

Mental Health and Wellbeing in New Zealand Education

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Abstract

This literature review examines the current findings of mental health and wellbeing research in New Zealand education systems. Māori adolescents, and those from lower socioeconomic groups, are disproportionately affected by mental health and substance abuse disorders. Current mental health and wellbeing support systems in New Zealand are grouped according to the three-tier approach, focusing on the severity of need of the adolescents, with school supports including a combination of these systems. Secondary school counsellors are used for early intervention, with primary and intermediate schools lacking government funding to provide this support currently. The findings discussed support the relationship between academic achievement and mental health in adolescents. Current research has found that depressive symptoms for adolescents were 2-3 times higher in poverty groups compared to students not experiencing poverty. Adolescents (15-24 years) had the highest rate of suicide, accounting for one in three deaths in 2013, with rates of suicide in Māori adolescents persistently higher than non-Māori. Research has found that offering free counselling can be used as an effective method for reducing mental health symptoms and concerns for both Māori and lower socioeconomic adolescents. Caring relationships between parents, schools, and community have been found to be important factors influencing happiness among adolescents. This review has identified not only a lack of New Zealand research focusing on mental health and wellbeing in adolescents, especially those from Māori or lower socioeconomic groups, but also a clear need for funding to provide school-based counselling services for primary aged adolescents.

Keywords: *Mental Health, Wellbeing, Anxiety, Depression, School Support Systems, Socioeconomic Factors, Adolescents, New Zealand.*



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Introduction

Mental health and substance use disorders are the leading global cause of disability in adolescents aged 10-19 years ([Erskine et al., 2015](#); Simpson, Wicken, Duncanson, Adams, & Oben, 2016; WHO, 2014). The number of adolescents suffering from recognised mental health disorders is 20% in most developed nations ([Clark et al., 2014](#); Fortune et al., 2010). In New Zealand, Māori adolescents and those from lower socioeconomic groups are disproportionately affected (Crengle et al., 2013; Simpson et al., 2016). New Zealand youth (aged 15-19) have the highest suicide rates in the Organisation for Economic Co-operation and Development (OECD). New Zealand also spends less than the OECD average on young children, despite international evidence that shows spending on young children is more likely to result in positive outcomes (OECD, 2009). Research has shown that mental health disorders during adolescence are often associated with a range of negative outcomes. These can include: increased anxiety, anger, bullying,

unhappiness, depression, educational underachievement, and suicide ([Chan et al., 2017](#); [Clark et al., 2014](#); [Cushman, Clelland, & Hornby, 2011](#); [Fergusson, Horwood, Ridder, & Beautrais, 2005](#)).

Current Support Systems

The current New Zealand mental health and wellbeing support systems include a range of government agencies with services, initiatives, and policies, which are designed to support the mental health of adolescents. These support systems are delivered through: schools, District Health Boards, non-governmental organisations (NGO's) and community based groups ([Macklem, 2011](#); New Zealand Mental Health Commission [NZMHC], 2012).

Government Support

The support systems provided can be loosely grouped according to the severity of need they are designed to address using the



three-tier approach. This approach has been widely adopted in health literature and policy development (Macklem, 2011; NZMHC, 2012). Tier 1 focuses on promoting wellbeing for all young people and has a preventative focus. The supports in this tier include: regulatory environment; The New Zealand Curriculum; Education Review Office (ERO) Wellbeing Resource, Positive Behaviour for Learning (PB4L), and professional frameworks (ERO, 2016; Health Select Committee, 2016; Ministry of Education, 2007, 2015; NZMHC, 2012).

Tier 2 is designed to respond to issues of young people and to resolve the issues where possible. The supports for Tier 2 include: School Guidance Counsellors, social workers in schools, PB4L, School based health services, and Resource Teachers. These include: Learning and Behaviour (RTLBs), Family and Crisis Counselling, Gateway Assessments, SPARX (self-help e-therapy tool), and Youth One Stop Shops (Health Select Committee, 2016; Ministry of Education, 2015).

Tier 3 responds to a crisis and aims to prevent a situation from worsening. These supports are targeted at individuals, based on their specific needs. These include: Child and Adolescent Mental Health Service, Intensive Wraparound Service, Regional Health Schools, Fresh Start Programmes, Traumatic Incident Teams, and Crisis counselling and helplines (Health Select Committee, 2016; Ministry of Education, 2016, 2017).

School Support for Students

The current school supports for students in New Zealand include a combination of Tier 1, 2, and 3 systems. For example, the Education Council of Aotearoa New Zealand has recently released an update to the Code of Professional Responsibility and Standards for the Teaching Profession called *Our code. Our Standards*. In Section 2.1, Commitment to Learners, it states “I will work in the best interests of learners by promoting the wellbeing of learners and protecting them from harm” (Education Council, 2017). Along with this, the Vulnerable Children Act (2014) 6 (a) for improving the wellbeing of vulnerable children, requires measures aimed at “improving their physical and mental health and their cultural and emotional wellbeing” (New Zealand Government, 2014).

Secondary school based counsellors are used as early intervention in childhood mental health issues in New Zealand. However, the current ratio of counsellors to students in secondary schools is often 1:1,000, when the ratio should be 1:400 to work with secondary students in an effective manner (New Zealand Association of Counsellors [NZAC], 2017). The New Zealand Association of Counsellors (NZAC) recommends that the Government should be looking to employ counsellors in primary and intermediate schools in order to provide more co-ordinated and consistent school-based support for all students (Cushman et al., 2011; NZAC, 2017). Other ways in which schools in New Zealand currently support student mental health and wellbeing, are through: The New Zealand Curriculum, PB4L, social workers and RTLBs (Health Select Committee, 2016; Ministry of Education, 2007, 2015).

Mental Health and Wellbeing in Schools

A study by Lambert et al. (2014) looked to determine possible factors which could be associated with happiness among New Zealand adolescents. They used data from the Youth’07 Health

and Wellbeing of Secondary School Students in New Zealand survey of 9,107 students and found caring relationships with parents, schools, and the community to be important factors for happiness among adolescents. Similarly, Clark et al. (2013) also identified that positive connections to family and schools are important indicators of student wellbeing. The studies by Fleming et al. (2014) and Clark et al. (2013) also used the same Youth’07 survey to determine trends and changes in the mental health of New Zealand secondary school students. The study by Fleming et al. (2014) investigated the self-reported mental health changes between 2007 and 2012 and found a slight decline, with an increased number of students reporting low mood, depressive symptoms, self-harm, emotional symptoms, hyperactivity, and peer problems in 2012, compared to 2007. In contrast, the study by Clark et al. (2013) found that there had been improvements in the health and wellbeing of New Zealand adolescents between 2001, 2007, and 2012, using three national health and wellbeing surveys as well as comparisons with international estimates. There was, however, little change in self-rated general health or depressive symptoms which agrees with the findings of Fleming et al. (2014). There was no change or continued poorer health status compared with other developed nations, with New Zealand continuing to rank poorly for suicide rates (Clark et al., 2013).

Unlike the studies described above, Cushman et al. (2011), did not use the national health and wellbeing surveys of New Zealand secondary schools and, instead, surveyed 318 New Zealand schools in order to determine teachers’ perceptions of mental health issues and the strategies schools had in place to address this. Unlike the studies described above, the survey was not limited to secondary schools and included primary and intermediate schools, using a random number generator to select the participants. The findings supported research that has found there is a definite relationship between academic achievement and mental health (Cushman et al., 2011).

Socioeconomic Risk Factors

Denny, Lewycka, et al. (2016) examined indicators of socioeconomic deprivation among New Zealand secondary school students, using a national adolescent health survey and found that depressive symptoms were 2-3 times higher in the poverty groups compared to students not experiencing poverty. In addition, students experiencing poverty, and living in affluent neighbourhoods, reported higher levels of depressive symptoms (Denny, Lewycka, et al., 2016). Correspondingly, Clark et al. (2014) identified that most mental health interventions are adult focused, with few demonstrating appropriateness for youth of Māori, Pacific, or lower socioeconomic communities. Furthermore, using an intervention method that offered free counselling was found to be an effective strategy to reduce mild to moderate mental health symptoms and concerns, especially for Māori and lower socioeconomic adolescents (Clark et al., 2014). Both studies highlight a clear need for an increase in research around adolescent mental health promotion and intervention in New Zealand. These findings are reinforced by both Clark et al. (2011) and Denny, Lucassen, et al. (2016) who found there is a scarcity of literature regarding New Zealand Māori adolescents, sexual minority students, and mental health outcomes.

Family connection has been demonstrated to reduce the risk of suicide attempt for Māori adolescents; however, it was found that it did not moderate the relationship between depressive

symptoms and suicide attempt (Clark et al., 2011). In New Zealand, Māori adolescents do not have equitable access to healthcare and equitable health outcomes compared to non-Māori adolescents. Conversely [Denny, Lucassen, et al. \(2016\)](#) found that sexual minority students (defined as gay, lesbian, bisexual, and transgender [GLBT] individuals) were more likely to report higher levels of depressive symptoms and suicidality than their heterosexual peers. Their results found that schools play an important role in providing safe and supportive environments for male sexual minority students. Their findings therefore support the inclusion and implementation of both general and specific school mental health and wellbeing education strategies.

The highest rate of suicide in 2013 was in the adolescent age group (15-24 years) accounting for one in three deaths. Over time, adolescent suicide rates for adolescents of Māori ethnicity, have been persistently greater than rates for non-Māori (Ministry of Health, 2016). In 2013, the highest rates of suicide were male adolescents (15-24 years), especially Māori adolescents and those living in the most deprived socioeconomic areas. However, higher rates of intentional self-harm hospitalisations were recorded in females, especially adolescents (15-24 years), Māori and European ethnicities and those living in neighbourhoods of high socioeconomic deprivation (Ministry of Health, 2016). It is, therefore, clear from current research, that the identification of risk factors is necessary for effective screening, referral, and treatment of suicidality among New Zealand adolescents ([Chan et al., 2017](#); [Clark et al., 2013](#); Clark et al., 2011; [Crengle et al., 2013](#); [Denny, Lewycka, et al., 2016](#); [Denny, Lucassen, et al., 2016](#)).

Strengths and Limitations

The findings discussed above have several strengths and limitations. For example, the use of national health and wellbeing surveys, by many of the studies discussed in this review, has meant that the resulting research provides contemporary information for a large, diverse, and random nationally representative sample of New Zealand secondary school students ([Clark et al., 2013](#); Clark et al., 2011; [Denny, Lewycka, et al., 2016](#); [Denny, Lucassen, et al., 2016](#); [Fleming et al., 2014](#); [Lambert et al., 2014](#)). In comparison, the study by [Cushman et al. \(2011\)](#), surveyed 318 schools and found that they were representative of a wide range of geographical locations, school types, and decile levels in New Zealand. Studies like the one by [Clark et al. \(2014\)](#) add to the small amount of research around effective mental health interventions in primary care and community settings, especially for Māori adolescents and those from lower socioeconomic backgrounds. This study provided a relatively simple and cost effective intervention by exploring the use of facilitated access to free counselling for youth with mild to moderate mental health concerns.

It is important to highlight some of the limitations of these studies. Most studies have highlighted the difficulty in exploring causal associations with cross sectional design methods. In the study by [Clark et al. \(2014\)](#) the mental health concerns and stressors may have resolved themselves without intervention. Similarly, it is not possible to attribute the improved outcomes of this study as a direct result of the intervention. The sample sizes, in the surveys of the studies discussed, are a limitation because they may reflect the views of the sample rather than the entire

New Zealand school and student population. It is also important to highlight that the research discussed in this review is focused on New Zealand secondary schools and secondary aged students. The exceptions are [Cushman et al. \(2011\)](#), who looked at both primary and secondary schools and [Clark et al. \(2014\)](#), who used a referral based service for any young person aged 10-24 years with mild to moderate mental health concerns.

Future Research

There are currently large gaps in the research around effective mental health interventions in primary care and community settings, particularly among Māori adolescents and those from lower socioeconomic backgrounds. There is also a lack of New Zealand research focusing on the relationship between mental health and wellbeing and student achievement, even though international research has shown that there is a fundamental relationship between mental health and student learning ([Cushman et al., 2011](#)). The studies have also highlighted that policies are needed which address household poverty alongside the reduction of socioeconomic inequalities of New Zealand adolescents. There is clearly a need for ongoing monitoring and evidence-based accessible interventions that focus on preventing mental ill health and on promoting mental health and wellbeing. The mental health of New Zealand secondary school students requires further attention, with clear statistics around youth suicide supporting this. There is also a growing need for funding to provide primary school based counsellors and to increase the training made available to professionals, both in initial teacher education and professional development for in school teachers.

Conclusion

The mental health of students is a major factor affecting their ability to learn and their resulting academic outcomes and therefore an integrated collaborative approach is required ([Clark et al., 2013](#); [Cushman et al., 2011](#)). This review of current literature has found that there has been no change or a continued poorer health status in New Zealand adolescents compared with other developed nations. Many of the studies identified positive connections to family and schools as being important indicators of student wellbeing. Most studies found that the strategies used were focused on responding to issues of concern, rather than the use of proactive and preventative approaches. Currently, secondary schools use counsellors to provide support to students with mental health and wellbeing concerns, while primary and intermediate schools rely on less qualified school-based and community-based support systems due to a lack of Government funding. This has highlighted a clear need for an increase in government support and funding for primary aged students with regard to in school counselling. Research has found that offering free counselling can be used as an effective method for reducing mental health symptoms and concerns for adolescents. Caring relationships between parents, schools, and the community have been found to be important factors influencing happiness among adolescents. Research discussed in this literature review is focused on New Zealand secondary school students due to the lack of literature and significant research gaps regarding primary aged students' mental health outcomes. Current findings support inclusion and implementation of both general and specific school mental health and wellbeing education strategies, with a stronger

focus for funding on a preventative rather than reactive systems needed. Research also highlights the need for effective screening, referral, and treatment of suicidality in New Zealand adolescents. This review has therefore identified a current lack of New Zealand research focusing on mental health and wellbeing in adolescents.

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