CHIARA DAVICO

Il fenomeno della suicidalità in adolescenza: aspetti epidemiologici e clinici

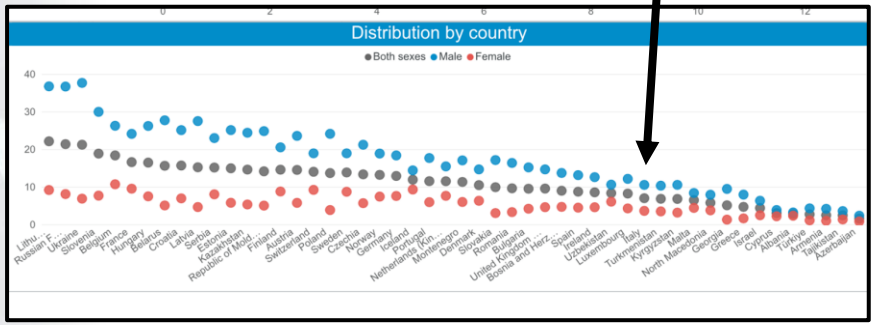
Epidemiologia del suicidio nel mondo

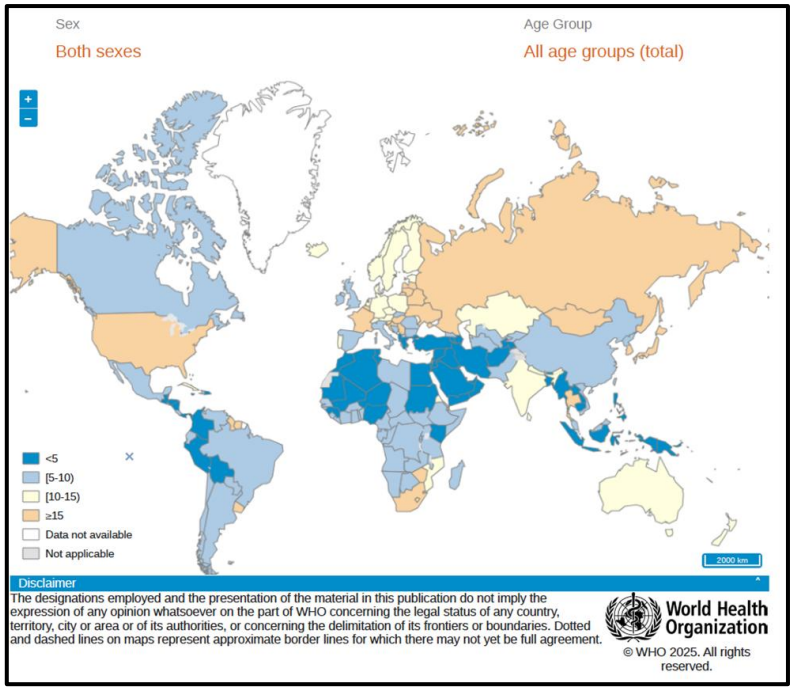
727 000 morti/anno

Tassi di suicidio **eterogenei**, che risentono di fattori economici, culturali, sociali.

Es: 7/100 000 Italia; Lituania 22.1/100 000,
USA 15.6/100 000

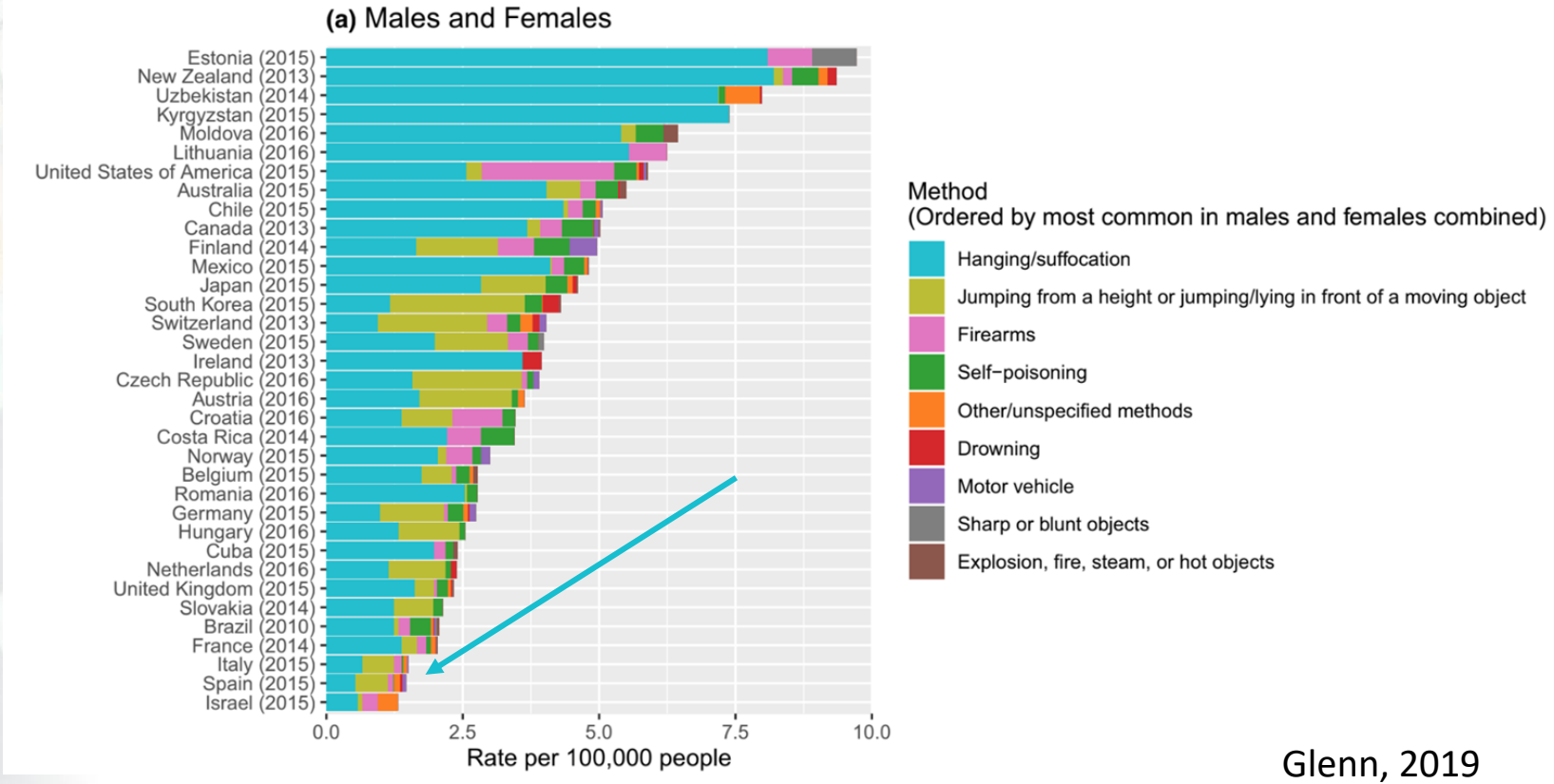
Perlopiù M>F





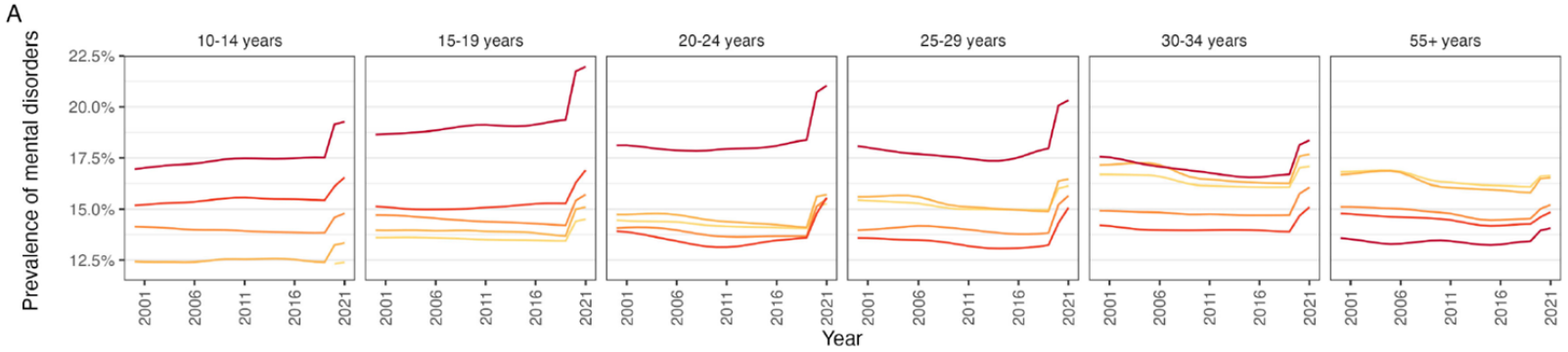
Epidemiologia: adolescenti nel mondo

II causa di morte nel mondo tra 14-24 anni.



Glenn, 2019

Significativo aumento dei disturbi psichici in infanzia e adolescenza negli ultimi anni



> femmine

++ adolescenti con disturbi d'ansia

++ adolescenti con disturbi alimentari

++ adolescenti con ideazione suicidaria

++ tentativi di suicidio

Benton, 2021; Racine, 2021; Trafford, 2023; Arakelyan, 2023; Kim, 2023; Madigan, 2023; Davico, 2024; Fond, 2025; Ward, 2025; Grande, 2025; GBD, 2021; McGorry, 2025

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Emergenza psichiatrica: i dati italiani

JAMA Network | Open

Original Investigation | Psychiatry

COVID-19 Pandemic School Disruptions and Acute Mental Health in Children and Adolescents

Chiara Davico, MD; Daniele Marcotulli, MD, PhD; Giuseppe Abbracciavento, MD; Thomas Anfosso, MD; Massimo Apicella, MD; Roberto Averna, MD, PhD; Marzia Bazzoni, MD; Dario Calderoni, MD; Luca Cammisa, MD; Alessandra Carta, MD, PhD; Sara Carucci, MD, PhD; Giorgio Cozzi, MD, PhD; Federica Di Santo, MD; Elisa Fazzi, MD, PhD; Caterina Lux, MD; Chiara Narducci, MD; Lino Nobili, MD, PhD; Ilaria Onida, MD; Tiziana Pisano, MD; Umberto Raucci, MD, PhD; Idanna Sforzi, MD; Laura Siri, MD; Stefano Sotgiu, MD, PhD; Simone Tavano, MD; Arianna Terrinoni, MD; Sara Uccella, MD, PhD; Stefano Vicari, MD; Caterina Zanus, MD; Benedetto Vitiello, MD; for the Italian Covid-Child and Adolescent Psychiatric Emergencies Study Group

Observational cross-sectional study

all the ED visits of children and adolescents

January 1, 2018 - December 31, 2021

9 university hospitals (Italy)

Humana

1 017 885

pediatric ED visits

13 014 (1.3%) **psychiatric** visits

Motivo visite

Aumento significativo di visite per:

- disturbi alimentari: + 294.8%
- ideazione suicidaria: + 297.8%
- tentativi di suicidio: + 249.1%

Davico & Marcotulli et Al. JAMA NO, 2024

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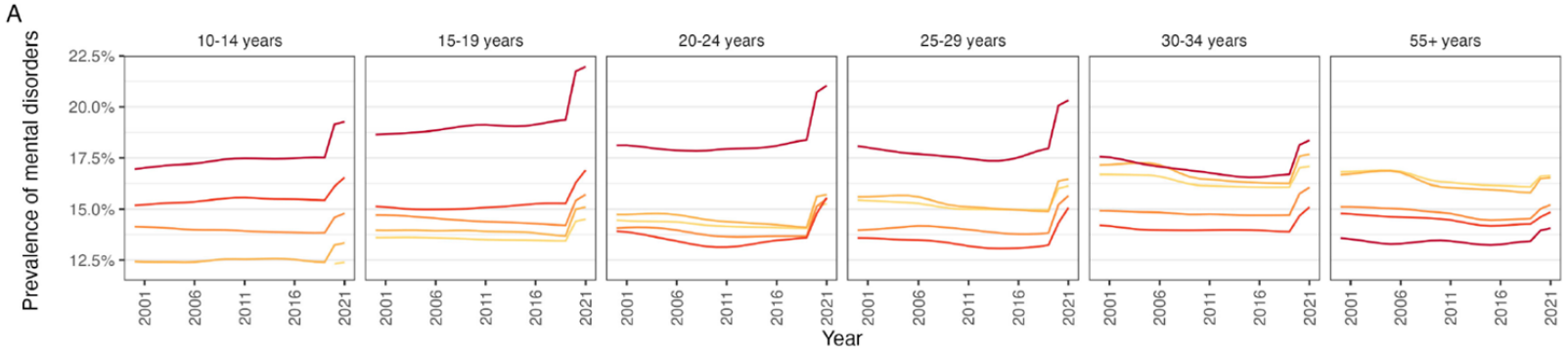
“the youth mental health crisis”

a call to action

“The worsening global youth mental health crisis **provides an unprecedented opportunity** to societies and communities around the world to dramatically **improve quality of life and life expectancy for their people and to improve social cohesion and economic productivity.** These outcomes can be achieved through a combination of **reversing harmful** social and economic policies, **investing strongly** in prevention and mental health research, and giving **top priority** to the mental health of young people within innovative systems of integrated health and social care.”

Patrick D McGorry

Significativo aumento dei disturbi psichici in infanzia e adolescenza negli ultimi anni



> femmine

++ adolescenti con disturbi d'ansia

++ adolescenti con disturbi alimentari

++ adolescenti con ideazione suicidaria

++ tentativi di suicidio

… suicidi????

Benton, 2021; Racine, 2021; Trafford, 2023; Arakelyan, 2023; Kim, 2023; Madigan, 2023; Davico, 2024; Fond, 2025; Ward, 2025; Grande, 2025; GBD, 2021; McGorry, 2025

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Journal of Psychiatric Research 181 (2025) 282–285

Contents lists available at ScienceDirect

Journal of Psychiatric Research

journal homepage: www.elsevier.com/locate/jpsychires

Suicide in Italy during the COVID-19 pandemic: Excess mortality in 2021 among men and adolescent girls

Enrico Grande *, Francesco Grippo, Stefano Marchetti, Luisa Frova

Integrated System for Health, Social Assistance and Welfare, National Institute of Statistics, Rome, Italy

Number of observed and expected suicide deaths in the resident population in 2021, observed-to-expected deaths ratio (OER) with 95% confidence intervals (CI) in the year 2021 and in the period 2020-2021, Italy, age ≥10 years.

Number of suicide deaths in 2021				OER (95% CI) 2021	OER (95% CI) 2020–2021
Sex	Age class (years)	Observed	Expected (95% CI)		
Males	10–24	160	150 (131.3–171.2)	1.07 (0.93–1.22)	1.01 (0.91–1.14)
	25–34	244	213.4 (192.1–237)	1.14 (1.03–1.27)	1.08 (0.98–1.19)
	35–44	343	333.1 (306.8–361.7)	1.03 (0.95–1.12)	1.02 (0.94–1.10)
	45–54	531	502 (468.6–537.8)	1.06 (0.99–1.13)	1.04 (0.98–1.11)
	55–64	567	536.7 (499.3–576.9)	1.06 (0.98–1.14)	1.02 (0.96–1.09)
	65–74	453	387.8 (357.7–420.5)	1.17 (1.08–1.27)	1.08 (1.01–1.16)
	75–84	426	363.8 (335.4–394.7)	1.17 (1.08–1.27)	1.20 (1.12–1.30)
	≥85	248	224.5 (200.3–251.7)	1.10 (0.99–1.24)	1.08 (0.99–1.19)
	All ages	2972	2711.3 (2491.5–2951.5)	1.10 (1.01–1.19)	1.06 (1.04–1.09)
Females	10–24	66	37.4 (28.8–48.6)	1.76 (1.36–2.29)	1.36 (1.11–1.76)
	25–34	73	67.2 (54.8–82.5)	1.09 (0.88–1.33)	0.89 (0.76–1.07)
	35–44	93	92.3 (79–107.9)	1.01 (0.86–1.18)	0.97 (0.85–1.13)
	45–54	153	167.9 (148.5–189.9)	0.91 (0.81–1.03)	0.98 (0.88–1.09)
	55–64	152	152.7 (133.5–174.6)	1.00 (0.87–1.14)	0.98 (0.88–1.10)
	65–74	127	117.1 (101.3–135.4)	1.08 (0.94–1.25)	1.03 (0.91–1.18)
	75–84	96	112.7 (96.7–131.3)	0.85 (0.73–0.99)	0.89 (0.79–1.02)
	≥85	59	52.8 (41.9–66.4)	1.12 (0.89–1.41)	1.12 (0.94–1.39)

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Suicidalità: alcune definizioni (CDC, Crosby, 2011)

Ideazione suicidaria: pensieri inerenti i comportamenti suicidari

Condotte autolesive non suicidarie: comportamento non fatale, autodiretto, potenzialmente dannoso, prodotto senza intento di morire come risultato del comportamento.

Tentativo di suicidio: comportamento non fatale, autodiretto, potenzialmente dannoso, prodotto con intento di morire come risultato del comportamento. Può anche non esitare in una lesione.

Suicidio: decesso come esito di comportamento fatale, autodiretto, dannoso, prodotto con intento di morire come risultato del comportamento.

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Gender paradox in suicidality

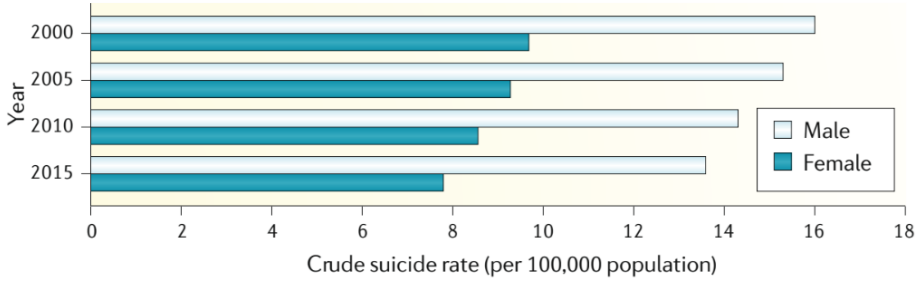

Fig. 2 | **Suicide rates by sex from 2000 to 2015.** Global suicide rates stratified by sex. In general, suicide rates in males are substantially higher than in females. Data from REF.[19].

I maschi muoiono più delle femmine;

Le femmine fanno più tentativi dei maschi;

differenza nei metodi scelti: violenti vs non violenti
help seeking behaviour
impulsività/aggressività nei maschi

… i nostri ambulatori e reparti sono pieni di ragazze che hanno fatto dei tentativi…

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Dimensioni dell'ideazione suicidaria

5 **Ideazione attiva + metodo + piano specifico + intenzione**

4 **Ideazione attiva + metodo (no piano) + qualche intenzione di agire**

3 **Ideazione attiva + metodo (no piano) no intenzione di agire**

2 **Ideazione attiva**

1 **Desiderio di essere morto**

Intensità: dai pensieri fugaci e rari,
a pensiero persistente, angoscioso, egosintonico.

Van Meter, 2023; Posner, The columbia lighthouse project, CSSRS

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Suicidio fenomeno complesso

Il suicidio si verifica per una **convergenza di fattori di rischio** genetici, psicologici, sociali e culturali, associati ad esperienze di trauma e perdita.

dolore mentale "**psychache**"

Il soggetto che arriva a compiere un tentativo si trova nella situazione di **non poter vedere altre soluzioni ai suoi problemi** e di ritenere che l'unica soluzione possibile sia appunto, la morte, in una condizione quindi di "costrizione mentale".

Van Heeringen, 2014; O'Connor, 2014; Hawton, 2009; Shneidman 2004; Shneidman 2005

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Fattori di rischio

NICE guidance on self-harm, updated in 2022, states that risk assessment tools and scales should **not be used to "predict future suicide or repetition of self-harm"** or **"determine who should and should not be offered treatment or who should be discharged."**[2] Instead, NICE advises clinicians to focus their assessment on "**the person's needs and how to support their immediate and long term psychological and physical safety."**

Ng, 2018; Zatti, 2017; Gobbi, 2019; Liu, 2019; Surace, 2021; Huang, 2022; Shain, Pediatrics, 2016

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Fattori di rischio

Ng 2018; Zatti, 2017; Gobbi, 2019; Liu, 2019; Surace, 2021; Huang, 2022; Shain, Pediatrics, 2016

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Fattori di rischio personali

- Sesso Maschile
- Storia famigliare di suicidio
- Familiarità psichiatrica
- Storia personale di adozione
- Orientamento sessuale omosessuale o incerto
- Disforia di genere
- Storia personale di abuso fisico/sessuale
- Precedente tentativo di suicidio
- Presenza di condotte autolesive non suicidarie
- Disturbi del sonno
- Diagnosi psichiatrica (disturbo bipolare, psicosi, depressione, attacchi di panico, disturbo post traumatico da stress…)
- Abuso di sostanze (alcool, cannabis…)
- Aggressività/Impulsività/Rabbia
- Utilizzo di internet patologico

Ng, 2018; Zatti, 2017; Gobbi, 2019; Liu, 2019; Surace, 2021; Huang, 2022; Shain, Pediatrics, 2016

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Fattori di rischio sociali

- Relazione genitori-figlio disfunzionale
- Bullismo o cyberbullismo (vittime e perpetratori)
- Difficoltà scolastiche
- Abbandono scolastico/frequenza scolastica incostante
- Isolamento/ritiro sociale
- Ambiente sociale non supportivo per i ragazzi con orientamento sessuale non eterosessuale
- Condizione di rifugiato
- Essere stati dimessi da una ospedalizzazione per motivi psichiatrici

Shain, Pediatrics, 2016

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Fattori di rischio precipitanti

- Stato di agitazione psicomotoria
- Intossicazione da sostanze d'abuso
- Recente Life-event stressante (lutto, separazioni, perdite, fallimenti)
- Accesso a metodi letali
- Esposizione al suicidio

Shain, Pediatrics, 2016

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Fattori protettivi

Research

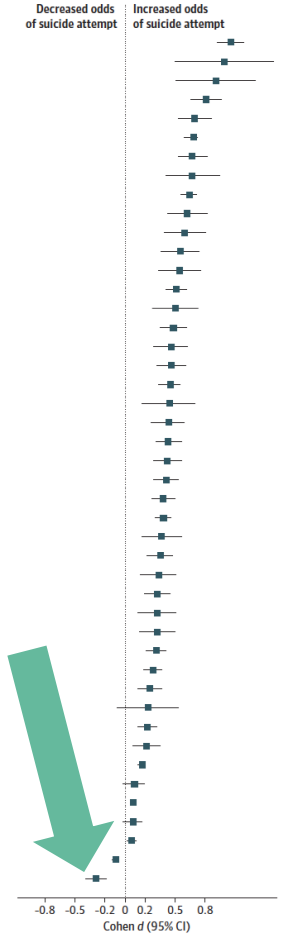
JAMA Psychiatry | Original Investigation

Social Determinants of Health and Suicide-Related Outcomes
A Review of Meta-Analyses

Peter Jongho Na, MD, MPH; Jeonghyun Shin, MD; Ha Rim Kwak, MD; Jaewon Lee, MD, MPH; Dylan J. Jester, PhD, MPH; Piumee Bandara, PhD, MPH; Jim Yong Kim, MD, PhD; Christine Y. Moutier, MD; Robert H. Pietrzak, PhD, MPH; Maria A. Oquendo, MD, PhD; Dilip V. Jeste, MD

Figure 3. Forest Plot of Cohen *d* for Suicide Attempt by Different Social Determinants of Health

Social determinant	Cohen *d* (95% CI)
Sexual minority status (bisexual)[41]	1.05 (0.92 to 1.18)
Sexual minority status (lesbian or gay)[41]	0.99 (0.50 to 1.48)
Childhood repetitive abuse[42]	0.91 (0.51 to 1.30)
Sexual minority status (overall LGBTQ+)[41]	0.81 (0.66 to 0.96)
Exposure to suicide attempt[22]	0.70 (0.53 to 0.86)
Childhood sexual abuse (youth)[44]	0.68 (0.59 to 0.76)
Being cyberbullied[60]	0.67 (0.53 to 0.82)
Childhood abuse (youth)[44]	0.67 (0.41 to 0.94)
Childhood sexual abuse[42]	0.64 (0.56 to 0.71)
Childhood combined abuse (incarcerated individuals)[45]	0.62 (0.42 to 0.82)
Exposure to suicide mortality[22]	0.59 (0.39 to 0.80)
Childhood emotional abuse (incarcerated individuals)[45]	0.55 (0.36 to 0.74)
Childhood sexual abuse (incarcerated individuals)[45]	0.54 (0.34 to 0.75)
Childhood physical abuse[42]	0.51 (0.41 to 0.61)
Childhood emotional abuse[42]	0.50 (0.27 to 0.73)
Bullying[52]	0.48 (0.35 to 0.61)
Childhood emotional neglect (incarcerated individuals)[45]	0.46 (0.29 to 0.62)
Childhood emotional neglect[42]	0.46 (0.32 to 0.60)
Childhood maltreatment[52]	0.45 (0.34 to 0.55)
Childhood emotional abuse (youth)[44]	0.44 (0.17 to 0.70)
Childhood physical abuse (incarcerated individuals)[45]	0.43 (0.26 to 0.56)
Childhood physical abuse (youth)[44]	0.43 (0.31 to 0.55)
Being bullied at school[19]	0.42 (0.28 to 0.55)
Childhood abuse, any[42]	0.41 (0.28 to 0.53)
General mistreatment (LGBTQ+ adolescents)[53]	0.38 (0.27 to 0.48)
Any interpersonal violence[52]	0.38 (0.30 to 0.45)
Childhood emotional neglect (youth)[44]	0.36 (0.17 to 0.56)
Being bullied because of LGBTQ+ bias (LGBTQ+ adolescents)[53]	0.35 (0.22 to 0.47)
Perinatal (mother aged <20 y)[34]	0.33 (0.15 to 0.51)
Negative family treatment (LGBTQ+ adolescents)[53]	0.32 (0.19 to 0.45)
Childhood physical neglect (youth)[44]	0.32 (0.13 to 0.51)
Perinatal (single mother)[34]	0.32 (0.14 to 0.49)
Perinatal (low SES)[34]	0.31 (0.21 to 0.41)
Dating violence[52]	0.28 (0.19 to 0.37)
Childhood physical neglect (incarcerated individuals)[45]	0.25 (0.13 to 0.37)
Childhood physical neglect[42]	0.23 (-0.08 to 0.53)
MSH/MSA[54]	0.22 (0.12 to 0.32)
Community violence[52]	0.22 (0.08 to 0.35)
Parental divorce in childhood[57]	0.17 (0.13 to 0.20)
Perinatal (later birth order)[34]	0.09 (-0.02 to 0.19)
Immigrants or refugees[40]	0.08 (0.05 to 0.10)
Internalized homophobia or transphobia (LGBTQ+ adolescents)[53]	0.08 (-0.02 to 0.17)
Lower parental education (youth)[56]	0.06 (0.02 to 0.11)
Religious affiliation[39]	-0.10 (-0.13 to -0.06)
School connectedness[58]	-0.29 (-0.39 to -0.19)



LGBTQ+ indicates lesbian, gay, bisexual, transgender, and queer; MSA, military sexual assault; MSH, military sexual harassment; SES, socioeconomic status.

Tentativi di suicidio: quale diagnosi?

DSM 5 TR: comportamento non disturbo

Abbondante letteratura sui tentativi nelle popolazioni specifiche

Goldstein, 2012; Strober, 1995; Kõlves, 2021; Ang, 2025; Fang, 2024

Studi di **autopsia psicologica**: storicamente una diagnosi psichiatrica è riportata nel 80% -90% dei decesduti per suicidio.

Dati attendibili?

Pirkis, 2023

…e il restante **10-20%?**

recenti dati americani hanno rivelato che la maggior parte dei giovani morti per suicidio non avevano alcuna diagnosi psichiatrica documentata

Chaudhary, 2024

Pfeffer, 1993; Oquendo, 2008; APA, 2013; APA, 2022; Fehling, 2020; Oliogu, 2024

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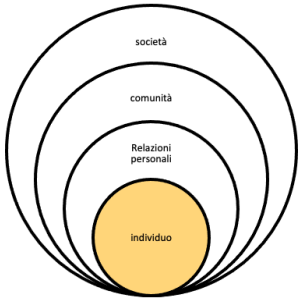
è possibile fare prevenzione del suicidio

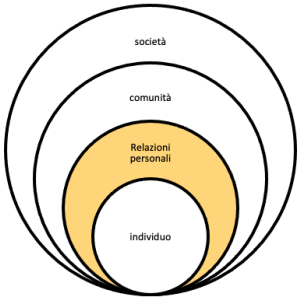
la prevenzione del suicidio
è una **priorità** in termini di salute pubblica

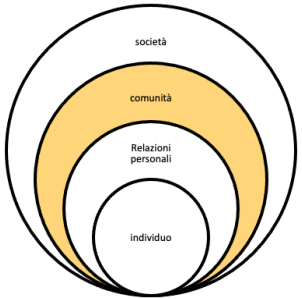
Goal 3 of the SDGs is to: **Ensure healthy lives and promote well-being for all at all ages.** Target 3.4 is: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Within Target 3.4, **suicide rate is an indicator**.



INDIVIDUO
trattamento adeguato del disturbo psichiatrico
sostanze d'abuso
impusività aggressività
pregresso TS

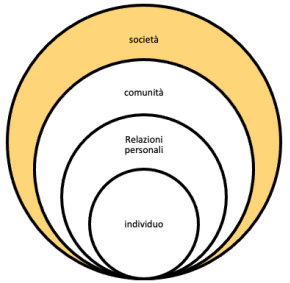
RELAZIONI PERSONALI
supporto alle famiglie fragili
bonifica relazioni violente
famigliarità per suicidio





COMUNITA'
programmi di intervento nelle scuole
formazione dei professionisti (salute mentale e medici di base)
percorsi di supporto dopo ospedalizzazione psichiatrica

SOCIETA'
restrizione accesso metodi letali
interazione con i media
disponibilità accesso servizi salute mentale



Zalsman, Lancet Psy, 2016

identificazione attiva dei soggetti a rischio

suicidalità: fare domande non è pericoloso

al contrario, è **protettivo**:

- può consentire alla persona di **parlare** finalmente della propria sofferenza
- di **trovare aiuto**, essere indirizzato ad un intervento


Appunti di Neuropsichiatria

Il ruolo del pediatra nella prevenzione del suicidio in adolescenza

CHIARA DAVICO[1], FRANCESCA DI FRANCO[1], ELENA LONARDELLI[1], CLAUDIA BONDONE[2], BENEDETTO VITIELLO[1]

[1]SC di Neuropsichiatria Infantile, Dipartimento di Scienze della Sanità Pubblica e Pediatriche, Università di Torino
[2]SC di Pediatria d'Urgenza, AOU "Città della Salute e della Scienza", Torino

Blades, 2018; Gould, 2005; Mathias, 2012; Luoma, 2002;

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Trattamenti e interventi

PRIMER

Suicide and suicide risk

Gustavo Turecki[1], David A. Brent[2], David Gunnell[3,4], Rory C. O'Connor[5], Maria A. Oquendo[6], Jane Pirkis[7] and Barbara H. Stanley[8]*

Management

In the past two decades, most efforts to develop suicide-specific psychosocial interventions have moved away from the view that treating the underlying psychiatric disorder would resolve suicidal urges and thoughts, to a perspective that suicide-specific treatments are necessary in addition to interventions for primary psychiatric disorders. Furthermore, in recognition that many people who become suicidal have limited access to behavioural treatments or do not wish to receive these treatments, brief suicide prevention approaches with limited or no health professional intervention have been developed (BOX 2).

Trattare la suicidalità, indipendentemente dalla diagnosi sottostante.

Turecki, Nature Review, 2019

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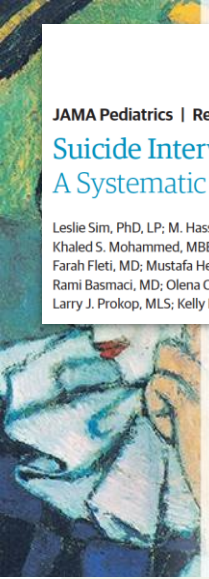

JAMA Pediatrics | Review

Suicide Interventions for Youths
A Systematic Review

Leslie Sim, PhD, LP; M. Hassan Murad, MD, MPH; Paul E. Croarkin, DO, MS; Alastair J. McKean, MD; Khaled S. Mohammed, MBBCh; Tamim I. Rajjo, MD, MPH; Mohammed Firwana, MBBS; Suvyaktha Simha, BA; Farah Fleti, MD; Mustafa Hegazi, MBBS; Mohamed E. Abusalih, MBBS; Mohammad Al-Kordi, MD; Rami Basmaci, MD; Olena Chuzhyk, MD; Samer Saadi, MD; Bashar Hasan, MD; Magdoleen H. Farah, MBBS; Larry J. Prokop, MLS; Kelly E. Viola, MPS; Zhen Wang, PhD

Despite an increase in suicidal thoughts, behaviors, and suicide deaths among young people and among youths from racial and ethnic minority groups, there are few evidence-based guidelines to inform the implementation of interventions for children, adolescents, and young adults at high risk for suicidal thoughts and behaviors. In practice, treatments for suicidal thoughts and behaviors typically include psychosocial and pharmacologic interventions or their combination, although most of the supporting evidence has been extrapolated from studies on adults.[4-6] Given

suicide awareness or gatekeeper programs, and community-based, culturally tailored adjunct programs). Dialectical behavior therapy showed moderate strength of evidence for reducing suicidal ideation. Other categories of psychosocial treatments showed insufficient to low strength of evidence for reducing suicidal outcomes. None of the studies evaluated adverse events. The evidence base on pharmacologic treatment for youths at risk of suicide was largely nonexistent.

Sim, Jama Pediatrics, 29 sett 2025

Humana

Interventi per ideazione suicidaria e comportamenti suicidari

Opinion

EDITORIAL

Confronting Gaps in the Evidence for Youth Suicide Prevention—Why Inaction Is Not an Option

Laura M. Prichett, MHS, PhD; Emily E. Haroz, MA, MHS, PhD; Holly C. Wilcox, MA, PhD

guide clinicians in treating youths at elevated risk.

However, it is critical to interpret this uncertainty with care. "Insufficient evidence" is not evidence of ineffectiveness. The more accurate conclusion is that many existing studies have

- No suicide contacts
- Safety plan
- Crisis respo

atients
cidal

inaction is not an option

Prichett, Jama Pediatrics, 29 sett 2025

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Interventi per ideazione suicidaria e comportamenti suicidari

Box 2 | **Interventions for suicidal ideation and suicidal behaviour**

Psychosocial

Longer-term psychosocial interventions

- Cognitive behavioural therapy
- Dialectic behavioural therapy
- Collaborative assessment and management of suicidality
- Acceptance and commitment therapy
- Mentalization
- Interpersonal psychotherapy

Brief interventions

- Caring contacts
- No suicide contacts
- Safety planning intervention
- Crisis response planning
- Attempted suicide short intervention programme
- Volitional help sheet

Pharmacological

Pharmacological agents with potential effect on suicidal behaviour

- Lithium
- Clozapine[a]
- Ketamine
- Selective serotonin reuptake inhibitors
- Buprenorphine

[a]Clozapine is indicated in treatment of patients with schizophrenia who present with suicidal ideation.

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Safety Plan (NICE guidelines self-harm)

1.11.7 Consider developing a safety plan in partnership with people who have self-harmed. Safety plans should be used to:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

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Safety Plan (NICE guidelines self-harm)

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Research

JAMA Pediatrics | Original Investigation | ADOLESCENT MENTAL HEALTH

Safety Planning Interventions for Suicide Prevention in Children and Adolescents

A Systematic Review and Meta-Analysis

Carly Albaum, PhD; Samantha H. Irwin, MSc; Jessica Muha, MSc; Anett Schumacher, PhD; Sherinne Clarissa, BSc; Yaron Finkelstein, MD; Jeffrey A. Bridge, PhD; Daphne J. Korczak, MD

and emergency contact details

- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

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Given the mandate for safety planning in working with patients at risk for suicide,[79] the lack of compelling evidence for acute safety planning interventions over treatment as usual was surprising, especially because these interventions were structured, multicomponent interventions. It is possible that adolescents assigned to receive treatment as usual also participated in safety planning in the context of follow-up outpatient care. However, the focus on safety planning may have also reduced session times to focus on interventions to address underlying risks and vulnerabilities.

Uncertain evidence does not mean that clinicians should not screen, treat, or proceed with safety planning. Rather, clinical practice and public health policies should be based on a combination of comparative effectiveness evidence, clinicians' expertise, and patients' and families' values, preferences, and unique social context and characteristics. These factors, in addition to evidence, can support decision-making. Because inaction is not an option, practice evaluation should continue alongside clinical practice.[80-82] In light

esistono farmaci specifici: si? quale?

Specifico effetto antisuicidario di:

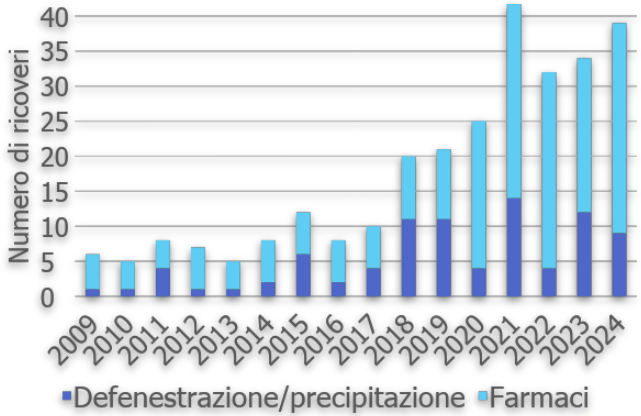
- litio nel disturbo bipolare
- clozapina nella schizofrenia
- …esketamina…

mended. A similar absence of studies on the benefits or harms of neurotherapeutics or other novel biological treatments (eg, ketamine) for youths at risk of suicide means that such treatments should remain experimental for youths at risk of suicide at this time.

->Trattare il disturbo sottostante

ATTENZIONE ALLA PRESCRIZIONE

limitare accesso ai metodi letali
= prevenzione universale



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