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Editorial: Two years of dynamics of Human health

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As 2015 draws to an end it marks a significant milestone for DHH; two years and two volumes of articles challenging conventional thinking, as well as acting as a resource providing training/information materials, e.g. on suicide prevention, adolescent behaviour, analytical methodology for health and social data, asthma, and TB.

Over the last two years, DHH has touched on matters of life and death that make health a dynamic process. DHH has published on a variety of topics, (these are available to download), on topics such as health service planning, research methodology, analytical methodologies, public health, as well as alternative and novel ideas in health promotion, nutrition and nutritional intervention, suicide and suicide prevention, and adolescent health.

Suicide prevention, in particular youth suicide, has been the area where DHH has had some influence. The collection of articles and resources on this topic in DHH re-emphasises and draws the attention of politicians and decision makers to the fallacies of a medical model that only provides "more of the same" but at a higher cost each year. Although, official guidelines still focus on mental illness and psychiatric services as the main strategy to prevent suicide, nevertheless, the syntax has changed. For example, the New Zealand Ministry of Health's web page no longer advises people to look for signs of depression/mental illness and to contact mental health services, as they did in the past (Shahtahmasebi, 2013a, 2013b). The advice now is what the "stop youth Suicide" campaign (http://www.stopyouthsuicide.com/) and the suicide prevention at grassroots have been promoting over the last fifteen years. That is, if you suspect someone may be at risk talk to them and show them you care, show compassion, listen without judging, stay with them, call for help even if they don't want you to (because an angry friend is better than a dead one).

Unfortunately, the official strategy for preventing suicide is still dictated by an interventional philosophy, i.e. suicide is a mental illness problem and belongs firmly in the domain of psychiatry. No one has ever asked the question that if psychiatric intervention is the answer then why has it not reduced the suicide rate let alone eradicate it.

It is estimated that between one-quarter and one-third of all completed suicides had come into contact with psychiatric services (Hamdi *et al.*, 2008; Niederkrotenthaler *et al.*, 2014; Shahtahmasebi, 2003, 2005) – yet these cases went on to complete suicide despite receiving psychiatric treatment. Based on these results it can be argued that psychiatric services may be a contributory cause of suicide (Shahtahmasebi, 2014; Shahtahmasebi & Smith, 2013).

The implications of pursuing a false causation for public health and its outcomes are fairly obvious: costly, poor and ineffective prevention policies. Policies based on a medical model are costly because they offer "more of the same" but they cost more each year in terms of lives lost and funding. Of course, "bad" policies will have unleashed their own adverse effects on health and social outcomes through the feedback effect. Both medical services and the wider public treat suicide as a mental illness issue and expect a psychiatric explanation and diagnosis. Therefore, after decades of following a medical model we seem to have lost the art of conversation when it relates to suicide. In addition, as a result of the mystification

and politicisation of suicide, people, including GPs, front line health and social workers, and the police do not know how to respond, or, what to say to a person at risk.

It is of serious concern that GPs, who are the primary contact for secondary health services, are ill-equipped to deal with individuals showing suicidal tendencies. Despite the emphasis on a medical model, health and social services appear ineffective and unable to intervene. For example, a suicidal adolescent needing urgent help was told to make an appointment for the following week (Shahtahmasebi & Smith, 2013), or the assumption that suicidal ideation is normal in adolescence and it is a phase they go through.

The youth suicide prevention at grassroots workshops reiterates that, unlike adults, on average adolescents do not plan to commit suicide but when faced with a life problem, they often react to their emotions on impulse. So the suicidal teen mentioned previously would probably have not survived had it not been for the immediate intervention by a person who had attended the grass roots workshop. Assuming that suicide ideation is a normal adolescent trait the service, which follows a medical model, failed to provide the appropriate interventional care support to ensure the immediate safety of the young person.

Another adverse outcome of bad policies is the passive "by-stander" effect where family and friends feel it is not their place to intervene but because they also feel scared and inadequately skilled to help. The irony is that family and friends are in a good position to help. However, the suicide discourse has excluded the public which has led to an inability by the public to communicate and contribute to suicide prevention. Public participation is an important feature of the grassroots suicide prevention strategy. In other words, strategies that prevents suicide being viewed as an option are more likely to succeed than the current model that waits for suicidal ideation to develop and then attempt to intervene; intervention is not prevention (Shahtahmasebi, 2013a).

Suicide prevention is one example where the policy formation process has been politicised and is one dimensional, similar process may be observed for other public health outcomes such as obesity, smoking, drinking, drug use (including party/recreational drugs), and bullying. These behavioural outcomes are subject to many influences from different stakeholders who have different targets to achieve. A single dimensional policy action to address and reverse the trends has to compete against the trends set by the interests of manufacturers and decision makers, growers, suppliers and so on. This tension between various stakeholders' aims and objectives has led to the growing trends in bullying management culture (Shahtahmasebi, 2015) in the public and private sector which has contributed to poor public health outcomes, including suicide, mental illness, obesity, smoking, drinking and drug abuse.

It is unwise to assume that bullying only occurs when a bully (often described as an incompetent, low self-esteem and with mental disorder individual) choses a victim (often described as a highly qualified, competent, and achiever individual). In reality this is the scenario under which bullying occurs, however, case studies (Shahtahmasebi, 2015) provide evidence to suggest it is a bullying management culture that creates a working environment for bullying to flourish. Bullying is now considered a valid management tool.

The dilemma is that governments and politicians fail to take action and continue to regard bullying cultures as employment issues. The problem is therefore exacerbated by political support for bullying in the workplace creating an non-level playing field thus allowing

employers and employment lawyers, the Law Society and Trade Unions, to waste vast amount of tax-payers money to vilify victims (Shahtahmasebi, 2015).

On this note, the grassroots approach to suicide prevention can be applied to reverse the growing trends in other undesirable health and social outcomes such as obesity, diabetes, heart disease, teenage pregnancy, teenage smoking, alcohol and drug abuse, and to eradicate a bullying culture (Shahtahmasebi, 2015).

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