

Populations who have received care for mental health disorders

An Overview

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Published in 2014

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ISBN 978-0-9876500-3-0

Suggested citation: Winnard D, Watson P, Papa D, Hallwright S, Russell S, Ahern T, Lee M, Boladuadua S, Butler K (2014) Populations who have received care for mental health disorders. Counties Manukau Health. An overview. Auckland: Counties Manukau Health.

Foreword

As the new Chair for Counties Manukau Health I am pleased to be able to release this timely and comprehensive report about those who have received care for mental health disorders in the Counties Manukau population. This report assists us in remaining very aware of the relevance and impact of mental health and addictions issues on the wellbeing of our communities.

The 2012 release of Blueprint II, the Mental Health Commission's guidance to Government and government agencies about what is needed to achieve the vision of improved mental health and wellbeing of all New Zealanders, and the Ministry of Health's mental health and addictions service development plan, *Rising to the Challenge*, signals a new wave of change upon the mental health and addictions sector.

Building on gains from the recent past, there is the recognition that mental health and addiction services of today and tomorrow need to continue to provide high quality care for those with the most severe and/or enduring mental disorders but also to increasingly work with those who have less severe mental health issues. There is a need to provide access to interventions both earlier in the life course and earlier in the course of developing disorders. This direction requires a mental health system engaged in integrating much more effectively across many parts of the health care system, particularly with primary care and community service providers.

To inform and guide this next transformation of the mental health and addictions sector, Counties Manukau Health has recently launched *Better Mental Wellbeing For All*, the Mental Health and Addictions Strategic Action Plan 2013-2018, and undertaken this population health needs analysis to ensure that the needs of our population continue to be central to our planning.

This report finds a high prevalence of care for mental health disorders in our population. 1 in 10 adults aged 18 or over were estimated to be receiving care for a mental health disorder in 2011 (this does not include those receiving non-pharmacological assistance in primary care); over 80% of these people were prescribed a psychotropic medication. The impacts of such common health issues on people themselves but also for their whaanau, families and wider community has significant implications for our communities' wellbeing.

Critically important is that our clinicians deliver effective services that match the needs of our population and this report will greatly assist the DHB plan how and where we should provide such services into the future. We recognise that specialist clinical interventions cannot improve the mental health of our population alone and this report strongly reinforces the need to focus on early intervention, prevention and mental health promotion across the whole of the health system and the wider community.



I thank the authors for producing this report and look forward to the discussions and debates of the report's findings. There is much to be done and this report marks an important place in understanding where we are now as we journey towards improving the mental health and wellbeing of all in Counties Manukau.

Dr Lee Mathias,
Chairman,
Counties Manukau Health

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Executive Summary

Mental health and addictions are a growing concern in New Zealand and worldwide. Mental disorders are now the third leading cause of health loss in the NZ population. Mental health and addictions issues can have major implications for the person affected themselves but also for whaanau and families, friends and the wider community. Understanding the nature and prevalence of mental disorders in a population has important implications for health services provision and planning. This report summarises an analysis of populations who have received care for mental health disorders in the Counties Manukau (CM) area that will support and inform the future development of mental health services in Counties Manukau.

In Counties Manukau

- It is estimated that in 2011, 35,180 or nearly 1 in 10 adults aged 18 and over living in CM received care for a mental health disorder (this does not include those receiving non-pharmacological assistance in primary care)
 - 82% of these people were dispensed a psychotropic medication
 - Two thirds were only seen by Primary Care.
- 25,300 people received care for depression and/or anxiety. This was the most common mental health diagnosis group occurring in nearly 7% of the adult population aged 18 and over. Receiving care for depression and/or anxiety was most prevalent in the female NZ European older age group.
- 5,450 or 1.5% of the population received care for a psychotic disorder in 2011.
- People living in socioeconomically deprived areas were more likely to have had contact with specialist mental health services or received care for a psychotic disorder but less likely to have received care for depression and/or anxiety.
- Maaori were more likely than those of other ethnicities to be receiving mental health care, having contact with specialist mental health services and/or identified as receiving care for psychotic disorder. People of Pacific ethnicities and Asian ethnicities were less likely to be receiving mental health care.
- Youth were increasingly likely to receive mental health care as their age increased from 12 to 24 years. Youth were much less likely than adults to be dispensed a psychotropic medication.
- Older people were more likely than younger people to have received care for a mental health disorder and much more likely to have received a psychotropic medication.
- Mental health disorders and long term physical health conditions commonly occur together. For example, 4,000 people were identified as receiving care for diabetes and a mental health disorder in 2011.
- Potentially avoidable non-mental health hospital admissions were two to three times as likely for people who had received care for a mental health disorder.

Key Reflections

The findings of this study reinforce many of the directions, principles for action and recommendations in 'Blueprint II, Improving mental health and wellbeing for all New Zealanders. How things need to be', and the CM Health 'Mental Health and Addictions Strategic Action Plan, 2013-2018, Better Mental Wellbeing for All', particularly in relation to

- issues of equity of access, treatment and outcomes for different populations
- developmentally appropriate responsiveness cross the life-course
- the need for system integration and greater attention to comorbidity of mental health disorders and long term physical health conditions
- appropriate care for those with low prevalence disorders such as psychotic disorders (including improving their physical health and wellbeing) as a high priority alongside improving care for those with high prevalence disorders such as depression/anxiety.

There are also specific reflections and questions arising from this study highlighted below.

- The distribution of the populations receiving care for mental health disorders across ethnicities, age groups and socioeconomic areas described in this report differ in some respects from those described in Te Rau Hinengaro and other prevalence studies.
- Across the age distribution of the population, there is also a pattern whereby with increasing age, identification as part of the population receiving care for mental health disorders is increasingly relating to medication use, with a corresponding decrease in the proportion identified as having contact with mental health services.
- To understand these patterns it would be helpful to review differences across age groups and various populations in
 - access/referral to and uptake of non-pharmacologic therapies and programmes that support resilience
 - entry to and discharge from mental health services
 - prescribing patterns for psychotropic medications (e.g. are there different thresholds for prescribing for different populations, is there more use of psychotropic medications for situations/conditions outside of standard indications than commonly acknowledged or recognised by this study).
- The patterns of care described in this study also raise fundamental issues about how we decide what is/are 'optimal levels' of care for mental health disorders and potential barriers to care. How we identify and quantify 'need' and what markers we use to understand 'coping', mental health resilience, and indeed 'flourishing' are important issues in relation to planning services for the various populations of Counties Manukau.
- This study also highlights
 - how helpful it would be to be able to include meaningful information from primary care to reflect the full use of primary care for mental health and addiction issues
 - the potential need for a national population survey to establish population prevalence and understand more about those identified with psychotic disorders and their needs.



Introduction

This report is a summary of a more detailed report which describes an analysis using data from three sources to identify people from the Counties Manukau population who have received care for mental health disorders:

- **People who have seen by a specialist mental health and addiction service** have their service contact details collected into PRIMHD (Programme for the Integration of Mental Health Data). PRIMHD is the national mental health service data base, which collects data from all publically funded specialist mental health and addiction services.
- **People who have had a hospital admission and during that admission have had a mental health or addiction diagnosis.** This diagnostic coding is collected in the national minimum data set (NMDS) which records coded information about all hospital discharges from publicly funded hospitals in New Zealand.
- **People who have been prescribed a psychotropic medication** and had it dispensed from a Community Pharmacy. This information is collected as part of the Community pharmaceutical dispensing claims PHARMS dataset.

It is acknowledged that there will be some people living in the Counties Manukau area who have a mental health disorder who will not be included in this report as they have not been seen by a specialist MH&A service, not been diagnosed with a mental health disorder during a hospital admission nor received psychotropic medication (for example those who have received non-pharmacologic treatment in primary care, or have not presented to health services).

This report therefore does not describe the population ‘who have mental disorders’ but rather the report is limited to the populations identified as ‘receiving care for mental health disorders’; it also does not include those receiving non-pharmacological assistance in primary care. There will also be some people included in the analyses in this report who were prescribed psychotropic medication for reasons other than mental health disorders.

Diagnostic categories were assigned by grouping:

- The diagnosis in PRIMHD (DSM-IV classification), and/or
- The diagnosis in NMDS (ICD-10-AM classification, primary or secondary code), and/or
- Dispensed medications identified as most commonly used for mental health disorders.

The report has defined 3 different populations from the data available.

1. **Overall mental health population** which draws on contact with specialist mental health services as recorded in PRIMHD from 2008-2011 inclusive, dispensing of mental health medications from 2006 -2011 and mental health diagnoses related to hospitals admissions from 2002-2011

2. **2011 snapshot mental health population** which draws on contact with specialist mental health services as recorded in PRIMHD, dispensing of mental health medications and mental health diagnosis related to hospitals admissions, any and all during 2011
3. **2011 mental health service contact population** identified as those with contact with specialist mental health services as recorded in the PRIMHD dataset for 2011.

This report also provides:

- analysis of the following age groups
 - all people aged 18 years and over - representing the age group for adult and older persons mental health services
 - 12-19 years to recognise the unique needs of adolescents and assist in planning for the package of initiatives announced in 2012 under the Prime Minister's Youth Mental Health Project 2012-2016
 - 20 to 24 years to recognise that young adults may have different needs from older adults, and
 - 65 years and over to assist in planning for Older Adults Mental Health services
- more in-depth analysis of some of the diagnostic categories of the 2011 snapshot mental health population (those with depression/anxiety, psychotic disorders)
- review of primary care enrolment and aspects of health service utilisation (e.g. potentially avoidable hospitalisations) for various mental health populations
- analysis of the prevalence of selected long term physical health conditions amongst mental health populations and how it compares to the populations not identified as receiving care for mental conditions.

No data is included in this report for those less than 12 years of age.

This work has a number of limitations and raises as many questions as it answers but provides a contribution to information for planning. There is much that would benefit from consideration and interpretation by those working with people receiving mental health care.

For more detailed information, there is a companion, full report available on the CM Health website.

Section 1. Population aged 18 years and over

In Counties Manukau it is estimated that in 2011, 35,180 or nearly 1 in 10 adults aged 18 and over living in CM received care for a mental health disorder (this does not include those receiving non-pharmacological assistance in primary care).

82% of these people were dispensed a psychotropic medication.

This report identified 35,180, or just under one in ten (9.6%) adults aged 18 and over as receiving care for a mental health disorder in the 12 months of 2011.

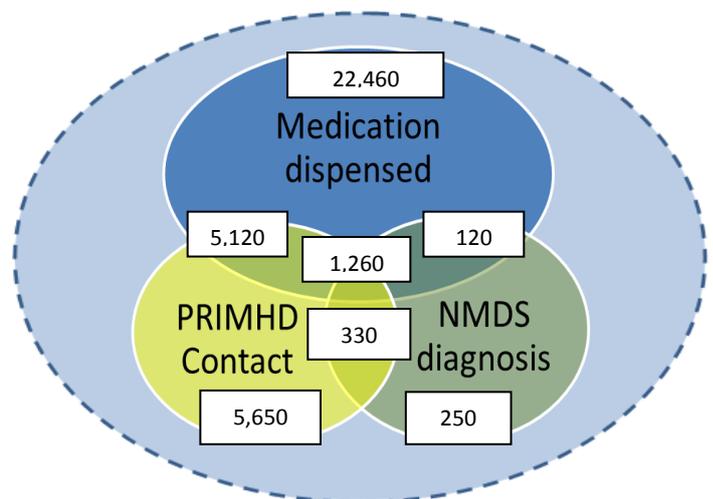
The majority (64%) of these people were only identified as receiving care for a mental health disorder as a result of having been dispensed a psychotropic medication. About a third (35%) were identified as having had contact with a specialist mental health service and of these service users about a half (52%) had been dispensed psychotropic medication.

If we add to this 'receiving care' population an estimate of those people who were treated for mental health conditions in primary care and were not dispensed psychotropic medications, the 'wider' population receiving care for mental health disorder in 2011 would be larger at approximately 1 in 6 adults (15.7%). Of this 'wider' population only 21% would have had contact with mental health services.

An even larger group was able to be identified as an 'overall' mental health population. 18% of the population (just over

65,000 people) aged 18 and over, alive at the end of 2011, made up the 'overall' mental health population indicating either an active mental health disorder or such a disorder in the prior 3-10 years as identified through medication, contact with mental health services or diagnosis when an inpatient (for any reason) in a public hospital.

Figure 1 Means of identification as part of the population aged 18 years & over receiving care for mental health disorder 2011, number of people per category (circles not in proportion)

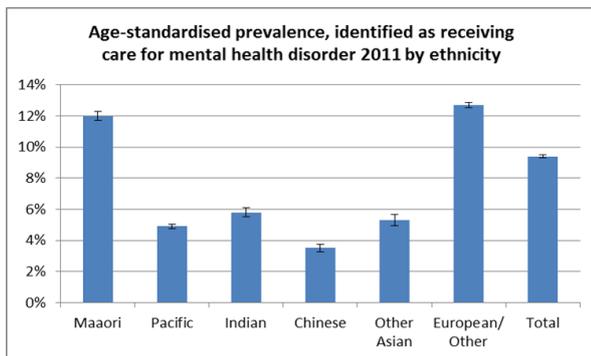


Ethnicity

Overall this report identified a high prevalence of care for mental health disorders for Maaori compared with people of other ethnicities, particularly in relation to specialist mental health service contact. There was also a relatively high prevalence of care for those of European/Other ethnicities, particularly in the elderly. Pacific and Asian groups had a much lower prevalence of care for mental health disorders than Maaori and European/Other groups.

In Counties Manukau Maaori were more likely than those of other ethnicities to be receiving mental health care, having contact with mental health services and/or identified as receiving care for psychotic disorder. People of Pacific ethnicities and Asian ethnicities were less likely to be receiving mental health care.

Figure 2



Maaori adults had a much higher prevalence of contact with specialist mental health services in 2011 than those of other ethnicities. About 30% of all mental health service contacts were with Maaori service users compared with Maaori accounting for only 14% of the total CMDHB adult population. Service contacts by Pacific and European adults were about the number expected from their population size while Asian peoples accounted for only 8.4% of the mental health service contact population compared with Asian peoples comprising 18.7% of the CMDHB adult population in 2011.

Gender

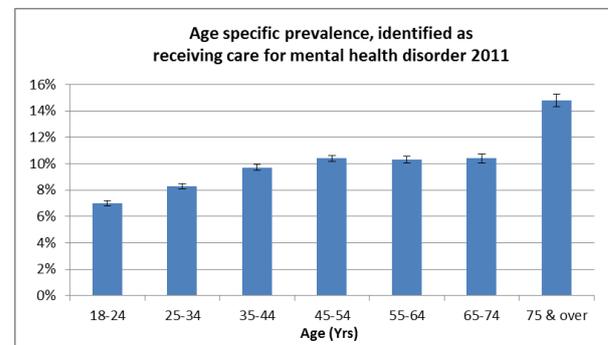
Overall this report found more females than male (59% vs 41%) were receiving care for mental health disorders in 2011. In contrast males predominated in those in contact with specialist mental health services in 2011 (54% vs 46%).

In several conditions women represented 60% or more of those identified as receiving mental health care – eating disorders, depression and/or anxiety and those with bipolar disorder. However, two thirds of those identified with substance abuse and ‘disorders with onset in childhood and/or adolescence’ were male. These gender results are largely consistent with the findings of the 2006 national mental health survey, Te Rau Hinengaro.

Age

The proportion of the population receiving care in 2011 for mental health disorders increased with age from 7% of 18-24 year olds to 14.8% of those aged 75 and over. This is very different to the earlier national mental health survey Te Rau Hinengaro findings of the highest prevalence of disorder being in young populations.

Figure 3



This pattern also differs from those who had contact with a specialist mental health service in 2011 which declined with age from 4.6% of 18-24 year olds to 1.7% of 65-74 year olds before increasing again to 3.4% of those aged for the 75 and over.

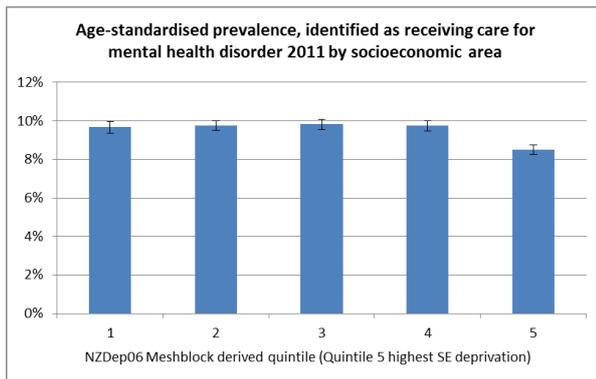
Socioeconomic Area

This study found that people living in the most socioeconomically deprived areas in CMDHB, were less likely than those living in less deprived areas to receive care for mental health disorders.

In Counties Manukau people living in socioeconomically deprived areas were more likely to have had contact with specialist mental health services or received care for a psychotic disorder but less likely to have received care for depression and/or anxiety.

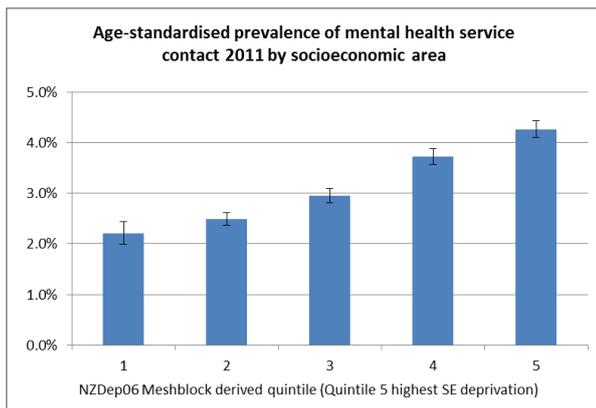


Figure 4



However people living in the most socioeconomically deprived areas had twice the prevalence of contact with specialist mental health services as those living in the least deprived area.

Figure 5



Compared to those living in the least socioeconomically deprived areas the populations living in the most deprived areas had higher rates of receiving care for psychotic disorders and lower rates of receiving care for anxiety and/or depression.

Localities

Across the Community Mental Health Centre (CMHC) residential areas of Counties Manukau the prevalence of care for mental health disorders and contact with mental health services varied. This likely reflects a range of factors, including where services have historically been developed as well as the ethnicity, age and socioeconomic profile of the populations living in these areas.

For example, a higher proportion of the population living in Awhinatia than the Cottage CMHC catchment were identified as receiving care for a mental health disorder in 2011. It is likely this reflects, at least in part, the higher proportions of those identifying as Maaori and European/Other ethnicities in the Awhinatia area, whereas the Cottage area has more Pacific and Indian people. In contrast people living in the Cottage, Manukau and Awhinitia catchments were as likely to have had contact with mental health services, while those in the Te Rawhiti area were less likely to have had contact with mental health services, likely reflecting the association between socioeconomic deprivation, specialist mental health service contact and psychotic diagnosis.

Figure 6

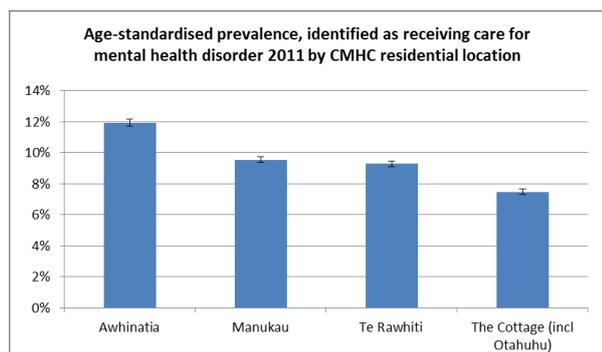


Figure 8

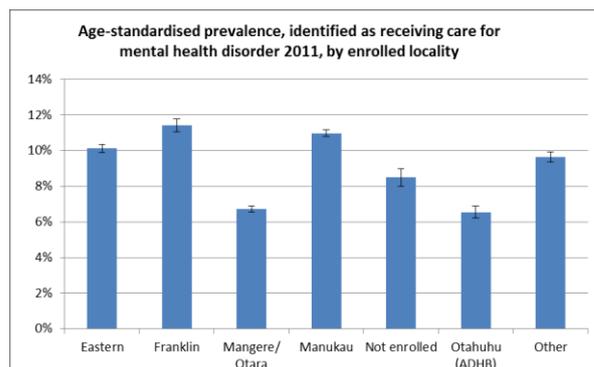


Figure 7

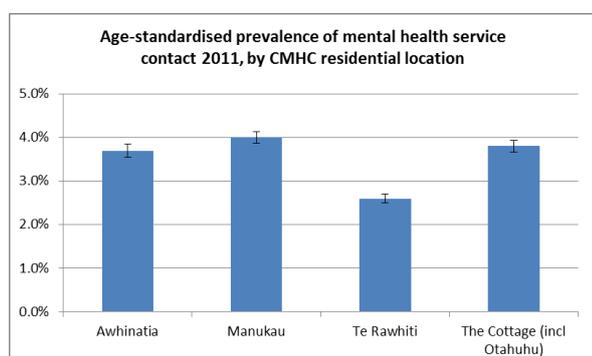
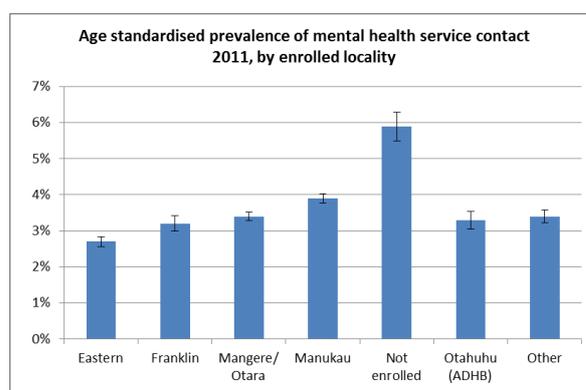


Figure 9



Primary Care Enrolment

In this report the majority of people (64%) were identified as receiving care for mental health disorder by virtue of being dispensed mental health medications and were not seen by specialist mental health services. It is assumed these people received their mental health care in primary care. However, over 1,100 people aged 18 and over who were identified as receiving care for a mental health disorder in 2011 were not enrolled with a primary care provider at the end of 2011 (i.e. they did not have an identified ‘medical home’); 800 of these people were seen by mental health services. 16% of those receiving care for mental health disorder in 2011 (5,520 people) were enrolled in practices beyond CM Health at the end of 2011.

Medication Usage

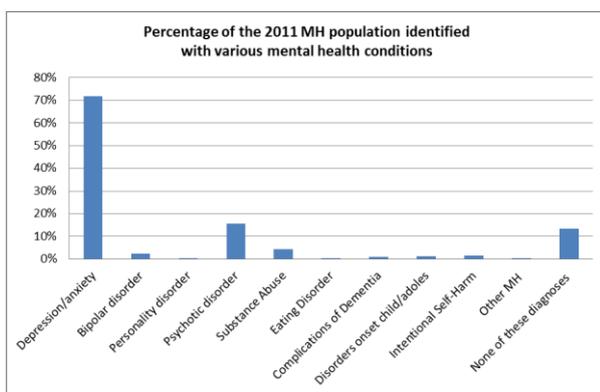
No data is available on the proportion of people receiving care for a mental health disorder in primary care who receive medication. However 48% of those aged 18 years and over who had contact with mental health services in 2011 were not receiving any mental health medications in the categories described in 2011. This is higher than for the other Northern Region DHBs, which ranged from 41.4% to 43.5%.

Diagnostic Categories

People may be receiving a variety of medications that span a number of the diagnostic groups where this is clinically indicated. In addition the use of medication may be outside of current best practice and/or there are emerging uses that have not been factored into the categories used for this analysis. This may overstate the numbers

in various groups, particularly the depressive and/or anxiety disorders group, but this was considered preferable to excluding people from one or other group. Notwithstanding this caveat, depression and/or anxiety was by far the most common diagnostic group (72%) and this was so for all age groups examined. The second most common diagnostic group overall was a psychotic disorder (this includes schizophrenia) – 15.5% of the population receiving mental health care in 2011.

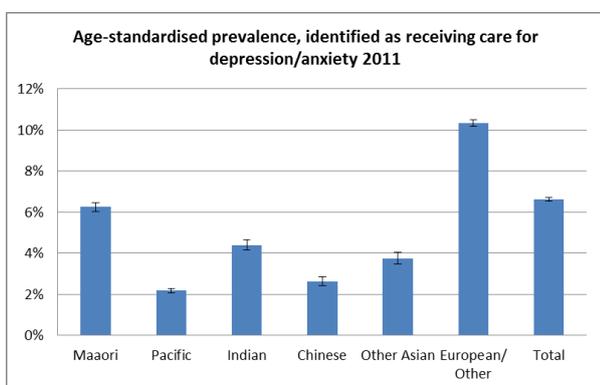
Figure 10



Depression/Anxiety

In 2011, this study found almost 1 in 14 people (25,300 people; 6.9% of population) aged 18 and over had received care for depression and/or anxiety.

Figure 11



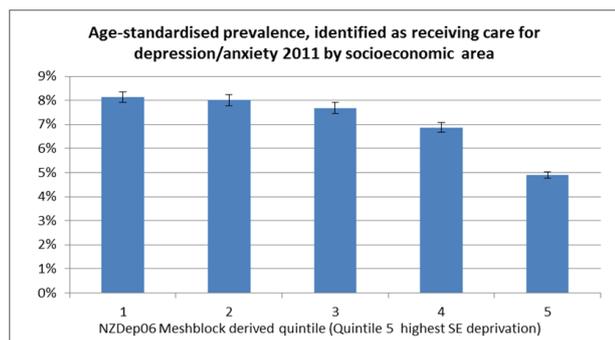
The prevalence of receiving care for depression and/or anxiety in 2011 was much

higher in those of European/Other ethnicities (10.3%) and also significantly higher in Maaori (6.2%) than those of Pacific and Asian ethnicities (2-4%). 83% of those identified as receiving care for depression and/or anxiety were identified only by medications dispensed – i.e. not seen by specialist mental health services, nor received a diagnosis of depression and/or anxiety in any admission to a public hospital in New Zealand. It is assumed these people were ‘managed in general practice’. Nearly three quarters of this group were of European/Other ethnicities.

In Counties Manukau 25,300 people received care for depression and/or anxiety. This was the most common mental health diagnosis group occurring in nearly 7% of the adult population aged 18 and over. Receiving care for depression and/or anxiety was most prevalent in the female NZ European older age group.

The prevalence of receiving care for depression and/or anxiety was significantly lower in the younger age groups compared with the older age groups (3.3% of 18-24 yr olds compared with 11.7% of those 75yrs and over). Likewise there was a significantly lower prevalence of receiving care for depression and/or anxiety for those living in the most socioeconomically deprived areas. These are the opposite patterns to those found in the national mental health survey Te Rau Hinengaro where the prevalence of anxiety and mood disorders declined with age and disorders increased with greater deprivation.

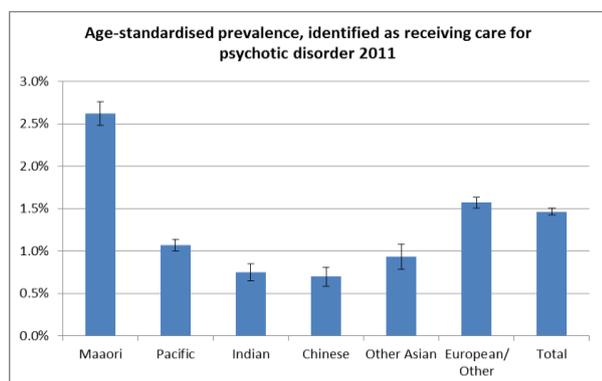
Figure 12



Psychotic Disorders

This study identified 1.5% (5,450 people) of the population aged 18 years and over identified as receiving care for a psychotic disorder in 2011. The prevalence of receiving care for psychotic disorders was higher for Maaori (2.6%), than those identified as European/Other ethnicities (1.6%) and those of Pacific and Asian ethnicities (0.7-1.1%).

Figure 13

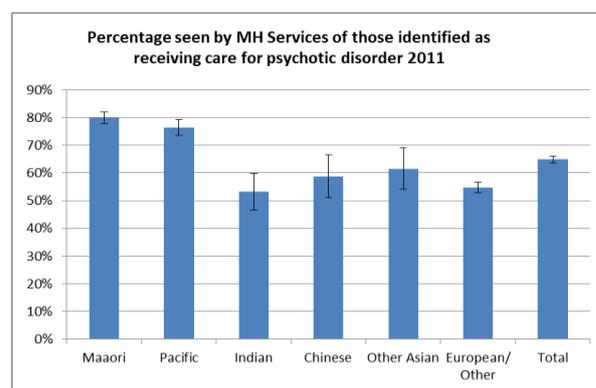


Nearly all (98%) people identified as receiving care for a psychotic disorder in 2011 were receiving mental health medication of some sort in 2011, the majority antipsychotics. Of the total group identified as receiving care for psychotic disorders (those receiving that care in 2011 and those receiving care in previous years as identified by this study), 57.7% also received medications classed as antidepressants at some point.

This study found that 65% of those identified as receiving care for psychotic disorders in 2011 (3,530 people) were seen by Mental Health Services in 2011. However this figure was significantly higher at 76-80% for Maaori and Pacific peoples and only 53-62% for those of other ethnicities. Maaori and Pacific peoples were less likely (20% and 23% respectively) than those of other ethnicities (38-46%) to be identified only by medications dispensed, and assumed to be 'managed in general practice' for their psychotic disorder.

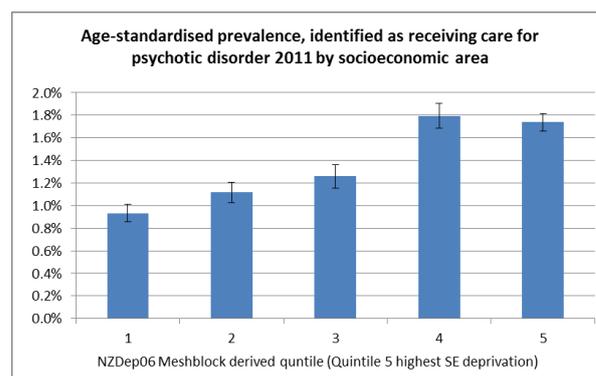
In Counties Manukau 5,450 or 1.5% of the population received care for a psychotic disorder in 2011.

Figure 14



The prevalence of being identified as receiving care for psychotic disorder was higher for those in the most socioeconomically deprived areas.

Figure 15

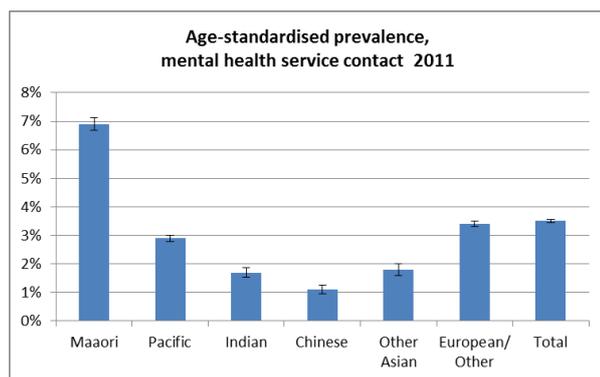


Specialist Mental Health Service Contact

In Counties Manukau those identified as Maaori, younger and living in more socioeconomically deprived areas were more likely to be seen by specialist mental health services. In 2011, 3.4% of the Counties Manukau/ Otahuhu population aged 18 years and over were identified as having contact with mental health services. This is consistent with national mental health access targets.

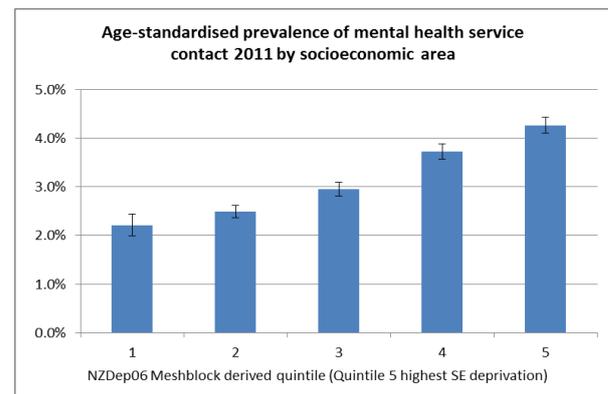
The age standardised prevalence of mental health service contact for Maaori in 2011 (6.9%) was twice or more than that of other ethnic groups.

Figure 16



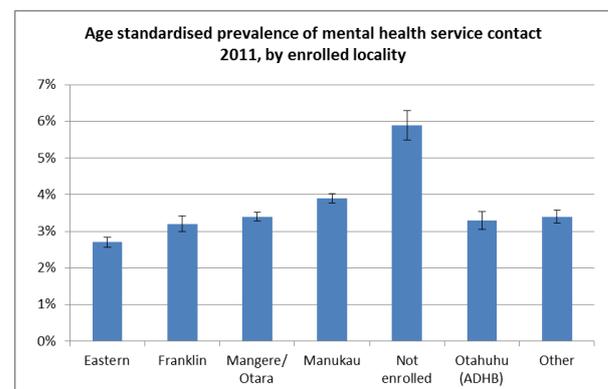
For those living in the most socioeconomically deprived areas (Quintile 5) the prevalence of mental health service contact was twice that of those living in the most affluent areas (Quintile 1). This finding contrasts with the opposite finding for the population who were identified as receiving care for mental health disorder in 2011 by medications only, where the prevalence in Quintile 1 was twice the prevalence in Quintile 5.

Figure 17



The prevalence of mental health service contact was significantly higher for those not enrolled in primary care than those enrolled in various localities. There were just over 800 people identified in contact with mental health services in 2011 who were not enrolled in a PHO as at the end of that year.

Figure 18



When combined with those enrolled in practices outside CMDHB there were 2,890 adults or nearly 1 in 4 (23.5%) of all those in contact with CMDHB mental health services in 2011 who were not accessing primary care through a Counties Manukau locality primary care practice.

Medication Use and Specialist Mental Health Service contact across age groups

Identification as part of the population receiving care for mental health disorders in 2011 was increasingly relating to medication use with increasing age, with a corresponding decrease in the proportion identified as having contact with mental health services.

Table 11 Percentages of the various age group mental health populations receiving medication

For the 2011 'snapshot' population	12-19 yrs	20-24 yrs	18 yrs & over	65 yrs & over
% receiving MH medication of some kind	34%	59%	82%	93%
% identified only through receiving medication	18%	37%	64%	78%
% identified as having contact with MH health services	81%	62%	35%	19%
% having contact with MH services and not identified as receiving MH medications	81%	41%	48%	30%

Long Term Health Conditions

The interaction between mental health and long term physical health conditions is complex and has been attracting increasing attention in New Zealand and overseas.

Consistent with international studies, people who received care for mental health disorders in Counties Manukau in 2011 had a higher prevalence than those who weren't identified as receiving care for mental health

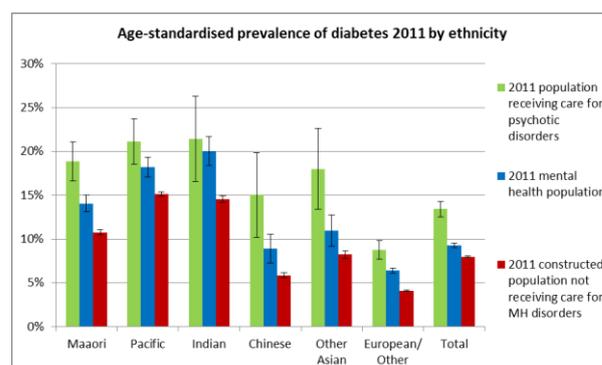
disorders of having long term conditions such as diabetes, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). For example, the age-standardised prevalence of diabetes in the Counties Manukau population who haven't received care for a mental health disorder was 8.0% compared to the population that had received care at 9.3% and of those in the psychotic disorders diagnostic group at 13.4%.

Numbers of people with long term health conditions and receiving care for Mental health conditions:

MH & Diabetes	4,000
MH & CVD	2,000
MH & COPD	1,200
MH & CHF	800

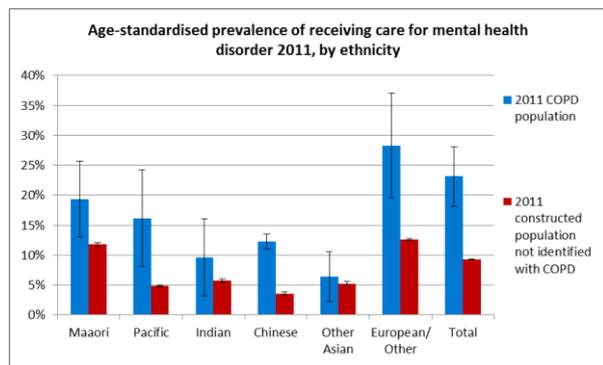
Mental health disorders and long term physical health conditions commonly occur together. For example, 4,000 people were identified as receiving care for diabetes and a mental health disorder in 2011 in Counties Manukau.

Figure 19 Age-standardised prevalence of diabetes in population receiving care for psychotic disorders aged 18 years & over, 2011 snapshot, compared with the prevalence in the mental health population and the population without identified care for mental health disorder, by ethnicity



It is also clear that people identified as having long term health conditions have a higher prevalence of mental health disorder. For example, the prevalence of receiving care for a mental health disorder in those identified with COPD was 23.1% and in the Counties Manukau population without COPD, 9.3%.

Figure 20 Age-standardised prevalence of receiving care for mental health disorder in the COPD population aged 18 years & over, 2011 snapshot, compared with prevalence in the population without identified COPD, by ethnicity



Potentially Avoidable Hospital Admissions and DNAs

People identified as receiving care for a mental health disorder were twice as likely as those who were not identified as receiving care for a mental health disorder (5.7% vs 2.8%) to have had an Ambulatory Sensitive Hospitalisation (ASH) in 2011 (ASH is a hospitalisation for a condition which is considered sensitive to preventive or treatment interventions in primary care). For those seen by mental health services the ASH rate (8.3%) was three times that for those not identified as receiving care for a mental health disorder. A similar pattern was found for another subgroup of “potentially avoidable” hospitalisations, those considered potentially avoidable due to housing-related factors (HRPAH).

Figure 21 Prevalence of having had ASH admission(s) in the mental health service contact population aged 18 years & over, 2011 snapshot, compared with prevalence in 2011 mental health population and the population without identified care for mental health disorder, by ethnicity

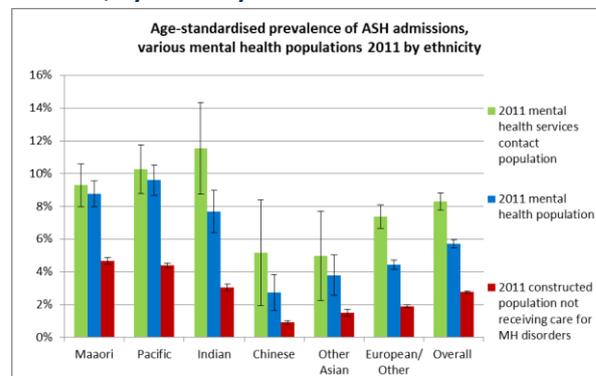
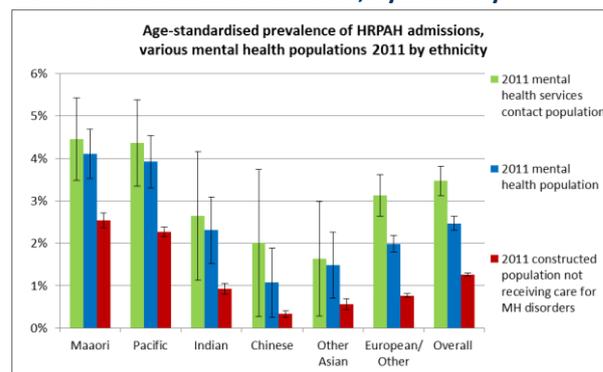


Figure 22 Prevalence of having had HRPAH admission(s) in the mental health service contact population aged 18 years & over, 2011 snapshot, compared with prevalence in 2011 mental health population and the population without identified care for mental health disorder, by ethnicity



Likewise the prevalence of having had one or more ‘Did Not Attends’ (DNAs) for non-mental health outpatient appointments had a similar pattern of being significantly higher in those identified as receiving care for a mental health disorder and higher again for those seen by mental health services.

In Counties Manukau potentially avoidable non-mental health hospital admissions were two to three times as likely for people who had received care for a mental health disorder.

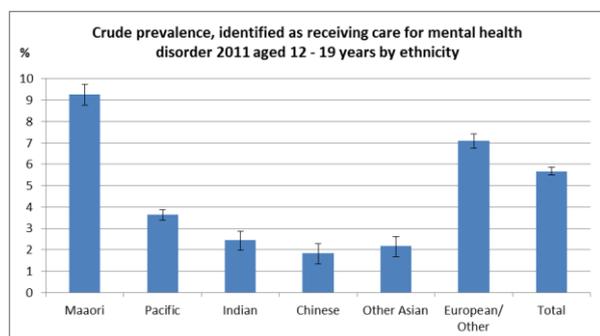
Section 2. Youth Mental Health

There was an increasing likelihood of receiving care for a mental health disorder as age increased for those aged 12 to 24 years. In Counties Manukau in 2011 just over 3,700 youth aged 12 to 19 years of age (5.7% of this population age group) were identified as receiving care for a mental health disorder. The proportion of youth receiving care increased from 4.0% of those aged 12-14 years, to 6.7% of those aged 15-19 years to 7.2% of those aged 20-24 years.

In Counties Manukau youth were increasingly likely to receive mental health care as their age increased from 12 to 24 years. Youth were much less likely than adults to be dispensed a psychotropic medication.

In Counties Manukau youth who are Maaori or European/Other were more likely to receive care for a mental health disorder. In 2011, between 7 and 10% of Maaori and European/Other youth received care for a mental health disorder compared to between 2-5% of Pacific and Asian youth of the same age.

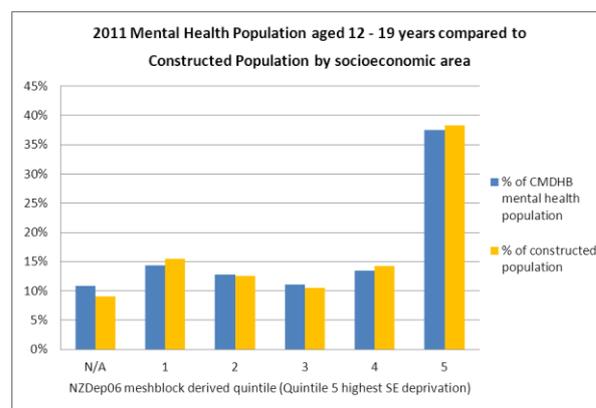
Figure 23



Between 30-40% of Counties Manukau youth are living in Quintile 5, the most socioeconomically deprived areas. Across the

deprivation spectrum there was a similar pattern of youth receiving care for mental health disorders to the underlying population, with no significant differences between the prevalences across the NZDep06 socioeconomic categories. This is different from the pattern for those 18 years and over where those in the more affluent areas were more likely to receive care.

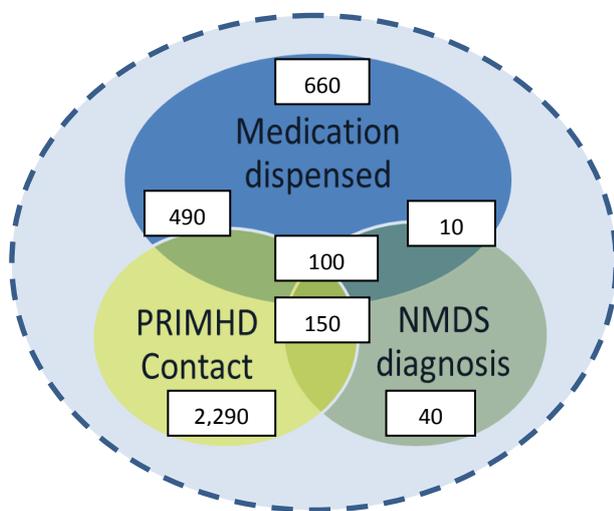
Figure 24



About one in three (34%) youth aged 12-19 years identified as receiving care for a mental health disorder were dispensed a psychotropic medication. This is a much lower proportion than the 4 out of five (82%) of the population 18 years and over that were receiving care for a mental health disorder and dispensed a psychotropic medication. The same figure was intermediate for those youth aged 20-24 years (59%).

A much higher proportion of youth aged 12-19 years receiving mental health care (accepting this does not include those receiving non-pharmacological assistance in primary care) had some contact with mental health services (81%) compared with 35% for those aged 18 years and older, again with intermediate results for those youth aged 20-24 years (62%).

Figure 25 Means of identification as part of the population aged 12 to 19 years receiving care for mental health disorder 2011, number of people per category (circles not proportionate)

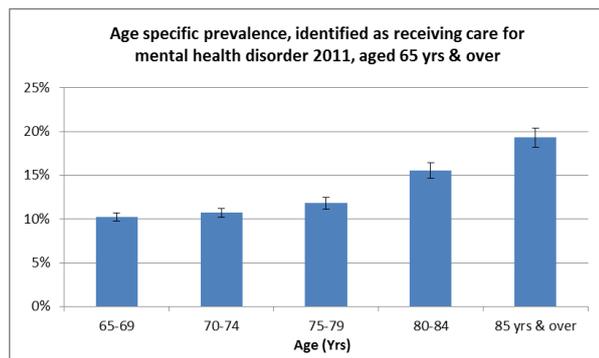


Maaori youth had a much higher prevalence of contact with specialist mental health services in 2011 (12-19 yrs, 8.4% and 20-24yrs, 7.8% respectively) than youth of other ethnicities (2-5%). The prevalence of receiving care for those living in the most socioeconomically deprived areas was one and a half times that of those living in the most affluent areas (5% vs 3% respectively).

Section 3. Mental Health & Older People

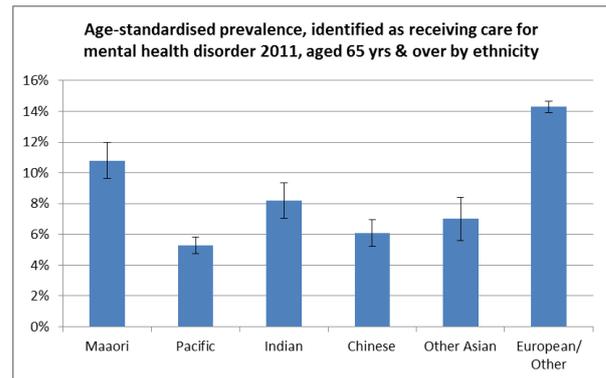
About 12% of the population (just over 6,190 people) aged 65 years and over, alive at the end of 2011, were identified as having received care for a mental health disorder in 2011. This is a higher prevalence than young age groups and as noted, this differs from Te Rau Hinengaro where the 12-month prevalence of any disorder declined across the age groups from 28.6% in the youngest age group (16-24 years) to 7.1% in those aged 65 years and over. Even within the 65 and over age group, prevalence increased with age in this study, from 10.2% for those 65-69 years to 19.3% for those aged 85 years and over.

Figure 26



European/Other people aged 65 years and over had a significantly higher prevalence of receiving health care for mental health disorder in 2011 (14.3%) than Maaori (10.8%), Pacific (5.3%) and Asian peoples (6.1%-8.2%).

Figure 27

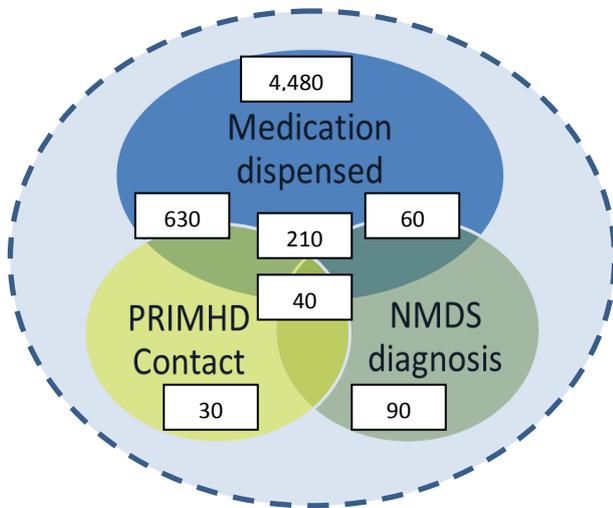


Those aged 65 years and over identified as receiving care for mental health disorder in 2011 were distributed across the NZDep06 quintiles in a similar U-shaped pattern to the underlying population of this age; the underlying population of this age differs from younger age groups who are concentrated in areas of high socioeconomic deprivation.

For 78% of the 2011 mental health population aged 65 years and over (4,840 people), a mental health medication was the only way they were identified as part of the mental health population, and only 19% had contact with specialist mental health services; this is quite a different picture from the wider population aged 18 and over where a higher proportion were seen by mental health services and less were receiving medication only.

In Counties Manukau older people were more likely than younger people to have received care for a mental health disorder and much more likely to have received a psychotropic medication.

Figure 28 Means of identification as part of the population aged 65 years and over receiving care for mental health disorder 2011, number of people per category (circles not proportionate)



Although the prevalence of specialist mental health service contact was significantly higher for Maaori, the majority (76%) of those in contact with mental health services aged 65 years and over in 2011 were of European/Other ethnic groups. This in part reflects the underlying population demography of these aged 65 years and over.

In this older age group there was a predominance of mental health care for high prevalence mental health conditions by European/Other women and a predominance of medication use. This pattern is particularly apparent in those identified as receiving care for depression and/or anxiety in those aged 65 years and over. The prevalence of receiving care for depression and/or anxiety in those aged 65 years and over was 10.4% (4,480 people), with 83.5% of this group identified as European/Other ethnicities (compared with 66.5% of the constructed population of this age) and 68% were women (compared with 54% females in the constructed population of this age). 85% were identified only by medication dispensed.

