Editorial: Suicide prevention de-constructed

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An interesting article by Kimber and Pridmore (1) published in this issue looks at suicide cases using a violent method of decapitation. The key information from these cases are, firstly, the cases had spent time and resources to manufacture a guillotine type device in their home/garage. Secondly, during this time no one suspected anything untoward. Thirdly, the cases seemed determined to complete suicide by choosing a method that ensures certain death. Fourthly, only two cases had been rumoured to have a mental illness.

By now the evidence against current suicide prevention strategies globally which blame mental illness as the cause of suicide has amassed beyond any shadow of a doubt. Yet, governments and the "experts" still continue to pursue strategies that seek the presence of mental illness before attempting to intervene to stop suicide. Even so, psychiatric intervention does not appear to stop cases completing suicide nor prevent and reduce suicide numbers.

What do we know about suicide?

- Based on the suicide literature, we do not understand suicide over and beyond its definition: which is an act of self-harm with the intention to end one's own life.
- The research literature refers to psychological autopsy type studies which link mental illness to suicide – but these type of studies are flawed for the following reasons.
- Other studies, e.g. (Hjelmeland, et al. 2012; Hjelmeland, et al. 2018; Hjelmeland & Knizek, 2017; Pridmore, 2011; Shahtahmasebi, 2003) have found psychological autopsies methodologically flawed.
- Suicide trends in a cyclic pattern (Hakko, et al. 2002; Shahtahmasebi, 2005).
- When the cycle is on the downturn governments and their "experts" claim victory and insist on following the same suicide prevention strategy across all risk factor groups.
- But when the cycle is on the upturn then they claim that suicide is a complex issue which requires more funding for further psychiatric research.
- On average, between one-quarter and one-third of all suicide cases had sought psychiatric intervention and had a psychiatric record (Hamdi, et al. 2008; Shahtahmasebi, 2003) – but not all had a recorded diagnosis for mental illness – despite psychiatric intervention they went ahead and completed suicide anyway.
- This means, on average, between two-thirds and three-quarters of all suicide cases did not come into contact with mental health services – as such we know nothing about this group.
- Death occurs only once, therefore we are unable to gain insight into an individual's reasons and decision to die.
- Most of our knowledge about suicide is based on limited medical records and information from third parties (family and friends) after suicide has taken place.
- But suicide prevention strategies have established a public mind-set that believes mental illness causes suicide, thus suicidality equates mental illness.
- Therefore, third party information is highly biased towards mental illness.
- The suicide literature also suggests a large number of risk factors e.g. bereavement, relationship breakups, divorce, unemployment, financial stress, being a male, mental

illness, physical health, loss of independence, occupation (e.g. farmer, accountant, pilot), trauma and stress, nutrition and diet, unstable childhood, domestic violence, addiction and substance abuse, and so on.

- Regardless of the risk factor suicidal people are treated for a mental illness that may or may not be present.
- As a result, suicide per se is omitted from the prevention/intervention equation.
- In New Zealand, between 1997 and 2005 antidepressant prescriptions doubled (Ministry of Health, 2007), between 2006 and 2011 they doubled again (Antidepressant use in New Zealand doubles, 2012)(2) and has been increasing since (3) but contrary to expectation suicide rates increased over the same period, breaking new records five years in a row (Shahtahmasebi, 2019).
- Notwithstanding suicide trends in New Zealand, the antidepressant prescription patterns are mis-represented in the media (4) as a positive sign that more people than ever are accessing and receiving the support they need – why then has this massive increase in antidepressant prescriptions s not resulted in commensurate reductions in suicide numbers?
- Current suicide prevention strategies also ban the public discussion of suicide.
- The wisdom of such policies has been challenged (Shahtahmasebi, 2014a).
- The adverse effects of a policy of silence is to mystify suicide, the public's inability to intervene, helps sustain the taboo status of suicide and mental illness, the isolation of suicide survivors (family and friends), misinformation, and the exclusion of main actors, all make intervention strategies irrelevant, and reduce the will to seek help (Shahtahmasebi, 2014b; Shahtahmasebi & Aupouri-Mclean, 2011).

Concluding comments

The above list is by no means exhaustive but it paints a sad picture of politics, science and public health. As mentioned above, the large number of risk factors means that the public at large is the at risk population, therefore, suicide is i) a process of decision making, and ii) a population based approach to preventing suicide is necessary (Shahtahmasebi, 2013).

If we divide the population into many categories as risk factors then, based on the suicide literature, there will be a suicide in every category over time.

Psychiatry claims that suicide is a mental illness – the reason that over two-thirds of all suicide cases have not yet been classified with a diagnosis is because a mental illness diagnosis is yet to be discovered.

Right or wrong, is it wise to sit on our hands and wait for the mental illness diagnoses that cause suicide to be discovered, while at the same time, families continue to lose loved ones to preventable suicide? Notwithstanding medicalisation and subsequent politicisation of suicide (Hjelmeland & Knizek, 2017; Pridmore, 2011), there are relevant and appropriate holistic approaches that decision makers can utilise in their suicide prevention strategies.

URLs used:
Antidepressant use:
(1) http://journalofhealth.co.nz/?page_id=2925
(2) http://www.radionz.co.nz/news/national/117826/pharmac-monitoring-use-of-anti-depressants

(3) https://pharmac.govt.nz/news-and-resources/official-information-act/official-information-act-responses/number-of-people-by-age-band-dispensed-antidepressants-from-2016-to-2020/

(4) https://www.stuff.co.nz/national/health/125782223/rise-in-antidepressant-use-positive-ministry-of-health-says

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