

# Time for a more evidence-based approach to suicide prevention

Sarah Fortune

*“Success is a science; if you have the conditions, you get the result.” – Oscar Wilde<sup>1</sup>*

There have been some encouraging signs of a reduction in lives lost to suicide in the past few years, after a decade of relatively static rates.<sup>2,3</sup> Aotearoa New Zealand was one of the first countries in the world to have a suicide prevention strategy and associated action plan.<sup>4</sup> National suicide prevention strategies have the potential to draw together a collective vision for suicide prevention, signal government commitment and increase accountability.<sup>5,6</sup>

Globally, the suicide prevention community has agreed that suicide prevention action plans need to reflect that suicide is a complex phenomenon that occurs due to the convergence of factors, some of which may be considered as individual, such as mental illness, but all of which reflect directly, or indirectly, broader social and commercial determinants.<sup>7</sup> A public health framework reflects this complexity<sup>8</sup> and frames successful suicide prevention actions across three levels: universal programmes that target a whole population; selective programmes targeting sub-groups thought to be at elevated risk of suicidal behaviour, such as those with substance use problems or bereaved by suicide; and indicated programmes that target specific individuals experiencing suicidal distress, such as those attending hospital with self-harm.<sup>9</sup>

Minister Doocey recently released a *Draft Suicide Prevention Action Plan* for public consultation covering 2025–2029.<sup>10</sup> Submissions closed on 1 November. The proposed plan has the potential to deliver so much more, with greater integration of high-quality evidence and a coherent public health framework that acknowledges the centrality of Te Tiriti o Waitangi for suicide prevention in Aotearoa New Zealand. My colleagues and I were recently commissioned to conduct an evidence synthesis on the most up-to-date and relevant local and international literature on suicide prevention. It is somewhat surprising that this significant work is not cited in the public consultation document. The emphasis of the proposed action plan does not strongly align with the evidence synthesis on

what types and levels of intervention are likely to save lives. While you are encouraged to read this document in its entirety (<https://www.health.govt.nz/publications/evidence-synthesis-of-the-research-on-suicide-prevention-and-postvention-aotearoa-new-zealand-and>), the key findings are highlighted below.

## Universal approaches

First, universal approaches are effective, relatively under-utilised in Aotearoa New Zealand and represent interventions that are likely to save lives. Universal approaches have the potential to prevent deaths among communities who are unlikely to seek clinical services, particularly men, young people and Māori.<sup>11</sup> No matter how much money we spend on clinical services, or how much we expand our mental health workforce, unless we tackle the structural determinants associated with suicide in Aotearoa New Zealand, particularly poverty, discrimination, violence and alcohol control,<sup>12</sup> we are unlikely to make major gains in preventing deaths by suicide, particularly for Māori.

While workplace programmes are attractive, those who do not have work are in particular need of suicide prevention interventions; recessions are often associated with increased suicide rates among men, and require increased expenditure on unemployment benefits, active return to work programmes<sup>13</sup> and employment protection legislation.<sup>14</sup> We have had multiple iterations of responsible media reporting guidelines, and should focus on increasing adherence to help prevent young deaths by suicide rather than creating further updates. As urban density is actively pursued, we should restrict access to locations associated with jumping and increase the chances of intervention, using surveillance combined with staff training and updated technology for faster stopping of trains.<sup>11</sup> We should also restrict access to other methods of suicide, including guns (to prevent deaths among older men), carbon monoxide gas and pesticides (to prevent deaths in the Asian community) and

paracetamol.<sup>15</sup> Adequate staffing and improved service user visibility in inpatient psychiatric facilities, police stations and prisons would likely reduce deaths in these settings, given current guidance on ligature points already exists.<sup>11</sup> We need action, not more reviews, to prevent deaths among Māori, who are over-represented in these settings. Reducing access to alcohol and increasing the price are important ways to prevent deaths among men, younger people and Māori.<sup>7</sup> There is a need for a greater focus on the prevention of all types of violence, and particularly sexual violence, as part of suicide prevention.<sup>7</sup>

## Selective interventions

Peer support and social support interventions are an area of innovation and need to be well-planned and appropriately resourced. Peer support is not a free or low-cost workforce. Gatekeeper training appears to improve the immediate knowledge, skills and self-efficacy of gatekeepers, but so far has not been shown to have a measurable impact on rates of suicidal behaviour at a community level. Positive training effects last around 4–6 months.<sup>11</sup> Novel approaches to addressing these aspects of gatekeeper training are being investigated locally.<sup>16</sup> First responder (e.g., military, police, firefighters, ambulance staff) multilevel workplace interventions are associated with reduced suicide rates in these groups; however, in Aotearoa New Zealand we know very little about the needs of former military personnel, and our Defence Force has very different characteristics to the Australian Force. Communities should think carefully about approaches offering screening apps, taking care to consider the ethics of screening, including the psychometric properties of the tools, the ability of the community to respond to those identified in need of support, data sovereignty and cultural competence.<sup>11</sup>

## Indicated interventions

Most psychological interventions focus on individuals as the unit of intervention, which is at odds with models of wellbeing such as Te Whare Tapa Whā and the evidence of good practice from Pacific peoples and Māori suicide prevention efforts in Aotearoa New Zealand.<sup>11</sup> The key unit of intervention should be whānau. Less costly,

brief, easy to deliver and scalable psychological interventions appear equally likely to be effective as technically complex, long-term, hard to deliver and less scalable interventions.<sup>17</sup> There are likely gains in enhanced adherence, with current best practice guidelines focussing on compassionate care in emergency department (ED) settings.<sup>18</sup>

The evidence for what works for youth is mixed, with mental health awareness training likely to be both effective and cost-effective. Interventions need to work for Māori youth, who drive our high rates. Early findings for rainbow youth are promising but need to differentiate between the needs of specific sexual and gender minorities. With an ageing population in Aotearoa New Zealand, more attention needs to be directed to the development and investigation of safe, culturally responsive and effective initiatives for this population. Interventions that target loneliness, address physical frailty, poverty and enhance social connection are promising (for women). The evidence for effective postvention is emerging; recent investment in bereaved by suicide services in Aotearoa New Zealand need increased facilitation of culturally specific grieving practices that do not pathologise grief or represent it as a mental health crisis.<sup>11</sup>

We need an agreed outcomes framework with greater clarity about the purpose of interventions and expected outcomes; for example, a rationale for how wellbeing interventions are expected to reduce suicide given the mixed findings and relatively weak correlation between the two, e.g.,<sup>19</sup> outcomes need to be publicly reported so the work can move forwards, rather than compromising scarce resources by re-doing work already done. We should look to implementation science<sup>8</sup> and evaluate the entire strategy, rather than expecting to be able to see benefit from individual elements.<sup>20</sup>

A great deal of the *Draft Suicide Prevention Action Plan* reflects a Western, individualised and psychiatric perspective on suicide, which is increasingly recognised as having significant limitations when considering the likelihood of success in preventing suicide across the whole population.<sup>7</sup> Significant reductions in suicide are unlikely to be achieved with isolated interventions that fail to connect with a coherent public health approach.

**COMPETING INTERESTS**

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