Editorial: the blame game

Said Shahtahmasebi
Email: editor@journalofhealth.co.nz

Suicide is a phenomenon that has been known throughout history. It occurs in every ethnic group and geographical region. Although it has been linked to culture but for the last two centuries, it has been described as a medical issue (Pridmore & Pridmore, 2018). In most countries psychologists and psychiatrists have claimed ownership of suicide and suicide prevention has been based on the assumption of the presence of a mental illness. As a result suicide prevention has been proclaimed the responsibility of medical professions in particular psychiatrists and mental health services. In terms of policy most governments have firmly placed suicide and suicide prevention under mental health.

Mental health services have been receiving huge resources to reduce suicide rate for decades, but not only they have failed to reduce the suicide rate but under such a policy, suicide has been on the increase. In 2018 New Zealand's suicide numbers reached a record high for the fourth year in a row, in the US it has increased by 30% since 1999 (CDC, 2018). No one has accepted responsibility while governments continue to allocate extra funding to mental health services for suicide prevention.

There has been a movement that has critically examined and discredited the medical model, through literature/history (Pridmore, 2009; Pridmore, 2018; Pridmore & Pridmore, 2018; Pridmore & Walter, 2013), through statistics (Shahtahmasebi, 2014), and methodology (Hjelmeland *et al.*, 2012) it was demonstrated that suicide *is not* predominantly a mental illness issue. But suicide prevention continues to be based on 'there must be a mental disorder' even if none was diagnosed.

On the subject of mental illness and suicide Pridmore (Pridmore, 2009) makes an important point: 'Every person who suicides can be ''diagnosed'' with something, if the category of 'mental health problem' is employed. But making this ''diagnosis'' is to medicalize life experiences'. Recently, the World Health Organisation (WHO, 2014) along with the Center for Disease Control and Prevention (CDC, 2018) stated that suicide is not exclusively a mental illness issue.

Furthermore, a recent analysis of Australia's 'Better Access' Scheme of expanding mental health services to make them accessible to the public at large suggests there was no impact on suicide rates, providing further evidence that mental illness may not be related to suicide prevention (Jorm, 2018).

Some scholars and medical modellist converts thread cautiously and state that although mental illness is not the sole cause of suicide it does cause some suicide. Whether mental illness is the cause of all suicides or some suicides the problem with this belief is that it implies *cause and effect* which has not been proven. To examine cause and effect a large prospective longitudinal study is required that takes into account definition of mental illness, cyclic patterns and lagging effect in suicide rates for each groups. Therefore, the medical model is only an opinion, and, suicide prevention is based on an opinion. We are still none the wiser about suicide per se and that is why we have not been able to reduce suicide rates.

Suspiciously, there seems to be a new game being played by medical modellists, and that is 'the *not* blame game'! Under this scenario some attempt to shift the blame away from the

medical profession for the rising suicide (e.g. see https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/75486). In this example the medical professional makes false statements about suicide and promises 'more of the same' but asks not to be blamed for failing to stop suicides.

Mental health services have failed the one-quarter to one-third of all suicides who sought help, i.e. they still went ahead and completed suicide while under psychiatric care or soon after discharge.

Psychiatry has refused to engage with other disciplines and/or investigate alternative approaches. Psychiatric and suicidology journals only publish a mental illness view of suicide. The only conclusion that can be made from suicide research is that we do not *understand* suicide and therefore we do not know why people kill themselves.

Suicide occurs in every group and subgroup, e.g. relationship problems or no relationship problems, healthy or unhealthy, mentally ill or not mentally ill, well-off or poor, employed or unemployed, famous or common, farmer or city dweller, but *suicide is not caused by belonging to any one of these groups* – which means that the public at large is at risk of suicide. In other words, with the available data cause and effect has not been established. The outcome of persisting with medicalization of suicide and suicide prevention has been for suicide to become synonymized with mental illness - regardless of a strong lack of evidence. A ridiculous consequence and unwise practice is that suicide or attempted suicide is now used as an indicator of mental illness, e.g. a GP's report to the coroner stated "…we had no insight into his mental health problem and so were not able to prevent this tragedy" (Shahtahmasebi, 2005).

The medical profession claimed ownership of suicide prevention and demanded that suicidal people be referred to them for treatment. Mental health services are given vast sums of money to prevent suicide and they consistently (predictably) fail to deliver. Therefore it is fair to blame them.

The psychologists/psychiatrists' only defense has been that non-psychiatrically trained individuals are not qualified to discuss suicide (Shahtahmasebi, 2018b), whilst one psychiatrist in an article published last year ignorantly claimed that 'nothing works' in a bid to address suicide rates (Stuff.co.nz, 2017) – there are non-mental illness working models of suicide prevention e.g., see (Shahtahmasebi, 2013).

The problem with the blame game is that psychiatry/psychology has persisted with mental illness as the only cause of suicide, has taken the funding for suicide prevention for decades, kept the public ignorant of suicide, has given the public 'more of the same' for years and have not delivered, but has refused to accept responsibility for outcomes. Why should they not be blamed – is this game a response to the turning of the tide in suicide prevention? On the other hand governments' (globally) suicide prevention policy has been to fund the medical model (despite flimsy opinionated evidence (Shahtahmasebi, 2014)) for decades without any checks and balances. In New Zealand, in particular, the government has supported a policy of silence and secrecy, because only a psychiatrist can deal with suicide, thus keeping the general public ignorant and uneducated about suicide. I have argued that under this policy the professionals and politicians/decision makers and the public are the problem of suicide e.g. see (Shahtahmasebi, 2014, 2018a).

In 2017, the New Zealand's newly elected Labour Government promised action against the rising suicide numbers. The government's action was to set up a $6.5m nine month inquiry into mental health services the outcome of which basically promises to deliver 'more of the same'. The government will defend itself by claiming that it has acted on its promise of setting up an inquiry. But this is not much of a defence as the inquiry was into mental illness and mental health services at a time when suicide numbers had already reached record high for the third year running. So while the government was running its inquiry more people killed themselves to a record high for the fourth year in a row.

So whilst it is reasonable to hold the government responsible in the first place for implementing a medical suicide prevention model without accountability. But equally psychiatrists/psychologists are responsible for spending funds year upon year but continue with the same failed methodology of mental illness intervention disguised as suicide prevention.

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