The moral and political economy of suicide prevention

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Abstract: Suicide prevention occurs within a web of social, moral, and political relations that are acknowledged, yet rarely made explicit. In this work, I analyse these interrelations using concepts of moral and political economy to demonstrate how moral norms and values interconnect with political and economic systems to inform the way suicide prevention is structured, legitimated, and enacted. Suicide prevention is replete with ideologies of individualism, risk, and economic rationalism that translate into a specific set of social practices. These bring a number of ethical, procedural, and distributive considerations to the fore. Closer attention to these issues is needed to reflect the moral and political contexts in which decision-making about suicide prevention occurs, and the implications of these decisions for policy, practice, and for those whose lives they impact.

Keywords: suicide; suicide prevention; sociology of health and illness; moral economy; political economy; policy

> Suicide is above and beyond politics. My loss, your loss, Australia's losses are hurting us emotionally, socially and economically. Suicide prevention is everybody's business (Suicide Prevention Australia 2016).

At first glance there appears to be nothing overtly problematic about the claim that suicide transcends politics. Globally, approximately 800,000 people die from suicide every year (World Health Organization 2019). Suicide occurs across the lifespan and is among the three leading causes of death in those aged 15–44 years (World Health Organization 2019). As one of society's most pressing social issues, suicide prevention commands multilateral support and is considered a just and legitimate function of the state and its institutions (Szasz 1986). The applied nature of suicide prevention, however, means that both empirical and normative aspects are integrated within its field of practice. Suicide prevention seeks to regulate, guide, and manage human conduct though the application of practical knowledge. It is therefore not value-free, but involves a set of moral and political commitments that shape the ways suicide is understood and responded to. Embedded in political, economic, institutional, and social domains, these commitments are translated into current suicide prevention policies and practices that seek to curb the social and economic impacts of suicide; foster a coordinated whole-of-government approach; build individual and community resilience and capacity for care; and improve the cost-effectiveness, quality, and efficiency of suicide prevention services. These moral and political commitments are dynamic, and involve opposing, and at times contradictory logics, values, and actions that entail, amongst other things: care and control, marketization and government reform, and depoliticisation and social justice.

Taking as its starting point the emergence of suicide prevention in the modern era and the shift from institutionalisation to whole-of-community interventions, this work aims to

develop a theoretical understanding of moral and political reasoning in current suicide prevention policy and practice through application of the concepts of moral and political economy. In deploying the concepts of moral and political economy, my intention is not to presuppose the existence of two autonomous realms, nor to disembed the moral from the political or the political from the moral (Palomera and Vetta 2016). Rather, I seek to highlight the potential complementarity of both approaches and important interdependencies between moral and political realms. Juxtaposing these two theoretical perspectives serves as a way of illuminating how political activity, in the broadest sense, is influenced by moral norms and values, and how, conversely, moral norms and values are compromised by political economy, and the tensions and implications that result (Sayer 2000).

The focus of analysis in later sections of this work derives primarily from the Australian context, and involves the review of policy and guidance documents published by the Australian Government and leading peak bodies in suicide prevention and mental health. These documents warrant careful analysis because they establish the foundation for key components and priority areas of Australia's current approach to suicide prevention. Australia's National Suicide Prevention Strategy adopts a comprehensive, integrated, multicomponent approach that utilises individual evidence based interventions and best practices to address a broad range of individual– and population–level risk and protective factors (Australian Government Department of Health 2016). While program components are designed to address specific populations and needs, they broadly align with program strategies that have evolved internationally over the previous decade and that emphasise the need for intersectoral, collaborative, multilevel approaches (World Health Organization 2014; 2018). Key components of these approaches include education, training, and awareness; screening for at-risk individuals; restricting access to lethal means; clinical treatment of

mental health disorders; crisis intervention; media reporting guidelines; and postvention for those affected by suicide and suicide attempts (World Health Organization 2014). Reviews of current strategies show that evidence is strongest for restricting access to lethal means while the effects of screening, public education, training, and media guidelines are unclear (Zalsman et al. 2016). In light of continued high rates of suicide in Australia, there is increasing pressure on governments to show political leadership for suicide prevention. Under the National Suicide Prevention Strategy, the Australian Government's total expenditure on program and service activity increased from $1.9 million in 1995–96 to $49.1 million in 2015–16. Australian state and territory governments also contribute to suicide prevention through their own suicide prevention plans. However, data on expenditure for implementation and evaluation of these plans is not publicly reported (Australian Institute of Health and Welfare 2018).

This paper is structured into four parts. First, I outline the conceptual frameworks of moral and political economy that underlie and inform this work. Second, I briefly trace the emergence of suicide prevention activities in the modern era to show how normalising judgements and interventionist practices persist, albeit in conjunction with new forms of knowledge and expertise for managing problematic conduct. Third, I examine how the concepts and language of community and risk provide the basis for a range of preventive activities that continue to bind suicide with specific moral values, obligations, and forms of conduct. Finally, in light of calls for ongoing reform of suicide prevention policy and practice, I consider the role of structural, organisational, and procedural factors in perpetuating dominant moral and political contexts, and in curtailing the radical potential of much critical work.

Concepts of moral and political economy

The concept of moral economy has attracted growing interest among scholars in recent years. This has led to different, often contradictory uses of the concept, with the most noticeable being the variance in analytic focus between the *economy* and the *moral*. That is, between *moral economies* on the one hand, and an *economy of morals* on the other (Palomera and Vetta 2016). In the former, moral economy has been used to scrutinise economic systems, practices, relations, and the ways in which they are embedded in a complex array of moral sentiments, values, and norms (Palomera and Vetta 2016). The concept serves as a way of reasserting consideration of the 'moral' in the evaluation of economic activity in light of amoral conceptualisations of capitalist markets (Götz 2015). In the latter, the close link to economics is broken in favour of a focus on multiple dimensions of morals, moralities, and ethics. Proposing the term 'moral anthropology', Didier Fassin (2015) describes this project as one characterised by an inductive approach where the complexity and subtlety of the social world is primary, as opposed to an allegiance to any one particular theory or philosophy. Outlining the object of study he writes:

> Moral anthropology deals with how moral questions are posed and addressed or, symmetrically, how nonmoral questions are rephrased as moral. It explores the moral categories via which we apprehend the world and identifies the moral communities that we construe, examines the moral signification of action and the moral labour of agents, analyses moral issues and moral debates at an individual or collective level. It concerns the creation of moral vocabularies, the circulation of moral values, the production of moral subjects and the regulation of society through moral injunctions (Fassin 2015: 4).

Engaging with moral economy allows for an examination of the moral values that govern and integrate different spheres, their sources, linkages to networks of power, and the ways they are translated into particular social practices. Because moral economies are not singular and stable but display considerable variability across time, geographically, and within different societies and systems, conflicts and tensions will invariably arise. Normative assessment of these moral configurations in terms of their differential effects and the ethical conundrums they give rise to marks a concerted attempt to speak to these issues both analytically and practically (Sayer 2000).

Such a conceptualisation of moral economy is not limited to the realm of economic systems. And while it can be traced and analysed within the sphere of politics, it cannot be considered "'political' in any advanced sense" of the term (Thompson 1971: 79). To this end, scholars working within a Foucauldian framework have provided new and original ways for thinking about political economy in relation to diverse issues such as crime (Garland 1997), mental health (Teghtsoonian 2009), and suicide (Tierney 2010). In particular, the theoretical perspective of governmentality has proved insightful for understanding the exercise of political power, and the emergence of new rationalities and technologies of (self-) government in distinct fields that is salient for this work (Bröckling et al. 2010).

In the work of Foucault (1991), governmentality designates 'an art of governing' that extends beyond traditional forms of state control to include a complex of productive practices, programs, and technologies for rendering populations governable. In this view, the 'state' is not conceived as an abstract, singular, and centralised entity and locus of power, but marks an ever-changing point of intersection between ideas and practices (Saar 2010). What is both significant and challenging about the theoretical perspective of governmentality for

our understanding of suicide, is its rejection of the view that modernity heralded a substantially novel approach to suicide. The progressivist view of suicide in terms of a necessary and linear transformation in which secular humanism and scientific reasoning unseated long held condemnatory and punitive responses is common to many contemporary renderings of the subject (Fitzpatrick 2015). Historical accounts frequently view the emergence of factors such as decriminalisation, medicalisation, and the growth of science as being associated with the de-moralising of suicide. Of course, these developments are often woven into moral ideals such as the more humane and liberal approach to suicide they ostensibly initiated. Yet the appeal of these factors in relation to the moral and political order they provided is not always made evident. Shifting analysis to the assemblage of rationales, practices, and technologies that delineate 'modern' forms of suicide prevention within a governmentality approach places these activities in an historical context that does not presume wholesale societal change, but rather, highlights specific continuities, breaks, and differences, and their connection with processes of power.

Care and control: The 'modern problem' of suicide

Drawing on Foucault's concept of bio-power, Tierney (2010) traces a departure from punitive and prohibitive approaches to suicide in the eighteenth and nineteenth centuries towards more enabling forms of government in which power is de-centred, and where public and social institutions create new "lines of force" (Bröckling et al. 2010: 13) to prevent suicide. Modern approaches to suicide, therefore, are not assumed to be a by-product of immanent social forces or structures such as secularisation, medicalisation, or Enlightenment humanism (Taylor 1995). Rather, they mark an attempt by those faced with the issue of suicide to make sense of it, and to devise new ways of responding to the challenges it presented. Suicide

continues to be subject to normalising judgements and interventionist practices, yet the way it is conceived and made manageable in the modern era draws upon new constellations of knowledge, expertise, ethics, and power.

Changes in the application of common law, the emergence and proliferation of humane societies, the rise of moral and medical treatment, and concerns over the supposed effects of fictional and non-fictional representations of suicide were emblematic of this changing moral and political economy. These developments would have a lasting influence on modern suicide prevention. Organisations such as London's Royal Humane Society (U.K) provided the template for modern crisis services through initiating emergency interventions to prevent suicide (Bell 2012), while moral and medical treatment sought to produce cures through a combination of physical and nonphysical management techniques (Scull 2015). Efforts calling for more selective media reporting led to the development and implementation of international and national guidelines regarding the responsible media reporting of suicide. The law remained a prominent force in formal responses to suicide, but with a transfer of responsibility from criminal justice to medical jurisdiction (Moore 2000).

This has led to reconsideration of the humanitarian goals of these approaches. Attempts to prevent suicide through coercive interventions repudiates the rationality and agency of the act and subjects the person to intervention against his or her will (Williams 2001). With regard to moral and medical treatment, the subjugation of patients through the provision of disciplinary environments, coupled with physical manipulation of the body via psychotropic or other physical treatments, exemplifies traditional authoritarian beliefs (Scull 2015). The censoring of media reporting signals a willingness to disregard liberal and secular values in order to sequester the experience of suicide from public space and preserve social orderliness

(Bell 2012). In a similar vein, the power of police and doctors to detain those deemed to be a harm to themselves that exist, with some variation, in common–law jurisdictions around the world, ensure that control over suicide is not loosened, but restructured in order to maintain social cohesion and stability (Moore 2000; Weaver 2009).

Much has been written about the cultural and political factors influencing medicalisation, with the role of the medical profession often considered pivotal to medicine claiming jurisdiction over social issues such as suicide (Busfield 2017). The association of suicide with medical power and dominance, however, overlooks two fundamental concerns. First, that medicine's power as an institution is founded on a confluence of social, economic, and political interests; whether through its commitment to providing treatment, its redefining of social problems as individual problems, or its creation of medical commodities, markets, and consumers (Busfield 2017; Cohen 2016). Second, that despite diverse intellectual currents in sociology, epidemiology, and psychological medicine supporting interventions at both the civic and individual level, it was the linking of medical knowledge and expertise with an assemblage of strategies and practices that was critical to the emergent hegemonic status of Western psychiatry in the study and treatment of suicidal behaviour. The design of controlled institutional spaces, statutory committal processes, instruments of physical restraint, case-taking and diagnosis, and the emergence of new psychotropic and psychological interventions were central to the project of suicide prevention that would take shape over the twentieth century (Lilleleht 2002; Rose 1996). At the same time, the literature of patient protest that emerged in parallel with the rise of psychiatry showed that resistance to psychiatric practice and the injustices habitually faced by patients was present from the outset (Scull 2015).

Community, risk discourse, and attributions of moral responsibility

At the start of the twentieth century, charitable organisations provided the most tightly organised suicide prevention services. Specialised psychiatric and psychological treatments did not break free of the public mental hospital system until after the First World War (Weaver 2009). Institutionalisation and community care, however, did not necessarily signify two opposing perspectives to care. Rather, the concept and language of community served as an organising theme for integrating the disparate elements of psychiatric expertise into a 'coherent system' through which to administer a range of preventive and curative activities (Rose 1996). The shift to community care, therefore, can be seen to include both a socially progressive element that was responsive to moral and humanitarian concerns about the harmful consequences of public mental hospitals, as well as a shift in the rationalities underpinning the management of mental health and suicide that would, over time, extend to new domains such as the market, the private sector, and multinational corporations (Carpenter 2000; Rose 1996).

The emergence of the concept and language of risk is indicative of this shift toward managing suicide in the community. Risk became a way of viewing and dealing with a new class of personal problems and activities that extended beyond biomedical understandings of mental illness and suicide (Lupton 1993; Rose 1996). Everyday concerns such as work, sex, finances, marriage, parenting, and alcohol became the basis for predicting vulnerabilities to suicide. This was compatible with the push to create new fields of practice outside of the institutional setting – for psychiatrists, but also psychologists, social workers, and counsellors (Horwitz 2002). With a central pillar of contemporary suicide prevention being to identify vulnerable individuals and groups to improve service and resource provision (World Health

Organization 2014), the identification, assessment, monitoring, and reduction of risk have become an integral part of professional and community action and judgement (Rose 1996).

Analysis of governmentality centres on the various micro-practices of suicide prevention and the resulting productive effects in creating and managing subjects (Bröckling et al. 2010). The effects of risk discourse on forms and attributions of moral responsibility and social relations are perceptible in a range of suicide prevention interventions. Screening instruments, clinical interviews, observation, as well as the elicitation of risk have, in many cases, come to override other forms of professional suicide prevention activity. The growing regulatory frameworks that govern clinical judgement and action mean that risk containment often takes precedence over care practices that acknowledge human agency and the dignity of risk and choice (Delano 2013; Nicholl et al. 2015). This places professionals in contradictory 'help giving–seeking' relations with those they seek to help, whereby the protection of organisational and professional status may dictate breaches in patient confidentiality and trust (Fullagar 2005; Nicholl et al. 2015; Reeves and Mintz 2001). Judgements about risk, harm, and safety can result in the abrogation of a person's right to consent to treatment. This type of non-consensual practice is not uncommon in Australia under jurisdictional mental health acts, and remains ethically and clinically contentious both for its coercive paternalism and detrimental patient outcomes (Goodman et al. 2012; Light et al. 2012).

The incursion of suicide prevention into schools and the workplace through interventions such as gatekeeper training and mental health education programs that are in keeping with community approaches to managing risk can also undermine conditions of trust and reciprocity between persons. Approaches that privilege the understanding and recognition of mental health symptoms as a way of improving help-seeking both shape and

mobilise particular subjectivities. These effect the way that certain experiences closely associated with suicide such as hopelessness, loneliness, pain, unworthiness, shame, and meaninglessness are articulated, heard, and responded to (Fitzpatrick 2020). The translation of people's experiences into clearly defined areas of thought and conduct that enable the management of risk makes visible the implicit regulatory processes that underpin contemporary suicide prevention strategies (Nicholl et al. 2015). That these strategies are designed to realise organisational objectives that may diverge from the objectives of those whose lives are entangled in them, reveals how responses to suicide are limited by regulatory frames carried out by frontline workers, but established at a more general institutional level (Smith, 2005).

The assigning of roles and responsibilities for suicide to individuals, communities, organisations, and the state are embedded in social, moral, and political contexts. While responsibility for suicide extends across multiple domains, a focal point of recent suicide prevention policies is on the individual as the locus of intervention (Fitzpatrick 2017). The emphasis on individual thoughts, moods, emotions, and behaviour as the gauge by which suicide risk is measured and known, thus becomes the solution toward which therapeutic and public health interventions are directed. This is reflected in an increasing emphasis on social obligations and personal responsibilities in the amelioration of suicide risk through education programs that target mental health literacy, help-seeking, stress management, resilience, problem solving, and coping skills.

Understanding these interventions in terms of the political rationalities that have emerged under neoliberalism is useful for considering why suicide prevention strategies are seldom the subject of ethical critique. Commonly associated with a range of ideological

positions that have been broadly termed New Right including economic rationalism, welfare reform, privatisation, and commercialisation, the forms of intervention that characterise contemporary suicide prevention are nourished by the democratic and progressive values of liberal democracies which they espouse. The language of 'participation', 'consumer choice', 'empowerment', 'co-design', 'well-being', and 'self-help' fit neatly within this ambit, giving suicide prevention strategies broad-based support while masking the moral and political contexts in which roles and responsibilities are defined (Petersen and Lupton 1996).

There exists within these suicide prevention strategies, and the research practices that support them, a paradox of responsibility and agency that continues to bind suicide with specific moral values and conduct (Münster and Broz 2015). While the view of suicide as attributable to social, psychological, and/or biological factors works to deflect moral responsibility from persons by locating its causes beyond (conscious) control (Münster and Broz 2015), it simultaneously places increased expectations on persons by making them responsible for their wellbeing and recovery in the case of ongoing suicidality, or following a suicide attempt. For example, it is commonly assumed that suicide does not occur in those who have good mental health, strong personal relationships, self-esteem, and positive coping strategies (Fullagar 2005; World Health Organization 2014). Because protective factors have been reported as improving resilience and countering risk, a key component of comprehensive suicide prevention policies has been the exhortation for individuals to engage in health-preserving and health-enhancing activities such as help-seeking, reflecting upon and managing emotions, building social networks, seeking and adhering to treatment regimens, and refraining from excessive drug or alcohol use (Suicide Prevention Resource Centre 2020).

These activities not only require high levels of self-efficacy to achieve, but adaptation to new logics of responsibility, choice, lifestyle management, and self-actualisation (Petersen and Lupton 1996; Rose 1996). This economy of moral values and norms serves to define morally good or bad actions and practices, demonstrating the degree by which organisations and the state create a frame of reference for intervention that is deeply rooted in political framing, and the production and mobilisation of suicidal subjects and subjectivities. Responsibilising citizens opens up new spaces of inclusion for those able to adapt to these new types of relationship to the self. However, those who lack insight, are non-compliant with treatment, display negative attitudes to help-seeking, demonstrate violence or aggression, or who in other ways fail to conform to the kinds of personal commitments and demands required of them may be subject to professional judgements, sanction, discrimination, and disadvantage (Fitzpatrick 2014; Petersen and Lupton 1996). Consequently, these approaches not only imply the importance of personal agency, but also the ethical obligations of citizenship with regards to matters of personal and social obligations and rights that reflect specific moral judgements and political ideologies (McKee 2009).

Political determinants within the social determinants of suicide

A significant evidence-base linking social, economic, and environmental factors to suicide (Milner et al. 2012), coupled with more public criticism of the harms caused by medicalised approaches (Fitzpatrick and River 2018), have led to the inclusion of social determinants frameworks and lived experience perspectives on government agendas. Reforms such as these create opportunities for shifting public perceptions, policy, and practice. It is in this context that moral concerns around discrimination, the dispossession of First Nations people,

economic adversity, environmental conditions, and other social justice issues are discussed in relation to suicide. In much the same way, formal processes have been implemented to enable those with lived experience to become centrally involved in the design of policy and services, while whole-of-government approaches to suicide prevention have become a key priority of many national strategies.

Whole-of-government initiatives signal a conscious effort on the part of political and administrative leaders to improve collaboration, planning, integration, and delivery of suicide prevention activities. In Australia, the recent appointment of the first National Suicide Prevention Adviser to the Prime Minister is intended to create coordinative structures across portfolios, sectors, services, and all levels of government. However, in a political economy of health in which decentralisation, privatisation, outsourcing, and commercialisation play an increasingly important role, achieving integration in planning and service delivery is difficult (Christensen and Lægreid 2007). The policy preferences of governments to address the problem of suicide within existing political agendas and institutional arrangements, for example, are considered ill-fitted to provide the kinds of complex, coordinated, and multifaceted responses implicit in the evidence on suicide (Baker et al. 2018; Baum et al. 2013).

Interventions that aim to increase the proportion of people with mental illness in suitable housing and employment that are the explicit focus of The Fifth National Mental Health and Suicide Prevention Plan are a case in point (Commonwealth of Australia 2017). To this end, better integration between mental health services and housing and employment providers is recommended. Yet any achievements in this area will also require that this work is positioned within the political arena – one in which the availability of affordable rental and

social housing is lacking, and where delays in access to housing lead to reduced assistance for certain groups (Bullen and Baldry 2019). The same applies to supporting employment opportunities. Reducing barriers to participation in paid work for those with mental health problems is an important objective. Yet this is unlikely to be realised without key reforms to Australia's public employment service system to eliminate stringent compliance requirements, and to reduce the high caseloads of providers to enable them to provide intensive individualised support to more disadvantaged job seekers (Thomas 2019). A political culture that is strongly resistant to moral arguments about inequalities in suicide mortality and the social and political determinants that shape them, creates formidable constraints on the development of more comprehensive suicide prevention policies (Baker et al. 2018; Collins et al. 2007). This gap between policy rhetoric and implementation of a whole-of-government approach pinpoints the collision between opposing political rationales, and the legitimacy of countervailing strategies (Flint 2002). The focus of governmentality on the potential disjuncture between political rationales opens up a critical space in which to explore how different rationalities are mediated, applied, or resisted in different local contexts, especially in relation to public policy on the social determinants of suicide (McKee 2009).

Economic imperatives, marketization and interest group politics

Orientation toward the economic costs of suicide, exemplified in a recent Productivity Commission (2019) inquiry, highlights the extent to which economic productivity and growth serve as a catalyst for directing suicide prevention activity. In the absence of ethical concepts and frameworks in national suicide prevention policies and strategies, decisions about resource allocation are invariably influenced by judgements about cost-effectiveness and

overall return on investment in terms of population health, rather than in reference to notions of equity, fairness, and social justice. The focus on resource allocation rather than on agreed health and social outcomes can result in inequitable and inefficient distributional decisions that favour some service options and at-risk populations over others (Henderson et al. 2019; Rosenberg et al. 2009). As a funder rather than a provider of suicide prevention services, political accountability focuses predominantly on the deployment of public resources, with little emphasis given to quality improvements in governance, management, and services (Rosenberg and Salvador-Carulla 2017).

Existing funding structures in research run parallel to processes of priority-setting in suicide prevention. Recent funding reforms in Australia have resulted in a greater emphasis on funding research that evaluates interventions, with effectiveness, including cost-effectiveness, an important outcome measure (Reifels et al. 2017). As a population group, young people aged 24 years and under have been identified as the highest research priority, with communities, workplaces, schools, and mental health services identified as settings that should be prioritised (Reifels et al. 2017). Questions regarding the ways these decisions have been made are particularly poignant given the role of values in priority setting. The moral status of vulnerable individuals and groups leads to confusion rather than clarity when assessing priority setting decisions and their grounding in an evidence base. Health economic measures such as years of productive life lost (YPLL) clearly preference young persons, while the estimated economic impact of workplace–based prevention strategies provide similarly strong guidance for action (Kinchin et al. 2017).

This is not to suggest that economic imperatives are the sole driver of agenda setting in suicide prevention. Other vulnerable populations such as Indigenous peoples and those with

mental health problems have also been identified as research priorities (Reifels et al. 2017). But with elevated rates of suicide also among the elderly, those not in the workforce, and those living in rural and remote areas, values clarification and transparency in priority setting are lacking. Instead of working toward systemic reform to change the logic of distributional decisions that drive inequalities in suicide mortality among these populations, the moral demands of certain interest groups can cloud political debate and increase competition for limited resources (Hankivsky and Cormier 2011). Moral economies are an effective tool for mobilising public support for preventive activities, but can also be used to advance individual and organisational interests.

Suicide prevention policy and priority-setting is especially susceptible to the influence of the corporate and business sector. Increased privatisation, together with the commercial transformation of the university and non-profit sector have skewed prevention toward market-oriented, short-term technological innovations such as pharmaceuticals, e-health apps, fit-for-purpose education programs, and therapies for mild to moderate mental health problems. Such interventions fit nicely with efforts to curb the rising cost of healthcare expenditure, while claiming to offer consumers greater choice, control, and person-centred care (Toebes 2008). In the context of the current emphasis on non-governmental organisations (NGOs) for the delivery of suicide prevention activities, the distinction between the not-for-profit and business sectors is becoming increasingly blurred (Koivusalo 2010). It is important, therefore, to consider the way that humanitarian and commercial interests conjoin to create suicide prevention policy frameworks, agendas, and priorities at a national and global level.

Non–governmental organisations, lived experience, and the depoliticisation of suicide

Rather than adopting a 'structural' conceptualisation of power in which medicalisation is seen as a tool of top-down state control, Katherine Smith's (2015) work has shown how structures are an effect of complex networks of actors, and that individuals and organisations play an important role in perpetuating and enacting (or resisting) dominant political and economic ideas. Such a view helps explain why psychiatry has been so successful in extending its reach into the realm of suicide prevention despite the observed gap between explanatory power and preventive and therapeutic efficacy. Furthermore, it recognises the role of diverse networks of actors in procuring social, economic, and political objectives, while acknowledging the pivotal role of governments in shaping arguments about problems, their causes, and proposed solutions (McKee 2009). The growing role of NGOs in suicide prevention is a case in point, with the activities of NGOs more likely to support interventions that focus on individual-oriented social determinants such as improvements in mental health literacy and access to services. This can be explained, in part, by the relatively small sphere of influence that many NGOs have in directly influencing the material conditions that shape poor mental health and suicide. However, changing approaches to government–NGO relations have also created an environment that is unstable, contested, and increasingly hostile to the progressive advocacy role of NGOs (Maddison and Denniss 2005). Restrictive funding contracts coupled with regulatory and policy frameworks ensure organisational compliance with governmental objectives through the demarcation of priority areas, and top-down accountability measures such as monitoring, auditing, budgeting, and reporting. Changes in government funding arrangements (including defunding) may also exclude and marginalise certain NGOs, or place excessive constraints on their ability to criticise government policy (Maddison and Denniss 2005; Mendes 2015).

Whether NGO depoliticisation can be considered a form of political manipulation by government in the domain of suicide prevention is, ultimately, an empirical question. In the absence of evidence to support this claim, some interrogation of influential national peak mental health and suicide prevention organisations is required. While generally sympathetic to social determinants of health approaches, leading Australian organisations such as Beyond Blue and Suicide Prevention Australia have had little to say about public policies that inequitably distribute them, preferring instead to cite problems of funding, coordination, service access, and culturally inappropriate services (Beyond Blue 2016; Suicide Prevention Australia 2019). The claims of governments and organisations to effectively respond to the pain, distress, and suffering associated with suicidal distress illuminate the conflicting moral and political economies of suicide prevention. Values and emotions such as benevolence, compassion, and empathy generate a sense of moral obligation toward the suffering of suicidal persons, yet these obligations are enacted within particular political rationales that delimit action targeting social inequalities in favour of those situated within the same neoliberal logic, namely pharmacological, psychological, or lifestyle/behavioural interventions (Mills 2014).

The creation of 'lived experience' networks by suicide prevention organisations demonstrates further how political struggles for recognition, participation, and social equality can become vehicles for normalisation, regulation, and for furthering institutional and political interests. Despite broader issues of social justice (discrimination, ineffective treatment, employment, secure housing, and human rights violations), lived experience accounts tend to be subsumed within the regulatory logics of mental health care systems (Costa et al. 2012). Without diminishing the benefits that accrue from lived experience storytelling, stories that coalesce around prevention focused issues such as the contextualising

of risk factors and the availability of services and resources (Everymind 2013) signal a fundamental realignment of the progressive politics of lived experience with the hegemonic practices of contemporary suicide prevention (Fitzpatrick 2016). And while opportunities for service-user and carer engagement in service and program design are increasing, it is doubtful if current accountability indicators reflect the health and social priorities of these groups (Rosenberg and Salvador-Carulla 2017).

There is a common tendency in the governmentality literature to overplay the role of government and to neglect patterns of resistance, while the concept of moral economy may appear to operate as an ideological cloak that legitimises hegemonic interests rather than serving as a demonstration of diverse, often overlapping, moral views (Palomera and Vetta 2016; Rose et al. 2006). Resistant practices that do not presume suicide prevention and the imperative to live that underpins it to be a self-evident and unqualified good, and those that actively attend to the effects of inequality, racism, and structural violence serve as a counterforce to contemporary suicide prevention assemblages (Baril 2020). Recognition of the ways that diverse actors and organisations actively contribute to the creation and sustaining of moral and political 'contexts', therefore, is important for understanding how, despite dissenting views, suicide prevention gives the impression of a coherent, uniform, and stable project (Fitzpatrick et al. 2015; Smith, 2015). This serves as a valuable first step in thinking and talking critically about the ways we, as researchers, practitioners, organisations, and media may be inculcated into particular ways of thinking and acting that perpetuate dominant ideas (Smith, 2015). It also gives us pause for reflection upon what kinds of politicisation and moralisation are permissible within the political contexts of suicide prevention reform. To insist there is unified apolitical consensus about the objectives of suicide prevention obscures important moral and political complexities and tensions that, if

more openly articulated, might serve to identify and make more transparent inherent ethical and political commitments.

Conclusion

This work provides an analysis of key moral, strategic, procedural, and distributive dimensions of suicide prevention to illustrate the role of value judgements, ideologies, and vested political and commercial interests in shaping the field. This is evident in attributions of responsibility for suicide prevention, the consensus on interventions and treatments over social policies, rationales around priority setting and resource allocation, and depoliticisation of the advocacy role of individuals and non-governmental organisations. With growing inequalities in suicide mortality in Australia and worldwide (Hong and Knapp 2013; Lorant et al. 2018; Too et al. 2018), efforts to separate normative and political inquiry from the field of suicide prevention are problematic, with implications for addressing questions of inequity, moral responsibility, social justice, and medical and political power. This work contributes to debates about the importance of bringing suicide and suicide prevention into the arena of moral and political life to reflect on dominant policy and practice paradigms, and, in particular, taken–for–granted ethical assumptions about progress, care, social responsibility, and the public good.

This study has traced the modernist origins of suicide prevention and the broad moral and political commitments that have become crystallised in policy and practice in Australia over the past decade. Future research directions may utilise and develop this theoretical framework to analyse how moral ideals inform current suicide prevention initiatives such as ‘Zero Suicide’, and their implications for practitioners, patients, and for public understanding.

The concepts of moral and political economy may also be of value for researchers interested in addressing questions relating to the formation of community suicide prevention interest groups, the ways in which they mobilise moral and political language in their advocacy work, and their bearing on priority setting and resource allocation. (Ryan 2012)

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