The New Zealand Health Survey’s mental health module 2016/17

Overview of key findings on mental wellbeing, needs and equity, July 2022

This brief report summarises information from the New Zealand Health Survey’s mental health module undertaken in 2016/17. This report expands on Manatū Hauora Ministry of Health’s overview of survey findings about adult mental wellbeing and health service utilisation. It includes additional context and discussion around future needs, along with considerations for building our understanding of mental wellbeing, needs, and equity.

Background

Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (Ministry of Health, 2021a) identifies information as one of six system enablers towards transforming our approach to mental wellbeing.

We do not reliably know how many people currently meet diagnostic criteria for mental health conditions or substance use disorder in Aotearoa New Zealand. It has been over 20 years since diagnostic data was last collected in Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne, Wells, & Scott, 2006). To address this need for up-to-date information, He Ara Oranga recommends a comprehensive mental health and addiction survey be undertaken and regularly updated (Government Inquiry into Mental Health and Addiction, 2018).

Kia Manawanui Aotearoa outlines the Ministry of Health’s actions for improving mental wellbeing over the next decade. This plan includes “building our understanding of mental wellbeing prevalence, needs and equity” (p. 48). As part of this objective, the potential scoping of a new comprehensive mental health and addiction survey is designated as a medium-term action, whilst a more immediate action is to “refresh the mental health and addiction content in the Ministry of Health’s New Zealand Health Survey” (p. 48). At the present time, the New Zealand Health Survey’s mental health module provides the most up-to-date information on mental health and addiction issues among the adult population.

About the New Zealand Health Survey

Every year the New Zealand Health Survey interviews over 13,000 adults (aged 15 years and over) living in the community.¹ In 2016/17, the questionnaire featured an additional mental health module which used brief screening tools to assess mental health symptoms and problematic substance use. While these brief screening tools are not equivalent to structured diagnostic interviews, they do provide useful information about mental distress and symptoms among the general population. The module also asks people about access to health services and other types of support, as well as unmet need for mental health and addiction services (Ministry of Health, 2020a).

¹ This excludes people in hospital, people who are homeless, and people in residential accommodation and prisons.
Summary of the mental health module

The *New Zealand Health Survey* 2016/17 mental health module provides useful information about mental wellbeing and service utilisation. The survey findings align with the issues raised in *He Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018). The module indicates experiences of mental health symptoms and problematic substance use are common among adults in Aotearoa New Zealand. Yet, many people do not access support from health services.

Key mental wellbeing findings from 2016/17 are highlighted below.

<table>
<thead>
<tr>
<th><strong>Anxiety symptoms</strong></th>
<th>Around 1 in 5 adults experienced anxiety symptoms with a mild, moderate, or more severe impact on their lives (in the past two weeks before the survey).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression symptoms</strong></td>
<td>About 1 in 5 adults experienced depression symptoms with a mild, moderate, or more severe impact on their lives (in the past two weeks).</td>
</tr>
<tr>
<td><strong>Psychological distress</strong></td>
<td>Around 1 in 12 adults experienced high or very high levels of psychological distress (in the past four weeks).</td>
</tr>
<tr>
<td><strong>Problematic substance use</strong></td>
<td>About 1 in 3 adults experienced a moderate or high risk of problematic substance use (in the past three months, including tobacco and alcohol use).</td>
</tr>
<tr>
<td><strong>Inequities</strong></td>
<td>Anxiety and depression symptoms were more common among women, Māori, Pasifika, and adults living in lower socioeconomic areas. On the other hand, problematic substance use was more common among men.</td>
</tr>
</tbody>
</table>

**Access to health services and other support**
Overall, around 1 in 3 adults accessed health services or other support in the past 12 months for concerns about emotions, stress, mental health, or substance use.

About 1 in 7 adults accessed general practice (such as general practitioners or nurses) and 1 in 11 adults accessed primary mental health services (such as counsellors and psychologists) for these concerns. Around 1 to 4 percent of adults reported accessing more specialised or urgent support with secondary or tertiary health services (such as mental health and addiction services, crisis teams, hospitals, or emergency departments).

Around 1 in 5 adults accessed complementary or alternative help (such as religious or spiritual advisors, traditional healing, meditation or mindfulness training, herbal medicine, and exercise therapies). Nearly 1 in 10 adults sought help from family, whānau, and/or friends for concerns about emotions, stress, mental health, or substance use.

**Unmet need for mental health and addiction services**
In general, the most common reason for not receiving professional help was wanting to handle it alone or with whānau support. Around 1 in 3 adults who experienced mental health symptoms with a severe impact felt the need for professional help but *did not* receive it.
Key findings from the mental health module

Findings about experiences of mental health symptoms and problematic substance use are presented first, followed by inequities in mental wellbeing, utilisation of health services and other supports, and unmet needs.

Experiences of mental health symptoms and problematic substance use

Table 1. Mental health symptoms and problematic substance use among adults in 2016/17

<table>
<thead>
<tr>
<th>Among adults:</th>
<th>16% experienced anxiety symptoms with a mild or moderate impact</th>
<th>2% experienced anxiety symptoms with a more severe impact</th>
<th>8% experienced high or very high levels of psychological distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>17% experienced depression symptoms with a mild or moderate impact</td>
<td>3% experienced depression symptoms with a more severe impact</td>
<td>32% experienced a moderate or high risk for problematic substance use (including tobacco and alcohol use)</td>
<td></td>
</tr>
</tbody>
</table>

Note: Mental health symptoms as indicated on the GAD-7 and PHQ-9 screening tools for the past two weeks prior to being surveyed. Psychological distress as indicated on the K10 scale for the past four weeks. Substance-related risks as indicated on the ASSIST tool for the past three months. Source: Ministry of Health (2020a). Appendix A provides an overview of these screening tools.

Anxiety and depression symptoms

In 2016/17, the New Zealand Health Survey estimates around 1 in 5 adults experienced anxiety symptoms and another 1 in 5 adults experienced depression symptoms in the past two weeks before the survey, though some people will have experienced both. Further analysis of the data is required to distinguish the overlaps.

Symptoms were categorised as having a mild, moderate, or more severe impact on people's lives based on scores from briefing screening tools. Appendix A provides an overview of the screening tools used and their criteria.

An estimated 618,000 adults experienced anxiety symptoms with a mild or moderate impact on wellbeing and 647,000 adults experienced depression symptoms with a mild to moderate level of impact. Mental health symptoms which have a mild or moderate impact on people’s lives may be supported by primary health, community, non-government organisation (NGO) or hauora Māori services (Te Pou, 2015). The survey findings provide an indication of the potential demand for these services among the adult general population, though other sources of information also need to be considered to obtain a more accurate estimate.

A further 91,000 adults experienced anxiety symptoms that had a more severe impact on wellbeing, and 117,000 adults experienced depression symptoms with a severe or

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2 Unadjusted rate provided by the Ministry of Health based on the percentage of adults who met the anxiety (GAD-7) and depression (PHQ-9) screening criteria in the past 2 weeks. Somatic symptoms (PHQ-15) within the last 4 weeks were also screened but not included in this summary as it can be more difficult to interpret or attribute to mental health challenges. The survey estimated 39% of adults experienced mild or greater somatic physical symptoms.

3 The weighted population estimates provided by the Ministry of Health (2020a).
moderately severe impact. Symptoms which have a greater impact on peoples’ lives may require specialised support from secondary and tertiary services for further assessment and more specific structured evidence-based therapies (Te Pou, 2015). It is important to note that the survey does not measure experiences or symptoms associated with psychosis.

**Problematic substance use**

An estimated 1.2 million adults (around 1 in 3 adults) experienced a moderate or high risk of problematic substance use in the three months before the survey. Tobacco and alcohol use were reported most, respectively impacting 1 in 5 adults (20 percent) and 1 in 7 adults (15 percent). Moderate to high risk of problematic substance use may require brief intervention in primary health care settings, within hauora Māori services, or more specialised support for harm reduction.

**Co-occurrence of mental health symptoms and problematic substance use**

Problematic substance use often occurs alongside mental health symptoms, thus it is important that people presenting with mental health symptoms are also screened for problematic substance use, and vice versa (Te Pou, 2015). Among adults who experienced some level of anxiety or depression symptoms, nearly half (48 percent) also experienced moderate or high risk of problematic substance use, and similarly around 30 percent who experienced moderate or high risk of problematic substance use also reported some level of anxiety and depression symptoms.

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**Additional information from the core survey**

Each year the core survey has asked people “have you ever been told by a doctor that you have depression, bipolar and/or anxiety disorder?” In 2020/21, 1 in 5 adults (21.5 percent) reported being diagnosed with a mood or anxiety disorder in their lifetime. This figure likely underestimates the true number in the adult population as it does not include people with undiagnosed conditions, who have not sought help and relies on people’s recall.

The core survey reports on psychological distress using the Kessler-10 depression scale. In 2020/21, 1 in 8 adults (7.6 percent) reported experiencing high or very high levels of psychological distress in the past 4 weeks (Ministry of Health, 2021b). Annual core survey findings can be compared across years, and trends over time suggest these rates are slowly rising.

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4 The Mental Health Data Explorer (Ministry of Health, 2020a) combines the reporting for moderate risk and high risk on the ASSIST tool. Respondents were categorised as having a moderate or high risk of problematic use of substances if they meet this criterion for any of the substances included in the ASSIST tool.
Inequities in mental wellbeing

Table 2. Mental health symptoms and problematic substance use among adults in 2016/17

<table>
<thead>
<tr>
<th>Anxiety symptoms were experienced by *</th>
<th>Depression symptoms were experienced by *</th>
<th>Substance-related risks were experienced by ^</th>
</tr>
</thead>
<tbody>
<tr>
<td>23% Māori</td>
<td>26% Māori</td>
<td>51% Māori</td>
</tr>
<tr>
<td>22% Pacific</td>
<td>26% Pacific</td>
<td>37% Pacific</td>
</tr>
<tr>
<td>18% Asian</td>
<td>19% Asian</td>
<td>19% Asian</td>
</tr>
<tr>
<td>18% European/Other</td>
<td>19% European/Other</td>
<td>31% European/Other</td>
</tr>
</tbody>
</table>

* As indicated by mild or greater symptoms on GAD-7 and PHQ-9. ^ As indicated by moderate or high substance-related risk for any substance included in the ASSIST. Source: Ministry of Health (2020a)

Survey results indicate some population groups are more likely to experience mental health symptoms and problematic substance use. It is important to ensure these groups are prioritised for regular screening and have access to a wide range of support. The rates of anxiety and depression symptoms were significantly higher among women and adults living in lower socioeconomic areas. Moderate or high risk of problematic substance use was significantly more common among men and adults living in lower socioeconomic areas.

Experiences of mental health symptoms and problematic substance use were more common among Māori and Pacific adults compared to other ethnic groups. Statistical analyses by the Ministry of Health indicate Māori adults were around 60 percent more likely to experience anxiety or depression symptoms with a severe impact compared to non-Māori, and 74 percent more likely to experience moderate or high risks of problematic substance use. Active protection is required to address and eliminate inequities experienced by Māori due to colonisation and institutional racism. Inequities will persist unless the primary health sector actively addresses these inequities through action and alignment across the system. As outlined in the Ministry of Health’s Māori health strategy, He Korowai Oranga, and the Whakamaua Māori Health Action Plan 2020-2025, implementation efforts must improve indigenous health outcomes to achieve equity (Ministry of Health, 2020a, 2020b).

5 Based on the statistical analyses undertaken by the Ministry of Health.

6 Based on adjusted odds ratios (AOR), adjusting for age and gender. Analysis of the rates among Māori and non-Māori indicated: AOR = 1.60 for anxiety symptoms with a severe impact; AOR = 1.65 for depression symptoms with a severe or moderately severe impact; and AOR = 1.74 for moderate or high substance-related risks. All comparisons were statistically significant.
Utilisation of health services and other support

Table 3. Access to health services and other support among adults in 2016/17

<table>
<thead>
<tr>
<th>Adults accessed support from:</th>
<th>14% primary health services</th>
<th>9% counselling, psychologist, and/or telephone services</th>
<th>4% primary/secondary care cross-over</th>
<th>1.2% specialised support from secondary and tertiary sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>21% complementary or alternative help</td>
<td>9% sought help from family, whānau, and/or friends</td>
<td>5% used the internet for help (other than to find out about symptoms)</td>
<td>3% participated in self-help groups</td>
<td></td>
</tr>
</tbody>
</table>

Note. Service utilisation and other support in the 12-month period prior to the survey for concerns about emotions, stress, mental health, or substance use. Definitions of the service types are outlined in Appendix B. Source: Ministry of Health (2020a)

Approximately 1 in 3 adults (37 percent) accessed some type of health service or other support in the past 12 months for concerns about emotions, stress, mental health, or substance use. This is an estimated 1.4 million adults seeking support each year.

Primary health services are accessed the most for concerns about emotions, stress, mental health, or substance use. An estimated 523,000 adults accessed support in general practice settings, such as consulting with a general practitioner or nurse, and/or being prescribed medication. Primary mental health supports such as counselling, psychological, and/or telephone support services were accessed by an estimated 347,000 adults. Primary health settings are a common first point of contact for concerns about emotions, stress, mental health, or substance use, and recent investments have focused on expanding access to these services. For example, the implementation of the integrated primary mental health model is providing people with access to health coaches and health improvement practitioners within primary care settings and aims to minimise barriers associated with referrals, wait times, and costs.

Adults experiencing mental health challenges and problematic substance use which are having a high impact on their lives may need or want more specialised support in secondary and tertiary health settings. Around 141,000 adults reported accessing primary/secondary care cross-over type services. This category includes community mental health or addiction services, hospital or residential stays, consultation with a social worker or psychiatrist, as well as programmes in prison. The survey defines access to secondary and tertiary sectors as receiving help from a hospital emergency department, after-hours medical centres, and/or a crisis mental health team. Around 45,000 adults reported accessing these types of urgent care in the past 12-months.

Many adults in the community sought other types of support for concerns about emotions, stress, mental health, or substance use. About 812,000 adults used complementary or alternative help in the past 12 months. This includes help from religious or spiritual advisors, traditional healing, meditation, mindfulness, herbal medicine, and exercise therapies.

Family, whānau, and/or friends provide important social support, with approximately 336,000 adults seeking help from their loved ones. This highlights the importance of mental health

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7 Further analyses are required to distinguish overlaps and patterns in service utilisation.
8 The New Zealand Health Survey data around secondary and tertiary service use is not comparable with PRIMHD data due to mental health and addiction services being categorised together with other service types, see Appendix B.
and addiction literacy and education programmes within communities to ensure people have the right knowledge and skills to respond to the mental wellbeing needs of others.

Wellbeing for Māori is shaped by culture and defined by drawing on tikanga Māori and kaupapa Māori approaches. An estimated 37,000 adults (1 percent) accessed Māori health services and/or traditional Māori healing and support practitioners, such as rongoā Māori, mirimiri, romiromi, karakia or cultural and spiritual supervision with a kaumātua or kuia.

With the growing availability of digital health solutions, around 174,000 adults (5 percent) reported using the internet for help. This includes finding where to get help, discussions with others through forums or support groups, or online therapy, such as e-therapy or online counselling.

### Unmet need for mental health and addiction services

<table>
<thead>
<tr>
<th>Unmet need for mental health and addiction services was reported by</th>
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</thead>
<tbody>
<tr>
<td>31% of adults experiencing mental health symptoms with a severe impact</td>
<td>14% of adults experiencing mental health symptoms with a moderate impact</td>
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</table>

Note: Unmet need for mental health and addition services in the 12-month period prior to the survey. Mental health symptoms were measured using the PHQ-SADS screening tool which includes anxiety, depression, and somatic symptoms. Substance-related risks and substance use disorders were screened using the ASSIST tool. Source: Ministry of Health (2020a)

Around 5 percent of adults felt a need for help from mental health and addiction services for their emotions, stress, mental health, or substance use but did not receive it. This indicates approximately 188,000 adults experience an unmet need for professional help each year. Women were more likely to report unmet needs for professional help (6 percent; 4 percent among men). The rate of unmet need was generally higher among Māori women (9 percent) and younger women aged 15 to 24 years (12 percent). Rates of unmet need for professional help were also higher among younger adults aged 15 to 24 years, Māori, and adults living in lower socioeconomic areas.

Rates of unmet need are even higher when looking specifically at mental health symptoms, particularly those with a more severe impact on wellbeing. Around 1 in 3 adults (31 percent) experiencing mental health symptoms with a more severe impact felt a need for professional help but did not receive it. This means an estimated 67,000 adults did not receive additional/specialised support from mental health and addictions services for potentially serious mental health needs. Around 1 in 12 adults (8%) experiencing a moderate or high risk of problematic use of substances reported an unmet need for mental health and addictions services. These findings highlight groups more likely to be at risk of falling through the gaps in the health system, thus requiring targeted initiatives and further exploration to ensure equitable access to services.

The survey asks adults about their reasons for not receiving professional help, but this is difficult to meaningfully interpret due to the low number of respondents (4 percent or lower). Results indicate that among adults who reported an unmet need, the most common reason for not receiving professional help was wanting to handle it alone or with whānau support. Other reasons for not receiving professional help include feeling professional help costs too much, being unsure where to go or who to see, thinking treatment would not work, and having concerns about what others might think.
Additional information from the core survey

An analysis of the core survey from 2015/16 (Lockett et al., 2018) shows adults who reported having been diagnosed with depression, bipolar and/or anxiety disorder in their lifetime were more likely to use primary health services (visits to a general practitioner, practice nurse, or after-hours medical centre in past 12 months regarding mental and emotional health as well as physical health) compared to adults who haven’t had a diagnosis. However, adults reporting a lifetime mental health diagnosis were also more likely to experience barriers, such as experiencing an unmet need for primary health care due to cost or transport, having unfilled prescriptions due to cost, and were less likely to report positive experiences with general practitioners (Lockett et al., 2018).

Discussion

The New Zealand Health Survey is useful for planners and funders, as well as a multitude of health providers, including primary health, mental health, and addiction services. The information enables decision makers to move from policy thinking toward policy implementation. Health service providers can make informed decisions on focus areas, target groups, and continue to build an evidence base for best practice. The survey results can also be used to progress and share evidence with wider communities, hapū and iwi.

The New Zealand Health Survey’s mental health module undertaken in 2016/17 provides a useful snapshot of mental wellbeing and service utilisation. However, this data is now six years out of date. Funders, planners, and policy makers require up-to-date and accurate data to inform the implementation of systems change. It is important the sector continues to have access to timely data and to track trends in mental wellbeing, service utilisation, and unmet need for mental health and addiction services. A regular collection of the New Zealand Health Survey’s mental health module every couple of years will help support this need for information. While the use of brief screening tools is not equivalent to structured diagnostic interviews, the mental health module provides useful information about key population trends over time for mental health symptoms and problematic substance use. The module also includes information about social factors, such as loneliness and employment status, which were not covered in this overview. However, the gap in diagnostic data remains an ongoing issue. Under the Ministry of Health’s longer-term actions, the use of structured diagnostic interviews will be a key methodological consideration in the scoping of a new comprehensive mental health and addiction survey.

The Kia Manawanui plan to strengthen the mental health and addiction content will help ensure the New Zealand Health Survey remains a key source of information for the sector. The mental health module captures a more in-depth snapshot of mental wellbeing and service utilisation compared to the annual core survey. The module’s findings can help inform planners and funders on ways to improve equitable access to services and expand the range of services that communities require. Monitoring disparities in service access and unmet need is particularly important during the current restructuring period in the health sector (Gauld et al., 2014). However, He Ara Oranga raised concerns around the current lack of comprehensive and robust information about unmet needs. Unmet need for secondary and tertiary mental health and addiction services is not routinely measured or well
understood. Further survey development and more in-depth data analysis of the mental health module can help build our understanding about the specific circumstances that may lead to an unmet need for health services, as well as the groups of people most likely to be impacted. The module provides valuable opportunities for researchers to explore patterns and relationships in service utilisation and unmet need as well as the potential contributing factors. Evidence-informed measures of service utilisation, unmet need, and access barriers are likely to be key considerations in the scoping of a new comprehensive mental health and addiction survey.

In addition to regularly undertaking the mental health module in the *New Zealand Health Survey*, other existing surveys and databases are crucial to building our understanding of mental wellbeing, needs and equity. This includes surveys conducted by Te Hiringa Hauora Health Promotion Agency, Statistics New Zealand, and local universities. Health service databases also provide key information, such as the Programme for the Integration of Mental Health Data (PRIMHD) which records the number of people accessing specialist mental health and addiction services. A supplementary document to this resource explores the different data obtained from a range of sources, see *Understanding Population Mental Health and Substance Use: An Overview of Current Data* (Te Pou, 2022).
References


Appendix A: Brief screening tools

Every year the New Zealand Health Survey asks adults (aged 15 years and over) living in the community about their health status and health service use. This work is funded by the Ministry of Health and the data is collected through kanohi ki te kanohi (in-person/face to face) interviews conducted by a specialist survey provider. In addition to the core questionnaire, the 2016/17 mental health module captured information about adults’ recent experiences of mental health, substance use, and access to health services or other support for concerns about emotions, stress, mental health, or substance use.

The 2016/17 New Zealand Health Survey module featured the following screening tools:

- depression symptoms were measured using the Patient Health Questionnaire 9 (PHQ-9)
- anxiety symptoms were measured using the General Anxiety Disorder 7 (GAD-7)
- somatic or physical symptoms that commonly co-occur with depression and anxiety were measured using the Patient Health Questionnaire 15 (PHQ-15)
- substance-related risks were measured using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

It is important to note that these self-report screening tools only provide an initial indication of symptoms and potential risks; further assessment by a clinician is required for diagnosis.

For more details about the New Zealand Health Survey methodology and results, see the Ministry of Health website.

Patient Health Questionnaire – Somatic, Anxiety and Depressive Symptoms (PHQ-SADS)

The PHQ-SADS was used to measure mental health symptoms. It combines the PHQ-9, GAD-7, and PHQ-15 screening tools into one instrument.

General Anxiety Disorder (GAD-7)

The GAD-7 can be used in primary health settings to provide an indication for the severity of anxiety symptoms. It contains seven questions aimed at determining the frequency of anxiety-related symptoms experienced by the respondent within the last 2-weeks. The threshold points used in the New Zealand Health Survey are outlined below.

<table>
<thead>
<tr>
<th>GAD-7 score</th>
<th>Provisional diagnosis/ severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 9</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15 – 21</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>

Source: Pfizer Inc. (n.d.)

Patient Health Questionnaire-9

The PHQ-9 can be used in primary health settings to provide an indication for the severity of depressive symptoms. It contains nine questions aimed at determining the frequency of depression-related symptoms experienced by the respondent within the last 2-weeks. The threshold points used in the New Zealand Health Survey are outlined below, along with the corresponding actions recommended in the tool’s instruction manual.

<table>
<thead>
<tr>
<th>PHQ-9 score</th>
<th>Provisional diagnosis/ severity</th>
<th>Recommended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 9</td>
<td>Mild depression</td>
<td>Watchful waiting; repeat PHQ-9 at follow-up.</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate depression</td>
<td>Treatment plan, considering counselling, follow-up and/or pharmacotherapy.</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderately severe depression</td>
<td>Immediate treatment with pharmacotherapy and/or psychotherapy.</td>
</tr>
<tr>
<td>20 – 27</td>
<td>Severe depression</td>
<td>Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management.</td>
</tr>
</tbody>
</table>

Source: Pfizer Inc. (n.d.)

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

The ASSIST tool obtains information about lifetime use of substances as well as use of substances and associated problems over the last 3-months. It provides an indication of the degree of substance-related risks across nine types of substances. The threshold points are outlined below. The New Zealand Health Survey categorised adults as having a moderate or high risk of problematic use of substances if they met this criterion for any of the substances included. Please note that risk of alcohol use has slightly different threshold points than other substances.

<table>
<thead>
<tr>
<th>ASSIST score</th>
<th>Provisional diagnosis/ severity</th>
<th>Recommended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 3</td>
<td>Low risk</td>
<td>Provide treatment as usual, give feedback about the screen, and encourage to remain low risk.</td>
</tr>
<tr>
<td>4 – 26</td>
<td>Moderate risk of health and other problems from your current pattern of substance use</td>
<td>Brief intervention in primary health care settings.</td>
</tr>
<tr>
<td>27 +</td>
<td>High risk of experiencing severe problems and are likely to be dependent on the substance</td>
<td>Brief intervention, referral for detailed clinical assessment and specialist treatment.</td>
</tr>
</tbody>
</table>

Appendix B: Support type definitions

**Used help from primary sectors (GP, nurse, medication)**
Adult respondents (aged 15+ years) are categorised as using primary sectors for concerns about their emotions, stress, mental health, or substance use if they declared having consulted a GP or a nurse, and/or if they have been prescribed medication or are taking prescription medication for their emotions, stress, mental health, or substance use in the past 12 months.

**Used counselling, psychologists and/or telephone hotlines**
Adult respondents (aged 15+ years) are categorised as using counselling, psychologists and/or telephone hotlines for concerns about their emotions, stress, mental health or substance use if they declared having used a telephone hotline, having had counselling that lasted 30 minutes or longer, having had an online therapy, such as e-therapy or online counselling, and/or having consulted a psychologist, counsellor or psychotherapist in the past 12 months.

**Used help in the cross-over between primary and secondary care (could also be called community care, collaborative services or possibly post-crisis care)**
Adult respondents (aged 15+ years) are categorised as using primary or secondary care cross-over for concerns about their emotions, stress, mental health, or substance use if they declared one or more of:

- Having consulted a social worker or a psychiatrist or other medical specialist in the past 12 months
- Having stayed, overnight or longer, in a hospital or a residential treatment centre in the past 12 months
- Having received at least one of the following help in the past 12 months:
  - Hospital ward
  - Māori health service (including Māori mental health or addictions services)
  - Community mental health or addictions service
  - Other community support services
  - Programme in prison or a youth justice centre

**Used help from secondary/tertiary sectors (could also be called crisis care)**
Adult respondents (aged 15+ years) are categorised as using secondary or tertiary sectors for concerns about their emotions, stress, mental health, or substance use if they declared having received help from a hospital emergency department or an after-hours medical centre, and/or a crisis mental health team in the past 12 months.

**Used Māori health services and Māori informal help**
Adult respondents (aged 15+ years) are categorised as using Māori services and Māori informal help for concerns about their emotions, stress, mental health, or substance use if they declared having used Rongoā Māori, Mirimiri, or other traditional Māori healing, having consulted a Kaumātua or Tohunga, and/or having received help from Māori health services in the past 12 months.

**Used complementary/alternative help**
Adult respondents (aged 15+ years) are categorised as using complementary/alternative help for concerns about their emotions, stress, mental health, or substance use if they declared having consulted a religious or spiritual advisor or a Kaumātua or Tohunga, and/or having used any of the following complementary or alternative therapies in the past 12 months:

- Massage
- Exercise, or movement therapy
- Herbal medicine
- Spiritual, psychic or energy healing
- Rongoā Māori, Mirimiri, or other traditional Māori healing
- Traditional Pacific healing
- Relaxation, meditation, mindfulness training, yoga or guided imagery
- Acupuncture
- Osteopathic or chiropractic treatment
- Hypnosis
- Other types of complementary or alternative therapies

**Used help from family, whānau and/or friends**
Adult respondents (aged 15+ years) are categorised as using help from family, whānau, a partner and/or friends for concerns about their emotions, stress, mental health, or substance use if they declared having consulted family, whānau, a partner and/or friends in the past 12 months.

**Used the internet for help (other than to find out about symptoms)**
Adult respondents (aged 15+ years) are categorised as using the internet for other purposes related to their concern about their emotions, stress, mental health, or substance use if they declared having used the internet to find out where to get help, to discuss with others through forums, support groups or internet social networks, and/or for reason other than learning about symptoms, diagnosis, causes, treatments, or medication side effects, in the past 12 months.

**Used self-help groups**
Adult respondents (aged 15+ years) are categorised as using self-help groups for concerns about their emotions, stress, mental health, or substance use if they declared having gone to an emotional or mental health self-help group, such as a group for eating disorders, bipolar disorder or bereavement, and/or having gone to an alcohol or drug use self-help group, such as Alcoholics Anonymous or Narcotics Anonymous in the past 12 months.