A 'SITUATIONAL APPROACH' TO SUICIDE PREVENTION

WHY WE NEED A PARADIGM SHIFT
FOR EFFECTIVE SUICIDE PREVENTION

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PREFACE

Suicide in Australia is a growing national concern, with its mortality having escalated alarmingly over the course of the last decade.

A very positive recent development in the field of suicide prevention is the collaboration of corporate, NGO, academic, and community interests. Bringing together vitally important intellectual and pragmatic capacities, this collaboration has the potential to ensure that resultant suicide prevention initiatives are outcomes driven, and grounded in the cultural and social realities of human community. Additionally, this collaboration may provide considerable leverage for exerting influence at both macro and micro levels of social policy and suicide prevention program commissioning.

It is time for us to re-think our fundamental approach to the tragedy of suicide, and to pursue a bold and determined new course of action. The situational suicide prevention approach suggested in this document is exactly that, and I commend it to you as a guiding consideration for all future suicide prevention efforts in Australia.

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EXECUTIVE SUMMARY

The content of this document proposes a new approach to how we conceptualise manifestations of human distress – given that significant mental and emotional distress can carry a potential risk of suicide. How we conceptualise human distress also has implications for how we approach the broader issue of mental health, and the work of preventative mental health.

The term that best describes this new approach is *situational 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 discussion will highlight why the current narrative of 'mental illness' that underpins our mental health system, and which has characterised suicide prevention initiatives, is problematic. Principally because the current conflation of mental illness and suicide (putting the main focus on 'illness'), has distracted much suicide prevention activity from its most important focus: the broader risk-associated spectrum of highly challenging, albeit common, life events and consequent experiences.

Suicide is a significant and hugely costly public health issue; a public health issue for which a public health approach is needed (not just a clinical one); one that recognises the potentially greater impact of a whole of population approach to prevention, rather than a merely individual problem oriented and reductionist approach focused on treating people with serious mental health difficulties.[1, 2]

A public health approach emphasises an 'up-stream' perspective: one that focuses on risk and protective factors in order to prevent the kinds of intense or prolonged distress that can escalate into suicidality, rather than a 'downstream' approach, which focuses on dealing with crises and their aftermath.

Better ways of gathering and cross-referencing suicide mortality and risk factor data for suicide prevention efforts, are also proposed, in order for initiatives to be tailored, targeted, and cost effective. Also, presented, is an example of how the *situational suicide prevention* approach can be applied to a particular at-risk demographic. This includes a profile of suggested suicide prevention initiatives.

Adopting the new situational approach to suicide prevention, and applying it to suicide prevention policy, planning, and initiatives, may not only address the urgent need for a more effective response to the burgeoning tragedy of suicide, but may also suggest precedents of reform for the wider mental health system.

1. Rosenburg, Sebastian & Mendoza, John. (2010). Suicide and suicide prevention in Australia: breaking the silence. Lifeline Australia, and, Suicide Prevention Australia.

2. Rose G. Strategy of prevention: lessons from cardiovascular disease. Br Med J (Clin Res Ed). 1981;282:1847-51. [PMID: 6786649]

SITUATIONAL SUICIDE PREVENTION – **DEFINITION**

Situational Suicide Prevention is an approach that 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 starting point of this approach is concern for and responding appropriately, competently, and gender specifically to the distress of individuals. However, this will also involve seeking to address wider issues that are known to be contributing to or strongly implicated in their distress.

This contextual focus helps guard against exclusively individual problem oriented clinical approaches which fail to address broader issues. This approach emphasises the vital importance of community engagement and capacity building, and primary prevention and early intervention initiatives, rather than the current predominance of tertiary suicide prevention services aimed at working with people who have already attempted suicide, have a high intensity mental health difficulty, or those bereaved by suicide (termed post-vention support). Such services are certainly important, but will contribute little to diminishing the national suicide death toll.

* *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 'illness' or 'disorder' (such as those associated with depression and anxiety).[3] Even when distress is sometimes inexplicable, there is no good reason to automatically assume illness or disorder.*

3. Ashfield, J., Smith, A., & Macdonald, J. (2017). Clarification of some key terms and definitions in suicide prevention. National Guidelines – Suicide prevention for males. Australian Institute of Male Health and Studies, and, Western Sydney University, Men's Health Information and Resource Centre.

1.
MEDICINE AND MEDICAL LANGUAGE MISAPPLIED

1.1 The problem with diagnosing experience as illness

The mental illness narrative that characterises our current mental health system, and which has significantly influenced suicide prevention initiatives, is grounded in the classical medical paradigm of detecting, diagnosing, and treating disease. Though helpful in responding to physical ailments, this paradigm falters considerably in its application to distressing human experience, which is not only uniquely individual but can only to some degree be made sense of, as it is mediated through language, and interpreted by inference.
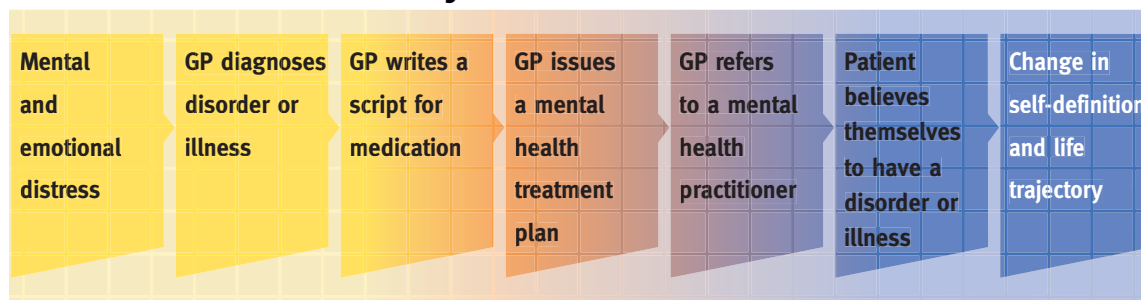
Human experience is the product of a complex interplay of mind, emotions, behaviour, physical sensations, and factors of social and physical environments. To 'shoehorn' this dynamic experience into static psychopathological illness categories, is arguably both a departure from science and from good clinical practice; it is a form of reductionism reflected in the saying: *if all one has is a hammer, all one sees is nails.*

1.2 How illness language can harm

People experiencing significant situational distress, commonly seek out a medical doctor for advice. A likely outcome of such consultations is: diagnosis of a disorder or illness (such as an *affective* or *mood disorder)*, a prescription for medication, and a referral to a mental health practitioner – supported by a Mental Health Treatment Plan (currently required for a subsidised service). However, medicalising and pathologising common (albeit perturbing) human experience, in this way, can result in harm (technically termed: *clinical iatrogenesis*). Internalising the language and meaning of such a consultation may result in a self-fulfilling prophecy: a person is told they are ill, medication, referral, and a Mental Health Treatment Plan reinforce a belief that they are ill, with the responses of others to their diagnosis perhaps adding further credence to this belief. Illness and treatment can thus unhelpfully and unnecessarily contaminate the person's self-definition, and in consequence, even their life trajectory.

Words are not merely descriptive, as one might imagine, they are causative, and can have unexpected consequences. Or, as the philosopher Heidegger put it: *Words, like the chisel of the carver, can create what never existed before, rather than simply describe what already exists.*

A Common Patient Journey:

| Mental and emotional distress | GP diagnoses disorder or illness | GP writes a script for medication | GP issues a mental health treatment plan | GP refers to a mental health practitioner | Patient believes themselves to have a disorder or illness | Change in self-definition and life trajectory |

(Figure 1)

1.3 The rise and rise of depression and antidepressants

The current mental illness narrative which has been allowed to encircle, medicalise, and redefine as pathological, much common human experience, is not only highly problematic for our mental health system and its unwitting consumers, it also has potentially negative implications for suicide prevention and suicide mortality.

For example, in recent decades, mental health literacy messaging has popularised depression in a way that is arguably not only exaggerated and misleading, but also significantly harmful and economically costly. Once an obscure psychiatric diagnosis (originally termed melancholia), depression is now deemed to be an 'epidemic' and a 'serious social issue'. There is of course a mental health difficulty termed 'depression' that can be profoundly debilitating. The problem is, depression is now a diagnostic explanation applied to a broad range of human distress that does not warrant an illness diagnosis or medication in most cases, even though it might be sufficiently intense to warrant referral for counselling or psychological support. Nevertheless, 'depression' has been popularised in such a way as to dominate contemporary thinking about the experience of distress, unhappiness, and dissatisfaction.[4]

Depression is diagnosed with much greater frequency now than throughout most of the twentieth century, and is the main condition for which antidepressant medication is prescribed. The prescribing of antidepressants has hugely escalated with increases in depression diagnosis.[5, 6] In Australia, antidepressant utilisation nearly trebled between 1990 and 1998, and has continued to increase.[7, 8, 9] Vastly more people are now being diagnosed with depression, and prescribed antidepressants, than several decades ago. These developments have profound social, economic, and public health implications.

Prevalence estimates of depression have been found to be exaggerated and flawed. Clinical assessments based on problematic diagnostic criteria, and powerful marketing biases favouring biological explanations of depression (such as those emphasising the role of serotonin) have aggressively popularised the use of drugs as a solution to depression, the efficacy of which is overstated, and the safety and adverse effects understated.[4]

1.4 Mental illness conflated with suicide: a dangerous diversion

The idea that suicide should, in the majority of cases, be considered to be the result of mental illness or disorder is erroneous.[10] 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 with suicide to a degree that is unsupported by evidence. 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.

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4.   Raven, M. (2012). Depression and antidepressants in Australia and beyond: A critical public health analysis. (Doctoral thesis) (pp. 13- 14) University of Wollongong, Faculty of Arts.

5.   Norman, Trevor R. (May 2006). Prospects for the treatment of depression. Australian and New Zealand Journal of Psychiatry, 40(5), 394-401. 13.

6.   Eccles, Martin, Freemantle, Nick, & Mason, James, for the North of England Antidepressant Guideline Development Group. (1 April 1999). North of England evidence-based guideline development project: summary version of guidelines for the choice of antidepressants for depression in primary care. Family Practice, 16(2), 103-111. Retrieved 8 September 2008 from http://fampra. oxfordjournals.org/cgi/content/full/16/2/103 14.

7.   McManus, P., Mant, A., Mitchell, P.B., Montgomery, W.S., Marley, J., & Auland, M.E. (2000). Recent trends in the use of antidepressant drugs in Australia, 1990-1998. Medical Journal of Australia, 173(9), 458-462. 15.

8.   Department of Health and Ageing. (2005). Australian Statistics on Medicines 2003. Canberra: [Australian] Department of Health and Ageing. Retrieved 12 March 2006, from http://www.health.gov.au/ internet/wcms/Publishing.nsf/Content/pbs-pubs-asm2003 16. Department of Health and Ageing. (2008). Australian Statistics on Medicines 2006. Canberra: [Australian]

9.   Department of Health and Ageing. Retrieved 21 August 2008, from www.health.gov.au/ internet/main/publishing.nsf/content/pbs-pubs-asm2006

10.   Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B., & Leenaars, A. (2012). Psychological autopsy studies as diagnostic tools: are they methodologically flawed? Death Studies, 36(7), 605-626, from http:// dx.doi.org/10.1080/07481187.2011.584015

Rethinking the proportionality of risk factors associated with suicide
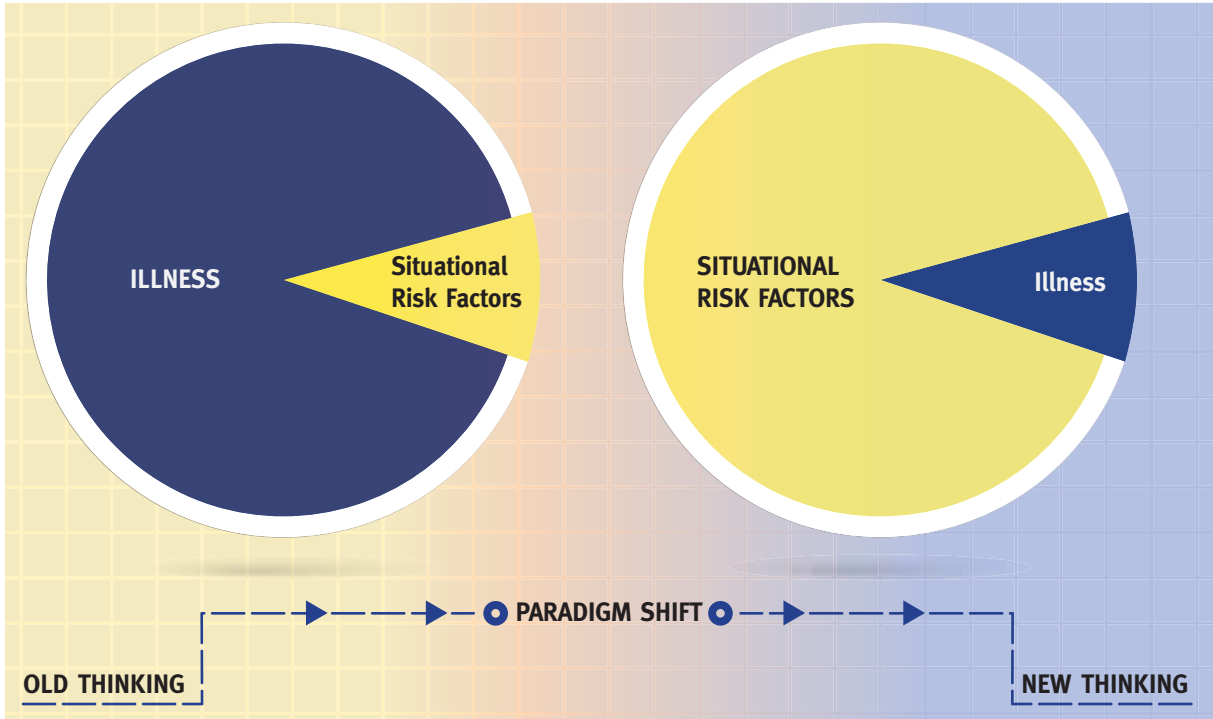
(Figure 2)

Suicide prevention initiatives that are preoccupied with detection of illness or disorder like major depression may well be putting people's lives at risk, by not attending to forms of distress that don't constitute illness or disorder, and yet which can result in suicidal ideation and suicide. A useful corrective term that can help counter the current mental illness/disorder narrative, and provide a sounder basis for suicide prevention is *situational distress* (see Terms and Definitions).
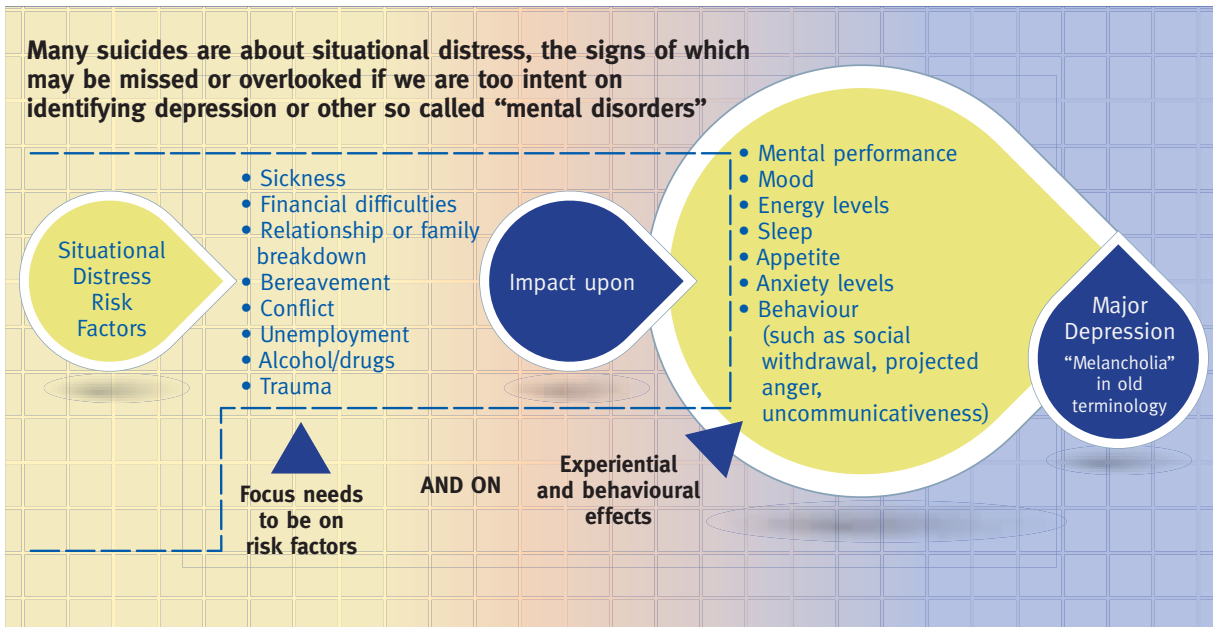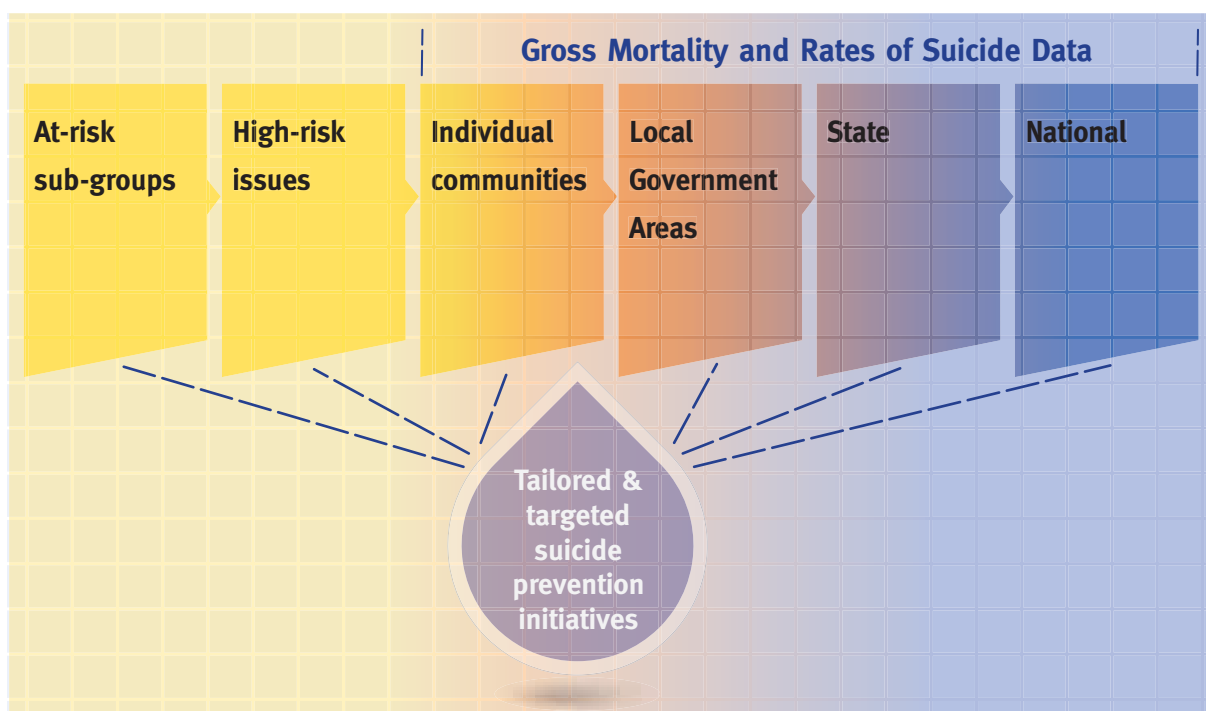

(Figure 3)

2.

LINKING AND CROSS-REFERENCING DATA FOR EFFECTIVE SUICIDE PREVENTION

2.1 Situational suicide prevention requires a different approach to the use of available suicide data

Adopting a *situational suicide prevention* model requires a new approach to data collection, integration, and cross-referencing – one that provides a data set encompassing: National, State, and local government areas (and any available individual community data), as well as ranked (where possible) high-risk issues and at-risk sub-groups. This allows for drawing-down visualised data (including with graphs and cross-referenced representations) to inform and guide any one or a combination of different suicide prevention strategies. This facility will provide for the targeting of:

- **Particular local government areas and their communities** with known high suicide mortality. This provides a basis for identifying and prioritising conspicuous local high risk issues and at-risk sub-groups, cross referenced with ranked high-risk and at-risk sub-group data.

- **One or more high-risk issues and at-risk sub-groups** across the whole population (or a sub-population). However, such a focus still needs to be referenced to data on local government areas (and their communities). An approach to suicide prevention that simply targets known high risk issues or at-risk sub-groups in a *general way*, can be wasteful of resources, and can make it more difficult to evaluate the effectiveness of programs. Focussing prevention efforts generally on sub-groups like unemployed or aboriginal youth, or issues like unemployment or aboriginal youth suicide, may not be appropriate in communities with little or no suicide mortality history. For example, a community with high unemployment, or a large indigenous male youth population may have no history of suicide because of historically effective local support and socio-cultural characteristics that mitigate suicide risk.

- **Events** (such as adverse climatic events, and industry closure) that are known to escalate suicide risk for certain cohorts, in regions, local government areas, or communities that are affected.

Whilst we need to innovate and do a better job of bringing together and cross-referencing existing credible sources of data germane to suicide prevention, just as important is admitting what we don't know in order to set a useful new agenda for researchers in this field, and to avoid wasting precious resources on initiatives that are not clearly indicated or justified by available data.

Gross Mortality and Rates of Suicide Data

| At-risk sub-groups | High-risk issues | Individual communities | Local Government Areas | State | National |

Tailored & targeted suicide prevention initiatives

(Figure 4)

2.2 Better data, better suicide prevention practice

Effective suicide prevention depends on us knowing all that we can about the factors that put people at risk. The most useful suicide risk data should ideally be drawn from robust longer term studies in cohorts of individuals that do not have an identified psychiatric disorder. Not to do so will impair our ability to formulate prevention responses that can have an impact on suicide mortality. Much research in the past has been over-reliant on categories of mental illness or has been corrupted by speculative psychological autopsy data, and has been deficient due to its failure to take into consideration socio-cultural factors and common dimensional indicators of distress.[11]

There needs to be a progressive endeavour of data gathering and knowledge enhancement, as a basis for ongoing suicide prevention activities, if they are to have integrity.

Industry data may contribute to us identifying high risk issues and at-risk sub-groups, as well as highlighting historical spikes (for pro-active predictive purposes) in suicide associated with events like industry closure, mass redundancies, drought, and bushfire disaster.

Wherever risk factor data are sourced they should be referenced to NDIS and coronial data. Another important source of local data that isn't generally available in the ABS or NDIS gross national data, may in some instances be available from a local coroner.

Ranking high risk issues and at-risk sub-groups can only be done on the basis of the best evidence available. In some instances, there is little available data. One form of evidence (albeit not definitive) that is of relevance and should not be overlooked, is that which can be obtained from a consensus of local opinion about local suicide incidents and observation of contextual associated risk factors. Though this level of evidence may not be immediately available, it can be gleaned from community engagement in the process of suicide prevention initiatives design.

Data for ranking risk issues and at-risk sub-groups, and relating to suicide by postcode will require considerable mining of a variety of data sources.

11   Knox, K. (2014). Approaching Suicide as a Public Health Issue. Annals Of Internal Medicine, 161(2), 151. http://dx.doi.org/10.7326/m14-0914

3.1 Foundational definition

Situational Suicide Prevention is an approach that 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.

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Situational Suicide Prevention: A Dual Focus Approach

(Figure 5)

Shifting the Prevention Focus and Emphasis in Line with a Situational Suicide Prevention Approach
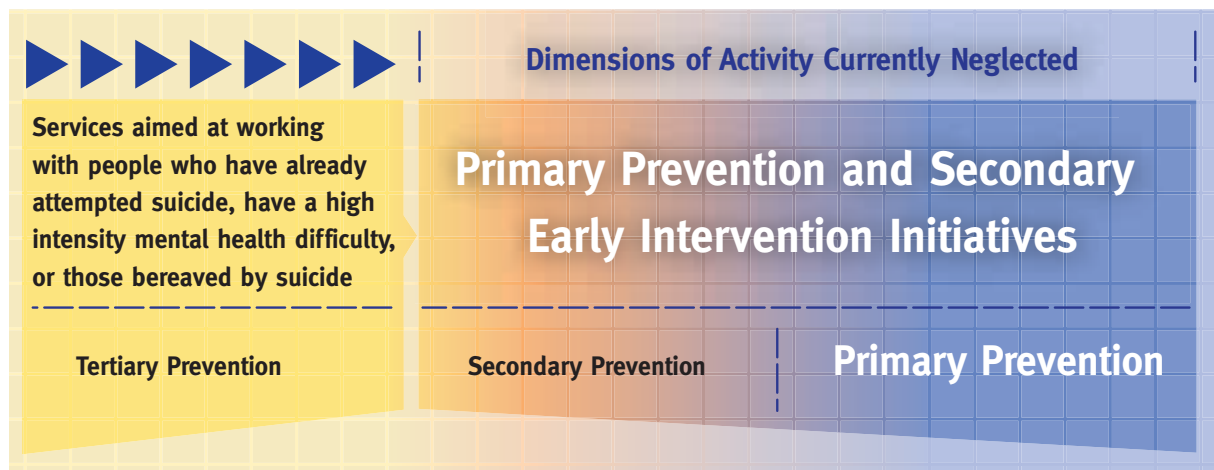
(Figure 6)

3.2 The correlation of unemployment and suicide

The utility of the situational suicide prevention perspective and approach can be easily understood by examining a prime example of a decompensating event that can give rise to situational distress, that of unemployment.

There is now a strong established link between suicide and unemployment. A global longitudinal analysis covering 63 countries found that the relative risk of suicide associated with unemployment was elevated by about 20–30% during the study period.[12] These findings are also in accord with Australian research.[13] In other research it was shown that greater spending on active labour market programs and levels of social capital appeared to mitigate suicide risk.[14] Countries with active labour market programmes and sustained welfare spending during recessions have less pronounced increases in suicide rates than those that diminish spending on welfare.[15]

Unemployment can be (and often is) a significant crisis event. This may be an isolated event for a given individual, who may be the only person that is made redundant. However, unemployment is not infrequently associated with wider contextual issues of industry closure, resource depletion, or a decision of corporate rationalisation. The effects may be immediately situational for the individual, as well as more widely social and economic, affecting a cohort of unemployed individuals.

12   Nordt, C., Warnke, I., Seifritz, E., & Kawohl, W. (2015. Modelling suicide and unemployment: a longtitudinal analysis covering 63 countries, 2000-11. The Lancet Psychiatry, 2 (3), 239-245. http://dx.doi.org/10.1016/s2215-0366(14)00118-7

13   Milner, A., Morrell, S., & LaMontagne, A. (2014). Economically inactive, unemployed and employed suicides in Australia by age and sex over a 10-year period: what was the impact of the 2007 economic recession?. International Journal Of Epidemiology, 43(5), 1500-1507. http://dx.doi.org/10.1093/ije/dyu148

14   Reeves, A., McKee, M., Gunnell, D., Chang, S., Basu, S., Barr, B., & Stuckler, D. (2014). Economic shocks, resilience, and male suicides in the Great Recession: cross-national analysis of 20 EU countries. The European Journal Of Public Health, 25(3), 404-409. http://dx.doi.org/10.1093/eurpub/cku168

15   Haw, C., Hawton, K., Gunnell, D., & Platt, S. (2014). Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors. International Journal Of Social Psychiatry, 61(1), 73-81. http://dx.doi.org/10.1177/0020764014536545

3.3 Contextual issues of suicide prevention initiatives focused on the unemployed

At the risk of stating the obvious, the most likely thing to ameliorate the mental and emotional distress of a person who has lost their livelihood – and very likely, an important element of their social connectedness, will be for them to have access to new employment. As has been stated by many politicians of various ideological persuasions: *the best form of welfare is to ensure people have meaningful and remunerative work and occupation.*

Given that unemployment is strongly associated with suicide, labour market reform and local intervention and innovation measures, need to be a crucial consideration and activity of State and local government, and corporate enterprise. Non-demeaning transitional income support responses that can shore up individuals' domestic economies until they can again procure appropriate employment, are also essential. These preventative responses are especially important at times of economic down-turn, industry collapse, and in the event of adverse climatic events affecting rural communities.

3.4 Rural males as an at-risk sub-group of unemployed

Responding appropriately, competently, and gender specifically to the psycho-social or situational distress of individuals is also of vital importance. In a suicide study by McPhedran and De Leo focusing on rural Queenslanders, it was found that over 40% of rural men who died by suicide, had previous contact with a mental health professional.[16] In the same study, a number of men who expressed suicidal intent (and had no contact with a mental health provider) apparently exhibited no signs of mental 'illness'. The study suggested that access to a formal mental health service alone, is likely not the key issue in rural suicide prevention. They concluded that the nature of support received may be a more crucial contributor to suicide prevention; that is, support that is well matched to men's specific characteristics and needs, that is appropriately accessible to them, is sustained, and appropriate to the underlying factors contributing to an individual's suicidality.[16]

[16]   McPhedran, S. & De Leo, D. (2013). Miseries Suffered, Unvoiced, Unknown? Communication of Suicidal Intent by Men in "Rural" Queensland, Australia. Suicide And Life-Threatening Behavior, 43(6), 589-597.http://dx.doi.org/10.1111/sltb.12041

3.5 Profile of suicide prevention initiatives for rural males as an at-risk sub-group

Following is a repertoire of tailored and targeted prevention initiatives that could be utilised in suicide prevention for rural males.

Unemployed Rural Males ◀ SUGGESTED SUICIDE PREVENTION INITIATIVES

The vital importance of community engagement in prevention efforts.

Initiating a radical shift in how we frame and respond to human distress and mental health difficulties, will open up a whole new potential for meaningful community engagement, and much more effective efforts of preventative mental health and suicide prevention.

Of vital important to shifting the emphasis of suicide prevention towards a more primary prevention approach, must be the utilisation of the good will and immense resourcefulness of communities and ordinary citizens. Despite mental health literacy campaigns purporting to conscript the public to help with the 'problem' (and the use of slogans like, 'mental health is everybody's business'), ordinary citizens are actively discouraged from all but superficial engagement, because the current emphasis on mental 'illness' and 'disorder' understandably persuades them to leave it to the professionals. Illness and disorder suggest that a professional medical response and medication are needed.

Community engagement: bringing community members together to discuss and to get involved in local suicide prevention initiatives

Community capacity building psycho-education: tailored and targeted preventative mental health literature dealing with issues that commonly precipitate distress for men.

Gender specific counselling and mental health support for men: ensuring ease of access, privacy, and reliable continuity, focusing on the underlying factors contributing to suicidality. This is particularly important for men and male suicidality

Male peer support training: training key men in rural communities to detect and provide first line support to men experiencing situational distress

Education for women: providing women with insights and strategies to support their partners, and other male family members in times of distress

Realistic income support: that can shore up individuals' domestic economies until they can again procure appropriate employment

Employment transition program: preparation for transitioning to alternative employment (in the event that such employment exists)

Advocating for labour market reform and local intervention and innovation measures: even in the absence of wider labour market reform, local employment creation measures are often feasible with government and corporate support

GP training: training GPs to understand a situational approach to suicide prevention, and to more effectively identify men at risk

Gender competency training: for allied health and human service professionals, as well as key people in organisations prepared to assist with preventative mental health and suicide prevention. This training educates people in better understanding and engaging with male clients/patients/constituents

Social Inclusion: connecting men with supportive male social groups and activities (such as men's sheds)

Clinical Iatrogenesis

Iatrogenesis (derived from the Greek term iatros, meaning physician) describes harm done or caused to patients or clients by doctors or other health professionals.

Mental Health

A definition of mental health may encompass: an agreeable and functional quality of everyday experience involving one's mental activity, emotions, physiology, reflexive and behavioural responses, and capacities.

Mental Health Difficulties – Low Intensity, and High Intensity

As an alternative to the use of *illness or disorder* references in the fields of *mental health* and suicide prevention, a disruption of mental health may simply be called – a *mental health difficulty*, encompassing the broad spectrum of emotional and mental functioning psychiatrists refer to as 'mental disorder' and 'mental illness'. The severity of this difficulty can be registered as either a *low intensity mental health difficulty* or a *high intensity mental health difficulty*. This simple substitution may help preserve people's dignity and enhance their wellbeing, whilst at the same time not trivialising complex difficulties the experience of which may on occasions be so painful, distressing, and seemingly inescapable, they can lead to potentially tragic consequences.

To clarify further: anyone can experience a *mental health difficulty;* and everyone likely will at some stage of their lives. A mental health difficulty in most cases does not emanate from a physical illness or disorder. It is a common human *challenge* to be tackled creatively and constructively, including sometimes with the use of psychotherapy, and yes, medication, should that genuinely have something to contribute.

A *Low Intensity Mental Health Difficulty* interferes with a person's usual or preferred mental, emotional, and social capacity, and perhaps as well, their experience of feeling capable and competent.

Low intensity mental health difficulties are usually associated with major life changes and challenges, like: unemployment, sickness, loss and grief, money troubles, relationship difficulties, conflict, and stress. Low intensity mental health difficulties are common and are usually resolved through a person's own coping ability, adjustments to lifestyle, and the support of friends and family. Of course, professional help may also be important, particularly if a person becomes 'stuck' and can't seem to recover or move forward.

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, will usually require more than a person's own coping ability, lifestyle adjustments, and support of friends and family. At least initially, it will may require mapping and analysing 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).

In some cases, a General Medical Practitioner or Psychiatrist will also recommend prescription medication, which should be carefully considered for its potential to harm, evidence supporting its effectiveness (efficacy), and its appropriateness for the difficulty. If prescribed, it should be regularly reviewed both for any side-effects, and for whether it is genuinely helpful or still necessary.

TERMS AND DEFINITIONS

Primary, Secondary, and Tertiary Prevention – relating to suicide prevention*

Primary prevention aims to prevent mental health difficulties and situational distress of a kind that are associated with suicide risk, from occurring. This approach may include community capacity building psycho-education, peer support training, lifestyle change training, but as well, addressing wider contextual socio-cultural, economic, political, and policy issues that impact on people's mental health and wellbeing.

Secondary prevention aims to reduce the impact of situational distress and mental health difficulties that have already occurred. This approach may include the provision of peer support, counselling and mental health support, identification of difficulties through GP screening, as well as self-identification through community or other forms of education. Such early interventions try and 'nip problems in the bud' and either halt or as soon as possible resolve them.

Tertiary prevention aims to soften the impact of an ongoing high intensity mental health difficulty, the ongoing risk subsequent to attempted suicide, and the ongoing impact of bereavement through suicide for those affected by a person who has died by suicide. Many current suicide prevention programs and initiatives are in the tertiary prevention category, which is a reflection of how suicide prevention has historically had its origins in and has been an element of activities within the mental health system, and has been conflated with mental illness.

*   *Adapted for this document from the RACGP Guidelines for the implementation of prevention in the general practice setting.[17]*

Situational Distress

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 'illness' or 'disorder' (such as those associated with depression and anxiety). Even when distress is sometimes inexplicable, there is no good reason to automatically assume illness or disorder.

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 bereavement through suicide) be at increased risk of suicide.

Situational 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.

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[17]   Putting prevention into practice Guidelines for the implementation of prevention in the general practice setting (2nd edition). (2017) (2nd ed.). Melbourne. http://www.racgp.org.au/download/documents/Guidelines/Greenbook/racgpgreenbook2nd.pdf

NOTES

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