CHILD AND YOUTH MENTAL HEALTH

Why New Zealand's young lead the developed world in poor mental health

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- Child Abuse & Family Structure: What is the evidence telling us? (2016)
- Imprisonment & Family Structure: What is the evidence telling us? (2018)
- Families: Ever Fewer or No Children, How Worried Should We Be? (2019)
- The Challenges Facing Children In Step-Families: What we know, don't know, and how to fill in the gaps. (2020)
- New Zealand's Teenage Birth Rate: Is it time to stop worrying about it? (2021)

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About Family First NZ

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- to promote and advance research and policy regarding family and marriage
- to participate in social analysis and debate surrounding issues relating to and affecting the family
- to educate the public in their understanding of the institutional, legal and moral framework that makes a just and democratic society possible
- to produce and publish relevant and stimulating material in newspapers, magazines, and other media relating to issues affecting families
- to speak up about issues relating to families that are in the public domain

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Executive summary

In 2020 UNICEF rated New Zealand children **last** of 38 'rich' countries in child mental well-being. Physical health ranked 33rd.[1] This begs the question, why?

The provisional suicide rate for 15–19-year-olds for the year to June 2020 was 18.69 – higher than the 2013-15 rate which heavily influenced the UNICEF ranking.[2] New Zealand continues to lead the developed world in the incidence of youth suicide.[3] The rates of hospital admission for self-harm are about 50–100-fold greater than those for suicide.[4]

In 2018 a government inquiry into mental health, He Ara Oranga, described how *"increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming."* The panel reported, *"Problems of access, wait times and quality were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services."* [5]

Increasingly children are exposed *in utero* and postnatally to drugs and alcohol and are at heightened risk of developing a range of mental disorders. According to Oranga Tamariki, *"...the alcohol and drug issue is prolific/increasing"* among Family Start clients (a flagship home visiting programme for pregnant mothers and whānau with young children). [6] Seventy percent of children who entered state care in 2019 had a parent with substance usage treatment recorded. Drug addiction is also the most commonly cited reason why thousands of New Zealand grandparents are raising their grandchildren. [7]

When rated for social and emotional functioning in 2015/16, eight percent of children aged 3-14 had a 'concerning' score. Children who do not develop age-appropriate social and emotional competencies are more likely to develop mental health problems throughout their lives. [8]

Children aged under 15 with *diagnosed* 'emotional and/or behavioural problems' grew from 3.3 percent in 2011/2012 to 5.7 percent in 2020/21.[9]

Adverse Childhood Experiences (ACEs) are associated with increased risk for a wide range of disorders, from mood and anxiety to psychotic and personality disorders.[10]ACEs include, *"exposure to maltreatment, witnessing violence, living with household members with mental illness, who abuse substances, have a history of incarceration, or have experienced parental divorce."*[11] The Growing Up in New Zealand (GUiNZ) longitudinal data showed 2.6 percent of children had experienced four or more ACEs by 54 months (4.5 years) of age; 6 percent had experienced three or more.[12] ACEs accumulate with age.

Awareness of links between mental disorder in parents and disturbance in their children is longstanding. Links may operate through genetics, the behaviour of parent towards child e.g., hostility or neglect, change in family structure due to illness, or factors that correlate with disorders such as drug use.[13] During the antenatal period 16.2 percent of children were exposed to maternal depression in the GUiNZ cohort.[14]

The percentage of 15–17-year-olds reporting 'psychological distress in the past four weeks' grew from 1.9 percent in 2011/12 to 15.6% in 2020/21; the 18–24-year-old age group showed an increase from 6.5 to 20.7 percent over the same period.[15]

The number of children and young people (aged 0-19) seen by Mental Health and Addiction Services grew from 20,800 in 2002/03 to 51,010 in 2020/21 or by 145 percent. [16] Young Māori are over-represented in treatment for 'schizophrenia' and under-represented in 'depression.' The incidence of 'personality disorders' and 'bipolar disorders' is similar for Māori and non-Māori. [17]

Antidepressant dispensings to 0–19-year-olds grew by 21 percent in the year to 2020/21 compared to 8 percent for the total population; antipsychotics increased by 18 percent compared to six - increases which are believed to have resulted from not only Covid 19-related stress but a lack of non-medical treatment alternatives.[18]

While comparable international data shows 35-50 percent of mentally unwell people do not receive treatment, New Zealand lacks similar information. [19] The 2022 Mental Health and Addiction Services Monitoring report explained, *"Our most recent comprehensive data on prevalence of mental distress and addiction is … based on data collected in 2003 and 2004. The age of this information makes it difficult to know whether the number of people currently accessing services is an accurate reflection of how many people need support from services. Furthermore [it] excluded children aged under 16 – a priority group experiencing increasing mental distress*."[20]

In 2020/21, only 65% of under twenty-year-olds were seen within three weeks of their referral, and 87% within eight weeks. Wait times have worsened since 2017/18. [21] Young people turning up to emergency departments with a mental health crisis increased by 178 percent between 2011/12 and 2020/21.[22] In May 2022 Health Minister Andrew Little acknowledged publicly that "children and adolescent mental health services are in crisis." [23]

Some psychologists have asked, *"…if our treatments work shouldn't we have fewer people presenting in crisis, less people on a disability benefit due to mental illness, a reduction in community measures of psychological distress and a decrease in the suicide rate? … despite access to costly biomedical treatment, something central to recovery appears to be missing in the social fabric of developed countries."* [24]

Academics in the field of psychiatry made a cautionary assertion: *"Our interventions should encourage, not replace or subvert, autonomy, independence and active coping."*[25] Similar counsel could apply in other spheres. Advocates and lawmakers should also consider if well-intended social and educational interventions undermine 'autonomy, independence and active coping.' An over-reliance on antidepressants is comparable perhaps to a wider societal dependence on historic non-medical quick fix 'solutions' notable in family law for instance.

Family structure has changed dramatically. From being quite rare, sole parent families have become common. Disproportionately, children in these families experience high levels of material hardship and their mothers are more likely to have depression or anxiety. [26]

GUiNZ data revealed high levels of change in family structure, even pre-birth. A key finding was, *"1095 (17.3%) of mothers were categorised as having experienced 1-4 relationship transitions from pregnancy to the 4.5-year interview."*[27] Relationship transitions were characterised as, *"…the count of the entrances and exits by biological parents, romantic partners, or spouses."* This matters because, *"Children raised in families that had experienced relationship transition(s) also reported higher externalising and internalising behaviour, and lower prosocial behaviour … In usual psychological usage, 'externalising' behaviours refer to expressions of anger such as fighting, yelling at others, and destruction of property, whereas internalising behaviour refers to inward expressions of dysfunction such as anxious and depressive symptoms."*[28]

Parental engagement – particularly paternal - has been progressively weakened by changing social policy.

Non-maternal day-care is increasingly utilised (and state subsidised) but remains controversial regarding effects on young children. Recent Auckland University GUiNZ analysis found, *"…more time in ECE per week was inversely associated with the development of emotional difficulties and peer problems."* The finding was not however particularly robust with the following caveat: *"It is possible*

that the positive association between child behaviour and ECE is in part due to children with behavioural difficulties being excluded from ECE (reverse causation) … It is also possible that parents with full time childcare responsibilities of two-year children may rate their behaviour as worse than the parents of children in childcare, because they see them all the time … Given limitations in the data collection noted elsewhere, it is not possible to determine why attendance appears to protect against emotional difficulties and peer problems, and hence why this finding contrasts with previous research."[29]

In older children, the extensive Youth 2000 surveys show reductions in substance use, sexual experience and risky driving but increases in symptoms of depression, suicide thoughts and attempts. Despite a decline over time, *"…levels of adolescent binge drinking remain high by international standards and disparities in tobacco and cannabis use by ethnicity and socioeconomic status are wide."*[30] The evidence of a causal link between alcohol and teen suicide is strong.[31] Unfortunately turning to substance use as a coping mechanism tends to *"compound psycho-social and mental health problems, rather than alleviating them."*[32]

Absenteeism is rife. Skipping school because of anxiety only serves to worsen anxiety creating another vicious cycle.[33] Mental health issues in the home were identified as a cause of chronic absenteeism at a 2022 parliamentary inquiry into poor school attendance. At March 2022, 5,277 beneficiaries with a primary incapacity of a psychological or psychiatric condition had children in their care – up twenty percent on 2014.[34]

Bullying contributes to absenteeism. Comprehensive PISA 2018 data for 36 countries found New Zealand had the highest percentage of 'frequently bullied students' (15%), tied second for experience of 'any type of bullying act' (32%), and 'other students left me out of things on purpose' (14%) and led in experience of, 'other students made fun of me' (23%).[35]

1,185 under 20-year-olds accessed mental health services for eating disorders in 2020/21 and 9 percent were male.[36] Public referrals have risen 65% in the past five years.[37]

In 2015 New Zealand children spent an average of around 160 minutes using the internet outside of school – seventh out of OECD countries.[38] A consensus is forming that either very low or very high internet use leads to heightened depression and anxiety.[39]

Young people suffering from anxiety will often fixate on 'what if' and worry about matters far off in the future. Today's world presents them with ample material to fret over. But past generations have faced equally frightening doomsday scenarios. The difference now is a highly connected world in which youth are constantly exposed to media-generated hysteria and unprecedented peer pressure to respond in a conformist fashion. This is compounded by the willingness of educators to engage the very young in debates and ideas that might be best avoided until students possess the maturity to think more critically about them.

Unquestionably a mental health crisis is occurring among New Zealand's young. The evidence is stark. It cannot be resolved with medication alone and there is no prospect of other therapies meeting demand any time soon.

A reversal of this upward surge demands a wider appraisal and acknowledgement of societal changes that have lessened the likelihood that children will experience material and emotional security and stability throughout their formative years.

It appears there are two New Zealand stories occurring simultaneously which explain why the country rates so poorly for child mental well-being.

The development of mental disorders due to *in utero* trauma and exposure to substances followed by chaotic lives characterised by transience and family violence affect probably (and

conservatively) 3 - 4 percent of all children. These experiences are by no means confined to Māori children and teens but their over-representation in youth suicide, substance abuse, schizophrenia, experience of maternal depression and parental imprisonment is long-standing. In 1983 the rate of first admission to a psychiatric hospital for Māori aged 10-19 was 168 per 100,000 compared to 102 for non-Māori.[40]

It is probably optimistic to assess this group as shrinking or even static given growth in gangs[41], family harm[42] and Oranga Tamariki's own 2019 findings: *"Across all case study sites, Family Start workers and managers … have been working with more high needs whānau/families. This includes those affected by insecure and inadequate housing, family violence, alcohol and drug addictions including methamphetamine, mental health issues including high rates of anxiety, incarceration, intergenerational exposure to Oranga Tamariki, immigrant and refugee whānau (some of whom have past trauma) and more whānau in crisis."*[43]

Indigenous people in Australia, Canada, and the United States also experience poorer mental health than non-Indigenous.[44]As a percentage of the total population, New Zealand's indigenous (16.5%) exceeds others: Australia (3.3%) Canada (4.9%) and the United States (2%). Thus, the *potential* for poorer mental health in New Zealand is greater.

The *existence* of poorer mental health among the young is supported by the available statistics. New Zealand leads the developed world in youth suicide, youth self-harm and bullying. But the statistics that are not available also suggest a strongly negative picture. Those lost to longitudinal studies overwhelmingly comprise the very population of concern. PISA surveys cannot capture the chronically absent.

The second scenario is of a more pervasive depression and anxiety problem exacerbated less by mayhem and material deprivation, and more by recent developments such as social media-driven poor self-image, heightened sensitivity to parental and/or peer pressure, fear of failure[45], climate change anxiety[46] and confusion over sexual and gender identity. The second group may also be dealing with separated parents, torn loyalties, school and home-life upheaval and adapting to stepsiblings. These stresses are occurring in similar countries. According to paediatrician and government advisor, Sir Peter Gluckman, *"The real pandemic that is emerging is this pandemic of loss of subjective wellbeing in that critical stage of life, adolescence, which is affecting 25 to 40 per cent of Western populations."* [47]

The surprisingly shallow socio-economic gradient for the incidence of diagnosed mental disorders also points to differing pathways to illness. Compared to the least deprived neighbourhoods, disorders are only one and a half times more common in the most deprived. (Further research would seek to establish if disorder types correlate by quintile.)

There will doubtless be overlapping characteristics between the two groups but the second is expanding faster than the first.

The first group enjoys very little positive parental control at any age whereas the second may struggle under intense parental protectiveness and expectation, especially as one child families become more common.

In both groups though, it is parents who hold the key – not governments. Enduring change begins at an individual level. If children were genuinely placed at the centre of the family, given time, given unconditional love, given space to explore but surety to return to … there may still be no guarantees. But the odds of that child growing into a secure and stable individual will massively increase.

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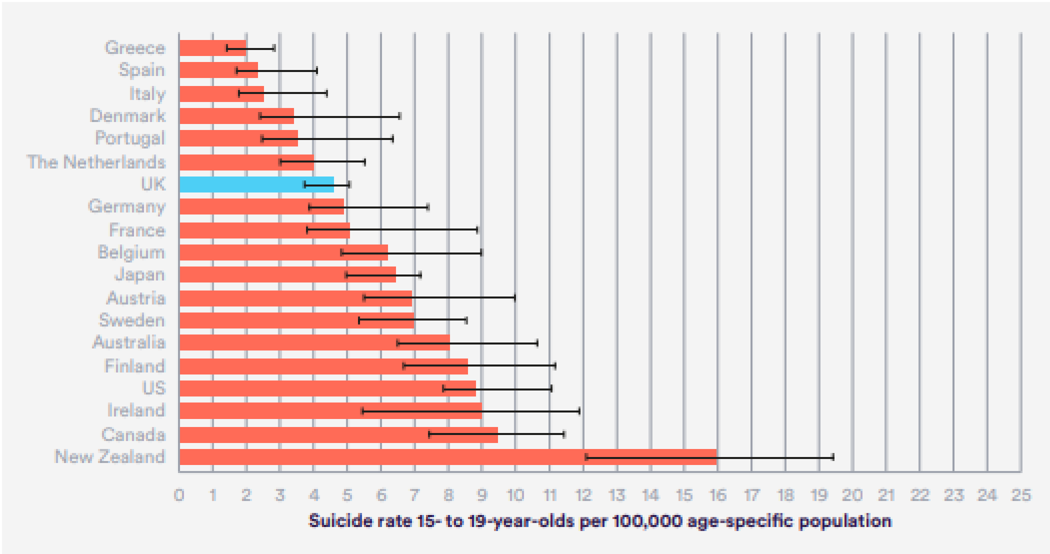
Youth Suicide

When UNICEF ranked New Zealand's child mental-wellbeing as last of 38 countries, our high youth suicide rate (14.9 in 2013-15)[48] appears to have been a strong influence.

By 2016 New Zealand had the highest youth suicide rate among comparable countries.

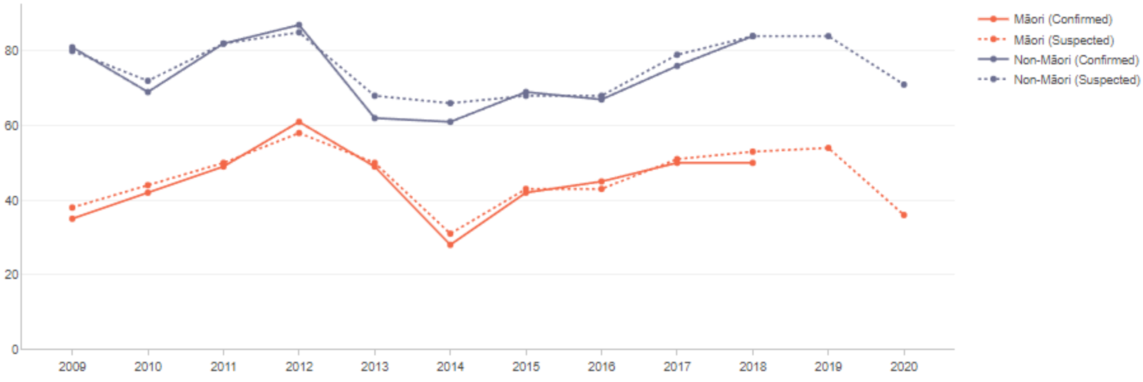


Source: International comparisons of health and wellbeing in adolescence and early adulthood, 2019 (95% confidence intervals displayed)

The Prime Minister, Jacinda Ardern, took issue with UNICEF rating because the suicide data was out-dated. She said, "…*the New Zealand statistics used for this report are based on average rates for 15-19 years olds between 2013 and 2015. The June 2020 provisional statistics have shown a drop for this age group, down from 73 to 59, with the overall suicide rate at its lowest rate in three years.*"[49] The provisional rate for 15–19-year-olds for the year to June 2020 was 18.69 – higher than 2013-15.[50]

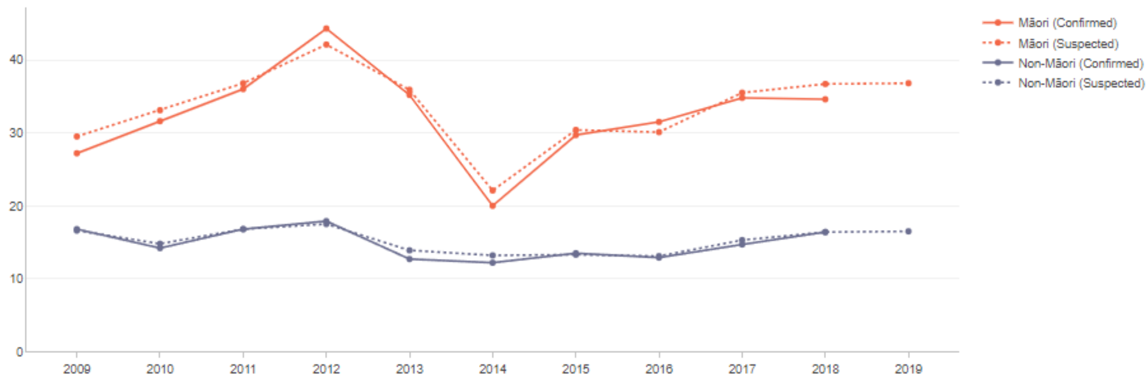
The most recently available age data for suicide deaths/rates is grouped by Māori/non-Māori and classified into 0-14/15-24-year age groups. The 0-14 data is 'S' (suppressed due to small numbers) and 15-19 is not separately identified.

Number of suicide deaths among Māori and non-Māori in the 15–24 years life-stage group, 2009–2020



Source: Suicide webtool Chief Coroner/ Ministry of Health (accessed August 10, 2022)

Rate of suicide deaths among Māori and non-Māori in the 15–24 years life-stage group, 2009–2019



Source: Suicide webtool Chief Coroner/ Ministry of Health (accessed August 10, 2022)

A media statement from the Chief Coroner (October 2021) reported a small decrease in the all-age suicide rate from 11.8 to 11.6 per 100,000 for the year to June 2021, covered ethnicity and gender but not age.[51]

In 2019 22% of surveyed youth who'd had contact with Oranga Tamariki (OT) reported a suicide attempt in the past 12 months, rising to 29 percent for Māori.[52]

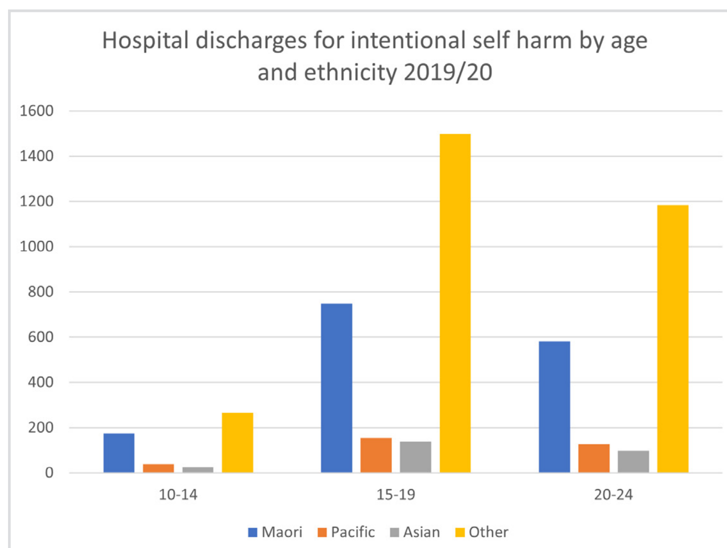
The 2018 government inquiry into mental health, He Ara Oranga stated, *"Every year, 20,000 people attempt to take their own life."*[53] That is 35-40 times higher than actual deaths.

Intentional self harm

In 2013 the Ministry of Health (MOH) reported,

> *"The highest rate of intentional self-harm hospitalisations for females was in the 15–19 years age group (912.6 per 100,000), and for males, the highest rate was in the 20–24 years age group (229.8 per 100,000). There were 2866 hospitalisations for youth (15–24 years) in 2013 (456.0 per 100,000). Three-quarters of youth hospitalisations were female."*[54]

The numbers have increased since, with 4,534 discharges for intentional self-harm recorded in the year to June 2020:



Data source: Publicly funded hospital discharges with an intentional self-harm external cause code, 2019/20

He Ara Oranga noted, *"Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming.... resulting in cutting, other forms of self-harm and eating disorders, which can be devastating and life threatening."*[55]

According to Sir Peter Gluckman, paediatrician and advisor to both National and Labour governments, in a 2017 youth suicide discussion paper, the rates of hospital admission for self-harm are about 50–100-fold greater than those for suicide.[56]

Victoria University psychology professor Marc Wilson conducted studies of non-suicidal self-harm among young people and found that, *"between a third and a half of our young people hurt themselves before they leave school. In the international context, this is a lot – on average, about 20% of young people around the world hurt themselves."*[57]

This paper opened with the most extreme expression of mental distress – suicide and self-harm - because it marks New Zealand as different, if only by degree. Why?

If suicide is the tip of the iceberg, what does the underwater mass look like; why is it so large and seemingly growing?

The beginning

The child begins before birth. His time in the womb affects the rest of his life.

Exposure to drugs and alcohol

Alcohol, cannabis, meth and opiates cross the placenta and impact fetal development.

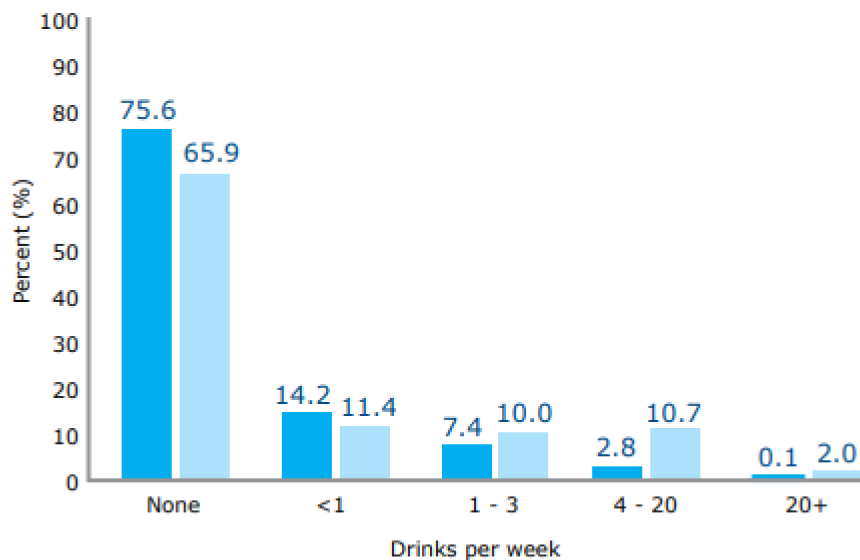
Auckland University researchers claim effects, *"... range from mild to severe and may depend on the timing of exposure during the pregnancy, and duration and level of exposure or dose, as well as genetics, the health of the mother and the fetal environment."*[58]

Fetal alcohol syndrome disorder (FASD) affects an unknown number of children.

For children diagnosed with FASD there is a higher prevalence of mental disorders including intellectual disability, ADHD, oppositional defiant disorder, reactive attachment disorder, conduct disorder, psychotic disorder, anxiety and depression. [59]

New Zealand estimates for FASD range from between 1,800 and 3,000 babies each year.[60] Or 3-5% of all births. These estimates are based on international data.

Growing Up in New Zealand (GUiNZ) is a longitudinal study tracking children born in the Auckland, Counties Manukau and Waikato DHB regions during 2009/10 and will crop up frequently throughout the paper. In the following chart, GUiNZ data is recorded for drinking alcohol any time during pregnancy with the first column representing 'planned' pregnancy and the second, 'unplanned'[61].



Source: Before we are born, Growing Up in New Zealand, 2010

Of the 4,091 mothers who had a planned pregnancy, 115 drank 4 - 20 drinks weekly and 4 drank 20+ drinks per week; of the 2,700 who had an unplanned pregnancy 289 drank 4 - 20 drinks and 54 drank 20+ drinks per week. (These data may not be population representative as only two thirds of the 10,315 mothers referred for the longitudinal study committed to the long-term participation required.)

Suffice to say 462 or 6.8 percent of mothers drank four or more drinks weekly.

Neurobehavioural Disorder Associated with Pre-natal Alcohol Exposure (ND-PAE) – a form of FASD – was first included as a recognized condition by the American Psychiatric Association and includes:

> *"(1) thinking and memory, where the child may have trouble planning or may forget material he or she has already learned, (2) behavior problems, such as severe tantrums, mood issues (for example, irritability), and difficulty shifting attention from one task to another, and (3) trouble with day-to-day living, which can include problems with bathing, dressing for the weather, and playing with other children."*[62]

To be diagnosed with ND-PAE, the mother of the child must have consumed more than 13 alcoholic drinks per month of pregnancy or more than 2 alcoholic drinks in one sitting.

These thresholds would encompass those New Zealand mothers drinking 4 or more drinks a week.

A recent evidence brief prepared for the Well Child Tamariki Ora programme claims around a quarter of expectant mothers drink at levels likely to be harmful to the developing embryo before realising they are pregnant.[63]

Additionally, *"Fathers' preconceptual drinking can have direct effects on pregnancy outcomes and increase the risk of their partner's use of alcohol during pregnancy."*[64]

Drug use in general is rising among women as genders become more equal.

As cannabis becomes more accepted, its use is also growing among pregnant and breastfeeding women.[65] As with alcohol, studies are mixed regarding the fetal effects of cannabis. Auckland University researchers note: *"For instance, one meta-analysis found no detectable effects after*

controlling for tobacco and other environmental factors." However, *"There are some well-designed longitudinal studies that found a range of long-term cognitive and neurobehavioural consequences associated with maternal use."*[66]

An important caveat is added:

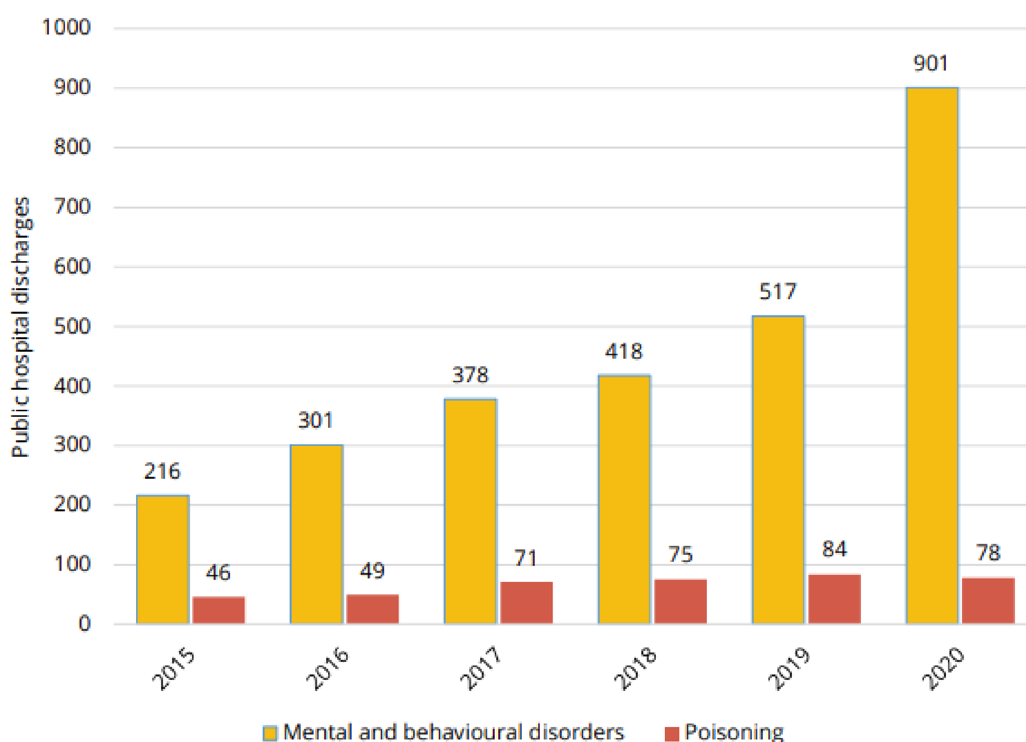
> *"...since the prenatal data in these studies was collected, the quantity of delta-9-tetrahydrocannibinol (THC), the psychoactive ingredient in cannabis, has increased and cannabis is being consumed more frequently in a variety of ways that may increase the level and frequency of exposure to the fetus."*[67]

United States and New Zealand studies are following children who have been exposed to methamphetamine *in utero*. To date they have found, *"atypical reflexes and behaviour at birth, delayed motor development over the first 3 years of age, an increase in externalising and internalising problems, poorer cognitive outcomes and structural brain changes at 6-7 years."*[68]

Methamphetamine use is growing in New Zealand. Advice to parliament describes how, *"Between 2014/15 and 2019/20, the number of discharges from publicly funded hospitals with a primary diagnosis of mental or behavioural disorders indicating methamphetamine increased from 216 to 901."*[69]

While the absolute numbers are not large in the scheme of things, the increase is.

Publicly funded hospital discharges with a primary diagnosis indicating methamphetamine, years ending 30 June 2015 to 2020



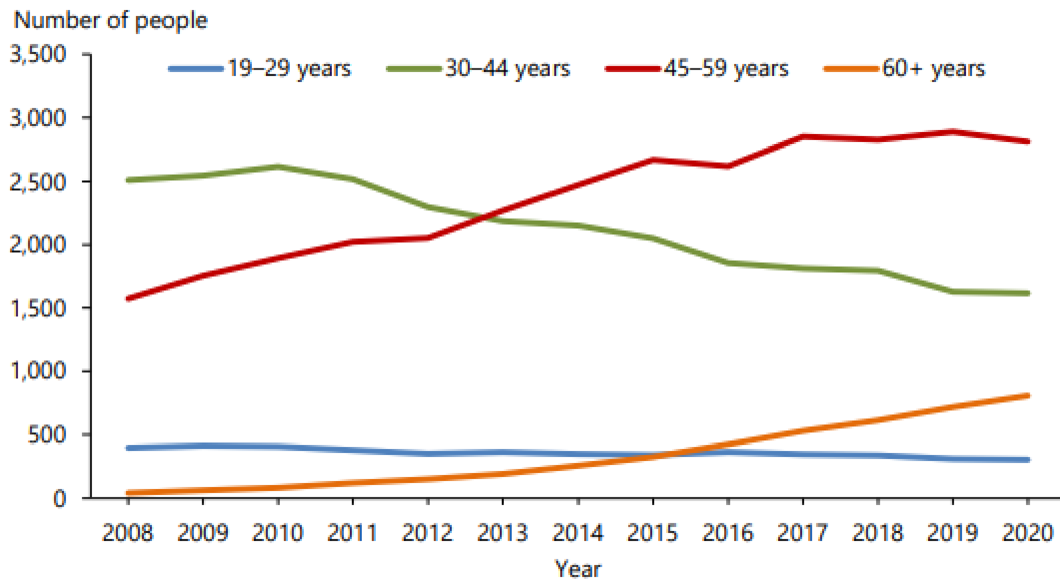
Source: Methamphetamine in New Zealand: A snapshot of recent trends

Of course, not all meth users are parents, but according to an Oranga Tamariki 2020 evidence brief, 'Methamphetamine and care' *"...the alcohol and drug issue is prolific/increasing"* among Family Start clients (a flagship home visiting programme for pregnant mothers and whānau with young children).[70] One Family Start provider, *"is developing a map of local methamphetamine or 'P' labs to help keep their workers informed of safety risks."*[71]

Meth-related referrals to the Alcohol Drug and Pregnancy Team at National Women's Hospital increased from 10% of total referrals in 2001 to 59% in 2003.[72]

New Zealand runs a nationwide methadone maintenance (MM) programme for heroin addicts. An unknown number of patients are female, and are either parents or of child-bearing age:

Number of opioid substitution treatment clients, by age group, 2008–2020



Source: Office of the Director of Mental Health and Addictions Services, 2020 Regulatory Report

United States research found, *"MM women had complex reproductive histories, chronic health problems, and were subject to high rates of socioeconomic adversity and comorbid mental health problems. During pregnancy, more than half continued to use licit and illicit drugs, although there was a general trend for drug use to reduce over time."*[73]

Anecdotally individuals on the methadone programme often form romantic partnerships.

A New Zealand study of 86 babies born to mothers on methadone maintenance discovered, *"... methadone-exposed infants showed poorer attention, suboptimal reflexes, poorer motor control, tighter muscles, and more fussing, crying and irritability..."*[74]

In addition to exposure to substances *in utero*, associated behaviours of substance-using mothers also pose risks:

> *"Important, also, is the added stressors often associated with illegal substance use which includes abuse of a range of legal and illegal drugs prenatally, and other maternal characteristics that can result in fetal harm, including high stress, lack of prenatal care, sexually transmitted infections and infections as a result of needle sharing through intravenous (IV) drug use, and high-risk behaviours such as drug seeking and drug trading activities that expose mothers to violence."*[75]

Exposure to high levels of maternal cortisol in the context of domestic violence pre-birth can render babies irritable, over-sensitive to touch and difficult to settle.[76]

Additional attention has been drawn to Māori with the following observations:

> *"...the likelihood of heavy or high risk drinking is higher for Māori women ... Māori women are more likely to use Meth intravenously, which predicts poorer neurobehavioural outcomes for infants at 24 months of age ... Māori boys are more at risk for motor and cognitive delay over the first 3 years of age, and Māori boys and girls exposed to methamphetamine in combination with alcohol do more poorly on measures of general and verbal IQ at 4.5 years of age (unpublished data, from NZ IDEAL Study). Meth and cannabis use are both higher in Māori populations than other New Zealanders and Māori women make up more than half of women accessing pregnancy and parenting services at the Waitemata District Health Board Community Alcohol and Drug Service. Some evidence suggests that Māori may be less likely to seek help for substance use problems due to normalisation of use within whānau, but it is not clear from existing research whether this includes use during pregnancy."*[77]

Genetic influence

Another influence at work pre-birth is genetics.

Substance abuse and poor mental health is strongly associated. Over 50% of mental health service users are estimated to have co-existing substance abuse problems.[78]

A strong genetic factor exists in the incidence of substance abuse: *"Evidence is clear from twin, family and adoption studies that there is a major genetic component in alcohol, stimulant and opioid abuse with heritability estimates ranging from 39% to 72%."*[79]

Other prenatal factors

Prenatal determinants of childhood depression have also emerged from the GUiNZ study. Reported in 2022:

> *"We found that the most significant predictors of depression in childhood, after controlling for multiple sociodemographic covariates, were the following maternal factors during pregnancy: perceived stress; smoking; body mass index in the overweight/obese range; and paracetamol intake."*[80]

A meta-analysis of other relevant studies found that maternal prenatal stress in particular, *"is associated with offspring socioemotional development (eg, difficult temperament, behavioral dysregulation) with the effect size for prenatal depression being more robust than for anxiety."*[81]

In summary, even before they are born some thousands of New Zealand children have heightened likelihoods of developing mental health problems working through either maternal, paternal or both pathways.

Distress in early childhood

In the case of substance abusers:

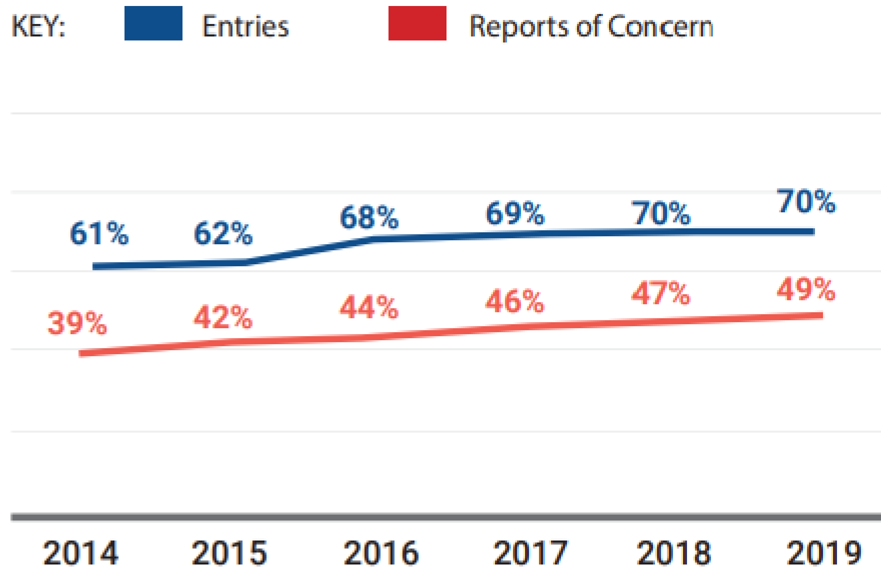
> *"Once the child is born, influences that may hinder development include low maternal IQ and verbal abilities, maternal mental illness, a chaotic lifestyle which may include ongoing drug seeking and involvement with child protective services."*[82]

At June 2022 there were 243 children dependent on caregivers receiving benefits for the *primary* incapacity of substance abuse.[83]

According to Oranga Tamariki however:

> *"Methamphetamine, in combination with alcohol and mental health issues, was a frequent cause of parents not being able to care for their children."*[84]

In 2019, seventy percent of parents whose children entered state care had substance usage treatment in their lifetime; for parents whose children received a report of concern to Oranga Tamariki the proportion was 49 percent.[85]

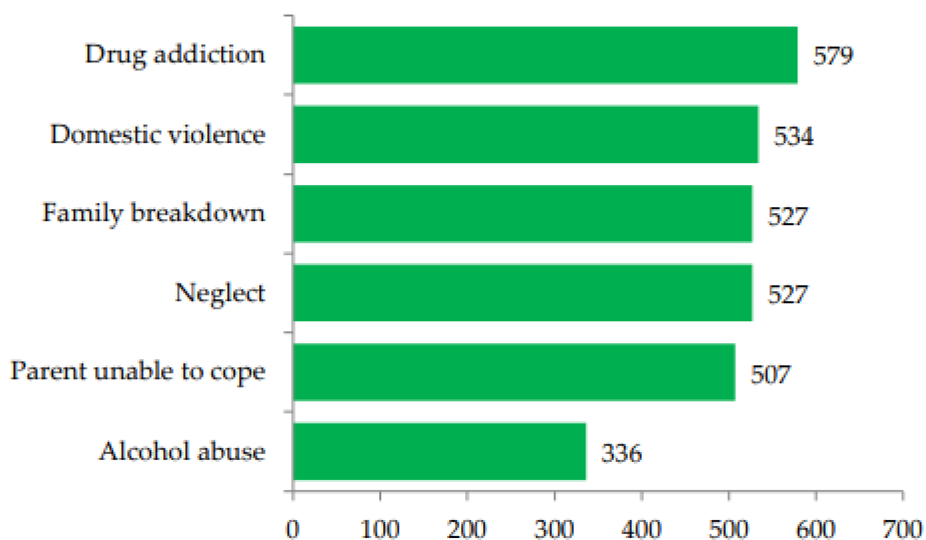


Source: Complexity of Tamariki Interacting with Oranga Tamariki: Reports of Concern compared to Entries to care

Drug addiction is also the most commonly cited reason why thousands of New Zealand grandparents are raising their grandchildren.

In 2016 a survey showed:

Top six reasons given for child coming into grandparent care, multiple reasons allowed

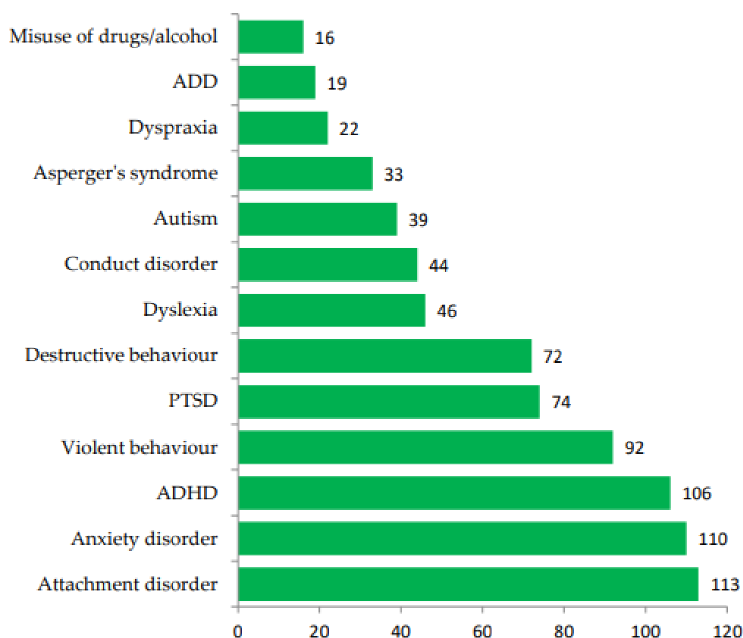


Source: The empty nest is refilled: The joys and tribulations of raising grandchildren in Aotearoa (p80)

The next most cited reason, at 299 positive responses, was "Mental illness of the parent".[86]

The incidence of psychological problems among the children (1,162) was relatively high with anxiety disorder diagnosed in 9.5 percent compared to 2.7% in the general 2-14 year-old population 2016.[87] Most of the study children were however aged between 6 and 14 and the likelihood of a diagnoses increases with age (see P17).

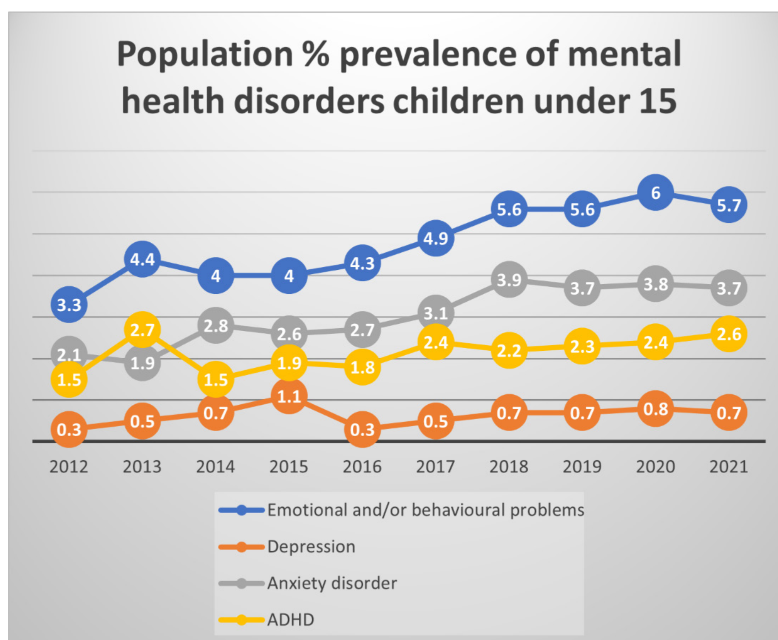
Incidence of diagnosed psychological problems (no. children =481)



The empty nest is refilled: The joys and tribulations of raising grandchildren in Aotearoa (p64)

Incidence of child mental health disorders

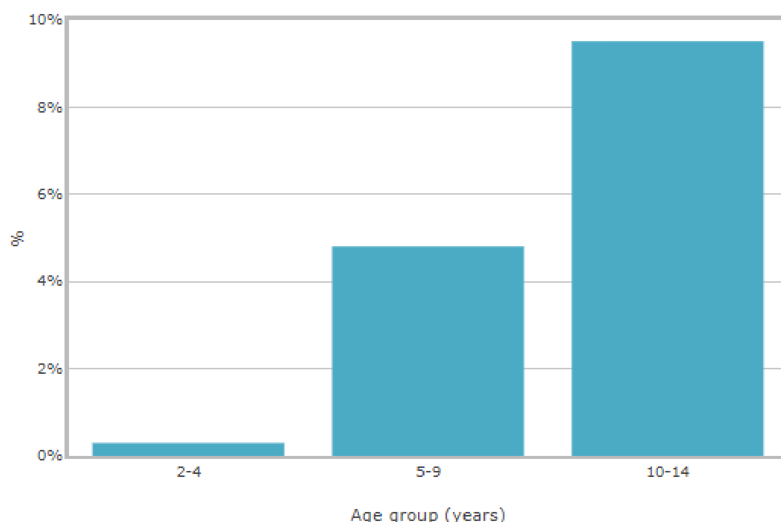
Moving to the general child population, the New Zealand Health Survey (NZHS), administered by MOH reports responses from parents/caregivers of over 4,000 children. The following chart presents the incidence of doctor-diagnosed disorders in children aged under 15 years. The prevalence of 5.7 percent represents approximately 48,000 children in the general population.



Data Source: New Zealand Health Survey 2020/21, Annual Data Explorer, Topic: Mental health

Within the under-15 age group, diagnosed disorders vary significantly with age. Of 10–14-year-olds 9.5 percent had a diagnosed problem. For 5–9-year-olds the percentage was 4.8 and for 2–4-year-olds, just 0.3 percent.

Age distribution of children with diagnosed emotional and/or behavioural problems (diagnosed depression, anxiety disorder and/or ADHD) (2-14 years)



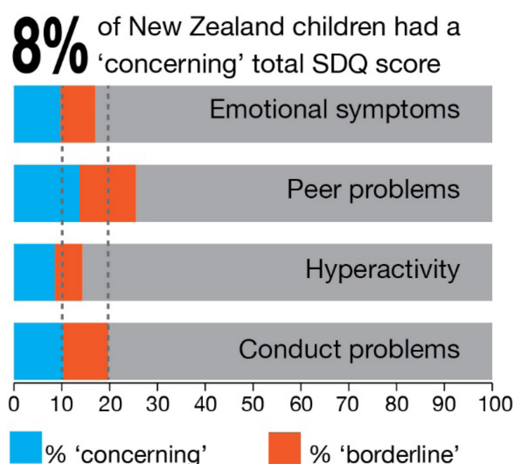
Source: New Zealand Health Survey 2020/21, Annual Data Explorer, Indicator: Mental health

Another method of measuring the incidence of mental ill health among children was unfortunately discontinued by the NZHS after results were last published in 2018.

The utility of the data is described by MOH:

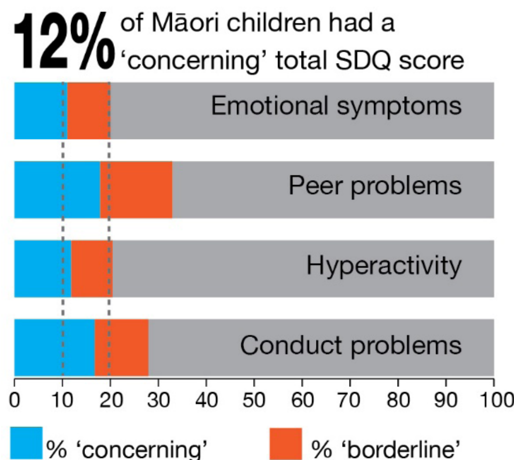
> *"Mental disorders, such as anxiety disorder or attention deficit hyperactivity disorder (ADHD), are the largest contributor to disability in young people aged 10–24 years. In 2013 they accounted for 35% of all health loss in those aged 15–24 years. The findings based on the Health Survey highlight that by using the SDQ it is possible to detect social, emotional and behavioural difficulties at an early age, which may be indicative of an underlying mental health problem."*[88]

Across 2012/13, 2014/15 and 2015/16, using a Strengths and Difficulties Questionnaire (SDQ) the NZHS questioned parents and caregivers about their child's (aged 3-14 years) behaviour with respect to social and emotional functioning. Eight percent of total children (representing approximately 57,000) had a 'concerning' score; a further seven percent were 'borderline'.



Source: Social, Emotional and Behavioural Difficulties in New Zealand Children, New Zealand Health Survey, 2018

Māori children had a 'concerning' score of 12% and a 'borderline' score of 10 percent.

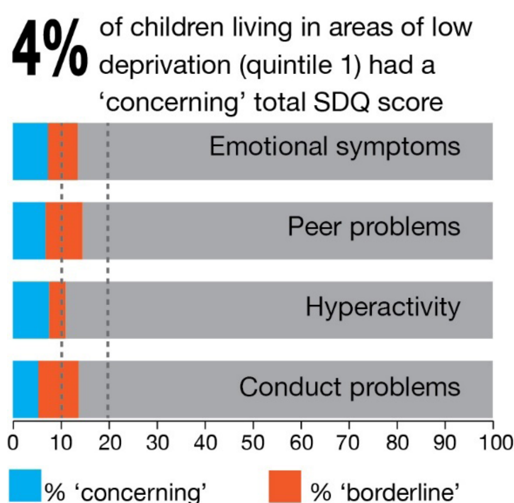


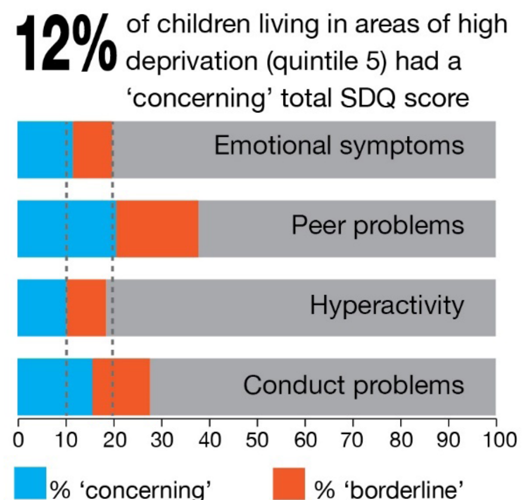
Source: Social, Emotional and Behavioural Difficulties in New Zealand Children, New Zealand Health Survey, 2018

'Concerning' scores for other ethnicities were Pacific 10%; Asian 4.9% and European/other 7.5 percent.[89]

Boys scored higher than girls at 9.5 compared to 6.6 percent. The split across the age groups was 10.2% for the youngest (3-4 years); 8.4% for the oldest (10-14 years) and 6.9% for those aged 5-9 years.

Other marked differences between children were associated with deprivation quintile.





Source: Social, Emotional and Behavioural Difficulties in New Zealand Children, New Zealand Health Survey, 2018

In a 2019 study using the SDQ, behaviour was assessed in 5,896 children aged 2 and 4.5 years:

> *"The majority of children who showed abnormal behaviour at 2 years improved at 4.5 years (57.9% for total difficulties). However, a notable proportion persisted in their difficulties from 2 to 4.5 years (42.1% for total difficulties). There was a small percentage of children who were categorised as abnormal only at 4.5 years. Children with difficulties at one or both time points had a greater proportion who were the result of an unplanned pregnancy, lived in highly deprived urban areas, and had mothers who were younger, of Māori and Pacific ethnicity and were less educated."*[90]

Report seven from GUiNZ, Now We Are Four, states:

> *"Children who develop age-appropriate social and emotional competencies are more likely to develop healthy relationships with peers and adults, achieve academic success and are more likely to display resilience in the face of adversity. They are also less likely to develop mental health problems throughout their lives."*[91]

The same report also touches on the issue of ACEs and self-control.

ACEs and Self-control

ACEs are Adverse Childhood Experiences. These include, *"exposure to maltreatment, witnessing violence, living with household members with mental illness, who abuse substances, have a history of incarceration, or have experienced parental divorce."*[92]

ACEs are associated with increased risk for a wide range of disorders, from mood and anxiety to psychotic and personality disorders.[93]

The GUiNZ longitudinal data showed 2.6 percent of children had experienced four or more ACEs by 54 months (4.5 years) of age; 6 percent had experienced three or more.[94]

A study encompassing 2,887 participants (1,464 female, 1,423 male) from the 2019 New Zealand Family Violence Survey found 11.6 % reported at least four ACEs before the age of 18 with those younger, having lower socioeconomic status, and identifying as Māori reporting higher prevalence.[95]

As adults 15% of individuals from the Dunedin Study cohort (born 1972-73) reported experiencing 4 or more ACES. [96] Unsurprisingly ACEs accumulate with age.

Regarding how ACEs cause harm:

> *"One of the pathways between ACEs and health is hypothesised to be harmful biological responses to stress. These physiological effects include a range of changes in the nervous system that have behavioural implications..."*[97]

GUiNZ researchers have also established an association between total ACEs experienced and the inability to delay gratification.

From the perspective of this paper the link is important. The ability to delay gratification, *"has been associated with fewer developmental and mental health issues, conduct disorders, addictive and antisocial behaviours, and increase in scholastic achievement."*[98]

The *"tendency to being impulsive"* is a risk factor for youth suicide.[99] An associated risk between early puberty and *"behavioural, psychological, and emotional disorder"* is raised by Professor Gluckman who stresses, *"... the importance of efforts to enhance self-control in children so as to reduce the risks for morbidity in their transition to adulthood."*[100]

Self-control is also associated with greater resilience; fewer conduct, addiction and antisocial problems; and greater educational achievement.[101]

Maternal Depression

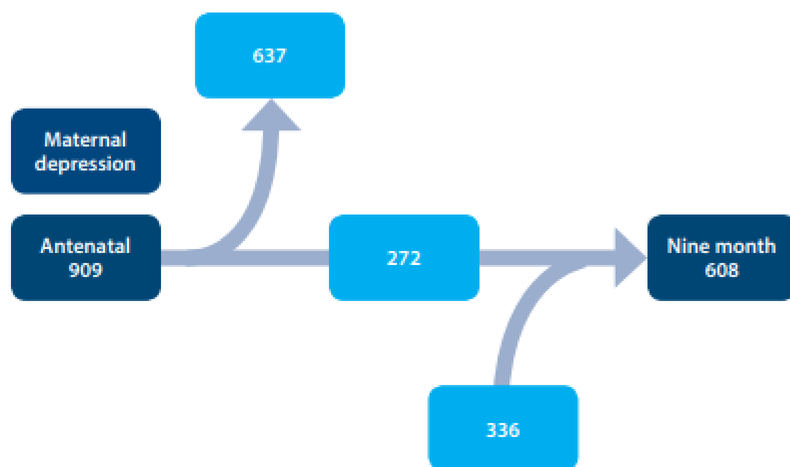
One of the identified ACEs is '*living with household members with mental illness*.' Awareness of links between mental disorder in parents and disturbance in their children is longstanding. Links may operate through genetics, the behaviour of parent towards child e.g., hostility or neglect, change

in family structure due to illness, or factors that correlate with disorders such as drug use.[102] The pathways may be bi-directional and compounding:

> *"...maternal depression may contribute to the start of difficulties in the relationship between mother and child, these difficulties may gather their own momentum and persist even when circumstances improve. This has implications for the mental state of both mother and child."*[103]

GUiNZ researchers include maternal depression as a risk factor for child vulnerability. During the antenatal period 16.2 percent of children were exposed to maternal depression.[104] At age nine months the percentage had dropped to 10.8% but only 272 mothers were depressed at both points.

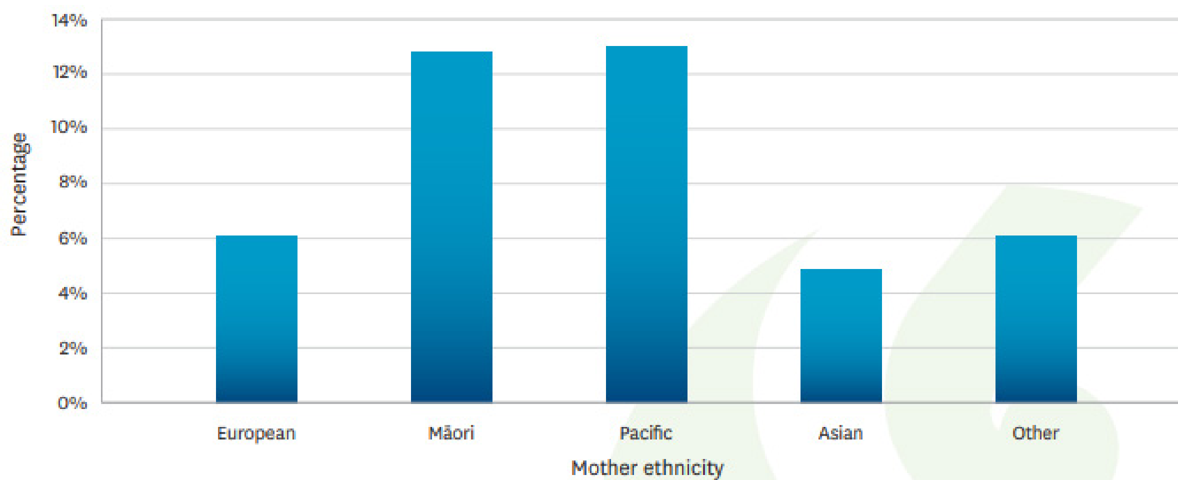
Change in exposure to symptoms of maternal depression between pregnancy and when their child was nine months old



Source: Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days 2014, Growing Up in New Zealand

At later data collection points – when the children were 4 and 8 years old – the overall percentage of mothers experiencing depression was approximately 8 percent. Māori and Pacific mothers were significantly more likely to experience symptoms.

Percentage of mothers experiencing depressive symptoms when their child was eight years of age by mother ethnicity

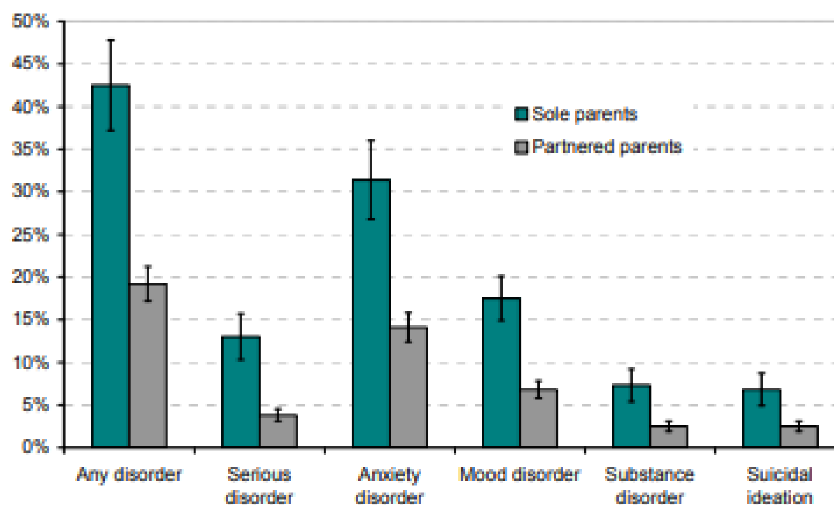


Source: Now we are eight: Life in middle childhood, Growing Up in New Zealand, MSD, 2020

Single mothers, particularly young mothers and Māori mothers, have the highest rates of depression among family types.

> *"Both international and New Zealand research shows that sole parents, particularly those receiving social assistance benefits, have elevated rates of mental health difficulty."*[105]

Proportion (%) with a diagnosed mental disorder in the last 12 months



Source: Sole parenting in New Zealand: An update on key trends and what helps reduce disadvantage, MSD, 2010

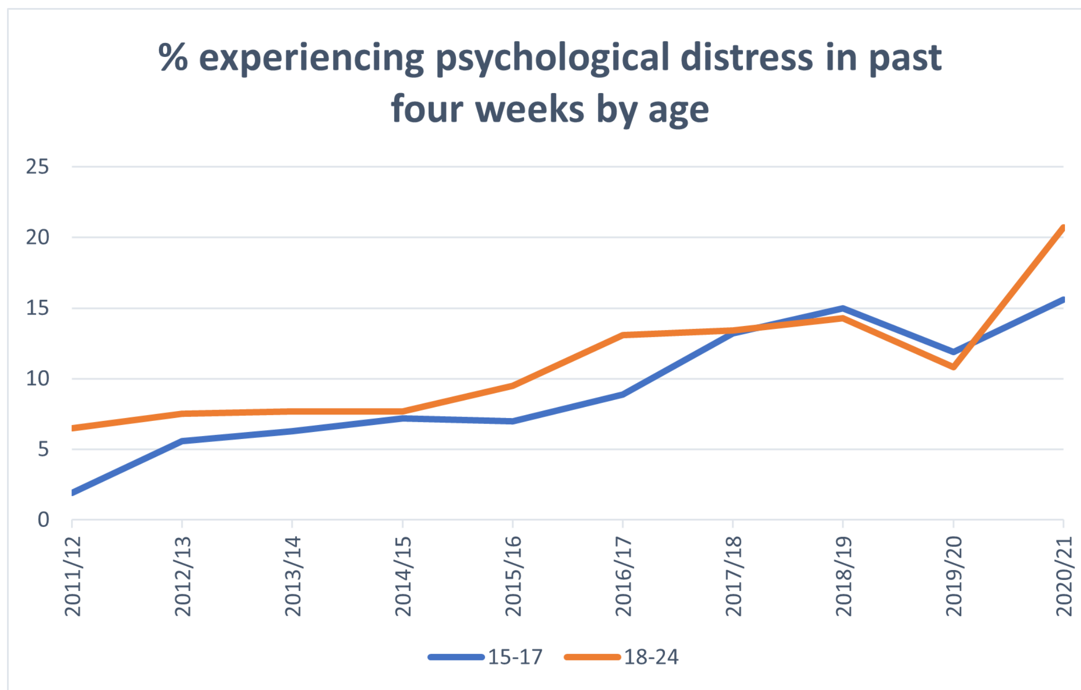
Antidepressant use in pregnancy

As an indicator of maternal depression prevalence GUiNZ analysis finds:

> *"Antidepressant prevalence across pregnancy was 3.2%, with a 2.7% prevalence in trimester one and 2.6% following the first trimester. There was no significant difference in usage within age bands and area-level deprivation quintiles. Ethnicity-specific data revealed that Pasifika and Asian ethnicities had the lowest antidepressant use, and New Zealand Europeans the highest. The rate of unmedicated depression, where women met the Edinburgh Postnatal Depression Scale criteria for significant depressive symptoms but did not receive antidepressants during pregnancy, was 11.8%, indicating that antenatal depression treatment may be inadequate. Greater rates of unmedicated depression were seen for younger women (≤24 years), those living in high deprivation areas and mothers of Pasifika, Asian and Māori ethnicities."*[106]

Distress in young people

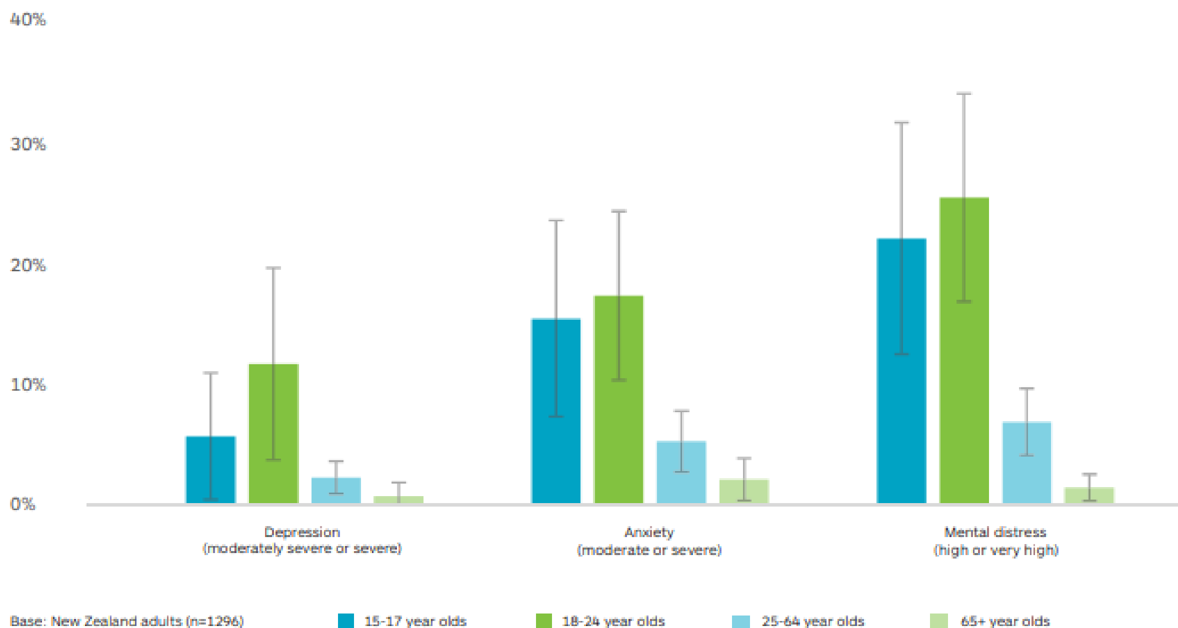
In 2020/21 the percentage of 15–17-year-olds reporting 'psychological distress in the past four weeks' was 15.6% – up from 1.9 percent in 2011/12; the 18–24-year-old age group showed an increase from 6.5 to 20.7 percent over the same period.



Data Source: Ministry of Health, NZ Health Survey 2020/21, Annual Data Explorer, Indicator: Mental health

Depression, anxiety and mental distress are consistently more prevalent among young people than the 25+ population.

Depression, anxiety and mental distress measures by age group in 2018

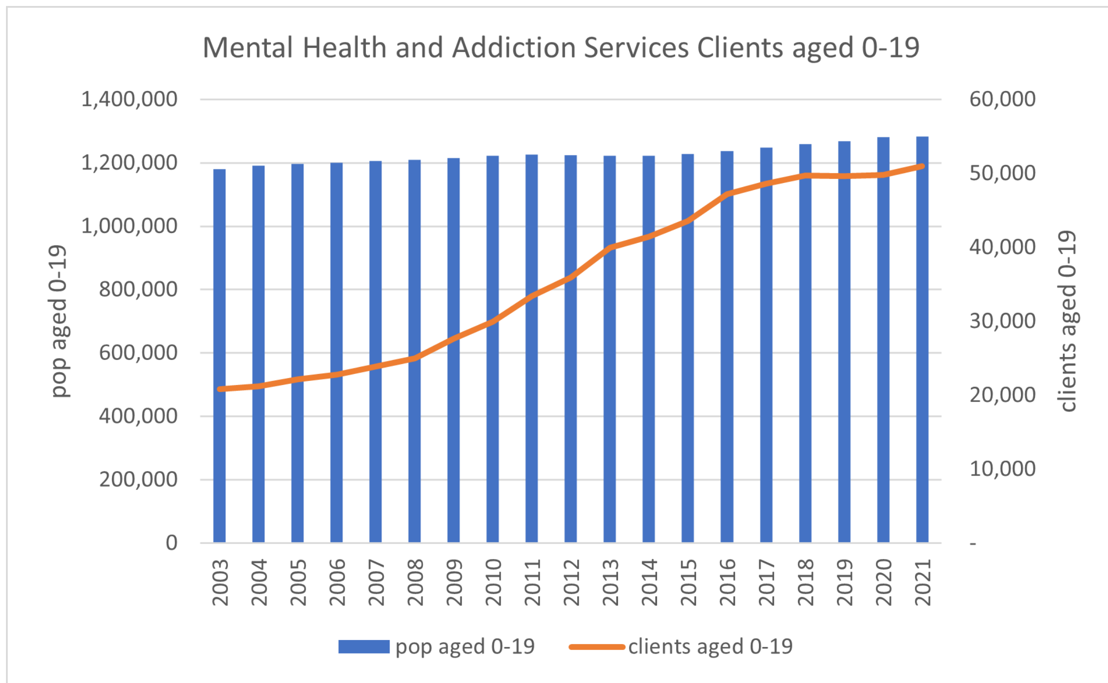


Source: Mental Health in Aotearoa 2018 Mental Health Monitor and the 2018/19 New Zealand Health Survey

Mental Health and Addiction Service Clients

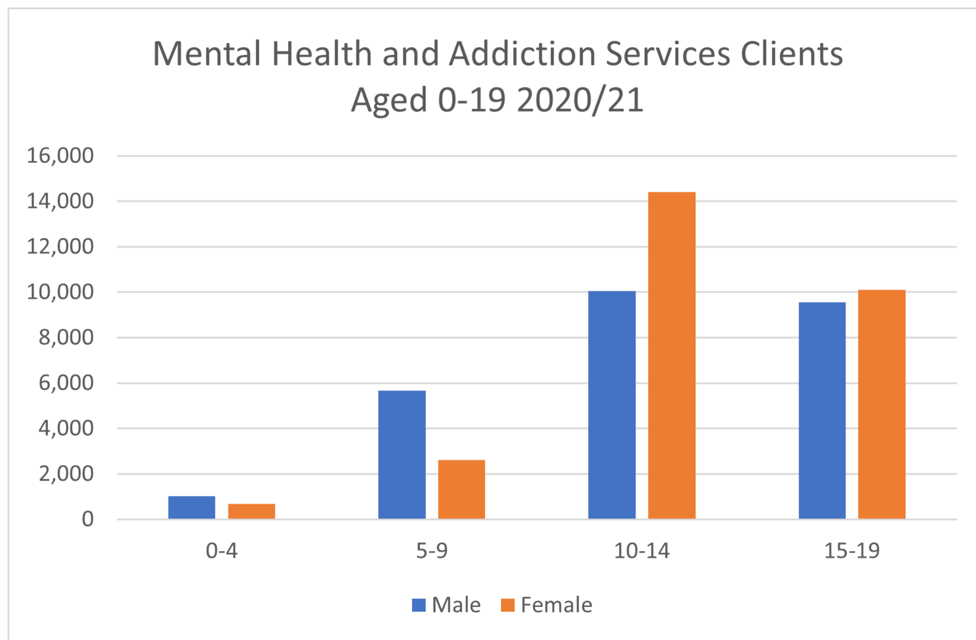
The number of children and young people (aged 0-19) seen by Mental Health and Addiction Services has grown from 20,800 in 2002/03 to 51,010 in 2020/21 or by 145 percent.[107].

The following data does not cover the provision of primary mental health care, for example by general practitioners; secondary mental health services funded by other government departments e.g., the Ministry of Social Development; problem gambling services or those with a mental illness who don't access services.



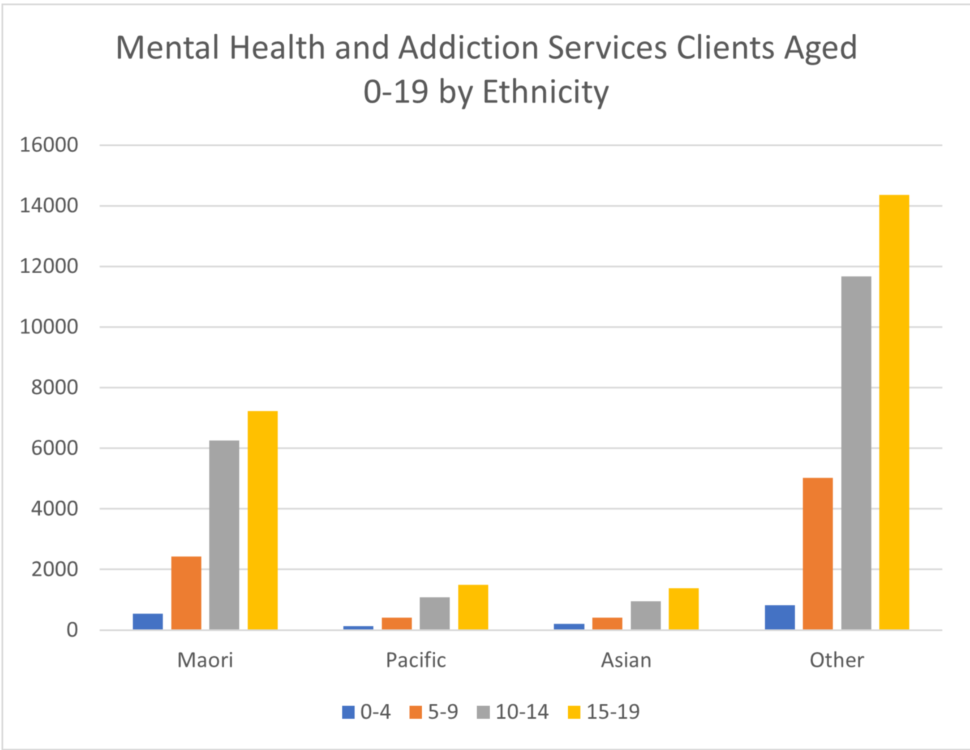
Data sources: Infoshare population estimates; Mental Health, Alcohol and Drug Addiction Sector Performance Monitoring and Improvement, Performance Measures

Males are more likely to be clients until age 9 when the pattern reverses and females become more likely from ages 10-19. This pattern is consistent across ethnicities.



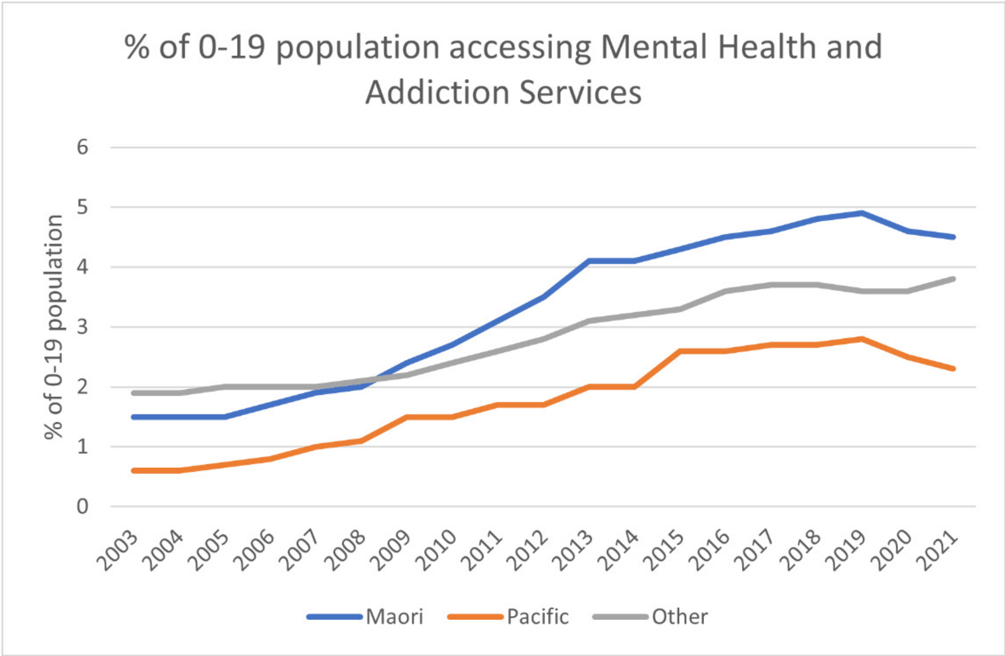
Data source: Mental Health and Addiction: Service Use web tool

Across every age group Māori are over-represented as clients of Mental Health and Addiction services.



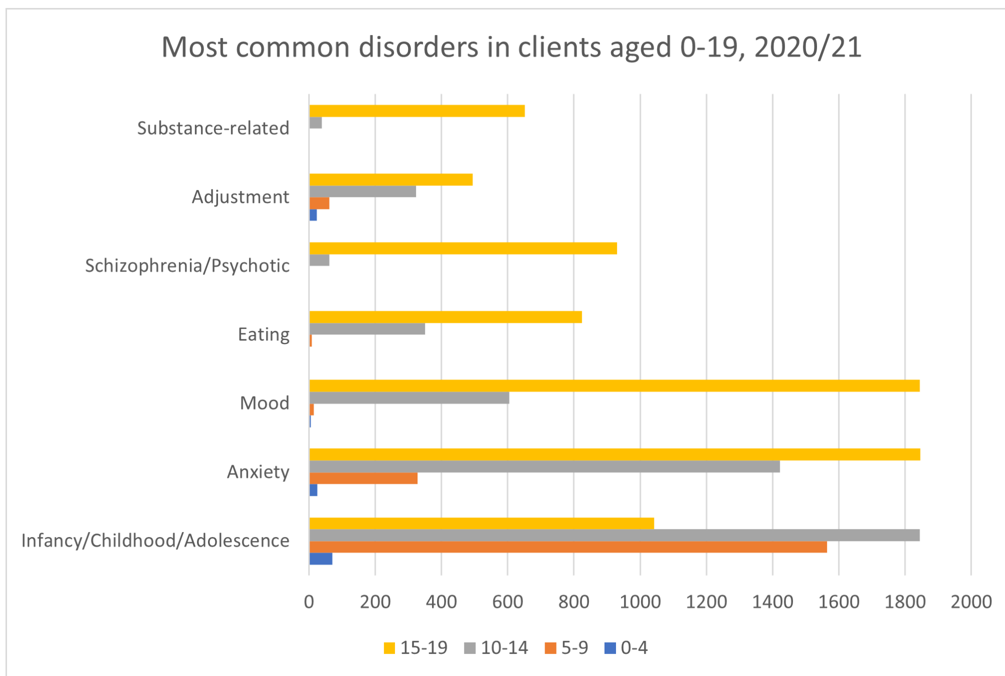
Data source: Mental Health and Addiction: Service Use web tool

In 2020/21, 4.5% of the Māori population aged 0-19 were Mental Health and Addiction Services clients compared to 2.3% of Pacific and 3.8% of 'other' ethnicities.



Data Source: Mental Health, Alcohol and Drug Addiction Sector Performance Monitoring and Improvement, Performance Measures

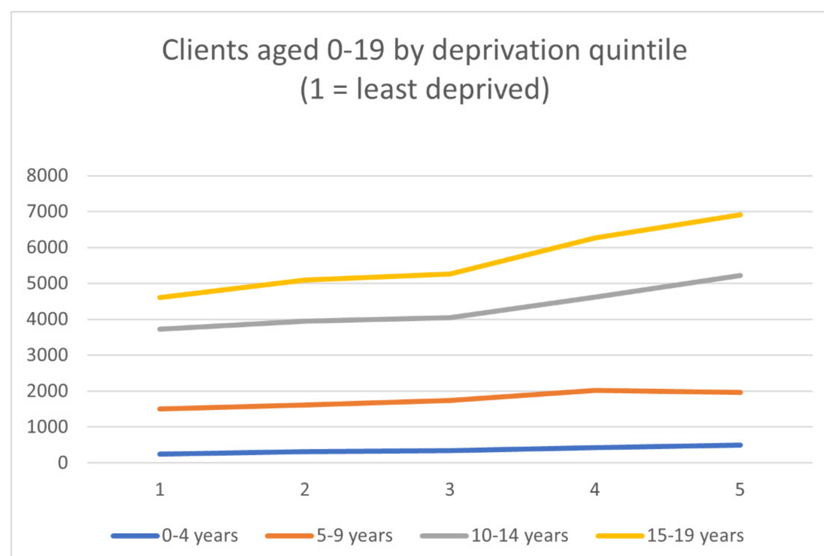
The most common disorders up to age 14 related to infancy/childhood/adolescence. These abate somewhat in 15- to 19-year-olds when anxiety and mood disorders become more prevalent.



Data source: Mental Health and Addiction: Service Use web tool

7 most common disorders	0-4	5-9	10-14	15-19
Infancy/Childhood/Adolescence	71	1564	1845	1043
Anxiety	25	328	1422	1846
Mood	5	14	605	1845
Eating	1	9	351	824
Schizophrenia/Psychotic	0	0	61	931
Adjustment	23	62	323	494
Substance-related	1	0	39	652

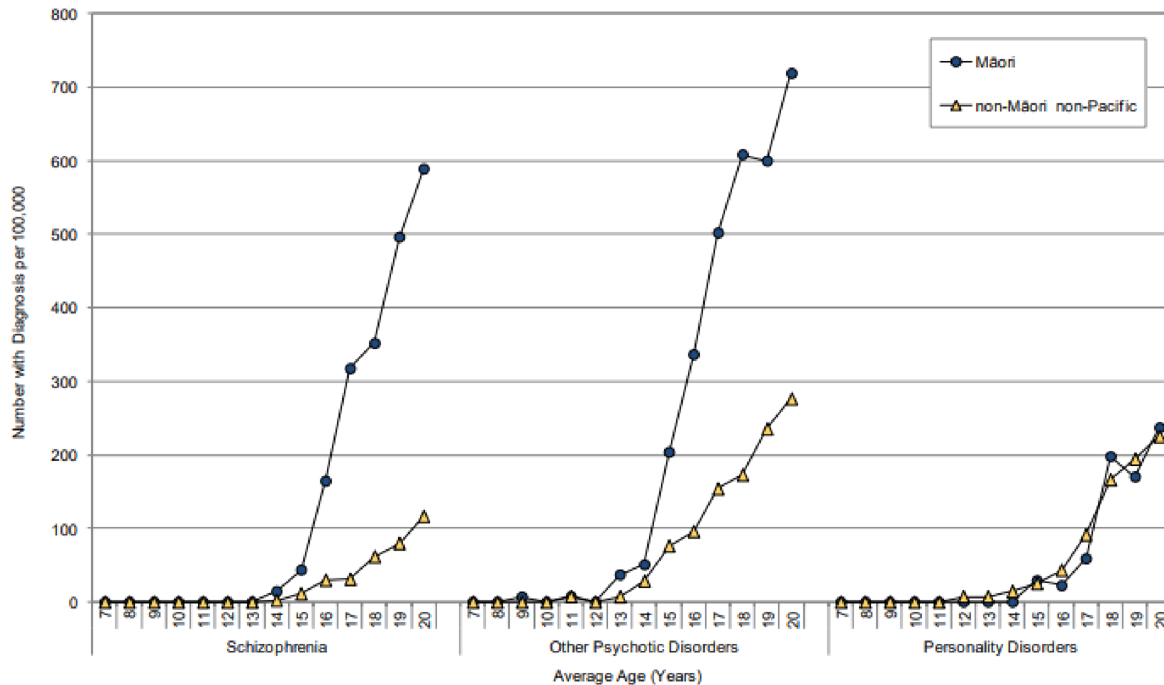
Among 15- to 19-year-olds 4,606 live in the least deprived quintile; 6,907 in the most deprived. Those residing in the poorest quintile are 1.5 times more likely to be treated for a disorder than those in the wealthiest.



Data source: Mental Health and Addiction: Service Use web tool

In 2009-11 the mental disorder profile for Māori and non-Māori/non-Pacific young people was strongly contrasting. The following Mental Health Service data represents those aged 7-20 years:

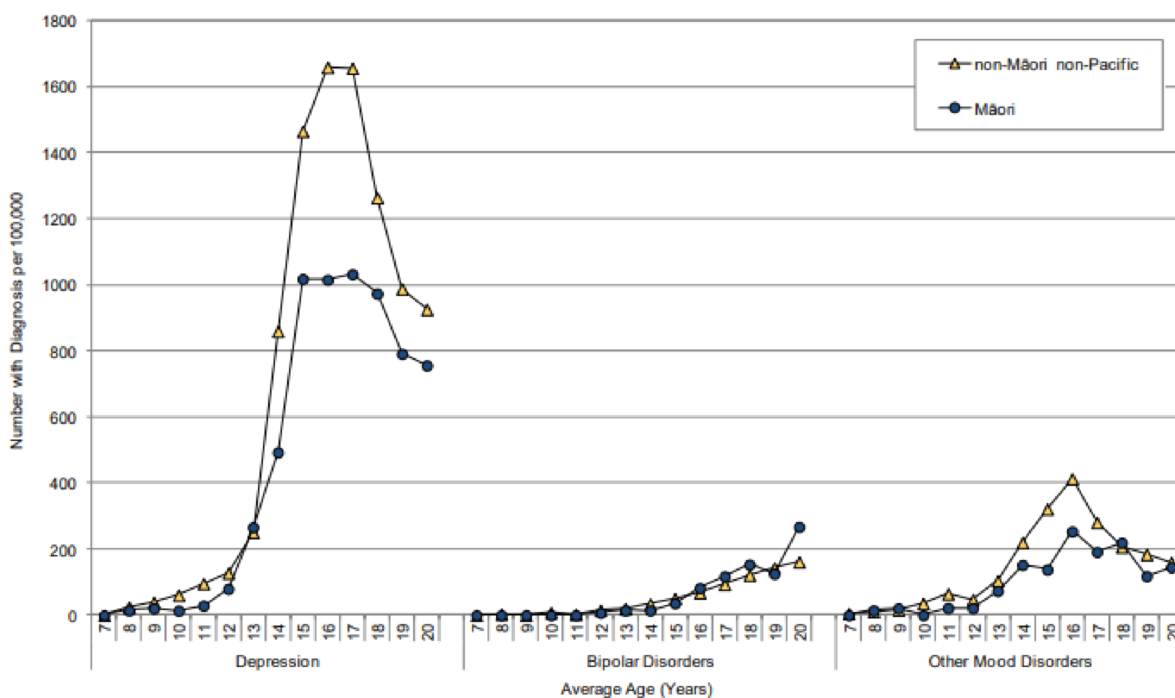
Children and Young People Accessing Mental Health Services with Schizophrenia, Other Psychotic Disorders or Personality Disorders by Ethnicity and Age, New Zealand 2009–2011



Source: Te Ohonga Ake, The Determinants of Health for Māori Children and Young People in New Zealand, MOH, February 2013

Published in mid-2021, an all-age prevalence study of the New Zealand population in 2015 found a Māori rate for schizophrenia of 3.36 versus 0.77 for New Zealand European.[108] It seems unlikely the data will have changed significantly in the interim.

Children and Young People Accessing Mental Health Services with Depression, Bipolar Disorder or Other Mood Disorders by Ethnicity and Age, New Zealand 2009–2011



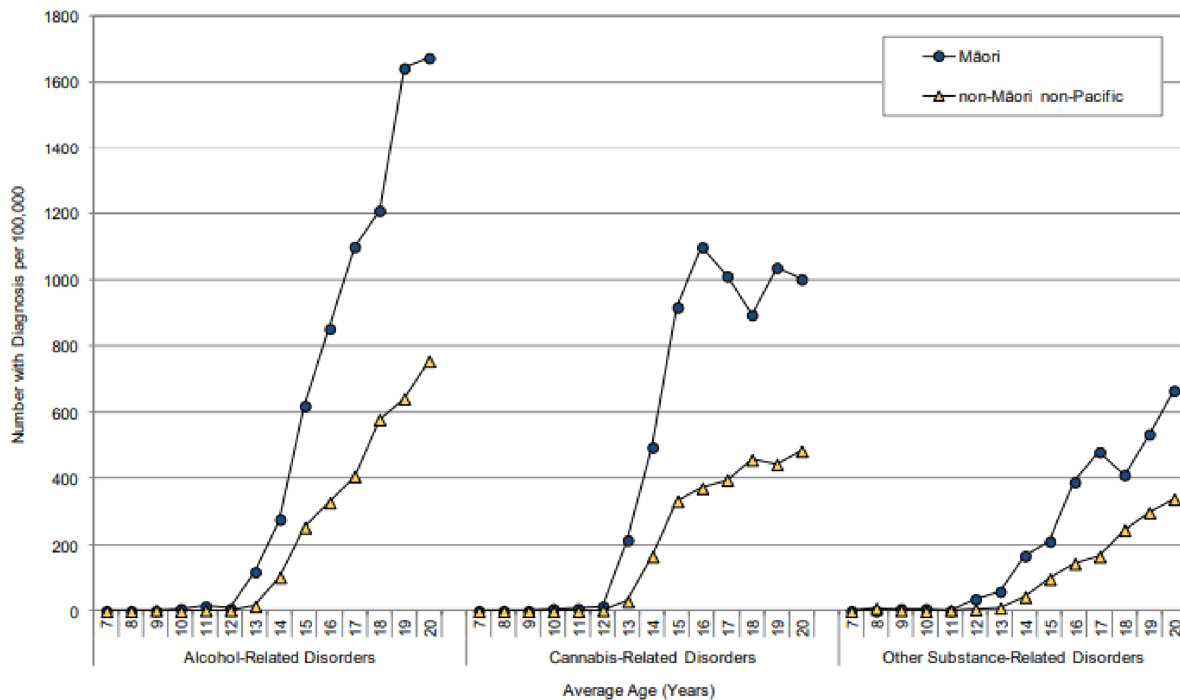
Source: Te Ohonga Ake, The Determinants of Health for Māori Children and Young People in New Zealand, MOH, February 2013

The accompanying text describes the contrast:

> *"In New Zealand during 2009–2011, the number of Māori young people accessing mental health services with schizophrenia and other psychotic disorders, and bipolar disorder was significantly higher than for non-Māori non-Pacific young people. Similar patterns were seen for mental health service contacts and inpatient bed nights. In contrast, the number of Māori young people accessing mental health services with depression and other mood disorders was significantly lower than for non-Māori non-Pacific young people."*[109]

The report also provides data for treatment of substance use in the same age group:

Children and Young People Accessing Mental Health Services with Mental Health Issues Associated with Substance Use by Ethnicity and Age, New Zealand 2009–2011



Source: Te Ohonga Ake, The Determinants of Health for Māori Children and Young People in New Zealand, MOH, February 2013

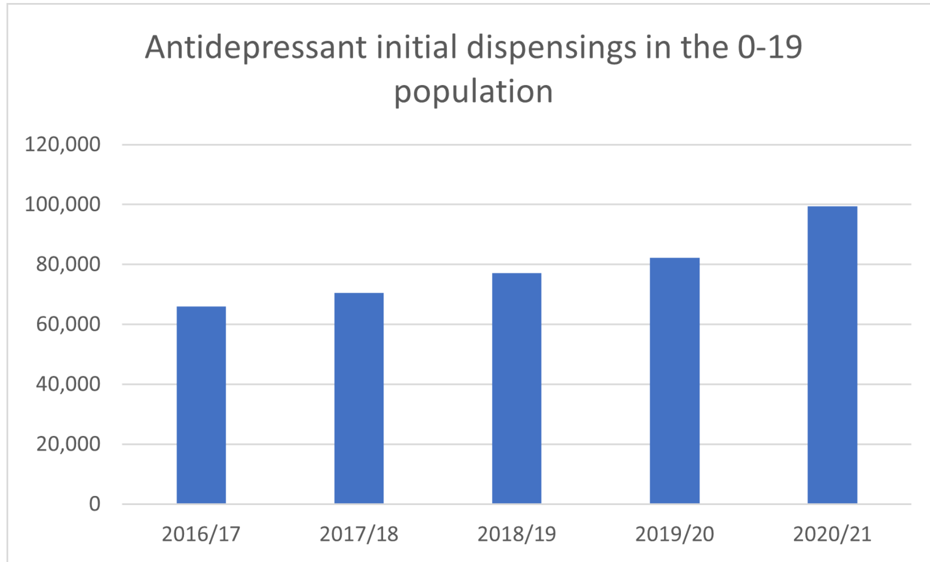
Medication

Post pandemic onset, initial dispensings of antidepressants to 0–19-year-olds grew by 21 percent in the year to 2020/21 compared to 8 percent for the total population; antipsychotics increased by 18 percent compared to six - increases which are believed to have resulted from Covid 19-related stress and a lack of non-medical treatment alternatives.[110]

Antidepressants

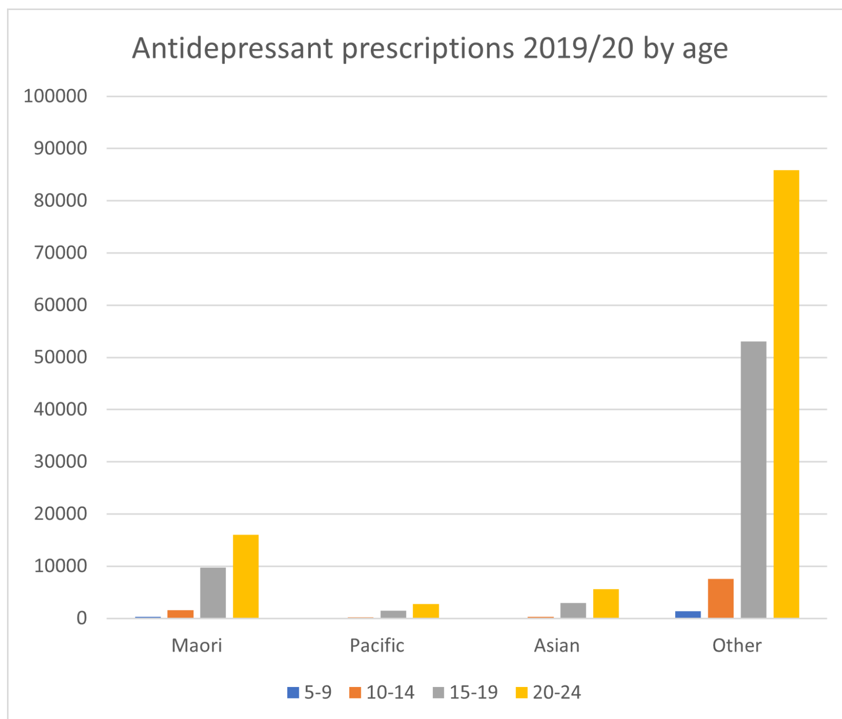
"Antidepressants are medicines used to treat depression, anxiety and related conditions, such as eating disorders, obsessive-compulsive disorder and post-traumatic stress disorder. Antidepressants are also sometimes used to treat people with long-term (chronic) pain."[111]

One prescription can equal multiple dispensings.



Data source: Te Huringa: Change and Transformation Mental Health and Addiction Services Monitoring Report 2022

Ethnicities other than Māori, Pacific and Asian disproportionately account for antidepressant prescriptions. 'Other' ethnicity is dominated by New Zealand European. There are more prescriptions written for 10–14-year-old 'others' (7,571) than for 20–24-year-old Asians (5,634).



Data source: Number of Pharmaceutical scripts for selected therapeutic groups, 2019/20

antidepressants	5-9	10-14	15-19	20-24
Māori	278	1590	9747	16054
Pacific	51	185	1425	2731
Asian	61	269	2919	5634
Other	1379	7571	53066	85837

Māori make up 26.9% of the 0–19-year-old population[112] (344,900/1,282,200) yet only 14.8% of antidepressant use.

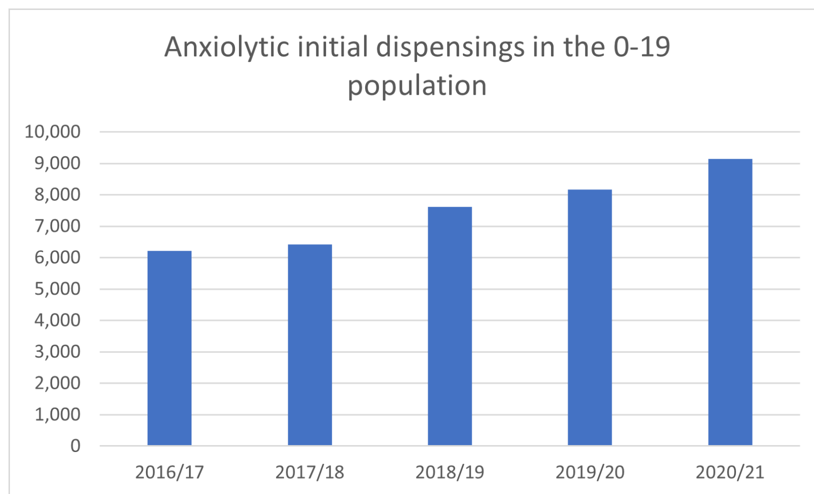
The Mental Health and Addiction Services Monitoring Report 2022 states:

> *"Māori are [also] less likely to be prescribed antidepressants compared with non-Māori. While it's not clear if this is because clinicians are less likely to prescribe to Māori, or Māori are less likely to want pharmacological treatment, the Health Quality & Safety Commission concludes that lower use of medication for Māori is not being compensated for with non-medical treatment alternatives."*[113]

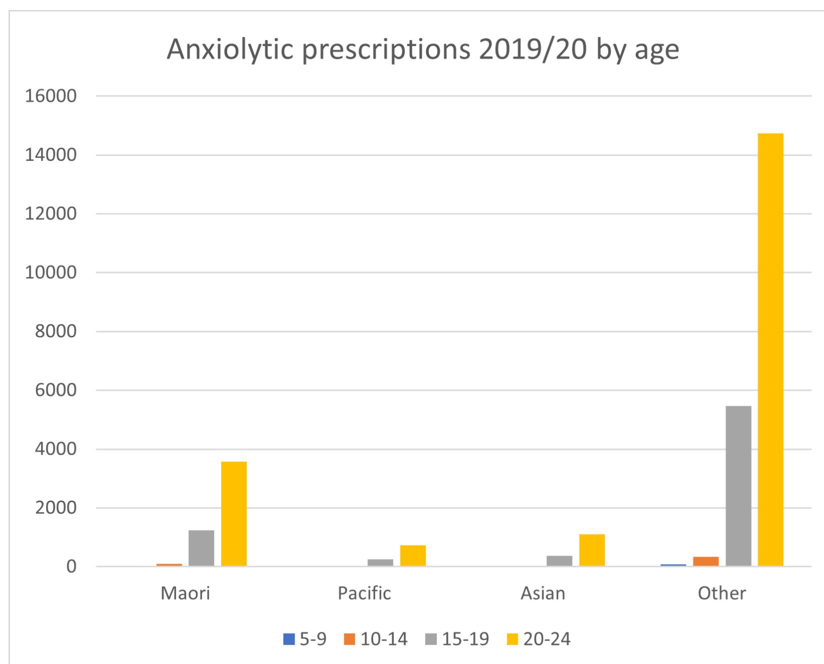
Based on the 2009-11 data (p26) Māori are also less likely to be diagnosed with depression. It's unclear whether the above comment takes account of this.

Anxiolytics

"Anxiolytics ... are medicines that work on the central nervous system to relieve anxiety, aid sleep, or have a calming effect."[114]



Data source: Te Huringa: Change and Transformation Mental Health and Addiction Services Monitoring Report 2022



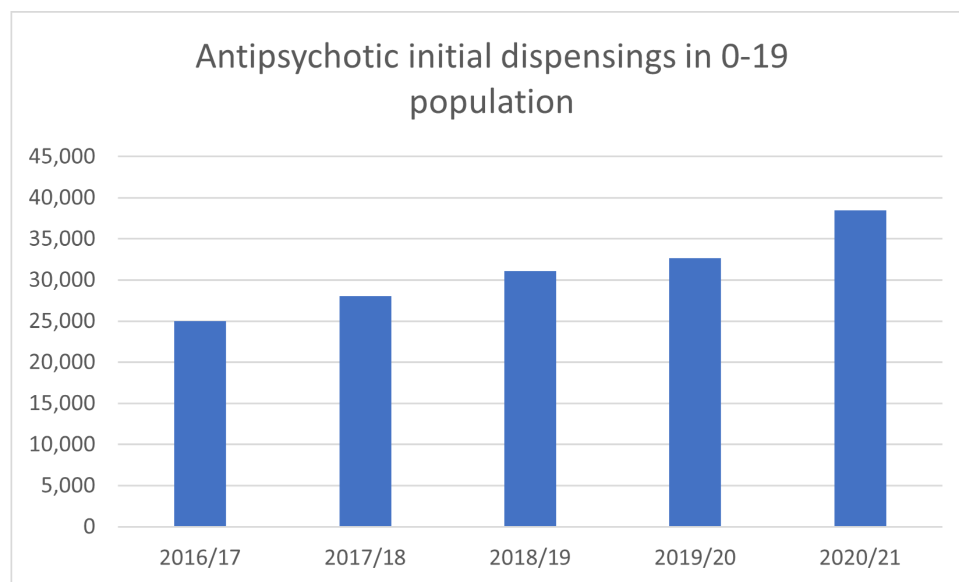
Data source: Number of Pharmaceutical scripts for selected therapeutic groups, 2019/20

anxiolytics	5-9	10-14	15-19	20-24
Māori	22	94	1243	3573
Pacific	8	22	254	732
Asian	14	20	363	1095
Other	72	342	5463	14736

Additionally, 28 antidepressant prescriptions and 24 anxiolytic prescriptions were written for 0–4-year-olds.[115]

Antipsychotics

"Antipsychotic medicines are used to treat some types of mental illnesses such as schizophrenia, bipolar disorder (previously known as manic depression), or very severe depression."[116]

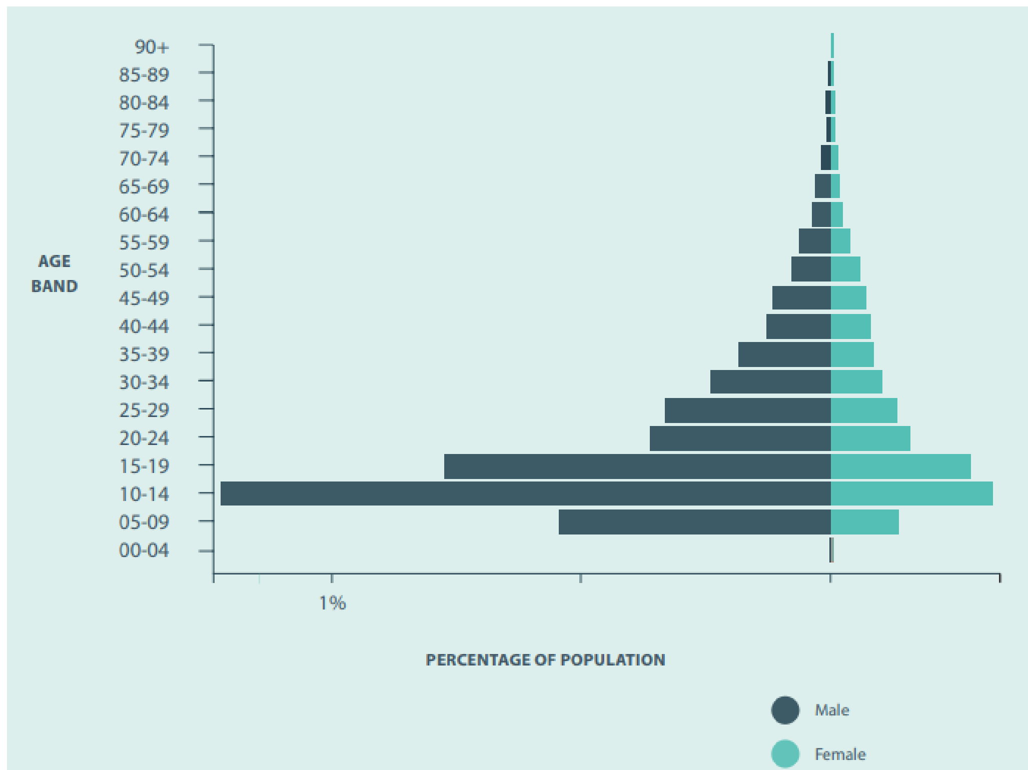


Data source: Te Huringa: Change and Transformation Mental Health and Addiction Services Monitoring Report 2022

ADHD medicines

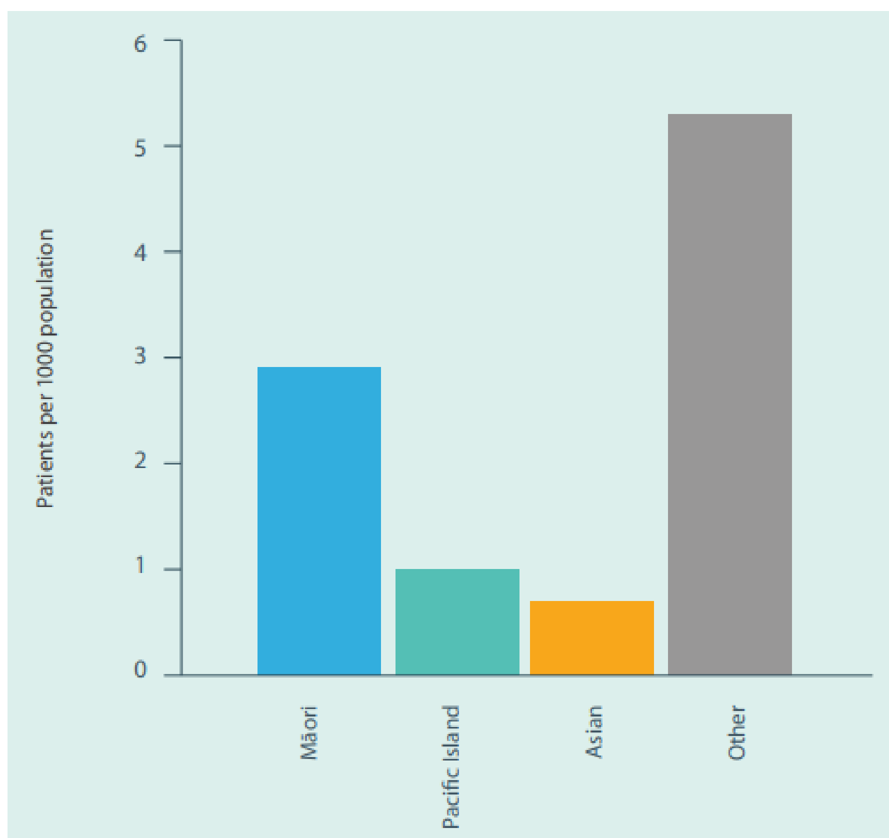
Medicines that treat attention deficit – hyperactive disorder (ADHD) are predominantly dispensed to young males. From 2007/08 to 2016/17 in New Zealand youth aged 1-24 years total dispensing prevalence almost doubled from 516 per 100,000 to 996 per 100,000.[117]

ADHD prescriptions by age and gender



Source: Going to your head, PHARMAC's analysis of data on psychiatric medicines prescribed in New Zealand 2017 Edition

The following chart depicts ADHD prescriptions by all ages notwithstanding a majority of the patients are young.



Source: Going to your head, PHARMAC's analysis of data on psychiatric medicines prescribed in New Zealand 2017 Edition

A New Zealand study into the prevalence of ADHD published in 2020 found, *"The most deprived quintile had a slightly lower dispensing prevalence relative to other quintiles."*[118]

Unmet need

While comparable international data shows 35-50 percent of mentally unwell people do not receive treatment, New Zealand lacks similar information. [119]

Assessing the level of unmet need is difficult if not impossible. The 2022 Mental Health and Addiction Services Monitoring report explained:

> *"Our most recent comprehensive data on prevalence of mental distress and addiction is ... based on data collected in 2003 and 2004. The age of this information makes it difficult to know whether the number of people currently accessing services is an accurate reflection of how many people need support from services. Furthermore[it] excluded children aged under 16 – a priority group experiencing increasing mental distress."*[120]

Relying on the anecdotal the following passage sums up what submitters told the 2018 inquiry into Mental Health and Addiction:

> *"Problems of access, wait times and quality were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services. Gaps in services, limited therapies, a system that is hard to navigate, variable quality and shabby facilities added up to a gloomy picture of a system failing to meet the needs of many people."*[121]

Three years later the Deputy Director-General, Mental Health and Addiction, Philip Grady could only add:

> *"We know right now the mental health and addiction system isn't where it needs to be. We know about many of the pressures, the shortages and the inequities."*[122]

And in May 2022 Health Minister Andrew Little acknowledged to NewstalkZB host Mike Hosking that *"children and adolescent mental health services are in crisis."*[123]

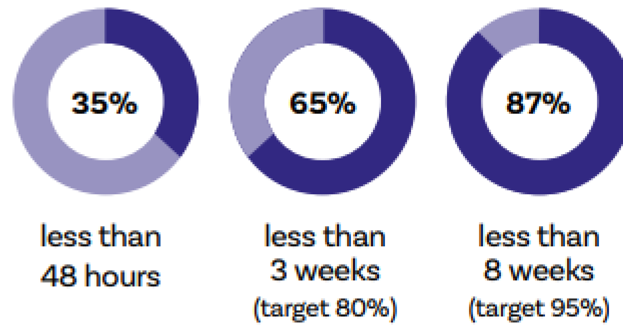
It is a fact that a GP will tell a parent their self-harming child needs to have actually attempted suicide before a referral is available.

Wait times

'Wait times' are only relevant then to those patients who can obtain a referral.

For those who do, the Mental Health Service and Addiction Service Monitoring Report 2022 records,

> *"Unlike other age groups, youth mental health services do not meet wait time targets. In 2020 / 21, only 65% of young people aged 19 and under were seen in the first three weeks of their referral, and 87% within eight weeks. Despite the prioritisation of youth in Government policy – including the Child and Youth Wellbeing Strategy, and the focus on increasing access to support for young people – these wait times have gotten worse for young people since 2017/18."*[124]

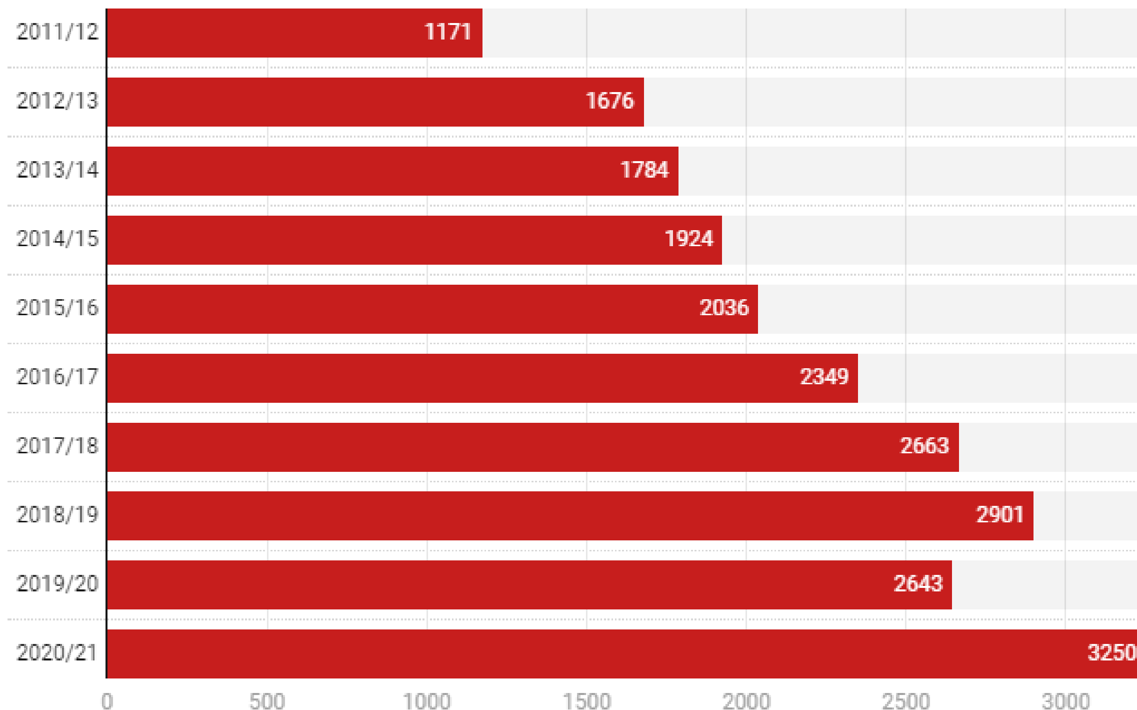


Source: Te Huringa: Change and Transformation Mental Health Service and Addiction Service Monitoring Report 2022

In addition, national average data can hide outliers. In April 2022, the Taranaki DHB Community Mental Health manager said in a written statement that on average, young people wait 166 days, more than five months, to be seen by a Children's and Adolescent Mental Health Service clinician.[125]

Young people turning up to emergency departments with a mental health crisis increased by 178 percent between 2011/12 and 2020/21.[126]

Young people seen in emergency departments for a mental health crisis



Source: Health officials say funding of child mental health services 'has not kept pace' with growing numbers in crisis, New Zealand Herald, May 2022

In July 2022 Health Minister Andrew Little acknowledged that waiting times at emergency departments were only getting longer.[127]

The following excerpt from the He Ara Oranga is lengthy but deserving of inclusion with little abridgement. In 4 years since, the pressure appears only to have built.

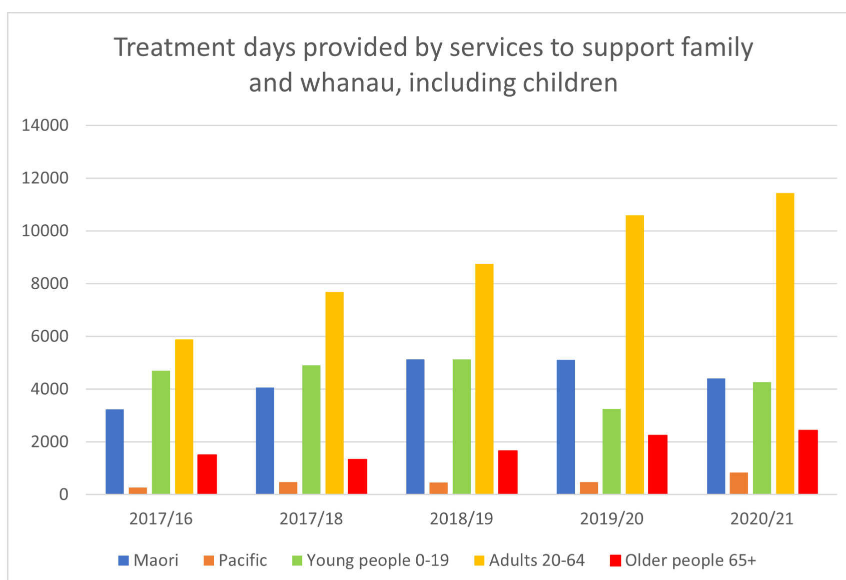
> *"We heard of a tidal wave of increased referrals to Child and Adolescent Mental Health Services and Behaviour Support Teams, which make it difficult to respond to the early signs of mental distress. Childhood trauma was reported to be a major issue... Sadly in New Zealand childhood exposure to maltreatment and relational trauma is extremely common and along with poverty can most often be found in the narratives of children diagnose[d] with mental health conditions. As a nation it is imperative that we increase our awareness and understanding of childhood trauma and its bio-psychosocial impact as a critical factor in determining child and family functioning and dysfunction. Paediatricians and other professionals working with children and young people described a 'patch-up' mentality in state-funded services, with pressure to record 'outcomes' in terms of case closures. In their view, complex health, developmental and familial challenges meant that engagement throughout a child's early life course, from the womb to early adulthood, is necessary. People said a short-term fix mentality is inappropriate and harmful, and that what is required is an opportunity to resource a long-term, consistent engagement and create a trusting and respectful relationship between a child or young person, their family, and a therapeutic team. Continuity of care is important, but it can be disrupted by setting a rigid age limit that requires moving to an adult service. We also heard about high levels of concern about the impact of poverty, student debt and deprivation on children and young people and about their regular exposure to alcohol and other drug abuse, violence (against themselves or between adults in the household), not having enough food and a warm home, and family turmoil (for example, frequent changes of address leading to disrupted schooling and opportunities for socialisation)."*[128]

Support for at-risk family and whanau of patients

The litany of misery continued:

> *"Many people expressed anger at the inadequacy of mental health services to act on early indications of suicidality and despair at the ongoing ripple effects of such traumatic loss on families, whānau and friends. Workers reinforced the message that our current responses are inadequate. They said that despite the complexity of the causes of suicidality, we can do better to prevent suicide and support family and friends through the aftermath of suicide, when they are at increased risk themselves."*[129]

The following statistics depict 'Support for family/whanau' and 'Children of Parents with Mental Illness and Addictions' combined. Adult support is trending up whereas for young people aged 0-19 support is tending down:



Data source: Te Huringa: Change and Transformation Mental Health Service and Addiction Service Monitoring Report 2022

What next?

The overwhelming response to the crisis described is heightened demand from the public and health workers for more treatment resources and greater expenditure.

Emphasis has seemingly and subtly shifted from prevention to containment. The dominant role the state plays in public health is broadly unquestioned therefore the state must hold the answer.

As such, little analysis has been undertaken to examine how public policy may have *contributed* to mental ill-health amongst the young.

Perhaps the state is not the solution. Perhaps it is part of the problem.

In July 2022 Sir Peter Gluckman said, *"It's all very well to say we need more psychologists or counsellors – and don't get me wrong, we need them for the kids who are falling off the cliff, of course we do – but we've got to stop people getting to the edge of the cliff. There's not really much thinking going on in New Zealand about preventative mental health for young people. And that's a much more complex and yet more urgent issue."*[130]

An emerging question

In 2017 three psychologists from Otago posed a new question:

> *"Why has increased provision of psychiatric treatment not reduced the prevalence of mental disorder?"*[131]

Their lead question was followed by more such as, *"...if our treatments work shouldn't we have fewer people presenting in crisis, less people on a disability benefit due to mental illness, a reduction in community measures of psychological distress and a decrease in the suicide rate? ... despite access to costly biomedical treatment, something central to recovery appears to be missing in the social fabric of developed countries."* [132]

The paradox is not peculiar to New Zealand.

The authors reflected on the scope for prevention through *"risk factor modification"* but also suggested,

> *"We need to, at the least, consider whether our current mental health systems might be causing unintentional harm in some areas. It is possible that in order to achieve better outcomes, we need to do less, not more."*[133]

Over reliance on medication?

Less of what? In 2007 the MOH explored a possible connection between certain antidepressants, and suicide and self-harm. The New Zealand findings were not conclusive but, *"... comparable with similar studies reported in the international literature that indicate a slight increase in suicidality for patients taking antidepressants in early treatment for most of the medications, particular for children and adolescents. However, we emphasize that depression and certain other serious psychiatric disorders are themselves the most important causes of suicide – not the drug treatments."*[134]

The paper nevertheless urged follow-up by doctors in the early prescribing phase.

The Best Practice Advisory Centre (BPACnz) states: *"Active follow-up is important for all patients presenting with distress or depression. Put a plan for review in place, e.g. a phone call from the practice nurse after 24–48 hours and a follow-up appointment in one to two weeks to assess their symptoms."* [135]

In an environment where resources are stretched so thin the ideal practice may be impractical or impossible.

BPACnz also cautions: *"Patients who are initiated on an antidepressant at the first consultation may attribute the improvement in their symptoms to the medicine, when it is likely that they would have improved anyway."*[136]

In his youth suicide paper of 2017 Professor Gluckman was more emphatic: *"The use of anti-depressant pharmaceuticals appears to be no more effective than CBT [cognitive behavioural therapy] in preventing suicide. Indeed, some antidepressant therapy appears to be associated with greater risks of suicide than using CBT; in general, the use of all anti-depressant therapies requires an appropriate safety plan."*[137]

There is an additional school of thought:

> *"...if people are encouraged to rely heavily on ADM [antidepressant medication] only, and if they consequently reduce spontaneous self-help activity, that the benefits of the ADM may be more than offset by reductions in beneficial effects as a consequence of reduced self-help activity."*[138]

In other words, patients may be less inclined to attend to exercise, diet and avoidance of stress factors in the belief the ADM will 'cure' their illness. This might happen disproportionately when and where patients cannot afford other forms of therapy such as counselling. People in more economically deprived areas may, *"have lower coping resources by virtue of educational, status or social capital variables, also greater income stress and other social determinants of depression."*[139]

Reliance on ADM will only be further encouraged by a scarcity of non-pharmaceutical interventions as is currently the case in New Zealand. Regarding the large increase in antipsychotic dispensings to young people, the Mental Health and Addiction Service Monitoring Report 2022 noted the likelihood that, *"these increases have resulted from increased stress from COVID-19 and a lack of non-medical treatment alternatives."*[140]

In Australia, *"In many socioeconomically disadvantaged, regional or remote areas, depressed people are more likely to get GP care than specialist, interdisciplinary or multidisciplinary care. Busy GPs in such areas, even if skilled and committed, may not themselves be able to add substantial psychological treatment to ADM prescription while psychology referral may not be available. Pharmaceutical marketing to GPs and medicalised public information both will influence the patient-doctor interaction."*[141]

Compounding all of the above, as medication becomes more prevalent and normalised, more young people – or parents on behalf of children - may consult a physician with a singular expectation of receiving a prescription.

Academics in the field of psychiatry made the following assertion:

> *"Our interventions should encourage, not replace or subvert, autonomy, independence and active coping."*[142]

Similar counsel could apply in other spheres. Advocates and lawmakers should also consider if well-intended social and educational interventions undermine 'autonomy, independence and active coping.'

An over-reliance on antidepressants is comparable perhaps to a wider societal dependence on historic non-medical quick fix 'solutions' notable in family law for instance.

Historic non-medical quick fix solutions

When Peter Gluckman described the background to youth suicide in New Zealand, he led with family structure:

> *"The way that young people live their lives has changed greatly over recent decades and this has created a range of poorly understood but probably critical pressures that affect their psyche and behaviour. Family structure has changed; childrearing practices have changed; for many, the level of parental engagement has changed."*[143]

It is the family environment that most heavily influences early development. Early experiences bed in for better or for worse. Most mental health disorders emerge during adolescence.[144] A brief summary of familial change - noting the role played by the state at certain junctures - follows.

Family Structure

Sixty years ago, the average family size peaked at 4.3 children per couple. Offspring experienced high levels of stability. Overwhelmingly parents were married. In 1961, 95.5 percent of children were born to married couples[145]; by 2022 the proportion had fallen to 51 percent.[146] Equity between household incomes was greater. [147]Internationally New Zealanders enjoyed a comparatively high standard of living.

But discontent rumbled. Feminism was a wave gathering in velocity and volume across the developed world. A New Zealand woman described the process of discovering feminist writing as, *"providing a theory and an explanation for the vague feelings of alienation and dissatisfaction..."*[148]

Women's rights crystallised: the right to keep a child out of wedlock; to leave a marriage with property; to state assistance to raise a child alone; to free contraception and ease of access to abortion, etc. Many demands appeared reasonable.

For instance, feminists attacked the practice of adoption which peaked at around 4,000 in the early 1970s. Couched in highly emotional terms, who could argue for a new-born to be ripped out of his mothers' arms? Mothers won the inalienable right to keep their child with support from the state. Today adoption is rare. Abuse and neglect of children by their biological mothers is not.[149]

As escalating demands were progressively met, a shift was occurring. Fathers were increasingly replaceable and redundant and as such, children's rights to material and emotional security were diminishing. At each step it was government that ceded to demands which had become more mainstream over time.

The late eighties and early nineties were also years of economic upheaval and uncertainty here and abroad. Unemployment reached 10.3 percent in 1992.[150] Many families experienced considerable economic stress. Jobless fathers either failed to form or were rejected from family units. Male suicide peaked during the latter part of the 1990s.

Broadly speaking, while the economy and employment eventually recovered (bar the GFC 2008-11) the family unit did not. By 2018 single parents made up 24.5 percent (131,829) of families with dependent children under 18.[151] In 2020 sole parents had the greatest material hardship rates of all households with children.[152]

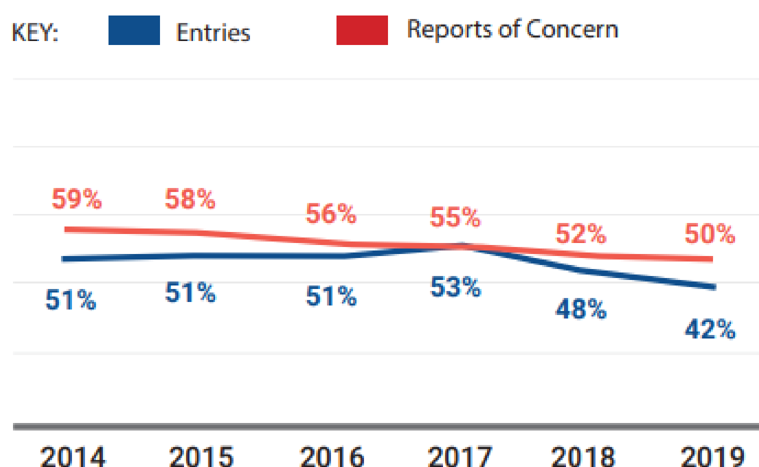
Maternal hardship and maternal depression are strongly associated. Cross sectional analysis of the GUiNZ data at 9 months showed mothers without a partner at the time of the interview were:

- more likely to be in material hardship.
- more likely to have depression or anxiety[153]

Specifically, *"Mothers experiencing high levels of material hardship were 4.8 times more likely to have moderate to severe anxiety compared with mothers with no material hardship. Similarly, mothers experiencing high levels of material hardship were 4 times more likely to have a moderate/high probability of depression compared with mothers with no material hardship. As the level of material hardship increased, the likelihood of poor maternal mental health increased significantly."*[154]

As shown previously maternal depression can have negative consequences for children's mental health (P19).

Children known to Oranga Tamariki are a particularly vulnerable group often traumatised by experiencing and/or witnessing family violence, and exposure to drug use. Half of those children entering state care in 2019, and 42 percent of those whose child received a report of concern, had a single parent on a benefit.



Source: Complexity of Tamariki Interacting with Oranga Tamariki: Reports of Concern compared to Entries to care

Sole parents often re-partner. In 2018, GUiNZ data revealed high levels of change in family structure, even pre-birth. A key finding was, *"1095 (17.3%) of mothers were categorised as having experienced 1-4 relationship transitions from pregnancy to the 4.5-year interview."*[155] Relationship transitions were characterised as, *"…the count of the entrances and exits by biological parents, romantic partners, or spouses."*

Participants assessed, *"…ranged from 6,853 at the antenatal interview to 6,156 at the 4.5-year interview,"* producing an attrition rate of ten percent. Later analysis of the lost cohort showed those mothers were more likely to be Māori and single, and included the comment that, *"those children who were lost to attrition likely represented those who would have also reported lower levels of cognitive and socio-emotional development."*[156]

Other researchers have described the GUiNZ data as not population representative because *"overall population births in New Zealand in 2009 comprised of 29% Māori which compares with 13% Māori in the GUiNZ sample."*[157]

These caveats are included to stress that the incidence of 1 in 6 children (17.3% of mothers) experiencing maternal relationship transitions before they were five years old must be considered a bare minimum across the population. This is highly relevant when considering:

> *"Children raised in families that had experienced relationship transition(s) also reported higher externalising and internalising behaviour, and lower prosocial behaviour … In usual psychological usage, 'externalising' behaviours refer to expressions of anger such as fighting, yelling at others, and destruction of property, whereas internalising behaviour refers to inward expressions of dysfunction such as anxious and depressive symptoms."*[158]

Today family structure is far more fluid. Diversity of families is embraced. But for too many children the 'new normal' is no nirvana.

Whereas marriage was once broadly valued, today it is out of favour. Politically anyway, despite a 2009 headline which announced: *"Marriage good news for mental health, though separation and divorce have negative impacts."*[159]

It arose from a wide-ranging study out of the University of Otago, Wellington - a first in exploring the mental health outcomes of marriage by gender:

> *"One of the more important findings is that in recent years it has been asserted that marriage is better for men than for women in terms of mental health. This study does not agree with that position.*
>
> *"We found that compared to never getting married, getting married is good for both men and women in terms of most mental health disorders."*

However,

> *"What our study points to is that the marital relationship offers a lot of mental health benefits for both men and women, and that the distress and disruption associated with ending marriage can make people vulnerable to developing mental disorders".*

Which prompts the question: should law changes have made it easier for people to divorce?

Views will vary. While conceding an overall negative impact for society many still want the freedom to choose in their own personal situation. But the correlation between divorce law liberalisation and divorce incidence is strong. As divorce is a significant contributor to mental ill-health again the state has played an unhelpful role in exacerbating unhappiness in adults *and their children.*

According to United States Professor of Sociology Paul Amato, *"The consistency of research findings across settings suggests that the link between divorce and child problems is a general phenomenon…"* These include, *"…academic failure, conduct disorders, depression, low self-esteem, and difficulties in peer relationships…"*

That is not to ignore, *"many children in two-parent families are exposed to stressful circumstances that have negative consequences, including poverty, chronic marital discord, domestic violence, inept parenting, substance abuse, and parents' mental illness. Indeed, several studies show that children living with parents who are chronically hostile or violent are better off, in the long run, if their parents divorce."*[160]

Alternatively, it may also have been better if acrimonious couples had never gotten together and produced children in the first place. But statutory financial support post-separation has made relationships easier to enter and exit. Commitment is dispensable.

Amato reminds us that it is the children who, *"are the innocent victims of their parents' inability to maintain a harmonious and stable home."*[161]

As an American, Amato finds solutions to these problems more obvious. Promotion of marriage before and after the event; education in expectations and professional help to resolve conflict; and failing the avoidance of separation, enhancing the ability of parents to maintain good relationships with their estranged children – for instance he suggests automatic shared custody.

Default shared parenting by law has been rejected in New Zealand and regard for the institution of marriage is foundering. In response to a suggestion that the trend away from marriage significantly increased child poverty the Prime Minister flippantly wrote, "...*here it was, the silver bullet we have all been looking for. Marriage. Getting hitched. Tying the knot. It turns out that we didn't need an Expert Advisory Group on child poverty, or any OECD analysis for that matter - apparently all we really need is a pastor and a party."*[162]

Parental engagement

The prior section broadly describes an increasing lack of father engagement in children's lives. Maternal absence is less common. Reduced parental engagement occurs at another level though.

Modern parents - often unavoidably - put their very young children in care in order to work. The state encourages this with subsidies despite the desirability of early childhood care remaining contentious.

In 1998 a Calgary University meta-analysis of 101 studies published between 1957 and 1995 found:

> *"Children in full time daycare as compared to their counterparts in home care, are at increased risk for negative psychological outcomes in four domains: 1) cognitive (7% over baseline), 2) social-emotional (8% over baseline), 3) behavioral (14% over baseline), and 4) attachment to mother (19% over baseline). A number of variables such as quality of daycare, mother's education, family socioeconomic status, and caregivers education, have no impact on moderating the negative outcomes... Accordingly, full-time nonmaternal care for infants and young children is contraindicated, as this would put a substantial proportion of the population at risk for psychological maladaptation."*[163]

In 2019 the Auckland University of Technology (AUT) prepared a paper for MSD which asked, *'Is participation in Early Childhood Education related to child health and development?'*[164]

It reported numerous studies (American, British, Australian) which found the larger the quantity of time spent in non-maternal care, the greater negative effects were. Of particular relevance, *"A Swiss study has also found that the accumulation of time in group-based childcare specifically was associated with greater externalising (aggression, ADHD symptoms, non-aggressive externalising behaviours) and internalising (depression, anxiety) behaviours at 7 years."*

AUT noted however, *"The Christchurch Health and Development Study found that ECE participation over time was not significantly associated with behavioural outcomes in childhood and adolescence once sociodemographic factors, child-rearing practices and child characteristics were accounted for."*

Analysing GUiNZ data AUT then concluded, *"...more time in ECE per week was inversely associated with the development of emotional difficulties and peer problems."*

This finding is not particularly robust.

Social, emotional and behavioural difficulties (via SDQ) were measured at 24 months. Children in full-time maternal care rated the highest level of 'abnormal' difficulties at 21.2 percent. Children in centre-based care recorded only 13.9 percent.

But the highest levels of abnormal difficulties also occurred in unemployed mothers (22.8%) and benefit recipient mothers (36.9%) – the group most likely to be parenting full-time.

The paper's authors acknowledge, *"parents who are employed are more likely to need, afford, and use ECE; this tendency will 'select' a particular group of children, many of whom may have different behavioural and health profiles to the converse group."*

Furthermore, in describing the limitations of the paper:

> *"It is possible that the positive association between child behaviour and ECE is in part due to children with behavioural difficulties being excluded from ECE (reverse causation). Unlike primary school, there is no requirement for early childhood education services to take children who have conduct or peer problems. It is also possible that parents with full time childcare responsibilities of two-year children may rate their behaviour as worse than the parents of children in childcare, because they see them all the time (so may be more aware of their behaviour) and also due to the increased stress of parenting fulltime... Given limitations in the data collection noted elsewhere, it is not possible to determine why attendance appears to protect against emotional difficulties and peer problems, and hence why this finding contrasts with previous research."*[165]

Adolescent years

As children move into their secondary school years the immediate influence of the family lessens as that of peers' increases. But the early formative experiences are embedded.

Thanks to the Youth 2000 series there is good evidence about the behaviours and emotional life of teens. Since 1999 the survey series has included more than 36,000 individuals. In 2019 over 7,000 young people from a range of circumstances were interviewed. A sample of NEET individuals (not in education, employment, or training) and a group in alternative education were included. Various findings arise from the data. Analysis found:

> *"... large reductions in substance use (e.g. prevalence of past-month binge drinking declined from 41.5% to 21.8%), sexual experience (31.6% to 20.6%) and past-month risky driving (58.8% to 37.1%). However, from 2012–2019 there were rapid increases in symptoms of depression (13.0% to 22.8%; RADS-SF), suicide thoughts (15.3% to 20.8%) and suicide attempts (3.9% to 6.3%) and declines in emotional wellbeing (76.0% to 69.1%; WHO-5)."*[166]

Despite a decline over time, *"...levels of adolescent binge drinking remain high by international standards and disparities in tobacco and cannabis use by ethnicity and socioeconomic status are wide."*[167]

A direct link between substance use and youth suicide was then considered:

> *"Because New Zealand has the highest rate of teenage suicide in the OECD, the links between substance use and suicidal behaviour deserve specific attention. Heavy substance use and suicidal behaviour are both 'externalising' behaviours (i.e. they can be ways of expressing distress) with similar underlying risk factors, so it is unsurprising they are associated. However,*

> *there is growing evidence of a causal relationship, with the case strongest for alcohol."*[168]

But what drives excessive use in some young?

> *"Risk of substance-related harm is greater in young people who use substances in response to previous or current adverse life experiences, as the dosage and frequency of use tend to be higher in this group."*[169]

Experience of 'previous' adverse life experiences – or ACEs – have been measured in the GUiNZ cohort and are reported on page 19. Of that cohort 2.6% had experienced 4 or more ACEs by the time they were four and a half; six percent had experienced three or more. The experiences continue to accumulate with age.

Coming full circle, the next finding recalls this paper's opening section about fetal risks:

> *"Problematic substance use can have intergenerational consequences, since in-utero exposure and parenting affected by substance use may have lifelong physical and psychological consequences for the next generation."*[170]

Sadly, the use of substances to ameliorate mental anguish only intensifies the problem:

> *"Young people may turn to substance use as a coping mechanism but unfortunately it tends to compound psycho-social and mental health problems, rather than alleviating them. The physiological effects of alcohol can cause or exacerbate depression, while nicotine and other stimulants can lead to anxiety and mood disorders. The behavioural aspects of substance use can result in relationship difficulties, disciplinary issues at school, and contact with the justice system. There are also bi-directional associations between substance use and sleep disturbance in young people, with inadequate sleep impacting on health and functioning. Young people can find themselves in a vicious circle of life difficulties leading to heavy substance use, which in turn leads to further life difficulties and mental health issues."*[171]

The conundrum presented by the recorded *decline* of substance use and *increase* in mental ill health leads to the following theory:

> *"The prevalence of clinically significant symptoms of depression among secondary school students approximately doubled between 2012 and 2019 but was not accompanied by an increase in teen suicide overall, or among rangatahi Māori. As discussed above, substance use and suicidal behaviour may be causally linked, with evidence strongest for alcohol. Therefore, lower levels of substance use (particularly binge drinking) may have helped to keep youth suicide rates relatively stable in the face of substantial increases in adolescent mental health problems."*[172]

This apparent divergence of trends is important and will be revisited in the conclusion of this paper.

Absenteeism

Submitters to a 2022 parliamentary inquiry into worsening school attendance noted that poor mental well-being created another vicious cycle.

> *"Submitters identified anxiety as a large cause of non-attendance. Some submitters believed the rise in non-attendance is in part driven by students taking mental-health days. Students may get in stuck in a cycle where they skip school due to anxiety, which only serves to worsen their anxiety."*[173]

Mental health issues in the home were also identified as a cause of chronic absenteeism. At March 2022, 5,277 beneficiaries with a primary incapacity of a psychological or psychiatric condition had children in their care – up twenty percent on 2014.[174]

It was also noted by the committee that truancy services had been evaluated back in 2009 due to the *"prevalence of mental health issues in students."*

In respect of covid the report commented, *"Students' wellbeing is suffering due to heightened anxiety and stress. Families are wary of sending children to school."* It has also been observed by principals that some parents condone absenteeism[175] and covid had only compounded a failure to ensure their child's attendance which had been declining since 2015.[176]

In response to the inquiry the Associate Minister of Education set new targets for attendance. For example, *"Increase the number of students attending school regularly from 60% in 2021 to 70% in 2024."*[177] Many believed the targets were pathetically low.[178] By implication, the state's standards were unambitious and yet a further failing of New Zealand's young.

A postgraduate who had attended school in South Auckland questioned the leaving age which was raised to 16 in 1989 (another well-intentioned policy that may have gone awry). As an advocate for Pacific achievement she said her school had aimed for 90 percent attendance but, *"compulsory schooling isn't for some learners. Instead, supporting them in alternative learning environments or employment opportunities where they can flourish was the best option."*[179]

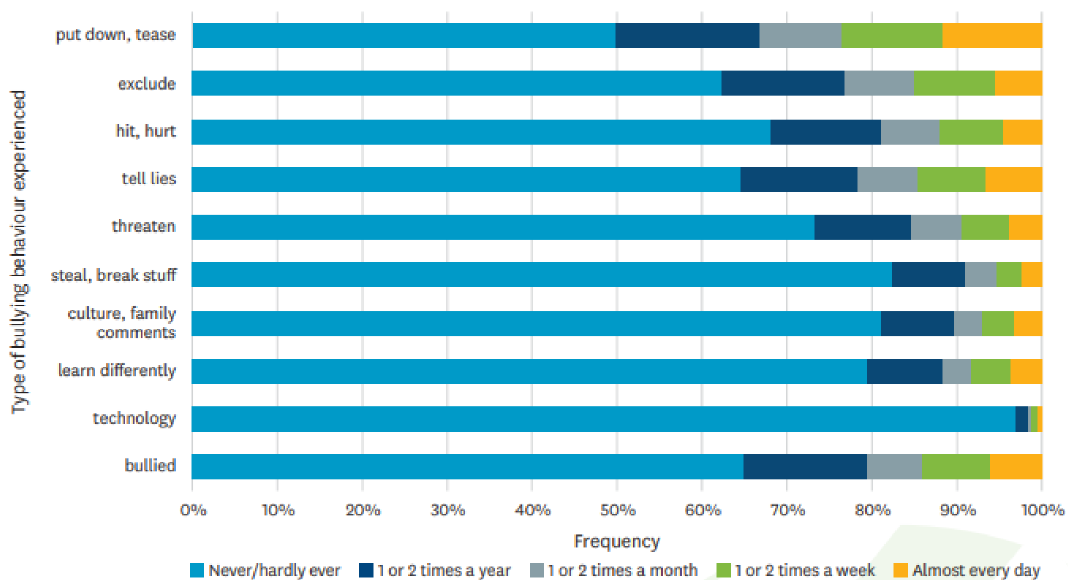
Bullying

Bullying also occurs at a high rate in New Zealand. The Programme for International Student Assessment (PISA) 2018 data for 36 countries found New Zealand (6,173 students) had the highest percentage of 'frequently bullied students' (15%), tied second for experience of 'any type of bullying act' (32%), and 'other students left me out of things on purpose' (14%) and led in experience of, 'Other students made fun of me' (23%).[180]

The PISA data pertains to 15-year-olds. Echoing these findings in younger students, the recent Now We Are Eight GUiNZ report noted, *"The extensive Trends in International Mathematics and Science Study (TIMS) of over more than 312,000 ten-year-olds showed that 16% of students internationally reported weekly bullying. However, findings from the New Zealand Year 5 students in the study (n=6,321) showed that 24% reported weekly bullying. These findings placed New Zealand at the bottom of similar OECD nations."*[181]

Gluckman's report confirms, *"Bullying in schools occurs in many countries to varying degrees but the reported rates are high in New Zealand. The effects of bullying on social and emotional well-being are well documented: increased anxiety and depression, and more aggression and antisocial behaviour; all of these are also linked to poor educational outcomes."*[182]

Just under 5,000 eight-year-olds answered questions about the range of bullying they'd experienced and lastly, if they felt they were bullied, producing the following results:



Source: Now we are eight: Life in middle childhood, Growing Up in New Zealand, MSD, 2020

Large numbers of children were experiencing bullying behaviours 'almost every day'. It appears over 200 were hit or hurt almost every day.

Bullying was also highlighted during the parliamentary inquiry into causes of school absenteeism. [183]

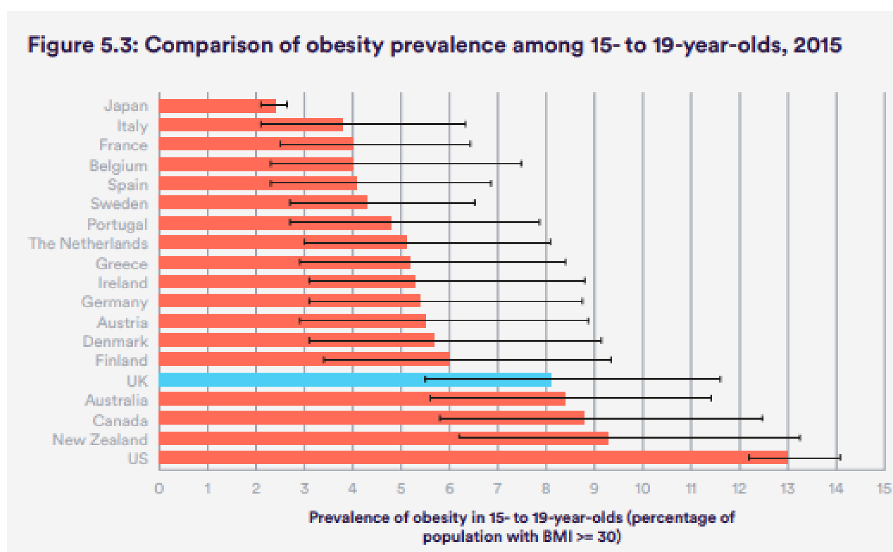
While bullying is nothing new, the opportunities to engage in it have increased with the advent of social media. The ability to film acts of bullying encourage it further. The dissemination of footage creates more victims by proxy.

An OECD paper describes how, *"digital technologies and social media are exacerbating feelings of anxiety and depression, disturbing sleep patterns, leading to cyber-bullying and distorting body image."*[184]

Body image

According to UNICEF, *"How adolescents feel about their bodies has an impact on their well-being. A positive body image is linked to greater self-confidence. A negative body image can lead to shame, anxiety, depression, isolation and low self-confidence."*[185]

In 2016 New Zealand had the second highest rate of youth (15-19 years) obesity among comparable countries.



Source: International comparisons of health and wellbeing in adolescence and early adulthood, 2019 (95% confidence intervals displayed.)

In 2020/21 12.7 percent of 2–14-year-olds were obese.[186] This is up from 11.1% in 2012/13 and 8.4% in 2006/07.[187]

Child obesity differs significantly by ethnicity, with 35.3% of Pacific and 17.8% of Māori obese, followed by 10.3% of European/Other and 6.6% of Asian children.

Body dissatisfaction can lead to the development of eating disorders (though is not a sole factor). The peak onset of eating disorders is during adolescence.[188]

1,185 under 20-year-olds accessed mental health services for eating disorders in 2020/21 and 9 percent were male.[189] Over 2009-11, only 20.75 per 100,000 young Māori aged 0-24 accessed services for eating disorders compared to 108.89 non-Māori, non-Pacific of the same age.[190]Obesity among Māori and Pacific young may pose more of a physical health risk than mental.

These stats are of course only a count of those able to access help in the public system. Data obtained by Stuff showed the Auckland DHB waitlist for first appointment at their eating disorder clinic was 61 days while, *"In Christchurch, the average wait time was 114 days, and in Wellington it was 80 days for a first appointment."*[191]

Given eating disorders can be life-threatening and rate amongst the most dangerous of mental disorders (if not the most dangerous) these wait times seem extraordinary.

A meta-analysis of 42 mortality estimation studies found*: "The aggregate annual mortality rate associated with anorexia nervosa is more than 12 times higher than the annual death rate due to all causes of death for females 15-24 years old in the general population (0.00045 deaths per year) and more than 200 times greater than the suicide rate in the general population (0.00002 suicides per year)."*[192]

Eating disorders are on the rise. Internationally,

> *"Despite the complexity of integrating all ED prevalence data, the most recent studies confirm that EDs are highly prevalent worldwide, especially in women. Moreover, the weighted means of point ED prevalence increased over the study period from 3.5% for the 2000–2006 period to 7.8% for the 2013–2018 period. This highlights a real challenge for public health and healthcare providers."*[193]

This is reflected domestically:

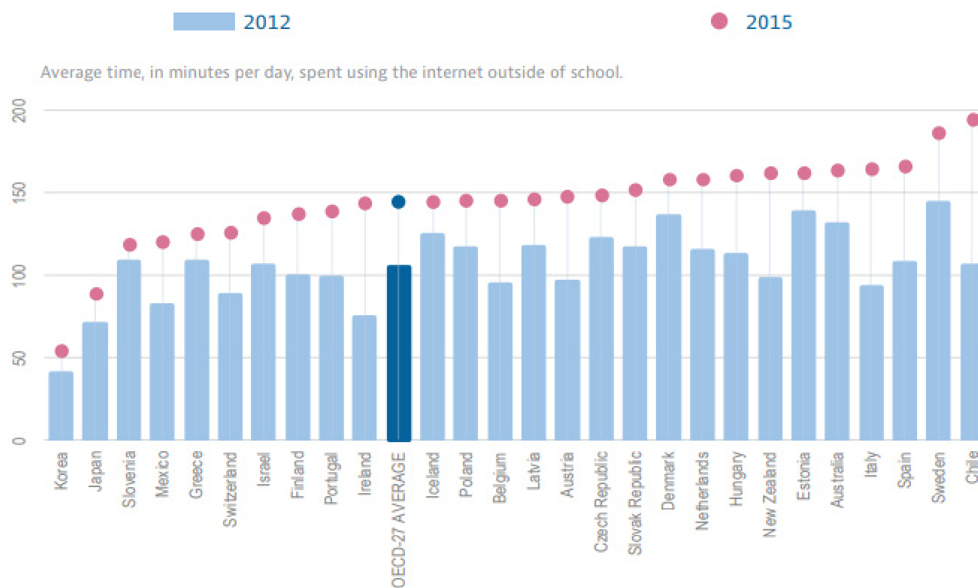
> *Public referrals in Aotearoa have risen 65% in the past five years, and private clinics are seeing more than twice as many patients as they did before the pandemic.* [194]

Again, the advent of social media has only heightened the risk with the OECD commenting, *"Studies indicate that social media usage is associated with body image concerns among young men and women as well as linked to disordered eating."*[195]

Social Media

In 2015 New Zealand children's use of the internet rated relatively high in international terms.

Average time, in minutes per day, spent using the internet outside of school



Source: Children & Young People's Mental Health in the Digital Age, Shaping the future, OECD, 2018

Around 160 minutes is an average.

A consensus is forming that either very low or very high internet use leads to heightened depression and anxiety.[196]

Researchers using the Youth 2000 surveys, linking data and contextualising internationally wrote:

> *"…levels of social media and smartphone use are not uniformly associated with increased mental distress among individuals, a finding repeatedly reported in large-scale studies and analyses. Factors related to internet use for some users, rather than use in itself, may be key here. These include experiences of cyber bullying, negative social comparisons and reduced face-to-face time with family and peers."*[197]

The type of social media in use and the characteristics of the user matter. According to most studies the axiom 'everything in moderation' certainly applies to internet use. An OECD PISA study found moderate users (1-2 hours per day) had the highest life satisfaction scores and, *"A large-scale study of adolescents in England has also found a little bit of online activity was associated with higher levels of wellbeing than no screen time at all."*[198]

Studies that have established a link between mental problems and social media find, *"the direction of the association remains unclear – that is, whether social media is contributing to elevated symptoms or social media is utilised more by those with anxiety and depression."*[199]

This confirms the earlier assertion that the user's characteristics have more bearing on a potential negative effect than the usage itself.

New Zealand researchers reflecting on whether the recent decrease in smoking and drinking among adolescents was associated with less time spent physically socialising found, *"Rather than having a protective effect, there is consistent individual-level evidence that heavy internet users (particularly social media users) are more likely to drink and smoke than those less active online."*[200]

PISA 2018 insights included, *"As is the case internationally, in New Zealand sense of belonging at school has been in decline. This may be related to increasingly high levels of social media use."*[201]

Young people suffering from anxiety will often fixate on 'what if' and worry about matters far off

in the future. Today's world presents them with ample material to fret over. But past generations have faced equally frightening doomsday scenarios. The difference now is a highly connected world in which youth are constantly exposed to media-generated hysteria and unprecedented peer pressure to respond in a conformist fashion. This is compounded by the willingness of educators to engage the very young in debates and ideas that might be best avoided until students possess the maturity to think more critically about them.

Conclusion

Unquestionably a mental health crisis is occurring among New Zealand's young. The evidence is stark. It cannot be resolved with medication alone and there is no prospect of other therapies meeting demand any time soon.

A reversal of this upward surge demands a wider appraisal and acknowledgement of societal changes that have lessened the likelihood that children will experience material and emotional security and stability throughout their formative years.

Just as antidepressants may represent no more than a quick-fix – or even worsen the problem - so too have decades-long interventions weakened families and the resilience of their members. Many families are fractured as are their children.

Reflecting on the risk of harm associated with substance use by those who've experienced childhood adversity and/or marginalisation, Youth 2000 researchers commended the basics for *"psychosocial and physical wellbeing"* as *"love, safety, a secure home, food on the table, freedom from discrimination and support to overcome life's challenges."*[202]

But even those conditions do not unequivocally ensure mental well-being.

Prompted by a UNICEF report, two questions were posed at the outset of this paper. Why does New Zealand lead the developed world in mental distress among the young, and why is the problem growing?

It appears there are two New Zealand stories occurring simultaneously.

Firstly, the development of mental disorders due to *in utero* trauma and exposure to substances followed by chaotic lives characterised by transience and family violence affect probably (and conservatively) 3 - 4 percent of all children. These experiences are by no means confined to Māori children but their over-representation in youth suicide, substance abuse, schizophrenia, experience of maternal depression and parental imprisonment is long-standing. In 1983 the rate of first admission to a psychiatric hospital for Māori aged 10-19 was 168 per 100,000 compared to 102 for non-Māori.[203]

It is probably optimistic to assess this group as shrinking or even static given growth in gangs[204], family harm[205] and Oranga Tamariki's own 2019 findings: *"Across all case study sites, Family Start workers and managers ... have been working with more high needs whānau/families. This includes those affected by insecure and inadequate housing, family violence, alcohol and drug addictions including methamphetamine, mental health issues including high rates of anxiety, incarceration, intergenerational exposure to Oranga Tamariki, immigrant and refugee whānau (some of whom have past trauma) and more whānau in crisis."*[206]

Indigenous people in Australia, Canada, and the United States also experience poorer mental

health than non-Indigenous.[207] As a percentage of the total population, New Zealand's indigenous (16.5%) exceeds others: Australia (3.3%) Canada (4.9%) and the United States (2%). Thus, the *potential* for poorer mental health in New Zealand is greater.

The *existence* of poorer mental health among the young is supported by the available statistics. New Zealand leads the developed world in youth suicide, youth self-harm and bullying. But the statistics that are not available also suggest a strongly negative picture. Those lost to longitudinal studies overwhelmingly comprise the very population of concern. PISA surveys cannot capture the chronically absent.

The second scenario is of a more pervasive depression and anxiety problem exacerbated less by mayhem and material deprivation, and more by recent developments such as social media-driven poor self-image, heightened sensitivity to parental and/or peer pressure, fear of failure[208], climate change anxiety[209] and confusion over sexual and gender identity. The second group may also be dealing with separated parents, torn loyalties, school and home-life upheaval and adapting to stepsiblings. These stresses are occurring in similar countries. According to Gluckman, *"The real pandemic that is emerging is this pandemic of loss of subjective wellbeing in that critical stage of life, adolescence, which is affecting 25 to 40 per cent of Western populations."* [210]

The surprisingly shallow socio-economic gradient for the incidence of diagnosed mental disorders also points to differing pathways to illness. Compared to the least deprived neighbourhoods, disorders are only one and a half times more common in the most deprived. (Further research would seek to establish if disorder types correlate by quintile.)

There will doubtless be overlapping characteristics between the two groups but the second is expanding faster than the first.

The first group enjoys very little positive parental control at any age whereas the second may struggle under intense parental protectiveness and expectation, especially as one child families become more common.

In both groups though, it is parents who hold the key – not governments. Enduring change begins at an individual level. If children were genuinely placed at the centre of the family, given time, given unconditional love, given space to explore but surety to return to … there may still be no guarantees. But the odds of that child growing into a secure and stable individual will massively increase.

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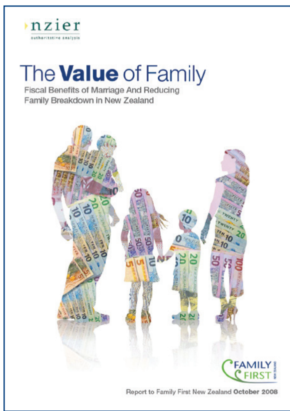

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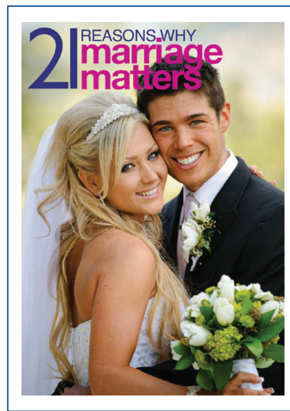

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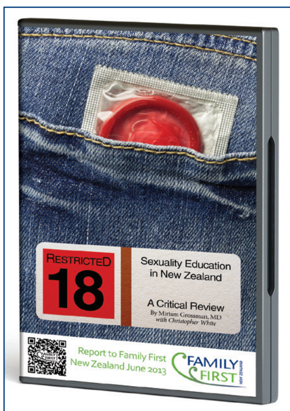

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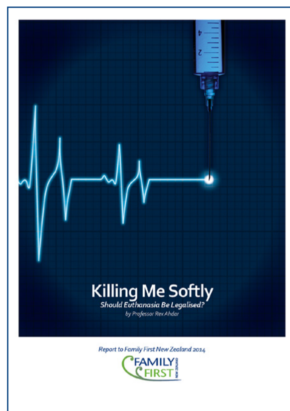

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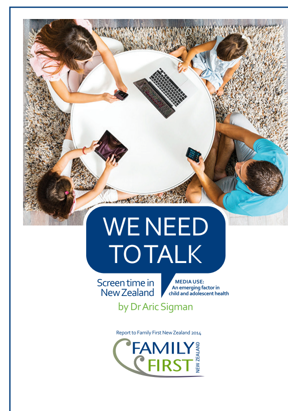

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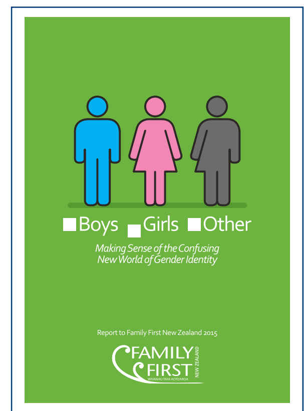

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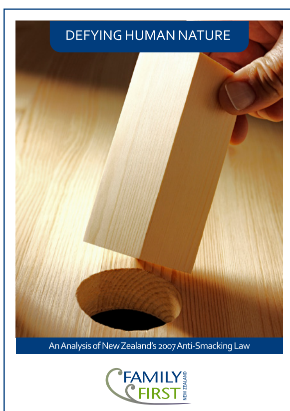

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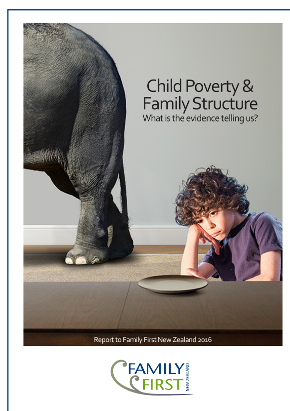

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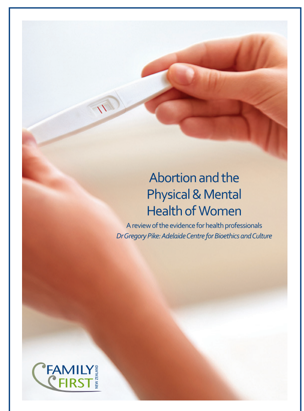

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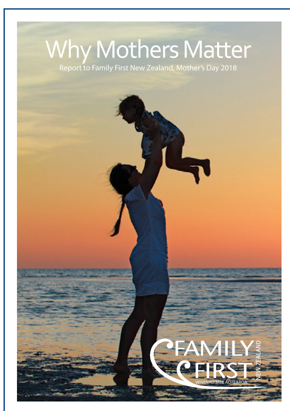

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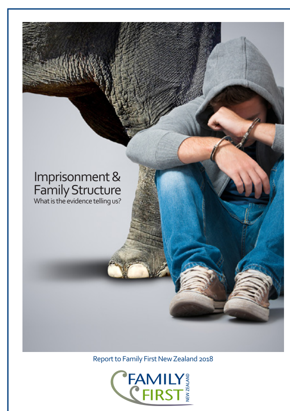

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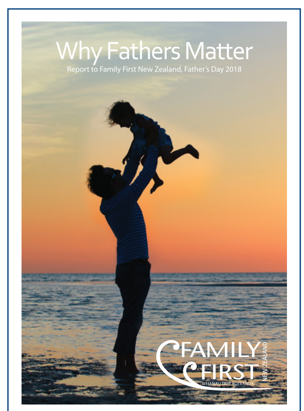

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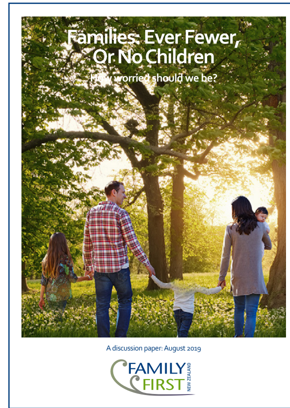

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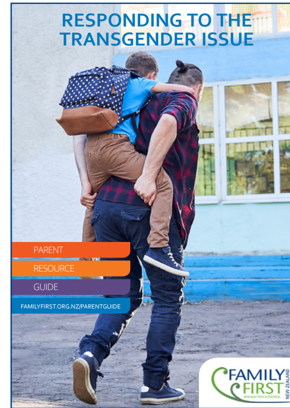

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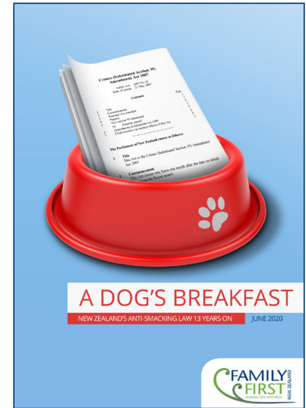

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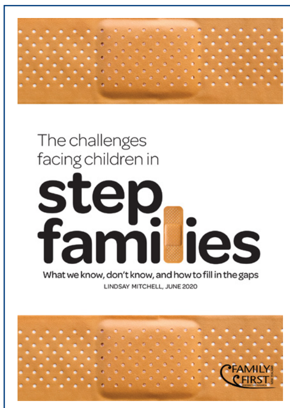

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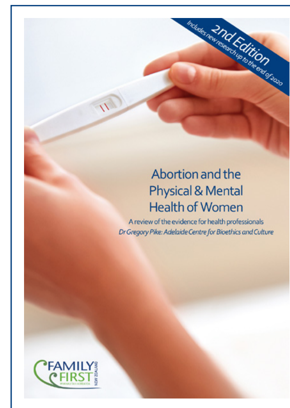

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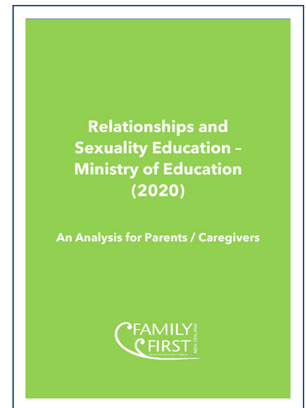

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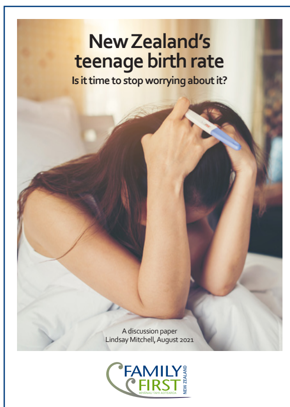

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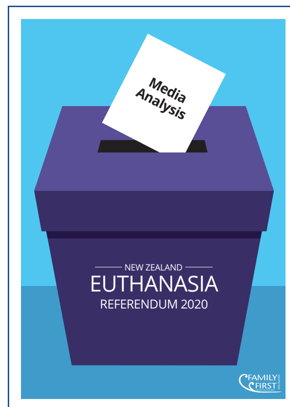

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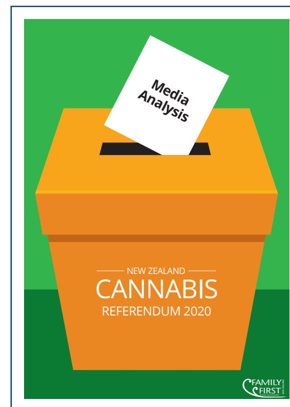

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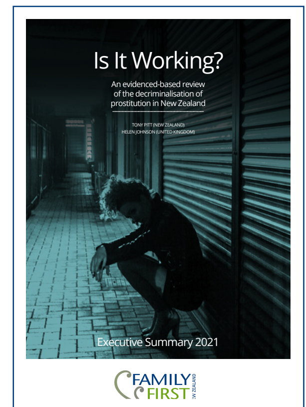

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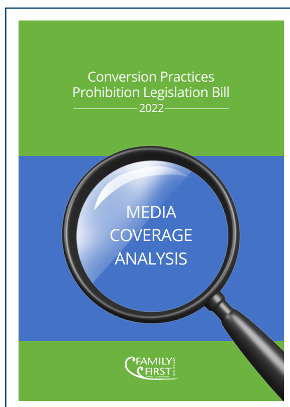

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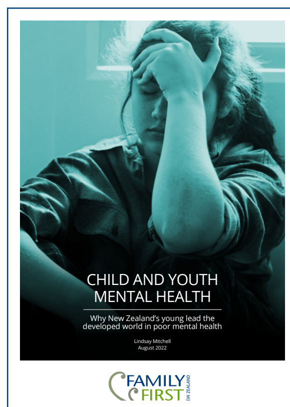

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