5 June 2018

Mental Health and Addiction Inquiry Panel
Panel Chair Professor Ron Paterson
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Dear Professor Paterson

Re: Mental health and addiction inquiry

About the NZSA
The NZSA is a professional medical education society, which represents over 600 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 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 of the inquiry
The lifetime prevalence rates of mental illness are much higher than many people assume with more than half the population likely to experience a disorder at least once in their lives. In any one year, one in five New Zealanders will present with a mental disorder that sufficiently impairs their lives to warrant intervention.[1] The NZSA welcomes the opportunity to provide input into the Government's Mental Health and Addiction Inquiry and commends the objectives of the panel to build positive mental health and well-being for all New Zealanders and to improve the quality of support and interventions given to those who need them. We are heartened by the panel's whole-of-society, integrated approach and the efforts being made to seek the views of communities, whānau and family, providers and government to work together to provide a clear direction for the future. We are also strongly supportive of the inquiry saying that it is looking beyond mental health services, to also assess the drivers behind New Zealand's high rates of depression and suicide, and the inequalities which exist.

[1] Vos T, Allen C, Arora M, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. The Lancet 2016; 388(10053): 1545-602.

NZSA role in promoting mental health and welfare
Promoting welfare and well-being is a priority of the NZSA's work and a core part of our mission statement in supporting our members. Some examples of this work to date are:

- Our submission in response to the Government's New Zealand Suicide Prevention Strategy.
- Our sub-specialty networks in obstetrics and paediatrics which are valuable for connecting and supporting anaesthetists, particularly those working in more remote regions of the country.
- Involvement in a workshop held earlier this year by the Australian and New Zealand College of Anaesthetists to develop a framework on health and well-being for fellows and trainees. This is a longer-term project which the College aims to have completed and in place by 2019-2020.
- Promotion of the Australasian Anaesthesia Welfare Special Interest Group's well-being resource documents and projects, with the NZSA represented on this Group.
- Raising awareness of well-being issues among our members, through a range of mechanisms including our publications and annual member forum.

As a community, anesthetists are deeply affected by mental health issues and suicide. [2] [3] Doctors have the highest rate of suicide of any profession, and evidence suggests that anesthetists have a higher rate of suicide than other medical specialties.[4] The reasons for the high prevalence of suicide among doctors is complex and multifactorial, but in part attributed to their specialist knowledge and that as high performers their high standards come into conflict with frustrating working conditions and/or problematic patient outcomes. An additional aspect is that doctors who are subjected to a complaint and/or investigation are at particularly high risk of mental health issues and suicide. There is a raft of studies and literature to back this finding and we will look at this more closely in our submission and put forward suggestions to better support doctors in this position.

We will also focus on preventive health measures and the provision of 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. [5]

[2] Mental Health and welfare in Australian anaesthetists.
McDonnell N J, Kaye R M, Hood S et al. Anaes. Int. Care 2013; 41: 461-647
[3] 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
[4] Cause specific mortality risks of anaesthesiologists. Alexander BH, Checkoway H, Nagahama SI, Domino KB. Anesthesiology 2000; 93: 922-930
[5] Are we at risk of losing the soul of medicine? Botha D. Canadian Anaesthesiologists Society Feb. 2016

Key themes and principles
The workshops that took place during the consultation for New Zealand's Suicide Prevention Strategy last year highlighted some key themes which are equally applicable to this inquiry's objectives. We would recommend that the panel be guided by these themes as follows:

- *Build individual, family and community resilience*
- *Build cohesive families and provide parents and whānau /families with ongoing support*
- *Reduce the stigma around mental health and encourage people to seek help*
- *Provide more resourcing for support, services and professional help*. Campaigns which seek to reduce the stigma associated with mental illness such as the John Kirwan long running depression awareness campaign, have led to more people seeking help. According to the Mental Health Foundation there has been a 75 per cent rise in demand for mental health services in the last decade but services have not kept up with demand for face-to-face therapy. This must be urgently addressed.
- *Use Maori and Pacific models of well-being to inform our work*, particularly when working with whānau/families.

We would also like to refer to the excellent paper by the Chief Science Advisor Sir Peter Gluckman *Toward a Whole of Government/Whole of Nation Approach to Mental Health* (May 2017) and some of the key points in this paper which stated the prerequisites for making progress including: a better understanding of the severity and extent of the problem; bringing the pieces of all sectors which influence and are affected by mental health into a coherent whole; upgrading skills and building new capacity across the mental health sector; a focus on prevention, early detection, and better treatment; and an understanding of the life course and its implications for mental health.

Depression, burnout and suicide
While strengthening resilience is an important concept and goal, it could be argued that physicians are resilient and have always worked long hours and had stressful and demanding jobs. We believe a greater focus needs to be placed on the institutional and working environment. There is a strong correlation between burnout and depression and suicidal ideation among healthcare workers. These have been causally linked to a problematic work environment such as staff shortages leading to intense workloads, fatigue, unrealistic demands from patients, loss of autonomy, time pressure including onerous on call duties, co-worker conflict, increasing social isolation as doctor-patient relationships and relationships among colleagues suffer due to time constraints, discordance between values of the physician and management, and harassment, bullying and intimidation from colleagues.

Some of these factors have been 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 2016 report "Tired, worn out and exhausted," published by the senior doctors' union the Association of Salaried Medical Specialists (ASMS). The report is based on a survey of specialists working in public health and explored the emotionally demanding nature of healthcare provision, including high anxiety levels in relation to patient outcomes. Burnout poses risks to the health of doctors but also their patients, due to the correlation between burnout, quality of care and the 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 provide support to those who are afflicted. They advocate for better resourced DHBs to address staffing levels, the volume of work and management culture.

Doctors and the duty of personal wellness

Doctors have a professional duty to look after their health and personal wellness. There is also an expectation that doctors, who have specialist healthcare knowledge, will be able to look after their own health needs. However, the evidence suggests otherwise. Dunn[6] studied the healthcare practices of residents and found that they delayed self-care for various reasons, including: academic consequences, what others will think of them, and privacy concerns. Residents are less likely to have a general practitioner or to seek routine healthcare, than the general population.[7] 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.[8] Convincing physicians that their personal health and well-being are as valuable as their patients' is no small feat and it is recognized that this requires a culture change, and that significant change will be a longer-term endeavour.

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.[9] However, an evaluation of research and initiatives undertaken in New Zealand and overseas, highlights a range of measures to promote well-being and resilience and to lower rates of depression and suicide. These measures include:

- Teaching medical students about self-care, social support, relationship management, self-awareness, drug and alcohol abuse and how to ask for help. The University of California, San Diego School of Medicine, demonstrated benefits associated with education, confidential screening and early intervention. [10] It found that the safety and privacy of participants is 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.
- Teaching medical students and physicians how to recognise signs of suicide risk in themselves and others and how to sensitively approach a struggling colleague.[11] 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 provides continuing medical education to enable anaesthetists to improve mental health, stress management and personal relationships.

[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] Mental health as above

[9] Suicide rates amongst physicians: a qualitative and gender assessment (meta analysis) American Journal of Psychiatry. 2004; 161: 2295-302

[10] 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

[11] Physician suicide rates show alarming need for education. Gray R. Tennessee Medicine 2009; 102: 39

- Introducing anesthesiology residency welfare programmer, such as those offered by the University of Saskatchewan.[12] Residents are encouraged to develop and share personal resilience skills, tools and strategies to maintain wellness. Initiatives have also been implemented to complement personal resilience by creating a safe, and supportive environment to promote well-being.
- Shifting away from treating individuals as 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[13], the authors looked at a range of tested interventions for promoting medical student and physician well-being and reducing depression and suicide. Some of these interventions included:

    - Student and resident seminars discussing the emotional, physical and social impacts of medicine – the seminars were kept to a small number of participants. These seminars are process oriented and structured, and the groups are longitudinal and address the stresses of being a doctor throughout a doctor's career.
    - Broadening medical education and training to include 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.

The article concludes: "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 they 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 bullied or harassed or 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."

[12] 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.

[13] 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

Some examples of institutional change include: ensuring trainees are valued members of the team, especially by senior staff; family friendly rostering; mentoring systems, and the cultivation of a team and community ethos in each department.

Medical error, complaints and investigations

Patients and families affected by medical error are the primary victims of medical error, and understandably the literature has focused on these patients and their families. The framework in New Zealand to assist patients to seek redress for a medical error is primarily through the Health and Disability Commissioner and the Medical Council of New Zealand. However, there is another victim, often referred to in the literature as the "second victim" which may include physicians, nurses and other healthcare providers who suffer mental and emotional distress following a medical error. These errors will happen to even the most well intentioned and skilled physicians and lead to distress in the form of guilt, shame, anxiety, post-traumatic stress disorder and even suicidality. The reasons for this are multifold: medicine's culture of perfectionism, the healthcare system not tolerating mistakes, and the tendency to blame individuals rather than looking at the team or the system itself. In relation to this last point, an article in the Journal of Emergency Surgery states: "Most errors are made by good people with good intentions who unintentionally commit errors because of various individual, workplace, communication, technologic, psychological, and organizational factors."[14] Additionally those involved in a medical error are not well supported by their institutions. Potential solutions in the literature propose better support for physicians to improve future patient safety, being able to learn from mistakes without fear of punishment, discussing mistakes with others, considering the failings in the system versus the individual, promoting a clinical teaching environment of support and nurturing, and emphasising provider wellness such as making counselling available.

Summary

We commend the Government and the panel for exploring and encouraging dialogue on how to improve mental health and well-being for all New Zealanders. We concur with the panel's description that this is a 'once in a generation opportunity for change.' To the panel's credit it has expressed a strong understanding that in addition to strengthening the availability of mental health services, there needs to be a focus on preventive measures and reducing the stigma associated with mental illness and seeking help. A quote from a doctor in an article about doctor wellness relates to how we are often too ashamed to seek help for mental health issues. "I was embarrassed by the extent of my depression and afraid to schedule an appointment with a psychiatrist. So, I put on a mask and performed an imitation of a happy, successful young physician while the suffering continued to boil below the surface." An increased focus on raising awareness and seeking help needs to continue, but with a commensurate expansion of mental health services in our community to meet growing demand.

We trust that the issues we have identified for physicians, and the initiatives and programs being used overseas to mitigate depression and suicide, are helpful, and can possibly be applicable to other professions also.

14 The Journal of Emergency Medicine, Vol.54, No.4, pp.402-409, 2018

We are happy to provide further information on the issues raised or to answer any questions the panel may have in relation to our submission. I can be contacted on: president@anaesthesia.nz

Yours sincerely

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NZSA President