

Measuring social inclusion

People with experience of mental distress and addiction

Office for
Disability issues
Te Tari Mō Ngā Take Hauātanga
Administered by the Ministry of Social Development



**Mental Health Foundation
of New Zealand**
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Abbreviations used in this document

CI	confidence interval
CIDI	composite international diagnostic interview
DSM-IV	Diagnostic and Statistical Manual IV
NZGSS	New Zealand General Social Survey
MAG	Multi-Agency Group
MCS	mental component score
NZHS	New Zealand Health Survey
PCS	physical component score

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Foreword

Discrimination is one of the biggest barriers to recovery for people with experience of mental illness or addiction. British and New Zealand research has shown that people with experience of mental illness report discrimination in all aspects of their lives, from employment and housing to discrimination from friends, family and the community as well as from those providing mental health services. Consequently, they often feel excluded from many activities of daily living.

Measuring Social Inclusion is a joint collaboration between a group of agencies that have come together to assist each other in working towards reducing discrimination, promoting social inclusion and the rights of people with experience of mental illness and addiction. Known collectively as the Multi-Agency Group (MAG), their aim is to advance a recovery perspective that involves an overarching, strategic focus on improving outcomes across New Zealand.

This publication is the first of its kind to address discrimination using a social inclusion lens. It includes 14 important indicators across 10 life domains to measure how included people with experience of mental illness and addiction are in society. Underpinned by a human rights framework and a holistic view of mental health, the publication's purpose is to inform policy-makers and planners.

In New Zealand, there has been no in-depth study in the area of mental health or addiction using a social inclusion lens. To fill this gap, MAG has chosen to undertake this joint work to measure the change in social inclusion experienced by people with mental illness and addiction.

This is the first release of *Measuring Social Inclusion*, and this is a work in progress. We have been very fortunate to be able to utilise the rich information from the New Zealand General Social Survey, which has greatly enhanced the evidence base on social wellbeing in New Zealand. However, that survey has only been through one cycle of collecting information, and as such, indicators that use this survey information are not able to report on trends. It is hoped that further publication of these indicators will address this issue as well as ensuring continual improvement occurs.

We hope that you find this publication useful, and we welcome any feedback.



Bice Awan
Chair MAG 2010–2011



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Executive summary

Introduction

Measuring Social Inclusion provides a high-level summary of the social inclusion of people with experience of mental distress and/or addiction in New Zealand. The purpose of the publication is to provide quantitative information that contributes to an understanding of social inclusion outcomes for people with experience of mental distress and/or addiction. The measures presented could also form the basis for on-going monitoring of social inclusion.

Social inclusion is inextricably tied to recovery. The concept of social inclusion is a complex, dynamic and multi-dimensional concept that varies over time, affects various life domains and occurs at multiple levels of society, from the interpersonal to wider civic responsibilities.

Ten areas of life have been identified as important by directly or indirectly impacting on the level of social inclusion experienced. This publication presents 14 indicators across these 10 life domains.

Key findings

The measures have shown that people with symptoms of mental distress feel less included in society than other New Zealanders at major cost to them and their communities. This has major significance for policy-makers across a number of social domains.

Relationships

There is a clear relationship between symptoms of mental distress and the isolation that people feel. In 2008, 25 percent of people with no symptoms of mental distress felt isolated from others in the last 4 weeks, compared with 49 percent of people with mild symptoms, 67 percent with moderate symptoms and 77 percent of people with severe symptoms.

People with symptoms of mental distress are less likely than people with no symptoms to be partnered, with the likelihood decreasing with the severity of symptoms. In 2008, 41 percent of people with severe symptoms of mental distress were partnered, compared with 65 percent of people with no symptoms.

Health

Outcomes in the health domain were relatively positive. People with symptoms of mental distress had a similar level of self-reported physical health as people with no symptoms of mental distress.

Visits to the GP within the last 12 months ranged from 80–91 percent across the population. People with moderate or severe symptoms of mental distress used GP services significantly more than people with no or mild symptoms of mental distress. In

2008, 91 percent of people with severe symptoms of mental distress visited GP services within the last 12 months, compared with 80 percent of people with no symptoms.

Civic participation

Overall, 79 percent of people reported voting in the last general election. For people with mild or moderate symptoms of mental distress, there was no significant difference in the proportion voting in the last general election. However, people with severe symptoms of mental distress (68 percent) were significantly less likely to report voting than people with no symptoms of mental distress (80 percent).

In total, one in 10 people felt they had been treated unfairly or had something nasty done to them in the past year because of the group they belong to or seem to belong to. People with symptoms of mental distress are more likely to have felt discriminated than people with no symptoms of mental distress. In 2008, 27 percent of people with severe symptoms of mental distress felt they had been discriminated against, 20 percent with moderate symptoms and 14 percent with mild symptoms.

Among those with moderate or severe symptoms of mental distress, the most common reasons given for being discriminated against were their nationality, race or ethnic group (37 percent) or their skin colour (36 percent), and 14 percent thought the discrimination was because of a disability or health issue.

Safety

People with symptoms of mental distress were significantly more likely than those with no symptoms to report having a crime committed against them. However, the level of severity of those symptoms made no significant difference to reporting having a crime committed against them. One-third of people with severe symptoms of mental distress (31 percent) reported having a crime committed against them in the past year, compared with 17 percent of people with no symptoms of mental distress.

Cultural identity

People with symptoms of mental distress were significantly less likely than those with no symptoms to find it easy to express their identity in New Zealand. However, the level of severity of those symptoms made no significant difference to how easily people were able to express their identity in New Zealand. In 2008, 69 percent of people with severe symptoms of mental distress found it easy to express their own identity in New Zealand, compared with 85 percent of people with no symptoms.

Leisure and recreation

Three-quarters of people reported that there are free-time activities or interests they would like to do but can't or there are free-time activities or interests they would like to be able to do more of. However, people with symptoms of mental distress were significantly more likely to report difficulty in doing free-time activities than people with no symptoms of mental distress. Nine in 10 people with severe symptoms of mental distress reported difficulty in doing free-time activities.

Knowledge and skills

People with severe symptoms of mental distress (55 percent) were significantly less likely than people with no symptoms (67 percent) to have gained a level 2 or higher educational qualification. Also, people with severe symptoms of mental distress (12 percent) were significantly less likely to gain a qualification than people with no symptoms of mental distress (20 percent).

Employment

People with symptoms of mental distress were less likely to be employed and have been satisfied with their job than people with no symptoms of mental distress. A quarter of people with severe symptoms of mental distress (27 percent) were employed and satisfied with their job, compared with 68 percent for those with no symptoms.

Standard of living

People with symptoms of mental distress were more likely to be living in hardship than people with no symptoms. In 2008, 57 percent of people with severe symptoms of mental distress were not living in hardship, compared with 87 percent of people with no symptoms.

People with symptoms of mental distress are less likely than people with no symptoms to be satisfied with the housing they are currently living in. In 2008, 63 percent of people with severe symptoms of mental distress were satisfied with the housing they are currently living in, compared with 89 percent of people with no symptoms.

Transport

There was no significant difference between people with varying symptoms of mental distress in having no access or being dissatisfied with their access to public transport. Rates ranged from 27–29 percent.

1 Introduction

1.1 Purpose of the report

The purpose of this publication is to provide a framework for how social inclusion is experienced by people with mental health and addiction issues. The Multi-Agency Group (MAG)¹ has been working intersectorally to address the prevalence of stigma and discrimination towards people with experience of mental illness. As part of this work, a set of measures was collated to provide a better understanding of the experiences of social inclusion. Adults with mental health problems are said to be one of the most excluded groups in society (Social Exclusion Unit, 2004).

This publication continues the work of the Mental Health Commission (the Commission) as presented in an occasional paper *Mental Health and Social Inclusion Concepts and Measurements* (2009), as well as the Commission's work outlined in its *Statement of Intent 2010–2013* (2010). This publication will provide the scope for on-going projects that are focused on social inclusion issues that impact on people's wellbeing and recovery from the experience of mental illness and/or addiction.

1.2 Defining social inclusion

The concept of social inclusion is a complex, dynamic and multi-dimensional concept that varies over time, affects various life domains and occurs at multiple levels of society, from the interpersonal to wider civic responsibilities. It has been said that the "biggest barrier to recovery is discrimination" (Mental Health Commission, 1998) – by collating these social inclusion indicators, MAG agencies can be more responsive to issues and ensure that the experience of mental distress and/or addiction does not result in exclusion and isolation. Anti-discrimination work undertaken nationally and regionally by the Like Minds, Like Mine programme is not just about 'fighting' discrimination where it exists – it also focuses on prompting social inclusion and that means addressing the barriers to recovery (Ministry of Health, 2007).

The Commission (2009) previously identified the following key components of social inclusion:

- People are able to exercise their rights.
- People are able to participate in activities.
- Participation is by choice – including the right to exclude yourself from society.
- Social inclusion results from the society in which people reside and its social norms.

From this review, social inclusion is defined as:

... the extent to which people are able to exercise their rights and participate, by choice, in the ordinary activities of citizens. (Mental Health Commission, 2009)

¹ The members of MAG are the Human Rights Commission, the Mental Health Foundation of New Zealand, the Ministry of Health, the Office for Disability Issues (of the Ministry of Social Development), Office of the Health and Disability Commissioner, two representatives from regional consumer networks, and the Mental Health Commission.

This definition of social inclusion is underlined by a social model of disability in which ‘disability’ is the result of poor societal responses rather than an individual’s ‘pathology’ (Minister for Disability Issues, 2001; Sayce, 2000, 2001). This contextual approach is supported by policy directions outlined in the New Zealand Disability Strategy in which the focus is placed on those doing the excluding rather than on the excluded (Minister for Disability Issues, 2001; Repper & Perkins, 2003).

This approach also acknowledges the role of government, business and public places to be more responsive to the systemic contributors to the experience of disability. This includes rights and responsibilities outlined in the United Nation’s Convention on the Rights of People with Disabilities (UNCRPD)² which outlines the requirements of government to ensure people with disabilities³ are able to participate in society, including the ability to exercise their economic, social and cultural rights.

Social inclusion is inextricably tied to recovery and is based on the knowledge that “recovery could never take place in an environment where people were isolated from their communities” (Mental Health Commission, 1998). Mental health services have come a long way, but without an environment conducive to (re)integrating and (re)establishing important social roles, responsibilities and relationships, recovery loses all its meaning. As Joe Marrone has said, “If you are on the road to recovery and you have nowhere to go, it quickly becomes a treadmill” (Marrone, 2006).

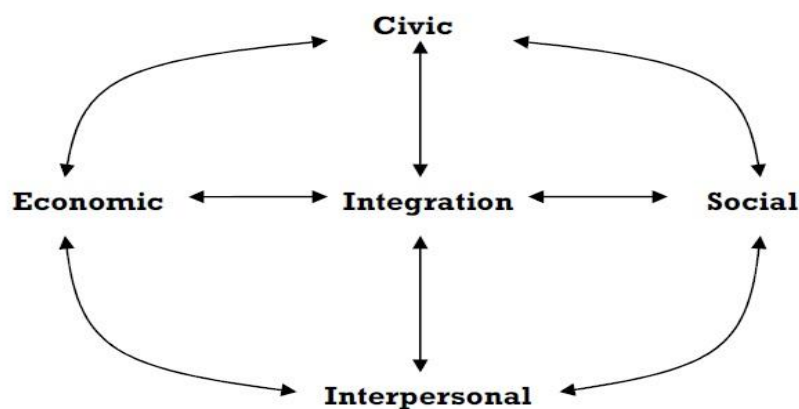
Commins (1993) refers to four fundamental systems of social integration (closely related to social inclusion) that are central to citizenship:

- **Civic integration** – promoted by the democratic and legal system and ensures that all people are equal citizens with a voice and right to vote.
- **Economic integration** – involvement in the labour market, having a valued economic function and being financially independent.
- **Social integration** – the ability of people to access the social services provided by government (such as benefits, training schemes, assistance with health).
- **Interpersonal integration** – this is the family and community system. Involvement within this system promotes greater social networks, which can provide care, companionship and moral support when these are needed.

² The UNCRPD is a ratified international treaty that outlines the requirements of government to make sure people with disabilities can access services and participate in society on an equal basis with others.

³ Mental health and addiction issues are defined as a ‘disability’ in legal discourses such as the Human Rights Act 1993.

Figure 1: The four areas of social integration



Source: Commins, 1993.

One's sense of belonging in society depends on all four systems... [these] systems are complementary; when one or two are weak, the others need to be strong. And the worst off are those for whom systems have failed. (Commins, 1993, p.4)

1.3 Measuring social inclusion

Social inclusion can be measured by indicators within life domains. These 10 life domains are presented in Table 1. The framework of indicators incorporated into this publication have been identified as important areas of life that directly or indirectly impact on the level of social inclusion experienced.

Currently, there is no established national dataset that can provide a high-level picture of the nature and extent of social inclusion for people with mental health and/or addiction problems in New Zealand. What information is available is collected by a number of agencies under broad categories that often cannot be disaggregated to identify differences for people with experience of mental illness and/or addiction. The indicators that have been selected for this publication can be broken down by levels of mental illness and addiction within these life domains.

An indicator is a measure that provides some evidence of an issue. When monitored over time, this measure can provide a clearer picture of the situation and whether there are any changes (Statistics New Zealand, 2008). Indicators are 'big picture' measures; therefore, they do not provide detailed explanations of the causes or implications of an issue. However, indicators can evoke debate and point to areas requiring further investigation. Indicators are increasingly used both in New Zealand and internationally to monitor developments and track progress. They are most helpful as they provide a summary of complex social issues and are therefore a crucial part to developing knowledge to support policy- and decision-making.

Table 1: Social inclusion framework

Domain	Outcome	Indicators
Relationships	People with mental illness and addiction have constructive relationships with family, whānau, communities, iwi and workplaces. They are supported by family and friends through their recovery.	<ul style="list-style-type: none"> • Isolation from others • Social partnership
Health	People with mental illness and addiction are able to maintain good physical health. They are able to access affordable, recovery-oriented health services to assist in their recovery.	<ul style="list-style-type: none"> • Physical health • Saw a GP
Civil participation	People with mental illness and addiction enjoy civil rights and have a voice in matters that are important to them.	<ul style="list-style-type: none"> • Voted in the last election • Perceived discrimination
Safety	People with mental illness and addiction feel secure and are free from victimisation, abuse and violence.	<ul style="list-style-type: none"> • Victims of crime
Cultural identity	People with mental illness and addiction feel a sense of belonging and are able to express their culture and be acknowledged in their world view.	<ul style="list-style-type: none"> • Expressing identity
Leisure and recreation	People with mental illness and/or addictions are able to participate in recreation, creative and cultural activities.	<ul style="list-style-type: none"> • Free-time activities
Knowledge and skills	People with mental illness and addiction have the knowledge and skills needed to participate fully in society.	<ul style="list-style-type: none"> • Educational attainment
Employment	People with mental illness and addiction have access to meaningful, rewarding employment.	<ul style="list-style-type: none"> • Employment and job satisfaction
Standard of living	People with mental illness and addiction have access to an adequate income and healthy, secure, affordable housing that meets their needs.	<ul style="list-style-type: none"> • Economic standard of living • Housing satisfaction
Transport	People with mental illness and addiction have access to affordable, timely, safe transport.	<ul style="list-style-type: none"> • Satisfaction with public transport

The process of selecting these indicators was iterative, undertaken with on-going consultation with the MAG, relevant stakeholders and data experts. Phoenix research (2009) also helped illuminate the potential areas and sources of data that were required to undertake this report.

The selection criteria are based on a comprehensive set of criteria developed by Statistics New Zealand (Advisory Committee on Official Statistics, 2009) and helped minimise subjectivity in the selection of the final indicator set:

- **Relevant and meaningful** – the indicator should adequately reflect the social outcome it is intended to measure and is appropriate to the needs of the user.
- **Grounded in research** – there should be sound evidence on key influences and factors affecting outcomes.
- **Statistically sound** – the measurement of indicators needs to be methodologically sound.
- **Able to be disaggregated** – indicators should have the potential to be disaggregated along relevant dimensions to show differences between important

population subgroups and other groupings. The indicators must help us understand disparities in the social outcomes of people with mental illness.

- **Consistent over time** – the usefulness of indicators is related directly to the ability to track trends over time, so indicators should be consistent.
- **Timeliness** – data needs to be collected and reported frequently to ensure indicators are providing up-to-date information.
- **Intelligible and easily interpreted** – the indicators should be sufficiently simple to be interpreted in practice and be intuitive in the sense that it is obvious what the indicator is measuring.

Trade-offs between these criteria were possible in some cases, but a firm requirement for this publication to be meaningful was that the data needed to be disaggregated alongside mental health groupings. Some indicators were not selected due to data collection times or frequencies that did not fit in to the timeframe of this project. In these cases, the Commission will be advocating for changes to data collection so as to improve the comprehensiveness of subsequent reports and to ensure sensitivity to trending data.

Despite the rigour in the selection process, no measure is ever complete, yet due to the nature of this data, the on-going feasibility of this social inclusion project is ensured. There is a sustainability to the data in which trends over time can be measured as these pools of data are drawn from statistics that are regularly collected and provide the disaggregation important in drawing out the view of social inclusion for people with experience of mental health or addiction issues.

Lastly, the New Zealand General Social Survey (NZGSS) is a survey of wellbeing on domains such as housing, health, employment, human rights and social wellbeing, providing an overall picture of New Zealand's social wellbeing (Statistics New Zealand, 2009). The purpose of this information is to contribute to government and community decision-making and responsiveness to social issues. Its greatest attribute for these purposes is its ability to be cross-referenced with mental health and addiction statistics for the New Zealand population.

1.4 Structure of the report

This publication is set out with each of the 10 life domains presented in a chapter. Within each of these life domains, the indicators will provide a picture of the overall population as well as groupings of 'mild', 'moderate' and 'severe' – limitations associated with the experience of a mental illness or an addiction. The results for each indicator are then considered by four variables:

- Sex
- Age
- Ethnicity
- Socioeconomic (NZ Deprivation Index).

Together, these indicators provide an overview of the experience of social inclusion for people with mental health and addiction problems.

First, an overview of the measures will be outlined, and the current prevalence data for the rates of mental illness is presented.

2 People with experience of mental illness and addiction

2.1 How this is measured

This publication relies on existing New Zealand surveys that include a tool that measures the mental health status of respondents. Surveys use a range of different approaches to measuring the mental health of a population:

- Self-assessment questionnaire of mental health or addiction status (for example, SF-12, SF-36, K10, AUDIT). These questionnaires ask a range of questions related to mental health or addiction with the aim of identifying those people with a mental health or addiction concern.
- Self-reported diagnosis of mental illness or addiction. Some surveys ask whether respondents have ever been diagnosed with a mental disorder.
- Structured diagnostic interviews that correspond to classificatory systems of mental illness.

A structured diagnostic interview is considered the ‘gold standard’ for measuring mental health within a population (Gill, Butterworth, Rodgers & MacKinnon, 2007). While these are able to provide specific and differential psychiatric diagnoses, they are expensive and time-consuming and therefore not regularly updated. Self-assessment questionnaires that measure non-specific psychological wellbeing or distress address these limitations and have shown to be sensitive to changes in health over time (Amir, Lewin-Epstein, Becker & Buskila, 2002).

2.1.1 Short-form health questionnaire

This publication draws primarily from the New Zealand General Social Survey⁴ (NZGSS) and the New Zealand Health Survey (NZHS).⁵ Both use the short-form health questionnaire (SFHQ) to obtain information about respondents’ health. The NZGSS uses the SF-12, and the NZHS uses the SF-36.

The SF-12 and SF-36 are multi-purpose short-form surveys with 12 and 36 questions respectively. They are designed for use in the general population to assess general self-rated health, physical and psychological symptoms and limitations in everyday activity due to physical and mental health over the previous 4 weeks. The items related to mental health cover limitations to usual activities and emotional state.

In each questionnaire, the questions are summarised in two weighted summary scales – physical component score (PCS) and mental component score (MCS), which range from 0 to 100, where a 0 score indicates the lowest level of health measured by the scales and 100 indicates the highest level of health. Research has revealed a strong

⁴ The General Social Survey is a multi-dimensional survey of social wellbeing and enables cross-sectoral and trend analysis of social outcomes.

⁵ The New Zealand Health Survey is repeated at regular intervals to monitor people’s health, measure access to health services and help develop health policies, programmes and services that better meet the needs of New Zealanders.

association between low scores on the MCS and a current CIDI⁶ diagnosis of anxiety and mood disorders. There is a lesser but significant association between the MCS and other mental disorder categories (including substance use disorder) and with the presence of any current mental disorder (Gill et al., 2007; Sanderson & Andrews, 2002; Ware, Kosinski & Keller, 1996).

2.1.2 Cut-off scores

The MCS score derived from the SF-12 and SF-36 has no definitive meaning in regard to a mental health diagnosis. Moreover, there exists no widely accepted screening cut-off score on the MCS-12 for probable diagnosis of any mental illness. There are research examples that have categorised the MCS-12 to extract more meaning, for example, Ware, Kosinski and Keller (1994) used a nine-level categorisation to help interpret the MCS scores – 9 to 29, then seven five-level increments (30 to 34, 35 to 39 and so forth, and then 65 to 74).

Sanderson and Andrews (2002) used a four-level categorisation of MCS scores by collapsing the nine-level categorisation used by Ware and colleagues as described above. These four-levels are no disability (represented by a score of 50 or higher), mild disability (scores between 40 and 49), moderate disability (scores ranging between 30 and 39) and severe disability (any score below 30). The validity of these four levels of disability were tested by comparing them to a range of disability-related variables such as the presence of a diagnosed mental health issue, none present and consultation with a mental health specialist.

Gill et al. (2007) investigated cut-off scores for the MCS by using ROC curves so as to graph the sensitivity and specificity of every possible cut-off score for depression, any anxiety disorder and any common mental disorder. A score of less than 45 was chosen as the best screening cut-off for depression and less than 50 for any anxiety disorder as well as any other common mental illness. A cut-off score of less than 36 was chosen to identify those with severe psychological symptomatology and/or impairment. Given the level of agreement around these cut-off scores, this publication adopts the four-level categorisation used by Sanderson and Andrews (2002) detailed above.

The mild, moderate and severe groupings used in the data and represented in the graphs are aggregated representation of levels of limitations and symptoms associated with mental health. Therefore, this publication talks about those people with symptoms of mental distress in this respect. MAG acknowledges that the focus on limitations or symptom severity is incongruent with a strengths perspective, and these groupings may best serve as simply heuristics for decision-making in policy and funding of services. The experience of mental illness is not limited to a category of severity. Instead, it is a fluid experience, much like the weather – people's experience of wellbeing is constantly shifting through the interaction between themselves, their family and their communities.

⁶ CIDI stands for composite international diagnostic interview and allows lay people to conduct an interview from which an assessment of mental health can be made.

2.2 Prevalence of mental illness

2.2.1 Te Rau Hinengaro

In late 2003 and 2004, the Ministry of Health undertook the New Zealand Mental Health Survey to determine the prevalence rates of major mental disorders among the adult population using criteria from the Diagnostic and Statistical Manual IV (DSM-IV; American Psychiatric Association, 2004).

The survey found that 20.7 percent of the population had experienced a mental illness within the past 12 months and 11.6 percent in the past month (Oakley Browne, Wells & Scott, 2006). The 12-month prevalence of serious disorder was 4.7 percent, moderate disorders 9.4 percent and mild disorders 6.6 percent, with the remaining 79.3 percent of the population with no diagnosed mental health issues. Anxiety disorders were the most common group of disorders in the past 12 months (14.8 percent), followed by mood disorders (7.9 percent), then substance use disorders (3.5 percent), with eating disorders the least common group (0.5 percent) (Oakley Browne et al., 2006).

2.2.2 General Social Survey

This publication primarily uses the NZGSS 2008 to measure the social inclusion of people who have experienced a mental illness and/or addiction. This section looks at the prevalence of mental disorder as described by the NZGSS 2008.

This survey shows that 27.9 percent (CI, 26.7–29.2)⁷ of people aged 15 years and over have symptoms and/or limitations associated with their experience of a mental health issue in the last 4 weeks.⁸ This includes 2.6 percent (2.2–3.1) of people with a severe mental illness, 6.7 percent (6.0–7.4) with a moderate mental illness and 18.6 percent (17.6–19.7) with a mild mental illness.

All four of the characteristics outlined in Table 2 (sex, ethnicity, age and the deprivation index) are significantly associated with rates of mental illness as measured by the NZGSS. These associations are very similar to those seen in Te Rau Hinengaro (Oakley Browne et al., 2006).

Females (31 percent) are significantly more likely than males (25 percent) to have experienced a mental illness. Younger people are more likely to have experienced a mental illness than older people, with people aged 25–34 years with the highest prevalence (33 percent) and people aged 65–74 years having the lowest prevalence (18 percent). Māori are more likely than people in the 'Other' group to experience a mental illness in general and specifically have higher prevalence rates in the 'severe' category. The Deprivation Index (NZDep2006 decile) also shows a clear association between those living in more deprived areas experiencing higher rates of mental illness.

⁷ Confidence intervals are included to give an indication of the margin of error. The confidence interval has a 95 percent probability of including the 'true value'. The confidence interval is influenced by the sample size of the group. When the sample size is small, the confidence interval will be wide, and there is less certainty about the rate.

⁸ For the remainder of the report, any references to 'people' will be related to those who have experienced some level of limitation due to their experience of a mental illness and/or an addiction.

Table 2: Sociodemographic characteristics and prevalence of mental disorder

Characteristic	Mild % (95% CI)	Moderate % (95% CI)	Severe % (95% CI)
Sex			
Male	17.2 (15.7, 18.8)	5.5 (4.6, 6.4)	2.0 (1.4, 2.7)
Female	19.9 (18.6, 21.2)	7.9 (6.8, 9.0)	3.2 (2.5, 3.8)
Age group (years)			
15-24	19.7 (16.6, 22.8)	6.7 (4.3, 9.0)	2.3 (1.0, 3.7)
25-34	21.5 (18.6, 24.4)	8.0 (6.2, 9.7)	3.1 (1.9, 4.2)
35-44	17.7 (15.8, 19.7)	8.8 (7.1, 10.5)	3.8 (2.7, 4.9)
45-54	20.7 (18.0, 23.5)	6.5 (4.8, 8.2)	2.3 (1.4, 3.3)
55-64	17.8 (15.3, 20.3)	5.0 (3.8, 6.3)	2.5 (1.2, 3.9)
65-74	13.0 (10.7, 15.3)	3.9 (2.7, 5.0)	1.2 (0.5, 1.9)
75 and over	14.7 (11.7, 17.7)	5.5 (3.2, 7.8)	1.8 (0.9, 2.7)
Ethnicity			
Māori	21.0 (17.3, 24.8)	7.9 (5.6, 10.1)	5.1 (3.0, 7.2)
Pacific	23.2 (17.9, 28.4)	8.1 (4.1, 12.2)	1.6 (0.3, 2.8)
Asian	19.2 (15.3, 23.4)	6.3 (3.7, 8.9)	1.7 (0.3, 3.2)
European/Other ⁹	17.9 (16.7, 19.1)	6.5 (5.7, 7.2)	2.4 (1.9, 2.8)
NZDep2006 deciles			
9 and 10 most deprived	20.7 (17.8, 23.5)	8.2 (6.1, 10.2)	3.5 (2.5, 4.5)
7 and 8	21.0 (18.8, 23.1)	7.8 (5.9, 9.6)	3.0 (2.1, 3.9)
5 and 6	19.0 (16.4, 21.6)	7.5 (6.1, 9.0)	3.3 (2.1, 4.5)
3 and 4	18.7 (16.3, 21.2)	5.5 (4.2, 6.8)	1.9 (1.2, 2.7)
1 and 2 least deprived	15.4 (13.4, 17.4)	5.8 (4.2, 7.3)	2.0 (1.1, 3.0)

⁹ Other ethnicities include New Zealander, Middle Eastern, Latin American and African.

3 Relationships

3.1 Why is this life domain important?

Connecting to others is a fundamental human need. A brief look around will show that our communities, workplaces and home life all function on the capital of human interactions. There has been substantial research on the importance of relationships from a range of disciplines, with all of the evidence pointing to the essentiality of relationships.

Developing the evidence base, the New Economics Foundation looked at the five ways to wellbeing and identified connection or relationships as “the cornerstones of your life ... building these connections will support and enrich you every day” (Aked, Marks, Cordon & Thompson, 2008, p.i). Being part of a social network is good for our mental health, a buffer against mental ill health (Diener & Seligman, 2002) and promotes a sense of belonging (Morrow, 2001) and greater life satisfaction (Wagner, Frick & Jurgen, 2007). There is research that shows that, when our primary social network (the total number of close relatives and friends) is three or less, there is a higher probability of experiencing a mental illness in the future (Brugha et al., 2005).

It was once believed that marriage was the predictor of good mental health, but recent research has shown that it is neither whether the relationship is legal nor the benefits of cohabitation, but the duration of the relationship that matters (Gibb, Fergusson & Horwood, 2011). This New Zealand study used the CIDI to survey respondents on a range of criteria such as the occurrence of suicidal thoughts or attempts, symptoms of depression and problematic substance use whilst controlling for mediating factors:¹⁰ “Longer relationships were associated with significantly lower rates of depression, suicidal behaviour and substance abuse/dependencies” for both genders equally (Gibb et al, 2011, p.24).

From the perspective of people who have experienced a mental illness or addiction, there are often barriers to intimate partnerships, successful familial relationships and connecting with members of the wider community. Primary to these barriers is the presence of stigma and discrimination in New Zealand society (Peterson, Pere, Sheehan & Surgenor, 2004). Mind, a mental health charity in the UK, completed a survey for the Time to Change anti-discrimination campaign and found that 57 percent of people would turn down a date with someone if they knew they had a mental illness, more so than turning down a date because of unattractiveness (44 percent) or who had different interests (43 percent) (Mind, 2010). Other factors such as periods of profound unwellness and prolonged time spent in inpatient services can set about a vicious cycle of social isolation, poor experiences of wellbeing (including greater feelings of self-stigma) and limited contact with a wider group of people found in workplaces, sports clubs and other avenues of social connectedness (Peterson, Barnes & Duncan, 2008; Peterson et al., 2004; Sayce, 2000; Marrone & Golowka, 1999).

¹⁰ Covariate factors (mediating variables) were parental history of illicit drug use, family socioeconomic status, exposure to childhood adversity, prior history of mental health problems, recent adverse life events and others (Gibb et al., 2011).

3.2 Isolation

3.2.1 Measure

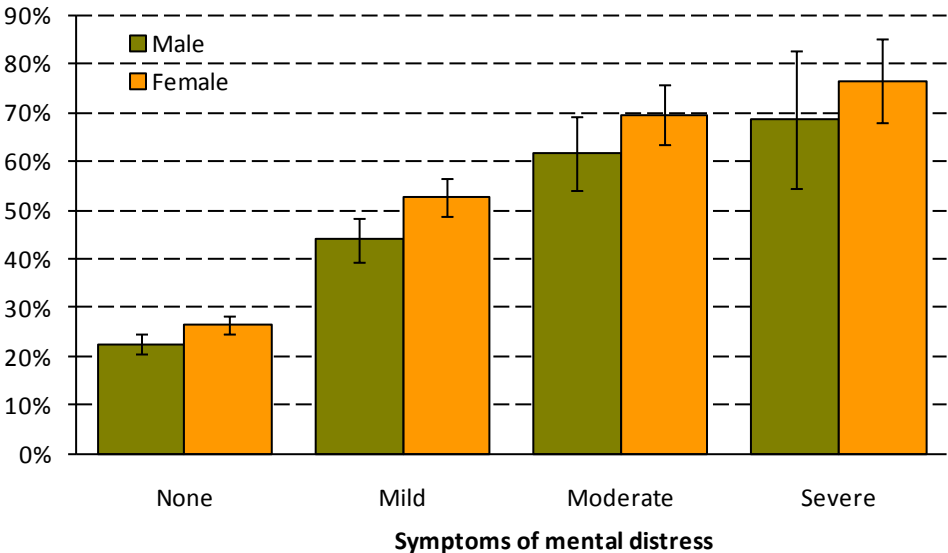
The proportion of people aged 15 years and over who have felt isolated¹¹ from others in the last 4 weeks, as measured in the New Zealand General Social Survey. Self-assessed isolation is a subjective indicator of people’s satisfaction with the amount and quality of relationships they have.

3.2.2 Findings

There is a clear relationship between severity of mental distress and the rates of isolation that people feel. However, there was no statistical significance in the difference between the isolation felt between moderate and severe symptoms of mental distress. The proportion of people with no symptoms of mental distress who felt isolated was at 25 percent, compared with 49 percent of people with mild symptoms, 67 percent with moderate symptoms and 77 percent of people with severe symptoms.

On average, females felt more isolated than males. Once symptoms of mental distress were taken into account, there was no significant difference between males and females with moderate or severe symptoms. For both sexes, the rate of feeling isolated was significantly higher for people with symptoms of moderate or severe mental distress (Figure 2).¹²

Figure 2: Felt isolated from others in the last 4 weeks by symptoms of mental distress and sex, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

¹¹ This measure is a combination of four responses to the question on feeling isolated from others in the last 4 weeks: ‘all of the time’, ‘most of the time’, ‘some of the time’ and ‘a little of the time’.

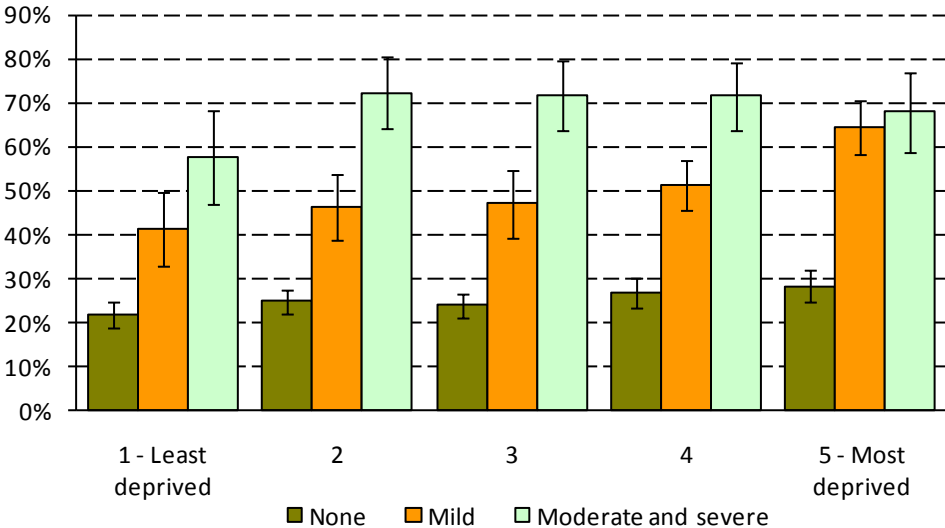
¹² Results are presented with error bars showing the 95 percent confidence intervals to give an indication of the margin of error.

There was a general trend that feelings of isolation tend to decrease with age. Largely, this was the case across all groupings. However, people with severe symptoms of mental distress followed a different pattern, with higher rates of isolation experienced in certain age groups: 15–24, 35–44 and 65–74 years. Furthermore, those aged 15–24 years had the highest reports of isolation – 58 percent for those with mild symptoms, 83 percent for those with moderate symptoms and 91 percent for those with severe symptoms. For people with no symptoms of mental distress, the most isolation was also experienced in the younger age groups (approximately between 15–44 years, but there was a much lower average across these age groups of 30 percent).

There was no difference across ethnicities for the reported ratings of isolation felt in the last 4 weeks.

Feeling isolated is not mediated through neighbourhood deprivation. Instead, symptoms of mental distress led to the same ratings of isolation regardless of a person’s socioeconomic factors. When there are no symptoms of mental distress, rates of isolation do not differ between deprivation areas. In contrast, those with mild symptoms of mental distress in the most deprived neighbourhoods reported significantly higher feelings of isolation but that was not true for those with moderate and severe symptoms.

Figure 3: Felt isolated from others in the last 4 weeks by symptoms of mental distress and NZDep2006 quintile, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

3.3 Social marital status

3.3.1 Measure

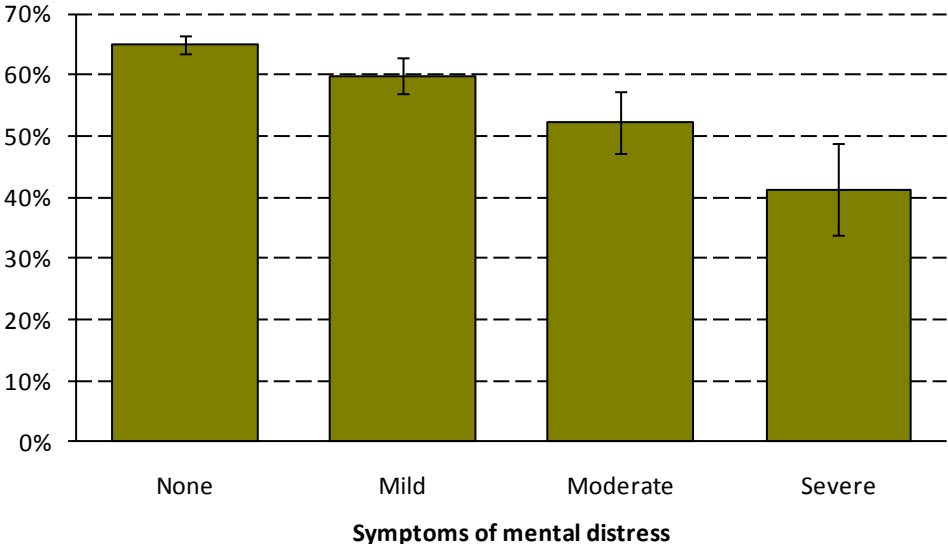
The proportion of people aged 15 years and over who are socially partnered (sometimes known as ‘social marital status’) – this is when a person is in a consensual union that is “a relationship between two people usually resident in the same dwelling

who consider their relationship to be akin to a marriage or civil union” (Statistics New Zealand, 2006).¹³

3.3.2 Findings

People with symptoms of mental distress are less likely than people with no symptoms to be partnered, with the likelihood decreasing with the severity of the symptoms. In 2008, 65 percent of people with no symptoms of mental distress were socially partnered, compared with 60 percent of people with mild symptoms of mental distress, 53 percent with moderate symptoms and 41 percent with severe symptoms. These differences were all statistically significant except between moderate and severe symptoms of mental distress.

Figure 4: Socially partnered by experience of mental illness or addiction, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

There was no significant difference between males and females for people with symptoms of mental distress when it came to being socially partnered. However, in general, males were more likely to be socially partnered than women.

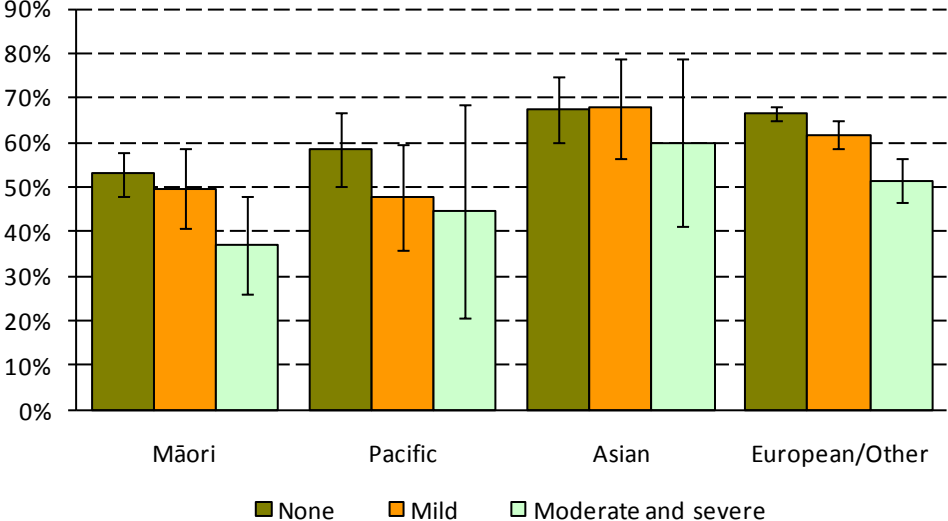
In the total population, people aged 35–64 years were the most likely to be partnered. A similar trend was shown for people with symptoms of mental distress. Across all groups aged 25 years and over, people with symptoms of mental distress were less likely than people with no symptoms to be partnered. However, for people aged 65 years and over, these differences were not statistically significant. For people aged 25–74 years with moderate and severe symptoms of mental distress, the rate of being partnered ranged from 58–64 percent.

Asian and European/Other people had the highest rates of social partnering, although this was only statistically significant when taking into account the total population.

¹³ Accessed from Statistics New Zealand – www.stats.govt.nz/Census/about-2006-census/information-by-variable/marital-status-legal-and-social.aspx

European/Other people were less likely to have a partner if they had symptoms of moderate or severe mental distress than if they only had mild symptoms of mental distress. No other ethnic group showed such a large decrease in partnership with severity of mental distress that was statistically significant. Across all severities of symptoms of mental distress, Māori had the lowest rates of social partnering.

Figure 5: Socially partnered by symptoms of mental distress and ethnic group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

The association between symptoms of mental distress and being partnered was mixed across levels of neighbourhood deprivation. There was no significant difference between people with mild symptoms of mental distress and people with no symptoms across all quintiles of neighbourhood deprivation.

4 Health

4.1 Why is this life domain important?

It is commonly acknowledged that there can be no health without mental health. Increasingly, the benefits of diet, exercise and lifestyle have been associated with more encompassing measures of general wellbeing. From a more holistic perspective, health is entwined with and supportive of a person's mental wellbeing, and likewise, good mental health also impacts on our physical health, including our perception of our physical health (National Mental Health Development Unit, 2011). Many cultures' understanding of health is based on this mutuality of mental and physical health, often with little differentiation between them (Chung & Samperi, 2004; Kagitcibasi, 1994).

Good health is critical to wellbeing because:

- it enables people to enjoy their lives to the fullest, take advantage of education and employment opportunities and participate fully in society and the economy
- health can have a cumulative effect on life outcomes – poor child health is linked to poor adult health and also to broader poor outcomes including unemployment and crime (Ministry of Social Development, 2004, p.33).

4.2 Physical health

4.2.1 Measure

The average physical health score for people aged 15 years and over from the SF-12 health questionnaire, as measured by the New Zealand General Social Survey.

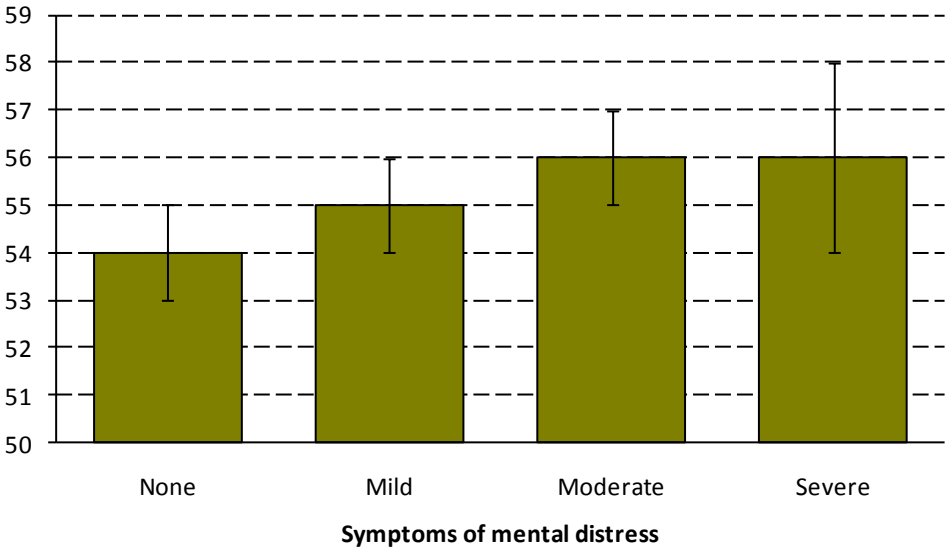
The SF-12 is a multi-purpose short-form survey that is designed for use in the general population to assess general self-rated health, physical and psychological symptoms, and limitations in everyday activity due to physical and mental health over the previous 4 weeks.

This survey is generally accepted as providing a reliable indicator of physical and mental health status and has widespread use internationally. The questionnaire is summarised into scores from 0–100, one for physical health status and one for mental health status.

4.2.2 Findings

There is no significant difference in the physical health of people with varying symptoms of mental distress.

Figure 6: Median physical health score (SF-12) by symptoms of mental distress, 2008

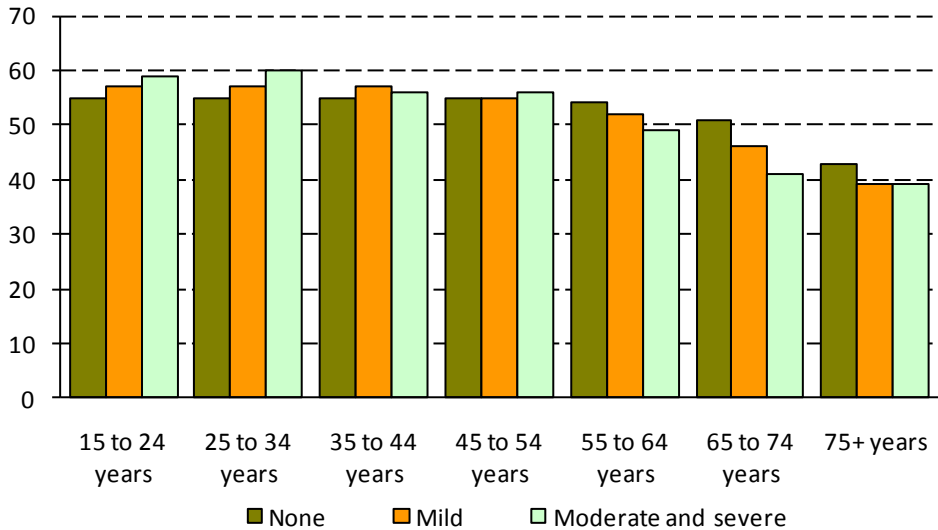


Source: Statistics New Zealand, New Zealand General Social Survey

Females had higher self-reported scores of physical health compared with males within moderate and severe mental distress groups. Conversely, females rated themselves lower than males when there were mild symptoms of mental distress. Males had a consistent score of 55 across all groupings.

Self-reported physical health ratings show a decreased pattern with age across the whole population. There was a similar pattern for people who had symptoms of mental distress (Figure 7). Within each age group, there was no significant difference in self-reported physical health across the levels of severity of mental distress.

Figure 7: Median physical health score (SF-12) by symptoms of mental distress and age, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

The pattern of higher self-reported physical health for people with moderate or severe symptoms of mental distress is driven by European/Other people. European/Other people with moderate or severe symptoms of mental distress had a self-reported physical health score of 57, compared with 54 for European/Other with no symptoms. In comparison, other ethnic groups with moderate or severe symptoms of mental distress had similar or lower self-reported physical health scores than those with no symptoms.

There is a clear association within levels of mental distress between neighbourhood deprivation and self-reported physical health, with those living in the most deprived neighbourhoods reporting the lowest levels of self-reported physical health. Conversely, there is some evidence again of the upward trend with better health scores being associated with increasing severity of mental distress – this is found for people living in the least deprived neighbourhoods.

4.3 Saw a GP

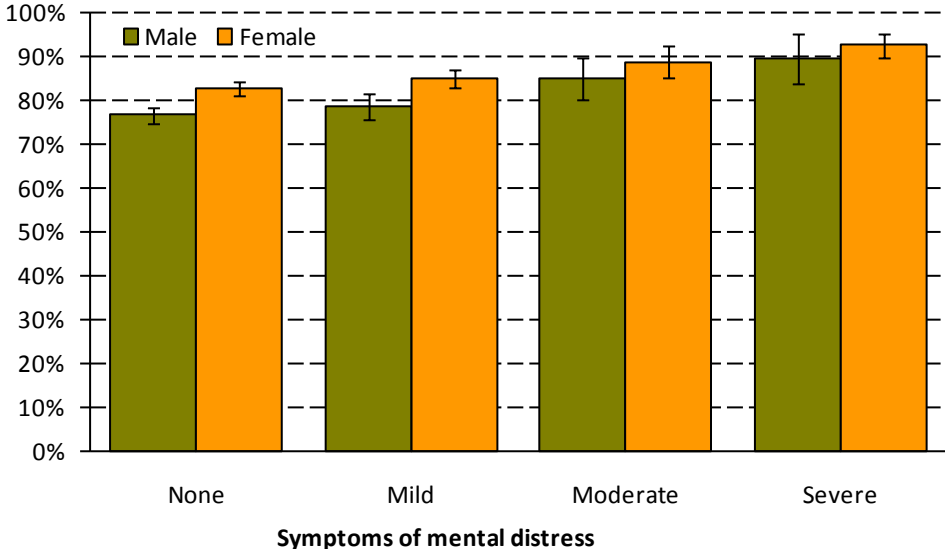
4.3.1 Measure

The proportion of people aged 15 years and over who saw a GP in the past year, as measured by the New Zealand Health Survey.

4.3.2 Findings

People with moderate or severe symptoms of mental distress were more likely to use GP services than people with no or mild symptoms of mental distress (none 80 percent, mild 81 percent, moderate 87 percent and severe 91 percent). Females were more likely to see their GP than males. This sex difference was significant only when there were no symptoms of mental distress or mild symptoms of distress. There was no sex difference between people with moderate or severe symptoms of mental distress in the utilisations of GPs.

Figure 8: Saw a GP in the past year by symptoms of mental distress and sex, 2008

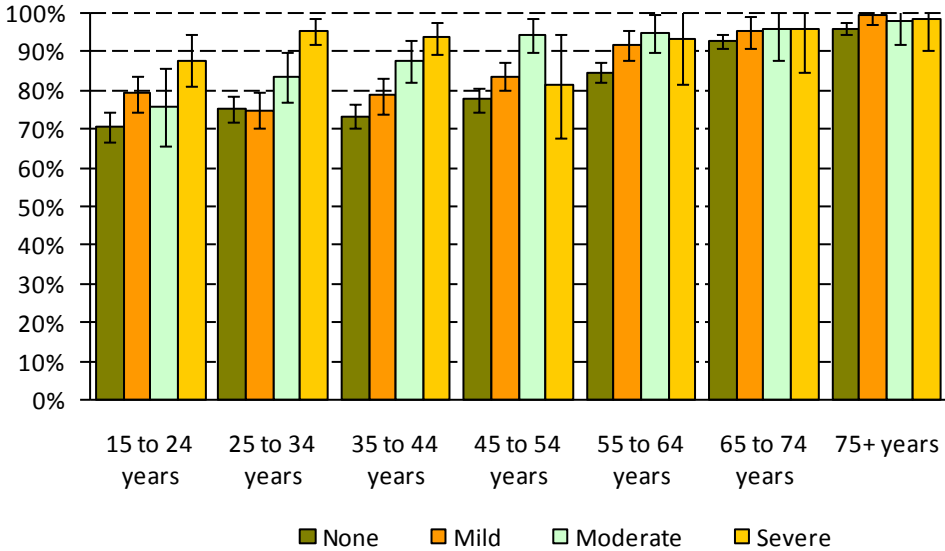


Source: Ministry of Health, New Zealand Health Survey

There was a general trend with GP visits increasing with age, in part due to a range of age-related and chronic health concerns commonly occurring later in life (such as high blood pressure, heart disease, diabetes, arthritis and osteoporosis) (Ministry of Health, 2008).

There was a marked increase in GP visits for people with severe symptoms of mental distress, especially for people aged 15–44 years compared with their peers.

Figure 9: Saw a GP in the past year by symptoms of mental distress and age, 2008

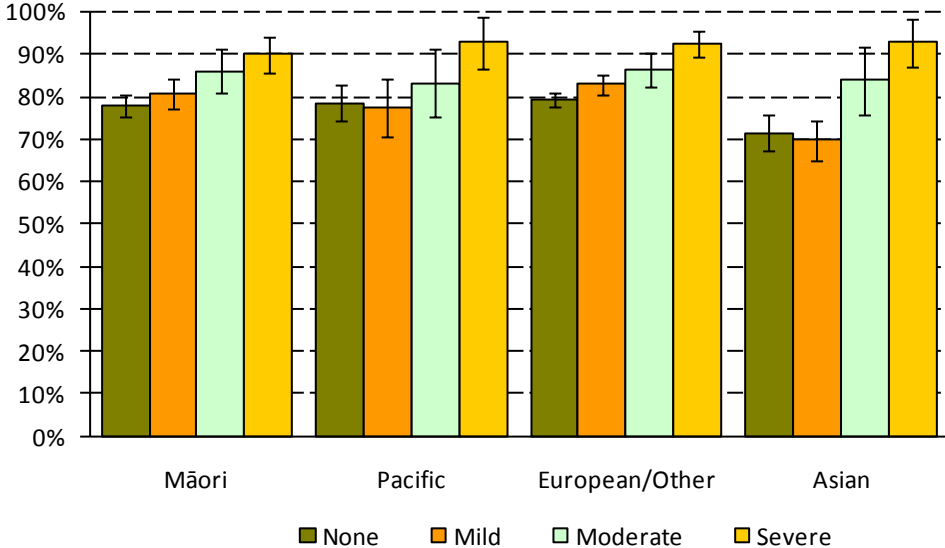


Source: Ministry of Health, New Zealand Health Survey

Across all ethnicities, people with severe symptoms of mental distress were more likely to see their GP than other people.

The only significant difference within each ethnic group was between no symptoms of mental distress and those with severe symptoms of mental distress. Asians reported the greatest variability in accessing GPs, with a 20 percentage point difference in the utilisation of GPs between people with severe symptoms of mental distress and people with no symptoms.

Figure 10: Saw a GP in the past year by symptoms of mental distress and ethnic group, 2008



Source: Ministry of Health, New Zealand Health Survey

There was no association between level of neighbourhood deprivation and symptoms of mental distress to GP access rates.

5 Civic participation

5.1 Why is this life domain important?

Acts of civic participation are acts of social inclusion. Civil and political rights are a cornerstone of democratic societies – this involves confidence in our police and justice system as well as trust of our political systems. Countries with high rates of civic participation exhibit improved relationships within communities, promote voter registration and result in more active citizenship (Ministry of Social Development, 2004). Moreover, there is a significant association between participation in society's civic arena and subjective rates of wellbeing (Brown, Woolf & Smith, 2010).

Democracy has a positive influence on population health and is partly mediated by one's socioeconomic position (Safaei, 2006). Being able to participate and have a say in things is vital to the health and wellbeing of populations. Setting priorities and exercising some control over your environment (community, workplace or school) are well established factors in increasing positive health outcomes (Wise & Sainsbury, 2007). On the other hand, lack of control over one's environment is associated with chronic stress and poor health outcomes (Sapolsky, 2004).

Civic participation is also vital to the effectiveness of any form of governance (Petrie, 2002). However, under the Electoral Act of 1993, 80(1) c (IV) (as at January 2011), some people with mental health or addiction problems are disqualified for registration as electors. A person detained under section 46 (*a detained persons in need of care and treatment*) of the Mental Health (Compulsory Assessment and Treatment) Act (1992) is subject to a suite of laws pertaining to special or restricted patients and their voting rights.¹⁴ Mental health is the only area of health where such legislative mechanisms are set up to define a 'special patient' so readily and rigorously, setting up some serious questions about the ethics of this practice from human rights and legal perspectives.

A key right of citizenship is the right not to be discriminated against. Discrimination occurs when a person is treated differently (and unfavourably) from another person in the same or similar circumstances. Discrimination is a barrier to social inclusion and also has negative effects on mental health. In New Zealand, the Like Minds Like Mine campaign helps address this by finding innovative ways to get people to question their attitudes and shift their behaviour towards people with experience of mental illness (Ministry of Health, 2007).

5.2 Voted in the last election

5.2.1 Measure

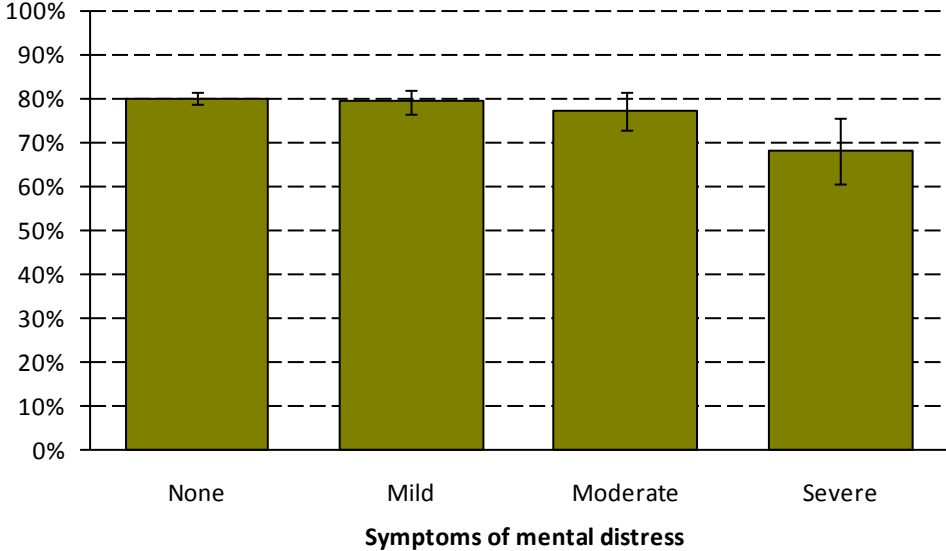
The proportion of people aged 18 years and over who reported voting in the last general election, as measured by the New Zealand General Social Survey.

¹⁴ Accessed 20 March 2011 from www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html

5.2.2 Findings

Overall, 79 percent of people reported voting in the last general election. People with mild or moderate symptoms of mental distress were as likely to report voting (mild 79 percent and moderate 77 percent). However, people with severe symptoms of mental distress (68 percent) were significantly less likely to report voting than people with no symptoms of mental distress.

Figure 11: Reported voting in the last general election by symptoms of mental distress, 2008

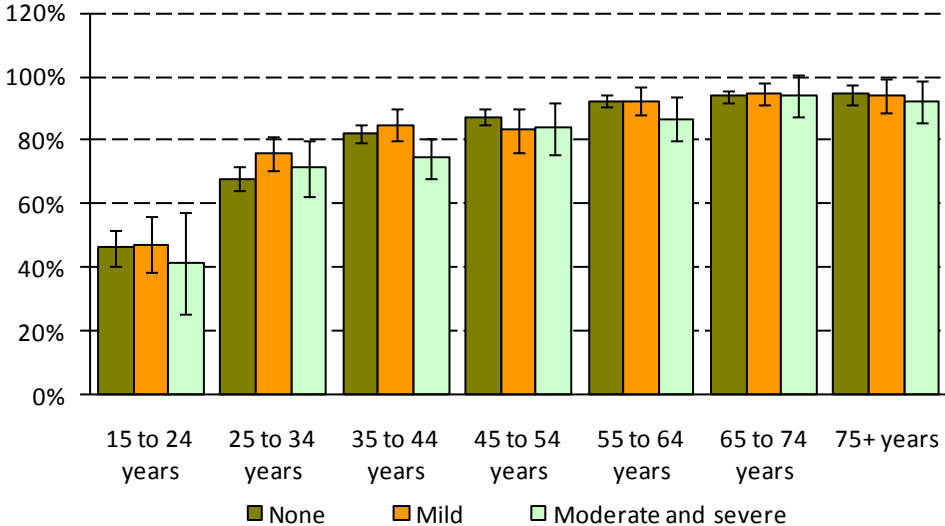


Source: Statistics New Zealand, New Zealand General Social Survey

Females (81 percent) were more likely to have reported voting in the last general election than males (78 percent). Across the mental health groupings, there was only one sex difference, and this was in the 'mild' group, with females (83 percent) more likely to report voting than males (75 percent) with mild symptoms of mental distress.

There was a general trend across the population for older people to be more likely to report voting in the last general election. This ranged from 46 percent of those aged 15–24 years to 93 percent of people 75 years or older. There were no significant differences in reported voting rates by severity of mental distress among each age group, except for those aged 35–44 years, where those with severe symptoms are significantly less likely to report voting in the last general election.

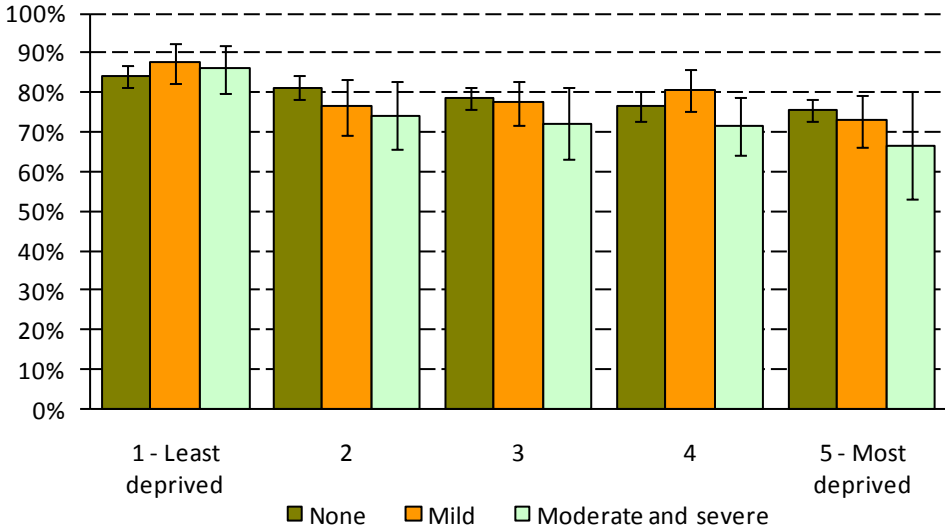
Figure 12: Reported voting in the last general election by symptoms of mental distress and age group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

All ethnicities had equal rates of reporting voting in the last general election regardless of severity of symptoms of mental distress. The one exception was the significant difference between European/Other people with no symptoms of mental distress voting (83 percent) and moderate or severe symptoms (76 percent).

Figure 13: Reported voting in the last general election by symptoms of mental distress and NZDep2006, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

Reporting voting in the last general election and deprivation index had a weak relationship across each grouping of symptoms of mental distress, with participation in national elections decreasing with the increase in the level of deprivation.

5.3 Perceived discrimination

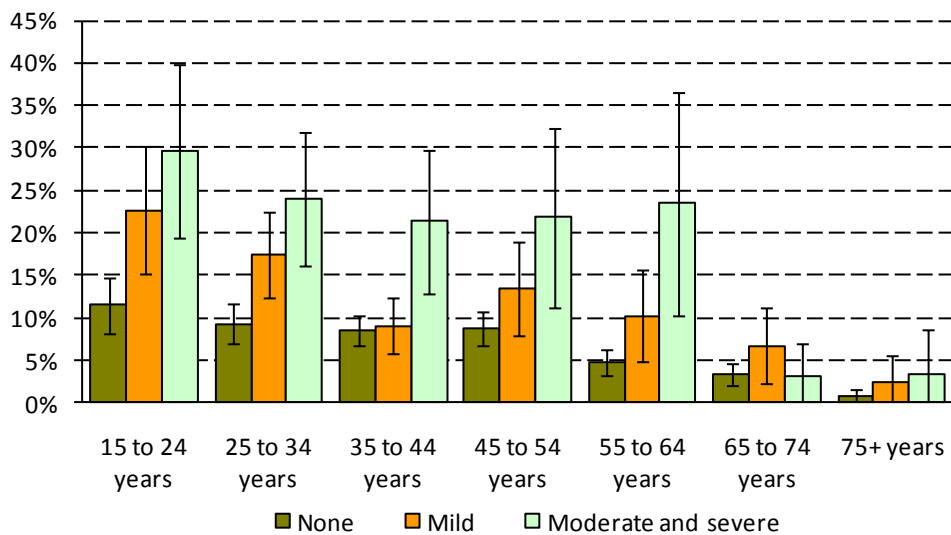
5.3.1 Measure

The proportion of people aged 15 years and over who feel that they have been treated unfairly or had something nasty done to them in the past year because of the group they belong to or seem to belong to,¹⁵ as measured in the New Zealand General Social Survey.

5.3.2 Findings

People with symptoms of mental distress are more likely to feel that they have been discriminated against in the past year than people with no symptoms. In 2008, 7.6 percent of people with no symptoms of mental distress felt they had been discriminated against in the past year, compared with 14 percent for people with mild symptoms, 20 percent with moderate symptoms and 27 percent with severe symptoms. All these differences were significant except for the difference between people with moderate and severe symptoms of mental distress.

Figure 14: Felt treated unfairly or had something nasty done to them in the past year because of the group they belong to by symptoms of mental distress and age group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

People with symptoms of mental distress did not only feel that they were discriminated against because of their mental health. The most common reasons for discrimination were nationality, race or ethnic group (37 percent), skin colour (36 percent) and health and disability issues (14 percent). The most common situations in which perceived discrimination occurred were in workplaces (41 percent) and 'public places' (32 percent).

¹⁵ The fact that someone feels that they have been discriminated against does not always mean that they have been, therefore this indicator refers to perceived discrimination rather than simply discrimination.

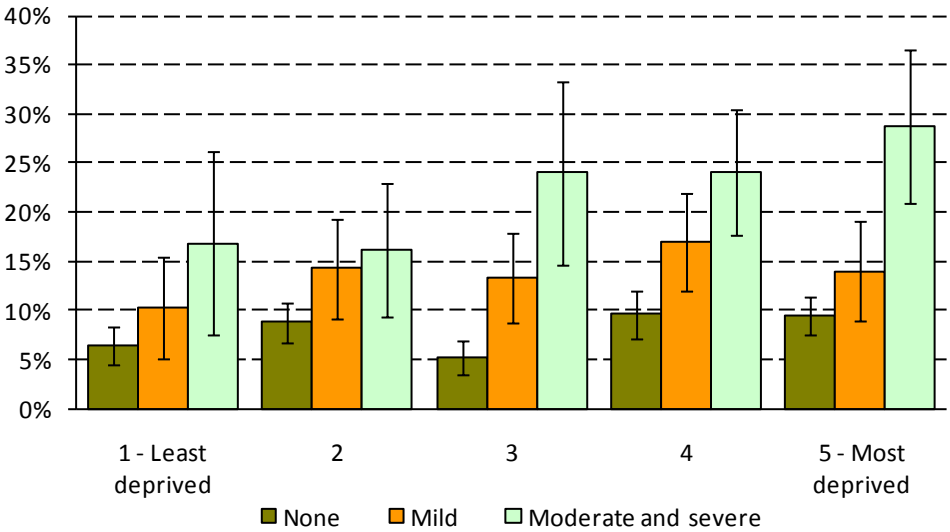
Males reported more discrimination than females, but this difference was not significant. The largest sex difference was between men and woman with severe symptoms of mental distress (men 38 percent and women 20 percent).

Youth aged 15–24 years reported more discrimination than older people across all symptoms of mental distress groups. Perceived discrimination was weakly associated with age, with older people being less likely to report being discriminated against. People aged 35–44 years with severe symptoms of mental distress were significantly more likely to feel they had been discriminated against than other people in this age group.

Māori (35 percent) and Asian (45 percent) were more likely to report feeling discriminated against than European/Other people (17 percent) if they had moderate or severe symptoms of mental distress. There is a similar trend among people with no symptoms of mental distress (12 percent for Māori, 20 percent for Asian and 5.6 percent for European/Other).

There were no significant differences in the rates of perceived discrimination across areas of neighbourhood deprivation for people with moderate and severe symptoms, ranging from 17 percent in the least deprived neighbourhoods to 29 percent in the most deprived areas. This was also the case for people with mild symptoms of mental distress, ranging from 10 percent in the least deprived neighbourhoods to 14 percent in the most deprived neighbourhoods.

Figure 15: Felt treated unfairly or had something nasty done to them in the past year because of the group they belong to by symptoms of mental distress and NZDep2006 quintile, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

6 Safety

6.1 Why is this life domain important?

Feeling safe and secure is a basic human right and important to an individual's social wellbeing. Feeling unsafe hinders social inclusion by hindering relationships and social connection. Safety is freedom from physical or emotional harm and freedom from the threat or fear of harm or danger. Physical injury causing pain and incapacity reduces victims' enjoyment of life and their ability to do things that are important to them, while psychological effects may go on long after physical scars have healed (Ministry of Social Development, 2008). The main reasons for feeling unsafe¹⁶ are due to people who feel dangerous to be around (40 percent), rising crime rates and increases in crime reporting in the media (34 percent), youth problems (24 percent) and alcohol and drug problems (23 percent) (ACNielsen, 2009).

A 2009 survey by AC Nielsen found that the perception of safety, whether it was walking alone after dark or visiting the city centre, was associated with distinct differences between different ethnicities, sexes, ages and socioeconomic status. For example, six in 10 New Zealand residents (62 percent) feel fairly safe or very safe walking alone in their neighbourhood after dark yet this was not the case for low-income earners (those earning \$20,000 or less) who are much less likely to feel safe (42 percent).

There is a context to safety. It is a combination of unique experiences – where we were raised, whether we are male or female and how much money we have and therefore which neighbourhood we live in. These different experiences of safety in the wider community also point to the possible differences in how mental health and addiction consumers experience safety. Mental health issues may increase the vulnerability of an individual in becoming a victim of crime, including theft, property crime and harassment in the community. Research has found that people with mental illness are more likely to be the victims of crime rather than the perpetrators of crime. Moreover, the strongest risk factors for violence are not attributable to mental illness or substance abuse but a past history of violence (Mental Health Commission, 2002, 2005).

Belonging is a two-way process that depends on relations characterised by safety, security and trust. (Bromell & Hyland, 2007, p.13)

Without a basic sense of security, there is little opportunity for growth (including personal growth in recovery) and progress. When people are victims of crime, especially violent crime, there is a sense of transgressions that impacts on a person's physical and mental health (Ministry of Social Development, 2008). People may find themselves withdrawing and having retraumatising memories of the crime. This is likely to have an adverse affect on a person's recovery from mental illness or addiction.

¹⁶ Based on a questionnaire about feeling unsafe in the city centre after dark.

6.2 Victims of crime

6.2.1 Measure

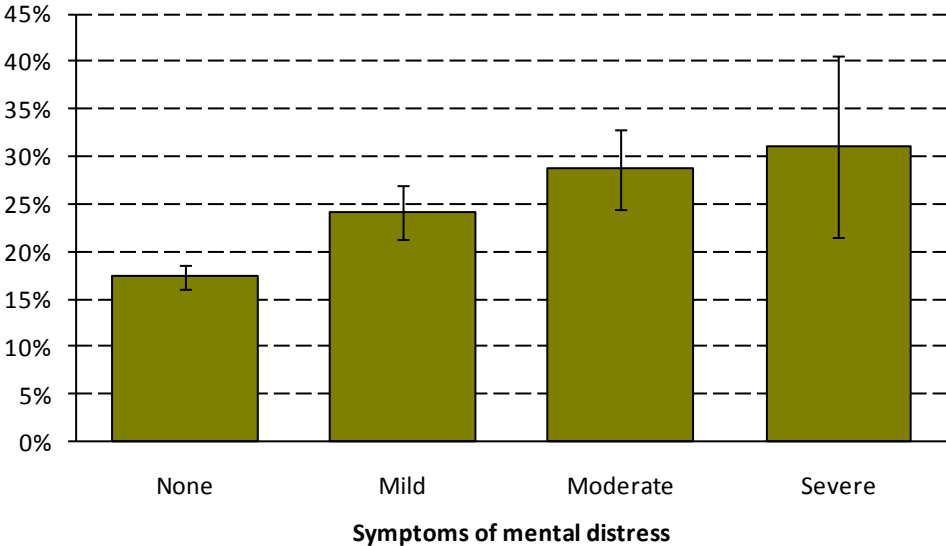
Proportion of people who reported having a crime committed against them in the past year, as measured in the New Zealand General Social Survey.

6.2.2 Findings

People with symptoms of mental distress were more likely than those with no symptoms to report having a crime committed against them in the past year. In 2008, 17 percent of people with no symptoms of mental distress reported having a crime committed against them in the past year, compared with 24 percent of people with mild symptoms, 29 percent with moderate symptoms and 31 percent with severe symptoms.

There are no significant differences between people with or without symptoms of mental distress when considering those who reported having a violent crime committed against them in the past year.

Figure 16: Reported having a crime committed against them in the last year by symptoms of mental distress, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

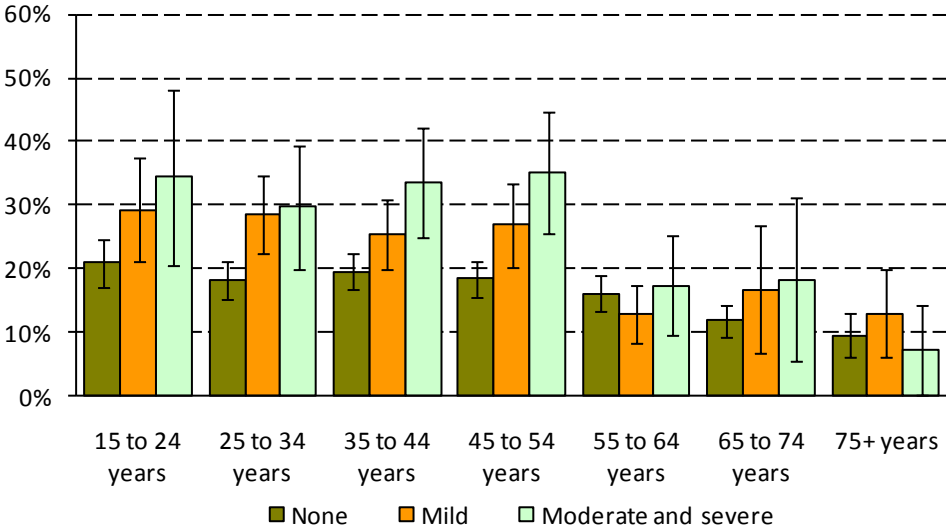
There are no significant differences between males and females in the proportion of people who reported having a crime committed against them in the past year, even when symptoms of mental distress are taken into account.

Overall, the proportion of people who reported having a crime committed against them in the past year was similar for those aged 15–54 years and then decreases for older people. This trend generally holds true for people with symptoms of mental distress (Figure 17).

For people aged 15–54 years, those with symptoms of mental distress were more likely than those with no symptoms to report having a crime committed against them in the

past year. However, this is not the case for people aged 55 years and over, where there is no significant difference between those people with symptoms of mental distress and those with no symptoms.

Figure 17: Reported having a crime committed against them in the last year by symptoms of mental distress and age group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

Among people with moderate or severe symptoms of mental distress, there is no significant difference between ethnic groups. However, for people with mild symptoms of mental distress, Pacific people (5.1 percent) are less likely than Māori (28 percent), Asian (26 percent) and European/Other (25 percent) to report having a crime committed against them in the past year. The same holds true for people with no symptoms of mental distress.

Among Pacific people and Asians, there was no significant difference between people with varying symptoms of mental distress in reporting having a crime committed against them in the past year. Māori and European/Other with moderate or severe symptoms of mental distress were more likely than people with no symptoms to report having a crime committed against them in the past year.

In general, there was no association between the level of neighbourhood deprivation and reporting having a crime committed against them in the past year. This holds true even after symptoms of mental distress are accounted for.

7 Cultural identity

7.1 Why is this life domain important?

Culture is related to the way we see the world, how we relate to others and our ways of behaving. Culture shapes our values and beliefs, which are, often unconsciously, incorporated into our daily lives. In essence, culture is a way of organising collective responses to a range of human needs, from our most basic – food, dress, and shelter – through to relationships, family kinship patterns and our societal institutions (Cross, 2003).

We only need to look at Abraham Maslow's hierarchy of needs to see that food, safety, and security, love and belonging, esteem and identity and self-actualisation are all shaped by culture. (Cross, 2003)

New Zealand Aotearoa has its own unique history and culture, with the main ethnic groups being European 68 percent, Māori 15 percent, Asian 9.2 percent and Pacific people 6.9 percent (Statistics New Zealand, 2006). Of particular importance are our obligations under Te Tiriti o Waitangi (and the articles of Kawanatanga, Tino Rangatiratanga and Oritetanga) and the acknowledgement that the expression of cultural identity is key to te ao Māori or a Māori worldview.

Culture is of interest in the lives of people with experience of mental illness, as often the pathway of recovery involves (re)acknowledging, (re)claiming or even refuting one's cultural past and deciding on a future path. For Māori and other collective cultural groups (such as Chinese, Indian, Pacific and African peoples), culture is a key driver of social inclusion, with many social activities being marae-based or organised around specific cultural practices (for example, kapa haka, tangi).

Dominant culture also provides ways of understanding which behaviours are socially acceptable or 'normal', with these prevailing views instilled within our institutions – including our mental health system. Therefore, it is important to acknowledge that, for people with experience of mental illness who are often marginalised in society, culture can be an important indicator in assessing whether people are able to feel like they are a part of a wider culture and society.

7.2 Expressing identity

7.2.1 Measure

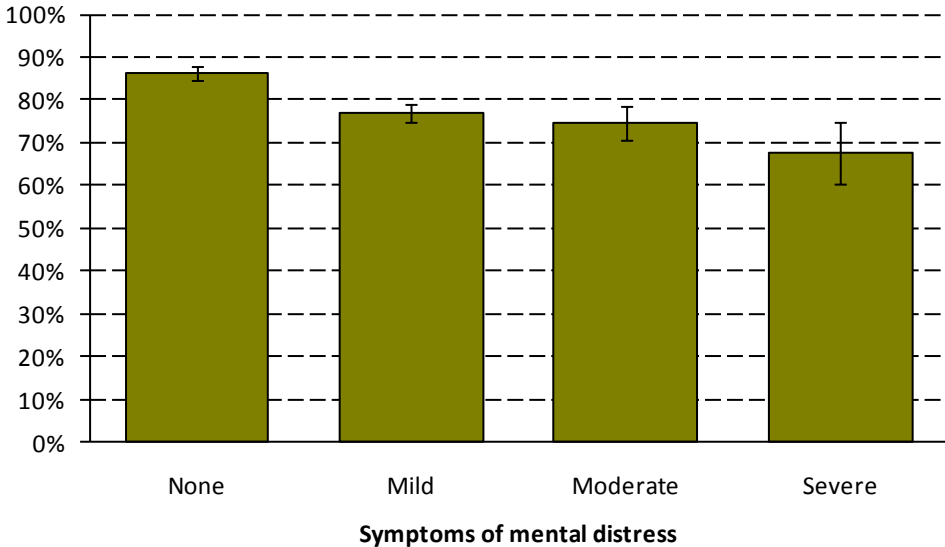
The proportion of people aged 15 years and over who report finding it 'easy' or 'very easy' to express their own identity¹⁷ in New Zealand, as measured in the New Zealand General Social Survey.

¹⁷ Statistics New Zealand defines identity as comprising of a set of distinct characteristics including traditions, values and shared activities that set apart a person or a social group. People can have more than one identity. A Statistics New Zealand analysis of survey responses shows that people are thinking of a range of things in relation to identity, including age, religion, culture, country of birth, language, sexual orientation, ethnicity and sex.

7.2.2 Findings

People with symptoms of mental distress were significantly more likely to find it difficult to express their identity in New Zealand. However, the level of severity was not a significant contributor to this. All people with symptoms of mental distress reported significantly lower rates of ability to express their identity – mild 78 percent, moderate 76 percent and severe 69 percent. People with no symptoms were more likely to find it easier to express their identity (85 percent).

Figure 18: Found it ‘easy’ or ‘very easy’ to express their identity in New Zealand by symptoms of mental distress, 2008



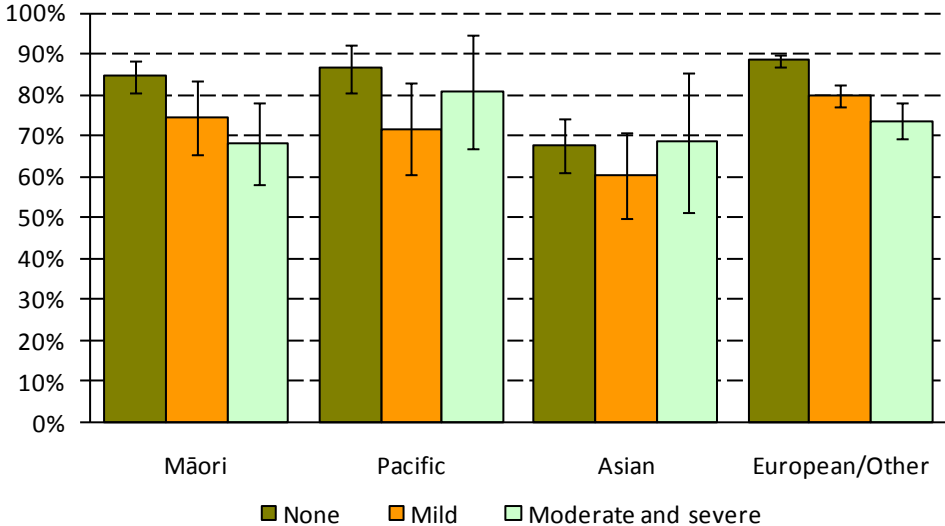
Source: Statistics New Zealand, New Zealand General Social Survey

There was no significant difference between sexes in this indicator – expressing identity for people with symptoms of mental distress was equitable for females and males.

Young people aged 15–24 years did not feel impeded in expressing their identity when they had symptoms of mental distress, although the youth age group found it the least easy to express their identity. The general trend was that the ease of identity expression increased with age. However, there was much variability among those with severe symptoms of mental distress where there is no clear association with age at all.

Asian people reported being less able to express their identity than other ethnic groups – 68 percent of Asians with no symptoms of mental distress reported being able to easily express their identity, compared with 60 percent mild and 68 percent moderate or severe. For Māori, the ability to express identity was rated the highest for those with no symptoms of mental distress but only significantly so in comparison to Māori with moderate or severe symptoms of mental distress.

Figure 19: Found it 'easy' or 'very easy' to express their identity in New Zealand by symptoms of mental distress and ethnic group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

For people with severe symptoms of mental distress, expressing their identity was significantly easier for people living in the least deprived neighbourhoods (83 percent), compared with people living in the most deprived neighbourhoods (50 percent). This was not found for people with mild or moderate symptoms.

8 Leisure and recreation

8.1 Why is this life domain important?

The common proverb ‘all work and no play...’ alludes to the importance given culturally in New Zealand (and overseas) to the benefits of taking part in leisure and recreation activities. Involvement in leisure activities is associated with improvements in physical and mental health, which can lead to fewer health problems and higher productivity at work and contribute to people’s overall quality of life (Ministry of Social Development, 2008).

Recreation also encourages personal growth, self-expression and increased learning opportunities and adds meaning to individual and community life. Furthermore, recreation and leisure are important to enhancing social inclusion and wellbeing by providing people a sense of identity and personal autonomy (Ministry of Social Development, 2008).

The benefits for mental health are equally important. Leisure and recreational activities are central to the effective management of stress (Iwasaki, Zuzanek & Mannell, 2001) – not only the demonstrated links between regular physical activity and symptoms of mild or moderate depression, stress and anxiety, but also the creativity and chance for self-expression provide an outlet that supports feelings of wellbeing (Ministry of Social Development, 2008). The lack of time to take part in social activities has been associated with poor mental health.

8.2 Free-time activities

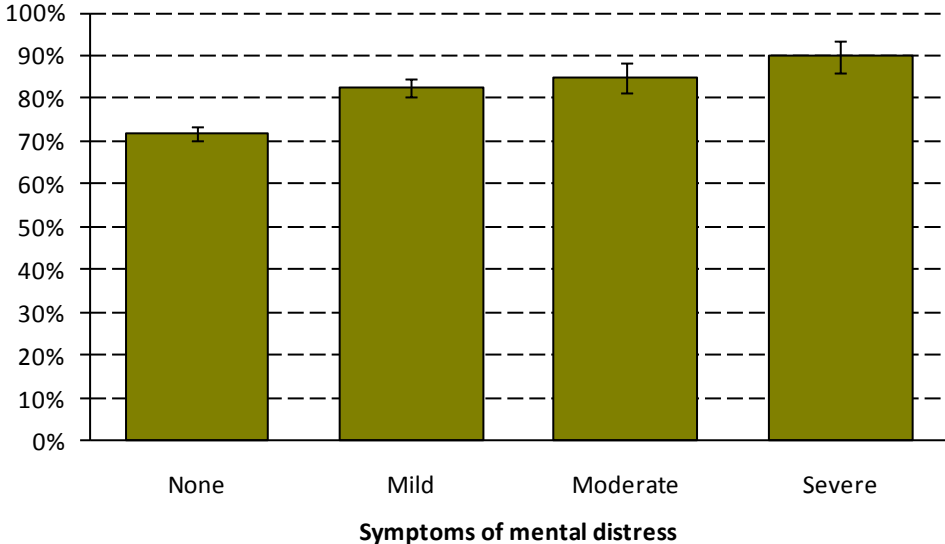
8.2.1 Measure

The proportion of people aged 15 years and over who report that there are free-time activities or interests they would like to do but can’t or there are free-time activities or interests they would like to be able to do more of, as measured in the New Zealand General Social Survey.

8.2.2 Findings

People with symptoms of mental distress reported they had significantly more difficulty in doing free-time activities (mild 83 percent, moderate 85 percent and severe 90 percent) than people with no symptoms (72 percent).

Figure 20: Would like to do, or do more of, any free-time activities or interest by symptoms of mental distress, 2008



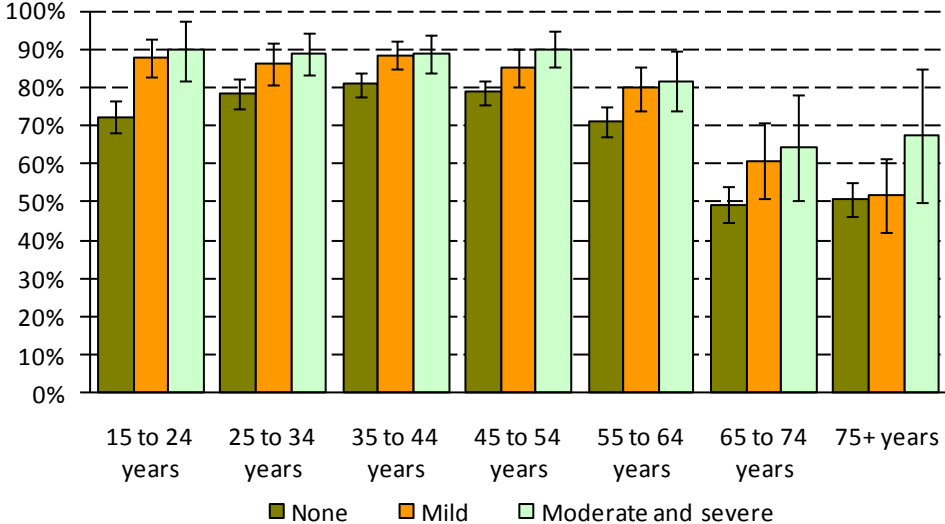
Source: Statistics New Zealand, New Zealand General Social Survey

Males (74 percent) were more likely to find it difficult to do free-time activities than females (69 percent) for those with no symptoms of mental distress. Amongst those with symptoms, there was no sex difference.

Ability to participate in free-time activities generally decreased with age for those with no or mild symptoms of mental distress. A similar decrease was seen for people with moderate or severe symptoms but to a less noticeable effect.

For young people aged 15–24 years, symptoms of mental distress created a significantly higher likelihood in having difficulty with participating in free-time activities (none 72 percent, mild 88 percent, moderate or severe 90 percent). For people aged 35–44 years, the only significant difficulty with free-time activities was found amongst those with severe symptoms.

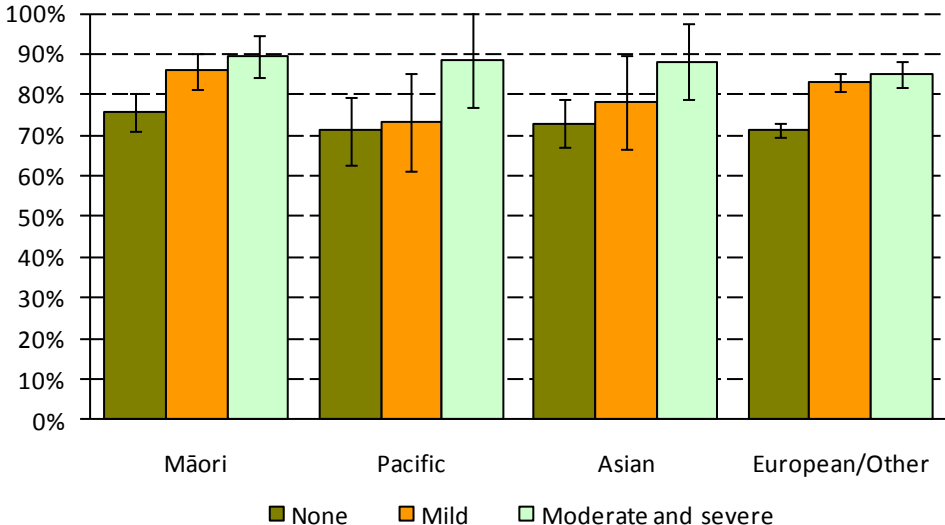
Figure 21: Would like to do, or do more of, any free-time activities or interest by symptoms of mental distress and age group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

Each ethnic category in the data showed the upward trend but most significantly for Pacific peoples (none 71 percent, mild 73 percent and moderate or severe 89 percent). There was no association between ethnicity and their ability to participate in free-time activities. However, on average, Māori had the most difficulty in participating in free-time activities.

Figure 22: Would like to do, or do more of, any free-time activities or interest by symptoms of mental distress and ethnic group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

There was no significant difference between groups when taking into account their level of neighbourhood deprivation, not even between people with mild and severe symptoms of mental distress across the levels of neighbourhood deprivation.

9 Knowledge and skills

9.1 Why is this life domain important?

Knowledge and skills enhance people's ability to meet their basic needs, widen the range of options open to them in every sphere of life, and enable them to influence the direction their lives take. (Ministry of Social Development, 2008, p.34)

New Zealanders need knowledge and skills to participate fully in society and ensure that "lifelong learning and education are valued and supported [and that] people have the necessary skills to participate in a knowledge society" (Ministry of Social Development, 2004, p.20). We increasingly live in a time in which managing vast amounts of information and our technological abilities require a level of proficiency never before experienced in human history. Education and training as well as the acquisition of new skills are in high demand for good employment outcomes. A basic level of literacy is also important for a person's ability to self-advocate (including advocacy through mental health services).

As a proxy for knowledge and skills, this publication examines educational attainment, as this has been effectively used to measure this area of life and is highly correlated with better quality of life, including subjective wellbeing, better physical health, increased employment opportunities, financial independence and higher socioeconomic status (Scott, 2010).

The Human Rights Commission reports systemic disparities in education and training for people with disabilities. Furthermore, a New Zealand survey of discrimination found that 21 percent (n=785) of people with a mental illness experienced discrimination while attending an education or training course, including refusal of entry and lack of support (Peterson et al., 2004).

9.2 Educational attainment

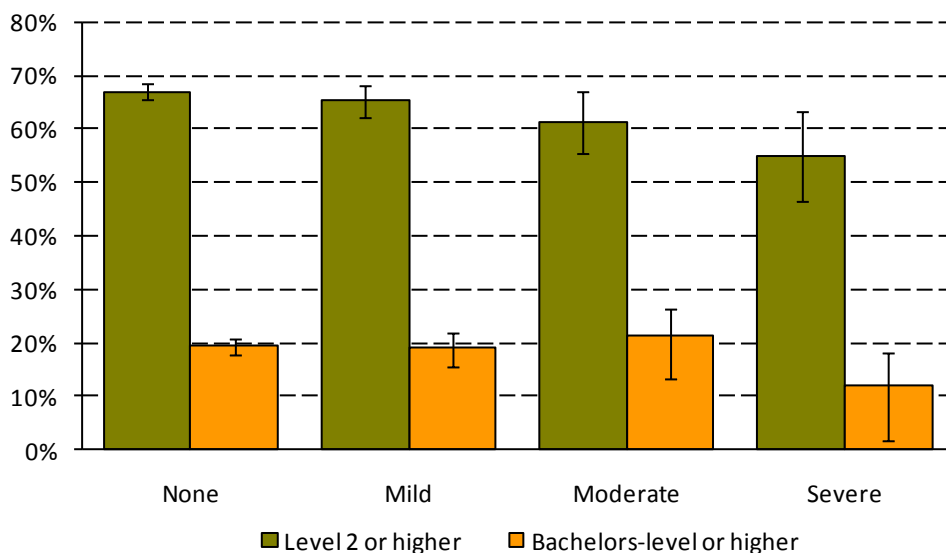
9.2.1 Measure

The proportion of people aged 15 years and over with an educational attainment of at least a level 2 qualification and including tertiary qualifications at bachelor's level and above, as measured in the New Zealand General Social Survey.

9.2.2 Findings

People with severe symptoms of mental distress (55 percent) were significantly less likely than people with no symptoms (67 percent) to have gained a level 2 or higher educational qualification. Also, people with severe symptoms of mental distress (12 percent) were significantly less likely have attained a bachelor's level or higher qualification than people with no symptoms (20 percent).

Figure 23: Educational attainment of people aged 15 years and over by symptoms of mental distress, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

There was a high proportion of males with moderate symptoms of mental distress (29 percent) who attained a bachelor’s level or higher qualification, significantly higher than all other groups. However, this was the only pattern of sex differences in educational attainment.

Youth (aged 15–24 years) were less likely to have attained a level 2 qualification or higher, and people aged 25–34 years had the highest average rates (significantly so for people with mild and moderate symptoms), after which rates decreased over the age groups.

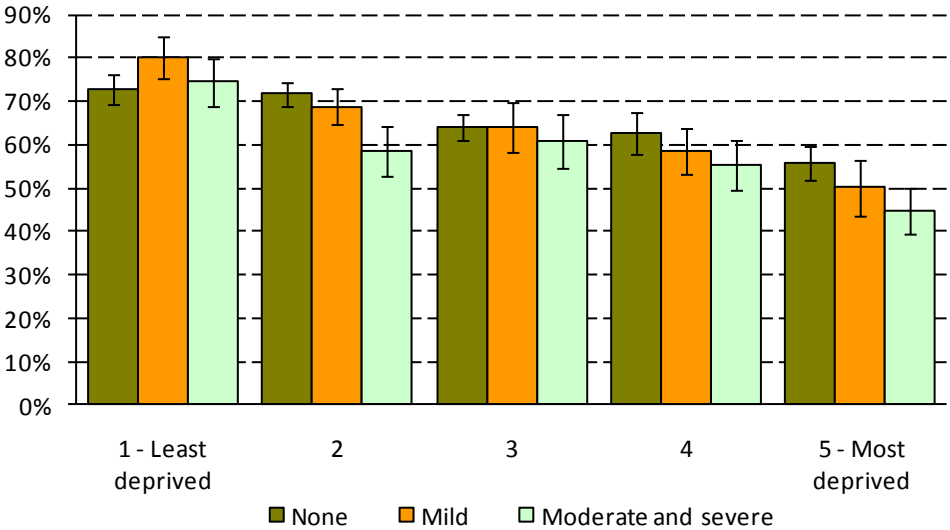
People with moderate symptoms of mental distress had the highest rate of attaining a bachelor’s level or higher qualification in the 45–54 age range, which is significantly different than the population trend of those aged 15–24 years rating the highest in degree qualifications. Those with severe symptoms of mental distress also had the highest rates of degree qualification in the 45–44 age range. Interestingly, this was followed by those in the 55–64 age range.

In general, Asians had the highest rates of level 2 or higher qualification attainment, and this was significantly so across all levels of symptoms of mental distress. Among ethnic groups, there were no significant differences in the attainment of level 2 or higher qualifications across the levels of symptoms of mental distress.

However, the rates of earning a bachelor’s level or higher qualification show a much less positive view when looking at ethnicity. Asians are significantly more likely to earn a bachelor’s level or higher qualification across all symptoms of mental distress. European/Other are also more likely than Pacific people of Māori to have attained a bachelor’s level or higher qualification. Māori with moderate or severe symptoms of mental distress fared the worst across all groups, with only 6.2 percent attaining a bachelor’s level or higher qualification.

People in the least deprived areas were significantly more likely to gain a level 2 or higher qualification. For people with any symptoms of mental distress, this pattern is also present. For people who live in the least deprived neighbourhoods, there is no significant difference in the attainment of level 2 or higher qualifications across symptoms of mental distress (Figure 24).

Figure 24: Attained a level 2 or higher educational qualification by symptoms of mental distress and NZDep2006 quintile, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

The general pattern across the population is that degrees are more likely to be attained in the least deprived neighbourhoods. It was found that, in the least deprived neighbourhoods, severity of symptoms of mental distress was positively associated (although not significantly) with the increased attainment of bachelor’s level or higher qualifications – no mental distress 24 percent, mild 28 percent and moderate and severe 36 percent.

10 Employment

10.1 Why is this life domain important?

Our workplaces are not just sites for daily routines that support our financial means – they are also places in which we can exert our skills and develop our interests and talents. Employment connects us socially through our interactions and often results in the formation of relationships and social support.

Working is an intimate experience; it sustains a sense of being and, within our culture, it identifies a contributing member of society. (Marrone & Golokwa, 1999, p.192)

However, jobs with poor working conditions can erode health and wellbeing (Leach et al., 2010). Moreover, for many people with mental health and addiction issues, employment may often be in low-paid unsatisfying jobs. Unemployment figures for people with mental illness are the highest of any disability group (Jensen et al., 2005). The latest available figures on employment rates showed only 44 percent of people with a mental illness are employed, with 27 percent of these workers employed in full-time roles (Jensen et al., 2005).

Social inclusion interventions have identified workplaces as an important site for addressing stigma in which, under certain criteria,¹⁸ a person who has experienced a mental illness works alongside others to address stigmatising views and discriminatory actions commonly experienced by people with mental distress (Case Consulting, 2005).

10.2 Employment and job satisfaction

10.2.1 Measure

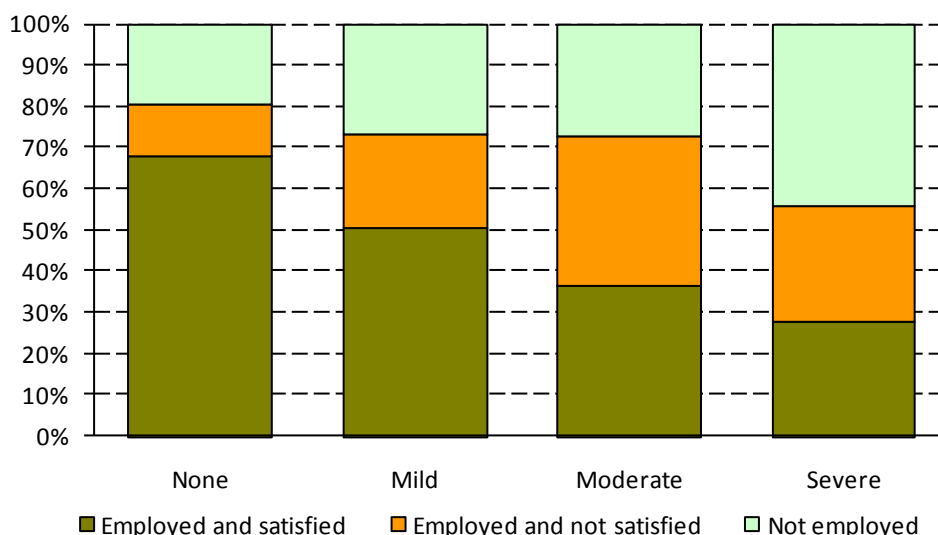
The proportion of people aged 15–64 years who are employed and have been satisfied with their job in the last 4 weeks, as measured in the New Zealand General Social Survey. This measure combines the objective measurement of people being employed and the subjective measurement of job satisfaction to provide an indicator of good working conditions.

10.2.2 Findings

People with symptoms of mental distress are less likely to be employed and be satisfied with their job in the last 4 weeks than people with no symptoms of mental distress (68 percent for those with no symptoms, 51 percent for mild symptoms, 36 percent for moderate symptoms and 27 percent for severe symptoms). The difference between each group was significant (except between moderate and severe), showing a clear negative relationship between severity and job satisfaction. There was an almost 40 percentage point variation between people with no symptoms of mental distress that experienced good satisfying jobs and those with severe symptoms.

¹⁸ For example, when working collaboratively on a task in which the people involved have equal status.

Figure 25: Employment status by symptoms of mental distress, 2008



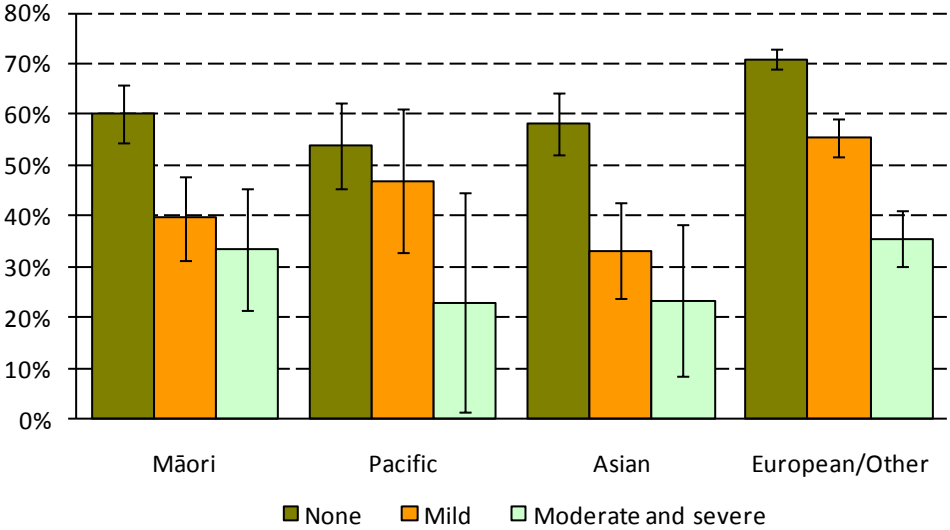
Source: Statistics New Zealand, New Zealand General Social Survey

For people with no symptoms of mental distress, there was a sex difference in the likelihood that you will be employed in a ‘satisfying’ job in the last 4 weeks, with males (71 percent) rating significantly higher than females (64 percent). This sex difference was not found for mild, moderate or severe groupings.

In general, older people are more likely than younger people to be employed and be satisfied with their job in the last 4 weeks, although there is a decline in ratings for people aged 55 years or older. However, this trend was not the case for people with moderate or severe symptoms of mental distress where there is an increase in one age group (for example, 15–24 and 35–44 years) followed by a decrease in job satisfaction in the next age group (for example, 25–34 and 45–54 years). Over most of the age groups (25–34 years, 35–44 years and 45–55 years), people with even mild symptoms of mental distress will experience substantially less job satisfaction than people with no symptoms. People with moderate and severe symptoms are even less likely to be employed and satisfied in their job, which is of statistical significance in the 25–34, 45–54 and 55–64 age groups.

Māori with no symptoms of mental distress (60 percent) had significantly higher rates of job satisfaction than Māori with mild (40 percent) or moderate or severe (33 percent) symptoms. For Pacific people, there was no significant difference across severity of symptoms. This was the complete opposite for European/Other people, with significant differences found between each level of severity – none 71 percent, mild 55 percent and moderate and severe 36 percent.

Figure 26: Employed and have been satisfied with their job in the last 4 weeks by symptoms of mental distress and ethnic group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

There was a pattern for job satisfaction to decrease as neighbourhood deprivation increased. This was most clearly seen when comparing people with no symptoms of mental distress from the most deprived neighbourhoods (59 percent) with those from the least deprived neighbourhoods (70 percent). For people with mild, moderate or severe symptoms, neighbourhood deprivation had no significant effect on how satisfying a job one had. In the least deprived neighbourhoods, people with moderate or severe symptoms fared significantly worse than their community peers.

11 Standard of living

11.1 Why is this life domain important?

Standard of living involves access to resources such as food, clothing and housing that are fundamental to participation in society and a sense of wellbeing (Ministry of Social Development, 2008). Times of economic prosperity are associated with higher rates of wellbeing across a population and are known to lead to greater social connectedness, educational advancement, wider employment options and increased life expectancy.

Housing is a basic human need, fundamental to social inclusion. However, housing problems such as cool temperatures, damp and humidity are strongly associated with health problems (Howden-Chapman et al., 2006). Overall housing satisfaction is a summary subjective measure of the quality of housing that people are currently living in.

Despite recent improvements in housing policy, there is evidence that people with on-going serious mental health issues are still disadvantaged in terms of housing affordability, accessibility and quality (Ministry of Social Development, 2004). Moreover, there are issues such as little choice to live alone and discrimination when people with lived experience seek shared accommodation such as flatting. A survey in the UK found that 60 percent of respondents would not want to share a flat with someone with a mental health issue – three times more than if they had a physical illness (18 percent) (Mind, 2010). In New Zealand, the Mental Health Foundation found that 17 percent of people with experience of mental illness had been discriminated against in relation to housing (Peterson et al., 2004). For people with serious on-going mental health issues, stable housing is especially a major issue, with many people being supported in a 'group home' of supported accommodation, which may not raise levels of independence and wellbeing. There is a general trend to move towards supported tenancies and work with landlords to support people into their own home or achieve home ownership.

11.2 Economic standard of living

11.2.1 Measure

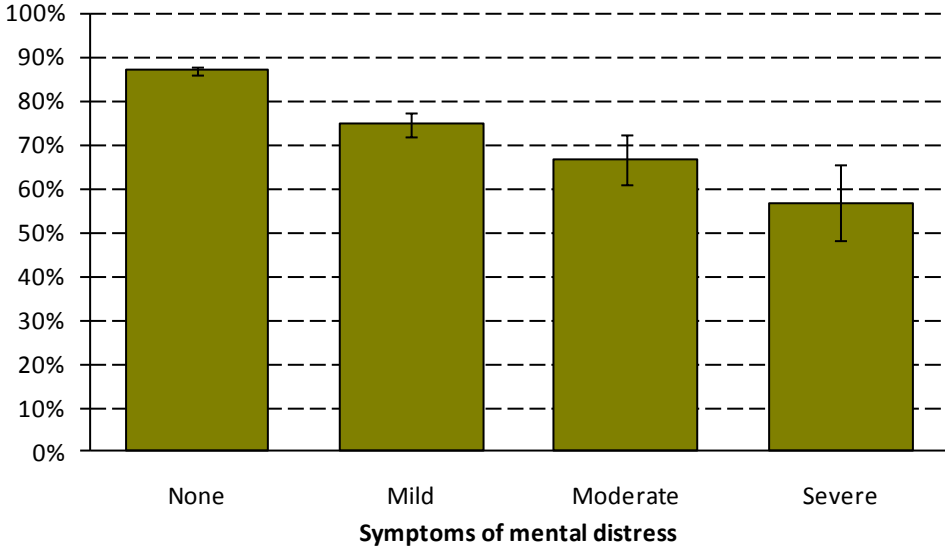
The proportion of people aged 15 years and over who scored 17¹⁹ or more on the Economic Standard of Living Index Short Form (ELSI_{SF}), as measured in the New Zealand General Social Survey.

11.2.2 Findings

People with symptoms of mental distress were less likely to have a 'fairly comfortable' or better standard of living than people with no symptoms (Figure 27). In 2008, 87 percent of people with no symptoms of mental distress had a 'fairly comfortable' or better economic standard of living, compared with 75 percent of people with mild symptoms, 67 percent with moderate symptoms and 57 percent with severe symptoms.

¹⁹ A score of 17 or more on the ELSI_{SF} relates to a 'fairly comfortable' or higher standard of living.

Figure 27: Proportion of people with a ‘fairly comfortable’ or higher economic standard of living by symptoms of mental distress, 2008

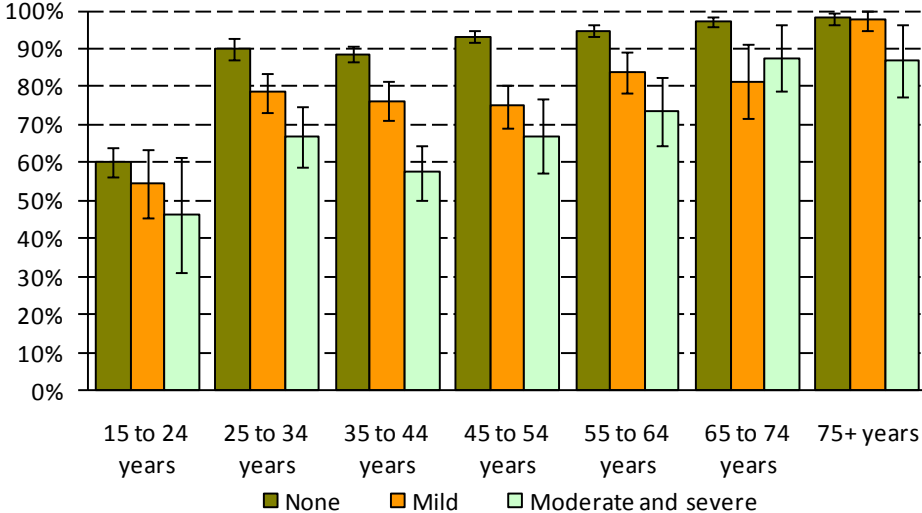


Source: Statistics New Zealand, New Zealand General Social Survey

Overall, males were more likely to have a ‘fairly comfortable’ or better standard of living than females. However, once levels of symptoms of mental distress are taken into account, there are no significant differences between male and females.

Younger people are less likely to have a ‘fairly comfortable’ or higher standard of living than older people (Figure 28). In 2008, 46 percent of people aged 15–24 years with moderate or severe symptoms of mental distress had a ‘fairly comfortable’ or higher economic standard of living, compared with 87 percent of people aged 65 years and over with moderate or severe symptoms.

Figure 28: Proportion of people with a ‘fairly comfortable’ or higher economic standard of living by symptoms of mental distress and age group, 2008

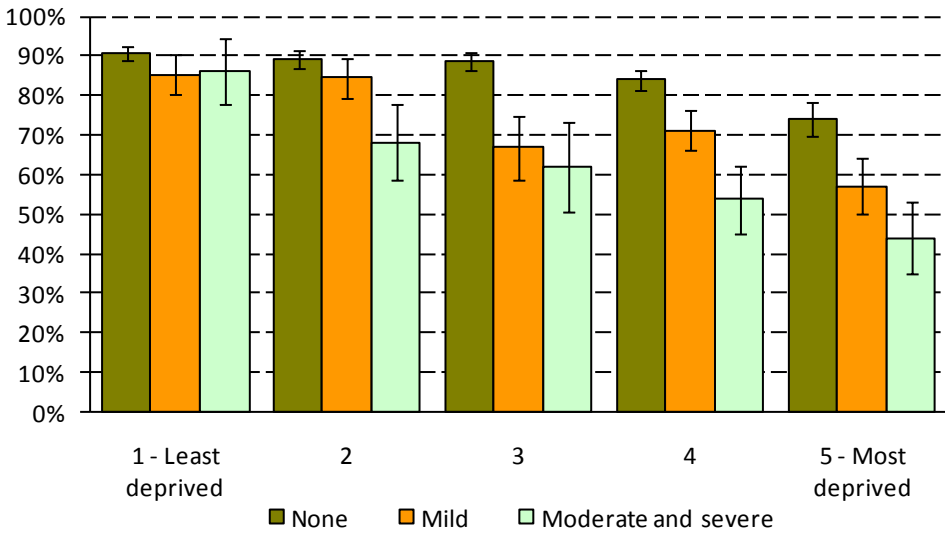


Source: Statistics New Zealand, New Zealand General Social Survey

Māori and Pacific people were less likely to have a ‘fairly comfortable’ or better standard of living than people from other ethnic groups. In 2008, 26 percent of Pacific people with moderate or severe symptoms of mental distress had a ‘fairly comfortable’ standard of living, compared with 42 percent of Māori with moderate or severe symptoms, 74 percent for Asians and 70 percent for European/Other.

For people living in the least deprived neighbourhoods, there was no significant difference between levels of symptoms of mental distress. However, for people living in the most deprived neighbourhoods, people with mild and moderate or severe symptoms of mental distress were less likely to have a ‘fairly comfortable’ or better standard of living than those with no symptoms.

Figure 29: Proportion of people with a fairly comfortable or higher economic standard of living by symptoms of mental distress and NZDep2006 quintile, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

11.3 Housing satisfaction

11.3.1 Measure

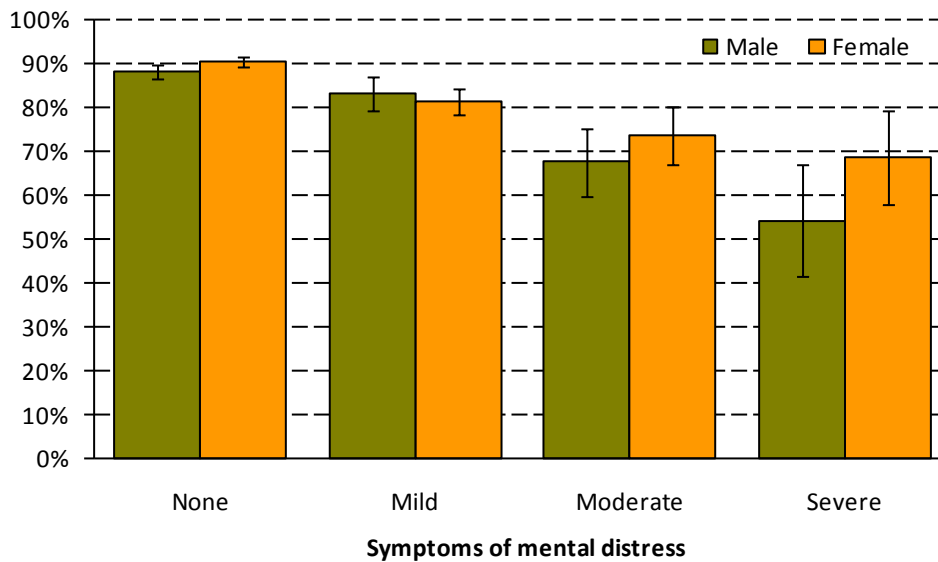
The proportion of people aged 15 years and over who are ‘satisfied’ or ‘very satisfied’ with the housing they are currently living in, as measured by the New Zealand General Social Survey.

11.3.2 Findings

People with symptoms of mental distress are less likely than people with no symptoms to be satisfied with the housing they are currently living in. In 2008, 89 percent of people with no symptoms of mental distress were satisfied with their current housing, compared with 82 percent for people with mild symptoms, 71 percent with moderate symptoms and 63 percent with severe symptoms.

In general, there is no difference in the levels of satisfaction with housing between males and females. This is also the case across all levels of severity of symptoms of mental distress (Figure 30).

Figure 30: Satisfaction with the housing currently living in by symptoms of mental distress and sex, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

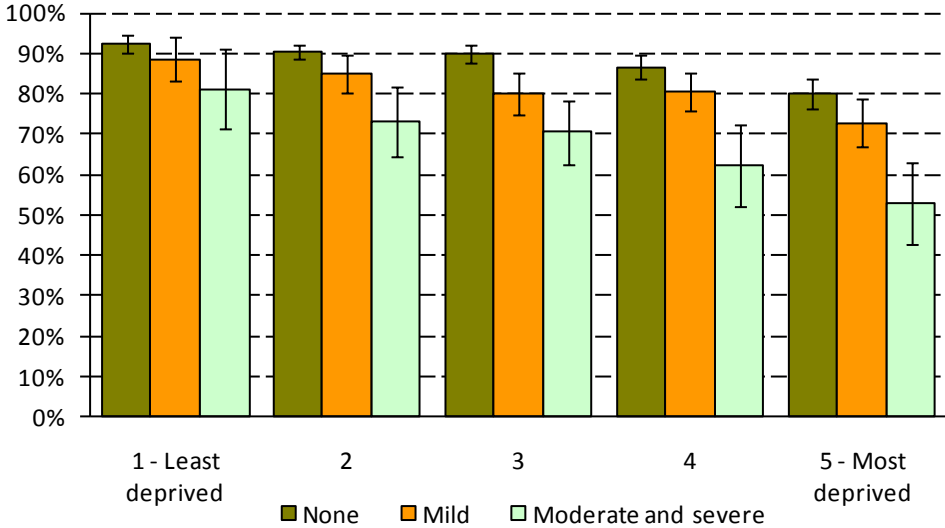
Across all age groups, people with moderate or severe symptoms of mental distress were less likely than people with no symptoms to report feeling satisfied with the housing they were currently living in. For people across all levels of severity of symptoms of mental distress, older people were more likely to be satisfied with the housing they were currently living in. In 2008, 96 percent of people with no symptoms reported feeling satisfied with the housing they currently lived in, compared with 95 percent with mild symptoms and 80 percent with moderate or severe symptoms.

Overall, Māori and Pacific people were less likely than other ethnic groups to report feeling satisfied with the housing they currently lived in. In 2008, 84 percent of Māori with no symptoms of mental distress reported feeling satisfied with the housing they currently lived in, compared with 81 percent with mild symptoms and 54 percent with moderate or severe symptoms. In 2008, 84 percent of Pacific people with no symptoms of mental distress reported feeling satisfied with the housing they currently lived in, compared with 74 percent with mild symptoms and 59 percent with moderate or severe symptoms.

People with moderate or severe symptoms of mental distress were less likely than people with no symptoms to report feeling satisfied with the housing they currently lived in across all levels of neighbourhood deprivation. However, the gap between the two levels of symptoms gets greater with the increase in neighbourhood deprivation (Figure 31).

In 2008, for people from the least deprived neighbourhoods, the gap between those with no symptoms and moderate or severe symptoms of mental distress was 11 percentage points. This compares with a gap of 27 percentage points for people from the most deprived neighbourhoods.

Figure 31: Satisfaction with the housing currently living in by experience of mental distress and NZDep2006 quintile, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

12 Transport

12.1 Why is this life domain important?

Our ability to get around is key to our physical and mental health, our economic prospects and our ability to engage with wider travel and cultural events that enhance our sense of wellbeing. The New Zealand Transport Strategy 2008 is aimed at ensuring that all New Zealanders have “an affordable, integrated, safe, responsive and sustainable transport system” (Ministry of Transport, 2008).

Access to public transportation ensures people are able to socially participate in their communities and workplaces and be a part of a productive society. Transport is more than the facilitation of the movement of people and goods – it also “significantly affects the social wellbeing of New Zealand and its people, as well as economic development and environmental sustainability” (Ministry of Social Development, 2007, p.52). Transport also prevents isolation and can help people overcome barriers to mobility.

12.2 Satisfaction with public transport

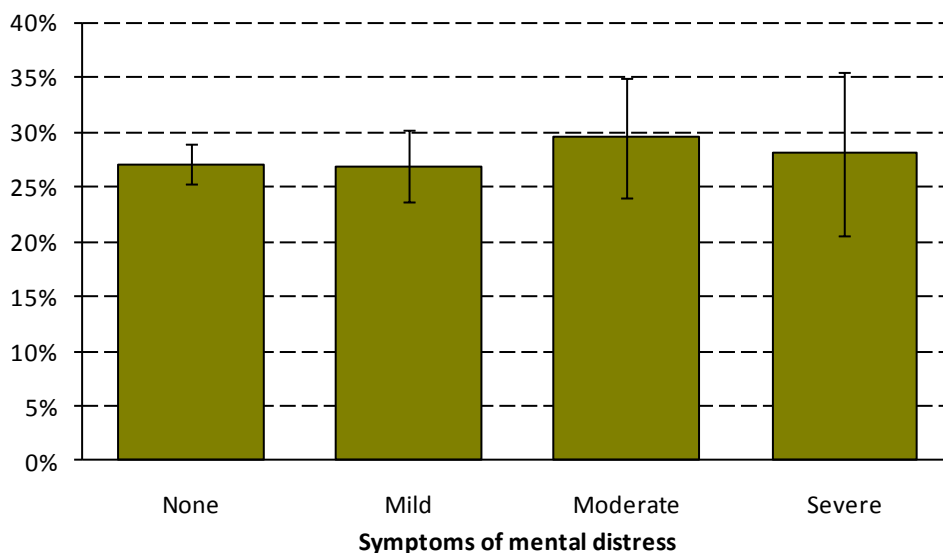
12.2.1 Measure

The proportion of people aged 15 years and over who have no access to or are dissatisfied with their access to public transport, as measured in the New Zealand General Social Survey.

12.2.2 Findings

In general, 27 percent of people reported having no access or limited access to public transport. This was not significantly different across symptoms of mental distress. There was no difference between females and males either.

Figure 32: No access or dissatisfied with access to public transport by symptoms of mental distress, 2008

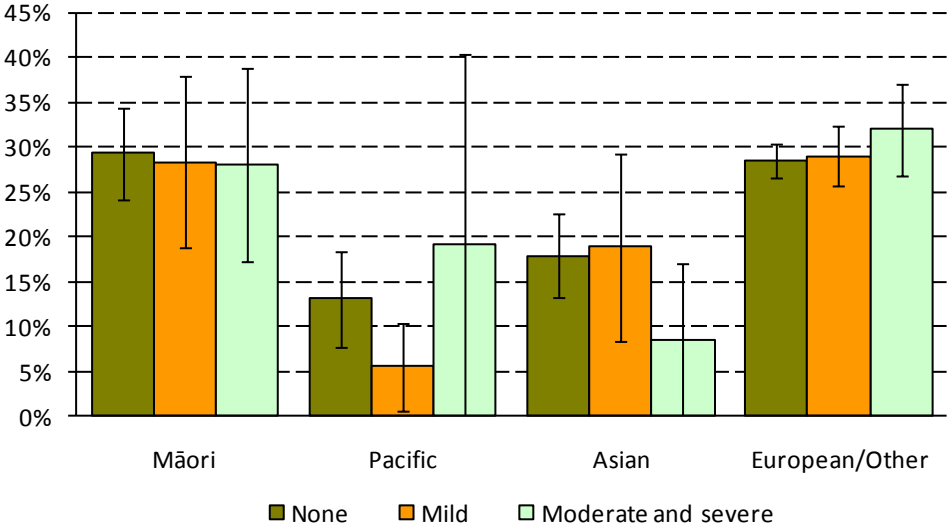


Source: Statistics New Zealand, New Zealand General Social Survey

Differences among age groups showed a few interesting facts, although these were not of statistical significance. For example, people with mild symptoms of mental distress aged 45–54 years reported the most dissatisfaction with public transport, and for people with moderate or severe symptoms, it was overwhelming those in the 35–44 age group closely followed by the 25–34 age group. Within the total New Zealand population, the highest rates of dissatisfaction were in the 45–54 age group, with age groups on either side decreasingly so.

Māori and European/Other had the highest levels of no access to or dissatisfaction with access to public transport and Pacific people and Asian had the lowest levels. Other than these difference between ethnicities, there was no ethnic difference by severity of symptoms of mental distress.

Figure 33: No access or dissatisfied with access to public transport by symptoms of mental distress and ethnic group, 2008



Source: Statistics New Zealand, New Zealand General Social Survey

Deprivation index was not associated with any difference in the response to access and dissatisfaction with public transport.

13 Conclusion

The determinants of mental health and wellbeing are influenced by a myriad of factors that lie outside the health sector. These include social and economic factors such as access to work, housing, education, goods and services, freedom from violence and discrimination, and supportive relationships. Together, these are the important ingredients in producing wellbeing within our communities. Social inclusion is not an ideal, but a fundamental human need. People need to have a sense of belonging and connection in order to function and make a contribution to society.

The purpose of producing this publication was to use the information to advocate for improved social inclusion for people with experience of mental distress and/or addiction. Although this publication helps to identify issues and trends, it does not provide solutions and it does not examine the lived experience from a qualitative perspective. However, alongside on-going data collated by the Commission and qualitative research, work across sectors by relevant agencies (such as those represented in MAG) will provide a clearer direction for national and regional strategies to increase recovery opportunities for all people impacted by mental health and addiction challenges.

This publication now provides a stable basis from which to provide on-going monitoring of the social inclusion of people who have experienced mental distress and/or addiction. It is intended that MAG will update this publication every 2 years.

References

- Advisory Committee on Official Statistics. (2009). *Good practice guidelines for the development and reporting of indicators*. Wellington: Statistics New Zealand.
- Aked, J., Marks, N., Cordon, C. & Thompson, S. (2008). *Five ways to wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being*. UK: New Economics Foundation.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- Amir, M., Lewin-Epstein, N. Becker, G. & Buskila, D. (2002). Psychometric properties of the SF-12 in a primary care population in Israel. *Medical Care*, 40, 918–928.
- Bromell, D. & Hyland, M. (2007). *Social inclusion and participation: A guide for policy and planning*. Wellington: Ministry of Social Development, Social Inclusion and Participation Group.
- Brown, D., Woolf, J. & Smith, C. (2010). *The determinants of subjective wellbeing in New Zealand: An empirical look at New Zealand's social welfare function*. Available from http://www.nzae.org.nz/conferences/2010/Papers/Session4/Brown_et_al__The_Determinants_of_Subjective_Wellbeing.pdf
- Brugha, T.S., Welch, S., Singleton, N., Lewis, G., Babbington, P.E., Jenkins, R. & Meltzer, H. (2005). Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout Great Britain. *Psychological Medicine*, 35, 705–714.
- Case Consulting. (2005). *The power of contact*. Wellington: Case Consulting.
- Chung, I. & Samperi, F. (2004). An east-west approach to serving migrants in a mental health setting. *Journal of Immigrant and Refugee Services*, 2(1–2), 139–159.
- Commins, P. (1993). *Combating social exclusion in Ireland 1990–94: A midway report*. Brussels: European Commission.
- Cross, T.L. (2003). Culture as a resource for mental health. *Cultural Diversity and Ethnic Minority Psychology*, 9(4), 354–359.
- Diener, E. & Seligman, M. (2002). Very happy people. *Psychological Sciences*, 13, 81–84.
- Gibb, S.J., Fergusson, D.M. & Horwood, L.J. (2011). Relationship duration and mental health outcomes: Findings from a 230-year longitudinal study. *British Journal of Psychiatry*, 198, 24–30.
- Gill, S.C., Butterworth, P., Rodgers, B. & MacKinnon, A. (2007). Validity of the mental health component scale of the 12-item short-form health survey (MCS-12) as measure

of common mental disorders in the general population. *Psychiatry Research*, 152(1), 63–71.

Howden-Chapman, P. & Housing and Heating Research Team. (2006). *Housing, heating and health study: 2005/2006 Report one – aims and methods*. Wellington: He Kainga Oranga/Housing and Health.

Iwasaki, Y., Zuzanek, J. & Mannell, RC. (2001). The effects of physically active leisure on stress-health relationships. *Can Journal of Public Health*, 92(3), 214–8.

Jensen, J., Sathiyandra, S., Rochford, M., Jones, D., Krishnan, V. & McLeod, K. (2005). *Disability and work participation in New Zealand: Outcomes relating to paid employment and benefit receipt*. Wellington: Ministry of Social Development.

Kagitcibasi, D. (Ed.). (1994). *A critical appraisal of individualism and collectivism: Toward a new formulation*. California: Thousand Oaks, Sage.

Leach, L.S., Butterworth, P., Strazdins, L., Rodgers, B., Broom, D.H. & Olesen, S.C. (2010). The limitations of employment as a tool for social inclusion. *BMC Public Health*, 10, 621.

Marrone, J. & Golowka, E. (1999). If work makes people with mental illness sick, what do unemployment, poverty, and social isolation cause? *Psychiatric Rehabilitation Journal*, 23(2), 187–193.

Marrone, J. (2006). If work is bad for people with mental illness...Presentation at "Employment & Recovery", Vancouver, WA, July 20.

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Wellington: Mental Health Commission.

Mental Health Commission. (2002). *Mental illness and violent crime: Factsheet*. Wellington: Mental Health Commission.

Mental Health Commission. (2005). *Reducing discrimination against people with mental illness. Te hekenga: Whakamana i te tangata whaiora. Multi-Agency Plan 2005–2007*. Wellington: Mental Health Commission.

Mental Health Commission. (2009). *Mental health and social inclusion concepts and measurements*. Wellington: Mental Health Commission.

Mental Health Commission. (2010). *Statement of intent 2010–2013*. Wellington: Mental Health Commission.

Mind. (2010). *Unlucky in love? Try dating with a mental illness*. Accessed 13 October 2010 from http://www.mind.org.uk/news/3908_unlucky_in_love_try_dating_with_a_mental_illness

- Minister for Disability Issues. (2001). *The New Zealand Disability Strategy*. Wellington: Ministry of Health.
- Ministry of Health. (2007). *Like minds like mine national plan 2007 to 2013*. Wellington: Ministry of Health.
- Ministry of Health. (2008). *A portrait of health. Key results of the 2006/07 New Zealand health survey*. Wellington: Ministry of Health.
- Ministry of Social Development. (2004). *Opportunity for all New Zealanders*. Wellington: Ministry of Social Development.
- Ministry of Social Development. (2007). *The social report: Indicators of social wellbeing in New Zealand*. Wellington: Ministry of Social Development.
- Ministry of Social Development. (2008). *The social report 2008*. Wellington: Ministry of Social Development.
- Ministry of Transport. (2008). *The New Zealand transport strategy 2008*. Wellington: Ministry of Transport.
- Morrow, V. (2001). *Networks and neighbourhoods: Children's and young people's perspectives*. London: Health Development Agency.
- National Mental Health Development Unit. (2011). *Factfile 4: Public mental health and well-being*. London: National Mental Health Development Unit.
- Nielsen. (2009). *Quality of life survey 2008 national report*. Wellington: Nielson.
- Oakley Browne, M.A., Wells, J.E. & Scott, K.M. (Eds.). (2006) *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health.
- Peterson, D., Barnes, A. & Duncan, C. (2008). *Fighting shadows: Self-stigma and mental illness*. Wellington: Mental Health Foundation.
- Peterson, D., Pere, L., Sheehan, N. & Surgenor, G. (2004). *Respect costs nothing: A survey of discrimination faced by people with experience of mental illness in Aotearoa New Zealand*. Auckland: Mental Health Foundation.
- Petrie, M. (2002). *Institutions, social norms and well-being*. New Zealand Treasury Working Paper 02/12. Department of Treasury: Wellington
- Phoenix Research. (2009). *Monitoring changes in discrimination and social inclusion experienced by persons with mental illnesses*. Auckland: Pheonix Research.
- Repper, J. & Perkins, P. (2003). *Social inclusion and recovery*. Edinburgh: Balliere Tindall.

Safaei, J. (2006). Is democracy good for health? *International Journal of Health Services*, 36(4), 767–786.

Sanderson, K. & Andrews, G. (2002). Prevalence and severity of mental health-related disability and relationship to diagnosis. *Psychiatric Services*, 53(1), 80–86.

Sapolsky, R.M. (2004). *Why zebras don't get ulcers (3rd ed.)*. New York: Henry Holt.

Sayce, L. (2001). Social inclusion and mental health. *Psychiatric Bulletin*, 25, 121–123.

Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. London: Macmillan.

Scott, D. (2010). *Social and economic indicators of education*. Wellington: Ministry of Education.

Social Exclusion Unit. (2004). *Mental health and social exclusion: Social exclusion unit report*. London: The Office of the Deputy Prime Minister.

Statistics New Zealand. (2006). *2006 census of population and dwellings*. Wellington: Statistics New Zealand.

Statistics New Zealand. (2008). *Statistics New Zealand's framework for measuring sustainable development*. Wellington: Statistics New Zealand.

Statistics New Zealand. (2009). *User guide for the basic confidentialised unit record file of the 2008 New Zealand general social survey*. Wellington: Statistics New Zealand.

Wagner, G., Frick, J.R. & Jurgen, S. (2007). *The German socio-economic panel study (SOEP): Scope, evolution and enhancements*. SOEP Papers 1, Berlin: The German Socio-Economic Panel.

Ware, J.E., Kosinski, M. & Keller, S.D. (1994). *SF-36 physical and mental health summary scales: A user's manual*. Boston: Health Institute.

Ware, J.E., Kosinski, W. & Keller, S.D. (1996). A 12-item short-form health survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34, 220–233.

Wise, M. & Sainsbury, P. (2007). Democracy: The forgotten determinant of mental health. *Health Promotion Journal of Australia*, 18, 3.