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ORIGINAL PAPER

O is for Awesome: National Survey of New Zealand School-Based Well-being and Mental Health Interventions

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Abstract

Although student well-being and mental health are government-identified responsibilities for New Zealand schools, the extent to which school-based well-being and mental health interventions are currently delivered is unknown. This survey of a nationally representative sample of schools was undertaken to identify: what well-being and mental health interventions are currently used by primary (elementary) and secondary (high) schools; what gaps exist between current practice and the evidence base; what ideas staff have for improving student well-being and mental health; and what barriers staff can identify for implementing evidence-based interventions and suggestions for how these may be overcome. Forty staff from 37 (22 primary, 13 secondary and 2 composite) schools participated in semi-structured interviews. Seven key themes were identified: (1) awareness and enthusiasm about student well-being and mental health; (2) existence of specific interventions to support student well-being and mental health; (3) support for government-sponsored programmes; (4) limitations of existing programmes; (5) drivers of new interventions; (6) perceived barriers to the implementation of new interventions; and (7) suggestions for future interventions and their implementation. Currently, a wide range of primarily non-evidence based well-being and mental health interventions are delivered in a variable manner by school-based and external providers. Despite current enthusiasm by schools, there is room for improvement in the quality and equity of intervention delivery.

Keywords Student mental health · Well-being · New Zealand schools · Programmes · Interventions

Introduction

Principles of school mental health have been recognised since Plato's *Republic* and put into practice for over a 100 years since the Chicago school board established a psychophysical laboratory within twenty school-based clinics in 1898, and the Pennsylvania State Department of Education implemented a workforce of school psychologists in the 1930s (Hoagwood & Erwin, 1997). Between the 1950s and 1960s, school-based health services had an increased focus on identifying children with learning needs until the 1970s when school counselling was introduced. The introduction of the system of care approaches in the 1990s (Friedman, 2001) emphasised a child-centred, family focussed, community-based, culturally competent flexible approach to providing services that led to school-based health services being formally recognised as a mental health provider. However, it was not until the new millennium that these services were defined as having a role in prevention of mental health issues (Rones & Hoagwood, 2000).

These days, school-based mental health services can be conceptualised as a continuum that varies by target group and service intensity. They may include universal and targeted services designed for primary prevention (Mackenzie & Williams, 2018) via enhancement of well-being (de Chavez et al., 2005), resilience (Southwick et al., 2014), social and emotional learning (SEL) (Payton et al., 2008) and mental health literacy (MHL) (Jorm et al., 1997). They may also include the early identification of mental health problems, such as anxiety, depression, conduct disorder

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and substance use via incidental or routine screening (Thabrew et al., 2017), as well as school-based services for indicated early intervention (Franklin et al., 2012; Werthamer-Larsson, 1994). Internationally, implementation of school-based mental health services is variable and affected by school culture and climate, teacher perception regarding needs and roles, funding mechanism, program fidelity and cooperation of school leadership (Durlak et al., 2008; Reinke et al., 2011). The quality of services is usually improved by having well-communicated program goals, rationale and components, provision of feedback on program effects, well-development plans to overcome implementation barriers and specification of individual responsibilities (Greenberg et al., 2005; Payne et al., 2006). Previous reviews (Rones & Hoagwood, 2000; Chuecas et al., 2022) have identified that programs designed to address specific behaviours (e.g. depression, substance use and conduct problems), with multiple components, and those that are developmentally appropriate and better integrated achieve better outcomes. They have also identified a bias towards school-based mental health services focussing predominantly on conduct problems in primary (elementary) school-aged students and depression in secondary (high) school-aged students.

In New Zealand, there are 1059 primary, 352 secondary and 192 composite schools (including kura Kaupapa Māori (Māori schools), which may be divided into state-funded, state-integrated and privately funded institutions. Almost all primary schools and two-thirds of secondary schools cater to all genders, while the remainder exclusively cater to either boys or girls. Despite student well-being being a Ministry of Education (MoE)-identified responsibility for schools and part of government's Child and Youth Wellbeing Strategy (New Zealand Government, 2021), high-level Education Review Office (ERO) policy documents outlining how student well-being should be supported (Education Review Office, 2016), and the New Zealand Council for Education Research (NZCER) making routine well-being surveys available to schools (https://www.nzcer.org.nz/tests/wellbeingschool), the extent to which New Zealand school-based health services actually support student well-being and mental health has not been well researched. Among publications from the past two decades, greater levels of school-based health support, routine comprehensive psychosocial screening and greater nursing and medical involvement have been shown to be associated with reduced levels of adolescent depression (Denny et al., 2018). Better defined and established school-based health teams have also been shown to support the sustainability of mentally healthy school initiatives (Dickinson et al., 2004). Schoolwide approaches such as Positive Behaviour for Learning (PB4L) have been implemented with variable fidelity and staff confidence (Tinetti, 2016).

Study Hypotheses and Research Questions

A nationally representative survey was undertaken to better understand the current landscape of New Zealand school-based mental health and well-being services, and to inform future service provision. We hypothesised that schools were using a variety of non-evidence-based approaches for managing student well-being and mental health. We also hypothesised that though there might be staffing, financial and other barriers to improving current practice, we would be able to identify underused opportunities for doing so. Our key research questions were as follows:

1. What well-being and mental health interventions are currently being used by primary and secondary schools?
2. What are the common drivers of well-being and mental health interventions?
3. What are the barriers to implementing new (and ideally evidence-based) interventions, and how can these be overcome?
4. What additional research is needed and how may current practice be improved?

Methods

Study Design

We used a qualitative, observational study design to ascertain participant views and identify currently utilised well-being and mental health interventions.

Participants

In order to achieve a nationally representative, geographically and demographically distributed sample, we divided all New Zealand schools listed in the Ministry of Education directory (https://www.educationcounts.govt.nz/directories/list-of-nz-schools) into the following demographic groups using Microsoft Excel® software: region (one of sixteen, the largest of which were Auckland, Canterbury and Waikato); type (primary or secondary); funding (state, state integrated and private); and gender (mixed, boys only, girls only). These data (see Supplementary Table 1) were then used to determine the approximate number of interviews to be conducted from each group. We initially estimated that we would probably need to conduct between 15 and 30 interviews to achieve saturation of themes (Braun & Clarke, 2013). However, as we also purposively wanted to sample schools from smaller regions for optimal geographic representation, we decided to recruit participants from a total of

37 schools. Principals, deputy principals and school-based health staff at eligible schools were invited to participate in the study by telephone (with more than one staff member from each school able to attend). Staff who expressed interest were sent the Participant Information Sheet (PIS) and Consent Form (CF) via email, and a date and time for a face-to-face, telephone or Zoom®-based interview were arranged, based on the interviewee preference. Permission for staff participation was also obtained from school principals.

A total of 40 staff from 22 primary, 13 secondary and 2 composite (primary and secondary) schools out of a total of 297 schools who were invited by telephone and email participated in semi-structured interviews. Out of the 297 invited schools, 231 did not respond to invitations and 29 declined to take part in the study as they were too busy ($N = 13$), they did not feel they would usefully contribute as their school did not focus or implement well-being measures ($N = 5$), they were participating in another well-being project ($N = 1$), were not interested ($N = 3$) or for no stated reason ($N = 7$). Full demographic characteristics of participants are presented in Table 1.

Procedure

The study was conceptualised by the primary author (HT). Semi-structured interviews were conducted in person at schools or via Zoom® by two researchers (RB, a male Swedish medical student on an international elective and HK, a New Zealand Asian research assistant with previous experience of qualitative research) within an 8 month period (February 2020–October 2020) using the format outlined in Supplementary Table 2. This was developed by two authors (HT and RB) based on the research questions and refined during the first five interviews as recommended by (Madill, 2012). Neither interviewer had any previous relationship with participants, and no one else was present during interviews. Each interview had three main parts. The first addressed 'preventative' school-based approaches to maintaining well-being (including mindfulness), improving resilience, SEL and MHL. The second enquired about school-based approaches to managing common mental health problems such as anxiety, depression, conduct problems, bullying (including cyberbullying) and substance use (including vaping and online addiction). Within this section, initiatives pertaining to the mental health of students of different ethnicities (especially New Zealand Māori) and sexual identity (LGBTQA plus and allied) groups were also specifically examined. The third part explored staff barriers to implementing student well-being and mental health interventions as well as ideas for how to overcome them. Interviews took around 1 h and were recorded using either a Phillips 2 VoiceTracer® device or Zoom software, then transcribed and not verified by participants prior to analysis.

Data Analysis

Participant and school demographics were analysed using basic statistical functions in Microsoft Excel®. Qualitative data were manually analysed by one researcher (either RB (18) or HK (19)), and all were cross-coded by a second researcher (HT) over an 8-month period, using the six step method of thematic analysis described by Braun and Clarke: familiarisation, coding, generating themes, reviewing themes, defining and naming themes, writing up (Braun et al., 2014). Key themes, subthemes and supporting quotes were independently identified and then combined, and disagreements were addressed by discussion between all three researchers. Results were presented according to COREQ guidelines (Booth et al., 2014).

Results

Key Identified Themes

Seven key themes were identified from the available data, namely: (1) awareness and enthusiasm about student well-being and mental health; (2) existence of specific interventions to support student well-being and mental health; (3) support for government-sponsored programmes; (4) perceived barriers to the implementation of existing programmes; (5) drivers of new intervention identification and adoption; (6) perceived barriers to the implementation of new interventions; and (7) suggestions for future interventions and their implementation.

Table 1 Demographic characteristics of participants

Number of participants	40
Role	Principal 17 (43%), Deputy Principal 7 (18%), School Counsellor 8 (20%), SENCO 3 (7.5%), Other (2.5%)
Type of school	Primary 22 (59.5%), Secondary 13 (35.1), Composite 2 (5.4%)
Funding source	Public 32 (86.5%), Private 5 (13.5%)

SENCO Special Educational Needs Co-ordinator

Awareness and Enthusiasm About Student Well-being and Mental Health

A majority of participants expressed support for school-based initiatives with which to improve student well-being and address common mental health problems. The link between well-being and academic achievement was highlighted as a driver of their enthusiasm, and many schools had officially incorporated well-being into their core values.

> ”Learning we’ve discovered doesn’t happen without the children’s well-being being in a good place, a positive place. And I think in society today, we have so many different home lives, different ways the children turn up to school, so we can’t assume that at nine o’clock when our bell rings the children are in a state ready to learn. So probably our main focus of business is to enhance the well-being as much as we can of the whole child, to build capacity for them to be able to learn to their best ability.” (PN 3, Primary School)
> ”For us well-being is more than just feeling good, it’s actually about being, it’s critical to learning and learning provides a level of success which contributes back into well-being.” *(PN 9, Primary School)*

Existence of Specific Initiatives to Support Student Well-Being and Mental Health

A range of existing approaches to supporting student well-being and mental health were described by participants. These fell into five subgroups: (i) universal approaches for improving well-being, resilience, SEL and MHL; (ii) targeted approaches for identifying and managing common mental health problems; (iii) specific staff, teams and communities; (iv) culturally congruent approaches; (v) externally sourced resources and interventions.

(i) Universal approaches for improving well-being, resilience, SEL and MHL were often ill-defined and varied between primary and secondary schools. Primary schools tended to focus on core SEL competencies of social skills, emotional awareness and self-management via classroom activities and school camps. Many also routinely employed positive behaviour recognition approaches espoused by the government-sponsored Positive Behaviour for Learning (PB4L) programme. In contrast, secondary schools most commonly offered relaxation, reflection-based and occasionally yoga-associated mindfulness programmes to improve student well-being.

> “We are now introducing some of the mindfulness activities. Focusing first on helping the children with their breathing and being more centred and more reflective.” (PN 11, Primary School)

Although no specific MHL programmes were identified, participants described how opportunities to improve MHL were sprinkled throughout the secondary school curriculum in an opportunistic manner. Similarly, resilience building was undertaken through role-playing activities and conversations about challenging situations and by promoting responsibility and problem-solving competency through assignment of leadership roles. A few schools identified community service as an additional means of improving purpose and influencing well-being.

> “Every Year 10 student in the school also has to do a day’s community service so they have to help the elderly or the infirmed people… that is very much part of our health and well-being programme because in the WHO definition, the ability to actually serve and help others improves well-being.” (PN 13, Secondary School)

(ii) Targeted approaches for identifying and managing common mental health problems also varied considerably between schools. No specific programmes for preventing anxiety or depression were described by participants. The most widely used programmes were aimed at behaviour management, including bullying. Ministry of Education-supported programmes such as Understanding Behaviour, Responding Safely (UBRS; https://www.education.govt.nz/school/student-support/special-education/behaviour-services-to-help-schools-and-students/support-for-schools-to-minimise-physical-restraint/) and Check in, Check out (https://pb4l.tki.org.nz/Media/Files/Check-In-Check-Out-CICO4) and externally sourced programmes such as Bucket Fillers (https://bucketfillers101.com/; during which students are encouraged to do or say something that makes others feel good) were most frequently mentioned for addressing problem behaviour. Restorative justice and bystander intervention programmes were usually used to address bullying when it occurred. Only a few schools had implemented cyber-safety programmes (e.g. Cybersmart; https://www.cybersmart.co.nz/) to target cyberbullying. Although substance abuse and addiction were included in the health curriculum in some secondary schools, others utilised externally sourced (e.g. Life Education Trust; https://www.lifeeducation.org.nz/) providers to deliver education on these topics to relevant classes.

> “One of the topics Life Ed focuses on is substance abuse, and that’s mainly targeted at the year seven and eight

students. That's a unit they can do if the teacher wants to." (PN 7, Primary School)

(iii) A number of schools had established, or were in the process of establishing, specific well-being and mental health teams. Examples included collaborations between year-level teachers and form deans termed 'whānau' (family) groups'; student-led well-being committees; and PB4L staff teams for managing behaviour problems.

"Like a lot of schools we have tutor teachers in the form of what we call waka huia teachers. I know some schools call them whānau groups and various other names, where that, it's basically a single point of contact for the students where they're able to build relationships with one particular teacher that they see on a daily basis." (PN 16, Secondary School)

Some schools also scheduled regular time (e.g. 'Waka Huia time' and 'Wānanga time') for connecting with form deans and promoting well-being. A handful of schools had invested in Question, Persuade and Refer (QPR; https://qprinstitute.com/) training for staff to be more efficiently able to detect signs of self-harm and suicide or invited specialist mental health staff to educate them about management of such issues. A few schools regularly evaluated their performance via student surveys.

"We do run the 'Me and My School Survey' each year, and that's, that's an external check of our internal systems."(PN 35, Primary School)

(iv) Most schools had embraced aspects of Te Reo (Māori language) and culturally congruent processes for working with students, both in relation to general learning and well-being. An example of the latter was the fusion of emotional regulation paradigms with traditional legends. Schools with a greater proportion of Māori or Pacific Island students appeared to have more formalised approaches for addressing student well-being, including family hui (conferences) to deal with difficulties and co-governance models with families and the wider community. Staff training was seen as an essential part of this journey.

"We also focus very strongly in terms of our local curriculum on whanaungatanga (kinship) and kaitiakitanga (guardianship). Which again fits really closely in with what our Māori families are wanting, and the values. So our Māori kids actually feel really, really comfortable here." (PN 29, Primary School)
"It's called Mana potential. It's kind of a kaupapa Māori kind of approach, tikanga Māori and it looks at zones of regulation. So, when your child is calm, it's got a colour with it and it's related to a Māori legend, so they are able to affiliate with it and things like that. They are able just to, you know, walk in the classroom and say I'm red and go out." (PN 27, Primary School)
"We have a Māori pathway here, so we have a class of sixty students who are learning in Māori. All of them are Māori and they're learning Māori and they very much have a restorative practice approach to, you know, if things don't go well. If a student has created hurt for another student, the family come in, they have a family conference." (PN 21, Primary School)
"This school, is looking towards a co-governance model so that we're ensuring that our Māori whānau are up at the decision-making table. So, we haven't got Europeans making decisions for them. Yeah. So I think it's just, yeah, really, really changing the whole structure." (PN 21, Primary School)
In contrast, initiatives for supporting LGBTQA plus and allied students were much less common. Only a couple of participants mentioned the availability of peer or mentor groups.
"I've got the Rainbow Group which is a group of LGBTQA plus, and allied students who meet once a week to talk, to make sure that students that are queer or questioning are supported. They have a meeting about once a month." (PN 25, Composite School)
"We have [person] who comes in, who represents, who's a person who works with rainbow youth in our area. He comes in and meets with them, and some of them go with him, there's a night that they can go and just be together and feel, have that sense of belonging." (PN 37, Secondary School)

(v) Many schools reported sourcing well-being and mental health programmes from external providers. Better funded schools (usually private) were more likely to access private, charitable external providers, while others mainly accessed government-sponsored programmes. Generally speaking, externally sourced programmes were offered to students in a developmentally appropriate manner. Primary schools were most likely to offer externally sourced programmes such as the Zones of Regulation (https://www.zonesofregulation.com/index.html) and Bounce Back programmes (https://www.bounceback-program.com/) for social and emotional learning, and the FRIENDS programme (https://friendsresilience.org/), Sparklers programme (https://sparklers.org.nz/) and Kiwi Can programme (https://dinglefoundation.org.nz/kiwi-can/) for improving resilience. Secondary schools were most likely to offer programmes for improving adolescent social skills and gender awareness (e.g. the Accident

Compensation Corporation (ACC)-funded Mates and Dates programme, https://www.matesanddates.co.nz/), preventing and addressing substance abuse (e.g. the SMASHED programme, https://www.lifeeducation.org.nz/in-schools/smashed), preventing bullying (https://www.bullyingfree.nz/), and managing change and transitions (e.g. the Traveller's programme, https://www.skylight.org.nz/build-resilience/travellers). A flexible approach such as that taken by the Life Education Trust (in which mental health-trained educators visit schools to deliver topics chosen by classroom teachers) was most valued by schools.

A list of the most popularly utilised school-based and externally sourced programmes is provided in Table 2. The three most commonly identified programmes were the Positive Behaviour For Learning (PB4L) programme (https://pb4l.tki.org.nz/), a NZ version of the internationally recognised School-Wide Positive Behavior Interventions and Supports (SWPBIS); Life Education Trust education modules on life skills and substance use (https://www.lifeeducation.org.nz/); and the Mates and Dates programme (https://www.matesanddates.co.nz/assets/resources/acc7219-mates-dates-secondary-school-programme.pdf), a government-sponsored education series about healthy relationships that aims to prevent sexual abuse.

Support for Government-Sponsored Programmes

Government-sponsored initiatives were better known and rated by staff than others. These included educational programmes such as the Ministry of Health-funded 'Sexwise' programme that teaches students about healthy relationships, sexual health and gender issues; the New Zealand Police course 'Loves Me Not' that teach young people relationship skills; the New Zealand Council for Educational Research (NZCER) 'Well-being at school' survey designed to assess student well-being; and the Positive Behaviour for Learning (PB4L) programme for preventing and managing behaviour problems. Better valued programmes were aligned with the five key competencies of the New Zealand curriculum, namely: thinking; relating to others; using language, symbols and text; managing oneself; and participating and contributing.

> "There is an NZCER survey, it's called the Wellbeing Survey that we're just about to do. And that generally brings our issues that we are unaware of. So we do that on a yearly basis to really start to try and gauge what the trend and patterns are within our school. ...Oh all students from Year 3 to Year 8. ...any younger and it's basically pointless. We do it in a more unofficial capacity type thing." (PN 1, Primary School)

> "PB4L would be the greatest initiative in that, because that just is so all-encompassing and we discuss things every week with staff. If there was a real behaviour problem, we would encourage them to see their head of department first, if it was a teacher that was having a behaviour problem with somebody." (PN 26, Secondary School).

Perceived Barriers to the Implementation of Existing Programmes

Lack of staff time, confidence and knowledge were identified as the main limitations to existing programme delivery.

> "I guess the busyness of school and curriculum. If it's seen as an add-on or something, you know, asked of them without a willingness to be involved, that sort of thing often you get negative or kickback on new programmes or new initiatives." (PN 29, Primary School).

"I think once you get into specific things, like when children are cutting, we aren't trained mental health workers, we're teachers." (PN 31, Primary School)

A number of participants also expressed reservations about the sustainability of programmes, particularly those that were externally sourced and dependent on available funding.

> "The barrier is finances. So the limited availability. It's having the resources to be able to support people." (PN 30, Primary School)
> "Unfortunately, it's all about money. And we spend a load of our budget, our own budget, as well as getting money for these other children, through teach-aiding. Our hugest resource is just people." (PN 27, Primary School)

Other problems with existing programmes included inconsistent incorporation into the curriculum; programmes not being tailored to issues pertinent to specific classes; programmes not meeting the needs of diverse groups of students; and students needing time to adjust to externally sourced providers.

> "If it didn't take into account our school values and the values of our community, it wouldn't work. If it was contradictory to something we we're already doing, if it wasn't sustainable or long-serving, if the school didn't have the ability to sustain the strategy then it's not going to work." (PN 25, Composite School)

Table 2 Most popular programmes for supporting student well-being and mental health

Programme or intervention	Target issue(s)	Description of content	Number of times mentioned by participants	Target age group	Provider	Culturally congruent*	Cost	Level of evidence[$]
PB4L School-wide	Behavioural issues	NZ version of the internationally recognised School-Wide Positive Behavior Interventions and Supports (SWPBIS). Three tiers: Tier 1 looks at the support systems and processes across the whole school—things that impact on all students and adults; Tier 2 looks at interventions for students who require additional behaviour and learning support; Tier 3 looks at more individualised and intensive support for students who experience chronic, severe and challenging behaviour	12	Primary	School staff	No	Free (government sponsorship)	2
Life Education Trust programmes	Wellbeing SEL Resilience substance abuse	Content across five major strands: food and nutrition, human biology, relationships & communities, identity and resilience, and substances. Three programs	10	Secondary	Private provider (NZ)	No	NZ$19 per child	5
Mates and Dates programme	Social/relationship skills to prevent the harm caused by sexual violence and dating violence Identity, gender and sexuality	Multi-year programme (9–13) taught in through five 50 min sessions over about 5 weeks. It builds year on year	7	Secondary	Accident and Compensation Corporation (ACC)	No	Free	4

Table 2 (continued)

Programme or intervention	Target issue(s)	Description of content	Number of times mentioned by participants	Target age group	Provider	Culturally congruent*	Cost	Level of evidence[$]
Loves me not programme	SEL Bullying and abuse	Domestic violence and violence within a relationship. Promoting healthy relationships. Bystander intervention training	4	Secondary	NZ Police	No	Free	5
Zones of regulation programme	SEL	ZOR curriculum and framework teaching emotional management/ awareness. Grounded in CBT	4	Primary	Private provider (NZ)	No	Cost for resources and staff training	4
PB4L Check and connect	Behavioural issues	Mentoring programme for students at risk of disengaging from school. Developed by the University of Minnesota in the late 1990s. School nominates students based on a number of risk indicators, including lateness to school and classes, incomplete homework, absenteeism	3	Primary	School staff	No	Free (government sponsorship)	4
Attitude programme	Resilience SEL Substance abuse	Online free/charged workshops for students. Presentations in assembly settings	3	Secondary	Charitable organisation (NZ)	No	Free	5
Keeping ourselves safe programme	SEL	Teaching students safe practices for interacting with other people and recognising and encourage students who have been or are being abused to seek help	3	Secondary	NZ Police	No	Free	5

Table 2 (continued)

Programme or intervention	Target issue(s)	Description of content	Number of times mentioned by participants	Target age group	Provider	Culturally congruent*	Cost	Level of evidence[$]
Travellers programme	Resilience SEL	In-school, 8 week programme that teaches young people skills to cope with change, loss and transition. Starts with survey of all the kids in their first year which indicates stress, and problemssocialising	3	Secondary	Charitable organisation (NZ)	No	NZ$500 for the programme and to train 2–4 staff	5
Sparklers programme	Well-being SEL	Multiple online and printable resources for improving student well-being	2	Primary	Canterbury District Health Board and partners	Some resources	Mixture of free and charged-for resources	4
Inside Out programme	Sexuality and gender identity	Staff development sessions and free online resources. Regional school coordinators to support on-site with e.g. setting up or strengthening QSAs (Queer-Straight Alliances) or Rainbow Diversity Groups	2	Secondary	Charitable organisation (NZ)	Some resources	Free	5
Smashed and stoned programme	Substance abuse	Early intervention programme to assist young people to think about their alcohol and drug use. It is recommended for groups of three to six young people. Two 1-h blocks a week for 6 weeks	2	Secondary	Waikato District Health Board and partners	No	Free	5

Table 2 (continued)

Programme or intervention	Target issue(s)	Description of content	Number of times mentioned by participants	Target age group	Provider	Culturally congruent*	Cost	Level of evidence[$]
Bounce Back programme	Well-being Resilience SEL	Programme to support student resilience using online resources	2	Primary	Private Provider (Australia)	No	Cost for all materials	5
Kia Kaha programme	Resilience Bullying	Information for teachers/parents/principals and differing learning activities students depending on age-group	2	Primary	NZ Police	Yes	Free	5
Mana Potential programme	SEL	An assessment and intervention tool to support people to understand and regulate their emotions and behaviours, using Maori legends (Atua Māori) as reference points. Similar to 'Zones of regulation'	2	Primary	Private provider (NZ)	Yes	Cost for staff training	5
Adventure Development programme	Well-being SEL	Longer outdoor expeditions or 1-day expeditions with activities and challenges. For 'at-risk youths'	2	Secondary	Charitable organisation (NZ)	No	Free	5
Poutama Pounamu	Cultural awareness well-being	Culturally responsive pedagogy, promoting mauri ora, the maori concept of spiritual wellbeing. Regional wānanga combined with online modules	2	Secondary	University of Waikato and partners	Yes	Free	5

Table 2 (continued)

Programme or intervention	Target issue(s)	Description of content	Number of times mentioned by participants	Target age group	Provider	Culturally congruent*	Cost	Level of evidence[$]
Tuakana Teina (Big Brother, Big Sister) programme	Well-being SEL	Secondary school students mentor primary school students for an hour each week. Big Brothers Big Sisters provides a resource box full of activities that the mentor and young person can use	2	Secondary	Charitable organisation (NZ)	Yes	Free	5
Sexuality Road programme	SEL well-being sexual and reproductive health	Resources for schools to support student sexual and reproductive health	2	Secondary	Charitable organisation (NZ)	No	Free	5

*Provided in Te Reo Maori language or developed by or with Maori communities

[$]Grade of evidence according to the UK National Institute of Clinical Excellence (NICE): 1 = systematic review; 2 = Randomised controlled trial; 3 = Pseudorandomised on non-randomised controlled trial; 4 = Case series or open trial; 5 = Case report or expert opinion

Drivers of New Intervention Identification and Adoption

Based on previous experience, participants identified key drivers for new well-being and mental health initiatives as being: current issues faced by students (e.g. online gaming at the time of our study); opportunistic awareness of programmes; promotion and funding of programmes by the Ministry of Education; availability of programmes; availability of surplus funding to access external providers; and easily integrated approaches that fit with either current well-being programmes or longer-term school plans.

> "When we first got involved with positive behaviour for learning it was very much, there was a carrot dangled for all the schools, which was ten thousand dollars. ..I would argue that some schools bought into it because they saw the money" (PN 16, Secondary School)

Perceived Barriers to the Implementation of New Interventions

When asked about potential barriers to the implementation of new well-being and mental health initiatives, participants identified a number of pertinent issues were raised. These included lack of staff time, confidence and professional development to support the delivery of programmes; and the sufficiency of funding.

> "Time because the curriculum is very crowded and time because teachers time is very stretched, it's hard to find time for teachers to meet when they have non-contact time that coincides." (PN 11, Primary School)
> "Quite a few teachers feel that they are out of their depth in this. They are not used to language in this way, they are a, you know, they started to be a teacher because they want to teach history or they want to teach maths."(PN 14, Secondary School)
> "It's heavily demanding on our resources… And at times we feel we could do so much more if we had some outside resourcing."(PN 13, Secondary School)

Stigma about mental health issues from staff and families and perceived appropriateness of content for students of certain ages were also relevant.

> "What's really interesting about even the term mental health, as soon as you use that term with a student, you'll see them, they lock down. …we've got to be very careful of the vocab we use, because in their minds they just hear the word mental." (PN 16, Secondary School)

Finally, concerns about the longevity of programmes and inadequate back-up from specialist services when mental health issues are identified and were also seen as dampeners of staff enthusiasm.

> "Outside experts come in, do their programme or whatever. They get the funding for doing those programmes and once they've gone, they've gone". *(PN 1, Primary School)*
> "I actually think at the moment too much is being asked by schools in these acute needs. I sort of feel at the moment that basically ...our guidance counsellors are asked to deal with the acute ones that used to go to CAMHS (Child and Adolescent Mental Health Services) because CAMHS has such a high waiting list. And then the deans are asked almost to be guidance counsellors..."(PN 13, Secondary School)

Suggestions for Future Interventions and their Implementation

Ideas for future well-being and mental health initiatives included education about online addiction and cyberbullying, the former being seen as more of an issue for male students and the latter more of an issue for female students. Education about vaping was also recommended.

> "I have to say, one of the biggest I think concerns about mental health at the moment is with our boys and online gaming." (PN 13, Secondary School)
> "I think they need more education on online social manners. I think they are very quick to post mean things online without really thinking through the impact. They need more, we keep telling them, but we need more ways for them to understand the longevity of some of their online comments" (PN 14, Secondary School)

The way in which new initiatives are promoted to students was also seen as a key driver of their success, with more strengths-based or positively focussed, developmentally appropriate and interactive, programmes being preferred.

> "…empowering the children through their signature strengths to build their resilience ahead of the adversities that will no doubt come their way." (PN 11, Primary School)
> "Mindfulness can be pretty boring it's taught in an unengaging way, you know. And to get children to sit still and have stillness of mind and things like that is challenging." (PN 1, Primary School)
> "Our students, this is just an estimate, would probably be around about 70 percent kinaesthetic learners and so… they have to be physically doing something to learn." (PN 16, Secondary School)

There was also support from most participants for online delivery of well-being interventions, as long as they were adequately engaging.

> "They would probably like someone online as long as it's not too long and as long as it, they have to engage with personalities, with a person, with some kind of story, I think." (PN 14, Secondary School)

Integration of new well-being and mental health programmes into the curriculum and longer-term health education plans were identified as being helpful; and already been undertaken by some schools.

> "Specifically we are developing and extending our health and physical education programs which would exitly plan for a two or three year coverage of some of these topics." (PN 11, Primary School)

Participants expressed divided opinions regarding well-being and mental health education being delivered by existing staff or external providers, with some sensing students would be more comfortable with known adults and others believing that external providers would be better able to engage students and provide more expert perspectives.

> "…it was good content, but the facilitators, our kids, they're pretty reticent to communicate with people they don't know. So they didn't open up at all." (PN 8, Composite School)
> "…external people are good 'cause it catches the kids attention a bit. It's something different." (PN 8, Composite School)

From a systems point of view, participants identified funding for staff development as being essential to the uptake of new programmes. Support for teachers to attend well-being courses and explore what other schools are using was also being undertaken and recommended by some better-funded schools. Inclusion of mental health education into future teacher training programmes was also suggested.

> "…if it was funded professional development (a) our teachers would be keen to do it and (b) the schools would be great, and we'd be happy to come on board with it." (PN 1, Primary School)
> "Our school is very open to taking any health and well-being interventions or programmes offered to us if we can fit them into the curriculum and if they don't cost us anything."(PN 22, Secondary School)
> "I asked one of my teachers who's passionate about this to actually have a term, I gave her time each week for a term to go to various schools to have a look at what they were doing. So we've got a programme

that's really just a synthesis of what worked best in other schools, if you know what I mean." (PN 13, Primary School)

"We kind of have taken a collaborative approach. We've been to well-being conferences for schools and listened to what other people are doing and thought about how we might do that." (PN 14, Secondary School)

"I think all teachers should do psychology papers in their teaching degree". (PN 10, Secondary School)

They also identified better support from specialist mental health services or joint school-based health teams as being likely to improve the confidence of educators in delivering well-being and mental health programmes.

"I know we'd never get a counsellor just for ourselves, because we're only a medium sized school. But, you know but if we were a part of a cluster that had a counsellor shared between them, that would make a significant difference." (PN 12, Primary School)

Finally, evaluation of new programmes was highlighted as important to a few participants.

"One of the dangers of course of trying to weave the concepts through and across the curriculum is that it's hard to keep track of what people have actually done. …So there needs to be having some way of having a stock take and make sure we have covered different aspects of Hauora (well-being)." (PN 11, Primary School)

Discussion

The enthusiasm of New Zealand school staff for supporting student well-being and mental health is not currently matched by the provision of effective interventions with which to achieve these aims. A wide range of primarily non-evidence-based well-being and mental health interventions are currently being delivered in a variable manner by school-based and external providers. Interventions focussed on social and emotional learning are more frequently available in primary schools, while relaxation and mindfulness-based approaches for improving well-being are more typically offered by secondary schools. Few schools have programmes explicitly geared towards preventing, identifying or addressing common mental health issues such as anxiety and depression. While culturally congruent approaches to supporting student well-being are commonplace, LGBTQA plus-oriented interventions are rare. Key barriers to the provision of interventions include staff time, knowledge, stigma about mental health and programme funding. Current areas of unmet need include online gaming, cyberbullying and vaping. There is openness to greater use of online interventions for improving student well-being. Implementation of new initiatives would be supported by adequate funding, staff training, government support, integration with the curriculum and expansion of school-based health teams.

Participants in our study appear to be primarily motivated to improve student well-being and mental health by the perceived benefits for learning that stem from these improvements. It has previously been shown that students attending schools with SEL programmes achieve 11–17% more on standardised tests than others (Durlak & Weissberg, 2011). The type of well-being interventions being offered by schools appears to vary according to the age of students. Primary schools are predominantly focused on addressing behaviour problems, usually in a universal manner and in keeping with international findings (Rones & Hoagwood, 2000). Secondary schools tend to be more focussed on general well-being, especially via relaxation and mindfulness-based education. Resilience building at both primary and secondary school tends to be undertaken in an opportunistic manner, while interventions to improve mental health literacy are rare. Reassuringly, in line with ERO recommendations, most schools we surveyed reported embracing culturally inclusive approaches to improving student well-being. Māori principles for engagement, models for understanding health and sharing of decision-making with whanau and communities were standard business for most participating schools.

Despite previous research indicating that the point prevalence of psychiatric disorders in school children internationally is between 8 and 18% and many more experiencing lower, yet impairing, levels of psychological distress (Fazel et al., 2014; Li et al., 2022), few surveyed schools appeared to have specific interventions in place for preventing, identifying and addressing common mental health. No schools were able to name any universal or targeted interventions for anxiety or depression. The latter is of particular concern, given New Zealand's high rates of youth depression and suicide (Gluckman, 2017). Substance use is also inconsistently addressed either via the curriculum or talks by external providers. Although 13-year old students attending a subset of (lower decile) secondary schools are routinely screened for psychosocial issues by a school nurse using a HEEADSSS assessment (an established interview covering Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, and Safety; Doukrou & Segal, 2018), no screening of other students is currently undertaken, and this is likely to limit possibilities for early intervention. Given the preference for students to disclose private matters via technology, the availability of rapid and cost-efficient, locally designed electronic screeners such as YouthCHAT (Thabrew et al., 2017) and increasing evidence that routine screening does not lead to excessive

onward referral (Thabrew et al., 2020), it would be good to see such interventions being incorporated into regular (ideally, annual) well-being assessments. Given the openness of schools to online interventions, improving access to e-therapies for first-line management of common mental health issues would also make sense. Priority should be given to interventions that have been locally developed, co-designed with young people, and that have evidence of acceptability, efficacy, safety and cultural appropriateness.

The limited use of evidence-based interventions (i.e. those with research evidence of efficacy and/or effectiveness) by participating schools was notable. This is despite the availability of multiple evidence-based interventions for the prevention and treatment of common mental health issues in schools (O'Reilly et al., 2018). Internationally, successful evidence-based, universal interventions include: the Promoting Alternative Thinking Strategies (PATHS) programme that has been widely used by primary schools for the prevention of conduct problems (Bierman et al., 2010) the FRIENDS for Life programme, a 10-lesson programme shown for the prevention of anxiety and depression, and the Resourceful Adolescent Programme (RAP) which, by improving self-esteem, conflict resolution and stress management, has been shown in most studies to reduce adolescent depression (Shochet et al., 2001). Some approaches may work better when used in different ways for different issues. For example, universal educator-delivered Cognitive Behaviour Therapy (CBT) interventions have been shown to be more effective at reducing anxiety while indicated CBT-based interventions have been shown to be more effective at reducing depression (Calear & Christensen, 2010; Neil & Christensen, 2009). Possible reasons for the lack of uptake of evidence-based interventions by New Zealand schools may include stigma and educator preference not to label students, lack of awareness of these interventions (Ahuja, 2012; Chodkiewicz & Boyle, 2014), and concerns about the suitability of imported interventions for use with local populations. Admittedly, there is also currently limited clarity among researchers about which evidence-based interventions are most clinically and cost-effective, and culturally relevant for use in the New Zealand context. Other factors also need to be taken into account when recommending evidence-based interventions. Substantial investment may be needed to equip schools and educators with skills to promote student well-being, as identified by the Australian Mind Matters campaign. Due to implementation issues (Durlak & DuPre, 2008), evidence-based programmes may not always yield expected dividends as shown by the Australian Beyond Blue programme, in which a 30-session CBT-based curriculum failed to reduce depressive symptoms in adolescents (Sawyer et al., 2010). Additionally, students with less obvious issues may actually benefit more from school-based interventions than those perceived by staff to be at greater risk (Merry et al., 2012). Notwithstanding these issues, there is a case for both the prioritisation of government funding towards evidence-based interventions and the recommendation that all new interventions are evaluated using comparable outcome measures.

The issue of whether well-being and mental health interventions should be delivered by educators or external (health or other) providers also warrants some discussion. Although it is likely that schools will continue to make this choice based on convenience, it should be noted that pros of external providers include specific expertise and greater effectiveness in some studies (Kellam et al., 2011; Stallard et al., 2014). Advantages of educator-led interventions include convenience, sustainability and reduction in stigma (Han & Weiss, 2005; Mcluckie et al., 2014). However, the latter also require greater investment for effective implementation (Powers et al., 2010). Overall, in line with previous studies (Beets et al., 2008; Sanetti et al., 2014), our findings indicate that New Zealand schools tend to depend on educators for universal interventions and external providers for more targeted interventions. In addition to clarifying who is responsible for specific interventions, it is also important for schools to clearly identify members of school-based health teams and their roles, as well as internal and external pathways for managing issues when they are identified.

Strengths and Limitations

The main strength of this study is the inclusion of primary and secondary schools from across New Zealand to provide a geographically representative sample. Despite this, we did not include schools from every region or every type of school, so our results may not be generalisable to all educational environments in New Zealand or overseas. Due to the sample size, we were also unable to identify any subgroup differences between schools in different regions. Participants were primarily principals, deputy principals or members of school-based health teams, and as such, their views may not represent those of all staff. Lack of objective evidence regarding programmes and the limited time available for interviews may mean that we did not identify all available programmes. More detailed description of implementation would also have been useful to understand how programmes were being used. Finally, interviewer characteristics and their level of familiarity with the education system may have affected the quality of information obtained.

Recommendations for Research

Further research is needed into the fidelity, efficacy and cost-effectiveness of currently used interventions; the role of locally developed and evidence-based interventions; and

interventions for students with specific issues (e.g. eating disorders and neurodevelopmental disorders). Adequately powered, randomised controlled trials are also warranted to ensure optimal uptake of new school-based interventions. Implementation may be supported by research using established models such as EPIS (exploration preparation, implementation and sustainability) (Aarons et al., 2011; Moullin et al., 2020). International recommendations for school-based research and implementation outlined in previous reviews (Fazel et al., 2014; Greenberg et al., 2005; Payne et al., 2006) are also relevant to the New Zealand context.

Recommendations for Practice

A formal Ministry of Education stocktake of universal, targeted and indicated well-being and mental health interventions is sorely needed. This could be based on international instruments such as 'The Survey of School Promotion of Emotional and Social Health' (SSPESH; Dix et al., 2019) that has been used to inform service provision in Australia (Laurens et al., 2021). The resulting list should be regularly updated and used to audit and improve current service provision. Schools should be incentivised to implement evidence-based interventions and accountability for student health should overtly be shared between health and education services. Cross-training of staff (e.g. health staff spending time in schools, educators receiving well-being and mental health training) would help break down existing silos between health and education and support this goal (Marks et al., 2002). Finally, consideration should also be given to ethical issues associated with school-based well-being and mental health provision. All schools should have formal processes in place for obtaining consent for the collection of health information and clear protocols for sharing these with other organisations (Evans, 1999).

Regardless of how many of these recommendations are enacted, it must be noted that school-based mental health services are unlikely to be a panacea. Some students may not attend school; some may continue to prefer to receive support outside of the school environment; and differences in perception regarding issues may persist between students, families and educators. Nonetheless, with consideration and investment, there does appear to be a lot that could change for the better.

Conclusion

Despite enthusiasm by New Zealand schools for supporting student well-being and mental health, there is considerable room for improving the delivery of universal, targeted an indicated interventions. To acknowledge both the effort of those doing the mahi (work) and the gap between current practice and aspiration, we borrow a common New Zealand phrase and give schools an 'O for awesome'.

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Declarations

Conflict of interest The authors declare that they have no conflicts of interest to report.

Ethical Approval The study was reviewed and deemed to be exempt from needing ethics approval by the New Zealand Health and Disability Ethics Committee on the 15th of October, 2019. As described above, to minimise coercion, participants were approached indirectly via school administrators. Data were transcribed by a registered employee of the University of Auckland who had signed a confidentiality agreement, only viewed by the research team, and stored on secure University of Auckland servers or in locked filing cabinets for 6 years, as per standard University of Auckland policy. Data were presented in a collated format to minimise potential identification of individual participants or schools.

Informed Consent Individual informed consent was obtained from all interviewees. Consent forms were collected prior to interviewing all school staff members.

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