12 June 2017

Suicide Prevention Strategy Consultation
Dr John Crawshaw
Director of Mental Health
Ministry of Health
PO Box 5013
Wellington 6140.
Email: suicideprevention@moh.govt.nz

Dear Dr Crawshaw

Re: A Strategy to Prevent Suicide in New Zealand 2017 – Draft for public consultation

About the NZSA

The NZSA is a professional medical education society, which represents over 550 medical anesthetists in New Zealand. Our members include specialist anesthetists in public and private practice, and trainee anesthetists. We facilitate and promote education and research into anesthesia and advocate on behalf of our members, representing and championing their professional interests and the safety of their patients. As an advocacy organisation, we develop submissions on government policy and legislation, work collaboratively with key stakeholders, and foster networks of anesthetists nationwide. The NZSA, established in 1948, also has strong global connections and is a Member Society of the World Federation of Societies of Anesthesiologists (WFSA).

Overview

The NZSA welcomes[1] the opportunity to provide feedback on "A Strategy to Prevent Suicide in New Zealand 2017." We have reviewed the draft for public consultation, along with other documents published by the Ministry of Health including:

- An overview of suicide statistics
- Suggested actions for suicide prevention
- Estimating the benefits of investment in ongoing suicide mortality review – a cost benefit analysis
- Themes from the community suicide prevention workshops 2017.

In principle, we agree with the key themes emerging from the workshops, which have focused on the need to:

- Build individual, family and community resilience

[1] Are Anaesthetists Prone to Suicide? A review of rates and risk factors
Swanson S P, Roberts L J, Chapman M D. Anaes and Int. Care. Aug 2003; 31: 4; 434

- Reduce the stigma around mental health and break down the fear of seeking help
- Provide better resources for support, services and professional help
- Build cohesive families and provide parents and whanau/families with ongoing support
- Use Maori and Pacific models of well-being to inform our work, particularly when working with whanau/families
- Publicly and safely talk about suicide (e.g. TV advertising, billboards and social media).

While anesthetists are not usually on the frontline dealing with suicide intervention, they do appreciate the value of families and community in supporting health and well-being.

New Zealand poet and GP Glenn Colquhoun's 2016 publication *Late Love: Sometimes Doctors Need Saving as Much as their Patients,* emphasises the place of family and community in a person's illness. He writes:

"Families are a young person's soul…. Many times, I have seen the whakapapa of a person's present illness begin generations earlier in community upheaval and loss of resource, language, belief and mana. Over times it has evolved through various stages: social dislocation, relative poverty, unemployment, frustration, negative self-esteem, anger, drug and alcohol use, violence, loss of attachment, school failure, abuse, depression, anxiety, disengagement, loss of hope and criminality. By the time it is only a short way into this journey to have become a template that is too easily stamped into the young of each succeeding generation.

In an overwhelming majority of cases, this cycle has been broken by care or tenderness or hard work or a good decision. It can be broken by spirituality or by dumb luck or resilience or maturity or by one individual's determination to make it stop. But in many cases, it remains to gobble up the new. The levers I would like to figure are ultimately aimed at reducing inequality, providing jobs for people, making schools and communities strong and attracting and rewarding the best teachers for working with the most difficult young people, and not leaving those young people to fend for themselves."

The suggested actions found in the themes from Community Suicide Prevention Workshops highlight many of these points.

In our submission, we will focus on providing care for the healthcare provider. It is only recently that physicians' limitations, vulnerability, and their need for support has been appreciated. Physicians strive for perfection and still regard vulnerability as a sign of weakness, which may partly explain why the phenomenon of physician burnout and suicide has not been adequately addressed. [2]

As a community, i.e. a self-organised network of people with a common agenda who collaborate by sharing ideas, information and other resources, anesthetists are deeply

[2] Are we at risk of losing the soul of medicine? Botha D. Canadian Anaesthesiologists Society Feb. 2016

affected by suicide within their own ranks. [3] [4] Doctors have the highest rate of suicide of any profession, and recent evidence suggests that anesthetists have a higher rate of suicide than other medical specialties.[5] The high prevalence of suicide among doctors is in part due to their specialist knowledge and that as high performers their high standards most easily come into conflict with frustrating working conditions or problematic patient outcomes.

An aspect regarding high prevalence of suicide among physicians is easy access to drugs. Ensuring that the main stock of Propofol is behind lock and key in theatres to avoid the potential for abuse, accidental overdose or suicide is worthwhile. The Ministry of Health could have some resources allocated to ensure this can happen, or to offer support by instructing DHBs to put this measure in place.

Depression, burnout and suicide

Depression, burnout and suicidal ideation among healthcare workers have been causally linked to a problematic work environment. Factors contributing to this situation include: unrealistic demands from patients, lack of autonomy, time pressure including onerous on call duties, co-worker conflict, staff shortages and intense workloads, discordance between values of the physician and management, harassment, bullying and intimidation.

Many of these factors are attributed to the very high rates of burnout in New Zealand's specialist workforce (50 per cent reported symptoms of burn out), which are explored in the report 'Tired, worn out and exhausted," published by the Association of Salaried Medical Specialists in 2016. The report is based on a survey of specialists in our public health sector, and looks at the emotionally demanding nature of healthcare provision, in part due to high anxiety levels in relation to patient outcomes. Burnout poses risks to the health of doctors who suffer from it but also their patients, due to the correlation between burnout, quality of care and risk of medical errors. Addressing burnout is therefore important for the health and well-being of patients and doctors alike. ASMS urges government, health policymakers and DHB chief executives to address burnout and assist those who are already afflicted. They advocate for changes to better resource DHBs, to address staffing levels, the volume of work and to improve management culture. ASMS also notes the relative under-investment in the senior medical workforce, which has led to entrenched shortages, exacerbated by an ageing workforce and increasing health needs due to our growing population. The survey collated comments from respondents, many of whom talked about the importance of having good collegial relationships and support from the wider hospital leadership to lessen their likelihood of burnout.

Anaesthetists and the duty of personal wellness

Anaesthetists have a professional duty to undertake effective self-management and personal wellness. There is an expectation that doctors, who have specialist healthcare knowledge, will be able to look after their own health needs. However, the evidence suggests otherwise.

---

[3] Mental Health and welfare in Australian anaesthetists.
McDonnell N J, Kaye R M, Hood S et al. Anaes. Int. Care 2013; 41: 461-647

[4] A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2013.
Fry R A, Fry L E, Castanelli D J. Anaesth. Intensive Care 2015; 43: 1

[5] Cause specific mortality risks of anaesthesiologists. Alexander BH, Checkoway H, Nagahama SI, Domino KB. Anesthesiology 2000; 93: 922-930

Dunn[6] studied the healthcare practices of residents and found that they delayed self-care due to worry about academic consequences, what others will think of them and privacy concerns. Residents are less likely to have a primary care physician or to seek routine healthcare, than the general population.[7] Medical students have a lower likelihood of seeking help for emotional distress as they are fearful of being less able and less respectable.[8] According to a 2013 article in the Australian Society of Anaesthetist's magazine, doctors engage in "self-denial, deflection and minimisation of symptoms."

Figures of authority within an institution, such as departmental heads and supervisors of training, do not appear to be considered a first port of care for welfare issues.[9]

Promoting wellness and the prevention of physician suicide

There is little information available on effective prevention of physician suicide, particularly because it is a low base rate event.[10] However, an evaluation of the research and initiatives undertaken in New Zealand and overseas, highlights a range of measures to promote well-being, resilience and to help prevent depression and suicide. These include:

- Teaching medical students about self-care, social support, relationship management, self-awareness, drug and alcohol abuse and how to ask for help. Model programmers, for example at the University of California, San Diego School of Medicine demonstrate benefits associated with education, confidential screening and early intervention. [11] The safety and privacy of participants are paramount. Much could be gained from introducing such a web-based service for physicians and other workers where there are major concerns about confidentiality, stigma and negative effect on career. Where the same programme was used, similar positive results were found within the resident programme at Davis Health System.[12]
- Teaching medical students and physicians how to recognise the signs of suicide risk in themselves and others and how to sensitively approach a struggling colleague.[13] The Australian and New Zealand College of Anaesthetists has a Welfare Special Interest Group (SIG) which offers resources to assist anaesthetists to help themselves and their colleagues. The SIG strongly endorses wellness by providing

[6] Delaying care, avoiding stigma: resident's attitudes towards obtaining personal health care. Dunn LB, Green Hammond KA, Weiss RI. Academic medicine 2009; 84:242-50
[7] A comparison between physicians and demographically similar peers in accessing personal healthcare. Gedfeldt AS, Bower EA et al. Academic Medicine 2012; 87: 327-31
[8] Depression, stigma and suicidal ideation in medical students. Schwenk TL, Davis L, Wimsatt LA. JAMA 2010; 304: 1181-90
[9] Mental health as above
[10] Suicide rates amongst physicians: a qualitative and gender assessment (meta analysis) American Journal of Psychiatry. 2004; 161: 2295-302
[11] The Suicide prevention and Depression Awareness Program at the University of California, San Diego School of Medicine. Moutier C, Norcross W, Jong P et al Academic Medicine 2012; 87: 320-326
[12] The Suicide prevention, depression awareness and clinical engagement programme for Faculty residents in the University of California Davis health System. Haskins J. Academic Psychiatry Feb. 2016 40 (1): 25-9
[13] Physician suicide rates show alarming need for education. Gray R. Tennessee Medicine 2009; 102: 39

continuing medical education activities, which enable anaesthetists to focus on lifestyle, mental health, stress management and personal relationships.

- Introducing anesthesiology residency welfare programmers, such as that offered by the University of Saskatchewan.[14] Residents are encouraged to develop and share personal resilience skills, tools and strategies to maintain wellness during residency and beyond. Initiatives have been undertaken to create a safe, supportive environment to promote well-being.
- Shifting away from treating individuals as being pathological, and creating a nurturing environment. This must be from the top down, starting with regulatory authorities applying non-discriminatory practices towards physicians suffering from depression.
- GPs need more training and support to treat doctors who are patients, as well as all other patients, presenting with mental health issues.
- In the article Physician Wellbeing: A Critical Deficiency in Resilience Education and Training[15], the authors looked at a range of tested interventions for promoting medical student and physician well-being, and reducing the prevalence of depression and suicide. Some of these interventions included:

    - Student and resident seminars discussing the emotional, physical and social impacts of medicine – the seminars are kept to a small number of participants, and are process oriented and structured. These groups are longitudinal and address the stresses of being a doctor at all stages of a doctor's career.
    - Broadening medical education and training to include topics such as personal transformation, the shift from 'lay person' to 'doctor', challenges in personal and professional lives, coping with unsuccessful results, and working in dysfunctional teams.
    - Learning how to be a reflective practitioner, which includes writing and sharing experiences and thoughts.
    - Developing curriculum modules on nutrition, exercise and a healthy diet.
    - Providing ongoing education about burnout, including the signs and symptoms, and offering resources for receiving professional help.
    - Developing resources to support physician well-being.

The authors of this article conclude: "One thing is clear: If we do not begin to change the culture of medicine and systematically address the wide range of dangers to the health of physicians, the negative trends in our own well-being and mortality will continue and potentially worsen."

Essentially, in addition to the measures outlined above (which are by no means exhaustive), it is crucial that these are complemented by institutional change from the top down, i.e. while resilience is important, you can only be as resilient as your work culture allows. This quote from a recent article in a Sydney newspaper, the Northern Daily Leader, aptly captures this point: "We're actually one of the most resilient bunches of people in society, but we're thrown into a system that is inflexible and intolerable. If you're being bullied or harassed or

[14] Anaesthesiology Resident Wellness Program at the University of Saskatchewan. Chakravarti A, Raazi M, O'Brien J et al. Can J Anaesth. (2017) 64; 199-210.

[15] Physician Wellbeing: A Critical Deficiency in Resilience Education and Training. Beresin EV, Milligan TA, Balon R, Coverdale JH, Louie AK, and Roberts LW. Academic Psychiatry 2016 40:9-12

being subjected to sleep deprivation, or harsh competition to get a training position in a college, it doesn't matter how resilient you are or how much mindfulness you practise. Every person has a breaking point."

Some examples of institutional change include: ensuring trainees are valued members of the team, especially by senior staff; not feeling stigmatised for having a day off work; family friendly rostering; mentoring, and the cultivation of a team and community ethos in each department.

A new initiative, Youth Initiated Mentoring, recently presented by visiting Professor Renee Spencer, Harvard, Boston, in parliament, may overcome many of the problems of current mentoring programmes,[16] attrition and low positive effects. By enabling at risk youth and other groups, such as physicians-in-training, to nominate their own mentors we can expect better outcomes to be achieved.

Additional comments

The MOH consultation paper provides an overarching strategy, but we are concerned that it fails to outline specific, explicit deliverable targets or timelines, as well as measures for evaluation. There is a lack of detail about how goals will be achieved. We would draw your attention to the following section in the paper:

- *P.12, No.6 Strengthen systems to support people who are in distress*
  There is no detail as to how this will be achieved.
- *Developing policies to promote protective factors and reduce risk factors for suicidal behavior*
  This is too broad a statement with no specifics detailed.
- *P.14 Developing and sharing information around some of the common myths and why they are false'*
  There is no explanation of what these 'common myths' are.
- *P.18 Making sure people can access appropriate services and support no matter where they live; supporting people with alcohol and other drug problems*
  For both the above points there is no mention of how this might be achieved or funded.
- *P.23 Once the final strategy is in place, we want to see suicide rates going down to lower than they are now.*
  This is a very vague target – we would recommend a target that is more specific.

How will the outcome targets on p.23, such as housing security; financial security; mental health; social and cultural connection; and well-being and respect, be measured?

We note that there is no actual commitment to increasing funding, e.g. on p.18, section six 'strengthening systems to support people who are in distress' includes the aim of "encouraging emergency department staff to consistently follow best-practice guidance on

[16] www.evensi.com/professor-renee-spencer-wellington-presentation

caring for people who present to emergency departments as being at risk of suicide," however this makes no mention of increasing access to appropriate psychiatric care or strengthening and properly funding in-patient care. As expressed in the document, the message is that if ED staff used best practice all the time, then there would be less of a problem. The reality is that staff are impeded from employing best practice as there is often nowhere to send the suicidal patient, except back out into the community.

We strongly support the initiative described on *p.15 Encouraging media to report responsibly on suicidal behavior (e.g. by reporting on stories of people who overcame suicidal thoughts and attempts),* which will help to promote conversation on this topic and raise public awareness.

Summary

We commend the Ministry of Health for looking at this critical issue, which affects everyone in our community, and for working towards increased prevention, however we believe the strategy is vague, and that it is essential to have specific, explicit targets. It is also crucial to address funding. We trust that the issues we have identified for physicians, and the initiatives and programmes being used overseas to mitigate depression and suicide, are helpful.

Thank you again for the opportunity to comment. If you would like further information or have any questions please email: president@anaesthesia.nz

Yours sincerely

David Kibblewhite
President