Wellbeing and Mental Distress in Aotearoa New Zealand:

Snapshot 2016

FEBRUARY 2018

hpa health promotion agency

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Key Findings and Implications

This report highlights key findings about wellbeing and mental distress in 2016 from two population surveys: the New Zealand Mental Health Monitor and the Health and Lifestyles Survey.

Key Findings

1. Mental distress is common: about four in five adults (aged 15 years or more) have experience of mental distress personally or among people they know. Although mental distress is strongly patterned by disadvantage, anyone and everyone can experience distress.

2. There are many different ways of experiencing mental distress beyond standard diagnoses of illnesses like depression and anxiety.

3. Feeling isolated from others is strongly associated with symptoms of depression, anxiety and other forms of mental distress, and also with lower levels of life satisfaction.

4. 15 to 24-year-olds report high levels of isolation and mental distress.

5. Awareness of mental distress in self or in others is associated with more positive attitudes (eg, being willing to work with someone with experience of mental distress); but people are reluctant to disclose mental distress, particularly at work.

Implications

Our findings are consistent with international research indicating that building a more connected society supports population wellbeing and that connectedness can also prevent a substantial proportion of mental distress.

Traditional labels such as depression, anxiety and mental illness do not capture the extent of mental distress and poor wellbeing. Moving away from such labels may help reduce stigma and make it easier for people experiencing distress to talk about their difficulties.

The results for young people highlight an urgent need to break the destructive cycle of isolation and mental distress, shown in previous research to be an indicator of increased suicide risk. The findings suggest several potential strategies to explore, such as promoting family/whānau wellbeing, supporting connections to culture, and providing opportunities to give as well as receive help.

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Executive summary

This Snapshot of mental distress and wellbeing aims to:

- provide an overview of the available data on mental distress and wellbeing
- highlight some key findings from 2016.

The analyses use data from the 2016 New Zealand Mental Health Monitor (NZMHM), with some supporting analyses from the 2016 Health and Lifestyles Survey (HLS).

What we measured

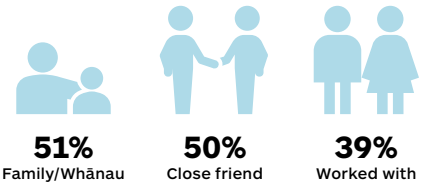
About the Health Promotion Agency's mental health datasets:

- Participants were adults aged 15 years and older living in Aotearoa New Zealand in 2016.
- There were 1,646 participants in the NZMHM and 3,854 participants in the HLS.
- Both the NZMHM and the HLS were conducted in people's homes using Computer Assisted Personal Interviewing.
- Reported results are statistically weighted to be representative of wellbeing and mental distress in the full Aotearoa New Zealand population.
- Methodology reports for the NZMHM and HLS are available online:
  - *2016 NZ Mental Health Monitor* (https://www.hpa.org.nz/research-library/research-publications/2016-new-zealand-mental-health-survey-methodology-report)
  - *2016 Health and Lifestyles Survey* (https://www.hpa.org.nz/research-library/research-publications/2016-health-and-lifestyles-survey-methodology-report).

What we learned

1 Mental distress is common

Four in five adults (aged 15 years or more) have experience of mental distress personally or among people they know. The survey results show that although mental distress is strongly patterned by disadvantage, anyone and everyone can experience distress.



51% Family/Whānau

50% Close friend

39% Worked with

37% Lived with

30% Self

20% Neighbour

2 There are many different ways of experiencing mental distress

NZMHM and HLS participants described concepts of mental distress that went beyond standard definitions of depression and anxiety to include feeling isolated, overwhelmed by stress and not able to cope. They reported experiencing difficult times and that the things they did in their life were not worthwhile.

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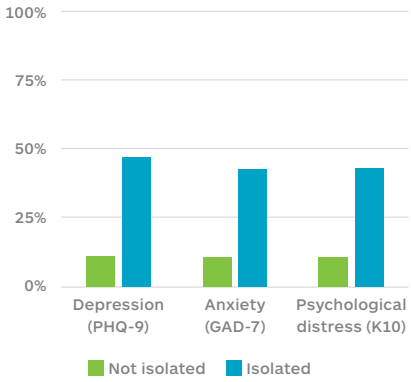
3 Isolation and connectedness are key factors in both wellbeing and distress

Feeling isolated from others emerged again and again in the analyses of the NZMHM and HLS data as strongly associated with depression, anxiety and other forms of distress.

Feeling isolated had a strongly negative association with life satisfaction, while strong family/whānau relationships, connections to culture, and being able to give as well as receive help were positively associated with life satisfaction.



4 Results for young people are extremely concerning

Participants aged 15 to 24-years-old reported high levels of social isolation and mental distress: 17% of young people reported both feeling isolated, and that the things they did were not worthwhile. Participants in this group (ie, feeling isolated and that things were not worthwhile) were seven times more likely than their peers to report moderately severe or severe levels of depression.

One result about young people that we found particularly concerning related to thoughts that they would be better off dead or about hurting themselves. Overall, 1 in 10 young people reported such thoughts over the previous two weeks. Recent research has shown that reporting these thoughts is a significant predictor of subsequent suicide attempt or death.

5 It's not always easy to talk about mental distress

Awareness of mental distress in self or in others was associated with more positive attitudes: 9 in 10 of those who were aware of having worked with someone with mental distress were willing to do so in the future, compared with only 7 in 10 of those without this awareness. However, participants also indicated a reluctance to disclose mental distress, particularly at work, which may reduce opportunities for positive attitudes to emerge.

Where to go for help

There are people and services available to provide or help you find extra support when you need it:

- Need to talk? (Free call or text 1737)
- The Depression Helpline (0800 111 757)
- Healthline (0800 611 611)
- Lifeline (0800 543 354)
- Samaritans (0800 726 666)
- Youthline (0800 376 633, free text 234)
- www.thelowdown.co.nz (for young people, free text 5626)
- www.depression.org.nz (for adults, free text 4202)

2016 Snapshot: Wellbeing and mental distress in Aotearoa New Zealand

Aim and scope

This Snapshot reports on wellbeing and mental distress in Aotearoa New Zealand, as reported by participants in the 2016 New Zealand Mental Health Monitor (NZMHM) and the 2016 Health and Lifestyles Survey (HLS).

Key concepts: wellbeing and mental distress

Wellbeing

We have reported on wellbeing using measures of life satisfaction, connectedness and social isolation, and participants' perceptions of whether the things they did were worthwhile. Wellbeing is a complex concept which is unlikely to be fully captured by these measures. HPA is developing a framework for defining and promoting wellbeing, and is currently conducting further work to identify population indicators of wellbeing for use in its monitors and evaluation studies.

Despite some limitations in reporting wellbeing, the analyses in this Snapshot confirm the importance of reporting on positive factors as well as difficulties. Because wellbeing is more than simply the absence of mental distress, participants in the NZMHM were able to report high levels of wellbeing even in the presence of high levels of difficulties. The ability to report on and compare both positive and negative aspects of people's lives is a significant strength of the NZMHM.

Mental distress

The established scales used in the 2016 NZMHM refer to 'mentally ill' and 'people with mental illness/es'. These have historically been common terms used to describe mental health challenges. However, a major concern with their usage is that by pathologising lived experience of mental health problems, there is an increase in associated stigma as those who discriminate seek to distance themselves from those with 'mental illness' (Ben-Zeev, Young, & Corrigan, 2010). Not referencing 'mental illness' also makes it easier for people experiencing distress to talk about their difficulties, as is borne out in the NZMHM and HLS: participants reported that they would be reluctant to disclose a mental illness diagnosis in some settings, particularly at work (see p21). They also identified a far broader range of distress than is captured by traditional diagnoses.

Thus, in common with government agencies and non-government organisations throughout Aotearoa New Zealand, the term 'mental distress' is used in this Snapshot to reflect the preference of those with lived experience. In keeping with this expressed preference and with findings from the NZMHM, reporting focuses on the experience of distress rather than on diagnosed illness.

About the Health Promotion Agency's 2016 mental health data

Data collection

In 2016 there were 1,646 participants in the NZMHM and 3,854 in the HLS. All participants were aged 15 years and older and were normally resident in Aotearoa New Zealand. The NZMHM and HLS were conducted in people's homes using Computer Assisted Personal Interviewing. Interviews for the NZMHM took place from June to September and for the HLS, from May to December.

What we measured

Methodology

The NZMHM and HLS used several design elements such as weighting procedures to support interpretation as representative of the mental health and wellbeing of the full Aotearoa New Zealand population.

Methodology reports for the NZMHM and HLS are available online at www.hpa.org.nz or by clicking the links provided:

- 2016 New Zealand Mental Health Monitor (https://www.hpa.org.nz/research-library/research-publications/2016-new-zealand-mental-health-survey-methodology-report)
- 2016 Health and Lifestyles Survey (https://www.hpa.org.nz/research-library/research-publications/2016-health-and-lifestyles-survey-methodology-report).

Interpreting the results in this snapshot

Base numbers and percentages

Most of the results in this Snapshot were estimated using the full NZMHM sample of 1,646 participants, but we have also reported some results for the 15 to 24-year age group (n=414). Because young people made up only a quarter of the total survey population we have taken a conservative approach to reporting statistical results within this age group, but we found that several differences were strong enough to be highly significant despite the relatively small sample size. Results presented in this Snapshot come from the NZMHM unless otherwise noted. A few additional results were produced using data from the HLS (n=3,854).

Percentages in this Snapshot are 'weighted' statistically to align the results to the full Aotearoa New Zealand population.

Measures of mental distress

Participants were asked about their first-hand experience of mental distress in several ways, including:

1. A question about lifetime personal experience ("Have you ever personally had an experience of mental illness?")
2. Three internationally recognised psychometric scales: the PHQ-9 (depression), GAD-7 (anxiety) and K10 (psychological distress). These scales are fully described in the methodology reports (see previous page).

As described in this report, participants' concepts of 'mental distress' and 'mental illness' appeared to be very different. This difference may explain why there was poor correlation between responses to the two types of question listed above, even after accounting for the difference between lifetime exposure in the first, and 2 to 4 weeks' exposure in the second. For this reason we have not presented person-level comparisons between the two types of measure. This observation highlights the importance of language and terminology in mental health research.

Causal interpretation of results

There is a need for caution in interpreting the associations presented in this Snapshot as causal relationships. Where indicated, we adjusted for known confounders such as age, gender and ethnicity, but mental health pathways are highly complex and the reported results may have been influenced by unmeasured confounding from factors that could not be captured by the questionnaires. In addition, the cross-sectional design can make it difficult to distinguish between likely cause and effect. However, as seen in the final section 'Reflections and next steps', the results presented in this Snapshot are consistent with causal models and longitudinal analyses reported in the peer-reviewed literature, and this coherence supports a cautious causal interpretation of the findings.

Abbreviations used in this snapshot

We have generally avoided abbreviations but to improve readability we have used the standard abbreviations listed in Table 1.

Table 1: Key to abbreviations

ABBREVIATION	WHAT IT STANDS FOR
CI	Confidence interval
HLS	Health and Lifestyles Survey
HPA	Health Promotion Agency
LGBTI	Lesbian, gay, bisexual, transgender and intersex
NZHS	New Zealand Health Survey
NZMHM	New Zealand Mental Health Monitor
RR	Risk ratio

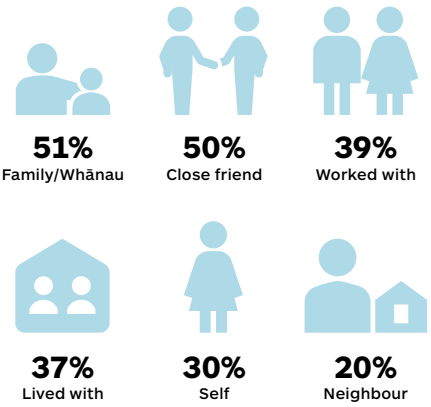
1 Mental distress is common

Awareness of mental distress in self or others

Lifetime exposure to mental distress was common: 30% of participants reported that they had "personally had an experience of mental illness", either in the past or at the time of being surveyed. Two-thirds of all participants (67%) knew someone who had "been diagnosed with a mental illness" and half (51%) of all participants were aware of mental distress experienced by a family or whānau member (Figure 1).

Overall, 80% of participants had either personal experience of mental illness or knew of others who had such experience: a high percentage, considering that the questions asked about mental illness and diagnosis, and hence were likely to have been interpreted by participants as asking about the more severe end of the spectrum of mental distress.

Figure 1: Lifetime experience of mental distress in self and others. Participants were able to select more than one option.

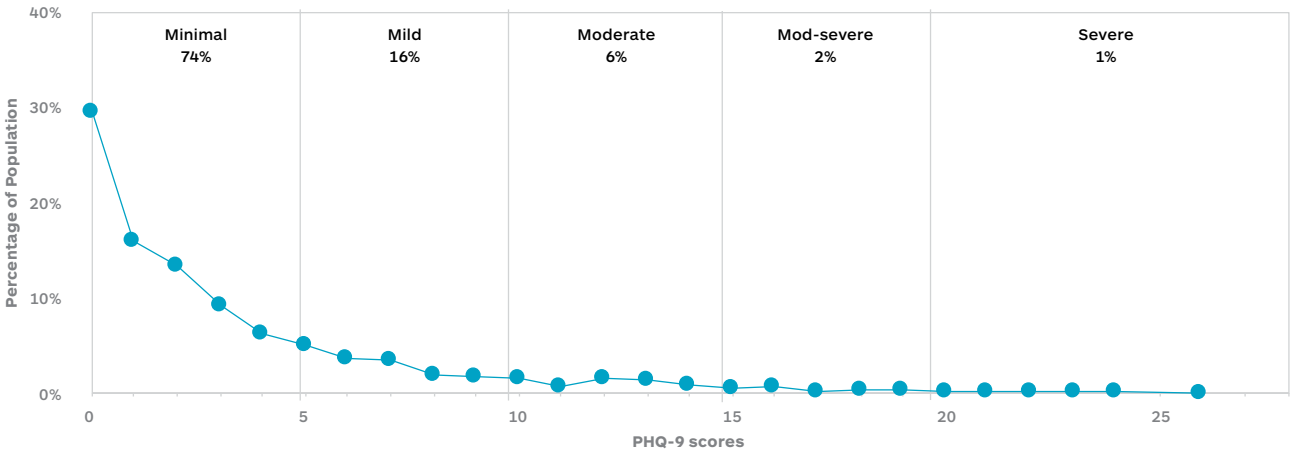


Depression

Figure 2 shows the population distribution of depression symptoms at the time of being surveyed, measured using the Patient Health Questionnaire (PHQ-9). This scale is widely used in primary care as a screening tool for depression. Moderately severe or severe levels were relatively less common (3% of the population), but mild or moderate symptoms of depression were common and were reported by 22% of the population in total.

Figure 2: Population distribution of depression, reported using PHQ-9 scores

The vertical bars show the cut-off points for categories used in this Snapshot (0 – 4 = 'Minimal; 5 – 9 = 'Mild'; 10 – 14 = 'Moderate'; 15 – 19 = 'Moderately severe'; 20 – 36 = 'Severe').



Anxiety

Figure 3 (below) shows the population distribution of the Generalised Anxiety Disorder (GAD-7) scale, which is used in outpatient and primary care settings to screen for anxiety and measure severity. As the graph shows, about a quarter (23%) reported some degree of anxiety (ie mild, moderate or severe).

Depression and anxiety combined

Depression and anxiety are often perceived as similar or overlapping conditions, so as well as considering symptoms separately we also investigated combinations of depression and/or anxiety in the population. For this analysis, 'depression' was classified as anything at or above mild depression on the PHQ-9 scale, and 'anxiety' as anything at or above mild anxiety on the GAD-7 scale. Individuals who scored at the lowest level for both depression and anxiety were classified as 'neither'. Figure 4 shows that a third of the population (33%) reported some degree of depression and/or anxiety (9% depression alone, 7% anxiety alone, and 17% both depression and anxiety).

Figure 4: Combinations of depression and anxiety.

'Depression' is counted as mild depression or above on the PHQ-9 scale, and 'anxiety' is counted as mild anxiety or above on the GAD-7 scale.

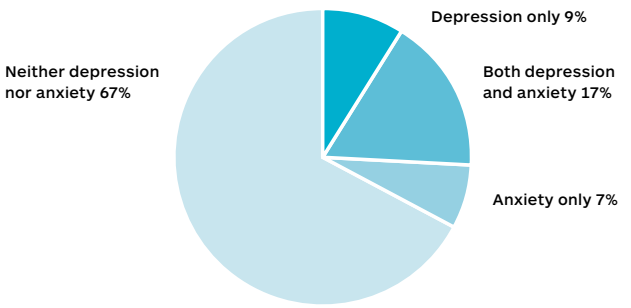
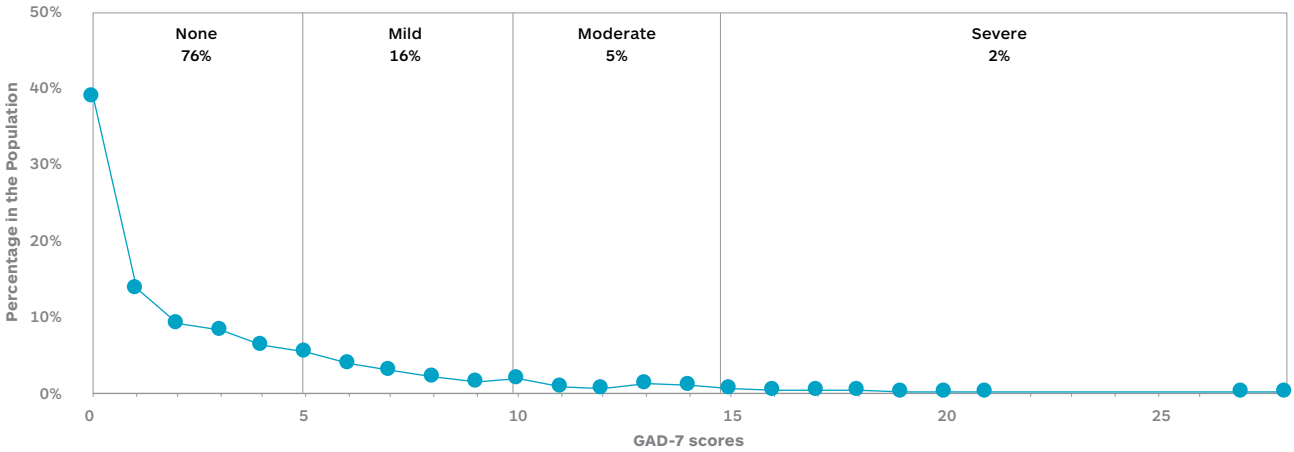


Figure 3: Population distribution of anxiety, reported using GAD-7 scores

The vertical bars show the cut-off points for categories (0 – 4 = 'None'; 5 – 9 = 'Mild'; 10 – 14 =' Moderate'; 15 – 28 = 'Severe')



Psychological distress

Psychological distress was measured using the Kessler Psychological Distress Scale (K10), a 10-item questionnaire that is used in clinical practice to screen for distress; it is also commonly used in population surveys as an overall measure of mental distress in the population. As shown in Figure 5, a quarter (24%) of adults reported medium or high levels of psychological distress.

Participants in the 2016 NZMHM and the 2016/17 New Zealand Health Survey (NZHS) were asked the same set of questions for the K10, but the scores were categorised differently. When the results were compared by applying the NZHS system to the NZMHM scores, the percentage of adults reporting psychological distress[1] was very similar in the two surveys: 7.6% in the NZHS[2] and 9.4% in the NZMHM.

Mental distress and life satisfaction

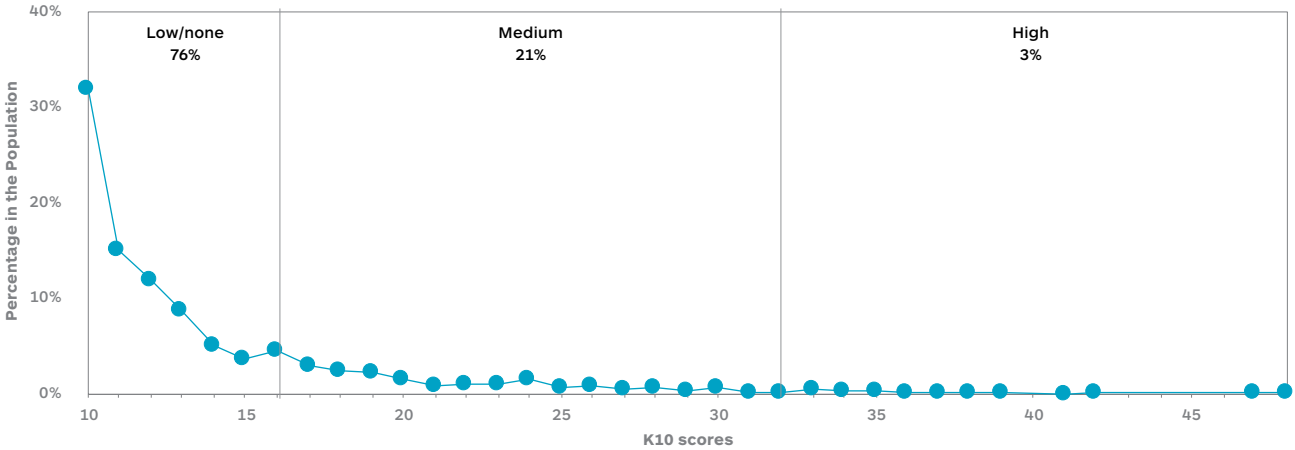
When asked to rate their satisfaction with life as a whole, 84% of participants replied that they were satisfied or very satisfied, with only 3% reporting dissatisfaction.

In view of this overall positive response, it was surprising that a large proportion of the study sample (30%) agreed that the past 12 months had been among the most difficult times in their life.

The apparent contradiction between reporting high levels of life satisfaction and also high levels of difficulties and distress prompted further investigation. We ran a series of generalised linear models to explore which circumstances were most strongly associated with participant reporting of high life satisfaction.[3] Table 2 (overleaf) shows the results of these analyses. For each positive or negative factor, a risk ratio >1 indicates that presence of the factor was associated with increased likelihood of reporting high life satisfaction (compared to lower life satisfaction), and a risk ratio <1 indicates that presence of the factor was associated with a lower likelihood of reporting high life satisfaction. For example, the first risk ratio of 1.72 shows that participants were 72% more likely to experience high life satisfaction if they reported being able to cope with the stresses of everyday life.

Figure 5: Population distribution of psychological distress, reported using K10 scores

The vertical bars show the cut-off points for categories (10 – 15 = 'Low or none'; 16 – 29 = 'Medium'; 30 – 50 = 'High')



1 Described as "A high or very high probability of anxiety or depressive disorder".
2 Further details can be accessed here: https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-tier-1/.
3 Estimates of effect: When estimating the strength of an association between two factors, we used generalised linear models with a Poisson distribution and a log link function for binary outcomes (Zou, 2004). This approach allowed us to report estimates of effect as risk ratios, which have a more intuitive interpretation than odds ratios (which are commonly reported for studies like this). All estimates of effect are presented as a central estimate with a 95% confidence interval, for example: (RR 1.32; 95%CI 1.14 to 1.54).

Table 2: Predictors of high life satisfaction

	LIKELIHOOD OF HIGH LIFE SATISFACTION	
	RISK RATIO	95% CONFIDENCE INTERVAL
Positive factors		
Able to cope with stress	1.72	1.10 to 2.70
The things you do are worthwhile	1.86	1.27 to 2.72
The family/whānau is doing well	2.22	1.51 to 3.29
Negative factors		
Personal experience of mental illness	0.79	0.64 to 0.96
Experiencing difficult times	0.65	0.52 to 0.82
Feeling isolated	0.43	0.34 to 0.56

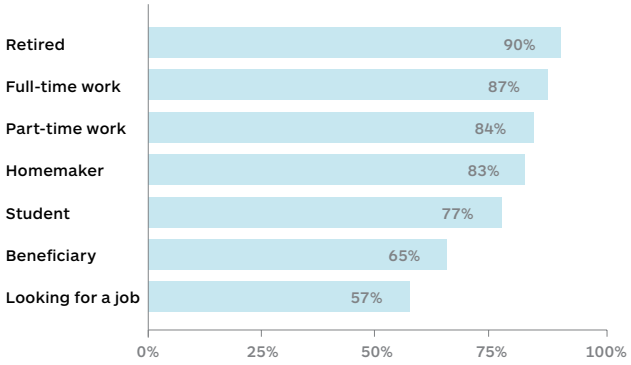
All of the associations in Table 2 were significant at the 95% confidence level, but the strength of the relationships varied. Participants who reported that they had "personally had an experience of mental illness" were slightly less likely to report high life satisfaction; the association was only narrowly significant at the 95% confidence level. On the other hand, feeling that the things one did were worthwhile or that the family or whānau was doing well had a strong and positive association with high life satisfaction, while feeling isolated had a strongly negative association.

These findings suggest that a variety of factors may influence how people report on life satisfaction, but the strong association with social isolation warrants further investigation. This key aspect of mental health is explored in more detail in sections 3 and 4.

Populations of particular concern

Levels of mental distress and wellbeing were not evenly distributed in the population. In a later section of this Snapshot we discuss results for young adults (see p19), but there were many other instances in which wellbeing or mental distress varied strongly by life circumstances or person characteristics, often showing strong associations with measures of disadvantage. For example, life satisfaction was strongly predicted by employment category (Figure 6). The highest prevalence of life satisfaction was reported by participants who were retired (90%) or in full-time employment (87%), while the lowest levels of life satisfaction were reported by participants who were beneficiaries (65%) or were looking for work (57%).

Figure 6: Percentage of participants in each employment category who reported that they were satisfied or very satisfied with their life



Experience of stress also varied strongly by employment category: 9% of full-time employees, 14% of part-time employees, and 34% of beneficiaries reported feeling unable to deal with the stresses of everyday life. Beneficiaries were significantly more likely than people in full-time work to report that they felt isolated (62% vs 35%), and they were also significantly more likely to experience moderately severe or severe levels of depression.

Māori and Pacific peoples experience disadvantage across a wide range of health outcomes. These inequalities are reflected in the data. Compared with non-Māori, Māori had significantly higher scores for depression, anxiety and psychological distress, while Pacific peoples had significantly higher depression scores compared with non-Pacific peoples. Future work will discuss these important results in more detail.

2 There are many different ways of experiencing mental distress

Over a third (36%) of participants had heard the term 'mental distress' used to describe mental illness. When asked to define mental distress, they offered varying interpretations about the meaning of the term (Table 3). Participants were able to select from several options in answering this question, and they were also able to select the option 'Other' to provide an additional interpretation which was recorded as a free text response. The results were stratified by respondents' personal experience of mental distress.

Table 3: Meaning of the term 'mental distress'.

The column percentages add up to more than 100% because participants could select 'yes' for more than one option

	PERSONAL EXPERIENCE?		
WHAT DO YOU THINK MENTAL DISTRESS MEANS?	NO (%)	YES (%)	ALL (%)
Not coping / feeling overwhelmed	45	60	50
Feeling stressed / under pressure	39	43	40
Mental illness / mental health problem	16	12	15
Not being able to think straight	11	15	13
Feeling like you're about to snap or melt down	8	8	8
When mental condition deteriorates	8	8	8
When you need help	8	5	7
Euphemism	0	0	0
Other	22	19	21
Don't know	5	4	5

As Table 3 shows, the most commonly reported interpretation was of not coping or feeling overwhelmed (50%), followed by feeling stressed or under pressure (40%). The third most commonly selected option was 'Other', and responses to this item are discussed further.

Although the responses were generally similar whether the participant did or did not report personal experience of mental illness, participants with experience (currently or in the past) were significantly more likely to agree that mental distress meant not coping or feeling overwhelmed (RR 1.33; 95%CI 1.15 to 1.53). They also appeared less likely to agree with the 'mental illness / mental health problem' definition, but this difference was not significant at the 95% confidence interval level (RR 0.74; 95%CI 0.54 to 1.03). There was close agreement about being stressed or under pressure from both groups of participants.

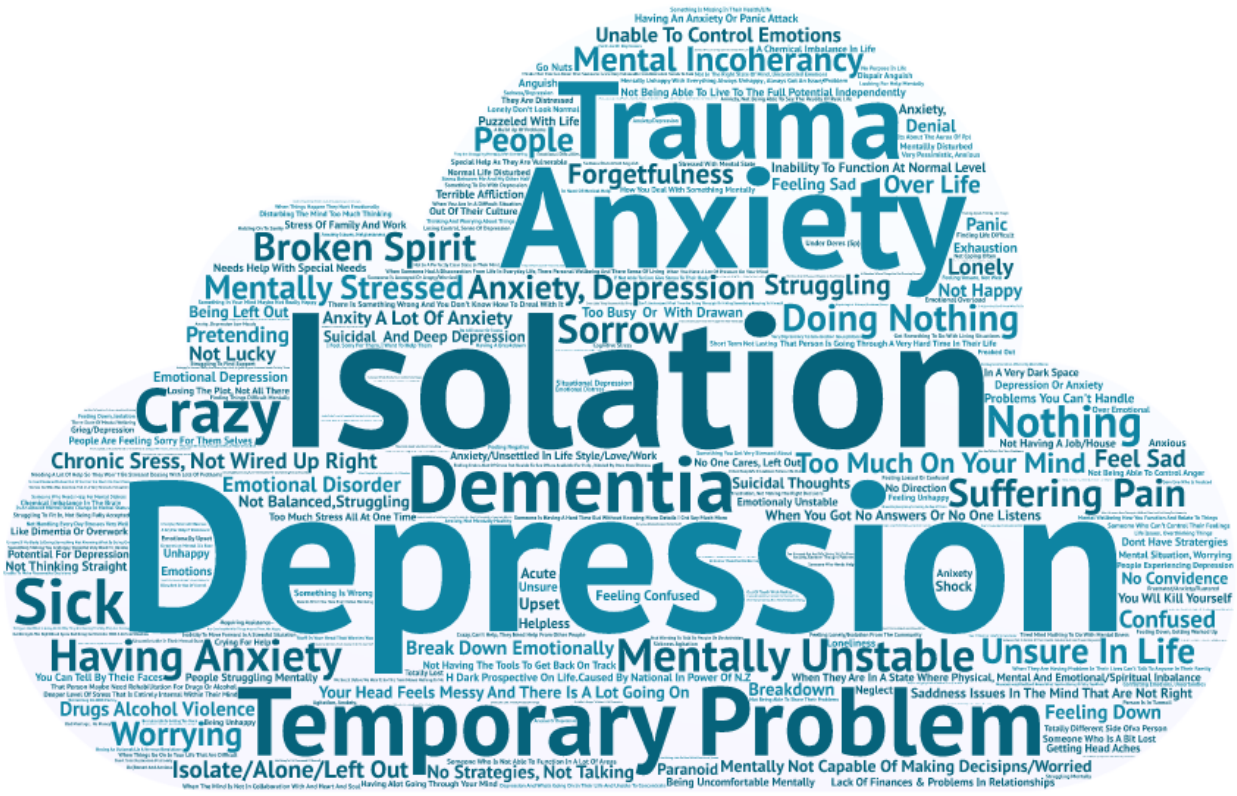
Just over a fifth of participants offered other interpretations in addition to the ones presented in the questionnaire. Figure 7 (p16) is an overview of these responses presented as a word cloud: the size of each word in the cloud is a measure of how often it was mentioned by participants. To simplify the cloud, 'depression' and 'depressed' were counted together, as were 'isolation' and 'isolated'.

The word frequencies were interesting in that 'depression' and 'isolation' strongly dominated the responses that were given, with 'anxiety' the third most common term. 'Trauma' was also a common answer. Some people used language that could be seen as stigmatising (eg 'mentally unstable' or 'crazy'), but many focused on everyday concepts like struggling or feeling stressed. The variety of answers to this question suggests that a formal analysis of themes would be a useful study for the future to understand more fully the different ways in which mental distress is perceived in the population. In this preliminary analysis the major unexpected finding was how often participants spontaneously mentioned isolation when asked to define mental distress.

The data also indicate that mental distress has a profound impact on the lives of people who live in Aotearoa New Zealand. Compared with those who did not have personal experience of mental distress, participants with lived experience were significantly more likely to experience difficulties in day-to-day functioning including difficulties in everyday activities (28% vs 4%) and difficulties in social functioning such as communicating, mixing with others, or socialising (30% vs 5%). Although as previously seen, lived experience of mental distress on its own did not have a strong association with life satisfaction, participants experiencing difficulties in day-to-day functioning were significantly less likely to report high life satisfaction (RR 0.60; 95%CI 0.41 to 0.90), and the association was even more marked for participants who were experiencing difficulties in social functioning (RR 0.51; 95%CI 0.31 to 0.83).

Taken together, these findings show that participants defined and experienced mental distress not just in terms of mental health conditions or diagnoses, but also in social terms: isolation in particular emerged as an important experience. In the next section isolation is explored in more detail.

Figure 7: Word cloud showing frequency of words used in the free responses about the meaning of the term 'mental distress'



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3 Isolation and connectedness are key factors in wellbeing and distress

Participants *were* asked, "*In the last four weeks, how often have you felt isolated from others?*"

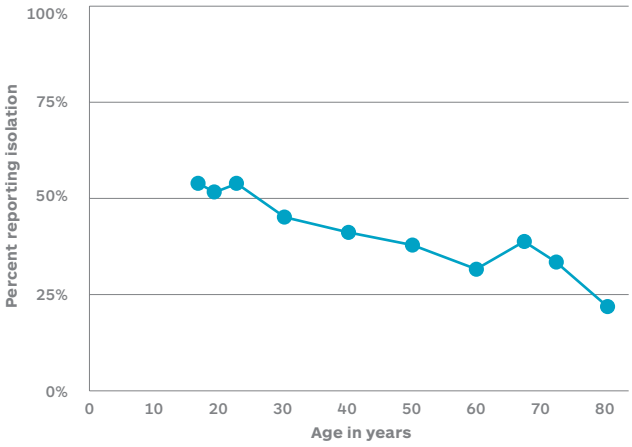
Overall, 3 in 5 participants (60%) stated that they did not experience social isolation at all during the past four weeks. However, this average figure concealed a wide variation in reported isolation across the population.

Isolation in Aotearoa New Zealand

Age

We first examined variations in reported isolation by age, with the expectation that isolation would be most common in the youngest and oldest age groups.

Figure 8: Social isolation decreases with age.



Instead, as Figure 8 shows, reporting of isolation decreased markedly with age: in the 15 to 17 age group, over half (54%) of participants reported that they felt isolated during the past 4 weeks. From about age 25 onwards, the proportion who felt isolated decreased to a minimum of 22% (around 1 in 5) in the oldest age group (75 years and older). The proportion who reported feeling isolated most or all of the time was low in all age groups (data not shown).

Deprivation

Deprivation (as measured by NZDep scores for the area participants lived in) was not a strong predictor of isolation (RR 1.03; 1.00 – 1.05); feelings of isolation appeared to be spread across the social gradient.

Gender and LGBTI

Although there were slightly higher proportions of women than men reporting feelings of isolation (43% vs 37%), this difference was not significant at the 95% level. What was significant was that 62% of participants who identified as LGBTI reported feeling isolated, compared with 39% of the reference population. Among the 15 to 24-year age group, this relationship was even stronger: 79% of these participants who identified as LGBTI reported feeling isolated, compared with 53% of their heterosexual peers (RR 1.50; 1.15 – 1.96).

Ethnicity

Participants identifying as Māori (48%), Pacific (47%) or Asian (47%) were more likely to report feeling isolated than participants in the reference group of all other ethnicities (37%).[4] These differences were less apparent in the 15 to 24 age group, where levels of isolation were more evenly distributed (Māori 49%, Pacific 55%, Asian 53%, and Other 55%).

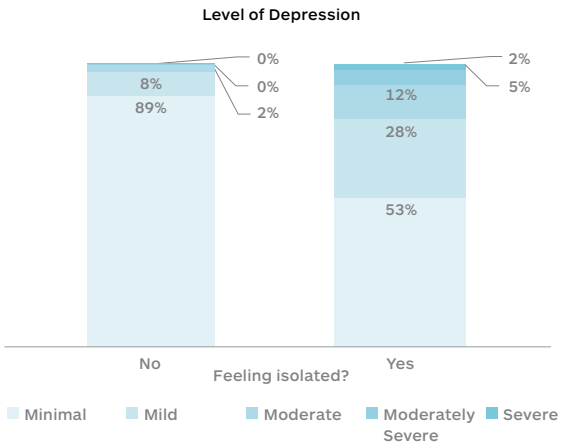
4 These comparisons use prioritised ethnicity, that is, each participant was allocated to a single ethnic group based on the ethnic groups they have identified with, which are, in order of priority: Māori, Pacific, Asian and Other. This means that if someone identifies as being Chinese and Māori, they are classified as Māori in this analysis.

Relationship with mental distress

Isolation and depression

Figure 9 shows the distribution of levels of depressive symptoms (PHQ-9) in participants who did and did not report feeling isolated. Around half of the participants who felt isolated reported symptoms of depression, compared to 1 in 10 of the participants who did not feel isolated.

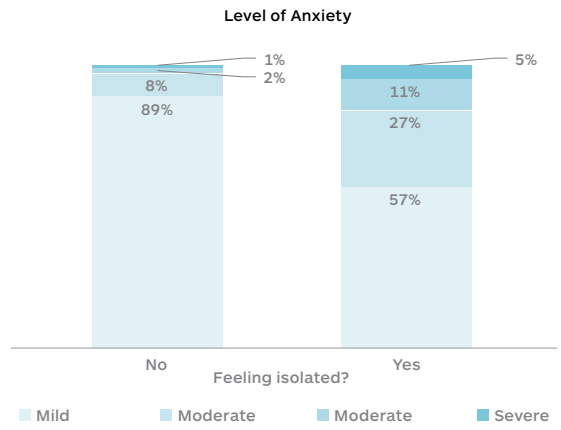
Figure 9: Comparison of levels of depression (PHQ-9) between participants who did and did not report feeling isolated



Isolation and anxiety

Using a similar approach, Figure 10 shows the levels of anxiety (GAD-7) reported by participants who did and did not feel isolated. There was a marked difference in the proportion of participants who experienced severe anxiety: 16% of those who felt isolated reported moderate to severe anxiety, compared with 3% of those who did not feel isolated.

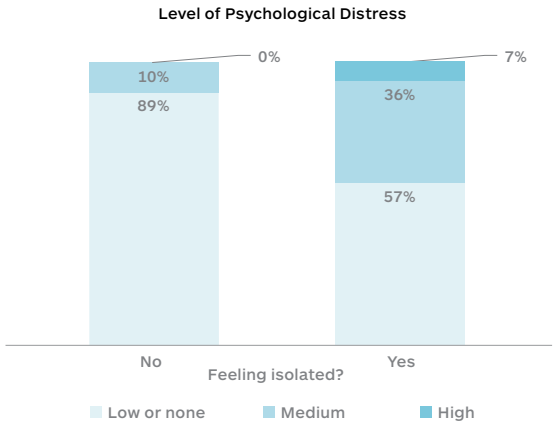
Figure 10: Comparison of levels of anxiety (GAD-7) between participants who did and did not report feeling isolated



Isolation and psychological distress

Figure 11 shows the same comparison applied to levels of psychological distress (K10). Once again, there were marked differences between participants who did feel isolated (43% medium or high levels of psychological distress) and participants who did not feel isolated (10%).

Figure 11: Comparison of levels of psychological distress (K10) between participants who did and did not report feeling isolated



Summary: isolation

Isolation was common, particularly among young people and among participants who identified as LGBTI. People who felt isolated were also more likely to report high levels of depression, anxiety and psychological distress. As previously mentioned (Table 2 on p14), participants who felt isolated were significantly less likely to report high life satisfaction.

Subjective experience of isolation is a different concept from objective measures of social interaction because it is dependent on the quality, not the number, of interactions. This is why people can report feeling lonely even when they have a lot of social contacts. In the NZMHM, participants who lived with at least one other person were 23% less likely to feel isolated than those who lived alone (RR 0.77; 95%CI 0.64 to 0.92; adjusted for gender and age), but there was no change to the probability of feeling isolated as the number of adults in the house increased (RR 1.04; 95%CI 0.96 to 1.12).

In the next section the results for young people are explored in more detail, in particular examining different types of social connections and their relationship with isolation.

4 Mental distress and wellbeing of young adults

Young people in the 2016 NZMHM reported low levels of wellbeing and high levels of mental distress compared with older age groups. These difficulties were not confined to disadvantaged populations but were reported among all ethnicities and all levels of area deprivation.

Mental distress

Table 4 shows the distribution of the three main measures of mental distress in this age group. The category levels of the three measures are as reported in Section 1.

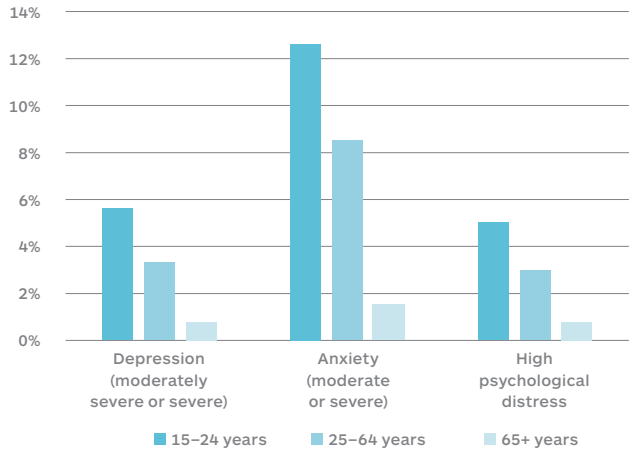
Table 4: Depression, anxiety and psychological distress among 15 to 24-year-olds

Note: Due to rounding, percentages do not add up exactly to 100

DEPRESSION (PHQ-9)		ANXIETY (GAD-7)		PSYCHOLOGICAL DISTRESS (K10)	
Minimal	60%	None	63%	Low or none	64%
Mild	21%	Mild	24%	Medium	31%
Moderate	13%	Moderate	10%	High	5%
Moderately severe	4%	Severe	2%		
Severe	2%				

Young people were more likely than older adults to have elevated levels of mental distress (Figure 12). For example, young people were almost twice as likely to have moderately severe or severe depression compared to the 25 to 64-year age group.

Figure 12: Comparison of mental distress prevalence by age.



Isolation

As noted previously, young people were much more likely to report feeling isolated than older adults. We also found that young people who identified as LGBTI were significantly more likely to report feeling isolated than their peers (79% vs 53%).

We next investigated the correlates of isolation in more detail, to explore specific relational measures and how they associated with isolation.

Table 5: Relational factors associated with reduced isolation in young people

	PROBABILITY OF FEELING ISOLATED	
	RISK RATIO	95% CONFIDENCE INTERVAL
Easy to find help	0.64	0.53 to 0.79
Easy to provide help	0.72	0.56 to 0.93
Feel connected to their culture	0.72	0.54 to 0.97
Family/whānau is doing well or very well	0.56	0.46 to 0.68
Number of adults in household	0.92	0.81 to 1.05

Table 5 shows that a number of relational factors were associated with decreased probability of feeling isolated. Young people were significantly less likely to feel isolated if:

- It was easy to find help
- It was easy to provide help
- They felt connected to their culture
- Their family or whānau was doing well or very well (this was a particularly strong association).

However, as for the general adult population, the probability of feeling isolated was not associated with the number of adults in the household, again indicating that isolation depended on the quality, not the number, of relationships.

Analysis of help-seeking behaviour for depression also indicated that, despite high uptake of social media and online presence in this age group, young people turn to friends or family/whānau rather than online sources of support if they feel depressed. This is additional evidence of the importance of relationships and connectedness in this age group.

Cumulative risk

Although the somewhat small sample size for this age group (n=414) limited our ability to conduct complex multivariable analyses, we observed some combinations of experience that were extremely concerning. In these analyses we combined the indicator of isolation with indicators of whether participants were able to cope with everyday stress and whether they felt that the things they did in their life were worthwhile. (Note: In answering the question about the things they did, participants were not directed to think about specific contexts eg work or school). The results showed that:

- 17% of young people reported feeling both isolated and that they did not feel that the things they did were worthwhile. Participants in this group were seven times more likely than their peers to report moderately severe or severe levels of depression.
- Similarly, 15% reported feeling both isolated and that they were not able to cope with everyday stress. Participants in this group were 16 times more likely than their peers to report moderately severe or severe levels of depression.

Because the data are cross-sectional, we are cautious about inferring causation and about assigning a direction of effect. For example, we cannot be certain whether feeling isolated caused depression or the other way around, or whether both were caused by a third factor. However, the potential cumulative effect of these experiences has important implications for mental distress given the high incidence of suicide in young people (Gluckman, 2017; Ministry of Social Development, 2016; Statistics New Zealand, 2013).

One result about young people that we found particularly concerning related to thoughts that they would be better off dead or about hurting themselves. Participants reporting such thoughts can be identified using a single item in the PHQ-9 questionnaire. Overall, 1 in 10 young people reported these thoughts over the previous two weeks, and if they felt isolated and that the things they did were not worthwhile, the proportion rose to 1 in 3. Recently, authors of a large study in the USA analysed over 1.2 million PHQ questionnaires and found that response to this item in the PHQ-9 was a strong predictor of subsequent suicide attempt or death (Simon et al., 2016).

5 Experience, stigma and who would you tell?

Experience and knowledge

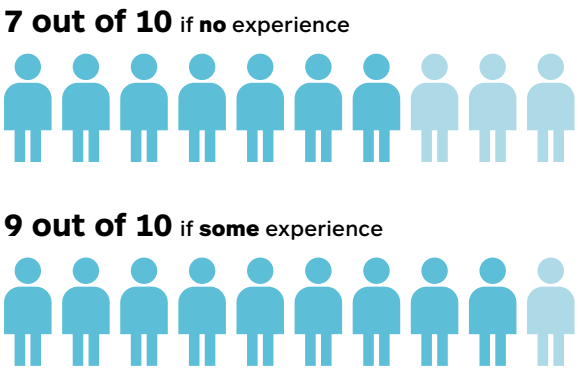
Experience of mental distress strongly influenced participants' perceptions and knowledge. Participants who did have lived experience were significantly less likely to agree that "most people with mental illness go to a healthcare professional to get help" and significantly more likely to agree that medication could be effective, compared with those with no personal experience of mental distress.

When asked if they would know what advice to give a friend who was experiencing mental distress and needed professional help, 73% of those with awareness of distress in self or others agreed that they would know what advice to give, compared with 59% of those with no awareness.

Reported attitudes, social exclusion and discrimination

More stigmatising attitudes were observed in participants who were older, male, Asian, and had no formal qualifications. Awareness of mental distress in self or others was strongly associated with more positive attitudes. One example of this effect was seen in the willingness of participants to work with someone with experience of mental distress: those who had previous or current experience of working with someone with such lived experience were much more likely to be willing to do so in the future, compared with those with no experience of working with someone with lived experience.

Figure 13: Willingness to work with someone with experience of mental distress in the future, based on past and current experiences

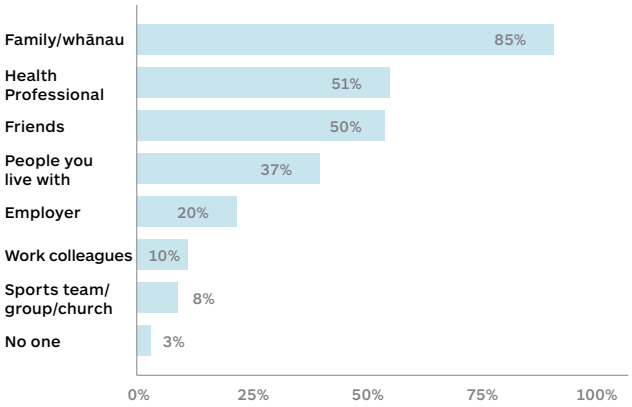


Participants were more likely to report experiencing social exclusion if they were younger, female or gender diverse.[5] Social exclusion was strongly associated with mental distress, and the associations with mental distress persisted after adjustment for age, gender and ethnicity, suggesting that mental distress was a cause of social exclusion even after these other factors had been taken into account.

Results from the 2016 HLS showed that a third of participants who had been diagnosed with "a mental illness" (the wording used in the question) reported that they had experienced discrimination and/or that they had altered their behaviour out of fear of discrimination. Workplace, family and friends, and health services were the three most common settings for discrimination. When asked whom they would tell if diagnosed with "a mental illness", participants were much more likely to mention family or whānau (85%) than an employer (20%) or work colleagues (10%).

Figure 14: "If you were diagnosed with a mental illness, who would you tell?"

Participants were able to select more than one option.



Source: 2016 Health and Lifestyles Survey

Conclusion

These results demonstrate how stigma and discrimination around mental distress can have a silencing effect, which in turn can perpetuate further stigma and discrimination. In the final section of this Snapshot, strategies for breaking this cycle are considered.

5 This result was generated using combined data (n = 3,002) from the 2015 and 2016 NZMHM. The method for combining the data can be found at: https://www.hpa.org.nz/research-library/research-publications.

Reflections and next steps

Some reflections

The survey results demonstrate that mental distress is common in Aotearoa New Zealand: most people have experienced mental distress personally or among people they know.

The true prevalence may be even higher than we have reported. One of the interesting findings of the analysis was how strongly language and terminology appeared to influence the responses that participants gave to survey questions. For example, the data showed little overlap between responses to questions about experience of "mental illness" and about everyday symptoms of distress, suggesting, in common with previous research, that 'illness' was seen as a separate concept from 'distress' (Biddle, Donovan, Sharp, & Gunnell, 2007). When participants in the NZMHM were asked to define mental distress, their responses extended well beyond standard diagnostic conditions to encompass a wide range of ideas and experiences.

Feeling isolated from others (more commonly known as loneliness) emerged from these responses as a key component of mental distress, and our analysis supports this perception. Loneliness was strongly associated with depression and reduced life satisfaction in our study, consistent with findings reported in the international literature (VanderWeele, Hawkley, & Cacioppo, 2012). Longitudinal studies demonstrate that depression and loneliness influence one another in a cyclical way (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006), explaining the strong correlation between depression and isolation in our work and that of others.

Loneliness is now understood to have a significant effect on both physical and mental health (Hawkley & Cacioppo, 2010). The combination of social isolation and depression reported by young adults in our study is extremely concerning, because social isolation combined with hopelessness is a known risk factor for suicidal behaviour (Daniel & Goldston, 2012). Conversely, interventions supporting a strong sense of connectedness and belonging have the potential to increase wellbeing (Noble-Carr, Barker, McArthur, & Woodman, 2014), prevent depression (VanderWeele, Hawkley, Thisted, & Cacioppo, 2011), and reduce suicide risk (Hatcher & Stubbersfield, 2013; Hill, 2009).

Our analyses showed that for young people, feeling connected to their culture was associated with a lower risk of feeling isolated, consistent with evidence that belongingness in the form of connection to culture can help to lower the incidence of depression and suicidal ideation in Indigenous peoples (Hill, 2009). In our study, young people who were able to give as well as receive help and whose family or whānau were doing well also had a lower risk of feeling isolated, suggesting further possibilities for intervention.

Discrimination can be a driver of the cycle of isolation and distress if it prevents people from disclosing mental distress. Around two in five participants were aware of working or having worked with someone with experience of mental distress, and these participants had highly positive views of continuing to do so in the future. Our results underline the importance of exposure in promoting better knowledge and more positive attitudes regarding mental distress. However, the results also indicate a strong reluctance to disclose mental distress in some situations, suggesting that many people who live in Aotearoa New Zealand may be unaware of mental distress experienced by those around them.

Future work

The NZMHM and HLS are extremely rich datasets and inevitably, many associations of interest could not be explored in this short report. There is considerable scope for additional detailed investigations of the topic areas to answer specific research or policy questions. We note for example that there are several free text responses in the surveys which capture the actual words used by participants, and therefore have the potential to provide additional information to complement the multiple-choice questions which form the bulk of the surveys. A simple visualisation of the data as a word cloud demonstrated the importance of isolation to participants, and a more rigorous exploration of these responses can doubtless provide further insights.

Social exclusion and discrimination around gender identity and sexual orientation are known to be powerful determinants of wellbeing, but only a small proportion of participants in the NZMHM identified as LGBTI, limiting our ability to explore wellbeing and mental distress in these often-marginalised

subpopulations. However, the results we do have suggest an urgent need to address the high levels of isolation and mental distress in LGBTI communities.

Future iterations of the NZMHM and HLS will enable us to monitor trends over time, with the ability to contribute to assessing the impact of population-wide strategies; future surveys will also present an opportunity to respond to emerging issues and evidence gaps in wellbeing and mental distress. The mental health of young people is of particular concern at present.

Finally, as outlined above, our results are consistent with other research findings indicating that connectedness is not only central to wellbeing but can also offer protection against distress, in particular depression. This in turn suggests that a wellbeing-orientated approach that promotes and enhances connectedness has the potential to be a highly effective strategy for supporting the mental health of people who live in Aotearoa New Zealand.

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