

# Indicators of Mental Health and Wellbeing of Adults

Findings from the  
2015 New Zealand  
Mental Health Monitor

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# Executive Summary

## Background

This report presents data from the 2015 New Zealand Mental Health Monitor (NZMHM) to provide a high-level summary of the mental health and wellbeing New Zealand adults. The NZMHM was developed by HPA in 2015, and is designed to be nationally representative.

The 2015 NZMHM collected data related to overall mental health and wellbeing, connectedness and support, mental distress (depression, anxiety and psychological distress), knowledge of depression and anxiety, help-seeking behaviour and intentions, and attitudes towards people experiencing mental distress. Measures relate to participants' personal lives, and in the community.

The 2015 NZMHM collected information from 1,377 adults aged 15 years-and-older nationwide in their homes using Computer Assisted Personal Interviewing (CAPI). The response rate was 59%.

Socio-demographic data, as well as respondents' answers to questions from psychometrically-validated scales were collected. These scales include: The Patient Health Questionnaire, The Generalised Anxiety Disorder 7-Item Scale, The Kessler Psychological Distress Scale, questions from Te Kupenga related to wellbeing and The Organisation for Economic Co-operation and Development (OECD) subjective wellbeing measure.

Analyses assessed responses and overall scores for each of the scales to provide population-level estimates of self-reported wellbeing and social connectedness, attitudes towards people experiencing mental distress, help-seeking knowledge and behaviour, and measures of personal mental distress. Responses were then compared by respondents' socio-demographic characteristics, and logistic regression analyses was used to examine whether there were differences among different population groups.

## Overall life and wellbeing

A range of measures was used to assess overall wellbeing and life satisfaction. The majority of New Zealanders (83%) report feeling satisfied with their life overall. A similar proportion (88%) felt the activities in their lives were worthwhile, and most adults (87%) felt able to cope with the stresses of everyday life.

Less than a third (29%) felt that the past year had been the most difficult of their life, which was surprising given the high levels of reported satisfaction, meaning, and perceived ability to cope.

## **Social connectedness and support**

The proportion of adults who reported they made an effort to see whānau and friends was high (86%). Most adults felt they could rely on a whānau member or friends for support (95%) and reported they could also provide support to others (87%). Most were positive about the wellbeing of their family, with 87% of adults saying in general their family got along well with one another. Over a third (36%) reported feeling a little or some social isolation within the last four weeks, a finding at odds with the high levels of social connectedness and support reported. A further 4% reported feeling isolated most or all of the time.

## **Mental distress**

The majority of adults (76%) reported no or minimal depression symptoms in the past two weeks (measured by the Patient Health Questionnaire, PHQ-9). Similarly, the majority of adults (77%) reported not experiencing anxiety in the past two weeks (measured by the Generalised Anxiety Disorder 7-Item Scale). Within the past four weeks, 80% of adults reported no or low levels of psychological distress (measured by the Kessler Psychological Distress Scale).

## **Help-seeking knowledge and behaviour**

The majority of adults believe they are able to recognise symptoms of depression or anxiety in themselves or friends. Over three-quarters of adults report believing they could recognise depression in themselves (77%), and a similar number said they believed they could recognise symptoms/signs in a friend (72%). Those more likely to feel they could recognise depression in themselves were: females (83%) compared with males (71%), and older adults (84%) compared with younger adults (73%).

Eight in ten people said they could recognise anxiety in themselves (80%), or symptoms/signs in a friend (70%). Females (84%) were more likely to report they could recognise anxiety in themselves compared with males (77%), and those identifying as European/other (85%) were more likely to say they recognise anxiety in themselves, compared with Māori (69%), or Pacific peoples (51%). Overall scores indicated that there were some effects related to socioeconomic deprivation: adults living in areas with low levels of deprivation (85%) were more likely to agree they would be able to recognise if *they* had problems with anxiety, compared with respondents living in areas with high levels of deprivation (72%). Respondents who knew someone (other than themselves) who had been diagnosed with a mental illness (84%) were more likely to agree they would be able to recognise if *they* had problems with anxiety, compared with respondents who did not know someone (73%).

The majority of adults identified a doctor as the help source they *knew* about for both depression and anxiety, followed by friends and whānau, and counsellors (Table 1). Table 1 shows that the order of the top two responses was reversed when participants were asked to name the first place they *would* go to access help for themselves if they thought they might be experiencing depression or anxiety: most adults said they would talk to a friend or whānau member first, before seeing a doctor.

**Table 1: Knowledge of help-sources and intended help sources, for depression and anxiety**

	Doctor %	Friends or whānau %	Counsellor %
Knowledge of help sources for depression	68	36	30
Knowledge of help sources for anxiety	67	25	25
Intended first help source for depression	30	54	4
Intended first help sources for anxiety	36	45	4

*Note: Responses given by fewer than one percent of respondents are not shown. These included: 'Would do an activity/find a distraction'; 'Go to a website'; 'Go to depression.org.nz/John Kirwan website'; 'Ring a helpline'; 'Go to a local mental health or community organisation/agency'; 'Go to the Emergency Department'; and 'Email/text/chat to internet help service'.*

Half of adults (50%) were able to identify the HPA website [depression.org.nz](http://depression.org.nz) as a website to assist people to find or get help for depression. While respondents knew of internet-based sources for help for depression, few said that this was the source of help they would most likely use. They were more likely to choose a face-to-face intervention (at least in the first instance) such as doctors, or family, whānau and friends – the latter being the *most likely* source of help.

# Introduction

## Background

The burden of depression and other mental health conditions is increasing, significantly impacting on health, society, human rights and economies globally. Depression impacts over 300 million people and is the leading cause of disability and a major contributor to the overall global burden of disease (World Health Organisation, 2016).

In New Zealand, the rates of diagnosed mental health conditions are also significant. In 2014/15, 636,000 or 17% of adults reported being diagnosed with a mood disorder, including depression, bipolar disorder, and/or anxiety disorder (including Generalised Anxiety Disorder, phobias, post-traumatic stress disorder and obsessive-compulsive disorder) at some point in their lifetime (Ministry of Health, 2015). Findings released by New Zealand Police show a marked increase in mental health-related calls made to them in recent years (New Zealand Police Mental Health Team, 2014). A review of suicide mortality undertaken in 2014/15 also reveals a raft of concerning statistics regarding the extent of mental distress experienced by three studied cohorts who ended their lives between 2007 and 2011. Specifically, over half of the 194 Māori aged 15-24 years at the time of their death (53.9%) and half of the 1,272 men aged 25–64 years at the time of their death (50.2%) had a record of publicly funded mental health service use. Of the 829 people who had had face-to-face contact with specialist mental health or addiction services in the year before their death by suicide, about half (48%) had contact with a mental health service in the last week of their lives (Suicide Mortality Review Committee, 2016).

Mental health promotion involves a range of actions aimed to create living conditions and environments that support people to adopt and maintain healthy lifestyles and increase their chances of experiencing better mental health (World Health Organisation, 2016). A public health approach to mental health and wellbeing requires that experiences of mental distress are treated as a matter that affects individuals, families, whānau and communities.

Since 2012 the Health Promotion Agency (HPA) has managed the National Depression Initiative (NDI) on behalf of the Ministry of Health; a programme aimed at reducing the impact of depression and anxiety on the lives of people by aiding early recognition, appropriate treatment, and recovery. The NDI specifically focuses on:

- strengthening individual, family, whānau and social factors that protect against depression and anxiety
- improving family, whānau, community and professional responsiveness to depression and anxiety.



The Health Promotion Agency (HPA) manages research, evaluation and monitoring related to the NDI. As part of a series of monitors designed to capture, track and monitor the health and wellbeing of adults and their knowledge, attitudes and behaviours in key health areas, in 2015 HPA developed the New Zealand Mental Health Monitor (NZMHM).

## The current report

The 2015 New Zealand Mental Health Monitor (NZMHM) collected data on overall wellbeing and connectedness, knowledge of depression and anxiety (including help-seeking knowledge and behaviour), attitudes towards people experiencing mental distress (using measures of stigma behaviours and stigma in the community), and personal mental distress (using measures of depression, anxiety, psychological distress and psychological/psychiatric impairment).

The aim of this report is to provide a high level summary of some indicators of mental health and a snapshot of the overall self-reported mental health and wellbeing of New Zealand adults, using data from the 2015 NZMHM. The results identify some of the social experiences that contribute to mental health and wellbeing among different population groups, and provide some indication of how many adults are affected by experiences of mental distress, including depression and anxiety.

This report does not present the entire analysis of the 2015 NZMHM. Another report, *Attitudes of adults towards people with experience of mental distress: Findings from the 2015 New Zealand Mental Health monitor*<sup>1</sup>, provides an initial overview of the self-reported views of adults who are aged 15 years and older, towards people with experience of mental distress, providing a 'baseline' from which to compare future changes in those attitudes.

## Limitations

It is important to note that this report is not intended to be an exhaustive examination of all mental health related issues in Aotearoa New Zealand. It focuses specifically on the 2015 NZMHM questions that relate to measuring the self-reported experiences, opinions, knowledge and awareness of mental distress (i.e., depression and anxiety) of a sample (1,377) of New Zealand adults, as well as their overall wellbeing and social connectedness (i.e., the degree to which they feel socially connected and satisfied with life).

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<sup>1</sup> This report can be found at <http://www.hpa.org.nz/research-library/research-publications>.

The study's limitations relate to the following standardised measures used to monitor depression, anxiety and psychological distress:

- The Patient Health Questionnaire (PHQ-9)
- The Generalised Anxiety Disorder 7-Item Scale (GAD-7)
- The Kessler Psychological Distress Scale (K10)
- The Organisation for Economic Co-operation and Development (OECD) subjective wellbeing measure.

These screening tools indicate people's *self-reported* overall wellbeing and connectedness, knowledge of depression and anxiety, and personal mental distress, as opposed to a clinical diagnosis.

Self-reported views can be affected by social desirability bias (Nederhof, 1985; Corrigan & Shapiro, 2010), or the stigma and discrimination that can be related to disclosure. Social desirability bias, the practice of respondents answering survey questions in a manner that they think will be viewed favourably by others, or to "say what they believe conforms to cultural morés, even if it varies from what they might otherwise report to be their "real belief" (Corrigan & Shapiro, 2010:912), is prevalent in this area (Michaels & Corrigan, 2013). Agreement or acquiescence bias, whereby respondents have a tendency to agree with a statement when in doubt, or indicate positive connotations, can also affect self-reported survey responses, particularly when surveys are conducted face to face such as the 2015 NZMHM. The Computer Assisted Personal Interviewing (CAPI) was used because this method has advantages over paper-based methods, including: standardisation of delivery, and better control over confidential recording and storing of responses.

## Terminology

The scales used in the 2015 NZMHM refer to 'mentally ill' and 'people with mental illness/es'. These are the most frequently used terms used to describe mental health challenges (in the literature). However, this report intentionally uses the terms 'mental distress', and 'people with experience of mental distress' to reflect the preference of those with lived experience who promote mental distress as a more accurate reflection of that experience.<sup>2</sup>

Historically, 'mental illness' has been framed within a medical model that has pathologised lived experience. This has been found, however, to increase the desire for social distance (Corrigan et al., 2001), effectively exacerbating the stigmatisation of those with lived experience, and countering the efforts of programmes such as the HPA led 'Like Minds, Like Mine.'

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<sup>2</sup> The exception is when reference is made to a "diagnosis of mental illness".

A key component of recovery from mental distress involves minimising its impact through the way it is framed (Slade et al., 2015). By reframing mental illness from a medical event to a more holistic and human experience of distress, discrimination is decreased. A primary aim of replacing the term 'mental illness' with 'mental distress' then, is to be as non-stigmatising as possible by focussing on the *experience* of distress rather than the diagnosis of an illness.

Although the preferred use of 'experience of mental distress' as a descriptor of 'mental illness' is not specific to New Zealand (Evans-Lacko et al., 2011), it has been spoken about and used within the mental health sector for a number of years now, with the move to focus on experience being widely accepted and used for at least a decade. 'Mental distress' is accordingly now commonly used by both government agencies and non-government organisations, such as Police and the Mental Health Foundation.

## **Report structure**

This report includes three sections:

1. **Method:** Outlines the methodology used in the 2015 NZMHM, including the survey design, measures, sampling frame, data collection method, respondent characteristics and questionnaire content, before briefly detailing the specific data analysis and weighting procedures used for this report.
2. **Results, focussed on:**
  - Overall wellbeing and social connectedness, whereby respondents' wellbeing is examined through key indicators, such as life satisfaction, ability to cope with difficulties, and social relationships;
  - Depression, anxiety and psychological distress, whereby data related to each is explored in terms of how well respondents understand the respective signs and symptoms, and how much they know about associated support available; and
  - The screening tools used to monitor depression, anxiety and psychological distress, which are outlined alongside the estimates of prevalence they provide.
3. **Conclusion:** Includes a brief analysis of the findings and their potential utility.

## Method

The key aspects of the survey method for the 2015 NZMHM are summarised below. More specific details related to the sampling, recruitment, selection process and interviewing procedures can be found in a separate report titled *2015 New Zealand Mental Health Monitor: Methodology Report* published on the HPA's website<sup>3</sup> (National Research Bureau, 2015).

### **Ethics**

The NZMHM was approved by the New Zealand Ethics Committee in April 2015.

### **Sampling frame and recruitment**

Participants were recruited using an area-based frame made up of 2013 New Zealand Census meshblocks, the smallest geographical measure used by Statistics New Zealand/Tatauranga Aotearoa. The selection process was stratified, whereby a sample of meshblocks was selected first, then a sample of dwellings within each selected meshblock, and finally one eligible adult (aged 15 years-or-older) from each selected dwelling. Selected dwellings or households were visited personally by interviewers to arrange suitable appointment times with eligible respondents, and respondents could only be interviewed at their own usual residence. That is, if they were visiting a household that was selected for inclusion in the 2015 NZMHM they could not be interviewed as part of that household. This process ensured that people did not have a chance of being counted more than once.

While the sample frame was designed to be nationally representative, oversampling of some population groups (15 to 24-year-olds, Māori, and Pacific peoples) was used to provide sufficient sample sizes for analyses with those sub groups. Weighting was later applied to ensure the data were nationally representative.

### **Data collection**

Interviews were conducted by National Research Bureau (NRB), between 25 July and 27 September 2015. Data were collected in people's homes using Computer Assisted Personal Interviewing (CAPI).

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<sup>3</sup> This report can be found at <http://www.hpa.org.nz/research-library/research-publications>.

A total of 1,377 respondents participated in the 2015 NZMHM. The response rate of 58.9% reflects the proportion of people interviewed from those who were selected into the sample. Although a higher response rate would suggest the survey results were more representative of the adult population, the response rate was considered sufficient to draw reliable findings. Response rates are affected positively and negatively by many factors, including self-selection bias. It is possible respondents who have more favourable attitudes towards mental distress were more willing to participate than those who do not, but it is unknown to what extent such biases may have affected the response rate to the 2015 NZMHM.

## Respondents

Of the 1,377 respondents, 270 were Māori, 245 were Pacific peoples, and 783 were of European/Other ethnicity (prioritised ethnicity). In terms of age, 334 of the respondents were young people (aged 15-24 years). Socio-demographic characteristics of the respondents are summarised in Table 1.

Table 2: Sample characteristics (sample size, weighted n) (n = 1,377)

Socio-demographic characteristics	Sample size	Weighted n
<b>Gender</b>		
Male	599	659.4
Female	778	717.6
<b>Age group</b>		
15-24	334	236.7
25-44	418	441.8
45-64	384	425.4
65+	241	273.1
<b>Ethnicity (prioritised)</b>		
Māori	270	171.1
Pacific	245	73.5
Asian	79	157.8
European/Other	783	974.7
<b>Deprivation status (NZDep2013)</b>		
Low (least deprived)	430	576.9
Moderate	509	523.8
High (most deprived)	437	276.3
<b>Total respondents</b>	<b>1,377</b>	

## Questionnaire

The NZMHM questionnaire was developed by HPA and refined through consultation with international researchers, expert in mental health monitor design. National Research Bureau (NRB) also provided feedback on the suitability of the questions and survey structure.

Questions were presented in English but translators were available if required.<sup>4</sup> To assess the suitability of the questionnaire including its length, and to ensure that questions were straightforward and unproblematic for respondents, a pilot survey was first conducted with 60 respondents. Results from the pilot survey demonstrated that the questionnaire was performing to task, and only minor changes in wording were made to the full-scale survey.

The final 2015 NZMHM contained both socio-demographic questions, including age, gender, and ethnic group membership, and a range of questions on mental health and wellbeing related issues (see [www.hpa.org.nz/research-library/research-publications](http://www.hpa.org.nz/research-library/research-publications) for the questionnaire). This report will focus specifically on the questions that relate to measuring the experience, opinions, knowledge and awareness of mental distress (i.e., depression and anxiety) of adults, as well as their overall wellbeing and social connectedness (i.e., the degree to which respondents felt socially connected and satisfied with life). The following standardised measures from the 2015 NZMHM were used.

### ***The Patient Health Questionnaire***

The PHQ-9 is a 9-item scale designed to assess depressive symptoms over the previous two weeks, with a lower score indicating fewer depressive symptoms (Kroenke, Spitzer & Williams, 2001). It should be noted that this scale provides an estimate of depressive symptoms, and should not be understood to provide a clinical diagnosis of depression.

### ***The Generalised Anxiety Disorder 7-item Scale***

The GAD-7 is a 7-item scale designed to assess the severity of Generalised Anxiety Disorder (Spitzer, Kroenke, Williams & Lowe, 2006). The GAD-7 comprises questions relating to an individual's level of anxiety in the previous two weeks, with a lower score indicating fewer anxiety symptoms. As above, this scale provides an estimate of level of anxiety, and should not be interpreted as providing a clinical diagnosis of Generalised Anxiety Disorder.

### ***The Kessler Psychological Distress Scale***

The K10 is a 10-item scale designed to give an indication of psychological distress, based on questions about anxiety and depressive symptoms that an individual has experienced in the most recent four-week period (Kessler et al., 2002). Lower scores indicate lower levels of psychological distress.

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<sup>4</sup> Nine respondents completed the survey with the help of a translator.

## **Wellbeing measures**

The OECD subjective wellbeing measure is designed to give a measure of life satisfaction (OECD, 2013).

The 2015 NZMHM also includes measures from Te Kupenga, Statistics New Zealand/Tatauranga Aotearoa's first survey on Māori wellbeing (Statistics New Zealand/Tatauranga Aotearoa, 2014). The survey provides general measures of wellbeing, including 'whānaungatanga', or 'social connectedness'. In-depth analysis of the responses specific to these questions, answered only by those respondents who identified as Māori, has not been undertaken as part of this report. However, this data, alongside the Te Kupenga data collected in the 2015 Health and Lifestyles Survey, the 2016 Health and Lifestyles Survey, and the 2016 NZMHM will be analysed in subsequent report/s.

## **Data analysis and weighting**

Analyses examined distribution of responses to the questions, and the overall responses were used to provide population-level estimates of the experience, knowledge and awareness of mental health and wellbeing factors. For questions that used a five-point agreement scale, 'strongly agree' and 'agree' responses were combined to indicate total agreement, and 'strongly disagree' and 'disagree' responses were combined to indicate total disagreement. 'Neither agree nor disagree' responses were counted as neutral and those who said 'Don't know' or refused to answer a question were excluded from that particular analysis.

Responses were then assessed by socio-demographic variables to determine whether there were variations in attitudes and experience of mental distress and wellbeing across the different population groups. To ensure that no population group was under- or over-represented in estimates from the survey, weights were calculated for every survey respondent. Weights are designed to reflect the probabilities of selection of each respondent and make use of external population benchmarks (typically obtained from a population census) to correct for any discrepancies between the sample and the population benchmarks. This improves the precision of estimates and reduces bias due to non-response. The weight, then, can be thought of as the number of people in the population represented by a given survey respondent.

The information in this report incorporates weighted responses (as percentages) to the questions among the total sample and subgroups.

# Results

## Overall wellbeing and connectedness

Feelings of wellbeing are associated with numerous social, emotional, physical, mental and economic benefits. For example, people with higher levels of wellbeing are more likely to show better physical health (Okun, Stock, Haring & Witter, 1984), increased productivity at work (Robertson & Cooper, 2011) and improved social relationships (Diener & Ryan, 2009). Wellbeing also brings economic benefit; those with higher levels of wellbeing being more able to contribute to communities (Diener & Ryan, 2009). Spiritual wellbeing has also been shown to reduce the severity of symptoms of mental distress (Bormann, Liu, Thorp & Lang, 2012; Siegel & Schrimshaw, 2002). This is particularly the case for Indigenous populations who view 'spirituality' as an integral component of wellbeing (Pere, 2006; Cherrington, 1994) that is intertwined with cultural identity. The complex interaction between social, emotional, physical, mental, economic, cultural and spiritual wellbeing, and their benefits, are inextricably bound within Indigenous worldviews and understandings of identity.

This section of the report presents findings of the 2015 NZMHM related to the overall wellbeing and connectedness of adults.

### Overall wellbeing indicators

Four questions drawn from the OECD (2013) and from *The 2014 Health and Lifestyles Survey* (Health Promotion Agency, 2015) were used as indicators of overall wellbeing. These questions related to self-reports of:

- life satisfaction
- life difficulties and stresses
- meaning and sense of purpose

The specific questions asked and summarised findings are provided in Table 2. As the questions use different scale descriptions (for example satisfaction or agreement) the results are presented for each individual question.

The majority of adults reported satisfaction with their life (82.7%), that they were doing worthwhile things in their life (87.6%), and that they believed they could cope with everyday stresses (86.9%) (Table 2). A small proportion of adults (less than 4% for each question) indicated that they were dissatisfied, felt the things they were involved in was not worthwhile or that they disagreed with the question on being able to cope. However, over a quarter (28.8%) agreed that the last twelve months were among the most difficult times in their life.



Table 3: Self-reported indicators of wellbeing from 2015 NZMHHM

Question	Proportions (95% confidence intervals in parentheses)		
	Satisfied %	Neutral %	Dissatisfied %
Overall, how satisfied are you with your life as a whole these days?	82.7 (79.5, 86.0)	13.6 (10.5, 16.8)	3.6 (2.2, 5.1)
	Worthwhile %	Neutral %	Not worthwhile %
Overall, to what extent do you feel the things you do in your life are worthwhile?	87.6 (84.7, 90.6)	10.6 (7.9, 13.4)	1.7 (0.7, 2.8)
	Agree %	Neutral %	Disagree %
The last twelve months have been among the most difficult times of my life	28.8 (25.2, 32.3)	16.9 (13.5, 20.2)	54.4 (50.0, 58.8)
I am able to cope with everyday stresses of life	86.9 (84.0, 89.8)	9.6 (6.8, 12.4)	3.5 (2.1, 5.0)

## Social connectedness

Seven questions were used as indicators of social connectedness that might impact wellbeing. These questions related to:

- frequency of contact with family, whānau and friends
- strength of social networks
- perceived levels of social support
- feelings of social isolation.

The specific questions asked and summarised findings are provided in Table 3 (except for social isolation, see Figure 1). As the questions use different scale descriptions (for example ease or agreement) the results are presented for each individual question.

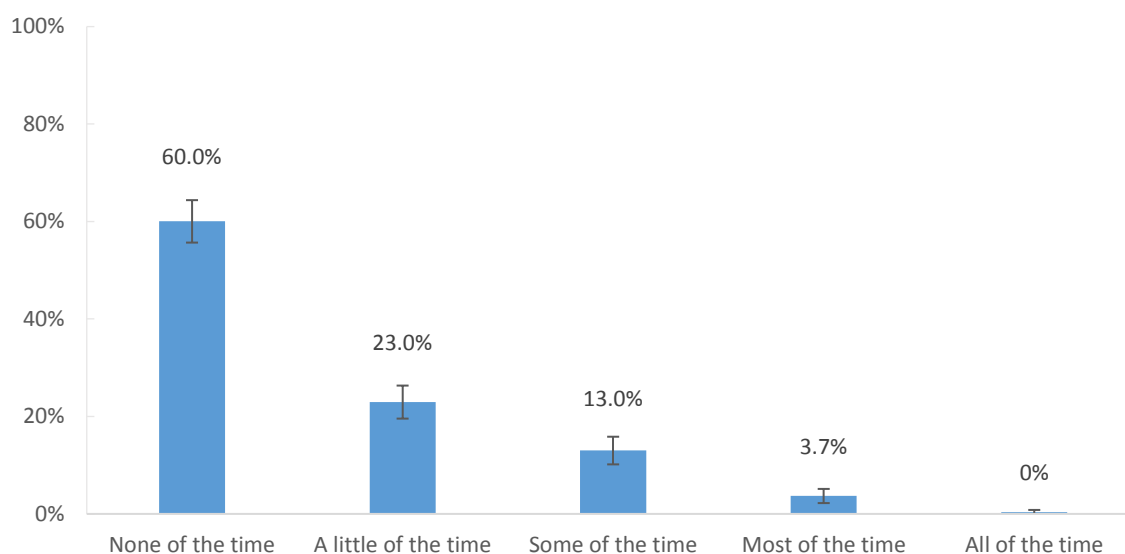
Table 3 shows that the majority of responses were positive. The majority of adults agreed that they made an effort to see family and friends they do not live with (86%) and believed they could rely on someone for support if needed (94.8%). The majority of adults also rated that they believed their family/whanau got along with each other well (86.9%) and were doing well (82.1%). Similarly they also report that they believed it would be easy to find someone to help to watch-out for their house when away (86.5%) or to get help in times of need (86.5%). Less than 6% of adults provided negative responses to these individual questions.

Table 4: Self-reported indicators of social connectedness from 2015 NZMHH

Question	Proportions (95% confidence intervals in parentheses)		
	Agree %	Neutral %	Disagree %
I make an effort to see family or friends I don't live with	86.0 (80.7, 91.2)	10.0 (4.7, 15.2)	4.1 (2.7, 5.4)
I can always rely on a friend or family member for support if I need it	94.8 (93.0, 96.6)	3.2 (1.8, 4.6)	2.0 (1.0, 3.0)
	Well %	Neutral %	Badly %
In general, how would you rate the way your family/whānau get along with one another?	86.9 (84.1, 89.7)	9.7 (7.2, 12.2)	3.4 (2.0, 4.9)
How would you rate how your family/whānau is doing these days?	82.1 (78.5, 85.6)	15.2 (11.8, 18.5)	2.8 (1.7, 3.9)
	Easy %	Neutral %	Hard %
How easy or hard would it be to find someone to help you with things such as looking after pets, collecting mail, or checking your house while you are away from home?	86.5 (84.3, 88.7)	8.0 (6.1, 9.9)	5.5 (3.9, 7.2)
How easy or hard would it be to find someone to help you in times of need, such as providing a place to stay if you suddenly needed one?	86.5 (83.7, 89.3)	8.5 (6.3, 10.7)	5.0 (3.3, 6.6)

Social isolation was examined by a question asking 'In the last four weeks, how often have you felt isolated from others?'. Figure 1 shows that 40% of adults indicated feeling some degree of social isolation within the last four weeks. This finding is interesting given the high proportion of adults (over 80%) who provided positive responses to the other measures of social connectedness summarised in Table 3. This apparent inconsistent response may suggest further investigation into the relationship between the positive indicators of wellbeing (i.e. social connectedness and support) and negative indicators (i.e. social isolation).

Figure 1: Percentage of time respondents had felt isolated in the most recent four-week period



## Depression

The 2015 NZMHM provides a baseline from which to measure changes in public awareness and understanding of depression. This section of the report presents findings related to depression in the following areas:

- Recognition of signs
- Knowledge of where to get help
- Intended help-seeking
- Reasons for not seeking help
- Knowledge of the HPA website depression.org.nz.

### Recognition of signs and symptoms of depression

Around three-quarters of respondents (77%) agreed they would be able to recognise if they had depression, and 72% agreed that they would be able to recognise the signs and symptoms if a friend had depression (Table 4).

Table 5: Perceived ability to recognise signs and symptoms of depression

	Agree % (95% CI)*	Neutral % (95% CI)	Disagree % (95% CI)
You would be able to recognise if you had depression	77.0 (73.1, 80.9)	13.1 (10.3, 15.9)	10.0 (6.5, 13.5)
If a friend had depression, you would be able to recognise the signs and symptoms	72.0 (68.1, 75.8)	17.7 (14.7, 20.7)	10.3 (7.1, 13.5)

\* CI = confidence interval

Respondents more likely to believe they would be able to recognise if *they* 'had depression' were:

- female (82.6%) compared with male (70.9%) [odds ratio = 0.52,  $p < 0.01$ ]
- aged 65 years or older (84.3%) compared with those aged 25–44 years (72.7%) [odds ratio = 2.02,  $p = 0.02$ ].

There were no significant differences identified by ethnicity, socio-economic deprivation, and knowing someone with experience of mental distress.

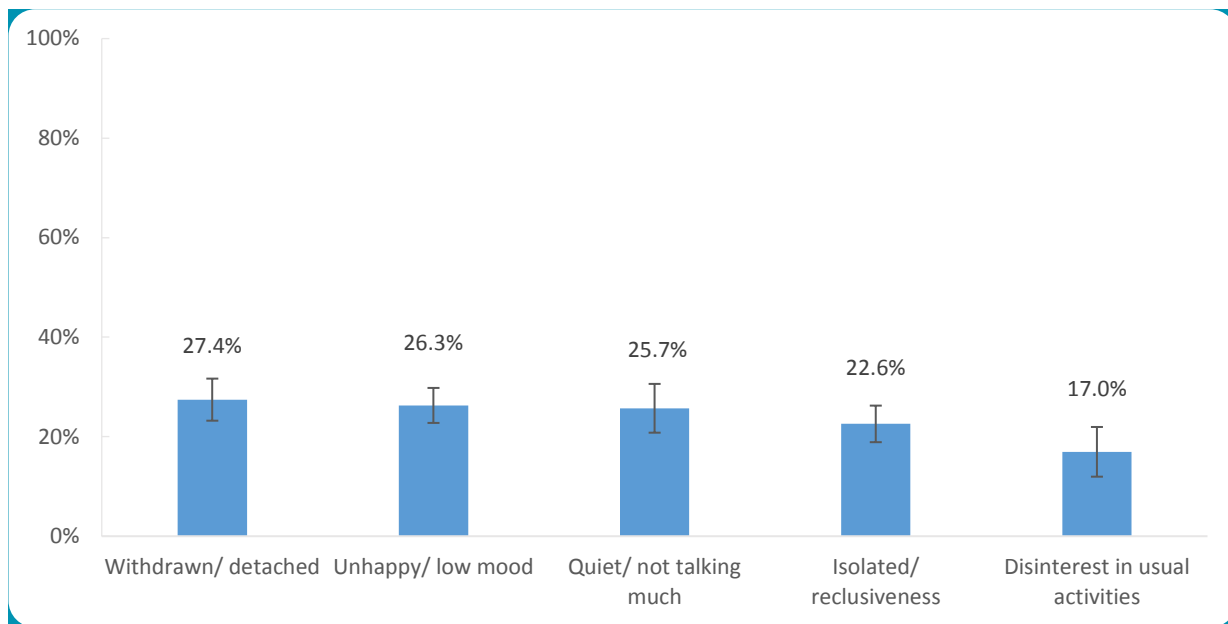
## **Description of signs and symptoms of depression**

Respondents were asked to list the signs or behaviours a person might have if they 'had depression'. Figure 2 shows the top five most commonly listed signs identified; being withdrawn or detached, being unhappy or having a low mood, being quiet or not talking much, being isolative or reclusive, and having a lack of interest in usual activities. These reflect the signs of depression to look for in yourself or a loved one identified by the Mental Health Foundation of New Zealand (Mental Health Foundation of New Zealand, n.d.).

The Mental Health Foundation of New Zealand signs are:

- persistent low, sad or depressed mood
- loss of interest and pleasure in usual activities
- irritable mood
- change in sleeping patterns
- change in appetite
- decreased energy, tiredness and fatigue
- physical slowing or agitation often comes with severe depression
- thoughts of worthlessness or guilt
- thoughts of hopelessness and death
- difficulty thinking clearly.

Figure 2: Most common signs of depression reported by respondents



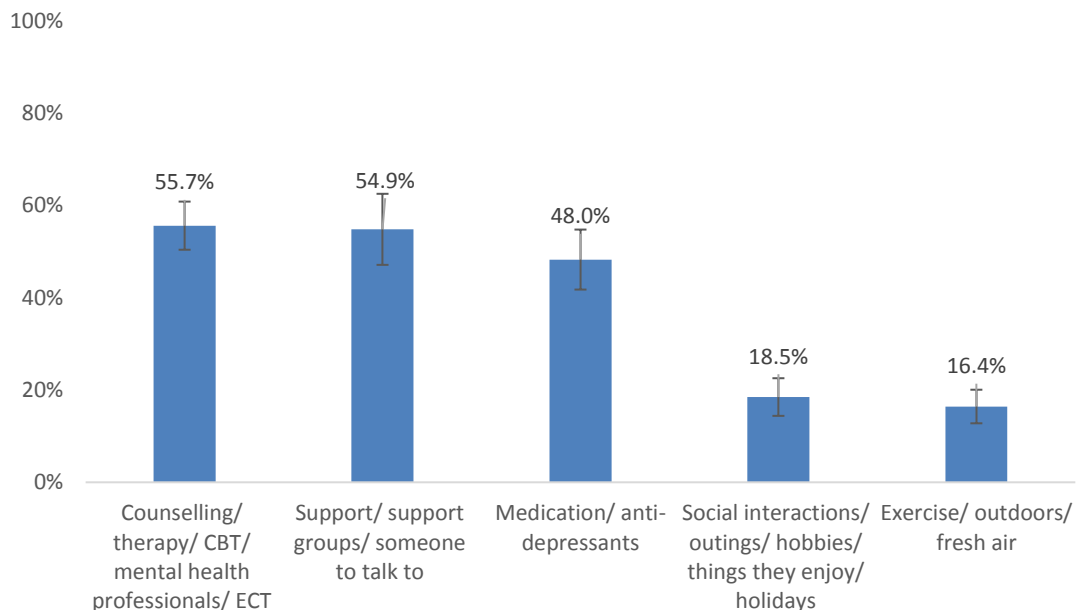
Note: Responses may add to more than 100% as respondents could give multiple responses (i.e., list multiple signs or symptoms)

## Help-seeking knowledge and behaviour

### ***Perceptions of suitable treatments for depression***

Respondents were asked to indicate what types of treatment they thought might be suitable for someone with depression (Figure 3). The most common treatments identified were medical interventions (including medication and antidepressants) or talking therapy related support (both formal and informal). These include treatments provided by health professionals (55.7%), support or support groups (54.9%) and medication (48%). Less than one fifth considered social interactions, engaging in activities, exercising, engaging with the outdoors or related activities as suitable treatment.

Figure 3: Treatments identified as suitable for someone with depression

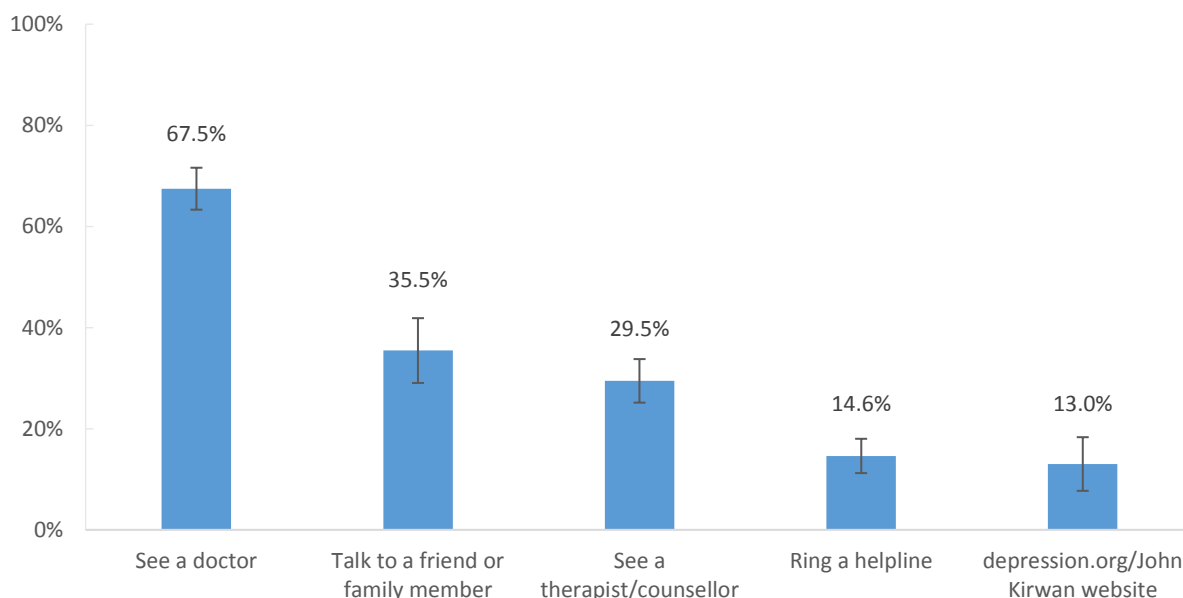


Note: Responses may add to more than 100% as respondents could give multiple responses (i.e., list multiple treatments)

### Awareness of potential sources of help for depression

Respondents were asked if they knew where to get help for someone they knew who might be experiencing depression. Figure 4 shows those sources of help that were reported by at least 10% of respondents. The top source of help identified was doctors (67.5%), followed by friends, family or whānau members (35.5%) and therapists (29.5%). Less frequently mentioned were helplines (14.6%) and the HPA’s website ‘www.depression.org.nz’ (13.0%).

Figure 4: Potential help sources identified for someone experiencing depression

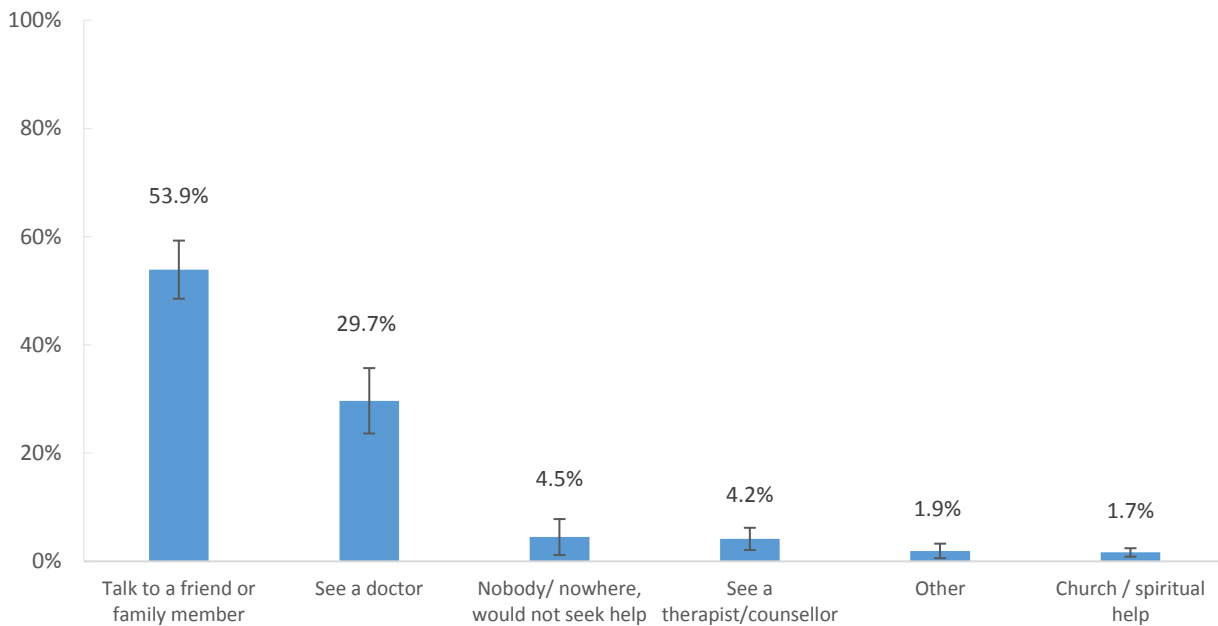


Note: Responses may add to more than 100% as respondents could give multiple responses (i.e., list multiple potential sources of help)

### ***Intended help-seeking for depression***

Respondents were also asked where they would be *most likely* to go to for help *for themselves* if they thought they might be experiencing depression. Around half of respondents (53.9%) indicated that they would talk to a friend or family member, and over a quarter (29.7%) said they would see a doctor (Figure 5).

Figure 5: Help sources respondents were most likely to turn to for help



*Note: Responses given by fewer than one percent of respondents are not shown. These included: ‘Would do an activity/find a distraction’; ‘Go to a website’; ‘Go to depression.org.nz/John Kirwan website’; ‘Ring a helpline’; ‘Go to a local mental health or community organisation/agency’; ‘Go to the Emergency Department’; and ‘Email/text/chat to internet help service’.*

Given doctors were the most identified source of help by adults looking for support for someone else who might be experiencing depression (see Figure 4), this finding is significant. Less than half of those who identified doctors as this potential source of help felt the same when it came to seeking help for themselves, and fewer than five percent of adults (4.2%) identified therapists or counsellors as their most likely source of help for depression. Talking to a friend or family member about it was preferred by adults who thought they might be experiencing depression.

Few adults (4.5%) indicated they would not seek help if they thought they might be experiencing depression (Figure 5). Of those who indicated they would not seek help for depression, however, the most common reasons were because they felt they would be able to deal with the problem themselves (46.6%), or would not want to admit that they had a problem (31.1%). Other responses are not presented as the sample sizes are too small to give reliable estimates.

## Knowledge of the HPA website 'www.depression.org.nz'

Half of adults (49.5%) named the HPA website 'www.depression.org.nz' unprompted, when asked if they could name any New Zealand websites that can assist people to find out about or get through depression. About two-thirds of respondents (67.7%) recognised this HPA website, both prompted and unprompted.

## Anxiety

The 2015 NZMHM collected data on respondents' recognition of signs and symptoms of anxiety, knowledge of potential help sources, and intended help-seeking behaviour.

### Recognition of signs and symptoms of anxiety

More than three-quarters of respondents (80.3%) agreed they would be able to recognise the signs and symptoms of anxiety in themselves, and over two-thirds of respondents (69.6%) agreed they would be able to recognise if a close friend had problems with anxiety (see Table 5). Around one out of ten respondents disagreed, feeling that they would not be able to recognise the signs and symptoms of anxiety in themselves (7.8%), or in a close friend (12.3%).

Table 6: Ability to recognise signs and symptoms of anxiety (in self and other)

	Agree % (95% CI*)	Neutral % (95% CI)	Disagree % (95% CI)
You would be able to recognise if you had problems with anxiety	80.3 (77.0, 83.6)	11.9 (9.2, 14.7)	7.8 (5.7, 9.8)
If a friend had anxiety, you would be able to recognise the signs and symptoms	69.6 (64.7, 74.4)	18.1 (14.0, 22.2)	12.3 (9.2, 15.4)

\* CI = confidence interval

Respondents more likely to agree they would be able to recognise if *they* had problems with anxiety were:

- females (83.8%) compared with males (76.5%) [odds ratio (OR)=1.6, p = 0.045]
- European/other (85.0%) compared with Māori (69.2%) [OR=2.5, p < 0.001], or Pacific peoples (51.3%) [OR=5.4, p < 0.001]
- adults living in areas with low levels of deprivation (84.5%) compared with those living in areas with high deprivation (71.7%) [OR=2.2, p = 0.032]
- adults who knew someone diagnosed with mental illness (83.8%) compared to those who did not know someone (72.5%) [OR=2.0, p < 0.01].

There were no significant differences by age.

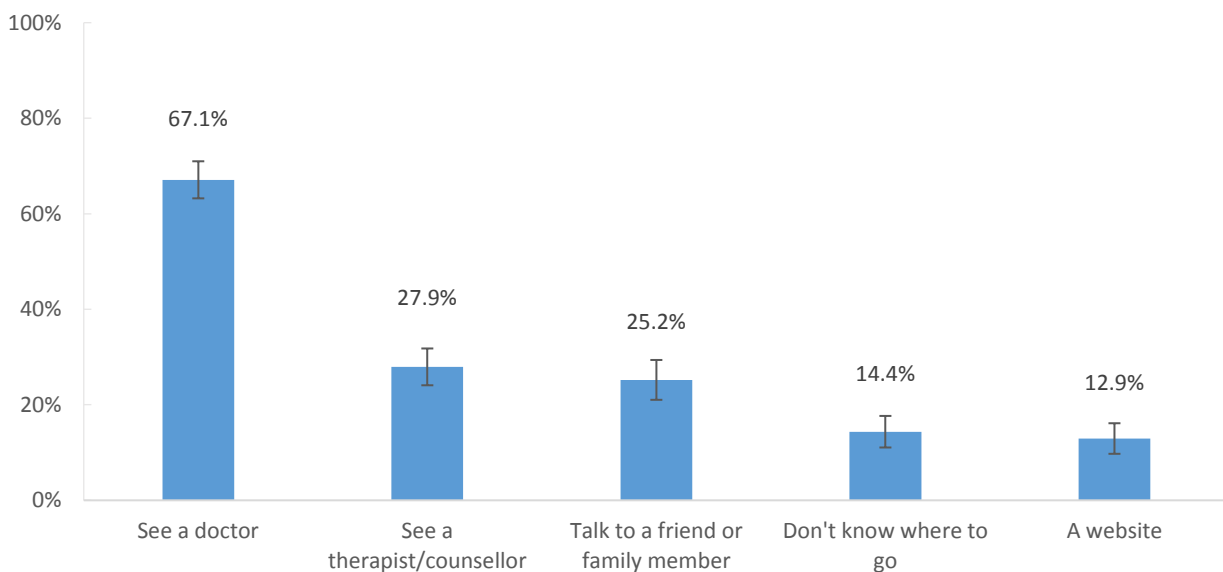


## Help-seeking knowledge and behaviour

### **Knowledge of where to get help for anxiety**

Respondents were asked if they knew where to get help if they or someone they knew might have problems with anxiety. Figure 6 provides information on the top four sources of help that they were aware of. The top source of help identified was doctors (67.1%), followed by therapists and counsellors (27.9%) and friends or family members (25.2%). One in eight (12.9%) identified websites as a potential source of help and 14.4% indicated they did not know where to go for help.

Figure 6: Reported knowledge of where to get help for anxiety

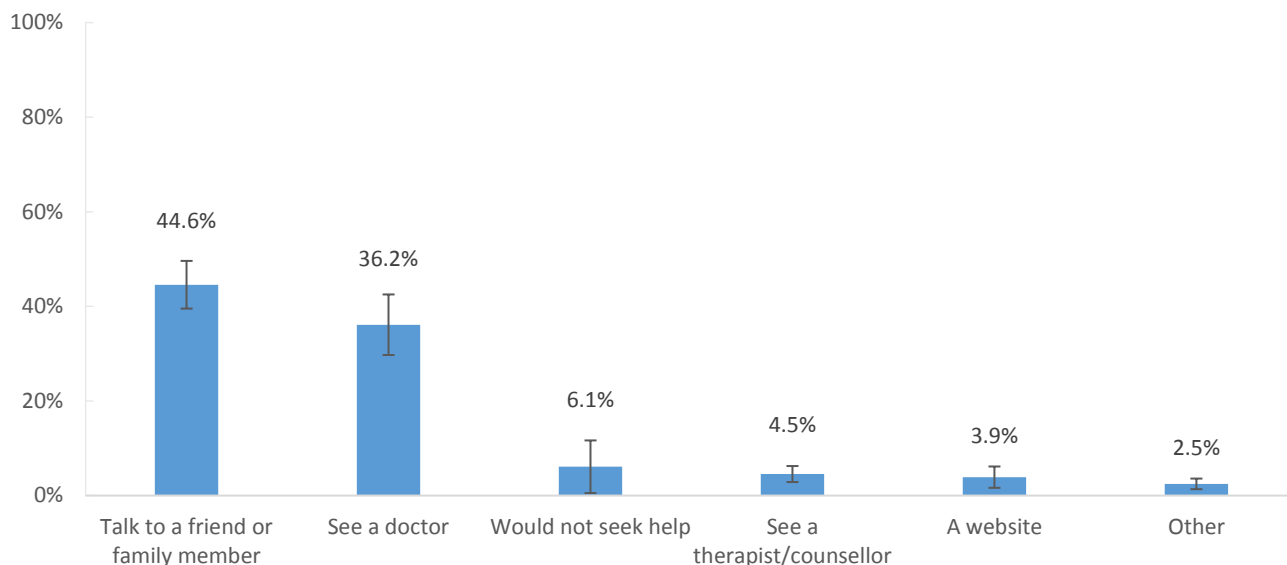


Note: Responses may add to more than 100% as respondents could give multiple responses (i.e., list multiple potential sources of help)

### **Intended help-seeking behaviour**

Figure 7 provides information on where respondents would be *most likely* to go to for help for *themselves* if they thought they might be experiencing anxiety. Despite doctors, therapists and counsellors being identified more commonly as a source of help for anxiety (see Figure 6), around four out of ten adults (44.6%) reported it would *most likely* be friends and family members they turned to for help if they thought they themselves might have problems with anxiety. Over a third of adults (36.2%) would see a doctor for help with anxiety.

Figure 7: Types of support adults were most likely to turn to for help for anxiety



Note: Responses may add to more than 100% as respondents could give multiple responses. Responses that had  $\leq 1\%$  response have not been included in the graph: church/spiritual help; ring a helpline; go to the emergency department; email/text/chat to internet help.

As was the case with seeking help for depression (see Figures 4 and 5), less than half of those who identified doctors as a potential source of support actually identified doctors as who or where they would *most likely* turn to for help for themselves if they thought they may have problems with anxiety.

Few adults (6.1%) reported that they would not seek help if they thought they might have problems with anxiety. The two most common reasons for this were that they:

- felt they could deal with the anxiety by themselves (39.1%)
- would not want to admit to having a problem (29.7%).

### **Knowledge of websites designed to provide information and support for anxiety**

Respondents were asked if they had heard about any New Zealand websites that could assist people to find out about, or get through, their problems with anxiety. Around a fifth of adults (19.9%) were aware of a website, and when they were asked to name the web-sites they had heard of, the most common website cited was HPA's 'www.depression.org.nz'. The limited knowledge of the HPA website 'www.depression.org.nz' for help with anxiety is not surprising, however, given the name of the website which implies it is relevant to depression only.

## Summary of depression, anxiety and psychological distress scale scores

### Depressive symptoms

The Patient Health Questionnaire (PHQ-9) is a screening tool used to assess depressive symptoms but it does not provide a clinical diagnosis of depression. Possible scores range from 0 to 27. In line with the scoring procedure described by Kroenke, Spitzer and Williams (2001), the following score categories were used:

- 0 to 4 (minimal)
- 5 to 9 (mild)
- 10 to 14 (moderate)
- 15 to 19 (moderately severe)
- 20 or greater (severe depression).

PHQ-9 scores indicated that around three quarters of respondents (76.1%) had experienced no or minimal depressive symptoms in the previous two weeks (see Table 6). Around one out of six (14.6%) had experienced mild depressive symptoms in this time period, and 6.0% had experienced moderate depressive symptoms. Just 2.2% of respondents received PHQ-9 scores indicating they experienced moderately severe depressive symptoms in the previous two weeks, and only 1.1% received scores indicating severe depressive symptoms.

Table 7: Depression symptom severity as indicated by the PHQ-9 depression scale

Score category (score range)	% (95% confidence interval)
<b>Minimal</b> ( $\leq 4$ )	76.1 (72.6, 79.6)
<b>Mild</b> (5-9)	14.6 (11.9, 17.3)
<b>Moderate</b> (10-14)	6.0 (4.0, 8.0)
<b>Moderately severe</b> (15-19)	2.2 (1.0, 3.5)
<b>Severe</b> ( $\geq 20$ )	1.1 (0.1, 2.1)

### Anxiety

The Generalised Anxiety Disorder 7-item Scale (GAD-7) is a scale designed to assess the severity of Generalised Anxiety Disorder but it does not provide a clinical diagnosis (Spitzer, Kroenke, Williams & Lowe, 2006). The scale contains questions relating to an individual's level of anxiety in the previous two-week period. The following score categories were used:

- 0 to 4 (none)
- 5 to 9 (mild)
- 10 to 14 (moderate)
- 15 or greater (severe).

GAD-7 scores indicated that around three quarters of adults (77.0%) had not experienced anxiety over the previous two weeks. Around one out of six (16.5%) had experienced mild anxiety in this time period, and 5.3% had experienced moderate anxiety (Table 7). Only 1.2% of respondents received GAD-7 scores indicating they experienced severe anxiety in the previous two week period.

Table 8: Scores on a brief measure of anxiety (GAD-7)

Score category (score range)	% (95% confidence interval)
<b>None</b> ( $\leq 4$ )	77.0 (73.6, 80.4)
<b>Mild</b> (5-9)	16.5 (13.2, 19.7)
<b>Moderate</b> (10-14)	5.3 (2.9, 7.7)
<b>Severe</b> ( $\geq 15$ )	1.2 (0.5, 1.9)

## Psychological distress

The 2015 NZMHM collected data on the level of psychological distress experienced by respondents in the most recent four weeks, using the Kessler Psychological Distress Scale (Kessler et al., 2002). The K10 is a 10-item scale based on questions about anxiety and depressive symptoms. Scores can range from a minimum of 10 to a maximum of 50, with low scores indicating low levels of psychological distress (Kessler et al., 2002). There are no standardised cut-off scores for the K10, but this report is guided by interpretations of scoring developed by the Clinical Research Unit for Anxiety and Depression (CRUfAD), School of Psychiatry, University of New South Wales (NSW) (Australian Bureau of Statistics, 2003). These cut-off scores are shown in Table 8.

Eight out of ten respondents (80.0%) received K10 scores indicating either low or no psychological distress in the previous four weeks. Of the remaining twenty percent, 17.7% received scores indicating medium levels of psychological distress, and 2.3% indicated high levels of psychological distress (Table 8).

Table 9: Psychological distress reported among adults from the K10

Score category (score range)	% (95% confidence interval)
<b>Low or none</b> ( $\leq 15$ )	80.0 (76.7, 83.3)
<b>Medium</b> (16-29)	17.7 (14.4, 21.0)
<b>High</b> ( $\geq 30$ )	2.3 (1.2, 3.3)

Respondents more likely to receive K10 scores indicating at least medium psychological distress were:

- females (23.5%) compared with males (16.1%) [odds ratio (OR)=0.63,  $p = 0.017$ ]
- adults aged 25 to 44-years-old (22.6%) compared with those aged 65 years and over (7.7%) [OR=0.29,  $p < 0.001$ ]
- Māori (31.2%) [OR=2.20,  $p < 0.01$ ] or Pacific peoples (28.4%) [OR=1.92,  $p = 0.01$ ], compared with European/other (17.1%).

There were no significant differences by socio-economic deprivation status.

## Conclusion

The purpose of this report was to provide information on the mental health and wellbeing of adults in New Zealand, and information on help-seeking knowledge and behaviour, using results from the 2015 NZMHM. Results showed that overall, indicators of wellbeing and social connectedness were high, as illustrated by reports of positive family relationships, high perceived levels of social support and whānau well-being. The findings from this report are consistent with previous research from 'The 2016 New Zealand General Social Survey', which found respondents scored highly on indicators of social connectedness; contact with family and friends. That survey also showed these measures of social connectedness have remained stable over time in New Zealand (2005 to 2014) (Statistics New Zealand, 2015).

These results are equally consistent with other research findings from Statistics New Zealand, (2014) indicating that a high proportion of people had felt some degree of social isolation in the past four weeks. Social isolation is associated with poor overall well-being, including depression and anxiety. Estimated levels of depression, anxiety and psychological distress collected in this report were high, with around two in 10 adults reporting mild to moderate levels of both depression and anxiety, and a similar proportion reporting medium or high levels of psychological distress. This report identifies groups that display higher levels of psychological distress and lower overall well-being and connectedness. These findings support previous research that suggests females, younger age groups (25-44 years), and Māori and Pacific peoples experience higher levels of anxiety and depression (Statistics New Zealand, 2015).

New Zealand adults were confident in their ability to recognise the signs and symptoms of depression and anxiety. There were statistically significant differences between population groups, with females and older participants more likely to recognise depression and anxiety than males and those aged 25 to 44-years. Therefore, it will be important to increase education, with a focus on tailoring intervention for males and younger participants. A high number of adults were able to identify HPA's 'www.depression.org.nz' as a website to assist people with finding or getting help for depression. Fewer adults were able to identify a website they could refer to in order to find out about or help manage anxiety (as compared with a depression website). It should be acknowledged that during the time of fieldwork for the 2015 NZMHM, there was a mass media campaign promoting the HPA website 'www.depression.org.nz', and so this level of recall may not be observed in future years.

While respondents knew of internet-based sources for help for depression, few said that is the source of help they would most likely use. They reported they were most likely to choose a face-to-face intervention (at least in the first instance) such as family, whānau and friends or a doctor. The data presented in this report provide a baseline from which to provide continuing monitoring of the mental health and wellbeing. The findings from this report can be used to inform the development of interventions for specific groups, and increasing knowledge, recognition, and help-seeking behaviours regarding mental distress.

## References

- Australian Bureau of Statistics. (2003). *Information paper: Use of the Kessler Psychological Distress Scale in ABS Health monitors, Australia, 2001*. Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/papersbyReleaseDate/4D5BD324FE8B415FCA2579D500161D57?OpenDocument>
- Bormann, J., Liu, L., Thorp, S. & Lang, A. (2012). Spiritual Wellbeing Mediates PTSD Change in Veterans with Military-Related PTSD. *International Journal of Behavioral Medicine*, 19(4): 496-502.
- Cherrington, Lisa (1994). *A comparison study of the presenting symptoms between Māori and Pākehā patients diagnosed with schizophrenia*. Unpublished master's thesis, Massey University, Palmerston North, Aotearoa New Zealand.
- Corrigan P. W., Shapiro J. R. (2010) Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review* 30: 907–922.
- Corrigan P. W., River L. P., Lundin R. K., Penn D. L., Uphoff-Wasowski K., Campion J., Kubiak M. A. (2001) Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin* 27: 187–195.
- Diener, E. & Ryan, K. (2009). Subjective well-being: A general overview. *South African Journal of Psychology*, 39(4): 391-406.
- Evans-Lacko, S., Rose, D., Little, K., Flach, C., Rhydderch, D., Henderson, C., & Thornicroft, G. (2011). Development and psychometric properties of the reported and intended behaviour scale (RIBS): a stigma-related behaviour measure. *Epidemiol Psychiatr Sci*, 20(3), 263-271.
- Health Promotion Agency. (2015). *The 2014 Health and Lifestyles Survey: Questionnaire*. Retrieved from <http://www.hpa.org.nz/research-library/research-publications/the-2014-health-and-lifestyles-survey-questionnaire>.
- Kessler, R., Andrews, G., Colpe, L., Hiripi, E., Mroczek, D., Normand, S., ... Zaslavsky, A. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32: 959-976.
- Kroenke, K., Spitzer, R. & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16: 606-13.
- Mental Health Foundation of New Zealand. (n.d.) *Depression*. Retrieved from <https://www.mentalhealth.org.nz/get-help/a-z/resource/13/depression>



- Michaels, P.J., & Corrigan, P.W. (2013). Measuring mental illness stigma with diminished social desirability effects. *Journal of Mental Health, 22*, 218-226.
- Ministry of Health. (2015). *Annual update of key results 2014/2015: New Zealand Health monitor*. Wellington: Ministry of Health.
- National Research Bureau. (2015). *New Zealand Mental Health monitor: Methodology Report*. Wellington: Health Promotion Agency Research and Evaluation Unit.
- Nederhof, A. J. (1985), Methods of coping with social desirability bias: A review. *Eur. J. Soc. Psychol.*, 15: 263–280. doi:10.1002/ejsp.2420150303
- New Zealand Police Mental Health Team. (2014). *Mental health week every week*. Retrieved from <http://www.police.govt.nz/sites/default/files/publications/nz-police-mental-health-team-newsletter-issue-1.pdf>
- OECD. (2013). *OECD Guidelines on Measuring Subjective Wellbeing*. Paris: OECD Publishing.
- Okun, M., Stock, W., Haring, M. & Witter, R. (1984). Health and subjective wellbeing: A meta-analysis. *The International Journal of Aging & Human Development, 19*(2): 111–32.
- Pere, L. (2006). *Oho Mauri: Cultural Identity, Wellbeing, and Tāngata Whai Ora/Motuhake*. Unpublished doctoral thesis, Massey University, Palmerston North, Aotearoa New Zealand.
- Robertson, I. & Cooper, C. (2011). *Well-being: Productivity and happiness at work*. Basingstoke, England: Palgrave Macmillan UK.
- Siegel, K & Schrimshaw, E. (2002). The Perceived Benefits of Religious and Spiritual Coping Among Older Adults Living with HIV/AIDS. *Journal for the Scientific Study of Religion, 41*(1): 91-102
- Slade M, Bird V, Le Boutillier C, Grey B, Larsen J, Leamy M, Oades L, Williams J (2015) Development of the REFOCUS intervention to increase mental health team support for personal recovery. *British Journal of Psychiatry, 207* (6): 544-550.
- Spitzer, R., Kroenke, K., Williams, J. & Lowe, B. (2006). A brief measure for assessing Generalized Anxiety Disorder: the GAD-7. *Arch Intern Med, 166*(10): 1092-7.
- Statistics New Zealand/Tatauranga Aotearoa. (2014). *Te Kupenga 2013 (English)*. Retrieved from [http://www.stats.govt.nz/browse\\_for\\_stats/people\\_and\\_communities/Māori/TeKupenga\\_HOTP13.aspx](http://www.stats.govt.nz/browse_for_stats/people_and_communities/Māori/TeKupenga_HOTP13.aspx)
- Statistics New Zealand/Tatauranga Aotearoa. (2015). *New Zealand General Social Survey: 2014*. Retrieved from <http://www.stats.govt.nz/nzgss2014>

Suicide Mortality Review Committee. (2016). *Ngā Rāhui Hau Kura: Suicide Mortality Review Committee Feasibility Study 2014–15*. Report to the Ministry of Health, 31 May 2016. Wellington: Suicide Mortality Review Committee.

World Health Organisation. (2016). *Fact sheets: mental health*. Retrieved from [http://www.who.int/topics/mental\\_health/factsheets/en/](http://www.who.int/topics/mental_health/factsheets/en/)