Country Profile "Sweden"

Suicide and Suicide Prevention: Key Facts and National Priorities

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Version:	1.3
Date:	03. 07. 2023

Contents

This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health" (**JA ImpleMENTAL**) has a duration of 3 years, from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL ja-implemental.eu. It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in two specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - Mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 and 17 participating EU-countries, respectively. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPs and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, and suicide prevention strategies in participating countries developed or revised. Sweden is participating in this Work Package.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

Sweden is a country located in the northern part of Europe. The capital city is Stockholm, and the country is divided into 21 regions and 290 municipalities. The Swedish health care system is mainly government-funded. It is universal for all citizens and **decentralised, which means that it is managed and run by either the regions, local authorities or municipalities** (although private health and dental care also exists) (1).

Basic health and medical care is generally referred to as primary care. Patient fees are set by each region and vary across the country. Some visits are free of charge, such as child and school health care, screening or health care for the elderly. The population in Sweden is about 10.5 million (2). In 2022, the population increased by 0.7 percent, and in 2022, Sweden had the lowest number of births since 2005 (3).

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (4)

	Sex		
Age group	male	female	**total**
<18	1 126 819	1 062 584	2 189 403
18 - 64	3 122 465	2 979 341	6 101 806
65+	973 563	1 114 523	2 088 086
Total	**5 222 847**	**5 156 448**	**10 379 295**

The life expectancy at birth is 81.4 for men and 85.0 for women (5), and at the age of 65 the life expectancy is 19.6 for men and 22.2 for women (6). 17.2% of the population is at risk of poverty and social exclusion (7). Income inequality, expressed as the Gini coefficient, is 26.8 (8) and total healthcare expenditure relative to GDP is 10.87% (9).

1.2 Mental Health System

Primary care is the first point of contact for mild to moderate mental health problems. This is where you turn to first (except in an emergency). The majority of patients with depression are treated within primary care services. Older people have a higher proportion of contact with primary care than specialist care. Primary care is also geographically located closer to the population, especially in rural areas where distance to a regional hospital where specialist care is delivered can be far.

Sweden has not had any mental hospitals since the mid-1990's when such institutions closed, and the treatment and care was integrated in the regular hospitals and the clinical psychiatric care units within them. The total number of hospital beds in Sweden is 2.0 per 1000 inhabitants (10).

In 2021, the proportion of people aged 18 and older who have been treated in adult psychiatry was 5.3% (11), and in child and youth psychiatry the corresponding number is 6.2% among people aged 0-17 (12). Data from 2014 shows that 22.3% of people who had the need for health care report unmet needs due to waiting times, distance or transport, or cost. Of these, 3.2% report not receiving mental health care due to financial reasons (13).

Services for mental health are financed primarily through taxes levied by regions and municipalities. It is therefore hard to determine the proportion of healthcare expenditure that is specifically allocated for mental health, since every region and municipality is responsible for managing and prioritising its own healthcare resources. In addition to the regional and local authorities' own financing, the national **government annually distributes stimulus funds of about 1.7 billion SEK**, to Sweden's municipalities and regions to work with mental health and suicide prevention. In 2021, the government announced seven focus areas for the stimulus funds. One of the focus areas is "Strengthened suicide prevention work" (14).

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

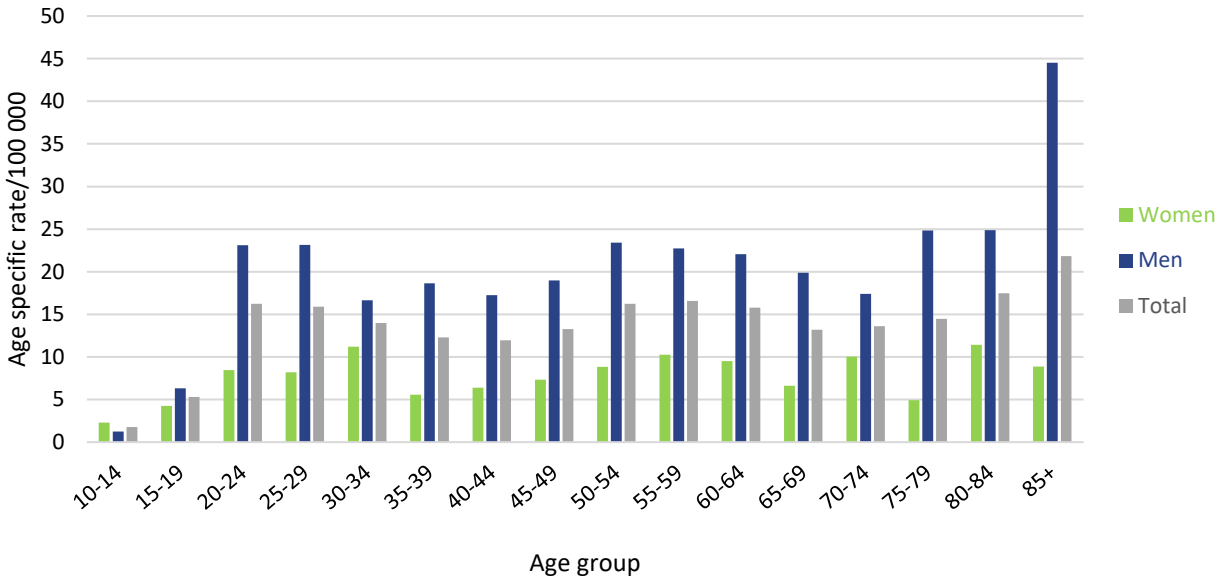
2.1.1 Number of suicides, suicide rate and suicide trends

In 2021, **1 226 people died by suicide in Sweden**. Of these, 873 were men and 353 were women. Eleven were children under the age of 15. A further 279 cases were registered as deaths of

undetermined intent, of which many could have been suicide. Two thirds of those who died by suicide in 2021 were men. In the population, the suicide rate (number of suicides per 100,000 inhabitants) was 6.82 for women and 16.65 for men. The highest suicide rate was among men who were 85 years or older. In this group, the suicide rate was almost 45, which is twice as high as among men in the younger age groups. Among children and young people (under the age of 18), there are approximately as many girls as boys who die by suicide. Suicide in relation to the total number of deaths in each age group, presents another picture. **Among young people (aged 15–29), who have a lower risk of dying due to an illness than older people, suicide accounted for one third of all deaths. For people over the age of 65, suicide was less than one percent of all deaths** (15).

The suicide rate in Sweden also varies significantly in relation to educational status and geographic factors. Suicide rates are higher among those with only pre-secondary education for example. Suicide rates are also higher in rural areas compared to urban areas (15).

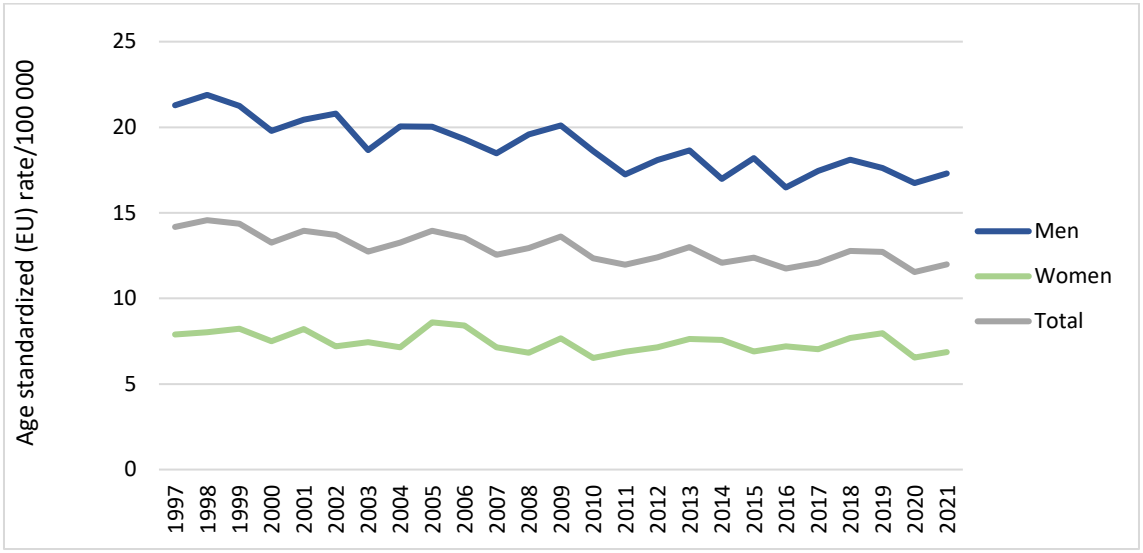
Figure 1: Suicide rate: 2021, by age groups and sex*.



* Swedish cause of death register, updated 2022-06-22, Includes X60-X84 (ICD-10).

The suicide rate in Sweden was at its **highest in the 1970's** and has since decreased. In recent years, however, the decline has slowed. In connection with the Covid-19 pandemic, many feared that the number of suicides would increase, but in 2020 fewer suicides were registered than the year before. Although the number of suicides increased slightly in 2021, the figure is still lower than before the pandemic (15).

Figure 2. Suicide deaths trend**,** 1997-2021, by sex.* Age standardized (EU).



* Swedish cause of death register, updated 2022-06-22, Includes X60-X84 (ICD-10).

During the last 20-year period, **the suicide rate has decreased in most age groups, except among young people.** At the same time, the differences in the suicide rates between different age groups has decreased over time (16).

Most of the data on suicide mortality is available and open to everyone. The National Board of Health and Welfare is the agency responsible for the Swedish cause of death register. The Public Health Agency annually publishes information about suicide mortality on the agency's website and in different reports.

2.1.2 Methods for suicide

Most suicides in Sweden are by **hanging or poisoning.** However, the methods differ between men and woman. The most common method for men is hanging, followed by poisoning and shooting. Among women, however, both poisoning and hanging are common methods, while shooting hardly occurs at all. Annually, approximately 130 suicides occur within the Swedish transport system, most within the railway and subway.

Table 2: Most common methods of suicide*: year, by age group and sex

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1. To hang oneself 2. In front of moving object 3. Self-poisoning	1. To hang oneself 2. Self-poisoning 3. In front of moving object	1. Self-poisoning, 2. To hang oneself 3. In front of moving object	1. Self-poisoning 2. To hang oneself 3. To drown oneself	1. Self-poisoning 2. To hang oneself 3. To drown oneself
Men	1. To hang oneself 2. In front of moving object 3. Jumping from height	1. To hang oneself 2. Self-poisoning 3. In front of moving object	1. To hang oneself 2. Self-poisoning 3. To shoot oneself	1. To hang oneself 2. To shoot oneself 3. Self-poisoning	1. To hang oneself 2. To shoot oneself 3. Self-poisoning

* Swedish cause of death register, 2016-2020, Includes X60-X84 (ICD-10).

2.1.3 Suicide attempts

In 2021, **6,577 people in the population received hospital care because of a suicide attempt or another intentional self-destructive act. This corresponds to 63 people per 100,000 inhabitants.** The number of hospitalizations was more (9,486) than the number of patients, which means that some people have been hospitalized more than once during the year.

Girls and women under the age of 25 were treated most often. Overall, m**ore women than men were hospitalized because of a suicide attempt**. In the entire population, 81 women and 45 men per 100 000 inhabitants were treated in 2021. Among the youngest (<25 years), about four to five times more girls than boys were treated in 2021.

The most common methods of self-harm, with or without a suicidal intent, are self-poisoning (for all age groups). The second most common method is self-cutting.

Table 3: Number of hospital admissions due to self-harm*: 2021, by age group and sex (National patient register)

	0-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
female	1538	130.4	3082	235.9	1125	87	479	44.2	189	57.3
male	236	18.9	1376	98.2	841	63.1	475	45.4	145	63.1

* Inpatient care for external cause X60-X84 (ICD-10)

2.1.4 Vulnerable groups and help seeking barriers

The vulnerable populations we have identified, based on data and dialogue with stakeholders, are groups such as **older men, economically vulnerable, males in general, young adults (20-35 years old), lgbtqi, migrants and persons with substance abuse disorders**.

Regarding the most common barriers people face when seeking psychosocial help, the results of data and dialogue with experts are shown i Box 1.

Box 1. Most common barriers people face when seeking psychosocial help

1. Stigma
2. Previous poor treatment and a lack of trust in health and social services
3. Accessibility such as long waiting periods (queues)
4. Health literacy (lack of knowledge) of mental illness and symptoms, of where to seek help, etc.

2.1.5 National action program and national activities to prevent suicide

A National Action Program, which was ratified by the Parliament in 2008, guides Sweden's suicide prevention efforts. **In 2020, the government commissioned the Public Health Agency and the National Board of Health and Welfare, in close cooperation with 24 other authorities, to develop a proposal for a new national strategy for mental health and suicide prevention**.

A majority of Sweden's 21 regions have their own regional policies and strategies on mental health and suicide prevention. In many cases, these strategies are based on the current national strategy and action program but adjusted to local and regional needs.

Since 2015, the Public Health Agency is **responsible for coordinating the work with suicide prevention** at a national level. The Agency's role is to develop coordination and monitoring of suicide and suicide preventive work, as well as to develop and disseminate knowledge support to national, regional and local stakeholders. Other national agencies, such as the National Board of Health and Welfare, also have government assignments to support suicide preventive work. Additionally, government funding is allocated to the National Centre for Suicide Research and Prevention (NASP) at the Karolinska Institute.

Since 2017, NGOs have been able to apply for funding for their supportive work with suicide prevention and projects related to suicide prevention. For example, much of the support given to bereaved after suicide is provided by NGOs that receive funding via grants from this ordinance. **The national suicide prevention hotline is operated by an NGO** also funded by such grants, other organisations and private donors. As mentioned, state stimulus funds also support mental health work in regions and municipalities. An amount of 200 million SEK per year has been earmarked for suicide prevention. The funds are used mainly to employ regional and local coordinators for suicide prevention and activities such as education and training, awareness raising and support to bereaved after suicide.

2.2 Needs Assessment (NA)

The main part of Sweden's need assessment was carried out and published in 2022. It is based on information and needs collected from 26 agencies and authorities and 48 organisations and NGOs. The agencies and authorities each conducted individual analyses of the current situation and of the long-term needs within their own area of mental health and suicide prevention. They identified areas that should be prioritized in a national strategy, analysed target groups that are affected and, where appropriate, pointed out development needs within their area of responsibility. Finally, they proposed how they could support the implementation and monitoring of the upcoming strategy. **All the submissions were analysed and summarised in a report published in June** (17).

A summary of the results of the needs assessment is presented in the SWOT Analysis below:

Table 4: SWOT Analysis

Strengths	Weaknesses/Needs
Since 2008, Sweden has a national action program on SP with measures on both individual and population levels (i.e. multi-sectoral approach). The PHAS has had a government commission since 2015 to coordinate efforts on a national level. A platform for coordination has been established, with a group of national agencies/authorities, an interest group of NGOs and researchers and a network of regional SP coordinators. The PHAS has close collaboration with researchers and also resources to produce and spread knowledge to different stakeholders. Sweden has data registries of high quality.	SP has traditionally focused on mental health services, mainly psychiatry. But many who die by suicide have not had contact with psychiatric care. The cross-sectoral nature of the area requires work by more stakeholders. The national action program from 2008 needs to be updated. It does not have a connection to mental health promotion. It also lacks a structure for implementation and a system for monitoring and evaluation. There are many stakeholders in the field of SP, from a diverse range of NGOs to researchers, practitioners, authorities and decision-makers. Many different perspectives and opinions have to be considered.

Every region has a SP coordinator, and nearly 70% of Sweden's municipalities have a coordinating function for SP. Many regions have cross-sectoral networks. Most regions have implemented education and training of different professions (e.g. MHFA and training for first responders). There are many active NGOs in the field. They operate several mental health support services, among them support groups for those bereaved by suicide and a national suicide prevention hotline, chats and counselling. The government allocates state grants for funding NGOs' operations and specific projects targeting e.g. risk populations such as LGBTQI+ or the elderly. Monitoring of media coverage of suicide and suicide-related topics shows that Swedish media reporting on suicide has improved significantly over the past decades. Most reporting in daily press adheres to the WHO guidelines. A media award is given out yearly by a national NGO.	Mandates are not always clear since there is often no law regulating the work specifically related to SP. Structured, public services for some vulnerable groups (e.g. bereaved) are lacking, or services are not equally available throughout the country. A pressed situation in the social welfare and health care sector e.g. lack of human resources (especially in child and adolescent mental health care) leads to among other things, long waiting periods for specialist care. Care and treatment methods should be developed to better identify and reduce suicidal behaviour and ensure good follow-up after suicide attempts, as well as a coherent chain of care, including the use of safety plans. Overall, collaboration around people at risk of suicide needs to be developed. There is still a stigma connected to suicide and suicidality. Many people feel uneasy talking about it. Though training and education exists, it needs to be continuously ongoing. Overall, knowledge and competence linked to suicide and SP needs to be strengthened. Mental illness and suicidality among men needs more attention.
Opportunities	**Threats**
There is generally high interest in suicide preventive work. The number of people working in the field has increased in recent years, as has public funding to stimulate development. The PHAS is a trusted organisation, and work on the strategy is being done in collaboration with the National Board of Health and Welfare, which is also a trusted authority. 24 other authorities/agencies have been commissioned by the government to participate in the work. This will lay the foundation for broad, cross-sectoral cooperation and coordination once the new strategy is in place. Quick wins such as updated website, knowledge support, webinars and conferences help keep spotlight on SP during the process of working on the strategy. JA ImpleMENTAL (networking with international experts in the field, training for Swedish stakeholders, advocacy). There is strong political support across all political parties. SP is regarded as an important topic and is thus high on the national political agenda.	High expectations i.e. "the strategy will solve everything". Risk for disappointment and critique. End product could also be perceived as too vague or watered down. Specific funding for SP is available at present. Will it continue? Funding is on a year-to-year basis which hinders long-term investments on local and regional levels. Negative developments or changes in society at large (e.g. climate change, global conflicts, economic recessions) can affect suicide rates and SP work; other issues can become more pressing and be prioritized. Such societal issues cannot be taken care of by a national strategy for SP. Further reductions in human resources availability within the social welfare system and health care services is a risk.

3 Reflection on SANA results

Since the beginning of the 2000's, the **decline in the national suicide rate has stagnated**, and in some groups, such as among young adults, there has been an increase in suicides in the last 15 years. Around 70% of all suicides are among men, and the **highest suicide rate is among older males**. Suicide attempts however, are more common among younger people, especially females. Among young girls, suicide attempts by poisoning are increasing alarmingly.

Suicide and suicide attempts are major public health concerns that require attention and action. Every suicide is a tragedy for the next of kin, who themselves risk deteriorating mental health and an increased risk of suicide. Many lives lost in this way also mean a great cost to society in years lost.

Although Sweden can be considered as having a well-developed structure for implementing suicide prevention measures in different areas of society, some challenges remain. There is still the need to broaden both professionals' and the public's view of suicide prevention, as something that is not limited to mental health treatment and care.

With the current pressed situation in the social welfare and healthcare sectors, especially in regards to lack of human resources, it is **imperative that the work is done more effectively, with better coordination and with a stronger focus on mental health promotion and prevention, using an integrated approach**. There needs to be more focus on building secure environments and fostering a more inclusive society, where people are able to receive help and support when needed.

3.1 Development of a draft national stategy

As an overall prioritized measure, a proposal for a new national strategy for mental health and suicide prevention in Sweden will be developed. It will propose **four overall** goals:

1) An improved mental health in the entire population.
2) Reduced negative consequences of mental illness.
3) Fewer lives lost to suicide.
4) Reduced mental health inequalities.

In order to achieve these goals, **the draft strategy proposes seven focus areas**, mapping out an integrated approach, centring on the determinants of mental health and wellbeing, as well as addressing issues related to mental ill health and suicide prevention:

- Mental health as a resource for the individual and for society
- Investments in the mental health of children and young people
- Income and good working conditions
- Increased participation and inclusion in society
- Services that meet the needs of individuals
- **Strengthened suicide prevention work**
- Research and knowledge development

The situation analysis as well as the SWOT-analysis revealed areas needed to focus on in order to improve suicide preventative efforts in Sweden. The focus area specifically centring on suicide prevention proposes **six prioritized measures** that are presented below (see Box 2).

Box 2. Prioritized measures for a draft national strategy

Overall prioritized measure:

Draft a new national strategy for mental health and suicide prevention

Measure 1: Minimize social and economic risk factors linked to increased risk of suicide

Measure 2: Secure mental health services and care for people at risk of suicide

Measure 3: Coordinate action in acute suicidal crisis

Measure 4: Reduce availability of methods and means for suicide

Measure 5: Reduce stigma and increase knowledge of suicide and suicidality

Measure 6: Strengthen support for breaved after suicide

QUICK WINS

- Quick win 1 Updated structure and contents of the PHAS website. Launch of new website targeting general population with focus mental health promotion and how to help others.
- Quick win 2 Collaboration with National Board of Health and Welfare to produce guidance material on support to bereaved after suicide .
- Quick win 3 Awareness-raising activities e.g. in connection with World Suicide Prevention Day; seminar on support to bereaved; activities to reduce stigma.
- Quick win 4 National 2-day conference on suicide prevention, fall 2023.
- Quick win 5 Collaboration with researchers to increase knowledge (e.g. on media reporting on suicide and monitoring how state funding is being used in regions and municpalities.

4 Next steps

At the time of writing this Country Profile, we are conducting several dialogues with different stakeholders, from authorities, NGOs, regions, counties and municipalities to professionals' organisations, in order to acquire input and to anchor the draft of a new national strategy for mental health and suicide prevention. The input we receive is being incorporated into the proposed final strategy document. The strategy is to be presented to the government no later than September 1, 2023. At the same time, we are working on communication planning, and we are also discussing issues relating to a long-term structure for implementation and a system for monitoring. Thus, the following are next steps:

- **Step 1:** Dialogue meetings with stakeholders for input and anchoring of the draft strategy.
- **Step 2:** Meeting with all 26 director generals for the authorities that have been commissioned to prepare the draft strategy.

- **Step 3:** Preparation of a communication plan that will include naming the strategy and deciding on its main messages, and which target groups and channels the draft should be communicated.
- **Step 4:** Finalizing the draft strategy and report to the government. Submission to the government no later than 1 September.
- **Step 5:** Await decision by the government on acceptance of the proposed draft strategy. This may take some time since the decision-making process in the government requires many procedural steps, especially if the strategy is to be put forward for decision in the Parliament. In the meantime, we plan to initiate first steps of implementation (e.g. creating a structure for collaboration and action plans) and building a system for monitoring and evaluation of the national strategy. We expect that our collaborating partners (i.e. 25 other national authorities) will be on board to begin planning their next steps for implementation as well.
- **Step 6 (parallel to step 5):** Continue work on quick wins, e.g. planning the national conference in the fall, where we can launch the draft strategy to a wider audience.

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