Support in Suicidal Crises

The Swedish national programme to develop suicide prevention
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The National Council for Suicide Prevention

The National Board of Health and Welfare
The National Institute of Public Health
The Centre for Suicide Research and Prevention
Foreword

Some 2,000 inhabitants of Sweden take their own lives each year, and roughly 20,000 make serious suicide attempts. This involves a great deal of personal suffering, for both the individuals concerned and those close to them. It also entails high direct and indirect costs. Suicide and attempted suicide are therefore a substantial public health problem, in Sweden as well as globally.

Declining mortality, especially from infectious illnesses and accidents, has had the effect of making suicide a relatively more prominent cause of death. In some youthful age groups suicide is now the foremost cause of death. The fall in mortality from infectious illnesses and accidents shows that preventive efforts can yield results. These efforts are also the primary means of influencing the suicide rate.

The World Health Organisation (WHO) has long worked for greater emphasis on knowledge of suicide and initiatives in suicide prevention. Objective number 12 in the Health for All in the year 2000 programme involves reversing the rising trends of suicides and suicide attempts in the European region. A WHO meeting in Szeged, Hungary, in 1989 pointed out that this requires national programmes for suicide prevention. These now exist in a number of western countries, including Finland and Norway. Objectives for national programmes of this kind were specified at the UN and WHO conference of experts in Canada in May 1993.

Given this development, the Swedish National Board of Health and Welfare and National Institute of Public Health, in co-operation with the Centre for Suicide Research and Prevention, have deemed it urgent to draw up a Swedish action programme to develop suicide prevention. A National Council for Suicide Prevention was therefore formed, and commenced its work in February 1994. In this publication, the Council gives an account of its view of the nature of suicide problems and its proposals for preventive strategies.

The Council has also compiled the report When Life Feels Hopeless – Support to Suicidal People (in Swedish), which is to be included in the series of informative booklets about ill-health and health issued by the Swedish pharmacies. As part of the Council’s work, Jan Beskow has discussed suicide as an existential problem in his Suicide as Freedom and Compulsion (in Swedish), published in 1994 by the Swedish Association for Mental Health as No. 39 in its monograph series.

This programme is intended to convey information, provide psychosocial support and enhance the quality of care and treatment, thereby achieving further development of inputs already under way and encouraging various organisations to assist in the work of preventing suicide. The programme is aimed at bringing about a better approach to dealing with people with suicide problems, restriction of access to means of suicide and an expansion of research and development work in the field.
The National Institute of Public Health, the Centre for Suicide Research and Prevention and the National Board of Health and Welfare aim to provide joint support for the development of suicide prevention by eg. encouraging educational and development projects.

For the National Council for Suicide Prevention

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Summary

About 2,000 inhabitants of Sweden commit suicide, and some 20,000 attempt it, every year. Since death rates from illnesses and accidents are declining, suicide has become a relatively more prominent cause of death. One of the goals of the WHO Health for All in the Year 2000 programme is to reverse the rising trend of suicide and suicide attempts in the European region.

The National Board of Health and Welfare and the National Institute of Public Health have established a National Council for Suicide Prevention, which began its work in February 1994 in collaboration with the National Centre for Suicide Research and Prevention. This national programme to develop suicide prevention was first published, in Swedish, in September 1995.

OBJECTIVES of suicide prevention in Sweden should be:

- a persistent decrease in the number of suicides and suicide attempts; the elimination, as far as possible, of circumstances conducive to suicides among children and young people;
- early detection and reversal of rising trends of suicide and attempted suicide in risk groups; and
- an increase in public knowledge of suicide, enabling laymen as well as social workers and medical staff to intervene to support suicidal people, and also to support those who experience the suicide or attempted suicide of a relative or close friend.

GUIDELINES. Attitudes towards suicide are divided between treating it as a taboo subject and regarding it as a human right. This programme must be based on scientific knowledge regarding this cultural situation and also on the following guidelines:

- a three-part model of prevention: (1) general suicide prevention, ie, psychological, instructional and social measures to promote health and prevent injuries in general; (2) indirect suicide prevention, ie, identification and treatment of illnesses and social/relational problems in risk groups and risk situations; and (3) direct suicide prevention, aimed at combatting the suicidal process itself, ie, suicidal thoughts, suicide attempts and suicides
- increased knowledge about suicidal behaviour and suicide prevention
- better measures to prevent suicide among risk individuals and those in risk situations
- improved professional expertise in helping people with suicide problems
- broad interdisciplinary and intersectorial collaboration
- systematic evaluation.
STRATEGIES are aimed at:

- **raising consciousness of suicide problems**, by disseminating current knowledge about suicidal behaviour and encouraging discussion of existential issues
- **providing social and medical support and treatment**, by identifying and providing adequate treatment for people with suicide problems, through crisis centres, emergency telephone helplines, health and medical services, and special support for the mentally and physically disabled; this includes eg, further training of primary-care staff in early identification and treatment of suicide crises and depressions
- **helping children and young people**, by teaching and training school-children and students to identify and manage conflicts, crises, depressions and suicide problems, and by observing risk factors and problem signals in families, children and students
- **helping adults**, by observing and offering increased support to people undergoing relational crises and experiencing psychosocial stress at work
- **helping elderly people**, by disseminating knowledge about crisis reactions and working-through, depressions and suicidal behaviour in old age, and paying particular attention to the situation of elderly immigrants
- **helping risk groups**, by providing training in social skills in dealing with alcohol and drug abusers, people infected with HIV or AIDS, victims of violence or narcissistic injury, and immigrants, and reaching an understanding of how conflicts, crises, depression and suicide problems are perceived and coped with by these people
- **providing training and promoting skills development**, ie, training programmes of a general nature for anyone who has come or may come into contact with suicidal people, supplemented by special courses for care services with supportive and treatment functions, and also setting up working groups aimed at developing skills and routines
- **making means of suicide less available**, ie, weapons, prescription drugs and in the transport environment
- **enhancing national knowledge of suicidology**, by further developing the Centre for Suicide Research and Prevention, and effective epidemiological monitoring
- **amending laws and regulations where necessary.**

The Institute for Public Health, the Board of Health and Welfare and the Centre for Suicide Research and Prevention have resolved to jointly support the future development of suicide prevention, eg, by encouraging training and development projects.
Definitions

ANALYSIS OF SUICIDAL PROCESS. Description and assessment of factors affecting the development of a suicidal process. This may be an assessment of (acute) suicide risk, a more systematic analysis during a more latent phase or a retrospective review following a suicide or suicide attempt.

ASSESSMENT OF SUICIDE RISK. Analysis of a suicidal process focusing on the risk of an individual committing suicide in the near future. This may sometimes relate to the risk in general, ie, on a lifetime basis.

THOUGHTS ABOUT DEATH, DEATH WISHES. Entertaining thoughts or wishes about getting away, ending it all or dying as a result of eg, an illness or accident.

EPIDEMIOLOGY. The study of the demographic incidence of illnesses or accidents and their dependence on eg, gender, age and other circumstances of importance for prevention and treatment.

UNVERIFIED SUICIDES. Deaths regarding which there is doubt as to whether the outcome was intentional or not.

MENTAL CRISIS. Overwhelming strains causing a breakdown in a person’s usual problem-solving methods, so that (s)he has difficulty in coping with the situation. Feelings of anxiety, depression, despair and helplessness are common. Desperate acts are sometimes resorted to.

MENTAL DISTURBANCE. Disturbance of mental functions. The notion is somewhat broader than that of mental illness, and takes into account biological, psychological and social factors.

RETROSPECTIVE REVIEW. An attempt, after the occurrence of suicide or attempted suicide, to reconstruct the suicidal process that led up to the act. The purpose is to gain increased knowledge as a basis for efforts to prevent suicide, but also to enable the people involved to understand and emotionally work through what has happened.

SELF-DESTRUCTIVE BEHAVIOUR. A collective term for acts entailing injury, or the risk of injury, to the individual concerned, such as uncontrolled drinking, burning oneself with cigarettes, cutting off body parts or carrying out suicidal acts.
SELF-INFLICTED INJURY. The injurious effect of suicide and attempted suicide. This includes injuries resulting from self-destructive acts carried out without the intention of dying.

SUICIDE. A deliberate, wilful, self-inflicted and life-threatening act resulting in death.

SUICIDAL TENDENCY. An attitude characterised by intentions, plans possible decisions and impulses to commit suicide.

SUICIDAL BEHAVIOUR. A comprehensive term denoting suicidal thoughts, suicide attempts and completed suicides.

ATTEMPTED SUICIDE/SUICIDE ATTEMPT (PARASUICIDE). Life-threatening or apparently life-threatening behaviour intended to endanger one’s life or give the impression of such an intention, but not resulting death.

SUICIDAL ACT. Attempted suicide or suicide.

SUICIDAL CRISIS. Crisis during which a the problem-solving methods available to a person fail, so that the option of suicide comes to the fore and may possibly be planned and implemented.

SUICIDAL COMMUNICATION (SUICIDAL SIGNAL). A conscious or unconscious manifestation of suicidal tendency. Such communication must be seen in its context if it is to be interpreted as such. Sometimes this is not possible until after the event. Sometimes such signals are extremely clear, as in suicide threats. The following are some examples of suicidal communication:

  Indirect non-verbal, eg, planning a will and funeral, giving away mementoes.

  Indirect verbal, eg, remarks like “Farewell, perhaps we won’t meet again.” Unwarranted references to death and suicide, eg, “Do you remember that man who killed himself when we were children?” or “It’s not surprising that lots of people commit suicide, the way the world is these days.”

  Direct verbal, eg, “If you leave me, I’ll kill myself.”

  Direct non-verbal, eg, collecting tablets, obtaining firearms or driving round with a vacuum-cleaner tube in the car.
SUICIDAL PEOPLE. People who
- have recently (within the past year) attempted suicide
- have serious thoughts about suicide, and who are deemed to be at risk in the immediate future
- without having serious thoughts about suicide, are otherwise deemed to be in the risk zone for suicide.

SUICIDE PREVENTION. Measures to prevent suicidal acts.


Indirect suicide prevention. Measures of suicide prevention aimed at underlying problems, such as mental disturbances, substance abuse, physical illnesses, sudden life crises or cumulative life problems. Environmental intervention against the incidence and ready availability of means of suicide.

General suicide prevention. Supportive measures (psychological, instructional, social) aimed at boosting people’s capacity to cope with life crises. Measures aimed at general prevention and mitigation of injuries.

SUICIDAL PROCESS. Development from the first serious thought about suicide to suicide attempts, if any, and (completed) suicide. The term emphasises development over time. It also suggests that suicide does not just happen – it always has a history.

SUICIDE RISK. The risk of committing suicide in the near future. Sometimes the term refers to a person’s risk in general, ie, on a lifetime basis.

SUICIDAL SITUATION. A situation involving elevated risk of a suicidal act, eg, when a person who has previously shown a suicidal tendency has a true depression or strongly perceived narcissistic injury.

SUICIDE RATE. The number of suicides per 100,000 inhabitants per annum. It may refer to the whole population or specifically to certain gender/age groups. The figure is used to eliminate the impact of changes in population size and composition in comparisons over time between different populations or demographic groups.

SUICIDAL THOUGHTS. Fantasies, thoughts, wishes and impulses to commit suicide. These may develop into intentions, plans and possibly decisions.
SUICIDOCENIC FACTOR. A factor that, for a particular person, exacerbates the risk of suicidal acts, eg, deep depression, acute influence of alcohol or the threat of divorce/separation.

SUICIDOLOGY. The study of suicidal thoughts, attempted suicide, suicide and suicide prevention.

SUICIDE-PREVENTING FACTOR. A factor that, for a particular person, reduces the risk of suicidal acts, eg, hope of a solution to a threatening problem, personal support during a divorce or separation, or antidepressive treatment of a depressive illness.

OVERDOSE. Ingestion of more than the prescribed dose of eg, sleeping pills.
Objectives

Objectives of suicide prevention in Sweden

To bring about a lasting reduction in the numbers of suicides and suicide attempts.

In addition, as far as possible, to eliminate circumstances that may result in children and young people taking their own lives.

To detect at an early stage, and try to arrest, the rising trends of suicides and suicide attempts in vulnerable groups.

To raise the general level of knowledge about suicide, so that human fellowship and social measures provide support for people with suicidal thoughts or experiences of suicide and attempted suicide among relatives and close friends.
In the 16th century, murder and manslaughter were much more prevalent than they are now (see Fig. 1), while suicide was unusual. During the 18th century, a change took place: suicide overtook murder and manslaughter as a cause of death. The same applies today. In Sweden, as elsewhere in the West, there has been a shift since the 16th century from outwardly directed violence, in the form of murder and manslaughter, to inwardly directed violence in the form of suicide. Outwardly directed violence is still common in populations living under heavy pressure. Our task now is to attempt to reduce inwardly directed violence as well.

The number of inhabitants and, accordingly, also the number of suicides have risen in Sweden over the past few centuries. The suicide rate, ie, the number of suicides per 100,000 inhabitants, rose above all in the 18th century and the second half of the 19th century (see Fig. 2). During the 20th century the rise has been fairly small, and mainly among women. During both world wars the suicide rate fell, but began rising again afterwards. Since 1970 it has fallen slightly; see Figure 3. The former substantial difference between major cities and the countryside has become somewhat less marked.
Every year, roughly 2,000 inhabitants of Sweden commit suicide, 20,000 make suicide attempts and 200,000 have serious thoughts of suicide. The ratio of suicides to attempted suicides and serious suicidal thoughts is thus approximately 1:10:100. Most suicidal processes subside; this happens both spontaneously and as a result of emergency interventions by other people followed by measures to deal with underlying causes.

Of those who commit suicide, one-third have previously made one or more suicide attempts. Including these, roughly two-thirds have consciously or unconsciously announced their intentions in one way or another. About one-third leave a (usually brief) letter of farewell. Thus, most people who commit suicide have not previously attempted it.

Of those who make serious suicide attempts, 10–15% die from suicide sooner or later. The saying that one can never stop anyone once (s)he has resolved to commit suicide is therefore untrue. Many people find other solutions to their life problems after one or a few suicide attempts.

Suicidal thoughts are not normal in the sense that all survey respondents have had them. Clearly, interviewees are capable of distinguishing between thinking about suicide in general terms and experiencing suicidal thoughts as a personal and pressing problem. In questionnaire surveys carried out in Sweden, the self-reported lifetime incidence of attempted suicide is around...
Figure 3: Suicides (verified and unverified) in Sweden in 1970-93, by gender and age group

Unverified suicides are deaths for which it is uncertain whether the death was caused intentionally or not. The overwhelming proportion of these have been considered as suicides.

2.5%, and the one-year incidence approximately 0.5%. In these surveys, 30% of respondents have stated that they have had suicidal thoughts at one time, and 10% that they have had them in the past year.

Disparities between suicide rates in different countries are substantial. In countries dominated by religion, the suicide rate is often low. At the same time, statistics on causes of death are often of poor quality; but this only partially explains the differences. In some countries, suicide rates have risen dramatically in conjunction with the collision of an older culture with the industrialised, liberated West. There are therefore good reasons to believe that suicide rates are affected by cultural and social factors.

Gender and age differences

Suicide patterns differ between the sexes. Men commit most suicides – often using active methods, such as hanging and shooting. They abuse alcohol more often, but make fewer suicide attempts, and have serious thoughts of suicide less often, than women. Women’s suicides occur more often as a result of poisoning. Women make more suicide attempts, report suicidal thoughts more often and suffer from depressions more frequently than men. However, in the past few decades a levelling-out has been taking place, in the sense that men also increasingly use prescription-drug poisoning as a means of suicide, while women are increasingly starting to use such methods as hanging and car-exhaust poisoning. Simultaneously, the number of suicide attempts among men is on the rise. These differences are in keeping with well-known gender differences: women are, for example, more oriented towards relationships and find talking about their problems easier, while men are more action-oriented. Since culturally conditioned differences between the sexes (gender differences) have decreased over the past few decades, differences in suicide patterns have also been partially ironed out. Differences in types of means of suicide that are most accessible to men and women also have an influence.

Around five people under 15 commit suicide in Sweden each year (see Table 1, page XX). However, the incidence then rises. It reaches a peak in middle and old age – the latter above all among elderly men who, on the other hand, make fewer suicide attempts. From the 1950s to the 1970s, the number of suicides among young men increased. A certain decrease among middle-aged and elderly men, in particular, is now observable.

Over the past few decades, suicidal thoughts and suicide attempts have been increasing. The latter are most prevalent in the 15–24 age group in women and the 25–34 age group in men. Of schoolchildren aged 16–17, roughly 4% of the boys and 9% of the girls state that they have attempted suicide at one time.
Table 1. Average annual numbers of verified and unverified suicides in the 10-29 age group in Sweden, 1970-93

<table>
<thead>
<tr>
<th>Age</th>
<th>Verified suicides</th>
<th>Unverified suicides</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>15-19</td>
<td>40</td>
<td>13</td>
<td>53</td>
</tr>
<tr>
<td>20-24</td>
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</tr>
<tr>
<td>25-29</td>
<td>127</td>
<td>38</td>
<td>165</td>
</tr>
<tr>
<td>10-29</td>
<td>275</td>
<td>82</td>
<td>357</td>
</tr>
</tbody>
</table>

Unverified suicides are deaths concerning which there is doubt as to whether the death was caused intentionally or not. The overwhelming share of these have been deemed to be suicides.

Source: statistics on causes of death issued by the National Board of Health and Welfare, revised by the Centre for Suicide Research and Prevention.

Background factors

In almost all cases, what underlies suicide is a mental disturbance – above all depressions, but also severe mental disturbances (psychoses), especially schizophrenia. In 10-15% of cases there are profound crisis reactions. Mortality from suicide among the mentally ill is many times higher than in the normal population. Personality disorders and various forms of substance abuse are also common background factors. Those who commit suicide during a depression are almost all untreated or inadequately treated. There are often several concomitant background factors, such as relationship problems, perceptions of narcissistic injury, social and financial problems and physical illness.

Of those who attempt suicide, roughly one-third are suffering from long-term mental disturbances, one-third are subject to transient disturbances and one-third are mentally healthy. Here, too, the above-mentioned background factors are highly important.

Relatively few of those who report that they have suicidal thoughts are mentally ill. However, many complain of other ailments, such as malaise, physical and mental fatigue and also psychological and somatic symptoms. Thus, suicide attempts and suicidal thoughts are important warning signs of psychosocial environmental problems.
Summary

Suicide varies geographically and over time in a manner that suggests the influence of cultural and social factors. However, it is difficult to forecast future development on the basis of these factors. This applies both to the suicide rate in the population and to individual suicides.

In the population there is – rather than a small number of suicidal processes that inexorably propel certain people towards death – a fairly large group of people with more or less serious suicidal thoughts who, in situations of particular pressure, may explode into a suicidal act. Only a minority of these actually commit suicide. The epidemiology for suicidal behaviour, with many risk situations in relation to relatively few personal injuries and even fewer deaths, resembles the epidemiology for road accidents. Like accidents, suicidal behaviour may have many causes, which can be tackled at various levels.
Suicide prevention

Declining mortality due to such causes as infectious diseases and accidents at work and on the road has made suicide a relatively more significant cause of death. In the 15–45 age group, for example, suicide is currently the most common single cause of death. The same applies if one measures the number of years lost up to the age of 65.

Work-related deaths have, in the past 40 years, fallen from roughly 500 to 100 cases annually. In a somewhat shorter period, the number of deaths from road accidents has been roughly halved and is now between 600 and 800 p.a. Both this and the declining figures for illnesses show that preventive work can yield good results.

The methods that have been most successful in the workplace and transport sectors have been passive methods, ie, those that exert a general effect and are not dependent on the individual’s active decision in each particular case. Such methods relate to the design of vehicles, the transport environment, work tools and measures restricting exposure both to the risk of harmful occurrences and to the consequences of injury. There is therefore reason to try similar injury-reducing methods in suicide prevention as well.

The World Health Organization (WHO) has long encouraged the development of knowledge about suicide and initiatives for suicide prevention. Objective 12 in “Health for All in the year 2000” is for the rising trend of suicides and suicide attempts to be reversed in the European region. At a meeting in Szeged, Hungary, in 1989, it was stated that national programmes for suicide prevention were now called for. These now exist in a number of western countries, including Finland and Norway. Objectives for such national programmes were specified in the UN and WHO expert conference in May 1993.

One task that broadly based suicide prevention must perform is to make people more aware of the role of suicidal thoughts and acts in suicide crises, mental disturbances and other problems, and also to promote attitudes and techniques that can prevent suicide. Suicide risk is often identified and the initial preventive measures are often taken in private life or at work, in the interplay between two people or in a group setting. However, various forms of social support—from training provided in advance to various forms of care input—are also needed.
Suicide, attempted suicide and suicidal thoughts have been subject to powerful religious and legal sanctions for 1,500 years. Since the end of the 17th century, a gradual liberalisation has taken place. In 1864 suicidal acts ceased to be criminal, and in 1909 the last religious sanctions were removed. Voices now raised also advocate that suicide be not only exempt from punishment but also a human right. However, this opinion has received no widespread support, either in Sweden or internationally.

Questions of death and suicide are shrouded in fear, partly because of our natural protective instinct. All cultures establish systems of notions and rites as protection against this fear of death. In our culture, however, traditional cultural and religious ideas about death and suicide have been weakened. Society has evolved towards increased individualisation and ideological disarray. Personal experience of dying people and animals has become rarer. Suffering and death that are impossible for the individual to influence, on the other hand, occur frequently on television and in other mass media.

Acquiring an ever better understanding of the conditions of life and death is an important element in human maturation. It includes understanding of the nature of suicide as, for example, something that brings one's own life into question. More than in the past, it is now up to every human being to make personal decisions about issues of the meaning of life, and accordingly also about death and suicide, and in this endeavour to derive as much benefit as possible from the ambient culture and the experience of previous generations.

Ambivalence towards suicide and suicide prevention

This situation has, however, resulted in an ambivalence towards suicide and suicide prevention. Suicide is deemed both wretched and noble, cowardly and brave, a desperate cry for help and a philosophical statement. Efforts to prevent suicide are seen as a self-evident response to major help needs, but at the same time as an infringement of personal integrity.

The language available to describe suicide-related problems is underdeveloped. Acts of a disparate nature are classified under the same term. Thus, a Buddhist monk's interrupted attempt to burn himself to death as a means of exerting political pressure, on the one hand, and an attempt by a Swedish teenager to gain “time out” with a double dose of sleeping-pills, on the other, are both defined as suicide attempts. In contrast, when it comes to killing other people there are a whole series of concepts, such as murder, manslaughter, grievous bodily harm or assault with a fatal outcome, accident, death penalty, act of war, etc. Each of these arouses distinctive ideas and preparedness for action.
Thoughts about suicide differ in significance for a person who is far from committing such an act and one who is on the brink. Normally, the healthy person does not think about suicide at all. If ever (s)he does so, it may – for some – represent the possibility of opting out if life becomes too much of a burden, ie, a matter of control and freedom. Suicide is then one of many conceivable ways out. The person close to suicide, on the other hand, is usually plagued by anguish, depression, conflicts and loneliness. For that person suicide is, rather, something he or she feels compelled towards because there seems to be no other solution.

Suicide is often seen as a specific problem, unconnected with kindred problem areas such as mental illness, abuse, relational problems and accumulated life problems. Added to this attitude is often a general feeling that it is such a complex matter that nothing can be done about it – an opinion that is in sharp contrast to experience in psychiatric care, for example. This is a common attitude both in healthy people, with their often more problem-free attitude towards suicide, and in people contemplating suicide, in their situation of compulsion.
Thinking about death, and about suicide as an option, is part of the human habit of reflection about one’s own existence. Such thoughts arouse profound questions about the meaning of life, as a basis for one’s attitude towards life, way of living and lifestyle.

When human beings encounter resistance or unexpected losses, their normal adjustment mechanisms are subjected to strains and may give rise to a crisis. In relatively few cases, and especially if the crisis deepens into a mental disturbance, this may be complicated by serious thoughts of suicide. In a full-blown suicidal crisis, thoughts may take a pathological turn. Conversely, a person who is mentally disturbed may have greater difficulties in coping with various life crises. Efforts to prevent suicide are one way of providing help in situations that endanger life.

A Swedish action programme for suicide prevention should be drawn up on the basis of scientific knowledge and with reference to the cultural situation outlined above. It should be based on the following guidelines.

Three-part prevention model
Suicide-prevention work should take place at three levels:

- **General suicide prevention**, ie, supportive measures (psychological, educational, social) aimed at enhancing people’s capacity for influencing their own lives and, accordingly, also their ability to cope with life crises and suicide problems. This also includes measures that generally prevent and alleviate injury.

- **Indirect suicide prevention**, intended to reduce the number of suicidal acts in risk groups and in risk situations, by measures focused on background factors. These also include environmental interventions with a general effect against the incidence and availability of means of suicide.

- **Direct suicide prevention**, directed at the suicidal process, ie, suicidal thoughts, suicide attempts and suicide. This also includes individually effective environmental interventions against the incidence and ready availability of means of suicide.

Increased knowledge
The work of suicide prevention involves disseminating knowledge of the role of suicide in efforts to work out one’s own attitude to life, in suicidal crises and in mental disturbance. The intention is thereby to pave the way for attitudes that prevent suicide.

Present knowledge of suicide problems must, first of all, be spread to broader groups. In the long term, additional knowledge must be obtained
through the development of interdisciplinary suicide research from the perspectives of epidemiology, medicine, the natural sciences, behavioural science, social sciences, the humanities and religion. This knowledge should serve, for example, to stimulate language development and ethical discussion.

**Better preventive measures for risk groups and in risk situations**

One precondition of prevention is increased knowledge of risk groups, such as the mentally ill and substance abusers; of situations that may precipitate suicidal acts, such as losses and narcissistic injuries; and of suicidal communications, ie, various ways of consciously or unconsciously communicating suicidal intentions to others.

**Improved professional expertise in helping people with suicide problems**

All those who are occupationally involved in health and medical care, emergency and social services, the practice of religion and work with children and young people are affected by problems of suicide and its prevention. It may be a matter of giving support to people with suicidal thoughts or after suicide attempts, either directly to those people themselves or indirectly, through family members or friends. This requires a basic capacity to understand and deal with people on the brink of suicide and suffering from mental disturbances, and also a knowledge of which opportunities for help exist.

**Broad interdisciplinary and intersectorial co-operation**

Purposeful and effective suicide prevention means seeing suicide problems not as isolated problems but, rather, relating them to kindred problem areas, such as issues of attitudes towards life, mental disturbance, substance abuse, unfavourable social conditions, accidents and violence. Suicide prevention requires broad intersectorial co-operation and collaboration between local, regional and national agents.

Approaches must be differentiated. Various types of prevention must interact and include individuals, families, workplaces and organisations.

The National Institute of Public Health, the Centre for Suicide Research and Prevention and the National Board of Health and Welfare aim to stimulate, support and spread local initiatives in co-operation with public
authorities, municipalities, county councils and other organisations, and also with voluntary and religious movements and associations.

**Systematic evaluation**

Target-oriented work requires evaluation and follow-up. Projects within the framework of suicide prevention must be evaluated with respect to both processes and effects. This means that evaluation methods must be developed.
Knowledge and attitudes that promote suicide prevention

1. TALKING ABOUT DEATH AND SUICIDE. Being able to talk about death and understand existential issues, i.e., questions relating to life and death, gives life a deeper dimension. It is also a precondition for an ability to talk about suicide. Developing one's capacity in this area is a way of preparing oneself to tackle one's own and other people's problems in life when they crop up.

2. THE TERM "SUICIDE" HAS DIFFERENT MEANINGS IN DIFFERENT LIFE SITUATIONS. A healthy person, remote from suicide, fairly seldom thinks about death and suicide. For some people who do, "suicide" means an additional possibility of control, and the freedom to put an end to painful situations. Suicide is then one of many conceivable ways out.

A suicidal person is in a completely different situation. (s)he is often tormented by numerous problems. Suicidal thoughts are a signal that there is a threat of breakdown. They should lead to increased activity on the part of both the person concerned and those close to him or her, for the purpose of finding a solution to the problems. If this does not succeed, suicide may be perceived as the only way out—a compulsion, that (s)he finally has difficulty in resisting.

3. THE SUICIDAL PROCESS—A THOUGHT DEVELOPS INTO AN ACT. Suicide is an act. It may be weighed carefully over a long period (philosophical suicide). If realised, this is often under the impact of increased pressure and heavier strains on close relationships during a depression, and often also under the influence of alcohol or drugs (chaotic suicide). The act then appears to be more of an occurrence, a mental accident.

4. THERE IS NO INEVITABLE DESTINY. Suicidal impulses may be perceived as impossible to evade. Nonetheless, they are usually more or less transient. Once the suicidal crisis is over, new opportunities often appear. Human beings have great vitality and a considerable capacity to find new paths.

5. SUICIDAL ACTS CAN BE PREVENTED. The chance to confide in someone who understands, to obtain support in handling difficult situations, to be put in touch with a person who can provide further help, such as diagnosis and treatment of mental disturbance, and to be prevented from gaining access to means of suicide—these are various ways in which suicidal acts may possibly be prevented.

6. HELP IS AVAILABLE. Knowledge of suicide problems and their links with underlying factors is constantly accumulating. Today, help of many kinds is available, for numerous different kinds of underlying problem.
Strategies

Suicide prevention is long-term work. Below, various measures are reported that can further develop the inputs that are already under way at present in the area.

**Raised consciousness**

In the long term we need a more thoroughly worked-out and generally accepted view of suicide problems. This view must be based on both Swedish cultural traditions and modern research. The contradiction between regarding suicide as a taboo topic of conversation and simultaneously as an act everyone is entitled to commit must be resolved, since it gives rise to unnecessary anxiety.

Dialogues on existential issues, especially death and suicide, are important to help people find a foothold in a rapidly changing world.

To be fully utilised, the knowledge that already exists in suicidology, psychiatry, crisis support and conflict-solving strategy, and also knowledge of the kind of help that is needed and where it is available, must be disseminated.

A certain degree of caution is, however, advisable. Increased awareness in an area that is emotionally charged but, in terms of knowledge, underdeveloped may have both negative and positive effects. Inappropriate mass-media presentation of suicidal acts and even unsuitably designed media training in suicide prevention have proved capable of inducing people to commit suicidal acts.

This experience must not prevent the development of balanced suicide-prevention work. On the contrary, we would like to see greater openness, but at the same time a greater depth in discussions of suicide problems. This can be effected by breaking the isolation of suicide problems and placing them in various contexts instead. These contexts are both general human ones (humanism, view of life, religion, existential issues) and specific ones (suicide crises and mental disturbance).

**Tasks**

**Providing information**

Regularly summarising the situation in suicide prevention, specifying new knowledge requirements and drawing up guidelines for future development.

Compiling information material. Stimulating other agents’ production and dissemination of information about suicide problems and suicide prevention.

Analysing the effects of the dissemination of knowledge on frequencies of suicide and attempted suicide, and especially the role of the mass media in suicide prevention.
Documenting basic knowledge of how suicide problems and suicide prevention should be presented for the purpose of optimising its health-promoting impact and preventing undesired effects.

**Stimulating conversations about existential issues**

Encouraging and developing people's ability to discuss existential issues, especially our attitude towards death and view of suicidal behaviour and suicide prevention.

Striving to bring about more open information and discussion in literature and the media, and at various meetings relating to such issues.

**Support and treatment**

Efforts to prevent suicide are initiated first of all when mental crises have deepened into suicidal crises. It is then a question of the *interplay between two people*, often within the family or at the workplace. Both the person with suicide problems and the discussion partner need support. This can be given by other people in their lives, such as relatives, friends, foremen or supervisors, personnel managers, care staff, etc. and by specialised organisations, such as emergency telephone helplines, crisis centres and care-providing bodies.

Shared awareness of suicide problems is an important basis for understanding and co-operation between different help bodies. It makes a firm foundation for the work of suicide prevention, and can therefore give both security and valuable help.

Treatment and care of suicidal patients in the *health and medical care services* should be conducted with reference to both general human aspects, as well as biological, psychological and social ones. This means early diagnosis and adequate treatment and follow-up, but also guidance and participation in networks surrounding people contemplating suicide. There must be ample resources enabling the patient to be well looked after, both at the emergency stage after a suicide attempt and during continued care.

The range of care available should include resources for pharmacological treatment, psychotherapy and social rehabilitation. Steps must be taken to combat loneliness, which appears to be the most burdensome form of social pressure. People whose life situation is successively deteriorating should be given particular attention.

Treatment of *suicidal mentally and physically disabled people* must be fulfilled with such measures as assistance to patients in their housing situation.

**Tasks**

**Project development and supervision**

Devising and issuing educational material.
Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.

The supervisory work of the National Board of Health and Welfare.

Crisis management
Education and training in crisis and conflict strategies, care on an individual and organisational basis of people who have suffered losses and disasters, early detection and assistance of suicidal people, recognition of mental disturbance and knowledge of help options. Suicide prevention as part of normal staff-policy work at workplaces.

Developing support for relatives and other helpers who are trying to help a suicidal person, and also for survivors – individually and in groups.

Health and medical care services
Every suicidal person who seeks help must be investigated and adequate support and treatment arranged.

Developing quality criteria for good health and medical care of patients close to suicide.

Developing care programmes for one’s own clinic, hospital and health-care area. One approach may be to introduce “suicide teams” who monitor progress in terms of knowledge, support knowledge transfer and guidance, and also propose successively improved routines.

Paying particular attention to needs of effective treatment and suicide prevention in the groups of mentally disturbed people where suicide is most common: depressions, psychoses (especially schizophrenia), substance abuse and personality disorders.

Continued training of staff in primary care in the early identification and treatment of suicidal crises and mental disturbances, especially depressions.

Developing outreach activities to contact and support suicidal people.

Striving for continuity in care.

Providing support for children in families with suicide problems.

Counselling for relatives and survivors.

Children and young people
Secure self-esteem, as a basis for mental health, is a suicide-preventing factor. Stable contacts with adults during the childhood years are an important prerequisite of healthy development. This requires particular care at a time of fragmented forms of cohabitation.

In present-day society, with its rapid changes, stringent requirements are imposed on the adaptive capacity of children and young people. At an early stage, they therefore need interests through which they can come into contact with other groups of people. Activity and relationships provide context and purpose.
During their childhood and school years, children and young people need to learn to cope with crises and conflicts and to master their own tendencies towards depression, substance abuse, violence and suicidal tendencies.

Schoolchildren and students in crisis, subject to excessive strains, who have developed depressions and suicidal behaviour must be promptly identified and receive help. Destructive family situations must be detected, and the families concerned given support. Here, the health and medical care services, as well as the social services, can make important contributions.

Tasks

Project development and supervision
Devising and issuing educational material.
Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.
The supervisory work of the National Board of Health and Welfare.

Education
Providing education and training in identification and handling of conflicts, crises, depressions and suicide problems.
Detecting signals and risk signals among schoolchildren and students, such as suicidal communications and suicide attempts, truancy or other frequent absence, tiredness, aggression, bullying, isolation, substance abuse, acting-out and asocial behaviour.
Detecting elevated risk of suicidal acts after a suicide or suicide attempt has taken place.
Taking into consideration risks associated with transition between different stages, eg, in the first year of higher education.
Developing welfare and health services for schoolchildren and students.

Health and medical care services, social work
Paying attention to risk factors in the environment in which children grow up.
Listening to children’s signals about disturbed home circumstances.
Development of skills in discussion of existential issues, crisis and conflict management and also suicide problems.
Increased inputs in the reception of and support for risk families, such as those with a history of suicide, attempted suicide or other self-destructive tendencies, alcohol and drug abuse, mental illness, assault and emotional inadequacy in the family. Paying particular attention to the problems of single people and immigrants.
Staff-welfare measures for the purpose of support, but also to improve expertise in handling crises and conflicts.
Developing co-operation between different organisations.
Adults

Three important areas for people's health and sense of satisfaction in life are their social network/living environment, work/leisure and capacity to see purpose and coherence in their existence.

**Social network and living environment**

The social network is the immediate environment, formal and informal, in which the individual moves and that can provide both material and emotional support, thereby considerably strengthening one's capacity to surmount problems even in highly unfavourable situations. Poor living environments often contribute to a lower quality of social networks.

The individualisation and mobility of modern society result in major strains on one's needs to feel continuity and security. Attitudes towards forms of cohabitation are constantly changing. Individuals need understanding of how much their own problems are personal and how much they are due to external factors.

*Relationship crises* in the form of threatened or actual divorce/separation and successively increasing loneliness are two important background factors in the development of suicide problems, especially among people with weak resources who have many problems in other areas as well.

**Work and leisure**

Apart from providing an income, work has positive social effects. Activation, with moderate stress and diurnal rhythm, helps to promote people's mental well-being. The lack of a meaningful occupation may give rise to perceptions of emptiness and existential anxiety. Difficulties in satisfying one's needs within the family are often accompanied by high expectations of compensation at work. However, the scope for satisfying personal social needs is often limited in the job setting, which is increasingly characterised by individualisation, increased efficiency and rapid changes.

Great care needs to be devoted to the *psychosocial working environment*. More than in the past, attention must be paid to conflicts, crises and suicide problems. Self-employed people or those who, owing to the content of their jobs, 'feel isolated and at the same time subjected to pressures tend to incur particular problems. The psychological strains ensuing from *unemployment* are an important factor to consider.

**Perception of context and purpose**

Human beings are bearers of culture. We gain our cultural identity by establishing and transferring norms, values and patterns of life. It is this
identity that gives our existence context and purpose. The cultural clashes and rapid changes of modern society make it difficult for individuals to resolve their own lives. More time and attention than before must therefore be devoted to the importance of individual and groups' psychological development.

**Tasks**

**Project development and supervision**
Devising and issuing educational material.
- Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.
- The supervisory work of the National Board of Health and Welfare.

**Marital and relational problems**
Enhancing expertise in dealing with marital and relational problems.
- Contributing to people’s personal maturity by creating groups for caring discussions concerning family and society.
- Enhancing understanding of and support for people who are threatened by or who face relationship crises and successively increasing loneliness.
- Developing knowledge of crisis reactions and coping with crises, depressions and suicidal behaviour in adults.

**Companies and workplaces**
Bringing to the fore issues relating to social development and the development of one’s own workplace, and of the importance of these issues for individuals' capacity to feel self-confidence and perceive purpose and context.
- Paying attention to structural problems at the workplace that create anxiety and, in sensitive individuals, may cause mental disturbances and suicidal crises.
- Establishing routines for providing support, both individually and through discussion groups, relating to acute problems that arise at the workplace, such as shutdowns, cutbacks and reorganisations.
- Paying attention to psychological pressures in the working environment, such as loneliness, substance abuse, mental disturbances and bullying.
- Education and training in crisis and conflict strategies, individual and organisational care of people who have suffered losses and disasters, early detection and assistance of suicidal people, recognition of mental disturbance and knowledge of help options.
- Particular consideration of problems for immigrants.
The elderly
Over the past few decades, chances of living an active and meaningful life have improved for many elderly people. With a deterioration in the economic situation and deficient services, there is a risk of their quality of life now once more starting to decline.
One particular problem group is elderly single men. Owing to their inadequate education and training, it is often difficult for them to tackle the demands of everyday life. If physical or mental illness arises, their difficulties may become overwhelming.

Fear of illness, of being unable to look after themselves and, instead, being increasingly dependent, of inadequate care in the final phase of life and of a painful death is greater among elderly people than fear of death, and contributes to the onset of suicidal crises.

Elderly immigrants have a high rate of suicidal behaviour. Linguistic difficulties contribute to their isolation. When dementia develops, it is the most recently learned language that disappears first.

Tasks
Project development and supervision
Devising and issuing educational material.
Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.
The supervisory work of the National Board of Health and Welfare.

Social and marital/relational problems
Enhancing expertise in dealing with the social situation and marital/relational problems of the elderly.
Making it easier for elderly people to make the most of their retained intellectual, emotional and social resources. Supporting old people’s own activities.
Creating opportunities for group discussions on social and individual development.
Developing knowledge of crisis reactions and coping with crises, depressions and suicidal behaviour in old age.
Paying particular attention to the situation of elderly immigrants.
Increasing co-operation between different organisations to facilitate smooth transitions between forms of care.
Developing social and medical care services for those in the final phase of life, including pain relief, to help individual people and mitigate their worry about these forms of care.
Vulnerable groups
Suicide problems among young people, the elderly and those who are physically and somatically ill have already been discussed. Here, we shall mention a few other vulnerable groups and some situations entailing an elevated risk of suicidal acts.

Abusers of alcohol and narcotic drugs
The connections between substance abuse and suicide are manifold. Alcohol and certain drugs reduce inhibitions against suicidal impulses. In the wake of intoxication, brief but profound and sometimes life-threatening depressions occur. The abuse results in social maladjustment, during which divorces/separations, criminal behaviour and loss of one’s driving licence may result in suicidal crises. Life as a sober alcoholic may also be a constant struggle against unbearable anxiety attacks.

People with HIV infection and AIDS
Perceptions of social prejudice and discrimination, uncertainty about the prognosis, the high mortality of AIDS, severe symptoms, psychiatric complications and the predominance of men and immigrants are factors that elevate the risk of mental symptoms, loneliness and suicide in this pathological group. Fear of the illness may itself be suicidogenic. In Finland, in the course of a year no one infected with HIV or suffering from AIDS died as a result of suicide. On the other hand, there were 28 people with mental illnesses, usually depression, who committed suicide in the belief that they were infected with HIV or suffering from AIDS.

Victims of violence and narcissistic injury
Physical abuse and various types of sexual violence (incest, rape, assault on women) often result in lasting mental symptoms, in the form of anguish, generalised thoughts of persecution, depression, feelings of inferiority and guilt, isolation, and suicidal thoughts and acts. Protection against more violence, a secure living situation and opportunities of mentally working through problems are important inputs for preventing suicidal acts. Having to leave one’s job in degrading circumstances, being accused of a crime, being caught shoplifting and losing one’s driving licence are examples of situations that are psychologically difficult to cope with and can precipitate a suicidal crisis.

Immigrants
Immigrants often have a higher suicide rate than the population in their respective home countries. Some immigrant groups also have a higher
suicide rate than the Swedish population. Torture and other war injuries often cause lasting mental suffering, not infrequently with suicide problems. Cultural clashes are often more pronounced for young immigrants of the second generation. The reciprocal cultural skills that ought to be a consequence of the growing element of immigrants in the population are growing too slowly. There are substantial—and, in the long term, dangerous—deficiencies in cultural skills, both among immigrants and in the Swedish population. Here, the need for research and knowledge development is considerable.

Tasks

Project development and supervision
Devising and issuing educational material.
   Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.
   The supervisory work of the National Board of Health and Welfare.

Health and medical care, social work
Through contacts with people belonging to these groups and by means of studies and training, enhancing social skills with respect to meeting people in these groups and understanding their particular problems.

   Making a particular effort to understand how conflicts, crises and suicide problems are experienced and dealt with, and how alcohol and drug abuse affect people's capacity to cope with such problems.
   To the extent that it is desirable and possible, organising special treatment centres for these groups, with specially trained staff.

Training and development
Suicide-prone people and their relatives or other helpers need to meet staff who understand suicidal behaviour and can therefore provide support and advice about it. People who only indirectly come into contact with those who have suicidal tendencies may also need help in handling the situation. What is needed for this purpose is general training programmes for everyone who comes, or may conceivably come, into contact with people with suicide problems. These programmes should be supplemented by special programmes for organisations whose functions include providing support and treatment.
Training programmes
These should contain sections on:
- background and risk factors in attempted suicide and suicide
- knowledge of suicidal communication and suicide-risk assessment
- attitudes and ethics
- discussion methods
- crisis and conflict intervention
- diagnosis and treatment of depressions and alcohol abuse
- how to carry out retrospective reviews
- knowledge of various treatment methods and their availability
- treatment, intersectorial co-operation and follow-up.
For occupational categories with direct responsibility for providing treatment, there should be special courses focusing on and designed to meet their needs.

Working groups
In conjunction with the courses, formal and informal groups (“suicide teams”) can be developed to monitor the development of knowledge, support knowledge transfer (by means of lectures, seminars and guidance) and propose successively improved routines. Members of such teams can also become involved in active crisis-solving work with individual clients, and also in heading retrospective reviews after completed suicides.

Prevention programmes
Long-term programmes for development of suicide prevention in an individual unit, or through co-operation with several units in an organisation or an area.

Tasks
Project development and supervision
Devising and issuing educational material that can reach individuals via schools, vocational training courses, adult education associations, companies, health and medical care services and pharmacies.
Stimulating local and intersectorial projects in suicide prevention, including training and organisational co-operation.
The supervisory work of the National Board of Health and Welfare.
Research and development
Research and development work on methods of teaching suicide prevention. Training of teachers to work at all educational levels. Inclusion of knowledge of crisis and conflict management, mental disturbances and suicide prevention in the teaching, especially for teachers and members of the caring professions, such as doctors, psychologists, social administrators, nurses and clergymen, and of certain service occupations, such as the police, emergency rescue services and armed forces.

School education
Educational programmes for schools (from year 7, i.e., 13-year-olds) integrated into the regular curriculum. Suicide-related problems should form part of a more general content, such as mental health care, crisis and conflict management and peer support. Knowledge and attitudes are conveyed by a broad range of teaching methods. Similar programmes should be initiated in the churches’ teaching of confirmation candidates.

Organisations providing support and treatment
Compiling study material and implementing educational projects specially adapted to the needs of each individual organisation.

Reduced availability of means of suicide
For a person who tries to help someone on the brink of suicide, it is essential for the latter not to have easy access to various means of committing suicide.

The great increase in toxic household gas in England in about the year 1900 resulted in a clear rise both in the number of carbon-monoxide suicides and in the total number of suicides. The change-over to non-toxic North Sea gas resulted in a marked decrease. Only several years later did a compensatory increase in suicides by such means as car-exhaust fumes begin. In other countries, the elimination of household gas did not have such major consequences. The most relevant measures for reducing carbon-monoxide suicides are those directed at the exhaust systems of vehicles.

Restrictiveness relating to toxic medicines has also resulted in a decline in the number of suicides. This includes withdrawal of the right to sell excessively toxic preparations, care in prescription, small-sized packages and blister packaging, which means that one tablet at a time has to be pushed out. Industrial development of less toxic medicines, e.g., against depression, is another way of tackling this problem.
There is a connection between the suicide rate and the ready availability of weapons in the USA and Australia, and also a chronological connection between the increasing number of weapons and the rising number of suicides using weapons in the USA. On the other hand, it is unclear whether making weapons difficult to obtain results in a decline in the overall number of suicides, or merely in a shift to other suicide methods.

In reducing injuries at work and in the transport sector, passive preventive methods – i.e., those not requiring the individual to make a decision in each new situation, but which can be implemented once and for all – have been most successful. These include methods that reduce exposure to injuries and reduce the scale of the injury if it occurs. A general reduction of the risk of death from road accidents and carbon-monoxide poisoning would thus possibly reduce both the number of suicidal acts by these means and the consequences of those that nonetheless take place. At underground stations, various methods have been tried, the most radical being to build protective walls similar to those used in lift systems. This already exists at, for example, the Liseberg station in Gothenburg, at Lyons in France and in Japan, and it is planned for the Jubilee Line in London.

Certain places have become legendary suicide sites. The best known is the Golden Gate Bridge in San Francisco. Reduced publicity in the media concerning jumps from heights and under or off trains, as well as various protective measures, have proved to reduce the rate of suicide by these particular methods. There is therefore reason to believe that one can reduce the suicide rate by limiting the availability, access to and attraction of certain means of suicide.

A sought-after reduction in availability of means of suicide may be attained through preventive measures with a general effect, but also by limiting availability for a particular person adjudged to be at risk of committing suicide. Many of the following proposals are long-term, and require further consideration.

**Tasks**

**Project development and supervision**
Stimulating development work aimed at making means of suicide less readily available.

- Compiling further data for documentation and analysis.
- Co-ordinating statistics of suicide attempts and suicide with registration of other injuries.
- Continued research and development work.
- The supervisory work of the National Board of Health and Welfare.
Transport etc
Introducing modified ignition locks that open only when exhaled air is devoid of alcohol (“alcolocks”), especially for alcohol abusers, who are thereby prevented from starting the vehicle.

Introducing idling shut-off devices activated by a high carbon-monoxide concentration, and carbon-monoxide detectors (easy to install in conjunction with “alcolocks”).

Extending exhaust-emission control to include carbon monoxide as well.

Introducing better-designed exhaust systems to prevent carbon-monoxide suicides.

Making airbags standard on all cars.

Designing locomotive front ends so that, on impact, a person is pushed aside instead of run over.

Equipping with various forms of protective device those underground stations that have a high frequency of accidents and suicidal acts.

Setting up protection (fences or nets) and SOS telephones at particularly frequent suicide sites (tall buildings, bridges).

Weapons
Safety grips on guns (for the left hand).

Complying with the regulations of the Weapons Act on separate storage of weapons and ammunition.

Taking suicide risk into account in drawing up regulations for weapon possession generally and for various services, and also in the event of illness.

Limited access to weapons for suicidal people, both by observing the reporting obligation for people unsuitable for possession of weapons and through observations and interventions on the part of relatives and colleagues, where severely depressed and suicidal people are concerned.

Prescription drugs
Developing less toxic prescription drugs, suitable forms of administration and packaging.

Cautious prescription routines, careful follow-up of patients.

Efforts to restrict possession of toxic prescription drugs by suicidal people.

National expertise in suicidology
For the development of expertise in suicidology and suicide prevention, extensive research with a broad orientation (in epidemiology, medicine, natural sciences, behavioural science and particularly teaching methods, but also social sciences, humanities and religious knowledge). Current research must be encouraged, developed further and expanded by means of cooperation between various research institutions.
**Databases**

For analysis and follow-up of suicidal behaviour as a problem of public health (research, training and preventive work), effective epidemiological monitoring is required. This is intended to result in readily accessible databases containing reliable data and with considerable potential for multiprogramming, capable of rapidly supplying up-to-date information. Not only particulars of suicidal behaviour, but also social, medical, economic and geographical data are required in order for the distribution of suicides and their background factors to be described and assessed. Groups, activities and areas with distinct suicide and attempted-suicide risks may then be described and rising trends detected at an early stage. The analysis must be carried out in co-operation with experts in suicidology. The following types of database (with identity particulars removed) should be developed:

- Database of suicide and attempted suicide in Sweden (age, sex, marital status, nationality, methods, information on geographical, social and psychological conditions).
- Database with particulars of suicide from Europe, especially the Nordic countries (for comparative studies).
- Database of current research in Sweden and the other Nordic countries: researchers, projects and materials, eg, biological data and personality features.
- Literature bank of all available scientific and popular-scientific articles, books and reports in the field, with special sections for instruments and methods (initially for Sweden and eventually for the other Nordic countries as well).
- Database for quality assurance, to monitor development in suicide prevention based on information from such sources as the health and medical care services.

**Information**

For projects that are being started, purpose-oriented summaries of literature and current epidemiological information are needed. The latter should be supplemented with an offer of directed analyses for various county councils and municipalities, eg, survival analyses relating to suicide-attempt patients. Information of more general interest should be disseminated in the form of a recurrent publication.

**Organisation**

To satisfy the national need of knowledge development in suicide prevention, the Swedish parliament (the Riksdag) has set up, at the National Institute for Psychosocial Factors and Health, a unit for suicide research and prevention that is integrated with the Stockholm County Council Centre for Suicide
Research and Prevention. This unit must be given scope for developing its work in close co-operation with other agents in the field.

Tasks

Resource development
Encouraging broad development of suicide research in Sweden, in terms of both ideas and resources.
- Encouraging the research councils to give priority to suicide research.
- Working for the development of databases.
- Supporting the development of the Centre for Suicide Research and Prevention.
- Identifying urgent research areas on the basis of this programme's general view of suicide research and suicide prevention.

National centre of expertise: the Centre for Suicide Research and Prevention: Centre for Suicide Research and Prevention
- Initiating and carrying out research (especially to investigate risk factors in suicide and attempted suicide) with interdisciplinary approaches.
- Developing various concepts and classification systems in suicidology, to be used in research and clinical work, but also in everyday parlance, and also disseminating information on these.
- Developing methods of analysing suicidological public-health consequences of various social changes, and also developing methods for implementing and evaluating primary and secondary suicide prevention.
- Devising evaluation instruments that can be used to appraise programmes for suicide prevention, both in the health and medical care services and at population level, eg, in schools.
- Planning, initiating and evaluating measures of suicide prevention.
- Developing networks of authorities and people engaged in suicide prevention, and primarily co-operating with the National Institute for Public Health and the National Board of Health and Welfare.
- Providing information on diagnosis, treatment and prevention of suicidal behaviour to the authorities concerned, care personnel and the public.
- Creating the basis for, and publishing, objective and target-oriented information and also educational material.

Other research
Extended research on suicide problems in the fields of epidemiology, medicine, natural sciences, behavioural science, social sciences, humanities, religious knowledge and linguistics. This research should include both individual people's experiences and cultural phenomena and, in the long term, provide a broader and more reliable scientific basis for suicide prevention.
Further development of the research inputs that are already under way, mainly at the departments of psychiatry that are engaged in clinical suicide research, namely the Departments of Clinical Neuroscience at Lund and the Karolinska Institute, and also the epidemiological research being conducted at the Department of Psychiatry at the University of Umeå.

Further development of the research inputs already in progress in the humanities and social sciences.

**Regulatory systems**

Many of society’s regulations (laws, statutes, etc) are important for the development of suicide prevention and for the level of suicide rates. These include statutes on health and medical care, alcohol policy, prescription drugs and weapons. The authorities that have supervisory responsibility should monitor developments in suicide prevention and consider the amendments to regulations that may be prompted by concern for the individual suicidal person.

**Tasks**

Considering which regulations need amending as a result of this programme, and initiating proposals at the authority concerned.
National Council for Suicide Prevention

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Claes Örtendahl, Director-General of the National Board of Health and Welfare

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SOME PEOPLE PONDER PHILOSOPHICALLY OVER SUICIDE. OTHERS ARE TORMENTED BY SUICIDAL THOUGHTS. FAMILIES AND ORGANISATIONS ARE OFTEN AT A LOSS. ATTITUDES TOWARDS SUICIDE ARE AMBIVALENT: SOMETIMES PEOPLE DO NOT EVEN VENTURE TO TALK ABOUT IT, AND SOMETIMES IT IS SEEN AS A HUMAN RIGHT. IF WE ARE TO PREVENT SUICIDE, WE MUST ESTABLISH A SHARED VIEW BASED ON EVERYDAY EXPERIENCE BUT ALSO ON SCIENTIFIC KNOWLEDGE.

THE NATIONAL COUNCIL FOR SUICIDE PREVENTION INVITES A BROADER APPROACH TO THESE PROBLEMS. THIS PUBLICATION OFFERS PROPOSALS FOR OBJECTIVES, GUIDELINES AND STRATEGIES FOR PREVENTING ATTEMPTED SUICIDE AND SUICIDE.

THE STRATEGIES INCLUDE:

- INCREASED KNOWLEDGE OF THE ROLE OF SUICIDE IN EFFORTS TO WORK OUT ONE'S PHILOSOPHY OF LIFE, IN LIFE CRISIS AND IN MENTAL DISTURBANCE
- IMPROVED PREVENTIVE MEASURES FOR RISK GROUPS AND IN RISK SITUATIONS
- ENHANCED PROFESSIONAL EXPERTISE IN HELPING PEOPLE WITH SUICIDE PROBLEMS
- REDUCED AVAILABILITY OF MEANS OF SUICIDE.

THE PROBLEMS OF SUICIDE CONCERN US ALL. MANY INDIVIDUALS, ORGANISATIONS AND AUTHORITIES NEED TO CO-OPERATE. HERE, GUIDANCE IS GIVEN AS TO WHO SHOULD DO WHAT. THIS PUBLICATION IS OF INTEREST TO EVERYONE WHO ENCOUNTERS SUICIDAL PEOPLE PRIVATELY AND IN THEIR WORK – ON EMERGENCY TELEPHONE HELPLINES, AT CRISIS CENTRES, IN CHURCH CONGREGATIONS AND IDEALISTIC POPULAR MOVEMENTS; IN THE RESCUE SERVICES, POLICE AND ARMED FORCES; IN THE HEALTH AND MEDICAL CARE SERVICES AND SOCIAL SERVICES; WITH CHILDREN AND YOUNG PEOPLE, ETC.

THIS PUBLICATION MAY BE ORDERED FROM THE NATIONAL BOARD OF HEALTH AND WELFARE, CUSTOMER DEPT., S-106 30 STOCKHOLM, SWEDEN, FAX +46-8-663 92 90, E-MAIL (INTERNET) KUNDTJ@sos.se, TEL. +46-8-783 30 03.

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NATIONAL BOARD OF
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CENTRE FOR SUICIDE
RESEARCH AND
PREVENTION
Some people ponder philosophically over suicide. Others are tormented by suicidal thoughts. Families and organisations are often at a loss. Attitudes towards suicide are ambivalent: sometimes people do not even venture to talk about it, and sometimes it is seen as a human right. If we are to prevent suicide, we must establish a shared view based on everyday experience but also on scientific knowledge.

The National Council for Suicide Prevention invites a broader approach to these problems. This publication offers proposals for objectives, guidelines and strategies for preventing attempted suicide and suicide.

The strategies include:

- increased knowledge of the role of suicide in efforts to work out one's philosophy of life, in life crises and in mental disturbance
- improved preventive measures for risk groups and in risk situations
- enhanced professional expertise in helping people with suicide problems
- reduced availability of means of suicide.

The problems of suicide concern us all. Many individuals, organisations and authorities need to co-operate. Here, guidance is given as to who should do what. This publication is of interest to everyone who encounters suicidal people privately and in their work — on emergency telephone helplines, at crisis centres, in church congregations and idealistic popular movements; in the rescue services, police and armed forces; in the health and medical care services and social services; with children and young people, etc.

This publication may be ordered from the National Board of Health and Welfare, Customer Dept., S-106 30 Stockholm, Sweden, fax +46 8 603 82 80, e-mail (Internet) kund@kvs.se, tel. +46 8 783 30 03.

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