# MENTAL HEALTH

## What is it?

***Mental health is not just the absence of mental disorder. It can be defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.***

Language and terminology in mental health is often debated and the terms mental illness, mental disorder and mental distress all have slightly different meanings but are often used interchangeably. This paper attempts to identify mental wellbeing issues as well as mental illness, though most of the current data reflects mental illness.

## Why is it important?

The New Zealand Mental Health Survey[1], 2006 identified that almost half (47%) of New Zealanders will experience a mental illness at some time in their lives. One in five people will be affected within any one year. Mental illness not only has a huge toll on the individual but also their families', wider society and the economy. Ensuring a focus on wellbeing is important as there is much research that looks at the importance of positive mental health as a positive contributor to society and the economy. A recent report in the UK identifies good mental health as the foundation for well-being and the effective functioning of individuals and communities; it suggests that there is no health without mental health.[2]

## Data

Most data presented here is about mental disorder rather than levels of mental wellbeing. See data limitations below.

There are two sources of information that provide an insight into Mental Illness Statistics The first is self reported information in the NZ Health Survey 2006/2007[3] and the second is the Mental Health Survey 2006 which gathered more detailed information upon which a clearer diagnosis was able to be made. The two sources are therefore not directly comparable and the Mental Health Survey information is the main source of data reported here. Note that while the survey is called Mental Health, it is about Mental Disorder not wellbeing.

The introduction to this topic identifies the proportion of New Zealanders who might have a mental disorder during their lifetime as 47.6%. The lifetime prevalence reported in this table is the actual lifetime prevalence of the respondents to this point in time, which is as would be expected slightly lower at 39.5%. Almost 21% of respondents had a mental disorder within the past twelve months and 12 percent within the last month.[4]

[1] Ministry of Health. 2006. Te Rau Hinengaro: The New Zealand Mental Health Survey. http://www.moh.govt.nz/moh.nsf/pagesmh/5223
[2] Department of Health and New Horizons. 2010. Flourishing People, Connected Communities: A framework for developing well-being. London http://www.medicalwomensfederation.org.uk/files/Summary%20FrameworkJuly%2009.pdf
[3] Ministry of Health. 2008. A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey http://www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health
[4] Ministry of Health. 2006 op cit.

**Table 1 Lifetime, 12 month and one-month prevalence of mental disorders, NZ Mental Health Survey, 2006**

| | Lifetime prevalence % | Twelve-month prevalence % | One-month prevalence % |
|---|---|---|---|
| Any anxiety disorder | 24.9 | 14.8 | 9.3 |
| Any mood disorder | 20.2 | 7.9 | 2.3 |
| Any eating disorder | 1.7 | 0.5 | 0.2 |
| No disorder | 60.5 | 79.3 | 88.4 |
| One disorder | 20.0 | 13.0 | 8.5 |
| Two disorders | 9.9 | 4.4 | 2.0 |
| Three or more disorders | 9.7 | 3.3 | 1.1 |
| **Any disorder** | **39.5** | **20.7** | **11.6** |

Anxiety disorders were slightly more common and around 10% of the population had a lifetime prevalence of two or more disorders. Table 2 below looks at 12 month prevalence and the prevalence of a serious disorder by a range of socio demographic factors. The definition of a serious disorder is not easily summarised and can be found within the document.[5]

**Table 2 Socio-demographic correlates and 12 month prevalence of any disorder and severity, NZ Mental Health Survey, 2006**

| | | Twelve-month prevalence % | Prevalence of a serious disorder % |
|---|---|---|---|
| **Gender** | Male | 17.1 | 3.9 |
| | Female | 24.0 | 5.4 |
| **Age** | 16-24 | 28.6 | 7.2 |
| | 25-44 | 25.1 | 5.8 |
| | 45-64 | 17.4 | 3.8 |
| | 65 and over | 7.1 | 1.1 |
| **Equivalised household income** | | | |
| | < half median | 27.6 | 8.1 |
| | Half median to median | 20.7 | 5.1 |
| | Median to one and a half median | 19.6 | 3.7 |
| | Over one and a half median | 16.6 | 2.8 |
| **NZDep2001** | 9&10 | 26.3 | 6.9 |
| | 7&8 | 21.4 | 5.2 |
| | 5&6 | 21.5 | 5.1 |
| | 3&4 | 19.4 | 3.5 |
| *Least deprived* | 1&2 | 15.7 | 3.2 |
| **Ethnicity** | Maori | 29.5 | 8.7 |
| | Pacific | 24.4 | 6.0 |
| | Other | 19.3 | 4.1 |

As can be seen with this data the rates are highest for females, those under 45 years of age, those in the most deprived deciles and on low incomes. Rates among Maori and Pacific are higher than for other populations.

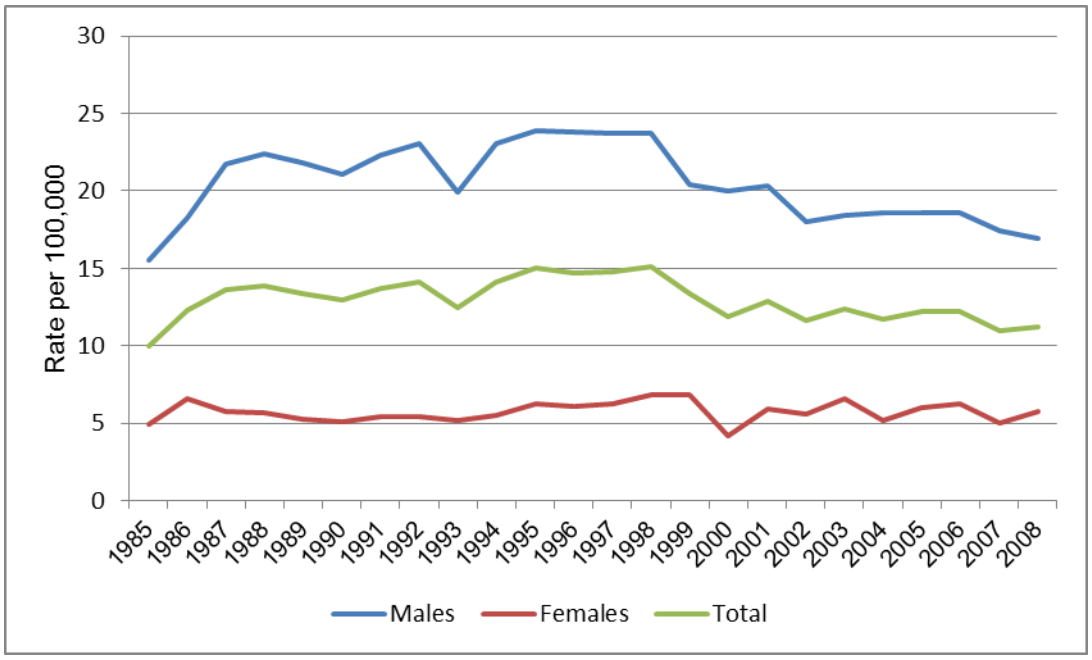
There is no data for Canterbury available from the Mental Health Survey but the data from the New Zealand health survey (which is self-reported data) indicates that within the Canterbury DHB overall prevalence is slightly higher than that for New Zealand as a whole (17.3% compared with 13.5%

[5] ibid

thought the difference in not statistically significant).[6] There was no difference in the ethnicity or gender trends for Canterbury and the rest of New Zealand though Canterbury's prevalence was consistently slightly higher in all groups.

Suicide data is presented below. This data is from the Ministry of Health Mortality data. The Coroner also releases provisional data each financial year but this data is generally higher than that reported below as it includes all self-inflicted deaths some of which will be ruled accidental. In 2010/2011 the data released by the coroner was 558 deaths and for 2007/2008 the figure was 540. The comparable figure for 2008 for Mortality data was 497 confirmed suicide deaths.[7]

**Figure 1 Suicide rates by gender, 1985 to 2008[8]**




There is little data published by region but the Suicide Facts document identifies that Canterbury suicide rates for 2004 to 2008 were almost exactly the same as the national rate over that time of 11.6 suicides per 100,000 population.

## *Impact on inequalities*

Building on strengths published in the early 2000's started looking at the issue of tackling inequalities and their relationship to mental health. It identified that those who experience mental health problems often have the worst access to conditions necessary for positive health such as adequate income, access to health services and opportunities to develop social coping skills. [9] People with mental health problems are more likely to engage in behaviours detrimental to overall health, such as poor diet, heavy smoking and drug and alcohol misuse.[10] Broader societal inequalities are a root cause of mental disorders, often by excluding people from things that support mental health. The WHO document "Closing the Gap" identifies an example around employment.

[6] CDHB. 2008. Health Needs Assessment. (unpublished)
[7] Chief Coroner. 2011. Media statement sent on behalf of the Chief Coroner, Judge Neil MacLean.
[8] Ministry of Health. 2010. Suicide Facts Deaths and intentional self-harm hospitalisations 2008. http://www.moh.govt.nz/moh.nsf/pagesmh/10482/$File/suicide-facts-2008-dec2010.pdf
[9] Ministry of Health. 2002. Building on Strengths: A Mental Health Promotion Strategy http://www.moh.govt.nz/moh.nsf/0/4a305bd9534765ffcc256cbc0010a6a5?OpenDocument
[10] Department of Health and New Horizons. 2010 op. cit.

Individuals with poor mental health outcomes are often in precarious employment i.e. no terms or contracts, part-time etc. Work insecurity has an adverse effect on physical and mental health.[11]

These documents all identified key determinants or frameworks for positive mental health and wellbeing with the common threads being:

- Participation in society and building resilience. This includes ensuring a positive start to life.
- Valuing diversity meaning and purpose. Particularly working to reduce discrimination.
- Creating safe and cohesive communities that are sustainable.

## *Solutions*

In 2005 the second Mental Health and Addiction Plan was published. This document looks at what had been achieved to date with increasing the role of Primary Care, the growth of the consumer voice, the integration of mental health services and a recovery philosophy and involvement of families and whanau. Ten challenges were identified; promotion and prevention; building services; responsiveness; workforce and culture for recovery; Māori mental health; Primary Health Care; addiction; funding; transparency and trust; and working together.[12]

One of the highest profile mental health actions over the past decade has been the Like Minds Like Mine campaigns and programs aimed at reducing stigma and discrimination around mental illness.[13]

The importance of primary care, as often being the first point of call with mental health needs was confirmed through a review of Primary Mental Health Initiatives. The review reported on studies that indicated that 36% of people attending general practice had one or more of the three most commonly presenting mental health disorders: anxiety, depression or substance-use disorder. Nearly all of these were mild to moderate conditions, and are first seen in primary health care settings. This review identified that much positive work was being done through these initiatives but there was still room for greater delivery and a wider focus on at risk groups.[14]

Building on strengths suggested that government agencies, research agencies and local government authorities need to advocate for consideration of mental health in the other service sectors – health, employment, housing, education, environment and social services.[15] The document also mentioned the importance of holistic health models such as Te Pae Mahutonga, which is a planning tool and the cornerstone of this City Profile document.[16] Another useful tool for holistic health models is Te Whare Tapa Wha which is adopted by some mental health agencies.[17]

Promoting positive mental health for youth has been identified in a recent review of Youth Mental health[18] and identified the importance of building resilience in young people by enhancing protective factors such as cultural identity, communication skills, connectedness and health lifestyles. This review also noted the importance of reducing inequalities by ensuring initiatives reach and are effective for those in greatest need. This might mean dealing with structural and material barriers for young people such as unemployment, family violence, poverty etc. A number of other recommendations were made that focus on participation, building on existing initiatives, best practice and taking a long term approach.

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[11] World Health Organisation. 2008. Closing the Gap in a Generation: Health Equity Through Actions on Social Determinants of Health. http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
[12] Ministry of Health. 2005. Te Tahuhu: Improving Mental Health 2005-2015. http://www.moh.govt.nz/moh.nsf/pagesmh/2182
[13] Like Minds Like Mine http://www.likeminds.org.nz/page/5-home
[14] Ministry of Health. 2009. Evaluation of the Primary Mental Health Initiatives: Summary Report. http://www.moh.govt.nz/moh.nsf/pagesmh/9281/$File/evaluation-primary-mental-health-Initiatives-summary-report-jul09.pdf
[15] Ministry of Health, 2002 op cit.
[16] Te Pae Mahutonga. http://www.hauora.co.nz/resources/tepaemahutongatxtvers.pdf
[17] Maori Health Model: Te Whare Tapu Wha. http://www.maorihealth.govt.nz/moh.nsf/pagesma/445 Accessed 03.10.10.
[18] Mental Health Foundation. 2010. Review of Evidence about the Effectiveness of Mental Health Promotion Programmes Targeting Youth/Rangatahi. Wellington: Quigley Watts. http://www.mentalhealth.org.nz/file/downloads/pdf/file_297.pdf

## Data limitations

There are a wide number of reviews, evaluations and strategies on which to call but no recent national survey data. There are also difficulties comparing data across surveys due to different definitions and terminology used. As mentioned above much of the data is around illness statistics rather than wellbeing.

## Connections with other issues

Income, Housing affordability, Maori Language (Te Reo), Active Transport, Activity and exercise levels, Age friendly city, Access to after hours primary care, Employment, Food security, Fuel poverty and home heating.

## Impact of the earthquakes

*As time passes and these papers are updated the initial sections on the impact of the earthquake are going to be kept as an archive. Updates are provided where possible.*

**As at October 2011**

The increase in need for mental health services in Christchurch has been commented on in the media many times. However ironically with the whole of city experiencing the uncertainties and anxieties of ongoing aftershocks there has been some de-stigmatising effects and greater recognition of mental wellbeing issues. Some time limited additional earthquake related funding for free psychological counselling through primary and NGO services as well as a small amount for Specialist Mental health services assessment and treatment has been provided since the February quake. The Coroner's data indicates that suicides in Christchurch have dropped slightly after the earthquakes. A hypothesis for this is that instead of people feeling a sense of isolation and alienation, the period immediately post quakes carried with it a sense of greater community cohesion. There is some concern that rates may rise again as time goes on if "collective support" and a sense of community ends.[19] Overseas studies have indicated a potential rise in domestic violence and alcohol and drug abuse post disasters and data on this needs to be monitored.

Immediately post quakes considerable energy was put into 'normalising' peoples responses to an 'abnormal' event and providing 'psychological first aid.' The effectiveness of this is not measured formally but it is hoped that this will reduce the demand for formal intervention by mental health services.

The earthquakes also created an opportunity to advocate for programs that maintain collectivism and community support.

*Prepared by Community and Public Health.*

[19] Media statement sent on behalf of the Chief Coroner, Judge Neil MacLean, August 2011