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Reporting suicide in New Zeeland

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Editor's note

In New Zealand (NZ) there is a policy of silence around suicide which has grown out of a moratorium on the media not to report method of suicide. The idea behind the moratorium is supposedly to prevent copycat suicide. Whether or not this is a wise move, the moratorium appears to have snowballed into a confused law leaving it up to individuals' and organisations' on how to interpret it. So, the corporate media adhere to the false assumption that mental illness is the main cause and psychiatry is the only way to prevent suicide. The media do not report anything that has not got its root in psychiatry.

Other organisations such as mental health services and schools practice an ad hoc interpretation of the moratorium on suicide reporting. Some district health boards have put a ban on their staff attending non-psychiatric suicide prevention training programmes, whilst at some schools staff have been disciplined for openly uttering the phrase 'suicide prevention at school' in the staff room.

The former Chief Coroner Judge MacLean's 2011 press release called (http://www.3news.co.nz/Chief-Coroner-releases-NZ-suicide-statistics/tabid/423/articleID/223638/Default.aspx#ixzz230JkrbCi) for a gentle opening up of the restrictions on media reporting suicide, which was lambasted by the proponents of a medical suicide model (Beautrais & Fergusson, 2012). But this attack on the Chief Coroner's statement was challenged and rebuked as baseless without any solid evidence (Shahtahmasebi, 2014).

In the context of suicide there is fear in the media. The line of reporting is to constantly pushing the message that suicide is on the increase because the mental health services are strapped for cash. But they fear to question whether or not mental health services are appropriate and relevant in preventing suicide.

However, the article below, first published in the Critic 8 October 2017 opens up the question of the appropriateness of the current suicide prevention strategy, in a much more balanced way and provides a critical assessment of NZ's suicide prevention strategy and the increasing numbers of suicide.

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Suicide in New Zealand

New Zealand is a country renowned for its beautiful scenery and idyllic landscapes, a country with some of the most laid-back people you'll ever meet. An ideal place to grow up in, raise a family, retire to and sight see.

In 2016, our little island nation won the title of 'best country in the world' for the fourth year running in the Telegraph Travel Awards (1). An accompanying article gave 26 reasons as to why this title should be given to New Zealand (2); its strong ties to Britain, its 'magnificent Maori culture' and its religious freedom were all praised. But beneath this believable gloss lies a dark and deadly secret.

Our country is locked in a perpetual struggle; we have one of the highest suicide rates in the Western world, and in particular the highest youth (15-24 years old) suicide rate in the OECD - a massive burden for a small nation to bear. The latest suicide statistics released by the Chief Coroner in late August showed that the number of New Zealander's taking their own lives has increased overwhelmingly in the last 3 years, with the year 2016-2017 having the highest numbers ever recorded. Frankly, it is startling, as we expect suicide rates to decrease, not increase; we certainly don't expect to find that 1,749 members from our own communities committed suicide in just three years – one wonders what exactly authorities and experts have been up to for decades with our taxpayer's money.

Why in a country that is consistently ranked as the world's best and recommended as a good place to live, are so many New Zealanders resorting to suicide as a way out?

The enormity of these statistics was illustrated by the 606 shoes that were displayed all over New Zealand in order to represent those lost to suicide. National MP the Hon. Michael Woodhouse commented that "one suicide is too many – this is a whole of society problem".

Labour party leader Jacinda Ardern believes "it's hard to say exactly what is behind this [rising suicide statistics]". She states that there are "a lot of things happening that sit behind that tragic statistic which could be a factor", such as; growing inequality, overstretched health services, increased societal pressures along with population growth. It is her opinion that a review is needed as to what the reasons are for these statistics, as "every single suicide is simply unacceptable".

"Suicide is an awful beast", declares University of Otago Honours student Jean Balchin. Tertiary students fall into the youth 18-24 age category thus there is concern about student suicide by institutions. At the University of Otago, suicide prevention is provided by the Student Health centre with a somewhat mixed approach. The health centre provides mental health support and counselling appointments for students and recently in order to be more responsive they have managed to increase the number of mental health clinicians and the number of same day assessment appointments they can offer to students. This year the centre has also adopted a proactive approach by highlighting a student led non-medical approach with the Silverline Festival – which aimed to challenge how we all engage with mental health and wellbeing - as its flagship to encourage not just students but also the Dunedin community to be more aware and look out for their students, colleagues and friends.

Last Saturday (16/9/17) Balchin spoke during the Silverline Festival, sharing the story of how she tragically lost her brother to suicide. Balchin discussed how suicide is considered a "huge shameful secret", and dispelled 12 myths about suicide, the first being the belief that talking about suicide plants the idea of suicide, when this is unequivocally not the case. The fact is that the secrecy around suicide means that people are not equipped to listen and are afraid to hear the word. But suicide is certainly not a topic to be swept under the carpet. Talking about suicide with appropriate and relevant information allows people to share their thoughts in a safe environment and for others to listen and help effectively.

Mr Woodhouse claims that "improvements have been made' but that there is a need to continue to increase and improve performance with regard to suicide prevention. Therefore funding for mental health and addiction services has increased from $1.1 billion in 2008/09 to $1.4 billion for 2015/16. He also believes we must continue to transform our mental health services in order to build resilience in children and young people to "help them better deal

with mental health issues". National plans to invest an additional $100 million into a social investment fund for mental health which includes 17 new initiatives "designed to improve access to effective and responsive mental health services."

Jacinda Ardern says that the reason so many of our young people are taking their own lives is due to many mental health disorders being prevalent in adolescence, thus there being a need for them to have access to health and support services, which are currently over-stretched. If successful this weekend the Labour party has committed to funding health services including mental health support in every public secondary school because "we know this will make a huge difference to our young people and there is evidence to show this will help." Since the devastating Christchurch earthquake, Canterbury now tragically boasts the highest suicide rate in New Zealand. Labour plans to provide primary and intermediate schools in the Canterbury and Kaikoura regions with 80 fulltime roles in mental health with the aim of assisting with earthquake-related issues. Their general health policy aims to reduce barriers for those accessing health care; by decreasing the cost of visits to the GP and giving additional funding to GP training places because "we need more of them."

A researcher in the field of suicide, Professor Said Shahtahmasebi, who believes in a holistic approach to suicide prevention questions Ardern's approach. Shahtahmasebi asks, "how can implementing more medicalisation of suicide, which has been the primary practice for decades and has only proved to be ineffective, prevent suicide? "Even if we install psychiatric units at every corner and in every classroom, it will not prevent suicide," Shahtahmasebi argues.

Earlier this year, mental health advocate and comedian Mike King announced his high-profile resignation from the suicide prevention panel, where had King felt "like a lone voice in a room full of people who wanted to do the right thing but weren't."

He labelled the government's approach to suicide prevention as "deeply flawed", the major issues being that the approach is "clinically and academically driven with the most important component taken out of the equation: the communities". The fact is we are not communicating with those affected and instead basing everything off "someone else's opinion."

"It's all academic bullshit," says King. Issue number two is that any literature about suicide in New Zealand gives the impression that suicide prevention strategies are only being aimed at one specific ethnic group – Maori. It's easy to understand why, due to the over-representation of Maori in the statistics, but the truth is suicide does not discriminate - it affects everyone. By only trying to alleviate the problem in one isolated section of the community the government and suicide prevention programmes have only succeeded in "isolating the majority of the community", when instead a collective approach would be far more effective.

"Suicide is a war… and we need to go to war as a nation to fight this blight on New Zealanders," King states adamantly, citing our "proud history of fighting together" – in World War II Maori and Pakeha fought together on the same ground, for the same cause. "Until we make this a fight for all New Zealanders we aren't going to get on top of the problem."

Housing, poverty, racism, colonisation and an increasing gap between the rich and the poor have been listed as five reasons for our high rates of youth suicide. But in all of King's time as an anti-suicide campaigner, not once has anyone ever told him: "I want to kill myself because of housing or poverty…" In his words, it doesn't make any sense at all. The country with the lowest suicide rate is South Africa – a country with housing, poverty, colonisation and racial problems that far transcends ours. Therefore it is not these factors that are killing our young people.

Young people are taking their lives because of the ever increasing gap between the generations. Nowadays, young people feel constantly judged by the significant adults in their lives, feeling like no matter what they do it will never be enough. If the significant adult in a young person's life is "yelling at them or putting them down for not passing a math test or for not making the bed, why on earth would they want to talk to that adult about their suicidal thoughts?" questions King, saying vehemently that "my generation needs to be made aware of this fact, as they are constantly looking for someone else to blame for their issues." Eighty percent of all school aged children who experience recurring suicidal thoughts never ask for help because they are worried about what other people will think, say or do if they share that information. The fact is we need to stop judging and instead bring young people into the conversation.

"For the record" states King, "this is not my opinion. This is what over 160,000 young people from Bluff up to Kaitaia have told me."

The governmental approach to suicide has been exactly the same for decades, so as King says, it's no surprise that there has been no changes to the number of people taking their lives (3). Professor Said Shahtahmasebi agrees, stating the government has just been giving us "more of the same", somehow expecting to see different results.

King likens being suicidal to being in a car crash; it feels exactly the same as being hit by a car but instead of help coming to you - as it would in the car crash case - the person in crisis has to get themselves help. The person suffering has to "ring up some random dude who is normal… explain why you want to commit suicide but maybe you don't even understand why you want to", or they have to get their "butt out of bed to go to hospital to show scars of previous attempts." Basically our current suicide prevention system actively encourages attempting suicide in order to get the help you need. Professor Shahtahmasebi argues that this is not prevention, instead a belated and sometimes unhelpful intervention. Suicide isolates you, so instead of putting the onus on people in crisis, why not put it on those who aren't. King shares that when he was suicidal the last thing he wanted was to call someone or talk to his doctor – "I wanted a friend to walk into my room and tell me they love me… that I mean something in their life."

The truth is we just don't understand suicide, how to deal with it, or even how to approach someone we suspect is suicidal. Both King and Professor Shahtahmasebi adamantly state that the biggest mistake of all is grouping depression, anxiety, suicide and mental illness all in the same category. King expresses that turning suicide, depression and anxiety into a mental illness is an instant over-reaction. By classing low to moderate depression, anxiety and suicidal thinking as a mental illness it means there is no longer a need to understand it, all we have to do is fix it.

But what young people who are anxious, depressed or suicidal want more than anything is to feel heard, to get their point across and hopefully be understood. Instead all they feel is invalidated and shut out.

Professor Shahtahmasebi also criticises the government's continued practice of pumping money into mental health services, and their refusal to see any evidence proving that this method does not work. The medical model of suicide focuses on finding a mental illness in a suicidal person that may or may not exist. Shahtahmasebi cites that "one-third of all suicide cases on average come into contact with mental health services and *yet* still go on to take their lives." Meaning we know nothing about the remaining two-thirds who committed suicide but had no contact with mental health services. Therefore they cannot be branded as being mentally ill, all of this is begging the question as to how exactly are mental health services making a difference? The whole medical notion drives the idea that only people with mental illnesses commit suicide which is not the case. A recent World Health Organisation (WHO) report states that the claim that all suicide is caused by mental illness is

a myth (4). As King declared, "being anxious, or depressed or having suicidal thoughts - that does not make you mentally ill, **it makes you HUMAN."**

But linking suicide with mental illness could at least, in part explain why over two-thirds of all suicide cases do not come into contact with health services, for fear of being labelled and the additional stigma related to mental illnesses.

The lack of understanding surrounding suicide makes it difficult to come up with a successful prevention scheme or strategy. Shahtahmasebi suggests that we should come up with a strategy based on what we do know about – human behaviour and interaction. By following such a model we would let members of our communities know that we love and care for them, making it possible to remove suicide as an option. People considering suicide would instead know that there are people around them that they can rely and communicate with. King suggests that the best way around this problem would be to have something akin to life coaches in all schools who identify children and young people who are struggling earlier. This would also involve training the school yard environment and encouraging kids to talk about small problems before they have the opportunity to become bigger.

Other known alternatives to the medical approach of suicide that actually work can be seen in the work of Professors Shahtahmasebi and Omar, of Kentucky University and chair of the Stop Youth Suicide campaign. They ran a series of workshops between 2010 and 2015 in order to mobilise communities at grassroots to decrease youth suicide rates in particular areas in New Zealand. Their work was extensive, involving workshops and community gatherings where they spread the word about suicide prevention and building caring communities. Their work in communities that participated – some with startling numbers of youth suicide - saw massive reductions in the time that the campaign was running.

With regard to the upcoming election King states that it doesn't matter which political party gets into power, because they don't control the suicide prevention programs. These programs are run and evaluated by clinicians and academics, without any consultation of the consumers – but "who can best evaluate a haircut, other than the customer?" Because of the way suicide prevention is structured in New Zealand and made into a mental illness, connotations surrounding mental illness results in the 'consumers' in this situation being considered untrustworthy.

"We do need the academics and clinicians, we need to work with them, but they also need us, we are the ones receiving the treatments, don't shut us out" protests King.

"It is time to stop pretending that we understand suicide, because we don't and instead focus on developing caring communities and removing suicide as a choice because it is not an option," says Professor Shahtahmasebi.

I have come to the conclusion that it is not the social and environmental factors, or mental illnesses that are responsible for rising suicide in New Zealand. The fact remains that until we have positive attitudes in our society nothing will change. If we really want to eradicate suicide we must depoliticise suicide and set to work in building strong and caring communities. There needs to be a change, and we need to work on change together.

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