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Suicide prevention as biopolitical surveillance: A critical analysis of UK suicide prevention policies

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Abstract

Suicide prevention policies set out government strategies and priorities for action and in doing so construct meanings, legitimise knowledge and frame possibilities. Despite their importance, prevention policies remain underexamined and taken for granted. Using Bacchi's post-structuralist 'What's The Problem Represented To Be' approach we critically analyse UK suicide prevention policies as sites of biopolitical surveillance and consider how suicide is constructed within such policy regimes. Drawing on Foucault, we contextualise suicide as an object and focus of biopolitical surveillance. We argue that suicide prevention policies seek to negate the contingency and complexity of suicide and

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instead represent it as amenable to biopolitical governance. Prevention policies do this by framing suicide as a visible and predictable object that can be known and governed via surveillance driven risk management. Such policies risk marginalising some publics, and diverting attention from the political, social and economic contexts of injustice in which suicides occur.

Keywords

biopolitics, critical suicide studies, policy analysis, suicide prevention, surveillance

Introduction

The prevention of suicide has become a central public health concern in the 'global north', with active state intervention into the lives of citizens considered necessary, appropriate and legitimate to prevent death by suicide (Szasz, 1986). A central component of this state intervention is surveillance, with the World Health Organisation (WHO) urging national governments to set up, develop and strengthen monitoring systems because 'improved surveillance and monitoring ... is a core element of the public health model of suicide prevention' (2016: 6). Surveillance is a taken for granted aspect of contemporary suicide prevention policies, often seen simply as a logical, 'obvious' process, necessary to enable prevention.

In this paper, we highlight the potentially problematic implications of a surveillance centred approach to conceptualisations of suicide. Our analysis examines government suicide prevention policies from all four nations of the United Kingdom (UK), which, despite their importance, are currently under examined. We suggest that UK suicide prevention policy has become part of what Armstrong (1995) termed a surveillance medicine approach which seeks to manage the problem of suicide through increased, enhanced and rationalised population level surveillance. Whilst we recognise that modern health surveillance presents both benefits and difficulties, possibilities and constraints (see for example Youde, 2010: 15–39), the purpose of this paper is to consider the unintended implications of a surveillance centred suicide prevention regime which constructs suicide as a visible and predictable object of governance. By utilising the work of Foucault, we aim to offer a radically different perspective on UK suicide prevention policy and to consider the implications of such a policy regime on the lives and deaths of our fellow citizens. In doing so, we build upon critical analyses of suicide prevention discourses as well as expanding understandings of the role surveillance occupies within contemporary social policy. Whilst prevention policies can

represent a significant opportunity to move beyond narrow biomedical conceptualisations of suicide and offer a more holistic approach to suicide prevention (Marzetti et al., 2022; Yip, 2005), we argue that the surveillance driven approach to suicide prevention limits the opportunity for a broader recognition of the political, social and economic contexts of injustice in which suicides can occur.

We begin by briefly exploring the context of modern suicide prevention, drawing on the work of Foucault to contextualise modern suicide prevention policy within the emergence of the biopolitical state. After detailing our methodology, we explore our findings, highlighting the importance that surveillance and risk management plays within UK suicide prevention policies. We show how a surveillance centred approach to suicide prevention leads to suicide being constructed as a visible and predictable problem which is amenable to population level governance. We argue that this construction of suicide as visible and predictable presents an idealised conception of suicide as an object which can be managed and controlled, thereby resulting in the decontextualisation and totalisation of suicide, and the marginalisation of some groups.

The biopolitics of modern suicide prevention

Government produced suicide prevention policies constitute a key power interface between the state, and the lives and deaths of citizens (Fitzpatrick, 2021). Over the past two decades the four nations of the UK have regularly published suicide prevention policies, with England and Scotland first producing policies in 2002, followed by Northern Ireland in 2006 and Wales in 2008. Whilst contemporary discourses primarily frame suicide as a pathological problem (Marsh, 2010; Szasz, 1986), this has not always been the case. Prior to being conceived of as linked to mental ill-health, suicide in Christian Europe was often framed as a sinful and criminal act and victims of suicide in England could be tried posthumously for *felonia de se* (self-murder), denied proper burial and suffer forfeiture of goods (Houston, 2009: 91). However, by the nineteenth century there had been a shift from understanding suicide as criminal (and sinful) to understanding it as pathological, as a problem of the body, or more often, of the mind (Hacking, 2008). This secularization of suicide (MacDonald, 1986) coincided with suicide becoming an object of the medical and psychiatric gaze. Suicide thus came to be defined through ‘a compulsory ontology of pathology’ (Marsh, 2010: 219), as an act existing within the individual and separate from broader political, social and economic contexts.

This move to a pathological conceptualisation of suicide was a central part of the emergence of biopower – a power which encompasses the knowledges

and strategies aimed at governing the life forces of populations (Nadesan, 2008: 8). Foucault contrasted modern biopower with the earlier pre-modern form of sovereign power, in which the sovereign claimed sole power over death, to 'take life or let live' (Foucault, 1998: 138). Unlike sovereign power, biopower established domination 'over life, throughout its unfolding' (Foucault, 1998: 138). Biopolitics, as an expression of biopower, therefore aims for the efficient and effective management of population life. It was only with the birth of biopower and the development of biopolitical techniques that the 'suicidal person' emerged (Baril, 2020: 6) as a categorical construct to be monitored, managed, and controlled through suicide prevention regimes. Biopolitics maintains 'numerous and diverse techniques for achieving the subjugation of bodies and the control of populations' (Foucault, 1998: 140); and through medicine, psychiatry, and surveillance, the modern state exerts power over life. Through what Hacking terms 'an avalanche of numbers' (Hacking, 2008: 80) including statistical techniques, mass data generation, observation and categorisation, the modern state attends to the security of the population, attempting to reduce chance and contingency (Petrov, 2013: 354) and maximise efficiency, certainty, and, importantly, control.

Suicide therefore emerged as a problem of population management and a focus point for biopolitical governance. This is because suicide resides:

at the borders and in the interstices of power that was exercised over life. This determination to die, strange and yet so persistent and constant in its manifestations, and consequently so difficult to explain as being due to particular circumstances or individual accidents, was one of the first astonishments of a society in which political power had assigned itself the task of administering life (Foucault, 1998: 138–139).

For a political power focused on life, self-inflicted death becomes an 'unacceptable' (Petrov, 2013: 354) object of frustration, even 'transgression' (Sharp and Linos, 2020: 129). In addition to this, owing to its inherent complexity, individual suicides cannot ever be known in advance (White, 2020: 76). Suicide is often hidden from the gaze of the state and exposes the explicit and inherent uncertainty and contingency which exists in the lives and deaths of citizens. Biopolitical governance responds to this uncertainty through the attempted construction of patterned regularity at the population level. Indeed, there has always been pressure to generate knowledge of suicide which is considered 'useful' for the governmental administration of the life of the population and for the scientific prediction of any risks posed to this administration of life (Tierney, 2010). Premised on statistical, scientific, and biological knowledge, the biopolitical state seeks to provide security and negate the uncertainty of

suicide through population level surveillance, prediction and risk management. However, as this biopolitical security is concerned with the population as a whole, managing possible and probable events (Gordon, 1991: 20), it is decidedly myopic in terms of individual lives.

Foucault highlighted the centrality that surveillance plays within the realm of public health (Elden, 2003: 242). With modern medicine claiming ownership of suicide as a pathological problem, prevention regimes seek to secure and control it using medical surveillance and risk management. In a 1983 interview, Foucault touches upon the subject of suicide in considering the ‘overmedicalisation’ of social problems, noting that social problems are often medicalised because ‘the medical solution was [believed to be] the most effective and the most economic’ means of correction (Foucault, 1990: 175). Within suicide prevention, medical surveillance acts as a security mechanism ‘Installed around the random element inherent in a population of living beings so as to optimise a state of life’ (Foucault, 2003: 246). The purpose of security is therefore to identify and monitor (‘problems’ of) uncertainty which threaten the population (Bell, 2006: 152) and surveillance becomes a central logic of biopolitical security policy.

Jennifer White argues that the dominant ‘suicide prevention agenda is driven by a common-sense approach that is so familiar that it appears to be beyond questioning’ (2017: 472). To begin to defamiliarize this ‘common-sense’ we used Bacchi’s (Bacchi and Goodwin, 2016) ‘What’s The Problem Represented To Be?’ (WPR) approach.

Methodology

Data

We examined a total of eight government produced suicide prevention policy documents, two from each of the four UK nations, in use between 2009–2019 in England, Northern Ireland, Scotland, and Wales.

Analysis

Our analysis of the eight policy documents was guided by Bacchi’s WPR post-structural policy analysis framework which aims to ‘question the taken-for-granted view prevalent among many ... that policy problems are self-evident, and that subjects, objects, and places simply exist’ (2016: 108). We have used WPR in an earlier examination of suicide prevention policy (Marzetti et al., 2022) and the current article expands upon our previous analysis, presenting a theoretically informed and focused consideration of the implications of a surveillance driven approach to suicide prevention. WPR challenges the notion that policies simply

address problems that are exogenous, and which are ‘discovered’ by and independent of governmental practices. Instead, influenced by Foucault, this approach recognises that policies produce problems in particular ways (Bacchi and Goodwin, 2016: 6) and the ways in which problems are represented within policy influences how they are understood and responded to by government, experts, services, and publics.

The WPR framework provides researchers with six analytical questions (Bacchi and Goodwin, 2016: 20). Our overall research project was broadly guided by all six questions; however, the specific analysis of surveillance within this paper is driven by two of the six questions: 1) ‘How has this representation of the problem come about?’ and 2) ‘What effects are produced by this representation of the ‘problem?’ Focusing on these two questions enabled us to 1) consider and defamiliarize the underlying surveillance rationality that was present within many of the suicide prevention policies that we examined and 2) consider the implications of a surveillance driven approach to conceptions of suicide.

Using the WPR approach as a guiding framework, the first stage of analysis involved exploratory, in-depth readings of the eight policy documents and open coding of each document supported by NVivo 12 qualitative analysis software. During this initial coding process, there was ongoing dialogue among the whole research team to identify and agree potential themes of interest. After the first stage of coding, Authors A and D produced reports on themes (including ‘surveillance’), which were discussed amongst the team, with Authors B and C providing additional analysis. This collaborative and ongoing process enabled us to refine and articulate our interpretations.

Findings

A surveillance centred suicide prevention regime

Surveillance practices and technologies played a central part in the suicide prevention policies. There was significant interest across many of the individual suicide prevention policy documents in strengthening and enhancing surveillance capacities and in maximising ‘data’ in terms of both gathering more data on certain selected population groups and monitoring population trends to manage the overall risk of suicide. This was emphasised via key objectives or commitments to enhance general population surveillance and monitoring capacities. For example:

Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action (Welsh Government, 2015: 17).

Area for action 6: Support research, data collection and monitoring (HM Government, 2012: 47).

Objective 3 – Improve the understanding and identification of suicidal and self-harming behaviour... (Northern Ireland Government, 2016: 70).

Across the documents there was clear consensus on the importance of surveillance technology within suicide prevention and a commitment to the role of ‘Reliable, timely and accurate suicide statistics...[as] the cornerstone of any suicide prevention strategy and of tremendous public health importance’ (HM Government, 2012: 47). In keeping with WHO guidance (2016), contemporary UK suicide prevention relies heavily upon techniques and instruments of surveillance. An explicit desire was expressed in the policies to continue to enhance and strengthen these mechanisms, a typical commitment being to ‘expand and improve the systematic collection of and access to data on suicides’ (HM Government, 2012: 47). To enable this population surveillance, specific tools and technologies were being developed to collect, categorise and cascade data. In the 2013 Scotland prevention policy there was significant mention of the Scottish Suicide Information Database (ScotSID) which was used to profile suicide risk and to shape policy directions. In England, the importance of ScotSID as a surveillance tool for profiling the population was highlighted (HM Government, 2012: 48) and by 2017 there was enthusiasm within English policy regarding the identificatory capabilities of a new surveillance instrument:

Public Health England has been developing further its Suicide Prevention Profile – often referred to as the Suicide Prevention Fingertips tool- which provides a range of data at a local level to support local authorities and the NHS to understand suicide trends in their areas. This tool provides valuable thematic data on local demographics which enables local areas to **identify high risk groups and locations** (HM Government, 2017: 34, emphasis added).

There was sometimes a tension within documents between the urge to encourage ever more surveillance, to generate ever more data, and the need to effectively utilise this data to construct knowledge. In England, there appeared to be frustration that:

A wealth of data is already collected... but only limited information is collected centrally or easily accessible and available to researchers or public health specialists (HM Government, 2012: 47, emphasis added).

Scotland, presumably because of the advanced development of ScotSID, was more confident about the use of surveillance data for knowledge generation, asserting that:

We have good evidence now about suicide, highlighting risk factors and providing an evidence base of effective interventions (Scottish Government, 2018: 18).

The importance placed on identification in solving the ‘problem’ of suicide thus ran through the policies. The Northern Ireland Government policies even defined suicide prevention as ‘**identifying** and reducing the impact of **risk factors** associated with suicidal behaviour...’ (Northern Ireland Government 2012: 5, emphasis added). In other policies many actions and intentions relate back to identificatory objectives; for example, the Northern Ireland Government’s 2016 document emphasises the importance of destigmatising suicide in part because a reduction in stigma ‘will increase the likelihood of early recognition of suicidal behaviour and suicide risk’ (9). Policies which sought to advance cross government and cross sector collaboration and which emphasised broader social and economic contexts still retained a surveillance logic. For example, in a Welsh policy, there is recognition that preventing suicide requires a broad collaborative approach that moves beyond a narrow health focus on suicide but there is also an emphasis on the importance of ‘the identification and management of depression and other mental disorders’ (Welsh Government, 2015: 14). The ministerial foreword of Scotland’s 2018 policy document expresses optimism ‘that by working together across sectors, organisations and society, we can better identify and support people in distress, strengthen communities, and save lives’ (Scottish Government, 2018: 2). This optimism seemed to be based in part upon the surveillance data generated by the ScotSID risk profiling surveillance system, with the Scottish policy seeking to strengthen this surveillance capacity, stressing that ‘it is essential that appropriate data about individuals is able to be shared’ (Scottish Government, 2018: 19) through ScotSID. As such, even where policies highlight the role of support and collaboration, surveillance remained prominent. Surveillance is thus a central logic within suicide prevention policy.

This emphasis on surveillance existed in conjunction with a focus on ‘risk factors’. Indeed, surveillance enables ‘risk factors’ to become a central part of the definition of suicide prevention, with Northern Ireland defining the activity of suicide prevention as ‘**identifying** and reducing the impact of **risk factors** associated with suicidal behaviour’ (Northern Ireland Government, 2012: 5, emphasis added). There is a nexus of surveillance and risk management:

Some groups of people ...[are] at higher risk of suicide than the general population. We have been able to identify these groups from research

and can monitor numbers from the routine data collected. In this way we identified:

- those groups that are **known statistically to have an increased risk** of suicide; and
- actual numbers of suicides in these groups.

(HM Government, 2012: 13, emphasis added).

Risk profiles are used to demonstrate the ability and viability of predictive health surveillance, for example, in the key learning section of one policy document, findings were shared on suicide risk:

Specific risk profiles identified included:

- Undiagnosed and untreated mental health problems;
- Alcohol and drug abuse;
- History of deliberate self-harm;
- Being adversely impacted by the recession;
- Recent separation of young men from partner/children;
- Long-term consequences of sexual abuse in childhood and adolescence.

(Northern Ireland Government, 2012: 73, emphasis added).

In addition to the specific uses of surveillance technology and commitments to the enhancement of surveillance and data generation which were prominent throughout the prevention policies, there also existed a more subtle surveillance discourse. Prevention policy documents in Northern Ireland, Scotland and Wales all used similar phrasing, informing readers that suicide prevention was ‘everyone’s business’. For example, the ministerial foreword to the Northern Ireland Government’s 2012 document ends with the words ‘*Suicide prevention is everyone’s business*’ (4); likewise, a ministerial foreword from Scotland claims ‘that suicide is preventable, that it is everyone’s business’ (Scottish Government, 2013: 1). A focus on identificatory practices within suicide prevention regimes is discussed in the Australian context by East et al., who analysed documents published by both government and charities. East et al. found that these documents exhorted the public to play an active role in identifying individuals who are experiencing suicidal thoughts (2021: 184). Such messages may be read as positive and action affirming, emphasising that we all have agency to prevent suicide. However, in linking prevention with identification, they serve to reinforce a construction of suicide as inherently visible, framing the primary role of prevention policy as the extension of this visibility.

Suicide as visible

There is a politics of visibility at the heart of the surveillance prevention approach which frames suicide as a ‘surveillable’ object, amenable to observation. Those who are experiencing suicidal distress are thereby framed as unproblematically identifiable to a societal gaze. Ceyhan has argued that surveillance generally takes the ‘visibility of the surveilled ... as seriously as the process of observing, classifying and studying’ (2012: 41).

Consequently, in this context, there is a conscious effort to train people to be able to spot suicide. For example, as part of a specific local intervention action plan, there is a commitment to:

developing suicide awareness and education or training programmes to teach people **how to recognise and respond to the warning signs for suicide** in themselves or in others (HM Government, 2012: 29, emphasis added).

Suicide is here constructed as both knowable and visible, resulting in a related imagining within prevention policy of a certain type of idealised and visibilised suicidal subject being imagined. This subject emits ‘warning signs’, signals which we can all be trained to identify. This representation resonates with Morris’ critique of suicide prevention training in which he argues that there is a knowledge/power relation which constructs suicide as visible through the recognition and interpretation of specific warning signs which claim to ‘make the suicidal subject knowable and recognizable’ (Morris, 2016: 85). The surveillance approach is predicated upon framing the identification of a suicidal subject as unproblematic, assuring us that we can, and we will, be able to know and recognise the suicidal subject through certain knowable warning signs. For example, ‘The majority of suicides have been preceded by warning signs...it is important to understand what **the warning signs are and look out for them**’ (Northern Ireland Government, 2016: 16, emphasis added). The policies imply that, through training combined with the collection of data, suicide can be made visible and prevented; professionals and the wider public can be trained to identify suicidal behaviours/warning signs. For example, ‘educational providers (both at schools and colleges/universities) **have an important role in identifying** and supporting at-risk young people’ (Scottish Government, 2018: 16, emphasis added). This is reinforced by the continued and consistent use of the phrase ‘suicide prevention is everyone’s business’ (see above), which encourages a form of disciplinary surveillance, an ever vigilant, ever watchful population. Suicide is the object of this gaze, with communities encouraged to participate in their own self-surveillance and self-monitoring (Ajana, 2007: 2).

There is also a broader politics of visibility within the surveillance approach to prevention, one which is explicitly stated in the foreword to the

England 2012 policy document by Professor Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group, who wrote that:

In identifying the high-risk groups who are priorities for prevention (action 1), **we have selected only those whose suicide rates can be monitored** – this is essential if we are to report on what the strategy achieves (HM Government, 2012: 4, emphasis added).

This statement demonstrates how groups are only prioritised for prevention if they are deemed amenable to monitoring. The groups which are prioritised for specialist interventions are selected based on their perceived visibility, on how effectively the state and its agencies believe that they can gather data, categorise, and monitor. Indeed, because of this surveillance driven risk management approach there comes the temptation to collect data which is available and collectable rather than to search for data that is actually relevant or useful (Power, 2004: 30). Some groups ‘**whose risk is hard to measure or monitor**, such as minority ethnic communities’ (HM Government, 2012: 4, emphasis added) were largely placed outside of categorisations, and thus, outside of, and peripheral to, the policy gaze. Whilst there is some acknowledgement that provisions for minority ethnic communities are inadequate (Northern Ireland Government, 2012: 74), within the documents we examined there appeared to be little attempt to strategize interventions or increase visibility of these groups. Indeed, in the period we studied, ethnicity was not recorded on death certificates and thus ethnicity and suicide could not be made visible, unlike male suicide for example (Yue, 2021: 2). Indeed, it has only been since 2021 that the ONS has released information on ethnicity and suicide, despite gaps in knowledge being recognised as far back as the England 2012 policy document.

Whilst some of the policies acknowledge contextual factors such as deprivation as being relevant to suicide, frequently the policies pull back from specifying actions or commitments to actual economic and social changes, instead favouring ever more and enhanced surveillance, seemingly as an end in itself. This can clearly be seen in discussions of training, which are prominent within the documents and build directly upon the surveillance approach. In a Scottish policy document, there is a focus on enhancing training for staff of various frontline services:

training for social security staff will enable them to **recognise signs of distress**, and to signpost people to appropriate support (Scottish Government, 2018: 10, emphasis added).

English prevention policy also highlighted the area of social security as a site of surveillance, specifically suggesting that jobcentres would be good

locations in which to identify ‘vulnerable people who may be at risk of suicide’ (HM Government, 2012: 29). Jobcentres, as locations that people in search of employment and in receipt of state benefits must attend, are key disciplinary and surveillance sites (Fletcher and Wright, 2018) for economically marginalised groups. However, within the document there was no policy consideration or awareness as to *why* a Jobcentre may be a site that was inhabited by vulnerable individuals. As Mills has argued the construction of benefits claimants ‘as a burden, through policies designed to dehumanise and impoverish ... [them], are key in creating the conditions that make people’s lives unliveable, making many people feel suicidal’ (Mills, 2022: 53). The current benefits system produces vulnerability and can, indeed, make certain suicide deaths more likely. Whilst this is tacitly accepted in the policies there is a failure to acknowledge, let alone address, the political contexts of injustice that produce suicide deaths by benefit claimants. Instead, the Jobcentre was framed as an apolitical site for opportunistic identification of those individuals deemed ‘at risk’, rather than as part of a complex systemic process of injustice. Whilst the Scottish policy did acknowledge that interactions with social security staff could come at a time of ‘*great difficulty*’ (Scottish Government, 2018: 10) for individuals, the emphasis remains on using these interactions as population surveillance opportunities rather than encouraging a deeper consideration of the structural contextual factors that make individuals in these situations vulnerable to suicide and which make their lives less liveable. Consequently, there is a minimalization of the importance of ‘unequal concentrations of primary goods (substantive rights, social connections, resources, opportunities, etc.)’ (Button, 2016: 270) that can lead to suicide deaths (see also, Mills, 2018).

Suicide as predictable

The suicide prevention documents are replete with discussions of risk, with risk factors deeply entwined with the surveillance approach because risk factors are simultaneously created through surveillance generated data whilst also providing a specific target for surveillance capabilities. By creating categories of ‘high risk’ groups and through statistical monitoring and surveillance the documents construct suicide as an object amenable to prediction. Underlying this policy is a logic that sees population level behaviour as categorically patterned and foreseeable. According to Welsh policy ‘suicide and self harm are largely **preventable, if risk factors** at the individual, group or population level are effectively addressed’ (Welsh Government, 2015: 6, emphasis added). Such a statement could provide an opportunity to make interventions centred on structural contextual factors such as poverty and deprivation, but these factors are not reflected upon in the policy’s suggested prevention actions (Welsh Government, 2015: 15–17). Whilst the policies may recognise that poverty and deprivation are risks,

they do not explicitly intervene in the conditions producing poverty, instead focusing on poverty as a risk predictor rather than a contingent context that could be actively addressed and acted upon through policy intervention.

Within the policies we see the biopolitical necessity of increasing data and surveillance to facilitate prediction and manage risk. A suicide policy document from Northern Ireland sets this out clearly when it plans to ‘manage risk’ through:

Screening and improved understanding of clinical, psychological, sociological and biological **risk to help identify high risk individuals** in health care settings, and subsequent management of risk (Northern Ireland Government, 2016: 106, emphasis added).

Crucially, such an approach does not encourage better understandings of the individual, but rather of the ‘risk’ factors, for the risk factors are linked to the ability to identify, predict and thus manage suicide. Individuals thus become a constellation of risk factors. Castel has argued that preventative strategies no longer focus upon a concrete individual but instead seek to address risk through ‘abstract factors which render more or less probable the occurrence of undesirable modes of behaviour’ (1991: 287).

There is a belief that through categorisation future behaviour can be predicted – we can ‘know’ who is most likely to die by suicide. Importantly, a strategy of focusing on predictive risk often only occurs within delineated settings, such as health care. This is because through risk assessments there is a belief that clinicians can categorise patients into risk groups (Mulder et al., 2016: 271) and thus predict future outcomes. Such an approach seeks to enhance the perception of security by minimising the appearance of contingency and maximising the perception of the knowable certainty of trends and behaviour. For instance, the policies have a consistent focus on mental ill health, which is framed as an unproblematic, identifiable, predictive population level risk factor for suicide:

Depression is one of the most **important risk factors for suicide**. **The early identification and prompt, effective treatment of depression** has a major role to play in **preventing suicide across the whole population** (HM Government, 2012: 6, emphasis added).

The biopolitical urge to portray suicides in this way expands, leading to ever more ‘at risk’ groups and ‘risk factors’ being sought out to demonstrate some form of predictability in the face of contingency. For example, the desire to identify and monitor suicide leads Scottish policy to set out a specific action point to consider ‘how risk of suicide is elevated for groups within the broader general population, and identify specific action to address this’ (Scottish Government, 2018: 14). In England the ‘high risk’ groups encompass a startlingly large proportion of the population:

The National Strategy identified the following high risk groups:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; and
- people with a history of self-harm

(HM Government, 2017: 9).

As Douglas has argued, the process of defining what exactly risk is, and therefore who is at risk, is a political process (Douglas, 1992). As with the politics of visibility, the politics of risk is selective, and categories and classifications are related to wider political and social anxieties and presumptions. This is explicitly seen in Northern Ireland policy which considers 'rural dwellers' as potentially being an 'at risk' group. This consideration seems, in some respects, linked to perceptions and assumptions regarding the behaviour and culture of such 'rural dwellers' which is explicitly described in the policy document, the document noting that 'The rural culture of self-reliance and stoicism works against help-seeking' (Northern Ireland Government, 2012: 31). However, whilst the policy acknowledges that service provision is seen as poor within rural communities (see also The Samaritans, 2018: 4) it remains vague as to how to increase rural support services, and there is more focus on the existing behaviours and attitudes of people in one rural region than on ways of increasing service and support provision:

Mental health as a term is most generally associated with mental illness within the rural reaches of the South West Action for Rural Development (SWARD) region; seen as something from which an individual will not recover and will have for life, and is generally referred to in negative and stereotyping terms such as 'psycho', 'schizo', 'mad' and 'nutter' etc (Northern Ireland Government, 2012: 74).

This demonstrates how concerns and anxieties about certain communities can drive risk management and highlights that the creation of groups as visible and 'at risk' is not a neutral process.

Discussion

We have shown how surveillance, and its expansion, are framed within the prevention policies as central to addressing the problem of suicide through the collection of surveillance data and the monitoring of groups defined as

high risk. This emphasis on surveillance can serve to constrain possibilities for prevention and push certain individuals and groups to the margins. The fixation on the ability to surveil and monitor leads to an exclusionary approach: it requires a visible subject, but, paradoxically, only subject groups who are perceived to be sufficiently visible are incorporated into intervention strategies, despite an awareness that those outside of the designated risk categories may be vulnerable to death by suicide. For example, ethnic minorities were largely outside of and peripheral to prevention policy. Ethnicity is recorded by state agencies in many contexts, but, until recently, there has been a complete absence of data on ethnicity in relation to suicide (Cohen et al., 2020). Even though available data shows that ethnic minorities suffer from inequalities within care systems, including higher rates of compulsory detention and forcible mental health treatment (Bhui et al., 2018) an absence of suicide data gathered on these communities was responded to within the policies not by a commitment to seek better information, but with silence and a lack of overt acknowledgement of the structural and contextual issues of racial injustice that may make certain lives less liveable.

On the other hand, for those groups who are deemed visible, the surveillance rationality within policies plays an active and constitutive role in the production of 'risk' with extensive discussion of groups deemed to be at high risk. However, because the emphasis is primarily on the ability to ensure surveillance of risk groups, the policies are largely silent on the actual causes of risk. Risk is seen primarily in terms of monitoring capacities rather than there being any significant attempt to intervene in the root causes that may make the risk of death by suicide more likely and thus predictable.

As a result of this emphasis on the visibility of suicide, prevention policies are less likely to recognise the diversity of people who may be experiencing suicidality. By focusing on signs which are deemed clearly identifiable and which people can be trained to 'spot' in themselves and in others, and through the categorisation of certain groups, suicide is homogenised into a visible and predictable uniform object. Such homogenisation risks marginalising those individuals who may not fit into pre-existing risk categories or groups; who do not display obvious warning signs; or who are considered less easy to identify and surveil at the population level. Such a homogenisation and attendant lack of diversity within the discourse around suicide can result in perceptions being totalized (Shin et al., 2020: 290) and suicide being perceived as having a set of uniform knowable and observable characteristics.

An example of this totalization of suicide is the emphasis on mental ill-health, and particularly on depression, within suicide prevention policy. Depression is simplistically characterised, as a predictive population level risk factor for suicide. However, there is little meaningful mention of the inherent complexity of the individual, or awareness of the contextual circumstances that may lead to or exacerbate depression (Brossard and Chandler,

2022). There is often an absence of context, a myopia towards the individual brought about by the biopolitical desire to provide population security through the construction of suicide as predictable. This means that surveillance driven suicide prevention policy serves to maintain the dominant pathologized conceptualisation of suicide because pathology is understood as visible, treatable and predictable. This pathologized approach to suicide serves to reinforce a ‘psychocentric’ view that understands human problems as being ‘due to a biologically-based flaw or deficit in the bodies and/or minds of individual subjects’ (Rimke, 2016: 5). Such an understanding of suicide means that suicide deaths tend not to be considered in terms of structural contextual factors (Button and Marsh, 2020: 3).

Such pathologized conceptions of suicide present in modern suicide prevention can lead to stigmatisation, whilst simultaneously ignoring the social, political, and cultural injustices faced by those experiencing suicidal ideation (Hjelmeland, 2016; Petrov, 2013; Rogers and Soyka, 2004; White, 2020). Overly biomedicalised approaches to suicide can objectify those struggling with suicidal ideations (see Bergmans et al., 2016: 134), whilst also ignoring the contexts in which their lives are embedded. Further, an over emphasis on mental health can mean that opportunities to make human lives more liveable in the long-term, through an improvement in environmental conditions, are missed within prevention policy (Marzetti et al., 2022) and can result in people who are living with suicidal thoughts experiencing coercive forms of medical intervention against their will (Webb, 2010).

Approaches which centre psychopathology can lead to the negation of the contextualised subject, who is ‘stripped of their contextual biography’ (Hjelmeland and Knizek, 2020: 169). Complex and situated individuals are replaced with abstracted and decontextualised population level risk factors. This is deeply problematic because individuals exist with ‘risk factors’ for entire lifetimes without dying by suicide, thus, suicide as a moment is never inevitable and thus never entirely predictable. The surveillance approach which we have outlined in this paper emphasises placing people into categories based on risk in a way which will not aid our understanding of the contexts in which suicide occurs, nor help us relate to individual sufferings. Indeed, even ignoring the harm that such a universalising approach can do to individuals, it is unlikely that such an approach can ever be successful. This is because such attempts to find cast-iron empirical regularities are unlikely to succeed due to the complexity of individuals making ‘it virtually impossible to conceive of any given behavioural measure as being an invariant function of only a limited number of determinants’ (Smedslund, 2009: 785). Despite these problems, a decontextualised and pathological framing of suicide dominates within these prevention policies because pathology offers the veneer of visibility and predictability to suicide. Thus, biopolitical suicide prevention, which is premised upon

surveillance, necessarily emphasises pathology as a key element of predictive risk management and so the recognition or acknowledgment of individual and situated complexity is largely sacrificed for a patterned idealised form of suicide which can be observed, predicted and thus secured and managed.

Conclusion

Biopolitical suicide prevention seeks to regulate the uncertain, through what Ian Hacking has termed ‘the taming of chance’ (2008), and intervenes ‘to improve life by eliminating accidents, the random element, and deficiencies’ (Foucault, 2003: 248). Surveillance becomes key to this chance taming because, through the exercise of surveillance, suicide as an uncertain and complex act can be portrayed as an object that is amenable to the biopolitical gaze and thus subject to regulation and governance. Surveillance in this sense serves as a panacea, to both enable the management of a defined population ‘problem’ through risk management and governance but also, and just as importantly, by acting as a mechanism of assurance provision for society as a whole, presenting life as understandable, manageable and thus secure. It has been argued that a focus on risk factors at the individual level, by clinicians, serves to ‘provide reassurance to all groups that suicidality can be made understandable and easily manageable’ (Mulder et al., 2016: 271). In this article we have argued that the focus on visibility, risk factors and prediction in prevention documents serves the same reassurance purpose, albeit on a macro scale, seeking to reduce societal anxiety and representing suicide as a predictable and thus governable object. The exigent aim of this risk management is to transform unknowable and incalculable risks into something which appear both visible and thus manageable (Power, 2004: 30). Surveillance is deployed ‘to capture the contingent features of the ‘uncertain’’ (Ceyhan, 2012: 38).

However, by constructing suicide as visible and predictable suicide prevention policies risk totalizing and decontextualising it, pushing some groups to the margins and providing little opportunity for a broader recognition of the political, social and economic contexts that impact individual lives. A surveillance centred approach means that even where ‘at risk’ populations are identified, and become the subject of surveillance, there is no concrete action to address structural injustices that can place people at increased risk. Instead, the emphasis is simply on identifying predictable risk in order to provide ‘support’ and enhance governance rather than considering why such risk might occur in the first instance; surveillance thus becomes the means and ends of prevention policy. Biopolitical prevention policies are therefore centred on a series of decontextualised and abstracted risk factors which are relatively blind to issues of social and contextual injustices which can make

lives less liveable for complex individuals. Within this surveillance driven prevention regime suicide remains firmly understood as pathological and apolitical (see Reynolds, 2016: 169) and therefore serious considerations of the structural landscapes of injustice in which suicide deaths occur are largely absent from prevention policy. Our analysis has provided a radical deconstruction of contemporary suicide prevention regimes and has offered a further critical perspective of the way in which surveillance is deployed within biopolitical social policy.

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References

- Ajana B (2007) Surveillance and biopolitics. *Electronic Journal of Sociology* 7: 1–8.
- Armstrong D (1995) The rise of surveillance medicine. *Sociology of Health & Illness* 17(3): 393–404.
- Bacchi C and Goodwin S (2016) *Poststructural Policy Analyses – Guide to Practice*. New York: Palgrave Macmillan.
- Baril A (2020) Suicidism: A new theoretical framework to conceptualize suicide from an anti-oppressive perspective. *Disability Studies Quarterly* 40(3): 1–41.
- Bell C (2006) Surveillance strategies and populations at risk: Biopolitical governance in Canada’s national security policy. *Security Dialogue* 37(2): 147–165.
- Bergmans Y, Rowe A, Dineen M, et al. (2016) When despair and hope meet the stigma of ‘manipulation’ and ‘ambivalence’. In: White J, Marsh I, Kral M and Morris J (eds) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: University of British Columbia Press, pp. 133–153.
- Bhui K, Nazroo J, Francis J, et al. (2018) The impact of racism on mental health. <https://synergicollaborativecentre.co.uk/wpcontent/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf>
- Brossard B and Chandler A (2022) *Explaining Mental Illness: Sociological Perspectives*. Bristol: Bristol University Press.
- Button ME (2016) Suicide and social justice: Toward a political approach to suicide. *Political Research Quarterly* 69(2): 270–280.
- Button ME and Marsh I (2020) Introduction. In: Button ME and Marsh I (eds) *Suicide and Social Justice: New Perspectives on the Politics of Suicide and Suicide Prevention*. New York: Routledge, pp. 1–12.
- Castel R (1991) From dangerousness to risk. In: Burchell G, Gordon C and Miller P (eds) *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press, pp. 281–298.

- Ceyhan A (2012) Surveillance as biopower. In: Ball K, Haggerty KD and Lyons D (eds) *Routledge Handbook of Surveillance Studies*. London: Routledge, pp 38–45.
- Cohen J, Katona C and Bhugra D (2020) National data on suicide must include ethnicity. *BMJ* 371. <http://dx.doi.org/10.1136/bmj.m4105>
- Douglas M (1992) *Risk and Blame: Essays in Cultural Theory*. London: Routledge.
- East L, Dorozenko KP and Martin R (2021) The construction of people in suicide prevention documents. *Death Studies* 45(3): 182–190.
- Elden S (2003) Plague, panopticon, police. *Surveillance & Society* 1(3): 240–253.
- Fitzpatrick SJ (2021) The moral and political economy of suicide prevention. *Journal of Sociology* OnlineFirst: 1–17.
- Fletcher DR and Wright S (2018) A hand up or a slap down? Criminalising benefit claimants in Britain via strategies of surveillance, sanctions and deterrence. *Critical Social Policy* 38(2): 323–344.
- Foucault M (1990) Social security. In: Kritzman LD (ed.) *Michel Foucault: Politics, Philosophy and Culture. Interviews and Other Writings, 1977–1984*. New York: Routledge, pp. 159–178.
- Foucault M (1998) *The Will to Knowledge: A History of Sexuality 1*. London: Penguin Books.
- Foucault M (2003) *Society Must Be Defended: Lectures at the College de France 1975–1976*. London: Penguin Books.
- Gordon C (1991) Governmental rationality: An introduction. In: Burchell G, Gordon C and Miller P (eds) *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press, pp. 1–51.
- Hacking I (2008) *The Taming of Chance*. Cambridge: Cambridge University Press.
- Hjelmeland H (2016) A critical look at current suicide research. In: White J, Marsh I, Kral M and Morris J (eds) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: University of British Columbia Press, pp. 31–35.
- Hjelmeland H and Knizek BL (2020) The emperor's new clothes? A critical look at the interpersonal theory of suicide. *Death Studies* 44(3): 168–178.
- HM Government (2012) Preventing suicide in England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf (accessed 4 April 2022).
- HM Government (2017) Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf (accessed 4 April 2022).
- Houston R (2009) The medicalization of suicide: Medicine and the law in Scotland and England, circa 1750–1850. In: Weaver J and Wright D (eds) *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World*. Toronto: University of Toronto Press, pp. 91–118.
- MacDonald M (1986) The secularization of suicide in England 1660-1800. *Past & Present* 111(1): 50–100.

- Marsh I (2010) *Suicide: Foucault, History and Truth*. Cambridge: Cambridge University Press.
- Marzetti H, Oaten A, Chandler A, et al. (2022) Self-inflicted. Deliberate. Death-intentioned. A critical policy analysis of UK suicide prevention policies 2009–2019. *Journal of Public Mental Health* 21(1): 4–14.
- Mills C (2018) ‘Dead people don’t claim’: A psychopolitical autopsy of UK austerity suicides. *Critical Social Policy* 38(2): 302–322.
- Mills C (2022) Burden and benefits–related suicides: “misperception” or state crafted reality? *Journal of Public Mental Health* 21(1): 46–56.
- Morris J (2016) Risky bodies: Making suicide knowable among youth. In: White J, Marsh I, Kral M and Morris J (eds) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: University of British Columbia Press, pp. 71–93.
- Mulder R, Newton-Howes G and Coid JW (2016) The futility of risk prediction in psychiatry. *The British Journal of Psychiatry* 209: 271–272.
- Nadesan MH (2008) *Governmentality, biopower, and everyday life*. New York: Routledge.
- Northern Ireland Government Department of Health (2016) Protect Life2: A draft strategy for suicide prevention in the north of Ireland. Available at: <https://www.health-ni.gov.uk/sites/default/files/consultations/health/protect-life-2-consultation.pdf> (accessed 4 April 2022).
- Northern Ireland Government Department of Health, Social Services and Public Safety (2012) Protect Life A Shared Vision: The Northern Ireland Suicide Prevention Strategy 2012 – March 2014.
- Petrov K (2013) The art of dying as an art of living: Historical contemplations on the paradoxes of suicide and the possibilities of reflexive suicide prevention. *Journal of Medical Humanities* 34: 347–368.
- Power M (2004) The Risk Management of Everything Rethinking the politics of uncertainty. Report, Demos <http://www.demos.co.uk/files/riskmanagementofeverything.pdf> (accessed 4 April 2022).
- Reynolds V (2016) Hate kills: A social justice response to suicide. In: White J, Marsh I, Kral M and Morris J (eds) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: University of British Columbia Press, pp.169–187.
- Rimke H (2016) Introduction - mental and emotional distress as a social justice issue: Beyond psychocentrism. *Studies in Social Justice* 10(1): 4–17.
- Rogers JR and Soyka KM (2004) ‘One size fits all’: An existential-constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy* 34(1): 7–22.
- Scottish Government (2013) ‘Suicide Prevention Strategy 2013–2016’. Available at: <https://www.gov.scot/publications/scottish-government-suicide-prevention-strategy-2013-2016/documents/>
- Scottish Government (2018) Every life matters: Scotland’s suicide prevention action plan. Available at: <https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/documents/>

- Sharp D and Linos N (2020) Dying to live in palestine: Steadfastness, pollution and embodied space. In: Broz L and Munster D (eds) *Suicide and Agency: Anthropological Perspectives on Self-Destruction, Personhood and Power*. London: Routledge, pp. 127–146.
- Shin HD, Price S and Aston M (2020) A poststructural analysis: Current practices for suicide prevention by nurses in the emergency department and areas of improvement. *Journal of Clinical Nursing* 30: 287–297.
- Smedslund J (2009) The mismatch between current research methods and the nature of psychological phenomena: What researchers must learn from practitioners. *Theory & Psychology* 19(6): 778–794.
- Szasz T (1986) The case against suicide prevention. *American Psychologist* 41(7): 806–812.
- The Samaritans (2018) Reducing Suicide in The Highlands Summary report.
- Tierney T F (2010) The governmentality of suicide: Peuchet, Marx, Durkheim, and Foucault. *Journal of Classical Sociology* 10(4): 357–389.
- Webb D (2010) *Thinking about suicide: Contemplating and comprehending the urge to die*. Monmouth: PCCS Books.
- Welsh Government (2015) Talk to me 2: Suicide and self harm prevention strategy for Wales 2015–2020. Available at: <https://gov.wales/sites/default/files/publications/2019-08/talk-to-me-2-suicide-and-self-harm-prevention-strategy-for-wales-2015-2020.pdf> (accessed 4 April 2022).
- White J (2017) What can critical suicidology do? *Death Studies* 41(8): 472–480.
- White J (2020) Hello cruel world: Embracing a collective ethics for suicide prevention. In: Button ME and Marsh I (eds) *Suicide and Social Justice: New Perspectives on the Politics of Suicide and Suicide Prevention*. New York: Routledge, pp. 197–210.
- White J (2020) Suicidology is for cutting: Epistemic injustice and decolonial critiques. *Social Epistemology Review and Reply Collective* 9(5): 75–81.
- World Health Organization (2016) Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Available at <https://www.who.int/publications/i/item/practice-manual-for-establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm> (accessed 4 April 2022).
- Yip PSF (2005) A public health approach to suicide prevention. *Hong Kong Journal of Psychiatry* 15(1): 29–31.
- Youde J (2010) *Biopolitical Surveillance and Public Health in International Politics*. New York: Palgrave Macmillan.
- Yue E (2021) Migrant suicide: A case for intersectional suicide research. *Journal Of Ethics In Mental Health* 11: 1–10.

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