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[Editorial] New Zealand's Suicide prevention plan 2025-29: More gloss, no substance

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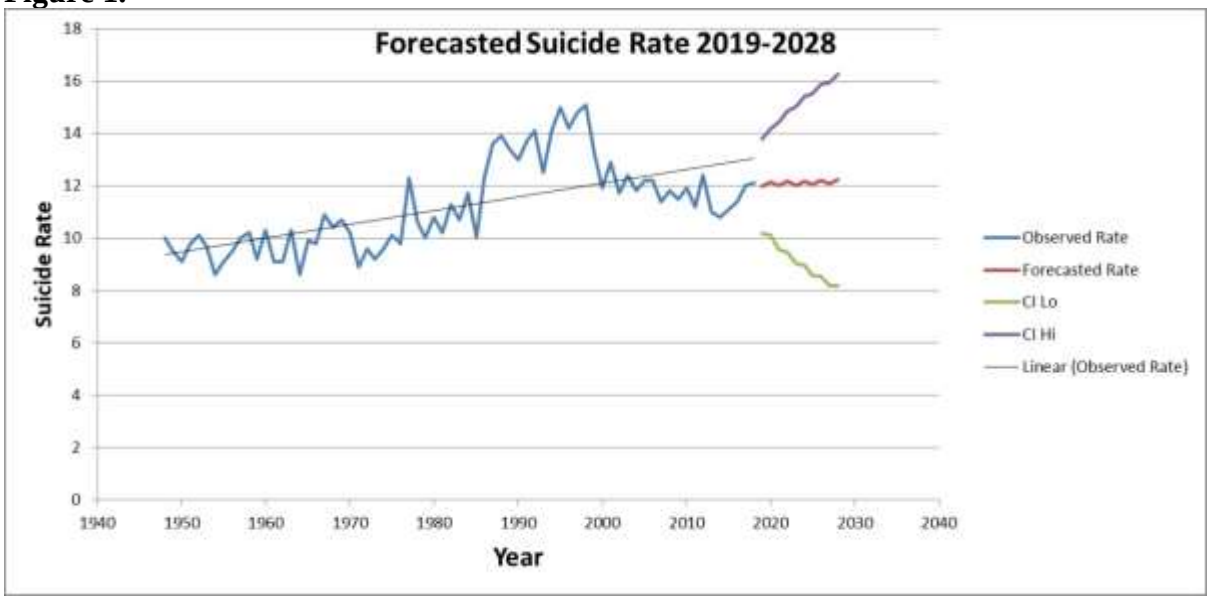
Introduction

In 2023, DHH published an article which explored what might happen to suicide rates in New Zealand if we continue with the current suicide prevention strategy based on mental illness (Shahtahmasebi & Gregory-Allen, 2023). Historical suicide rates from 1948 to 2018 were used to forecast the suicide rates for the next 10-year period (2019-2028), see Figure 1.

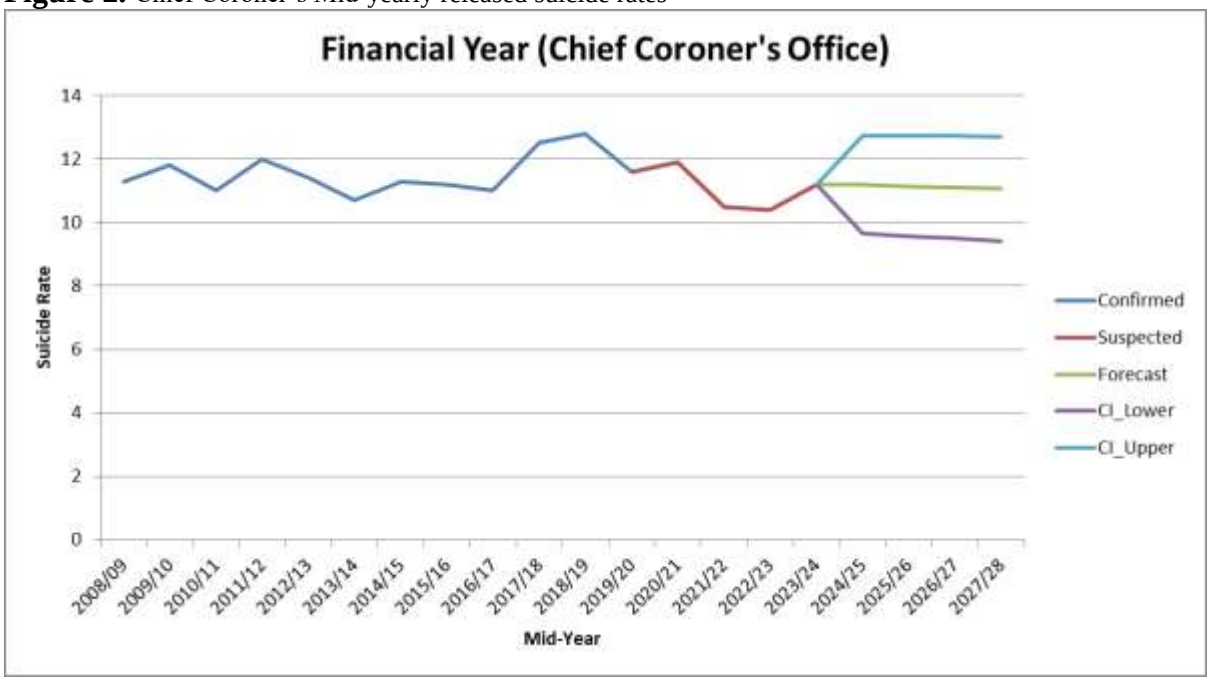
Figure 1.



The modelling was based on suicide rates per calendar year which are reported by Health New Zealand. For more information visit the link https://tewhatuora.shinyapps.io/suicide-web-tool/. The forecast suggested that while suicide rates may go up and down, overall they exhibit an increasing trend, as can be seen by the linear trend line (Figure 1). One way of checking the strength of the forecast is to replace the forecast values with observed values. Unfortunately, there have not been enough subsequent confirmed suicides beyond 2020 to shorten the forecast window (2019-28).

However, in New Zealand, the Chief Coroner also releases confirmed and suspected suicides up to 2023/2024, these rates are collected over financial year, so they are not appropriate to be appended to our historical data. Nevertheless, there are no reasons as to why we shouldn't carry out a forecast model based on data from the Chief Coroner (https://tewhatuora.shinyapps.io/suicide-web-tool/), these remain as suspected suicides until they have been confirmed by the coroner, See Figure 2.

Figure 2. Chief Coroner's Mid-yearly released suicide rates



The simple forecast in Figure 2 demonstrates an overall flat trend. We need more actual data to get some indication as to where in the cycle the suicide trend is. If the cycle is peaking then suicide rates will show downturn in suicide trend, if the cycle is troughing then suicide rates will trend up. Unfortunately, we will have to wait many years, as we have been doing, just to see which way suicide rates may be trending. In other words, mental illness-based suicide preventions have failed to prevent and reduce suicide rates and will continue to fail. Nevertheless, we tend to persevere with the same failed policies (Shahtahmasebi & Gregory-Allen, 2023), hoping that one day a newly discovered mental illness disorder will explain suicide (Pridmore & Rostami 2020). In the meantime, a loved one who has died needlessly by suicide is a very high price to pay for waiting for a disorder to manifest (Shahtahmasebi, 2013).

Based on longer historical data, as in Figure 1, we must prepare to prevent suicide rates trending upward. However, a major problem facing the process of developing suicide prevention policies is a common misconception/misinterpretation of the cyclic patterns in suicide rates. The policy of mental illness-based prevention is credited with success when the cycle peaks and is decreasing, but no such accountability is assumed when suicide rates are reversed and follow an upward trend. Instead, social and economic factors are blamed for an increase in suicide trends! Furthermore, suicide attempts are indication that our suicide prevention policies have failed, yet, unwisely, past suicide attempts is listed as a suicide risk factor.

The question arises: what shall we do now?

The government issued a draft suicide prevention strategy and action plan in 2019 "Every Life Matters" (Ministry of Health, 2019), for a discussion of this strategy see (Shahtahmasebi, 2019a). The document states the strategy's vision as:

"We believe that every life matters and, by working together, we can achieve a future where there is no suicide in Aotearoa New Zealand."

The document then presents the "Every Life Matters" framework in a flowchart. Outcomes are defined as "reducing suicide" and "wellbeing for all".

"Focus areas" of the policy are subtitled "building a strong system" with four elements: "National leadership", "using evidence to make a difference", "developing the workforce", and "evaluation and monitoring", that supports wellbeing and responds to people's needs.

Clearly, based on these focus areas it can be concluded that this policy is not a suicide prevention strategy because it can only intervene if suicidality or a mental illness manifest. This strategy only allows medical intervention after an event, e.g. suicidality or depression, has occurred. Although, this policy document does not refer directly to mental illness, it would seem that "mental wellbeing" is the proxy for mental illness. Furthermore, it is not made clear what is meant by "developing the workforce". In other words, what are the criteria for developing a workforce to perform what task, and how this will impact suicide rates. The only conclusion that can be made is that this solution involves addressing the shortage of psychiatrists/psychologists and mental health professionals.

Policy documents 2019-29 and 2025-29, like their predecessors reads like a wish list without any substantive support. Over decades of developing suicide prevention policies based on such sentiments there is no commensurate drop in suicide rates that the government can show. Surely, the only conclusion that can be made is that such policies are inappropriate and irrelevant.

On average, about two-thirds of all suicide cases do not have a psychiatric record or a psychiatric diagnosis (e.g. see Shahtahmasebi 2013, WHO 2014, CDC 2018) it then begs the question what the National Suicide Prevention Office, which was set up to promote national leadership is going to do to prevent suicide and reduce suicide rates. Since its creation there has not been any new strategy and actions other than following and promoting the mental illness approach (see Shahtahmasebi 2019b, 2022). This makes the other two elements of "using evidence to make a difference", and "evaluation and monitoring" a flight of fancy and a waste of resources. For example, in the "Every Life Matters" framework (Ministry of Health 2019), suicide prevention is stated as "promotion: promoting wellbeing", "prevention: responding to suicide distress", "intervention: responding to suicidal behaviour", and "postvention: supporting after a suicide". In this document, wellbeing is not defined and ignores the ever changing socio-economic and socio-political landscape, e.g. covid19, cost of living crisis, housing crisis. Furthermore, the actions proposed in this document can only be operationalised after a suicidal behaviour has manifested which means time to apply an intervention. Thus this policy is nothing more than "more of the same" failed mental illness intervention.

The draft consultation policy plan 2025-29 (Ministry of Health 2024), is ostensibly a statement of the government's action plan rather than a consultation document. It claims that "we have a stronger suicide prevention system, and people have access to more and better supports, services, resources and tools to support their wellbeing and respond to their needs." There is no evidence provided to support the many claims of improvement in service provision and service uptake, and, furthermore, there is no discussion of how the claimed improvements may translate to reductions in suicide rates and suicide trends.

It also lists a number of "insights", including a collective effort to suicide prevention, talking about suicide, access to supports, and using data and evidence. The suicide support services are mental illness-based intervention services and therefore the idea of a collective effort is encouraging a greater collaboration between the health agencies which provide support. Therefore this strategy does not offer anything new and appropriate (Shahtahmasebi 2013). We should certainly talk about suicide, we should certainly have competent well-funded, well-resourced and responsive mental health services, and we should certainly remove the blinkers and take serious note of the evidence. Only then can a policy that promotes collective participation, the role of a workforce, public discussion of suicide make the suicide prevention policy development more sensitive and relevant to preventing suicide.

Every suicide intervention support that the government has provided and is proposing to provide can only be "accessed" if and only if suicidality is present. How does waiting to be suicidal and then seek help prevent suicide, particularly young people, of those who die whilst under treatment, those who chose death in isolation, those who do not wish to be labelled mentally ill, those who show non-mental illness signs which were missed because no one talks about suicide? The idea of suicide prevention is to discredit suicide socially and remove it as a viable option/solution to a problem.

I have previously discussed these issues and the fundamentals of a working suicide prevention policy (e.g. see Shahtahmasebi, 2013) – all issues considered, the government's suicide prevention policy 2025-29 is not prevention, nor will it meet the criteria for an intervention plan.

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