken in response. These may vary from ‘observation’ under the Health and Medical Services Act (all staff members are vigilant and the patient may not leave the ward alone) to ‘intensive surveillance’ (according to the Compulsory Mental Care Act), whereby the patient must never be left alone, even when visiting the lavatory.

<table>
<thead>
<tr>
<th>Care inputs depend on the seriousness of the suicide attempt and the network resources available.</th>
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<tr>
<td>Examples of alternative forms of care:</td>
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<tr>
<td>• Inpatient care under the Health and Medical Services Act (HSL)</td>
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<tr>
<td>• Inpatient care under the Compulsory Mental Care Act (LPT)</td>
</tr>
<tr>
<td>• Various intermediate forms of care or day care</td>
</tr>
<tr>
<td>• Outpatient contact with patients and their families</td>
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<tr>
<td>• Care in the home</td>
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<tr>
<td>• Using the patient’s network</td>
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<tr>
<td>• Care for family members.</td>
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In child and adolescent psychiatry, the above-mentioned forms of care may sometimes need to be supplemented by assistance under the Social Services Act (SOL, Chapter 14, Section 1), the Compulsory Care of Young Persons Act (LVU) or the Compulsory Care of Alcohol and Drug Abusers Act (LVM).
When inpatient care under HSL is deemed insufficient, compulsory psychiatric care should be provided.

Compulsory psychiatric care is a measure that encroaches on personal integrity. The loss of freedom involved is often perceived as an outrage and may in itself trigger further suicide attempts – a risk that the care provided must take into consideration.

**Treatment planning**

Treatment should be planned on the basis of the patient’s problems and of existing knowledge and experience of long-term suicide-risk assessment. If violent methods have been used in previous suicide attempts, this has a bearing on significance for current and future suicide risk.

For adolescents with psychoses – schizophrenia or bipolar disorders – and male youth offenders who abuse alcohol or drugs, suicide risk is extremely high and persistent. The risk of suicide is elevated in the year or years following the onset of schizophrenia, and bizarre, dramatic suicide attempts may occur. Comorbidity further boosts the risk of suicidal acts and, moreover, makes the suicidality more chronic (see section on ‘Diagnostics’). As mentioned above, the risk is especially high when conduct disorder, depression, and alcohol and drug abuse are combined. The combination of anxiety disorder and depressive illness has been identified as a risk factor for suicidal behaviour among teenagers. Although the diagnosis of ‘personality disorder’ should be used with caution for teenagers, personality structures with pronounced impulsiveness and aggression are important factors to consider in treatment planning.

Care planning after a suicide attempt must be based on a holistic approach. Suicidal adolescents and their families should be offered the kind of psychotherapeutic treatment that is included in all child and adolescent psychiatric care, i.e. treatment addressed at individuals, families and their social networks.

Initially, therapists should focus on clarifying what has happened, reinforcing and developing the patient’s resources and, in every way, facilitating the family’s external situation by, for example, sick leave, certificates, etc (see also the section on ‘Care in the acute crisis’). Patients must be given opportunities to talk about and structure their emotional experiences, as well as access to instructional models for coping with trying emotions and destructive life patterns. The parents need knowledge about how to respond to, support and protect their children. Dysfunctional family patterns and parents’ mental ill-health are other key aspects to consider in treatment of suicidal adolescents.

For many such adolescents and their families, these measures are entirely adequate if suicide risk is low. When suicide risk is judged moderate or
high, however, more specialised care inputs are required. Treatment in these cases often demands combinations of the various options listed in the following overview.

<table>
<thead>
<tr>
<th>Treatment options for various mental states associated with suicide problems</th>
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</table>
| A. Psychotherapeutic treatment | - Psychodynamic treatment options  
- Cognitive Behaviour Therapy (CBT)  
- Interpersonal psychotherapy (IPT)  
- Dialectical behaviour therapy (DBT)  
- Family treatment/family therapy |
| B. Pharmacological treatment |
| C. Treatment for alcohol and drug abuse |
| D. Individual skills training |
| E. Aggression replacement training (ART) |
| F. Health education |
| G. Using the patient’s network/network therapy |
| H. Treatment in another environment |

Therapists should activate support for the family early, and regardless of the form of care chosen, preferably in the acute treatment phase. This should be done by establishing contacts with the patient’s private (family, friends, schoolmates, etc) and professional network (care services, school, social services, etc). These contacts may be helpful later on if, for example, setbacks arise in staff-patient relationships or family members’ help is necessary to motivate the patients for further treatment. It is the patient and the family, after all, who will assume responsibility in the long term. Various network inputs can restore adolescents’ capacity to assume personal responsibility for their situation.

Healthcare staff are sometimes excessively custodial. This may prevent young people from exploring, with the help of their social network, their own alternative solutions to problems. This can in turn contribute to adolescents repeating suicidal behaviour.

Members of the Swedish Association for Suicide Prevention and Support to Survivors of Suicide (SPES) have drawn attention to the importance of the following points:

- Continuity should be as uninterrupted as possible.
- Professional child and adolescent psychiatric assessment should take place promptly.
- Advice for the care staff: use empathy, be humane, provide security and continuity, and generate trust. Approaching the psychiatric care services is a big step for a parent to take, and it is often difficult for family
members to get the gravity of their concern for the child’s affliction confirmed. As one conference delegate put it, ‘A mother who is too understanding gets a negative response.’

- Parents need information and help to make the home environment as supportive as possible and set reasonable limits. They may overestimate their own abilities during the acute stage of the crisis, or react with fear and aggression.

Relatives also pointed out that they did not perceive early involvement on the part of social services as offensive but, rather, as a matter of mobilising ‘all the help available’.

**Treatment of somatic illness**

When somatic illness is present, it should be treated in consultation with the responsible unit in paediatric or primary care services, or other care provider. In the event of alcohol or drug intoxication, detoxification must take place before more long-term psychiatric or psychotherapeutic treatment can begin. In intoxication cases, it is especially important to consider the possibility the patient may have ingested a number of pharmacological or narcotic drugs that boost the toxic effect. Attention should be routinely focused on drugs, such as paracetamol, methanol and psychopharmaceuticals, that can have systemic effects. Although many modern preparations have fewer side-effects than psychopharmaceuticals of longer standing, some individuals may be particularly sensitive to them.

**Treatment of psychiatric illness**

Treatment of psychiatric illness often demands a combination of the methods that follow. In certain cases, therapists must take special measures. Electroconvulsive therapy (ECT) for severe depression is one example.

Long-term psychiatric treatment usually comprises combinations of the various options listed below.

A. Psychotherapeutic treatment

To establish a therapeutic alliance with young people and their families is a condition – although no guarantee – of treatment success. Successful individual psychotherapy must have as its starting point an understanding of the mechanisms that underlie symptoms. Negative thought patterns (cognitive dysfunctions) that govern both feelings and actions, as well as deficiencies in memory function, commonly impede therapy at first. Adolescents’ hopelessness and lack of trust can be further obstacles. See below for information on family therapy and the importance of a supportive family environment.
**Psychodynamic options**

Psychodynamic forms of treatment are of long standing. Their results – as well as the efficacy of such treatment in combating suicidality – are difficult to summarise. Meta-analyses, however, suggest that there are indeed positive effects, and these should not be ignored.

**Cognitive Behaviour Therapy (CBT)**

Cognitive Behaviour Therapy (CBT) is a well-documented form of treatment for a number of conditions that predispose patients for suicidality, including, especially, major depression, dysthymia and panic syndrome. Treatment focuses on the patient’s current psychiatric state and the suicidal notions and self-harming behaviour that have ensued. The principle underlying CBT is that thoughts influence behaviour and feelings, which in turn affect mood.

Key components of treatment include inducing patients, early on, to engage in activities that counteract isolation, and to reconfigure their negative thought patterns that arise automatically or in certain situations. Unsolved problems exacerbate despondency and the sense of powerlessness. Exploring these problems, considering various solutions and trying new approaches based on therapeutic strategies can, step by step, mitigate the patient’s hopelessness and despondency.

**Interpersonal psychotherapy (IPT)**

Interpersonal psychotherapy (IPT) has shown some effect in treating acute, mild and moderate depression in adolescents. For adults, the treatment has also been shown to prevent relapses of illnesses. Like CBT, IPT is transitional and goal-oriented; but IPT focuses on relationships. Interpersonal problems can cause or worsen depressive conditions, which in turn can lead to breakdowns in relationships. Working from ‘the situation here and now,’ IPT employs support, encouragement and instruction to help patients to work through their losses, unresolved grief and life crises. Poor self-esteem, vulnerability and touchiness are other factors that IPT can influence. Patients acquire insights into how their communication patterns work, what is not constructive, and alternative ways to express themselves in relation to others.

Promising results have been noted in studies of adults who received short-term treatment with IPT after attempting suicide.

**Dialectical behaviour therapy (DBT)**

Dialectical behaviour therapy (DBT) has proved effective in the treatment of adults with personality disorders and ‘chronically suicidal’ women (who have made two or more suicide attempts), and is now also being tested for treating adolescents. With roots in many different forms of therapy, DBT aims to help patients compensate for their emotional vulnerability and unstable reaction patterns. It involves a combination of individual therapy and group psychosocial skills training.
Family treatment/family therapy

Socioeconomic difficulties must also be addressed. Therapists should offer help and support so that parents can cope better with their parental roles. Parents need information about youth suicidal behaviour and psychiatric illnesses, and also about how to respond to, support and protect their children. Since parent-child conflicts are extremely common in these families, much hope has been placed in various types of treatment methods involving family therapy. To date, however, follow-up studies of family therapy for teenage suicidality have not indicated any reduced risk of repeated suicide attempts. Nonetheless, family therapy is a valuable tool for improving dysfunctional relationship patterns. A home environment characterised by hostility and alienation greatly influences the course of the suicidal process in teenagers. For this reason, the family must be offered treatment that results in better conflict resolution and greater openness, as well as encouraging warmth and closeness among the family members.

Parents of suicidal adolescents may themselves have affective disorders, be alcohol or drug abusers and/or exhibit antisocial behaviour. Acute dysfunction, such as neglect and physical and sexual abuse, must be considered. An essential part of the care plan is to identify and treat the parents’ own psychiatric disturbances. Follow-up studies have shown this to be an effective measure with respect to adolescents’ future suicide risk.

When working with dysfunctional families, one must always bear in mind the obligation to report cases of child abuse (SOL, Chapter 14, Section 1).

B. Pharmacological treatment

Choice of medication depends on symptoms and comorbidity. Psychopharmaceuticals are appropriate for acute and severe anxiety (anxiolytics are then the drugs of choice), severe depression and chronic anxiety (SSRIs) and bipolar conditions (lithium, valproate). Adolescents with psychotic symptoms and/or disorientation need to be hospitalised, and the primary aim of treatment should be to afford security and restore normal sleep. The main supplementary pharmacological agents for the acute phase are anxiolytics. Treatment with neuroleptics can be started when it is deemed likely to benefit the patient.

It is an advantage to begin pharmacological treatment while the patient remains hospitalised, although this is not always practically possible. Therapists should remember to prescribe drugs in small, iterated packages if the patient is being treated in outpatient care. Alternatively, the patient or a relative can pick up the daily dose at the clinic. All prescriptions require careful third-party supervision so that no overdoses occur, and any side-effects must be reported promptly.

Some patients and family members have unrealistic expectations of the positive effects of medication and the time it usually takes for an effect to be attained. Other adolescents react negatively to having to take pills every
day. Taking medicine may be perceived as final proof that they are ‘abnormal’.

Correct information is vital to maximise the patient’s compliance. Expected effects and side-effects of drugs must be presented in detail to patients and parents alike, orally and preferably also in writing. This information needs to be conveyed in such a way that young people can feel safe and take personal responsibility for reporting side-effects. In this way, there is less risk of patients abruptly ceasing to take – or overdosing – their medication. In particular, therapists must explain the initial effects medicine may have on, for example, sleep and bowel function. Increased anxiety has been reported during the first weeks of treatment with certain SSRI antidepressants. Accordingly, the physician and family members must monitor the patient with particular care during this period. With all pharmacological treatment, teenage girls should be asked when they last menstruated to make sure that they are not pregnant.

If the parents are separated, it is especially important to seek both parents’ consent and inform them both about their child’s pharmacological treatment. Although adolescents have a strong need to function independently of their parents, they nonetheless depend on their support when it comes to taking medication.

C. Treatment for alcohol and drug abuse

Overconsumption or abuse of alcohol and/or drugs is often part of the adolescent suicidal process. Under their influence, judgement and impulse control are impaired. Even a hangover can mean that a person prone to anxiety and depression becomes suicidal.

If alcohol or drugs have been used in connection with the suicide attempt or there is established alcohol or drug abuse, the treatment is commonly impeded. Others may underestimate the seriousness of the situation if the young person’s social adjustment is otherwise good. Accordingly, excessive consumption and/or abuse may be played down and underlying psychiatric diagnoses can be overlooked. It is difficult to treat anxiety and depression successfully if simultaneous alcohol or drug abuse ‘sustains’ the psychiatric problems. If the young person’s cognitive faculties have deteriorated owing to this abuse, treatment methods selected must be adjusted to take this problem into account.

Initial detoxification and treatment for alcohol and drug abuse must be coordinated with other treatment inputs. Collaboration with a ‘detox’ unit and/or the social services is often necessary. Adolescents seldom need pharmacological abstinence treatment during the detox stage, but they invariably require good psychological support and care.

Because abuse of alcohol and drugs inhibits the natural teenage process of emancipation, treatment focusing on the dependence – such as relearning interventions and perhaps aversion therapy – should be combined with
individual and family therapy. Severe abuse problems call for care in a residential treatment centre.

Effective pharmacological methods recently developed for treating alcohol and heroin dependence in adults are not yet in use for treating teenagers.

D. Individual skills training
The goal of this type of training is to give adolescents better control over their life situation. This is accomplished primarily through increased self-esteem and problem-solving abilities, and sound stress management. Healthy interaction with others, particularly parents, plays a vital role in long-term treatment. Therapists should help teenagers to function effectively in everyday life and take responsibility for themselves; support their adjustment to school, friends and adults; and try to discourage truancy and poor school attendance.

E. Aggression Replacement Training (ART)
Aggressive behaviour is a common personality trait in suicidal teenagers, especially boys. ART promotes social skills by means of a behaviour-therapy technique that involves anger regulation in a group.

F. Health education
It is essential for both the patient and the patient’s family to be well-informed about and in agreement over what triggered the suicidal process and any illness that contributed to it. An important part of treatment is learning about one’s individual vulnerability and susceptibility to stressors and lifestyle factors, and also how to influence the suicidal process or prevent relapses. Adolescents commonly experiment with different lifestyles during their teens, with no detailed knowledge of the risks that may accompany such behaviour (see section on ‘Diagnostics’). Good daily routines and meaningful occupations at school or at work are essential to a person’s sense of wellbeing.

G. Using the patient’s network/network therapy
Using the patient’s social network – parents or other persons involved outside the family (to support the patient) – may serve initially as, or is sometimes the only feasible, treatment input. If so, resource persons in the network need continuous support and guidance. Various kinds of network therapy using a multimodal treatment approach should always be considered, and these become essential in cases where young people and/or their parents are non-compliant.

H. Treatment in another environment
Placement in a foster home or residential treatment centre, for the short or long term, must sometimes be considered. This requires careful joint planning with the social services. Moving the patient elsewhere for
treatment is necessary, for example, in cases of severe parental neglect, assault or cruelty.

Basic requirements: protection and care, with therapeutic response and treatment that are part of all child and adolescent psychiatric care. Effective treatment of suicidal behaviour and underlying psychiatric or somatic illness with e.g. Cognitive Behaviour Therapy (CBT), treatment for alcohol and drug abuse, and pharmacotherapy. Treatment that enhances quality of life, such as individual skills training and health education, and also treatment of family dysfunction and parents’ mental ill-health.

Options: interpersonal psychotherapy (IPT); dialectical behaviour therapy (DBT).
ACTIVE FOLLOW-UP

All patients who present after a suicide attempt should be offered treatment according to an individual care plan. This includes ‘active follow-up’, i.e. further efforts aimed at preventing new suicide attempts and completed suicide.

Planning for active follow-up

The risk of new suicidal acts is greatest in the first year after a suicide attempt. A plan for treatment and follow-up – according to a signed contract – should therefore be in effect for one year after the attempt. Adolescents who fail to keep an appointment should be telephoned immediately or otherwise traced, and offered further treatment.

A suicide attempt is often a ‘last resort’, a call for help after a prolonged period of stress. Treatment and follow-up should therefore be planned in consultation with the patient, patient’s family, school, social services and healthcare services. For example, patients and their families should be told that it is important to seek help promptly if severe interpersonal conflicts arise (the family should be offered a ‘green card’, i.e. high priority, for care).

After the first meeting with the patient – regardless of whether it was an emergency visit and resulted in outpatient treatment or hospitalisation – the therapist should get in touch the following day, either by telephone or through a repeat visit. A patient who has been hospitalised should be seen on the first day following discharge.

Continuity

Adolescents who exhibit suicidal behaviour have often had painful experience of losing key people in their lives, which has commonly impaired their trust in adults. Continuity is therefore a cornerstone in all care planning, and should apply both to the choice of administrator/therapist and to the chain of care provided.

From the risk point of view it is therefore vital, in the active follow-up planning, to bear the following points in mind:

• Changing the care provider or therapist should be avoided, since these patients usually lack trust in the adult world. If it is unavoidable, it is vital for the patient to be given a chance to continue seeing the original therapist for the transition period.
• If adolescent suicide attempters are ‘shunted’ from one care provider to another, responsibility for follow-up may be ‘mislaid’, since different providers’ care traditions may vary. On each change of unit administra-
tor or care provider, a special agreement should therefore be reached on who is to be responsible for the active follow-up.

The issue of continuity must also be considered in organisational terms when it comes to support for suicidal patients aged below 25. This means minimising the number of care-provider changes in the transition from child to adult psychiatric care and later.
SUPPORT FOR SURVIVORS FOLLOWING A SUICIDE

Risks among close family members

Suicide and attempted suicide impose severe strains on the family and other intimates. It should be remembered that siblings, friends and fellow patients may repeat such acts. This section mainly discusses the effect a completed suicide may have on others.

The grief that ensues after suicide is extremely oppressive and onerous for those concerned. Sorrow and longing mingle with feelings of guilt and anger in a way that surpasses ‘normal’ grief. This mix of feelings is difficult to handle and endure. Family members sometimes report that support from their social network has been too weak or entirely non-existent, since others have felt insecure in their encounters with the family’s intense feelings. When a child or teenager has committed suicide, the child and adolescent psychiatric clinic should offer the siblings and parents crisis support if the deceased was a patient at the clinic. Family members should be given plenty of time on a number of occasions to consult with the doctor in charge and other staff who helped to care for the deceased. When the teenager was not known to the clinic and where child and adolescent psychiatric resources are lacking, support for the parents should be offered elsewhere.

Support and therapy are vital components of suicide prevention since suicide in a family tends to pave the way for other family members to commit suicidal acts, both during the acute phase and subsequently. The amount and duration of support and counselling needed vary according to individual needs. Children aged below 18 are particularly hard hit by a parent’s suicide. Parents who have lost a child need long-term support. Siblings who lose a brother or a sister have needs that may be overlooked alongside their parents’ grief. One should know that siblings’ reactions may come much later, and that their need for help may then be urgent. If the family rejects help immediately after the death, a health professional should telephone (not write) some time later and ask whether they would now like to meet – saying, for example, ‘I’ve been thinking a lot about you – how are you getting on?’

Risks among vulnerable friends

Vulnerable people close to suicide victims tend to identify with the self-destructive acts committed, especially if they are of the same sex and age. Sometimes a cluster of suicides and suicide attempts arises in school or other settings where adolescents mix (leisure groups, psychiatric inpatient care, etc). Although this phenomenon has roots in both individual personalities and group dynamics, it also indicates a deficient capacity in the community to deal with crises and disasters. Young people need adult
help and guidance to cope with the private, as well as the universal aspects of grief.
STAFF SUPPORT AND TRAINING

Approaches

Regardless of the institution they work in, care staff should have a clear understanding of their own attitudes and values regarding human beings’ responsibility for their own lives, since these attitudes and values greatly influence how they relate to their young patients. Staff should also be well-trained and experienced, present a united front and agree on which approach and treatment programme work best for treating patients with various types of problems.

Teenagers expect as much – or as little – support from the staff as they are used to receiving from the adults in their lives. Sometimes teenagers choose to confide in their friends rather than their parents – and often only their best friends know what they are thinking and feeling deep down inside. In other cases, teenagers feel completely isolated with their troubles and are incapable of communicating with anyone around them. This is why people working in day nurseries, schools, recreation centres, healthcare, law enforcement and other institutions must be attentive to signs that a child, adolescent or young adult does not seem to be doing well. A common knowledge base is needed for people who work in healthcare and various community agencies. Representatives of the various public authorities must develop better channels of communication when it comes to responsibility for our teenagers.

Management attitudes

Inadequate training or supervision of staff can increase the risk of completed suicide. The management at every institution should therefore have sufficient information about their co-workers to be able to assess their need for further training. It is also a management responsibility to ensure that enough time and money are allocated for supervision of all staff categories.

Mutual respect

How the management relate to staff affects, in turn, the staff’s ability to treat patients. Similarly, the ways in which all staff members treat their colleagues will affect their attitudes when they meet the patients. Our views, political stances, experiences and prejudices, as well as our personalities, influence how we view and appraise our colleagues.

The weakest link in an organisation invariably determines whether its performance objectives are met. The management must therefore make sure that everyone working on a ward has good basic training – and is informed of the latest research findings.
If the management do not live up to these objectives, the attention and focus staff should reserve for their patients can easily be shifted into conflicts arising from relationships within the organisation. Patients may experience this as a repetition of their experiences in the home, school environment or other social contexts.

**Specific training programmes**

Staff responsible for supporting and treating suicidal young people should have access to special programmes that contain the following components (according to ‘Support in Suicide Crises’, the Swedish national programme to develop suicide prevention).

- Background and risk factors for suicide attempts and suicides
- Information about suicidal communication and suicide-risk assessment
- Attitudes and ethics
- Consultation methods
- Crisis and conflict intervention
- Diagnosis and treatment of depression and alcohol abuse
- Psychological autopsies
- Information about various treatment methods and their appropriateness
- Treatment, interdisciplinary collaboration and follow-up

There should be training tailored to meet the needs of professional staff categories with direct responsibility for treatment.

**General training programmes**

Anyone who has or may conceivably come into contact with suicidal adolescents should have access to general training programmes developed for various municipal organisations, such as day nurseries, schools, cultural and leisure associations, the social services and other relevant institutions. A common knowledge base should be developed to permit staff working in municipal organisations and in healthcare – as well as the general public – to communicate with one another.

**Crisis support for care staff**

Information about how to support care staff in a crisis should be available on each ward, along with a written plan for how to handle a suicide or suicide attempt on the ward. When such an event occurs, family members must be informed immediately. The head physician should also be notified and a psychological autopsy, i.e. a retrospective review of what happened, carried out. There are a number of methods for accomplishing this. Most importantly, each ward must be prepared to conduct both an ‘emotional’ debriefing – with the aim of providing emotional support to the staff.
members involved, family members and other patients – and a retrospective intellectual summary aimed at enhancing suicide-prevention skills in a hospital or outpatient department.
QUALITY DEVELOPMENT

Every clinic that treats suicidal adolescents needs to design a local care programme for this group of patients. The care programme should include at least some quality indicators for structure, processes and treatment results.

A quality indicator may be deemed to be fulfilled if the clinic corresponds to the base level laid out in these guidelines.

Structural quality indicators

- The clinic has a care programme for suicidal adolescents.
- Inpatient care can be offered whenever it is deemed necessary.
- The clinic has adequate registration of suicide and suicide attempts for its inpatient and outpatient care.
- An outpatient appointment within a week can be offered whenever it is deemed necessary.
- The clinic has sufficiently diversified skills in psychotherapy and family therapy.
- The clinic has in-house expertise in psychopharmacology.
- Staff who treat emergency cases have been trained in suicide-risk assessment.
- Emergency-ward staff are trained in protecting and caring for suicidal patients.
- There is organised collaboration with a child and adolescent medical department, an intensive care ward, an adult psychiatric department, treatment centres for alcohol and drug abuse, the social services, school staff and the police.

Process indicators

- Suicide-risk assessments are documented.
- All patients have been assessed in terms of the diagnoses defined in ICD-10 or DSM-IV. The ICD-10 diagnostic X numbers (certain suicides, i.e. intentionally self-destructive acts: X60-X85) and Y numbers (uncertain suicides, i.e. incidents of self-harm with unclear intentions: Y10-Y34) are entered in the records of all patients admitted to care.
- All suicide-attempt patients treated in outpatient care are registered.
- Individual care plans are drawn up for all suicide-attempt patients, in consultation with the patient and one or both parents, and documented in the patient’s records.
- All adolescents seeking care at the clinic after a suicide attempt or owing to suicide plans are offered appointments on the same day.
• Psychiatric assessment of suicidal adolescents is carried out according to these guidelines.
• Documented follow-up plans are drawn up in consultation with the patients and their families.
• Contacts with school pupil-welfare unit and the social services are established when necessary.

Performance indicators
• Proportion of patients dying from suicide or in other violent circumstances.
• Proportion of patients attempting suicide once or more during the follow-up year.
• Proportion of patients completing agreed treatment during the follow-up year.
• Proportion of patients scoring more than 60 points on the Children’s Global Assessment Scale (CGAS) at the end of the follow-up year.

Suicide-prevention group
A group comprising child and adolescent psychiatrists, psychologists, social workers and care representatives should be established at the clinic:

• The group should develop and be responsible for a locally adapted care programme in accordance with these guidelines.
• The group should function as a knowledge bank and receive continuous supplementary training.
• The group should be responsible for training in its field of knowledge, both internally and outside the clinic.
• The group should keep up to date on current training programmes and research.
• The group should be responsible for following up and evaluating the clinic’s suicide prevention.
TRAINING COURSES AVAILABLE IN SWEDEN

• The Swedish Association for Child and Adolescent Psychiatry arranges courses for resident doctors and advanced training in suicidology and suicide prevention for specialists in child and adolescent psychiatry.

• NASP provides a 200-hour training course in suicidology and suicide prevention for staff in child and adolescent psychiatric care. The course confers 10 credits at Karolinska Institute. The training includes implementing an in-house suicide-prevention development project at the student’s workplace or organisation, as well as conducting retrospective reviews.

• NASP regularly – each spring and autumn – offers a three-day training course in suicide prevention for staff in youth facilities (schools, social services, etc). The course is based on the video documentary ‘Love is the Best Kick’ and the Life Skills programme.
WEB SITES

American Academy of Child and Adolescent Psychiatry
http://www.afsp.orgap.org/

American Association of Suicidology
http://www.suicidology.org/

American Foundation for Suicide Prevention
http://www.acap.org/

American Psychiatric Association
http://www.psych.org/

Global Child Mental Health An international initiative to prevent mental ill-health among children and adolescents, supported by the World Psychiatric Association (WPA), WHO Geneva and the International Association for Children and Adolescent Psychiatry and Allied Professions (IACAPAP) www.globalchildmentalhealth.com


Canadian Association for Suicide Prevention
http://www3.sympatico./masecard/

Centers for Disease Control and Prevention
http://www.aepo-xdv-www.epo.cdc.gov/wonder/prevguid/m0031525/m0031525.htm

National Institute of Mental Health
http://www.nimh.nih.gov/research/suicide.htm

Prevention Yellow Pages
http://www.tyc.state.tx.us/prevention/

The following sites are mainly in Swedish:

Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health http://www.sll.se/suicid or www.ki.se/suicide

Swedish Association for Child and Adolescent Psychiatry (the Swedish Society of Medicine’s Section for Child and Adolescent Psychiatry) http://www.svls.se/sektioner/bup/

Swedish Association for Suicide Prevention and Support to Survivors of Suicide (SPES) http://www.spes.nu

National Helpline emergency service (call 020-220060 in Sweden). The Swedish National Helpline is an emergency telephone service open ever
evening for people suffering from psychological distress. Callers can ring on their own behalf or on that of close friends or relatives. The helpline can also be reached by e-mail: info@nationellahjalpen.a.se. Information (in Swedish) is available at the web site, http://www.nationellahjalplinjen.se
REFERENCES


Definitions
(Swedish National Council for Suicide Prevention, 1995)

Suicidal act
A suicide attempt or suicide.

Suicidal behaviour
Comprehensive term covering suicidal ideation, suicide attempts and suicide.

Suicidal crisis
Crisis during which a person’s available problem-solving methods fail, so that suicide comes to mind and may possibly be planned and carried out.

Suicidal ideation
Fantasies and thoughts about and/or wishes and impulses to commit suicide.

Suicidal persons
Individuals who:

- have recently (within the last six months) attempted suicide,
- have serious suicidal ideation and are judged to be at risk of committing suicide in the near future,
- do not have serious suicidal ideation but are, owing to other circumstances, judged to be at risk of committing suicide.

Suicidality
Attitude characterised by intentions, plans, possible decisions and impulses to commit suicide.

Suicide
A deliberate, self-directed, life-threatening act that results in death.

Suicide attempt (attempted suicide)
Life-threatening or seemingly life-threatening behaviour that is intended to put one’s life in danger or to give the impression of doing so, but does not result in death.

Suicide process
Development from the first serious suicidal thought of a possible suicide attempt to (completed) suicide. This term denotes development over time. It also implies that suicides do not just happen; they always have a history.

Suicide risk
Danger of committing suicide in the near future. This risk is sometimes viewed globally, i.e. over an entire lifespan.
Progressive scale of suicidality

1. Despondency/hopelessness
   - Are you often despondent and sad?
   - Do you usually feel ‘down’?
   - Do you feel that everything is hopeless?
   - Do you believe that things will get better again?

2. Thoughts of death
   - Do you feel that everything is meaningless?
   - Have you thought that it would be a relief to escape from life?

3. Death wishes
   - Have you wished you were dead?
   - Would you like not to have to wake up tomorrow morning?

4. Suicidal ideation
   - Have you thought of doing something to yourself?
   - Have you thought that you could take your own life?
   - Have you thought about how you would do it?

5. Suicidal wishes
   - Have you thought that you’d like to take your own life?
   - Have you come close to taking your own life? I Is there something holding you back?
   - Is there something that tells you to go on living?

6. Suicide attempts
   - Have you ever attempted suicide before?
   - Did you carry out what you were planning to do, or not?
   - What did you do? When? Where? Why?

7. Suicide plans
   - Do you have plans to take your own life?
   - Have you thought about how you would do it?
   - Have you decided when you would do it?

8. Suicide preparations
   - Have you made any preparations? What preparations?
   - Have you got hold of pills? Do you have weapons at home?
   - Have you got hold of other instruments? Rope? A knife?

9. Suicidal intent
   - Have you decided to take your own life?
   - When? Where? How?
   - Have you written a suicide note?
   - Have you got rid of things you don’t want to leave behind?
   - Have you arranged to meet your friends for the last time?
   - Have you arranged to meet your friends for the last time?
# Annex 3

## Clinical assessment of suicidality

Name:  
Swedish Nat. Reg. No.:  

Date of assessment:  
Time  
Unit:  

Assessment situation:  
- Emergency assessment  
- Inpatient Care  
- Outpatient Care  

Assessor:  
Occupation:  

Recent suicide attempt:  
Yes  
No  
Date:  

Prepared for suicide attempt:  
Yes  
No  
Since:  

Planned suicide attempt:  
Yes  
No  
Since:  

Suicidal ideation:  
Yes  
No  
Since:  

Description of the recent suicidal act, if any:  

Assessment according to SIS:  
Points:  
Qualitatively high intention acc. to SIS:  

Description:  

Previous suicide attempts?  
No  
Yes  
Number:  

Description:  

Latest:  
- Week  
- Month  
- Quarter  
- 6 months  
- Year  
- >1 year ago  

### Current mental illness(es):

- Depression  
- Bipolar disorder  
- Conduct disorder/Antisocial behaviour  
- Anxiety disorder  
- Eating disorder  
- Psychosis  
- Alcohol or drug abuse  
- PTSD  
- Other:  

Depression scale  
Points:  

### Other risk factors:

- Suicidal act in close environment  
- Violence in the family  
- Sexual assault  
- Acute social failures  
- Impulsiveness  
- Aggression  
- Propensity for violence  
- Touchiness  
- Low stress tolerance  

Other:  

CGAS, current:  
Highest in past year:  

### Suicide risk:

- Very high  
- High  
- Hard to judge  
- Moderate  
- Minor  

How sure are you of your assessment?  
- Unsure  
- Slightly unsure  
- Sure  
- Very sure
Annex 4

Tools

The following tools may be used:

- BDI (Beck Depression Inventory)
- BHS (Beck Hopelessness Scale)
- CBCL (Child Behaviour Check List)
- CDI (Children’s Depression Scale)
- CES-DC (Center for Epidemiological Studies – Depressive Child)
- CGAS (Children’s Global Assessment Scale)
- DICA (Diagnostic Interview for Children and Adolescents)
- DSRS (Depression Self-Rating Scale)
- KSADS (Schedule for Affective Disorders and Schizophrenia for School-Aged Children (6-18 years old)
- SDQ-B (Strengths and Difficulties Questionnaire for physicians, parents and children; see http://www.sdqinfo.com)

Side-effects of SSRI (selective serotonin reuptake inhibitors)

- SIS (Suicide Intent Scale)
- YSR (Youth Self-Report)

GAF (Global Assessment of Functioning) may be found in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV), American Psychiatric Association.
Published reports

Att satsa på psykisk hälsa – förebygga självmord och självmordsförsök/
To focus on mental health – preventing suicide and suicide attempts

1/95  Självmord i Stockholm 1986-90. Kartläggning av självmorden i Stockholms läns sjukvårdsområden och psykiatriska sektorer
1/97  Självmordspatient på psykiatrisk klinik
2/97  Självmordstankar bland sjuksköterskor i Sverige
1/98  Suicidriskbedömning
1/99  Den första nationella nätverkskonferensen i självmordsprevention
2/99  Future risk after an attempted suicide
1/00  “Kärleken är den bästa kicken”
2/00  Den andra nationella nätverkskonferensen om självmordsprevention
3/00  Att påskynda livets slut. Historik, forskning och aktuell svensk och internationell debatt om eutanasi
4/00  Hasening the end of life. History, research and current Swedish and international debate on the issue of euthanasia
5/00  Literature review: relationship between cholesterol and suicide
1/01  Guidelines for suicide prevention in schools
1/02  Den tredje nationella nätverkskonferensen om självmordsprevention – barn och ungdomar
2/02  Hur upptäcker vi sårbara elever? Utvärdering av en film dokumentär för självmordsprevention bland gymnasieelever
3/02  Det går att leva vidare – en rapport om sorg, när någon som står oss nära tagit sitt liv
4/02  När livet inte längre är värt att leva – berättelser om fyra unga adopterade

Gröna serien/The green series

- Kristeamkris – ett mini-projekt. Debriefing och retrospektiva genomgångar på psykiatrisk öppenvårdsmottagning: Erfarenheter vid implementering
- Könsparadoxen – varför tar dubbelt så många män som kvinnor sina liv, samtidigt som det är flest kvinnor som är deprimerade?
- Suicide among the elderly in Sweden
- Suicide and attempted suicide in Sweden 1989-1998
Riktlinjer/Guidelines
- Assessment and Treatment of Suicidal Children and Adolescents: the Swedish National Guidelines
- Att förebygga självmord och självmordsförsök hos skolelever
- Världshälsoorganisationens stödmateriel för lärare och annan skolpersonal anpassat till svenska förhållanden Riktlinjer
National Centre for Suicide Research and Prevention of Mental Ill-Health
NASP

The Swedish state’s and Stockholm County Council’s central expert unit in suicide research and suicide prevention.

The Centre has national and regional responsibility for accumulating and disseminating knowledge, and for initiating and conducting research and development projects that promote suicide-prevention measures. The Centre’s national responsibility dates from a parliamentary resolution of 1993.

The Centre is a WHO Collaborating Centre for Suicide Research and Prevention of Mental Ill-Health.

Its activities fall into four main categories:
* research and development
* analysis and monitoring of epidemiological data
* information and publicity

Stockholm Center of Public Health
National Institute for Psychosocial Factors and Health - IPM
Karolinska Institutet
WHO Collaborating Centre for Suicide Research and Prevention of Mental Ill-Health