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Stuck in a rut: intervention disguised as prevention

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A recent article in the Guardian reported the death of four junior doctors by suicide (https://www.theguardian.com/commentisfree/2017/mar/21/to-stop-doctors-ending-their-lives-we-need-to-hear-from-those-suffering). In this article mental illness was assumed to be the cause before any details are given. In the subheading it is asserted "… obliges us to look at why doctors with mental illnesses don't speak up". The article focuses on mental illness and depression and linking them to workplace bullying. Ironically, the article indicates that bullying is systemic and widespread in the health service, it is certainly a management tool in New Zealand (Shahtahmasebi, 2004, 2015). Yet, like any other group (e.g. those with mental illness, medical professionals) only a fraction commit suicide.

A clear case of déjà vu, because there have been similar reports in the past. Suicide trends follow a cyclic pattern (see next article http://journalofhealth.co.nz/?page_id=759) and such reports surface every time the suicide trend complete its cycle and then follows upward trend for the next cycle. These cycles are also observable for various groups such as age, gender, occupation, and so on.

Interestingly, the Guardian published another article reporting that male construction workers and women employed in culture, media and sport, healthcare and primary school teaching are at the highest risk of suicide (see https://www.theguardian.com/society/2017/mar/17/male-construction-workers-greatest-risk-suicide-england-study-finds?CMP=share_btn_link). Public Health England (PHE) who commissioned the report encourages all employers to treat mental health as seriously as physical health. But physical health and mental health are closely causally correlated which begs the question has there been no progress with the UK Government's action plan "no health without mental health"? There are attempts to explain suicide through linking the nature of each occupation including rate of income/salary to mental illness and suicide.

Déjà vu, because usually not much happens other than a re-enforcement of the taboo that only the mentally ill commit suicide – therefore, would an employee, whether on a low income or not, risk their career by speaking up and be labelled mentally ill?

Déjà vu, because the public is provided with a remix of the same revamped by picking out particular groups without providing evidence of lowering suicide rates other than more suicides. Farmers were the focus a couple of years ago (http://www.huffingtonpost.com/terezia-farkas/why-farmer-suicide-rates_1_b_5610279.html), and over the years we have seen similar reports on pilots, accountants, students, etc.

More importantly, there is no statistical evidence to support the simplistic belief that mental illness is the cause of suicide (Shahtahmasebi, 2014, Hjelmeland *et al.*, 2012). This may explain why over two-thirds of suicide cases do not come into contact with mental health services and the other one-third that do complete suicide while under care or soon after discharge.

One conclusion may be that people with suicidal behaviour do not consider themselves as mentally ill but perhaps with problems that they cannot resolve on their own. In other words socially and culturally suicide is seen as an acceptable solution (Pridmore *et al.*, 2016; Shahtahmasebi *et al.*, 2016). No matter how much mental health care they are given it does not help resolve the problem, and at the end of the day they are sent back to the same circumstances that caused the suicidal behaviour in the first place.

A mental illness suicide prevention model only tackles mental illness or depression that may or may not exist and does very little towards alleviating the issues that influence an individual's process of decision making.

By insisting on the presence of mental illness and depression we are changing the focus from an 'individual' centred health and social care support to medical professionals. This does not seem to sit well with any number of at risk group in our society.

Instead of waiting for the evil of suicide to occur so that the medical profession might be able to intervene we must empower individuals and their support networks to prevent suicide even being considered as a solution. Examples of such an approach has been provided elsewhere (Shahtahmasebi, 2013) and briefly summarised in the next two articles.

This issue of DHH includes two articles on suicide prevention encouraging all stakeholders to join forces and adopt a community-based strategy that empowers communities to make decisions at local level.

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