Book project

Provisional title: SUICIDE – THE BROADER VIEW (see call for contributions below)
Editors: Said Shahtahmasebi & Hatim Omar
Publisher: Cambridge Scholars Publishing
Email: radisolevoo@gmail.com

Here some details about how to prepare your chapters:

Important dates
1/3/2019: submission of all chapters
1/5/2019: finalizing & proofing to be completed.

Chapter length

Chapters should be:
Minimum: 2,500-3000 words (approximately 7 pages, single spaced)
Maximum: 4,000-4,500 words (approximately 12 pages single, spaced)

Formatting
Please see attached guideline for the main body format (click to download file: M3 Sample – format.pdf).

Preparing your chapters
Please see attached guidelines for Tables, graphs and images (click to download file: M2 Manuscript guidelines.pdf)

Referencing
Referencing must be in the APA style. Select APA 5th (or latest version) from your Endnote or reference manager.

Any issues/questions please email: radisolevoo@gmail.com.

Call for contributions

In the light of the WHO (http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/) and CDC's (https://www.cdc.gov/vitalsigns/suicide/) announcement that suicide is not always mental health problem, we are planning a broader exploration and discussion of suicide as a book project. Cambridge Scholars Publishing (www.cambridgescholars.com) has accepted our book proposal, and we are in the process of signing a contract to publish the proposed book.
For this book we are looking for contributions on all aspects of suicide and suicide *prevention* [please note the emphasis]. We would be interested to review any reports/discussion/examples of working strategies, e.g. the role of integrated behavioural health and law enforcement in suicide prevention; youth suicide; suicide and/or suicide prevention in minority/indigenous groups; historical accounts; accountability of services and governments; case studies; critical reviews; religious aspects and approach; the nature of suicide; and anything that can contribute in our understanding of suicide beyond its

dictionary definition and mental illness connection. Please note that the book is not about compartmentalizing suicide (e.g. suicide in certain groups with a condition) but we will be interested in accounts of successful suicide prevention activities in any given group.
The book's focus is a move away from predicting suicide through presence of mental illness and depression in order to intervene and stop it. The emphasis is on prevention.
Please let us know if you are interested in contributing a chapter or two and a summary of your proposed chapter. In the next couple of weeks we will broadcast a timetable and schedule.

Here is a short background

The problem with suicide research and prevention is that aims and objectives and action plans are usually pursued without a broad understanding of the topic.
Other than a dictionary definition of suicide we really have very little understanding of suicide, e.g. why do people with similar characteristics and circumstances some choose to end their lives whilst others choose life?
This confusion has allowed the idea that all suicide is the result of mental disorder to establish roots without any evidence, other than the belief that one must be mad to kill himself/herself.
In recent decades, the notion of a mental illness, mainly depression, as the cause of all suicide is so well established in the public mindset that unwise and misleading conclusions are normal behaviour. For example, (i) when suicide rates drop it is claimed a success due to mental health service intervention, but when rates go up it is the people's fault for not accessing mental health services, (ii) completed or attempted suicide are often used as indicator of mental illness, (iii) suicide prevention strategies are often psychiatric intervention *after the event or signs of suicidality* without any attempt at understanding suicide, (iv) over medication of the population including very young children (e.g. https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10462684, or, https://www.nytimes.com/2015/12/11/us/psychiatric-drugs-are-being-prescribed-to-infants.html), and (v) suicide research is heavily biased towards mental illness causing suicide, (vi) by law all admissions to emergency departments due to an attempted suicide must be evaluated by a psychiatrist, anecdotal evidence suggest that some needing this service, but not receiving it, use attempted suicide as a foot in the door. Psychiatric evaluation is based on a psychiatric checklist seeking a mental disorder which may not exist, thus leading to discharging of a potential suicide case.
It is not surprising that decades of funding mental health services to prevent suicide have failed to break the cyclic and overall upward suicide trends. In New Zealand suicide numbers have reached record high 4 years in a row, and in the US they have gone up by 30% - this is despite massive year upon year monetary investment in the mental health services specifically to reduce suicide.
Recently, WHO followed by CDC acknowledged that suicide is not a mental health problem. But the medical modellists who continue to promote mental illness as causing suicide are still working hard to continue their key influence in policy development, by hacking at the periphery. For example, the notion of a deficiency in the human genome or brain by studying brain scans or proposal of genetic research. These types of approaches are neither progressive nor innovative as they operate under the same old philosophy that suicide is an illness of the mind (one must be mad to suicide), i.e. they still look for a 'fault' in individuals' make up as the cause of suicide, and thus prevent developing an understanding of suicide.
Our own view is that before we can solve problems we must understand them. In the case of suicide we have an added complication that we do not understand it through a risk factor approach (suicide occurs in any group: rich, poor, famous, happy, unhappy, employed,

unemployed, with or without medical conditions, in any occupation farming/medicine/psychiatry, etc), and there are no substantive theories that can explain suicide. But suicide is the outcome of a human behaviour, and we do understand human behaviour much better than suicide. So, any suicide prevention strategy will have a better chance of success if it is community/grassroots based. This means that a prevention scheme which is useful in one community may not necessarily work for another community, therefore, there will be many tailor-made community specific suicide prevention schemes.