Roses in the Ocean
stemming the tide of suicide

MENTAL HEALTH & SUICIDE PREVENTION

The Differences

Despite a growing awareness of the broad range of factors that contribute to suicide risk, suicidal distress is predominantly framed as a mental health crisis requiring an acute, clinical response. People bereaved through suicide will also often have their experiences of grief and loss pathologized and seen as needing intervention by mental health professionals.

There are a number of significant limitations for suicide prevention policy and practice in continuing to understand and respond to suicide exclusively within the domain of the mental health system and sector:

- It fails to acknowledge the wide range of factors that lead people to consider ending their lives which are not reducible to a diagnosable mental health condition. Poor living circumstances, relationship breakdown, loss of a loved one, substance use, bullying, a lack of social support, and a history of trauma have all been shown as contributing to an increased risk of suicide.

- The mental health system is predominantly a biomedical one that has been designed to provide clinical care for people with persistent and enduring mental illness. It is therefore ill-equipped to effectively respond to people experiencing situational distress that arises from complex and challenging life events.

- It is now recognised that childhood trauma plays a significant role in the development of complex and enduring mental illness. As such, the biomedical approach often fails to address the underlying trauma that give rise to suicidality and can often compound this trauma.

- Regardless of whether people receive appropriate care, studies have demonstrated that the conventional risk assessment tools employed by mental health clinicians have little predictive utility in determining who will go on to die by suicide or attempt to do so.

- A large proportion of people who die by suicide have had no contact with the mental health system in the year prior to their deaths and will therefore not have their needs met by this system.

- Approximately half the people who die by suicide do not have a diagnosed mental illness.

- People who do not associate their thoughts of suicide and suicidal crisis with mental illness often will not reach out for help from mental health services due to the stigmatisation associated with these services and the lack of understanding of their emotional distress beyond the biomedical model.

- Situating suicide prevention within the domain of mental health has not been effective in reducing suicide rates.

While there has been a growing recognition of the complex and diverse range of contributors to suicide risk, as well as the limitations of the mental health system in providing appropriate care for people impacted by suicide, suicide prevention continues to be conceptualised by many as a sub-set of the mental health system and sector in Australia. If we are to be effective in reducing the suicide rate and substantially improving support for everyone, there must be a meaningful separation between the policy and practice domains of mental health and suicide prevention.

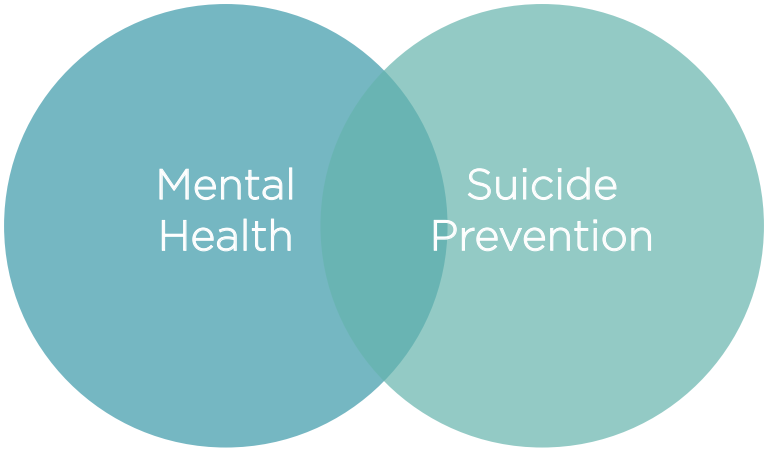
Roses in the Ocean
stemming the tide of suicide

MENTAL HEALTH & SUICIDE PREVENTION

The Differences

FIGURE 1: Suicide prevention contained within the remit of the mental health system.

FIGURE 2: Suicide prevention recognised as a unique field with some overlap with the mental health system.



1300 411 461
enquiries@rosesintheocean.com.au
www.rosesintheocean.com.au