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Adolescence, mental illness, and suicide prevention

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Mike King is a prominent New Zealander and former entertainer and comedian who campaigned for youth suicide prevention, who then inevitably turned mental health advocate. Decades of suicide prevention policies that have been based solely on mental illness has isolated suicide and removed it from the public domain therefore there is no suicide discourse, no understanding of suicide per se, and public unawareness, leading to an inability to prevent suicide before it becomes a problem; and an inability to engage with the person when it becomes a problem. This approach transforms all involved into ambulances at the bottom of the cliff.

Mike has dedicated his time and energy to raising funds to bypass the long waiting list for mental health services and facilitate immediate access to mental health services. In 2019, he was named "New Zealander of the year" for his mental health advocacy, and was awarded the New Zealand Order of Merit.

In 2016, the Labour government promised action to tackle the suicide problem through conducting a nine-month review of mental health services, followed by the 'wellbeing budget' (Shahtahmasebi, 2019a) which allocated substantial funds for mental health services. Such political interventions have not led to commensurate changes in public and in particular teenage mental wellbeing. Mike has become much busier and has had to raise even more funds.

In 2021, Mike returned his New Zealand Order of Merit medal in response to a lack of care and action to improve adolescent mental health services. New Zealanders witnessed a very distressed and teary Mike King highlighting the lack of access to mental health services for teenagers with mental health issues.

As part of his campaign Mike published an open letter to the Prime Minister, Jacinda Ardern, and followed it up with feedback from those who had the misfortune of experiencing mental health services.

As expected, the government response was that it has allocated more resources to mental health. Which is true!! In its 'wellbeing budget' the government allocated $1.9 billion for mental health services (Shahtahmasebi, 2019a), but, without checks and controls and accountability. It appears that the minister for health, Andrew Little, became frustrated with how the money had been spent after Mike King had returned his medal. Andrew Little's frustration raised hopes of a serious intervention, but ordering a review was the only intervention promised by the minister.

The current Labour government began its first campaign promising to tackle mental health services and suicide. Upon winning the general election in 2016 the new PM, Jacinda Ardern, established a committee for a nine month inquiry (Shahtahmasebi, 2019b). into mental health services and suicide prevention at a time when suicide numbers had broken records three

years in a row. During the nine month review suicide numbers reached a new record for the fourth consecutive year (Shahtahmasebi, 2019c).

Setting up committees and reviews to review the reviews is a political solution to a political problem, as hilariously portrayed in the movie, 'Life of Brian', in particular in the final scene when it was time for action the leaders called for a committee meeting. Like the movie, the hero, in this case Mike King, was hung out to dry!

Suicide myths have been debunked (Shahtahmasebi, 2014), and there is ample evidence to show that a holistic approach to suicide prevention works (Shahtahmasebi, 2013). Yet, committees and reviews and promise of more resources have not had much impact on suicide trends, and no one has been held accountable:

- roughly between two-thirds and three-quarters of all suicides had no first contact with mental health services and ,
- the other one-quarter to one-third who did seek psychiatric help went ahead and completed suicide,
- over the last century depression was blamed for suicide:
    - in 2006 the government dedicated $6 million to tackle depression (depression.co.nz) as its suicide prevention strategy,
    - moreover, 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,
- 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) report that more than half of the people who died by suicide did not have a known mental disorder,
- 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 more funding it needed to research suicide!

Without checks and balances suicide prevention has been 'more of the same' policy but at much higher cost each year, both in lives lost, and financially.

The use of buzz words such as 'wellbeing budget', 'taking mental health seriously', and 'every life matters' does not make 'more of the same' any more effective, as Mike King so desperately expressed: 'no one is listening', 'there is no accountability' and 'no one cares'. This means that the government, 'experts', policy makers, and the public are the problem. Clearly, every life matters *not* - given the government's muted response to Mike's plea for action.

These problems can be eliminated by taking 'politics' out of suicide prevention. The suicide prevention approach at grassroots aims to depoliticise suicide prevention and is described in a 2013 publication (Shahtahmasebi, 2013).

A number of suicide prevention grassroots workshops were delivered starting in 2010 with successful outcomes. The irony is that at every workshop a number of delegates reported that they had been barred from attending suicide prevention training that are not based on mental illness, some had been threatened with the loss of their job some were refused leave to

attend (they took annual leave). These reports of intimidation and restricting suicide prevention to mental illness are not surprising.

The 'experts' (psychiatrists/psychologists) have gone on the record to explicitly claim ownership of the suicide problem by proclaiming that no one is qualified to talk about suicide other than those psychiatrically trained (in Hjelmeland and Knizek, 2017, page 5), which has been easily challenged. Such behaviour is un-academic, goes against the ethos of research, implies a lack of understanding of research, and demonstrates arrogance. By the same token, based on psychiatry's track record and in suicide prevention, and accounts from suicide survivors (parents, siblings, and friends), psychiatrists are the least qualified to deal with suicide and suicide prevention. One only needs to read the account of a mother whose daughter attempted suicide six times and each time she was saved and received a psychiatric assessment and treatment and each time the family was told their daughter was cured and she won't attempt suicide again. Unfortunately, the case's seventh attempt was fatal which was made in a foreign country away from family and friends (Shahtahmasebi & Smith 2013). Such cases are not outliers or rare.

The grassroots workshops demonstrated that suicide prevention need not cost millions of dollars, and that communities are in a much better position to understand their community issues. Thus, through the grassroots workshops, communities were empowered to own the problem and develop locally funded inclusive preventative action plans at a fraction of the cost.

A mental illness approach does not prevent suicide – instead it has medicalised adolescence, and only intervenes when mental illness/suicidality has manifested. There is no suicide discourse, thus adolescent development is confounded with mental illness. Therefore, mental health advocates such as Mike King are overwhelmed with a large number of adolescents with unmet needs. Compelled to reach out to support young people, has inevitably and unwittingly made Mike King (and other suicide prevention advocates) the 'ambulance at the bottom of the cliff' for which he has spent all his energy on raising funds.

Those who responded to Mike's returning his medal sympathetically urged him not to give up. But, a strategy of ambulance at the bottom of the cliff is not sustainable – and Mike does not have superhero powers and is not superman – only humanity does. At some point he will have to give up – so then who will catch the people who are falling off the cliff? What will the government do? 'More of the same', perhaps?

'Experts' and the government have explicitly claimed ownership of the suicide problem but have failed to provide answers; instead they have confounded the problems faced by our young people that is adolescent development.

References

Radios New Zealand (2012). Antidepressant use in New Zealand doubles. Accessed 2013 Apr 4. URL: http://www.radionz.co.nz/news/national/117826/pharmac-monitoring-use-of-anti-depressants.

CDC. (2018). Suicide rising across USA. *Vital Signs*(June, 2018), https://www.cdc.gov/vitalsigns/suicide/.

Heidi Hjelmeland and Birthe L. Knizek (2017). Suicide and mental disorders: A discourse of politics, power, and vested interests. *Death Studies, 41*(8), 481–492. https://doi.org/10.1080/07481187.2017.1332905

Ministry of Health (2007). Patterns of antidepressant drug prescribing and intentional self-harm outcomes in new zealand: An ecological study. Wellington: Ministry of Health.

Shahtahmasebi, S. and Smith, Lindie (2013). "Has the time come for mental health services to give up control?" J Altern Med Res **6**(1): 9:17.

Shahtahmasebi S (2014). Suicide research: problems with interpreting results. British Journal of Medicine and Medical Research: 5(9), 1147-1157. from https://www.journaljammr.com/index.php/JAMMR/article/view/15745/29169.

Shahtahmasebi S (2013) De-politicizing youth suicide prevention. Front. Pediatr. 1:8. doi: 10.3389/fped.2013.00008, URL: http://journal.frontiersin.org/article/10.3389/fped.2013.00008/abstract.

Shahtahmasebi, Said. (2018). What does a statistician know about suicide and suicide prevention? Dynamics of Human Health (DHH), 5(1): https://journalofhealth.co.nz/?page_id=1512.

Shahtahmasebi, Said. (2018). Only psychiatry: a strategy void of substantive theory and statistical concepts. Dynamics of Human Health (DHH), 5(2): https://journalofhealth.co.nz/?page_id=1574.

Shahtahmasebi, S. (2019a). Suicide prevention strategy: buzzwords and personal opinions. DHH; 6(2): https://journalofhealth.co.nz/?page_id=1838.

Shahtahmasebi, S. (2019b) Editorial: Politics of Suicide Prevention Revisited. DHH, 6(1): https://journalofhealth.co.nz/?page_id=1740.

Shahtahmasebi, S. (2019c). Suicide prevention: flawed politics and gimmicks. DHH; 6(3): https://journalofhealth.co.nz/?page_id=1876.

WHO. (2014). Preventing suicide: A global imperative. *http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/*.