**Editorial: Suicide prevention: a global problem, a local solution**

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## INTRODUCTION

The aim of this short editorial is to highlight some important issues in suicide prevention which is also the focus of this issue.

In 2010 a series of youth suicide prevention workshops were provided to a number of communities in Waikato, New Zealand by Professor Hatim Omar, the Chair of Stop Youth Suicide in Kentucky, USA (http://www.stopyouthsuicide.com/). This was the start of a grassroots approach to suicide prevention. Some of the workshop attendees helped establish suicide prevention groups in their own communities, with initiatives developed and delivered at community level. The workshops proved popular with the local communities and by 2013 the grassroots initiative and workshops were presented across New Zealand. The grassroots initiative maximised community involvement through the provision of appropriate information about adolescence and adolescent behaviour and suicide prevention. The idea is that quality and relevant information will empower communities to formulate appropriate solutions for problems in their communities. The initiative is not prescriptive and acts only as a sounding board in supporting the communities. The main reason for this approach is that local communities vary in their makeup and needs and only grassroots are best placed to understand community's resources and needs.

Because of its popularity it was decided to develop the grassroots initiative as a People's Conference in 2014 where many communities could attend. However, despite the demand from the grassroots and support from the Chief Coroner and community organisations such as Trust Waikato and Foodstuffs community grants, government funding organisations failed to financially support this event. Further stumbling blocks were from organisations who claim to be serving their communities! This was not totally unexpected so the event is now scheduled for 2015. A grassroots approach will be used to fund this event.

One of the advantages of the grassroots approach is the clarification of what is meant by "prevention" in the phrase suicide prevention. To prevent suicide within a community and in a social setting is a complex notion. It involves understanding social and community parameters as well as those of individuals' in order to develop strategies and action plans to diminish and eradicate suicide as a valid 'solution' to problems.

Preventing suicide in an individual setting where suicidality may be suspected is not prevention per se but an intervention, and requires different strategies and action plans to convince the case that suicide is not the answer.

Therefore, a one glove fits all approach is inappropriate for suicide prevention or intervention. The current approach to suicide intervention is to look for signs and refer to mental health services. Decades of data from applying this approach has not led the authorities and researchers delivering such an action plan to ask the most obvious question: is this approach working? The medicalization of suicide has helped interventional strategies to

focus treatments on mental illness symptoms and ignore suicide altogether. There is no doubt that medical intervention will work for some but not for all.

Much has been written about suicide but we are still none the wiser as suicide rates still follow an upward trend. In other words, our current understanding of suicide does not sufficiently support our suicide prevention action plans. In fact, our knowledge of suicide is leading suicide prevention in the opposite direction. The reason for this lack of insight is that most 'expensive' and leading suicide research has been guided by psychiatric and mental illness theories.

There is nothing wrong with theory driven study. Indeed most applied and blue sky research are designed to gain insight, prove or disprove a theory. However, problems arise when such research is used uncritically to inform the process of policy formation over many decades. In other words, previous and new research in suicide presumes mental illness and depression from the outset. The resulting outcomes are inappropriate policies, 'more of the same' inappropriate action plans, politicisation of suicide and suicide prevention, compounding and confounding suicide prevention by making researchers, policy makers and the public part of the problem rather than a solution.

One of the major adverse effects of politicisation is that the adopted approach to suicide prevention has left no room for integration of other evidence-based alternative and complimentary approaches and views. In other words, the current suicide prevention approach is an exclusive medical model despite a change in the syntax over the last few years of acknowledging that suicide is complex and may be influenced by other social and economic factors. Nevertheless, the resulting preventive strategy and action plans are medically based, e.g. look for signs and refer, and training programmes for front line workers, grassroots etc to recognise signs and refer to medical services.

Once again, there are no major problems with such an approach provided that the evidence can support the link between the 'signs' and suicide, but that is not the case. There is a growing body of work to refuting the evidence linking mental illness and depression to suicide.

An implication of exclusivity is the development of a false perception that alternative approaches and critical evaluations are anti psychiatry, which has been used to defend the medical model. This argument is false and is a fallacy. Firstly, do anti-psychiatry comments automatically validate the medical model? Secondly, critical evaluations are usually carried out on an existing policy comparatively. In other words, current policy may be compared with alternatives or with previous policies. In the case of suicide prevention there has not been any existing or previous alternative policies. Furthermore, suicide prevention has always been psychiatry led. Therefore, critical assessment of psychiatry's approach to suicide prevention, which has been officially adopted by governments, cannot be avoided. Therefore, it is a false and invalid defence to make the claim that other alternative views of suicide prevention are anti-psychiatry.

There is also anecdotal evidence that individuals may not be interested, for whatever reason, in a medical intervention. Therefore, even if such individuals are identified as at risk they are likely to deny any symptoms and refuse intervention. Stigma may explain a proportion of these cases' refusal to acknowledge symptoms and seek medical assistance. For some, the reasons may be related to a fear of hospitalisation, loss of freedom, feeling of being powerless, and perceived inappropriateness of services.

## SUMMARY

Suicide is a phenomenon that cannot be explained by one or two disciplines, especially in order to design prevention strategies and action plans. The suicide literature is probably right about the many risk factors linked to suicide, but each reported link might only be valid in the context of the study that reported them. Therefore, no one study can appropriately be used to infer or to generalise these links to the population. In other words, the medical approach may only work for those whose mental illness directly relates to suicidal behaviour but will not necessarily be effective for others, e.g. stress, trauma, pain, bereavement, unemployment (and employment) and so on. We must remember that although a proportion with depression may commit suicide, a larger proportion never contemplate suicide; conversely, a proportion of people without depression also commit suicide. Similarly, unemployed people may commit suicide but so do those in employment; those bereaved may commit suicide but so do those who are not bereaved. Therefore, we need to be holistic in our thinking in designing prevention strategies and action plans to include the various dimensions of suicide all at once.

It is a folly to train individuals to recognise the "signs" and "refer" when (i) governments' policies exacerbate the sources of problems, and (ii) health and social infrastructure is not capable of supporting needed care. For example, anecdotal evidence suggests that sometimes individuals seeking help when feeling suicidal do not receive the help they need when they need it and are offered an appointment with a psychiatrist days or even weeks later (Shahtahmasebi & Smith, 2013). Another example of discord between policy and action, amongst many, is bullying in the workplace. Bullying is quite common, especially within the health and education sector, and is associated with workplace stress and adverse physical and mental health outcomes including suicide (Shahtahmasebi, 2004). Ironically, some employers offer stressed staff a limited number of counselling sessions and others offer token gestures such as making jigsaw puzzles available in the staffroom! Clearly, recognising the "signs" and "referring", counselling and jigsaw puzzles are ineffective in removing the source of the problem. It would be more productive and economical if "stress" is abandoned as a management tool to manage/control employees (Shahtahmasebi, 2004). Governments must adopt a holistic approach to developing suicide prevention strategies and have appropriate action plans.

Ideally a suicide prevention approach will be multi-dimensional in real time dictating the collaboration and involvement of all actors and groups. The grassroots approach empowers and enables such a holistic methodology.

*Let's start the conversation… radisolevoo@gmail.com*

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