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Editorial: suicide numbers a record high for the third year running

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Investing massive amounts of taxpayer's money in mental health services or doing absolutely nothing results in the *same* suicide outcome.

Over the last few decades the New Zealand Government has not changed its suicide prevention strategy of medicalising suicide and investing heavily in mental health services to reduce suicide rates. In 2006 they invested $6 million specifically in an official suicide prevention policy to tackle and reduce depression rates. More recently, as a response to a record high 2016/17 suicide numbers, the government announced $300 million will be given to mental health services (http://www.radionz.co.nz/news/national/338160/suicide-numbers-rise-to-highest-on-record).

The problem is that record high suicide numbers were also recorded for 2015/16 and 2014/15 (http://www.radionz.co.nz/news/national/315925/suicide-stats-remain-'unacceptably-high', and http://www.newshub.co.nz/home/new-zealand/2015/10/nz-suicide-stats-highest-ever-recorded.html)! It is not the first time suicide numbers have risen three years in a row and it will not be the last time as long-term suicide trends show (e.g. see Fig 1, http://journalofhealth.co.nz/?page_id=759).

This is a major dilemma for governments around the world and proponents of the medicalisation of suicide because they are unable to explain why suicide is on the increase in an environment where all the resources are directed to tackle mental illness. As a result, short-term trends are used to explain suicide:-

1- The rising suicide rate is explained as being a very complex mental illness with social and environmental issues with resources being invested in the mental health services to reduce suicide,
2- The downturn in suicide rates is explained as the result of investing in mental health services to reduce suicide!

This pattern of short-term political response to suicide trends has blinded policy makers and the public and covered up the evidence which supports there is no link between mental illness and suicide. Only when viewed as part of a long-term suicide trend it becomes obvious that the current pattern should have been expected, and, only then it becomes astonishing clear that there were no policy actions in place to combat the expected rise. And only then it becomes unbelievably apparent that suicide prevention strategies have been 'more of the same' costing more each year in terms of taxpayer's money and lives lost to suicide – and for 2016/17 'more of the same' got even more expensive.

The medical model, as a suicide prevention strategy, does *not* work. Zero suicide was recorded in Canterbury (New Zealand) following the 2010/11 earthquakes but 'experts' and

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the authorities forecasted that this will not last. Indeed, instead of developing an action plan to *prevent* future suicide occurring, the authorities implored the public to look for signs of mental illness and depression in friends and relatives and refer them to mental health services. While the 'experts' sat on their hands and waited for signs of mental illness to develop Canterbury now boast the highest suicide rate in New Zealand (http://www.stuff.co.nz/the-press/news/85452513/canterbury-records-most-suicides-in-new-zealand).

The simplistic notion that suicide is the outcome of mental illness/depression has been challenged before (Hjelmeland *et al.*, 2012; Hjelmeland & Knisek, 2017; Pridmore, 2009; Pridmore & Walter, 2013; Shahtahmasebi, 2013a, 2013b, 2014a, 2014b). the World Health Organisation has recently described as a myth the claim that all suicide is caused by mental illness (WHO, 2014).

Current estimates suggest that between one-quarter and one-third of all suicide cases have had contact with mental health services and yet went on to kill themselves. Furthermore, Government documents (Antidepressant use in New Zealand doubles, 2012; Ministry of Health, 2007) show antidepressant prescriptions have more than quadrupled since 2006 and yet New Zealand continues to have a record high suicide rate.

There are alternatives to medicalisation of suicide that actually work (Shahtahmasebi, 2013a).

All we have to do to eradicate suicide is firstly, to focus on suicide instead of focusing on treating a mental illness and/or depression. The medicalisation of suicide ignores those suicide cases without any symptoms, thus increasing the risk of a suicide outcome. Just treating depression (that may not exist), and/or a mental illness symptom (that may not exist) will not necessarily remove suicidality nor will it stop suicide. Secondly, we must *depoliticise* suicide prevention and aim for the common goal of eradicating suicide together. Thirdly, we need to acknowledge that suicide is a community problem and therefore adopt a more inclusive approach rather than the current top-down approach.

In a paper to appear in the next issue I will explain how an inclusive approach to suicide prevention can be developed and implemented.

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