

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**The CAMHS Referral Process: The Perspectives of School Counsellors on the Front  
Line of Youth Mental Health in Aotearoa New Zealand**

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Science

in Psychology

at Massey University, Manawatū,

Aotearoa New Zealand

Ashley Holland

2025

## **Abstract**

School counsellors are fundamental to supporting the mental health of young people in Aotearoa New Zealand. They are crucial in not only providing primary care services but also for facilitating the referral to Child and Adolescent Mental Health Services (CAMHS) when counselling alone is not sufficient. Mental health in Aotearoa New Zealand is increasing in both prevalence and severity, rangatahi mirroring this nationwide trend. There are significant stressors influencing all key stakeholders involved with supporting rangatahi mental health, with strains on public mental health services such as CAMHS. There is a disparity between CAMHS nationwide, in both service and delivery processes. As school counsellors are responsible for many of the referrals made to CAMHS, this research study gathered perspectives from school counsellors to shed light on the current state of the referral process.

**Method:** Participants completed a mixed methods designed online survey, and the responses were analysed using both descriptive statistical analysis and reflexive thematic analysis.

**Results:** School Counsellors identified key areas of strengths, weaknesses and changes needed within the CAMHS service. A list of beneficial next steps for CAMHS was generated.

**Conclusion:** There is a considerable need for a more responsive CAMHS referral process in Aotearoa New Zealand, catering for the increasing complexity and demand of rangatahi mental health. There are both strengths and weaknesses of the current CAMHS referral process, and with collaboration and cooperation with school counsellors they will be able to implement changes which will improve this process, benefiting vulnerable rangatahi.

## Acknowledgments

Firstly, I wish to acknowledge and thank my supervisor, Dr Matthew Shepherd, I could not have completed this thesis without his wisdom and guidance. Thank you for your patience and pragmatic approach, boosting my confidence when I was having self-doubt.

To the participants of this research, thank you for seeing the value in my research and taking time out of your busy schedule and away from the precious work that you do. Thank you also for always advocating for the rangatahi in your care.

To all of my teachers who inspired me, thank you! I have not always found my educational journey enjoyable, but your belief in my ability and your passion for education, sparked inside of me the desire to be a life-long learner.

To the rangatahi that I have had the honour and privilege of teaching. Thank you for being as enthusiastic as me about Science and Chemistry. Thank you for trusting me with your education and for being open to the educational process.

To my parents, Dwight and Janet, thank you for always encouraging me. You have instilled in me a life-long passion for learning, and you are always by my side cheering me on every step of the way. Thank you for continuing to encourage me throughout my entire lifetime of education. Who would have thought I would not only make school my career but would continue to be a student myself! It has been a long 32 years of education!

To my wonderful husband, Wayne, you have been my rock through this sometimes insanely stressful process, and you have put up with me throughout it all. Thank you for your unwavering support, love and belief in me.

## Table of Contents

Abstract.....	i
Acknowledgments.....	ii
Table of Contents.....	iii
List of Tables.....	vii
List of Figures.....	viii
List of Keywords.....	ix
Introduction.....	1
Chapter One: Mental Health.....	3
Mental Health in Aotearoa New Zealand.....	3
Diversity of Mental Health.....	4
Increasing Awareness of Mental Health in Aotearoa New Zealand.....	5
Funding of Mental Health Services in Aotearoa New Zealand.....	6
Chapter Two: Child and Adolescent Mental Health (CAMH).....	7
Child and Adolescent Development.....	7
Child and Adolescent Mental Health Prevalence.....	8
Child and Adolescent Mental Health in Aotearoa New Zealand.....	9
Difficulty Accessing Appropriate Services.....	11
Chapter Three: Child and Adolescent Mental Health Services (CAMHS).....	13
CAMHS.....	13
Gender.....	14
Cultural Considerations.....	15
LGBTQI+ and Disability Considerations.....	16
Wait times/Availability.....	17
Whakawhanaungatanga (Relationships).....	18
Pressures Experienced within Child and Adolescent Mental Health Services.....	18
Increased Demand and Time Pressures.....	19
Training and Cultural Competencies.....	20
Funding and Access.....	21
Input into Child and Adolescent Mental Health Services.....	23
Support Network.....	23
Cultural Lens.....	25
Autonomy.....	26
Models of Service.....	27
The Choice and Partnership Approach (CAPA).....	27

Digital Health/ e-Health Models.....	28
Participation in Partnership Models (PiP) .....	29
Chapter Four: Child and Adolescent Mental Health Service Referral Process .....	30
Accessing CAMHS .....	30
Increasing Rates of Referral.....	30
Referral Criteria.....	31
Te Piki Oranga.....	31
MICAMHAS .....	32
CAFS .....	32
Referrer Factors Influencing Decision to Refer .....	33
Chapter Five: School Counsellors on the Front Line.....	35
Importance of School Counsellors .....	35
Factors and Issues Faced by School Counsellors.....	36
Stress.....	36
Workload .....	37
Severity of Mental Health.....	37
Network .....	38
Influence of School Counsellors on CAMHS .....	39
Factors that Influence School Referral to CAMHS .....	39
Chapter Six: Aims & Hypotheses .....	41
Aims: .....	41
Hypotheses: .....	42
Chapter Seven: Methodology .....	43
Pragmatism.....	43
Mixed Methods Research.....	44
Quantitative Methodology.....	46
Data Collection .....	46
Analysis .....	46
Qualitative Methodology.....	47
Data Collection .....	47
Analysis .....	48
6 Phases of Analysis .....	49
Reflexivity in Thematic Analysis.....	50
Ethics.....	51
Consent.....	51

Participants .....	51
Survey Questionnaire .....	52
Questionnaire Briefly Unpacked .....	53
Chapter Eight: Results .....	55
Demographics.....	55
Participants’ Opinions of Process .....	57
Numbers of Students per Year and Quantity Referred .....	58
Mean Average of Students and Referrals.....	59
Qualitative Thematic Analysis of Written Responses.....	62
Confidence Rating Analysis.....	62
Reason for Referral Analysis .....	62
Thematic Analysis of CAMHS Referral Criteria.....	63
Strengths of the CAMHS Referral Process .....	65
Weaknesses and Limitations of CAMHS Referral Process .....	65
Suggested Changes to CAMHS Referral Process .....	66
Other Comments on the CAMHS Referral Process .....	67
Chapter Nine: Discussion .....	69
At a Glance: The importance of this research .....	69
The Research .....	69
School Counsellors’ Voice .....	70
Community Driven Change.....	72
Identified Strengths .....	72
Familiarity of the CAMHS Referral Process.....	73
Communication .....	73
Collaboration .....	74
Availability of Service.....	75
Identified Weaknesses.....	76
Lack of Referral Acceptance .....	76
Time.....	78
Resourcing .....	78
Other themes of interest to consider: Mixed Messaging and Consent .....	79
Changes Beneficial to All .....	80
Accessibility .....	81
Resourcing .....	83
Time.....	84

Communication .....	85
Collaboration .....	85
Recommendations .....	86
Limitations of the Research.....	87
Sample Size .....	88
Research Design .....	88
Data.....	90
Input of Key Stakeholders .....	91
Future Areas of Research .....	91
Input of CAMHS .....	92
Voice of Rangatahi .....	92
Type of school .....	93
Culture and Gender.....	94
Factors affecting School Counsellors .....	95
Alternative Tools to Support Mental Health .....	95
Conclusion.....	96
References.....	99
Appendices.....	118
Appendix A Anonymised Raw Data exported to Microsoft Excel™ spreadsheet from Microsoft Forms™ Questionnaire .....	119
Appendix B Copy of Text that was sent out in email to participants on Massey University Letterhead.....	122
Appendix C Printed Copy of Online Microsoft Forms Survey.....	124
Appendix D The Survey Questionnaire Unpacked .....	128

### List of Tables

<b>Table 1</b> Summary of Questionnaire, Data Type and Analysis Approach .....	54
<b>Table 2</b> Role of Participants in Research Project .....	55
<b>Table 3</b> Region of practice .....	56
<b>Table 4</b> Gender of Students at School .....	56
<b>Table 5</b> School Type of Participants .....	56
<b>Table 6</b> CAMHS Referral Experience of Participants .....	57
<b>Table 7</b> Confidence Level of CAMHS Referral Process .....	57
<b>Table 8</b> Observational Estimation of Referrals Accepted by CAMHS.....	57
<b>Table 9</b> Participants Understanding of CAMHS Referral Criteria .....	58
<b>Table 10</b> Analysis of Counsellors Capacity in a Calendar Year .....	59
<b>Table 11</b> Mean Average of students seen per year vs. referrals per year split by school type .....	60
<b>Table 12</b> Mean Average of students seen per year vs. referrals per year split by Gender of school .....	60
<b>Table 13</b> A Summary of Justifications of Referral Process Confidence rating .....	62
<b>Table 14</b> A summary of the Reasons for CAMHS referral and the frequency of this response by participants.....	63
<b>Table 15</b> Frequency of Numbers of Referral Reasons Given by Participants .....	63
<b>Table 16</b> Justification of Answering ‘Yes’ to Clarity of Referral Criteria.....	64
<b>Table 17</b> Justification of Answering ‘No’ to Clarity of Referral Criteria .....	64
<b>Table 18</b> Justification of Answering ‘Maybe’ to Clarity of Referral Criteria.....	65
<b>Table 19</b> A Summary of Strengths of CAMHS Referral Process .....	65
<b>Table 20</b> A Summary of Weaknesses of CAMHS Referral Processes .....	66
<b>Table 21</b> A Summary of Changes to CAMHS Referral Process: Benefiting School Counsellors .....	67
<b>Table 22</b> A Summary of Changes to CAMHS Referral Process: Benefiting Rangatahi .....	67
<b>Table 23</b> A Summary of Other Comments about CAMHS Referral Process .....	68

**List of Figures**

<b>Figure 1</b> <i>The Correlation Between Students seen by Participants per Year and the Number of Referrals made to CAMHS .....</i>	<b>61</b>
<b>Figure 2</b> <i>Summary of Change to CAMHS to Improve Referral Process for Rangatahi .....</i>	<b>87</b>

## List of Keywords

<b>Keyword</b>	<b>Definition</b>
<b>CAMHS</b>	Acronym for Child and Adolescent Mental Health Services
<b>Concept-creep</b>	Expansion of psychological concepts related to mental health symptomology (Haslam & Tse, 2024).
<b>Health loss</b>	Experiencing a decrease in health.
<b>LGBTQI+</b>	Acronym encompassing lesbian, gay, bisexual, transgender, queer, intersex, and other gendered.
<b>Mental distress</b>	Difficult emotions or feelings which are out of the ordinary and make it difficult to cope with everyday life.
<b>Pastoral Care</b>	Care which is concerned with social, emotional and spiritual support. Typically used in an educational setting.
<b>Rangatahi</b>	A Te Reo Māori word referring to the younger generation, typically used in reference to adolescents.
<b>Self-harm</b>	Intentional harm of oneself.
<b>Suicidal ideation</b>	Having thoughts of or planning a suicide.
<b>Taha hinengaro</b>	Psychological /mental health (From Māori health model Te Whare Tapa Whā)
<b>Taha tinana</b>	Physical Health (From Māori health model Te Whare Tapa Whā)
<b>Taha wairua</b>	Spiritual Health (From Māori health model Te Whare Tapa Whā)
<b>Taha whānau</b>	Social Health (From Māori health model Te Whare Tapa Whā)
<b>Tangata Whenua</b>	Indigenous Māori people, born of the land.
<b>Tikanga</b>	Correct Māori customs and procedures.
<b>Wellbeing</b>	A healthy state of being, usually in relation to mental health.
<b>Whakawhanaungatanga</b>	A Te Reo Māori word which means process of developing connections and relationships through shared experiences.
<b>Whānau</b>	Te Reo Māori word for family, can refer to extended family members.
<b>Whanaungatanga</b>	Te Reo Māori word for relationships or connections.

## **Introduction**

School Counsellors have been operating in Aotearoa New Zealand for a number of years and they are clearly an integral part of pastoral care networks within Aotearoa New Zealand Secondary Schools (Crowe, 2006). They have the key role and responsibility of ensuring the wellbeing of rangatahi and advocating for them to other parties such as their whānau, teachers, and outside agencies (Ferguson, 2012). They are often also expected to function as the figure head and driving force for the implementation of school wide pastoral care initiatives that aim to spread mental health awareness and improve the wellbeing of the school community. While school counsellors are a fount of knowledge, they are under immense pressure themselves, as their role diversifies but their capacities and remuneration often stagnate.

This research project will involve a review of literature with a focus on the exploration of the state of Child and Adolescent Mental Health (CAMH) in Aotearoa New Zealand, the pressures facing Child and Adolescent Mental Health Services (CAMHS), the invested parties who have input into CAMHS, the role of school counsellors in Aotearoa New Zealand Secondary Schools including the pressure they face, and school counsellors' roles in bridging the divide between rangatahi and CAMHS. With very little information available about school counsellors' opinions of CAMHS, the research aims to gather information from school counsellors working within Aotearoa New Zealand Secondary Schools and their perception on the efficacy of the CAMHS referral process.

An overarching philosophy of a pragmatism research paradigm will guide the mixed methods research design involving, both descriptive statistical analysis (Kaur et al., 2018) and reflexive thematic analysis (Braun & Clarke, 2006). The analysis will endeavour to identify key areas of strength and weakness within the CAMHS referral process, with the aim of generating a list of suggested areas of improvement to the referral process, which could

improve its efficacy and be of most benefit to the rangatahi of Aotearoa New Zealand, who utilise these vital services.

## **Chapter One: Mental Health**

Mental health is a holistic concept which consists of a person's total wellbeing. The World Health Organisation (WHO) defines mental health as one's state of mental wellbeing which allows the individual to function well in their everyday life (Ministry of Health, 2024c), being able to cope with normal life stressors and continue on a path of self-actualization. Overarching definitions of mental health could include but are not limited to psychological health, emotional health, spiritual health, social health and physical health. In Aotearoa New Zealand the Māori model of wellbeing, Te Whare Tapa Whā (Kahu et al., 2012), is often used to represent and explain not only mental health but the importance of addressing all four pillars of health (Taha Tinana, Taha Wairua, Taha Hinengaro, Taha whānau) in maintaining a balanced wellbeing. Despite being pioneered by Sir Mason Durie back in 1984 (Mental Health Foundation of New Zealand, 2024), it is still a well-balanced and well used model of wellbeing, adopted by many mental health organisations as a basis for best practice.

Although a commonly used concept which could be viewed with neutrality, mental health is generally viewed in a negative light. When mental health is mentioned, it is at the forefront of our consciousness that it is automatically a terrible or frightful thing (Haslam & Tse, 2024). Perpetuation of negative narratives of mental health concerns and mental illness in media only further solidifies societal stereotyping. For the purpose of this chapter, the focus on mental health will be that of a psychological health lens (Taha hinengaro) and will be primarily focused on levels of mental distress, the incidences and consequences of poor mental health, and the supports available for individuals who are struggling with these concerns.

### **Mental Health in Aotearoa New Zealand**

Mental Health in Aotearoa New Zealand is an increasingly hot topic, often politicised and punted from political party to political party as the proverbial football (Mental Health

Foundation of New Zealand, 2022). In 2023, wellbeing statistics reported that 26% of the population had experienced poor mental health (Statistics New Zealand, 2024). The decline in mental health and a rise of mental distress is in the forefront of media broadcast. Although increased awareness is often viewed in a positive light, it does also mean that there is increasing pressure and monumental expectations to solve what is often described as Aotearoa New Zealand's mental health crisis (Fortune & Clarkson, 2006).

Mental Health concerns appear to be trending upwards worldwide, although the full extent of this trend remains largely unknown, as surveying of mental health remains inadequate across the globe (Office of the Auditor-General, 2024). Of those individuals with reported Mental Health concerns in Aotearoa New Zealand, approximately 40% will experience lifetime prevalence, and despite a large proportion of individuals experiencing mental distress and meeting the threshold of mental disorder criteria, over half will not receive the necessary healthcare required (Ministry of Health, 2024c).

### **Diversity of Mental Health**

Mental health is a diverse and complicated field to navigate. While perfectly normal to experience mental distress on occasion in response to life's stressors, mental distress which increases, in frequency and pervasiveness, can manifest as mental illness. Mental distress comes in many shapes and sizes and often does not perfectly adhere to specific well-defined mental illness criteria. The most common mental health concerns in Aotearoa New Zealand are anxiety and depression (Peiris-John et al., 2024), the severity and longevity of which can be very diverse with both short-term and long-term consequences for the individuals experiencing these. Mental health concerns are often intertwined, many individuals presenting with comorbidity of disorders (Lumb, 2009). Comorbidity of disorders can also have the inclusion of Specific Learning Disorders, which add a further layer of complexity for both the individual with the mental health concern but also those who are tasked with

supporting that individual. The increasing complexity of mental health concerns, coalesced with increasing poverty in Aotearoa New Zealand, including increased levels of poor living environments and increased levels of poor physical health (Lumb, 2009), has led to a mental health system that is near breaking point (Paterson et al., 2018).

### **Increasing Awareness of Mental Health in Aotearoa New Zealand**

While it is ultimately a positive thing that today's society is very aware of mental health and is invested in improving overall wellbeing within Aotearoa New Zealand. This has given rise to an increase in society's mental health literacy (Haslam & Tse, 2024). This awareness has also led to a rise of "concept creep", which involves the broadening of what is understood to be symptomology of mental illness (Haslam & Tse, 2024). Where an individual's bad day can now be understood by that individual as a 'traumatic experience'. This is an interesting concept to explore, as awareness of mental health terminology and labels has increased and normal levels of mental distress are becoming pathologised (Haslam & Tse, 2024).

In everyday conversations, individuals may now describe natural or normal feelings of anxiousness, as having Generalised Anxiety, or a need for order as possessing the traits amenable to an obsessive-compulsive disorder diagnosis! The expansion of what is understood to be mental distress or mental illness (Haslam & Tse, 2024), puts increasing pressure on an already fractured system. It then becomes an additional task of mental health professionals to provide education around appropriate mental health definitions to ensure correct public usage and application (Haslam & Tse, 2024).

The rise of the digital ecosystem (Bowden et al., 2020) has further driven societal awareness of mental health, increasing demand for services not only in Aotearoa New Zealand but also globally. While there are a number of digital support tools, such as online

counselling or mental health help lines, the demand for these services far exceeds the current resources and capacity.

In more recent years, the rise of the COVID-19 pandemic, which indiscriminately plagued the world with experiences of illness, loss, loneliness, and isolation saw an increase in the prevalence of mental distress and placed unprecedented demand on mental health services (Bowden et al., 2020). The repercussion of the global lockdown is predicted to have far reaching consequences for mental health for the foreseeable future (Eapen et al., 2023).

### **Funding of Mental Health Services in Aotearoa New Zealand**

Aotearoa New Zealand is one of a handful of countries that can boast offering publicly funded mental health services, which is inherently beneficial (Stanton et al., 2017), however, financial constraints of this funding puts limitations on the number of individuals who can receive these benefits. The Government inquiry He Ara Oranga (Paterson et al., 2018) into Mental Health and Addiction made a number of recommendations including the expansion of accessibility of publicly funded services. In response, Government budgets have dedicated increasing funds to mental health and addiction services, 2024's budget has earmarked a huge \$2.6 billion for mental health and addiction services (Victoria University of Wellington, 2024), however, even this vast quantity does not meet the current need. The Government wants services that can demonstrate both quality and cost effectiveness (Eggleston & Watkins, 2008), which in such a diverse landscape of mental health concerns, can be hard to quantify. Distribution of funding and availability of services is also not equal throughout Aotearoa New Zealand (Office of the Auditor-General, 2024) and under the current conditions of high demand, it is becoming increasingly more challenging to provide equitable supports and services across the country (Bowden et al., 2020). Population sizes, access to health facilities and staffing are all logistical factors that must also be considered alongside funding.

## **Chapter Two: Child and Adolescent Mental Health (CAMH)**

Child and Adolescent Mental Health is concerned with the mental wellbeing of individuals from the age of 1-19 years. The majority of mental health concerns for rangatahi are being reported during the adolescent years, between 15-19 years of age (Lumb, 2009). Child and Adolescent Mental Health is a unique field, as adolescent rangatahi are the midst of their developmental years and mental health concerns can manifest in very different ways when compared with adult mental health concerns.

### **Child and Adolescent Development**

The developments which occur within the child and adolescent years are exponential, not only do individuals develop physically, their bodies undergoing change through growth and maturation (puberty), but they also develop rapidly from physiological and cognitive standpoints (Nobilo, 2017). Throughout this period of time, rangatahi are rapidly learning not only new skills but also how to navigate through new socio-emotional environments. They are starting to experiment with emotional and behavioural responses, as they explore their own identities. Enormous cognitive development occurs throughout childhood and adolescence, the brain forming multiple new neural pathways (Nobilo, 2017).

As rangatahi shift through adolescence, their cognitive functioning develops significantly, further solidifying their personal identities whilst also starting to develop problem-solving skills and critical thinking, which will be required in adulthood. However, due to these rapid social, emotional, physiological and psychological changes, it is normal for adolescents to experience incidences of mental distress or moments of poor mental health (Nobilo, 2017). These rapid developments also account for the very reason that child and adolescent mental health must be viewed independently from adult mental health. Presentations typical in adolescence may be considered atypical when viewed through an adult mental health lens.

## **Child and Adolescent Mental Health Prevalence**

Mental health is at the forefront of global concern; however, societal awareness is generally in relation to adult mental health and does not account for the manifestation or prevalence of mental illness in rangatahi. Much of what is known about mental health, is garnered from research with adult participants (Thabrew et al., 2018). A survey by the World Health Organisation outlined that one fifth of the youth population experienced mild to moderate mental distress (Mariu et al., 2012), this rate is of obvious concern to the adult population, who not only care for these individuals but view them as the hope for the future. Given the exponential development of adolescence, it is no surprise that it is also the time when individuals are most vulnerable to stressors or adverse life events (Kutcher, 2015). Thus leaving them prone to the development of mental illness, with greatest vulnerability of this development during the years of late adolescence (Lumb, 2009).

The manifestation of mental illness around the globe is strongly linked to these adolescent years, with 75% of clinical mental illness (Eapen et al., 2023) establishing itself before the age of 24 years (Lopez-Carmen et al., 2019), 35% of mental illness emerging before 14 years of age and nearly half (48%) of all adult mental illness having some onset before 18 years of age (Ministry of Health, 2024b). According to the Youth 2000 survey, there has been a persistent and invasive increase of child and adolescent mental health concerns (Barnes, 2023), with an increase of the number of young people reportedly experiencing depressive symptoms (Theodore et al., 2022).

While traditional factors which have been relevant throughout history including health, economic poverty, and living environment (Tarren-Sweeney, 2018) have an impact on elevated rates of mental health among specific groups of children and adolescents. It is the evolutionary advancement of humans which could hold some blame in the increasingly alarming rates of poor mental health in rangatahi. Factors of modern living have undoubtedly influenced this increase, schools have shifted their wellbeing approach, with a strong focus

on mental health awareness and models such as positive psychology to enhance wellbeing (Allison et al., 2008). However, with awareness, one would also expect to see an increase of reported mental distress/illness.

The global pandemic also had a considerable influence on reported child and adolescent mental health concerns. The identity crisis of adolescence was further exacerbated by the lack of autonomy and social isolation of the COVID-19 lockdowns (Office of the Auditor-General, 2024), consequentially leading to higher reported rates of mental distress (Barnes, 2023). Compounding the impacts of post-covid and modern environments, the personal identities of some rangatahi are leading to them experiencing disproportionate levels of mental distress and mental illness. Rangatahi of indigenous or minority communities and those who have disabilities or identify as part of the LGBTQI+ community, often face discrimination (Ministry of Health, 2024a), leading to much higher levels of reported severe mental distress (Peiris-John et al., 2024).

### **Child and Adolescent Mental Health in Aotearoa New Zealand**

With the emergence of more youth focused reviews (Peiris-John et al., 2024), the pertinence of child and adolescent mental health is of growing concern globally. Aotearoa New Zealand's youth make up approximately 17% of the total population and the number one identified health need for rangatahi is mental health (Ministry of Health, 2024b). However, the mental health statistics, particularly for child and adolescents are alarming. Aotearoa New Zealand has one of the highest youth suicide rates in the Organisation for Economic Co-operation and Development (OECD), with the indigenous Māori population grossly overrepresented in these figures (Peiris-John et al., 2024). Underlying this confronting revelation are several pertinent observations of the state of Aotearoa New Zealand's child and adolescent mental health.

Nationally there has been an increase in experiences of mental distress from 8.0% in 2018/2019 to 13.0% in 2023/2024 (Ministry of Health, 2024a) and Māori populations are 50% more likely to experience mental distress when compared with non-Māori (Paterson et al., 2018). The 2023 Health and Independence Report (Ministry of Health, 2024c) highlights that reported incidences of anxiety and depression for the total population were increasing significantly from 25% in 2016/2017 to 34.8% in 2021-2023. Within this timeframe, Māori (45.2%), Pacific (81.8%) and disabled (59.4%) populations were experiencing anxiety and depression at disproportionate rates when compared with the rest of the population (Ministry of Health, 2024c). When drilling down further into Aotearoa New Zealand's mental health statistics, adolescent rangatahi are more likely to experience anxiety and depression when compared to any other age group (Paterson et al., 2018). Anxiety, depression and self-harm were all ranked within the top 10 reasons (Ministry of Health, 2024c) for health loss among rangatahi and the Youth19 survey (Peiris-John et al., 2024) identified an increase in prevalence of these factors along with suicidal ideation and attempts between 2012 and 2019.

Indigenous Māori, Pacific and Asian rangatahi populations all increased in reported experiences of depression (Peiris-John et al., 2024), and there was also a reported increase in suicide attempts for Māori and Pacific rangatahi populations (Fleming et al., 2024). The Youth19 survey also highlighted areas of disparity between rangatahi mental health experiences, especially rangatahi in the LGBTQI+ or disabled communities. LGBTQI+ rangatahi were twice as likely to have self-harmed (Paterson et al., 2018) and less than 60% of disabled rangatahi reported to having good wellbeing (Peiris-John et al., 2024). Within the LGBTQI+ community, rangatahi who identified as not cis-gendered reported rates of depression and self-harm which were 30% higher than cis-gendered rangatahi. Individuals who did not identify as heterosexual also reported increased rates (Peiris-John et al., 2024) within these areas of mental health.

While these alarming child and adolescent mental health statistics do not encompass all of the struggles or mental illnesses experienced by Aotearoa New Zealand's rangatahi (Theodore et al., 2022), they do provide a snapshot of what could be contributing to our dismal youth suicide rates. For example, rising levels self-harm which can be seen as an outwards expression of poor mental health, is often used as a maladaptive coping mechanism. However, self-harm can have far reaching and unintended consequences for young people, both in the short and long-term (Thabrew et al., 2018), the impulsivity of adolescent decision making (Nobilo, 2017), may also link this coping mechanism to the poor suicide statistics in Aotearoa New Zealand.

### **Difficulty Accessing Appropriate Services**

The reportedly increasing rates of poor mental health among child and adolescent populations globally is only just scratching the surface of the state of mental health for young people. The state of concern ultimately spreading far beyond what is currently reported by media and found in research. Most mental health concerns of children and adolescents go unreported, as they are not officially acknowledged by those around them or wrongly attributed to 'normal' developmental ages and stages (Clark et al., 2014). Due to the widespread invisibility of child and adolescent mental health, these concerns largely go undiagnosed (Barnes, 2023) or untreated, as individuals do not receive access to the support that could be beneficial to their needs (Merry et al., 2020).

Rangatahi, especially those in their adolescence, are complex and require health services which are specifically attuned to their unique and individual needs. Adult services, while robust and well-suited to the developed adult brain, often do not possess the skill sets or expertise to deal with the psychopathologies which are linked with the aged-related mental health concerns of children and adolescents (Park et al., 2011). It is, therefore, imperative that services are set up to specifically support the mental health of children and adolescents.

Importantly there are a number of these services around Aotearoa New Zealand, allowing a number of rangatahi to access support on a regular basis. However, to be successful these services must take into consideration a number of barriers which may hinder access or prevent successful support of these rangatahi. Barriers to accessing services include but are not limited to:

- Cultural differences. When viewed through a different cultural lens things such as hearing voices may be considered a gift from ancestors, possessing Wairua (Kahu, Roimata, & Graham, 2016), whereas when viewed through a Western culture lens, hearing voices is considered unwell or crazy.
- Geographical location. Individuals may live in an isolated area of Aotearoa New Zealand and simply can't access support services (Te Maro et al., 2019), or they are located in an area which lacks the specialist services they may require. There are even some areas in Aotearoa New Zealand who have General Practices running without resident General Practitioners, maintaining a reliance on locums when they are available (The Royal New Zealand College of General Practitioners, 2024).
- Stigma. Many individuals struggle to ask for help and adolescent rangatahi are no exception to this. Worries of judgement may prevent individuals from reaching out and accessing the support that they need (Garisch et al., 2020).

Mental health services in Aotearoa New Zealand need to consider among other things, geographical location, cultural background, gender (Eapen et al., 2023), socio-economic status, and living environment (Tarren-Sweeney, 2018), as all of these factors will have an impact on the success of service access and delivery, and ultimately the wellbeing of a number of young people (Clark et al., 2014).

### **Chapter Three: Child and Adolescent Mental Health Services (CAMHS)**

#### **CAMHS**

The Aotearoa New Zealand health system currently provides funding for a number of services to support the health of rangatahi, these include school-based services (for qualifying schools) such as school counsellors and nurses, external general health services like youth one stop shops (YOSS) and specialist mental health services for rangatahi (Ministry of Health, 2024b). Child and Adolescent Mental Health Services (CAMHS) are, as the name implies, mental health services which are set up solely for the support of children and adolescents with mental health concerns. These services have specificity of design so that they should cater to the age-related concerns of children and adolescents in need of this mental health support (Park et al., 2011). CAMHS emerged in the 1990s (Brunton, 2011) and has grown to include a multidisciplinary team of both clinical and non-clinical staff, including support workers, social workers, psychiatrist, psychologists, doctors and nurses (Ministry of Health, 2024c). These services are tasked by Health New Zealand Te Whatu Ora with delivering mental health support to approximately 3% of Aotearoa New Zealand's child and adolescent population, despite in reality only being able to currently cater to 1.5% of rangatahi (Paterson et al., 2018). These services are generally only accessible to those with moderate to severe mental health needs (Paterson et al., 2018).

While as a nation, Aotearoa New Zealand recognises the need for CAMHS, not all services are created equal, despite government regulation, different branches of Health New Zealand Te Whatu Ora (2024b) preside over different regions, offering slightly different models of service or systems of delivery (Wille & Nixon, 2008), due in large by staffing availability and disparities caused by regional funding (Office of the Auditor-General, 2024). While there are slight differences between the services throughout the country, there is little to no assessment of which of these models of service is the most effective (Paterson et al., 2018). What is undisputed, however, is that there is an increasing need for these services.

Everyday life influences, especially post-COVID-19, are dramatically impacting the mental health of Aotearoa New Zealand's young people, who are seeing a significant increase of psychosocial difficulties (Merry et al., 2020) which are linked with poor mental health outcomes.

Many young people who do experience poor mental health and wish to seek support, are unable to access an appropriate support service to meet their needs (Case et al., 2015). Limited funding and unclear referral criteria, coupled with youths' perceptions (Clark et al., 2014) of CAMHS, may explain why there is a significant difference between numbers accessing adult services versus those able to access CAMHS. CAMHS appears to be grossly underutilised when compared to equivalent adult mental health support services (Eggleston & Watkins, 2008). Given that the majority of mental illness manifests during adolescence (Lucassen et al., 2015), it is of grave concern that CAMHS is not being accessed more readily or regularly. According to the Youth19 survey only 17% of secondary school students are getting the mental health support they require, and one in five rangatahi reported to having not been able to access health care professionals in the last year when needed (Peiris-John et al., 2024). What is clear from these observations is that there appears to be significant barriers to accessing the CAMHS service. These barriers include:

### ***Gender***

Gender differences are important considerations when analysing those who access CAMHS. While males are more likely to conceal their emotions or struggles, perhaps to conform to societal gender stereotyping (Henshaw, 2024); females are much more likely to express their emotions or access support for their mental distress, twice the number of females accessing CAMHS when compared with males of the same age (Raeburn et al., 2015). Social learning theory posits that individuals learn through observation and imitation (Dodgers et al., 2023). In a society such as Aotearoa New Zealand, much like the rest of the

world, men are portrayed as ‘strong’ and practical individuals who do not readily or outwardly express their emotions or share these with others. If male rangatahi are modelling their own behavioural responses on these observed stereotypes, then this would account for the findings of the Youth 19 survey. Male rangatahi expressed that they chose not to seek support for the following reasons: they had a “handle it myself” mentality (45.9%) or were too “embarrassed” (40.6%) to do so (Peiris-John et al., 2024).

### ***Cultural Considerations***

Mental Health concerns are viewed in different lights by different cultures, some viewing these struggles as ‘shameful’ (Park et al., 2022) and others viewing these as part of a larger spiritual experience. Effective treatment of mental health via services such as CAMHS must, therefore, be culturally responsive to each individual. Māori, Pacific and Asian populations are much younger when compared to other ethnicities, 17.4%, 17.9% and 8.8% of their populations falling within the youth category respectively. It is, therefore, essential that CAMHS are considerate of cultural differences which may act as barriers toward these populations accessing these age-appropriate services.

In Aotearoa New Zealand, Māori are grossly overrepresented in nearly all negative statistics, and it is, therefore, imperative that our health services, including CAMHS be accommodating of the Māori world view (Kahu, Roimata, & Graham, 2016). However, what is evident from the literature, despite overrepresentation, the Māori population has significantly less access to these vital services (Theodore et al., 2022). Approximately 30% of Māori are living with undiagnosed mental illness (Paterson et al., 2018) and 9.4% of Māori report that their mental health needs are not being met (Ministry of Health, 2024c). Rangatahi Māori are Tangata Whenua (Paterson et al., 2018) and should be treated as such in accordance with Te Tiriti o Waitangi (1840), however, Western practices in the clinical settings of CAMHS may be further perpetuating generational effects of colonisation,

presenting a significant barrier to access (Fleming et al., 2024). A number of other factors including socioeconomic status, living environment and food security (Paterson et al., 2018) could also be compounding the mental health of rangatahi Māori. However, it is safe to assume that a lack of cultural competency within CAMHS could be a significant factor leading to the decrease of Māori access.

Pacific rangatahi, have unique cultural backgrounds which may present challenges when trying to access culturally appropriate CAMHS. Pacific people tend to take a collectivist approach to issues such as mental health and this relational approach (Gossage et al., 2022) often time does not align itself with the individualistic nature of CAMHS settings (Paterson et al., 2018). Pacific rangatahi are more likely to have strong religious beliefs and strong familial relationships (Gossage et al., 2022) and may choose to rely upon their close support networks, particularly if a culturally appropriate service does not appear to be readily available.

Asian rangatahi also often hold beliefs outside of a Western worldview and may find the CAMHS setting does not align with their cultural needs. Confounding this barrier to access is the commonly held belief that to struggle with one's mental health is 'shameful' (Park et al., 2022). Stigmatisation of mental health and the fear of bringing one's family into disrepute may stop Asian rangatahi accessing mental health support at all (Park et al., 2022).

### ***LGBTQI+ and Disability Considerations***

Rangatahi who are members of either the LGBTQI+ or disability communities find it difficult to access CAMHS which meet their needs. Already facing a level of societal discrimination (Bauer et al., 2021), these rangatahi have expressed that there is a lack of CAMHS with appropriate expertise or resources to meet their needs (Paterson et al., 2018). LGBTQI+ and disabled rangatahi experience both poorer mental health and more unmet health needs (Ministry of Health, 2024a) and, therefore, the barrier of accessing mental health

support needs to be significantly reduced (Paterson et al., 2018) where possible, and this can only be done if CAMHS are appropriately staffed and resourced.

### ***Wait times/Availability***

Like all health care services, CAMHS is plagued with unprecedented demand and, therefore, significantly increased wait times. This coupled with staffing shortages makes accessing CAMHS for many individuals an insurmountable barrier (Allison et al., 2008). Despite CAMHS delivering an invaluable service, children and adolescence are waiting far too long to receive specialist treatments (Henshaw, 2024). Health New Zealand Te Whatu Ora (2024a), has generated a wait time guideline formula which is to be used to estimate the total wait time for individuals seeking mental health support. This, however, results in generic wait time estimates of either ‘less than three weeks’ or ‘more than three weeks’ and is not indicative of actual wait time (Health New Zealand Te Whatu Ora, 2024a). In reality wait times for CAMHS appointments are an average of 23 days (Office of the Auditor-General, 2024), with a range from 4 days to 41 days depending on both the region of the service and the severity of the mental health need. In 2023, 63% of CAMHS referrals were seen within three weeks, while 85% were seen within eight weeks (Office of the Auditor-General, 2024). These wait time statistics are further compounded by the average wait time for the third appointment, often referred to as the treatment appointment, which can be upward of 64 days (Office of the Auditor-General, 2024). These extensive wait times for CAMHS appointments could lead to an exacerbation of the mental health concerns of rangatahi or could act as the confirmation bias required for many to stop trusting CAMHS, giving up on seeking support altogether (Auger et al., 2018).

### ***Whakawhanaungatanga (Relationships)***

“He aha te mea nui? Māku e kii atu, he tāngata, he tāngata, he tāngata”

*"What is the most important thing in the world? It is people, it is people, it is people". – Meri Ngāroto (Morrison, 2023)*

A significant barrier to accessing CAMHS by young people is their lack of trust in those specialists who are delivering the services (Manthei, Tuck, Agee, et al., 2020).

Whakawhanaungatanga (Bishop & Berryman, 2010) is the forming of relationships through collective experiences and shared understandings. It is imperative, particularly for adolescents who are navigating through the treacherous waters of forming connections and building their own identities, that services such as CAMHS foster a sense of whanaungatanga (Bishop & Berryman, 2010) within their interactions. Positive relationships are the key to success (Kutcher, 2015) in many different life-scenarios and are of particular importance when considering vulnerable topics in relation to an individual's mental health (Allison et al., 2008). Rangatahi may develop mistrust and concerns around confidentiality, when they do not feel as if they have a good working relationship with the service's clinician, choosing instead to rely upon their familiar but perhaps ill-equipped established support networks (Auger et al., 2018).

Unfortunately, there is a lack of information on what should be considered the 'gold standard' of care for child and adolescent mental health concerns (Eggleston & Watkins, 2008), therefore, clinicians are doing their best to deliver services that are fit for purpose. Balancing internal pressures, alongside the external pressures of society, and the expectations of those to which their services are critical.

### **Pressures Experienced within Child and Adolescent Mental Health Services**

Pressures exist within many of the government funded services of Aotearoa New Zealand. CAHMS is no exception to this. From the outside looking in, it can be very easy to

point the finger at health care services which are not fit for purpose. However, it is important to consider the internal balancing act services such as CAMHS face, continuing to function despite encountering a number of pressures, some easier to contend with than others.

### ***Increased Demand and Time Pressures***

As previously stated, there is a growing demand for CAMHS (Evans et al., 2019), as the number of individuals seeking support is increasing rapidly. This increase could be attributed to a much larger awareness of mental health and there is growing societal pressure for services to 'fix' the mental health problem (Fortune & Clarkson, 2006). CAMHS around the world are facing staffing shortages (Lambie & Stewart, 2010), as the world population size has increased, services have not been able to recruit or retain the specialised staff (Sharpe et al., 2016) required to meet this growing need (Ball et al., 2022). Having staffing numbers which do not meet population size has a direct impact on the time available for support services to be provided (Every-Palmer et al., 2022), further limiting the capacity of the service and the number of individuals it can support (Lumb, 2009).

While staffing varies between regions due to both geographical isolation and population density it is evident that staffing of CAMHS is not equivalent to the needs of the population, in 2019 it was estimated that CAMHS were 400 Full Time Equivalent (FTE) staff short to meet the required ratios for the population (Faculty of Child and Adolescent Psychiatry, 2019). Aotearoa New Zealand recommends that there should be 2 FTE psychiatrists for every 100,000 rangatahi, however, there is currently only 1 FTE psychiatrists per 100,000 rangatahi, falling significantly short of recommended ratios (Faculty of Child and Adolescent Psychiatry, 2019). Government mandated administrative tasks are also having a considerable impact on CAMHS staff's time, Routine Outcome Measures (ROMS) (Barry, 2011) and other requirements such as general administrative

paperwork are slowly eroding clinical contact time and distorting services away from treatment (Lambie & Stewart, 2010).

### ***Training and Cultural Competencies***

To become a specialist within the CAMHS environment requires a significant sacrifice, those professionals who pursue this challenging but rewarding career invest considerable time, money and dedication to become qualified. However, after leaving the tertiary environment and entering the workforce, first time clinicians are often struck with the enormity of the ‘step-up’ that real practice entails (Levinson et al., 2021). While universities do their best to equip students for the real-world, the realities of navigating real-world clinical challenges, often requires them to further improve their clinical practice (Fortune & Clarkson, 2006) to best meet the needs of the young people in their care. Newly qualified clinicians will encounter a diverse range of rangatahi, and they must be ready and willing to upskill to meet their needs. This is of particular importance when considering rangatahi who have disabilities or those who identify as part of the LGBTQI+ community. These often-marginalised groups (Fleming et al., 2024) must feel that their mental health needs are being met and that the services offered (Paterson et al., 2018) to them are delivered by clinicians who either have experience of their worldviews or the competency to suitably relate to their realities (Peiris-John et al., 2024).

Cultural competency is also an area of pressure, especially for newly qualified CAMHS clinicians. As Māori and Pacific populations are overrepresented in (Park et al., 2011) health services such as CAMHS, it is essential that practitioners align themselves in a culturally responsive way, as to best meet the needs of their diverse client base. CAMHS must meet the need of rangatahi Māori (McClintock, Tauroa, & Mellsop, 2016), however, this may be a work in progress for some clinicians, requiring them to consider a worldview outside of their own. While a culturally responsive practice, which honours the partnership

outlined in Te Tiriti o Waitangi (1840), and meets the needs of Māori, is crucial (McClintock et al., 2012). It is also essential that a balance between clinical competency and cultural competency is struck, so that clinicians deliver services which are founded on evidence of best practice (Lavery, 2002). The model of Te Whare Tapa Whā outlined briefly in the introduction, is a culturally responsive approach which many health services including CAMHS base their model of clinical practice on. This is promising in two-fold, firstly because rangatahi of any culture or ethnicity will have experienced this model of health during their time at school, as it is one of the principles underpinning the Health and Physical Education Curriculum (Ministry of Education, 2024a), giving them a unique familiarity and perhaps helping to strengthen relationships. Secondly, indigenous studies, such as those first pioneered by Russel Bishop and Mere Berryman (2010) outline that educational designs which work for rangatahi Māori, will also work for rangatahi of other cultural backgrounds such as Pākehā or Pacific. This could likely also be the case for Te Whare Tapa Whā as a model of mental health practice.

### ***Funding and Access***

CAMHS around the world provide vital support to young people experiencing mental health concerns, however, internationally these services are severely underdeveloped (McClintock, Tauroa, & Mellsop, 2016). Small amounts of Government funding, which is often over promised and underdelivered (Every-Palmer et al., 2022), mean that CAMHS are constantly needing to triage and prioritise, so that these limited resources can reach those who are in most critical need (Lambie & Stewart, 2010). This unfortunately equates to a very small percentage of individuals, in no way representative of the number of children and adolescents who seek support (Sharpe et al., 2016). In 2023, the Government spent \$20 billion (Office of the Auditor-General, 2024) on the treatment of mental illness, so they are invested in trying to prevent this level of expenditure in years to come by investing in

preventative measures. However, their investment in CAMHS to date does not match the growth within the population size of rangatahi accessing CAMHS, which has increased by 30%, whilst funding has only increased by 24% (Office of the Auditor-General, 2024). Increased demand and inadequate funding often limits CAMHS to the ambulance at the bottom of the cliff approach, despite being proven that early treatment (even in individuals with mental health needs under the severity threshold for CAMHS) may serve as preventative in the long term (Raeburn et al., 2015). Which in turn would alleviate pressure on adult mental health services in the future.

Aotearoa New Zealand is geographically sparse, and alongside the pressures of limited funding, CAMHS are also under pressure due to capacity of certain geographical locations (Park et al., 2011). Some CAMHS have large populations to contend with on limited resourcing, while other young people may struggle to access appropriate support based on a lack of CAMHS in their area of residence (Ministry of Health, 2024c). Compounding geographical and resourcing pressures of CAMHS within Aotearoa New Zealand is the transient nature of some young people, who may lose touch with their CAMHS provider, moving out of the area with their families. If this drop out occurs part way through a programme of support it can be considered a waste of resources invested, CAMHS and clinicians experiencing a lack of return on their investment, of both time and money (Johnson et al., 2009). Although it would not be a 'silver-bullet', it is evident that greater government investment (McCann & Lubman, 2012) is required to eliminate the funding and resourcing pressures that CAMHS face.

The pressures faced by CAMHS are varied and challenging, however, they are not insurmountable, and the input of others in the support of children's and adolescents' mental health journeys is essential for effective service delivery in its current state.

## **Input into Child and Adolescent Mental Health Services**

### ***Support Network***

CAMHS is a vital support to many young people who are struggling with their mental health, however, rangatahi do not exist as a solitary construct and are part of a wider network of individuals. Mental health concerns do not just affect the individual seeking support, but will also have a wider reaching impact on those around them (Lumb, 2009). What a clinician sees in CAMHS may just be a very small sliver of a much wider picture. Whānau, friends, schools, and the wider community are uniquely positioned to provide further insight into behaviours, environmental factors, life stressors, or risk factors which may be contributing to the young person's distress. To ensure that CAMHS best meets the needs of rangatahi, community voice and cooperation is important. Communities have the ability to provide services and programmes that benefit rangatahi and an open dialogue could ensure that these programmes are also going to support the work which CAMHS is doing (Lopez-Carmen et al., 2019). For example, the community may be looking to offer a programme which meets the emotional needs of young people. This could be viewed as a preventative measure and collaboration with experts at CAMHS may ensure that these community leaders have the skills to deliver these low-end programmes but also have the appropriate knowledge to act when a young person needs the support of CAMHS.

Whānau are key stakeholders in young people's lives, they are often viewed as their safety nets, they have high trust of them and will often confide more openly with them than they would with a 'stranger' in a clinical setting. As immediate whānau have a greater knowledge and understanding of their young people and their environment, they are well positioned to be able to inform clinicians on what interventions could realistically and effectively be implemented outside of the clinical environment (Mares & Jureidini, 2004). There are, however, concerns of efficacy around immediate whānau as adequate supports for rangatahi. Both rangatahi Māori and Pacific experienced improved mental health when their

immediate whānau were included in the CAMHS process. This was provided that the relationship with their whānau was one of positivity and support (Fleming et al., 2024). It could, however, have the opposite effect, resulting in a decline in mental health, especially if the relationship was perceived as negative (Fleming et al., 2024). Pacific rangatahi's depression symptom severity was strongly correlated with their relationship with their mothers (Gossage et al., 2022), once again acting to either support or hinder the CAMHS process. Wider whānau for rangatahi include friends, who at this age of development are of significant importance, their opinions often mattering more than that of immediate family. This support is of particular importance to rangatahi in the LGBTQI+ community (Bauer et al., 2021). However, a lack of wider whānau support is associated as a risk factor for further poor mental health, particularly within this group of rangatahi, who often do not have the same familial supports as cis-gendered and heteronormative counterparts (Bauer et al., 2021). Whānau support is variable in nature and whilst has been beneficial as a support of the CAMHS process, it can also be a hinderance, especially if the whānau support is weak or distrusting of mental health services.

Another key area where young people receive support is from their schools. Schools are increasingly focusing on mental health awareness and implementing programmes which aim to maintain positive wellbeing. They are places where rangatahi build wide whānau connections and develop their understanding of appropriate social, emotional and behavioural responses. Schools foster a sense of belonging which have a direct positive impact on the wellbeing of rangatahi (Key, 2023).

Teachers, counsellors, and other key staff interact with these young people on a day to day basis and have the opportunity to play an important role in supporting young people who are struggling with their mental health (Lopez-Carmen et al., 2019). Due to the perceived stigma associated with mental health (Mitchell-Lowe & Eggleston, 2009), young people,

especially adolescents, struggle to ask for help and will often rely on teachers or school counsellors to notice and approach them about an issue, giving them the opportunity to open up and ‘save face’. Positive teacher relationships alone have been proven to act as protective factors against poor mental health (Key, 2023). If CAMHS invites open dialogue and a collaborative partnership with schools, this can serve to ensure that young people receive the support they need in a timely manner. This will also allow schools to respond appropriately and with confidence when dealing with mental health and promoting ways of improving wellbeing (Smith et al., 2018).

### ***Cultural Lens***

Culturally responsive practice is essential within any Aotearoa New Zealand service setting, as authentic treaty partners, clinicians must strive to ensure the supports they provide are aligned with the principles laid out in Te Tiriti o Waitangi (1840), encompassing the tikanga most appropriate to meet the needs of the indigenous Māori population (Bishop & Berryman, 2010). By adopting a culturally responsive practice, mental health services such as CAMHS can ensure that they are endeavouring to minimise the perpetuation of generational trauma of colonisation of Aotearoa New Zealand’s indigenous people (Paterson et al., 2018). For many clinicians honouring Te Tiriti is not just a goal to be aspired to but a legal and ethical requirement of their profession. Te Tiriti o Waitangi is outlined in the Rules of the New Zealand Psychological Society, the Code of Ethics and the New Zealand Psychologists Board’s Core Competencies (Levy & Waitoki, 2016).

While already broached in the previous section, CAMHS in Aotearoa New Zealand cannot be successfully implemented without acknowledging the bicultural setting in which these services exist. The ethos of Te Tiriti o Waitangi embodies participation and partnership (Lumb, 2009). It is, therefore, imperative that the voices of the indigenous people of Aotearoa New Zealand have input into the development and implementation of CAMHS. There are

several models of service internationally which have a good amount of research behind them, however, it is important to acknowledge that these models may not transfer directly to the Aotearoa New Zealand context and input to modify them to best suit the needs of those in the service is essential (Newman & Birleson, 2012).

Inclusion of the indigenous Māori worldview (Lopez-Carmen et al., 2019), ensures that services meet the needs of the overrepresented Māori rangatahi accessing CAMHS. The Te Tomo Mai Survey (2016) strongly indicated that input from all key stakeholders was essential for an appropriate CAMHS service. Specifically outlining the need of these services to include the voice of Māori (Kahu, Roimata, Graham, et al., 2016), ensuring that culturally responsive practices were prioritised to meet the needs of Māori rangatahi. Input from indigenous people should always be a priority for CAMHS, as many clinicians working in this space may not have a firsthand experience of Māori culture and may indeed see the world through a different cultural lens. Therefore, having external input into their practices ensures that cultural differences are always accounted for and carefully considered (McClintock, Tauroa, Mellsop, et al., 2016).

### ***Autonomy***

During development, adolescents start to seek further independence, relishing the ability to make decisions for themselves, standing on the threshold of adulthood. However, when it comes to mental health support, they often struggle to have their voices heard. Decisions are made for them, restricted by service legislation and rules which are determined by a small group of people, excluding the expertise of what it is to actually be those young people (The Werry Centre, 2010). Autonomy could be considered a basic human right, however, adolescents, especially those who are yet to reach the age of consent, struggle to have their voices heard. For services such as CAMHS to be effective and responsive to the young people accessing them, they must place rangatahi at the centre of their concern

(Paterson et al., 2018) and consider the voice and choice of young people (Mitchell-Lowe & Eggleston, 2009). As young people develop greater awareness of mental health, they are requesting more options for treatment (Stasiak et al., 2013) and CAMHS should be positioned in a way that it can respond dynamically to this need (Office of the Auditor-General, 2024). This is not to say that CAMHS should be solely directed by the voice of youth, but it must be taken, with balance, into consideration. Youth perspective, while valuable may be overloaded, clouded by multiple environmental and internal factors (such as stigma or peer relationships) which may skew their view of what is best for them (Mitchell-Lowe & Eggleston, 2009). Ultimately CAMHS is a mental health service which by design should support the needs of Aotearoa New Zealand's young people, and it should be the goal to hear these 'voices of the future' and support them through their mental health journeys (Lumb, 2009).

### **Models of Service**

CAMHS around the world are not created equal, even in Aotearoa New Zealand different models of service exist between different practices (Paterson et al., 2018), and there is very little literature available to evaluate which model of service is most effective. What is well-known is that rangatahi are a diverse group and require different approaches to meet their mental health needs (Pine, 2021). Outlined below are a few different models of service delivery which have been piloted and, in some cases, seen widespread adoption and implementation by CAMHS practices.

#### ***The Choice and Partnership Approach (CAPA)***

The Choice and Partnership Approach piloted by CAMHS in Aotearoa New Zealand shows immense promise. Allowing for the voice and choice of young people and collaboration between multidisciplinary teams to construct a realistic and effective plan for young people struggling with their mental health. The set up of this model allows for quick

and efficient triaging of individuals, which should ultimately reduce wait time, increase autonomy and increase the number of people who can access the service (Naughton et al., 2018). Choice appointments at the start of this process have some supporting evidence to suggest that this first choice appointment/triaging process may lessen symptoms alone (Hansen et al., 2023). The Auditor General's report (2024) of youth mental health, highlighted that this model, while effective in minimising initial wait time may in turn increase the amount of time between the first appointment and actual subsequent treatment appointments (Office of the Auditor-General, 2024). Although this seems an ideal model, there is little research outlining if this approach has a direct impact on patient outcomes.

### ***Digital Health/ e-Health Models***

There are several e-health models which have been explored. This is promising as most young people are operating in a digital space and would feel confident in the use of these e-tools. This could allow for more individuals to be quickly triaged and pointed in the right direction, low level mental distress given a support plan which does not require the time or resources of CAMHS (Arps et al., 2018). As a generalisation most rangatahi have access to a smart device and the internet, and a digital model for supporting mental health could eliminate barriers and meet the demand of those who require a different approach, or do not meet the threshold for a face-to-face service (Pine, 2021). However, caution must be taken when considering e-health models of service, as socioeconomic and geographical isolation may factor into access of digital devices and services (young people may not have access to a mobile phone, computer or the internet. This digital divide may cause a further inequity in health services offered (Merry et al., 2020). Health professionals also caution that the e-health model should not replace face-to-face services (Pine, 2021) offered by organisations such as CAMHS. Many e-health models lack longitudinal studies to prove their efficacy when used alone (van Kessel et al., 2016). In a recent study of a digital tool for the treatment of

rangatahi, the tool was found useful, however, some of the text was too difficult for the individuals to understand and would require a further explanation by clinicians (Quayle et al., 2024). Of more concern, however, are the inability of digital tools to assess risk in the same way that a clinician may assess risk. In order for e-health tools to be successfully implemented in the CAMHS treatment programme, an initial in-person risk assessment should be made. Ensuring that rangatahi are 'safe' to use a digital tool, their mental distress mild enough to self-manage while waiting for further face to face treatment (van Kessel et al., 2016). e-Health models alone may run the risk of missing vital life-saving clues within a rangatahi's presentation, or they may simply minimise their symptoms 'digitally', some of which their body language may not have been able to hide from a clinician.

#### ***Participation in Partnership Models (PiP)***

Promisingly many CAMHS operate under a participation in partnership model (Lumb, 2009), requiring the added input from a range of individuals, including the young person, family, school and wider support network. This is imperative as the support network will be there in the 'real-world' context and will be able to support the implementation of any suggested plans by CAMHS. Utilising programmes such as School-link within this model of service improves communication between different parties, so that they can operate seamlessly in support of the mental health of young people (Maloney & Walter, 2005).

While it is unclear which model is the best, CAMHS providers are 'living and breathing' entities who should be looking to constantly improve. However, what is abundantly clear is that the process to refer young people to these services is not universal between practices and can be hard to navigate.

## **Chapter Four: Child and Adolescent Mental Health Service Referral Process**

The CAMHS referral process is not clear cut, many referrals are made each year and only a limited proportion of these referrals are accepted by CAMHS. The Ministry of Health identified that the population need of the CAMHS service had increased from 30% in 2015 to 36% in 2023 (Office of the Auditor-General, 2024) and increasing referrals (Paterson et al., 2018) are having an adverse impact on the number of referrals rejected, up from only 8% rejected in 2012/2013 to 14% in 2022/2023 (Office of the Auditor-General, 2024). It is, therefore, important to unpack factors which may be impacting the referral process.

### **Accessing CAMHS**

As introduced previously, CAMHS is an underutilised service, with only a very small percentage of young people with mental health concerns accessing this support (Lucassen et al., 2015). Access to these services appears to be regionally dependent, some services have limited capacity (Peiris-John et al., 2024), whilst some practices are required to service large areas of the country, therefore, also operating at a diminished capacity (Eggleston & Watkins, 2008). Referrals are often made by primary health care providers, including General Practitioners and school counsellors, as they are usually the first line of 'defence' when dealing with rangatahi mental health concerns. However, the referral process is not straightforward, some primary healthcare providers have express exasperation in trying to predict if a referral will be accepted (Newman et al., 2024).

### **Increasing Rates of Referral**

As mental health awareness among society becomes more prevalent, there has been a significant increase in the number of referrals that CAMHS are receiving (Paterson et al., 2018). This increase is problematic due to a shrinking workforce, therefore, a limited capacity to sift through and deal with additional referrals. The Ministry of Health reported that there was a notable increase of referrals to CAMHS between 2019-2020, particularly by the older adolescent population (Ministry of Health, 2020). This timeframe coincides with the

worldwide increase of referrals to CAMHS, which was undoubtedly influenced by the stressors of the global pandemic (Eapen et al., 2023). This increase in adolescent referrals both during and post the pandemic, put further strain on an already under pressure mental health service (Merry et al., 2020). This in turn meaning that only a small number of referrals can actually be attended to, which will typically be the more acute cases. Morphing CAMHS away from preventative care of those with early signs of mental distress, and into crisis management of those with severe mental illness (Every-Palmer et al., 2022). While CAMHS most certainly should provide attention to acute cases, it is important that balance is not lost, as prevention for those with early signs of mental illness will be far less time consuming, costly, or risky than if left to manifest into more serious concerns.

### **Referral Criteria**

It is obvious that unnecessary referrals are a waste of time, resources, and funding (Trynes, 1998), however, it remains unclear as to which criteria young people must meet in order for their referral to be accepted by CAMHS (Evans et al., 2019). When comparing the referral forms for just three different services here in Aotearoa New Zealand, found via a simple web search, it is abundantly clear that this process needs to be standardised (Trynes, 1998), providing a more uniform framework to which a referrer could adhere to (Allison et al., 2008), streamlining the referral process and cutting down on unnecessary referrals.

### ***Te Piki Oranga***

Te Piki Oranga is a wide-ranging Māori Health Service with responsibility for providing services to the top of the South Island. The referral form found on their website (Te Piki Oranga Māori Wellness Service, 2024), is aptly generic as it serves as a referral for all the different services they offer, not just CAMHS. There is one question with limited space asking why the individual is being referred to this service, one question about environmental safety (perhaps for home visits), and one question about other agency involvement. While it

can be appreciated that this form is for multiple services, from a CAMHS perspective it does not adequately cover the complexities of child and adolescent mental health concerns. There was limited information on their website to indicate which criteria would make an individual eligible for CAMHS.

### ***MICAMHAS***

MICAMHAS is the mental health service at Whanganui Hospital, servicing the Whanganui-Rangitīkei region. Its services cater to both mental health concerns and addiction and is available for mothers, infants, children and adolescents. The referral form is slightly more detailed than the previous from Te Piki Oranga, however, it does not give any set criteria that must be met to be accepted by the service (Health New Zealand Te Whatu Ora, 2024c). What was pleasing to see is that when asking about reason(s) for referral it listed examples that could be expected and information that would be useful in the referral process.

### ***CAFS***

CAFS provides mental health and addiction services to children and adolescents within the Midcentral region and is based out of Palmerston North Hospital. The referral form for CAFS (MidCentral Health, 2021) was by far the most extensive of the three forms explored. It requires a family history, gathering background information which could be influential on the young person. It asks if the referrer believes that the young person meets the criteria for a serious mental health disorder and gives some examples of justification of this. It also pleasingly asks for observational inputs of the young person's behaviours in the school or workplace environments. Of a similarly satisfactory nature, it asks the referrer to outline protective factors which will be important to utilise during the intervention / treatment process. The CAFS referral form also included a list of mental health concerns that it was able to provide service for. This is an ideal addition, as it will provide referrers with more reassurance that their referral is appropriate.

From this comparison what remains evident is a lack of consistency or transparency of referral criteria. This can make the referral process stressful, as referrers may not provide appropriate information or struggle to understand when a CAMHS referral is necessary (Newman et al., 2024). The brief questionnaires of the CAMHS referral are by no means thorough enough to truly navigate the complexities of mental health (Stasiak et al., 2013).

There is a worldwide disparity between mental health prevalence in young people and access to mental health services (Barnes, 2023) such as CAMHS, however, there is little evaluation of why referrals are rejected. There is reportedly a high rate of rejection of CAMHS referrals (Hansen et al., 2023), due to unnecessary or poorly written applications. However, there are no current measures evaluating why rejections occur and what happens to the young people who are not accepted into CAMHS (Stasiak et al., 2013). Factors within referrers' personal and/or professional lives may have undue influence on the decision to make a referral (Trynes, 1998).

### **Referrer Factors Influencing Decision to Refer**

Primary healthcare providers are feeling the same strain as those working in the CAMHS service. They are often overworked and under-resourced, lacking experience to deal with the complex nature of mental health (Clark et al., 2014). If a referrer is uncertain of the set criteria or the process is interpreted as too time consuming, they may choose not to refer, even if the mental health concern is beyond their scope of practice (Hansen et al., 2021). To avoid this, the referral process must be user-friendly, and clarity must be given to the requirements (Allison et al., 2008). If CAMHS is seen as accessible and helpful with clear communication it is more likely that appropriate referrals will be made, as the referrer will perceive the CAMHS staff as working alongside and supporting them with their concerns for the young people they are seeing (Allison et al., 2008). Stressors in the referrer's personal life (Trynes, 1998), such as adverse life events, coupled with work pressures can lead to quick

and unnecessary referrals (Hansen et al., 2023) as the referrer may believe they do not possess the capacity to handle the situation.

A large proportion of primary healthcare providers who would be making referrals to CAMHS are those in secondary schools working as counsellors. These individuals are often the first people that adolescents reach out to for support with their mental health. It is, therefore, important to explore their experiences working on the front lines, and how they perceive their working relationships with CAMHS and their evaluation CAMHS referral processes.

## **Chapter Five: School Counsellors on the Front Line**

### **Importance of School Counsellors**

The majority of secondary schools are in a privileged position of having at least one school counsellor on site who is able to help support adolescents who are struggling with mental health concerns. The prevalence and complexity of behavioural and emotional problems is continuously increasing (Allison et al., 2008) and teaching staff alone do not necessarily have the capacity or skills to deal with this. Studies have shown that schools who can provide on-site health services, such as school counselling were less likely to see increased levels of depression or suicide risk (Manthei, Tuck, Agee, et al., 2020). While many schools do have a counselling service, it is important to acknowledge that there is a disparity in availability and funding for these services between schools (Denny et al., 2019), some only being afforded enough funding to procure part time counselling services and others unable to employ an appropriate person based on their isolated geographical location. The Ministry of Education provides guidance counsellor funding to schools, however, there is little evidence as to whether the services provided are meeting the needs of rangatahi (Office of the Auditor-General, 2024).

Appropriately qualified school counsellors have been operating in Aotearoa New Zealand schools for well over 50 years (Manthei, Tuck, Crocket, et al., 2020). They are key members of the pastoral care team and are often responsible for implementing the wellbeing vision of the school (Wasson, 2014), however, their main role is advocating for the students who seek their support (Ferguson, 2012). School counsellors are afforded the opportunity to view the student through their unique lens. What may present in a classroom as defiant behaviour, when viewed more holistically (Ferguson, 2012) may actually be a way of managing anxiety and perfection paralysis. They have the sometimes-unenviable task of building connections and positive rapport with rangatahi, having to master the art of winning over adolescents quickly. This is of great importance as a positive connection is seen as one

of the primary protective factors which improves outcomes when rangatahi face mental distress (Crowe, 2006). School counsellors often have the task of highlighting to staff problem areas than may have remained invisible to them, whether that be with an individual student or systemic issues and school wide trends (Wasson, 2014). They are well equipped in highlighting these key issues and often employ a psychological approach which is both strengths based and from the field of positive psychology (Bright et al., 2022), the latter of which has become increasingly popular among Aotearoa New Zealand secondary schools.

While intervention work with individual students is often short lived, students accessing counselling for an average of five sessions (Manthei, Tuck, Crocket, et al., 2020); the scope and complexity of the school counselling role continues to evolve (Manthei, Tuck, Crocket, et al., 2020).

### **Factors and Issues Faced by School Counsellors**

As highlighted above, school counsellors are in a unique position and play a pivotal role as part of a school's pastoral care system to provide mental health support for rangatahi. However, the literature is sparse when analysing how this role impacts on the wellbeing of counsellors (Augustine, 2016). The passage below will explore the factors and issues which are impacting on school counsellors.

#### ***Stress***

Experiencing stress is a normal part of human life, it can be a healthy motivating factor. However, in roles with high demand where the consequence of the individual doing their job effectively has implications for the health and wellbeing of others, adds an additional layer of stress. Factors such as personal relationships and economic hardship (Crowe, 2006), which are faced by many can also further compound stress for school counsellors. School counsellors should be well versed in the signs of stress and their training should imply they have the necessary tools for coping with it. However, due to the increasing

demands of their work they are finding it harder to manage a work life balance (Evans & Payne, 2008) and are vulnerable to experiencing levels of stress which could be harmful (Hemi & Maor, 2023). Less work life balance and exposure to harmful levels of stress have reportedly led to some school counsellors struggling to prioritise their own wellbeing (Evans & Payne, 2008), focusing solely on the care of others and neglecting their own needs, very rarely taking the time to reflect upon themselves (Augustine, 2016).

### ***Workload***

As mentioned previously, many roles, particularly in mental health care are experiencing increasing levels of demand and increasing staffing shortages, which puts further pressure on staff workload. School counsellors are no exception to this, they are experiencing increasing demand for their services, and as their roles are diversifying to not only include one-on-one with rangatahi but also school wide initiatives (Bright et al., 2022), this demand intensifies further. School populations are generally increasing and the ratio of school counsellors to students in some schools is much higher (1:600 approximately) when compared to the recommended 1:400 ratio laid out by the New Zealand Association of Counsellors (NZAC) (Manthei, Tuck, Agee, et al., 2020). Despite the recommendations from both NZAC and the Post Primary Teachers' Association (PPTA) for the ratio of school counsellors to students to increase, little shift has occurred. This is of increasing concern as research has proven that a factor influencing better outcomes for rangatahi is improved school counselling (Manthei, Tuck, Agee, et al., 2020), and this can only occur if school counsellors' workloads are lessened, so they practicably have the time and resourcing to do so (Te Maro et al., 2019).

### ***Severity of Mental Health***

School counselling services in Aotearoa New Zealand are in the business of working with adolescent rangatahi. This is a challenging time developmentally (Bright et al., 2022) for adolescents, and school counsellors are tasked with providing them with the autonomy they

crave, whilst also advising and guiding (Ranui et al., 2018) them through an often difficult mental health journey. They are also responsible for providing a safe and supportive environment (Bright et al., 2022) in which counselling can occur, however, they are working in a non-clinical setting and have little influence on peers who may leave rangatahi feeling unsafe (Gossage et al., 2022), or well-intentioned staff giving the impression that confidentiality has been breached. Compounding an already challenging task, adolescent rangatahi are reporting to school counsellors not only more frequently but also with increased severity of mental health concerns (Te Maro et al., 2019). Psychological distress such as depression, anxiety and phobia are becoming more common place (Te Maro et al., 2019), and the severity of symptoms are increasing. School counsellors have found themselves responding to a lot more incidents of self-harm (Garisch et al., 2020) and do not necessarily believe they are well-equipped to deal with the severity and complexity of this issue (Bright et al., 2022). With self-harm they are not only dealing with the immediate confronting need of injury, which can elicit unhelpful reactions from other school staff, but they must also advocate for the rangatahi's mental health needs (Garisch et al., 2020), as society has the unhelpful tendency to stereotype self-harming as 'attention seeking'. Increasingly the role of school counsellor is being dominated by crisis work (Evans & Payne, 2008), leaving little time for more long-term therapeutic intervention or addressing mental health needs at a lower level. The increasing severity of mental health needs of rangatahi (Paterson et al., 2018) is having a direct impact on school counsellor wellbeing.

### ***Network***

School counsellors do not perform their jobs in isolation, they are part of a wider team (Bright et al., 2022) of health care workers who are tasked with providing support to Aotearoa New Zealand's rangatahi. However, the confidentiality of the role they play can lead to feelings of isolation. It can be challenging for school counsellors to ask for help, as

they are the ‘experts’ in mental health and must deal with the perceived stigma (Evans & Payne, 2008) of admitting when they are struggling. Every individual requires a support network, and this is no exception for school counsellors. Collegiality and connection are important for feeling good and functioning well (Te Maro et al., 2019). Having colleagues around them can also ensure that they are able to better manage issues they feel are outside of their scope of practice (Bright et al., 2022).

### **Influence of School Counsellors on CAMHS**

Aforementioned above, children and adolescents very rarely self-refer when they are struggling with a problem, choosing to rely predominantly on their established support networks. It is, therefore, the important role of school counsellors to bridge the gap between the young person and services such as CAMHS (Barnes, 2023). There are a myriad of barriers (both real and perceived) to accessing CAMHS and school counsellors have a key responsibility of organising and working through these logistical challenges to make CAMHS a possibility for some young people (McCann & Lubman, 2012). Not only do school counsellors bridge the access gap between students and CAMHS, but they are also tasked with keeping lines of communication open between CAMHS, students and their wider support networks, thus ensuring the best possible outcomes for these young people (Fortune & Clarkson, 2006). As primary care services such as those provided by school counsellors have a large influence on the mental health of young people (Garralda, 2001), the relationships they establish are also often key to the successful interventions put in place by CAMHS (Munford & Sanders, 2016).

### **Factors that Influence School Referral to CAMHS**

As the complexity and prevalence of mental health concerns among adolescents increases (Theodore et al., 2022), school counsellors’ capacities are not increasing proportionally. There is an increased need for specialist supports within schools, and

CAMHS is one avenue which can supply this support (Sharpe et al., 2016). Whilst school counsellors are generally highly skilled individuals, they may lack the expertise needed to deal with more high-end mental health concerns. School counsellors have expressed a general frustration at being ill-equipped to deal with more complex situations which may arise due to external environmental or familial factors, for example, dealing with the mental health complexities of an individual who has an incarcerated parent (Levkovich & Ne'emani, 2022). Although counselling is responsive to the needs of the individual, counselling sessions alone may not be sufficient when dealing with certain mental health concerns (Clark et al., 2014) and referring to CAMHS is the most logical course of action.

School counsellors refer to CAMHS when it is in the best interest of the young person and when they believe further specialised care is needed. Educational services such as school counsellors play key roles in referring to CAMHS (Hansen et al., 2021), and it is, therefore, important to explore their opinions on the CAMHS referral process. Gathering information on referrer satisfaction (Allison et al., 2008) allows for CAMHS to improve the quality of their services and strengthen their relationships with the support network of the young people that they work with (Boyce, 2015).

There is an overwhelming need for professional organisations such as CAMHS to support school counsellors (Harrison et al., 2022) and not only can evaluating the referral process provide feedback for CAMHS itself, but it can also outline for school counsellors the restrictions or criteria within services (Every-Palmer et al., 2022). Providing them with a greater understanding of the underlying capacity of CAMHS. It is also an opportunity to see potential areas of training for school counsellors which could be supported and strengthened by the input of CAMHS (Berger & Samuel, 2020).

## **Chapter Six: Aims & Hypotheses**

My interest as the researcher of investigating school counsellors' perceptions of the CAMHS referral process comes from 13 years of working as a teacher in the secondary school context, seeing first-hand the rise of mental health concerns within the adolescent population, and observing the tiresome work of school counsellors who consistently advocate for the holistic needs of the individual. At times, I have observed the frustration of school counsellors when trying to seek additional support for students. They have expressed concerns around the inconsistencies of the referral process and the communication and feedback they receive from CAMHS around this process. There is very little literature which explores the perspectives of school counsellors around the referral process to mental health services such as the Child and Adolescent Mental Health Services in Aotearoa New Zealand. Therefore, it is appropriate to gather their feedback to provide further insight to CAMHS throughout the country, in order to improve their services and potentially streamline some of the processes which are compounding staff workloads. Ultimately improving outcomes for young people accessing these services.

### **Aims:**

1. To gather information on the quantities of rangatahi accessing school counselling support and the proportion of those who are referred on to CAMHS, and the opinions of school counsellors as to if there is a sufficient rate of referral acceptance by CAMHS.
2. To find out school counsellors' confidence levels of their familiarity with the CAMHS referral processes and referral criteria.
3. To determine, in the opinions of school counsellors the current strengths and weaknesses of the CAMHS referral process.

4. Use the perceptions of school counsellors to understand the changes they believe would make the CAMHS referral process more user-friendly, and therefore, more beneficial to the adolescents of Aotearoa New Zealand.

**Hypotheses:**

1. The proportion of referrals made to CAMHS will be small in comparison to the total number of individuals accessing school counselling services. The proportion of referrals accepted by CAMHS will be minimal.
2. School counsellors will possess some confidence in the CAMHS referral process but will struggle to predict the outcome of these referrals.
3. School counsellors will be able to articulate multiple strengths and weaknesses within the CAMHS referral process and this may go on further to reflect their perceptions of the service overall.
4. School counsellors will provide considered insight into changes to the CAMHS referral process which would have the potential to benefit the rangatahi within their care.

## **Chapter Seven: Methodology**

When considering a methodological approach and studying the literature available in relation to this research topic, there was a distinct balance between quantitative approaches and qualitative approaches, this was for both data gathering and analyses. Upon weighing up options for this and wanting to gather the voice and opinion of the school counselling community the researcher chose to use a mixed methods research approach (Houchins et al., 2023). Embracing pragmatism (Lees & Locke, 2021) and incorporating aspects of both quantitative and qualitative data collection, and quantitative descriptive statistical analysis (Dhong, 2023) and qualitative reflexive thematic analysis (Braun & Clarke, 2006). The data collection was done via an online semi-structured survey questionnaire using Microsoft Forms™ from the Microsoft Office™ suite. This survey questionnaire was disseminated via email to an email group for Aotearoa New Zealand school counsellors. This communication process was kindly facilitated by the researcher's school counsellor colleague. Data from this questionnaire was collected over a two-week period in September 2023, however, the survey remained open for the remainder of 2023.

### **Pragmatism**

Based on the pioneering work of John Dewey, William James, Charles Sanders Peirce, and Richard Rorty; the philosophical paradigm of pragmatism (Bishop, 2015) is a solution focused way of viewing the world (Kaushik & Walsh, 2019). It is a socially just philosophy which looks for the best way to solve problems while also acknowledging that the world cannot be viewed through a singular scientific lens (Kaushik & Walsh, 2019). Worldviews create a person's reality and a combination of worldviews is required to have a shared meaning of the problem at hand, in order to promote joint action for positive change (Madill & Gough, 2008). It is promoted as being 'the best of both worlds,' combining aspects from the research paradigms of both positivists and constructionists. Positivists view problems through a 'bias free' lens, where universal truths are absolute, a person's values or

culture is independent from how they view a situation or research problem. Whereas, constructionists acknowledge problems exist within the cultural and societal frameworks of each individual, therefore, positing that the research problem and solutions are largely down to interpretations through worldview lenses (Bishop, 2015).

Pragmatists are always looking to adopt the method or methods which best serve the research problem at hand (Kaushik & Walsh, 2019) in order to generate a real-world practical and beneficial solution (Muir, 2023). Despite working as a Chemistry Teacher for a number of years, and therefore, having a grounding in absolute truths, it seems only logical to adopt a more pragmatic approach when considering the research project (Kaushik & Walsh, 2019) at hand. This research aims to gather opinions of school counsellors with the further aim of contributing to the improvement of the CAMHS referral process, thereby improving the outcomes for Aotearoa New Zealand's rangatahi. A research paradigm of pragmatism has been used in social research for a number of years (Kelle, 2017) and as this research project would like to make a positive change in the world, it seems only fitting to use pragmatism as the overarching paradigm of methodology.

Pragmatism also fits well when considering a mixed-methods design (Lipatov & Nesterova, 2024), the research questionnaire has been specifically designed to elicit both qualitative and quantitative response, which fits within the mixed methods design approach.

### **Mixed Methods Research**

Through a pragmatic paradigm, mixed methods research design seems to be the logical solution to examine the research problem through both a quantitative lens and qualitative lens. To gather data which in theory can be analysed to find statistical significance and also gather participant voice, interpreting this in a reflexive manner (Lipatov & Nesterova, 2024) to establish the most prevalent themes which are shared between the different lenses of the participants' worldviews. Using both the solid data and extracted

themes to produce suggested changes to the CAMHS referral process, which would benefit CAMHS staff, school counsellors, and rangatahi themselves. As a mixed methods research design will be better at addressing the intent of the research (Houchins et al., 2023) it is logical to suggest that this type of design will also produce more robust data (Lees & Locke, 2021), than quantitative or qualitative alone. In Lees and Locke's (2021) book on Mixed Method Research Design in Wellbeing and Health, Chapter 7 authors Gray, Manning, and Ofteadel-Moghadam (2021) advocated for using mixed methods research design when working in research about the wellbeing of young people. This design can allow for the full expression of different worldviews or perspectives (Gray et al., 2021). This approach to design also helps to eliminate some of the negative consequences of using a singular approach. If qualitative design is used alone, the research runs the risk of being coloured by the worldview of the researchers and their interpretations of the data, potentially heavily influenced by bias (Parker, 1994). Similarly, challenges can arise when only applying a quantitative design, especially when working with young people. Quantitative researchers must be conscious of how the presentation of this data or indeed the design of the research could further perpetuate negative or harmful stereotypes or ideologies about a group of people (D'Costa et al., 2024). Quantitative research design rarely allows for culture or special learning needs, which is pertinent to consider when working with rangatahi. Especially as rangatahi with mental health concerns often have comorbidity with a specific learning disorder (Lucassen et al., 2015).

The research questionnaire will be structured with both quantitative questions and open ended questions (Madill & Gough, 2008) which allow for qualitative responses. A questionnaire, such as the one proposed for this research project is a valid approach of data collection for mixed method design (Bishop, 2015), however, it is limited in the fact that if delivered on its own (as this research project intends), there is not the ability to follow up or

further question responses to gain a richer understanding, which a face-to-face mixed methods interview would allow for (Madill & Gough, 2008). The design of the questionnaire is aiming to reflect a triangulation concurrent design outlined by Creswell and Plano Clark (2007) in Bishop's (2015) examination of mixed method research. The responses to the qualitative questions will form the dominant method of analysis, while the statistical analysis of the quantitative questions will be used to triangulate the generalisability of this information (Bishop, 2015). The questionnaire is designed to be minimalistic, so that it is easy for the participants to interact with and respond to (Muir, 2023). Items 10, 12, 15-20 of the questionnaire are designed to be open-ended but are specifically worded to elicit opinion responses about certain aspects of the CAMHS referral process (Tracy, 2010). These responses will be qualitatively analysed using a reflexive thematic approach to elicit common overarching themes (Muir, 2023).

## **Quantitative Methodology**

### ***Data Collection***

Data will be collected via online survey. Items 1-8, 11, 13-14 will elicit quantifiable responses through structured close-ended questioning (Madill & Gough, 2008). Some questions are designed to produce discrete data (Kaur et al., 2018) with predetermined check boxes. For example, Yes or No or a rating scale of confidence level (Confident to No Confidence). Other questions will require a nominal response and elicit continuous data (Kaur et al., 2018), for example, the number of rangatahi the participants estimate to have seen in a year. This data will be primarily for demographic and comparative purposes. See the section on the unpacking of the questionnaire below for further specifics on each item.

### ***Analysis***

The collected quantitative data will be transcribed into the open source statistical software jamovi™, and statistical analyses will be run using the software (R Core Team, 2024; The jamovi project, 2024). The fundamental method (Dhong, 2023) of descriptive

statistical analysis has been chosen to analyse this data set. It is easily understood mathematically and is often used in a health context (Kaur et al., 2018) to not only demonstrate relationship patterns between data but make important decisions around policy and process (Kaur et al., 2018). Descriptive statistical analysis is a nice fit for this research project as it will give an overall holistic view of the data (Dhong, 2023) and can be easily combined with qualitative analyses to formulate conclusions related to the aims of the research.

Demographic questions, such as region of practice, gender of school, and type of school will be presented in frequency tables, and the percentages of responses will be compared. Nominal responses (number of counsellors, number of rangatahi per year, and number of referrals per year) will also be presented in frequency tables and further analysed with comparisons between categories and split by categories (for example, number of rangatahi per year and number of referrals per year, split by type of school). Rating scale items will also be analysed using frequency tables and percentage comparison. Statistical analysis of nominal responses will also include comparisons of means, standard deviation and normal distribution. Normal distributions and standard deviation analysis can be used to demonstrate dispersion from the mean or general distribution (Dhong, 2023), however, caution must be taken here, as a small sample size can diminish the reliability of statements about statistical significance. For this specific reason the Shapiro Wilks test for normal distribution has been chosen as it has been specifically designed to work with smaller sample sizes (Malato, 2023).

## **Qualitative Methodology**

### ***Data Collection***

Data for the qualitative methodology will also be collected via the online survey in the form of open ended questions (Madill & Gough, 2008), which should elicit qualitative opinion based responses from the participants. Participants are able to write as much or as

little as they choose, however, the question prompts should give them some direction for their answers. Items 10 and 15 require responses in justification of their choices for the preceding quantitative questions. All information for these responses will be stored as raw data (whole responses, Appendix A) before being further analysed.

### *Analysis*

Qualitative evaluation and analysis can raise concerns about validity (Kelle, 2017), as it requires the interpretation of responses by the researcher who views the world through their own unique lens, coloured by their culture, beliefs, values and environmental settings (Muir, 2023). Thematic analysis is a widely used qualitative analysis method with varying levels of success based on the rigor of the approach (Bott, 2010). It is a complex process involving making multiple choices and decisions as the analyst, while also being aware of the balance which must be struck between one's objectivity and subjectivity (Gough & Madill, 2012), minimising bias while still applying personal judgment to data (Braun & Clarke, 2006).

Thematic analysis will be used to evaluate the qualitative data, each question carefully considered and prominent themes identified, and meaning (Muir, 2023) will be extracted by the researcher. Themes will ideally be made up from responses found across participant data, but may also be included if judged to be pertinent to the intent of the research (Braun & Clarke, 2006). As subjectivity and objectivity (Parker, 1994) can come into question with this type of analysis, a reflexive thematic analysis approach (Braun & Clarke, 2023) will be adopted, whereby the text is initially studied to become familiar with, and themes will be identified and defined, and then specific evidence from the text will be used to qualify these themes and their meanings. Constant reflection during this process will be of particular importance to ensure biases held by the researcher (D'Costa et al., 2024) are not dominating the presentation of the results. As the researcher, I am hyperaware of how my experience working with rangatahi within the pastoral care space, and my own experience of working

alongside CAMHS may colour the lens by which I analyse the data, however, it is acknowledged that this makes me uniquely positioned to understand and interpret this data appropriately (Tracy, 2010). Below is a detailed description of how Braun and Clarke's (2006) suggested six-phase framework for thematic analysis was adopted in the analysis of this data:

### *6 Phases of Analysis*

**Phase 1 – Familiarity of data.** I will spend significant time reading and revisiting the data from the open-ended items of the survey. Initially trying to get a 'feel' for the overall trends of the data and making judgements on whether this was valid in terms of the research aims.

**Phase 2 – Generation of Initial Coding.** This was ultimately a significantly small set of data so the process of coding responses did not prove to be overly challenging, however, judgment was still required to ensure that responses were appropriately coded, being attributed to a code due to semantic analysis rather than latent coding (Braun & Clarke, 2006) based heavily on assumptions.

**Phase 3 – Searching for overarching Themes.** Due to the small size of the data set, themes were immediately apparent within responses. These themes were organised, representing each qualitative questionnaire item, however, common themes were recognised throughout the analysis, for example, 'time'. Researcher experiential judgment was utilised in the formation of themes, because ideally themes would be formulated from more than one response, however, some themes were deemed pertinent based on their 'keyness' (Braun & Clarke, 2006) to the research aims.

**Phase 4 – Reviewing the Themes.** This phase of the analysis was rather short-lived as the themes were particularly apparent within such a small sample size. A reflexive approach was required here to ensure that the themes were accurately representing the data.

**Phase 5 – Defining and Naming Themes.** Deciding on the names for themes was relatively easy as these names often occurred prominently in participant responses. However, a reflexive approach was once again employed to ensure that definitions of themes and the chosen text excerpts as evidence truly reflected the overarching theme.

**Phase 6 – Writing up information.** Themes and information derived from the reflexive thematic analysis and presented in results tables, was further analysed and appropriately linked to the aims of the research, the relevant descriptive statistical analyses, and supporting information from reviewed literature, to draw conclusions on the CAMHS referral process in Aotearoa New Zealand. This formed the basis of rich evidence for the discussion section (Tracy, 2010).

### **Reflexivity in Thematic Analysis**

Reflexivity is crucial within qualitative analysis of any kind, particularly within a paradigm of pragmatism. This is because often the feedback that is given and analysed will form the basis of decision-making, which will ultimately have an impact on others (Muir, 2023), in this case the school counsellors and rangatahi of Aotearoa New Zealand, and their experiences with the CAMHS referral process. Qualitative analysis is steeped in questions about validity (Kelle, 2017), despite being used by researchers for an extended period of time. Written text, as is the response method of the questionnaire, may prove hard to interpret (Parker, 1994) and the anonymous nature of the set up will make it impossible to gain clarity or a shared understanding (Madill & Gough, 2008) between the researcher and participants.

Adopting a reflexive approach during thematic analysis will serve to quell the questions of objectivity and subjectivity, however, it cannot eliminate the risk of bias completely (D'Costa et al., 2024). The reality is the researcher cannot remove themselves from their worldview. However, consistent reflection during analysis (Braun & Clarke, 2006) will ensure that their beliefs and values do not overwhelm their judgment (Muir, 2023) and

the meaning derived from established themes will be carefully weighted and relevant to the purpose of the research (Braun & Clarke, 2006).

### **Ethics**

As a study which examines the experiences of school counsellors referring young people to Child and Adolescent Mental Health Services, rather than examining the opinions of vulnerable young people themselves, and a survey design which allows the participants and their schools to remain anonymous, it was determined by peer review that the proposed research project posed low ethical risk. It was, therefore, approved without a full review by one of the University's Human Ethics Committees.

### **Consent**

An informed consent information sheet was provided outlining the intent and procedures of the research project (Appendix B). Choice for anonymity was provided, however, an email address needed to be supplied if participants were to go in the incentive prize draw. Consent for participation in this research project was initiated upon clicking the link to complete the online survey. Participants were provided with the email addresses of the researcher and other appropriate Massey University staff, so they could reach out with any concerns or questions they may have had. To encourage participation there was an incentive prize draw, those who gave their email address, were able to enter for the chance to win one of two \$50 New World Grocery Vouchers.

### **Participants**

Participants for this research project were fielded through online recruitment via an email, addressed to a school counsellors email group. The email also encouraged participants to forward this email on to other relevant parties who may not have been part of this group. A subsequent reminder email was sent out four weeks after the original invitation email.

Exclusion criteria for participants included: working as a school counsellor outside of Aotearoa New Zealand or not having experience in referring students to CAMHS. Secondary schools were targeted in the promotion of this research project as primary schools in general do not employ school counsellors on a regular basis. In this research study, a very small number of participants responded, six in total, so analysis of data must be done with care and there will be consequently limited generalisability.

### **Survey Questionnaire**

The online survey questionnaire (Appendix C) generated in Microsoft Forms™ for ease of use and accessibility, as it is a system already used in the researcher's daily life to administer satisfaction surveys for learning and pastoral care. The survey was comprised of twenty compulsory items. Eight items were multiple choice or nominal, while the remaining twelve items were posed as open-ended questions, where participants were invited to provide their justifications of multiple-choice selections and opinions on the CAMHS referral process in their own words. Participants were asked for general demographic information about themselves and their schools (non-identifiable information only); their main reasons for referral (e.g. self-harm, anxiety etc.); their understanding of the CAMHS referral process; what the strengths and weaknesses of the referral process are; their opinion of improvements to the process which would be beneficial to them as school counsellors and to the rangatahi who utilise their services. It was estimated that the survey questionnaire would take approximately 10 minutes to 20 minutes to complete.

Once completed and submitted the survey was automatically uploaded to the researcher. To safeguard against invalid data, if participants had no experience or knowledge of referring to CAMHS, they were sent to the end of the survey and were not required to provide their opinions on the strengths, weaknesses or offer improvements on the CAMHS referral process. Of note, anonymization was chosen to encourage participants to share

openly and frankly without concerns of repercussions. Similarly, as this was primarily opinion data and CAMHS providers were not approached for comment, non-identifying region options were available as to avoid singling out one specific service without the right of reply.

***Questionnaire Briefly Unpacked***

The intent of Table 1 below is to provide a summary of the type of items in the questionnaire and how they were analysed. Further expansion of the rationale of each question can be found in Appendix D. The following codes were adopted for ease of classification: D – discrete, C – continuous, DSA – descriptive statistical analysis, Q – qualitative, TA – thematic analysis.

**Table 1**  
Summary of Questionnaire, Data Type and Analysis Approach

Question	Response Data Type	Analysis
1. Please define your current role.	D	DSA
2. Which general region of Aotearoa New Zealand is your school in?	D	DSA
3. Please select the gender which your school caters for.	D	DSA
4. Please select your school's type.	D	DSA
5. How many school counsellors are employed by your school?	C	DSA
6. On average, per year, how many students utilise your school counselling services?	C	DSA
7. In your current role, do you have experience making referrals to your local CAMHS?	D	DSA
8. If 'yes' how confident is your knowledge of the referral process? / If 'no', do you have an understanding of what is required for a CAMHS referral?	Yes = D No = Q	Yes = DSA No = TA
9. Please elaborate on your choice for Question 8.	Q	TA
10. On average per year, how many CAMHS referrals do you make?	C	DSA
11. What are the most common reasons for your referral of students to CAMHS?	Q	TA
12. On average per year, how many of your referrals are accepted by CAMHS?	D	DSA
13. Do you think the referral criteria set by your locals CAMHS are easily understood?	D	DSA
14. Please elaborate on your choice for the previous question.	Q	TA
15. In your opinion, what are the strengths of the CAMHS referral process in your region?	Q	TA
16. In your opinion, what are the current limitations/weaknesses of the CAMHS referral process in your region?	Q	TA
17. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to you as a counsellor?	Q	TA
18. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to the students engaged in your counselling services?	Q	TA
19. Are there any other comments you would like to make about the CAMHS referral process?	Q	TA

## Chapter Eight: Results

A total of six participants chose to participate in this research project by responding to the online questionnaire. The survey questions took them an average of 15 minutes and 26 seconds to complete; this was converted from the Microsoft Forms™ raw average score of 926 seconds. Raw data from this survey can be found attached as Appendix A.

### Demographics

The information presented below in Tables 2- 5 is representative of the demographic data collected from participants during the questionnaire.

Table 2 represents the official title that participants define their role in school as. Fifty percent (n = 3) defined their role as a ‘school guidance counsellor’, 33.3% (n = 2) defined their roles as ‘school counsellor’, and 16.7% (n = 1) defined their role as ‘social worker’. While social worker was outside of the researcher’s intent of the research, from reading the participant’s answers, it can be assumed that within their role they act in the same capacity as what is expected of a school counsellor. Therefore, their data was included for the remainder of analysis.

**Table 2**  
Role of Participants in Research Project

Role	Counts	% of Total	Cumulative %
School Guidance Counsellor	3	50.0%	50.0%
School Counsellor	2	33.3%	83.3%
Social Worker	1	16.7%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

Table 3 represents the region in which the participants practice as school counsellors. Although offered options of ‘northern’, ‘central’, and ‘southern’, 100% (n = 6) of participants selected ‘central’. All participants are practising in schools located in the central region of Aotearoa New Zealand.

**Table 3**

## Region of practice

School Region	Counts	% of Total	Cumulative %
Central	6	100.0%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

Table 4 represents the gender catered to by the participants' schools. The majority (n = 5) of participants were working at a 'Co-educational' school, catering to both females and males, 16.7% (n = 1) of participants were working at a 'Single-sex Girls' school, catering only for females.

**Table 4**

## Gender of Students at School

Gender of School	Counts	% of Total	Cumulative %
Co-educational	5	83.3%	83.3%
Single-sex Girls	1	16.7%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

Table 5 represents the type of school the participants are employed at. Two thirds (n = 4) of participants were employed by 'state' schools, 16.7% (n = 1) of participants were employed by 'state-integrated' schools, and 16.7% (n = 1) of participants were employed by 'special character' schools.

**Table 5**

## School Type of Participants

School Type	Counts	% of Total	Cumulative %
State	4	66.7%	66.7%
State-Integrated	1	16.7%	83.3%
Special Character	1	16.7%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

## Participants' Opinions of Process

The information presented below in Tables 6-9 is representative of the participants' opinions of CAMHS in relation to their experiences referring, confidence referring, referrals accepted by CAMHS, and their understanding of the referral criteria set out by CAMHS.

Tables 6 and 7 represent the participants' experience referring rangatahi to CAMHS and their confidence level with doing so. All of the participants (n = 6) had experience in referring rangatahi to CAMHS and 100% (n = 6) stated they were 'somewhat confident' in the process of referral.

**Table 6**  
CAMHS Referral Experience of Participants

CAMHS Experience	Counts	% of Total	Cumulative %
Yes	6	100.0%	100.0%

**Table 7**  
Confidence Level of CAMHS Referral Process

Confidence Level	Counts	% of Total	Cumulative %
Somewhat Confident	6	100.0%	100.0%

Note: Data was collected by researcher and calculations and tables were produced using jamovi™ software (The jamovi project, 2024).

Table 8 represents the estimated acceptance rate of referrals by CAMHS. Fifty percent of participants (n = 3) estimated that a 'minimal' number of the referrals made to CAMHS were accepted. While 33.3% (n = 2) of participants estimated that a 'moderate' number of referrals were accepted, and 16.7% (n = 1) participants estimated that a maximal' number of referrals were accepted.

**Table 8**  
Observational Estimation of Referrals Accepted by CAMHS

Referrals Accepted	Counts	% of Total	Cumulative %
Minimal	3	50.0%	50.0%
Maximal	1	16.7%	66.7%
Moderate	2	33.3%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

Table 9 is representative of participants' understanding of the CAMHS criteria for the referral process. One participant selected 'Yes' indicating they understood the criteria by

which CAMHS referrals are made and accepted. While 16.7% (n =1) of participants selected ‘maybe’ indicating that they were unsure of the referral criteria, and 66.7% (n = 4) of participants selected ‘no’ indicating that they had little to no understanding of the CAMHS referral criteria.

**Table 9**  
Participants Understanding of CAMHS Referral Criteria

Clarity of Process	Counts	% of Total	Cumulative %
Maybe	1	16.7%	16.7%
No	4	66.7%	83.3%
Yes	1	16.7%	100.0%

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024).

### Numbers of Students per Year and Quantity Referred

The information in Table 10 below is representative of the number of school counsellors at the participants’ schools, the estimated number of students seen per year by participants, the estimated number of student referrals made to CAMHS by participants each year, and the percentage of their total number of students who were referred to CAMHS. Please see raw data set (Appendix A) for specific participant information.

The number of school counsellors operating at participant schools ranged between 1 – 2 school counsellors, with an average of 1.33 counsellors per school, the Shapiro-Wilk p value <0.05 (0.001) indicating that this data is not normally distributed, although sample size of this research makes the statistical significance of the p value uncertain.

The number of students estimated to have been seen by the participants each year ranged from a minimum of 70 students to a maximum of 150 students. With an average of 109 students seen each year, the Shapiro-Wilk p-value > 0.05 (0.922) indicating that the data is normally distributed.

The number of student referrals to CAMHS by participants ranged from a minimum of 5 student referrals to a maximum of 20 student referrals per year, the average number of

student referrals across the six participants was 10.8 students per year. The p-value  $> 0.05$  (0.483) indicating that this data falls within a normal distribution.

The final column of Table 10 indicates the percentage of students referred to CAMHS when student referrals were compared with the total number of students seen by participants in their school counselling roll. The minimum referral rate was 3.3%, and the maximum referral rate was 28.6%. The average rate of referral to CAMHS by participants was 11.5%.

**Table 10**  
Analysis of Counsellors Capacity in a Calendar Year

	Number of Counsellors	Students per Year	Referrals per Year	Percentage Referred
Mean	1.33	109	10.8	11.5
Median	1.00	110	10.0	9.58
Standard deviation	0.516	27.3	5.98	9.23
Minimum	1	70	5	3.33
Maximum	2	150	20	28.6
Shapiro-Wilk W	0.640	0.975	0.917	0.837
Shapiro-Wilk p	0.001	0.922	0.483	0.123

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024). Analysis was aided by additional software within jamovi™ (R Core Team, 2024).

### Mean Average of Students and Referrals

The information display in Table 11 below compares the mean average of students seen by school counsellors per year compared to the referral per year, split by school type. With reference to Table 5, the only data worth further analysis is that for ‘State’ schools, as four participants represent this data, whereas only one participant represents the data for ‘State-Integrated’ and ‘Special Character’ schools respectively. The mean average of students seen per year for the four state school participants per year was 109 students, and the mean average of students referred to CAMHS was 10.0 students per year.

**Table 11**

Mean Average of students seen per year vs. referrals per year split by school type

	School Type	Students per Year	Referrals per Year
Mean	State	109	10.0
	State-Integrated	70.0	20.0
	Special Character	150	5.00

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024). Analysis was aided by additional software within jamovi™ (R Core Team, 2024).

Table 12 provides a similar analysis of data as in Table 10, however, students seen per year and referrals made to CAMHS per year, is split by Gender of participants' schools. As with Table 11, there is only one category which requires further analysis. Five participants are working in a co-educational setting, whereas one is working in a single-sex girls' school. Therefore, it is only pertinent to further comment on the mean average for the co-educational setting. The mean average of estimated students seen by participants per year was 117 students. The spread of the data from the mean was relatively large ( $SD = 21.7$ ), however, due to small sample size statistical significance of this spread cannot be qualified. The mean average of students referred to CAMHS per year for co-educational schools was 9 students. The spread of data from the mean was relatively small ( $SD = 4.42$ ), however, once again the statistical significance of this spread cannot be qualified.

**Table 12**

Mean Average of students seen per year vs. referrals per year split by Gender of school

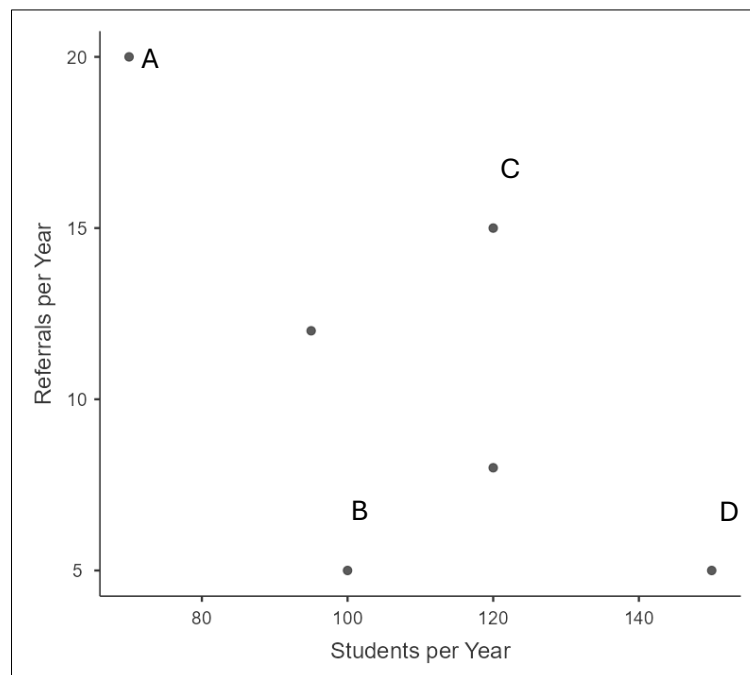
	Gender of School	Students per Year	Referrals per Year
N	Co-educational	5	5
	Single-sex Girls	1	1
Mean	Co-educational	117	9.00
	Single-sex Girls	70.0	20.0
Standard deviation	Co-educational	21.7	4.42
	Single-sex Girls	NaN	NaN

Note: Data was collected by researcher and calculations and table were produced using jamovi™ software (The jamovi project, 2024). Analysis was aided by additional software within jamovi™ (R Core Team, 2024).

The scatterplot represented in Figure 1 examines the correlation between the students seen by participants per year compared with the number of referrals made to CAMHS. A linear relationship was not evident between the scatterplot points, as the data set was very small, however, excluding outlying participant points B and C, a negative correlation can be seen between participants represented by the remaining points, trending down between participant point A towards participant point D. Interestingly, the participant represented by point A, estimated to have seen the least individual students per year ( $n = 70$ ) but made the most referrals per year ( $n = 20$ ). Whereas, the participant represented by point D, estimated to have seen the most students per year ( $n = 150$ ), but made the least number ( $n = 5$ ) of referrals to CAMHS.

### Figure 1

*The Correlation Between Students seen by Participants per Year and the Number of Referrals made to CAMHS*



Note: Data was collected by researcher and scatterplot was generated using jamovi™ software (The jamovi project, 2024). Additional note: Each 'dot' on the scatterplot represents an individual participant in the research project.

### Qualitative Thematic Analysis of Written Responses

In the Tables (13-23) below, Braun and Clarke’s (2006) Reflexive Thematic Analysis (Braun & Clarke, 2023) model has been used to analyse and summarise the information provided by participants to the open ended questions in the questionnaire.

### Confidence Rating Analysis

Table 13 is a summary of themes in relation to the participants justifications of selecting a confidence rating of ‘somewhat confident’ in response to item 7 of the questionnaire. The themes of counsellor experience, familiarity of the CAMHS referral process, and communication between CAMHS staff and participants were identified. Interpretations of each theme by the researcher were outlined and specific text examples were provided as evidence. The theme: counsellor experience was highlighted, despite only relating to one participant, as this will be a pertinent point of discussion for this research project.

**Table 13**

#### A Summary of Justifications of Referral Process Confidence rating

Theme	Interpretation	Specific Text Example
<b>Counsellor Experience Familiarity</b>	Less time in counselling role, less confidence in referring. Familiarity with some services referral process.	“have not been at school for that long” “I am more familiar and confident with the process ...for CAMHAS... and less confident with CAFS”.
<b>Communication</b>	Uncertainty around time frame or communication of outcome or next steps.	“I know how to refer but lack in confidence knowing there will be adequate follow up in a timely manner”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

### Reason for Referral Analysis

The information in Table 14 below summarises the participants reasons for referral of rangatahi and the frequency in which these themes occurred in response to item 12. Self-harm, as a theme for referral, was reported with the greatest frequency, while suicidal ideation and/or suicide attempt was ranked second. Table 15 delved deeper into the themes for CAMHS referral, reporting the number of participants against the number of reasons for

referral. Three of the participants gave three reasons for referral, while one participant gave a singular reason (“suicidal ideation”), and two participants gave two reasons. The participant who gave singular reasoning for referral to CAMHS, was the only individual not to identify self-harm as a reason for referral.

#### **Table 14**

A summary of the Reasons for CAMHS referral and the frequency of this response by participants

<b>Referral Reason</b>	<b>Frequency of Response</b>
<b>Self-harm (non-life threatening)</b>	5
<b>Suicidal Ideation and/or Attempt</b>	4
<b>Trauma</b>	2
<b>Disordered Eating</b>	2
<b>Depression</b>	2

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and frequency of their occurrence are summarised in the table above.

#### **Table 15**

Frequency of Numbers of Referral Reasons Given by Participants

<b>Number of Reasons</b>	<b>Number of Participants</b>
1	1
2	2
3	3

Note: Table above represents researcher breakdown of number of reasons given by participants for referral and the frequency at which this occurred.

### **Thematic Analysis of CAMHS Referral Criteria**

The information in Tables 16-18 contain thematic analyses of the participants’ justifications of their responses to item 14 of the questionnaire around the clarity of CAMHS referral criteria.

The singular participant who answered ‘Yes’ to the clarity of CAMHS referral criteria (Table 15) identified the themes of good communication by CAMHS staff, and clarity of the form which is required to be filled in by the referrer.

**Table 16**  
Justification of Answering ‘Yes’ to Clarity of Referral Criteria

Theme	Interpretation	Specific Text Example
<b>Communication</b>	CAMHS are communicative during referral process	“...happy to answer questions I may have around the referral”.
<b>Form Clarity</b>	Referral form is clear and easy to understand	“CAMHAS have a straightforward referral form...”

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

Table 17 highlighted the responses of the four participants who responded ‘no’ to the clarity of CAMHS referral criteria. Throughout their responses to these items, the themes of lack of acceptance, time, and severity of mental concern were all identified. Lack of Acceptance was interpreted as students not being accepted to CAMHS, despite referral. Time was interpreted as lengthy waits for responses to referrals. Severity of Mental Health Concern was interpreted as referrals only accepted when the mental health concern was at the high end of the severity scale.

**Table 17**  
Justification of Answering ‘No’ to Clarity of Referral Criteria

Theme	Interpretation	Specific Text Example(s)
<b>Lack of Acceptance</b>	Students referred are not accepted despite participants judging that they need referral.	“A number bounced back...” “Don’t feel like many get across the line”. “It seems referrals are only accepted if severe symptoms...” “...difference between what is accepted by one and not bey the other...”
<b>Time</b>	Wait times for responses or actions are long.	“...there is a significant time delay in this.” “...lack of time...”
<b>Severity of Mental Health Concern</b>	Mental Health concern needs to be severe for referral to be accepted.	“I cannot guarantee that a severe case is sufficient to access CAMHS support”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

A singular participant answered ‘maybe’ to the clarity of CAMHS criteria (Table 18), and the themes of form clarity, and acceptance uncertainty were identified. While only pertaining to one participant, it is of interesting note that overarching theme of acceptance was also identified in the responses of participants in Table 17. Similarly, form clarity was highlighted in both Tables 16 and 18, although for diametrically opposing reasons.

**Table 18****Justification of Answering ‘Maybe’ to Clarity of Referral Criteria**

<b>Theme</b>	<b>Interpretation</b>	<b>Specific Text Example</b>
<b>Form clarity</b>	Form and guidelines clear and easy to understand.	“...clear guidelines by which to refer and the referral forms are clear...”
<b>Acceptance Uncertainty</b>	Not sure if student will meet the criteria despite participant believing they do.	“...sometimes those who meet the service requirements are not accepted”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

**Strengths of the CAMHS Referral Process**

The information collated below in Table 19, gathered the responses to strengths that participants identified within the CAMHS referral process. The strengths of the CAMHS referral process will be explored further within the discussion section.

**Table 19****A Summary of Strengths of CAMHS Referral Process**

<b>Theme</b>	<b>Interpretation</b>	<b>Specific Text Example(s)</b>
<b>Communication</b>	Communication is clear, friendly and timely.	“They send me copies of letters to whānau. They will phone with any concerns they have for a student.” “Friendly and experience...” “Maybe that they answer the phone”. “Quick communication after initial referral. The staff are personable...good at communicating appointment times”
<b>Collaboration</b>	Collaborate with school counsellors and other interested parties to support referred student.	“They have also come to school to meet with our team or hold meetings”. “...so that the school can be aware / supportive of that individual student if necessary”.
<b>Availability of Service</b>	A CAMHS services is available to the participant.	“They have also come to school to meet with our team or hold meetings”. “There is a CAMHS service here”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

**Weaknesses and Limitations of CAMHS Referral Process**

All six participants were able to identify an extensive list of weaknesses and or limitations of the CAMHS referral process. Table 20 identifies the key themes from the responses to item 17 of the questionnaire. These themes are further explored within the discussion section.

**Table 20**  
A Summary of Weaknesses of CAMHS Referral Processes

Theme	Interpretation	Specific Text Example(s)
<b>Time</b>	A lack of time to see or respond to referrals.	“They don’t contact whānau straight away.... (don’t) give a time frame for when they will be in contact again...” “The wait time”. “Wait times for appointments is not ideal”. “Accessing them in an emergency”
<b>Communication</b>	Poor or no communication with participants or with whānau.	“Don’t call whānau straight away...” “I would like to receive more information when students are not accepted into the service and can therefore follow any recommendation they might have when referred back to school counselling”. “Too many questions, not relevant”. Following up with reluctant clients and their whānau”. “Limited suggestions offered if an individual is decline(d) / refused from service...”
<b>Staff Shortage</b>	A lack of specialised staffing at CAMHS	“...they do not have a psychologist on staff...”
<b>Mixed Messaging</b>	Unhelpful messaging to referred students	“A lack of staffing and resourcing is evident”. “can be very unhelpful with messages she gives students...for example recommending... not receive a formal ASD diagnosis as future employers will not want to hire...”
<b>Consent</b>	Needing adult consent for referred students under the age of 16 years.	“Parent permission!”

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

### Suggested Changes to CAMHS Referral Process

Participants were also very forthcoming in their responses to item 18 (Table 21) of the questionnaire which asked them to suggest changes to the CAMHS referral process which would be beneficial to them as school counsellors. The themes of referral acceptance (more acceptance), communication (improved with interested parties), collaboration (improved with schools and whānau), and time (shorter wait times) were identified as themes pertinent to suggested beneficial changes. Four participants identified increasing rates of acceptance as a needed change. Four participants also identified the need for improved collaboration and communication. While one participant identified time as an important theme for improvement.

**Table 21****A Summary of Changes to CAMHS Referral Process: Benefiting School Counsellors**

<b>Theme</b>	<b>Interpretation</b>	<b>Specific Text Example(s)</b>
<b>Accepting Referrals</b>	A higher rate of referrals accepted	“Accepting Referrals” “Accepting with parent permission if they are old enough. Gillick principle”.
<b>Communication</b>	Communicating with school counsellors, whānau, and outside agencies more readily	“If the referral process was universal in all regions”. “Them calling whānau...especially around safety”. “...more information as to why, coming directly from the practitioners, and any recommendations of support”. “...hard to do that without a clear plan and clear communication”.
<b>Collaboration</b>	Collaborating with schools and whānau more frequently and effectively	“...explanation was given to ensure individuals still received appropriate support”. “More collaboration when students are not accepted...” More collaboration between CAMHS and school...”
<b>Time</b>	Referrals are acted on in a timely manner	“...ensure individual still receives appropriate support”. “Knowing that a referred client will see someone quickly...”

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

Item 19 (Table 22) asked participants to outline key areas of change to the CAMHS referral process which would be beneficial to rangatahi. The themes of communication (improved with rangatahi), collaboration (with rangatahi and whānau), accessibility (making access easier), and relationships (building rapport with rangatahi), were identified. Only five participants made suggested changes in response to this item, one was unsure.

**Table 22****A Summary of Changes to CAMHS Referral Process: Benefiting Rangatahi**

<b>Theme</b>	<b>Interpretation</b>	<b>Specific Text Example(s)</b>
<b>Communication</b>	Clear communication with rangatahi	“Transparency, communication with the young person”.
<b>Collaboration</b>	Collaborating with rangatahi and wider support network.	“...which could give further explanation of next steps...”
<b>Accessibility</b>	Making access to services easier for rangatahi.	“Accepting without parent permission...If they came to see them at school”. “Shorter wait times, perhaps triage...a quick initial evaluation...”
<b>Relationship</b>	Building a positive rapport with rangatahi.	“More relational and taking time to build trust.... Also, there is a reluctance to share as whānau are informed what has been said”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

**Other Comments on the CAMHS Referral Process**

Item 20 of the questionnaire (Table 23) allowed participants to make any further comments on the CAMHS referral process and two themes were identified. Only three participants responded to this item, however, both time and resourcing were interpreted as the

most relevant themes. Participants expressed the need for CAMHS to make improvements to their use of both their time and the time of referrers. However, participants also highlighted that CAMHS has a lack of resourcing, and this is having an impact on the CAMHS referral process.

**Table 23**

**A Summary of Other Comments about CAMHS Referral Process**

<b>Theme</b>	<b>Interpretation</b>	<b>Specific Text Example</b>
<b>Time</b>	Time consuming referral process for school counsellors and a lack of timely response from CAMHS.	“A lot of questions which don’t seem relevant” “...wish CAMHS had a service to respond to an immediate need...and following through until resolution.”
<b>Resourcing</b>	A lack of resourcing, making it hard for referrals to be accepted or followed up.	“...even in critical cases, if the client or whānau don’t engage very little is done to draw them back into the process”. “...seems hard to get referrals through”.

Note: Thematic analysis (Muir, 2023) was conducted by the researcher and main themes and interpretations are summarised in the table above.

## **Chapter Nine: Discussion**

Both school counsellors and CAMHS provide vital services to the rangatahi of Aotearoa New Zealand. Throughout the following chapter, results of this research will be discussed, highlighting the importance of such research projects in emphasising the voices of school counsellors and the communities in which they operate. It will then further go on to unpack and outline the strengths, weaknesses and limitations of the CAMHS referral process. Finally, making recommendations to improve the CAMHS referral process, whilst also scrutinising the limitations and next steps of this research.

### **At a Glance: The importance of this research**

#### ***The Research***

The purpose of this research was to understand school counsellors' opinions of the efficacy of the CAMHS referral process for rangatahi. It aimed to understand the level of referral being made to CAMHS by school counsellors in comparison to the total number of students they were seeing and whether the level of accepted referrals was sufficient. It also was designed to gain further insight into the perspectives of school counsellors on the strengths and weaknesses of the CAMHS referral process. Consequentially gaining an understanding of the changes to this process that they as school counsellors would find most beneficial for themselves and the rangatahi in their care.

No research design is without its pitfalls, however, viewing this research project's aims under a pragmatic paradigm (Kaushik & Walsh, 2019) and utilising a mixed method research design, allowed for the generation of data which best addressed the ultimate goal of the research (Houchins et al., 2023), to contribute positively to the real-world issue of improving rangatahi's access to vital Child and Adolescent Mental Health Services in Aotearoa New Zealand. The open-ended nature of the qualitative questions in the research questionnaire allowed for the compilation of genuine unfiltered responses and robust analyses

(Tracy, 2010) of emerging themes. While quantitative questions were able to be analysed and used to qualify (Dhong, 2023) these perspective responses.

Gaining understanding of the lens through which school counsellors view the CAMHS referral process is of key importance, as it is essential to acknowledge that individual groups have different perspectives. It requires the input of all these worldviews to develop a universal understanding of the problem at hand. There is very rarely an absolute truth, but shared understanding ensures that everyone is in agreement (Kaushik & Walsh, 2019), especially when it comes to something as important and complex as the mental health of rangatahi.

### ***School Counsellors' Voice***

The voice of school counsellors is essential in advocating for the needs of rangatahi (Ferguson, 2012), especially those who are experiencing utmost vulnerability due to poor mental health. This research demonstrates that school counsellors are passionate about promoting the wellbeing of rangatahi and they have provided a diverse range of responses which contribute to the larger picture of evaluating and improving the CAMHS referral process. There is a significant shortage of reviews on school counsellors' perspectives (Augustine, 2016), so it is important as key stakeholders within the sphere of youth mental health that their voices are heard. Participants in this study were able to clearly articulate their opinions of the strengths, weaknesses, and beneficial changes.

It is important at this point to acknowledge that each participant in this research study is a unique individual who sees the world through their own lens. Their worldview is influenced by their pre-held beliefs and ideologies and the cultural and socioeconomic environments they are situated in. These unique differences may account for not only their diverse responses, but their experiential differences of the CAMHS referral process. It is of note that similar themes within the results have been identified as both strengths and

weaknesses by different participants, for example, ‘communication’ was highlighted as a strength in one instance but a weakness in several others. This speaks volumes to not only how our worldviews influence our realities (Kaushik & Walsh, 2019), but also gives credence to the reported inconsistencies between CAMHS around Aotearoa New Zealand.

In their privileged position working alongside rangatahi, school counsellors are privy to the ‘unseen’ and have the responsibility to bring light (Wasson, 2014) to school wide trends in wellbeing, or the need for systemic change. One example of bringing an issue to light from the research study, which may not have been on the forefront of thought for improving the CAMHS referral process was the theme of consent.

Although the issue of consent was only raised by one participant, it created a new area of consideration for the researcher, and therefore, was included as a theme. It also introduced the researcher to a new phrase, “Gillick principle” which required further unpacking to comprehend. While the consent process is widely understood, the school counsellor raised this as both a weakness and change needed of the CAMHS referral process, it brought to light a need for its further consideration. If the whānau who are required to consent are either hesitant or contributing risk factors (Park et al., 2022), should their permission or lack thereof stand in the way of consenting rangatahi receiving the appropriate level of care for their need?

With an appalling youth suicide rate (Thabrew et al., 2018) and an increasing prevalence of mental health concerns among rangatahi in Aotearoa New Zealand (Lumb, 2009). It is imperative that school counsellors, who contribute enormously to prevention and treatment of mental illness (Lucassen et al., 2015), are given a platform from which they can bring awareness to the changes they believe would improve services such as CAMHS.

### ***Community Driven Change***

There is a need for change within the CAMHS referral process, the participant responses have made this abundantly clear. However, they have also highlighted the need for greater participation by all contributors to child and adolescent mental health services, whether that be greater input from schools in general or collaboration with rangatahi's vital whānau and community support networks. Literature overwhelmingly supports this need for further collaboration between interested parties. Educational services are vital in the referral process (Lucassen et al., 2015), and leaders within schools have the opportunity to fuel momentum for change (Yavuz et al., 2017). An increase in community awareness of the state of rangatahi mental health, increases expectation for essential change (Fortune & Clarkson, 2006). Any improvements will need to be community driven (Lopez-Carmen et al., 2019) in order to ensure they are effective and happening at a systems level. Ensuring referrer satisfaction through seeking feedback (Allison et al., 2008) and measuring the outcomes of services (Boyce, 2015) is proven to be beneficial in the efficacy of CAMHS worldwide. It is, therefore, pertinent that this research plays a small role in ensuring that the perspectives of school counsellors are shared.

### **Identified Strengths**

There is no debate that CAMHS play a vital role within Aotearoa New Zealand, they have been operating for a number of decades in the endeavour of supporting rangatahi with their mental health needs. It is, therefore, crucial to appreciate that they certainly do have strengths upon which they operate. Throughout the research study areas of strength were identified by the participants, outlining common themes which school counsellors perceived as being a strength of the referral process. It is evident, however, that participants were less forthcoming with identifying strengths, than they appear to have been with weaknesses. For clarity of discussion, the researcher has judged that some themes identified were linked, so have been explored in combination with each other.

### ***Familiarity of the CAMHS Referral Process***

The descriptive statistical analysis identified that all participants of this study had experience with the CAMHS referral process and all expressed being somewhat confident with the process. This is a positive, as it not only qualifies the opinions provided by the participants, but it also indicates that these school counsellors must have a familiarity of the referral process. This was corroborated by the identified strength themes of both familiarity of the CAMHS referral process, and additionally the clarity of the referral form. These themes have been combined for discussion as they are interrelated. The referral form would not be easy to use if the process was not familiar to the school counsellor, and vice versa.

Participants expressed confidence with their knowledge of the referral process and this is an essential strength, as familiarity is an indicator of a user friendly service (Allison et al., 2008), which in turn ensures that the CAMHS referral process is working well. Having a good understanding of what is required of the referral form is also key to the CAMHS referral process functioning optimally. As evidenced in the literature review, referral forms can differ between CAMHS regionally in both their brevity and clarity. Ensuring that the referral form is clear and easily interpretable, makes certain that the quality of applications (Hansen et al., 2023) received by CAMHS are sufficiently detailed. This has a twofold benefit of minimising unnecessary referrals and securing necessary supports for rangatahi.

### ***Communication***

Communication was another key theme of strength extrapolated from thematic analysis. Four participants identified this area as a strength of the CAMHS referral process and more specifically outlined that clear communication of the staff within CAMHS was beneficial for a smooth referral of rangatahi.

Given that some participants are referring up to twenty rangatahi a year but are responsible for the care of on average 100 students per year, it is evident as to why good communication would be highlighted as an asset in the CAMHS referral process. Balancing

the needs of all those individuals and ensuring their care, requires a good level of open communication. Literature also highlights the importance of communication as a strength of mental health services, such as CAMHS. Good communication between CAMHS, school counsellors, whānau, and rangatahi is proven to contribute to positive outcomes for rangatahi (Smith et al., 2018). If the communication during the referral process is clear, effective and perceived as helpful it is linked with increasing referrer satisfaction (Allison et al., 2008), in this case the satisfaction of school counsellors. Communication is a foundation for success in many aspects of life, so it is gratifying that some of the participants have experienced this as a strength of CAMHS.

### ***Collaboration***

We have all heard sayings such as “we are in this together”, and this resonates strongly with those involved in the mental health of rangatahi. When rangatahi are experiencing poor mental health it does not only have implications for the individual but also those around them (Manthei, Tuck, Agee, et al., 2020). It is, therefore, imperative that collaboration takes place between all stakeholders who are supporting the rangatahi through their mental health journey. Only one participant clearly identified collaboration as a strength, however, elements of collaboration have also been identified through interpretation in other participant responses. It was, therefore, decided to include collaboration as a strength which is possessed by some CAMHS referral processes.

Collaboration between stakeholders leads to an improvement in service delivery, decreasing wait times (Smith et al., 2018) and minimising unnecessary referrals.

Collaboration between CAMHS and school counsellors, can facilitate an increase in confidence of the school counsellor in their clinical skill level (Fortune & Clarkson, 2006), giving them reassurance that they have the ability to appropriately support rangatahi.

Willingness to collaborate is also seen in a positive light by whānau. When CAMHS includes

them in the referral process, they are much more likely to be accepting of the service (McClintock, Tauroa, & Mellsop, 2016). This will lead them to be more supportive in the implementation of any recommendations. Also, collaboration allows whānau to advise CAMHS if they think the plan is feasible. As Barnes (2023) outlined, strong collaboration between CAMHS and key stakeholders is essential to support rangatahi struggling with poor mental health, to make changes which they may not have been willing to do alone.

### *Availability of Service*

Aotearoa New Zealand, although small in both land area and population, is in the fortunate position of having a mental health care system which is predominantly free to access. That being said, due to geographical isolation of some areas and overpopulation in others, access to and availability of services is not always guaranteed (Merry et al., 2020). Participants identified that they had all had experience referring to CAMHS, albeit all located centrally, indicating that a CAMHS service is available to them. Some participants further qualified this by expressing gratitude for access to these services. The availability of service theme has been defined and interpreted in two ways. Initially, it is defined simply as CAMHS and the subsequent referral existing in the first instance. Furthermore, it is also interpreted as a willingness on CAMHS behalf to ‘come to the source’, by meeting rangatahi at their schools, in the process eliminating a barrier to access (Stasiak et al., 2013).

Researchers concur that availability of service can be a strength of the CAMHS referral process. Despite the challenges faced by CAMHS with a variability of funding (Denny et al., 2019), striving to achieve equitability of availability is important (Merry et al., 2020). If CAMHS are able to break down referral barriers, such as leaving the clinical settings of hospital practices, they will be able to provide more variability of service options (Stasiak et al., 2013), which is something rangatahi are increasingly expressing a need for.

### **Identified Weaknesses**

Inadequacies in mental health services have been identified worldwide (James & Buttle, 2008), particularly in the mental health services designed for children and adolescents. While many participants of this study struggled to fully articulate themselves about strengths of the CAMHS referral process, they did not have the same difficulty when asked to identify the weaknesses. Concerningly, from the quantitative analysis, the majority of participants did not believe that the CAMHS referral criteria were easily understood. Half of them stated that only a minimal amount of their referrals were accepted by CAMHS each year. The qualitative analysis and further researcher reflection identified the overarching themes of lack of acceptance, time, and resourcing as the main areas of weakness for the CAMHS referral process. The themes of consent and mixed messaging were also identified by the researcher as areas of weakness which warrant further discussion, despite being identified by singular participants.

### ***Lack of Referral Acceptance***

Lack of acceptance was identified as an overarching area of weakness for the CAMHS referral process; and it encompasses two related subthemes of communication and severity of symptoms. Firstly, participants are becoming disheartened by the unreliability and uncertainty of the CAMHS referral process, they expressed concerns of not knowing if the referral would be accepted. They also expressed frustration at the communication or the lack thereof when working through the referral process. Participants also observed that it seemed that symptomology of rangatahi needed to be severe in order for the referral to be accepted.

Only a very small percentage of rangatahi with mental health concerns are accessing services such as CAMHS (Lucassen et al., 2015) and a lack of acceptance into service may be hindering the full utilisation of CAMHS's capacity. If school counsellors are making the effort to refer, they must ultimately believe that CAMHS is beneficial to the rangatahi.

However, with the perception that minimal referrals are accepted, this further confirms that accessibility to mental health services for rangatahi is low (Eggleston & Watkins, 2008).

Further compounding the lack of CAMHS referral acceptance, is when school counsellors are experiencing poor communication about the process (Allison et al., 2008). If they have a lack of understanding about the criteria (Evans et al., 2019), due to poor communication on CAMHS behalf, they are unable to fully comprehend what is required of them. This can make an already stressful process feel increasingly disheartening (Newman et al., 2024).

Finally, under the umbrella of lack of referral acceptance is severity of symptoms. As previously stated, the prevalence and severity of mental health symptomology which rangatahi present with, is continuing to increase (Te Maro et al., 2019). This not only puts increasing strain on school counselling services, but also on CAMHS. Both CAMHS and school counselling services are morphing towards risk management and assessment (Fortune & Clarkson, 2006) and are unable to accommodate the needs of those who present with less severity. Participants overwhelmingly identified self-harm, and suicidal ideation and or attempt as their reason to refer to CAMHS, thus indicating the severity of symptoms which school counsellors themselves are facing. This was clearly highlighted as an area of concern for participants referring to CAMHS, the perception being that referrals would only be accepted if symptoms were sufficiently severe. This is a considerable area of weakness and concern for the CAMHS referral process and CAMHS in general. It is evident in research that early intervention of less severe mental health concerns can act as a preventative measure, minimising the risk of lifetime prevalence of mental illness (Every-Palmer et al., 2022). However, if CAMHS referrals for low level mental health concerns are being rejected, despite school counsellors deeming a referral necessary, it stands to reason that the criteria and purpose of the CAMHS referral needs to be reevaluated.

***Time***

In the ever-increasing pace of human life, time pressures are becoming more and more of a concern for everyone. In mental health services, time is most definitely a factor of concern, even more so now that there is increased public awareness of mental health concerns (Haslam & Tse, 2024). This awareness often leading to an increased expectancy of immediacy when it comes to ‘solving problems’ (Fortune & Clarkson, 2006). Four participants highlighted a lack of time given to them by CAMHS as an area of weakness in the referral process. This included their availability to follow up with whānau, the length of time taken for responses to referrals, and the wait times required for rangatahi to be seen.

Time is key for mental health intervention and prevention, especially when dealing with the additional complexities of adolescent development (Lumb, 2009). Response time needs to be fast, but it can also be acknowledged that due to the constraints already faced by CAMHS, they are utilising their precious time wisely and will be acting in good faith when working their way through CAMHS referrals. However, long wait times are having a discernible impact on the mental health of rangatahi, they are simply having to wait far too long for specialist mental health support (Henshaw, 2024).

***Resourcing***

Resourcing of CAMHS is precious, not only are mental health services lacking sufficient financial resourcing, but they are also struggling to recruit and retain sufficient, appropriately qualified staff (Office of the Auditor-General, 2024) to meet the needs of their communities. CAMHS is further under resourced when compared with equivalent adult mental health (Ball et al., 2022) services in Aotearoa New Zealand. Lack of resourcing was identified through participant responses as a prominent theme of weakness for the CAMHS referral process. It is also included as a weakness as it is apparent that limited resourcing also has a direct influence on the weaknesses already discussed previously. Of note, one participant identified that their regional service did not have a psychologist on staff, meaning

that if they are referring individuals to the service, they cannot guarantee that there is going to be someone sufficiently qualified or experienced to meet the mental health requirements of the rangatahi referred.

Factors aside from lack of funding which may be affecting the resourcing of CAMHS include the increase in population of Aotearoa New Zealand, as the population has increased, CAMHS sizes have stayed much the same (Ball et al., 2022). Consequently, they are unable to keep up with the demand of increased referrals. The significance of continued under resourcing (Te Maro et al., 2019) means that staff of CAMHS services do not receive the training or support they may need (Berger & Samuel, 2020), especially when dealing with increased severity of symptomology. They are also unable to provide the specialist support (Sharpe et al., 2016), which schools are in desperate need of.

***Other themes of interest to consider: Mixed Messaging and Consent***

There were two other areas which participants highlighted as weaknesses of the CAMHS referral process. They were singularly identified, but were further analysed by the researcher, as one elicited alarm, whilst the other warranted consideration and contemplation.

Regarding mixed messaging, the participant highlighted that a CAMHS clinician had discouraged a referred rangatahi from pursuing a formal diagnosis of Autism Spectrum Disorder (ASD) as it may impact on their employability. This being despite what can only be assumed as a significant amount of time and resources having been dedicated by the school counsellor to not only make the referral but also to convince the rangatahi to explore this idea further. This example outlines how values and beliefs influence the world views of even clinicians. It also outlines the importance of relational practice within adolescent mental health. Telling an individual not to pursue a diagnosis, may have eroded their trust in the CAMHS referral process (Every-Palmer et al., 2022) and it most definitely would not have aided in building whakawhanaungatanga (Bishop & Berryman, 2010). Interestingly, a study

done by McMahon, Henry, and Linticum (2021), found that although there is some stigma around an ASD diagnosis, when employers were knowledgeable of ASD and were socially aware of appropriate responses, they were less likely to refuse employment to theoretical individuals who disclosed their diagnosis. They were more concerned with the individual's ability to meet the requirements of their employment.

Consent was the other theme highlighted by a single participant, as discussed in the introduction of this section. While it is proven that CAMHS referral is more accepted when whānau have involvement in the process (McClintock et al., 2012), it is not always feasible to seek consent from rangatahi's parents or guardians. This could be for a myriad of reasons, including worrying about the reaction or the stigma associated with disclosing their struggles. The Gillick principle (1986) was raised as a reasoning for CAMHS referral without parental consent. This principle outlines that individuals who are under the age of consent but who demonstrate the intelligence and maturity to comprehend the process, should be able to self-consent (Fenton, 2020). A study in the United Kingdom (Paul et al., 2008) found that individuals as young as 14 years old were just as able as their of-age counterparts to give informed consent. Does it then stand to reason if parental consent is a barrier to CAMHS referral for recommended intervention, that it is worth giving more consideration to? Especially in establishing more easily understood CAMHS consent guidelines (Fenton, 2020) for both clinicians and school counsellors. This does not, however, eliminate the need for parental consent in its entirety. Different considerations around risk to rangatahi must be explored, including considering a rangatahi's right to privacy, confidentiality, autonomy and capacity to self-consent.

### **Changes Beneficial to All**

The main goal of this research project was to understand the perceptions of school counsellors toward the CAMHS referral process. To draw upon collective themes from their

identification of strengths and weaknesses, alongside their recommended changes, to synthesise a list of recommendations for changes to the CAMHS referral process, which would be most beneficial to rangatahi.

The participants' opinions identified strong themes of areas for change, in aid of benefiting both themselves as clinicians and the rangatahi who require these services. The themes identified were in some cases further defined within the overarching categories of accessibility, resourcing, time, communication and collaboration.

### ***Accessibility***

Accessibility was identified as a significant area of weakness for the CAMHS referral process, this included themes of accessing the service and having referrals be accepted. The researcher deems that acceptance of referrals fits within the overarching theme of accessibility.

As this research study has highlighted, school counsellors feel frustration toward the fact that referrals are often refused and there is uncertainty of the criteria by which a referral would likely be accepted. For school counsellors to get to a stage of referral, they do not think that the support they provide alone is sufficient. They are, therefore, entrusting rangatahi to a service which should have the expertise to support them (Berger & Samuel, 2020). However, if referrals continue to be declined without apparent reason, it may lead school counsellors to distrusting the process, increasing their reluctance to refer (Allison et al., 2008). Criteria between CAMHS providers appear to be fluid and this inconsistency is leading to unnecessary or low quality referrals (Hansen et al., 2021). It is, therefore, the recommendation of this research that the CAMHS referral process be reviewed across Aotearoa New Zealand and a universally agreed upon set of criteria is developed and disseminated to referrers. Education around the criteria should also be provided to ensure that referrals are necessary and of high quality (Hansen et al., 2023). The intended effect of this

universal criteria will be to eliminate the stress (Newman et al., 2024) associated with referring and also increase appropriate access to rangatahi. Some of whom might otherwise have missed the opportunity to receive vital support due to a lack of clarity (Lucassen et al., 2015).

Physical accessibility is also an area for important change that CAMHS must address. Despite barriers of inadequate funding (Denny et al., 2019) or geographical isolation (Merry et al., 2020), it is imperative that rangatahi receive mental health support when they are seeking it (Every-Palmer et al., 2022). As the complexity of modern life continues to evolve, rangatahi are seeking a variety of access options which best suit their circumstances (John & Cohen, 2024). For schools, rangatahi, and whānau, it is often not practicable to travel upwards of an hour in some cases to attend an appointment. If CAMHS had the ability to attend schools more readily, this may eliminate a barrier which is significant in the referral process.

It is evident from this research and is supported by literature that supply of services such as CAMHS has not kept up with demand. Increasing populations are overwhelming the existing health care structures and ratios of experts within CAMHS need to increase to keep up with demand (Manthei, Tuck, Agee, et al., 2020). It is also essential these additional staff have the appropriate skill sets to expertly deal (Berger & Samuel, 2020) with the mental health of rangatahi. If more options were offered alongside increasing of staffing, it would ensure that the CAMHS referral process was increasingly more accessible to all (John & Cohen, 2024). For example, if additional day clinics, or rural clinic days were made available, rangatahi may have better opportunities for access. It is, therefore, the recommendation of this research that options for increasing both the size and expertise of CAMHS staffing is explored. This will allow CAMHS to meet recommended ratios for

optimal service, and provide outreach programmes, and consider visiting schools or rural areas on a regular basis.

All three of these recommendations could affect positive change in accessibility for the CAMHS referral process, benefitting all involved parties.

### ***Resourcing***

As previously stated, resourcing is essential to the successful functioning of CAMHS around Aotearoa New Zealand. While closely linked to the aforementioned themes for change, and those themes still to come, it is an important theme to acknowledge individually as without appropriate resourcing, CAMHS ceases to exist. Participants in the study alluded to a shortage of resources and one noted that a psychologist was not employed by the service in their region. Although some of this could be attributed to staffing shortages, ultimately it comes down to a lack of funding (Office of the Auditor-General, 2024). Without money, resourcing simply isn't possible.

Throughout the research literature, the need for adequate funding of mental health is emphasised (Clark et al., 2014). Governments need to prioritise spending in relation to mental health services (McCann & Lubman, 2012). They must deliver what they set out in their budgets. Increased funding will lead to better resourcing, allowing adequate training for those within CAMHS (Levinson et al., 2021). It will also equip services with enough resourcing that they are able to focus on initiatives which promote prevention of poor mental health, rather than only having the resources to manage crises (Saadat Mehr et al., 2024). It is, therefore, the recommendation of this research study that the Government of Aotearoa New Zealand continues to prioritise mental health, especially of rangatahi, while also reevaluating the funding it provides. Consulting with CAMHS around the country to ensure that funding is both sufficient and equitable.

### *Time*

Time was highlighted as a key theme throughout this research study, CAMHS services are time critical and despite often operating in time-poor societies, it is essential that rangatahi do not wait too long when they are requiring specialist support (Henshaw, 2024). While time is distinctly linked to other themes such as resourcing and accessibility it must be considered as a focus for change.

Rangatahi should not be waiting for extended periods of time to see if their referral has been accepted, or to be triaged by CAMHS. If they are seeking their support, there is a level of immediacy which must be met (Fortune & Clarkson, 2006). Similarly, a smaller wait time would also be beneficial for school counsellors, as they too are often working in a time-poor practice (Manthei, Tuck, Agee, et al., 2020). The provision of additional screening tools or assessments in referral processes could serve to reduce symptoms for some rangatahi, while also streamlining and strengthening the referral, as to not waste anyone's valuable time (Hansen et al., 2023). Within minimising time wastage, administrative tasks and mandatory routine outcome measures could be streamlined to lessen the non-clinical work load experienced by CAMHS staff (Eggleston & Watkins, 2008). He Ara Oranga (2018), the Report of the Government Inquiry into Mental Health and Addiction called for more uniformed systems, nationally co-designed to improve the equity of mental health care for all, increasing both staff capacity and resourcing (Paterson et al., 2018).

In regard to the theme of time, this research recommends that an agreed upon maximum wait time for referral acceptance or decline is universally established. This will ensure that school counsellors, whānau and rangatahi have awareness of the time frame for next steps in the process. It is also recommended that a minimum time of face-to-face clinical practice is set as a target, which CAMHS around Aotearoa New Zealand should aim to meet.

### ***Communication***

Communication was identified by participants of this research study as both a strength and a weakness, alongside identifying themes of this throughout their suggested changes.

This was also evident in the descriptive statistical analysis, with most participants finding the CAMHS referral process unclear, which can be interpreted as a lack of communication on the part of CAMHS. Therefore, it was of utmost importance that this be considered as a key theme for change. Everyone has experienced situations where things have gone awry simply down to lack of effective communication. When it comes to supporting the mental health needs of rangatahi, CAMHS cannot afford for their communication to be found lacking.

Excellent communication with schools, whānau, outside agencies, and rangatahi is crucial to the effective operation of the CAMHS referral process (Mitchell-Lowe & Eggleston, 2009). This not only gives agency to rangatahi (Ranui et al., 2018), allowing their voices to be heard, but it can also serve as a way of further educating those in the wider support network about mental health. This educational communication from the experts at CAMHS may serve to lessen the stigma associated with mental health and will aid in decreasing the mental distress (Garisch et al., 2020) of rangatahi. Drawing upon the perspectives of school counsellors and associated literature it is the recommendation of this research that communication between CAMHS and those they work with, both directly and indirectly, be prioritised. CAMHS should have the aim of ensuring that their communication is both effective, timely and where appropriate educational.

### ***Collaboration***

Of all themes highlighted during thematic analysis (Braun & Clarke, 2006) of participant responses, collaboration was one of the most prominent. It was evident in all items of qualitative response about the CAMHS referral process. It was mentioned by five of the six participants, either with direct use of the phrase or through interpretation and categorisation of their comments. Rangatahi do not exist in isolation and the support network

they have around them is even more important when they are experiencing poor mental health (Bauer et al., 2021), it is therefore, essential that services such as CAMHS collaborate (Bright et al., 2022) with those around them to ensure the best possible outcomes.

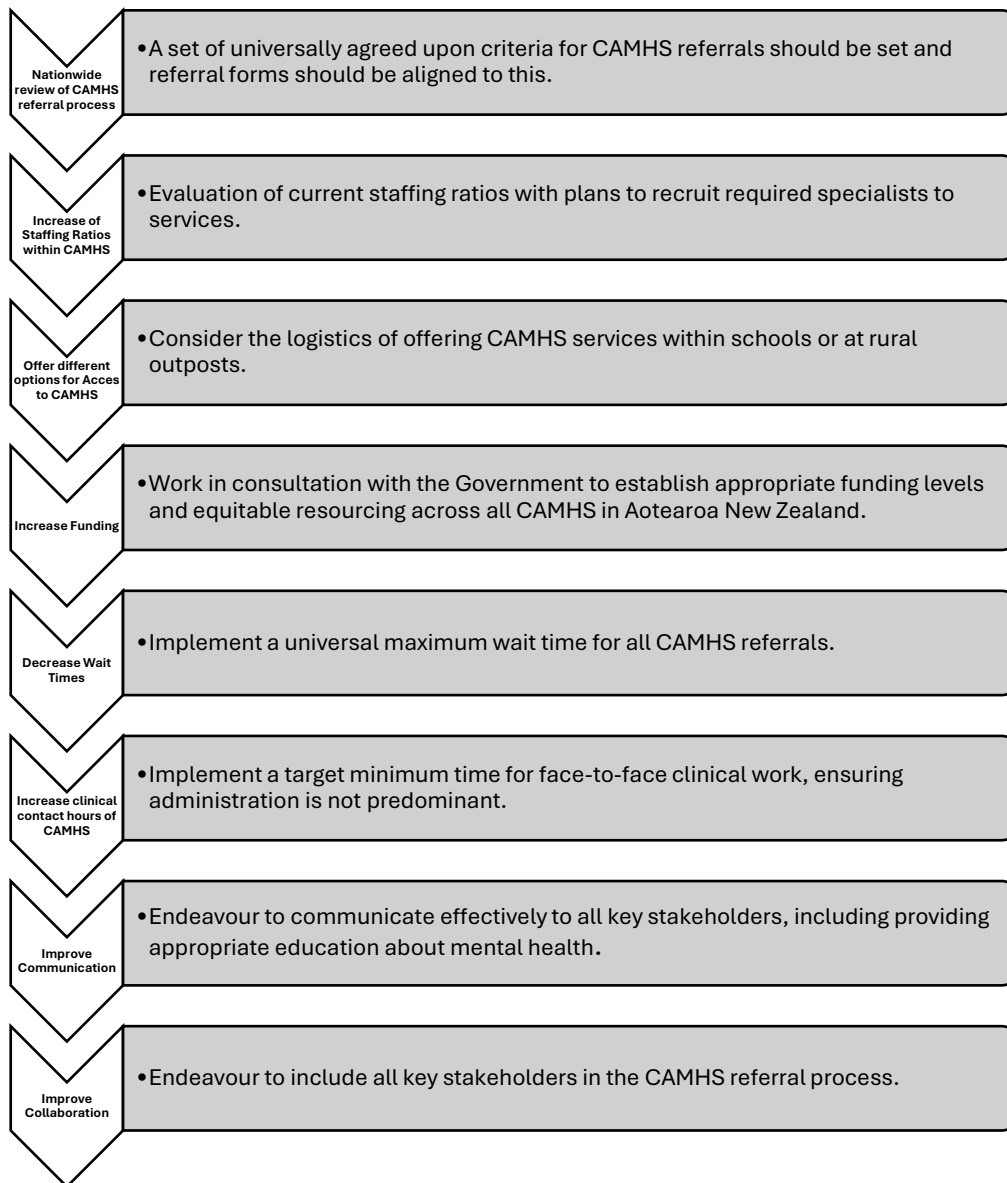
Collaboration is not merely endeavouring to keep people in the loop, it is about building positive working relationships, and utilising skill sets to reach a common goal, in this case the best possible mental health care for rangatahi. Building a rapport with rangatahi and their networks ensures that the CAMHS clinician is able to establish a safe and positive clinical environment (Bright et al., 2022), increasing the efficacy of potential intervention plans. Building positive relationships (Munford & Sanders, 2016) is foundational to positive outcomes in mental health treatment (Kutcher, 2015). Relationship building through collaboration will also build trust within the process (Auger et al., 2018) and is an added opportunity for CAMHS clinicians to increase the culturally responsive nature of their referral process (McClintock, Tauroa, & Mellsop, 2016). Ultimately, having a focus on improved collaboration between all parties, ensures that a sense of whanaungatanga is established and that rangatahi and their support networks will work together (Bishop & Berryman, 2010) with CAMHS towards a common goal. It is strongly recommended, that CAMHS evaluates its collaborative partnership between school counsellors, rangatahi and whānau, to ensure that everyone is working as a team during the referral process.

### **Recommendations**

For clarity, the figure below is a flow chart diagram representing a summary of suggested changes that this research has identified, through the experiential lens of school counsellors.

## Figure 2

### *Summary of Change to CAMHS to Improve Referral Process for Rangatahi*



## Limitations of the Research

The discussion above and recommendations for change are most definitely deserving of further consideration and exploration, however, no research study is without its limitations. In this section the limitations of sample size, research design, resulting data, and input of key stakeholders will be explored.

### ***Sample Size***

Only six participants responded to the survey questionnaire, this meant that there was very little data to analyse, therefore, it is not practicable to assume that a richness of data is possible (Lees & Locke, 2021). However, Malterud, Siersma, and Guassora (Malterud et al., 2016) would argue the opposite, particularly in reference to qualitative analyses. They postulate that ‘information power’ is more important than sample size. If the data is ‘rich’ and meets the needs of the research, then it is deemed to be sufficiently large to hold significance and warrant further consideration (Malterud et al., 2016). The six participants in this research study were able to provide rich and relevant data meeting the needs of the research. However, it is acknowledged that analysis may have been slightly easier with a larger abundance of responses. This limited data, also means that credibility and generality (Bright et al., 2022) of this research cannot necessarily be guaranteed. Six samples from a population of school counsellors across Aotearoa New Zealand is not sufficient to make the assessment that their responses are representative of all school counsellors. Similarly, credibility of this research study is not assured, due to the anonymity of this small sample, there is no guarantee that they are: 1. All operating in the school counselling space, and 2. Representative of the diverse voice of school counsellors. Although the email for recruitment was sent to over 50 people, via a school counsellors’ email group, this advertisement was insufficient to generate a large interest in this research study, despite a prize draw incentivisation. To have further promoted this research study, in hindsight, advertising on paid platforms such as Facebook could have bolstered numbers, as would have remunerating participants for their time.

### ***Research Design***

Overall, choosing a mixed methods research design under an umbrella of pragmatism (Kelle, 2017) was the appropriate choice for the intent of gathering school counsellors’ perceptions on CAMHS. However, certain parts of the physical design and then the subsequent reflexive thematic analysis (Braun & Clarke, 2023) proved challenging. To begin

with, the research questionnaire was designed with both quantitative analysis and qualitative analysis in mind. On the surface this was a well-balanced mix of different questions which allowed the researcher to gather data that was pertinent to the aim. However, in part due to the small number of respondents, there were limited open ended responses to analyse, and due to the anonymity of the online survey design, there was no opportunity for a subsequent semi-structured interview. This would have allowed the interviewer to ask clarifying questions of participants (Madill & Gough, 2008), particularly when small or hard to interpret responses were given. With an absence of clarifying questions, reflexive thematic analysis at times proved to be challenging. Obviously this was not due to the volume of data to be waded through, but indeed the researcher's ability to be fully conscious of bias (D'Costa et al., 2024) when searching for themes and commonalities within the text. Although initially agreeing to analyse the responses with a semantic lens, only interpreting words for actual real meaning, the researcher caught themselves multiple times during the analysis process looking for latent meaning beyond the text (Braun & Clarke, 2006), wanting in part to ensure the results helped contribute to a solution. Analysing such a small amount of qualitative data was very challenging to accurately interpret the discourse (Parker, 1994). Compounding this was also the very real challenge of ensuring a consistent reflexive dialogue throughout the process (Braun & Clarke, 2023). Despite best efforts it cannot be guaranteed that the researcher did not allow their bias to cloud the findings in some instances.

Statistically speaking, the small sample size also presented limitations to this research study. When sample sizes are small, there are limited statistical analyses which are effective. Although, both mean average, standard deviation, and the Shapiro Wilk's test (chosen specifically to analyse spread within a small set of data) were all run, the reliability of these results could not be qualified (Dhong, 2023), as spread or variation from the mean, signifies very little in a data set of six! Finally, in regard to the research's physical design elements,

there were missing quantitative items that were thought of during the analysis phase.

However, these will be further discussed in the section on future areas of research.

### *Data*

Once again, unavoidably linked to small sample size, the generated data also caused limitations to this research study. Despite the email invitation being sent to school counsellors around Aotearoa New Zealand, all of the participants were located in the central region of the country. This could be due in part to them knowing the disseminator of the email, who at the time was located centrally, and feeling an obligation to take time from their busy schedule to respond to their request. Regardless of the reasoning, all participants selected the same geographical area, which was limiting twofold. Firstly, their data could not be interpreted to be generalised across all of Aotearoa New Zealand geographically (Te Maro et al., 2019), as their responses may only be relevant to their local experiences of the CAMHS referral process. As previously discussed, funding and resourcing for CAMHS is inequitable (Merry et al., 2020) around the country, therefore, it is not reasonable to assume that the voice of these participants would be representative of those located elsewhere (Tracy, 2010). Secondly, as all participants were all located in the central region, further comparative statistical analysis could not occur (Dhong, 2023), possible trends unable to be further identified.

Another area where data limited this research project, was the participant's confidence rating of the CAMHS referral process. They all rated themselves as 'somewhat confident', however, gave a myriad of responses to justify this answer, some more positive than others. This then made it challenging, not only to perform further statistical analyses on this set of data, but it was also challenging to interpret how the participants qualified the term 'somewhat confident' with accuracy.

### ***Input of Key Stakeholders***

Although the intent of the research was to gain the school counsellors' perspectives of the CAMHS referral process, with the aim of improving the process to benefit rangatahi, this singular perspective also limits the scope of this research. Throughout this research it has been made evident that successful mental health programmes require the input of all key stakeholders (McClintock, Tauroa, & Mellsop, 2016). While it would have been impracticable to incorporate voice for all stakeholders in this short study, if the research wants to exist with integrity under the pragmatism paradigm, seeking perspective from other stakeholders would have been ideal. Especially from those staff within CAMHS around Aotearoa New Zealand. Presenting this voice, also, rather than simply covering interpretations of this within the literature review, would have allowed for a more balanced review of the state of the CAMHS referral process. Furthermore, including voice of CAMHS alongside of school counsellors would have allowed for more collaboration of ideas. Thus ensuring the generation of a collective understanding, with the common goal of improving the referral process for rangatahi (Kaushik & Walsh, 2019). Scope for research with other key stakeholders will be explored further in the following section.

### **Future Areas of Research**

Although centralised on school counsellors' perspectives of the CAMHS referral process, this study generated a myriad of different areas where future research could further expand on the current findings. The first area of future research could be to expand the outreach of this study, increased advertisement and further promotion could generate data which provides a more balanced view from school counsellors around Aotearoa New Zealand (Te Maro et al., 2019). Other future areas of research which should be taken into consideration include, the input of CAMHS, the voice of rangatahi, the type of school, culture, gender, factors affecting school counsellors, and alternative tools to support youth mental health.

### ***Input of CAMHS***

There are a limited number of models assessing the rigour of the CAMHS referral process (Mansell et al., 2021) and who better to contribute voice to its evaluation than the individuals at the heart of the service. As previously discussed, there are a number of pressures within CAMHS, similar in part to those experienced by school counsellors (Lambie & Stewart, 2010). It would be interesting to gain the perspectives of those working within CAMHS around Aotearoa New Zealand to see what they believe would be most beneficial to refining and improving the current processes. Clarity could be gained about the universality or lack thereof of the process (Allison et al., 2008), alongside assessing the challenges faced by CAMHS staff. Do they view resourcing as an issue? (Wille & Nixon, 2008). Do they feel they have the skill set (Levinson et al., 2021) to keep up with the increasing prevalence and severity of rangatahi mental health? (Eapen et al., 2023). What are their perspectives of the current acceptance rate (Barnes, 2023) and what do they believe needs to change for CAMHS to be more accessible to all rangatahi? (Park et al., 2022). To work towards a common goal of improving mental health outcomes for the rangatahi of Aotearoa New Zealand, it is imperative that those who deliver these vital services are onboard with creating change. It is, therefore, important that they are allowed to share their perspectives to collaborate what would practicably work for them, as the experts in child and adolescent mental health.

### ***Voice of Rangatahi***

Rangatahi are the future of Aotearoa New Zealand, therefore, their voice is of utmost importance around services that directly impact their wellbeing needs (Mitchell-Lowe & Eggleston, 2009). With the prevalence and severity of youth mental health rapidly increasing (Theodore et al., 2022), it is evident that something must change to provide these individuals with better access to support. However, throughout literature it is seen that services or initiatives are often developed without consideration for those who utilise them, despite the knowledge that most individuals are more receptive to programmes which allow them a level

of autonomy (Berger & Samuel, 2020). Taking the perceptions of rangatahi into consideration, the following research questions could be posed: What are the barriers (Clark et al., 2014) rangatahi perceive towards accessing appropriate services? What are the qualities of CAMHS staff that rangatahi perceive as valuable or effective (Auger et al., 2018) when engaging in the service? What would they suggest as being appropriate alternative models of service (Stasiak et al., 2013), which would help to increase access to CAMHS by rangatahi?

Although rangatahi are not always at the cognitive stage of development where they can fully appreciate what is best for them, they are much more likely to engage well with a service which is going to value their voice, therefore, this future area of research has the potential to contribute to this sense of belonging.

### ***Type of school***

Highlighted by the quantitative data and further validated by the research literature, the type of school a young person attends may have an influence on the access they receive. In the current study, the majority of schools were state schools, owned and funded by the Government, meaning that their resourcing is reliant on this funding alone (Every-Palmer et al., 2022). Interestingly the school which identified as state integrated, saw the least students (could be due to population size) but referred the most individuals to CAMHS. Could the alternative funding source provided by the primary owner(s) of the school allow for more resourcing of the school counselling space, therefore, allowing for an increase of access (Clark et al., 2014) to services? An investigation into the investment schools are able to make in their school counselling space, may shed light on any disparities the differences of school type (Denny et al., 2019) may play in rangatahi mental health. A larger scale comparative analysis of the descriptive statistics between funding, school type, and referral rate would draw attention to any links between funding type, amount, and access to CAMHS.

### *Culture and Gender*

Culture and gender also warrant further consideration, both of these factors have a significant influence on attitudes and access towards CAMHS. Gender was only briefly touched upon in the gathering of data for this study, most participants worked at co-educational schools, catering to both males and females, however, a further opportunity was missed by not exploring the percentage break down of gender that accessed these services, or indeed were referred on to CAMHS. While beyond the scope of the current research, gender should be considered when evaluating the overall efficacy of the CAMHS referral process. Within Aotearoa New Zealand, it is overwhelmingly female rangatahi who are accessing supports (Manthei, Tuck, Crocket, et al., 2020), whereas males are much more likely to mask their emotional struggles (Raeburn et al., 2015) through attitudinal fears of stigma (Auger et al., 2018) around mental health. Future investigation could explore the barriers of males and non-cis-gendered individuals accessing CAMHS and the potential solutions which could lead to an equality of access by all genders.

Existing within a bicultural partnership, all practices and services should be operating in a culturally responsive manner (McClintock, Tauroa, Mellsop, et al., 2016). This is of utmost importance within the area of mental health. Māori are overrepresented in mental health statistics and have significantly less access to services (Park et al., 2011), reporting worse outcomes. The purpose of this research study did not encompass culture, however, upon further reflection it is an important area for future research. What are the barriers that limit those from Māori or minority cultures (such as Pacific or Asian cultures) from accessing support? (Park et al., 2022). How does the framework of mental health services offered by CAMHS and school counselling embed a culturally responsive lens? (Kahu et al., 2012). What are the perceived benefits to Māori health models (Mental Health Foundation of New Zealand, 2024) being adopted and implemented by CAMHS?

### ***Factors affecting School Counsellors***

While the current study gained school counsellor perspectives on the CAMHS referral process, it did not inquire into reasons for referral or the factors which may be influencing them in both decisions to refer and everyday practice. It is, therefore, suggested that further information is gathered to establish the factors that are affecting school counsellors of Aotearoa New Zealand and how this is influencing their decision making in referrals to CAMHS. Experience is a factor to investigate more closely, one participant justified their confidence in the CAMHS referral process by stating that they had not been at the school that long, so how does length of time impact on experience (Levinson et al., 2021) and skill to deal with rangatahi mental health? Does this experience shift attitudinal beliefs about the state of CAMHS? As outlined previously, school counsellors are not immune to the stressors of life, and social and socio-economic factors may play a role in influencing school counsellors perceptions and capacity (Crowe, 2006). How do these life stressors interact with increasing mental health prevalence in rangatahi, and what influence does this have on frequency of referral? (Trynes, 1998). Investigating these factors could also shed further light on their initial responses to current research study. It may illuminate areas of frustration further, but also give balance to the data, acknowledging the world view (Kaushik & Walsh, 2019) through which they perceived the CAMHS referral process.

### ***Alternative Tools to Support Mental Health***

Finally, in the response to rangatahi's need for alternative models of access to CAMHS, future research could explore the potential of alternative tools to support their mental health. CAMHS reported both inadequately detailed referrals (Hansen et al., 2023) and drop-outs of service, both of which are impacting on CAMHS's use of time and the number of rangatahi who can physically access the service (Johnson et al., 2009). Of particular note would be exploring the utilisation of digital tools (Arps et al., 2018). These have the potential to add screening information to the CAMHS referral process, ensuring

these are of the appropriate depth (Hansen et al., 2023). They would also be of benefit to rangatahi who cannot physically access a service with immediacy, providing alternative access and potentially reducing symptomology. What is the efficacy of utilising digital tools in the CAMHS referral process? How do Government policies, such as ‘away for the day’ (Ministry of Education, 2024b), impact on their implementation?

## **Conclusion**

School counsellors have played a vital role in securing the futures of vulnerable rangatahi for a number of years in Aotearoa New Zealand, and they will continue to advocate for the mental health of rangatahi for years to come. It is, therefore, of significant importance that their voices continue to be heard, so that improvements can be made in the way we approach the mental health of rangatahi. Child and Adolescent Mental Health Services (CAMHS) are pivotal in providing essential expert mental health care for rangatahi and their services are becoming of increasing importance as the prevalence and severity of mental health concerns continues to increase. Mental health care services for rangatahi cannot operate in isolation, as the leaders of our future, rangatahi deserve to have a collaborative approach to mental health which has them at the centre of their focus. It is, therefore, imperative that school counsellors are able to include their evaluative voice in the construction of an effective referral process for CAMHS. The initial aim of this research study was to investigate the perceptions of school counsellors on the number of referrals that were accepted by CAMHS. It was identified that school counsellors perceived only a minimal number of their referrals to CAMHS were accepted. This perception is troubling, as it then calls into question the clarity and efficacy of the CAMHS referral process. This could account for what literature reports as an underutilisation of CAMHS nationwide. Rangatahi who need support, may simply have had their access denied due in part to the clarity of the referral process.

The second aim of the research study was to identify school counsellors' confidence in the referral process, and although hypothesised that school counsellors would have some confidence in the process, the value of this confidence was varying. School counsellors were somewhat confident in the process but identified this in both a positive and negative light, primarily concerned with the uncertainty of referral acceptance.

Thirdly, the research aimed to gain an understanding of school counsellors' perceptions of the strengths and weaknesses of the current CAMHS referral process. The strengths of communication and collaboration were identified as most prominent here. This is supported by literature which suggests that effective collaboration and communication leads to increased referrer satisfaction, alongside also improving the outcomes for rangatahi. However, the school counsellors presented a much larger list of weaknesses for the CAMHS referral process and the most important themes of resourcing, communication, collaboration, lack of acceptance, and time were identified. Not surprisingly, communication and collaboration appeared as themes again, mirroring literature which suggests that when these areas are not well addressed, systems do not function optimally. Resourcing is a weakness which overarches much of CAMHS capacity to deliver an effective service and it is of no surprise that poor resourcing and/or funding does not support the optimal performance of the CAMHS referral process.

The final aim of this research study was to gain an understanding of the perceptions school counsellors hold around changes to the CAMHS referral process, in benefit of both them and the rangatahi in their care. It was hypothesised that school counsellors would be articulate in their expression of these ideas, and indeed they were able to shed light on many aspects which would lead to improvement of the process. School counsellors were able to aptly express ideas, which are supported by literature for the overall improvement of the CAMHS referral process. These ideas were then synthesised further into a list of action

points, which if addressed have the potential of contributing to the improvement of the CAMHS referral process. These included the development of a list of universally agreed upon referral criteria, an examination of the staffing ratios within CAMHS, a review of the equity of funding, agreed upon targets for both wait times and clinical face-to-face time, and increased communication and collaboration with key stakeholders. If any of these suggested changes, interpreted from the perception of school counsellors were implemented, it would have a significant impact on the process itself and the perception of the school counsellors referring to it.

The mental health of the rangatahi of Aotearoa New Zealand is of critical importance and it is time that those working most closely with them, supporting them through this often-rocky journey have their voices heard. With partnership and participation between school counsellors and CAMHS, Aotearoa New Zealand can move one step closer to its goal of preventative health care, avoiding being the proverbial ambulance at the bottom of the cliff.

## References

- Allison, S., Roeger, L., & Abbot, D. (2008). Overcoming barriers in referral from schools to mental health services. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 16(1), 44-47.  
<https://doi.org/10.1080/10398560701769525>
- Arps, E. R., Friesen, M. D., & Overall, N. C. (2018). Promoting youth mental health via text-messages: A New Zealand feasibility study. *Applied Psychology: Health and Well-Being*, 10(3), 457-480. <https://doi.org/10.1111/aphw.12143>
- Auger, R. W., Abel, N. R., & Oliver, B. M. (2018). Spotlighting stigma and barriers: Examining secondary students' attitudes toward school counseling services. *Professional School Counseling*, 22(1). <https://doi.org/10.1177/2156759X18811275>
- Augustine, L. (2016). Factors of psychological well-being among school counsellors. *Indian Journal of Health & Wellbeing*, 7(6), 662-667.
- Ball, W., Rowlands, H., Black, C., Paranjothy, S., Rasalam, A., Ritchie, D., Rzewuska, M. T., Elaine, Wilde, K., & Butler, J. (2022). Inequalities in children's mental health prescribing and referrals for specialist mental health services. *International Journal of Population Data Science*, 7(3). <https://doi.org/10.23889/ijpds.v7i3.1980>
- Barnes, S. R. (2023). *Parental perspective on children's mental health : an Investigation into Aotearoa New Zealand parental figures mental health literacy : A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University, Manawatū, New Zealand* [Masters Thesis], Massey University Library Catalogue.
- Barry, A. (2011). *The search for a routine outcome measure for multidisciplinary interventions with young people in New Zealand : A thesis presented in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology at*

*Massey University, Manawatu campus, New Zealand* [Doctoral Thesis], Massey University Library Catalogue.

- Bauer, A., Stevens, M., Purtscheller, D., Knapp, M., Fonagy, P., Evans-Lacko, S., & Paul, J. (2021). Mobilising social support to improve mental health for children and adolescents: A systematic review using principles of realist synthesis. *PLoS ONE*, *16*(5), 1-23. <https://doi.org/10.1371/journal.pone.0251750>
- Berger, E., & Samuel, S. (2020). A qualitative analysis of the experiences, training, and support needs of school mental health workers regarding student trauma. *Australian Psychologist*, *55*(5), 498-507. <https://doi.org/10.1111/ap.12452>
- Bishop, F. L. (2015). Using mixed methods research designs in health psychology: An illustrated discussion from a pragmatist perspective. *BRITISH JOURNAL OF HEALTH PSYCHOLOGY*, *20*(1), 5-20. <https://doi.org/10.1111/bjhp.12122>
- Bishop, R., & Berryman, M. (2010). Te Kotahitanga: Culturally responsive professional development for teachers. *Teacher Development*, *14*(2), 173-187.
- Bott, E. (2010). Favourites and others: Reflexivity and the shaping of subjectivities and data in qualitative research. *Qualitative Research*, *10*(2), 159-173. <https://doi.org/10.1177/1468794109356736>
- Bowden, N., Gibb, S., Thabrew, H., Kokaua, J., Audas, R., Merry, S., Taylor, B., & Hetrick, S. E. (2020). Case identification of mental health and related problems in children and young people using the New Zealand Integrated Data Infrastructure. *BMC Medical Informatics & Decision Making*, *20*(1), 1-13. <https://doi.org/10.1186/s12911-020-1057-8>
- Boyce, P. (2015). Are we there yet? *Australian and New Zealand Journal of Psychiatry*, *49*(9), 765-766. <https://doi.org/10.1177/0004867415601783>

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2023). Is thematic analysis used well in health psychology? A critical review of published research, with recommendations for quality practice and reporting. *Health Psychology Review*, 17(4), 695-718. <https://doi.org/10.1080/17437199.2022.2161594>
- Bright, C., Devine, N., Du Preez, E., & Goedeke, S. (2022). Strength-based school counsellors' experiences of counselling in New Zealand. *British Journal of Guidance & Counselling*, 50(5), 710-731. <https://doi.org/10.1080/03069885.2021.1981231>
- Brunton, W. (2011). *Story: Mental health services*. Te Ara - The Encyclopedia of New Zealand. <http://www.TeAra.govt.nz/en/mental-health-services>
- Case, R. J. L., Barber, C. C., & Starkey, N. J. (2015). Psychosocial needs of parents and children accessing hospital outpatient paediatric services in New Zealand. *Journal of Paediatrics & Child Health*, 51(11), 1097-1102. <https://doi.org/10.1111/jpc.12949>
- Clark, T. C., Johnson, E. A., Kekus, M., Newman, J., Patel, P. S., Fleming, T., & Robinson, E. (2014). Facilitating access to effective and appropriate care for youth with mild to moderate mental health concerns in New Zealand. *Journal of Child & Adolescent Psychiatric Nursing*, 27(4), 190-200. <https://doi.org/10.1111/jcap.12095>
- Crowe, A. (2006). Guidance and counselling in New Zealand secondary schools: Exploring the issues. *New Zealand Journal of Counselling*, 26(3), 16-25. <https://doi.org/10.24135/nzjc.v26i3.58>
- D'Costa, S., Grant, S., Kulkarni, T., Crossing, A., Zahn, M., & Tanaka, M. L. (2024). A call for QuantCrit methodologies: Unpacking the need for a critical lens in school psychology research. *School Psychology International*, 45(3), 254-279. <https://doi.org/10.1177/01430343231202753>

- Denny, S., Grant, S., Galbreath, R., Utter, J., Fleming, T., & Clark, T. (2019). An observational study of adolescent health outcomes associated with school-based health service utilization: A causal analysis. *Health services research, 54*(3), 678-688. <https://doi.org/10.1111/1475-6773.13136>
- Dhong, Y. (2023). Descriptive Statistics and Its Applications. *Highlights in Science, Engineering and Technology, 47*, 1-8.
- Dodgers, S., Cordoba, S., & Coe, J. (2023). Examining the role of childhood experiences in gender identity and expression: An interpretative phenomenological analysis using Social Learning Theory. *Gender Issues, 40*(2-4), 255-274. <https://doi.org/10.1007/s12147-023-09314-4>
- Eapen, V., Stylianakis, A., Scott, E., Milroy, H., Bowden, M., Haslam, R., & Stathis, S. (2023). Stemming the tide of mental health problems in young people: Challenges and potential solutions. *Australian & New Zealand Journal of Psychiatry, 57*(4), 482-488. <https://doi.org/10.1177/00048674221136037>
- Eggleston, M. J. F., & Watkins, W. G. A. (2008). Mental health services for children and adolescents in New Zealand, outcomes, and the 'Health of the nation outcome scale for children and adolescents' (HoNOSCA). *New Zealand medical journal.*
- Evans, N., Edwards, D., & Carrier, J. (2019). Admission and discharge criteria for adolescents requiring inpatient or residential mental health care: A scoping review. *JBI Database of Systematic Reviews and Implementation Reports.* <https://doi.org/10.11124/JBISRIR-2017-004020>
- Evans, Y. A., & Payne, M. A. (2008). Support and self-care: Professional reflections of six New Zealand high school counsellors. *British Journal of Guidance & Counselling, 36*(3), 317-330. <https://doi.org/10.1080/03069880701729466>

- Every-Palmer, S., Grant, M. L., & Thabrew, H. (2022). Young people don't tend to ask for help more than once: Child and adolescent psychiatrists' views on ailing mental health services for young New Zealanders. *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists*, 30(6), 684-688.  
<https://doi.org/10.1177/10398562221115624>
- Faculty of Child and Adolescent Psychiatry. (2019). Child and adolescent psychiatry: meeting future workforce needs. *The Royal Australian & New Zealand College of Psychiatrists*. <https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/child-and-adolescent-psychiatry-meeting-future-workforce-needs>
- Fenton, C. (2020). Is consent causing confusion for clinicians? A survey of child and adolescent mental health professional's confidence in using parental consent, Gillick competence and the Mental Capacity Act. *Clinical Child Psychology and Psychiatry*, 25(4), 922-931. <https://doi.org/10.1177/1359104520931586>
- Ferguson, C. (2012). Out of our comfort zone. *New Zealand Journal of Counselling*, 32(1), 25-36. <https://doi.org/10.24135/nzjc.v32i1.159>
- Fleming, T., Crengle, S., Peiris-John, R., Ball, J., Fortune, S., Yao, E. S., Lindsay Latimer, C., Veukiso-Ulugia, A., & Clark, T. C. (2024). Priority actions for improving population youth mental health: An equity framework for Aotearoa New Zealand. *Mental Health & Prevention*, 34. <https://doi.org/10.1016/j.mhp.2024.200340>
- Fortune, S., & Clarkson, H. (2006). The role of child and adolescent mental health services in suicide prevention in New Zealand. *Australasian Psychiatry*, 14(4), 369-373.  
<https://doi.org/10.1080/j.1440-1665.2006.02306.x>

- Garisch, J. A., Robinson, K., & Wilson, M. S. (2020). Responding to non-suicidal self-injury in New Zealand secondary schools: Guidance counsellors' perspectives. *New Zealand Journal of Counselling*, 40(1), 15-29. <https://doi.org/10.24135/nzjc.v40i1.240>
- Garralda, E. (2001). Child and adolescent psychiatry in general practice. *Australian & New Zealand Journal of Psychiatry*, 35(3), 308-314.
- Gossage, L., Narayanan, A., Dipnall, J. F., Iusitini, L., Sumich, A., Berk, M., Wrapson, W., Tautolo, E.-S., & Siegert, R. (2022). Risk factors for depression in Pacific adolescents in New Zealand: A network analysis. *Journal of Affective Disorders*, 311, 373-382. <https://doi.org/10.1016/j.jad.2022.05.076>
- Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods*, 17(3), 374-384. <https://doi.org/10.1037/a0029313>
- Gray, D., Manning, R., & Oftadeh-Moghadam, S. (2021). Using mixed and multi-modal methods in psychological research with young people. In A. Lees & R. Locke (Eds.), *Mixed-methods research in wellbeing and health* (1st ed., pp. 156-173). Routledge.
- Hansen, A. S., Christoffersen, C. H., Tellés, G. K., & Lauritsen, M. B. (2021). Referral patterns to outpatient child and adolescent mental health services and factors associated with referrals being rejected. A cross-sectional observational study. *BMC Health Services Research*, 21(1), 1-12. <https://doi.org/10.1186/s12913-021-07114-8>
- Hansen, A. S., Kjaersdam Tellés, G., Mohr-Jensen, C., Færk, E., & Lauritsen, M. B. (2023). The effect of the Development and Well-Being Assessment as an adjunct to standard referral letters on referral decisions by child and adolescent mental health services — A randomized feasibility trial. *Clinical Child Psychology & Psychiatry*, 28(2), 434-449. <https://doi.org/10.1177/13591045221081384>

- Harrison, M. G., Wai, F., & Cheung, J. K. F. (2022). The experiences of school counsellors in Hong Kong: implications for policy innovation. *British Journal of Guidance & Counselling*, 50(6), 847-864. <https://doi.org/10.1080/03069885.2022.2164758>
- Haslam, N., & Tse, J. S. Y. (2024). Public awareness of mental illness: Mental health literacy or concept creep? *Australasian Psychiatry*, 1. <https://doi.org/10.1177/10398562241292202>
- Health New Zealand Te Whatu Ora. (2024a). *Calculating waiting times for mental health & addiction target: faster access to specialist mental health & addiction services*. <https://www.tewhatauora.govt.nz/assets/Our-health-system/Data-and-statistics/National-Collections-Files/PRIMHD-File-Specification/mental-health-calculating-waiting-times.pdf>
- Health New Zealand Te Whatu Ora. (2024b). *Health information and services*. Retrieved 01/12/2024 from <https://info.health.nz/>
- Health New Zealand Te Whatu Ora. (2024c). *Mental health and addiction services in Whanganui*. <https://info.health.nz/locations/manawatu-whanganui/whanganui-hospital/mental-health-and-addiction-services-in-whanganui#AccordionItems-6970>
- Hemi, A., & Maor, R. (2023). Stress in the school counsellor's contemporary role: Scale development and validation. *Educational Studies*, 49(2), 350-368. <https://doi.org/10.1080/03055698.2020.1865132>
- Henshaw, P. (2024). Mental health crisis: The children and young people waiting years for CAMHS support. *British Journal of Child Health*, 5(2), 87-88. <https://doi.org/10.12968/chhe.2024.5.2.87>
- Houchins, D. E., Hitchcock, J. H., & Conroy, M. A. (2023). A Framework for approaching mixed methods intervention research to address the emotional and behavioral health

needs of children. *Behavioral Disorders*, 48(3), 151-162.

<https://doi.org/10.1177/01987429221131279>

James, S. A., & Buttle, H. (2008). Attitudinal differences towards mental health services between younger and older New Zealand adults. *NEW ZEALAND JOURNAL OF PSYCHOLOGY*, 37(3), 33-43.

John, S., & Cohen, D. (2024). Short research article: Opening a new CAMHS day hospital – does it affect inpatient admissions and does it help at all? *Child & Adolescent Mental Health*, 29(3), 276-280. <https://doi.org/10.1111/camh.12680>

Johnson, E., Mellor, D., & Brann, P. (2009). Factors associated with dropout and diagnosis in child and adolescent mental health services. *Australian & New Zealand Journal of Psychiatry*, 43(5), 431-437. <https://doi.org/10.1080/00048670902817687>

Kahu, M., Graham, M., Tess, M.-M., & Chris, F. (2012). Pilot of Te Tomokanga: A Child and Adolescent Mental Health Service evaluation tool for an Indigenous population. *International Indigenous Policy Journal*, 3(1), 5-5.

Kahu, M., Roimata, T., & Graham, M. (2016). An examination of Child and Adolescent Mental Health Services for Māori rangatahi [youth]. *International Journal of Adolescence and Youth*, 21(1), 56-63. <https://doi.org/10.1080/02673843.2012.692658>

Kahu, M., Roimata, T., Graham, M., & Chris, F. (2016). Pilot of Te Tomo mai, a child and adolescent mental health service evaluation tool for an indigenous rangatahi (youth) population. *International Journal of Adolescence and Youth*, 21(1), 96-103. <https://doi.org/10.1080/02673843.2013.813861>

Kaur, P., Stoltzfus, J., & Yellapu, V. (2018). Descriptive statistics. *International Journal of Academic Medicine*, 4(1), 60-63.

- Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for Social Work research. *Social Sciences*, 8(9).  
<https://doi.org/10.3390/socsci8090255>
- Kelle, U. (2017). The integration of qualitative and quantitative research - theoretical foundations of "mixed methods". *Kolner Zeitschrift Fur Soziologie Und Sozialpsychologie*, 69, 39-61. <https://doi.org/10.1007/s11577-017-0451-4>
- Key, S. (2023). *The perceptions and understandings of wellbeing during early adolescence: The perspectives of adolescents, whānau and teachers in Aotearoa New Zealand*. University of Canterbury.
- Kutcher, S. P. (2015). *School mental health: Global challenges and opportunities*. Cambridge University Press.
- Lambie, I., & Stewart, M. W. (2010). Workforce factors for psychologists in CAMHS in New Zealand. *Child & Adolescent Mental Health*, 15(3), 164-170.  
<https://doi.org/10.1111/j.1475-3588.2010.00561.x>
- Lavery, L. (2002). *And then what happened? : interviews about parent use, expectations, and evaluations of therapies used by five families with children with autism in Canterbury*. NZARE 2001, Christchurch.
- Lees, A., & Locke, R. (2021). *Mixed-methods research in wellbeing and health* (1st ed.). Routledge.
- Levinson, S., Nel, P. W., & Conlan, L.-M. (2021). Experiences of newly qualified clinical psychologists in CAMHS. *Journal of Mental Health Training, Education & Practice*, 16(3), 187-199. <https://doi.org/10.1108/JMHTEP-08-2019-0043>
- Levkovich, I., & Ne'emani, H. (2022). 'Childhood in the shadow of prison bars': How school counselors cope while counseling children of incarcerated parents. *Children & Society*, 36(6), 1139-1155. <https://doi.org/10.1111/chso.12562>

- Levy, M., & Waitoki, W. W. (2016). Our voices our future: Indigenous psychology in Aotearoa New Zealand. In W. W. Waitoki, J. S. Feather, N. R. Robertson, & J. J. Rucklidge (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed., pp. 29). The New Zealand Psychological Society.
- Lipatov, S. A., & Nesterova, E. M. (2024). Integration of Qualitative and Quantitative Approaches as a Methodological Issue in Social Psychology. *National Psychological Journal*, 19(3), 81-90. <https://doi.org/10.11621/npj.2024.0306>
- Lopez-Carmen, V., McCalman, J., Benveniste, T., Askew, D., Spurling, G., Langham, E., & Bainbridge, R. (2019). Working together to improve the mental health of indigenous children: A systematic review. *Children and Youth Services Review*, 104. <https://doi.org/10.1016/j.chilyouth.2019.104408>
- Lucassen, M. F. G., Stasiak, K., Crengle, S., Weisz, J. R., Frampton, C. M. A., Bearman, S. K., Ugueto, A. M., Herren, J., Cribb-Su'a, A., Faleafa, M., Kingi-'Ulu'ave, D., Loy, J., Scott, R. M., Hartdegen, M., & Merry, S. N. (2015). Modular Approach to Therapy for Anxiety, Depression, Trauma, or Conduct Problems in outpatient child and adolescent mental health services in New Zealand: Study protocol for a randomized controlled trial. *Trials*, 16, 457. <https://doi.org/10.1186/s13063-015-0982-9>
- Lumb, T. (2009). *Participating in partnership : guidelines for enabling effective family/whānau participation in CAMH and AOD services in New Zealand* (2nd ed ed.). Werry Centre for Child and Adolescent Mental Health Workforce Development.
- Madill, A., & Gough, B. (2008). Qualitative research and its place in psychological science. *Psychological Methods*, 13(3), 254-271. <https://doi.org/10.1037/a0013220>
- Malato, G. (2023). *An Introduction to the Shapiro-Wilk Test for Normality*. Built In. <https://builtin.com/data-science/shapiro-wilk-test>

- Maloney, D., & Walter, G. (2005). Contribution of 'school-link' to an area mental health service. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 13(4), 399-402. <https://doi.org/10.1080/j.1440-1665.2005.02233.x>
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753-1760. <https://doi.org/10.1177/1049732315617444>
- Mansell, L., Hughes, K., Heyes, J.-W., Brownlee, A., Charm, C., Blake, D., Collinge, S., & Smith, J. (2021). A new consultation, Assessment and reflection model (CARM) used in child and adolescence mental health services (CAMHS). *Clinical Child Psychology & Psychiatry*, 26(4), 1046-1052. <https://doi.org/10.1177/13591045211016512>
- Manthei, R., Tuck, B., Agee, M., Crocket, A., & Gardiner, B. (2020). The case for increasing the number of counsellors in secondary schools: Ratios, research, and recommendations. *New Zealand Journal of Counselling*, 40(2), 3-19. <https://doi.org/10.24135/nzjc.v40i2.244>
- Manthei, R., Tuck, B. F., Crocket, A., Gardiner, B., & Agee, M. N. (2020). Exploring counselling outcomes in New Zealand schools. *Counselling & Psychotherapy Research*, 20(4), 615-625. <https://doi.org/10.1002/capr.12353>
- Mares, S., & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention -- clinical, administrative and ethical issues. *Australian & New Zealand Journal of Public Health*, 28(6), 520-526. <https://doi.org/10.1111/j.1467-842X.2004.tb00041.x>
- Mariu, K. R., Merry, S. N., Robinson, E. M., & Watson, P. D. (2012). Seeking professional help for mental health problems, among New Zealand secondary school students.

*Clinical child psychology and psychiatry*, 17(2), 284-297.

<https://doi.org/10.1177/1359104511404176>

McCann, T. V., & Lubman, D. I. (2012). Young people with depression and their experience accessing an enhanced primary care service for youth with emerging mental health problems: a qualitative study. *BMC Psychiatry*, 12(1), 96-104.

<https://doi.org/10.1186/1471-244X-12-96>

McClintock, K., Moeke-Maxwell, T., & Mellsop, G. (2012). Appropriate Child and Adolescent Mental Health Service (CAMHS): Māori caregiver's perspectives.

*Pimatisiwin: A Journal of Aboriginal & Indigenous Community Health*, 9(2), 387-398.

McClintock, K., Tauroa, R., & Mellsop, G. (2016). An examination of Child and Adolescent Mental Health Services for Māori rangatahi [youth]. *International Journal of*

*Adolescence & Youth*, 21(1), 56-63. <https://doi.org/10.1080/02673843.2012.692658>

McClintock, K., Tauroa, R., Mellsop, G., & Frampton, C. (2016). *Tomo Mai Responsive Child and Adolescent Mental Health Services Survey*.

McMahon, C. M., Henry, S., & Linthicum, M. (2021). Employability in autism spectrum disorder (ASD): Job candidate's diagnostic disclosure and asd characteristics and employer's ASD knowledge and social desirability. *Journal of Experimental*

*Psychology: Applied*, 27(1), 142-157. <https://doi.org/10.1037/xap0000282>

Mental Health Foundation of New Zealand. (2022). *Wake-up call to all politicians: Decades of neglect have led to a mental health crisis in NZ*. Mental Health Foundation of New

Zealand,. <https://mentalhealth.org.nz/news/post/wake-up-call-to-all-politicians>

Mental Health Foundation of New Zealand. (2024). *Te Whare Tapa Whā*.

<https://mentalhealth.org.nz/te-whare-tapa-wha>

- Merry, S. N., Cargo, T., Christie, G., Donkin, L., Hetrick, S., Fleming, T., Holt-Quick, C., Hopkins, S., Stasiak, K., & Warren, J. (2020). Debate: Supporting the mental health of school students in the COVID-19 pandemic in New Zealand - a digital ecosystem approach. *Child and adolescent mental health*, 25(4), 267-269.  
<https://doi.org/10.1111/camh.12429>
- MidCentral Health. (2021). *Child, adolescent and family mental health and co-existing disorder service*. <https://healthpoint.co.nz>
- Ministry of Education. (2024a). *The New Zealand Curriculum - Health and physical education*. <https://newzealandcurriculum.tahurangi.education.govt.nz/the-new-zealand-curriculum---health-and-physical-education/5637209122.p>
- Ministry of Education. (2024b). *Phones away for the day*.  
<https://education.govt.nz/cellphones>
- Ministry of Health. (2020). *Referrals received by mental health and addiction teams in New Zealand from child, adolescent and family/whānau mental health services - By age group and sex, year ended June 2018, number of new referrals*. Figure.NZ.
- Ministry of Health. (2024a). *Annual update of key results 2023/2024: New Zealand Health Survey*. Ministry of Health. <https://www.health.govt.nz/publications/annual-update-of-key-results-20232024-new-zealand-health-survey>
- Ministry of Health. (2024b). *Briefing: Overview of youth health*. Ministry of Health,.  
<https://www.health.govt.nz/system/files/2024-08/h2024036868-briefing-overview-of-youth-health.pdf>
- Ministry of Health. (2024c). *Health and Independence Report 2023 - Te Pūrongo mō te Hauora me te Tū Motuhake 2023*. Ministry of Health.
- Mitchell-Lowe, M., & Eggleston, M. (2009). Children as consumer participants of child and adolescent mental health services. *Australasian psychiatry : bulletin of Royal*

*Australian and New Zealand College of Psychiatrists*, 17(4), 287-290.

<https://doi.org/10.1080/10398560902862657>

Morrison, S. (2023). Up to speed with te reo: Stacey Morrison follows wisdom in words - proverbs. *The New Zealand Herald*.

Muir, R. (2023). From data to insights: Developing a tool to enhance our decision making using Reflexive Thematic Analysis and qualitative evidence. *Journal of the Australian Library & Information Association*, 72(2), 150-165.

<https://doi.org/10.1080/24750158.2023.2206603>

Munford, R., & Sanders, J. (2016). Understanding service engagement: Young people's experience of service use. *Journal of Social Work*, 16(3), 283-302.

<https://doi.org/10.1177/1468017315569676>

Naughton, J. N. L., Carroll, M., Basu, S., & Maybery, D. (2018). Clinical change after the implementation of the Choice and Partnership Approach within an Australian Child and Adolescent Mental Health Service. *Child & Adolescent Mental Health*, 23(1), 50-

56. <https://doi.org/10.1111/camh.12208>

Newman, K. L., Sayal, K., Thomson, L., Ewart, C., Lang, A., Bhardwaj, A., Dubicka, B., & Marshall, T. (2024). Snakes and ladders: The experience of being referred to and seen by Child and Adolescent Mental Health Services. *SSM - Mental Health*, 6.

<https://doi.org/10.1016/j.ssmmh.2024.100343>

Newman, L., & Birleson, P. (2012). Mental health planning for children and youth: Is it developmentally appropriate? *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists*, 20(2), 91-97.

<https://doi.org/10.1177/1039856211432479>

Nobilo, H. (2017). *An Insight into Adolescence*. Brainwave Trust.

<https://brainwave.org.nz/article/an-insight-into-adolescence/>

- Office of the Auditor-General. (2024). *Meeting the mental health needs of young New Zealanders* (1179-0725). Office of the Auditor-General.  
<https://oag.parliament.nz/2024/youth-mental-health>
- Park, C., Loy, J. H., Lillis, S., & Menkes, D. B. (2022). What stops Korean immigrants from accessing child and adolescent mental health services? *Child and Adolescent Psychiatry and Mental Health*, 16(1). <https://doi.org/10.1186/s13034-022-00455-0>
- Park, C., McDermott, B., Loy, J., & Dean, P. (2011). Adolescent admissions to adult psychiatric units: Patterns and implications for service provision. *Australasian Psychiatry*, 19(4), 345-349. <https://doi.org/10.3109/10398562.2011.601311>
- Parker, I. (1994). Reflexive research and the grounding of analysis: Social Psychology and the Psy-complex. *Journal of Community & Applied Social Psychology*, 4(4), 239-252.  
<https://doi.org/10.1002/casp.2450040404>
- Paterson, R., Durie, M., Bisley, B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He Ara Oranga: Report of the Government Inquiry into mental health and addiction*. Government Inquiry into Mental Health and Addiction.
- Paul, M., Berriman, J. A., & Evans, J. (2008). Would I attend Child and Adolescent Mental Health Services (CAMHS)? Fourteen to sixteen year olds decide. *Child and Adolescent Mental Health*, 13(1), 19-25. <https://doi.org/10.1111/j.1475-3588.2007.00453..x>
- Peiris-John, R., Ball, J., Clark, T., Fleming, T., & Adolescent Health Research Group. (2024). *Youth Mental Health Needs and Opportunities: Leveraging 25 Years of Research from the Youth2000 survey series*. The University of Auckland and Victoria University of Wellington.

- Pine, R. (2021). Teachers' and health professionals' attitudes towards adolescent mental health and digital mental health interventions. *Advances in Mental Health, 19*(3), 295-305. <https://doi.org/10.1080/18387357.2020.1814160>
- Quayle, E., Larkin, A., Schwannauer, M., Varese, F., Cartwright, K., Chitsabesan, P., Green, V., Radford, G., Richards, C., Shafi, S., Whelan, P., Chan, C., Hewins, W., Newton, A., Niebauer, E., Sandys, M., Ward, J., & Bucci, S. (2024). Experiences of a digital health intervention for young people exposed to technology assisted sexual abuse: a qualitative study. *BMC Psychiatry, 24*(1), 1-12. <https://doi.org/10.1186/s12888-024-05605-6>
- R Core Team. (2024). *R: A language and environment for statistical computing*. In (Version 4.4) <https://cran.r-project.org>
- Raeburn, T., Walter, G., & Cleary, M. (2015). How can we better engage boys in mental health care? *International Journal of Mental Health Nursing, 24*(6), 449-450. <https://doi.org/10.1111/inm.12139>
- Ranui, A., Kelly, S., & Haggerty, C. (2018). Understanding the mental health support worker role in Aotearoa New Zealand: A literature review. *Whitireia Nursing and Health Journal*(25), 74-81.
- Saadat Mehr, R., Karimian, A., Abdullahzadeh, M., & Bakhshian, F. (2024). Teachers and counselors talk: The psychological impact of COVID-19 school closures on secondary school students. *Journal of School Health, 94*(10), 957-964. <https://doi.org/10.1111/josh.13501>
- Sharpe, H., Ford, T., Lereya, S. T., Owen, C., Viner, R. M., & Wolpert, M. (2016). Survey of schools' work with child and adolescent mental health across England: A system in need of support. *Child & Adolescent Mental Health, 21*(3), 148-153. <https://doi.org/10.1111/camh.12166>

- Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services. *Child & Adolescent Mental Health*, 23(1), 41-49. <https://doi.org/10.1111/camh.12207>
- Stanton, J., Lahdenperä, V., & Braun, V. (2017). Referral to an Acute Child and Adolescent Inpatient Unit: The Experiences and Views of Community Mental Health Referrers. *Qualitative Health Research*, 27(11), 1664-1674. <https://doi.org/10.1177/1049732316689782>
- Stasiak, K., Parkin, A., Seymour, F., Lambie, I., Crengle, S., Pasene-Mizziebo, E., & Merry, S. (2013). Measuring outcome in child and adolescent mental health services: consumers' views of measures. *Clinical child psychology and psychiatry*, 18(4), 519-535. <https://doi.org/10.1177/1359104512460860>
- Statistics New Zealand. (2024). *Wellbeing statistics: 2023*. <https://www.stats.govt.nz/information-releases/wellbeing-statistics-2023/#:~:text=percent%20in%202021,-.Mental%20wellbeing%20lower%20among%20women%20than%20men,from%2062%20percent%20in%202021.>
- Tarren-Sweeney, M. (2018). The mental health of adolescents residing in court-ordered foster care: Findings from a population survey. *Child Psychiatry & Human Development*, 49(3), 443-451. <https://doi.org/10.1007/s10578-017-0763-7>
- Te Maro, B., Cuthbert, S., Sofo, M., Tasker, K., Bowden, L., Donkin, L., & Hetrick, S. E. (2019). Understanding the experience and needs of school counsellors when working with young people who engage in self-harm. *International Journal of Environmental Research and Public Health*, 16(23). <https://doi.org/10.3390/ijerph16234844>
- Te Piki Oranga Māori Wellness Service. (2024). *Health Services for Rangatahi (Youth)*. <https://www.tpo.org.nz/health-services-for-rangatahi>

Thabrew, H., Gandeza, E., Bahr, G., Bettany, D., Bampton, C., Cooney, E., Coleman, N., & Tiatia-Seath, J. (2018). The management of young people who self-harm by New Zealand Infant, Child and Adolescent Mental Health Services: Cutting-edge or cutting corners? *Australasian Psychiatry*, 26(2), 152-159.

<https://doi.org/10.1177/1039856217748248>

The jamovi project. (2024). *jamovi*. In (Version 2.6) <https://www.jamovi.org>

The Royal New Zealand College of General Practitioners. (2024). *Future of the Workforce Report*. [https://www.rnzcgp.org.nz/our-voice/workforce-](https://www.rnzcgp.org.nz/our-voice/workforce-survey/#:~:text=Aotearoa%20is%20facing%20a%20shortage,%2C%20respiratory%2C%20and%20cardiovascular%20issues)

[survey/#:~:text=Aotearoa%20is%20facing%20a%20shortage,%2C%20respiratory%2C%20and%20cardiovascular%20issues](https://www.rnzcgp.org.nz/our-voice/workforce-survey/#:~:text=Aotearoa%20is%20facing%20a%20shortage,%2C%20respiratory%2C%20and%20cardiovascular%20issues).

The Werry Centre (Ed.). (2010). *Evidence-based age-appropriate interventions: A guide for Child and Adolescent Mental Health Services (CAMHS)* (2nd ed ed.). Werry Centre for Child and Adolescent Mental Health Development.

[http://www.werrycentre.org.nz/site\\_resources/library/Workforce\\_Development\\_Publications/FINAL\\_EBP\\_Document\\_12\\_May\\_2010.pdf](http://www.werrycentre.org.nz/site_resources/library/Workforce_Development_Publications/FINAL_EBP_Document_12_May_2010.pdf).

Theodore, R., Bowden, N., Kokaua, J., Ruhe, T., Hobbs, M., Hetrick, S., Marek, L., Wiki, J., Milne, B., Thabrew, H., & Boden, J. (2022). Mental health inequities for Māori youth: A population-level study of mental health service data. *The New Zealand medical journal*, 135(1567), 79-90. <https://doi.org/10.26635/6965.5933>

Tracy, S. J. (2010). Qualitative quality: Eight a"big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.

<https://doi.org/10.1177/1077800410383121>

Trynes, M. M. (1998). *Client characteristics and waiting time effects at a Child, Adolescent and Family Mental Health Service : A thesis presented in partial fulfilment of the requirements for the degree of Masters of Arts in Psychology at Massey University*

[Masters Thesis], Massey Research Online. Massey University.

<http://hdl.handle.net/10179/9932>

van Kessel, K., Krägeloh, C., & Babbage, D. (2016). eTherapy and psychological practice. In W. W. Waitoki, J. S. Feather, N. R. Robertson, & J. J. Rucklidge (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed., pp. 285-302). The New Zealand Psychological Society.

Victoria University of Wellington. (2024). *Mental health targets aren't enough—unless NZ backs them up with more detail and funding.*

<https://www.wgtn.ac.nz/news/2024/07/mental-health-targets-arent-enoughunless-nz-backs-them-up-with-more-detail-and-funding#:~:text=The%20government%20has%20also%20promised,Addiction%20Community%20Sector%20Innovation%20Fund.>

Wasson, K. (2014). Key competencies or key incompetencies? *New Zealand Journal of Counselling*, 34(2), 32-58. <https://doi.org/10.24135/nzjc.v34i2.186>

Wille, A., & Nixon, B. (2008). Workforce planning in child and adolescent mental health services and addiction services: A New Zealand perspective. *The Journal of Mental Health Training, Education and Practice*, 3(1), 28-32.

<https://doi.org/10.1108/17556228200800005>

Yavuz, O., Dahir, C., & Gumuseli, A. I. (2017). School principal perceptions of the school counsellor's role: Traditional or transformed? *Journal of Educational Leadership, Policy and Practice*, 32(2), 81-97.

## Appendices

**Appendix A**  
**Anonymised Raw Data exported to Microsoft Excel™ spreadsheet from Microsoft Forms™ Questionnaire**

ID	Please define your current role:	Which general region of Aotearoa New Zealand is your school in?	Please select the gender of your school caters for:	Select your school's type:	How many school counsellors are employed by your school?	On average per year, how many students utilise your school counselling services?	In your current role, do you have experience making referrals to your local Child and Adolescent Mental Health Service (CAMHS/CAMS)?	If yes, how confident is your knowledge of the referral process?	If no, do you understand what is required for a CAMHS referral?	Please elaborate on your choice for Question 8:	On average per year, how many CAMHS referrals do you make?	What are the most common reasons for your referral of students to CAMHS?	On average per year, how many referrals are accepted by CAMHS?	Do you think the referral criteria set by your local CAMHS are easily understood?	Please elaborate choice for Question 12:	In your opinion, what are the strengths of the CAMHS referral process in your region?	In your opinion, what are the current limitations/weaknesses of the CAMHS referral process in your region?	In your opinion, what change(s) to the CAMHS referral process would be most beneficial to you as a counsellor?	In your opinion, what change(s) to the CAMHS referral process would be most beneficial to the students engaged in your counselling services?	Are there any other comments you would like to make about the CAMHS referral process?
1	SGC	Central	Co-educational	State;	Two	100	Yes	Somewhat confident		I have only made a few referrals, haven't been at the school that long.2	5	Suicidal ideation	Minimal	No	A number are bounced back, or don't meet criteria.	Hard to define. Maybe that they answer the phone.	They don't call the Whanau straight away to acknowledge the referral and to explain the process and give a timeframe for when they will be in contact again to book appointment.	Them calling the Whanau, having that initial conversation, especially around safety. Explaining the next steps to them. Accepting referrals.	Transparency, communication with the young person.	A lot of questions which don't seem relevant.
2	School counsellor/registered psychologist	Central	Single Sex Girls	State-Integrated;	One	70	Yes	Somewhat confident		I am more familiar and confident with the process (including criteria for acceptance) with CAMHAS Whanganui, and less confident with CAFS (Palmerston North). I refer most students to CAMHAS as our school is within Whanganui DHB. When I	20	Self-harm, trauma, major depression	Maximal	Yes	CAMHAS have a straightforward referral form, and are happy to answer questions I may have around the referral.	They show willingness to collaborate and answer questions. They send me a copy of letters to whanau. They will phone with any concerns they have for a student. They have also come to school to meet with our team, or hold meetings.	I would like to receive more information when students are not accepted into the service, and can therefore follow any recommendation they might have when referred back to school counselling. As for the service itself, they do not have a psychologist on staff. The psychiatrist who normally reviews rangitahi can be very unhelpful with the messages she gives students (for example, recommending a student not receive a formal ASD diagnosis as future employers will not want to hire her).	More collaboration when students are not accepted - more information as to why, coming directly from their practitioners, and any recommendation for support	I'm not sure	N/A

									have referred to CAFS I do not always receive confirmation letters or updates.										
3	School Counsellor	Central	Co-educational	Special Character;	Two	150	Yes	Somewhat confident	Can be confusing.	5	Disordered eating, suicidal ideation.	Minimal	No	Doesn't feel like many get across the line.	Don't know.	Too many questions, not relevant. Parent permission!	Accepting without permission if they are old enough. Gillick principle.	Accepting without parent permission if they are old enough. Gillick principle. If they came to see them at school.	No.
4	Social Worker/Wellbeing Team Lead	Central	Co-educational	State;	One	120	Yes	Somewhat confident	I know how to refer but lack confidence in knowing there will be adequate follow up in a timely manner.	8	Suicide ideation/attempt, significant self-harm, Significant trauma	Minimal	No	It seems referrals are only accepted if severe symptoms but again there is a significant time delay in this. I cannot guarantee that a severe case is sufficient to access CAMHS support	There is a CAMHS service here.	The wait time. Following up with reluctant clients and their whanau. Accessing them in an emergency.	Knowing that a referred client will see someone quickly or at all.	more relational and taking time to build trust for future work. Most students do not continue due to aloofness or clinical nature of conversations. Also there is reluctance to share as whanau are informed what has been said.	I honestly just wish CAMHS had a service to respond to an immediate need and follow through until resolution. It feels as though, even in critical cases, if the client or whanau don't engage very little is done to draw them back into the process

5	School Guidance Counsellor	Central	Co-educational	State;	One	120	Yes	Somewhat confident	I have familiarity referring to CAMHS, but sometimes I don't know if my referral will be accepted	15	suicidal ideation, self-harm, eating disorders.	Moderate	Maybe	Although some CAMHS services provide clear guidelines by which to refer and the referral forms are clear, sometimes those who I think meet the service requirements are not accepted.	Friendly and experienced, especially with eating disorders.	Lack of communication when a referral is made, have to follow up to see if it has been received.	More collaboration between CAMHS and school. We have to support students in this environment and it can be hard to know how to do that without a clear plan and clear communication.	Shorter wait times, perhaps a triage system, so that a quick initial evaluation can be done, so CAMHS are actually meeting with the student and getting a rough idea about what would be right for them, CAMHS or not.	CAMHS is a much needed service but it can seem hard to get referrals through.
6	Guidance Counsellor	Central	Co-educational	State;	One	95	Yes	Somewhat confident	I have confidence in the referral process for the most part, as the online referral form is straight forward to follow. However, I am not always confident that my referrals will be accepted, despite my judgement that a student needs more than what I can provide in the way of support.	12	Depressive symptoms and self-harm.	Moderate	No	I have referred to two different CAMHS services and it is apparent that there is a difference between what is accepted by one and not by the other, unsure if this is because of a strain on the workforce/service or a lack of time/funding.	Quick communication after initial referral. The staff and personable and seem to genuinely want to support young people. They are good at communicating appointment times, so that the school can be aware/supportive of that individual student if necessary.	A lack of staffing and resources is evident. Wait times for appointments is not ideal. Limited suggestions offered if an individual is decline/refused from service as to what counsellor could put in place first.	If the referral process was universal in all regions. If a referral was denied, adequate reasoning and explanation was given to ensure individual still received appropriate support.	A cut in wait times. A short screening appointment or triage which could then give further explanation of next steps/acceptance/decline.	No.

**Appendix B****Copy of Text that was sent out in email to participants on Massey University  
Letterhead****The CAMHS Referral Process: The Perspectives of Aotearoa New  
Zealand School Counsellors*****INFORMATION SHEET*****Researcher(s) Introduction**

*This research is being conducted by Ashley Holland for the fulfilment of the requirements for the degree of Master of Science in Psychology. The academic supervisor involved is a clinical psychologist and Associate Professor, Dr Matthew Shepherd (Massey University, School of Psychology). Please read this Information Sheet carefully before deciding whether or not to participate.*

**Project Description and Invitation**

*We know that the mental health of Aotearoa's adolescent/rangatahi population is of increasing concern, with Child and Adolescent Mental Health Services (CAMHS/CAFS) under increasing demand. However, very little consideration has been given to how Secondary School Counsellors find the referral processes for these services. This project aims to investigate the efficacy of the CAMHS referral process from the perspective of secondary school counsellors who are the primary referrers of adolescents/rangatahi in Aotearoa New Zealand. We would like to invite you to participate by filling in a survey asking about your experiences interacting with the CAMHS referral process of your region. By filling in this survey you will go in the draw to win one of five \$50 grocery vouchers. This will hopefully broaden our understanding of the strengths, weaknesses and limitations of the current CAMHS referral processes in Aotearoa New Zealand.*

**Participant Identification and Recruitment**

*You have received this invite because it has been distributed to a school counsellors' group (i.e., national organisation or Facebook group).*

**Selection Criteria**

*We are looking for participants who: Are school counsellors working with adolescents/rangatahi within Aotearoa New Zealand secondary schools who have experience referring to CAMHS/CAFS.*

**Exclusion Criteria**

*School counsellors who do not work with adolescents in a secondary school context and school counsellors who do not have experience referring to an Aotearoa New Zealand CAMHS/CAFS.*

**Project Procedures**

*We will ask for general demographic information about yourself and your school (non-identifiable information only); your main reasons for referral (e.g. self-harm, anxiety etc.); your understanding of the CAMHS referral process; what the strengths and weaknesses of the referral process are; your opinion of improvements to the process which would be beneficial to yourself as the school counsellor and to the rangatahi who utilise your services. We estimate that the questionnaire will take approximately 10 minutes to 20 minutes to complete. Once you have completed the online survey and you have selected submit, the survey will be automatically uploaded to the researcher.*

**Data Management**

*The data from the completed surveys will be analysed and the subsequent findings will be reported in the thesis written by Ashley Holland. It is our intention that findings will also be written up into a peer reviewed journal. We hope that these findings will help inform a better understanding of the CAMHS/CAFS referral process and will allow for improvements to be made to these processes to*

benefit the adolescents/rangatahi who access these services. Data will be analysed and reported in group format and individuals will not be able to be identified. If you wish to receive a summary of these findings you will be given the opportunity to provide an email address which will NOT be linked to the survey you have completed, ensuring anonymity. All data will be secured in a secure database.

### **Participant's Rights**

You are under no obligation to accept this invitation. Completion and return of the survey implies consent. If you decide to participate, you have the right to: decline to answer any particular question; ask any questions about the study at any time during participation; withdraw from the study up until the survey responses have been submitted; be given access to a summary of the project findings when it is concluded.

### **Project Contacts**

If you have any questions regarding this project, please don't hesitate to contact the following:

Researcher Ashley Holland

MSc student – Endorsed in Psychology

School of Psychology Massey University

Email: [ash.graham1@gmail.com](mailto:ash.graham1@gmail.com)

Phone: [REDACTED]

Supervisor Dr Matthew Shepherd

Clinical Psychologist, Associate Professor

School of Psychology Massey University, Auckland

Email: [M.Shepherd1@massey.ac.nz](mailto:M.Shepherd1@massey.ac.nz)

Phone: 092 136094

Massey University School of Psychology – Te Kura Hinengaro Tangata

Palmerston North, New Zealand

T +64 6 356 9099 ext 85071

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)

Thank you for your participation in this project.

Kind regards,

Ashley Holland

**Appendix C**  
**Printed Copy of Online Microsoft Forms Survey**

## The CAMHS referral process - Secondary School Counsellors' Perspectives

A Research Project for the fulfilment requirements of thesis for MSc



\* Required

1. Please define your current role:

2. Which general region of Aotearoa New Zealand is your school in? \*

Northern

Central

Southern

3. Please select the gender which your school caters for: \*

Single Sex Girls

Single Sex Boys

Co-educational

## 4. Select your school's type: \*

Please select at most 2 options.

- State
- Private
- State-Integrated
- Special Character

## 5. How many school counsellors are employed by your school? \*

- One
- Two
- Three
- Four

## 6. On average per year, how many students utilise your school counselling services? \*

## 7. In your current role, do you have experience making referrals to your local Child and Adolescent Mental Health Service (CAMHS/CAFS)? \*

- Yes
- No

## 8. If yes, how confident is your knowledge of the referral process? \*

- Very confident
- Somewhat confident
- Neutral
- Somewhat not confident
- No confidence

9. If no, do you have an understanding of what is required for a CAMHS referral? \*

- Yes
- No
- Not sure

10. Please elaborate on your choice for Question 8: \*

11. On average per year, how many CAMHS referrals do you make? \*

12. What are the most common reasons for your referral of students to CAMHS? \*

13. On average per year, how many of your referrals are accepted by CAMHS? \*

- Minimal
- Moderate
- Maximal

14. Do you think the referral criteria set by your local CAMHS are easily understood? \*

- Yes
- No
- Maybe

15. Please elaborate choice for Question 12: \*

16. In your opinion, what are the strengths of the CAMHS referral process in your region? \*

17. In your opinion, what are the current limitations/weaknesses of the CAMHS referral process in your region? \*

18. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to you as a counsellor? \*

19. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to the students engaged in your counselling services? \*

20. Are there any other comments you would like to make about the CAMHS referral process? \*

21. Provide your email address here if you wish to be eligible for the grocery voucher draw and also receive a summary of the findings of this research:

## **Appendix D**

### **The Survey Questionnaire Unpacked**

1. Please define your current role. This is to ensure data is gathered from individuals who are working as school counsellors, expected responses include the terms: school counsellor, counsellor, guidance counsellor, or school guidance counsellor. Any other response will be carefully considered before its inclusion in analysis. (D, DSA)
2. Which general region of Aotearoa New Zealand is your school in? This question is to gain an idea of geographical spread of participants. The options were kept very general to ensure that responses could not identify an individual. This geographical information will allow the researcher to determine if the results are generalisable to the whole of Aotearoa New Zealand. (D, DSA).
3. Please select the gender which your school caters for. This item will provide interesting information about demographics and has the potential to give rise to further research in regard to gender of rangatahi and access. (D, DSA).
4. Please select your school's type. Similar to item 3, this will provide demographic information and may give rise to discussion around the needs between different school types. (D, DSA).
5. How many school counsellors are employed by your school? This should elicit a number, which can be used in analysis of school counsellor to student ratios and demand. (C, DSA).
6. On average, per year, how many students utilise your school counselling services? This again will give rise to a number and will allow a comparison of numbers and averages between schools. (C, DSA)
7. In your current role, do you have experience making referrals to your local CAMHS? This question is a safeguard questions, hopefully all participants have had experience referring to CAMHS in their roles as school counsellors, but this will allow the research to weight those participants responses who have not had experience. (D, DSA)
8. Item 8 split into two pathways: If 'Yes' how confident is your knowledge of the referral process? Or, if 'No' do you have an understanding of what is required for a

CAMHS referral? If participants answered yes, they are required to give their confidence rating, this information will allow potential observations about the participant's experience and views on the CAMHS referral process. If participants answered no, the researcher wishes to gain knowledge of their total understanding of the CAMHS referral process, before discontinuing their questionnaire. As, only firsthand experience qualifies participants to answer the remaining questions. (Yes =D, DSA), (No = Q, TA, then end of survey).

9. Please elaborate on your choice for Question 8. The information here will allow participants to justify their confidence levels. This will also allow the researcher to gauge how participants interpreted the confidence level options. For example, if participants selected 'confident', how do they qualify this level? (Q, TA).
10. On average per year, how many CAMHS referrals do you make? This will provide a nominal response and should also give rise to observations about workload and demand for CAMHS support. (C, DSA).
11. What are the most common reasons for your referral of students to CAMHS? This should generate a list of responses, and patterns and commonalities between participants may emerge. (Q, TA).
12. On average per year, how many of your referrals are accepted by CAMHS? This item will be rated with the terms maximal, minimal, or moderate. This is to gain insight into the perspective of the participants without requiring participants have specific quantities readily to hand. (D, DSA).
13. Do you think the referral criteria set by your local CAMHS are easily understood? This will require a simple selection of response but will give insight into the participants perception of understanding CAMHS criteria. (D, DSA).
14. Please elaborate on your choice for the previous question. This should provide further insight into what participants understand about the referral process as well as areas which may require further clarification. (Q, TA).
15. In your opinion, what are the strengths of the CAMHS referral process in your region? This should elicit a qualitative response and will be able to generate a

potential list of the strengths of the CAMHS process. The frequency with which shared themes arise may also be analysed. (Q, TA).

16. In your opinion, what are the current limitations / weaknesses of the CAMHS referral process in your region? Once again this should elicit a qualitative response, generating a potential list of areas for improvement within the CAMHS service. (Q, TA).
17. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to you as a counsellor? Qualitative responses which are open to thematic analysis that should give insight into changes that participants think would be beneficial in supporting them. (Q, TA).
18. In your opinion, what change(s) to the CAMHS referral process would be most beneficial to the student engaged in your counselling services? Once again, qualitative responses should be shared, and analysis should reveal areas of change which could be beneficial for rangatahi going through the CAMHS referral process. (Q, TA).
19. Are there any other comments you would like to make about the CAMHS referral process? This question is provided to allow participants to feel 'heard' and gives them free reign to express any further insights they have into the referral process. Analysis of this section could provide useful information that has not been covered in previous items or will further add to the understanding of the overall results. (Q, TA).
20. The last question asked participants if they would like to supply their email address to go in the prize draw for a grocery voucher. This has been excluded from the raw data in the attached appendix to protect anonymity of participants.