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What is suicide prevention?

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This issue of DHH is dedicated to youth suicide prevention campaign in Kentucky, USA which began in 2001 as a one year youth suicide awareness campaign and developed into a major grassroots programme. In this editorial I present a brief discussion of some of the controversies in suicide research and prevention in order for the reader to grasp the enormity of the problem that is inherent to developing a successful suicide prevention plan.

Suicide is a major public concern, yet, in most countries suicide prevention has mostly been viewed as a mental illness and suicide prevention has been planned under mental health policy. Suicide 'experts' and decision makers appear to be confused about the difference between intervention and prevention. Using mental illness as the cause of suicide in order to intervene and prevent suicide has been criticised as far too simplistic and an ineffective way of preventing suicide (Hjelmeland et al., 2012; Pridmore & Walter, 2013; Shahtahmasebi, 2003). As a result a number of issues arise.

Firstly, despite many countries, including New Zealand, allocating resources to make mental illness less taboo and more mainstream, it is still a social embarrassment. Linking suicide to mental illness automatically attaches the label 'mentally ill' to the suicide ideation. It is highly plausible that someone with suicidal tendencies may not seek help in order to avoid being labelled as mentally ill.

Secondly, current estimates suggest that between two-thirds and three-quarters of all completed suicides do not come into contact with mental health services (Hamdi et al., 2008; Shahtahmasebi, 2013). Very little is known about this population and therefore it is unwise to insist that suicide is caused by mental illness.

Thirdly, the mental illness approach as a prevention strategy has never worked for the main reason that waiting for suicide symptoms (depression, mental illness) to manifest is not prevention but intervention. Furthermore, due to the lack of quality data the effectiveness of psychiatry to intervene and prevent suicide is questionable as between one-quarters and one-third of all suicide cases received mental health intervention/treatment but went on to complete suicide (Shahtahmasebi & Smith, 2013).

Fourthly, unlike other medical procedures and intervention, psychiatry rarely provides treatment *specification*, e.g. risk assessment, likelihood of success/failure, in particular when applied in the treatment of suicide victims (Shahtahmasebi & Smith, 2013). It is, basically, a process of trial and error which leads to poor data and a belief that a mental illness approach is the only way to prevent suicide.

Fifthly, persisting on a strategy which is based on training the public to recognise signs of suicide and refer to mental health services is the result of a 'top-down' approach where 'experts' and decision makers and politicians know best. An artefact of a 'top-down' approach is contempt for evidence. For example, long-term suicide trends provide evidence of cyclic effects suggesting that suicide rates appear to have a memory/pattern. 'Experts' often use short-term trends and at the cycle's downturn when the suicide trend is downward they claim credit for their policies, but at the cycle's upturn when the suicide trend is upward they claim that suicide is a very complex issue and requires further research. Insisting on mental illness as the cause of suicide leads to mental illness defining the parameters of suicide research and limit it resulting in poor and flawed research, and erroneous conclusions (Hjelmeland et al., 2012; Shahtahmasebi, 2009; Shahtahmasebi, 2013; Shahtahmasebi, 2014). Decades of further research has not provided any answers but has instead provided us with

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more of the same at a higher cost, i.e. cycle after cycle of not only increasing investments in monetary terms but also in terms of lives lost to suicide.

Sixthly, if psychiatric intervention is the most effective method of preventing suicide, then why does the service not demonstrate a sense of urgency to do so? There is anecdotal evidence to suggest the current perception amongst potential victims is that the only way to see a psychiatrist is to make a suicide attempt (Shahtahmasebi & Smith, 2013). The service has no provisions for weekends and holidays. Often, those needing the service or being referred, or being discharged from hospital on a Friday have no support; it is no surprise that some won't make it until the following working day (Shahtahmasebi & Smith, 2013).

In New Zealand, anti-depressant prescriptions doubled between 1997-2005 (Ministry of Health, 2007), and since 2005 anti-depressant prescriptions have doubled again (Antidepressant use in New Zealand doubles, 2012), yet, over the same period suicides increased to 540 in 2007/8 and up to 558 in 2010/11 (Chief Coroner, 2011).

The case against adopting a single simplistic intervention to prevent suicide is very strong and yet policy makers continue with the same strategy that suicide is caused by mental illness and the same action plans to intervene and categorise and treat those seeking help with a mental illness diagnosis. This is not suicide prevention nor is it intervention as this method fails to tackle suicide and places undue emphasis on mental disorders.

To break or interrupt the cycles in both suicide trends and 'more of the same' action plans we must place the emphasis back on 'suicide'. We may not understand suicide per se, but the literature suggests that we have a better understanding of human behaviour than suicide. Suicide is the outcome of the process of decision making that is heavily influenced by social, health, economic, culture and environmental parameters. Therefore, the best place to start suicide prevention is at the grassroots (Pridmore, 2014; Pridmore & Walter, 2013; Shahtahmasebi, 2013) to empower communities to own the problem and thus own the solution.

One such prevention approach is the 'Stop Youth Suicide' Campaign which was developed in Kentucky in 2001 (see Chapter 2). The campaign began with suicide awareness programmes which engaged all sections of the community. Through public engagement a number of action plans were developed and led by an adolescent specialist. The campaign, through a mix of clinical intervention, suicide prevention awareness and training in schools, law changes, and so on, has reduced suicide rates in Kentucky. More importantly, there is some evidence that this reduction in suicide rates may have been achieved by changing adolescent's attitudes, perceptions to suicide and health related behaviour (see Chapter 5).

In this issue of DHH, the 'Stop Youth Suicide' Campaign is described from its inception (Chapter 1), methodology (Chapter 2), it community impact (Chapter 3), methodology for the secondary data source used for evaluation, to presentation and discussion of recent evidence supporting the effectiveness of this programme. In other words, recent evidence (Chapter 4 & 5) supports that the Campaign has resulted in a change in adolescents' behaviour as well as community awareness and community actions such as changes in law to restrict access to prescription drugs, fire arms, and suicide education in schools. In turn, this change in behaviour occurred over the same period of a sustained reduction in suicide rates in Kentucky.

Operationalising a holistic suicide prevention strategy may be achieved successfully through establishing suicide prevention units called *grassroots centres* (without any link to suicide) with the task of owning the suicide problem and delivering local solutions to prevent and when necessary intervene appropriately.

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