

# National Guidelines – Suicide Prevention For Males – 2017



## Clarification of Some Key Terms and Definitions in Suicide Prevention

There is widespread concern throughout Australia with the rising toll of suicide deaths. The last 10 years have seen an alarming increase in the national toll from 2,118 in 2006 to 3,027 in 2015<sup>1</sup> – a 42.9 % increase.

To address the challenges of suicide prevention more effectively we need to ensure that our understanding of key terms and definitions is clear and consistent. These guidelines propose clear terms and definitions covering important concepts in suicide prevention and are consistent with the best available current thinking and data.

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### Suicide Prevention

**Suicide prevention** is a broad term describing activities aimed at reducing the risk of suicide. Prevention is part of a continuum from broad scale activity to reduce suicide through to working with an individual identified as at risk of suicide. Broad scale suicide prevention is sometimes known as 'universal prevention' and targets the whole population. This approach focuses on precursors and social determinants and not on management or treatment.

Selective and Indicated programs target individuals who have displayed significant suicide risk.

### Suicide Intervention

**Suicide intervention** generally refers to working with individuals identified at risk of suicide, or who have attempted suicide. Interventive action may be preventive, in the sense that it targets individuals who have been identified as at risk of suicide.

### Suicide Post-Vention

**Suicide Post-vention** – refers to follow-up support for people affected by a suicide death. This may include grief counselling and preventive support for family and friends of individuals who have died by suicide. This support is important, because family and friends may themselves (due to the suicide) be at increased risk of suicide. Like **intervention, post-vention** is limited in generally targeting only those who have been identified by support services as at-risk through their connection to individual suicide deaths.

Intervention and post-vention are both limited in their capacity to influence the overall male suicide death toll because men who attempt suicide in most cases succeed on their first attempt.

Health and human service agency responses to suicide in Australia are generally known as **suicide prevention**. However, much of the work done in this field in Australia, though vitally important, is not so much **preventive** as a reactive response to the tragedy of suicide. Though in part this reactive response has an important preventive aspect to it – such as providing follow-up support for those personally affected by suicide and who may be at an elevated risk of suicide, it has limited preventive impact at the population level.

This reactive response consists of follow-up interventions generally conducted by health or mental health agencies after a suicide death, attempted suicide, or an incident of intentional non-fatal self-harm. The problem remains that, prior to their death by suicide, most men have not experienced any appropriate clinical or deliberate strategic preventive program engagement. Moreover, most suicide deaths are male, of which the majority killed themselves on their first attempt. Many, perhaps most who had contact with services prior to their death, experienced them as problematic; such services may even have compounded their difficulties<sup>2</sup>.

*Since systemic change within mental health institutions is slow, and many men are reluctant to contact standard mental health or suicide prevention agencies, and because they do not have a mental health disorder anyway, a quite different approach to suicide prevention is needed.*

*Frequently, men's suicidal distress is situational or due to life circumstances. We need to become much more adept at addressing intra and interpersonal issues that do not constitute mental disorder, as well as social determinants (which impact profoundly on individuals) such as, unemployment, financial difficulties, and relationship breakdown.*

## Suicide Deaths as Distinct from Non-Fatal Intentional Self-harm

As well as the alarming increase in the number of suicide deaths in Australia, there are many incidents of non-fatal intentional self-harm. Whilst there is some demographic overlap of these two categories – suicide deaths and non-fatal intentional self-harm, there is also a notable difference: gender. Suicide deaths are largely male, while non-fatal self-harm incidents (including incomplete attempts at suicide) are largely female. To work towards effective reduction in both these categories requires the acknowledgment of this gender difference and the development of strategies designed to suit the different needs and characteristics of both genders.

## Role of Mental Health Difficulties in Suicide Deaths

People with *high intensity mental health difficulties*\* have an elevated risk of suicide. Such people may be much in need of and may benefit from timely and competent professional support. However, with many suicide deaths, there is no evidence of previous mental disorder<sup>2</sup>.

Despite the now discredited 'research' suggesting a high prevalence of mental 'disorder' associated with suicide<sup>3</sup>, much of the current approach to suicide prevention is still erroneously premised on a presumption of mental disorder. Whilst conditions like major depression are an important consideration in the design of appropriate preventive measures, this should not be considered license to assume an association with suicide that is unsupported by evidence.

Limiting preventative strategies to those built upon the unfounded presumption of mental disorder will simply not help many, perhaps the majority, of those at risk of suicide. Effective suicide prevention requires that measures of prevention are non-pathologising, gender specific, and part of a broader more encompassing approach that takes account of social determinants.

## Situational Distress as Distinct from 'Mental Disorder'

*Situational distress* encompasses a significantly challenging or troubling mixed experience of mind, thoughts, emotions, bodily sensations, or behaviours, associated with an apparent decompensating event, such as bereavement, a change in health status, relationship breakdown, financial, or occupational difficulties. This distress may significantly overlap with many of the symptoms usually taken to suggest mental 'disorder' (such as those associated with depression and anxiety). Where more severe or *high intensity mental health difficulties* appear not to fit within the definition of *situational distress*, and require a more cautious and

interventive helping approach, every effort should still be made to avoid unnecessarily pathologising the individual.

\*The term, *high intensity mental health difficulty* is proposed as a less pathologising alternative to *mental disorder or mental illness*. By *mental health* we mean an agreeable and functional quality of everyday *experience* involving one's mental activity, emotions, physiology, reflexive and behavioural responses, and capacities.

## Circumstantial Distress as Distinct from 'Mental Disorder'

*Circumstantial distress*, in common with situational distress, encompasses a significantly challenging or troubling mixed experience of mind, thoughts, emotions, bodily sensations, or behaviours, yet is associated with apparent decompensating circumstances arising from a wider context than is usually the case with situational distress (such as the failure of a local employing industry, natural disaster, or community tragedy). As with situational distress, circumstantial distress may significantly overlap with many of the symptoms usually taken to suggest mental 'disorder' (such as those associated with depression and anxiety). Where more severe or high intensity mental health difficulties appear not to fit within the definition of *circumstantial distress*, and require a more cautious and interventive helping approach, every effort should still be made to avoid unnecessarily pathologising the individual.

Circumstantial distress is often associated with wider social determinants which affect not just an individual but a whole cohort of individuals. How an individual is affected may constitute *their situation*, but circumstantial distress arises from wider influences than those evident in an individual's situation.

In the event that situational or circumstantial distress lead to a high intensity mental health difficulty, therapy or treatment should not be confined to an individual problem oriented approach, but should be properly considerate of contextual correlates (outside influences and factors impinging on the experience of the individual). Not to do so, may exacerbate an individual's sense of powerlessness and distress, and compound their difficulties. This is an important consideration particularly given that research suggests that for many men, their contact with the mental health system is unhelpful<sup>2</sup>.

## Evidence and Evidence Base

It is vitally important that evidence underpins suicide prevention activities. Evidence should be sought to inform each activity and target of activity. As there is a range of different target groups that require different considerations for effective prevention work, properly defining a target group, and suitable prevention activity is fundamentally

important. Contrary to much current suicide prevention activity, 'one size does not fit all'.

Much current suicide prevention activity in Australia is too generic and reductionist to be effective. It lacks crucial gender differentiation, frames suicide within a narrow mental disorder paradigm, and tends to ignore compelling recent international research highlighting important social determinants of suicide, such as unemployment.<sup>4,5,6</sup>

## Gender Specificity in Suicide Prevention

Given that by far the majority of suicides are male, that most males die on their first attempt (in contrast to women who more frequently attempt but do not complete suicide), and that men are not being successfully engaged by our health or mental health systems, one would expect that health and social policy settings, and expenditure on suicide prevention should clearly reflect these conspicuous realities; they do not.

That the significance of gender skewed suicide mortality is largely ignored in the field of suicide prevention, is arguably undermining the effectiveness of prevention efforts, potentially putting lives at risk, and is a poor use of public and private sector funding.

*Addressing as a priority the suicide mortality of males by no means sidelines the importance of female suicide mortality.*

*Adopting a gender specific focus on males (given the disproportionately high incidence of male suicide), will serve to highlight the critical importance of gender differences in suicide prevention and will provide a starting point for the development of a comparative male/female psychosocial profile.*

## Suicide Prevention Expertise

Since there is overlap of suicide prevention activities and those of clinical services of the mental health system and its professionals, and, that in some cases, individuals experiencing high intensity mental health difficulties associated with suicidal ideation or self-harm may require clinical intervention, the role of the mental health system remains important.

Nonetheless, because many individuals who experience suicidal ideation, or that self-harm, do not have high intensity mental health difficulties, suicide prevention activities need to occur largely outside of the clinical remit of mental health services. These services will have a role in informing and liaising with suicide prevention activity endeavours, however, such endeavours will need to be shaped and characterised by much broader expertise.

This expertise will include (if it doesn't already):

- Knowledge of male psychology (which reaches beyond popular notions of male behaviour)
- That of population health and social determinants
- Mental health related epidemiology
- Community development and health promotion (especially including knowledge of how to successfully engage with male constituents)
- Social research and research analysis
- Adult education
- Male specific group work
- Knowledge of mental health, the mental health system, and Commonwealth PHN companies and their preferred providers of psychological and mental health services
- Knowledge of the relevant competencies of mental health related allied health professions
- Knowledge of the role of GPs and Psychiatrists in the current provision of mental health services
- Knowledge of industry activities in mental health and suicide prevention, and of how collaborative partnerships can be formed

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