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Suicide prevention

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Suicide has been in the news again recently in New Zealand. The Coroner's findings of suicides that occurred between 2013 and 2014 were widely reported as the result of family violence, see http://www.radionz.co.nz/news/regional/303584/family-violence-in-four-flaxmere-suicides. As the result of the investigations the coroner was reported in the media to have called for (as reported in the media):-

- a co-ordinator to set up a multi-agency, coordinated response young people who are believed to suicide risks
- a whānau well-being facility in Flaxmere to provide a place for families and young people to drop in to for support
- the automatic appointment of a lawyer to advocate for a child in cases involving allegations of family violence
- judges to be given the power to direct counselling for children exposed to family violence.

see http://www.radionz.co.nz/news/regional/303584/family-violence-in-four-flaxmere-suicides.

The following excerpts are from media's reporting of an inquest into another suicide case that occurred in the same region in 2014: -

> 'A coroner has recommended the Hawke's Bay District Health Board make changes after a depressed man took his own life in 2014.'
>
> 'After an inquest, the Coroner recommends emergency mental staff be required to record discussions with patients relating to identifying support people who can be contacted for further information. Another recommendation is that staff record if a patient declines consent for that contact or any reason for contact not being made.'
>
> 'The coroner also recommended the DHB ensure availability in waiting areas, and provide to Mental Health Service patients and their supporters, copies of the two publications produced by the Ministry of Health, "TIHEI MAURI ORA-supporting whanau through suicidal distress" and "Are you worried someone is thinking of suicide?"' (see http://www.nzherald.co.nz/hawkes-bay-today/news/article.cfm?c_id=1503462&objectid=11632400).

The first point to note is that these recommendations are case specific or heavily case-biased. In other words, coroners, frontline workers and professionals, often make a causal inference based on their own personal experiences. Therefore, recommendations or a course of action seem to vary with inquests according to the presumed cause of suicide. There are two major problems with this process: first, in New Zealand, as is in other countries, coroners' recommendations are based on an analysis of the circumstances of a suicide case. Second, these recommendations are based on a perception that 'at suicide risk' groups are already known to the relevant services.

These two issues are major problems because we have no way of predicting a suicide or identifying a potential suicide case in the population in spite of a long list of perceived risk

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factors (Shahtahmasebi, 2013b, 2014). As demonstrated in the example of the second inquest above, the case had begun treatment and yet he went ahead and committed suicide. Reanalysing the coroner's comments it can be argued that the coroner is also making a causal inference based on his/her inquest by recommending changes to mental health services, i.e. mental health care services causing suicide.

It is estimated that between two-thirds and three-quarters of all suicide cases do not come into contact with mental health services. The reason for this statistic is the current suicide prevention policy – which is similar to banking policies in that customers are allowed a bank loan when they prove they have the resources to repay - the suicide prevention policy intervenes after a suicide attempt. However, the intervention ignores suicide itself and instead seeks to treat symptoms such as depression for which medications are available. The model is not sensitive to the needs of the suicide cases and those affected by suicide (Shahtahmasebi & Smith, 2013).

The remaining one-third or one-quarter of suicide cases, who received psychiatric treatments to prevent them from committing suicide yet went ahead and completed suicide, did not all have a medical condition (Shahtahmasebi, 2003). Psychiatric records of suicide cases collected from a psychiatric unit, i.e. all suicide cases who received psychiatric treatment suggest that only 16% of the patients had depression recorded or mentioned in their records, and 32% of the patients had no recorded diagnosis (Shahtahmasebi, 2003).

The current knowledge on suicide is heavily biased towards explaining suicide as a result of a medical cause (condition) which makes this knowledge inappropriate and irrelevant (Shahtahmasebi, 2014)– consider this: if this knowledge was even fractionally relevant then suicide rates would have been sliding down given that decades of suicide prevention policy was heavily funded based on this knowledge. As it is, suicide rates over long periods follow a cyclic trend (Shahtahmasebi, 2013a). Interestingly, over the same decades when the cycle has peaked and turns downward the medical fraternity and decision makers (politicians) take credit for reducing suicide and allocate more funding to maintain exactly the same prevention policy. On the other hand when the cycle is troughed and turns upward then suicide suddenly is a very complex issue and even more funding is diverted to support a medical model. The net result of this process is a suicide prevention policy that provides the public with 'more of the same' every year but each time at higher cost in terms of lives lost and monetary value, while the cycles in suicide trend continues.

This problem was aired by the previous chief coroner who not only suggested that current suicide prevention methods are not working and that new approaches are necessary but also recommended demystifying suicide through open and responsible dialogue - unfortunately the chief coroner came under fire from proponents of medical model who want to keep the lid on suicide (Shahtahmasebi, 2014).

Over time, by relying on the medical fraternity for suicide prevention the public is unable to deal or cope with suicidal behaviour in order to prevent suicide – the public look to the medical services to intervene. But despite a wealth of evidence against the medical model for suicide prevention (Hjelmeland et al., 2012; Shahtahmasebi, 2014), medical professionals, politicians, judiciary and the media still refuse to pull their heads out of the sand and continue to persist with a medical cause for suicide.

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Suicide per se cannot be prevented through medical interventions because such interventions seek to treat medical symptoms, i.e. depression or another diagnosis is treated instead of suicide. For example over the last twelve-fifteen years antidepressants prescriptions have quadrupled in New Zealand (and potentially similarly in other countries), yet, suicide rates have continued to maintain an upwards overall trend and continue with their cyclic pattern (Shahtahmasebi, 2014). Anecdotal evidence also suggests that medication has had the reverse effect on patients causing them to complete suicide (Shahtahmasebi, 2009; Shahtahmasebi & Smith, 2013).

Alternative models will be just as unsuccessful as the medical model. This is because the available data on suicide does not support any one life event as a significant contributor to suicide. You see, people with depression may commit suicide but so do those who are not depressed, unemployed people may commit suicide but so do those in employment, bereaved/divorced/traumatised people may commit suicide but so do those with no trauma, and so on.

The only effective suicide prevention model is the one that eliminates suicide from the public mindset as a viable solution to a problem. In this context, the approach that we found which works well is the grassroots approach to youth suicide prevention (Shahtahmasebi, 2013a). This approach works well with indigenous as well as minority populations.

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