

# THE SITUATIONAL APPROACH TO SUICIDE PREVENTION AND MENTAL HEALTH LITERACY

## CHALLENGING THE DEFICITS OF THE CURRENT ORTHODOXY

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The Situational Approach to suicide prevention and mental health literacy\* challenges fundamental deficits in the narratives and practices of these fields – deficits that are systemic, pervasive, and deeply entrenched. Facing these deficits squarely and honestly is essential if we are to show respect for the best interests of consumers and service recipients, and the considerable public and donor funds that sustain current suicide prevention and mental health literacy activities.

Organisations promoting approaches and programs implicated by these deficits also need to be challenged to revise their approaches and to accommodate the wider expertise and informative opinion that now exist in these fields.

### **Deficits the Situational Approach highlights and critiques include:**

- The unnecessary and potentially harmful medicalisation and pathological categorisation of human distress – and disregard for the situational and dimensional nature of human experience
- The conflation of mental illness and suicide
- The conflation of intentional non-fatal self-harm with suicidality
- The disempowerment of communities in their capacity to take a leadership role in local and regional suicide prevention and preventative mental health
- Disregard for important implications of gender specificity and differentiation in program and service design and subsequent service and program delivery
- Significant neglect of primary and secondary prevention efforts in favour of crisis intervention, which leaves those most vulnerable to mental health difficulties, and suicide to simply ‘fall through the slats’
- Over-reliance on mental illness perspectives from the mental health sector in suicide prevention, and disregard for expertise relevant to a broader perspective on suicide and effective suicide prevention
- Lack of appropriate support for GPs in primary care settings.
- Community ‘engagement’, whether focused on mental health literacy or suicide prevention, that is dominated by mental illness information sessions, and awareness raising. Informing and raising the awareness of the public about mental illness, can in fact discourage engagement, because illness suggests the need for a medical or professional intervention

- Lack of innovation and relevance of some research in the fields of mental health and suicide
- The increasing phenomenon of non-health and non-mental health organisations (influenced by mental health literacy messaging) directing clients to GPs rather than other more appropriate support services
- Suicide prevention and mental health training programs that continue to present limited and orthodox perspectives without enough critical analysis of their inherent problems, contradictions, or outcomes for consumers

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## IN DETAIL:

- **The unnecessary and potentially harmful medicalisation and pathological categorisation of human distress – and disregard for the situational and dimensional nature of human experience.**

In recent decades, there has been a substantial increase in the diagnosis of ‘mental disorders’ – particularly ‘depression’ and anxiety ‘disorders’, and a corresponding growth in the number of prescriptions for anti-depressant and anxiolytic medications. This is largely a consequence of the limited scope in busy primary care settings for GPs to deal adequately with difficult human experience and distress of patients, due to too few appropriate referral options, and the requirement for *Mental Health Treatment Plans*.

All too often, people in distress who turn to their GP for help, must accept a diagnosis of mental disorder if they are to be referred on to subsidised support, and regardless of the contextual factors associated with and perhaps even causing their distress.

Frequently, stressors or situational factors such as relationship difficulties, bereavement, issues of transition and change, work related problems, conflict, or financial difficulties may be much more effective targets of intervention for changing a person’s emotional and psychological experience, and which avoid unnecessarily medicalising common albeit difficult human encounters with everyday life.

- **The conflation of mental illness and suicide**

The unhelpful conflation of mental illness with suicide is partly built on discredited research around ‘psychological autopsies’ – the practice of collecting data retrospectively in the form of opinions, especially of friends and family about the mental state of the deceased person, after the death.

Another factor reinforcing the conflation of mental illness and suicide, has been the growth of human service organisations that began with a focus on depression and have expanded their scope into suicide prevention, bringing the same focus and approach with them – one that is largely limited to a clinical understanding of depression. This has contributed to the broad-scale misunderstanding and overstatement of the place of mental health difficulties (especially depression) as a factor in suicide deaths.

- **The conflation of intentional non-fatal self-harm with suicidal behaviour**

Self-harm (with non-fatal intent) and suicidal behaviour are often presented without clear distinction. Repeated acts of self-harm do equate statistically with a higher risk of suicide, and in the case of adolescents with major depression, may be a stronger predictor of a future suicide attempt than a prior suicide attempt (perhaps highlighting the danger of unremitting distress). Nonetheless, these are separate phenomena, and need to be understood individually in terms of consequences, potential mortality, and gender specificity (their prevalence exhibits a clear gender differentiation). Not to do so, can confuse and compromise prevention efforts.

- **The disempowerment of communities in their capacity to take a leadership role in local and regional suicide prevention and preventative mental health**

Funding sources to support local suicide prevention initiatives are generally administered by government health or mental health bureaucracies and large high-profile non-government organisations. Policies governing how this money is spent are generally very much weighted to the medicalised mental illness approach and the crisis end of both the suicide prevention and preventative mental health spectrum. Communities are consequently often restricted in their freedom to pursue activities of prevention that are properly tailored to local needs.

- **Disregard for important implications of gender specificity and differentiation in program and service design and subsequent service and program delivery**

Gender marks a significant difference in relation to intentional non-fatal self-harm and suicide deaths. Most deaths are males, most incidents of non-fatal self-harm are female, and yet there is very little consideration of gender differences in policy or planning for suicide prevention or preventative mental health, other than the perpetuation of simplistic male stereotypes and the idea that: 'men should improve their help-seeking behaviour'.

Prevention and intervention strategies for suicide and mental health must be properly informed by knowledge of gender differences if they are to succeed. Sadly, this is likely one of the chief reasons why, particularly in the field of suicide prevention, that suicide mortality has, in the last two decades alarmingly worsened rather than diminished, despite huge expenditure of public funds in this field.

- **Significant neglect of primary and secondary prevention efforts in favour of crisis intervention, which leaves those most vulnerable to mental health difficulties, and suicide to simply 'fall through the slats'**

Much current activity in suicide prevention is directed towards the 'downstream' end of the continuum, the point at which crisis intervention is a final option, and largely occurs within the compass of health and mental health agencies.

Characteristically, 'upstream' activity (which includes early support and early intervention) often consists of merely awareness raising, and with an emphasis on mental 'disorder' – most popularly, depression. Crisis intervention activities, rather than more upstream prevention activities, also perpetuate and reinforce a wide-spread perception that difficult human experience necessarily requires intervention by a health professional, thus discouraging community engagement and involvement in ways that could otherwise be enormously useful.

- **Over-reliance on mental illness perspectives from the mental health sector in suicide prevention, and disregard for expertise relevant to a broader perspective on suicide and effective suicide prevention**

There exists expertise beyond the 'mental health' field that is vital to providing leadership of suicide prevention and preventative mental health efforts nationally. This should include:

- Research experience and skills beyond 'mental health'
- Communications and mass media knowledge and skills appropriate for mental health promotion and suicide prevention, and that can help inform mainstream media in accurate and helpful messaging and themes
- Partnership brokerage – especially focussed on corporate and non-government organisations, for sponsorship and financial support of prevention efforts
- Marketing knowledge and skills attuned to and informed by an intimate knowledge of appropriate health, mental health, and suicide prevention concepts and messaging that reflect them

- **Lack of appropriate support for GPs in primary care settings.**

GPs are expressing much concern about current approaches to suicide prevention, mental health, and mental health literacy. In particular: the quality and content of GP suicide prevention and mental health training, lack of options for managing the situational distress of clients, and the questionable narratives and messaging of suicide prevention and mental health permeating the community, which influence directly the pressures doctors experience in general practice settings.

- **Community 'engagement', whether focused on mental health literacy or suicide prevention, that is dominated by mental illness information sessions and awareness raising can be counterproductive**

Informing and raising the awareness of the public about mental illness without consideration of the context of broader social issues, may in fact discourage much needed community engagement, because the emphasis on illness suggests the need for medical or professional intervention, and that anything less could be hazardous or could exacerbate a vulnerable person's condition.

- **Lack of innovation and relevance of some research in the fields of mental health and suicide**

Professor Kerry Knox<sup>1</sup> has alluded to some of the shortcomings of research in these areas:

*'To date, research has been insufficient to explain why men, especially during middle age, are particularly vulnerable to taking their own lives. The shortcomings of prior studies include lack of longitudinal follow-up, failure to measure such factors as social integration and dimensional indicators of stress, overreliance on categorical measures of psychopathology, and a focus on proxy outcomes instead of death by suicide.'*

Too little research answers the important questions which readily permit the crucial academic knowledge transfer needed by prevention planners and practitioners to do their work effectively. And too much research tends to merely indulge nuanced questions relating to orthodox thinking and approaches, rather than challenging the status quo and forging creative new paths to better ways of thinking upon which prevention efforts can be based.

Dissent and innovation of a kind that is arguably needed, have also been hindered by mere cursory regard for the work of some local and international researchers whose findings run contrary to orthodox narratives of preventative mental health and suicide prevention.

- **The increasing phenomenon of non-health and non-mental health organisations (influenced by mental health literacy messaging) directing clients to GPs rather than other more appropriate support services**

It is increasingly common policy and practice that agencies from a range of sectors including those that concern themselves with employment and unemployment, vocational guidance and training, and work place safety and welfare, are directing clients to GPs for diagnosis of depression, often regardless of the factors involved in distress and sometimes as a condition of continuing support by these organisations.

- **Suicide prevention and mental health training programs that continue to present limited and orthodox perspectives without enough critical analysis of their inherent problems, contradictions, or outcomes for consumers**

Over the last 10 – 15 years there has been an enormous increase in non-government organisations in the suicide prevention and mental health sectors. This has also meant significant growth in the number of suicide prevention and mental health training programs being offered. A number of aspects of this growth in the training industry are in need of scrutiny:

- There is no formal oversight process to ensure the quality of these programs
- There appears to be little critical analysis of the inherent problems and contradictions of the current approach, or outcomes for consumers.
- Even the well-established suicide prevention and mental health training programs continue to present a partial perspective of many of the challenges involved, and consequently serve to reinforce common ambiguities and misunderstandings that are unhelpful to informative or practical education. They have been described by many participants as, providing merely a 'band-aid' solution without practicable and actionable strategies that can involve them in a meaningful way.

## **A 'Situational Approach' To Suicide Prevention**

Ashfield, J., Macdonald, J. and Smith, A. "A 'Situational Approach' To Suicide Prevention". (2017): n. pag. Web. 31 May 2017.  
<https://doi.org/10.25155/2017/150417>

## **A 'Situational Approach' To Mental Health Literacy In Australia**

Ashfield, J., Macdonald, J., Francis, A. and Smith, A. "A 'Situational Approach' To Mental Health Literacy In Australia". (2017): n. pag. Web. 30 May 2017.  
<https://doi.org/10.25155/2017/150517>

## **Support for the 'Situational Approach'**

[http://malesuicidepreventionaustralia.com.au/wp-content/uploads/2017/08/Support\\_for\\_Situational\\_Approach\\_Aug2017\\_web.pdf](http://malesuicidepreventionaustralia.com.au/wp-content/uploads/2017/08/Support_for_Situational_Approach_Aug2017_web.pdf)

<sup>1</sup> 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>