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Suicide Prevention Strategy Consultation
Ministry of Health
P O Box 5013
Wellington 6140

Email: suicideprevention@moh.govt.nz

Dear Cross-government Suicide Prevention Working Group

Draft suicide prevention strategy

Thank you for giving the Royal New Zealand College of General Practitioners (the College) the opportunity to provide feedback on the consultation document, *A Strategy to Prevent Suicide in New Zealand* (the draft strategy).

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the College, is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Your consultation

We understand the draft strategy was developed by a cross-government working group. It aims to set out a framework for working together to reduce suicidal behavior in New Zealand, and focuses on both prevention and supporting people while they are in distress and after suicidal behaviour. The draft strategy proposes areas for action and potential activities. The working group is now seeking feedback on the draft strategy and how to turn the framework into practical action.

The College's response

The College strongly supports the development of a strategy that demonstrates the government's commitment to tackling suicidal behaviour in New Zealand. We commend the efforts of the working group in the aim of developing a strategy tailored to New Zealand's cultural and social context. However, the College is concerned that while the draft strategy is broad, encompassing a range of different action areas to prevent suicidal behaviour, it is left rather vague in nature and lacks a framework that can be implemented based on evidence of effective interventions for suicide prevention.

Set out below is our feedback on the draft strategy with a particular focus on its relevance to general practice.

Cross-government approach

The College commends the cross-sectoral approach taken by various government agencies in developing the draft strategy. We acknowledge that no one person or organisation is able to directly influence the factors associated with suicidal behaviour. Therefore, collaboration across multiple sectors is vital for the prevention of suicide.

However, the College is concerned the draft strategy is not explicit on what each government organisation or agency will do to contribute to the strategy, and the necessary coordination among individuals and groups. The absence of any discussion of accountability for the strategy and proposed actions is a major shortfall. Furthermore, we note the document omits to identify the groups involved in the development of the draft strategy and whether these groups are capable of implementing the action areas. We consider that for a cross-government approach, each agency should know what the others are doing. Furthermore, it may be appropriate for the Ministry of Health to take the lead on the strategy with its commitment to making progress on reducing the rates of suicide in New Zealand.

We also note there is no indication in the draft strategy of the financial resources available or required for the action areas.

The pathways

The draft strategy proposes the following three pathways to reduce suicidal behaviour:

- Building wellbeing throughout a person's life.
- Recognising and appropriately supporting people in distress.
- Relieving the impact of suicidal behaviour.

The College supports the proposed pathways and recognising the importance of improving the mental health of the population as a whole to reduce suicide, and the provision of better support for those affected by suicide.

Prioritising actions

The draft strategy describes ten potential areas for action and lists possible activities under each area.

(i) General practice

The College is disappointed that the draft strategy makes very little explicit reference to the importance of primary care in preventing suicide. General practice is often the first point of contact for New Zealanders seeking health care. Recent data from the New Zealand Health Survey revealed that almost 80 percent of adults and children visited a GP in the past 12 months.[1] GPs are consulted by people with many of the known risk factors for suicide, eg long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. General practice is often the first point of contact for people who are distressed or have suicidal thoughts. A GP might be the first and only contact that a person with a mental health problem has with a health care provider. Therefore, GPs offer a unique opportunity at the frontline to influence a person's safety and mental health.

The College considers that the primary care setting is ideal for detecting and responding to mental health problems, assessing a person's risk of suicide or self-harm, and for people to seek help as early as possible to prevent mental health problems leading to suicide. Early intervention for mental health problems such as depression is important to maximise patient wellbeing.[2] This is reflected by the New Zealand Health Strategy, which has identified the pivotal role of general practice in mental health and addiction and the shift of more of these services into the community and primary care.[3]

Importantly, primary health care workers may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.

GPs play a key role in all three of the proposed pathways, ie building positive wellbeing throughout people's lives, recognising and supporting people in distress, and relieving the impact of suicidal behaviour on people's lives. This is further discussed below.

In relation to building positive wellbeing, the College stresses the importance of seeing mental and physical health as equally important. Mental health and physical health are interlinked. In this regard, the College has endorsed the *Equally Well* consensus position paper[4] and is committed to the *Equally Well* collaborative, which looks to improve the overall physical health of people with mental health and addiction issues. GPs can make a positive contribution by being aware of inequitable health outcomes, taking a model of wellbeing-focused prescribing, and actively avoiding diagnostic overshadowing.[5]

Building and supporting the capability of the primary care workforce, including GPs, to recognise and appropriately support people in distress is crucial. Research from the London School of Economics has shown that education for GPs on suicide prevention can have an impact as a population-level intervention to prevent suicide. The researchers noted that this intervention appeared to be highly cost-effective from a health system perspective alone.[6] An Australian study showed that an educational

[1] Ministry of Health. *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health; 2016.
[2] Carey M, Jones K, Meadows G, et al. Accuracy of general practitioner unassisted detection of depression. Aust N Z J Psychiatry. 2014;48(6):571-578.
[3] Ministry of Health. New Zealand Health Strategy 2016. Wellington: Ministry of Health; 2016.
[4] Te Pou o te Whakaaro Nui. Equally Well consensus position paper. 2014 September 11. Available from: https://www.tepou.co.nz/resources/equally-well-consensus-position-paper/546.
[5] The Royal New Zealand College of General Practitioners. Equally Well: Improving the physical health of people experiencing mental health and/or addiction issues. Wellington: The Royal New Zealand College of General Practitioners; 2017 May. Available from https://oldgp16.rnzcgp.org.nz/assets/New-website/Publications/Policy/Equally-WellPB9May2017.pdf
[6] Knapp M, McDaid D, Parsonage M. (eds.), London School of Economics and Political Science. Mental health promotion and mental illness prevention: The economic case. London: Department of Health; 2011.

intervention targeting GPs had a modest effect in reducing the prevalence of clinically significant depression or self-harm behaviour.[7]

In relation to relieving the impact of suicidal behaviour (page 9), GPs have an important role in providing effective and timely emotional and practical support to people who are bereaved in order to help the grieving process and support recovery. Furthermore, providing support to health practitioners who themselves are affected by suicidal behaviour of their patients is also important.

We note that many media articles or official communication (eg through schools) often provide a list of agencies from where to get help, and most of these are telephone helplines. There is often no advice given about visiting a GP or practice nurse. We consider this to be a vital source of support that many people, particularly young people, might not consider themselves. We strongly advocate for this option to be better publicised.

A group of College members highlighted their role as GPs in suicidal behaviour. Over a month in 2017, their local community experienced three adult suicides and a number of attempted suicides, which lead to much concern and distress amongst families, the community and health care staff. On one occasion, three GPs remained with one patient, who was significantly distressed and suicidal, until urgent support from police arrived. The GPs also explain that many patients are discharged from specialist mental health services to 'the community', and ongoing care is expected from families (if any) and GPs.

The GPs raise serious concerns that mental health services are under-resourced so people cannot get the help they require. They have called for increased resources for:

- primary care (including wider funding for psychologists and qualified counsellors) for less severe cases;
- follow-up community care, eg community mental health clinics;
- urgent psychiatric secondary care, eg for prompt attention for crisis such as suicidal behaviour and deterioration in major mental health.

The College advocates for accessible, affordable and culturally appropriate services to reduce suicidal behavior for all New Zealanders regardless of their location.

(ii) Access to means to suicide

The College acknowledges that one of the most effective ways to prevent suicide is to reduce access to means of suicide.[8] Some of the methods amenable to intervention include hanging in psychiatric wards and criminal justice settings and self-poisoning. The intervention of reducing access to means to suicide is not explicitly discussed in the draft strategy.

(iii) Focussing on identified population groups

The draft strategy identifies four population groups who have markedly higher rates of suicidal behaviour (page 11). It also discusses three different types of approaches needed to prevent suicidal behaviour, ie universal (all people), targeted (some people particularly those in higher risk groups), and indicated (people at high risk of suicidal behaviour) (pages 4-5). The College considers that the proposed areas for action or the activities set out in the draft strategy are not tailored towards these groups or approaches. It would be appropriate to prioritise action along these lines and according to evidence (discussed below). We also consider that the focus on individuals who are at high risk of

[7] Almeida OP, Pirkis J, Kerse N, et al. A Randomized Trial to Reduce the Prevalence of Depression and Self-Harm Behavior in Older Primary Care Patients. Ann Fam Med. 2012 July/August;10(4):347-356. doi: 10.1370/afm.1368

[8] World Health Organization. The Mental Health Action Plan 2013-2020. Geneva. World Health Organization. 2013.

suicidal behaviour (indicated approach) is as important and should not be weakened by taking a targeted approach.

An examination of the suicide mortality data would be helpful to identifying specific areas for prevention. For example, a recent study discussed hanging as the most common cause of death from suicide in Pacific peoples overall, followed by poisoning. The researchers stated that due to its accessibility, hanging could be extremely challenging to confine, and that prevention strategies should focus on safe messaging on the process and consequences, the possibility of neurological damage if one survives, and the impact it may have on the person who discovers the deceased.[9]

Suicide among children and young people is of particular concern. We note that young people are increasingly vulnerable to suicidal behaviours with the youth suicide rate being one of the highest among developed countries.[10] The draft strategy does not appear to tailor approaches to improve mental health for this specific group.

(iv) Resilience

One of our members noted that the draft strategy does not mention the usefulness of improving resilience by exploring and developing one's spiritual side. She considers that 'nourishing the soul' in whatever faith, tradition, or meditative practice can influence mental health, and was surprised that encouraging engagement and questioning, pursuing the questions around 'why are we here', 'what is my purpose', 'what do I believe', 'does a god exist' and 'what do my people/cultural group believe' were not mentioned as potential activities.

(v) Example of a local initiative

One GP informed us of an example of a local initiative in their small, but very rapidly expanding, settlement in coastal south east Auckland. It has a current population of 12,000, and had six suicides in the past 12 months. Two of the individuals were well known people in public visibility. The issue was brought to the leadership of the Presbyterian Church and within three months, three volunteers organised a response that included door knocking, contacting local businesses and organisations, producing and distributing resources, and an interview with the local paper. They arranged speakers for variety of organisations and a free community gathering. The outcome was at least 10 people committed to undertaking a mental health first aid course. The organisers hope that this action is a first step towards supporting those who are bereaved, struggling or want to learn how to help, and to build community systems that increase resilience.

Evidence-based activities

The draft strategy lists a broad range of activities under each of the ten potential areas for action that aim to contribute to reducing the rate of suicide. The College has strong concerns that the draft strategy does not apply evidence of effective interventions. The draft strategy does not discuss which of the past or current national and local interventions have been effective, or state which of the proposed activities are already in place. We question how the government will know which of the many activities in the draft strategy to fund without data on their effectiveness.

For instance, the College questions how or if the findings from the evaluation of phase 2 of the New Zealand Guidelines Group's Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga (which aimed to improved crisis care in emergency departments, Māori Health, Māori mental health and

[9] Tiatia-Seath J, Lay-Yee R, Von Randow, M. Suicide mortality among Pacific peoples in New Zealand, 1996-2013. N Z Med J. 2017 Apr 28;130(1454):21-29.
[10] Coppersmith DDL, Nada-Raja S, Beautrais AL. An examination of suicide research and funding in New Zealand 2006-16: implications for new research and policies. Aust Health Rev. 2017 March. doi.org/10.1071/AH16189

mental health services) apply to the draft strategy.[11] As another example, has there been any evaluation on the suicide prevention workshops across rural New Zealand, or on the workshops to assist health professionals to better manage suicidal patients in a rural setting?

The authors of a systematic review on suicide prevention strategies in *The Lancet* state:[12]

> "Because suicide is a major cause of death and disability, the implementation of proven, evidence-based, and cost effective strategies are the duty and responsibility of public health policy makers and health-care providers."

Moreover, the authors of a recent research article on suicide research in New Zealand concluded that future research investments should focus on effective translation of research findings into suicide prevention programmes.[13]

Therefore, the College advocates for a strategy that identifies cost-effective, evidence-based approaches which work as early as possible. We consider that using these interventions is in the best interests of consumers and would enable services to make best use of limited resources. It is important to use evidence on effectiveness to prioritise and guide activities.

The draft strategy states that it considers how different sectors and the whole community can contribute (page 1). The College acknowledges the importance of carrying out work locally to prevent suicides and the need to adapt interventions according to regional and local variations. For example, in rural communities, lowering the suicide rate could include rural-based organisations providing opportunities for people to talk about how they feel. Therefore, we consider that a discussion on evidence-based interventions and key resources would also better support and inform the local approaches to suicide prevention.

Aims and goals

The purpose of the draft strategy is "to reduce the suicide rate through reducing suicidal behaviour" (page 7). The College is concerned the draft strategy does not set a target for the government, and hence the ability to monitor progress towards this target. This is a major gap of the draft strategy.

You will be aware that in May 2013, the Sixty-sixth World Health Assembly adopted the Mental Health Action Plan of the World Health Organisation (WHO), and suicide prevention is an integral part of the plan.[14] The WHO's global target is a reduction in the rate of suicide in countries by 10 percent by 2020. The College considers that it would be appropriate to include the WHO target and New Zealand's progress towards it (from baseline year 2012 or 2013) and/or an alternative appropriate target. A well-defined aim is necessary for the effectiveness of the strategy, and commitment to targets would help to improve knowledge about suicide prevention.

We also note the draft strategy aims to support those who are supporting a person in distress or affected by suicide, and it would be appropriate to include this under the Purpose.

The draft strategy states that "government agencies will monitor the impact of activities" and "will lead the development of clearly defined outcomes and indicators" (page 23). The College is concerned that the draft strategy does not provide an outcomes framework or measurable objectives. We consider

[11] Te Pou and Ministry of Health. Evaluations of the NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga (Phase 2) Evaluation: Final Report. 2010 Aug: Te Pou o Te Whakaaro Nui; Auckland.
[12] Zalsman G, Hawton K, Wasserman D, et al. Suicide prevention strategies revisited: 10-year systematic review. Lancet Psychiatry. 2016 Jul;3(7):646-59. doi: 10.1016/S2215-0366(16)30030-X.
[13] Coppersmith DDL, Nada-Raja S, Beautrais AL. An examination of suicide research and funding in New Zealand 2006-16: implications for new research and policies. Aust Health Rev. 2017 March. doi.org/10.1071/AH16189
[14] World Health Organization. Mental health action plan 2013-2020. Geneva. WHO Press. 2013.

that reliable, timely and accurate suicide data is essential for effective suicide prevention. All implemented activities will need their progress monitored, with activities being carried out at the same time as data collection.

For instance, the draft strategy proposes first targeting national activities for population groups who have markedly higher rates of suicidal behaviour. Therefore, it would be essential to monitor suicide rates in these groups to report on what the strategy achieves.

We note the WHO states that measuring a strategy's progress can include:[15]

- a percentage reduction in the suicide rate;
- the number of suicide interventions successfully implemented;
- a decrease in the number of hospitalised suicide attempts.

Concluding remarks

There is a clear need for a comprehensive suicide prevention strategy that includes well-defined goals, measurable objectives and the identification of agencies who will implement the action. A robust monitoring and evaluation framework would foster a sense of accountability and help to provide a sustained focus on suicide prevention in New Zealand. The College welcomes the opportunity to be involved in relevant activities such as developing and promulgating appropriate training packages for GPs.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely

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[15] World Health Organization. Preventing suicide: A global imperative. Geneva. World Health Organization. 2014.

Information about the person/organisation providing feedback

You are encouraged to fill in this section. The information you provide will help government agencies analyse the feedback. However, your submission will be accepted if you do not fill in this section.

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