New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

7 June 2017

Ministry of Health
PO Box 5013
Wellington 6140

By email: suicideprevention@moh.govt.nz

A Strategy to Prevent Suicide in New Zealand

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

We welcome the development of a draft strategy to prevent suicide in New Zealand and congratulate the Ministry for considering the wider social and environmental determinants of health. Taking this type of holistic approach is essential to addressing suicide as well as a host of other complex health and social issues. We are supportive of the strategy's three main pathways (building positive wellbeing throughout people's lives; recognising and appropriately supporting people in distress, relieving the impact of suicidal behaviour on people's lives). We consider all ten potential areas for action in the strategy have merit, and have included these as an appendix for the benefit of our members.

Our main concern relates to the draft strategy's failure to include a target to inform efforts to prevent suicide. We believe there is a strong case for setting evidence-based targets for suicide prevention that take into account the specific epidemiology over time. We note that the Ministry already publishes age-standardised suicide rates.[1] Setting targets for suicide prevention would be much akin to how the government set a better public services target for reducing the rates of rheumatic fever. Like rheumatic fever, suicide is a nationally important issue that has proved resistant to conventional policy instruments to date. We understand that an earlier iteration of the draft strategy contained the aspirational target of a 20% reduction in suicide rates over 10 years.

[1] Ministry of Health. Suicide Facts. 2014 data. Available from http://www.health.govt.nz/publication/suicide-facts-2014-data

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While this exact figure could be debated, we contend that a strategy to prevent suicide that fails to include a target for reduction in suicide is a major shortcoming. We urge officials to reinstate a well-formed aspirational target for suicide prevention.

Likewise, we believe that some of the proposed outcomes and indicators in the section on 'Keeping track of progress' are too vague to be of meaningful use (eg, 'mental health' and physical health). We contend there is a need to develop more sophisticated and nuanced indicators. For example, as indicators of mental health, it would be more useful to monitor the incidence and prevalence of non-fatal major depression, and the incidence and prevalence of alcohol/substance abuse. We also suggest that it could be useful to monitor rates of bullying and harassment.

Another major concern is the strategy's failure to address the need to adequately fund mental health services, including addiction services. Improving mental health and wellbeing, and addressing alcohol and other drug issues, particularly in at-risk groups including youth, are fundamental to reducing suicide. Funding of such services, ensuring appropriate workforces and reducing barriers to access must be priorities. It is disappointing that the entire 32-page consultation document contains just a single reference to funding. We draw attention to a Health Workforce New Zealand review of the mental health and addiction services workforce in 2011.[2] This review called for "a 250% increase in access to organised mental health and addiction responses by 2020 - to address unmet mental health needs that are the single greatest contributor to poor health and social outcomes at an individual, family and population level". Given the previously recognised extent of unmet mental health needs, we believe the draft strategy must include specific commitments to adequately fund mental health and addiction services.

While the draft strategy excludes dealing with physician-assisted suicide, it is our view that every sort of suicide is unacceptable. Society and its legislators should not expect doctors to assist a person to commit suicide, regardless of the person's age, disability or medical condition.[3] We ask the authors of the draft strategy to include mention of the provision and funding of effective palliative care services to cover the group of people with intractable terminal illnesses who are seeking suicide for reasons that can be alleviated. Likewise, we ask for the inclusion of services for people who are not terminally ill but who have other intolerable disability/symptoms.

In addition to the above points, we wish to make the following comments:

- We suggest that the Ministry explore the opportunities for collaboration with existing suicide prevention programmes. We draw attention to, but do not endorse, an Australian initiative known as the Black Dog Institute. This initiative already appears to have excellent resources, including skills-based training programmes for businesses and organisations.

- We suggest that the strategy highlight the usefulness of the healthcare profession with respect to suicide prevention, giving particular emphasis to the important role of GPs. The continuity of care that GPs provide and their insight into the wider determinants of a patient's health can be helpful. Nurses are also often in a useful position to elicit

[2] Health Workforce New Zealand. Towards the next wave of mental health and addiction services and capability: Workforce Service Review Report, June 2011. Available from https://www.health.govt.nz/system/files/documents/pages/mental-health-workforce-service-review.pdf

[3] New Zealand Medical Association. Investigation into ending one's life in New Zealand. Submission to the Health Select Committee. February 2016. Available from https://www.nzma.org.nz/__data/assets/pdf_file/0015/47022/sub_Investigation-into-ending-ones-life.pdf

information about a patient's mental health. Training programmes and resources for healthcare professionals would be of value.

- We suggest that the strategy include references to support the various claims made relating to potential effective actions.

- We support the development (or acquisition and modification) and dissemination of resources that increase mental health and suicide prevention literacy, and support people in distress. In addition to traditional print resources (such as pamphlets in GP reception areas), electronic resources such as apps are likely to be useful.

- We support the provision of wellbeing programmes across sectors including the education system and in workplaces. We support training for employers and employees on recognising distress and on how to support each other.

- We welcome the focus on "programmes and strategies to promote positive wellbeing at all life stages" including specific recognition of the needs of older adults.

- We welcome the focus the strategy gives to Māori and Pasifika. We suggest that the strategy also give specific attention to suicide prevention in refugees, given they may have many risk factors (eg, trauma, loss of culture/identify/social connections, poor physical health, cultural stigma).

- We welcome the strategy's emphasis on encouraging media to report responsibly on suicidal behaviour (eg, by reporting on stories of people who overcome suicidal thoughts and attempts).

- We note the strategy suggests "encouraging emergency department staff to consistently follow best-practice guidance on caring for people who present to emergency departments as being at risk of suicide". While we support this recommendation, we ask for clarification on what 'best-practice guidance' is, and to be directed towards a national guideline if one exists.

- We suggest that the authors may wish to mention copycat suicides and how to prevent these. We also suggest that the authors may wish to mention the difficulty sporting heroes may have transitioning to ordinary citizens.

- We note the strategy refers to "reducing myths associated with suicidal behaviour" and suggest that it would be helpful to include some examples of these.

- We suggest that the draft strategy add mention of 'harassment' wherever bullying is mentioned (eg, pages 4, 13, 17, 25). Harassment may be related to a person's ethnicity, gender, sexual orientation, disability or other factor.

- We suggest that the rates of bullying and harassment (including sexual harassment) could be added to the proposed outcomes and indicators in the section 'Keeping track of progress'.

- On page 11, paragraph 2, there is a word missing in the second sentence.

- On page 12, paragraph 1, there is a typo in the second sentence. The word ‘reach’ should be ‘each’.

- In the list of risk factors for suicide on page 4, there needs to be a semicolon to separate hopelessness from alcohol and drug misuse (ie, it should read “hopelessness; and alcohol and drug misuse”).

We hope that our feedback is helpful and look forward to seeing the finalised strategy.

Yours sincerely

Dr Kate Baddock
NZMA Chair

Appendix. Potential areas for action

Building positive wellbeing throughout people’s lives

1. Support positive wellbeing throughout people’s lives.

2. Build social awareness of and well-informed social attitudes to suicidal behaviour.

3. Encourage responsible conversations about suicidal behaviour and preventing suicidal behaviour.

4. Increase mental health literacy and suicide prevention literacy.11

5. Support and partner with communities to develop and carry out activities that help to prevent suicidal behaviour.

Recognising and appropriately supporting people in distress

6. Strengthen systems to support people who are in distress.

7. Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors.

Relieving the impact of suicidal behaviour on people’s lives

8. Strengthen systems to support whānau, families, friends and communities.

9. Strengthen and broaden collaboration among those working to prevent suicidal behaviour.

10. Strengthen systems for collecting and sharing evidence and knowledge about suicidal behaviour and for tracking our progress.