Situational Approach to Suicide Prevention MHIRC. WSU
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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.

In this Edition:

In this edition of the **Situational Approach** Bulletin we take a closer look at the breakdown for our national figures for suicide deaths. We challenge the description of 'mental disorder' being applied to many of these deaths.

We call for a thorough review of how we collect and analyse our suicide data; important changes need to be made in this process if we are to make any inroads at all into reducing the mounting toll of suicide deaths.

Contents:

Men's Health Week 2020

MHIRC thanks all the individuals and communities for another successful Men's Health Week from June 15th to 21st, 2020. Despite the challenges of COVID-19, there were over 100 registered events (both physical and virtual) across the country and many more unregistered community events. The campaign has reached thousands of people through social and mainstream media. It is important that together we maintain this momentum and continue the community action to make Men's Health a national priority. In line with one of the themes of Men's Health Week "Preventing Suicide Together", MHIRC is

committed to build more evidence on the situational approach to suicide prevention and work towards preventing male suicides in Australia.

We would also like to acknowledge the winners of National Men's Health Awards 2020 presented by Australian Men's Health Forum (AMHF). The Award winners were announced during Men's Health Week and include:

- **Uncle Mick Adams**, from HealthInfoNet, for the Local Men's Health Hero Award
- **Dave Oliver**, Sexuality, Sport and Masculinity Resource, for the Best Men's Lived Experience Speaker Award
- **Camping on Country** for the Best Men's Program or Group Award
- **Mary O'Brien**, founder of Are You Bogged Mate? For the Women's Working in Men's Health Award
- **Parents Beyond Breakup** for the Significant Response to COVID-19 Award.

More than 5000 people across Australia voted for the 2020 Men's Health Awards. The National winners for each category were decided by a judging panel from the Australian Men's Health Forum and announced in a special event to celebrate all finalists during Men's Health Week.

The dates for **Men's Health Week 2021 are June 14th to 20th.**

National data – Suicide Deaths

There is a very common abiding idea throughout suicide literature that mental disorders make up the majority of all suicide deaths. We challenge this idea.

We believe the current system of data collection and analysis inflates mental disorders at the expense of evidence based social determinant factors such as unemployment. In doing this, the current system thereby reinforces the idea that it is appropriate that the leadership for suicide prevention is largely limited to mental health 'experts' – those with a background and training in the medical side of 'mental health'.

A re-consideration of the ABS data suggests a very different picture of the place of 'mental disorders'. We can begin this with re-categorising. The Situational Approach to suicide prevention and mental health literacy recommends initiating and promoting changes in language and definitions used in relation to human experience and mental health. This is critical to treating people with respect, preserving their dignity, and avoiding doing harm. It should also be noted that appropriate language used in mental health can also contribute to building individuals' sense of personal agency and hope, and can result in empowerment. 1

In summary, we argue that ***high intensity mental health difficulties**** make up a smaller percentage of suicide deaths than is commonly believed. We contend that many other deaths that are labelled according to psychiatric coding systems may not be 'mental disorders' at all. We argue that we need a thorough review of how we collect and analyse our suicide data if we are to make any inroads at all into reducing the mounting toll of suicide deaths.

*A ***High Intensity Mental Health Difficulty*** usually significantly impairs a person's ability to function on a day to day basis and noticeably interferes with their usual or preferred mental, emotional, or social capacity, and their experience of feeling capable and competent.

Such a difficulty usually requires more than a person's own coping ability, lifestyle adjustments, and support of friends and family. At least initially, it may require thoughtful observation and tentative assessment by a qualified health professional (a doctor, psychotherapist, psychologist, or, in some cases a psychiatrist), who will also suggest and perhaps provide appropriate psychotherapy (psychological therapy).

A 'Situational Approach' To Mental Health Literacy In Australia http://malesuicidepreventionaustralia.com.au/wp-content/uploads/2017/06/Mental_Health_Literacy_Paper_web.pdf

ABS Table - Cause of Death

Key points to make about the ABS data below:

1. The number of people suffering what we can call ***high intensity metal health difficulties*** is relatively low – see the ABS Table below. Schizophrenia, schizotypal and delusional disorders (F20-F29) account for only a very small percentage of the ABS list.
2. Mood Disorders, which make up the largest category, appear to be largely due to diagnoses of depression. However the listed symptoms for Mood Disorders are largely normal human experience and may not necessarily indicate a clinical 'mental disorder' at all – for more about this see Mood Disorder section below.
3. A number of the other categories listed are also questionable as clinical mental disorders - while people may well be in distress as a result of serious health issues, this should not be considered as 'mental disorder. These are surely not a 'mental disorder'
    1. Malignant neoplasms (C00-C97, D45-D46, D47.1, D47.3-D47.5)
    2. Diseases of the musculoskeletal system (M00-M99)
    3. Chronic pain (R522)
    4. Ischaemic heart diseases (I20-I25)
    5. Chronic lower respiratory diseases (J40-J47)
    6. Diabetes (E10-E14)
    7. Heart failure (I50-I51)
4. For effective suicide prevention, there is good argument to say that some of the other larger categories may be better considered in terms of the context and history of the individual rather than rely solely on a mental health diagnosis and treatment approach – especially given the high death rates of people accessing mental health treatments.
    1. Mental and behavioural disorders due to psychoactive substance use (F10-F19)

2. Other symptoms and signs involving emotional state (R458) (c)
3. Anxiety and stress-related disorders (F40-49)
4. Findings of alcohol, drugs and other substances in blood (R78)

5. Important social factors in suicide deaths such as unemployment are not listed **AT ALL**. In Australia, unemployment accounts of the majority of all suicide deaths with over 55 % of suicides of people of working age 2. If we approached the collection and analysis of data so that we included evidence based factors outside 'mental health' we would have a very different looking list.

In summary ***high intensity mental health difficulties*** (such as schizophrenic and psychotic experience) appear to make a relatively small percentage of all suicide deaths. Other categories that are assumed to be 'mental disorders' appear to be highly inflated by questionable diagnoses of depression. We need a thorough review of how we collect and analyse our suicide data if we are to make any inroads at all into reducing the mounting toll of suicide deaths Collection of suicide data should

ABS Table

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

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

— 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 suicid
Explanatory Notes 91-100.

(b) Causes of death data for 2017 are preliminary and subject to a revisions process. See Explanatory Notes 57-

(c) Includes suicide ideation

Mood Disorders

The category Mood Disorders makes up the largest category in the ABS list of Cause of Death. However it is instructive to look into what constitutes a diagnosis of ‘Mood Disorder’ and what are listed as the symptoms of “Mood Disorder’. The content below has been taken from the **Johns Hopkins University School of Medicine**

We are particularly concerned that in many instances the ‘types’ and the ‘symptoms’ of mood disorders are not mental illness at all but are instead better described as examples

of distress responses – perfectly normal responses to stressful circumstances. The process of medicalizing common human experience and categorising them as symptoms of mood disorder (such as depression) leads to over-diagnosis and highly inflates the general category of 'mental disorder' generally as well as among suicide deaths.

Johns Hopkins University School of Medicine https://www.hopkinsmedicine.org/health/conditions-and-diseases/mood-disorders

Mood Disorders

Overview

A mood disorder is a mental health class that health professionals use to broadly describe all types of depression and bipolar disorders.

What are the different types of mood disorders?

These are the most common types of mood disorders**:**

- **Major depression.** Having less interest in usual activities, feeling sad or hopeless, and other symptoms for at least 2 weeks may indicate depression.
- **Dysthymia.** This is a chronic, low-grade, depressed, or irritable mood that lasts for at least 2 years.
- **Bipolar disorder.** This is a condition in which a person has periods of depression alternating with periods of mania or elevated mood.
- **Mood disorder related to another health condition.** Many medical illnesses (including cancer, injuries, infections, and chronic illnesses) can trigger symptoms of depression.
- **Substance-induced mood disorder.** Symptoms of depression that are due to the effects of medicine, drug abuse, alcoholism, exposure to toxins, or other forms of treatment.

What causes mood disorders?

Many factors contribute to mood disorders. They are likely caused by an imbalance of brain chemicals.

Our comment here: …they are **LIKELY** caused by an imbalance of brain chemicals….? So much for a rigorous scientific base…

Life events (such as stressful life changes) may also contribute to a depressed mood. Mood disorders also tend to run in families.

What are the symptoms of mood disorders?

Depending on age and the type of mood disorder, a person may have different symptoms of depression. The following are the most common symptoms of a mood disorder

- Ongoing sad, anxious, or "empty" mood
- Feeling hopeless or helpless
- Having low self-esteem

- Feeling inadequate or worthless
- Excessive guilt
- Repeating thoughts of death or suicide, wishing to die, or attempting suicide (**Note:** People with this symptom should get treatment right away!)
- Loss of interest in usual activities or activities that were once enjoyed, including sex
- Relationship problems
- Trouble sleeping or sleeping too much
- Changes in appetite and/or weight
- Decreased energy
- Trouble concentrating
- A decrease in the ability to make decisions
- Frequent physical complaints (for example, headache, stomachache, or tiredness) that don't get better with treatment
- Running away or threats of running away from home
- Very sensitive to failure or rejection
- Irritability, hostility, or aggression

Of course people may be distressed as a result of some of these experiences – that does not mean they have a clinical mental disorder and merely ticking a few boxes of what are clearly common human response to stressful circumstances should not constitute a diagnosis of clinical mental disorder.

The so-called science behind a process of ticking a relatively few boxes of 'symptoms' to determine a clinical metal disorder is highly questionable: A thorough and independent review of this process should made.

Every suicide death has a situational context

Even high intensity mental health challenges such as people distressed with schizophrenic experience:

As far as suicide prevention efforts go - people distressed with high intensity mental health challenges, even where there appears to be no external or social cause that can be pointed to, need their situational context to be considered as a priority for their on-going care and support – their family context, finances, health service availability, employment context….

References

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Ashfield, J., Macdonald, J., Francis, A. and Smith, A. "A 'Situational Approach' To Mental

Health Literacy In Australia". (2017): n. pag. Web. 30 May 2017. https://doi.org/10.25155/2017/150517

2. Saar, E., Burgess, T., Intentional Self-Harm Fatalities in Australia 2001-2013. Data Report DR16 – 16 (2016) National Coronial Information System

See NCIS Report - Table 10

https://malesuicidepreventionaustralia.com.au/wp-content/uploads/2017/01/NCIS-Report-2016_FINAL.pdf

3. ABS. 4329.0.00.006 - Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data. Accessed May 4 2020 https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4329.0.00.006Main+Features25Analysis%20of%202011%20data?OpenDocument

People accessing mental health-related treatments had a standardised death rate of 11 deaths per 1,000 people, almost twice that of Australia overall (6 deaths per 1,000 people).

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