Depression
Service Plan

December 2005
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1. **INTRODUCTION**

Depression is one of the most common and most serious mental health problems facing people today. Up to one in four women and one in six men can expect to experience depression at some time in their lives. Depression can affect people of any age, race or economic group. It can be devastating to all areas of a person's everyday life, including family relationships, friendships, and the ability to work or go to school. At its worst, depression can lead to suicide\(^1\).

MidCentral District Health Board (MidCentral) is responsible for the development and implementation of a coordinated, district wide plan for the management of depression.

As Figure 1 illustrates, it is estimated that 20% of the population have a diagnosable mental illness (including depression) at any one time. About 3% of adults – and about 5% of children and young people – have a severe mental health disorder. A further 5% of adults have a moderate to severe disorder, and 12% have mild to moderate disorders or problems.

**Figure 1: Estimated Prevalence of Mental Health Problems Amongst Adult New Zealanders\(^2\)**

MidCentral District Health Board's Primary Health Care Strategy identifies depression as one of six high priority disease states to be addressed in order to improve the District's health status. In addition, reducing the rate of suicide and suicide attempts is a priority in the New Zealand Health Strategy (2000) and the New Zealand Injury Prevention Strategy. These health gain priorities have been chosen because of their potential for improvement – Depression being one of the most successfully treated illnesses. When properly diagnosed and treated, more than 80% of those suffering from depression recover and return to their normal lives.

Depression is a spectrum of disorders. As well as Depressive Disorders, this plan also encompasses Adjustment Disorder, such as when a person develops emotional or behavioural symptoms in response to an identifiable stressor. If help is not obtained, this may develop into a more troublesome depressive condition. The plan also includes the mental health

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\(^1\) World Health Organization (Sept 2003) Depression http://www.who.int/topics/depression/en/

\(^2\) Ministry of Health (2003) DHB Toolkit – Mental Health pg 10
needs of children and young people (defined as those aged 0-19 years).

The Service Plan is strategic for the development of services over the next three years and has been developed collaboratively with primary and secondary care providers and community stakeholders.

1.1 Why Do We Need a Depression Service Plan?

In any two week period, one in 12 people (8.5%) will have a Depressive Disorder, 6.4% will have Dysthmic Disorder and 3.7% will have a Major Depressive Episode.1

People with significant depression report lower quality of health, lower quality of life and take more time off work. One estimate puts the cost of depression to New Zealand at approximately $750 million a year.

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self worth, disturbed sleep or appetite, low energy, and poor concentration.

Depression is the leading cause of disability as measured by years lived with disability (YLD) and the 4th leading contributor to the global burden of disease (DALYs4) in 20005. By the year 2020, the World Health Organization has estimated that, in developed regions of the world, depression will be the highest ranking contributor to the burden of disease and will reach 2nd place in the ranking of DALYs calculated for all ages and including both sexes.

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1 in 5 New Zealanders will experience mental illness in their lifetime.
1 in 7 will experience depression at some time in their life.
It is likely that you or someone you know will be affected.


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Around half of the people who experience depression will have their first episode before the age of 25 years.
Women are almost twice as likely as men to experience depression. The lifetime prevalence of Major Depression is 24% for women and 15% for men.
The lifetime rate of attempted suicide is 30 to 50% of people with depression. About 10 to 15% actually commit suicide.
10% of patients with depression receive both timely diagnosis and effective treatment.

Te Kete Whaiora – Mental Health Foundation (2005) A Resource About Depression for People Who Work With Young People
Ferguson (December 2004) Whither Primary Mental Health Care NZFP, Volume 31 Number 6 pg 372

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2 National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 10
3 DALYs = Disability-Adjusted Life Years: The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.
1.2 Purpose of the Depression Service Plan

Based on the continuum of care, the overall purpose of MidCentral’s Depression Service Plan is to:

- Develop and improve access to services for people with depression
- Manage the incidence of depression
- Reduce suicide rates and suicide attempts
- Enhance wellbeing through effective treatment and recovery
- Improve the health status of Maori and Pacific peoples
- Promote a community and lifestyle that is supportive of positive mental health.

1.3 Vision for the Future

This service plan strives to offer people in the community the best possible health and independence. Our vision for depression in MidCentral district is to:

"Promote the mental wellbeing of the community by working together to improve the identification of, and reduce the impact of depression through improved access to health services."

Access to health services includes access to health information, treatment and support.

Figure 2 below shows the pathway to our vision for Depression services.

Figure 2: The Pathway to Our Vision

1.4 **Objectives**

The objectives of the Depression Service Plan are based on the continuum of care. They are:

1. To reduce the impact of depression through mental health promotion and prevention strategies
2. To ensure early detection and early intervention to minimise the impact of depression on wellbeing
3. To manage depression through support, effective treatment and recovery to improve wellbeing
4. To improve depression services through a responsive workforce
5. To improve depression services through planning, innovation, and quality assurance.

1.5 **Principles**

The vision and objectives of this plan are based on the following underlying principles:

- Every person is unique and requires options from which they can select the services that best suit them
- Children and youth are a priority group
- The care provided to people with depression will be organised, and coordinated across providers and the continuum of care
- Inequalities in health outcomes will be addressed, in particular: Maori and Pacific peoples and minority group health outcomes will be improved through targeting in a manner that accounts for client needs
- All services will be person centred – actively ensuring participation of service users in care. Given the importance of self care, people with depression and their family/whanau will be considered a part of the health workforce and require appropriate skills. This includes people:
  - making their own decisions and managing their own recovery pathway
  - participating in the delivery of services to others
  - participating in the planning of services
- Service options will be consistent in terms of quality and best practice. Advice and support provided by services will also be consistent
- Where possible, programmes and services will be delivered in the community
- Depression services will be accessible and affordable
- Access will be available for psychological assessment and treatment of depression
- Continuous quality improvement, including auditing, will occur in all services
- Issues for Maori will be addressed by working within the framework of the Treaty of Waitangi
- Cultural diversity will be recognised and respected.
2. THE PLANNING FRAMEWORK – STRATEGIES

2.1 MidCentral’s Planning Framework

The depression planning framework (Figure 3) has been developed by considering national and international literature, and building on the principles of MidCentral’s Primary Health Care Strategy. It involved focussed consultation with people in the community and other key stakeholders.

Figure 3: The Depression Service Planning Framework
2.2 Government Strategies

The key government strategies which provide the strategic context for this depression plan are:

- The New Zealand Health Strategy (December 2000)
- The Primary Health Care Strategy (February 2001)
- Youth Health Strategy (September 2002)
- The New Zealand Disability Strategy (April 2001)
- The New Zealand Youth Suicide Prevention Strategy (March 1998)
- The New Zealand Injury Prevention Strategy (June 2003)
- Mental Health Strategy (September 2004)
- Health of Older People Strategy (April 2002)
- Building on Strengths – A New Approach to promoting Mental Health in New Zealand/Aotearoa (December 2002)
- He Korowai Oranga – Maori Health Strategy (November 2002)
- The Pacific Health and Disability Action Plan (February 2002)
- Palliative Care Strategy (2001).

Chronic conditions can affect people’s mental, emotional and spiritual wellbeing as well as their physical health. Depression is a common ongoing condition in itself, and can be associated with many other chronic conditions such as diabetes or cardiovascular disease. For instance, depression is a risk factor for cardiovascular disease, and people with cardiovascular disease have a higher likelihood of experiencing depression than those without cardiovascular disease. In addition, people with mental illness experience relatively high levels of physical illness⁶. Table 1 illustrates the link between depression and other priority health areas.

### Table 1: Main Linkages Between Depression and Other Priority Health Areas in the New Zealand Health Strategy and MidCentral’s Primary Health Care Strategy

<table>
<thead>
<tr>
<th>Objective</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce diabetes</td>
<td>Several studies suggest that diabetes doubles the risk of depression compared to those without the disorder. The chances of becoming depressed increase as diabetes complications worsen.</td>
</tr>
<tr>
<td>Reduce cancer</td>
<td>Major Depressive Disorder occurs in approximately 25% of patients with cancer and is even more common in advanced cancers. Depressed mood is a common side effect of the drugs used to treat cancer.</td>
</tr>
<tr>
<td>Increase physical activity</td>
<td>Researchers have found that exercise is likely to reduce depression and anxiety and help people to better manage stress.</td>
</tr>
<tr>
<td>Improve oral health</td>
<td>Embarrassment about the shape of teeth or about missing, discoloured or damaged teeth can adversely affect people’s daily lives and wellbeing.</td>
</tr>
<tr>
<td>Improve child health</td>
<td>Depression in children can lead to school failure, alcohol or other drug use, and even suicide.</td>
</tr>
<tr>
<td>Minimise alcohol and drug use</td>
<td>The relationship between depression and alcohol is quite strong, especially among women. When women experience symptoms of depression, they are at increased risk for alcohol dependence subsequently.</td>
</tr>
<tr>
<td>Manage respiratory illness</td>
<td>Respiratory illness represents a particularly debilitating health burden contributing to depression according to the University of Southern California.</td>
</tr>
<tr>
<td>Reduce cardiovascular disease</td>
<td>Research has shown that people with heart disease are more likely to suffer from depression than otherwise healthy people, and conversely, that people with depression are at greater risk for developing heart disease. Furthermore, people with heart disease who are depressed have an increased risk of death after a heart attack compared to those who are not depressed.</td>
</tr>
<tr>
<td>Reduce suicide and suicide attempt</td>
<td>Depression can lead to thoughts of suicide. Generally, a much higher incidence of suicide, both completed and attempted, is associated with alcohol.</td>
</tr>
</tbody>
</table>

* DBSA Depression and Diabetes http://www.dbssalliance.org/Diabetes.html
* National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 52
* National Mental Health Association (USA) Children’s Mental Health http://www.nmha.org/infoctr/factsheets/78.cfm
* University of Southern California Longitudinal Study of Generations http://www.usc.edu/dept/gero/research/4gen/teheran.htm
* DBSA Depression and Heart Disease http://www.dbssalliance.org/HeartDisease.html
* DoctorNet.co.uk Alcohol and Depression http://community.netdoctor.com/cses/uk/depression/coping/social/article.jsp?articleIdnt=uk.depression.coping.social.uk_depression_article_1032
2.2.1 Chronic Disease Management

A global health needs assessment completed during 2001 indicated disease (morbidity) and death (mortality) rates for people living within MidCentral District’s boundaries needs to be addressed adequately in primary health care\(^6\). Such issues are goals of the local Primary Health Care Strategy\(^7\).

The goals of the Primary Health Care Strategy have six objectives:

1. **Access** – People will have ease of access to health care services throughout the district
2. **Community participation** – The community will actively contribute to shaping primary health care services
3. **Coordination of services** – There will be seamless follow-through of services for all people
4. **Infrastructure development** – Primary health care services are supported by planned infrastructure development
5. **Integration between primary and secondary care** – People receive care that is not interrupted between primary and secondary care events
6. **Quality** – People can expect the best possible quality when receiving primary health care services.

The MaGPIe (Mental Health and General Practice) Study results were launched in April 2003. One of the key findings of the MaGPIe study is that over one third of all patients attending a general practice had experienced a diagnosable disorder in the previous 12 months.

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\(^6\) MidCentral DHB (2004) Primary Health Care Strategy pg 35
\(^7\) Adapted from TADS Training Programme presentation July 2004
3. MAORI AND PACIFIC HEALTH

It is important that Maori and Pacific peoples are heard, so this document has included some sections specifically related to Maori and Pacific peoples.

3.1 Maori Health

The need to address health inequalities among Maori has been emphasised in strategic health policy documents including The New Zealand Health Strategy (2000), The New Zealand Public Health and Disability Act 2000 and He Korowai Oranga – Maori Health Strategy (2002).

He Korowai Oranga – Maori Health Strategy (2002) recognises that there must be a partnership between Maori and health and disability organisations if aspirations for Maori health and desired whanau outcomes are to be realised.

It is essential that the principles of the Treaty of Waitangi are followed:

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Working together with iwi, hapu, whanau/family and Maori communities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Involving Maori at all levels including planning, development and the delivery of health care programmes and services.</td>
</tr>
<tr>
<td>Protection</td>
<td>Striving for equal levels of health as non Maori and caring for the cultural concepts and values of Maori.</td>
</tr>
</tbody>
</table>

The Maori world view places greater emphasis on the group dynamic as opposed to the individual. In keeping with this belief the Maori view of health is that personal wellbeing is based upon a balance of spiritual, whanau, mental and physical wellbeing. This is encapsulated in the Whare Tapa Wha model, a concept recognised by the World Health Organization.

<table>
<thead>
<tr>
<th>Taha Wairua</th>
<th>Taha Hinengaro</th>
<th>Taha Tinana</th>
<th>Taha Whanau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Spiritual</td>
<td>Mental</td>
<td>Physical</td>
</tr>
<tr>
<td>Key Aspects</td>
<td>The capacity for faith and wider communion</td>
<td>The capacity to communicate, to think, and to feel</td>
<td>The capacity for physical growth and development</td>
</tr>
<tr>
<td>Themes</td>
<td>Health is related to unseen and unspoken energies</td>
<td>Mind and body are inseparable</td>
<td>Good physical health is necessary for optimal development</td>
</tr>
</tbody>
</table>
Te Whare Tapa Wha likens the four dimensions of health (taha wairua, taha hinengaro, taha tinana, taha whanau) to the walls of a house. Symmetry of these four dimensions gives strength and balance to a person in much the same way that walls contribute to a house.

This concept, together with upholding the principles of the Treaty of Waitangi (ie, partnership, participation and active protection) need to be carefully considered when developing and implementing strategies to address Depression in the Maori population.

3.2 The Pacific Concept of Health

The Pacific Health and Disability Action Plan (2002) sets out a strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non Pacific peoples. The vision, principles and priorities of the plan form the basis of Pacific health and disability support policy and services.

MidCentral's Depression Service Plan is consistent with the six priority areas identified in the Pacific Health and Disability Action Plan.

For Pacific peoples, health is a holistic concept which encompasses spiritual, emotional, mental, physical and social wellbeing. The emphasis is on total wellbeing of the individual within the context of the family. The family includes both the nuclear family and the extended family.

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4. DEMOGRAPHIC PROFILE FOR MIDCENTRAL DISTRICT

MidCentral District Health Board services a wide geographical and demographic district, throughout which we aim to improve, promote and protect the health of the approximately 163,000 people we serve.

4.1 Geography

Territorial Local Authorities (TLAs) are local council areas. In MidCentral District there are five TLAs: Manawatu, Palmerston North, Tararua, Horowhenua and part of the Kapiti Coast. In the Kapiti Coast TLA, the Census Area units (CAUs) included within MidCentral District are Otaki, Otaki Forks and Te Horo. These CAUs make up 20% of the population of Kapiti Coast TLA.

While public transport is generally available in Palmerston North and Feilding, public transport in the more rural areas is less available making it difficult to use public transport to access health services. MidCentral District has a significant rural population; 28% of the population live outside a major urban or secondary urban area.

4.2 Population

MidCentral District's population comprises 15.3% Maori, 2.0% Pacific peoples, 3.5% Asian peoples, and 79.3% other ethnicities including European (Figure 4) – evenly distributed across gender: males 49% and females 51%.

Figure 4: MidCentral District – Ethnicity Breakdown

Appendix B provides a more detailed demographic profile of MidCentral District.

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21 MidCentral District Health Board (2001) An Assessment of Health Needs in the MidCentral District Health Board Region
22 2001 Census
23 MidCentral District Health Board (2001) An Assessment of Health Needs in the MidCentral District Health Board Region pg 8
5. **DEPRESSION BURDEN PROFILE**

Depression is a mental state of depressed mood characterised by feelings of sadness, despair and discouragement. As Table 2 illustrates, in New Zealand, depression is the number one cause of total years lost to disability (YLD) in New Zealand. It is also the number one cause of YLD in females and the 5th highest cause of YLD in males.

**Table 2: Top 10 Causes of Years Lost to Disability (YLD) in New Zealand by Gender 1996**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Male Cause</th>
<th>Female Cause</th>
<th>Total Cause</th>
<th>YLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Asthma</td>
<td>Depression</td>
<td>Depression</td>
<td>20,497</td>
</tr>
<tr>
<td>2</td>
<td>COPD</td>
<td>Anxiety Disorders</td>
<td>Anxiety Disorders</td>
<td>17,930</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes</td>
<td>Asthma</td>
<td>Asthma</td>
<td>17,059</td>
</tr>
<tr>
<td>4</td>
<td>Anxiety Disorders</td>
<td>Diabetes</td>
<td>Diabetes</td>
<td>14,684</td>
</tr>
<tr>
<td>5</td>
<td>Depression</td>
<td>Dementia</td>
<td>COPD</td>
<td>12,418</td>
</tr>
<tr>
<td>6</td>
<td>Hearing Disorders</td>
<td>Osteoarthritis</td>
<td>Osteoarthritis</td>
<td>11,126</td>
</tr>
<tr>
<td>7</td>
<td>Ischaemic Heart Disease</td>
<td>COPD</td>
<td>Dementia</td>
<td>11,070</td>
</tr>
<tr>
<td>8</td>
<td>Osteoarthritis</td>
<td>Ischaemic Heart Disease</td>
<td>Ischaemic Heart Disease</td>
<td>9,708</td>
</tr>
<tr>
<td>9</td>
<td>Dementia</td>
<td>Stroke</td>
<td>Hearing Disorders</td>
<td>9,427</td>
</tr>
<tr>
<td>10</td>
<td>Stroke</td>
<td>Breast Cancer</td>
<td>Stroke</td>
<td>7,775</td>
</tr>
<tr>
<td></td>
<td>Top 10</td>
<td></td>
<td></td>
<td>131,694</td>
</tr>
</tbody>
</table>

COPD = chronic obstructive pulmonary disease

Depressive disorders are differentiated from normal mood changes by the extent of their severity, the symptoms and the duration of the disorder, ranging from normal feelings of the blues through Dysthymia to Major Depression. Figure 5 shows the common course of Depressive Disorders such as Bipolar Disorder, chronic Major Depression and Dysthymia.

**Figure 5: The Common Course of a Depressive Disorder**

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[Asthma and Respiratory Foundation of New Zealand (Dec 2001) The Burden of Asthma In New Zealand](pg6)
The following section highlights the burden of depression.

5.1 Unipolar Major Depression (Major Depressive Disorder)

Research consistently reports that 1 in 13 (6-8%) of all people presenting to primary care have a Major Depressive Disorder\(^5\).

A diagnosis of Unipolar Major Depression (or Major Depressive Disorder) is made if a person has five or more symptoms and impairment in usual functioning nearly every day during the same two week period. Major Depression often begins between ages 15-30 or even earlier. Episodes typically recur\(^6\). In 1990 Unipolar Major Depression was ranked fourth of the 10 leading causes of Disability Adjusted Life Years. The World Health Organization projects that by 2020 it will rank second (Table 3). In other words it will have the second highest number of disability adjusted life years globally, after ischaemic heart disease.

Table 3: Change in Rank Order of Disability Adjusted Life Years For the 10 Leading Causes in the World, 1990-2020\(^7\)

<table>
<thead>
<tr>
<th>Year 1990</th>
<th>Year 2020 (Baseline Scenario)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease or Injury</td>
<td>Rank</td>
</tr>
<tr>
<td>Lower respiratory infections</td>
<td>1</td>
</tr>
<tr>
<td>Diarrhoeal disease</td>
<td>2</td>
</tr>
<tr>
<td>Conditions arising during the perinatal period</td>
<td>3</td>
</tr>
<tr>
<td>Unipolar Major Depression</td>
<td>4</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>5</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>6</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>7</td>
</tr>
<tr>
<td>Measles (drops to rank 25)</td>
<td>8</td>
</tr>
<tr>
<td>Road traffic accidents</td>
<td>9</td>
</tr>
<tr>
<td>Congenital abnormalities</td>
<td>10</td>
</tr>
</tbody>
</table>

\(^5\) National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 14
\(^7\) Ministry of Health (July 2003) Mental Health Toolkit pg 12
If untreated, depression is associated with an increased risk of suicide and other violent acts. It has also been estimated that up to 10-15% of those ever admitted to hospital with a severe Major Depressive Disorder will commit suicide—a rate approximately 30 times higher than for the general population. Suicide attempts have been reported in 25-50% of those with a Major Depressive Disorder. Untreated or prolonged depression can result in occupational and social dysfunction, especially within the family and at work.

5.2 Bipolar Affective Disorder (BD)

Formerly called manic depressive illness, this illness affects about 30,000 New Zealanders and their families. Not nearly as prevalent as other forms of Depressive Disorders, Bipolar Disorder (BD) is a mood disorder that involves cycles of depression and elation or mania. It occurs equally in men and women.

Approximately 20% of all patients with BD have their first episode during adolescence but diagnosis is often delayed for years. Delayed recognition that low moods (depression) and highs (mania) are symptoms of a treatable mental disorder can foster related problems, such as substance abuse and suicidal behaviours.

The exact cause of BD is unknown. However, studies suggest that the problem may be an imbalance in brain chemicals (norepinephrine and serotonin). Other chemicals may be involved. There may also be a genetic basis for the disorder.

Although there is no cure for Bipolar Disorder, the symptoms can be controlled. Eighty percent to 90% of people who have Bipolar Disorder can be treated effectively with medication and psychotherapy.

5.3 Dysthymia (Chronic Low Grade Depression)

Dysthymia (the Greek roots of the word mean "bad state of mind" or "ill humour") is a disorder with similar but longer-lasting and milder symptoms than clinical depression. Dysthymic Disorder occurs twice as often amongst women as men, but is equally common amongst boys and girls. The rate of Dysthymic Disorder increases with age, reaching about 1 in 10 people in the 45-64 age group.

Differentiation between Dysthymic Disorder and Major Depressive Disorder can be difficult. Their symptoms are similar, differing only in duration and severity. By the standard

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28 National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 13
29 Mental Health Foundation of New Zealand http://www.wordworx.co.nz/depression.html
30 American Foundation for Suicide Prevention Bipolar Disorder and Suicide Prevention http://www.afsp.org/about/manicdep.htm
32 National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 10
psychiatric definition, this disorder lasts for at least two years (in children and adolescents, mood can be irritable and duration must be at least one year), but is less disabling than Major Depression; for example, victims are usually able to go on working and do not need to be hospitalised.33

Individuals who initially present with Dysthymic Disorder frequently go on to develop concurrent Major Depressive Disorder.

People with Dysthymia usually suffer from poor appetite or overeating, insomnia or oversleeping, and low energy or fatigue. People with Dysthymia are often unaware that they have an illness because their functioning is usually not greatly impaired. They go to work and manage their lives, but are frequently irritable and often complaining about stress. However, people with Dysthymia may also sometimes experience Major Depressive episodes.

Consistently, the first episode of Major Depression occurs 2-3 years after the onset of Dysthymic disorder, suggesting that the latter is one of the gateways to recurrent mood disorders.

The primary aims of treatment for Dysthymic disorder should be to resolve depressive symptoms, reduce the risk of developing other mood disorders over time and strengthen psychosocial functioning, especially in children and adolescents, in order to prevent the potentially serious follow on of this disorder.34

5.4 Adjustment Disorder

Adjustment Disorders are a reaction to stress and occur when a person develops emotional or behavioural symptoms in response to an identifiable stressor. Stressors can be natural disasters, events or crisis (such as car accidents, or development of a medical disorder) or interpersonal problems (such as divorce, or abuse). The person displays either marked distress, or impairment in functioning (ie, unable to work or study)35. Adjustment Disorder with Depressed Mood is relevant to depression services.

By definition the Adjustment Disorder ends within six months after the onset of the stressor (or the consequences of the stressor). There is no way to predict which people are likely to develop Adjustment Disorder, given the same stressor. A given person's susceptibility to stress may be influenced by such factors as social skills, intelligence, flexibility, genetic factors, and coping strategies.36

People with no history of prior psychiatric symptoms, and who have stable environments and strong social support, are likely to return to their functioning level prior to the onset of the

33 National Mental Health Association (USA) Dysthymia http://www.nmha.org/infoctr/factsheets/26.cfm
Scientific Institute 'Taggenio Medea', Italy
35 Drake University Adjustment Disorder http://soe.drake.edu/nri/syslab/reha222/psychmods/adjustment/default.html
Adjustment Disorder. The majority of these people will have a very positive prognosis, and are likely to display no further psychological symptoms in the future. If a person still has severe symptoms after six months, the diagnosis should be reviewed.

5.5 Depression in Children and Youth

Depression is one of the three most common mental health problems in young people. (Along with alcohol and drug misuse and addiction and anxiety disorders.)

Many depressive episodes in young people will resolve without treatment, however, these episodes may last months or years if left untreated. Long episodes of depression in young people adversely affect their personal, social, academic and vocational development and heighten their risk of suicide.

Approximately 90% of people who complete or make suicide attempts will have one or more recognisable mental illness (eg, depression), alcohol, cannabis and other drug use or significant behavioural problems. Therefore a young person with depression is at risk.

In New Zealand the prevalence of depression increases from 0.5% for a Major Depressive Episode and 0.9% for Dysthmic Disorder at age 11 to 3.4% for Major Depressive Episode and 3.2% for Dysthmic Disorder at age 18.

5.6 Depression in Women

Women are more likely to experience a depressive disorder than men: lifetime prevalence of 19.4% for females, 10% for males and 14.7% overall.

A variety of factors unique to women's lives are suspected to play a role in developing depression.

5.6.1 The Issues of Adolescence

Before adolescence, there is little difference in the rate of depression in boys and girls. But between the ages of 11 and 13 there is a precipitous rise in depression rates for girls. By the age of 15, females are twice as likely to have experienced a Major Depressive episode as males. This comes at a time in adolescence when roles and expectations change dramatically. The stresses of adolescence include forming an identity, emerging sexuality,

\[ \text{REFERENCES} \]

-- Mental Health Foundation of New Zealand [http://www.wordworx.co.nz/depression.html](http://www.wordworx.co.nz/depression.html)

-- Te Rote Whaiora – Mental Health Foundation (2003) A Resource About Depression for People Who Work with Young People pg 45

-- [Ibid pg 45](#)

-- National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals pg 10

-- [Ibid pg 10](#)

-- Cyranowski JM, Frank E, Young E, Shear MK. Adolescent onset of the gender difference in lifetime rates of major depression. Archives of General Psychiatry, 2000; 57: 21-27.
separating from parents, and making decisions for the first time, along with other physical, intellectual, and hormonal changes. These stresses are generally different for boys and girls, and may be associated more often with depression in females\textsuperscript{43}. Studies show that female high school students have significantly higher rates of depression, anxiety disorders, eating disorders, and Adjustment Disorders than male students, who have higher rates of disruptive behaviour disorders\textsuperscript{44}.

5.6.2 Adulthood: Relationships and Work Roles\textsuperscript{45}

Stress in general can contribute to depression in persons biologically vulnerable to the illness. Some have theorised that higher incidence of depression in women is not due to greater vulnerability, but to the particular stresses that many women face. These stresses include major responsibilities at home and work, single parenthood, and caring for children and ageing parents. How these factors may uniquely affect women is not yet fully understood.

For both women and men, rates of Major Depression are highest among the separated and divorced, and lowest among the married, while remaining always higher for women than for men. The quality of a marriage, however, may contribute significantly to depression. Lack of an intimate, confiding relationship, as well as overt marital disputes, have been shown to be related to depression in women. In fact, rates of depression were shown to be highest among unhappily married women.

5.6.3 Reproductive Events\textsuperscript{46}

Women's reproductive events include the menstrual cycle, pregnancy, the post pregnancy period, infertility, menopause, and sometimes, the decision not to have children. These events bring fluctuations in mood that for some women include depression. Researchers have confirmed that hormones have an effect on the brain chemistry that controls emotions and mood; a specific biological mechanism explaining hormonal involvement is not known, however.

Many women experience certain behavioural and physical changes associated with phases of their menstrual cycles. In some women, these changes are severe, occur regularly, and include depressed feelings, irritability, and other emotional and physical changes. Premenstrual syndrome (PMS) typically begins after ovulation and become gradually worse until menstruation starts. Scientists are exploring how the cyclical rise and fall of oestrogen and other hormones may affect the brain chemistry that is associated with depressive illness\textsuperscript{47}.

\textsuperscript{46} Ibid
\textsuperscript{47} Rubinow DR, Schmidt PJ, and Roca CA. Estrogen-serotonin interactions: Implications for affective regulation Biological Psychiatry, 1998;44(9):899-90
Postpartum mood changes can range from transient "blues" immediately following childbirth to an episode of Major Depression to severe, incapacitating, psychotic depression. Studies suggest that women who experience Major Depression after childbirth very often have had prior depressive episodes even though they may not have been diagnosed and treated.

Pregnancy (when desired) seldom contributes to depression, and having an abortion does not appear to lead to a higher incidence of depression. Women with infertility problems may be subject to extreme anxiety or sadness, though it is unclear if this contributes to a higher rate of depressive illness. In addition, motherhood may be a time of heightened risk for depression because of the stress and demands it imposes.

Menopause, in general, is not associated with an increased risk of depression. In fact, while once considered a unique disorder, research has shown that depressive illness at menopause is no different than at other ages. The women more vulnerable to change of life depression are those with a history of past depressive episodes.

5.6.4 Self Harm

New Zealand's suicide rate is trending downwards, however, for every completed suicide there are a far greater number of attempted suicides. Self harm is a term used to describe deliberately injuring oneself through a variety of means such as cutting, poisoning, burning. As Figure 6 shows, more females are hospitalised for intentional self harm than males.

Females more commonly choose methods such as self poisoning that generally are not fatal, but still serious enough to require hospitalisation. The female to male ratio for intentional self harm in New Zealand in 2002 was 2.1 female hospitalisations to every male hospitalisation\(^8\).

Figure 6: National Rates of Suicide and Self Inflicted Injury Hospitalisation by Age, 2002 (National Statistics)\(^9\)

\(^8\) Ibid pg 16
\(^9\) Ibid pg 17
5.7 Depression in Men

Men's depression is often masked by alcohol or drugs, or by the socially acceptable habit of working excessively long hours. Depression typically shows up in men not as feeling hopeless and helpless, but as being irritable, angry, and discouraged; hence, depression may be difficult to recognise as such in men. Even if a man realises that he is depressed, he may be less willing than a woman to seek help. Encouragement and support from concerned family members can make a difference. In the workplace, employee assistance professionals or worksite mental health programmes can be of assistance in helping men understand and accept depression as a real illness that needs treatment.

5.8 Depression in the Elderly

Untreated depression is the most common psychiatric disorder and the leading cause of suicide in the elderly. Approximately 20% of older adults suffer from clinically significant symptoms of depression. The risk of depression among elderly women is two to three times higher than that of elderly men. Additionally, elderly adults residing in long term care are at an even greater risk of developing depression.

Depression in elderly adults can be debilitating and can affect functional, cognitive, and emotional health. Serious depression can also cause great disruption and suffering for family/whanau as well as the person who is ill.

Depression in the elderly increases risks for infections, falls and injury, and poor nutrition. In addition, some medical illnesses are a common trigger for depression, and often depression will worsen the symptoms of other illnesses. Parkinson's Disease, stroke, heart attack, certain kinds of cancers, vascular dementia, and Alzheimer's disease are common causes of late life depression. Depression makes it more difficult to treat the other medical illness, since depressed patients may not take care of themselves and follow prescribed treatment.

About 1-2% of people 65 years of age or older have Major Depressive Disorder. Severe Major Depressive Disorder can sometimes be accompanied by delusions or hallucinations. When this happens, the depression is called psychotic depression. Psychotic

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Ibid
Pierce et al (July 2003) Analysis of the Concept of Aloneness as Applied to Older Women being Treated for Depression. Journal of Gerontological Nursing
Ibid pg 32
depression is most common in late life.\textsuperscript{55}

Depression in older adults has different physical symptoms from those of young adults. Changes in appetite, sleep patterns or fatigue are important signs of depression in young people. However, in older people, such experiences are often a natural part of the ageing process or as a result of a medical illness. For this reason, doctors often fail to recognise depression in older people, especially since older people are less likely to report emotional symptoms than younger people.\textsuperscript{56}

5.9 Depression in Maori and Pacific Peoples

There is a marked difference in health status between people from lower socioeconomic backgrounds, people who live in rural areas, Maori and Pacific peoples, new arrivals and refugees. Research has found that people in lower socioeconomic groups and those people experience mental problems have the worst access to conditions necessary for positive wellbeing. This includes suitable housing, adequate income, access to health services and opportunities for developing individual social coping skills.\textsuperscript{57} As a population group, Maori have, on average, the poorest health status of any group in New Zealand.\textsuperscript{58}

International evidence shows that cultural alienation is a valid explanation for indigenous experiences of being at high 'risk' for drug abuse, alcohol, mental health problems including depression, suicide and other adverse behaviours.\textsuperscript{59}

Cultural alienation may also place young Pacific peoples born in New Zealand at increased risk.

5.10 Depression in Asian Peoples\textsuperscript{60}

MidCentral district's Asian population is 3.4%, representing a significant population. Although there is very little data on Asian peoples and health needs in MidCentral district, a Ministry of Health Asian Public Health Project Report (February 2003) conducted in Auckland identified mental health as the most important health concern for Asian communities as identified in the consultation meetings and key informant interviews.

Asian communities indicated that the migration experience has produced alarming psychological problems such as depression and stress. Both participants at the consultation meetings and key informants noted that lack of social support, stress induced by migration compounded by disruptions in the family unit (separation), and settlement/integration

\textsuperscript{55} Ibid, pg 2
\textsuperscript{56} Ibid. pg 3
\textsuperscript{57} Ministry of Health (Dec 2002) Building on Strengths – A New Approach to Promoting Mental Health in New Zealand/Aotearoa pg 16
\textsuperscript{58} Ministry of Health Addressing Maori Health www.moh.govt.nz/maori.html
\textsuperscript{59} Ministry of Youth Development http://www.myd.govt.nz/page.cfm?i=176
\textsuperscript{60} Ministry of Health (February 2003) Asian Public Health Project Report: Public Health Needs for the Auckland Region
frustrations with host country conditions contribute to the prevalence of mental health issues.

Participants at the consultation meetings also noted that Asian mental health is an issue because of stigmatisation and discrimination (differential treatment in society) and factors such as employability and unemployment, which can induce high stress levels. Some key informants stated that some new migrants arrived with pre immigration mental health conditions such as post traumatic stress disorder (PTSD), which is especially prevalent in refugee population groups. Asian communities seek more responsive and effective mental health services. Problems include, lack of trained professional interpreters, lack of Asian mental health workers, lack of cultural sensitivity, and lack of campaigns to promote access to and availability of existing Asian mental health service.

5.11 Suicide

Suicide is an important and serious health issue. A lack of community awareness of the symptoms of depression, where and who to seek help, the effectiveness of the common methods of treatment, along with stigma, lead to depression being the largest single risk factor for suicide.

Suicide remains one of the common and often unavoidable outcomes of depression. It is a major source of morbidity and mortality, and a significant contributor to social, economic and health costs.

Although most depressed people are not suicidal, Depressive Disorders and Schizophrenia are responsible for 60% of all suicides\(^6\). Thirty percent of all depressed inpatients attempt suicide\(^6\).\(^2\).

In recent years, New Zealand’s suicide rate has been trending downwards, however, on average, approximately 550 people die by suicide each year in New Zealand and these rates are particularly high compared to other countries. As Figure 7 shows, in 2001, New Zealand had the sixth highest total suicide rate for females (5.4 per 100,000 population) for selected OECD countries. These rates were higher than the United States, the United Kingdom and Australia. Total male suicide rates were the fifth highest at 18.4 per 100,000.


\(^2\) American Foundation for Suicide Prevention Depression and Suicide Prevention http://www.afsp.org/about/depression.htm
As Table 4 shows, MidCentral’s Standardised Mortality Ratios (SMR) for suicide deaths (101.9) are not significantly different from the national rate (100).

Table 4: Suicide Deaths by DHB Region and Sex, 1997-2001*

<table>
<thead>
<tr>
<th>DHB region</th>
<th>Male</th>
<th></th>
<th></th>
<th>Female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SMR</td>
<td>95% CI</td>
<td>SMR</td>
<td>95% CI</td>
<td>SMR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Northland</td>
<td>103.6</td>
<td>80.0–127.6</td>
<td>146.2</td>
<td>93.9–180.5</td>
<td>113.6</td>
<td>91.6–135.6</td>
</tr>
<tr>
<td>Waitemata</td>
<td>91.3</td>
<td>79.0–103.5</td>
<td>89.8</td>
<td>67.3–112.4</td>
<td>90.8</td>
<td>80.1–101.6</td>
</tr>
<tr>
<td>Auckland</td>
<td>82.7</td>
<td>70.6–94.5</td>
<td>104.3</td>
<td>76.7–129.6</td>
<td>87.1</td>
<td>76.1–98.0</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>83.8</td>
<td>71.9–96.6</td>
<td>88.3</td>
<td>64.1–112.5</td>
<td>84.4</td>
<td>73.2–95.7</td>
</tr>
<tr>
<td>Waikato</td>
<td>100.5</td>
<td>85.4–115.5</td>
<td>80.0</td>
<td>55.1–105.5</td>
<td>96.5</td>
<td>83.4–109.6</td>
</tr>
<tr>
<td>Lakes</td>
<td>121.6</td>
<td>91.1–152.1</td>
<td>150.9</td>
<td>87.9–214.0</td>
<td>128.1</td>
<td>100.5–165.7</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>124.8</td>
<td>101.8–147.8</td>
<td>126.7</td>
<td>100.9–149.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taranaki</td>
<td>127.6</td>
<td>104.4–147.9</td>
<td>108.4</td>
<td>70.3–146.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>128.3</td>
<td>105.2–154.1</td>
<td>123.2</td>
<td>101.0–145.5</td>
<td></td>
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</tr>
<tr>
<td>Taranaki</td>
<td>129.9</td>
<td>105.4–157.1</td>
<td>123.6</td>
<td>99.7–147.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MidCentral</td>
<td>88.1</td>
<td>58.1–116.5</td>
<td>90.4</td>
<td>69.0–124.1</td>
<td>84.4</td>
<td>62.5–108.6</td>
</tr>
<tr>
<td>Whanganui</td>
<td>110.0</td>
<td>81.3–155.6</td>
<td>114.7</td>
<td>70.2–224.7</td>
<td>125.4</td>
<td>91.6–159.1</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>76.0</td>
<td>64.3–80.0</td>
<td>88.8</td>
<td>70.8–117.9</td>
<td>78.3</td>
<td>65.4–91.1</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>92.7</td>
<td>70.3–115.0</td>
<td>103.4</td>
<td>80.2–147.6</td>
<td>95.3</td>
<td>75.2–115.3</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>71.3</td>
<td>42.4–120.8</td>
<td>93.0</td>
<td>50.8–141.5</td>
<td>87.8</td>
<td>56.6–100.1</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>129.9</td>
<td>102.0–167.1</td>
<td>96.8</td>
<td>52.1–141.5</td>
<td>123.6</td>
<td>99.7–147.4</td>
</tr>
<tr>
<td>West Coast</td>
<td>184.3</td>
<td>118.2–248.9</td>
<td>133.8</td>
<td>14.1–213.7</td>
<td>172.6</td>
<td>115.4–228.8</td>
</tr>
<tr>
<td>Canterbury</td>
<td>108.7</td>
<td>75.5–121.9</td>
<td>89.2</td>
<td>65.9–110.6</td>
<td>104.4</td>
<td>73.5–115.9</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>130.2</td>
<td>78.5–172.7</td>
<td>88.0</td>
<td>23.0–154.2</td>
<td>121.9</td>
<td>85.4–158.3</td>
</tr>
<tr>
<td>Otago</td>
<td>124.7</td>
<td>75.2–114.3</td>
<td>82.5</td>
<td>48.8–116.2</td>
<td>91.6</td>
<td>74.7–108.5</td>
</tr>
<tr>
<td>Southland</td>
<td>117.6</td>
<td>89.5–145.8</td>
<td>88.4</td>
<td>42.1–134.7</td>
<td>112.7</td>
<td>88.1–137.2</td>
</tr>
</tbody>
</table>

*Note:
- Shaded areas indicate regions with significantly higher or lower SMRs.
- CI = Confidence Interval
- SMRs (Standardised Mortality Ratios) are a means of comparing regional variations in rates of mortality or morbidity. In a regional analysis, SMRs compare sub-national rates, in this case District Health Boards, with that of the national rate. These ratios indicate whether a region is below or above the national rate, i.e., below or above 100.
- The SMR for a DHB is significant if the 95% confidence interval does not include 100. If the confidence interval includes 100, then the region’s rate is not significantly different from the national rate.
5.11.1 Youth and Suicide

Suicide is a leading cause of death among youth (15–24 years). The total rate of youth suicide in 2001 was 20 deaths per 100,000 population compared with 18.1 per 100,000 population in 2000. Figure 8 shows the high rate of youth suicide compared to other age groups.

Figure 8: New Zealand Suicide Death Rates by Age Group, 1948-2001

Males continue to have significantly higher rates of suicide in New Zealand. In 2001, a total of 107 young people aged 15-24 years died by suicide. Of these 107 young people, 84 were male and 23 were female. Figure 9 illustrates the high male suicide rate compared to females.

Figure 9: Youth Suicide Rates (aged 15-24), 1982-2001

The rate of youth suicide for males (aged 15-24) in 2001 was 31.1 deaths per 100,000 population compared to a rate of youth suicide for females of 8.7 deaths per 100,000 population.

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63 New Zealand Health Information Service http://www.nzhis.govt.nz/stats/suicidefacts1.html #05
64 Ibid
65 Ministry of Health (April 2004) Suicide Facts – Provisional 2001 Statistics (all ages) pg 8

23
While nationally female suicide rates are significantly lower than male rates, New Zealand has both the second highest male, and the second highest female youth suicide rates compared to other OECD countries (Figure 10).

Figure 10: Male and Female Youth Suicide Rates (15-24 years) for Selected OECD Countries (2001 New Zealand)

Research has consistently suggested that approximately 90% of young people, who die by suicide or make suicide attempts will have had a recognisable (but not necessarily recognised) mental disorder at the time.

The three mental disorders most commonly associated with suicidal behaviour are:

- Depressive Disorders – present in almost three quarters of those making suicide attempts
- Alcohol, cannabis and other drug abuse – present in over one third of those making suicide attempts
- Significant behavioural problems (such as Conduct Disorders and antisocial behaviours) – present in one third of young people making suicide attempts.

It is important to recognise that while most people who die by suicide or make suicide attempts will experience a recognisable mental disorder, this does not mean that most people experiencing mental disorders and/or life difficulties will attempt to take their own lives.

5.11.2 Maori and Suicide

As Figure 11 illustrates, Maori continue to have higher suicide rates than non-Maori. 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.
The suicide rate for Maori youth in 2001 was 28 deaths per 100,000 population, compared with the non Maori rate of 18.1 per 100,000 population.

Figure 11: Maori and Non Maori Suicide Death Rates, 1996-2001

Research has suggested it is likely that the higher rates of suicidal behaviour amongst Maori reflect enduring impact of colonisation, the difficulties Maori face within mainstream institutions (eg, schools and health services), the loss of land, and the breakdown of cultural identity and Maori social structures such as the whanau.

Mason Durie maintains that a secure Maori identity will act to protect against poor health even in the presence of adverse socioeconomic conditions.

5.11.3 Suicide and Pacific and Asian Peoples

The number of suicide deaths accounted for by Pacific and Asian peoples is small. In recent years, Pacific and Asian peoples suicide deaths have each accounted for about 2% of all suicide deaths. The numbers are so small that it would be misleading to attempt to calculate suicide rates for these populations.

5.11.4 Suicide and the Elderly

As Figure 12 illustrates, suicide rates in New Zealand among the older population are significant, particularly in elderly men.

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68 Ministry of Youth Development
69 New Zealand Health Information Service http://www.nzhis.govt.nz/stats/suicidefacts1.html #05
70 Ministry of Health (2003) Suicide Prevention Toolkit
Suicidal behaviour in the elderly has a number of features that are not shared with younger age groups. Older adults make fewer non-fatal suicide attempts than younger people. Reasons for this may include them being physically more frail, and therefore less likely to survive suicide attempts; that they are more often living alone, and so less likely to be found in time to be helped after a suicide attempt; and that they use more lethal methods of suicide attempt, perhaps reflecting a stronger intent to die. Finally, although the risk factors for elderly suicide overlap with risk factors for other age groups, amongst older age groups mental health factors, predominantly depression, play a more significant role.7

Risk factors and protective factors for depression are discussed in Appendix C.
6. **CURRENT MENTAL HEALTH SERVICES AND PROVIDERS**

In MidCentral District there are a large and varied number of agencies involved in the prevention, promotion and treatment of people with depression and their family/whanau. A detailed list of these providers is in Appendix D.
7. **THE WAY FORWARD – SUMMARY OF OBJECTIVES AND INITIATIVES**

This section sets out the five objectives and 53 initiatives designed to achieve the planned outcomes.
8. **OBJECTIVE ONE**

To reduce the impact of depression through mental health promotion and prevention strategies

The major determinants of health are factors located outside the individual. They include economic, social, cultural and environmental structures of society. Figure 13 illustrates some of the key factors that can positively or negatively determine mental health and wellbeing. Some of these impacts are direct while others are mediated through lifestyle and other health related behaviours.

**Figure 13: Model of the Social and Economic Determinants of Health**

![Diagram](image)

**Structural Features of Society, Economy and Environment:**
- Low unemployment
- Clean, healthy environment
- Safe working conditions with high job control
- Adequate income and wealth
- Affordable, available education and health services
- Low crime
- Favourable economic conditions
- All ethnic groups feel able to participate in society
- Implementation of Treaty of Waitangi obligations

**Health Related Behaviours:**
- No smoking
- Moderate alcohol
- No illicit drug use
- No problem gambling
- Regular exercise
- Adequate sleep
- Low-fat diet
- Safe sex

**Sufficient Disposable Income to Afford:**
- Stable, adequate housing
- Nutritious diet
- Adequate health care
- Adequate educational opportunities
- Safe working conditions, with high job control

**Psychological Factors:**
- Social Support
- Spouse or confident
- Strong ethnic identity
- Open sexual identity
- Positive future prospects
- Perceived control

**Healthy Individual Family/Whanau**

**Healthy Community/Strong social capital**

*Note: Arrows indicate possible causality*

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**Health Promotion**

Health promotion is a combination of educational, organisational, economic and political actions designed with community participation, to enable individuals, groups and whole communities to increase control over and to improve their health through attitudinal,
behavioural, social and environmental changes. While health promotion recognises that personal lifestyle factors have an important impact on the health of the individual, it places emphasis on changing the environment to enable optimum conditions for health and for behaviour change.

Health promotion is more than health education. Health education focuses on health information and behaviour change and is just one strategy of health promotion. Health promotion strategies include policy, community action and environmental changes.

Health promotion in New Zealand is underpinned by Te Tiriti o Waitangi and the Ottawa Charter. The Treaty provides a set of principles including partnership, participation and protection. The Ottawa Charter has five key strategies for action which relate very well to the Treaty principles:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorientating the health services.

Mental health promotion is the process of enhancing the capacity of individuals and communities to take control of their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice and personal dignity\(^75\).

**Prevention**

Prevention means eliminating or minimising exposure to the cause of illness as well as maximising protective factors such as healthy wellbeing. Prevention activities include:

- Primary prevention strategies
- Effective public health strategies
- Community action
- Personal skill development
- Support
- Treaty based health promotion practices.

The following initiatives will help minimise the risk of developing depression in MidCentral district.

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\(^{75}\) Mental Health Foundation (2004) *Mind Your Health – How to promote mental health & wellbeing* MHF Auckland
Initiatives

1. In conjunction with the education sector, support schools to understand and educate children and youth on depression and preventative strategies including stress and conflict management.
   - Support the “Health Promoting Schools” programme to enhance healthy wellbeing.
   - Support targeted education and life skill development including anti bullying.

2. Ensure increased counselling and social worker hours in schools.

3. Work with the community including Public Health Services to raise awareness of the signs and symptoms of depression and its consequences.

4. Encourage mentally healthy workforces through workshops on the issue.

5. In collaboration with all health professionals, work with Public Health to reduce the stigma of mental illness through education in the recognition and understanding of depression.

6. In collaboration with community agencies including Public Health Services, develop mental health promotion and activities.

7. Advocate in collaboration with the community, including Public Health and Social Health Services for policy change which enhances mental wellbeing.
   - Maintain an awareness of any local or national social policy changes or initiatives.
Maori and Pacific Peoples

Initiatives

8. Further develop and implement mental health promotion and education programmes for parents and family/whanau of Maori and Pacific children/youth to create awareness of depression and prevention practices. Deliver these programmes in such settings as Kura (school), Wananga (university) and maraes.

Such education should:

- incorporate Maori knowledge (matauranga Maori) and follow appropriate cultural processes (tikanga)
- be based on Maori health frameworks and models (eg, Whare tapa wha/Te Pae Mahutonga) and guided by Maori principles (such as tapu/noa, aroha, and family/whanaungatanga)
- be delivered through closer coordination with Maori health providers and local kaumatua/iwi.

9. Encourage mental health services provided to Maori and Pacific peoples to encompass a holistic, integrated and culturally competent approach in an appropriate setting.

Asian Peoples

Initiatives

10. Develop and utilise culturally appropriate or sensitive mental health promotion resources for key Asian population groups.
9. **OBJECTIVE TWO**

To ensure early detection and early intervention to minimise the impact of depression on wellbeing

The earlier the diagnosis – the more effective the intervention. The following initiatives will minimise the impact of depression on wellbeing.

**Initiatives**

11. Work with Primary Health Organisations (PHOs) to ensure effective training is provided to general practice and other appropriate primary health professionals.

12. Support PHOs to put in place quality systems and processes that provide greater opportunity to detect and manage depression and allow rehabilitation to occur.

13. In collaboration with other government agencies provide training in the recognition and understanding of depression to frontline staff, including Child, Youth and Family Services, Work and Income NZ, Ministry of Education and the justice system to reduce the stigma of mental illness.

14. Promote opportunistic screening of depression in the primary care setting.

15. Further develop and implement resources for depression to be used in the community including self assessment tools.

16. Provide resources to improve the liaison between primary and secondary care for people with depression.
   - Ensure appropriate links are in place between primary and secondary care.

17. Enhance population knowledge of access to crisis mental health services.
Maori and Pacific Peoples

**Initiatives**

18. Provide supplementary resources to support general practice screening of depression in Maori and Pacific peoples.

Asian Peoples

**Initiatives**

19. Monitor and respond to the needs of Asian peoples in MidCentral district.
10. **OBJECTIVE THREE**

**To manage depression through support, effective treatment and recovery**

There is a window of opportunity to change lifestyles. One of the biggest gaps is in the area of psychological services.

Psychological treatment with the aim of facilitating and supporting self management is extremely important for people with depression and needs to be strengthened. Psychological treatment can vastly increase the ability of people to come to terms with their diagnosis more quickly, which in turn will enable them to cope better with their condition.

To improve health outcomes and enhance wellbeing, people with depression need to access appropriate assessment and treatment from primary and secondary care providers.

**Support and Self Management**

**Initiatives**

20. Ensure the pathway being provided is seamless, and clinically and culturally appropriate.
   - Ensure health professionals engage in evidenced best practice guidelines and consistent pathways.
   - Ensure an identified single point of contact with services for people to access needed support.

21. Support Primary Health Organisations to ensure that every consumer has a treatment plan in place enabling continuity of care.


23. Ensure appropriate access to a range of coordinated home support and carer relief services.

24. Enhance and support the development of support networks. For example, community groups such as Post-Natal Depression Support and Bipolar Support.

25. Ensure depression is supported and managed through collaboration with appropriate services. This includes support for self management to better manage problem solving and dealing with stress.

26. Provide support for wider families/whanau.
Treatment and Recovery

Initiatives

27. Work with community clinicians to support a greater range of psychological treatment options. For example, counselling and therapy including Cognitive Behaviour Therapy.

28. Individuals suffering moderate to severe depression, and depression complicated by ongoing comorbid factors, should be offered a choice of psychological or pharmacological intervention, or a combination of both.

29. Increase the number of specialist clinicians available to Primary Health Organisations to provide clinical oversight and ensure support is available and responsive to general practice.

30. Implement and support the recovery approach/model in primary and secondary care.

31. Provide support for people with comorbidities.

32. Ensure the involvement of family/whanau in the treatment of people with depression.

33. Investigate the feasibility of establishing a mobile specialist mental health nursing team to hold clinics in primary care settings such as general practice.

Children and Youth

Initiatives

34. Enhance youth support groups through activities including sporting, therapeutic programmes and cultural interventions.

Maori and Pacific Peoples

Initiatives

35. Ensure Maori and Pacific peoples continue to have the opportunity to access health care through Maori and Pacific providers.

36. Target resources specifically for Maori and Pacific peoples to ensure more responsive and culturally appropriate suicide prevention services.

Royal Australian & New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004; National Advisory Committee on Health & Disability, 1996
11. OBJECTIVE FOUR

To improve depression services through a responsive workforce and workforce development

It is important to maintain competence and expertise through professional development and credentialing. This section highlights the initiatives to obtain this in the mental health/depression field.

Initiatives

37. Work with tertiary training professionals to ensure depression and the recovery approach/model is included in the delivery of training courses.

38. Provide recovery approach/model training to all mental health professionals.

39. Provide stigma and discrimination training to all health professionals including those working in Mental Health.

40. Enhance the provision of training in the recognition of depression to the wider health workforce.

41. Encourage all health professionals, particularly in the primary care setting, to identify depression in their clients and to provide appropriate interventions or referral to other services.

42. Increase the appropriate Mental Health workforce to provide for increasing demand.

Maori and Pacific Peoples

Initiatives

43. Provide training on Kaupapa Maori models of practice in order to ensure the delivery of culturally appropriate services.

44. Build the capacity of the workforce to understand the needs of Maori and Pacific peoples experiencing depression.

Children and Youth

Initiatives

45. Ensure additional training for people both in primary care and in child and youth mental health services in evidence based therapies for depression such as cognitive behavioural therapy.
12. **OBJECTIVE FIVE**

To improve depression services through planning, innovation and quality assurance.

Initiatives in this section are designed to improve the overall functioning of depression services. This is achieved through coordinated activities and resources.

**Initiatives**

46. Support innovation in depression services, especially around high needs groups and pilot projects.

47. Support Primary Health Organisations to include depression in their plans, including prevention, promotion and early detection measures.

48. Develop a broader health promotion strategy for the District to coordinate and focus actions across health areas and ensure the best use of the resources available.

49. Ensure depression issues are included in other service plans, for example Disability Support Services, Child Health Strategy and the Youth Strategy.

50. Investigate the feasibility of developing and maintaining a “Web Health Directory”.

51. Undertake a stocktake of current psychological and therapy services to identify any gaps in services.

**Maori and Pacific Peoples**

**Initiatives**

52. Continue to work with local iwi/Maori providers and Maori/Pacific communities in planning, purchasing, delivering and monitoring culturally appropriate services for Maori and Pacific peoples who have depression and their family/whanau.

**Asian Peoples**

**Initiatives**

53. Ensure research is undertaken with a focus on Asian peoples to ensure appropriate outcomes for their cultural background.
13. INVESTMENT APPROACH

To support the plan over the next three years, the Funding Division has developed a high level framework that is based upon the continuum of care model. The Division is currently working on the detailed costings.

The framework is represented in Table 5 below.

Table 5: Depression Service Plan Investment Approach

<table>
<thead>
<tr>
<th>Continuum of Care</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health promotion and prevention strategies</td>
<td>40 000</td>
<td>40 000</td>
<td>40 000</td>
</tr>
<tr>
<td>Early detection and early intervention</td>
<td>240 000</td>
<td>240 000</td>
<td>240 000</td>
</tr>
<tr>
<td>Effective support, treatment and recovery</td>
<td>340 000</td>
<td>340 000</td>
<td>340 000</td>
</tr>
<tr>
<td>A responsive workforce and workforce development</td>
<td>60 000</td>
<td>60 000</td>
<td>60 000</td>
</tr>
<tr>
<td>Planning, innovation, and quality monitoring</td>
<td>120 000</td>
<td>120 000</td>
<td>120 000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>800 000</strong></td>
<td><strong>800 000</strong></td>
<td><strong>800 000</strong></td>
</tr>
</tbody>
</table>
Glossary of Terms and Abbreviations

**Age Standardised Rate:** Weighted average of age specific rates according to a standard distribution of age to eliminate the effect of different age distributions and thus facilitate valid comparison of groups with differing age compositions.

**Antidepressants:** Drugs used to treat depression. Antidepressants are not addictive; they do not make you "high," have a tranquilizing effect or produce cravings for more.

**Anxiety Disorder:** An illness that produces an intense, often unrealistic and excessive state of apprehension and fear. This may or may not occur during or in anticipation of a specific situation, and may be accompanied by a rise in blood pressure, increased heart rate, rapid breathing, nausea and other signs of agitation or discomfort.

**Biochemistry:** The chemistry of living organisms and life processes.

**Bipolar Affective Disorder (Manic Depressive Disorder):** A mental illness that causes people to have severe high and low moods. People with this illness switch from feeling overly happy and joyful (or irritable) to feeling very sad and hopeless. In between mood swings, a person's moods may be normal.

**Chronic:** Continuing over a certain period of time; long term.

**Cognitive Behaviour Therapy:** A structured, short term, present oriented psychotherapy, directed toward solving current problems by modifying distorted thinking and behaviour. It is based on the model of Cognitive Psychology which proposes that distorted thinking (which influences an individual's mood and behaviour) is common to all psychological disturbances.

**Continuum of Care:** A comprehensive system of care that includes each of the following elements: prevention, health promotion, screening, early intervention, self management, acute care, and recovery. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.

**DALY:** The DALY combines in one measure the time lived with disability and the time lost due to premature mortality: $\text{DALY} = \text{YLL (years of life lost due to premature mortality)} + \text{YLD (years lived with disability)}$.

**Depression:** A clinical mood disorder associated with low mood or loss of interest and other symptoms that prevents a person from leading a normal life. Types of depression include: Major depression, bipolar depression, dysthymia and seasonal depression (seasonal affective disorder).

**DHB:** District Health Board.

**Diagnosis:** The process of identifying the nature of a disorder.

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77 Massey University [http://psychology.massey.ac.nz/grad/cogbehav.htm](http://psychology.massey.ac.nz/grad/cogbehav.htm)

**Dysthymia:** A chronic (ongoing), low grade depression that often begins in childhood or adolescence and may last for many years in adulthood if not treated. Less intense than Major Depression.

**Early Intervention:** A process used to recognise warning signs for mental health problems and to take early action against factors that put individuals at risk. Early intervention can help people get better in less time and can prevent problems from becoming worse.

**Health promotion:** A combination of educational, organisational, economic and political actions designed with consumer participation, to enable individuals groups and whole communities to increase control over and to improve their health through attitudinal, behavioural social and environmental changes. While health promotion recognises that personal lifestyle factors have an important impact on the health of the individual, it places emphasis on changing the environment to enable optimum conditions for health and for behaviour change.

**Intersectoral:** Between sectors.

**Major Depression:** A diagnosis of major depression is made when, in addition to a depressed mood, the individual suffers from several other typical depressive symptoms that are lasting and disabling.

**Mania:** A disturbance of mood in which the individual experiences a euphoria characterised by unrealistic optimism and heightened sensory pleasures.

**Manic Depression:** See Bipolar Affective Disorder.

**Maori:** Indigenous people of New Zealand.

**Mood Disorders:** Psychological disorders involving depression and/or abnormal elation.

**Morbidity:** Illness.

**Mortality:** Death.

**Objective:** The end result a programme seeks to achieve.

**Ottawa Charter:** The Ottawa Charter was presented at the first International Conference on Health Promotion (Ottawa 21 November 1986) to achieve Health for All, by the year 2000 and beyond. It outlined the ultimate ideal and vision of how the goal of health should be obtained through actions at various levels: global, national, community and individual.

**Pacific Peoples:** The population of Pacific Island ethnic origin (eg, Tongan, Niuean, Fijian, Samoan, Cook Islands Maori and Tokelauan), incorporating people born in New Zealand as well as overseas.

**Primary Health Organisations (PHOs):** Funded by District Health Boards, PHOs work with their communities to provide primary health care services for their enrolled populations.

**Postpartum Depression:** Postpartum depression is a complex mix of physical, emotional and behavioural changes that occur in a mother after giving birth. It is a serious condition, affecting 10% of new mothers. Symptoms range from mild to severe depression and may
appear within days of delivery or gradually, perhaps up to a year later. Symptoms may last from a few weeks to a year.

**Prevalence:** The number of instances of a given disease or other condition in a population at a designated time. Prevalence includes both new (incidence) and existing instances of a disease.

**Prevention:** Eliminating or minimising exposure to the cause of illness, and maximising protective factors such as healthy lifestyle choices/healthy wellbeing.

**Psychiatrists:** Physicians who specialise in treating mental, emotional or behavioural disorders. They have completed four years of study in an accredited medical school in combination with four years of postgraduate training in a certain area of psychiatry. They are doctors who can prescribe medications.

**Psychologists:** Specialists who concentrate in the science of the mind and behaviour. They usually have a doctoral degree and receive additional training to work with patients. Psychologists are not medical doctors and cannot prescribe medication, but do perform evaluations and use psychotherapy.

**Psychotherapy:** Psychotherapy is a term used to describe a variety of different talking therapies used to treat depression. Psychotherapy involves talking to a licensed professional during a scheduled series of appointments. It has proven to be effective in treating mild and moderate forms of depression, and can be combined with drug therapy to treat all degrees of depression.

**Risk factor:** An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or intended characteristic that is associated with an increased risk of a person developing a disease/illness.

**Schizophrenia:** A mental illness in which the person suffers from distorted thinking, hallucinations and a reduced ability to feel normal emotions.

**Seasonal Affective Disorder (SAD):** SAD is a depression that occurs each year at the same time, usually starting in fall or winter and ending in spring or early summer.

**Self harm:** The deliberate committing of direct physical harm to one's own body, without conscious suicidal motivation. Also known as: self harm, self injury, and self mutilation, self injurious, self wounding.

**Suicide:** From Latin Sui caedere, to kill oneself. It is the act of intentionally ending one’s own life.

**Support group:** A group of people who share a similar problem or concern. The people in the group help one another by sharing experiences, knowledge, and information.

**Symptom:** Any indication of disease noticed or felt by a patient; in contrast, a sign of an illness is an objective observation.

**Target:** An intermediate result towards the objective that a programme seeks to achieve.

**Treaty of Waitangi:** The founding document of New Zealand.
Unipolar Major Depression: An affective disorder characterised by episodes of deep unhappiness, loss of interest in life, and other symptoms. Also known as Major Depression, Major Depressive Disorder.

Violence: To injure or abuse another with physical force. Violence can be a sign of depression in young males, or can trigger it.
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MidCentral District Health Board (2004) Cancer Services Plan Discussion Document pg 10


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Ministry of Health Addressing Maori Health www.moh.govt.nz/maori.html

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National Health Committee (September 1996) Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals


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Alcohol and Addictions Resource Guide Alcohol and Depression, Is There a Relationship? http://www.soberrecovery.com/Articles/Alcoholism-Depression.html

American Foundation for Suicide Prevention Depression and Suicide Prevention http://www.afsp.org/about/depressf.htm

American Foundation for Suicide Prevention Bipolar Disorder and Suicide Prevention http://www.afsp.org/about/manicdep.htm


Depression and Bipolar Support Alliance Depression and Diabetes http://www.dbssalliance.org/Diabetes.html

Depression and Bipolar Support Alliance Depression and Cancer http://www.dbssalliance.org/Cancer.html

Depression and Bipolar Support Alliance Depression and Heart Disease http://www.dbssalliance.org/HeartDisease.html

Appendix A – Stakeholders

The stakeholders who assisted in the development of this Plan were:

- Andy Aston: Clinical Director, Mental Health Services, MidCentral DHB
- Aroha Ellwood: Manawhenua Hauora representative
- Christine Zander: Manawatu Schizophrenia Fellowship Manager
- Claudine Tule: Child, Adolescent and Family
- David Barrett: Consumer and Chair for "Pathway to Wellbeing"
- Dean Chapman: St Dominics Centre
- Denise Walls: Team Leader, Alcohol and Drug Service, MidCentral DHB
- Faith Brown: Team Leader, Mental Health Unit, Oranga Hinengaro, MidCentral DHB
- Frances Guthrie: MIPA representative
- Jeanine Corke: Mental Health Portfolio Manager, Funding Division, MidCentral DHB
- Leonie Hanara: Te Whanau Maanaki (Consumer Alcohol and Drug Service)
- Mahalia Paewai: Rangitane representative
- Nicholas Glubb: Group Manager, Mental Health Services, MidCentral DHB
- Pauline Brown: Mental Health Promoter, Public Health Unit, MidCentral DHB
- Peter Keedwell: MASH Trust Manager
- Robyn Richardson: Health Promotion, Maori Health, Public Health Unit, MidCentral DHB
- Shirley-Anne Gardiner: Health Planner, Funding Division, MidCentral DHB
- Teresa Keedwell: Consumer Advisor, Mental Health Services, MidCentral DHB
- Vivienne Martin: Service Coordinator, Mental Health Services, MidCentral DHB
Appendix B – Demographic Profile
MidCentral District

Population

Table 6 is a breakdown of MidCentral district by Territorial Local Authority (TLA) and ethnicity.

Table 6: MidCentral District Population Breakdown by TLA and Ethnicity (2001)

<table>
<thead>
<tr>
<th>TLA</th>
<th>Total</th>
<th>European</th>
<th>%</th>
<th>Maori</th>
<th>%</th>
<th>Pacific</th>
<th>%</th>
<th>Asian</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manawatu</td>
<td>27510</td>
<td>24576</td>
<td>89.3</td>
<td>3369</td>
<td>12.2</td>
<td>366</td>
<td>1.3</td>
<td>26</td>
<td>0.1</td>
</tr>
<tr>
<td>Palmerston North</td>
<td>72036</td>
<td>59316</td>
<td>82.3</td>
<td>9426</td>
<td>13.1</td>
<td>2172</td>
<td>3.0</td>
<td>4332</td>
<td>6.0</td>
</tr>
<tr>
<td>Horowhenua</td>
<td>29820</td>
<td>24549</td>
<td>82.3</td>
<td>5793</td>
<td>19.4</td>
<td>918</td>
<td>3.1</td>
<td>663</td>
<td>2.2</td>
</tr>
<tr>
<td>Tararua</td>
<td>17859</td>
<td>13569</td>
<td>76.5</td>
<td>3159</td>
<td>17.7</td>
<td>204</td>
<td>1.1</td>
<td>174</td>
<td>1.0</td>
</tr>
<tr>
<td>Kapiti Coast (part)</td>
<td>7758</td>
<td>5034</td>
<td>65.5</td>
<td>1875</td>
<td>24.2</td>
<td>216</td>
<td>2.8</td>
<td>273</td>
<td>3.5</td>
</tr>
<tr>
<td>MidCentral District</td>
<td>154983</td>
<td>117468</td>
<td>75.8</td>
<td>23625</td>
<td>15.2</td>
<td>3039</td>
<td>2.0</td>
<td>5352</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Note: For TLA figures, multiple responses for a single person are allowed. For the DHB figures, the MOHI hierarchy of ethnicities is used to assign one ethnicity per person.

Horowhenua District
The Horowhenua TLA has the second largest population grouping at 19% of MidCentral district (29,820 people), with the highest proportion of Maori at 19.4%, and is the most socioeconomically deprived of the five TLAs.

Kapiti Coast District
The smallest population cluster in MidCentral district sits around the Kapiti Coast CAUs (7,758 people). This group makes up 5% of the district’s population, and comprises a large aged population reflective of retirees settling on the Coast.

Manawatu District
The Manawatu TLA makes up 18% of the District’s population (27,510 people). It has low socioeconomic deprivation, and has, proportionally, a lower Maori population at 12.2%.

Palmerston North City
Forty six percent of MidCentral district’s population resides in the Palmerston North TLA (72,036 people).

Tararua District
The Tararua TLA makes up 12% of the District’s population (17,859 people), and has proportionately, the second highest number of Maori within its population at 17.7%. It has some high socioeconomic deprivation but overall tends towards moderate to low deprivation.

\[=\] Sex by Ethnic Group (Grouped Total Responses) for the Census Usually Resident Population Count 2001
\[=\] MidCentral District Health Board (2004) Cancer Services Plan Discussion Document pg 10
Age Structure

MidCentral district's population distribution is similar to that of New Zealand and the World Health Organization World Population (WHO WP), but with notable features. As Figure 14 shows, MidCentral district's population distribution reveals two peaks in the 10-14 years age group and the 35-39 age group. These two peaks arise from a gap in the 20-35 year age group. This grouping at 27% of the total population is 4% lower than the WHO WP. Figure 15 shows MidCentral district's age distribution.

Figure 14: MidCentral District General Population Distribution by Age (2001)

Maori continue to have a younger population structure than non-Maori, due to a higher birth rate and lower life expectancy (Figure 15). The difference in life expectancy between Maori and non-Maori is improving; however, it will take time for the population structure to show these changes.

Figure 15: Age Structure by Ethnicity MidCentral District, 2001

The Maori age structure by gender (Figure 16) shows steadily declining population numbers as the population ages, whereas the European age structure by gender (Figure 17) shows relatively stable population numbers until the age of approximately 60, when numbers start to decline.

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81 Statistics NZ DHB Population by Sex & 5 year Age Group 2001
82 MidCentral DHB Community & Public Health Advisory Committee (CPHAC) report January 2003 Needs Analysis Update 2
Figure 16: Maori Age Structure by Gender MidCentral District, 2001

Figure 17: European Age Structure by Gender MidCentral District, 2001

Figure 18 shows the projected populations for 2006 and 2011 (2001 base). As the graph illustrates, younger age groups are diminishing and older age groups are increasing.

Figure 18: Age Band Comparison of Projected Populations 2001 [Base], 2006, 2011*3

The district’s population is estimated to show negligible growth. Statistics NZ forecasts have MidCentral district growing at a rate of 0.5% per annum, slowing to 0.23% per annum from 2007-2026.

*3 Source: Statistics NZ, Population Projections 2001-2026
Deprivation

Socioeconomic factors play an important role in increasing disease prevalence and severity through environmental determinants and may also result in adverse health outcomes caused by the lack of access to appropriate health care. High deprivation areas (deciles 9 or 10) are an important indicator of likely areas of health needs. Figure 19 shows overall, MidCentral district presents a slightly more deprived picture when compared to the national average.

Figure 19: MidCentral District Deprivation Profile

Figure 20 is a breakdown of MidCentral district's deprivation by territorial area.

Figure 20: MidCentral District Deprivation Distribution

Maori

The proportion of Maori living in MidCentral district is 15%, which is slightly higher than in the total New Zealand population (14%). Table 7 illustrates the marked socioeconomic disadvantage, disparity and overall health needs for Maori in New Zealand and MidCentral district.

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84 Technical Advisory Service (TAS) District Health Board, Territorial Authority & Ward Deprivation Profiles (2001)
85 MidCentral DHB (2001) An Assessment of Health Needs in the MidCentral District Health Board Region pg 12
Table 7: Maori – Society Issues (National and Regional Statistics)\(^{86,87}\)

<table>
<thead>
<tr>
<th>Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The People</strong></td>
</tr>
<tr>
<td>• 15.2% of MidCentral district’s population.</td>
</tr>
<tr>
<td>• At the time of the 1996 Census, 43% of Maori mothers were solo mothers.</td>
</tr>
<tr>
<td>• 60% of Maori are under 30 and a third are under the age of 15.</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
</tr>
<tr>
<td>• Maori are far more likely than non Maori to live in the most deprived areas of New Zealand (56% of Maori live in areas with a deprivation index of 8 or more compared to 21% of non Maori).</td>
</tr>
<tr>
<td>• In 1996, only 50% of Maori compared to 72% of non Maori lived in owned homes.</td>
</tr>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td>• Maori incomes in MidCentral district are lower than Maori incomes nationally, and are around 60% of non Maori incomes in the district.</td>
</tr>
<tr>
<td>• Maori household incomes are on average $10,000 lower than non Maori household incomes.</td>
</tr>
<tr>
<td><strong>Work and Education</strong></td>
</tr>
<tr>
<td>• Maori are less likely than non Maori to stay on to be senior secondary school students.</td>
</tr>
<tr>
<td>• Maori are less likely than non Maori to leave school with a qualification. In 1999, 35% of Maori school leavers left school with no qualifications compared with only 13% non Maori leaving with no qualifications.</td>
</tr>
<tr>
<td>• Only 18% of Maori school leavers receive a seventh form qualification compared with 44% of non Maori school leavers.</td>
</tr>
<tr>
<td>• The Maori unemployment rate is two to three times higher than the non Maori rate.(^{88})</td>
</tr>
<tr>
<td>• In 1997 Maori represented 40% of those who had been registered as unemployed for more than two years.</td>
</tr>
<tr>
<td>• Nearly one third (32%) of all Maori aged 15-19 years are unemployed.</td>
</tr>
<tr>
<td><strong>Health Issues</strong></td>
</tr>
<tr>
<td>• The smoking rate for Maori women was two and a half times greater than the rate for non Maori women (53% compared to 20%).</td>
</tr>
<tr>
<td>• More than one-quarter of Maori aged 15 years and over are hazardous drinkers (27%), compared to 16% of non Maori adults.</td>
</tr>
<tr>
<td><strong>Issues for Mental Health</strong></td>
</tr>
<tr>
<td>• Maori suicide, particularly among males, has become an increasing phenomenon attributed to loss of land and culture, alcohol and drug use, mental illness and despair.</td>
</tr>
<tr>
<td>• Seventy nine Maori died by suicide in 2001, compared to 80 in 2000 and 78 in 1999.</td>
</tr>
<tr>
<td>- Fifty seven were male compared to 69 in 2000 and 58 in 1999.</td>
</tr>
<tr>
<td>- Twenty two were female compared to 11 in 2000 and 20 in 1999.</td>
</tr>
</tbody>
</table>

\(^{88}\) MidCentral District Health Board (2001) An Assessment of Health Needs in the MidCentral District Health Board Region pg 12-13
\(^{89}\) New Zealand Health Information Service http://www.nzhis.govt.nz/stats/suicidefacts1.html#05
Table 8 shows the socioeconomic indicators by TLA in MidCentral district for Maori and the total population. As the table illustrates, Maori in MidCentral district have higher socioeconomic disadvantages compared to the population as a whole.

Table 8: Maori and Total Population Socioeconomic Indicators by TLA, 2001

<table>
<thead>
<tr>
<th>TLA</th>
<th>No Telephone (%)</th>
<th>No Vehicle (%)</th>
<th>Unemployment Rate (%)</th>
<th>No Qualifications (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maori Total</td>
<td>Maori Total</td>
<td>Maori Total</td>
<td>Maori Total</td>
</tr>
<tr>
<td>Manawatu</td>
<td>8.9</td>
<td>2.8</td>
<td>8.4</td>
<td>6.3</td>
</tr>
<tr>
<td>Palmerston North</td>
<td>7.8</td>
<td>2.9</td>
<td>12.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Horowhenua</td>
<td>10.4</td>
<td>4.7</td>
<td>13.6</td>
<td>11.5</td>
</tr>
<tr>
<td>Taranua</td>
<td>12.9</td>
<td>4.6</td>
<td>13.7</td>
<td>9.0</td>
</tr>
<tr>
<td>Kapiti Coast (part)</td>
<td>10.4</td>
<td>4.7</td>
<td>13.0</td>
<td>10.2</td>
</tr>
<tr>
<td>MidCentral District</td>
<td>9.5</td>
<td>3.5</td>
<td>12.2</td>
<td>9.6</td>
</tr>
</tbody>
</table>

Qualifications: proportion of 15+ yrs population
Unemployment rate: Proportion of persons unemployed divided by the total persons in the labour force
Phone access & vehicle access: proportion of households
NA= Not available

Pacific Peoples

The Pacific population is the largest immigrant minority and it is one of the fastest growing ethnic minority communities in New Zealand.

Although Pacific peoples make up a relatively small portion of MidCentral district’s population (1.9% of MidCentral district 2001 population) their morbidity and mortality rates are over represented in our statistics. Table 9 lists some key features of Pacific peoples. These findings are national statistics.

Table 9: Pacific Peoples – Society Issues (National Statistics)

Pacific Peoples

The People
- Samoan, Cook Island, Tongan, Niuean, Fijian, Tokelauan.
- 58% are New Zealand born.
- 89% speak English.
- 1.9% of MidCentral district’s population (approx 3000 people).

Pacific Children
- There are approx 61 000 Pacific children aged under 15 years in New Zealand.
- 53% of children live in houses with 6 or more people.
- 34% live in households shared by relatives.
- An average of 3 dependant children live in two parent families.
- 62% of Pacific children are aged between 5-14 years are obese.

Pacific Women
- There are approx 64 000 Pacific women aged 15 and over in New Zealand.
- 24% of Pacific women have given birth to 4 or more children.
- 12% of Pacific women receive the Domestic Purposes Benefit.
- 48% of Pacific women and 27% of Pacific men are obese.

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2001 Census. Taken from MidCentral DHB (2005) Oranga Pumau – Maori Health Strategy

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### Pacific Peoples *contd*

| Housing | • 20% do not have access to a telephone compared to 7.7% of all of New Zealand.  
|         | • 56% of Pacific peoples live in rental accommodation.  
|         | • 32.8% own their own home or are rent free (All ethnicities in NZ 67.5%).  
| Work and Education | • Pacific youth aged between 15 and 19 experience higher unemployment rates (33%) than other ethnicities.  
|         | • Overall unemployment rate 17%.  
|         | • Most common occupations are service workers and plant and machine operators.  
|         | • 3.3% of Pacific peoples have a school qualification.  
|         | • 19% have a tertiary qualification.  
| Income | • Average income for all Pacific peoples 15 years and over is $12 400.  
|         | • Average household income is $30 000.  
|         | • 32% of Pacific peoples main source of income was a government benefit.  
|         | • Only 50% of Pacific peoples are eligible for a community services card actually hold one.  
| Health Issues | • Highest abortion rates.  
|         | • Highest rates of Hepatitis B.  
|         | • Low uptake of screening services.  
| Issues for Mental Health | • Suicide and unintentional injuries account for 60% of deaths in the 15-24 age group.  
|         | • Traditionally mental illness was thought to be a possession of the body by aitu (demon), or a punishment for a past sin committed by the sufferer or their family. This belief is still strongly supported by some members of Pacific communities.  
|         | • For younger members of the Pacific community, there is a greater understanding and acceptance of mental illness, largely due to the increase in mental health education in schools and communities.  
|         | • In 2001 in New Zealand, 22 Pacific peoples died by suicide (20 males and two females), compared to 12 deaths in 2000 and 14 deaths in 1999.  

By the year 2031, it is estimated that the Pacific peoples population will have grown by 114% and constitute 7.2% of the total New Zealand population.

### Asian Peoples

MidCentral district's Asian population is 3.4%, representing a significant population. There is currently no data available on Asian peoples in MidCentral district however a Ministry of Health Asian Public Health Project Report (February 2003) conducted in Auckland identified health and societal issues. Table 10 illustrates the health and social status of Asian peoples in New Zealand (national statistics).

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92 Ministry of Health Pacific Islands Health Information pg 7
<table>
<thead>
<tr>
<th>Table 10: Asian Peoples – Society Issues (National Statistics – 2001 Census)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asian Peoples</strong></td>
</tr>
<tr>
<td><strong>The People</strong></td>
</tr>
<tr>
<td>• Chinese, Indian, Korean, Filipino, Thai, Japanese, Sri Lankan, Cambodian, Vietnamese, Other Asian.</td>
</tr>
<tr>
<td>• 3.4% of MidCentral district’s population (approx 5300 people).</td>
</tr>
<tr>
<td>• Net migration to New Zealand from Asian countries leads net migration figures with an average of over 15,000 people per year.</td>
</tr>
<tr>
<td>• 65% of all Asian peoples live in the Auckland region.</td>
</tr>
<tr>
<td>• Less than 5% of the Asian population is older than 65 years.</td>
</tr>
<tr>
<td><strong>Language</strong></td>
</tr>
<tr>
<td>• Of Asians who have been resident in NZ for less than 10 years, the % of people who cannot speak English or Maori is:</td>
</tr>
<tr>
<td>- 1 in 3 Cambodian and Vietnamese</td>
</tr>
<tr>
<td>- 47% of Cambodian women and 36% of Vietnamese women</td>
</tr>
<tr>
<td>- Between 22% and 28% of Chinese and Korean people</td>
</tr>
<tr>
<td>- 8% of Indian men and 14% of Indian women.</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
</tr>
<tr>
<td>• 5.6% do not have access to a telephone compared to 7.7% of all of New Zealand.</td>
</tr>
<tr>
<td>• 8.4% of Asian households are without a car (9.7% all ethnicities in New Zealand).</td>
</tr>
<tr>
<td>• 58.6% own their own home or are rent free (67.5% all ethnicities in New Zealand).</td>
</tr>
<tr>
<td><strong>Work and Education</strong></td>
</tr>
<tr>
<td>• Overall unemployment rate 7.2% (4.8% all ethnicities in New Zealand).</td>
</tr>
<tr>
<td>• The Asian ethnic group has the lowest % of people with no qualification (12.2%) compared with any other ethnic group (all groups 23.7%).</td>
</tr>
<tr>
<td>• 30.5% have a tertiary education (all ethnicities 27.7%).</td>
</tr>
<tr>
<td>• There is considerable variation in education across the Asian immigrant population:</td>
</tr>
<tr>
<td>- 30% of Indian men and 26% of Indian women have a university degree or higher qualifications</td>
</tr>
<tr>
<td>- Chinese and Korean immigrants with tertiary qualifications range between 13% and 23%</td>
</tr>
<tr>
<td>- Between 0%-5% of Cambodian and Vietnamese recent immigrants have a university qualification.</td>
</tr>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td>• 17% of Asian peoples aged 15 and over had an income of $30,000 or more compared with 31.2% for the whole population.</td>
</tr>
<tr>
<td>• 1.8% of Asian peoples receive the Domestic Purposes Benefit (compared to all ethnicities 3.7%).</td>
</tr>
<tr>
<td><strong>Health Issues</strong></td>
</tr>
<tr>
<td>• High abortion rates.</td>
</tr>
<tr>
<td>• Asian refugees generally have a poorer health status than other Asians and other population groups.</td>
</tr>
<tr>
<td>• High incidence for refugee Asians of post traumatic stress disorder.</td>
</tr>
</tbody>
</table>

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*Statistics from Auckland region*
**Issues for Mental Health**

- Mental health is highly stigmatised in the Asian community.
- Difficult to access service as many are not aware of available services in New Zealand.
- Mental illness is displayed through physical symptoms rather than talking about things they are experiencing.
- In New Zealand in 2001, 20 Asian peoples died by suicide (15 males and 5 females).

**Smoking Prevalence**

Tobacco use is a major cause of premature death. Around 4500 people in New Zealand die prematurely from smoking each year; this equates to around 12 people a day dying from smoking.  

According to a MidCentral 2003 survey, Maori smoking levels are higher than those of non-Maori (32.9% compared to 19.7%). While a significant proportion of MidCentral district's population do still smoke, it is encouraging to note that 30.3% of Maori and 28.9% of non-Maori are ex-smokers. Overall, people who have quit smoking actually outnumber those who continue to smoke (Figure 21).

**Figure 21: MidCentral District Smoking Status by Ethnicity (2003)**

According to the Ministry of Health's tobacco toolkit, MidCentral district's smoking prevalence is slightly above the national average for both females and males as illustrated in Table 11 below.

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*Ibid*
Table 11:  Smoking Prevalence (Indirectly Standardised) by DHB Region 1998-2000

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Waitemata</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Auckland</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Counties Manakau</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Waikato</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Lakes</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>38</td>
<td>39</td>
</tr>
<tr>
<td>Taanaki</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>Whanganui</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>MidCentral</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Hutt</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>West Coast</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Canterbury</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Otago</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Southland</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>National Average</td>
<td>25.9</td>
<td>24.9</td>
</tr>
</tbody>
</table>

According to a MidCentral 2003 survey, Maori smoking levels are higher than those of non Maori (32.9% compared to 19.7%). While a significant proportion of MidCentral district’s population do still smoke, it is encouraging to note that 30.3% of Maori and 28.9% of non Maori are ex-smokers. Overall, people who have quit smoking actually outnumber those who continue to smoke.

Alcohol Consumption

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*Prevalence was calculated by multiplying crude NZ gender specific rates (male 26% and female 25%) by the indirectly age standardised DHB region rate ratio. The matching of TLAs to DHB regions is approximate only.
A Health Knowledge, Attitudes and Practices (KAP) Survey of the residents of MidCentral district conducted in 2003 found that while approximately one quarter of respondents never drink alcohol (27.3%), about one out of five respondents drink alcohol three or more times weekly (21.1%) (Figure 22).

**Figure 22: Alcohol Consumption in MidCentral District – KAP Survey (2003)**

![Bar chart showing alcohol consumption frequency]

Figure 23 shows the alcohol intoxication rates from the MidCentral KAP survey. As the results show, males have a significantly higher rate of excessive alcohol consumption than females in MidCentral district. 20.6% of males get intoxicated 1-2 times fortnightly versus 9.1% of females. A higher proportion of females report they never become intoxicated.

**Figure 23: Alcohol Intoxication in MidCentral District – KAP Survey 2003**

![Bar chart showing alcohol intoxication rates]

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1. Ibid pg 20
2. Ibid pg 21
Alcohol intoxication by ethnicity (Figure 24) shows Maori have a higher proportion of people getting intoxicated than non-Maori.

Figure 24: Alcohol Intoxication in the MidCentral District by Ethnicity – KAP Survey 2003

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Ibid pg 22
Appendix C – Risk and Protective Factors for Depression

The causes of depression can vary. Psychosocial factors, such as adverse living conditions, can influence the onset and persistence of depressive episodes. Genetic and biological factors can also play a part.\textsuperscript{104}

**Biological Factors**

Biological factors that might have some effect on depression include: genes, hormones and brain chemicals (neurotransmitters).

**Genetic factors**

There is a risk for developing depression when there is a family history of the illness, indicating that a biological vulnerability may be inherited. The risk is somewhat higher for those with bipolar disorder. However, not everybody with a family history develops the illness. In addition, Major Depression can occur in people who have had no family members with the illness. This suggests that additional factors, possibly biochemistry, environmental stressors, and other psychosocial factors, are involved in the onset of depression.\textsuperscript{105}

**Hormones**

Research has found that there are some hormonal changes that occur in depression. The brain goes through some changes before and during a depressive episode and certain parts of the brain are affected.

This might result in an over or under production of some hormones, which may account for some of the symptoms of depression.

**Brain chemicals**

Evidence indicates that brain biochemistry is a significant factor in Depressive Disorders. It is known, for example, that individuals with Major Depressive illness typically have dysregulation of certain brain chemicals, called neurotransmitters. Additionally, sleep patterns, which are biochemically influenced, are typically different in people with Depressive Disorders. Depression can be induced or alleviated with certain medications, and some hormones have mood-altering properties. What is not yet known is whether the “biochemical disturbances” of depression are of genetic origin, or are secondary to stress, trauma, physical illness, or some other environmental condition.\textsuperscript{106}

\textsuperscript{104} World Health Organization (Dec 2001) Mental and Neurological Disorders – Fact Sheet no. 265
\textsuperscript{105} National Institute of Mental Illness (USA) Depression http://www.nimh.nih.gov/publicat/NIMHdepmenknows.pdf
Psychological Factors

Anhedonia
One of the core symptoms of human depression is anhedonia, the loss of interest or pleasure in daily activities. Daily stressful life events are recognised as predisposing factors in the etiology of depression. Studies have shown that normal behaviour can be restored by chronic treatment with tricyclics, atypical antidepressants, monoamine oxidase inhibitors and electroshocks, but not by other psychotropic agents such as antipsychotics.

Thinking
Persons with certain characteristics — pessimistic thinking, low self esteem, a sense of having little control over life events, and a tendency to worry excessively — are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them or with getting well. Upbringing or sex role expectations may contribute to the development of these traits. It appears that negative thinking patterns typically develop in childhood or adolescence.

Environmental and other social factors
Significant loss, a difficult relationship, financial problems, or a major change in life pattern have all been cited as contributors to depressive illness. Sometimes the onset of depression is associated with acute or chronic physical illness. In addition, some form of substance abuse disorder occurs in about one third of people with any type of depressive disorder.

Comorbidities
The MaGPIe study found that 50% of all psychological presentations in general practice are comorbid with physical illness. It is also known that any chronic illness such as diabetes, heart disease or cancer virtually doubles the incidence of a comorbid underlying psychological illness.

Alcohol
Problematic alcohol use also frequently coexists with other mental health problems such as depression, anxiety disorders, anti social personality disorders and Schizophrenia. A recent study undertaken in New Zealand identified alcohol (and/or drug) abuse as one of the factors that predispose young people to suicide.

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Ferguson (December 2004) Whither Primary Mental Health Care. NZFP, Volume 31 Number 6, pg 372.

Risk Factors for Suicide

Figure 25 illustrates a conceptual model of the factors for suicidal behaviours amongst young people.

**Figure 25: Conceptual Model of Domains of Factors for Suicidal Behaviours Amongst Young People**

Suicide is a complex problem for which there is no one cause or cure. Instead there are a range of biological, cultural, economic, social and psychological influencing factors. Research has identified four main factors that distinguish young people who make suicide attempts from other young people:

- social and educational disadvantage
- a history of exposure to multiple family and parental disadvantages during childhood and adolescence
- the development during adolescence of significant mental health problems or adjustment difficulties
- exposure to a serious or stressful life event immediately prior to the suicide attempt.

Although some risk factors for indigenous youth and taitamāriki mirror in part those of non indigenous people other specific risk factors are as follows:

- the impact of institutional factors (eg, mainstream education systems, prison)
- cultural and historical factors (eg, social dislocation and breakdown of whanau support and cultural identity).

Less is known about protective factors that protect against suicidal behaviour. Research has demonstrated that improved recognition and treatment of depression can result in a reduction of suicides, and improved mental health outcomes for individuals, family/whanau.

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and carers, and the community. Other factors that have been suggested as playing a potentially protective role include good coping skills and problem solving behaviours, positive beliefs and values, feelings of self esteem and belonging, connections to family or school, secure cultural identity, supportive family/whanau, hapu and iwi, responsibility for children, social support, and holding attitudes against suicide. For older adults, having a hobby and participating in social organisations protect against suicidal behaviour.
Appendix D – Current Mental Health Services and Providers

MidCentral spends approximately $25 million on the provision of mental health services. Of this amount, $17 million is spent in the secondary care setting and $8 million is spent in primary care/community mental health services.

Community Services

There are a number of community providers that do not receive mental health funding directly from the Funding Division but receive health funding through sub contracting arrangements with mental health providers. Such services include: counselling, advocacy and peer support, education and information, respite care, family and community support services to individuals, their families, friends and the community at large.

Other providers – excluding health community service groups – may access funding from the: Department of Justice, Department of Social Policy, Department of Internal Affairs, Lotteries Grants Board, and Hillary Commission; and from Local Government, Philanthropic Trusts or private sponsors/donations.

Schizophrenia Fellowship

Schizophrenia Fellowship provides family/whanau support, education courses and advocacy particularly for rural people in the Horowhenua and Tararua Districts.

Pathways to Wellbeing

MidCentral's mental health consumer governance group. This contract provides funding to support the training and development needs of this group.

Youth One Stop Shop

The Youth One Stop Shop offers youth one place where they can go for support and advice from a wide range of health and support services.

General Practice Teams

General practice teams include general practitioners and practice nurses and are a significant first point of contact for people with undiagnosed or diagnosed depression. For people with mild to moderate depression general practice teams do the majority of depression management, that is, the assessment of depression risk profiles, lifestyle change, diagnosis, management and ongoing follow up. They also provide generalist palliative care for their patients.

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115 MidCentral District Health Board (2004) 2004/05 District Annual Plan
116 MidCentral DHB (October 2001) An Assessment of the Health Needs in the MidCentral DHB Region pp 30-32
There are approximately 110 general practitioners (GPs) in MidCentral district. While MidCentral district as a whole is slightly higher than the New Zealand average for GP full time (FTE) equivalent per 100,000 population, the distribution is uneven with a higher proportion in Palmerston North and a lower proportion in rural areas.

There are three Independent Practice Associations (IPAs) in MidCentral district covering the majority of practicing GPs. They are MIPA (Manawatu IPA), TIPA (Tararua IPA) and The Doctors.

Iwi and Maori Providers

There are five Iwi and Maori Providers that provide Mental Health and Kaupapa Maori Alcohol and Drug services in MidCentral district. They are located in Dannevirke, Horowhenua, Manawatu and Palmerston North.

Best Care (Whakapai Hauora) Charitable Trust
Provides Kaupapa Maori Alcohol and Drug Services.

Rangitaane o Tamaki Nui a Rua
Provides the following three services:
- Kaupapa Maori Mental Health Services – Adult Community Teams
- Activity Based Rehabilitation Service/Day Activity and Living
- Kaupapa Maori Alcohol and Drug Services.

Te Runanga o Raukawa Incorporated
Provides the following services:
- Children and Young People Community Services
- Kaupapa Maori Mental Health Services – Adult Community Teams
- Activity Based Rehabilitation Service/Day Activity and Living
- Kaupapa Maori Alcohol and Drug Services.

Te Whanau Manaaki o Manawatu Trust
Provides advocacy/peer support – families/whanau (alcohol and drug).

Whaioro Trust Board
Provides Rangatahi work and rehabilitation/employment and educational support services.

MidCentral Health

MidCentral Health is a provider arm of MidCentral District Health Board, and is the largest mental health service provider in the district. Services provided include:
- Acute beds – 20
- Intensive care inpatient beds – 4
- Sub-acute beds – 12
- Alcohol and drug medical detoxification beds – 2
- Total inpatient beds – 38.

MidCentral Health onbuys two extended care/clinical rehabilitation beds from Capital & Coast Health, and six intensive residential beds from Good Health Wanganui. Utilisation rates for inpatient beds are high.

These services are complemented by the following: Community Alcohol and Drug Services, Child, Adolescent and Youth Community Services, Community Mental Health Teams, Kaupapa Maori Mental Health Services, Maternal Mental Health, Forensic Liaison and Prison Services, Specialist Eating Disorders Services, and Methadone Treatment. Home based support service coordination and residential coordination services are also incorporated into MidCentral Health’s services. MidCentral Health provides dual diagnosis and maternal maternity mental health services across the district.

Other Services

There are various other services available to people and their family/whanau in the community such as:

- Barnados
- Methodist Social Services
- Youthline
- Victim Support
- Samaritans.

Pharmacy

The pharmacist is an integral part of the health care team. The practice of pharmacy includes the custody, preparation and dispensing of medicines and pharmaceutical products, the provision of advice on health and wellbeing, including health screening, and the selection and provision of non prescription medicine therapies and therapeutic aids. The pharmacist acts as a medicines manager, ensuring safe, quality use of medicines and optimising health outcomes by contributing to the selection, prescribing, monitoring and evaluation of medicine therapy. The pharmacist researches information and provides evidence based advice and recommendations on medicines and medicine related health problems to patients, their carers and other healthcare professionals. Pharmacy is an essential part of the health care system in New Zealand.\(^1\)

\(^1\) The Pharmacy Council of New Zealand
Primary Health Care

Manawatu Health Trust
Community mental health service (other clinical FTEs).
General practitioner and practice nurse training has commenced for the provision of general health services to specifically target mental health consumers.

Primary Health Care Nurses

Primary health care nurses are crucial to the implementation of the Primary Health Care Strategy, and can contribute to reducing health inequalities, achieving population health gains, and promoting and preventing disease. Nurses working in primary health care have a number of roles, such as: public health nurses, practice nurses, district nurses, Plunket nurses, community nurses, disease state nurses and child health nurses.

Primary health care nurses work in many environments, such as: being mobile within the community, in general practice clinics, within MidCentral Health, and in Maori health provider organisations.

The majority of community based nurses in MidCentral district work in general practice, with large numbers also working in district nursing roles and providing community based and focused health care, for example diabetes, respiratory and palliative care.

The registered nursing workforce in MidCentral district totals 1,955 (nurses working in both primary and secondary health care) of which 157 (8%) are Maori, well below the district's proportion of Maori (17%). The ratio of nurses per 10,000 population is 122, compared with the national ratio of 106.

Primary Health Organisations

Funded by District Health Boards, Primary Health Organisations (PHOs) work with their communities to provide primary health care services for their enrolled populations. PHOs will improve coordination between primary and secondary care and develop closer links between communities and primary health care providers such as GPs, practice nurses and Maori health providers.

Currently there are four PHOs in MidCentral district:

- Tararua PHO – established 1 July 2003, it has an estimated enrolled population of 15,500
- Otaki PHO – established 1 April 2004, it has an estimated enrolled population of 5,500
- Horowhenua PHO – established 1 July 2004, it has an estimated enrolled population of 23,000
- Manawatu PHO – established 1 January 2005, it has an estimated enrolled population of 94,000.
Public Health Services

Public Health Nurses work in early childhood centres and primary and secondary school settings providing health promotion to support teachers working in the health curriculum.

Health Promoting Schools offers training and professional development for health providers who have involvement with the schools and for those within the education sector. This ‘whole school’ initiative links with teacher training, professional development and the Ministry of Education to ensure consistent messages are delivered in areas of curriculum, school culture, policies and community involvement. The Health Promoting Schools Advisor works alongside the public health nurses promoting best practice such as physical activity and nutrition in the school setting.

The Lifestyle and Health Development Team includes a Maori Health and Mental Health Promotion Advisor who deliver projects under the mental health promotion programme that include:

- Mental health promotion
- Suicide prevention
- Like Minds – Like Mine Programme.

Residential Providers

There are a total of 117 level two, three and four residential beds in the district. Additionally there are six regional beds for dual diagnosis Alcohol & Drug and one adult respite bed.

MASH Trust
MASH Trust provides a number of services for MidCentral, including administering the Luck Venue, a drop in centre that offers day activities for mental health consumers, and a Community Support Workers Service for the Manawatu and Horowhenua. It also has the following residential contracts:

- Community Residential – Level 4 Palmerston North
- Community Residential – Level 3
- Community Residential – Level 2.

MASH provides Activity Based Rehabilitation Service/Day Activity and Living, and Adult Planned Respite.

MASH also holds contracts with other District Health Boards. The first of these is a 30 bed level four residential service in Wellington that is available to all District Health Boards in the Central Region. The second is a six bed pilot dual diagnosis Alcohol & Drug residential service that covers Hawke’s Bay, Whanganui and MidCentral District Health Boards.

Dalcam Company Limited – St Dominic’s
Provides community residential – Level 3.