Problems with Interpreting and reporting suicide research

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In 2013/14 a paper (Shahtahmasebi, 2014) highlighting and critiquing two myths most commonly referred to as facts in suicide research and suicide prevention was submitted to several top journals in the fields of psychiatry and suicidology. The response from the journals was swift and very similar. Their reason for not reviewing this paper was a large number of submissions as their reason for prioritising only certain types of research, e.g. longitudinal studies, systematic reviews or meta-analysis. A quick exploration of the journals' Table of Contents told a different story. My reply to the editors was that by such an editorial strategy the editors were contributing to the problem. Of course, there were no replies.

Naturally, journal editors need to maintain quality and relevance within a defined scope in search of insight and knowledge. To achieve this, journal editors take the responsibility in making sure that various topics discussed in a journal issue are well articulated and critiqued. After all, the main aim of scientific academic research is to withstand rigorous academic critique.

In practice, however, journals wanting to be aligned with a particular school of thought may be subject to political interference/influence. There is no difficulty with journals wishing to follow or promote a particular line of enquiry or methodology. Problems arise when a handful of journals become the main source of influencing policy and decision makers.

Major problems arise when politicians and policy makers align the process of policy formation with those promoted by journals without a critical assessment of the evidence presented. The obvious outcome of uncritical use of evidence to base policy formation on a mental illness link to suicide is circular logic or logical fallacy that in previous publications I have referred to as "more of the same".

Despite growing evidence questioning the value of a medical model for suicide prevention and intervention (Hjelmeland et al., 2012; Pridmore, 2014; Pridmore & Walter, 2013; Shahtahmasebi, 2003; Shahtahmasebi, 2013; Shahtahmasebi, 2014), health authorities and researchers have continued to promote a medical model to prevent suicide. As a result, suicide prevention/intervention policies often tackle mental illness and depression but leave 'suicide' untreated, therefore contributing to the suicide patterns shown by long-term suicide trends. Frequently, researchers and authorities alike use short-term trends usually at the end of a cycle: when the end of the cycle happens to be a downturn in suicide trends then they claim success for the medical model; when it shows an upturn in suicide trends they claim suicide is complex and influenced by many factors within the medical model. Therefore, every year and every policy making cycle the suicide prevention strategy presents mental illness and depression as the only way to stop suicide, i.e. look for signs of mental illness and depression and refer to medical services: therefore "more of the same".

Even attempts at being innovative such as a grassroots or community-based strategy (e.g. http://www.prevent-suicide.org.uk/) provides "more of the same" because the goal of such approaches is to train communities, minorities and indigenous population (e.g. Maori) to look for signs and refer to medical services.

The problem with the medical model for preventing suicide is that by the time signs have manifested and being observed it is too late and an event has occurred, so referring to medical services becomes an intervention. And because of the emphasis on a medical cause for suicide the subject is treated for symptoms of mental illness and depression completely ignoring suicide. It is not surprising that:

- Between two-thirds and three-quarters of all suicide cases do not come into contact with mental health services
- A proportion of those suicide case who receive mental health support complete suicide either during treatment or shortly after being discharged from mental health units
- Patient data from a mental health hospital in Leeds, UK, revealed that only about 16% of the patients who completed suicide had depression either as diagnosis or as a comment; about 32% had no diagnosis (Shahtahmasebi, 2003)
- Over the last 12 years the number of antidepressant prescriptions had more than quadrupled in New Zealand but over the same period suicide rates have maintained an upward trend

Why do we insist on a model that does not work for the general population? One possible answer could well be that while politicians and decision makers have taken too long to debate alternative approaches the medical model is now rooted and established as the gold standard. Therefore, any critiquing of this gold standard model including statement of the facts (as above) is often dismissed as anti-psychiatry.

The fact is that our current information about suicide is incorrect, invalid and based on flawed research and irrelevant to a suicide prevention policy. Leading journals continue to insist on and promote a flawed model to explain suicide in spite of the overwhelming evidence to the contrary; researchers, the media and the public follow the journals' lead and continue with flawed research and flawed methodology; politicians and decision makers continue to use flawed information to develop "more of the same" policies but at higher costs each year in lives lost to suicide and in economic terms. The uncritical use of evidence has made researchers, their publishers, politicians and decision makers part of the suicide problem rather than a solution.

Anti-psychiatry has been used as a reason to dismiss critical assessment of current suicide prevention policies. Firstly, the above comments and associated references are a critical assessment of current official suicide prevention strategies and policies. Secondly, it must be noted that psychiatry and the medicalization of suicide is the only approach to developing a suicide prevention strategy. Thirdly, there are no 'official' alternative and non-medical strategies in operation. Therefore, it is wrong to claim critical assessments of 'evidence' are

anti-psychiatry. Furthermore, most alternative approaches, in particular a holistic approach, are not exclusive but are inclusive of the medical model.

In contrast, strategies based on the medicalization of suicide continue to exclude knowledge of communities, culture, human behaviour and micro- and macro level problem solving, so that we will forever continue to offer "more of the same".

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