

# Systemic review of male suicide in Queensland

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# Background

- ▶ Addressing disproportionately high rates of male suicide has been prioritised in whole of government commitments such as *Every life: The Queensland Suicide Prevention Plan 2019-2029*.
- ▶ Common view that men are resistant to expressing distress/seeking help.
- ▶ ‘Whole of life’ perspective needed - multiple potential intervention points.
- ▶ Gaps in what is known about pathways to suicide, complex interplay between risk and protective factors.
- ▶ Systems and services not well considered.

# Purpose of this work

- ▶ *Every life* commits to undertaking a systemic review of male suicides to inform a comprehensive strategy for men's suicide prevention.
- ▶ Moving beyond *who* dies by suicide - better understanding about *why* suicide among males occurs and *how* suicide may be more effectively prevented.
- ▶ New insights about possible points of intervention and opportunities for systemic reform.

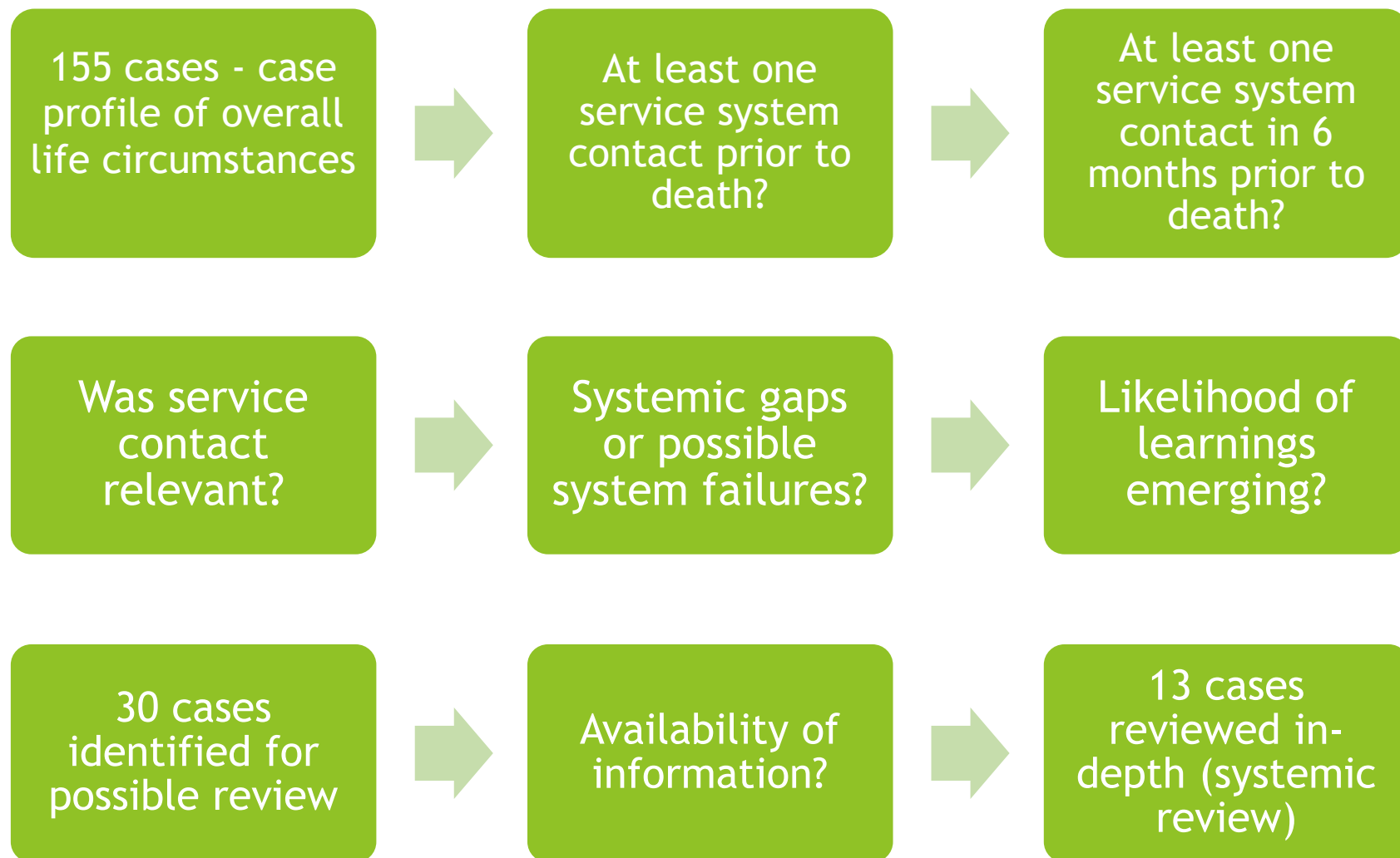
# What is 'systemic review'?

- ▶ Systemic death review processes facilitate deeper learnings about certain types of deaths and opportunities for ongoing enhancement to systems and services.
- ▶ Already used in QLD - domestic and family violence related homicides and suicides, deaths of children known to the child protection system.
- ▶ Takes a number of different cases and uses highly detailed, in-depth examination to look for commonalities across those.
- ▶ Emphasis on system 'touch points' and how systems responded.
- ▶ Not about 'blame' but about learning and improving what we do.

# Sample and information sources used

- ▶ All males aged 25 years and over, who died by suspected or apparent suicide in QLD over an approximately three-month period in 2021 (n=155).
- ▶ Information routinely gathered by the coroner to inform coronial investigation.
- ▶ Hospital records/health and medical reports, AODS records, suicide notes, social worker/case worker notes, court records, police occurrence records (i.e., contacts with QPS), text/social media messages, etc...
- ▶ Goes far beyond the information within Form 1 and Supplementary Form 1 reports (QPS)
  - ▶ Demographics, mental health history, past suicidality, possible 'triggers' for suicide, open-ended text fields, statements from next of kin...

# Process for selecting systemic review cases



# Making the most of information

- ▶ Getting to the systemic review component produced a lot of information about ALL cases.
- ▶ 1. Detailed descriptive information: all cases (n=155).
- ▶ 2. 'Profiles' of male suicide in QLD: all cases (n=155).
- ▶ 3. Systemic review: subsample of cases (n=13).
- ▶ Today: a couple of 'snapshots' from each of those different sets of findings...a taste of what is possible!

# CAVEAT!

- ▶ Information for each case is unlikely to be 100% complete.
- ▶ Amount of information varied greatly between cases.
- ▶ Findings driven by available information - strong bias towards mental health information.
- ▶ Relatively small number of cases - findings may change with greater numbers.



The background features abstract, overlapping geometric shapes in various shades of green, ranging from light lime to dark forest green. These shapes are primarily located on the left and right sides of the frame, creating a modern, layered effect. The central area is a plain white space where the text is located.

What can descriptive  
information tell us?

# Do men really resist help-seeking?

- ▶ 45 cases (29 per cent) - mental health-related service contact in the six months leading up to their death.
  - ▶ General Practitioner the main contact point.
- ▶ 74 cases (47.7 per cent) - access to at least one form of psychiatric medication.
- ▶ 71 cases (45.8 per cent) - known to have communicated suicidal thoughts, plans, or intent at some point in their lives.
- ▶ **112 cases (72.3 per cent) - at least one form of help-seeking behaviour.**
- ▶ Men seem to be getting the message to seek help...but the help they get may not be the help they want or need.

# What else is going on?

<b>Life event/circumstance/history</b>	<b>Number of cases</b>	<b>Per cent of cases</b>
Criminal history (offending – any time)	69	44.5
Relationship breakdown	47	30.3
Physical condition/illness (incl. chronic pain)	36	23.2
Housing instability/insecurity	19	12.3
Developmental trauma/ACEs	14	9.0
Financial problems	14	9.0
Prospect of criminal sanction	14	9.0
Carer relationship (giving or receiving)	12	7.7
Domestic violence	10	6.5
Other	9	5.8
Bereavement by suicide (past or recent)	8	5.2
Recent unemployment	7	4.5
Social isolation/loneliness/lack of social support	7	4.5
Bereavement/loss of a loved one	5	3.2
Child custody issues	3	1.9
Sexual abuse (victimisation)	2	1.3

Typologies of male  
suicide - does 'one size  
fit all'?

# 'Profiling' male suicide

- ▶ Bayesian Profile Regression - 'subgroups' among small number of cases with highly correlated covariates (e.g., mental illness and substance use).\*
- ▶ Many different factors modelled - e.g., demographics, socioeconomics, mental health history, developmental history, life events.
- ▶ 'Cluster defining' factors:
  - ▶ Employment status; contact with a health professional for mental health reasons; any history of mental health issues; recent psychiatric hospitalisation; recent attendance at a Mental Health Unit; access to psychiatric medication; past suicidal behaviour (communication of intent, past attempt/s, past hospitalisation/s for self-harm/suicidal behaviours); substance use; criminal history; housing instability/insecurity.
- ▶ To a lesser extent, chronic pain and social isolation/loneliness defined clusters.
- ▶ Clusters are useful tools for enhancing understanding NOT definitive categories into which individuals are 'pigeonholed.'

\*Special thanks to Dr Clair Alston-Knox for statistical support.

# Four distinct 'types'

## Cluster 1 (n=63)

- Outwardly 'normal' looking lives.
- Relatively low levels of known mental health issues.
- Lower than average substance use.
- Often evidence of life circumstances that may have contributed to suicide.

## Cluster 2 (n=53)

- Considerable mental health history.
- Contact with health/mental health services, including for suicidality.
- Low unemployment.
- Average substance use and housing instability/insecurity.
- Slightly higher relationship breakdown.

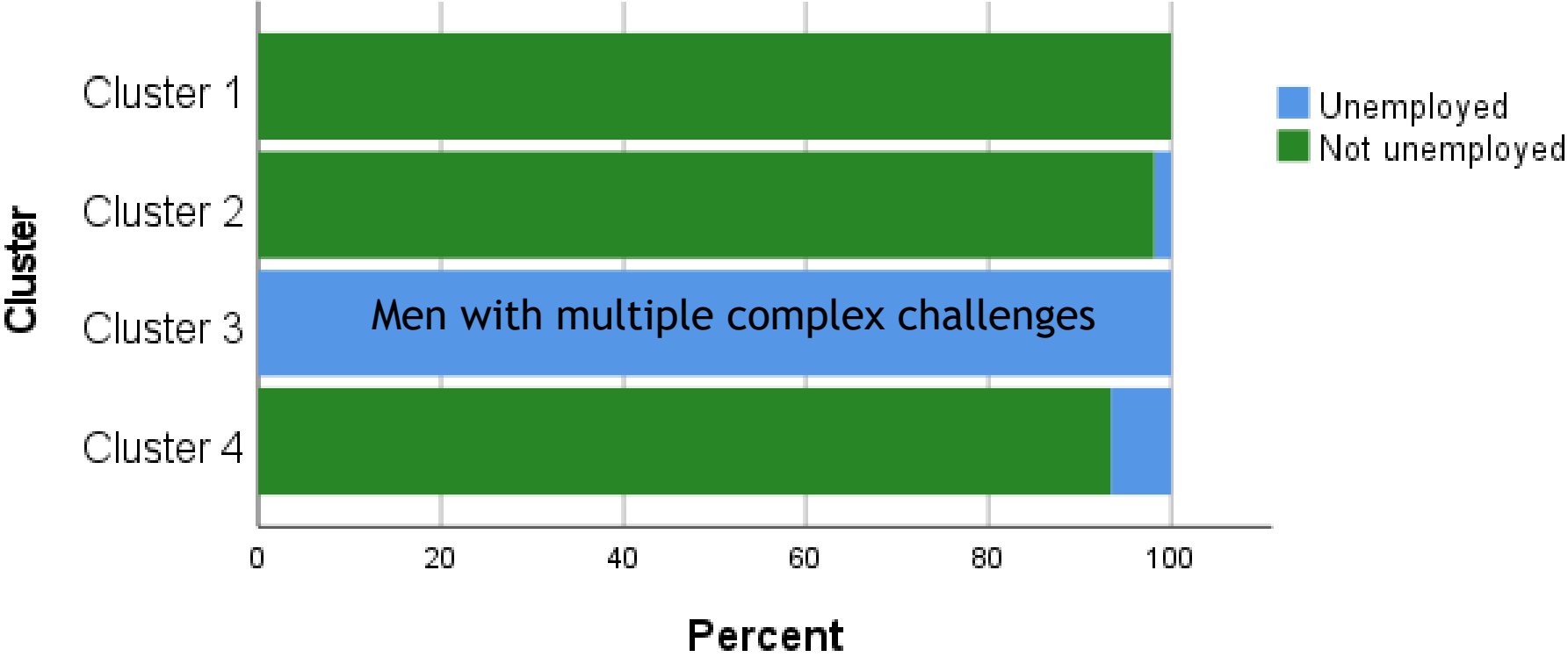
## Cluster 3 (n=24)

- Multiple life stressors
- Very high unemployment.
- Higher than average mental health history/suicidality, criminal history, housing instability/insecurity, substance use, chronic pain.
- Highest % past communication of suicidal intent!

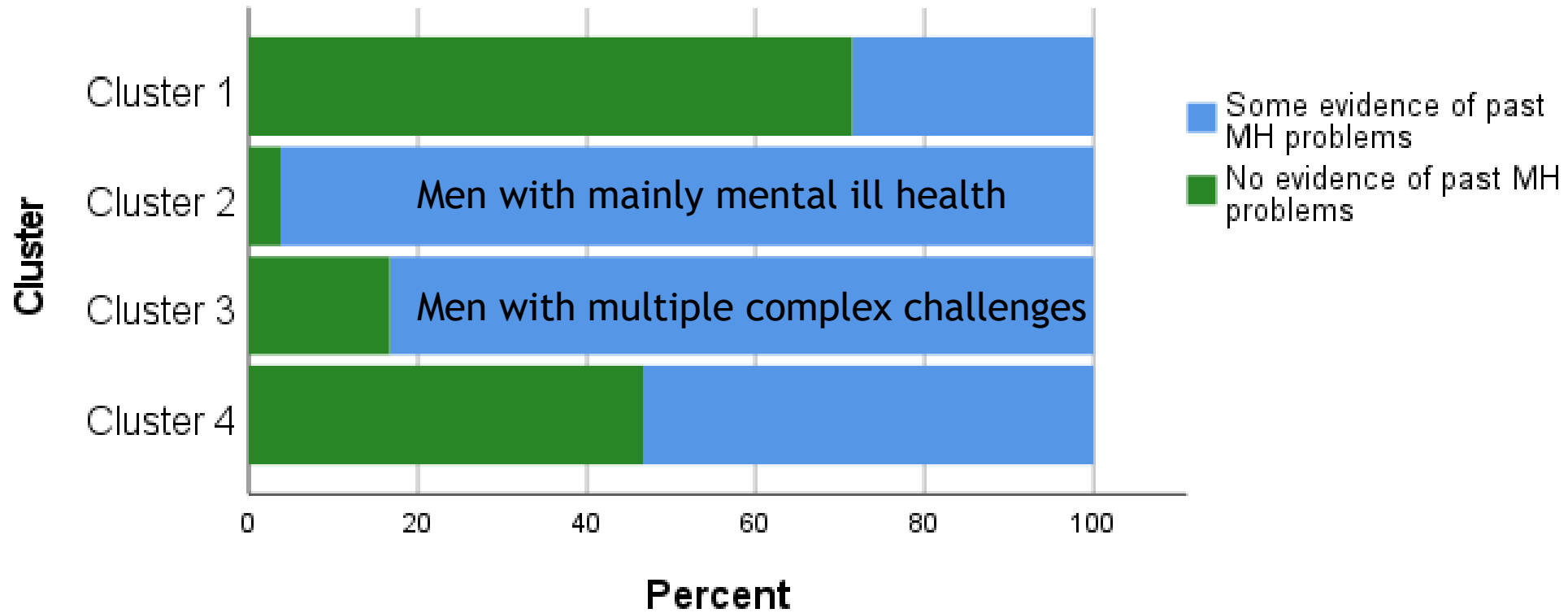
## Cluster 4 (n=15)

- Lots of missing information about mental health and life history.
- Higher housing instability/insecurity and (to a lesser extent) social isolation/loneliness.

# Unemployment by typology



# Mental health problems by typology





How effectively did  
systems respond?

Systemic review findings

# ‘High visibility’ cases over-represented

- ▶ Most cases reviewed in-depth (n=13) were from two specific clusters.
- ▶ Dual diagnoses, multimorbidity, personality disorders, chronic pain and/or acquired brain injury/intellectual impairment (also possible organic brain change relating to age)....
- ▶ Multiple different services to navigate - gaps in communication and care.
- ▶ Appears to be a lack of integrated services that can effectively respond to complicated cases.

# Opportunities for learning and change

- ▶ Pattern-based responses not fully apparent - cumulative risk.
- ▶ Limited psychological interventions in hospital settings.
- ▶ GP knowledge highly variable.
- ▶ Protective factors not always well understood.
- ▶ Perceived (in)appropriateness of services (e.g., objection to being viewed as “a junkie” - AODS in prescription opiate dependence/chronic pain context).
- ▶ Family engagement a ‘double edged sword’.
- ▶ Choosing to decline to engage.

# Key points

- ▶ Overall, little evidence of systems failures.
- ▶ Hospital contact - referrals consistently offered (note: cannot say this for GP contact...).
- ▶ Mismatches between needs identified during psychosocial assessments and supports offered/available.
- ▶ Referrals almost exclusively for outpatient/community-based mental health services and/or AODS.
- ▶ Most cases had needs outside those systems - e.g., relationship and social support, housing support, and/or employment or financial services.

# New ways forward?

- ▶ Most responses were crisis-focused and emphasised mental health services.
- ▶ Highly ‘medicalised’ paradigm of responding to suicide - at odds with actual life circumstances/needs of men.
- ▶ Little evidence of early intervention from a ‘whole of systems’ perspective or recognition of the role of multiple systems in suicide prevention efforts.
- ▶ Many cases had life circumstances where other (non-mental health) services may have helped reduce likelihood of suicide AND development of suicidality in the first instance.
- ▶ Significant ‘missed opportunities’ at the systems level.

# Implications

# Improving surveillance

- ▶ Potential contributors to suicide not well considered within existing QLD suicide surveillance models.
  - ▶ E.g., criminal history, housing instability/insecurity, carer relationships, chronic pain, dual diagnoses/multimorbidity.
- ▶ This work: heavily skewed towards health system responses, even when known contacts with other services.
- ▶ Identification of systemic issues remains incomplete.
- ▶ Ongoing systemic review function for suicides in Queensland may assist to address gaps in understanding and identify emerging issues as well as monitor system reforms.

# Enhancing policy and practice

- ▶ Men seek help...but the help they get may not be the help they want or need.
- ▶ 'One size fits all' response unlikely to be successful in reducing or preventing suicide.
- ▶ Medicalised/mental health responses alone are not enough (and sometimes not the 'right' response!) - need a whole of systems approach.
- ▶ Pervasive systemic belief that mental health systems carry the greatest responsibility for addressing suicide.
- ▶ Obscures true picture of men's needs, particularly for those whose circumstances may be best addressed by services other than mental health.



# Conclusions

- ▶ Contact with mental health systems - unless just one potential aspect of a whole of life approach - unlikely to be effective in preventing or reducing suicide.
- ▶ Possibility of early intervention points across multiple systems.
- ▶ Greater investment outside of crisis-oriented systems, to reduce need for (and demand on) those services.
- ▶ Cross-sectoral approaches and ensuring that response planning and delivery prioritises integration.
- ▶ System-wide, holistic measures.
- ▶ Targeted efforts to address the needs of specific sub-groups of men, reinforced by a more general prevention framework that emphasises meaningful, well supported, and socially included lives.

# Acknowledgements

- ▶ The individuals who died by suicide, and their loved ones.
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