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Editorial: prevention blind-sided by intervention

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Every now and then the media focuses on an issue and portray themselves as the guardians of public interest, they champion the issue for a short while after which the issue sinks into the abyss, until the next cycle. Suicide, stress and bullying in the workplace are amongst the issues that have been championed many times. But, what the media frequently fails to achieve is ensuring that championing an issue leads to a changes in behaviour.

In New Zealand, suicide numbers reached a record high in 2015, then in 2016, and again in 2017, and the Government's reaction was to state that mental health services must be reinforced, and allocating $millions to mental health services without demanding accountability (Shahtahmasebi, 2017). The net result was that in 2018 suicide numbers reached another new record high (for the fourth year running). This time both the media and the Government have been peculiarly silent. There has been no outcry and outrage by the champions of public interest.

Unsurprisingly, the New Zealand Mental Health Foundation's (MHF) offers the following more of the same interventions under the banner of suicide prevention. Under this banner the MHF offers information to help people stay safe in the days and weeks after a suicide attempt or serious self-harm (https://www.mentalhealth.org.nz/assets/Suicide/Flyer-SuicidePreventionResources.pdf), for reporting mental illness/suicide (https://www.mentalhealth.org.nz/get-help/media-guidelines/) and talking to young people (https://www.mentalhealth.org.nz/get-help/connecting-through-korero). Whilst people who survive suicide attempt need support but intervention is not it. Such interventions are void of an understanding of the dynamics of human behaviour are offered as strategies to prevent suicide. A climate where suicide is forcefully promoted as a mental illness and is removed from public domain renders useless such interventions. Decades of failing to reduce suicide rate has led to misinformation, therefore, on what evidence the MHF can offer information and guidelines? So in the absence of appropriate and relevant information about suicide it is curious that the MHF and mental health services who are charged with protecting the public are unable to visualise a world beyond intervention?

The problem with the medicalisation of suicide is that regardless of the type of prevention strategy the end result is always an intervention, i.e. 'treatment' can be offered only when suicidality is manifested and help is sought. In other words, the medical model does not in general offer support for non-medical issues before suicidality is developed, thus by waiting for symptoms of mental illness or suicidality this approach is a suicide risk factor. The implications are that the medical model does not enable, indeed it prevents informing individuals' process of decision making very early on in their life in such a way that suicide is removed/discounted as an off-the-shelf option.

Furthermore, even when strategies are claimed to take into account social and environmental factors such as bereavement, divorce/breakup, chronic illness or financial problems, these are often reduced to risk factors through an assumption that an adverse life event/trauma could cause depression/mental illness! Thus, funds are diverted to mental health services year after year without any accountability.

This callous approach fails the public at all levels. It cannot help the estimated two-thirds to three-quarters of all suicides who succeed the first time and had not come into contact with mental health services. The other one-quarter to one-third who do receive psychiatric intervention then go on to complete suicide. And the unsuccessful suicide attempters that can be helped are let down by this approach because it seeks to diagnoses depression/mental illness/symptoms that may not exist. Unfortunately but unsurprisingly, some of these people will inevitably join the one-third group.

No one, least of all the government, seems to be asking what are the funds being spent on? Why is suicide on the rise? I, for one am not satisfied with the common excuse that suicide is a complex issue with many social, environmental and mental illness risk factors. Complex issues of suicide can be resolved (Shahtahmasebi, 2013).

Ironically when suicide occurs, where there is no evidence of any adverse life event or mental illness, the common response has been 'it is sad that we were not aware of his/her mental health problems', or placing the blame on the suicide case for not talking about his/her mental problems (e.g. see Shahtahmasebi, 2005)!

The scientific community must put an end to the culture of 'blame' and stop using suicide as an indicator of mental illness. The wisdom that it is always easier on the conscience to blame someone or something else for our failures is directly responsible for the increasing trends in suicide or a lack of progress in suicide prevention.

How would such a wisdom influence policy formation. In other words, how would the diagnosis of a mental illness help the two-thirds to three-quarters of all suicides cases who were successful the first time, and how would the diagnosis of a mental illness has helped the other one-quarter to one-third of all suicide cases who received psychiatric intervention?

Unfortunately, the top-down approach is not limited to suicide prevention. Another example of social policy void of dynamics of human behaviour is managing workplace stress (https://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=12083487). Once again, the media seems to champion stress but often personalise it, or links it to bullying due to conflict between two colleagues or an employee and his/her manager. Where the media consistently is fails the lack of attention to a management culture in which bullying and stress thrives. Accounts collected from people who were subjected to workplace bullying in New Zealand provide very strong evidence of a bully management culture - where senior managers get away with expecting and receiving sexual favours in their offices whilst employees are bullied out of work for simply questioning a management decision – generating high levels of stress over and above the person's workload (Shahtahmasebi, 2004; Shahtahmasebi, 2016a).

The accounts of workplace bullying included isolating the victim from colleagues, an increased workload, de-humanising the victim, demolishing their self-esteem and confidence, belittling, vilifying, spreading negative rumours, and so on, leading to chronic illness, nervous breakdown and finally leaving employment without any compensation (see (Shahtahmasebi, 2004; Shahtahmasebi, 2016a)). The problem does not end there; a bully management culture ensures that through overt and covert bullying activities other 'difficult' staff would simply leave without challenging management.

Those who do make a complain are often referred to institution's 'comprehensive' policies on bullying, sexual harassment, and other documents declaring that the institution does not tolerate bullying and deals sternly with such issues. But frequently, complaints are passed to the perpetrator(s) to investigate – unsurprisingly, during this process the victim becomes the aggressor and is then subjected to investigation!

Under such a climate, employees are more likely to be on the edge, worried that it they may be next, do not get involved in management and development for fear of asking the wrong question and refrain from challenging their line managers for unfair high workload, or lack of blocking of personal development resources. Therefore, high levels of stress and anxiety are expected in the workplace.

Stress and bullying has always been linked to personalities and conflict between two employees, but never to the management culture. And as such most guidelines on anti-bullying and anti-stress policies are supposedly written to deal with the issues at an individual level. As a result, psychologists and human resources (HR) managers fall over themselves trying to promote and sell self-improvement courses/techniques such as assertiveness, time management, and relaxation classes. A bully management culture renders all such development useless as what is the good of becoming *assertive* only to be bullied out of employment?

It is a similar story in other areas of policy formation as every policy, every action, and every outcome is due to the dynamics of human behaviour. In the health service we seem to be fixated with the philosophy of intervention. Our health informatics is run on an intervention premise, and hundreds of millions of dollars spent on informatics so far has not produced any insight in understanding disease development (Shahtahmasebi, 2016b). It is of no surprise that, given decades of investing vast amounts of funding in interventional services, heart disease is still the leading cause of death (http://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)).

In the late 1980s in the UK the then Conservative Government published its policy on improving the health of the population called 'Health of the Nation' (HoN) (Department of Health, 1992). The main problem with this document cited by many health professionals and managers at all levels of seniority was the (arbitrary) targets set by the government to reduce national mortality due to a number of causes such as heart disease, cancers, suicide, and accidents. There were also targets on morbidity. During the early 1990s regional health authorities and district health authorities spent (wasted) time wanting to know how these targets were set, allocated funds and resources to HoN targets, many HoN targets committees were created, new HoN officer positions were created, and the final response to the national targets was to translated HoN targets into local targets, and the NHS went through a major restructuring. The HoN targets were relaxed by the new Labour government in mid 1990s.

This was a great opportunity lost. Regardless of the arbitrary nature of the targets, the *political will* to embark on reducing morbidity and mortality was the biggest opportunity to develop strategies to improve public health. But the health professionals and managers squandered this opportunity.

It is highly likely that the philosophy of intervention blind-sided the decision makers and failed to investigate the process of disease development. In other words we missed the chance to understand the problems so that we could resolve them, thus achieving the targets.

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