The Situational Approach - A new approach to suicide prevention: This approach acknowledges the predominant association of situational distress, rather than mental illness, with suicide (though in some cases the two are linked), and is principally informed by and responds to risk factors of a broad spectrum of difficult human experiences across the life span. This approach is also mindful of and wherever possible seeks to address: contextual, systemic, and socio-cultural risk and protective factors and determinants: the real world of individuals' lived experience.

The approach is being promoted by Mengage at MHIRC (WSU)

The Situational Approach Bulletin is published monthly on Mengage.

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New Suicide Prevention Australia (SPA) Report confirms the importance of the broader perspective of the Situational Approach

SPA KPMG TURNING POINTS: IMAGINE A WORLD WITHOUT SUICIDE September 2019

https://www.suicidepreventionaust.org/wp-content/uploads/2019/09/2019_Sept_SPA_Turning_Points_White_Paper.pdf

Suicide Prevention Australia (SPA) released the Report on September 19 2019. KPMG were engaged by SPA to assist in the development of this paper. There are some encouraging aspects to this paper which acknowledges the importance of life stressors other than 'mental illness' as influencing suicide behaviour.

There is acknowledgment of the importance of unemployment:

Additionally, we know that long periods of increased financial pressure such as unemployment can result in decreased self-esteem and anxiety about the future, and have severe consequences for suicidal behaviour[11]. This is reflected by the finding that unemployed males are 4.6 times more likely to suicide than employed males[12].

There is acknowledgment of the importance of gender difference:

Certain work related risk factors and triggers for mood disorders and suicide are different in men and women, which some research attributes to historical psychosocial factors such as gendered roles in relationships, and the associated shame that may occur when men no longer fulfil these roles.

The report also recognises the importance of 'up-stream' prevention and there appears to be openness to a broader consideration what types of support may be helpful to people in distress.

The trends identified in this paper highlight a need to understand what opportunities there are to intervene earlier and better support people at risk of suicide outside of traditional service environments. Indicative data shows that these key time periods might be in the immediate 6 months following job or relationship loss. Further research is needed to understand what type of supports has the greatest impact, with the ultimate objective being a world without suicide.

We hope that SPA can see the value of the Mt Druitt Shed as a strong model of inter-agency integration and service support, that the leadership of the Mt Druitt Shed should be considered as experts in this field and that consequently the Mt Druitt Shed should be included as a key part of the proposed research?

While there are there some encouraging aspects of this Report we do nevertheless have queries about others.

In 2017, ABS data found that 20% of deaths by suicide did not mention any co-morbidities, such as mood disorders or chronic pain, as a contributing factor[3].

How do we interpret this? The statement implies that 80% of suicide deaths are 'mental illness' and that only 20% are not. However if we look at some of the categories listed under

Intentional self-harm top 10 multiple causes, proportion of total suicides , by age group, 2017 (a)(b)(c)

https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

- Other symptoms and signs involving emotional state

- Findings of alcohol, drugs and other substances in blood

- Anxiety and stress-related disorders

Aren't these typical symptoms of stress?

There is a valid argument to say that the majority of the ABS list below is not mental illness at all – even without the concerns for ICD categories and questionable mental health diagnoses.

Intentional self-harm top 10 multiple causes, proportion of total suicides , by age group, 2017 (a)(b)(c)

Cause of death and ICD code	5-24 years	25-44 years	45-64 years	65-84 years	85 years +	All ages
Mood disorders (F30-F39)	34.3	43.0	49.0	40.3	26.0	43.0
Mental and behavioural disorders due to psychoactive substance use (F10-F19)	25.9	41.6	26.7	10.1	2.6	29.5
Other symptoms and signs involving emotional state (R458) (c)	20.6	16.9	19.5	16.4	11.7	18.1
Anxiety and stress-related disorders (F40-49)	15.2	19.7	17.9	13.6	9.1	17.5
Findings of alcohol, drugs and other substances in blood (R78)	18.5	17.0	13.7	9.6	7.8	14.9
Schizophrenia, schizotypal and delusional disorders (F20-F29)	3.5	7.9	5.2	2.3	—	5.5
Unspecified mental disorder (F99)	7.2	5.0	4.3	1.8	—	4.5
Malignant neoplasms (C00-C97, D45-D46, D47.1, D47.3-D47.5)	0.5	0.9	1.9	16.1	24.7	3.7
Diseases of the musculoskeletal system (M00-M99)	0.2	1.7	3.3	11.1	15.6	3.6
Personality disorders (F60-F69)	5.4	5.0	2.0	1.3	—	3.5
Chronic pain (R522)	0.5	1.3	3.7	5.3	5.2	2.6
Ischaemic heart diseases (I20-I25)	0.2	0.7	1.8	7.8	16.9	2.3
Chronic lower respiratory diseases (J40-J47)	0.2	0.5	2.0	6.0	9.1	1.9
Diabetes (E10-E14)	0.5	0.6	2.0	5.0	9.1	1.8
Heart failure (I50-I51)	0.2	0.2	1.0	5.0	7.8	1.2
Behavioural disorders usually occurring in childhood and adolescence (F90-F98)	3.7	1.1	0.6	—	—	1.1
Disorders of psychological development (F80-F89)	2.1	0.5	0.1	—	—	0.5

— nil or rounded to zero (including null cells)
Footnote(s):
(a) Includes ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 91-100.
(b) Causes of death data for 2017 are preliminary and subject to a revisions process. See Explanatory Notes 57-60.
(c) Includes suicide ideation

We hope that this Report is not simply perpetuating the mental illness ideology that dominates the suicide prevention sector.

Language and the mental illness ideology

One of the strongest concerns we have about the current approach to suicide prevention and 'mental illness' is that the sector is dominated by language that reinforces the limited and simplistic bio-medical approach to human distress. There is a pervasive ambiguity of terminology throughout the suicide prevention / mental health sector so that for example, the generic term 'depression' is often used in a way that suggests a clinical mental condition when this may not be the case at all. Even the term 'mental health' itself is highly ambiguous and adds to confusion about what we are really dealing with. In general, distress as a result of serious adverse life circumstances such as unemployment, financial difficulties and relationship breakdown, is commonly reduced to a 'mental health' issue and therefore part of the mental health domain rather than a broader social domain and consequently serves to diminish the opportunity to properly address the fundamental issues.

However there are options in practicable terminology available within the published literature that we can use to help avoid this sort of ambiguity and confusion.

Rather than the term 'depression' we can use 'psychological distress'; rather than the idea of 'treatment' of a distressed person, which often is limited to prescribing of harsh antidepressant drugs, we can use language such as 'salutogenic dialogue' to open up a meaningful relationship with the distressed person – a must in finding support suitable to their needs.

Understanding persons with psychological distress in primary health care

Excerpt:

Psychological distress is a state of emotional suffering associated with stressors and demands that are difficult to cope with in daily life.

This imbalance was described in three dimensions: Struggling to cope with everyday life, Feeling inferior to others and Losing one's grip on life. It seems to be associated with a gradual depletion of existential capacities and lead to dissatisfaction, suffering, poor self-esteem and lack of control. As psychological distress may be a forerunner to mental, physical and emotional exhaustion, there is a need to initiate preventive or early interventions to avoid mental, physical and emotional chaos in such patients. Patients' with psychological distress need to be involved in a person-centred salutogenic dialogue with health professionals to become aware of and strengthen their own capacities to regain health and well-being

Risk factors include stress-related and sociodemographic factors and inadequate inner and external resources (4).

Arvidsdotter, T., Marklund, B., Kylén, S., Taft, C., & Ekman, I. (2015). Understanding persons with psychological distress in primary health care. *Scandinavian Journal Of Caring Sciences*, *30*(4), 687-694. doi: 10.1111/scs.12289 https://www.nature.com/articles/s41599-018-0063-2

The issue of appropriate language is not an incidental or minor issue but is in fact vital to changing the paradigm in how we address the real causal factors in suicide. Moving the language away from the more clinical and bio-medical perspective begins to allow us to consider that there are professionals from other sectors outside health /mental health that may have the experience and professional wherewithal to allow them to more effectively work with people in distress – as happens at the Mt Druitt Shed. For example: someone having trouble with paying the rent – surely it is better to speak with a professional from the housing sector to address this than someone from health / mental health only?

Belgium Leadership – challenging the mental illness ideology

The country of Belgium, through the Superior Health Council (SHC) is once again showing world leadership in directly challenging key aspects of the current approach to 'mental illness', in this case specifically challenging the classification system of the 2 key international classification systems, the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Classification of Diseases and Related Health Problems (ICD).

The SHC has this year released a report into diagnosis and classification of mental health problems; the points they make are strongly worded and leave no doubt as to their own concerns about the validity of classifications for mental health problems under these systems.

> **SUMMARY**
> The SHC notes that the most commonly used tools for diagnosing mental health problems (the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or the *International Classification of Diseases and Related Health Problems* (ICD)) pose several problems and recommends that they be used with caution and that the DSM categories not be at the centre of care planning.
> From an epistemological point of view, classifications are based on the assumption that mental disorders occur naturally, and that their designations reflect objective distinctions between different problems, which is not the case. The boundaries between people with a disease and those who are free from it are more dimensional than categorical.

At an organizational level, the SHC raises the question of the function of diagnostic psychiatry from the pressures of change, while mental health care is in a state of flux. On the other hand, this biomedical approach does not, as hoped, reduce stigma and discrimination of patients in mental health care.

In Belgium, the authorities give stakeholders and organisations a wide margin of freedom to use these systems, mainly used for registration purposes (MPD).

At a clinical level, classifications do not provide a picture of symptoms, management needs and prognosis because they lack validity, reliability and predictive power. On the other hand, they do not respond to new conceptions of health, defined by the ability to adapt, despite bio-psycho-social obstacles. However, it is more useful to understand the combination of factors causing and maintaining symptoms than to identify a category. A recovery-based approach (clinical, personal and social) better contextualizes symptoms and adapts interventions according to patients' values, affinities and goals, working closely with them.

Superior Health Council. DSM (5): The use and status of diagnosis and classification of mental health problems. Brussels: SHC; 2019. Report 9360.
https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/shc_9360_dsm5.pdf

It's Time to Stop Blaming Men for Their Mental Health Woes

One of the most obstructive brick walls in trying to achieve more effective suicide prevention of men is the pervasive blaming of men for their distress that features throughout the culture of the suicide prevention / mental health sector – through research, media and publicity and campaign activity .

Masculinity is blamed; 'risk-taking' is blamed along with the offensive idea of 'toxic masculinity'. These ideas are presented as though somehow there are distinctly different forms of 'masculinity'; presumably some masculinity is toxic while some is not. Risk-taking for example: Risk-taking is presented as bad in some research and general publicity literature - except of course when it's important such as SES work ,or entrepreneurship, or sport, or defence, or work in vital but hazardous industries…

Several recently published articles articulate these concerns very well. And it is interesting to note the international criticism of the approach of the Australian organisation, Beyond Blue, and its approach to men in distress.

It's Time to Stop Blaming Men for Their Mental Health Woes

Many mental health campaigns consistently encourage people to spend more time talking. These campaigns consider talking as a sign of emotional literacy and essential to the development of positive mental health and psychological resilience. This encouragement to talk is commonly deployed when discussing men's mental health, where men are frequently

stereotyped as self-destructively silent, stubborn and stoical in the face of mental health issues.

For example, the Australian national mental health campaign 'Beyond Blue' starts its men's mental health web-page with the sentence 'men are known for bottling things up'. Likewise, recent media articles on men's mental health focus on men's alleged taciturnity, with accusatory titles such as 'men need to talk about their mental health' or 'not talking about mental health is literally killing men'. In this discourse, men themselves are implicitly blamed for their mental health woes. 'If only men would talk more, their mental health would improve and their problems would be solved' or so the argument goes. However, such a simplistic rendering of the issue is highly problematic for a variety of reasons.

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https://www.psychologytoday.com/au/blog/talking-about-men/201806/it-s-time-stop-blaming-men-their-mental-health-woes

Men's Mental Health: Beyond Victim-Blaming

Numerous scholars have noted that the wider social discourse around men's health per se has often adopted a narrowly focused, deficit-based approach that borders on victim-blaming, eschewing a multi-level, social context-oriented approach.[23,25,26] This narrow focus often singularly attributes the cause of a health problem to the attitudes and behaviours of men, rather than acknowledging a highly complex web of causation.[27,28] This discourse often centres on the concept of 'masculinity'

This singular focus on 'masculinity' not only propels a narrow research focus but also leads to health promotion campaigns that may have a limited effect. For example, the US Agency for Healthcare Research and Quality campaign ran billboards plastered with the slogan 'this year thousands of men will die from stubbornness'. Likewise, a visitor to the men's mental health webpage of 'Beyond Blue', the Australian national mental health campaign, is greeted with the sentence 'Men are known for bottling things up'. The sub-text of such campaigns is an implicit criticism of the illness-bearer's attitudes, behaviour, or lifestyles; sometimes laying the blame squarely at the feet of the afflicted menthemselves.[2]

Whitley, R. (2018). Men's Mental Health: Beyond Victim-Blaming. *The Canadian Journal Of Psychiatry*, *63*(9), 577-580. doi: 10.1177/0706743718758041

https://journals.sagepub.com/doi/pdf/10.1177/0706743718758041

A roadmap to men's health: current status, research, policy & practice.

'Traditional masculinity' has been negatively portrayed, as the cause of men's poor health behaviours; but this portrayal risks: blaming the victim; undervaluing positive male traits; and alienating men in whom we seek to instil healthier behaviours.

Bilsker, D, Goldenberg, L, Davison, J. A roadmap to men's health: current status, research, policy & practice. Vancouver: Men's Health Initiative of British Columbia; 2010.

https://www.sfu.ca/content/dam/sfu/carmha/resources/mens-health/A-Roadmap-to-Mens-Health.pdf

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