ISSN 2382-1019

Suicide: forecast and prevention

Said Shahtahmasebi, PhD
The Good Life Research Centre Trust, New Zealand.

Correspondence: Said Shahtahmasebi, email: radisolevoo@gmail.com
Key words: suicide, guillotine, zombie policies.
[**citation**: Shahtahmasebi, Said (2026). [Editorial]: Suicide: forecast and prevention. DHH, 12(1):https://journalofhealth.co.nz/?page_id=3315].

It seems that suicide intervention/prevention strategies have always faced issues of relevance, appropriateness, availability and accessibility, but, there is an unwillingness to do anything to address them. The medicalisation of suicide has constrained suicide prevention into an intervention focusing on the portion of suicides where a mental illness is present and/or is a main contributory factor. A medical approach instinctively looks for signs/symptoms (usually a depression and/or a mental illness) and takes action (i.e. refer the victim to mental health services). At a national or global level this policy is of benefit to a portion of those who exhibit a mental illness, because firstly, we have to wait for signs to develop. Secondly, it ignores cases who do not display signs or are good at hiding them, and despite medical intervention some continue to make suicide attempts (Shahtahmasebi and Smith, 2013a). Because, at some point in time suicide rate is lower than the previous year is not proof of a successful prevention plan. Suicide rates trend up as well as down during each cycle. For this reason, in an earlier paper, long-term suicide trend was used to forecast future pattern (Shahtahmasebi and Gregory-Allen 2025). The results suggest an overall upward cyclic suicide trend which is likely to continue in the future.

The following case, a male, provides a description of the immediate impact of suicide using violent methods (Shahtahmasebi 2009):-

> Case 3M [the narrative below was received soon after the event and provided here unedited]:–
>
> "apparently had quite a history of mental problems of whatever degree I am not totally sure… caused his family great anxiety over the years and his health worsened latterly. His last attempt was remembered very clearly at the hospital by the orderlies... Hospital staff said that nobody quite knew how he managed to survive - Skilful Doctors and nurses probably. Made a right proper mess of himself. Really horrific. Nobody who saw him has forgotten. Well this time he had it sussed - even more gruesome … And so he died of blood loss [and probably shock] and what a bloody unpleasant and painful way to exit this world. The irony is that every time they save a life … then leave them to their own devices… back to square one!"

The final sentence is a summary of mental illness-based suicide prevention policies which have not changed over decades; it still aims to treat a mental illness as the cause for suicide, discharge to the community as "cured", followed by suicide attempts soon after discharge, e.g. see Shahtahmasebi and Smith (2013a).

Suicide methods and suicide prevention have featured in a series of articles published in the DHH, specifically, an article reporting the use of a guillotine designed and constructed (in

ISSN 2382-1019

secret) by the suicide case (Kimber and Pridmore 2023). Since its publication in 2023, another case of suicide by guillotine has come to light, which we report in this issue of DHH (Pridmore and Naguy 2026).

We do not pretend to know what would make someone resort to an extremely violent method to end their life. Some western countries have a moratorium in place where the method of suicide is omitted from any media reporting of suicide. The merits and evidence for this policy has been challenged elsewhere (Shahtahmasebi 2014). However, the method of suicide may reveal some secrets about the suicide case that can help to further our understanding of suicide, and must be included in suicide research.

No one denies that suicide is a major health concern, and suicide prevention must be the highest priority in policy development. To prevent suicide, we must understand suicide beyond its definition of intentional self-harm causing death.

The evidence suggests that policy makers have been developing suicide prevention policies without understanding suicide (Shahtahmasebi 2013b; Hjelmeland & Knizek 2019). The evidence also suggests an elective affinity style of policy making where mental illness and depression are considered the main causes of suicide and are favoured as the only pillars of any suicide prevention strategy. Thus, the mental health care service is the direct beneficiary of government funding for suicide prevention. The evidence supports the contrary that suicide is a discipline in its own right, for example: -

- On average, between two-thirds and three-quarters of all suicides do not have a psychiatric record (Hamdi et al. 2008; Shahtahmasebi 2003). Of the remainder who did seek psychiatric intervention not all were diagnosed with depression, but went ahead and completed suicide.
- The idea that all suicide is a consequence of a mental disorder has been described as a “myth” by the World Health Organization (WHO, 2014)
- Centers for Disease Control and Prevention (CDC, 2018) reported that more than half of the people who died by suicide did not have a known mental disorder,
- Over the last century depression has often been blamed for suicide:-
    - in 2006 the New Zealand government dedicated $6 million to tackle depression (depression.co.nz) as its suicide prevention strategy,
    - moreover, New Zealand government documents (Ministry of Health, 2007; Radio New Zealand, 2012) show that between 1997-2012 prescription for antidepressants quadrupled, but over the same period (and beyond) suicide rates continued to rise,
- Suicide rates follow a cyclic pattern; the cycles have been ignored – instead, when the cycle is on a downturn the ‘experts’ and policy makers claim credit – but when the cycle bottoms out and is trending up they claim suicide is a complex social, environmental, and mental illness problem and demand more funding to research suicide!

Unfortunately, we are conditioned to accept cycles as natural phenomena in man-made processes such as economy, and healthcare. In the era of evidence-based decision making, politicising of such processes supports popular illusions rather than holistic evidence informing policy development. One of the outcomes of the elective affinity approach is perpetual zombie polices that are based on discredited ideas (Shahtahmasebi 2013; Hjelmeland, et al. 2012; Quiggin 2010).

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