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MENTAL ILLNESS

Key Findings

- **The most contact with clients is with those aged 15-44 and there has been a decrease in those seen from the 2003 year to the 2004 year.**
- **Those in the more deprived areas, NZDep2001 quintiles 3, 4 &5 are more likely to be hospitalised for mental illness than those in the least deprived areas.**
- **The Wairarapa hospitalisation rate is generally higher than the NZ rate but this is not statistically significant**
- **Wairarapa Maori and non-Maori, non-Pacific have significantly higher rates of self harm than their national counterparts.**
- **In 2002 and 2003 the hospitalisation rate for suicide was significantly higher than the national rate.**

Strategic context

The New Zealand Health Strategy (NZHS) includes among its 61 population health objectives a number of objectives that relate to mental health. Among the 13 stated priorities, four are specifically related to mental health.

The improved responsiveness of mental health services is also one of the five service priority areas identified in the NZHS as being particularly important in progressing its objectives.

Mental health services funded by the Wairarapa DHB include a mix of local and regional services that cover a wide range of mental health and alcohol and other drug addiction needs. Most of these are provided in the community by a combination of NGO providers and Masterton Hospital and include a mix of residential support, community support, day programmes and services. Through this configuration of services most needs can be supported ranging from those for people with more mild to moderate illness whose needs are mostly met in the primary care environment to those experiencing more severe illness where specialty services are required.

Those people requiring more intensive treatment are supported through Masterton Hospital's Mental Health Service and include services for children, adolescents and their families, Maori, adults and those experiencing alcohol and drug issues. Those requiring a further level of support receive this through regional services that specialise in areas such as young people, maternal mental health, forensic, and eating disorders.

Improving the health status of people with mental health illness is one of the Wairarapa DHB's four strategic priorities.

It is estimated that 3% of the adult total population have severe mental health disorders and another 5% have moderate/severe mental health disorders. A total of 20% of the population have some kind of mental health disorder during their life.

The outcomes sought by the DHB are:

1. All people affected by mental illness have easy access to safe effective, recovery oriented services appropriate to their needs.

2. A strong treaty framework underpins all interactions, policy and service developments.

3. All sectors of the community have good understanding of mental illness and mental health issues.

4. Mental health is part of everyone's agenda and seen as the responsibility of all agencies and sectors.

5. All agencies and sectors work collaboratively together to ensure they deliver comprehensive, holistic and well co-ordinated services.

Prevalence

There is currently no direct data on the prevalence of mental health problems in the Wairarapa DHB therefore estimates can only be made from other studies conducted in New Zealand and overseas.

A major psychiatric epidemiology study is currently underway in New Zealand. This is known as the NZ Mental Health Epidemiology Study or the NZ Mental Health and Wellbeing Survey, Te Rau Hinengaro[i]. This survey involves extensive household interviews throughout New Zealand and will provide information on a range of diagnoses at regional level. It will also provide comparative data across age, gender and ethnicity.

The survey took place from November 2003 to October 2004. It is expected that a final report will be available in 2006.

Data can be extracted from the utilisation data of local, regional and national services providing services to the Wairarapa. This information includes:

Hospital discharge data for mental health diagnoses

Data was extracted from the NMDS system (Ministry of Health) and analysed by the Central Technical Advisory Services (TAS), the Central Region shared support service.

MHINC data (Mental Health Information National Collection)

The national database of information on secondary mental health and alcohol & drug services. This data was also analysed by the Central Technical Advisory Services (TAS).

This data is limited as it shows take up of services rather than reporting of mental illness.

Utilisation figures for mental health services can be limited in what they can demonstrate but can give clear indications of:

- Level of engagement with mental health service users.
- The take–up for community versus hospitalised/residential services which in turn indicate how well community based services are engaging with the community.
- Over representation, if any, of age and ethnic groups.

However, it is unclear what percentage of services are taken up by people with severe mental health problems (i.e. mental health disorders) and people with less serious mental health issues. Unknown factors include the percentage of people who do not

access services with mental health issues, the number of times any one person has accessed and needed services, the level of need for services, and the level of need for particular services.

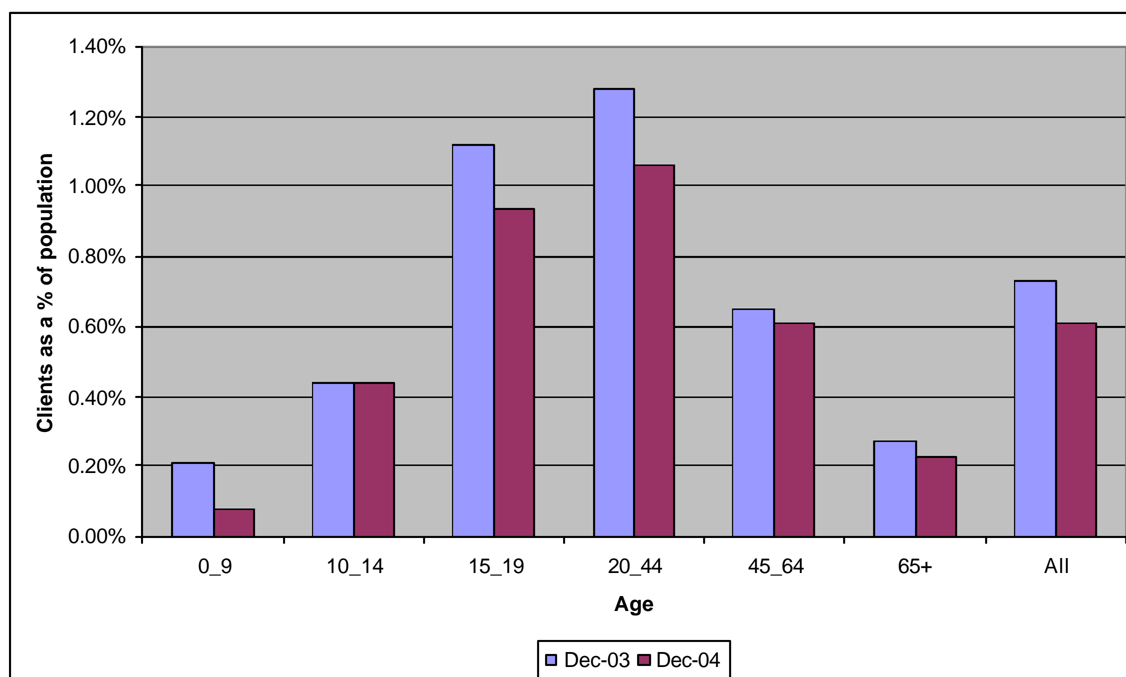
Table 1: Number of clients seen by the Wairarapa DHB, 2000 to 2004.

	2000	2001	2002	2003	2004
Jan	247	258	234	304	263
Feb	302	286	276	336	251
Mar	332	301	286	323	291
Apr	285	254	291	305	287
May	324	286	325	345	274
June	304	293	319	323	252
July	309	250	330	385	274
Aug	306	281	345	369	270
Sept	307	257	351	354	282
Oct	288	238	378	344	288
Nov	308	318	361	317	267
Dec	263	239	338	302	248
Total	**5575**	**5262**	**5836**	**6010**	**5251**

Source: **Mental Health Information National Collection**

Figure 1 shows the clients seen as a percentage of the population by age. It shows that the most contact is with those aged 15-44 and there has been a decrease in those seen from the 2003 year to the 2004 year.

Figure 1: Clients seen by age, and percentage of population 2003 & 2004



New Zealand Health Survey

The recently completed New Zealand Health Survey has asked a limited number of questions around mental illness and is the most up-to-date source of local prevalence data. The survey included a self-reported health status questionnaire.

The information currently available from the New Zealand Health Survey estimates the prevalence of severe mental illness in the population to be:

Overall, one in 40 adults (2.5%; 2.1–2.9) had ever been diagnosed with a serious mental disorder (i.e., depressive disorder, bipolar disorder or schizophrenia). Depressive disorders were most common (1.9%; 1.6–2.2), followed by bipolar disorder (0.5%; 0.3–0.7) and schizophrenia (0.2%; 0.1–0.4).

There was no significant difference in the prevalence of serious mental disorders between males (2.1%; 1.4–2.8) and females (3.2%; 2.5–3.8).

In males, there was no significant difference in the prevalence of serious mental disorders (i.e., a diagnosis of serious mental disorder at any time) between Maori and non-Maori. In females, non-Maori were nearly twice as likely as Maori to have been diagnosed with a serious mental disorder, although this difference was not significant.

The New Zealand Health Survey further estimates the prevalence of severe mental illness in the population to be comprised of:

- 1.9% depressive disorders.
- 0.5% bipolar disorders.
- 0.2 schizophrenia.

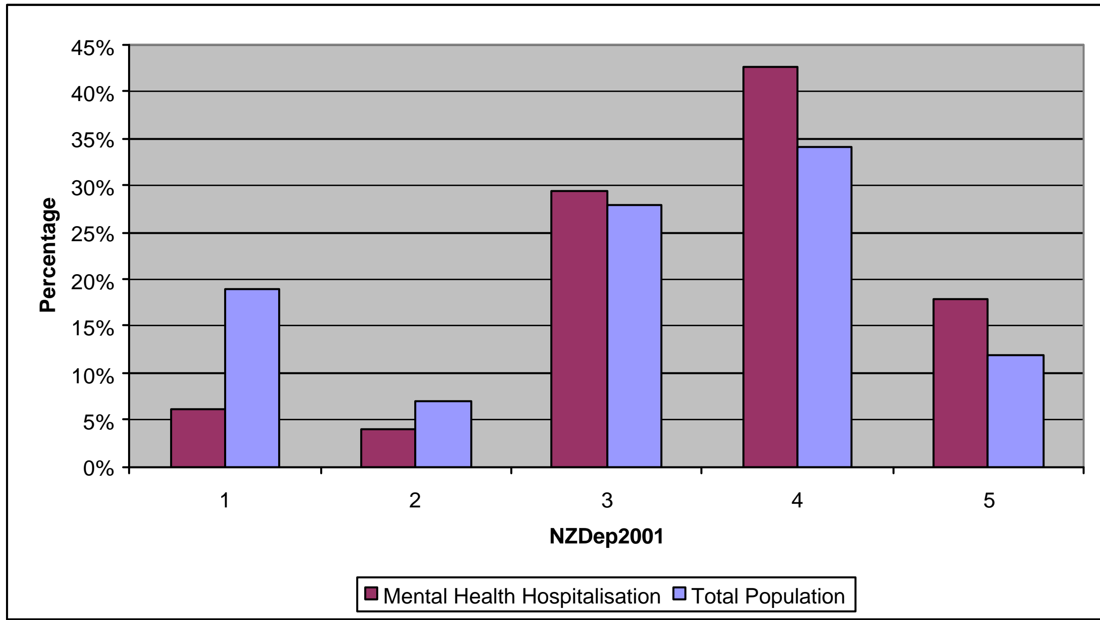
Socio-economic Factors

Anxiety, depression, dissatisfaction with one's present life, experienced strain, negative self-esteem, and other negative emotional states have each been demonstrated in cross-sectional studies to be higher in areas of high deprivation than in matched areas of low of deprivation.

There is also an emerging consensus that the physical, as well as mental health, of unemployed people is also generally lower than that of employed people. Furthermore, there is evidence that recovery is also affected by high deprivation factors. A speedy and early recovery from mental illness is also understood to reduce long term damage including future susceptibility to breakdowns and physical illness.

Hospitalisations for mental illness in Wairarapa show an association with deprivation. As shown in Figure 2 below. Those in the more deprived areas, NZDep2001 quintiles 3, 4 & 5 are more likely to be hospitalised for mental illness than those in the least deprived areas.

Figure 2: Mental disorder hospitalisations: Wairarapa DHB deprivation profile

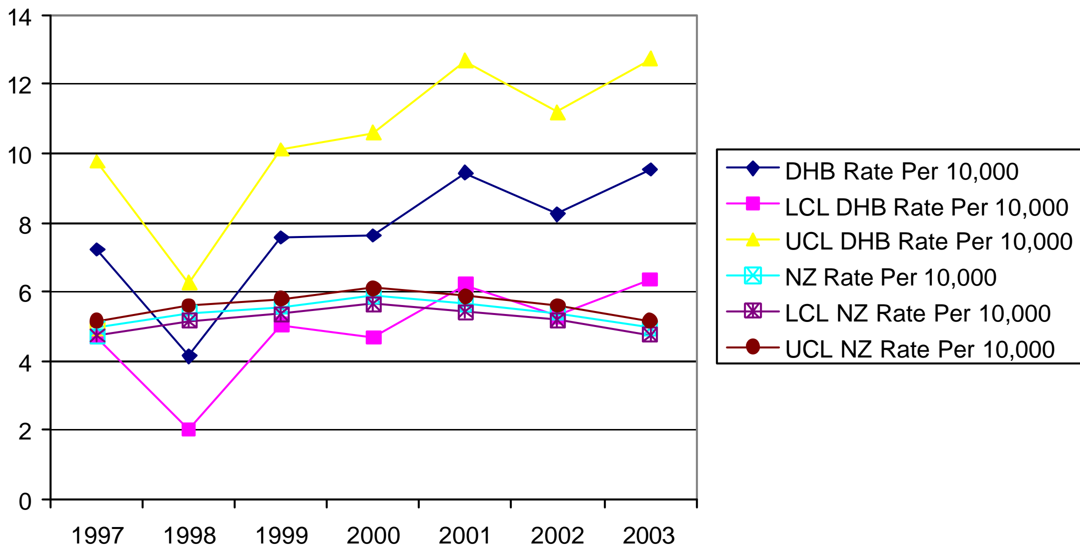


Source: TAS Fact sheet

Morbidity

The DHB age standardised hospitalisation rate for mental illness is shown in Figure 3. The Wairarapa rate is generally higher than the NZ rate but this is not statistically significant. The rate of increase is also higher than the NZ rate.

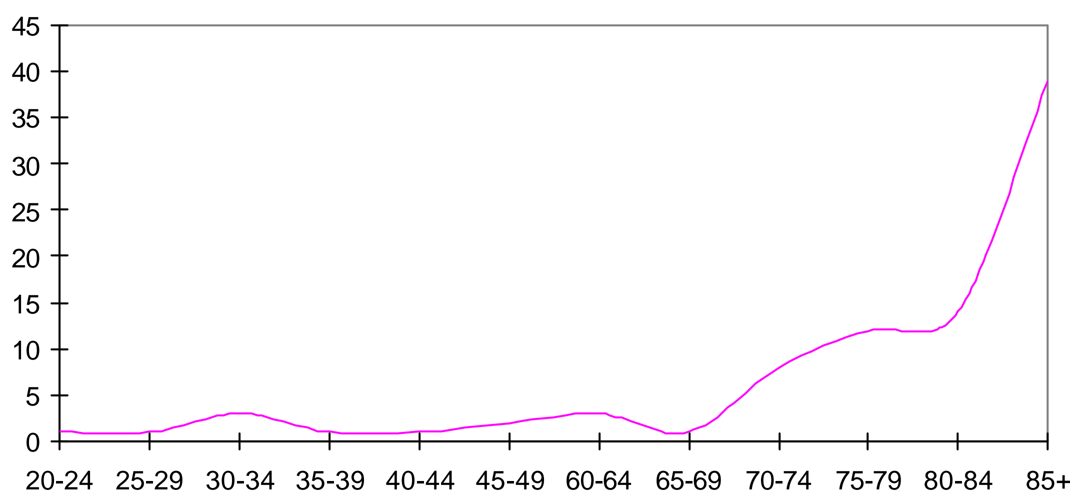
Figure 3: Age standardised hospitalisation rate per 10,000, NZ and Wairarapa 1997 – 2003.



Mortality

Overall mortality caused by mental disorder is low. For the years 1988 to 2001 there was a total of eighty eight deaths attributable to mental disorders and only two of these were Maori. The age distribution of these deaths shows a strong association between death attributed to mental illness and age as shown in figure 4 below.

Figure 4: Mortality by mental disorder: Age, volume profile 1988-2001



Suicide and intentional self harm

For information on youth suicide see the Youth Health chapter.

Reducing the rate of suicides and suicide attempts is one of the thirteen population health objectives in the New Zealand Health Strategy. Suicide and deliberate self-harm is also one of the six national injury prevention priority areas in the New Zealand Injury Prevention Strategy.

Individuals at greatest risk of suicide include men, mental disorders (in particular, mood, substance use and psychotic disorders), a history of admission and contact with services for mental health care, exposure to recent stressful life events and low socioeconomic status. The single most significant risk factor for suicidal behaviour in adults is mood disorder.

Suicidal behaviours occur on a continuum from idea and thoughts about suicide which are not acted on, through to suicide attempts and completed suicide. A far greater number of people attempt suicide each year than die by suicide. Suicidal behaviour is preventable, and is a significant public health issue in New Zealand. It is a major source of morbidity and mortality and is a significant contributor to social and health costs.

There is general agreement that a comprehensive approach to suicide prevention needs interventions to address the following eight themes:

1. mental health promotion including strengthening social cohesion and providing supportive environments
2. effective, accessible and responsive services for people with mental disorders or suicidal behaviours

3. training and skill development on suicide risk assessment and management
4. a managed approach to media and publicity about suicide
5. reducing access to the means of suicide
6. support for families and friends following suicide
7. data collection, information dissemination and research
8. a framework for community action.

Suicide in New Zealand

The Commonwealth Fund benchmarked and compared health care system performance in Australia, Canada, New Zealand, the United Kingdom and the United States. The report identified New Zealand as having the highest suicide rate for the population aged 15-19 and 20-29.

The report Suicide Facts highlighted the following:

- the total age-standardised suicide rate in 2001 was 11.7 deaths per 100,000 population (compared to 11.2 in 2000). Males continued to have a higher suicide death rate than females in 2001 (18.3 compared to 5.5 deaths per 100,000 population)
- in 2001, people aged 20-24 years had the highest suicide rate (25.3 deaths per 100,000 population), followed by people aged 25-29 years and 30-34 years (21.7 and 21.2 per 100,000 population respectively)
- in 2001, the total number of suicides was 499, up from 458 in 2000 but down from 516 in 1999. The 2000 number was the lowest total number since 1990 (455)
- the total rate of youth suicide (15-24 years) increased with 20.0 deaths per 100,000 population in 2001 compared with 18.1 per 100,000 population in 2000
- New Zealand has the highest male youth suicide rate (15-24 years), and the second highest female youth suicide rate compared to other OECD countries
- Maori continue to have higher suicide rates than non-Maori in 2001. In 2001, the rate of suicide among Maori was 13.4 deaths per 100,000 population compared with 11.2 for non-Maori
- the 2001 suicide rates for Maori males and females were 20.7 and 6.8 per 100,000 population respectively and for non-Maori males and females were 17.7 and 4.9 per 100,000 population respectively
- the Injury Prevention Research Unit (IPRU), University of Otago, has estimated that in 2000 suicide and intentional self-inflicted injury made up the greatest proportion of all injury related fatalities
- 79 Maori died by suicide in 2001, compared to 80 in 2000 and 78 in 1999
- in 2001, 22 Pacific people died by suicide (20 males and two females), compared to 12 deaths in 2000 and 14 deaths in 1999

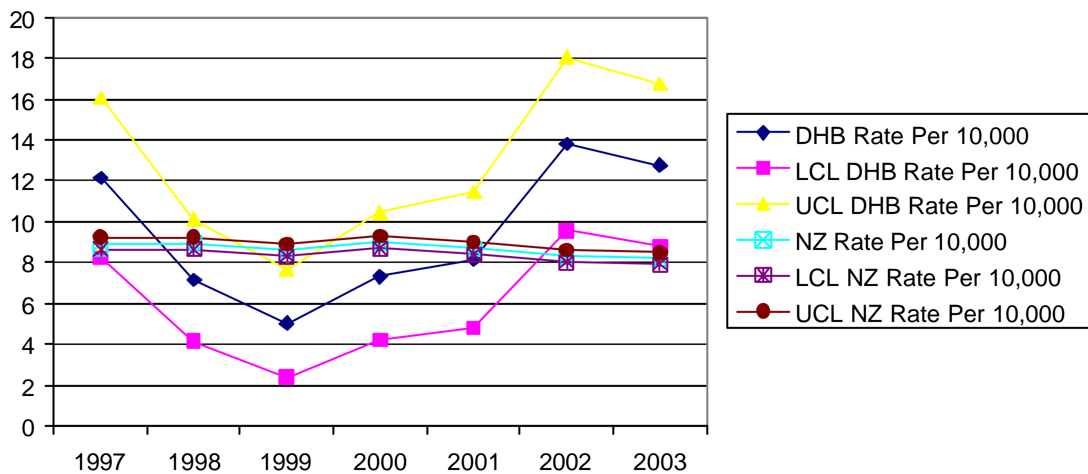
Numbers of suicide attempts are difficult to quantify because many do not result in serious physical injury and do not need medical treatment. Data on suicidal behaviour are frequently misunderstood or misinterpreted. Key problems in analysing data on suicidal behaviour include incorrectly drawing conclusions from small numbers of

suicide deaths; comparing data over a period that is too short; or incorrectly comparing city or regional data.

Wairarapa

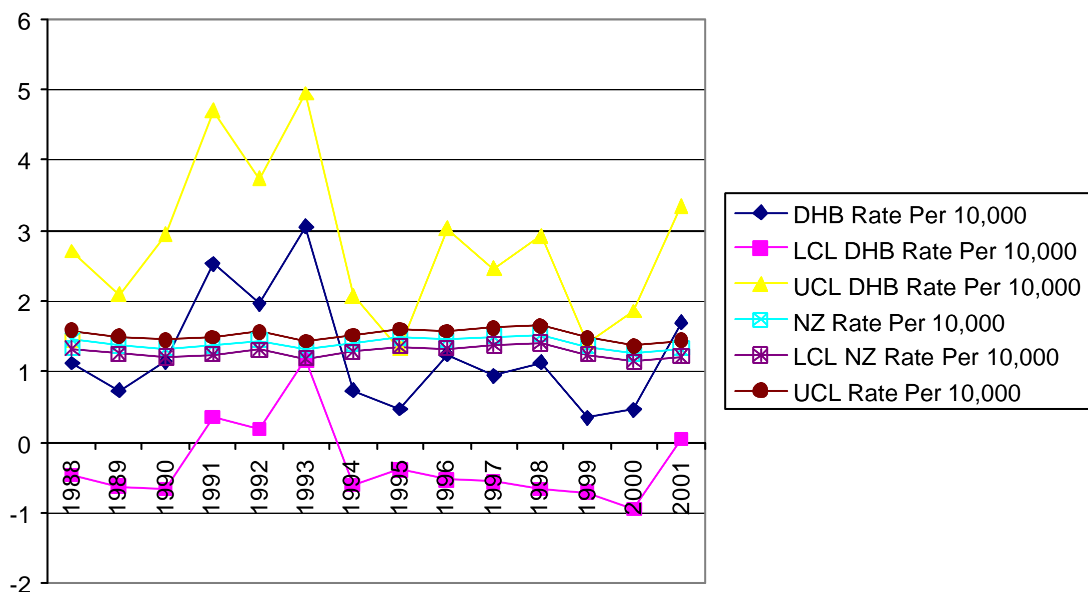
The suicide rate in the Wairarapa has fluctuated over time as illustrated in the hospitalisation and mortality graphs below. The hospitalisation rate was significantly below the national rate in 1999 then increasing until in 2002 and 2003 it was significantly above the national rate. The mortality rate has consistently shown no significant variation from the national rate.

Figure 5: Suicide hospitalisation, hospitalisations, rate per 10,000, 1997-2003



Data Source: Ministry of Health, Health Needs Assessment Version 7.

Figure 6: Suicide mortality, age standardised rate per 10,000 1988-2001



Source: Ministry of Health, Health Needs Assessment Version 7.

When considering the self harm hospitalisation rate Wairarapa Maori and non-Maori, non-Pacific have significantly higher rates of self harm than their national counterparts.

Table 2: Intentional self harm hospitalisations, rate per 100,000, 2002/03

	Male	**Female**	**Gender combined**
Wairarapa			
Maori	131 (48,285)	199 (95,366)	168 (96,273)
Non-Maori	72 (44,109)	169 (124,225)	120 (93,152)
New Zealand			
Maori	68 (61,76)	102 (94,111)	85 (80,91)
Non-Maori	56 (53,58)	124 (120,128)	90 (88,92)

Source: New Zealand Health Information Service

Conclusion

The NZ Mental Health Epidemiology Study (also called the NZ Mental Health and Wellbeing Survey, Te Rau Hinengaro) will provide valuable information for the mental health sector.

Current information is limited but gives clear indication that there is an association between socioeconomic status and mental illness.

Self harm and suicide hospitalisation information indicates that suicide and self harm is major concern for the Wairarapa.

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[i] Health Research Council of New Zealand (2003) The New Zealand Mental Health and Wellbeing Survey 2003-2004