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Editorial: the dynamics of suicide prevention

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Over time and more recently there have been reports of suicides by celebrities (e.g. https://www.bbc.com/news/world-us-canada-44416727, https://www.radionz.co.nz/news/world/359157/kate-spade-s-death-ruled-a-suicide, https://www.radionz.co.nz/national/programmes/afternoons/audio/2018648754/how-to-support-people-with-mental-illness). Although, such reports bring suicide to the public attention however the discussion is often one-sided and top-down. The media's reporting links depression and mental illness to the case's suicide. The only evidence of proof of this association offered by the media are claims by the case's partner or a close relative/friend about the individual's long-term battle with depression and mental illness. The media although quick to highlight a history of depression and mental illness fails to mention that these cases still committed suicide despite seeking psychiatric treatment.

With the help of media depression and mental illness as causes of suicide are well established in the public mindset. Whether reporting suicide by celebrities or members of the public the media presents depression as the main cause of suicide and always recommend that people who are feeling suicidal, or know of someone who is suicidal to contact mental health services. In other words, the 'outcome' suicide has become an indicator of mental illness – a person is/was tagged mentally ill or depressed following a suicide. It is baffling what purpose this indicator serves especially when the outcome is completed suicide, i.e. how would mental health services help the suicide cases' mental wellbeing when they are dead?

There are several problematic issues: first, we don't know anything about the suicide case and the case is no longer alive to provide insight into their actions, yet, following a suicide an automatic connection with mental illness is made – people will freely make comments and judgement about the case. This is readily observed in the case of a celebrity suicide in particular through social media. Second, this presumption of depression and labeling the cases as mentally ill reinforces the taboo and prevents people from seeking help. Third, the presumption of mental illness causing suicide can lead to over medication of the public. For example, *The New Zealand Medical Journal* claims that depression is a common, serious, and significant illness and links it to suicide and recommends medication (http://www.nzma.org.nz/journal/117-1206/1200/). It is not surprising to hear that young people have been prescribed antidepressants, including preschool children, but more alarming is the prescribing of antidepressants to some under 1 year old (http://www.nzherald.co.nz/section/1/story.cfm?c_id=1&objectid=10462684, see also https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11870484). In New Zealand antidepressant prescriptions more than quadrupled during 1996-2012 while suicide numbers maintained an upward trend reaching record high three years in a row in 2015, 2016, and 2017 (Shahtahmasebi, 2018).

There is a wealth of evidence which discredits mental illness as the cause of suicide, but never reported by the media. So is it the lack of competency in investigative reporting by the media, or, the stranglehold on suicide by psychiatrists that the recent announcements by the

World Health Organisation (WHO) and Centers for Disease Control and Prevention (CDC) were not reported in the media? WHO has recently described as a myth the claim that all suicide is caused by mental illness (WHO, 2014), and the CDC has finally declared that suicide is not a mental health problem (CDC, 2018). In the light of rising suicide rate why doesn't the media show any interest in questioning the status quo - and for that matter why aren't governments interested in challenging the status quo and investigate alternative suicide prevention strategies?

This is a question that only the media can answer but at the periphery there is substantial evidence of a highly politicised suicide prevention policy formation. Psychiatric and suicide research journals refuse to publish suicide studies that deal with prevention rather than psychiatric intervention. Therefore, the public and decision makers are rarely exposed to the idea of prevention and are continually presented with mental illness and psychiatric intervention as the only way to prevent suicide.

Despite the lack of exposure the suicide discourse has been changing (e.g. see https://www.bbc.com/news/world-us-canada-44416727). Some governments, including in New Zealand, infer alternative risk factors when setting out their suicide prevention strategy documents. But their prevention strategy action plans, so far, have been to further resource mental health services and psychiatric interventions.

So what is wrong with psychiatric intervention?

To intervene suicide or suicidality must have occurred and it will be too late to prevent suicide. Conversely, a suicide prevention strategy seeks to remove as many risks as possible in the population in order to reduce the risk of suicidality, and ultimately removing suicide as a 'solution' to a problem.

Feedback effect: the presumption of a mental illness as the only cause of suicide means that only psychiatrists are qualified to comment. This is a major problem because it immediately excludes relevant contributing knowledge to the suicide debate. A second problem is the inclusion of bias in studies of suicide– with the public mindset inclined towards depression – results are automatically heavily biased towards mental illness and depression.

Clinical bias: the presumption of mental illness as the cause of suicide means that psychiatric intervention would seek to diagnose/identify a mental illness in individuals presenting suicidality which may or may not exist – thus ignoring and excluding suicide per se as part of the intervention. It is not surprising that one-third of all suicide cases who receive psychiatric intervention go on to complete suicide while receiving treatment or soon after discharge, and the remainder two-thirds successfully complete suicide the first time,.

Suicide data: in New Zealand apart from suicide mortality data which is released by the Ministry of Health and also the Chief Coroner's office (since 2008) psychiatric data is not readily accessible.

Accountability: it is astonishing that the government does not demand accountability but continues to provide millions of dollars in additional resources to mental health services dedicated to reducing suicide rate.

In New Zealand, government documents show that antidepressant prescriptions have more than quadrupled since 1996 but over the same period the suicide rate has maintained an increasing trend. Following the 2010 earthquake in Canterbury suicide numbers dropped to zero but with the authorities following a mental illness suicide prevention strategy Canterbury now boasts the highest suicide rate in New Zealand (Shahtahmasebi, 2017). And despite the injection of new resources in mental health services by the government in 2015 when suicide numbers hit a new record, suicide numbers also reached new record in 2016 and again in 2017.

So why does the media ignore an alternative discussion of suicide prevention?

Intrinsically, one assumes that the role of the media is to ask questions independently. For example, in the case of reporting celebrity suicides an inference that should be made is the failure of psychiatric intervention leading to suicide rather than presenting long-term depression and mental illness, without any evidence as explanation of suicide. From the media reports it can be deduced that the reported cases had suffered long-term mental illness issues for which they had received treatment and yet – just like the one-third of suicide cases who sought psychiatric help – these cases went on to complete suicide. Of course a celebrity's suicide receives substantial air time in the media especially with the advent of social media with comments such as 'depression kills', thus maintaining the status quo.

The media should be asking who is benefiting from the current suicide prevention strategy – judging by suicide mortality data over the past decades – it is certainly not the public. But it is easier to have something else to blame for adverse events beyond our comprehension than our own attitudes, perceptions and behavior.

References

CDC. (2018). Suicide rising across USA. *Vital Signs*(June, 2018), https://www.cdc.gov/vitalsigns/suicide/.

Shahtahmasebi, S. (2017). Editorial: Suicide numbers a record high for the third year running. *Dynamics of human health (DHH), 4*(3), http://journalofhealth.co.nz/?page_id=1160.

Shahtahmasebi, S. (2018). What does a statistician know about suicide and suicide prevention? *Dynamics of Human Behaviour (DHH), 5*(1), http://journalofhealth.co.nz/?page_id=1512.

WHO. (2014). Preventing suicide: A global imperative. *http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/*.