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.

Contents:

1. Men in Crisis – Are we helping or compounding their difficulties?

What are we doing to support men in trouble?

We are spending huge amounts[1] on what we call 'mental health' as a key strategy in our suicide prevention activity. Despite this, the numbers of suicide deaths continues to rise[2] and is now averaging over 3000 per year for the last 4 years. The great majority of these deaths are adult men.

Much of the focus of the suicide prevention / mental health sector is the general idea that it will help people in distress to 'talk to someone'.[3] This pervasive message has enormous funding behind it with campaign activity and organisations pushing this at every level of our community.

How valid is this general idea – to 'talk to someone'?

There is a good deal of good intention throughout our community to help people in distress and to try to reduce the number of people who end up on the tragic pathway to suicide death. However, this good intention is rendered less effective than it might be because the suicide prevention / mental health sector is swamped with ambiguous ideas and language as well as simplistic notions around 'mental health'.

The term ***mental health*** itself is highly ambiguous. There is broad confusion and conflation between the general use of the term which refers to a person's state of psychological / emotional wellbeing, on the one hand, and on the other hand, the more clinical medical use of the term inferring clinically diagnosable mental disorder.

This general ambiguity is further complicated with the widespread confusion and ambiguous use of the term ***depression***, especially where the terms *depression* and *mental health* seem to be used interchangeably.

In general use, *mental health* refers to personal psychological / emotional well-being. The term implies an opposite, that is, mental ill-health / mental illness, which implicitly endorses a medicalised view of personal well-being: to be stress free is to be in good mental health; to be distressed is symptomatic of poor mental health / mental illness. This confusion sets up a culture of misunderstanding with consequential poorly conceptualized research and policy targets.

To describe the experience of distress as mental illness only adds to the general community wide confusion and ambiguity. Common terminology used to describe general distress, such as feeling troubled, feeling down, feeling low, loss of spirit, loss of energy etc. are all common descriptions of common human experiences –they should not be taken to imply a clinical mental disorder. However they have now become equated with ***mental health***.

Of course we should offer a comfort and support to people in distress – but if we are to begin to reduce the toll of suicide deaths we need to take a more upstream approach to this issue. We need to ask people in trouble 'What has caused the distress in the first place?' And this is particularly pertinent to men in distress.

How helpful is it for men to 'talk to someone'?

Recent published research suggests that we should seriously consider this idea. From an article in the Age October 2019[4]

> **We tell men to open up more. But are we ready to listen? (October 2019)**
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> Excerpt:
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> Research released this week by Movember surveyed 4000 men globally and showed that, while three quarters of men have at least one person they can talk to when in need, two in five (41 per cent) have regretted opening up to someone about their mental health.
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> These men reflected on how opening up resulted in them feeling like they weren't taken seriously, had lost respect or were made to feel embarrassed or weak for doing so. Even more worryingly, over half of these men (53 per cent) said that this negative experience would prevent them from sharing again. These men did everything that the mental health community asked of them. It is now up to us to do

right by these men and teach those on the other end of the conversation, whether it be their doctor, psychologist, spouse or a colleague, how to give these men what they need.

The 'Talk to Someone' message

The ubiquitous 'Talk to Someone' message is controversial. It is a prevalent message with huge financial backing for campaign activity. However, the evidence for the value of this as a population wide preventative activity is thin. Anecdotal stories of a distressed person who 'talked to someone' (a favourite of the media and popular on home pages of websites), while making a compelling case for and about those individuals, does not constitute solid evidence for the efficacy of this approach as a general tool. Published research offers a contrasting view altogether; internationally published research led by Dr Samara McPhedran[5] as well as the Movember research referred to above shows that this sort of strategy leads a significant proportion of people, especially men in trouble, into a very problematic and possibly tragic pathway.

There are important questions to ask about this contentious 'talk to someone' message. Who should people speak with if they are in crisis? What are the appropriate skills for supportive engagement for people whose distress is clearly related to adverse life events rather than any internal brain deficiency / mental disorder?

From the McPhedran article:

> Referring to rural men:
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> The fact that many men had contact with a mental health professional but nonetheless went on to take their own lives indicates a need to consider factors such as the adequacy and appropriateness of available mental health services, the type of support provided, the intensity and level of care, and whether available services match well to rural men's specific characteristics and needs. Suicide prevention efforts should also take into account underlying factors that may contribute to an individual's suicidality (for example, relationship breakdown or financial stress), as well as the full spectrum of experiences that may lead to, or occur independently of mental illness.
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> Referring to suicidal men:
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> It may be the case that common suicide prevention strategies, such as encouraging greater use of mental health services by men and focusing on raising awareness of links between mental illness and suicide, are unlikely to lead to effective interventions for such individuals.

We need to put a little more thought into this. To whom should men in trouble speak? What are the relevant qualifications / experience etc that are appropriate for someone to be a supporting listener to a man in crisis? What training is appropriate to ensure listeners have the appropriate understanding and attitudes to offer quality support – and who should deliver that training? What are the stereotypical ideas that compound the difficulties for men in trouble that we need to avoid? What are the appropriate messages for media?

As men make up the overwhelming majority of all suicide deaths, it is vitally important that these questions be taken seriously; they should be at the forefront of suicide prevention discussion at all levels. They should be priority considerations for research and policy development.

2. Mental Illness Ideology

The mental illness ideology pervades the current approach to suicide prevention. It influences how research is designed and policy developed. To become effective in preventing suicide deaths, the current approach must be revised to ensure the conceptual basis is sound and properly evidence-based.

The mental illness ideology: An ideology is a system of ideas and beliefs – it is a deep set way of thinking; an ideology is often used to describe a broad system of political, economic or cultural beliefs. The ideology is usually built on a set of core concepts and principles.

The mental illness ideology refers to the general ideas and beliefs of the current approach to mental illness and suicide prevention and how we deal with psychological and emotional distress. The mental illness ideology associates mental illness with suicide; in so-doing it can undermine effective suicide prevention efforts, because mental illness alone does not correlate with a significant proportion of suicide deaths.

Within the broad general concept of the mental illness ideology there are a number of core ideas such as ***The Bio-Medical Model*** and the process of ***Medicalization / Pathologization***.

There are some strong published articles expanding on these ideas and adding strength to the argument for a need to move our current approach towards the **Situational Approach**.

The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research[6]

Abstract

The biomedical model posits that mental disorders are brain diseases and emphasizes pharmacological treatment to target presumed biological abnormalities. A biologically-focused approach to science, policy, and practice has dominated the American healthcare system for more than three decades. During this time, the use of psychiatric medications has sharply increased and mental disorders have become commonly regarded as brain diseases caused by chemical imbalances that are corrected with disease-specific drugs. However, despite widespread faith in the potential of neuroscience to revolutionize mental health practice, the biomedical model era has been characterized by a broad lack of clinical innovation and poor mental health outcomes. In addition, the biomedical paradigm has profoundly affected clinical psychology via the adoption of drug trial methodology in psychotherapy research. Although this approach has spurred the development of empirically supported psychological treatments for numerous mental disorders, it has neglected treatment process, inhibited treatment innovation and dissemination, and divided the field along scientist and practitioner lines. The neglected biopsychosocial model represents an appealing alternative to the biomedical approach, and an honest and public dialog about the validity and utility of the biomedical paradigm is urgently needed.

The Medicalization of Mental Disorder[7]

Abstract

Medicalization occurs when previously nonmedical problems become defined and treated as medical problems, usually in terms of an illness or disorder. After setting the historical context for how certain forms of deviant behavior became defined and treated as medical and psychiatric problems, we examine three more recent instances of medicalization. First is the growth of attention deficit hyperactivity disorder (ADHD) from a children's disorder to a lifespan disorder, which highlights medicalization through the expansion of an existing medical category. Second, we discuss the emergence of social anxiety disorder (SAD) as a common diagnosis, focusing on how a pharmaceutical company initially marketed shyness and social anxiety as a disorder and then advertised Paxil as its preferred treatment. Third, we consider the debate about whether to remove the bereavement exclusion from the diagnostic criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders, V (DSM-V), which would make normal grief a basis for psychiatric diagnosis and treatment.

The mental illness ideology pervades all aspects of the current approach to suicide prevention. The current approach to suicide prevention is clearly not working; not only are we NOT managing to reduce the suicide death toll, but the numbers continue on an upwards trend as they have been for nearly two decades. If we are to make any progress in reducing the ever-increasing suicide death toll, we need to move our thinking on this issue to a more appropriate conceptual framework - which is provided by the **Situational Approach**. We will need to move key aspects of the current approach away from the mental illness ideology which will require new targets for research, new targets for policy development and new targets for program funding – and all led by a re-invigorated leadership with integrity.

3. Consultation Paper for the National Preventive Health Strategy Closes on 28th September 2020

Preventive health is a key pillar of Australia's Long-Term National Health Plan.

As announced by the Minister for Health, the Hon Greg Hunt MP in June 2019, the Australian Government is developing a 10-year National Preventive Health Strategy (the Strategy).

The purpose of this consultation is to seek stakeholder and community feedback on the Consultation Paper. The diverse perspectives, experiences and knowledge of all stakeholders and interested members of the community are valued and respected and will contribute to the final Strategy.

The Consultation Paper and link to submit you feedback can be found here.

4. Connect 2020 – Suicide Prevention Australia

Connect 2020 is Suicide Prevention Australia's webinar series. The webinar series connects thought leaders and innovators to share ideas and support our vision of a world without suicide. The webinars will explore a range of topics including mentally healthy workplaces, Men's' health, carers and postvention. Attendees at all eight webinars will receive an official certificate of completion. Read more: www.suicidepreventionaust.org/connect-2020

5. Male Health Initiative – Evaluation Survey

MHIRC is encouraging you to participate in a survey to evaluate the funding for MENGAGE under Male Health Initiative.

At the end of the survey you can go into the draw to win one of six cash prizes of up to $500. Please remember to provide your details if you wish to enter the draw.

Link to the Survey: Click Here

Please note:

- This research is being conducted by Urbis, an independent organisation, on behalf of the Commonwealth Department of Health.
- The answers you provide are anonymous and will not be used for any purpose other than this research. You can access Urbis' privacy policy at https://urbis.com.au/privacy/.
- Your participation is voluntary, and you can stop the survey at any time.

References

[1] Australian Government Department of Health. 2019–20 Federal Budget advances long term national health plan https://www.health.gov.au/news/2019-20-federal-budget-advances-long-term-national-health-plan

$736.6 million for mental health including youth suicide prevention (4 year plan)

NSW Health https://www.health.nsw.gov.au/news/Pages/20190618_04.aspx

Victorian Government Health.Vic Suicide Prevention in Victoria https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria

[2] Australian Bureau of Statistics. (2019). Causes of Death, Australia, 2018. Catalogue No. 3303.0. Belconnen, ACT: Commonwealth of Australia. Accessed September 27, 2019 from: https://www.abs.gov.au/ausstats/abs@.nsf/0/47E19CA15036B04BCA2577570014668B?Opendocument

[3] Aust. Government. https://www.healthdirect.gov.au/how-to-talk-about-your-mental-health-concerns

> **How to talk about your mental health concern**

Beyond Belief https://www.beyondblue.org.au/get-support/have-the-conversation/talking-to-someone-you-are-worried-about

> **Talking to someone you are worried about**
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> A conversation can make a difference in helping someone feel less alone and more supported in recovering from anxiety and depression. Don't underestimate the importance of just 'being there'.

[4] Seidler Z. We tell men to open up more. But are we ready to listen? (2019) The Age. https://www.theage.com.au/lifestyle/life-and-relationships/we-tell-men-to-open-up-more-but-are-we-ready-to-listen-20191017-p531mg.html

> The male survey respondents '…reflected on how opening up resulted in them feeling like they weren't taken seriously, had lost respect or were made to feel embarrassed or weak for doing so. Even more worryingly, over half of these men (53 per cent) said that this negative experience would prevent them from sharing again'.
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> We tell men to open up more. But are we ready to listen?

[5] McPhedran, S. and De Leo, D.(2013) 'Miseries suffered, unvoiced, unknown? Communication of suicidal intent by men in "rural" Queensland, Australia'. The American Association of Suicidology Suicide and Life-Threatening Behavior, Dec. 2013. Available from: https://www.ncbi.nlm.nih.gov/pubmed/23829683

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[7] Conrad P., Slodden C. (2013) The Medicalization of Mental Disorder. In: Aneshensel C.S., Phelan J.C., Bierman A. (eds) Handbook of the Sociology of Mental Health. Handbooks of Sociology and Social Research. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-4276-5_4