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Bipolar Disorder in New Zealand

By Kerry Ann Jacobs

In New Zealand a 2011/12 survey showed that 1% of the adult population have been diagnosed with Bipolar Affective Disorder.

In response, the government has put processes and resources in place to help these mental health consumers, with a particular focus on acute care, as far as public funding will allow.

This supplement will firstly explore the mental health sector's response to cultural barriers related to mental health conditions, by focusing on three minority ethnic groups being: Maori, Pacific and Asian people.

Secondly the supplement will feature the brief medical histories of two mental health consumers with bipolar disorder, John and myself, Kerry Ann Jacobs. Some issues highlighted in these histories will be backed up by extracts from primarily New Zealand resources such as medical journals.

The Cultural Aspects of Bipolar Disorder from a New Zealand Perspective

The report 'The Health of New Zealand Adults 2011/12' (15 years and over) presents key findings about adults' health and access to health services in 2011/12. These statistics come from the New Zealand Health Survey.

Mental disorder is common in New Zealand. More than half a million adults (16%) have been diagnosed with common mental disorders being: depression, bipolar disorder and/or anxiety disorder in their lifetime. This included 14% of adults who have ever been diagnosed with depression, 6% with anxiety disorder and 1% with bipolar disorder. This has increased since the last survey in 2006/7 which was 13% overall.

Women

Women aged 35–64 years have higher rates of diagnosed common mental disorders. Women were more likely than men to have been diagnosed with depression, bipolar disorder and/or anxiety disorder in all age groups. In particular, one in five women aged 25–74 years had been diagnosed with a common mental disorder. For men, rates of common mental disorders were highest in those aged 25–64 years.

Women were more likely to have been diagnosed with a common mental disorder in their lifetime (20%) than men (12%). Women were 1.7 times as likely as men to have been diagnosed with a common mental disorder, after adjusting for age differences.

Deprivation



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People living in deprived areas are more likely to have been diagnosed with common mental disorders. The rates of diagnosed common mental disorders were similar for people living in the least deprived areas (14%) and the most deprived areas (17%). However, after adjusting for differences in age, sex and ethnic group, people living in the most deprived areas were 1.7 times as likely to have ever been diagnosed with a common mental disorder as people in the least deprived areas.

Pacific, Maori and Asian People

Pacific and Asian adults have lower rates of diagnosed common mental disorder. About 7% of Pacific adults had been diagnosed with common mental disorder. Asian adults also had low rates of diagnosed common mental disorder (4%). Pacific and Asian adults were much less likely to have been diagnosed with a common mental disorder than non-Pacific and non-Asian adults respectively, after adjusting for age and sex.

The percentage of Māori adults who had ever been diagnosed with a common mental disorder increased from 12% in 2006/07 to 16% in 2011/12 (the same as the national average) By contrast, the percentage of Asian men diagnosed with common mental disorder decreased from 2006/07 to 2011/12, and did not change for Pacific adults.

In summary, in the New Zealand Survey for adults (aged 15 and over) for the year 2011/12:

- 16% of the adult population had been diagnosed with common mental disorders, 1% of which was with bipolar disorder.
- Women were more likely than men to be diagnosed with common mental disorders being: 1.7 times as likely as men.
- People living in deprived areas were more likely than those living in the least deprived areas to be diagnosed with common mental disorders being: 1.7 times as likely as those in the least deprived areas.
- While the national average of 16% of the adult population has been diagnosed with common mental disorders, Pacific people were less at 7% and Asian people amounted to only 4%, while Maori people equaled the national average.

In conclusion, statistics suggest that rates of women being diagnosed with common mental disorders is of more of a concern than for men, particularly for those living in deprived areas. Further, lower rates of diagnosis for Pacific and Asian adults suggest that these ethnic groups may be going undetected by health authorities.

Asian Mental Health in New Zealand

In “*Mental Health Issues for Asians in New Zealand: A Literature Review (May 2003)*” it states that limited research findings have suggested that the mental health levels among Asians do not differ significantly from those of the general population, however there appear to be barriers to the utilisation of mental health services.

At page “xi” it states: “*Mental illness is highly stigmatising in many Asian cultures. In these societies, some forms of mental illness such as schizophrenia or organic*



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brain disorder are conceived of as supernatural punishments for wrong-doings, and as such entail intense shame and stigma. Consequently, many Asians are reluctant to use mental health care, or would delay seeking care until disturbed members become unmanageable. Among Asian recent immigrants, a lack of English proficiency, inadequate knowledge and awareness of existing services, and cultural differences in the assessment and treatment of mental illness, are additional barriers to their use of the mental health care system. All these issues draw attention to the need for more responsiveness to the needs of Asian service users and their families in the mental health system.”

(Prepared for Mental Health Commission: Elsie Ho, Sybil Au, Charlotte Bedford and Jenine Cooper; Migration Research Group, Department of Geography, University of Waikato

At www.amhcs.org.nz Asian Mental Health Cultural Support Coordination Services, they aim to tackle the problem by providing services such as:

- One free cultural consultation per client;
- Interpreters;
- Family group meetings and
- Video conferencing

Pacific Mental Health in New Zealand

The under-representation of Pacific peoples under the mental health statistics may be attributed to their unwillingness to engage with legal professionals when they become mentally unwell

“Pacific Models of Mental Health Service Delivery in New Zealand (September 2004)” is based on research on a number of Pacific people participants in New Zealand being: mental health consumers and their families and the mental health workers who deal with them.

According to the 2001 New Zealand Census, Pacific peoples make up approximately 6% of the total population. In regard to mental disorders many Pacific peoples of today still tend to view some as ‘spiritual possession’, for which the remedy is believed to be a traditional healer with spiritual powers, rather than conventional doctors. Medical professionals where possible, need to differentiate between mental illness and spiritual warfare. In this case, psychologists could be more effective than psychiatrists at dealing with this issue.

Ways in which Pacific peoples may be encouraged to seek help from mental health service providers includes the following:

- Working with consumers and their extended families to provide spiritual, moral and practical support;
- Providing an inviting atmosphere such as culturally appropriate physical surroundings and the practice of Pacific hospitality;



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- Engaging in an initial ‘roundabout’ approach to the consultation such as discussion with the consumer and family about something of common interest before addressing the issue;
- Undertaking work tasks for consumers over and above stated job description or “going the extra mile” and
- Review how stigma can be addressed particularly in relation to Pacific youth consumers.

(Clinical Research and Resource Centre, Waitemata District Health Board Auckland, Francis Agnew, Fuimaono Karl Pulotu-Endemann, Gail Robinson, Tamasailau Suaalii-Sauni, Helen Warren, Amanda Wheeler, Maliaga Erick, Tevita Hingano, Helen Schmidt-Sopoaga)

Maori Mental Health in New Zealand

According to Statistics New Zealand, the estimated population of New Zealand for June 2011 is 4.41 million, of which 15% are Maori. However in “*Cultural Interventions and the Treatment of Māori Mental Health Consumers (October 2005)*” it states that Maori rates of admission for mental health related disorders continue to exceed non-Māori. For many Māori, initial contact with a mental health service is under compulsion through the justice system. Psychosis and alcohol and drug abuse is a leading cause of admissions for Māori. Past studies have shown that Māori are over-represented in acute disorders, and are almost twice as likely to be readmitted when compared to non-Māori. Further, suicide increased by 162% during the 1980’s and continues to have a dramatic effect on Māori communities today.

The following processes have been used to mental health providers in New Zealand to try and deal with the issue of the over-representation of Maori in the mental health system:

- The use of Pōwhiri (or a formal Māori welcome) for therapeutic purposes;
- Employing Kaumātua or cultural advisors to provide support on issues of tikanga (custom) and protocol;
- Engaging with the consumer in Te Reo Maori (Maori Language);
- Including the consumer’s whanau (family and community group) and
- Involving consumers in non-verbal cultural activities such as playing a guitar to assist with communication

(Te Kani Kingi, Te Pūmanawa Hauora, Research School of Public Health, Massey University, Wellington, Auckland University Conference Centre)

In conclusion, in relation to the ethnic aspects of bipolar disorder in New Zealand, research suggests that stigma, traditional beliefs and a lack of understanding about the condition and conventional medical practices, mean that the above-mentioned groups are reluctant to come forward for treatment. However, mental health providers are attempting to address the problem by catering to traditional ethnic practices.



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The Medical Aspects of Bipolar from a New Zealand Perspective

John and I have Bipolar Affective Disorder:

My story highlights two key points:

- Adherence by bipolar patients to medication
- The general circle of advocacy and support available to acute bipolar patients, in New Zealand.

John's story highlights four key points;

- Difficulty of diagnosis in some cases,
- The use of institutions prior to deinstitutionalisation,
- The side-effects of medication for Bi-Polar patients
- The need for long-term medical and psychosocial intervention for bipolar patients.

Kerry Ann Jacobs (author): Mental Health History

I was born on 26 August 1965 and I am a New Zealand European. I first became unwell through work stress when I was 44 years old. I gradually became psychotic over 2009 and in January 2010 I was admitted to Wellington's Psychiatric Intensive Care Unit.

In the ward I refused medication because I was delusional and hallucinating. I received a cocktail of drugs by injection until finally a large dose of Risperidone calmed me down and took away the hallucinations. At that time I was diagnosed as having had an isolated psychotic episode.

Initially I remained on a large dose of Risperidone. It made me feel like a zombie because I couldn't function at all. In response to my mother's ongoing protests over the dosage of my medication, my doctor decided to gradually reduce the Risperidone to nothing, because at that time they thought that the psychotic episode was a single episode that would not re-occur.

I was officially free of medication for about four months during which time I went out with friends and had fun. However I could not really communicate and my mind wasn't as sharp as it was before I became ill.

Near the end of 2010 for no identifiable reason, I started to hallucinate again and in November 2010, I had to be re-admitted to hospital, where I was diagnosed with bipolar disorder. I was again prescribed Risperidone but this time it took longer to calm me down. Also, when I was discharged on 23 December, I was calm but unknown to medical staff, I was still hallucinating.

Upon my release, my new psychiatrist changed my medication to a high dose of Ziprasidone, but I was only taking it sporadically because the voices inside my head were comforting to me.



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My psychiatrist wanted to deal with the problem himself because I told him that I was fearful of returning to hospital. He re-admitted me to Key-We-Way where they supervised me to ensure that I took my medication. The voices went away and I continued to take the medication myself but my eyesight was failing and I was left feeling like a zombie again.

My psychiatrist added an anti-depressant because I told him that I didn't really care if I lived or died. However I eventually stopped the anti-depressant without consent because it was making me feel worse.

This time, I asked to have my anti-psychotic reduced myself. In the end, a subsequent psychiatrist reduced the Ziprasidone by half and another psychiatrist changed it to Abilify and maintained the mood stabiliser. I later had the Abilify reduced and since then I have never looked back. My concentration has returned and I am now working part-time as a lawyer again.

Discussion on My Mental Health History

There is an abundance of information on manic depression and schizophrenic psychosis, however my research in respect of bipolar psychosis has been very limited.

Adherence to Medication – While I was unwell but recovering, I did not adhere to my medication on four separate occasions: twice when I was in hospital, once when I went to Key-We-Way and once when I ceased my anti-depressant.

An Australian & New Zealand Journal of Psychiatry, 46(4) April 2012 stated *“Effectiveness of Interventions to Improve Medication Adherence in Bipolar Disorder”* it states from paragraph two: *“Numerous interventions have been studied in an attempt to improve medication adherence in long-term conditions – but ... it was found that less than half the interventions tested were associated with statistically increased medication adherence.”*

In my case, while I was psychotic, adherence really only worked under compulsion and that was when I was given injections in hospital. It was only when the voices in my head became threatening and I feared re-admission to hospital that I decided that I needed to take my medication without fail!

Advocacy and Support: I had a very effective network of support to see me through my illness as an acute patient and my eventual wellness. These were my parents, my mental health nurse, doctor, assigned support worker, staff at Key-We-Way, friends and staff at Choices Support Group. If not for them I would never have come through it as well as I did.

After three weeks in hospital, I was discharged and admitted to a halfway house in Kapiti called Key-We-Way, where I was fully supported by the staff. In fact as an acute patient I also got the best care from the medical community, which was all on public health funding. I had my own support worker who would visit me daily and my mental health nurse would attend consultations with my mother and me.



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In “Bipolar Disorder New Zealand Treatment Guide for Consumers and Carers” by the Royal Australian and New Zealand College of Psychiatrists, March 2005 at page 37 it states: “There is now a growing awareness of the benefits of support groups for people with a bipolar disorder. They have been found to influence positively: the person’s recognition of a need for practical and experimental information about the illness; the awareness of the need for medications; and they have been found to assist with the interpersonal difficulties associated with this condition”.

John: Mental Health History

I was born on 14 June 1954 and I am a New Zealand European. I first became ill in 1972 but had no diagnosis for six years. Then I was diagnosed with schizophrenia and with bipolar disorder in early 2012.

Until 1978 I was extremely unwell. I would push myself to the limit physically, my thoughts would be racing and my mind was a tangled mess of thought patterns.

I thought I would come right so I didn’t see a doctor until 1975 when he prescribed Stelazine (anti-anxiety) but I got worse. I couldn’t sleep and I couldn’t stand still. The doctor booked me into Ashburn Hall in Dunedin a private psychiatric hospital, where I would hear about a patient suicide every other week. They only medicated me with Cafergot (caffeine) for my headaches but it didn’t work. They tested me in every way but they couldn’t diagnose me. After four months I discharged myself.

Following my discharge and without any medication, I tried to manage life in my manic state and with my mind racing and confused. Finally, around May 1977, I admitted myself into the psychiatric ward at Wellington Hospital. After four months I was told to leave the hospital because they thought there was nothing wrong with me.

On my release and still un-medicated I went downhill both psychologically and physically and wound up on the street and sleeping in my car. One day I had been drinking alcohol at a pub all day and when I went to drive away. I was arrested and spent one night in a police cell and one night in Mount Eden Prison.

The Judge remanded me without charge to Oakley a medium security psychiatric hospital with hardened criminals. At Oakley I was finally medicated with Modecate an anti-psychotic and within two days I started to come right. After six weeks I was released and remained on Modecate for the next nine years. However over that time, I also gained a lot of weight, was a loner, lethargic and gradually deteriorated physically.

In 1987 I crashed and started thinking that people were staring at me. The doctor put me back into Wellington Hospital. They tried me on various anti-psychotics until one finally worked so after about a month I was discharged. Then in 1992 I stopped taking



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my medication altogether because I felt that it wasn't working. I was re-admitted to Wellington Hospital and tried to commit suicide because of a broken relationship.

Since 1992 I have been on antidepressants, antipsychotics, sleeping pills and mood stabilisers, but have never really felt well. In mid 2012, I was prescribed Lithium and I no longer have racing tangled thoughts. However, I still feel lethargic, unmotivated and have memory problems.

Discussion on John's Mental Health History

Difficulty of Diagnosis

John went undiagnosed for six years, was diagnosed as schizophrenic and then in 2012 was finally diagnosed with bipolar disorder.

In the "New Zealand Listener" article: "Mood Malady" (October 16 2010, p19) it states: "Bipolar is notoriously difficult to diagnose. About two-thirds of people start off with another diagnosis....often depression if this is the first obvious symptom, schizophrenia if mania is the first indication of illness or one of a number of different anxiety disorders if this is prompting the patient to seek treatment."

The use of Psychiatric Institutions and Prisons

John went to several private mental institutions, one being Oakley. However, John is now benefiting through psychiatric care out in the community.

In "The Saga of Psychiatric Services", following "deinstitutionalisation (keeping patients out of hospital and moving inpatients into the community)...[t]here is now a general recognition that any good psychiatric service must provide a wide spectrum of services ranging from high security for dangerous patients..to entirely patient-driven services which reach their apex in private services."

Side-effects of Medication for Bipolar

An ongoing issue for John is that he persistently feels lethargic, unmotivated and has memory loss, among other things.

In the "Australian and New Zealand Journal of Psychiatry" (46(3) March 2012 at page 200): "The Science and Practice of Lithium Theory" it states that side effects include general fatigue but also states "that the effects are usually transient...and usually last no more than a day or so, but in some patients troublesome side effects can persist for days or weeks."

Perhaps we still have a way to go in terms of advances in psychiatric medicine.

The Need for Long-term Medical and Psychosocial Intervention

John has been unwell since 1972. Over the years he has experienced homelessness, incarceration and has been suicidal because of the short term effectiveness of the medications.



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It has been suggested that what is needed for many bipolar patients is an ongoing system of support and monitoring.

In “*Mood Malady*” (p21) it states: “[R]elying on an acute model of care alone is not going to work. [There needs to be] a specific bipolar disorder service providing long-term medical and psychosocial intervention (helping people to manage their psychological state within a social environment) staffed by people with expertise in the field.”

It further states: “All the research supports the need for medication and a structured psychosocial intervention. It is a chaotic disorder and it can wreak havoc but there are strategies and interventions that can help. One of the crucial elements is the continuity of care.”

In conclusion, research into issues relating to bipolar disorder suggests the following:

- A 2012 report indicates that adherence to medication by bipolar patients remains a concern for practitioners
- New Zealand has an effective network of support and public funding in acute care for bipolar patients
- Bipolar disorder can be difficult to diagnose in some cases, making treatment of patients difficult
- Patient-driven services out in the community may be preferable to patients having previously been institutionalised.
- The side-effects for many medications for bipolar remain an issue
- The state should go beyond acute care measures and implement long-term support and treatment programmes for bipolar patients.