Situational Approach Bulletin

Situational Approach to Suicide Prevention MHIRC. WSU ed Anthony Smith

Welcome to the eighth edition of our Situational Approach to Suicide Prevention Bulletin**.** We welcome feedback, and would of course be very happy to have a conversation with any people or organisations who are working in this vital area**.**

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) and we welcome the words of the newly appointed National Suicide Prevention Adviser, Ms, Christine Morgan, quoted in the SMH (July 15th) as saying:

"We have to look further upstream, right away from the immediate suicide crisis. Are there things happening to people that we can work on that might stop them. Let's take ourselves outside health and look at some of the other risk factors and see if by addressing those we get some change."

MHIRC runs a drop in centre for Suicide prevention in Western Sydney on this basis and is looking for other projects with this approach.

The Situational Approach Bulletin is published monthly on Mengage.

Contents of this issue:

1. International confirmation of key tenets of the 'Situational Approach'
2. UN statement challenging 'biomedical model of 'mental health'
3. Belgium – Superior Health Council
4. **PsychWatch**

- Latest blogs
- Seven year old girl on antidepressants

Also

In our Words - Charles

International confirmation - key tenets of the 'Situational Approach'

UN statement challenging 'biomedical model of 'mental health'

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2019

https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/41/34

P 10 # 49

Current mental health policies have been affected to a large extent by the asymmetry of power and biases because of the dominance of the biomedical model and biomedical interventions. This model has led … to the medicalization of normal reactions to life's many pressures, including moderate forms of social anxiety, sadness, shyness, truancy and antisocial behaviour. The most vocal message that can reach stakeholders with the resources and power to support meaningful transformation in global mental health is the need to close the "treatment gap". The Special Rapporteur is concerned that this message may further the excessive use of diagnostic categories and expand the medical model to diagnose pathologies and provide individual treatment modalities that lead to excessive medicalization. The message diverts policies and practices from embracing two powerful modern approaches: a public health approach and a human rights-based approach.

> Pūras, D. (2019). Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. United Nation Human Rights Council, Forty-first session (24 June–12 July 2019). A/HRC/41/34. Retrieved from: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/41/34

Other brief excerpts:

P 12 Over medicalization is especially harmful to children, and global trends to medicalize complex psychosocial and public health issues in childhood should be addressed with a stronger political will.

P 17 91.Mental health services suffer from an excessive focus on outdated approaches through which the majority of resources are allocated to individual treatment for diagnosed mental health conditions, including psychotropic medications and institutional care. This global imbalance continues to reinforce an equity, evidence and implementation gap.

Recommendations include:

P 19 Adopt prevention strategies to address depression and suicide through a modern public health approach that focuses on tackling determinants, enhancing life skills and resilience, promoting social connection and healthy relationships, and avoiding excessive medicalization;

Belgium – Superior Health Council

DSM (5): THE USE AND STATUS OF DIAGNOSIS AND CLASSIFICATION OF MENTAL HEALTH PROBLEMS

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

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 classifications, which tend to legitimize a structure based on a biomedical model and protect 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.

PsychWatch

The PsychWatch website continues to provide strong critiques of aspects of the current approach to suicide prevention and mental health.

https://www.psychwatchaustralia.com/

The latest blogs are all worth looking at

27 June 2019 - An **open letter to Prime Minister Scott Morrison in regard to antidepressants and youth suicide**

23 June 2019 - **Ten truths the ADHD Industry don't want you to know**

15 June 2019 - **Beginning in August 2019, every month, PsychWatch Australia will be announcing a 'Disease-Monger of the Month' Award.**

1 June 2019 - **More young Australians suicide/self-harm and use antidepressants while 'experts' dismiss FDA warnings**

8 May 2019 - **Drug companies secretly donate to political parties, while sharing in $12.7 Billion of our taxes via the PBS, and hiding product safety data behind a FOI law loophole.**

24 April 2019 - We revealed **1 in 8 (over 3 million) Australians were prescribed an antidepressant** from July 2017 and June 2018. What is driving this epidemic - real mental illness or a sick system?

Seven year old girl on antidepressants

The latest PsychWatch blog also recounts the horrific story from 'The West Australian' newspaper of a mother describing the ordeal of her 7 year old daughter having been prescribed antidepressants.

> "A mother wants the horrifying ordeal of her 7 year old daughter being prescribed antidepressants and developing an obsession with death…."
>
> https://www.psychwatchaustralia.com/post/dear-pm-re-youth-suicide-and-antidepressants-please-don-t-listen-to-the-same-failed-local-experts

In Our Words

In Our Words is a series of articles written be clients from the Mt Druitt shed, a suicide prevention initiative in the west of Sydney

Shed, Mt Druitt

In Our Words: Charles

3 years ago I was homeless, recently separated and in a very toxic relationship. I was still in recovery, had depression & anxiety. I was living in a caravan at that stage, and a bit before that I was in a car. I was disconnected because I had no family and for Aboriginals, that's disconnection. Anyway another koori guy used to come here (I don't see him around too much anymore) and he told me about The Shed. So, I came with him one day for a Wednesday lunch. And I just joined in. I didn't know anyone – I don't know anybody here, it's not my tribal area either. So I had a yarn with the workers and introduced myself.

They helped me out with a few things – even got me a house. Then I started volunteering here, helping out, because that's the kind of person I am. Before long, the mob across the road heard about me and employed me as a counsellor. I got involved doing things, so, I continued helping out here and I run a men's group. The Shed got me on my feet – doing things, helping myself, they put a roof over my head, a paid job.

I've been involved in community & men's programs for 40 years, so it's not new for me. I just went through a bad circumstance. The Shed helped me straight away with my support. It was a comfortable place to not be judged and to just be yourself. That's what I like about it. You keep the politics out of it and try to keep the personality stuff out of it. That was the most comfortable thing about it. So, you have the opportunity to sit and unpack. So, people can just share their day, tell stories, have a yarn; get that validation, get that dopamine fix. But, it's also an opportunity to delve deeper as well. Don and Rick always have an ear, and it's a chance to unpack further. A place like this – it's comfortable, relaxed and cultural in a lot of ways they specialise, which is great – it's unique specialist, niche. They're big on advocacy, big on social supports, big on cultural support, and big on a healing framework.

The mob at The Shed were a ready-made community. They were always a phone call away, or come in on a Wednesday and have a feed and a yarn. It's an oasis in a desert, and people know the oasis is there and they gravitate to it when they need the nourishment. That's the sort of environment, and here – no matter what tribe or mob you're from – here is that escape from judgement and criticism. You can be yourself in that moment.

The yarn-ups are a chance to sit and feel connected – belong to and belonging. For those ones with a mental illness or depression or addiction or who are lonely and isolated or people who are just having a bad day – it's an opportunity just to sit and gather. Much like a family; I reminded people it's just like sitting around a kitchen table or a family function.

The connections are everything; you don't want to be around misery or negativity either all the time. Come in, and just belong. You don't have to tell your story; you don't have to do anything other than just be there. If you want to volunteer or get involved, be free. When you're ready and most people eventually tell their story or parts of it. Again, it's about being safe, supportive, and nurturing. There is [sic] always people here you can talk to. Everyone just contributes. You know everything fits.

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