

# Are some Aspects of National Suicide Prevention Programs Contributing to the Problem?

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## ABSTRACT

Despite the introduction of National suicide prevention programs, a number of countries have reported not only no reduction, but increases in suicide rates. While it is possible that social factors have inexorably raised the rates, and that initiatives should be increased, an alternative question should be asked: are the programs introduced contributing to the problem?

There are a number of studies which suggest that that may be the case. This is particularly so with regard to the media and public education programs, with an absence of evidence for the effective translation of appropriate help-seeking action in vulnerable persons. The possibility that intense media campaigns may simply normalise suicidal behaviour as a readily understood common reaction has also been raised, as has the possibility that repeated media campaigns may lead to a negative attitude towards the message portrayed.

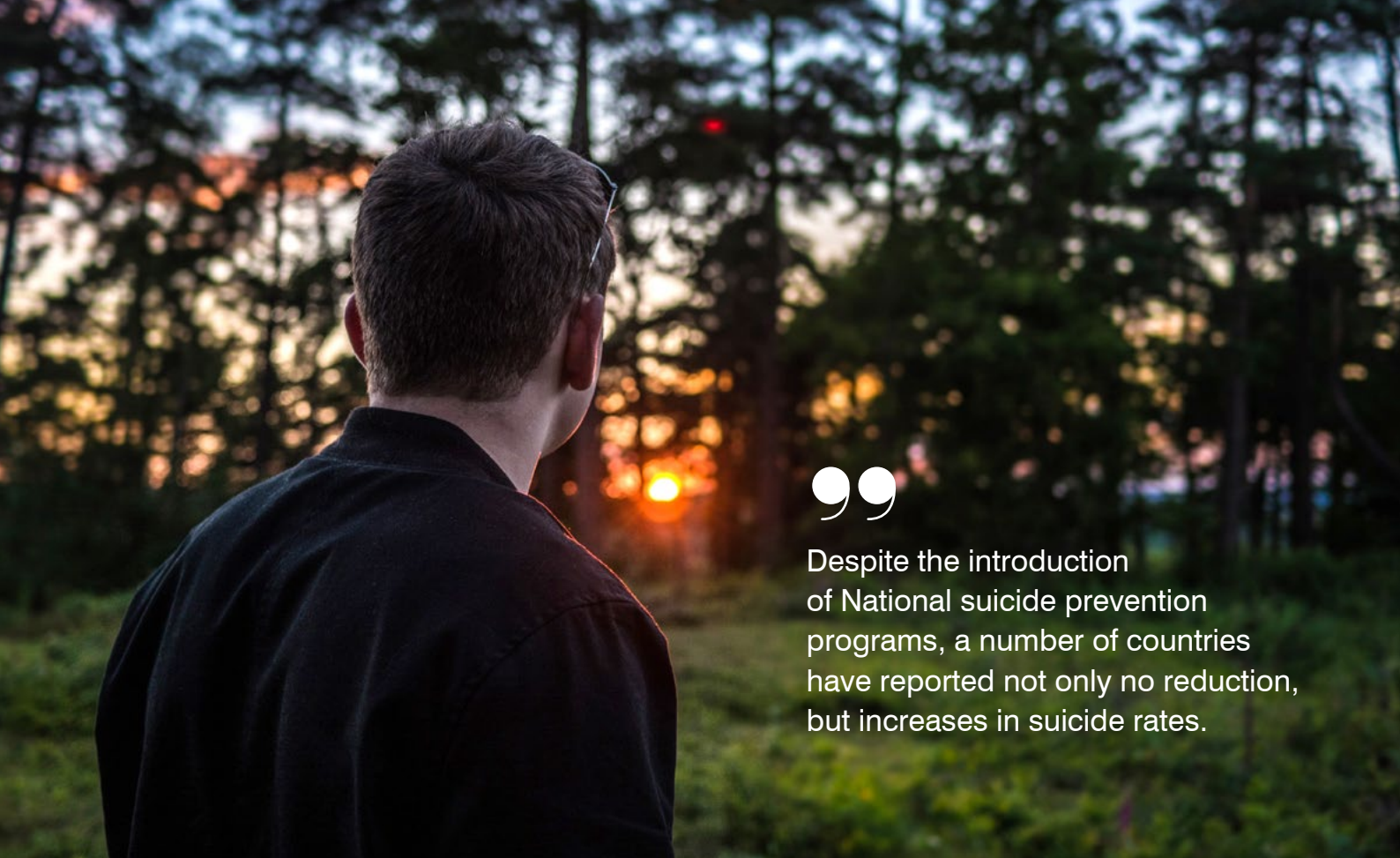
It appears important to pursue this question further, and not only to ensure that existing programs have convincing outcome data, but to only introduce new programs when they have been subjected to rigorous review.

## SAMMENDRAG

Til tross for at mange land har gjennomført nasjonale selvmordsforebyggende programmer, har flere av dem rapportert at de ikke observerte noen reduksjon. Enkelte av disse landene har til og med rapportert økning i selvmordsraten. Selv om det er mulig at sosiale faktorer står for slike økninger, og at selvmordsforebyggende initiativer derfor bør forsterkes, bør vi også stilles det alternative spørsmålet: Bidrar forebyggingsprogrammene som er introdusert til å øke problemet i stedet for det motsatte?

En rekke studier som antyder at det kan være tilfelle. Dette gjelder spesielt forebygging knyttet til mediene og offentlige utdanningsprogrammer, der vi mangler evidens for at programmene fører til bedring i hjelpesøkende atferd hos risikoutsatte personer. Muligheten for at intense mediekampanjer rett og slett kan normalisere selvmordsatferd som en lett forståelig vanlig reaksjon på problemer, har også blitt reist som en mulighet.

Det er viktig å undersøke dette spørsmålet videre, ikke bare for å sikre at eksisterende programmer faktisk har overbevisende effekt, men også for å sikre at vi bare innfører nye forebyggingsprogrammer når de har blitt grundig undersøkt.



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### The problem

The recent Editorial in the Journal of the Norwegian Medical Association by Ekeberg and Hem (2019) on “Why is the suicide rate not declining in Norway” not only resulted in a number of thoughtful responses, but it was a salutary reminder that the suicide rates of a number of developed and other countries have been stubbornly resistant to suicide prevention measures. This is notwithstanding intense efforts over the last few decades to address what has been regarded as one of the biggest challenges of health and social care systems.

The fundamental correlates of suicide have been well investigated and documented for over two hundred years (Kapur & Goldney, 2019). However, even by the mid 20th century, the stigma associated with suicide imposed cultural and clinical constraints on detailed investigation. This not only led to certain inhibitions in suicide research design, but also to a reluctance to engage the community in our efforts.

However, over the last 50 years this has changed markedly. Countries, which had not previously acknowledged suicide, have done so, and in general suicide rates have increased worldwide. It is of interest that this increase has been concurrent with an expo-

ponential increase in research, and the establishment of usually well publicised local and regional initiatives, often with a volunteer basis, as well as broader National suicide prevention strategies.

While Norway may have seen no downturn in suicide rates, of great concern is the fact that in some countries there has been a resurgence. In Australia there was an initial reduction from a peak in 1997 until 2007, but there has been a rise of 13% from 2009 to 2018 (Australian Institute for Health and Welfare, 2020); in England and Wales the 2019 suicide rate for males was the highest since 2000, and the female rate the highest since 2004 (Iacobucci, 2020); and in the United States there has been an increase of 35% between 1999 and 2018 (Center for Disease Control, 2020). Each country, as has Norway, have well established National suicide prevention programs.

The basis of these programs depends on the zeitgeist of their proponents, with there ideally being a balance between acknowledging the relative importance of clinical factors as opposed to sociological contributors to suicide. While both are important, their relativity is influenced by a myriad of factors depending on which country is being addressed. This is illustrated well by the need to focus on limiting



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toxic pesticides, a preferred mode of death in some developing countries, which would be pointless in those countries where drug abuse and mental illness were the predominant contributors.

Ekeberg and Hem (2019) acknowledged that there had been debate about this balance in regard to Norway's National Plan, and they observed that when it had been initiated in 1995 "a number of proposed measures had been curtailed or cut", and that the revised plan "failed to take previous plans into account with evaluations of measures to be expanded or reduced". Importantly, they noted that "most of the research tends to focus on risk factors and epidemiology, and less on the effect of treatment. In particular, we need more knowledge about what kinds of interventions are effective." This is a significant point, as there are hard won data demonstrating the effectiveness of some clinical and administrative suicide prevention measures (Kapur & Goldney, 2019).

This balance was also addressed in reviews of at least two other countries. The experienced psychologist, Kerkhof (1999), in a review of what was probably the first National suicide prevention program in Finland, noted that: "The work has particularly influenced organizations and professionals in the social services sector, though not in the health sector as much as was hoped for." Similarly, in a review of the Australian plan (Robinson et al., 2006), with the lead author again a psychologist, it was concluded that "Certain high risk groups (particularly people with mental illness and people who have self-harmed) have been relatively neglected," an extraordinary observation considering the aim was suicide prevention.

It is possible that the situation would be worse without these programs, an approach invariably used as an argument for more funding. However, the reality is that what we are doing is not effective at the population level, and an awkward question should be

asked: are we contributing to the problem?

This review will be confined predominantly to an examination of two overlapping areas which are integral to broad suicide prevention programs. These are the role of community education and the role of publicity in the proliferation of professional and volunteer organisations purporting to prevent suicide.

### **The role of educational programs**

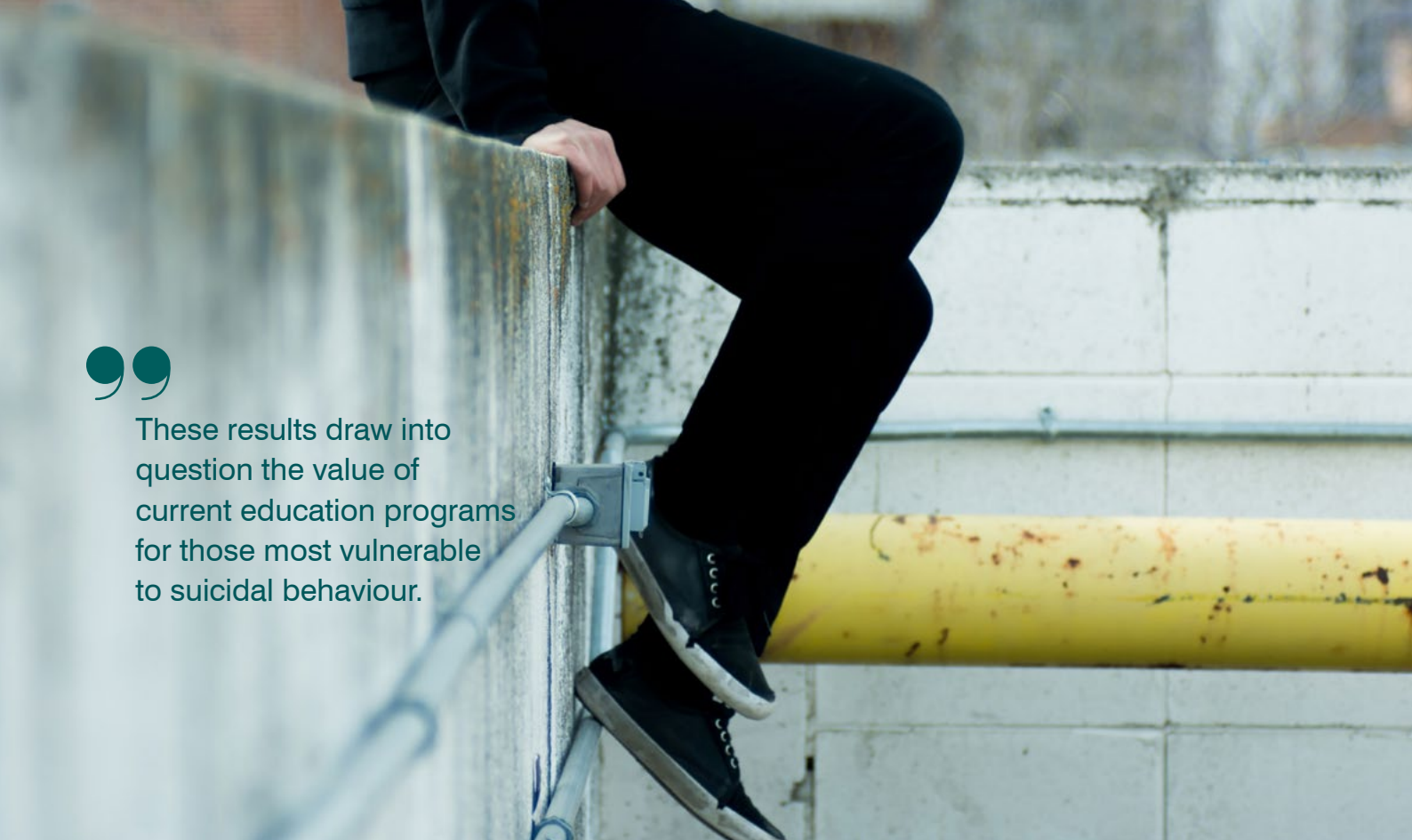
This issue will be addressed in two ways. First in relation to education in general, and then in relation to more specific depression and suicide awareness programs.

It may seem counter-intuitive to address these, as it is reasonable to assume that better education would be associated with better health and fewer suicides. However, by the end of the 19th century a review of a number of studies concluded that "On the whole, suicide is more prevalent among the educated than the uneducated" (Tuke, 1892).

Education in relation to suicide has been explored infrequently in the 20th century, although several studies have provided thought provoking data. Using the Human Development Index (HDI) calculated by the United Nations Development Program in 33 medium HDI countries, it was found that higher education was associated with higher suicide rates in males, but not females (Vijayakumar et al., 2005); in another study from Italy, this was the case for both males and females (Pompili et al., 2013); but mixed results were reported from the United States. There it was noted that the relation between suicide and education was not linear, as although those with a high school diploma had higher rates than those without, the lowest rates were for those with a college or greater education (Phillips & Hempstead, 2017).

These papers are limited by the scope of their inquiry, as education and literacy per se are blunt concepts. However, they are a forerunner to what has emerged as the 'vulnerability paradox'.

The Vulnerability Index of the 2016 World Risk Report is based on summary data from 96 countries of 23 indicators in examining 'susceptibility' (e.g. malnutrition, sanitation and income), 'lack of coping capacity' (e.g. number of doctors and hospital beds and a measure of public sector corruption) and 'lack of adaptive capacities' (e.g. school attendance and



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literacy). In an examination of its relationship with suicide, a significant negative relationship was reported between vulnerability and suicide rates (Dückers et al., 2019). A similar relationship was found using World Bank Data, with lower suicide rates in low income countries (Dückers et al., 2019).

These results are intriguing, and clearly the situation is complex. Nevertheless, it is not unexpected that a more focussed form of education has been used to promote public awareness of the features of common mental disorders, and potential avenues for assistance, as well as more explicit messages about warning signs of suicide. As an aside, it is pertinent to note that the latter measure of describing 'warning signs' of suicide is rarely, if ever, associated with the caveat that even those with assumed specific experience in suicide prevention are unable to predict suicide in an individual person (Kapur & Goldney, 2019).

The aim of these public awareness programs is sometimes referred to as enhancing mental health literacy (MHL), a term which embraces the knowledge a person may have about mental disorders and their management (Jorm, 2000). There are measures of MHL which can be used to examine the effectiveness of these education programs.

There has been success in enhancing community knowledge about depression, but when population

studies in Australia have drilled down on those with major depression with suicidal ideation, there was not only less increase in their MHL, but there were fewer changes in appropriate treatment seeking (Goldney & Fisher, 2008). This study was repeated after a further four years of widespread general community education, with similar results (Chamberlain et al., 2012). It was concluded that: "These results draw into question the value of current education programs for those most vulnerable to suicidal behaviour".

Similar findings using a different methodology were found in a recent American study of public service announcements presented to young adults. Those considered at high risk of suicide "were significantly less likely than low-risk participants to include a description of the help-seeking message" (Wiglesworth et al., 2020).

Although in a sense these results are unexpected and disappointing, they do appear to be consistent with what Erwin Ringel, a founder and driving force of the International Association for Suicide Prevention, postulated as the 'Pre-suicidal syndrome' (Sonneck, 1986). This describes the withdrawal from others and constriction of affect and intellect and focus on suicidal fantasies which precede suicidal behaviours. Bearing these characteristics in mind it is not unexpected that those with depression and suicidal ideation,

the putative target population, would benefit less from education programs.

Another potential clinical and research education issue is how much to focus on the behaviour per se. An unexpected observation by Klimes-Dougan (1998) was that there was better outcome in those who had forgotten previously acknowledged suicidal ideation.

This finding has been replicated in other studies. One reported that those who did not recall past suicidal behaviour were less likely to have depressive or somatoform disorders (Christl et al., 2006); another noted that those who denied previous suicidal ideation had fewer ruminations, lower Beck Depression Inventory scores and a better global functioning score (Klimes-Dougan et al., 2007); and a third found that those who denied previous suicidal ideation were experiencing better mental health on a range of measures including the Hopelessness, Depressive affect and Self-esteem scales, and the General Health Questionnaire (Goldney et al., 2009).

These findings not only have implications in terms of the reliability of epidemiological studies examining suicidal ideation, but also in regard to clinical management. Forgetting or denial of suicidal thoughts appears to be adaptive, and revisiting thoughts about suicide may not necessarily be therapeutic. Indeed, we have been reminded that “It is clear that counselling and psychotherapy are not beneficial to everyone” (Rose et al., 2003). This raises questions about publicity associated with suicide prevention programs, as repeated advertising may perpetuate and exacerbate suicidal thoughts in vulnerable people. It also suggests that clinical endeavours should be focussed on the future rather than on distressing past events.

None of the studies referred to so far can answer the question posed. It is also acknowledged that, like all suicide research, being of interest does not necessarily equate to being useful (Goldney, 2014). However, at the very least they do provide an element of doubt about what we do, particularly in regard to some of our contemporary approaches.

### **The Australian experience**

The Australian experience may be illustrative of the broader problem.

As well as traditional mental health and social services, a number of Australian organisations have been

established specifically to address suicide prevention, or have changed their focus to do so. These include National and State programs, Beyond Blue (previously badged as ‘beyondblue’), headspace, RUOK, One in five, Life in mind, Mindframe, CORES, Safetalk, Mindmatters, Alive and kicking goals, Safeside, Everymind, SANE, Zero Suicide and Mates in construction. It is interesting that many of these use advertising techniques such as catchy names, words elided and all lower case or upper case letters, presumably to capture attention.

This proliferation has often been associated with the mantra of “Suicide prevention is everyone’s business” (Rosenberg, 2018), a clear invitation for anyone to participate. Then there is invariably the claim to be filling a gap in traditional services, as well as being ‘evidence based’, albeit without outcome data. Notwithstanding the introduction of so many programs, there has been an increase in suicide rates in Australia, and no change in the prevalence of psychological distress (Australian Institute for Health and Welfare, 2020; Jorm & Kitchener, 2020; Mulraney et al., 2020).

More specifically, detailed analysis of two Government initiatives has cast further doubt on their effectiveness. The ‘Better Access’ scheme was introduced to increase the provision of mental health services by family physicians, psychologists and other allied health professionals. A review concluded that ‘Better Access’ scheme “had no detectable effect on the prevalence of very high psychological distress or the suicide rate” (Jorm, 2018a).

The second to be examined, ‘headspace’, was introduced in 2006 and designed for people aged 12 – 25 years. Although stand-alone, it is staffed by a range of professionals, and is in essence complementary to existing services. It has spread nationally, despite lack of outcome measures of its effectiveness. Indeed, in a critique of what to date is its only independent evaluation (Hilferty et al., 2015), the possibility that spontaneous remission could have explained the minor changes reported was raised. It was concluded that “the improvements seen in headspace clients are similar to those seen in untreated cases, and it would seem that the services provided may have had little or no effect” (Jorm, 2015). In a response, McGorry et al. (2016) stated that “it has proven very difficult to assemble a comparable control group”, citing the



“non-homogeneous samples of patients”, which in reality is a common challenge in mental health research.

In the absence of any further outcome data, three years later it was reiterated that “we cannot be certain of how much the observed outcomes vary from naturalistic patterns of disease or illness progression that might have been observed in an untreated population” (Jorm, 2018b). Nevertheless, these programs continue to receive considerable Government funding at the expense of traditional services which are bound by outcome principles. In a recent commentary it was noted that “Resources for mental health are finite, and new treatments or innovative programs should be rigorously tested with convincing outcome data, rather than simply process data, before being introduced widely, no matter how much superficial appeal they may have” (Goldney, 2020).

### **Comparison of National programs**

Because of the myriad factors contributing to suicide, it is challenging to both assess the impact of an individual country’s program, or to compare countries with and without National suicide prevention programs. However, there has been an attempt to do so (Lewitzka et al., 2019). The difficulties were acknowledged, and data from Finland, Norway, Sweden and Australia, who each had National programs, albeit with different

iterations over time, were compared with results from Denmark, Austria, Switzerland and Canada, who did not have such programs. It is pertinent to digress to reiterate that, as noted initially, the suicide rate in Norway has not declined and Australia’s has been rising again after an initial fall. Furthermore, of the comparison countries, Canada has had relatively stable rates for several decades, and the others have all had reductions and then generally stable figures. Clearly a challenging analysis!

Their abstract concluded, without caveat, that “Our study implies that the implementation of a national strategy is an effective tool to reduce suicide rates”.

However, it is difficult to reconcile this conclusion with the results section in the body of their report, where they stated “One would expect a statistically significant negative level change a few years after implementation. [...] However, we detected no significant level or trend change regarding the overall rates for all demographic groups including males or females and made the same observation when analysing the males and females divided into different age groups”.

Notwithstanding their conclusion, it is fair to state that these results are hardly an unambiguous endorsement of National programs. Indeed, it is of note that Denmark, which has not to date had a national program, is one of the few countries which has had

a reduction and then maintenance of a lower rate of suicide (Nordentoft & Erlangsen, 2019). It may be pertinent that Denmark has focussed on the restriction of lethal methods and on improving psychiatric services, with an expansion of outreach programs and generous access for comprehensive assessment of those with suicidal ideation, all of which have evidence-based outcome data of effectiveness.

Another earlier examination of National programs in 1997 (Taylor et al., 1997) found a number of commonalities between those of Finland, Norway, New Zealand and Australia. In a table of 13 'Themes and intervention in different countries', Public Education and the Media were noted first and second, and then followed standard measures such as detection and treatment of depression and other mental disorders and attention to substance abuse, among others.

This focus on public education and the media has continued unabated in National and regional suicide prevention programs. This is illustrated well by the following montage of publicity from the United States which is aimed at encouraging people to contact various helping agencies.

This publicity undoubtedly conforms to advertising fundamentals such as being memorable, for example depicting a noose, and being repetitive with the word 'suicide'. However, it is fair to state that in reality they are encouraging people to contact groups, none of which have outcome data to determine their effectiveness in preventing suicide. Furthermore, the possibility remains that it may be exacerbating the problem.

In view of reservations about the effectiveness of such publicity initiatives, as noted in the studies above, it is pertinent to examine the role of publicity more closely.

### **The influence of publicity**

The influence of publicity via various media modalities has been acknowledged since the 17th century, although it was not demonstrated beyond doubt until the seminal work of Schmidtke and Hafner (1988). However, the strength of that relationship, as well as the use of the media in suicide prevention, has been questioned (Goldney, 2001).

A significant contribution to this debate is in an important but infrequently cited paper by Littman

(1985). Although related to newspaper reporting of suicide a decade earlier, and before the proliferation of suicide prevention advertising, its message is clear. In concluding comments he stated: "A matter of serious concern is the possible normative influence that over-reporting on suicide-related issues may exert on entire populations. [...] Frequent reporting on suicide and related issues can by itself exert a normative role: "everybody seems to do it" is not far from "suicide is a common understandable way out for many people.""

Littman went on to note that "the normative argument would be that the more any phenomenon is talked about publicly, in the absence of any value or moral connotation, the greater the likelihood that such behaviour, in the mind of the general public, will take on the appearance of a commonplace, everyday occurrence, somewhat similar to changes in the weather."

It is pertinent to emphasise that although when suicide occurs it is dramatic and memorable, it is in fact a very low frequency event. However, Littman's comments appear apposite for Australia, not only judging by the number of organisations promoting suicide prevention, but also by warnings before distressing news stories, which inevitably are always present, and which are then followed by offering contact details of suicide prevention organisations, none of which have outcome data to demonstrate their effectiveness.

It is not possible to assert that such media presentations are necessarily harmful, but it may be pertinent that there is a literature which indicates that the repetition of similar messages may be counterproductive. In a critical review of "Advertising Repetition", Pechmann and Stewart (1988) referred to an inverted 'U-shaped' relationship between frequency of advertisements and outcomes, in which initial advertising had positive results, whereas later repetitions led to



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more negative attitudes. Clearly more food for thought in considering the complexity of suicidal behaviours.

### What is the answer?

None of the studies cited provides a definitive answer to our question, and one is left with speculation. The present paper has addressed the closely associated issues of education and publicity. Clearly, in a multifactorial problem, these issues are not the only potential problems. However, their implications are not inconsistent with recent commentary.

In Australia Jorm (2020) focussed on three broad areas. The first was that suicide is influenced by social factors that are outside the domain of mental health services. This is undoubtedly true, and education and the media are good illustrations of that. There is no doubt that they have been embraced enthusiastically by national and regional programs, but perhaps this has been without sufficient introspection.

His second point was that treatments may have limited impact on suicide deaths. This is correct, but that renders it even more important that only those interventions which have demonstrated effectiveness



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should be promoted. However, as discussed before, much publicity and advice, including that which is government sponsored, promotes well-meaning organisations with no outcome data.

The third point was that mental health professionals may not be present when suicide risk is highest. That is also the case, and it is probable that that would only be exacerbated by encouraging referrals



to organisations with no demonstrated effectiveness in suicide prevention. Related to this point are the results of the Vulnerability Index study, where it was suggested that “living in such (vulnerable) countries fosters protective factors that more than compensate for the limitations in professional healthcare capacity” (2019). Not only does that indicate that self-reliance may have been enhanced by an absence of helping agencies, but an alternative view could be that what is being introduced in more developed countries has been counterproductive.

## Conclusion

There is no simple answer, but, with an absence of convincing evidence that national suicide prevention programs are effective, hard questions need to be asked. While it is acknowledged that absence of evidence is not evidence of absence, this review indicates that there are sufficient clues to closely examine broad educational and media programs. It also emphasises the need to use management with demonstrated effectiveness, and, with finite resources, to only introduce new programs when they have been subjected to rigorous review.



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