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Suicide debate: Part II – Suicide Prevention: a mixed bag of personal beliefs

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Suicide debate MUST be about preventing suicide, saving lives, breaking the cycles and reversing the suicide trend. Unfortunately, the debate is far from it.

Suicide has been medicalised, politicised, and a handful of medical modellists who seem to hold the power have been engaged in preventing progress by refusing to face the facts. Using their power and status, they direct all their energies to promote a failed medical model of suicide prevention to snuff out alternative approaches.

Discussion

This is an extremely sad state of affairs. Top suicide journals refuse publication of papers which critique the medical model, they refuse to engage in debate, and perhaps their worst behaviour is their hostile reaction to outspoken colleagues (e.g. see (Hjelmeland & Knisek, 2017)). In their mind, by belittling researchers with alternative findings then by association their findings and evidence against the medical model is discredited! Perhaps the politics of such behaviour is, on the one hand, to scare less senior researchers to toe the line, and on the other hand, stupefy politicians, media and the public alike with the false belief that suicide is caused by mental illness.

As a result, some researchers have adopted an approach of appeasing medical modellists by suggesting that *mental illness causes some suicides*, or *mental illness is not the sole cause of suicide*. Whether mental illness is associated with all suicides or some suicides, the problem with this belief is that it implies *cause and effect* which has **not** been proven. If this link was present then decades of medicalization of suicide would surely have led to a downward suicide trend which is not the case (Pridmore & Shahtahmasebi, 2018). Of course some people with a mental illness may commit suicide, but so do people who don't have a mental illness. There is no evidence to support the statements such as mental illness caused suicide, or bereavements or break up caused suicide.

If we divide "mental illness" into the many mental illness diagnosis categories, e.g. schizophrenia, bipolar, depressive disorders, then it can be seen that suicide occurs in each category but the number of suicides in each diagnosis category forms a small proportion in that group. In other words, out of all the people with bipolar disorder, say, a small proportion will suicide. It is unwise to claim cause and effect as the medical modellists insist (see below).

For decades the public has been force-fed the belief that mental illness causes suicide by politicians, governments, and media. And for decades, vast sums of taxpayer money have been thrown at the mental health services specifically for suicide prevention. And for decades, with the extra funding the public has been given "more of the same" old mental

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health interventions whilst suicide rates continue to trend upward. So, it seems that the medical modellists and the government and media are quite happy to stick to their beliefs while more and more young people die unnecessarily by suicide (see below).
This is appalling behaviour; it is immoral, it is anti-academic and goes against the ethos of research. It is against humanity itself.

Evidence against mental illness as the cause of suicide

To understand the evidence against the medical model one is required to have some understanding of research methodology and substantive theory that guides not only study design and analytical methodology but also interpretation of results (Said Shahtahmasebi & Berridge, 2009). This is particularly important but is lacking in suicide research (Said Shahtahmasebi, 2013a). Suffice to say that it is beyond belief that in the 21st century, in the age of evidence-based practice and academic cooperation, that power and decision making is based on fallacy and superstition.

The belief that mental illness causes suicide is based on psychological autopsy type studies(Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Said Shahtahmasebi, 2005, 2013b). The medical modellists have not put forward any other evidence to support their claims/beliefs.

The case against this belief is simple but solidly effective. Psychological autopsies are based on a survey of suicide survivors (family and friends) of suicide cases in a case-control design. These studies have been discredited and are extremely biased by design (Hjelmeland et al., 2012; Said Shahtahmasebi, 2008, 2014). These types of studies are biased towards mental illness from the outset: the matching of suicide cases to controls are often suspect, the measurement instrument (survey questionnaires) are loaded with overt and covert references to mental illness, they measure the cases' mental status from a third party after the event of suicide, whilst failing to acknowledge and account for any of the sources of bias – this guarantees that almost 100% of suicide cases are categorised as mentally ill.
But substantive theory prevents us from such arguments. You see, mental illness is not a single measureable entity, it encompasses a myriad of symptoms and conditions – then the question is which mental illness condition(s) might be associated with the outcome suicide?

On another level, it is estimated that 50-80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime (Mental Health and Addiction Inquiry, 2018). So, whether classifying suicide cases according to the many mental illness diagnosis or classify them all under one main category of "mental illness" suicides form a very small proportion of the population of people with mental illness. So *cause and effect* cannot be inferred, but, mental illness as cause of suicide has been forced into the suicide prevention strategy.

Further evidence comes from published suicide data as follows. In New Zealand like, many other countries, suicide prevention policy is based on medical intervention rather than prevention with the idea that if mental illness symptoms are treated and if we don't talk about it suicide will go away. So, in return for additional taxpayer investment on suicide prevention, year upon year the public is given "more of the same" *look for signs/symptoms and refer to mental health services*. Presumably "signs" mean mental illness symptoms:-

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- But waiting for symptoms to show up is no prevention, when suicidality is manifested then it is too late for prevention and we must have an effective interventional plan.
- There are two major problems: first, this approach ignores the majority of people who do not exhibit mental illness symptoms perhaps because they don't have them, or are good at hiding them.
- Second, published estimates suggest that only between one-quarter and one-third of all suicide cases have a psychiatric record, i.e. those who were referred to or sought psychiatric help with their suicidality – yet they went on to complete suicide.
- We have no real knowledge of the other two-thirds to three-quarters of suicide cases who were successful in their first attempt. *So it is unwise and wrong to claim that 90-100% of suicides are mentally ill*.
- Long-term trends in suicide rates are absent from the suicide literature.
- On another level, the rising suicide numbers in itself discredits this political belief, and any top-down suicide prevention schemes that are firmly based on mental illness as the cause of suicide.
- But medical modellists have come up with a cunning plan: long-term suicide trends show a cyclic pattern. These cycles have short-term (3-5 years), medium-term (up to 10 years) and long-term length (70+ years). But presentation of suicide trends is often limited to the current short-term cycle. So when suicide is on the downturn they claim victory and take credit for a drop in suicide and demand more funding to pursue with the same prevention policies. But when the suicide rate is on the upturn they claim that suicide is highly complex with many risk factors and demand more funding to study it!
- In New Zealand, government documents show that between 1997-2005 antidepressant prescriptions more than doubled, and doubled again between 2005-2012, and again since 2012 (Antidepressant use in New Zealand doubles, 2012; Ministry of Health, 2007).
- During this period suicide numbers have trended upward reaching a **record high four years in a row** 2015, 2016, 2017, and 2018 (Said Shahtahmasebi, 2017; S Shahtahmasebi, 2018).
- Similarly, during the Canterbury earthquakes, suicide in Christchurch went down to zero. Ironically the "experts", whilst attempting to take credit for this drop, warned that suicide would rise again without prevention. So whilst, the "experts", the government and media sat on their hands waiting for signs of mental illness to manifest, the suicide rate went up and now boasts the highest regional suicide rate in New Zealand.
- So decades of treating mental illness to prevent suicide not only has had zero effect on national suicide rates but also helped to reach record levels four year in a row.
- What is astonishing is that the public is oblivious to the fact that there is no accountability: no one held to account; not the government as the owner of the prevention policy; not the "experts" – i.e. medical modellists as self-proclaimed owner of the suicide problem, and not the media for propagating misleading information.
- This explains why medical modellists so strongly defend and promote the policy of "not talk about suicide". In other words if there is no public discussion of suicide then issues such as rising suicide rates, funding, and accountability are never raised.

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Like the religious extremists who in the face of unfaltering evidence deny evolution, the medical modellists, in spite of unfaltering evidence, insist that suicide is a mental illness. Their strategy is simple. With their high priests in powerful positions they have been able to form an exclusive circle of medical modellists and promote their belief whilst blocking out the dissemination of alternative beliefs.

In fact, Hjelmeland and Knizek (Hjelmeland & Knisek, 2017) provide an example of how some medical modellists in positions of power have made a career of attacking other researchers rather than discussing the evidence. For example, the researchers who have discredited the assertion that 90-100% of suicides had mental illness have been described as not qualified to comment on suicide because they are not psychiatrically trained or have the wrong qualifications and their work as polemic! ((Hjelmeland & Knisek, 2017), p. 5&6).

Another group of medical modellists have heavily criticised the New Zealand's chief coroner in the NZ Medical journal (Beautrais & Fergusson, 2012) for stating in a press release that our current suicide prevention is not working and a new approach is needed, and suggesting that there may be room for a gentle opening up of the restrictions on the media reporting of suicide. The Chief Coroner went on to say that we need to consider all viewpoints – especially those of families – so we can make informed decisions (https://www.newshub.co.nz/nznews/chief-coroner-releases-nz-suicide-statistics-2011082615).

Concluding remarks

In the light of an unjustified disregard for the evidence, exclusiveness, and a lack of interest in saving lives it is time for a revolution to do something positive rather than accepting "more of the same".

In 1978 Italy implemented Law Number 180 blocking all new admissions to public mental hospitals (Barbui, Papola, & Saraceno, 2018). The authors report that after 40 years without mental hospitals, amongst other things, the age-adjusted suicide rate remained stable, ranging from 7·1/100,000 population in 1978 to 6·3/100,000 population in 2012. The study has some limitations and the authors appear to ignore the cyclic patterns in suicide rate between 1978-2012 but the general suicide trend over the same period is downward.

The issue of accountability for suicide and its prevention was being discussed as early as the 18th century, but the earliest easily accessible published document is in the 19th century by Wade (Wade, 1879). Wade argues that, at least in cases where mental illness is present, there is somebody to blame for suicide, and raises the question why no one ever is blamed?

A grassroots approach empowers communities to take responsibility and ownership of the suicide problem and develop local solutions. In 2010 the grassroots approach was introduced in Waikato, New Zealand, where there was huge interest from local communities. These were communities with high rate of teenage suicide. Communities were given appropriate information about suicide and adolescent development and empowered to own the suicide problem. The communities then came up with an action plan to combat suicide. The idea was that members of each community know more about local issues than a politician based hundreds of miles away or medical modellists working from a university office, and therefore are able to devise local solutions to local problems. The upshot was that communities

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developed their own approach to suicide prevention and as a result the suicide numbers dropped substantially in the communities that took part in the grassroots approach (Said Shahtahmasebi, 2013a).

Inexplicably, during the grassroots workshops on 'youth suicide prevention' which were provided free at no cost to the public purse, there were reports by some frontline workers that they had been told by their employers not to attend. It was reported that those who dared and defied their employer simply booked the day as an annual holiday and attended in their own time.

The above effectively summarises New Zealand's suicide prevention policy.

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