

Te Rau Hinengaro: The New Zealand Mental Health Survey

Chapter 8: Health Services

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8 Health Services

Key results

- There is a significant unmet need for treatment for people with mental disorders. Of all 12-month cases of mental disorder, 38.9% had a mental health visit to a health or non-healthcare provider in the past 12 months. Of these 12-month cases, 16.4% had contact with a mental health specialist, 28.3% with a general medical provider, 4.8% within the human services sector and 6.9% with a complementary and alternative medicine (CAM) practitioner.
- Of the total population, 13.4% had a visit for a mental health reason in the 12 months before the interview.
- In all treatment sectors, over 50% of contacts involved between one and five visits. However, in the mental health and CAM sectors, a small minority of people accounted for a substantial proportion of the total number of visits.
- The majority of people who had mental health visits reported they were ‘very satisfied’ or ‘satisfied’ with the treatment received. The majority of people who had treatment perceived that treatment as helping ‘a lot’ or ‘somewhat’.
- Unmet need for treatment was greatest in younger people and Pacific people. People with lower educational attainment and people resident in rural centres or areas had lower rates of visits to the mental health specialty sector. Unmet need for treatment did not vary significantly by socioeconomic status.
- Most people with lifetime disorders eventually made contact before their disorder ended, with proportions making contact varying from 55.7% for post-traumatic stress disorder to 99.5% for alcohol dependence. However, the percentages seeking help at the age of onset were small for most disorders and several disorders had large percentages who never sought help.
- The median duration of delay until contact varied from one year for major depressive disorder to 38 years for specific phobias.
- The most commonly endorsed reasons for delaying seeking, stopping treatment early, or not seeking help were attitudinal (such as ‘I thought the problem would get better by itself’).

8.1 Introduction

8.1.1 Government mental health plans

Over the past decade government national mental health plans have emphasised the development of community mental health services, the development of the mental health workforce, strengthening the primary health sector's responsiveness to people with mental health problems, and the coordination of care provision across the health and social service sectors (Minister of Health 1997, 2005; Ministry of Health 1994). These plans have also highlighted the need to improve mental health service provision for specific groups in the community, especially Māori, Pacific peoples, children and young people, and older people. The plans also recognise the importance of reducing the stigma and discrimination associated with mental illness that may act as barriers to people accessing appropriate care for recovery (Ministry of Health 2001a; Ministry of Health and ALAC 2001).

Although the first two national mental health plans focused on the needs of the estimated 3.0% of the adult population who suffer from major mental health problems, the second plan widened the focus of service provision to include the estimated 17% of New Zealanders who experience mild to moderate mental illness (Minister of Health 2005).

The key goals of these plans have been to (Minister of Health 1997: 2 and 56; Ministry of Health 1994: 4):

- 'decrease the prevalence of mental illness and mental health problems in the community'
- 'increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers and the general community'.

8.1.2 Evidence available

As presented in the introduction to this report (chapter 1), the epidemiological evidence used in the national mental health plans has been drawn from the limited information available from New Zealand community surveys and records of inpatient or outpatient contacts within specialist mental health services. The former data are based on regional surveys undertaken more than a decade ago, with very limited participation by Māori and Pacific peoples. Consequently, the information may no longer be relevant and representative at a national level. The latter data are unlikely to be representative of the extent of need for the whole New Zealand population, as they do not include information about the majority of people with mental disorders who do not have contact with specialist mental health services.

Estimates of psychiatric morbidity and service use have also been based on the results from surveys in Australia, Canada and the United States (US). The population demographics and health service structures in these countries are very different from those in New Zealand and it is uncertain how applicable the results from such overseas studies are to New Zealand.

The Christchurch Psychiatric Epidemiology Study (CPES) showed that of the participants with a Diagnostic Interview Schedule (DIS) DSM-III mental disorder (see 1.10.1) during the last six months, only 29% had visited a health service or professional for a mental health consultation, although 75% had sought healthcare, over that period.

Mental health consultations were more commonly reported with general practitioners than mental health specialists, who saw only 7.0% of those with recent disorder. Only 5.0% of the participants had ever had an inpatient admission for mental health reasons. Of participants with a DSM-III disorder in the previous six months, 10% had ever been admitted for mental health reasons.

This study showed that for those who at some point in their lives had not sought help even though they or others had considered it necessary, attitudinal reasons were more important than practical concerns such as finance, time or access to care (Hornblow et al 1990).

The findings from the CPES were similar to those in the multicentre US Epidemiologic Catchment Area Study (ECA) (see 1.7.1), where only 19% of participants with an active disorder had an inpatient treatment in the past 12 months or an outpatient consultation in the past six months (Narrow et al 1993; Regier et al 1993). A comparison between one ECA site (St Louis) and Christchurch showed that the reasons for not seeking help were almost identical and mainly attitudinal, despite differences in the two cities' demographics and health services (Wells et al 1994).

More recent overseas studies have shown similar patterns to the above studies and provided more detailed information about the unmet need for mental health services. The US National Comorbidity Survey (NCS) (see 1.7.3) found that only 25% of participants with a 12-month DSM-III-R disorder received outpatient treatment in the 12 months before interview (Kessler et al 1999c).

In the Australian National Survey of Mental Health and Well-being (see 1.7.4), only 35% of people with an International Classification of Disease (revision 10) mental disorder in the 12 months before the survey had consulted someone for a mental problem during that year, although most had seen a general practitioner (Andrews et al 2001).

The European Study of the Epidemiology of Mental Disorders (ESEMeD) (see 1.7.5), a community mental health survey conducted in six European nations, obtained information from the participants about mental health visits and the type of treatment received. It was found that of the participants with a 12-month DSM-IV disorder, 25.7% had consulted formal health services during that period, and of these 21.2% had received no treatment (Alonso et al 2004e).

The NCS was replicated (NCS-R) one decade after the first NCS (see 1.7.5). It showed that of 12-month DSM-IV cases, 41.1% received some treatment in the past 12 months. Of these, 12.3% were treated by a psychiatrist, 16.0% by a general medical services provider, 8.1% by a human services provider and 6.8% by a complementary and alternative medical (CAM) provider. This study found that the unmet need for treatment was greatest in older people, people from racial-ethnic minority groups, people with low incomes, people without health insurance, and people resident in rural areas (Wang et al 2005b). The pattern seems consistent across mental health surveys from several countries: only a minority of people with recent mental disorder have a consultation about, or receive treatment for, that disorder, and unmet need seems greatest in the groups traditionally under-served with respect to health resources.

The NCS showed that, although the age of onset for many disorders is in late childhood, the teenage years or young adulthood, a substantial delay often occurs before the person receives treatment (Kessler et al 1998a). The US findings were very similar to those of the Ontario Health Survey, despite the differences in health service systems in the US and Canada (Olfson et al 1998).

The NCS-R also revealed delay among those with lifetime disorders, with treatment contact delays ranging from 6 to 8 years for mood disorders and 9 to 23 years for anxiety disorders. Thus, in the US, the pattern of treatment delay after the onset of mental disorder persisted despite significant changes in the organisation and financing of mental healthcare; the availability of evidence-based therapies; and public attitudes to, and awareness of, mental health problems.

8.1.3 New Zealand mental health initiatives since mid 1990s

Since the mid 1990s in New Zealand, several important initiatives have been introduced to improve the accessibility, effectiveness and appropriateness of mental health services. These initiatives have included the development and implementation of the new mental health plans, the restructuring of general health and mental health services, a real increase in funding for mental health services, the development of the mental health workforce, the implementation of clinical practice guidelines for specialist mental health and primary health sectors, and a nationwide public awareness campaign about mental health (Mental Health Commission 1998, 1999, 2002a, 2004b).

8.1.4 Uses of data from survey

The data from this survey may be used to:

- describe the current situation since the reforms outlined in 8.1.3
- provide baseline data for the Second National Mental Health Plan
- inform the development of further mental health initiatives.

Importantly, the survey provides community data for the first time for Māori and Pacific people, for whom indirect data suggest access to appropriate treatments and services may be problematic.

8.1.5 Categorisation of health and non-health services

In the interview, all participants were asked: ‘Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, mental health or your use of alcohol or drugs?’. A list of treatment providers was then presented to the participant to aide recall. This list included:

- a psychiatrist
- a general practitioner or family physician
- any other medical doctor such as a cardiologist, urologist or gynaecologist
- a psychologist
- a social worker, youth aid worker, child welfare officer, school counsellor or teacher
- a counsellor other than a school counsellor
- any other mental health professional such as a psychotherapist or psychiatric nurse
- a general nurse, occupational therapist or other health professional
- a religious or spiritual advisor like a minister, priest or tohunga
- any other healer, like a herbalist, homeopath, naturopath, chiropractor, spiritualist or traditional healer.

The participants were also asked about their use of support groups, self-help groups and mental health crisis helplines, and admissions to hospitals and other facilities. Separate questions were then asked of those participants who had contact for a mental health problem about each care or service provider. These questions included the age at first contact and age at most recent contact. The number and duration of visits in the past 12 months was also obtained. For those participants who were admitted overnight, each day of admission was assumed to include a visit with a psychiatrist. Participants who had received care were asked to rate their satisfaction with, and the perceived helpfulness of, the care received.

The data on contacts within the past 12 months were categorised into four groups:

- the mental health specialist sector, which includes psychiatrist and non-psychiatrist mental health specialists (psychiatrist, psychologist or other non-psychiatrist mental health professional; social worker or counsellor in a mental health specialty setting; use of a mental health helpline; or overnight admissions for mental health or drug or alcohol problems, with a presumption of daily contact with a psychiatrist)
- the general medical sector (general practitioner, other medical doctor, nurse, occupational therapist or any healthcare professional)
- the human services sector (religious or spiritual advisor or social worker or counsellor in any setting other than a specialty mental health setting)
- the CAM sector (any other type of healer such as a herbalist or homeopath, participation in an internet support group, or participation in a self-help group).

The mental health specialist sector and general medical sector were then combined into the healthcare sector. The human services sector and CAM sector were also combined into the non-healthcare sector.

8.1.6 Content of chapter

This chapter provides information on the patterns of 12-month mental health treatment in New Zealand across the four service sectors: mental health specialist service, general medical sector, human services sector and CAM sector. As described above, these four service sectors are further grouped into a healthcare sector and a non-healthcare sector.

Data are presented on:

- the percentage of participants treated in the four service sectors (see 8.2)
- the distributions of patients, by number of visits; and the proportion of all visits, by treatment sector and professional group (see 8.3)
- participants' satisfaction with, and perceptions of helpfulness of, treatment and services received (see 8.4)
- the average duration of visit, by professional group (see 8.4)
- sociodemographic correlates of mental health treatment (see 8.5)
- the proportions of treatment contacts in the year of disorder onset and median duration of delay among cases that subsequently made treatment contact (see 8.6).
- participants' reasons for delaying seeking help, stopping treatment early and not seeking help (see 8.7).

8.2 Probability of 12-month use of mental health services

In this survey, 4.9% (4.5, 5.4) of the population had ever been admitted overnight to a hospital or other facility to receive help for a mental health or substance use problem. Of people with any DSM-IV mental disorder in the past 12 months, 1.8% (1.3, 2.6) had been admitted within that period.

8.2.1 Use of services by people with a diagnosed disorder, by sector

Table 8.1 presents 12-month mental health service use in separate sectors for people with mood, anxiety, substance use and eating disorders. The visits reported in Table 8.1 are for any mental health problems or for problems with alcohol or drugs, which makes them all mental health visits regardless of the sector in which they occurred. The percentage of participants with a disorder who visited one of the four sectors for a mental health reason (ie, 'had a mental health visit') was low. Of all people who met criteria for a mental disorder within the past 12 months, 16.4% had a mental health visit to a mental health specialist (ie, a visit within the mental health sector) and 28.3% had a mental health visit within the health sector. Within the mental health and health sectors, 6.2% had visited a psychiatrist, 13.5% visited another mental health specialist and 28.3% visited another health practitioner. Of 12-month cases, 10.3% had a mental health visit to the non-healthcare sector (human services and CAM sectors); 4.8% had a mental health visit within the human services sector; and 6.9% had a mental health visit to a CAM practitioner. Of 12-month cases, 38.9% had at least one mental health visit to a care provider within either the health sector or the non-health sector.

In the general medical sector it is important to note that the majority of visits were with general practitioners. Of the population, 23.2% (21.8, 24.6) stated that they, at some time in their lives, had a mental health visit with a general practitioner. A very small percentage, 1.3% (1.1, 1.5) visited both a general practitioner and another medical practitioner (other than a psychiatrist), and only 0.6% (0.4, 0.8) visited only another medical practitioner. That is, of those in the population who visited a medical practitioner other than a psychiatrist for a mental health problem, 92% visited only a general practitioner.

Because of the structure of the questionnaire, it was not possible to determine what percentage of those visiting the general medical sector in the past 12 months had been seen in primary care. However, the structure of the New Zealand health system (where the general practitioner acts as the gateway to other medical specialists) means it can be reasonably assumed that most of these people did see a general practitioner.

Table 8.1: Prevalence of 12-month mental health service use in separate service sectors, by 12-month anxiety, mood, substance use and eating disorders

Type of disorder group ³	Healthcare % (95% CI)				Non-healthcare % (95% CI)			Any service use % (95% CI)	
	Mental health specialty			General medical ¹	Any healthcare provider	Human services	Complementary or alternative medicine ²		Any non-healthcare provider
	Psychiatrist	Other mental health specialist	Any mental health specialist						
Any anxiety disorder	6.8 (5.4, 8.6)	13.6 (11.7, 15.7)	16.7 (14.6, 19.0)	28.4 (26.0, 31.0)	35.9 (33.2, 38.7)	5.0 (3.9, 6.4)	7.8 (6.2, 9.8)	11.3 (9.4, 13.4)	39.4 (36.7, 42.3)
Any mood disorder	10.7 (8.5, 13.4)	21.7 (18.7, 25.0)	25.8 (22.7, 29.2)	41.6 (37.8, 45.5)	51.7 (47.9, 55.5)	6.8 (5.1, 9.0)	9.4 (7.2, 12.2)	14.1 (11.4, 17.2)	55.1 (51.2, 58.9)
Any substance use disorder	6.9 (4.5, 10.4)	12.0 (8.9, 16.0)	14.5 (11.1, 18.7)	20.0 (15.9, 24.8)	27.3 (22.6, 32.6)	2.6 (1.3, 4.8)	5.7 (3.5, 8.6)	7.5 (5.2, 10.9)	29.9 (25.1, 35.1)
Any eating disorder	9.3 (3.5, 19.2)	25.6 (13.9, 40.6)	27.9 (15.8, 43.0)	42.6 (27.6, 59.2)	45.6 (30.4, 61.7)	3.1 (0.3, 11.2)	5.9 (1.8, 13.9)	7.9 (2.9, 16.6)	46.7 (31.4, 62.7)
Composite									
Any disorder	6.2 (5.0, 7.6)	13.5 (11.9, 15.2)	16.4 (14.7, 18.4)	28.3 (26.2, 30.6)	35.7 (33.4, 38.1)	4.8 (3.9, 6.0)	6.9 (5.7, 8.4)	10.3 (8.8, 12.0)	38.9 (36.5, 41.3)
No disorder	0.7 (0.5, 1.0)	1.8 (1.4, 2.3)	2.2 (1.8, 2.8)	4.1 (3.5, 4.8)	5.7 (5.0, 6.6)	0.7 (0.5, 1.1)	1.5 (1.1, 2.1)	2.1 (1.6, 2.7)	7.2 (6.3, 8.2)
Total population	1.7 (1.5, 2.0)	4.0 (3.6, 4.5)	4.9 (4.5, 5.5)	9.1 (8.5, 9.7)	11.7 (11.0, 12.4)	1.6 (1.3, 1.9)	2.5 (2.1, 2.8)	3.6 (3.2, 4.1)	13.4 (12.7, 14.2)
Severity⁴									
None	0.7 (0.5, 1.0)	1.8 (1.4, 2.3)	2.2 (1.8, 2.8)	4.1 (3.5, 4.8)	5.7 (5.0, 6.6)	0.7 (0.5, 1.1)	1.5 (1.1, 2.1)	2.1 (1.6, 2.7)	7.2 (6.3, 8.2)
Serious	15.6 (12.2, 19.7)	29.8 (25.7, 34.2)	35.3 (31.0, 39.8)	45.7 (41.0, 50.4)	58.0 (53.3, 62.6)	8.5 (6.2, 11.5)	12.4 (9.3, 16.4)	17.6 (14.1, 21.7)	60.9 (56.3, 65.4)
Moderate	4.8 (3.2, 7.1)	11.6 (9.4, 14.4)	14.6 (11.9, 17.7)	28.9 (25.8, 32.3)	36.5 (32.9, 40.4)	4.3 (3.0, 6.2)	7.0 (5.2, 9.4)	10.2 (8.0, 12.8)	39.9 (36.2, 43.7)
Mild	1.4 (0.6, 2.8)	4.4 (2.8, 6.8)	5.6 (3.8, 8.1)	15.0 (12.1, 18.5)	18.5 (15.3, 22.3)	2.9 (1.7, 4.7)	2.9 (1.6, 4.8)	5.2 (3.6, 7.5)	21.7 (18.2, 25.7)

1 The general medical sector includes nurses and other healthcare professionals as well as doctors.
 2 Complementary or alternative medicine includes self-help groups.
 3 DSM-IV CIDI 3.0 disorders.
 4 For severity, see 2.3 and 12.12.3.

8.2.2 Use of services by people without a diagnosed disorder

A small percentage of people who did not have a diagnosed DSM-IV CIDI 3.0 12-month disorder had mental health visits within the 12 months before interview. This group had an overall rate of 7.2% for any mental health visit: 2.2% reported visits to the mental health sector, 4.1% to the general medical sector, 0.7% to the human services sector and 1.5% to the CAM sector.

Although the percentages are small, the numbers with mental health visits within this 'No disorder' group were moderately large, because 79.3% of the population were without disorder. For example, the total number who visited psychiatrists within the past 12 months comprised:

- 6.2% of the 20.7% of the population who met criteria for disorder (1.3% of the population)
- 0.7% of the 79.3% of the population who did not meet criteria for disorder (0.5% of the population).

Thus, for visits to psychiatrists, 70.8% (approximately 1.3/1.8) were by people with disorder and 29.2% (approximately 0.5/1.8) were by people without a 12-month disorder.

It is possible this group includes people with a history of mental disorder, but which is currently in remission, subthreshold cases, or people with disorders or behavioural problems that were not assessed in the interview. These possibilities will be explored in future analyses.

8.2.3 Use of services by specific disorder

As in the DSM-IV classification system, in this report specific disorders are grouped with similar disorders into disorder groups. The disorder groups are: any anxiety disorder, any mood disorder, any substance use disorder and any eating disorder. In the tables in this chapter, information is presented about disorder groups and related patterns of service use. Additional information about some specific disorders and patterns of service use is provided below.

Of the anxiety disorders, panic disorder is associated with the highest rate of visits by participants, across all service sectors: 29.2% (22.7, 36.8) of participants with panic disorder had contact with a practitioner in the mental health sector, 55.9% (47.8, 63.7) in the general medical sector, 5.2% in the human services sector (2.6, 9.1) and 13.5% in the CAM sector (8.6, 20.5). Of all 12-month cases of panic disorder, 65.9% (58.1, 73.0) reported a mental health visit within the 12 months before the interview.

For major depressive disorder, 26.2% (22.3, 30.4) of 12-month cases had contact in the mental health sector: 44.1% (39.6, 48.8) in the general medical sector, 6.5% (4.6, 9.2) in the human services sector and 10.3% in the CAM sector (7.6, 13.8). Of all 12-month cases of major depressive disorder, 58.7% (53.9, 63.3%) reported a mental health visit within the 12 months before the interview.

For alcohol abuse and alcohol dependence disorders, the rates of service contacts are low. For alcohol abuse disorder, 13.1% (9.3, 18.1) of 12-month cases had contact in the mental health sector, 17.2% (13.0, 22.6) in the general medical sector, 2.7% (1.1, 5.5) in the human services sector, and 4.3% in the CAM sector (2.2, 7.3). Of all 12-month cases of alcohol abuse only 25.8% (20.8, 31.5) reported a mental health visit within the 12 months before the interview. Similarly, for alcohol dependence, the rates of service contact are low, although higher than the rates for alcohol abuse. For alcohol dependence, 21.6% (15.1, 29.9) of 12-month cases had contact in the mental health sector, 24.4% (17.5, 33.0) in the general medical sector, 2.3% (0.7, 5.2) in the human services sector, and 7.6% in the CAM sector (3.8, 13.3). Of all 12-month cases of alcohol dependence, 36.9% (28.8, 45.8) reported a mental health visit in the 12 months before the interview.

People with drug abuse or drug dependence are more likely to have a mental health visit than people with alcohol abuse or dependence. For drug abuse, 20.8% (14.0, 29.7) of 12-month cases had contact in the mental health sector, 23.4% (15.8, 33.1) in the general medical sector, 4.5% (1.2, 11.0) in the human services sector, and 10.1% in the CAM sector (5.2, 17.2). Of all 12-month cases of drug abuse disorder, 37.7% (28.4, 48.0) reported a mental health visit within the 12 months before the interview. For drug dependence, 25.3% (14.6, 38.7) of 12-month cases had contact in the mental health sector, 25.1% (15.4, 37.1) in the general medical sector, 3.5% (0.8, 9.2) in the human services sector, and 9.0% in the CAM sector (3.8, 17.4). Of all 12-month cases of drug dependence, 40.1% (28.3, 53.2) reported a mental health visit within the 12 months before the interview.

8.2.4 Use of services by severity

Table 8.1 shows the visits to the service sectors by severity of disorder (none, serious moderate, mild). It is apparent that participants with moderate and serious disorders account for the highest rates of mental health visits across all service sectors. These differences in rates of visits by severity are statistically significant for any disorder and for anxiety, mood, substance use and eating disorders, for all sectors within healthcare ($p \leq .01$ for all except eating disorders, where $p \leq .05$). The differences in rates of visits by severity are also statistically significant for any disorder and each disorder group for the summary categories of any non-healthcare provider ($p \leq .001$ for all) and any service use ($p \leq .001$ for all). Within the human services sector, the differences in rates of visits by severity are statistically significant only for anxiety ($p < .0001$) and substance use disorders ($p = .04$). Within the CAM sector, the differences in rates of visits by severity are statistically significant only for anxiety ($p < .0001$) and mood disorders ($p = .01$).

8.3 Distribution of participants in treatment sectors

Table 8.2 presents the distribution of participants by number of visits in the treatment sector and the proportion of all visits to the sector provided to participants in the various categories of individual-level visits.

The majority of participants who had treatment in the past 12 months recalled 1–4 visits, regardless of the treatment sector. For instance, for participants who visited a psychiatrist, 20.6% had one visit and 34.6% had 2–4 visits. Moderate numbers of participants had 5–9 visits (15.2%) and 10–19 visits (17.2%). Small numbers of participants had 20–49 visits (6.7%) and 50 or more visits (5.7%). However, it is notable that the latter two groups of participants accounted for large proportions of the total number of visits to psychiatrists: participants who attended for 20–49 visits accounted for 19.2% of the total number all visits; and participants who attended for 50 or more visits accounted for 39.9% of the total number of all visits.

Similar patterns are seen for visits to other mental health specialists, practitioners in the human services sector and practitioners in the CAM sector: a small number of participants account for the largest proportion of visits. This pattern is not observed for participants who attend other health practitioners in the general medical sector. In this sector, participants who attend for 2–4 visits comprise 58.2% of all participants and account for the largest proportion of visits (42.9%).

Table 8.2: Distribution of participants, by numbers of visits in each service sector and proportions of all visits to each treatment sector provided to participants

Treatment sector	Numbers of visits made by participants in each service sector within the past 12 months % (SE)					
	1	2–4	5–9	10–19	20–49	50+
Psychiatrist						
Participants	20.6 (3.4)	34.6 (3.9)	15.2 (2.9)	17.2 (3.6)	6.7 (2.0)	5.7 (2.3)
Visits	2.0	9.5	9.1	20.4	19.2	39.9
Non-psychiatrist mental health specialty						
Participants	21.5 (2.3)	27.2 (2.4)	18.6 (2.1)	14.1 (2.1)	14.9 (2.0)	3.8 (0.9)
Visits	2.0	7.1	11.2	16.1	40.6	23.0
Other general medical						
Participants	28.3 (1.6)	58.2 (1.7)	7.3 (0.9)	4.0 (0.7)	1.8 (0.5)	0.4 (0.2)
Visits	8.3	42.9	12.9	14.4	14.9	6.6
Human services						
Participants	21.9 (3.8)	36.7 (4.2)	19.1 (3.7)	11.4 (2.8)	8.2 (2.4)	2.6 (1.3)
Visits	2.9	13.0	16.1	18.3	32.3	17.5
Complementary or alternative medicine						
Participants	17.2 (2.4)	33.4 (3.5)	12.4 (2.1)	9.8 (2.0)	14.1 (2.7)	13.0 (2.6)
Visits	0.8	4.2	3.8	6.1	20.8	64.3

8.4 Satisfaction with care, perceived helpfulness of care and average duration of visit

Table 8.3 shows participant satisfaction with care and the perceived helpfulness of the care received. This information is presented by professional group. No participant refused to respond to these questions or stated they could not answer the questions.

The majority of participants reported that they were very satisfied or satisfied with the care they received across all professional groups. However, ratings of dissatisfaction ('dissatisfied' or 'very dissatisfied') tended to be higher for mental health professionals than for other professional groups. For ratings of the perceived helpfulness of the care received, the majority of participants responded they had been helped 'a lot' or 'some'. A minority did respond that the care received had helped 'not at all' and these negative ratings were more frequent in other mental health professionals (14.9%), psychiatrists (14.1%), and general practitioners or other medical doctors (11.6%).

Table 8.3 also shows the average duration of visit by professional group. The most frequent durations of visits across all professional groups, were 15–30 minutes or for 46 minutes or longer. This distribution may reflect professional traditions in allocation of time for consultations.

Table 8.3: Participant rating of satisfaction with care, perceived helpfulness of care received, and average duration of visit, by professional group

Rating of satisfaction	Psychiatrist	Psychologist	Other mental health professional	General practitioner or any other medical doctor	General nurse, occupational therapist or other health professional	Social worker	Counsellor	Religious or spiritual advisor	Any other healer
	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)
Satisfaction with care									
Very satisfied	40.0 (4.8)	44.2 (2.1)	33.0 (4.4)	38.9 (5.8)	44.1 (3.3)	49.5 (7.1)	56.7 (7.6)	61.6 (5.4)	59.7 (4.6)
Satisfied	29.4 (4.3)	34.6 (2.0)	33.4 (4.8)	42.6 (6.0)	37.2 (3.3)	33.3 (6.4)	31.8 (7.1)	26.2 (5.1)	30.4 (4.1)
Neither satisfied nor dissatisfied	15.6 (3.7)	11.2 (1.3)	17.7 (4.2)	7.7 (2.8)	12.1 (2.1)	12.7 (5.0)	5.2 (3.4)	9.8 (3.0)	5.9 (2.9)
Dissatisfied	8.7 (2.4)	7.3 (1.2)	11.5 (3.6)	6.9 (3.0)	5.1 (1.4)	4.5 (2.6)	4.9 (2.6)	1.0 (0.6)	2.8 (1.4)
Very dissatisfied	6.2 (2.4)	2.7 (0.7)	4.4 (2.0)	3.8 (2.4)	1.6 (0.8)	0.0 (0.0)	1.3 (1.3)	1.4 (0.8)	1.2 (0.7)
Perceived helpfulness									
A lot	52.2 (4.8)	51.8 (2.1)	41.2 (4.8)	50.2 (6.1)	54.1 (3.2)	56.1 (7.1)	74.7 (6.3)	74.7 (4.7)	58.0 (5.7)
Some	19.1 (3.4)	28.5 (1.9)	27.5 (4.8)	29.8 (5.8)	29.3 (3.2)	23.8 (5.7)	16.2 (5.7)	18.7 (4.4)	30.8 (5.7)
A little	14.7 (3.3)	12.6 (1.4)	16.4 (3.9)	8.4 (2.8)	12.2 (2.0)	17.0 (5.7)	3.3 (1.8)	5.3 (2.0)	6.4 (3.0)
Not at all	14.1 (3.3)	7.1 (1.1)	14.9 (3.8)	11.6 (3.9)	4.5 (1.3)	3.1 (2.2)	5.8 (2.8)	1.3 (0.8)	4.7 (1.9)
Average duration of visit									
Less than 15 minutes	5.8 (2.2)	29.7 (1.9)	3.0 (1.3)	5.9 (2.9)	4.1 (1.6)	3.8 (2.9)	22.7 (6.9)	15.1 (3.6)	12.2 (3.5)
15–30 minutes	34.5 (4.4)	64.5 (1.9)	19.4 (4.2)	42.1 (6.7)	15.8 (2.4)	36.1 (6.6)	47.4 (8.2)	43.3 (5.9)	33.4 (4.9)
31–45 minutes	11.7 (3.4)	2.6 (0.7)	8.3 (2.6)	16.1 (5.9)	11.5 (2.3)	5.0 (2.6)	3.2 (1.9)	2.9 (1.4)	11.2 (3.0)
46 minutes or longer	48.1 (4.8)	3.1 (0.7)	69.4 (4.7)	35.8 (6.1)	68.5 (3.2)	55.0 (7.1)	26.7 (7.4)	38.7 (5.3)	43.1 (4.7)

8.5 Sociodemographic correlates of treatment contact

Table 8.4 presents the demographic correlates of 12-month service use by people with a disorder in the past 12 months. Individual-level correlates are sex, age group, educational qualifications and equivalised household income. In addition, three community-level sociodemographic correlates were examined: the small area measure of socioeconomic deprivation, the New Zealand Index of Deprivation 2001 (NZDep2001); geographic region of place of residence; and urbanicity/rurality.

Table 8.5 presents the prevalences of 12-month service use by ethnicity for those with a 12-month disorder. The prevalences presented are unadjusted, adjusted for age and sex, and adjusted for age, sex, educational qualification and equivalised household income (see 2.4 and 12.10.2).

Both Tables 8.4 and 8.5 present the percentages of those participants who met criteria for a mental disorder within the past 12 months who had:

- visited a professional in either the healthcare sector or non-healthcare sector ('any visit')
- had any visit and had visited a professional in the healthcare sector ('any healthcare visit')
- had any healthcare sector visit and had visited a mental health professional in the specialty mental health sector visit ('any mental health specialty visit').

Other tables such as Table 8.1 present the absolute percentages of participants who made a particular type of visit. Tables 8.4 and 8.5 provide a different perspective. As per the definitions above, Tables 8.4 and 8.5 present a series of conditional percentages. For example, for those with any 12-month disorder, 38.9% made a mental health visit to any sector in the past 12 months. Of these people with any visit, 91.8% had made a visit to the healthcare sector. Of those who made a healthcare visit, 46.0% had made a visit to the mental health speciality sector. These proportions in Table 8.4 can be calculated from Table 8.1 but presenting them explicitly makes clearer where differences in access occur. It is evident that the majority of people who made mental health visits contacted the healthcare sector, not just the human services sector or CAM sector. Of those with a mental health visit in the health sector, just under half were seen by a mental health practitioner.

Table 8.4 shows that the youngest age group (16–24 years) was less likely than other age groups to have any visit for a mental health reason ($p = .03$). However, among those in this age group who did have a mental health visit, there appears to be no difference compared with other age groups in the rates of healthcare sector visit or mental health specialty sector visits.

Males had lower rates of any mental health visits than females ($p < .0001$), but higher rates of any healthcare sector visits ($p = .007$). The rates of mental health specialty visits for males are marginally higher than those for females, but the difference is not statistically significantly different ($p = .08$). This suggests females make greater use of the non-healthcare sector for mental health visits than males.

Participants with lower educational achievement had lower rates of any visit for a mental health reason and any healthcare sector visit, and lower rates of mental health specialty sector visits compared with participants with higher educational achievement. However, this is statistically significant only for any mental health specialty visit ($p = .03$).

There were no clear patterns of differences in rates of visits by equivalised household income or the small area measure of socioeconomic deprivation (NZDep2001).

Participants who were resident in secondary or minor centres had higher rates of healthcare sector consultation ($p = .03$) compared with participants in the main urban centres or other (rural) areas. Participants resident in secondary, minor and other (rural) areas had lower rates of mental health specialty sector visits compared with participants in the main urban centres ($p = .01$). Participants resident in rural centres and areas had the second lowest rate of healthcare sector consultation and the lowest rates of mental health specialty sector visits. There are no differences in rates of visit by region.

Table 8.5 presents the same description of mental health visits among participants with a 12-month diagnosis, by ethnicity. The ethnicity data are presented unadjusted, adjusted for age and sex, and adjusted for age, sex, education and household income (see 2.4 and 12.10.2).

For any visit for a mental health reason, there are significant differences across the three ethnic groups ($p < .0001$ overall). Without adjustment, 25.4% of Pacific people made any mental health visit compared with 32.5% of Māori and 41.1% of the Other composite ethnic group. For pairwise comparisons, Māori have lower percentages of visits than Others ($p = .0009$); Pacific people have lower percentages of visits than Others ($p < .0001$); and, while Pacific people have lower percentages of visits than Māori, this difference approaches, but does not reach, statistical significance ($p = .06$).

Table 8.4: Sociodemographic correlates of 12-month service use in people with 12-month mental disorder¹

Correlate ²	Any visit for mental health reason % (95% CI)	Any healthcare sector visit among patients with any visit % (95% CI)	Any mental health specialty sector visit among patients with healthcare sector visit % (95% CI)
Individual characteristics			
Sex			
Male	32.4 (28.5, 36.5)	95.3 (91.6, 97.4)	51.4 (43.8, 58.9)
Female	43.2 (40.2, 46.2)	90.0 (87.2, 92.3)	43.2 (38.6, 48.0)
Age group (years)			
16–24	32.1 (26.7, 38.0)	91.6 (84.0, 95.8)	51.9 (40.1, 63.6)
25–44	39.5 (36.1, 43.1)	91.1 (88.1, 93.4)	48.2 (42.6, 53.8)
45–64	43.0 (38.6, 47.5)	91.6 (86.9, 94.8)	39.7 (33.2, 46.7)
65 and over	42.0 (31.9, 52.8)	98.9 (92.2, 99.8)	39.4 (19.6, 62.1)
Educational qualifications			
None	35.1 (30.6, 39.8)	95.3 (91.4, 97.4)	37.5 (30.1, 45.5)
School or post-school only	38.2 (34.5, 42.1)	89.7 (85.5, 92.9)	44.5 (38.0, 51.2)
Both school and post-school	41.5 (37.6, 45.5)	92.2 (88.8, 94.6)	51.0 (44.7, 57.3)
Equivalent household income			
Under half of median	40.8 (36.8, 44.9)	91.3 (86.8, 94.3)	47.3 (40.2, 54.6)
Half median to median	40.5 (36.3, 44.8)	90.2 (85.7, 93.4)	46.7 (39.3, 54.3)
Median to one and a half times median	35.8 (30.6, 41.4)	91.7 (86.2, 95.1)	41.9 (33.5, 50.8)
One and a half times median and over	37.7 (32.6, 43.2)	94.7 (89.3, 97.5)	47.3 (38.1, 56.7)
Area characteristics			
NZDep2001 deciles			
9 and 10 most deprived	36.8 (31.0, 43.0)	92.0 (84.6, 96.0)	46.6 (36.6, 56.9)
7 and 8	43.9 (38.5, 49.4)	92.6 (86.4, 96.1)	43.9 (34.5, 53.7)
5 and 6	38.5 (33.5, 43.7)	90.1 (84.7, 93.7)	52.9 (44.9, 60.8)
3 and 4	39.0 (33.2, 45.0)	92.0 (87.2, 95.1)	38.3 (30.3, 47.1)
1 and 2 least deprived	36.7 (32.3, 41.4)	92.5 (88.3, 95.2)	47.8 (40.1, 55.6)

Correlate ²	Any visit for mental health reason % (95% CI)	Any healthcare sector visit among patients with any visit % (95% CI)	Any mental health specialty sector visit among patients with healthcare sector visit % (95% CI)
Urbanicity			
Main	38.4 (35.6, 41.3)	91.1 (88.5, 93.2)	49.3 (44.6, 54.0)
Secondary	43.2 (34.3, 52.6)	93.5 (80.7, 98.0)	36.6 (23.8, 51.1)
Minor	39.2 (32.2, 46.6)	97.1 (93.1, 98.8)	41.4 (31.1, 52.6)
Other (rural)	40.6 (34.0, 47.6)	91.7 (84.0, 95.8)	31.6 (21.7, 42.9)
Region			
North	37.9 (33.6, 42.5)	90.3 (86.1, 93.4)	51.1 (44.1, 58.1)
Midland	38.2 (33.4, 43.3)	93.3 (88.9, 96.0)	38.9 (31.2, 47.2)
Central	36.3 (31.1, 41.8)	94.0 (89.4, 96.7)	40.9 (32.6, 49.9)
South	42.6 (38.4, 46.9)	91.2 (86.2, 94.5)	47.8 (40.3, 55.4)
Percentage getting treatment overall	38.9 (36.5, 41.3)	91.8 (89.6, 93.5)	46.0 (42.0, 50.0)

1 DSM-IV CIDI 3.0 disorders with hierarchy, see 12.4.1.

2 Sociodemographic correlates are defined in 12.12.1.

Adjustment by age and sex, or age, sex, educational qualification and equivalised household income, leads to minimal changes in these percentages and no change in the significance of the difference between them. The clear pattern is that Pacific people with disorder are the least likely to make a mental health visit, whether this is analysed unadjusted, adjusted for age and sex, or adjusted for age, sex, educational qualifications and equivalised household income. Māori are less likely than Others, but more likely than Pacific people, to have made a visit. However, the latter Māori–Pacific comparisons approach, but do not reach, statistical significance.

In contrast to the ethnic differences seen in the percentage with disorder making any visit, there were no significant differences in the percentage with a healthcare visit, given any visit, nor in the percentage with a mental health speciality visit among those with a healthcare visit. The ethnic differences in the percentage making treatment contact are to do with making contact at all, not to do with the sector someone is seen in.

Table 8.4 is based on those with any disorder in the past 12 months. An alternative analysis in Table 2.4 looks only at access to the healthcare sector, but takes account of severity. This analysis also found that a lower percentage of Pacific people made treatment contact, in comparison with Others, and these differences persisted after adjustment for sociodemographic correlates.

Table 8.1 indicates that people with mood disorders are more likely to contact services than people with anxiety or substance use disorders. As Pacific people have lower prevalence of mood disorder (Table 3.6), this might account for their lower use of services. Therefore, ethnic comparisons were made within each of the three main disorder groups (anxiety, mood and substance) for mental health visits to any sector. (The same trends were also seen for any mental health speciality visit and for any healthcare visit, calculated as in Table 8.1.)

For anxiety disorders Pacific people were the least likely to make any visit, with Māori intermediate between Pacific and Others: 22.2% (16.8, 28.9) for Pacific people; 35.3% (30.3, 40.5) for Māori; and 41.3% (38.0, 41.6) for Others. For mood disorders the same order was seen, but Māori were close to Pacific people rather than halfway between Pacific and Others in the percentage who made treatment contact: 38.1% (27.6, 49.7) for Pacific people; 43.1% (36.7, 49.9) for Māori; and 58.5% (53.7, 63.2) for Others. In contrast there were no significant differences across the ethnic groups in the percentage with substance use disorder who made treatment contact: 35.7 (24.0, 49.4) for Pacific people; 27.8% (21.6, 35.0) for Māori; and 30.2% (23.6, 37.7) for Others. The ethnic differences in making any treatment contact that are seen in Table 8.5 cannot be explained away by a lower prevalence of mood disorder for Pacific people.

These three sets of analyses (Tables 2.4 and 8.4 and ethnic comparisons within disorder groups) all support the same conclusion: Pacific people, and to a lesser extent Māori, are less likely than Others to access services for mental health problems, although the differential is absent for substance use disorders.

There is some similarity between these results and those for access to general practitioners as reported from the 2002/03 New Zealand Health Survey (Ministry of Health 2004a, 2004b). Māori males were less likely than European/Other males to have visited a general practitioner in the past 12 months. For males, unmet need for a general practitioner was most likely to be reported by Pacific people, followed by Māori, with the least unmet need reported by European/Others, although these differences were not significant. Māori females were particularly likely to report an unmet need for a GP.

Table 8.5: Ethnicity and 12-month service use in people with 12-month disorder¹

	Any visit for mental health reason % (95% CI)	Any healthcare sector visit among patients with any visit % (95% CI)	Any mental health specialty sector visit among patients with healthcare sector visit % (95% CI)
Unadjusted			
Māori	32.5 (28.3, 36.7)	90.3 (86.7, 93.8)	49.8 (41.5, 58.1)
Pacific	25.4 (19.4, 31.4)	87.7 (81.2, 94.2)	41.6 (26.7, 56.5)
Other	41.1 (38.1, 44.1)	92.2 (89.9, 94.5)	45.6 (41.0, 50.2)
Adjusted for age and sex			
Māori	32.9 (28.7, 37.2)	90.8 (87.4, 94.2)	49.1 (40.7, 57.5)
Pacific	26.1 (20.0, 32.2)	88.0 (81.5, 94.4)	39.8 (24.8, 54.7)
Other	41.0 (38.0, 43.9)	92.1 (89.8, 94.4)	45.8 (41.2, 50.3)
Adjusted for age, sex, educational qualification, equivalised household income²			
Māori	32.6 (28.0, 37.1)	90.1 (86.3, 94.0)	51.2 (42.2, 60.1)
Pacific	25.3 (19.3, 31.3)	88.8 (82.5, 95.2)	40.3 (25.2, 55.3)
Other	41.1 (38.1, 44.1)	92.2 (89.9, 94.4)	45.4 (40.9, 50.0)

1 DSM-IV CIDI 3.0 disorders with hierarchy, see 12.4.1.

2 Sociodemographic correlates are defined in 12.12.1.

8.6 Cumulative lifetime probabilities of treatment contact

Survival curves were used to estimate the percentage of DSM-IV CIDI 3.0 cases that would eventually make treatment contact for each disorder assessed (see 12.10.3).

These cumulative lifetime probabilities of treatment contact are presented in Table 8.6.

The table reports the:

- percentage with a lifetime diagnosis of specific disorder who ever made treatment contact at the age of onset of that disorder (that is, the reported age of onset equalled the reported age of first treatment contact)
- the percentage with a lifetime diagnosis of specific disorder who will ever make treatment contact if their disorder continues
- the median duration of delay to first treatment contact, reported in years.

Of the anxiety disorders, panic disorder is associated with the highest percentage making treatment contact at the age of onset (33.2%) and the shortest median duration of delay (three years). In contrast, specific phobia is associated with very low percentages of cases (2.2%) making treatment contact at the age of onset and the median duration of delay is very prolonged (38 years). Generalised anxiety disorder is associated with the highest percentage (91.3%) and post-traumatic stress disorder the smallest percentage (55.7%) of cases ever making treatment contact.

Of the mood disorders, for major depressive episode 45.0% made treatment contact in the year of onset and 97.0% ever made treatment contact. The median duration of delay to treatment is one year, which is the shortest for all the disorders. In contrast, the bipolar disorders have low percentages (12.2%) of treatment contact in the year of onset, only 53.2% eventually made treatment contact and the median duration of delay is 13 years.

For alcohol and drug abuse, the percentages making contact at the age of onset were low: 8.9% for alcohol abuse and 13.0% for drug abuse. Of all participants with alcohol abuse, 85.9% eventually made treatment contact, but the median duration of delay is 16 years. For drug abuse, 92.1% eventually made treatment contact and the median treatment delay is eight years.

Similar patterns are found for alcohol dependence and drug dependence. Only 19.4% of participants with alcohol dependence and 25.2% with drug dependence made contact at the age of onset. The majority of persons with these disorders did eventually make treatment contact: 99.5% of those with alcohol dependence and 98.0% of those with drug dependence. The median durations of delay are seven years for alcohol dependence and three years for drug dependence.

For bulimia, 26.8% of cases made treatment contact in the year of onset and 98.7% eventually made treatment contact. The median duration of delay to first treatment contact is 10 years. For anorexia, 11.0% of cases made contact in the year of onset, 98.2% eventually made treatment contact and the median duration of delay is 15 years. These estimates for anorexia must be regarded with caution, as they are based on a very small number of cases.

Table 8.6: Percentage who made treatment contact and median duration of delay among cases of mental disorder¹ who would ever make treatment contact

Disorder groups	Percentage making treatment contact at age of onset %	Percentage estimated to ever make treatment contact ² %	Median duration of delay ² years
Anxiety disorders			
Panic disorder	33.2	90.3	3.0
Agoraphobia without panic	18.7	77.9	13.0
Specific phobia	2.2	68.7	38.0
Social phobia	4.9	77.4	28.0
Generalised anxiety disorder	31.8	91.3	6.0
Post-traumatic stress disorder ³	11.5	55.7	19.0
Obsessive–compulsive disorder ³	17.4	69.6	7.0
Mood disorders			
Major depressive episode	45.0	97.0	1.0
Dysthymia	29.7	99.0	5.0
Bipolar disorder	12.2	53.2	13.0
Substance use disorders			
Alcohol abuse	8.9	85.9	16.0
Alcohol dependence	19.4	99.5	7.0
Drug abuse	13.0	92.1	8.0
Drug dependence	25.2	98.0	3.0
Eating disorders			
Bulimia ³	26.8	98.7	10.0
Anorexia ³	11.0	98.2	15.0

1 DSM-IV CIDI 3.0 disorders with hierarchy, see 12.4.1.

2 Projections based on time-to-contact survival analyses, see 12.10.3.

3 Assessed in the subsample who did the long form of the interview, see 12.4.2.

8.7 Reasons for delaying seeking help, stopping treatment or not seeking help in the past 12 months

Some participants who did make treatment contact in the past 12 months acknowledged that they delayed seeking help for their mental health problems (including problems with alcohol and other drugs). These participants were told: ‘I’m going to read a list of reasons why people delay seeking help and ask you to say “yes” or “no” for whether each one was a reason for why you didn’t get professional help more quickly than you did’.

These participants were then shown a list of 15 possible reasons for their delay in seeking help and asked to endorse any that applied to them. The three most frequently endorsed reasons for delaying seeking help were:

- ‘I wanted to handle the problem on my own’ (79.3%)
- ‘I thought the problem would get better by itself’ (63.2%)
- ‘The problem didn’t bother me very much at first’ (48.9%).

Some participants acknowledged that they had entered treatment and then stopped treatment. They were asked the following question: ‘You mentioned stopping your treatment before you had finished. I’m going to read a list of reasons and would like you to say “yes” or “no” for whether each one was a reason you stopped’.

Participants most commonly endorsed the following reasons, from the 16 potential reasons, for stopping treatment:

- ‘You got better’ (45.8%)
- ‘You didn’t need help any more’ (41.2%)
- ‘You wanted to handle the problem on your own’ (24.5%).

Some participants acknowledged not seeking help in the past 12 months when they believed they might need to see a professional for mental health reasons (including alcohol or drug problems). These participants were asked the following question: ‘Here are some reasons people have for not seeking help even when they think they might need it. Please tell me “yes” or “no” whether each statement is a reason as to why you did not see a professional’.

The most frequently endorsed reasons, from a list of 16 reasons, for not seeking help were:

- ‘I wanted to handle the problem on my own’ (43.5%)
- ‘The problem went away by itself, and I did not really need help’ (37.3%)
- ‘I thought the problem would get better by itself’ (31.8%).

Cost might be expected to be a barrier to care. However, it was not among the top three reasons given for any of the three sets of reasons considered here. Nonetheless, the percentage of people citing costs as a reason was not trivial: 36.7% for delaying seeking treatment, 20.7% for stopping treatment and 25.9% for not seeking treatment at all.

8.8 Conclusions

The patterns of these findings are broadly consistent with previous New Zealand community studies and overseas studies. Of those participants with a mental disorder within the past 12 months, a large number do not have a mental health visit within the 12 months. However, the majority of lifetime cases do eventually make treatment contact, although the median duration of delay can be long and varies greatly, depending on the disorder. Of the three ethnic groups, Pacific people have the lowest rates of mental health visits across all service sectors.

Some findings may be compared with recent results from similar overseas studies. When comparisons are made with developed countries in the World Mental Health (WMH) Survey Initiative (Demyttenaere et al 2004) it is evident that, within New Zealand, the rates of mental health visits grouped by severity are very similar. In New Zealand, 60.9% (56.3, 65.4) of participants with any serious disorder had a mental health visit in the past 12 months. This compares with 52.3% (48.5, 56.1) in the US, 53.9 (25.2, 82.5) in Belgium, 63.3% (38.6, 88.1) in France, 49.7% (26.6, 72.8) in Germany, 50.2% (29.5, 70.8) in the Netherlands and 64.5% (49.2, 79.7) in Spain. Comparisons between New Zealand and the other WMH Survey Initiative developed countries for moderate and mild disorders show the rates are also broadly similar.

As the diagnoses at interview vary among the different WMH Survey Initiative sites, it is best to compare the rates of visits across sectors for the total sample. It should also be remembered that the New Zealand sample included people aged 16 and over, whereas the ESEMeD and NCS-R included people aged 18 and over. The six European sites in the ESEMeD have published rates of visits to formal health services in the past 12 months (Alonso et al 2004e). In the ESEMeD, rates for the total sample were 6.4%, which is lower than the rate of 11.7% in New Zealand. Examination of the New Zealand rates and those from the NCS-R reveals that the rates were generally lower in New Zealand than in the US. For the total sample, 13.4% had a mental health visit in the past 12 months compared with 17.9% in the US (Wang et al 2005b). Compared with the US, the rates of visits were lower in New Zealand to the mental health specialty sector (US, 8.8%; New Zealand, 4.9%), general medical provider (US, 9.3%; New Zealand, 9.1%), any healthcare provider (US, 15.3%; New Zealand, 11.7%) and the non-healthcare sector (US, 5.5%; New Zealand, 3.6%).

The New Zealand data on the percentage ever making treatment contact and duration of delays to treatment contact may also be compared with data from the NCS-R (Wang et al 2005a). For panic disorder, 90.3% in New Zealand and 95.3% in the US eventually make treatment contact. For major depressive episode, 97.0% in New Zealand and 88.1% in the US eventually make treatment contact. These findings are broadly similar. However, there are differences between the New Zealand and NCS-R data for the percentages ever making treatment contact for substance use disorders. For alcohol abuse the percentages are 85.9% for New Zealand and 52.7% for the US. For alcohol dependence the percentages are 98.0% for New Zealand and 69.8% for the US. For drug abuse, the percentages are 92.1% for New Zealand and 57.0% for the US. For drug dependence, the percentages are 98.0% for New Zealand and 76.9% for the US.

Although there are differences between the US and New Zealand in percentages ever making treatment contact, the percentages for people making contact within the 12 months of age of onset are very similar. For panic disorder, in New Zealand 33.2% make contact in the year of age of onset compared with 33.6% in the US. For major depressive disorder, the percentages making contact in the year of age of onset are 45.0% in New Zealand and 37.4% in the US. In New Zealand the percentage for alcohol abuse is 8.9% and in the US 12.4%. For alcohol dependence, the percentages are 19.4% in New Zealand and 20.7% in the US. The percentages for drug abuse are 13.0% in New Zealand and 12.5% in the US. The percentages for drug dependence are 25.2% in New Zealand and 26.5% in the US.

These findings suggest a significant unmet need for treatment for people with mental disorder exists in the New Zealand community, as in other comparable developed countries. There are other similarities and differences in other aspects of service use between countries. These will be described in future papers on 12-month service use that the WMH Survey Initiative consortium will publish.