Systemic Review (Male Suicides)

Queensland Mental Health Commission

In Queensland, throughout Australia, and internationally, males continue to experience disproportionately high rates of suicide.

Introduction

As part of a range of strategies that aim to better understand and respond effectively to reduce suicide among particular cohorts and groups, addressing these disproportionate rates has been recognised and prioritised in whole of government commitments such as *Every life: The Queensland Suicide Prevention Plan 2019-2029 ('Every life')*.

Suicides are considered one of the most preventable types of deaths because there are often key indicators or warning signs prior to the death. It is this context that suicide prevention activities often focus on, because overt expressions of suicidality and/or contact with services provide a clear point at which intervention can occur.

A challenge with preventing male suicide is the view that men may be resistant to expressing psychological distress and/or to having contact with services for mental health issues/suicidality. This points to the importance of understanding suicide in a much broader context: one that takes into account other possible points of intervention and opportunities for systemic reform.

There remain important gaps in what is known about pathways to suicide, and about the complex interplay between different risk and protective factors. This report lays the foundations for a new way of understanding suicide. Its focus is on moving our understanding beyond the already well-established information about who dies by suicide, in order to better understand why suicide among males occurs and how suicide may be more effectively prevented.

It does this by using quantitative and qualitative information and combining three different approaches: case-based, type-based, and systems-based. Together, these approaches generate new insights and novel information that can inform service system responses and broader suicide prevention initiatives.

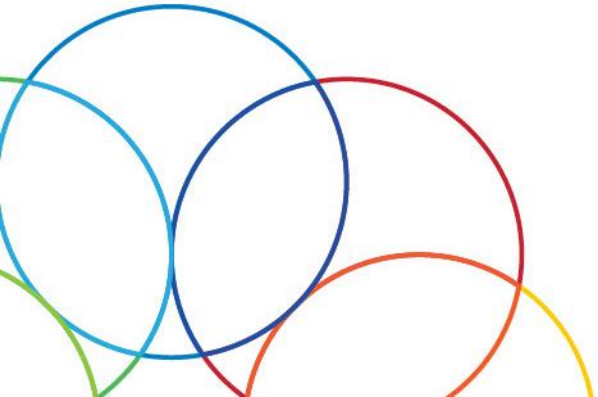
Focal group and case numbers

The focal group consisted of all males aged 25 years and over, who died by suicide in Queensland over an approximately three-month period in 2021.

The decision to focus on suicides among males aged 25 years and over was made for pragmatic reasons. The number of suicides occurring in under 25-year-olds is relatively small compared to other age groups, and merits separate consideration. The three-month timeframe was selected to provide a useable number of cases, while ensuring that the agency resources required to support the project remained within feasible parameters.

Case records were provided by the Coroners Court of Queensland. The deaths examined in this report comprise both 'open' and 'closed' cases – that is, some cases were still being investigated by Coroners, while others had been finalised.

A total of 155 cases was examined.



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Information sources

Although there are many potential information sources that may provide insights into male suicide in Queensland, this report used a pragmatic approach. It focused on information that is routinely gathered by the coroner to inform the coronial investigation, with a particular focus on information that is routinely and pro-actively provided to the coroner due to consistency in availability of this information across cases.

For most cases, the majority of information came from Form 1 reports provided by the Queensland Police Service (QPS), along with Supplementary Form 1 reports (including, in some instances, full statements from next of kin and other witnesses). Form 1 reports include a mix of quantitative and qualitative information.

For some cases, additional information was available. This typically came from hospital records and/or other medical reports, however in some instances also included materials such as suicide notes, case worker/support worker notes, court records, police occurrence records (that is, contacts with police), and screenshots of text and social media messages.

Where such information was available, it was carefully reviewed and used to build a more comprehensive profile of each case.

What do suicide cases look like?

Almost half of all cases (71 cases or 45.8 per cent) were known to have communicated suicidal thoughts, plans, or intent at some point in their lives. Almost half of all cases had evidence of some form of contact with health professionals for mental health issues (such as having a prescription for psychiatric medication, or known contact with a general practitioner or other health professional for mental health-related reasons).

Just under one third of cases (45 cases or 29 per cent) had apparent mental health-related service contact. The most commonly reported professional contacted for mental health concerns was a general practitioner (34 cases, or 76 per cent of all cases with known mental health contact), followed by psychiatrists (10 cases, or 22 per cent of all cases with known mental health contact) and psychologists (5 cases, or 11 per cent).

Almost half of all cases – 74 cases, or 47.7 per cent - had access at the time of their death to at least one form of psychiatric medication. The proportion of cases who had access to psychiatric medication was substantially higher than the proportion who had known ‘recent’ health system contact. This suggests that actual levels of contact with services such as general practitioners may be considerably higher than identified from the available information.

While the use of psychiatric medication to treat conditions such as depression is an important aspect of suicide prevention efforts, suicide prevention requires a range of different strategies in combination (for example, effective psychosocial supports alongside pharmacological methods). The discrepancy between psychiatric medication access and known service contact may indicate that psychiatric medication was for many cases being used in isolation rather than as part of a broader strategy involving professionals outside of general practice.

When help-seeking – indicated through the behaviours of seeing a professional for mental health-related issues, and/or having access to psychiatric medication, and/or communication of suicidality - was considered, almost three out of four cases (72.3 per cent) had at least one form of help-seeking behaviour. These findings challenge the perception that men do not seek help. The results also suggest that help-seeking may not result in effective responses to the needs and circumstances that underlie an individual developing mental health issues and/or suicidality.

Alcohol problems were found for 32 cases (20.6 per cent), and 28 cases (18.1 per cent) had other drugs use. There was overlap between alcohol problems and other drugs use; seven cases (4.5 per cent) had both. The combined total of cases with some form of substance use was 53 (or around one third of all cases).

Fourteen cases, or nine per cent, had some form of reported adverse childhood experience/childhood trauma; this is likely to be a conservative estimate. Those cases were also more likely to have alcohol and/or other drugs problems, to have recently attended a mental health unit, and to be on psychiatric medication/s.

Many studies only consider events that occurred around the time of the death. In contrast, this report took a life-course approach and considered factors that may have occurred throughout a

person's life (such as criminal history). This approach recognises that stressors can be sequentially related and/or cumulative over a period of time.

Almost all cases - around nine out of 10 - had life histories characterised by negative or stressful life circumstances and events. The most commonly reported types of circumstances and events were, in order of frequency:

- history of criminal offending (44.5 per cent)
    - there were differences by age group, with over half of males aged under 55 years (57 per cent) having a known criminal history
- relationship breakdown (20.3 per cent)
- physical condition/illness (12.3 per cent)
    - this included chronic pain, which was often not explicitly recognised as a potential trigger for suicide
- housing instability/insecurity (12.3 per cent)
- financial problems (9.0 per cent)
- prospect of criminal sanction (9.0 per cent)
- being in a carer relationship (7.7 per cent)
    - this comprised giving or receiving care; most cases were recipients of care

Many of these factors, such as relationship breakdown and financial problems, have been well documented in previous work. However, factors such as having a criminal history, housing instability/insecurity, chronic pain, and being a recipient of care have been less well recognised as relating to male suicide in Queensland.

What do suicide typologies look like?

Individuals who die by suicide are not homogeneous. Several researchers and theorists have proposed that distinct subgroups exist, and that different subgroups may differ markedly in their pathways to suicide.

For this project, a wide range of demographic, psychosocial, health and life history factors were entered into a Bayesian Profile Regression (BPR) model. Results suggest four distinct male suicide typologies:

- Cluster 1 – characterised by relatively low levels of known mental health issues but often with evidence of life circumstances and events that may have contributed to their death
- Cluster 2 – characterised by a clear history of mental health issues and contact with mental health/primary health care services, including for suicidality
- Cluster 3 – characterised by the presence of multiple life stressors, including unemployment, criminal history, housing instability/insecurity, and problematic substance use
- Cluster 4 – characterised by a great deal of missing information about their mental health and life histories, which may be due to their higher levels of housing instability/insecurity and (to a lesser extent) social isolation/loneliness.

Although each cluster had distinct characteristics, many characteristics (such as geographic location) did not help to define the clusters, and many characteristics were the same across different clusters. Clusters should be viewed as useful tools for enhancing understanding, rather than definitive categories into which individuals are 'pigeonholed.' The relatively small number of cases means that the typologies should be treated as preliminary, not conclusive.

What does systems contact look like?

In-depth systemic review was undertaken for selected cases (n=13) who had known service contact in the lead-up to their deaths. This identified systemic issues associated with suicide, as well as potential missed opportunities for prevention. Emphasis was on 'touch points' where service system contact occurred.

Available information about service system contact was heavily skewed towards health system (and particularly mental health) responses, even when it was apparent that individuals had other types of service contact. This means that knowledge about service system contact is unlikely to capture the full spectrum of system 'touch points' an individual had prior to their death.

Findings suggest that improvements can be made to health service responses, particularly in areas such as integrated case management and communication between different services.

A number of broader systemic issues were identified, to assist response improvements.

It appears that a 'medicalised' model of suicide may be creating challenges for effective service delivery. Some men perceived that their suicidality could be addressed through medication, rather than by addressing the life circumstances surrounding their mental health issues.

Most cases who had hospital contact for suicidal thoughts/behaviours appear to have been offered referrals and advice about support services. However, referrals were almost exclusively for outpatient/community-based mental health services and/or alcohol and other drugs services.

Many cases had needs that extended far beyond those systems – such as relationship support, housing support, and/or employment or financial services. There were notable gaps in referrals to community-based services for such needs, and mismatches between the needs identified during psychosocial assessments and the supports offered/available. This may have impacted on individuals' engagement with services and their eventual outcomes. This may reflect a lack of accessible services and/or an absence of health service provider knowledge about those services.

Many cases had dual diagnoses/multimorbidity and/or additional complicating factors. Personality disorders, chronic pain and/or acquired brain injury/intellectual impairment were particularly challenging circumstances surrounding service responses.

Typically, the presence of dual diagnoses/multimorbidity and complicating circumstances led to multiple different services interacting with an individual, at times giving rise to gaps in communication and care, and to the consumer having to manage multiple different contacts and appointments. Existing service provision models appear to face difficulties in effectively responding to complicated cases.

Most responses were crisis-focused and emphasised mental health services. A number of cases had life circumstances where other (non-mental health) services may have been relevant not only to reducing the likelihood of eventual suicide but also to reducing or preventing the development of suicidality in the first instance. However, there was little evidence of early intervention from a whole of systems perspective or recognition of the role of multiple systems in suicide prevention efforts.

Implications

Improving practice and policy

Based on the profiles and circumstances of males in this report, and consistent with the evidence of suicide as a multifactorial and dynamic phenomenon, a 'one size fits all' response is unlikely to be successful in reducing or preventing suicide.

Contrary to the perception that males resist seeking help, many cases had some form of contact with services (usually, general practitioners) for mental health issues. Many had access to prescription psychiatric medication. While it is not in any way suggested that appropriate medical attention is unimportant, the findings strongly imply that medicalised responses alone fall short of meeting the needs of males who are at risk of taking their own lives.

Overall, findings appear to indicate a pervasive systemic belief that health – and, particularly, mental health – systems carry the greatest responsibility for addressing suicide. This view, however, may be based on incomplete knowledge about pathways to suicide and on perceptions about suicidality that are driven by males who are in crisis and highly visible to mental health systems. This in turn may obscure the true picture of men's needs, particularly for those whose circumstances may be best addressed by services other than mental health.

There are various complex trajectories that may contribute to and/or exacerbate suicide risk. Contact with mental health systems – unless seen as just one potential aspect of a far more comprehensive, whole of life approach to suicide prevention – is unlikely to be effective in preventing males from taking their own lives. In some situations, contact with mental health services may contribute to adverse outcomes.

In addition to the importance of referral pathways to appropriate services outside mental health and whole of person approaches that ensure social, economic and health supports are provided in an integrated way, it is clear from cases examined in this report that the potential (or need) for intervention and prevention frequently begins long before the immediate lead-up to an individual's death. A number of cases (some of whom were highly 'visible' to mental health systems but many of whom were not) had complex circumstances underlying their suicide. Their needs - particularly, material needs such as housing, financial, and employment - appear to have been largely unrecognised and/or unmet through existing response strategies.

Many cases, including those who did not have known recent contact with services of any kind, had life histories and circumstances characterised by factors that are associated with suicide, including:

- adverse childhood experiences (e.g., experiencing abuse and/or being exposed to domestic and family violence)
- substance use
- intermittent and/or insecure employment, or unemployment
- past criminal justice system contact
- unstable/inadequate housing
- financial stress
- other chronic and interconnected life challenges.

Understanding and disrupting those pathways requires a comprehensive approach. A whole of life approach that recognises the role of early intervention, is likely to deliver broader benefits given that many of the factors associated with the development of suicidal behaviour represent negative outcomes in and of themselves – even if they do not result in suicide.

Despite the role of longer term (and interconnected) factors in pathways to suicide, responses typically occurred after a crisis point had been reached. There were relatively few indicators, in any cases examined, of early intervention and/or holistic responses across agencies/services. It may be suggested, in some cases, that the lack of such responses was a key contributor to why the individual developed suicidal behaviours. This appears to indicate a need for greater investment outside of crisis-oriented systems, to reduce the need for (and demand on) those services. This confirms the importance of cross-sectoral approaches and ensuring that response planning and delivery prioritises integration.

Improving surveillance and identifying opportunities for prevention

There are opportunities for improvement in the collection and use of information.

It is recommended that consideration be given to improving the clarity, definitions, and coding processes used for Form 1 reports.

The findings in this report confirm the possibility of early intervention points across multiple systems, and highlight potential contributors to suicide - such as criminal history, housing instability/insecurity, carer relationships, chronic pain, and dual diagnoses/multimorbidity - that do not appear to have been considered within existing surveillance models.

It is unclear why these factors and the associated implications for policy and practice have not been previously identified in Queensland, given that many of the novel insights in this report emerged from careful examination of Form 1 and Supplementary Form 1 information. These are the same information sources that are already used for suicide surveillance in Queensland (such as the Queensland Suicide Register).

This report clearly shows that the available information can be used more comprehensively and effectively than is currently the case, to maximise what is known about suicide in Queensland and better support suicide prevention initiatives. It is recommended that future suicide prevention efforts include redesign of the current model of surveillance, to enable information collection to support both surveillance and prevention functions. While current processes go part of the way towards that, it is apparent that existing information collection and analysis processes – unless integrated into a more comprehensive framework – are only suitable for a high-level surveillance function, rather than informing a more detailed and nuanced prevention function.

The methods used in this report strongly suggest that a surveillance function that considers (chiefly) Form 1 and Supplementary Form 1 information and a prevention function that centres around tailored systemic review using more detailed information can – and, arguably, should – be incorporated into one integrated practice model, to maximise the efficient use of both quantitative and qualitative information.

There is a need for better knowledge about service responses for males who had documented engagement with services for mental health issues, but whose other life circumstances (which seem to have driven their mental health concerns) appear to have gone largely unrecognised and/or unaddressed. It would be desirable to establish an ongoing systemic review function for suicides in Queensland, to address these gaps in understanding and identify emerging issues as well as monitor system reforms.

Limitations and future directions

This report contains unavoidable limitations, chief of which are the relatively small number of cases and lack of complete information. The information was very heavily skewed towards health system responses even where there were known contacts with services outside the health system. There remain gaps that require further exploration, including contacts with non-health services.

It is recommended that future suicide prevention initiatives take into account the importance of system-wide and holistic measures that consider the wide range of factors associated with suicide. Targeted efforts to address the needs of specific sub-groups of men at elevated risk of suicide should be reinforced by a more general prevention framework that emphasises meaningful, well supported, and socially included lives.