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Suicide prevention: politics or conspiracy

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As I put the final touches to yet another paper on suicide prevention, it was announced on Radio New Zealand (Tuesday 18/10/16, 1pm: http://www.radionz.co.nz/news/national/315925/suicide-stats-remain-'unacceptably-high') that suicide numbers in New Zealand are unacceptably high and have increased to an all-time high 579. I guess we have heard this so many times that feelings of anger are replaced by despair. Over the last 20 years I have repeatedly challenged the conventional wisdom about suicide emphasising that suicide rates follow a cyclic pattern (the sequence of downward and upward movement of suicide rate). Instead of concentrating efforts on breaking the cycle, decision makers, mental health services and researchers, claim credit for lowering suicide rates when the cycle is on the downturn, and demand more funding to continue with the same services. But when the cycle is on the upturn, they claim that suicide is a very complex issue with many socio-economic and environmental risk factors and that more funding is required to outreach the same service to more people.

This maybe fine the first time, however, after many decades of researching and psychiatric intervention, the reality is that suicide prevention is really more of the same: 'look for sign of mental illness and refer to mental health services"! Except that each year a strategy of 'more of the same' is costing more in terms of lives lost and monetary terms.

You see, suicide is not a mental health problem. Not many people with mental illness or depression commit suicide but some suicidal people receiving psychiatric intervention do. Current estimates suggest that about one-third of all suicide cases had had previous contact with mental health services but still they went ahead and completed suicide.

On the other hand, between two-thirds and three-quarters of all suicide cases have no contact with mental health services, which means we don't know anything about their state of mind. Furthermore, psychological autopsy studies linking mental disorder to suicide have been challenged and discredited (Hjelmeland *et al.*, 2012; Shahtahmasebi, 2013b; Shahtahmasebi, 2014). So how can psychiatrists and politicians still claim that suicide is the result of mental illness?

A UK study (Shahtahmasebi, 2003) using patients' record from a psychiatric/mental health hospital showed that out of those who sought psychiatric help and completed suicide only 16% had depression recorded as a diagnosis or as a note somewhere in their medical notes, 33% had a different classification such as schizophrenia, alcohol or drug abuse, paranoia, personality disorder – 17% had 'other', and astonishingly 33% did not have a diagnosis. Therefore, about 50% of the patients had no mental illness diagnosed at the time of suicide. The question arises that what is known about those cases who had no contact with health services?

The whole notion of 'look for signs of mental illness and refer' to prevent suicide defies logic and is counter intuitive. There are several problems with this strategy. First, it assumes that only people with a mental disorder commit suicide. *This is not true*. Second, clearly, this

method will ignore majority of people who may be suicidal and needing help. Third, by associating suicide to mental illness, people who experience suicidal thoughts/behaviour potentially avoid seeking help. Fourth, if signs are detectable then prevention has failed and it is time for *effective* interventions. Fifth, psychiatric intervention failed to prevent a proportion of all suicide cases who were referred to mental health services.

Government's documents (Antidepressant use in New Zealand doubles, 2012; Ministry of Health, 2007) show that in New Zealand prescriptions for antidepressant has more than quadrupled since 1997, yet the suicide rate has continued in a cyclic upward pattern, now reaching an all-time high of 579.

If mental illness is the cause of suicide, given the massive resources redirected to mental health services for suicide prevention, we should observe two main outcomes: first, a proactive psychiatric service, and second a continual reduction in the number of suicides. Over the past decade we have observed none of these outcomes (psychiatric services: http://www.radionz.co.nz/news/national/316339/young-people-wait-months-for-mental-health-appointments, suicide numbers: http://www.radionz.co.nz/news/national/315925/suicide-stats-remain-'unacceptably-high'). This suggests that mental health services themselves do not believe that (a) mental illness is the cause of suicide, and (b) mental health services can prevent suicide.

So it is not only 'more of the same' in suicide prevention action plan but also 'more of the same' in rhetoric: at every cycle upturn ministers and their 'experts' claim that suicide is 'unacceptably' high and mental health services must be strengthened.

'More of the same' is symptomatic of a lack of accountability!

Unfortunately, patronising the public is an artefact of authority without accountability. Consider other health outcomes such as heart disease. After decades of research, innovation, and technological advancement – ironically compared with suicide we have a much better understanding of heart disease – yet, according to WHO cardiovascular diseases are still the number one killer (http://www.who.int/mediacentre/factsheets/fs310/en/index2.html).

The philosophy of preventing suicide through mental health intervention is no longer tenable.

Psychiatric research promoting mental illness as the cause of suicide has been challenged and debunked/discredited. In a recent publication WHO lists mental illness causing suicide as one of the many myths and has modified it's guidelines (Preventing suicide: A global imperative. *http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/*).

Unsurprisingly, during the news report on latest suicide numbers, the minister for health's response was 'we should strengthen our mental health services'!

There is no doubt that mental health services must be supported effectively to deliver efficient services and to improve health outcomes. However, mental health services cannot prevent suicide.

Another false assumption is that insight about suicide can only be obtained from psychiatry and suicidology journals. However, prominent psychiatry and suicidology journals publish

only conventional articles that promote the mental illness as the cause of suicide despite ample evidence to the contrary.

So although, some blame for the lack of understanding of suicide can be apportioned to prominent journals for biased coverage of suicide, a larger proportion of the blame must surely be accepted by the governments' researchers and policy makers. After all the point of doing research is to eliminate bias and provide appropriate and relevant information to inform the process of policy making.

In 2011, the former Chief Coroner of New Zealand, Judge Neil MacLean stated that current suicide prevention techniques are not working and stressed that a new approach is needed. "I have suggested that there may be room for a gentle opening up of the restrictions on media reporting of suicide, but we need to consider all viewpoints – especially those of families – so we can make informed decisions." (http://www.3news.co.nz/Chief-Coroner-releases-NZ-suicide-statistics/tabid/423/articleID/223638/Default.aspx#ixzz230JkrbCi).

The Chief Coroner was criticised by proponents of the medical model some of whom are members of government committees on mental health. Uninspiringly, their criticism was based on the discredited research linking mental disorder to suicide. Unperturbed Judge MacLean continued supporting alternative approaches to suicide prevention. The new Chief Coroner has been very quiet.

With the recent release of suicide data rising to an all-time high of 579 (http://www.stuff.co.nz/national/health/85449334/nz-suicide-toll--unacceptably-high). The only conclusion that can be made is that the strategy of 'more of the same' does not work, because of its central philosophy of waiting for mental disorder symptom to develop and be recognised before action can be taken! A very good example is the case of Christchurch, New Zealand. During the year that Christchurch was devastated by a series of earthquakes (2010-11) zero suicide was reported but authorities and 'experts' warned that suicide would not stay at zero and would go up. This was the extent of suicide prevention in Christchurch post-earthquake. If signs and symptoms are what the 'experts' wanted there were aplenty (http://www.radionz.co.nz/programmes/christchurch-dilemmas/story/201811951/episode-2-christchurch's-mental-health-crisis)! The same 'experts' missed the opportunity of activating programmes to maintain zero suicide because they sat on their seats waiting for symptoms to show up.

A simple but effective strategy would have been a collaborative approach between the Ministry of Health, Minister for earthquake, the Government, Earthquake Commission, and insurance companies to avoid lengthy and highly stressful process of settling earthquake damage.

The ups as well as downs in suicide numbers are pretty predictable and yet again at every upturn 'experts' demand more funding without accountability, and funders appear to be blindsided by predictable upturns!

During my 20 years involvement with suicide research it transpired that globally the public at large is looking to the government and their 'experts' for initiatives and resources. In the meantime, a lack of public discussion of suicide has led to misinformation and myths about suicide. As a result the language of suicide discourse is heavily mental illness biased which is not only foreign to the public but also taboo. So for fear of saying the wrong thing people do

not know how to communicate with someone who may be suicidal, or how to prevent it, or even how to conduct a conversation with a suicide survivor (those who have lost a loved one to suicide).

The problem is exacerbated by an uncritical media who push the medical model and refer to proponents of the medical model as the 'experts'.

The truth is that we do not understand suicide because all of our efforts have been on treating a mental illness that may or may not exist. In other words, if an individual is referred to mental health services (whether they are self-referred or because of a suicide attempt or by a health professional) the intervention looks to establish a mental disorder such as depression for which medication can be prescribed. So in the process of treatment 'suicide' per se is taken out of the equation and is ignored. Treating a condition that does not exist explains the reason why the proportion of all suicide cases who received psychiatric treatment completed suicide.

Through the process of raising research funds, I realised several points:

1- it is futile to wait for the government to take the initiative and act in the interest of the public,
2- suicide prevention does not require major funding and can be operationalised with a small amount of resources,
3- uncritical and flawed suicide information is contributing to mis-information in the public domain,
4- so long as suicide prevention remains highly politicised 'more of the same' is the only suicide prevention action plan available to the public.

In order to achieve a change in direction suicide prevention must be de-politicised. A sure way of achieving this is to engage the public. This can be achieved by providing the public with quality and appropriate information about suicide and human behaviour. In 2010, the grassroots approach to suicide prevention (Shahtahmasebi, 2013a) was rolled out in the Waikato Region and Kawerau through a series of training workshops. The philosophy behind the grassroots approach is that we, the public, cannot wait for signs of mental disorder to manifest and then seek psychiatric intervention. The aim is to prevent people getting to the stage where they feel that suicide is a viable option.

A couple of very important outcomes from the workshops were; first, we received many personal comments from suicide survivors (parents who had lost a loved one to suicide) e.g. "had they known this information then their loved one would probably be alive today." Second, participating communities formed suicide prevention groups enforcing prevention rather than intervention. The groups developed local-based suicide awareness activities designed to inform and to prevent. The frontline health and social workers in the participating communities reported that suicide, in particular youth suicide, had substantially reduced. A trend that continues to the present date.

The communities have reported that they are much more confident in engaging in problem situations and preventing them becoming a suicide crisis.

The workshops were funded through local institutions and charitable trusts, a Fulbright grant, frontline workers and volunteers. Attendees included social workers, mental health frontline workers, police, coroners, psychiatrists, GPs, teachers, church representatives, youth, general

public, and suicide survivors. Unlike the medical model, the grassroots approach is an inclusive strategy.

I guess the concluding message is that if the public is sick of 'more of the same' suicide intervention strategy then the grassroots must mobilise and take action… after all it is the grassroots who know their communities better than the 'experts' or government decision maker.

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