

A large, stylized graphic of a blue leaf or branch, curving from the top left towards the bottom right. The leaf has a central vein and several smaller veins branching off, creating a pattern of light and dark blue shapes.

Te Rau Hinengaro

The New Zealand Mental Health Survey

SUMMARY

Editors

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MANATŪ HAUORA



Foreword

This survey provides landmark information on mental disorders in New Zealand.

Knowing who needs services and who uses services will be critical to implementing *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005). This survey fills that need.

A very brief snapshot of the results of the survey is provided in this report.

If you want further information on the survey or the results, I would encourage you to visit the Te Rau Hinengaro: The New Zealand Mental Health Survey 2006 web page on the Ministry of Health website: <http://www.moh.govt.nz>

A handwritten signature in black ink, reading "Pete Hodgson", with a horizontal line underneath.

Hon Pete Hodgson
Minister of Health





Whakatauki

Ahakoā te momo mate, whakanuia tangata

This whakatauki or proverb is an expression of hope: regardless of illness or disease, people deserve dignity and respect and the opportunity to become well again.





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Objectives of the survey

The four main objectives of *Te Rau Hinengaro: The New Zealand Mental Health Survey* were, for the total New Zealand, Māori and Pacific populations living in New Zealand, to:

- describe the one-month, 12-month and lifetime prevalence rates of major mental disorders among those aged 16 and over living in private households, overall and by sociodemographic correlates
- describe patterns of, and barriers to, health service use for people with mental disorder
- describe the level of disability associated with mental disorder
- provide baseline data and calibrate brief instruments measuring mental disorder and psychological distress to inform the use of these instruments in future national health surveys.

‘Te rau hinengaro’ literally translates as ‘the many minds’ and is a reference to how the mind may be thought of as having many different states or levels. It is used to capture the objective of the survey to measure mental disorder.





The interview

The New Zealand interview was based on the Composite International Diagnostic Interview (CIDI 3.0). The CIDI is a fully structured interview suitable for use by trained lay interviewers. Diagnoses of mental disorders were made from responses to the symptom questions. Laptops were used for Computer Assisted Personal Interviews; interviewers read questions off the laptop screen and entered responses.

Four groups of mental disorders were assessed: anxiety disorders (panic disorder, agoraphobia without panic, specific phobia, social phobia, generalised anxiety disorder, post-traumatic stress disorder and obsessive–compulsive disorder), mood disorders (major depressive disorder, dysthymia and bipolar disorder), substance use disorders (abuse or dependence on alcohol or other drugs) and eating disorders (anorexia and bulimia).

Other modules assessed suicidal behaviours, health service use, chronic physical conditions, disability, psychological distress and alcohol use and its consequences in the past 12 months.



Survey design and sample

The target population was people aged 16 and over living in permanent private dwellings throughout New Zealand. The survey design was for a nationally representative sample. To improve the precision of estimates for Māori and Pacific people oversampling was used. The number of Māori was doubled and the number of Pacific people was quadrupled compared with that expected without oversampling. Nonetheless, unbiased estimates for the whole population could be made because of the appropriate weighting of participants.

The National Research Bureau, under contract to the Ministry of Health, carried out the fieldwork in late 2003 and 2004.

The response rate was 73.3%.

The total number of interviews was 12,992. The number of participants reporting Māori ethnicity was 2,595 and the number reporting Pacific ethnicity was 2,374.





Content of the report

The report *Te Rau Hinengaro: The New Zealand Mental Health Survey*:

- provides important and not previously available information about the prevalence of mental disorders and their patterns of onset and impact for adults in New Zealand
- explores the relationship between mental disorders and physical disorders
- provides information about the patterns of health and non-health service use by people with mental health problems
- examines the relationship between sociodemographic correlates and the probability of people meeting criteria for a mental disorder or accessing care
- describes the prevalence and correlates of suicidal behaviour.

Results related to the mental health instruments for future health surveys will be reported separately.

The report has been written to meet the aims of the survey and to interpret findings; it does not advocate actions or policies.





Prevalence of disorder

Prevalences across the whole population

Mental disorder is common in New Zealand: 46.6% of the population are predicted to meet criteria for a disorder at some time in their lives, with 39.5% having already done so and 20.7% having a disorder in the past 12 months.

Sociodemographic correlates

Younger people have a higher prevalence of disorder in the past 12 months and are more likely to report having ever had a disorder by any particular age.

Females have higher prevalences of anxiety disorder, major depression and eating disorders than males, whereas males have substantially higher prevalences for substance use disorders than females.

Prevalences are higher for people who are disadvantaged, whether measured by educational qualification, equivalised household income or using the small area index of deprivation (NZDep2001).

Ethnic comparisons

The prevalence of disorder in any period is higher for Māori and Pacific people than for the Other composite ethnic group. For disorder in the past 12 months, the prevalences are 29.5% for Māori, 24.4% for Pacific people and 19.3% for Others, which indicates that Māori and Pacific people have a greater burden due to mental health problems. Much of this burden appears to be because of the youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage.



After adjusting for sociodemographic correlates no ethnic differences in the prevalence of anxiety disorders in the past 12 months are apparent, but even with adjustments the prevalence of bipolar disorder remains higher for Māori and Pacific people (Māori, 3.4%; Pacific people, 2.7%; Others 1.9%), and substance use disorder is higher for Māori (6.0%) (Pacific people, 3.2%; Others, 3.0%). Major depression shows a different pattern: after adjustment, Māori and Others have very similar prevalence (5.7%, 5.8%), whereas Pacific people have lower prevalence (3.5%).





Health service use

Health service use across the whole population

People with more serious mental disorder in the past 12 months are more likely to have visited the health care sector for mental health reasons, including for problems with their use of alcohol or other drugs, in that period. However, the proportion making a mental health visit to the health care sector is low (only 58.0% of those with serious disorder, 36.5% of those with moderate disorder and 18.5% of those with mild disorder).

Sociodemographic correlates

In contrast to the marked differences in prevalence across sociodemographic correlates, only a few small differences exist in the percentage seeking help, and these are sometimes not in the same direction as for prevalence. For example, the youngest age group had a much higher prevalence of disorder in the past 12 months than the oldest age group, but almost identical percentages from both groups that made contact with treatment services, when the distribution of severity in these two age groups was taken into account. These findings indicate that, given a need for treatment, no marked inequality of access to health care treatment in relation to sociodemographic correlates is apparent. However, people with lower educational attainment and people resident in rural centres or areas had lower rates of visits to the mental health specialty sector.



Ethnic comparisons

Pacific people and, to a lesser extent, Māori are less likely than Others to make contact for mental health reasons with services. For those with disorder in the past 12 months 25.4% of Pacific people, 32.5% of Māori and 41.1% of Others made a mental health visit. The extent of these disparities is little affected by adjustment for sociodemographic correlates. This indicates barriers to access for Māori and Pacific people that are not explained by youthfulness or socioeconomic disadvantage.





Comorbidity

Comorbidity of mental disorders (the co-occurrence of two or more disorders) is common, with 37.0% of those experiencing 12-month disorders having two or more disorders. Mood disorders and anxiety disorders are most likely to co-occur. Comorbidity is associated with suicidal behaviour and increased service use.

There is also comorbidity between mental and physical disorder. People with mental disorders have higher prevalences of several chronic physical conditions compared with people without mental disorders of the same age. People with chronic physical conditions are also more likely to experience mental disorders compared with those without physical conditions.





Disability

Mental disorders are associated with impairment in several domains of functioning. Mood disorders are reported to be more disabling than either anxiety disorders or substance use disorders. The experience of multiple mental disorders is associated with greater role impairment than is associated with single disorders. Mental disorders and chronic physical conditions are, on average, associated with similar degrees of disability, and the combination of the two is more disabling than either alone.





Suicidal behaviour

Prevalence across the whole population

Of the population, 15.7% reported ever having thought seriously about suicide (suicidal ideation), 5.5% had ever made a suicide plan and 4.5% had ever made an attempt.

In the past 12 months, 3.2% experienced suicidal ideation, 1.0% made a suicide plan and 0.4% made a suicide attempt.

Sociodemographic correlates

The risk of suicidal ideation in the past 12 months was higher in females, younger people, people with lower educational qualifications and people with low household income, and among people living in more deprived areas (measured using the small area descriptor of socioeconomic adversity, the New Zealand Index of Deprivation) and in urban areas. The risk of making a suicide plan or suicide attempt was more common among younger people, people with low household income, and people living in more deprived areas. The risk of making a suicide attempt was higher in people in urban areas.

Mental disorders

Individuals with a mental disorder had elevated risks of suicidal behaviour, with 11.8% of people with any mental disorder in the last 12 months reporting suicidal ideation, 4.1% making a suicide plan and 1.6% making a suicide attempt in that period.

Mood disorders, anxiety disorders, eating disorders and substance use disorders were all associated with suicidal ideation, suicide plan and suicide attempt. Of individual disorders, major depressive episode had the strongest association with suicidal ideation, suicide plan and suicide attempt.



Ethnic comparisons

Māori and Pacific people had higher prevalences of suicidal ideation, suicide plans and suicide attempts in the past 12 months than Others. After adjustment for sociodemographic correlates differences in suicidal ideation disappeared, but Māori and Pacific people still had higher prevalences of suicide plans (Māori 0.9%; Pacific people 1.0%; Others 0.3%); and suicide attempts (Māori 0.7%; Pacific people 0.8%; Others 0.3%).





Overall summary

Mental disorder is common in New Zealand, but is much more common in some groups in the population than in others.

Access to health care for mental health problems is low, but for people with a need for such care it is fairly equitable across population groups except for Pacific people and, to a lesser extent, Māori. Both these ethnic groups are less likely to have had access to services.

People with a mental disorder frequently have more than one disorder. There is also a relationship between mental disorder and chronic physical conditions.

Mental disorder can severely impact on people's lives.

Suicidal behaviours are more common in some groups in the population than in others.



Strengths of the survey

The survey's key strengths are as follows.

- The researchers used a survey design and sample frame consistent with best practice, so the survey generates estimates of acceptable precision that can be generalised to the New Zealand adult population.
- Māori and Pacific people were selected at higher rates to allow (for the first time) estimates of acceptable precision for those communities.
- The diagnostic instrument used is known to have acceptable reliability and validity for community surveys.
- The fieldwork conformed to best practice standards and incorporated quality controls to ensure adherence to best practice.
- The data were extensively checked for quality.
- The analysis took account of the complex sample design appropriately.





Limitations of the survey

The survey's key limitations are as follows.

- The survey does not provide useful prevalence rate estimates for people with a severe low-prevalence disorder, because the:
 - diagnostic interview used does not generate diagnoses for specific psychotic disorders such as schizophrenia or schizoaffective disorder
 - sample frame does not include people within institutions, so people with such severe but uncommon disorders are likely to be under-represented.
- The survey does not provide estimates of rates of dementia and associated cognitive impairment in older people (for similar reasons as above).
- While an initial attempt was made to translate the survey questionnaire into languages other than New Zealand English, for reasons of cost and logistics, this was not possible.
- People living in institutions (such as rest homes, hospitals, sheltered accommodation, university colleges, prisons and armed forces group accommodation) and homeless people were not included in the sampling frame.
- The diagnostic instrument used does not incorporate Māori or Pacific peoples' beliefs about health, as the systems of disease classification it follows are the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and the International Classification of Diseases, reflecting Western or Eurocentric conceptualisations and beliefs about mental disorder.



- The study is quantitative and aggregates information across individuals to arrive at estimates for the population and subgroups within the population, so it does not capture each person's unique experience.





Background to the report

Key organisations and people

Many organisations and people have been involved with this survey:

- The Mental Health Research Development and Strategy Steering Committee initiated the survey.
- The Ministry of Health, Health Research Council of New Zealand and Alcohol Advisory Council funded the survey.
- The research team was contracted to Auckland UniServices, University of Auckland.
- The World Mental Health Survey Initiative Consortium (sponsored by the World Health Organization and Harvard University) assisted with the survey.
- The Public Health Assessing Committee, Health Research Council of New Zealand, reviewed and approved the survey protocol.
- All 14 New Zealand regional ethics committees reviewed and approved this survey.
- The field components of the project were undertaken by NRB Limited.

Pilot study

The main survey (originally called the New Zealand Survey of Mental Health and Wellbeing) was preceded by a pilot study that involved community consultation. The survey firm that undertook the survey did field testing to ensure the duration of the interview would be acceptable to participants and that an adequate response rate was likely to be achieved for the main survey.





Contributors

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