

YOUTH MENTAL HEALTH IN AOTEAROA NEW ZEALAND: GREATER URGENCY REQUIRED

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KEY INSIGHTS

- **There is a silent pandemic of mental morbidity amongst the global youth population which will have adverse lifecourse consequences**
- **The last decade has seen a rapid and concerning rise in youth psychological distress and suicide rates**
- **Nationally, poor mental health for youth is persistently inequitable and worsening**
- **Impacts of COVID-19 on youth mental health is likely to be extensive and enduring**
- **Protection and promotion of mental wellbeing for youth is now a matter of urgency**

A GROWING MENTAL HEALTH PANDEMIC

Global statistics about youth mental health and suicide over the last decade reveal a disturbing trend. They showed a marked increase in psychological distress for this age group, perhaps reflecting the rapidly increasing magnitude of the challenges faced by young people currently. As the pandemic of psychological distress among youth rises at an alarming rate, the underlying causes and the need for prevention and intervention remains largely ignored. There is a seemingly unappreciated urgency around this issue, which is now largely lost amidst the global COVID-19 crisis, although the pandemic almost certainly exacerbates the issues. This glaring oversight must be acknowledged, understood and addressed. Continued failure to do so will ultimately result in significant harms to the overall wellbeing and economic prosperity of many nations, including Aotearoa New Zealand.

Worldwide, the rapid rise in mental morbidity and frequency of psychological distress among young people indicates their right to optimal mental health and wellbeing is not realised. This is not conducive to societal resilience, which relies to an extent on individuals being resilient to rapid change. The World Health Organization (WHO) notes that the “promotion and protection of mental health can improve quality of life, strengthen human capital, contribute to socioeconomic development and lead to a more equitable world”.¹ There is enormous unmet need and this leads to a deeper question – what is the basis for this very rapid rise in morbidity that is being seen in so many countries?

The WHO reports that 16% of the global burden of disease and injury for adolescents aged 10-19 years is attributable to mental morbidity, such as depression and anxiety. They estimate that 10-20% of adolescents worldwide will experience mental illness to some extent – a disturbing percentage and one that is likely to be under-estimated.² Further, a large portion of the 1.2 billion global youth population have symptoms that compromise their mental wellbeing, which when combined with the normal risk taking of adolescence increases their risks of injuries, self-harm and substance abuse. For youth belonging to disadvantaged populations and marginalised communities, the risks of mental illness, addictions and suicide are much higher. Ethnicity, poverty and sexual orientation are particularly critical determinants of mental health and wellbeing.³

1 WHO. 2019. Adolescent Mental Health: Time for Action. Available from <https://www.who.int/pmnch/knowledge/publications/AMH.pdf?ua=1>

2 Moffitt, T. E., Caspi, A., Taylor, A., Kokaua, J., Milne, B. J., Polanczyk, G., & Poulton, R. 2010. How common are common mental disorders?

Evidence that lifetime prevalence rates are doubled by prospective versus retrospective ascertainment. *Psychological Medicine*, 40(6), 899–909.

3 WHO. 2019. Adolescent Mental Health: Time for Action.

RISING RATES OF YOUTH DEPRESSION

Unfortunately, the situation in Aotearoa New Zealand is particularly concerning, with mental morbidity rates more than doubling over the last two decades, for both males and females. More specifically, the national prevalence of mental health morbidity (using somewhat stricter criteria than those used in many studies in 2011/12) was 5%, rising to 14.5% in 2018/19.⁴ The national teenage (15-19 years) suicide rates are among the highest in the OECD⁵ and 2013 findings from the Youth12 survey of secondary school students reported 24% of all respondents had intentionally self-harmed in the preceding 12 months.⁶ The Youth2000 project has undertaken repeated cross-sectional studies to produce snapshots of youth populations. Data for 2000, 2007, 2012 and 2019 surveys show persistent concerning and rising self-reported rates for depression and suicidality.⁷

Preliminary findings from the Youth19 survey (2019 wave of the series) of 7,721 school students aged 13-19 years paint an especially bleak picture of youth mental health and wellbeing,⁸ with only 69% reporting good emotional wellbeing.⁹ Of the total cohort, 23% (29% of females and 17% of males) report having symptoms of depression, which is almost twice the rate found in 2012 (17% and 9% respectively). Similarly, 6% of the 2019 cohort (7.3% of females and 5% of males) report they attempted suicide in the previous 12 months, which for males is twice the rate (2.2%) reported in 2012. These gender differences and rates are compatible with overseas data. For example, repeated standardised mental health surveys in Denmark show a 50% increase in mental health morbidity between 2010 and 2017, to 24% in 16-25 year old females and to 13% in males.¹⁰

GENDER AND ETHNIC INEQUITIES

The gender inequities in youth mental health highlighted in the Youth19 findings are not new. Between 2000 and 2019, the cross-sectional Youth2000 findings reveal female youths consistently have rates of depression symptomatology and suicidality that are almost double the rates reported by their male peers.¹¹ Within ethnic minority groups this inequitable trend holds true for Māori and Pasifika females, over this time period. However, the 2019 survey findings show the gender inequity in depression has increased among Pasifika youth with a sharp increase in female rates to 37% compared to 15% for males.

Moreover, the Youth19 findings also provide strong evidence of a social gradient in youth mental health,¹² with youth from high deprivation areas having higher rates (30%) of self-reported depression symptoms than those from medium (23%) and low (17%) deprivation areas. Likewise, a social gradient is apparent with regards to attempted suicide, with rates doubling between each deprivation classification: low (2.7%), medium (6%) and high (11%).

In addition to these socioeconomic inequities, there is evidence from the Youth19 survey of ethnic inequities in youth mental health.¹³ For example, rangatahi Māori have higher reported rates for symptoms of depression than their Pākehā counterparts. Specifically, findings for female youths reporting depression symptoms revealed substantial inequity, with 38% for Māori and 24% for Pākehā youth. Depression rates for male youth were found to be 19% for Māori compared to 15% for Pākehā. Similarly, findings for Pasifika youth show significant ethnic inequity with 37% of Pasifika females reporting symptoms of depression compared to 24% of Palangi females.

4 Ministry of Health. 2020. New Zealand Health Survey Online. Available from: <https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey>

5 OECD. 2017. Teenage suicides (15-19 years old). See http://www.oecd.org/els/family/CO_4_4_Teenage-Suicide.pdf

6 Adolescent Health Research Group. 2013. The Health and Wellbeing of New Zealand Secondary School Students in 2012: Youth'12 Prevalence Tables (p 97). The University of Auckland. Available at <https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012prevalence-tables-report.pdf>

7 Youth2000, Adolescent Health Research Group, The University of Auckland. See <https://www.fmhs.auckland.ac.nz/en/faculty/adolescent-health-research-group/publications-and-reports.html>

8 Youth19: A Youth2000 Survey. See <https://www.youth19.ac.nz/>

9 Youth19 Rangatahi Smart Survey. 2020. See <https://www.youth19.ac.nz/publications/2020/8/24/youth19-rangatahi-smart-survey-webinar-initial-findings>

10 National Board of Health. 2018. Dane's Health – The National Health Profile 2017. Copenhagen, Denmark: National Board of Health (Denmark).

11 Youth19 Rangatahi Smart Survey. 2020.

12 ibid

13 ibid

A particular concern are the Youth19 survey's mental health and wellbeing findings related to the gender identity and sexual orientation of youth. Among the Rainbow (T&LGBTQA) young persons surveyed, a staggering 57% reported experiencing symptoms of depression.¹⁴

DETERMINANTS OF YOUTH MENTAL HEALTH

The question arises: why have these rates risen so quickly? What are the features of contemporary adolescence that have fueled this mental health pandemic? In seeking answers we should examine both proximal issues such as the digital milieu, and more removed issues such as early life experience, trauma, educational structures, and changing parenting, family and social contexts.¹⁵

The most important issues for youth, as identified by respondents in the Youth19 survey, were (1) social media and technology, (2) bleak futures, (3) climate change, and (4) risky choices.¹⁶ Interestingly, these findings are supported by international literature investigating the mental health of young persons aged 10-24 years.¹⁷ Although the biological and developmental determinants of poor mental health and increased suicide risk have been well-researched, there is need to focus on what underlies this rapid deterioration and increasing prevalence.

There is growing evidence that a complex interplay of contextual determinants, sociocultural and historic factors, and personal-behavioural mechanisms play a significant role in the higher risk of mental health morbidity and suicidality among young people.¹⁸ For example, research highlights factors such as cultural identity,¹⁹ resilience,²⁰ and self-regulation²¹ as protective for youth mental wellbeing. By focusing upon key vulnerabilities and resilience factors, emphasis is placed on core determinants of adolescent mental health, such as development of emotional self-regulation. This has its antecedents in early childhood, and insufficient evolution of this mechanism impairs capacity to deal with rapid change, and with the inevitable stresses of adolescence.²²

The high risk of sub-optimal mental wellbeing, progressing towards depression, substance abuse, self-harm and suicide supports a continuum model of mental ill-health, which interacts with a range of developmental, educational and sociological factors to determine overall mental wellbeing.²³ There is an urgent need to better understand the problem, particularly among youth when it first emerges, and to find and test causal rather than symptomatic solutions.

In our ongoing work, we have identified approximately 20 factors, many of them novel in the context of considering mental health that may contribute to the growing and unacceptably high rates of adolescent mental morbidity. Some are obvious, such as the role of social media or the use of alcohol/drugs.²⁴ Others are more complex and need exploration, such as the existential fear of climate change or the impact of insufficient development of emotional self-control. The latter is likely significant among families with intergenerational disadvantage, which affects more than 20% of our population, given evidence that maternal mental health during the perinatal period is a major factor in affecting offspring's self-control. However, no one factor is causal. Many of these factors interact and can be analysed in multiple ways, for example, in the case of the digital environment. We are engaged in research to explore the relative importance of such factors.²⁵

¹⁴ *ibid*

¹⁵ JL Sligo, HM McAnally, JE Tansley, JM Baxter, AE Bolton, KM Skillander & RJ Hancox. 2017. The dynamic, complex and diverse living and care arrangements of young New Zealanders: Implications for policy. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 12(1), 41-55. DOI: 10.1080/1177083X.2016.1196715

¹⁶ Youth19 Rangatahi Smart Survey. 2020.

¹⁷ Gluckman, P. 2017. *Youth suicide: A discussion paper*. Auckland: Office of the Prime Minister's Chief Science Advisor.

¹⁸ *ibid*

¹⁹ Williams AD, Clark TC and Lewycka S. 2018. The Associations Between Cultural Identity and Mental Health Outcomes for Indigenous Maori Youth in New Zealand. *Frontiers in Public Health*, 6:319. 9

²⁰ Dray et al. 2017. Systematic Review of Universal Resilience-Focused Interventions Targeting Child and Adolescent Mental Health in the School Setting. *Am Acad Child Adolesc Psychiatry*, 56(10):813-824.

²¹ Daniel, S.K., Abdel-Baki, R. & Hall, G.B. 2020. The Protective Effect of Emotion Regulation on Child and Adolescent Wellbeing. *J Child Fam Stud*, 2010-2027. <https://doi.org/10.1007/s10826-020-01731-3>

²² *ibid*

²³ WHO. 2019. Adolescent Mental Health: Time for Action.

²⁴ *Youth suicide: A discussion paper*

²⁵ We acknowledge The Tindall Foundation for their support

PROTECTING AND PROMOTING YOUTH MENTAL HEALTH

Unfortunately, these determinants, which are highly fluid and not well understood, become increasingly complex when intergenerational trauma, marginalisation and disadvantage is at play in the lives of Indigenous and other minority groups, as is the case for many Māori and Pasifika youth. This is compounded by a lack of national, routine monitoring of youth mental wellbeing, with existing mental health assessments not tapping and/or capturing all relevant factors, especially for minority youth. By identifying the relevant constellations of causal risk factors, we can develop interventions that protect against poor mental health outcomes. Therefore, there is an urgent need for research to identify the risk and protective factors influencing youth mental health and to design effective solutions to sustainably improve mental wellbeing for young people.

Although self-evident, a very basic point bears repeating: only with a good baseline of national mental health and wellbeing will we know whether we are making any difference to the nation's mental wellbeing. This baseline data is only obtainable by a new, fit-for-purpose national survey (including children, adolescents and adults). Without mental wellbeing, there is no overall wellbeing; indeed some argue they are synonymous. Without mental wellbeing, social cohesion will be undermined to the detriment of all.

Recognising youth as experts of their own needs and preferences, it is critical to explore the determinants of mental health and sustainable mental wellbeing from their perspective, in accord with principles of youth development and co-design and we are developing protocols to do just this. In this vein, the Youth19 respondents suggested changes they felt were needed to improve youth mental wellbeing, including listening to youth, promoting connection and fun, updating education, and protecting their futures. These observations suggest it is critical to acknowledge the aspirations and diversity of youth in Aotearoa New Zealand. In particular, in recognising obligations under Te Tiriti o Waitangi, protection and strengthening of mental wellbeing for rangatahi Māori needs to be prioritised to ensure equitable and sustainable improvements are made as a matter of urgency.

Collectively, the poor state of mental health and wellbeing found among our youth is a matter of deep concern that has received insufficient attention for far too long. But this is arguably just the tip of iceberg. Since the Youth19 survey, we have of course been blindsided by the current COVID-19 pandemic. The global and national impacts of this crisis, in the short- and long-term, on already vulnerable youth are yet to be seen and fully appreciated. However, recent reports revealed detrimental impacts of lockdowns on school-aged youth with potentially lifelong implications,²⁶ and expert warnings around the heightened vulnerability of youth during the pandemic and beyond.²⁷ It is suggested that a paradigm shift towards promoting mental wellbeing and preventing mental illness within schools and communities will be a key strategy in protecting youth mental health and providing early interventions. Here we might look to evidence-based international examples of co-designed, youth-specific mental health support services that have shown efficacy amongst the culturally-diverse youth population in Aotearoa New Zealand.²⁸

SUMMARY

The rapid rise in mental health concerns among young people over the last decade cannot be ignored any longer. There is an urgent need to identify youth-specific risk and protective factors to inform effective prevention strategies that can be implemented from early childhood. A greater emphasis on mental wellbeing promotion will require collaboration with young persons to co-design youth-specific and culturally responsive solutions for better mental health outcomes. During these times of unprecedented uncertainty and disruption, such targeted efforts will promote greater wellbeing and brighter futures for our increasingly vulnerable youth population.

²⁶ Hunia, R., Salim, S., McNaughton, S., Gluckman, P., Menzies, R., & Bardsley, A. 2020 *Addressing education challenges facing rangatahi after COVID-19* – A Ngāti Whātua Ōrākei & Kōi Tū: The Centre for Informed Futures Partnership report. See <https://informedfutures.org/wp-content/uploads/Addressing-rangatahi-education.pdf>

²⁷ Poulton, R., Gluckman, P., Menzies, R., Bardsley, A., McIntosh, T., & Faleafa, M. 2020 *Protecting and Promoting Mental Wellbeing: Beyond COVID-19*. Kōi Tū: The Centre for Informed Futures. See <https://informedfutures.org/wp-content/uploads/Protecting-and-Promoting-Mental-Wellbeing.pdf>

²⁸ Hetrick et al. 2017. Integrated (one-stop shop) youth health care: best available evidence and future directions. *MJA*, 207(10), S5-S18.

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