In Debate

Can Psychiatry Prevent Suicide? Not Yet!

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Let me begin by saying that I believe psychiatrists can and should play a significant role in the prevention of suicide in Canada. Whether this is currently the case is another question. Dr Lesage has advanced the "pro" opinion on this matter. It is my aim to examine these arguments in terms of scope, accuracy, and future planning.

The "pro" part of this debate suggests that psychiatrists can prevent suicide in 3 ways: first, by adopting a shared care model that allows greater collaboration and thus better support for treatment of mental disorders (particularly depression) by general practitioners (GPs); second, by optimizing treatment of depression via the application of clinical management procedures as outlined by the Canadian Psychiatric Association; and third, by collaborating with addiction services, because alcohol and drugs are heavily involved in cases of completed suicide.

Scope

The merits of these points notwithstanding, they encompass an approach that falls far short of what might be considered comprehensive in regard to suicide prevention. In the first place, all the focus is on treatment of individuals who are actively suicidal and (or) suffer from mental illness. This approach has no room for early detection and intervention, no focus on healthy child development, and no emphasis on community development or ecologic interventions. To be fair, perhaps this is outside the purview of the In Debate section, since the topic refers to what psychiatrists can do, rather than to a comprehensive suicide prevention plan. Second, the focus seems to be on depression, but the evidence shows that virtually all mental disorders are associated with suicidal behaviour (for example, 1). In fact, schizophrenia and bipolar disorder show an equal or higher level of association with suicidal behaviour than does major depression (2,3). Third, it is important to consider suicide–substance abuse comorbidity, but suicide is related to any number of other social problems and conditions, including interpersonal violence, relationship difficulties, unintentional injuries, and being left out of the mainstream (4,5). This suggests that something causal underlies all these conditions, perhaps something social in nature. Finally, although it is reasonable, from the point of view of this journal's readers, to conceive of a scheme with the medical profession at its centre, not everyone else sees it that way. Other professionals compete with psychiatry and general practice medicine to deliver treatment services—not as team members, but as primary care clinicians. It does not seem sensible either to ignore this or to compete. It should be noted, however, that the primacy of any mental health treatment specialist declines when we consider interventions at the societal level and when we engage in primary prevention with presuicidal children and youth.

Evidence

The arguments about scope may be important, but they could be rendered meaningless by a body of solid evidence showing that certain interventions have consistently reduced suicide rates to near-zero levels. In spite of some encouraging work and some isolated and delimited projects, however, it can be safely said that no one has demonstrated an enduring causal relation between purposeful interventions and reduced suicide rates. The Alberta Heritage Foundation for Medical Research has produced 2 health technology assessments focusing on suicide: one deals with programs for children and youth (6), and the second comprises a review of systematic reviews on suicide prevention (7). Neither report was able to identify a demonstrated reduction in suicide that could be attributed to a particular approach, although the second document (7) offered the faint praise that some approaches seemed "promising." The American Association of Suicidology also reviewed several promising programs, but after applying reasonable standards of evidence, only a handful remained. One showed improvement in coping skills and reduced suicidal ideation, 2 showed reduced suicide attempts, and one other produced reduced hopelessness in an Aboriginal population. One program that did show reduced suicides in the US Airforce emphasized the enhancement of protective factors and the reduction of risk factors. Unfortunately, the design was pre–post, making the results less compelling than those from the studies that involved comparison groups. Is this

another example of an increase in the rigour of inclusion criteria accompanied by the disappearance of studies purporting to show reductions in suicide? In any case, the reviews are worth reading. They are available without charge as downloadable files from the Association Web site (8). All this leaves me in agreement with the *British Journal of Psychiatry* editorial statement that "suicide prevention remains essentially a land of hopes and promises but not of certainties" (9, p 373).

The Gotland Initiative

There are no studies on the efficacy of psychiatrists vis-à-vis the suicide rate. However, the effect of training family or general practice physicians regarding suicide was studied on the Swedish island of Gotland. Initially, the results were very good (10). Suicide rates did go down, gaining worldwide attention, but unfortunately, they soon returned to "normal" levels (11). It would be hard to believe that there are not some extremely valuable lessons here, but at this juncture, we cannot draw any firm conclusions that can be used to direct major policy or practice changes.

Antidepressant Medication Studies

Several investigations seem to indicate that higher levels of antidepressant use have produced lower suicide rates. This is heartening, but not conclusive. Most of these studies are correlational, and it would therefore be more accurate to say that the 2 phenomena are associated, removing the notion of causation from the equation. A case in point would be findings from Sweden, Denmark, Norway, and Finland, where a 3.5-fold increase in antidepressant use was accompanied by a 19% reduction in suicide (12). By the author's own admission, however, this study is naturalistic and not conclusive. Conversely, a careful study of suicides in Iceland over 25 years found no effect from a ninefold increase in antidepressant sales (13).

The Baby and the Bathwater

There is a danger that unbridled skepticism coupled with the absence of definitive proof could lead policy-makers to conclude that nothing useful is going on. About all we can say now is that there is an absence of evidence for a positive effect—which is a different thing. That is, we do not know the effect on suicide rates of removing all psychiatric services. I for one prefer to leave that question in its hypothetical state. It is highly likely that several societal and service factors keep the "resting level" of suicide from being higher; these include the work of psychiatrists and other mental health professionals, family support, community organizations, social structure, and perhaps, random acts of kindness.

The Way Forward

Many good arguments exist for the current emphasis on shared care. In the context of suicide prevention, however, I cannot get too excited about it. The shared care approach leaves suicide too much a part of the medical model wherein physicians refer patients to specialists and have them referred back to carry out a suggested treatment plan with some level of subsequent consultative contact between the medical practitioners involved. This model is, in fact, pretty useful for certain problems and for certain aspects of many conditions. Suicide, though, is strongly linked to other social problems: rates are higher in communities with a weak social fabric, they are higher among individuals who are left out of the mainstream, and the tendency begins many years before the first overt suicidal act. A comprehensive approach cannot be forthcoming from a service that does not mobilize until after the appearance of a major problem and that is unable to alter the social and family environment of potentially and actively suicidal individuals.

Having said that, psychiatry might be advised to do the active-treatment piece of the overall prevention pie well, leaving the rest to others. Nevertheless, many psychiatrists operate in a population health, public health, or health promotion mode—or in all of them! Further, evidence from the field of psychiatric epidemiology indicates a broader and earlier type of intervention. One example is the positive role played by social psychiatrists and epidemiologists in Australia's systematic planning and promotion efforts, such as "beyondblue," which is a nationwide program to improve detection of depression and use of treatment services (14). Thus, regardless of the extent to which the current question is true or false, my position is that psychiatry can contribute to suicide prevention more strongly by investing time and energy in the following:

1. Collaboration beyond shared care. It is not enough to engage in shared care—broader collaboration would have significant benefit. Much (enough to build on) is already going on, but psychiatrists need to put the kind of planning and energy into other forms of collaboration that they currently devote to shared care.

2. Building an evidence base for the efficacy of interventions. This is the age of evidence-based decision making, accountability, and outcomes (at least it was recently). Psychiatrists (and all other mental health service providers) would benefit from the enhanced efficacy that comes from monitoring patient outcomes, evaluating performance, improving interventions, monitoring again, and so on. Perhaps individual practitioners could monitor their own caseloads, participate in evaluation–outcome studies, or support systemic approaches to evaluation and planning.

In any case, you cannot claim to prevent suicide if you don't know how well you are doing.

3. Acting locally. Many (often small) community-based intervention programs across Canada were set up without the benefit of good clinical input and operate with the same deficit. There is no doubt in my mind that their impact on suicide would be significantly enhanced by psychiatric input. It should be said that this is sometimes impeded by psychiatrists who want to run things and (or) imply that treatment (often thought of as medication only) is the only way to go.

In closing, it is interesting to note that many of the points raised here would also apply to my own profession, psychology. The In Debate question was about psychiatry, but the answer involves many disciplines and many perspectives.

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