Editorial: Politics of Suicide Prevention Revisited

Said Shahtahmasebi, PhD.
email: editor@journalofhealth.co.nz

In New Zealand when suicide numbers reached a new record for the third year running in 2017, the Government's response was that we need to strengthen mental health services (again) and pledged more funding, promising an inquiry into the mental health service. The Inquiry was established in January 2018 and finally reported its findings in November 2018 (Mental Health and Addiction Inquiry, 2018).

Having read the executive summary one can't help but feel a sense of déjà vu. The inquiry has failed to address the suicide problem by compartmentalising it as a mental illness outcome to be resolved by changes to the mental health delivery system, i.e. more mental health intervention. This is a huge mistake and will restrict suicide prevention to the status quo within the confines of mental illness. This is in spite of the report admitting that New Zealand's persistently high suicide rates were one of the catalysts for the Inquiry. In other words, whilst the failure to reduce suicide is implied an overstretched mental health system is explicitly blamed for this failure. Yet, the Inquiry reports what is already known about suicide prevention in a short chapter. The main focus of the Inquiry is on expanding the mental health service delivery system which amounts to more of what the public has been given over past decades or so; i.e. "more of the same". It is plausible that the Inquiry assumes that changes in the service delivery system will lead to a commensurate reduction in suicide rates.

On the other hand, the Inquiry admits that mental health services can only respond to a diagnosed mental illness and that it is not equipped to deal well with other scenarios:

> "Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through too narrow a lens. People may be offered medication, but not other appropriate support and therapies to recover…"

Thus, by assuming suicide as a function of mental illness the Inquiry has framed suicide prevention within the mental health service delivery, and has failed to address suicide per se. As a result the Inquiry has failed to break new grounds and make appropriate recommendations. On suicide prevention the Inquiry is offering:-

> **"Prevent suicide.** Urgently complete and implement a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030. New Zealand's persistently high suicide rates were one of the catalysts for this Inquiry. Suicide affects people of all ages and from all walks of life, with thousands of New Zealanders touched by suicide every year. Suicide prevention has suffered from a lack of coordination and resources. Reducing suicide rates should be a cross-party and cross-sectoral national priority. Suicide prevention requires increased resources and leadership from a suicide prevention office. Suicide bereaved families and whānau, who are at increased risk of suicide, need more support, and the processes for investigation of deaths by suicide, which are often slow, traumatic and costly, need to be reviewed."

This is yet another top-down view of suicide proposing vague ideas about prevention. For example, what does it mean to urgently complete and implement a national suicide prevention strategy? Does it mean we now help ourselves to off the shelf suicide prevention strategies (i.e. do we know all there is to know about suicide)? I suspect, reading between the lines, that the Inquiry is suggesting investing even more funding to extend the mental health service. Furthermore, in the absence of any insight into suicide how would specifying a target comprise a suicide prevention strategy? On the other hand, setting up a target requires developing and carrying out research designed to understand suicide which, based on current experience, means "more of the same". It is not clear what the Inquiry means by increased resources for suicide prevention; the Government has over the years committed additional millions to mental health services specifically for suicide prevention – but there has not been any accountability on how these millions are spent and with what outcome(s). It would have been better for the Inquiry to recommend more accountability by decision makers, "experts" and recipients of funding. Moreover, another recommendation of the Inquiry is to establish a Suicide Prevention Office to provide strong and sustained leadership - how and by whom would such an office be staffed? Under the guise of a national strategy is this Office a means by which to enforce compliance with the medical model? Over the past decade there have already been several stories from some staff (teachers, front line mental health workers, etc.) of threats to job security and disciplinary actions for attending alternative suicide prevention workshops. In other words, suicide has been bounded by mental illness therefore, suicide prevention process is limited to the mental health service framework. Major problems that we have been witnessing are the result of suicide being wrongly framed with no feedback loop(s) to alternatives.

Clearly, the Inquiry views the suicide problem part and parcel of mental health service and recommends making mental health services accessible to others with less serious issues:-

> "New Zealand has deliberately focused on services for people with the most serious needs, but this has resulted in an incomplete system with very few services for those with less severe needs, even when they are highly distressed."

But isn't this what has been central to the national suicide prevention strategy for decades?

The Inquiry's attitudes and views about suicide should not have come as a surprise, their philosophy lies in intervention rather than prevention, with recommendations such as:-

> "We need to ensure practical help and support in the community are available *when people need it*, and government has a key role to play here." [italic added]

We are back to square one, i.e. wait for suicidality to develop, then refer to mental health service: "more of the same"! And "more of the same" it will be as long as governments and their "experts" view care service provision as a response to a crisis.

It must be noted that the Inquiry's remit was not to recommend a strategy and an action plan to reduce suicide but to shed new light and add insight –this Inquiry, like its predecessors view suicide solely in the confinement of mental illness therefore to be resolved by increased access to mental health services. However, whilst the Inquiry, the Government's response to record high suicide numbers three years in row, was being conducted, New Zealand's Chief Coroner announced another record suicide numbers for the fourth year running for the period

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2017/18. And if the Government accepts the Inquiry's recommendations then it will be "more of the same" for years to come.

It is highly likely that suicide rates will follow its cyclic pattern and the current upturn will sooner or later peak out and turn downward and once again the "experts" will take credit for it until the cycle bottoms out and begins a new cycle. Unfortunately, every suicide number that makes the suicide rates is somebody's loved one.

Suicide and its prevention must be taken out of the mental illness framework and discussed in its own merits.

Mental Health and Addiction Inquiry. (2018). He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction. *https://mentalhealth.inquiry.govt.nz/inquiry-report/*.