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.

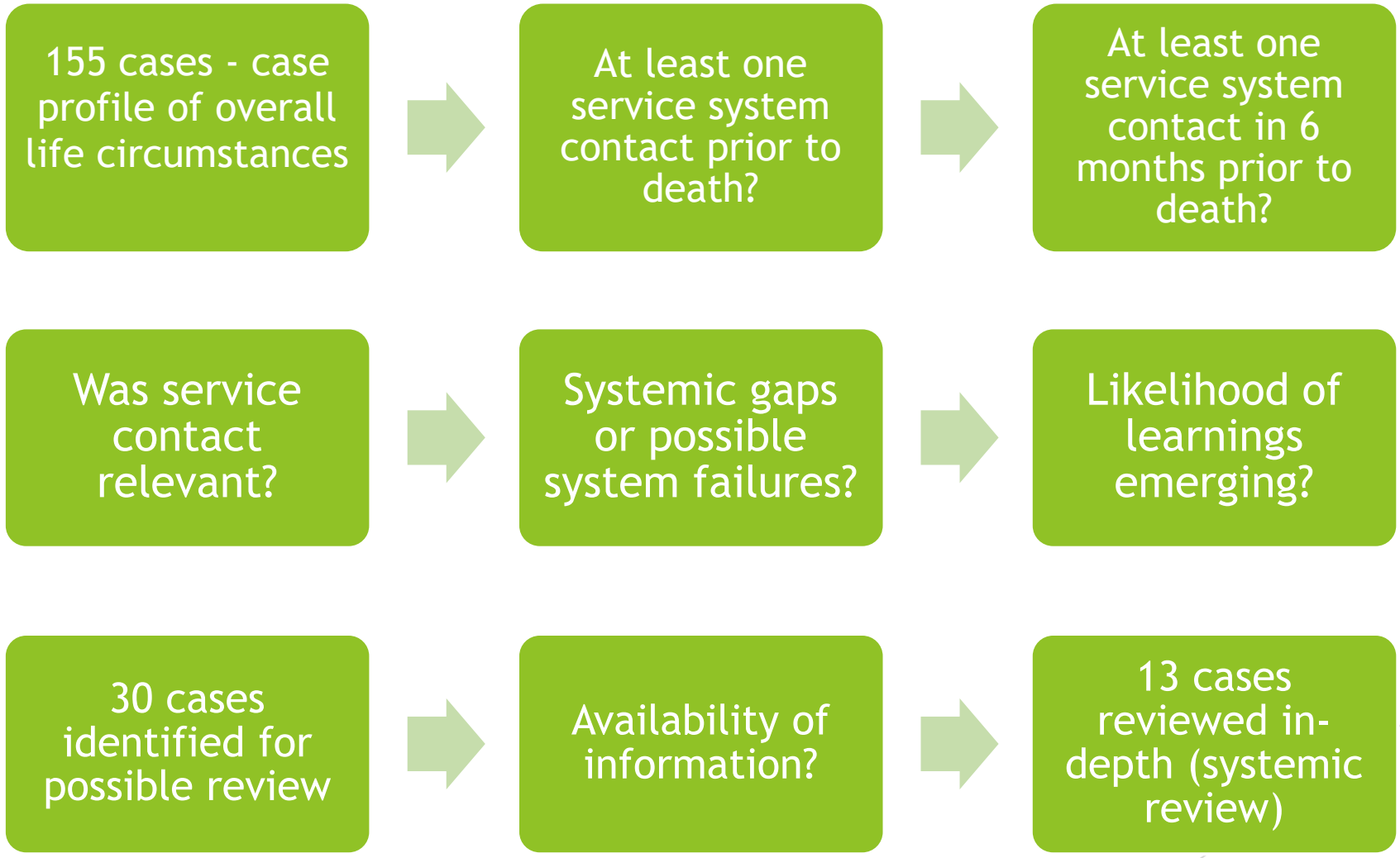
What is ‘systemic review’?

- 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.

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?

Life event/circumstance/history	Number of cases	Per cent of cases
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)

- 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.

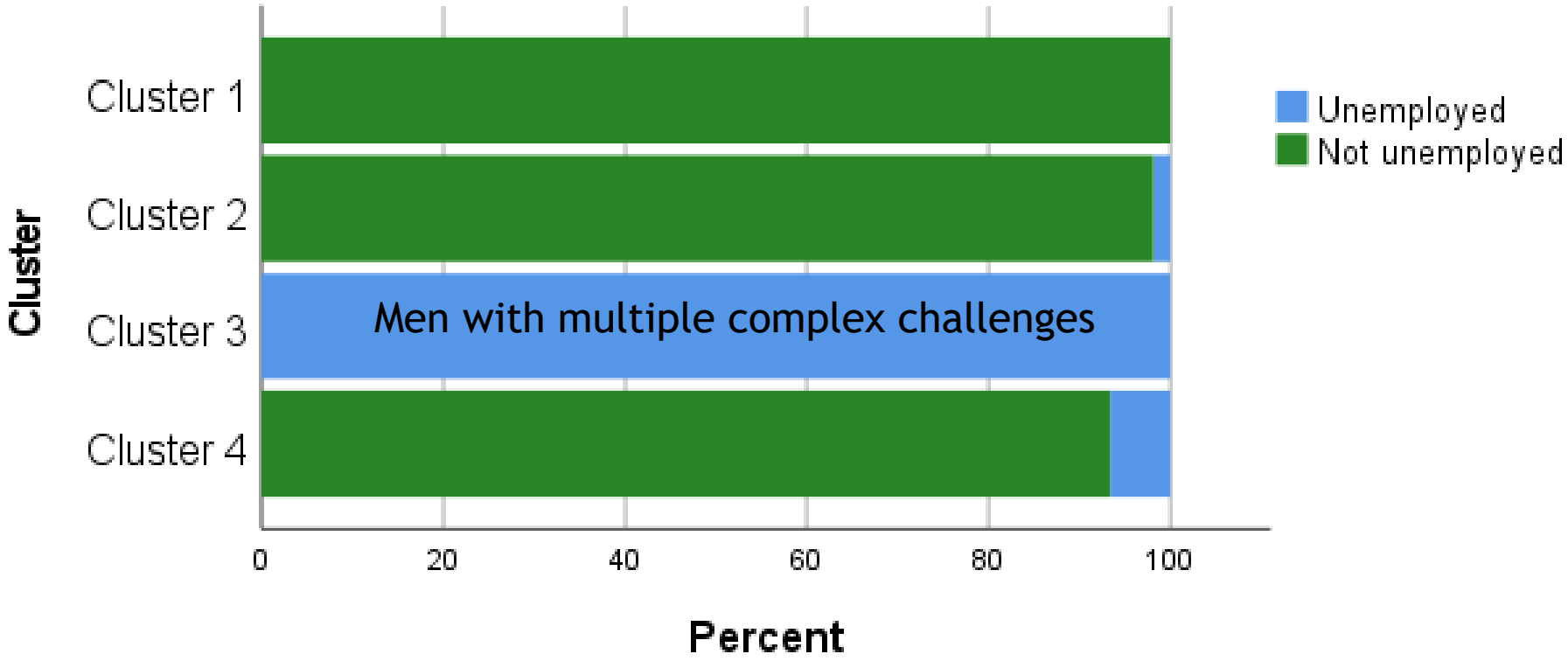
Cluster 3 (n=24)

- 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!

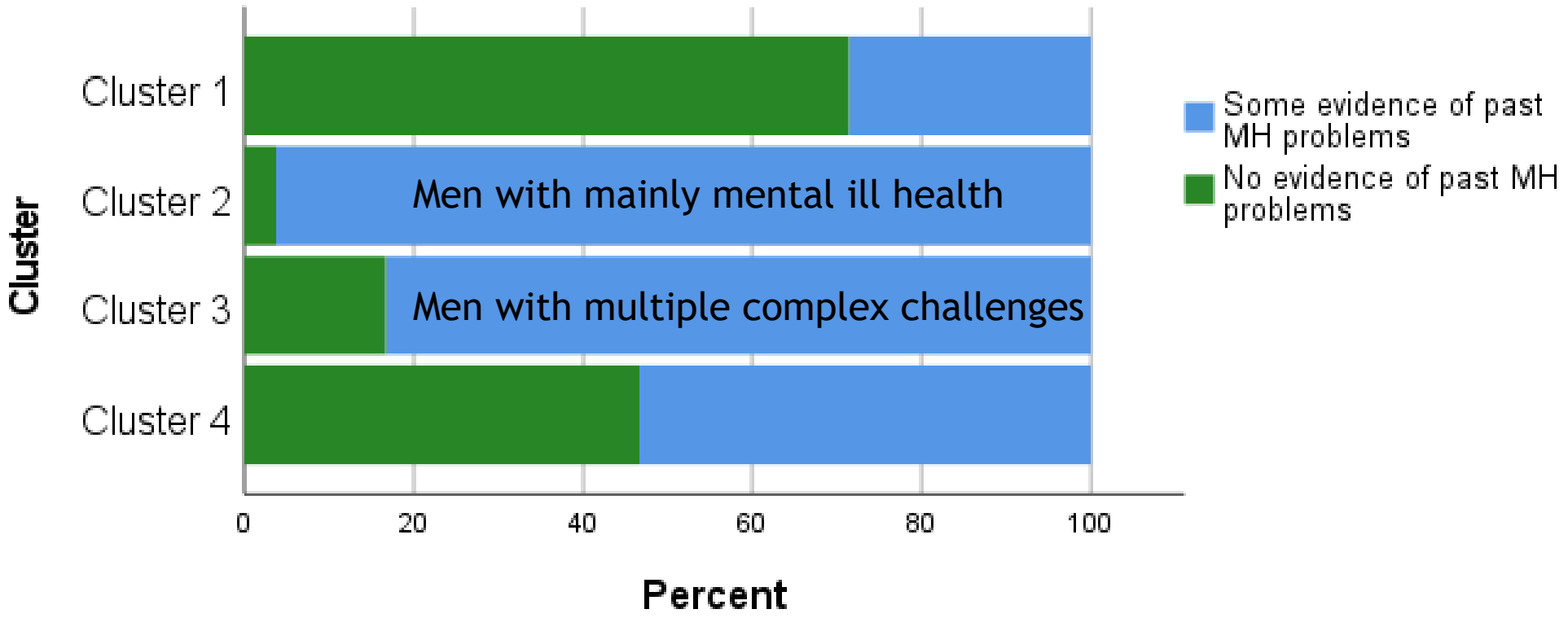
Cluster 4 (n=15)

- 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.

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