

## **Situational Approach to Suicide Prevention MHIRC. WSU ed. Anthony Smith Bulletin no. 3 January 2019**

The Situational Approach to suicide prevention seeks to prevent suicide by paying particular attention to the social/situational factors that lead to suicide.

Welcome to the third edition of our Situational Approach to Suicide Prevention Bulletin. We are hopeful of a big 2019; certainly the response to the Situational Approach on the international stage is very encouraging.

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.

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## **Health Specialist training in UK**

*That the situational approach immediately resonates with practitioners, and has clear benefits for patients and clients, is a strong incentive to see it more widely disseminated, and to pose a real challenge to the entrenched mental health status quo.*

### **Dr John Ashfield reports on his work in the UK**

As a mental health clinician, and leader of a team of specialist palliative care counsellors in England, I am constantly seeing patients diagnosed with depression and anxiety 'disorders' and, unsurprisingly who have been prescribed SSRI, SNRI, and other antidepressant medications.

Most patients are not experiencing an exacerbation of pre-existing mental health difficulties, but situational distress experientially consistent with their life-limiting or terminal diagnosis and illness trajectory.

The situational approach emphasises the imperative that patients be treated as persons, taken seriously, and given the time needed for proper assessment and the use of evidence based supportive strategies. Inconvenient though it may be, listening to patients, taking proper histories,

contextualising their experience, and examining remediable situational factors, is the least they deserve.

The use of medication should always be a last resort and must be considered for potential harm, evidence-based efficacy, adverse effects, and if used, should be closely monitored not just continuously prescribed.

Part of my role is to be an educator for other health professionals. I have found with few exceptions, that when I explain the situational approach to doctors, nurses and other allied health professionals, as an alternative to the present mental health paradigm, they are pleased to encounter both a conceptual and practical alternative to the evidently 'sinking ship' of mental illness orthodoxy.

## **'The Madness of our Mental Health System'**

- published in Mad in America

<https://www.madinamerica.com/2018/12/madness-mental-health-system/>

### **'The Madness of our Mental Health System'**

The current mental illness narrative evident in mental health literacy messaging and commentary on suicide prevention has tended to reinforce the idea that suicide should, in most cases, be considered to be the result of mental illness or disorder. However, evidence does not support this claim. Whilst conditions like major depression may sometimes be implicated in cases of suicidal ideation and death by suicide, and are an important consideration in the design of appropriate preventative measures, this should not be considered license to assume an association between the two that is simply unsupported. Limiting preventive strategies to those built upon the unfounded presumption of mental illness or disorder will simply not help many, perhaps the majority, of those at risk of suicide.

### **The Madness of our Mental Health System**

#### **Excerpts:**

Are we really succumbing to a pandemic of mental illness, or is there another explanation for what is happening? Well, what so many ordinary citizens (non-mental health professionals) have suspected for some time actually goes right to the heart of the matter: that perhaps there is a problem with the way we have come to define and respond to personal distress — including psychological and emotional difficulties which previously

would not have been the domain of medical intervention and diagnosis, and would have been largely resolved with various forms of non-medical human support.

Augmenting this idea with some closer analysis of the mental health ‘industry’, what we discover, contrary to what we have been told so often, is not a crisis of mental ill-health at all, but the effects of a deeply flawed narrative of ‘mental illness’, directly related to *the systematic medicalisation of common human experience*. Put simply, a whole gamut of common, albeit sometimes very challenging and disconcerting human experience has been corralled by medicine (and in particular its specialty of psychiatry) and referred to as illness; and where there is illness, treatments and especially drugs are utilised to attempt to cure it. Had this been a sudden event or decision of governments it might have been seriously questioned, but unfortunately, it is a phenomenon which has crept up on Western societies over recent decades. To use the words of poet Francis de Quevedo, it is one where *not only are things not what they seem, they are not even what they are called*.

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**Mad in America is published by Robert Whitaker**

<https://www.madinamerica.com/robert-whitaker-new/>

**Robert Whitaker** is an American journalist. In 1998, he co-wrote a series on psychiatric research for the Boston Globe that was a finalist for the Pulitzer Prize for Public Service. His first book, *Mad in America*, was named by *Discover* magazine as one of the best science books of 2002. *Anatomy of an Epidemic* won the 2010 Investigative Reporters and Editors book award for best investigative journalism.

## **Suicide and mental disorders: A discourse of politics, power, and vested interests**

A strong paper from Professor Heidi Hjelmeland of Norway challenges key fundamental ‘truths’ about suicide prevention. The paper, **Suicide and mental disorders: A discourse of politics, power, and vested interests** was published in the Journal, *Death Studies* in 2017 **Volume 41, 2017**

- **Issue 8: A Special Issue on Critical Suicidology** <https://doi.org/10.1080/07481187.2017.1332905>

‘It is time to discuss whether mental disorders not only play a significantly lesser role in suicidality than hitherto assumed, but also that too much focus on mental disorders in suicide prevention may well be counterproductive.’

The authors conclude:

We have presented several examples showing that the discourse on the relationship between mental disorders and suicide is permeated with ideology, politics, and power positioning suicide as a predominately medical/psychiatric issue. Critical voices/arguments are often dismissed as ideological, political, polemical, or as just unsubstantiated opinions. There is, however, no indisputable evidence for the claim that suicide always, or almost always is a consequence of mental disorder. Moreover, there is quite some research evidence questioning the 90% statistic. It is interesting to observe that arguments only seem to be considered political, ideological, polemical, or unsubstantiated when well-established “truths” are questioned, and not when poorly founded “truths” are maintained. It is time to acknowledge that today’s suicidology is highly politicized.

Marsh ... has extensively described how suicide came to be a medical issue in the first place; how “a compulsory ontology of pathology in relation to suicide” has been constructed. It is perhaps time to “de-medicalize” suicidology. Psychiatry does have a role to play in suicide prevention, but its importance should be weighed alongside other perspectives and approaches. Qualitative research has, for instance, found that existential issues seem a lot more important to suicidality than mental. It is time to discuss whether mental disorders not only play a significantly lesser role in suicidality than hitherto assumed, but also that too much focus on mental disorders in suicide prevention may well be counterproductive

Heidi Hjelmeland & Birthe L. Knizek (2017) Suicide and mental disorders: A discourse of politics, power, and vested interests, *Death Studies*, 41:8, 481-492,  
DOI:10.1080/07481187.2017.1332905

To link to this article: <https://doi.org/10.1080/07481187.2017.1332905>

## The Situational Approach - Communications and Mass Media

### Advocating for a new Multi-Sector Approach

<http://malesuicidepreventionaustralia.com.au/wp-content/uploads/2018/02/SA-Advocating-for-a-new-multi-sector-approach-140218.pdf>

Excerpt from:

### **The Situational Approach to Suicide Prevention and Mental Health Literacy - Advocating for a New Multi-sector and Multidisciplinary Approach**

The current approach by the media to the issues of suicide and ‘mental health’ is clearly dominated by a focus on the present conceptualisation of depression and by the ‘experts’ and high-profile personalities who represent and promote this focus. Journalists tend to turn to a very select few to

obtain opinions on suicide and mental health issues; consequently, the content of reporting and commentary is nearly always informed by the mental illness ideology.

Adopting new and better language is vitally important if we are to progress toward more effective suicide prevention and effective mental health literacy initiatives that promote the psychological well-being and mental health of individuals and our community. Such language is a vital centrepiece of the Situational Approach. This approach advocates that:

Anyone can experience a **mental health difficulty**; and everyone likely will at some stage of their lives. Such difficulties can be described in two ways:

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).

For more on the Situational Approach, see

<http://malesuicidepreventionaustralia.com.au/resources/resources/>

<http://malesuicidepreventionaustralia.com.au/papers/>