ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Diana

Draft Suicide Prevention Action Plan for 2025-2029

Thank you for the opportunity to provide feedback on the Draft Suicide Prevention Action Plan for 2025-2029. Please find attached analysis of the draft plan from Toi Mata Hauora – the Association of Salaried Medical Specialists.

We would be happy to speak with the Ministry about any aspect of our feedback on this critically important plan. Please contact Virginia Mills in the first instance at virginia.mills@asms.org.nz

Nāku noa, nā

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Enclosures: Toi Mata Hauora submission on the Draft Suicide Prevention Action Plan for 2025-2029

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Submission on the proposed Suicide Prevention Action Plan

Thank you for the opportunity to provide feedback on the proposed Suicide Prevention Action Plan.

Toi Mata Hauora (the Association of Salaried Medical Specialists (ASMS)) is the union and professional association of salaried senior doctors and dentists. We were formed in April 1989 to advocate and promote the industrial and professional interests of our members, most of whom are employed by Te Whatu Ora as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. We have over 6,000 members.

Toi Mata Hauora ASMS has a strong interest in ensuring Aotearoa New Zealand has a safe, high quality, and equitable health system and effective measures to address the determinants of ill health. The current consultation is relevant to that aim.

In brief

We have no confidence the proposed Action Plan will achieve its aim. The proposed specific actions are not adequate to the task in the face of existing, and growing, unmet need for mental health care, and broader government policies that run counter to suicide prevention. In 2023 an estimated 329,000 adults and 55,000 children had unmet need for Mental Health and Addiction (MHA) services – an increase of 73 per cent and 45 per cent respectively since 2016/17. This out-strips the growth of the MHA workforce. Government policies that will exacerbate factors associated with suicide include those that will increase poverty, reduce access to many social services and increase the risks for Māori and Pacific peoples, who are already over-represented in the prevalence of suicide.

Suicide prevention – and the population's health and wellbeing in general – will improve when political parties overcome their narrow focus on short-term surplus targets and recognise expenditure on health and social services as a long-term economic and social investment. Also, when addressing health inequities, ethnicity as an evidence-based marker of need. must be recognised.

Recently released provisional suicide statistics show an increase in the number of suspected suicides in the last year. It is critical that meaningful, evidence-based, multi-agency action on suicide prevention is implemented.

The proposed Action Plan

We note the new action plan is aligned with the Government's Mental Health portfolio priorities, which in this context are to:

- improve access to suicide prevention and postvention support
- grow a workforce that is able to support those at risk of or impacted by suicide
- strengthen our focus on prevention and early intervention across the range of factors that can influence suicide

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- improve the effectiveness of suicide prevention and postvention supports by improving research and data collection.

The evidence for effective suicide prevention

We note research commissioned by the Ministry of Health reviewing the evidence on suicide prevention and postventionshows the following actions have evidence of effectiveness:[1]

- Reducing the societal factors associated with suicide such as poverty, loss of land and language, discrimination and violence.
- In times of recession, increasing expenditure as a proportion of GDP focusing on unemployment benefits, active support of return to labour market programmes, social welfare, and robust employment protection legislation.
- Increasing adherence to responsible media reporting guidelines.
- Restricting access to and installing barriers, signs and advice in locations associated with jumping from height; and updating technology for faster stopping of trains.
- Continued restrictions on lethal means for suicide such as firearms (and monitor the impact of recent legislation on these deaths), carbon monoxide gas and pesticides.
- Stronger restrictions on medicines able to be misused and linked with suicides, with monitoring of the impact of such changes.
- Targeting acute alcohol misuse by restricting access and increasing price.
- Ensuring adherence to existing requirements in specific settings to reduce access to hanging as a method of suicide, including inpatient psychiatric settings, police stations and prisons.
- Ensuring adherence to the basic approaches of adequate staffing and service user visibility in these settings.
- Having workplace interventions for first responders (eg, police, firefighters, ambulance staff, military), noting also that health and social care workers are "experiencing significant pressure and require specific focused interventions which focus on the organisational sources of their distress".
- Prevention of all forms of violence and particularly sexual violence.

The review also emphasises that:

"Te Tiriti o Waitangi is central to the success of suicide prevention in Aotearoa. A clear commitment to a nuanced and appropriately resourced national suicide prevention action plan will support success."

And:

"Overall, the strongest evidence base for suicide prevention in psychiatric in-patient settings is the use of ward environment modifications, such as staff training, increasing staff to patient ratios,

[1] Fortune S, Sharma V, Papalii T, et al. 2023. *Evidence Synthesis of the Research on Suicide Prevention and Postvention: Aotearoa New Zealand and International Perspectives.* Wellington: Ministry of Health

optimising patient visibility and conducting regular safety checks and monitoring both inside and outside the ward…"

However, the review does not acknowledge the impact of staffing shortfalls beyond in-patient settings.

Toi Mata Hauora ASMS key points

1. To ensure the proposed Action Plan (the Plan) is in scale with community need, it must be considered in the context of significant and growing unmet need for mental health services and significant workforce shortages.
2. Government policies to reduce public services and support for non-government organisations (NGOs) with critical roles in suicide prevention run counter to the aims of the Action Plan.
3. Some government policies and approaches run counter to the research findings that Te Tiriti o Waitangi is central to the success of suicide prevention in Aotearoa.
4. Workforce shortages and lack of data are hindering suicide prevention for the medical profession.
5. Cuts to the Ministry of Health and research funding is hindering an urgent need to invest more in research and data collection to improve the effectiveness of suicide prevention and postvention supports – and provide evidence for cost-effective investment.

1. To ensure the proposed Action Plan is in scale with community need, it must be considered in the context of significant and growing unmet need for mental health services and significant workforce shortages.

In 2022/23 an estimated 329,000 adults and 55,000 children had an unmet need for Mental Health and Addiction (MHA) services – an increase of 73 per cent and 45 per cent respectively since 2016/17.[2]

The steep growth rate is due to several factors:

- Adults reporting high or very high psychological distress grew by 72.5 per cent between 2016/17 and 2022/23: the need for MHA services is growing.
- The number of clients accessing MHA services increased by just 10.4 per cent from 2016/17 and 2021/22 (figures are not yet available for 2022/23).[3]

[2] New Zealand Health Survey 2022/23. https://www.health.govt.nz/publication/annual-update-key-results-2022-23-new-zealand-health-survey

[3] Te Whatu Ora. Mental Health and Addiction: Service Use Webtool. https://tewhatuora.shinyapps.io/mental-health-and-addiction-web-tool/ *Note: 2021/22 figure is based on 2020/21 estimates as data for 2021/22 are incomplete; Te Whatu Ora explain that "*it is likely that overall, there has been a net increase in access to services and support [from 2020/21].*"

- The MHA workforce grew by less than half that rate (5%) from 2017/18 to 2021/22.[4]

Universal access to timely, coordinated, high quality mental health care is a critical component of suicide prevention, particularly for people with serious mental illness and substance use disorders. Good access to 24-hour crisis care is one of the most important aspects of mental health service provision in the prevention of suicide.[5]

Good access requires an adequate workforce. The draft plan aspires to "grow the workforce" without any proposed actions to do that. A separate *MHA Workforce Plan 2024-2027* includes plans to train 177 more MHA workers in 2025 compared to the previous year, 237 more in 2026 and 277 more in 2027.[6] While increases in training is welcomed, for a total MHA workforce of approximately 9,000, this averages around 2.6 per cent, which is far less than the growth needed to match increasing service pressures and allow for attrition rates.

For the psychiatrist workforce, plans to increase training positions is a positive step but there is a critical need for more immediate measures. As the workload is increasing at a higher rate than workforce growth, Te Whatu Ora forecasts show pressures continuing to mount for psychiatrists over the coming years unless recruitment and retention improve significantly.

The forecasts in **Figure 1** are projected from workforce entry and exit trends over the five years to 2023 for public and private sectors combined.[7] Other data also show workforce movement from the public to the private sector. Unpublished Medical Council figures show a 77 per cent increase in the number of full-time-equivalent (FTE) psychiatrists working privately from 2019 to 2023 (from 53 FTE to 94 FTE). On average, nearly 30 per cent of psychiatrists' time is now spent in the private sector or in other non-public health service employment.[8]

[4] Te Pou. *Adult mental health and addiction workforce: 2018 secondary care health services* (2019*); Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services* (2022); *NGO workforce estimates: 2022 survey of adult alcohol and drug and mental health services* (2023). Auckland. *Note: Data for 2016/17 is not available.

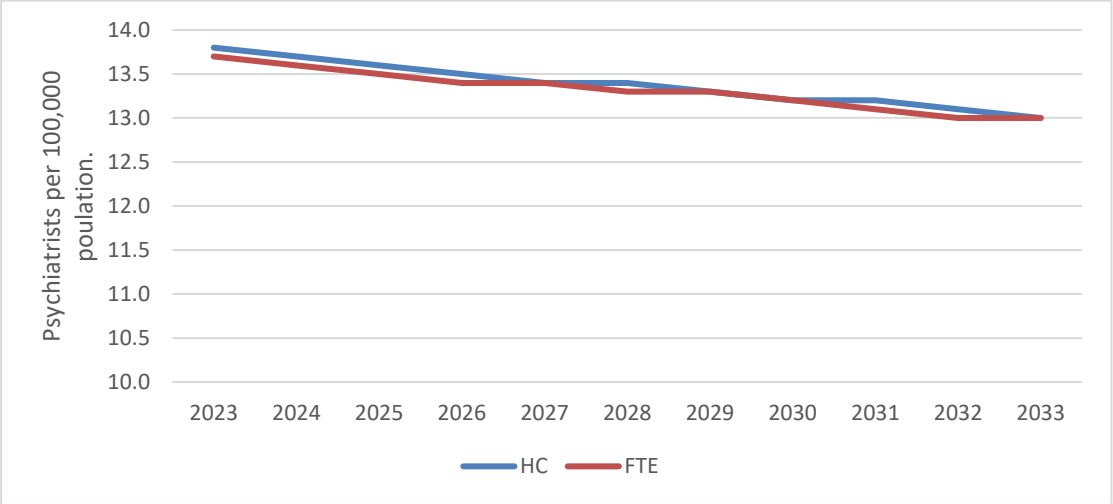
[5] Krysinska K, Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N, et al. Best strategies for reducing the suicide rate in Australia. Australian & New Zealand Journal of Psychiatry. 2015;50(2):115-8.

[6] Te Whatu Ora. *Mental Health and Addiction Workforce Plan 2024-2027*.

[7] Ministry of Health, 2021.

[8] MCNZ. Unpublished medical workforce data, 2024.

Figure 1: Forecast psychiatrist workforce (public and private) by headcounts and full-time-equivalent numbers, 2023-2033



Source: Te Whatu Ora 2023

The public-to-private shift, along with the effects of an ageing workforce (nearly 20 per cent of psychiatrists are aged 65 or older) has resulted in more psychiatrists leaving the public sector workforce than are entering it.

In the year to March 2022, 12.9 per cent of the Te Whatu Ora psychiatrist workforce resigned while recruitment totalled 9.1 per cent. Nearly one in five Te Whatu Ora psychiatrist positions were vacant in 2022 (Table 1).[9]

Table 1: Te Whatu Ora psychiatrist workforce, year to 31 March 2022

Psychiatrists	FTE employed	FTE vacant	Vacancy rate (%)
Adult Mental Health	303.2	74.2	19.7
Adults Forensic Mental Health	33.4	4.2	11.3
Adults Addiction	28	5.4	16.1
Total	**364.6**	**83.8**	**18.7**

Source: Te Pou 2023

[9] Te Pou. *Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services.* Auckland, April 2023. https://www.tepou.co.nz/resources/te-whatu-ora-adult-mental-health-and-addiction-workforce-2022-adult-alcohol-and-drug-and-mental-health-services-report.

2. Government policies, including reducing public services and support for non-government organisations (NGOs) with critical roles in suicide prevention run counter to the aims of the Action Plan.

The commissioned research highlights the importance of reducing the societal factors associated with suicide "such as poverty, loss of land and language, discrimination and violence." However, there is nothing in the draft plan to indicate such factors will be alleviated.

Treasury forecasts that targets on reducing child poverty will be missed significantly.[10] Benefit indexation changes, real terms cuts to the minimum wage, changes to the Healthy School lunches programme, the reintroduction of prescription fees, and public transport subsidy cuts, will negatively impact those in poverty.

While the Plan sees $18 million go towards a range of community activities, plus $6 million for youth counselling and $11 million for a Community Sector Innovation Fund (much of it brought forward from 2023/24), at the same time, the community-based social sector is facing $139 million in funding reductions, including cuts to violence prevention and support services. This year's Budget also saw cuts to the MHA Infrastructure Programme, the Problem Gambling Service and the Mental Health and Wellbeing Commission, and removal of dedicated funding to develop Comprehensive Primary Care Teams, and MHA funding for the Ministry of Health.[11] The Suicide Prevention Office within the Ministry no longer employs full-time staff, thereby weakening the cohesion and leadership required to develop and support suicide prevention policies. [12]

Ministry correspondence to Mental Health Minister Matt Doocey obtained by Radio New Zealand under the Official Information Act, said: "Several agencies noted that they are limited in what actions they can propose leading at this time due to uncertainty about future priorities for agencies and agency resources." [13]

We note that the findings of the commissioned research into effective suicide prevention measures are not fully reflected in the proposed plan. For example, a Ministry-commissioned review of the alcohol levy suggested a strong case to increase the levy quantum to enable the Ministry of Health and providers of levy funded activities to address the consequences of the cumulative shortfall resulting from a lack of inflationary adjustments… [since 2012/13].[14] However, there is nothing in the plan to suggest a raising of the levy. Nor is there any proposal to reduce the availability of alcohol, which is acknowledged in the plan as implicated in a quarter of suicides.

Remediating and minimising ligature points in correctional facilities is a good idea. However, the plan should also approach this from a preventative perspective, with a lens of improving 'social

[10] Willis Hon N. *Child Poverty Report*, NZ Government, 30 May 2024.

[11] ASMS & NZNO. *Just Treading Water*: A joint analysis of the health budget for 2024/25, June 2024. https://asms.org.nz/wp-content/uploads/2024/06/Just-Treading-Water-ASMS-NZNO-June-2024.pdf

[12] Bradley A. Suicide Prevention Office to continue in name - but with no full-time staff, *Radio NZ*, 15 May 2024.

[13] Mythen S. Lack of resources may frustrate new suicide prevention plan, *Radio NZ*, 4 October 2024.

[14] *Allen + Clarke*, NZIER (2023), *Interim Report of Independent Review of the Alcohol Levy*. Wellington: Manatū Hauora

connection' at all ages and stages to reduce both suicide rates and incarceration rates, as well as having multiple co-benefits for other social and health outcomes.[15] [16]

3. Some government policies and approaches run counter to the research findings that Te Tiriti o Waitangi is central to the success of suicide prevention in Aotearoa.

The Treaty Principles Bill is set to be supported at its first reading and will proceed to the Select Committee stage where public consultation will be invited. This process is likely to be divisive and damaging. As outlined by the Waitangi Tribunal, affirming rangatiratanga is integral in meeting Māori healthcare needs, and the Crown has a responsibility to support "earnest and expert-supported" translations of Te Tiriti. Policy, legislative and constitutional processes that impact Māori, must be undertaken in partnership with Māori. The Waitangi Tribunal has found the policy on the proposed legislation as unfair, discriminatory and significantly prejudicial to Māori.[17] [18]

Regardless of how far the proposed Bill progresses through Parliament, divisive and damaging debate that is neither "earnest and expert-supported" risks being detrimental to Māori and Māori mental health.

In addition to the Treaty Principles Bill, Government policies have limited the use of Te Reo in the public service. Māori Language Commissioner Rawinia Higgins has described government policies to limit the use of the language in the public service as "a risk" to the half-century effort to revive it.[19] [20]

4. Cuts to the Ministry of Health and research funding is hindering an urgent need to invest more in research and data collection to improve the effectiveness of suicide prevention and postvention supports – and provide evidence for cost-effective investment.

The Ministry's commissioned research, echoing the findings of the 2018 Mental Health Inquiry, highlights gaps in research evidence that should inform a suicide prevention research agenda. It calls for "a strategic research prioritisation approach including a clear signal … about what the next big questions in prevention research in Aotearoa New Zealand are." It also highlights a need for real time surveillance of both self-harm and suicide, to evaluate the efficacy of interventions.

Further, "research funders need to focus on studies which integrate Te Ao Māori, are well designed trials using standardised measures of suicide outcomes, address the tendency to exclude participants

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[15] Milner A, Page A, Morrel S, et al. Social connections and suicidal behaviour in young Australian adults: Evidence from a case–control study of persons aged 18–34 years in NSW, Australia, *SSM Popul Health*, 2015 Oct 9;1:1–7

[16] Szanto K, Whitman K. Improving Social Connections to Reduce Suicide Risk: A Promising Intervention Target? *Am J Geriatr Psychiatry*. 2021 May 5;29(8):801–803.

[17] Loring B, Reid P, Curtis E, et al. Ethnicity is an evidence-based marker of need (and targeting services is good medical practice), Editorial, *NZMJ* 2024 Sep 27; 137(1603)

[18] Ministry of Justice. *Regulatory Impact Statement: Providing certainty on the Treaty principles*, 28 August 2024.

[19] Cabinet Office Circular CO(24)5, 13 September 2024.

[20] Tahana J. Māori language 'at risk' as a result of government policies, commissioner says, *The Guardian*, 23 September 2024.

due to elevated suicide risk, address intervention fidelity, and include cultural responsiveness as safe practice."

The research also calls for health economic evaluations to be integrated to inform decisions about investment.

There is growing evidence internationally identifying a broad range of policies and interventions to prevent mental disorders and promote wellbeing that are cost effective and can produce significant economic benefits. An international review of the cost effectiveness of mental health prevention and promotion interventions found that "preventive interventions for suicide and externalising problems in children/adolescents as well as for depression and substance use in adults produce significant returns."

The researchers noted, however, that the generalisability of these finding were open to question – which again highlights the urgent need for more local research and data collection. Recent cuts to research funding in this year's Budget are driving in the opposite direction.

5. Workforce shortages and lack of data are hindering suicide prevention for the medical profession

A recently published study examining suicide rates of doctors in 20 countries, including New Zealand[21], found evidence for increased suicide rates in female doctors compared with the general population, and for male doctors compared with other professionals. An Australian study found a substantial increase in suicide risk for female doctors, which doubled between 2001 and 2017.[22]

The covid-19 pandemic has put additional strain on the mental health of doctors, potentially exacerbating risk factors for suicide such as depression and substance use.[23]

As the Ministry's commissioned research points out, health professionals are "experiencing significant pressure and require specific focused interventions which focus on the organisational sources of their distress".

Such focused interventions, however, are hindered by a lack of data. In the United Kingdom, there is ready access to data relating to suicides of health care professionals which allows for targeted interventions and open and frank discussion about the issue and potential solutions. No such data is readily available in New Zealand.

The Plan addresses the importance of clinical supervision for those who work directly with patients who are at risk for suicide. Feedback from ASMS members, however, points out that it does not address the need for clinical supervision for those health care professionals who are involved in the care of individuals who have attempted or completed a suicide. This includes paramedics, health care professionals in Emergency Departments and Intensive Care Units, and also general medicine. Many

[21] Zimmermann C, Strohmaier S, Herkner H, et al. Suicide rates among physicians compared with the general population in studies from 20 countries: gender stratified systematic review and meta-analysis: *BMJ*, 21 August 2024.

[22] Petrie K, Zeritis S, Phillips M, et al. Suicide among health professionals in Australia: a retrospective mortality study of trends over the last two decades. Aust N Z J Psy

[23] Myran DT, Cantor N, Rhodes E, et al. Physician health care visits for mental health and substance use during the covid-19 pandemic in Ontario, Canada. *JAMA Netw Open* 2022;5:e2143160.

of these professionals will care for these patients under highly stressful circumstances, and typically will not have extended input from the psychiatric team into patient care until the patient is "medically cleared". The patient is then transferred to psychiatric services for ongoing care. There is little information available to tell whether the health care workers caring for the patients in the immediate crisis phase are at risk. However, anecdotally (and data from the UK would also suggest), these craft groups are at higher risk than in other areas. New Zealand must collect data to develop a better understanding of the impact on these groups.

The literature identifies a range of strategies and actions to prevent suicide among health workers, including mandating staff wellbeing programmes. However, staffing shortages in Aotearoa have impacted the ability to take leave due to lack of cover, and basic entitlements like proper rest and meal breaks are not consistently implemented. Effective wellbeing initiatives must include ensuring safe and sustainable working conditions. Currently, Aotearoa is a long way from achieving the basics of healthy working environments.