Chapter 19

SUICIDE PREVENTION DEPOLITICISED

Said Shahtahmasebi*

The Good Life Research Centre Trust, Christchurch, New Zealand

ABSTRACT

Suicide literature has placed a heavy emphasis on mental illness and depression, hence suicide prevention strategies have targeted mental illness in order to prevent suicide. Exacerbating the problem for suicide prevention policy development is the lack of appropriate information and evidence, and what evidence is available is based on flawed research. In this chapter experiences from community work in Kentucky and New Zealand are discussed. It is interesting to note that the actions and activities that the communities had organised are all designed to engage the community at grassroots including open discussion and debate. As a result, actions at grassroots refocus suicide and address social, community and individual parameters, such as ‘the community cares’, or ‘talking and listening to your children’, ‘listening and talking to your neighbour/friend’, these actions will tackle the many risk factors reported in the literature, e.g., loss, divorce, and reverse the perception that suicide is a valid option. This approach also highlights the availability and importance of interventional mental services.

INTRODUCTION

Suicide prevention is highly politicised. The reason for this is because the suicide literature has placed a heavy emphasis on mental illness and depression hence suicide prevention strategies have targeted mental illness in order to prevent suicide. Exacerbating the problem for suicide prevention policy development is the lack of appropriate information and evidence, and what evidence is available is based on flawed research (1-4).

The problem with adopting a flawed process for suicide prevention has led to an intervention action plan that places a heavy emphasis on addressing mental illness/depression rather than addressing suicide per se. In other words, cases studies provide evidence that a

*Corresponding author: Said Shahtahmasebi, The Good Life Research Centre Trust, 11A Highsted Rd., Bishopdale, Christchurch 8053, New Zealand. E-mail: radisolevoo@gmail.com.
suicidal person is treated exactly in the same way as someone suffering an episode of mental illness/depression, often using a check list, supplying them with medication (antidepressants), and discharging them into the community (5). It is not surprising that odds of a completed suicide within the first week of discharge from mental health services is estimated to increases 278-fold (6-8). This evidence raises a number of questions, specifically:

- Are mental health services causing suicide?
- Do mental health services contribute to the risk of completing suicide?
- Is mental health services intervention effective to prevent suicide?
- Is mental health services intervention appropriate to prevent suicide?
- Why do ‘experts’, politicians, and decision makers continue to overlook such evidence both in practice and in informing policy development?

One of the important effects of persisting with flawed research is that there are many risk factors, as such it is easier to tackle the symptoms of mental illness, especially where medication can be prescribed, than tackle the relevant individual, social, economic and educational parameters for which medication cannot be prescribed.

In this context, politics has a much larger influence and over-rides all other processes. This dilemma also creates additional ignorance rather than insight. For example, trends in suicide rates over a long period of time show a cyclic effect. These cycles indicate that suicide trends have a memory, i.e., a pattern. And where there is a pattern there must be a reason, be it changes in social or economic policies affecting the masses or more than a number of individuals, or, policies and events that contribute to national feel good factor (e.g., budget announcements, winning the world cup). Of major concern is how the information is used; at the beginning of a cycle when suicide rates begin a downward trend the “experts” praise and take credit for “successful” suicide prevention policies. But, at the end of the cycle when the trend is upward the “experts” blame the public for not accessing mental health services. The “experts” further claim that suicide is a complex issue involving mental illness, social, environmental and individual parameters and more research is required. This ‘top-down’ experts-know-best approach to suicide prevention has made researchers, experts and decision-makers part of the suicide problem rather than part of the solution (1, 5, 9, 10).

The evidence from decades of suicide prevention shows that mental illness as the cause of suicide is a very simplistic view and nothing more than an intervention. For, to utilise mental health services to prevent suicide an individual must either make a suicide attempt, or, be referred to the services for symptoms of mental illness. This suggests intervention not prevention. Furthermore, the evidence shows that after decades of suicide prevention we may know a little more about symptoms of mental illness but nothing about suicide. This is the reason for our failing suicide prevention plans, we have no insight into an individual’s process of decision making when it comes to the decision to take one’s own life.

To free suicide prevention from politics we must acknowledge our lack of insight into suicide but at the same time utilise our knowledge about human development and human behaviour. This is not to dismiss the role of politics in suicide prevention; it is more a question of what, how and how much politics can help prevent suicide.

The Kentucky ‘Stop Youth Suicide’ (SYS) campaign was initiated by an adolescent specialist in 2000. The premise of the SYS campaign was based on inclusiveness, i.e., the campaign enlisted the involvement of all sections of the community through awareness
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Campaigns, lobbying politicians for law changes, and more importantly young people. This campaign led by a medic has the benefits of medical facilities. However, as mentioned before, medical facilities are only useful at the point of intervention – the difference with this campaign is that individuals seeking medical help are viewed and treated as a person without presumption of a mental illness from the outset, and they are listened to.

It is a slightly different story in New Zealand. The grassroots approach was devised (1996-2010) in order to balance the influence of politics. The strategy was implemented in New Zealand in 2010 to attenuate the influence of politics and medical modelist approach to suicide prevention. The premise of the grassroots approach was that communities know more about their particular social and environmental strengths and weaknesses than any politician or ‘expert’. The help of the Kentucky SYS was enlisted to train participating stakeholders and individuals, and to empower them to own the suicide problem and apply ‘local’ solutions to prevent it. The grassroots suicide prevention plan did not have medical facilities or medical experts leading it. Participating communities were provided with relevant information through training workshops and working examples of successful suicide prevention plans, which were facilitated and provided by the initiator of the Kentucky SYS (Professor Hatim A Omar). Following the training workshops interested communities formed grassroots suicide prevention groups and based on their newly acquired knowledge and their insight into their own community devised action plans and activities that best suited their communities. All the ideas and developmental work came from the groups whilst the trainers were used as a sounding board and as advisors. In other words, the ‘top-down’ approach of experts ‘know best’ was completely reversed and made the experts a resource to be utilised and part of the solution rather than part of the problem. Again, this approach is inclusive and does not dismiss the role of other suicide prevention/intervention plans including mental health services. Ironically, due to political factors, the grassroots approach was not implemented till 2010. Between, 2010 and 2015 participating communities reported a sharp drop in youth suicide.

The grassroots approach is sustainable, it is economically viable to set up and to maintain, it is a low investment with high returns, i.e., achieving high rate of reduction in mortality due to suicide with very little monetary investment. To sustain this success, grassroots groups must not be complacent and continue with developing local solutions regardless of the reduction in suicide rates.

Until recently, in New Zealand, the official suicide prevention advice was to look for signs of mental illness and depression and then refer to mental health services. Such advice has been criticised and challenged (2). It is noticeable that this advice has somewhat changed more in line with the SYS training and the grassroots approach. For example, the official advice now includes: staying with the person who may be suicidal until help has arrived, talking about suicide with the person and finding out if s/he has planned a suicide, and so on. All that needs to happen is a change in the attitudes of the decision makers and ‘experts’ so that saving lives can begin, and the social and economic costs of suicide can be eliminated.

This chapter explores the development and implementation of the grassroots approach to suicide prevention in New Zealand.
NEW ZEALAND

New Zealand has one of the highest suicide rates in the OECD. Typically, suicide is often referred to as a major public health concern but, in practice, it is classed as a mental health issue for intervention and prevention policy development. The New Zealand approach to prevention is a one-dimensional medical model with a moratorium on suicide reporting in the media which has led to a culture of secrecy. In an earlier attempt, the New Zealand Government’s suicide prevention strategy document (11) demonstrated a move away from the medical model by including all other possible factors reported in the literature as potential contributors: from alcohol and drug abuse to bereavement, family break-up, unemployment, educational and financial failure and so on. Yet, policy actions have been based on a long established view that mental illness (specifically depression) causes suicide. For example, in 2006 the New Zealand Government claimed “We know that up to 90% of suicides are caused by depression and that each year 500 New Zealanders are dying by suicide.” Therefore, despite its own strategy document that listed a large array of socio-economic and environmental risk factors the $6.4 million campaign was focused on reducing the impact of depression (12). It would have been much better and more value for money had the Government aimed at reducing the incidence and prevalence of depression.

The problem is that, the Government’s statement is misleading because current estimates suggest that between two-thirds and three-quarters of all suicides do not have a first contact with psychiatric services (13, 14). Of those who do have a psychiatric record only a fraction have depression recorded as a diagnosis (14). Therefore, the question arises how do we know that 90% of suicides are caused by depression? This claim has been challenged, and there is strong evidence to show that it is based on flawed research (1, 3). Therefore, it is unwise to base suicide prevention strategies on such claims.

As a consequence, the guidelines for suicide prevention recommend that the public look for signs of mental illness and depression and refer the case to a mental health unit. But, waiting for symptoms to show up is not prevention. If symptoms are detected then an event has occurred, in which case it is time to intervene. Intervention is always difficult and unsustainable as a prevention strategy when there is little understanding of the nature of the problem.

The problem with such a prevention system is that it ignores the majority who do not exhibit symptoms or are good at hiding them, or who do not have them. In addition, the emphasis on mental illness as the main cause of suicide will make sure that suicide is treated as depression rather than ‘suicide’ and reinforces its taboo status. As a result of the relentless emphasis on mental illness and depression as causes of suicide, prevention policies do not address suicide nor do they prevent suicide or depression occurring.

Clearly, a single-dimensional mind-set about suicide prevention means a highly politicised suicide prevention process, with grave implications for suicide prevention, research, and, distribution of funds and resources. In this chapter, I discuss a grassroots approach to the de-politicisation of suicide prevention policy development, and the way in which a methodology based on the Kentucky SYS empowered communities to reduce youth suicide rates in their areas.
Processes and Actors

A quick visual analysis of conflicting trends for youth suicide in New Zealand (see figure 1), suggests the presence of a cyclic effect as well as a lagging effect in male and female suicide trends. On average, a low point on the trend for females appears to coincide with a high point for the males at the same time point. This pattern seems to be repeated every 7-10 years approximately. A similar pattern can be observed for all suicides by age group, as in figure 2. That is, while one group’s trend is decreasing another is increasing which can be observed in terms of the gender differences in figure 1 and age-group differences in figure 2.

Source: Ministry of Health New Zealand Health

Figure 1. Age-specific youth suicide rates by sex in New Zealand 1985-2008.

Source: New Zealand Health Information Service

Figure 2. Suicide rates by age, New Zealand 1923-2003.
This information should be informing the process of suicide prevention policy development. Yet, when the overall trend is slowing down the authorities claim that their policies are working. They then request more funding to apply the same policies to sub-group(s) whose trend is lagging or has completed the cycle and is increasing. And when the overall trend is upward the authorities claim that suicide is a very complex issue with many risk factors including socio-economic, environmental and mental illness factors, and request more funding to increase access to mental health services in particular for low income groups and young people.

This is fine the first time, but when it happens year after year and cycle after cycle, then suicide prevention becomes more of the same old interventions but at a higher costs in terms of lives lost and resources. Furthermore, if mental illness and depression were direct causes of suicide then surely after decades of treating suicide for depression we should have observed a decreasing trend (15) rather than continuing cycles. Moreover, between 1997 and 2005 prescriptions for anti-depressants had doubled in New Zealand (16) and since then it has doubled again (17), whilst over the same period the suicide rate has increased.

The findings, collected by the Ministry of Justice, show suicide in New Zealand has risen from 540 deaths annually in 2007/2008 to 558 in 2010/2011 (18). It is not surprising that in 2011 the New Zealand chief coroner stated that current methods are not working and called for a new approach to suicide prevention (18).

The government’s own policy documents list a large number of risk factors, it is interesting that these are often translated into policy actions for mental illness intervention (19). A single model for suicide prevention based on unproven cause and effect will be limited to the politics of a top-down approach, i.e., ‘experts’ vs. the public, and, political gestures. For example, in 2011 the Associate Health Minister chaired a meeting with media, mental health professionals and researchers to update the guidelines on suicide prevention (20). There was no mention of involving communities or victims/survivors of suicide (family of a suicide case). Following public protests a spokesman for the Associate Health Minister suggested that suicide survivors would be able to participate in the meetings later in the year. Involving the public after decisions are made is merely a political gesture of no value.

Associated with political gestures is the release of confirmed suicide data. For example, in August 15, 2012, the Associate Minister for Health stated (21) “A total of 522 people died by suicide in New Zealand in 2010, or 11.5 deaths per 100,000 people. As a proportion of the population, this is 23.6 per cent below the peak of 577 in 1998, but up slightly on the 510 deaths in 2009.” Eleven days later on August 26, 2012, the chief Coroner stated that suicide in New Zealand had risen from 540 deaths annually in 2007/2008 to 558 in 2010/2011 (18). Clearly, the chief coroner’s statement about New Zealand’s suicide trends describes a scenario worse than that described by the Minister for Health.

Over two-thirds of cases do not come into contact with mental health services. Various attempts to include these cases in research have made such studies highly biased because of design and analytical methodologies that fail to account for sources of bias. First, researchers and authorities have established depression and mental illness in the public mind-set as causes of suicide. Second, these same researchers collect statements about the suicide cases’ mental wellbeing from family and friends after the event of suicide. It is no wonder that time and again this type of research leads to erroneous results and mis-conclusions that mental illness is the major cause of suicide (22). The flipside of the coin is the negative and undesired
consequences of policy based on erroneous results, e.g., increased antidepressant prescriptions, including for very young children (22).

The main actors in the current suicide prevention system are the government who controls the resources, and the ‘expert’ advisors. Various organisations, including mental health units, who have modelled their care services on the government suicide prevention guidelines, compete for resources. Naturally, politics is a main feature in policy development which leads to top-down policy action plans. The net effect of a top-down policy is the exclusion of alternative approaches to suicide prevention. Change and flexibility in the model are overdue.

**CONCEPTUALISING A GRASSROOTS APPROACH**

In order to address a problematic issue, the nature of the problem must be understood. The fact is, at the centre of each suicide there is a human being with his/her family and a social community network. We may not understand suicide but there is capability in the literature to address aspects of human behaviour. However, the large number of variables reported in the literature as risk factors suggests that the public at large is at risk of suicide. In other words, everyone can potentially be exposed to life changing events and therefore at risk of suicide, e.g., divorce, illness (physical or mental), unhappiness, too much happiness, employment issues, financial difficulties, loss and bereavement, relationship issues. Thus, the main actors in a suicide prevention strategy must be the public. To attenuate the link between suicide prevention policy and politics the main actors must take ownership of the suicide prevention problem.

To conceptualise a dynamic model for collaboration suicide must be placed at the centre of this model (23), and merge current knowledge while seeking new information and updating our understanding of suicide (see figure 3). In order to emphasise positive suicide prevention, the influence from all relevant processes (including the negative effects from erroneous policies) must be equalised. With such a conceptualisation, depoliticisation is a natural process due to the willingness to collaborate rather than one discipline dominating others.

![Figure 3. Graphic visualisation of suicide prevention.](image-url)
It can be visualised that all processes are interconnected (see figure 3) through temporal dependencies of all aspects of life and the subsequent feedback effect. Suicide prevention must follow a holistic grassroots approach to allow for complexities due to environmental, social and health processes. It is important to anticipate the feedback effect from each policy decision within these processes to prevent policy and policy makers becoming part of the problem (23).

A subsequent and natural step of the conceptualisation process (23) was to engage the main actors, i.e., members of the public. This idea utilises the local community/public and local knowledge to address local issues (24-26). In order for a community approach to suicide prevention to be relevant and appropriate some insight into the community’s understanding and perceptions of suicide and suicide prevention was necessary. This issue was easily addressed by linking in with communities at a local level, focussing on adolescent health and youth suicide prevention and securing the commitment of an international adolescent health expert (26) to contribute to the project. Raising funds was not so straightforward despite a sympathetic Associate Minister of Health (in 2006) and international support for a new approach. A key component of the conceptualisation was to engage community agencies in working together for a common goal.

**OPERATIONALIZING A GRASSROOTS APPROACH**

For the approach to be successful it had to address the needs of the participating communities as perceived by them. In order to address this problem informal information gathering was conducted. Frontline health workers from three communities in Waikato, New Zealand, were contacted for their perceptions of the community’s needs in the context of suicide prevention. The frontline health workers indicated that their greatest need was for information, training and for upskilling in order to be able to deal with youth and adolescent issues. The resulting outcome was a pilot project offering training workshops. These training workshops were based and modelled on the Kentucky SYS. The first series were delivered in 2010.

The frontline health workers organised the community workshops including venues, publicity, invited local dignitaries and other community members e.g., police, teachers, social workers, counsellors, young people, and the general public. The project intended to empower communities to plan and make decisions at family and community level by increasing their awareness of adolescence issues. In this context the role of the researchers was to facilitate training workshops and basically play a support and mentoring role. All the community projects and activities that followed were designed and developed at grassroots level by the communities themselves.

**WORKSHOPS**

The 2010 pilot workshops identified a number of important issues such as public frustration with the secrecy surrounding the suicide debate, a lack of preparedness of public and health workers to intervene early, a lack of appropriate support for suicide survivors, and a great need for training (27, 28). The public demand and requests for repeat workshops provided the
evidence needed for community training in suicide prevention and a follow up was organised in 2011. The 2011 workshops were funded by a Fulbright specialist grant, participating communities, and Trust Waikato (a local Charity).

Once again, the workshops were organised by community liaisons who were the frontline health workers representing their communities. The workshops were presented by Kentucky SYS (26). Based on feedback from the first workshop series, the follow-up workshops were developed to cover the knowledge and skills gap in each community. The training materials were designed to tackle suicide prevention more holistically by understanding adolescence and adolescent behaviour. The key message of these programmes is that suicide is not a solution to problems, and that the community cares (26).

Attendees at the workshops included health workers, community police, educators, students, counsellors, suicide survivors (families of suicide cases) and the general public. The main issue that was identified during the pilot project and follow-up workshops was the secrecy around suicide which has led to public silence. Suicide survivors want to be able to talk about their experiences and to contribute to suicide prevention but they felt that no one was listening. The frontline workers felt they were unprepared for suicide prevention, and, that intervention was restricted to following the official guidelines of looking for signs of depression and then referring to mental health services.

Figure 4. Local media announcement about suicide prevention groups.
The evaluations for the workshops were 100% positive and armed with additional and new knowledge, communities set about devising plans to prevent or intervene in suicide (see figure 4). Establishing a local suicide prevention group to help with planning and operational issues followed by more talking were the key actions decided by the groups. Some communities worked faster than others and developed more ideas, for example: one group organised suicide awareness activities (29), e.g., suicide awareness street festival that included quizzes, t-shirts, surveys with prizes, leaflets about the availability of and how to contact community and medical support, ‘shout-out’ cards where the cardholder is encouraged to list people they would contact for help or to talk to. Interestingly, a local newspaper has been running regular articles on suicide (29) and some communities reported lives saved as a result.

The grassroots project aspired to inform communities so that they make informed choices about suicide prevention as opposed to telling them what to do, how to do it, and not to talk about it. As a result, the communities were empowered to mobilise themselves to address suicide. One of the main achievements of such suicide prevention groups was to engage the whole community including local businesses, clubs and societies, health services, by contributing funds, sponsorship, free advice, or resources (e.g., donating materials, manpower, venues).

CONCLUSION

It is interesting to note that the actions and activities that the communities had organised are all designed to engage the community at grassroots including open discussion and debate. As a result, actions at grassroots refocus suicide and address social, community and individual parameters, such as ‘the community cares’, or ‘talking and listening to your children’, ‘listening and talking to your neighbour/friend’, these actions will tackle the many risk factors reported in the literature, e.g., loss, divorce, and reverse the perception that suicide is a valid option. This approach also highlights the availability and importance of interventional mental services.

Through engaging the community (e.g., simply talking and the use of shout-out cards) at least two potential suicides have been prevented. This suggests that the secrecy and taboo status of suicide must be lifted in order for communities to be empowered to care for themselves. Grassroots-level action does not label people with mental illness categories or alienate them. Over time, it is more likely that individuals will talk about their issues and seek appropriate help rather than suffer and make life and death choices in isolation and silence.

The most striking impression with the grassroots approach is how quickly the community mobilised itself (within six-seven months of the follow-up workshops) to own the problem and implement local solutions with very little resources and no funding. Since the workshops, there has been a substantial drop in youth suicide in the two communities that adopted the grassroots approach to suicide prevention. For example, in terms of statistics, front line workers from a couple of communities reported an average of one youth suicide per month before the training workshops. This rate dropped considerably following the workshops, e.g., in one community this rate was halved, in another it went down to 3 for the whole period 2012-15.
Complacency and leadership are the two major limitations of the grassroots approach. There is ample evidence that a grassroots-based suicide prevention plan is effective in reducing the suicide rate. The success of the approach must not lead to complacency, and the grassroots groups must continue with their activities to continue to lower suicide. As the grassroots suicide prevention groups are predominantly made up of volunteers, such groups are more dynamic than committees where members are appointed for a period of time, the volunteers may leave at any time. Therefore, it is important that leadership is maintained.

In summary, the grassroots approach such as the Kentucky SYS and the NZ grassroots approach are effective in reducing suicide, they are empowering and can mobilise communities to take action, they are inexpensive, and sustainable. The grassroots approach, while focusing on suicide prevention, will inevitably tackle other social, education, economic and environmental parameters at a local level. Thus, such an approach will simultaneously address other problematic issues too, such as teen pregnancy, truancy, smoking and drug abuse.

REFERENCES