

Distress, waitlists and unmet needs: parents' reports of child psychological difficulties in Aotearoa New Zealand

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Abstract

Objective: Demand for children's mental health services has increased in New Zealand, yet little is known of young children's experience of psychological difficulties and treatment. This study investigated psychological symptoms and treatment experiences among primary-aged children.

Method: An online survey of parents assessed children's anxiety, depression, attentional, emotional, conduct and peer problems, and experiences seeking psychological treatment.

Results: Based on 382 parental reports, between 24.9 and 34.6% of children experienced abnormal-range symptoms. Older children had higher distress, depression, and anxiety. Boys had more conduct, hyperactivity, and peer problems. Ethnicity was not associated with the incidence of symptoms, but parents of Pākeha/European children reported greater impact than Māori parents. One-third of children had been referred for assessment; more often older children, and those with higher hyperactivity, impact, and anxiety. Parents reported difficulties accessing assessment, common barriers included waitlists (53%), cost (43%), and not knowing who to contact (36%). Following intervention, only 51% of parents reported improvements.

Conclusion: NZ primary-aged children are experiencing more symptoms of psychological distress than previously reported and extensive difficulties accessing treatment.

Implications for Public Health: There is a need for further screening and increased access to treatment to prevent worsening mental health outcomes in children.

Keywords: child, anxiety, depression, ADHD, barriers, treatment, NZ

Accessibility and need for children's mental health services in Aotearoa New Zealand

Increasing demand for children's mental health services has been reported both internationally and in Aotearoa New Zealand (NZ) in recent years.^{1,2} Across neurodevelopmental and emotional difficulties, research overwhelmingly recommends early screening, identification, and intervention to prevent worsening child mental health problems—however, services for young children tend to be scarce.³

Internationally, the prevalence of childhood difficulties has been well established, with estimates of attention hyperactivity disorder (ADHD) in 4–7% of children,^{4,5} anxiety disorders in 5.2% and mood disorders in 1.3%.⁵ In NZ, an earlier Ministry of Health survey reported that

approximately 8% of children experienced concerning levels of emotional symptoms.⁶

Primary school years (from approximately age 5–11), are formative for emotional, social, and mental health. In particular, adolescent presentations for depression, self-harm, eating disorders, and substance use are often preceded by difficulties with anxiety, emotion regulation, behaviour, and social skills in childhood.^{7–9} NZ has one of the world's highest adolescent suicide rates¹⁰ and high rates of youth depression, anxiety, and substance use disorders.¹ Rangatahi (adolescent) Māori have even higher rates, linked with systemic disadvantage, intergenerational trauma, racism, and high deprivation.¹¹ Decades of research have established that early intervention is key for reducing psychological morbidity and mortality. For example, intervening early to support children with

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ADHD creates better opportunities to learn, socialise, and manage emotions and improves school achievement.¹² Supporting children with emotional challenges such as anxiety significantly improves functioning and attenuates distress,¹³ while untreated early symptoms predict worsening difficulties into adolescence.^{14–16}

Despite this overwhelming evidence, relatively little research exists in NZ regarding early screening and treatment for psychological difficulties in children. There has been a clear increase in demand for crisis and intensive mental health services among adolescents and adults in NZ since the COVID-19 pandemic.^{3,17,18} However, rates are unknown for primary school aged children. The available data suggest that children are presenting for psychological therapy with increasingly severe symptoms while private and community clinicians report unmanageable caseloads and waitlists, with public mental health system access limited for severe cases.^{3,19–21} However, the extent of the increase in demand and need is unclear.

Accordingly, this study aimed to investigate the incidence of psychological distress of primary-aged children in NZ, and their experiences accessing mental health support services.

Method

Participants

Participants were 412 parents or caregivers of children aged 5–11 years, in NZ, recruited via social media invitations (see Procedure). Fourteen (3.4%) participants had children outside the target age range and further 16 (3.9%) participants missing sufficient responses, thus, were removed. The final sample size was 382 (92.7%), with no demographic differences for those excluded based on missing data.

Measures

Revised Child Anxiety and Depression Scale, Parent short version (RCADS-25-P)

The RCADS-25-P is a parent-report measure of children's anxiety and depressive symptoms,^{22,23} commonly used in clinical and community samples.^{24,25} Twenty-five items are scored from 0 (never) to 3 (always), with 10 relating to depressive symptoms (yielding a total possible score of 30), 15 to anxiety symptoms (total possible 45), and all 25 items creating an overall score (total possible 75). The RCADS-25-P provides excellent specificity for clinically relevant symptoms of anxiety and depression, good test-retest reliability and criterion validity,²⁶ and internal consistency, with Cronbach's alpha from 0.70 to 0.82.^{25,26} In the current sample, Cronbach's alpha were $\alpha=.91$ (total symptoms), $\alpha=.83$ (depression), and $\alpha=.87$ (anxiety).

To allow consideration of the clinical levels of symptomatology relative to normative data, the RCADS-25-P authors recommend calculating T-scores, although these are only valid for children older than 8 years. Accordingly, we calculated T-scores for 8–11 year-old children to compare with age and gender normative data, with bands indicating borderline (top 7%) and clinical (top 2%) range scores for each subscale, in which children are likely to meet criteria for diagnosis²⁷ (see Table 2). Notably, these are US norms—norms for NZ populations are unavailable in the literature.

Raw scores for the RCADS-25-P were used in all other analyses to allow inclusion of all participants aged 5–11 years.

The Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) assesses internalising and externalising symptoms for children aged 4–17,^{28–30} commonly used and validated in NZ.³¹ The Parent-report version assesses their child's symptoms across Emotional Problems, Conduct Problems, Hyperactivity, Peer Problems, and Prosocial subscales, with five items per scale scored from 0 (not true) to 2 (certainly true). Total difficulties are the sum of the first four subscales (ranging from 0 to 40), excluding Prosocial (positive) scores. The Internalising score sums the Emotional and Peer Problem scales (from 0 to 20), and Externalising score sums Conduct and Hyperactivity scales (from 0 to 20). These two overarching scales are often used in community samples.²⁹ Impact scores assess the extent to which the difficulties cause distress or interference for the child (scored 0–10). The SDQ can be categorised into severity bands based on community norms, where 80% were “normal”, 10% “borderline”, and 10% “abnormal”.³²

The SDQ has established internal consistency, test-retest reliability, and construct validity in community and clinical samples.^{33,34} It shows good sensitivity in discriminating clinical from non-clinical subjects.³⁵ In our sample, the SDQ subscales showed good internal consistency (Emotion $\alpha=.78$, Conduct $\alpha=.73$, Hyperactivity $\alpha=.86$, Peer Problems $\alpha=.71$, Prosocial $\alpha=.83$, Total Difficulties $\alpha=.88$).

Access and Barriers to Treatment

Further questions investigated caregivers' experiences seeking psychological assessment and treatment for their children and were informed by previous research³⁶ (see Appendix B). Questions asked whether a professional had suggested assessment, whether assessment had occurred and with whom (GP, community mental health service, school special education needs coordinator, private psychologist, or psychiatrist etc), and about diagnoses and treatment received. Furthermore, participants were asked about difficulties or barriers to treatment, and the outcomes of treatment. Participants were also asked whether they would be willing to seek psychological support for their child at school if it were available.

Procedure

The Auckland University of Technology Ethics Committee approved this study. Invitations to participate were shared via community and parenting social media groups across NZ, including a link to the survey. Participants provided informed consent online, then completed the anonymous survey using Qualtrics.

Data analysis

Power analysis was calculated based on a child population of 494,340³⁷ with a confidence level of 95% and a margin of error of 5%, with the sample adequate. SPSS v.28³⁸ and an online calculator (www.graphpad.com) were used for analyses. Missing data was prorated from the remaining items within each scale, for responses missing less than 20%. Priority ethnicity ranking was used, following protocols from the NZ Ministry of Health.³⁹ Categorical variables were condensed where cell sizes were small and it made conceptual sense to do so (e.g., treatment received/intervention type).

Independent-sample *t*-tests were used to investigate differences between our sample and comparable datasets reported in the literature.^{6,40} Where insufficient previous data was available,

Table 1: Descriptive statistics for symptom scales, and bivariate correlation coefficients (*r*) with age.

Child Outcome Measures	Min	Max	<i>M</i>	<i>SD</i>	<i>r</i> _{age}
SDQ Emotion	0	10	3.571	2.642	.203**
SDQ Conduct	0	9	2.479	2.157	.076
SDQ Hyperactivity	0	10	5.046	3.077	.058
SDQ Peer Relations	0	9	2.300	2.190	.067
SDQ Prosocial Behaviour	0	10	7.578	2.283	-.015
SDQ Impact	0	10	1.906	2.461	.199**
SDQ Total	0	33	13.397	7.645	.134**
RCADS-25-P Depression	0	24	7.190	4.712	.263**
RCADS-25-P Anxiety	0	37	9.950	6.685	.175**

** *p* < .01.

Note: SDQ = Strengths and Difficulties Questionnaire; RCADS-25-P = Revised Child Anxiety and Depression Scale, Parent Short Version.

confidence intervals were compared to estimate differences. Frequency analyses were used to investigate pathways to assessment and treatment. Multiple linear regression investigated predictors of child symptoms, controlling for other variables. Binary logistic regression investigated factors predicting whether a child had (or had not) received assessment or treatment. In these models, ethnicity was represented by two dichotomous variables. The first was whether the participant identified as Pākeha/NZ European (*n* = 252) or not (*n* = 130), and the second if they were Māori (*n* = 85) or not (*n* = 297). Continuous predictors were tested for logit linearity according to Allen and colleagues,⁴¹ whose approach also guided the analysis of potential outliers.

Results

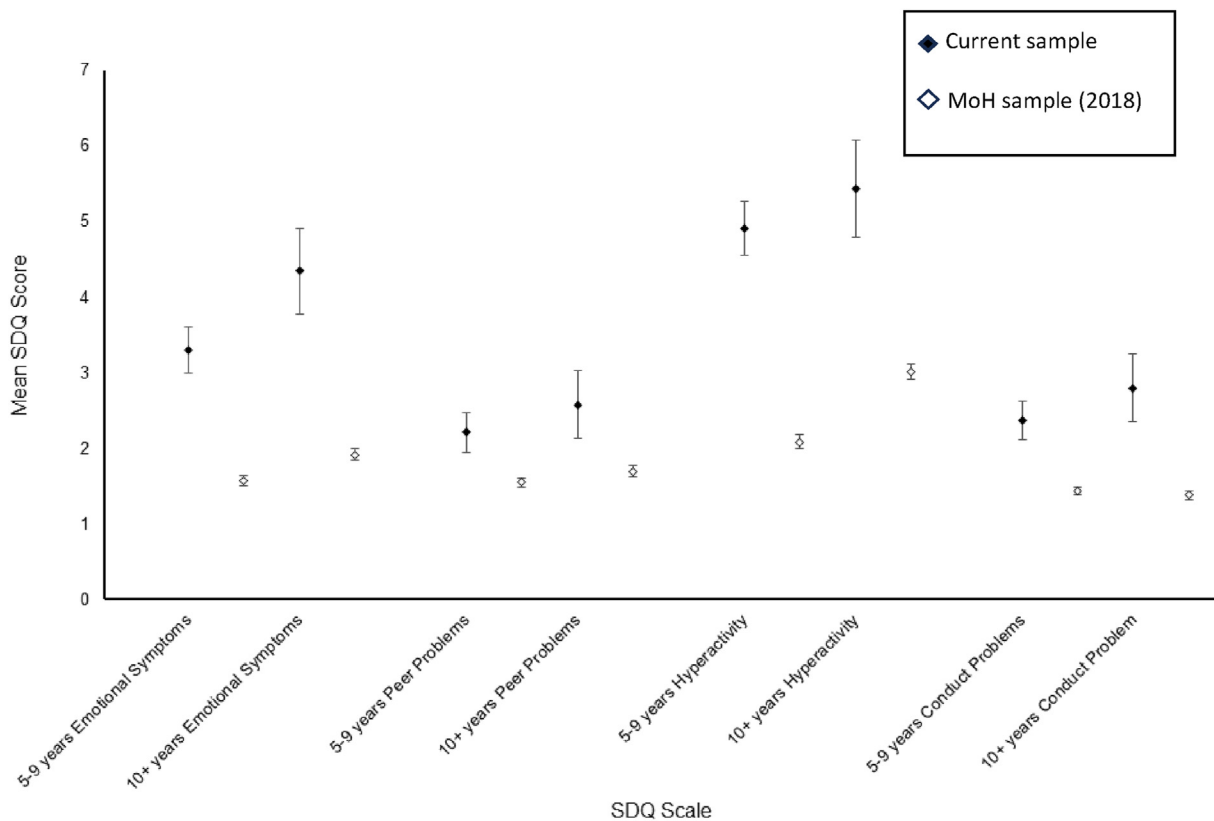
Participant characteristics are described in Appendix A. The majority of participants were mothers (94%), and from large cities (46% Auckland, 12.3% Wellington), with the remainder fairly evenly distributed across the country. Children’s age and gender distributions were evenly spread. Participants could select more than one ethnicity, with the distribution of ethnicities approximating the NZ population.⁴²

Table 1 presents descriptive statistics for the SDQ and RCADS-25-P subscales. The calculation of partial correlations between age and child measures, while controlling for child gender, did not alter the pattern of significance exhibited in Table 1. Exploratory independent samples t-tests revealed no significant gender differences for the RCADS-25-P depression (*M*_{male} = 7.62, *SD* = 4.46 vs. *M*_{female} = 6.68, *SD* = 4.85) or anxiety (*M*_{male} = 10.01, *SD* = 6.32 vs. *M*_{female} = 9.80, *SD* = 6.92) subscales (both *p* > .05). For the SDQ subscales by gender, Conduct Problems (*p* < .001), Hyperactivity (*p* < .001), Peer Relations (*p* = .007), and Prosocial behaviours (*p* = .003) were all significant (see Appendix C).

Comparisons with other populations

Our sample returned comparable mean RCADS-25-P Anxiety (*M* = 9.7, *SD* = 8.6; *t*(397) = 0.08, *p* > .05) and Depression (*M* = 5.7, *SD* = 6.0; *t*(397) = 0.61, *p* > .05) scores to a pandemic-era Australian sample, and notably higher than usual.⁴⁰ No recent NZ data was found for comparison, and only limited data is available from an earlier National Mental Health Survey of children.⁶ As such, it is not

Figure 1: Mean SDQ scores and 95% C.I. for the current sample (a) and earlier NZ sample (b, MoH, 2018).



possible to run significance tests across the two samples, however, our mean score and 95% confidence interval for each SDQ subscale are markedly higher (see [Figure 1](#), and [Appendix D](#)). The difference in sample sizes between the two studies explain the differences in CI size.

Clinical Range Symptoms

Our sample also reported high rates of symptoms in the clinical/abnormal ranges. Previous NZ research reported abnormal range scores for 8% on SDQ Total Difficulties, 9.7% Emotional symptoms, 13.7% Peer problems, 8.5% Hyperactivity and 10.3% Conduct problems,⁶ while our sample found 24.9-34.6% of children in these abnormal ranges (see [Table 2](#)). Our sample also greatly exceeded expected percentages in abnormal/clinical ranges for the RCADS-25-P (2%) and SDQ (10%; see [Table 2](#)).

A frequency analysis investigated pathways to treatment (see [Appendix E](#)). Of those who received a professional recommendation to seek an assessment ($n = 118$), 100 (84.7%) did and 18 (15.3%) did not pursue assessment. Of those assessed, 72 received diagnoses, of whom 69 (95.8%) sought professional treatment for their child. Of the 28 parents whose child did not receive a diagnosis, 16 (57.1%) still enrolled their child in therapy.

For those parents not receiving a professional recommendation ($n = 253$), 29 (11.5%) had their child assessed, of which ten (34.5%) resulted in a formal diagnosis, and all ten diagnosed children went on to therapy. Additionally, 78% of respondents said they would access treatment through their school if available, 19% said maybe, and 3% no.

Predictors of child symptoms

[Appendix F](#) presents multiple linear regression models containing demographic factors (age, gender, ethnicity) as predictors of child mental health outcomes. The categorical variables ethnicity (Māori Yes/No, European Yes/No) and gender were coded as dummy variables. All regression models satisfied collinearity tests (tolerance measures and variance inflation factor), and all had coefficients of determination greater than zero (all $p < .05$). For the SDQ subscales, gender was the main predictor, with males having higher scores on the Conduct, Hyperactivity, and Peer Problems scales. Higher SDQ Emotion scores were seen for older and for European children. Ethnicity was not a strong predictor of symptom outcomes in this data. Interestingly, being Māori predicted lower SDQ Impact scores. European children had higher RCADS-25-P Depression and Anxiety scores, with age positively correlated with the RCADS-25-P Depression scores.

Table 2: Incidence of high range symptoms for children across all groups.

RCADS-25-P (8-11 years)						
	Total sample ($n=214$)	Māori ($n=52$)	European ($n=142$)		Previous Australian data ⁴⁰	
Anxiety Symptoms ($n, \%$)						
Borderline	15 (7%)	4 (7.7%)	8 (5.6%)		44 (5.6%)	
Clinical	44 (20.6%)	5 (9.6%)	37 (26.1%)		148 (18.9%)	
Depression Symptoms ($n, \%$)						
Borderline	23 (10.7%)	6 (11.5%)	16 (11.3%)		38 (4.9%)	
Clinical	68 (31.8%)	11 (21.2%)	53 (37.3%)		159 (20.3%)	
Total Symptoms ($n, \%$)						
Borderline	25 (11.7%)	3 (5.8%)	20 (14.1%)		-	
Clinical	55 (25.7%)	10 (19.2%)	42 (29.6%)		-	
SDQ (5-11 years)						
	Total sample ($n=373$)	Māori ($n=82$)	European ($n=249$)	Younger children (5-7 years) ($n=159$)	Older children (8-11 years) ($n=213$)	Previous NZ data ^{6,a}
Emotional Difficulties						
Borderline	42 (11.3%)	11 (13.4%)	28 (11.2%)	15 (9.4%)	27 (12.7%)	-
Clinical	129 (34.6%)	26 (31.7%)	91 (36.5%)	41 (25.8%)	88 (41.3%)	9.7%
Conduct Problems						
Borderline	48 (12.9%)	13 (15.9%)	29 (11.6%)	20 (12.6%)	28 (13.1%)	-
Clinical	118 (31.6%)	23 (28.0%)	87 (24.9%)	45 (28.3%)	73 (34.3%)	10.3%
Hyperactivity						
Borderline	27 (7.2%)	3 (3.7%)	21 (8.4%)	13 (8.2%)	14 (6.6%)	-
Clinical	128 (34.3%)	28 (34.1%)	90 (36.1)	52 (32.7%)	76 (35.7%)	8.5%
Peer Problems						
Borderline	49 (13.1%)	11 (13.4%)	31 (12.4%)	20 (12.6%)	29 (13.6%)	-
Clinical	93 (24.9%)	19 (23.2%)	67 (26.9%)	39 (24.5%)	54 (25.4%)	13.7%
Total Difficulties						
Borderline	46 (12.3%)	10 (12.2%)	30 (12.0%)	15 (9.4%)	31 (14.6%)	7.0%
Clinical	133 (35.7%)	28 (34.1%)	96 (38.6%)	51 (32.1%)	82 (38.5%)	8.0%
Impact						
Borderline	47 (12.6%)	12 (14.6%)	30 (12.0%)	22 (13.8%)	25 (11.7%)	-
Clinical	151 (40.5%)	24 (29.3%)	112 (45.0%)	46 (28.9%)	105 (49.3%)	-

Note. RCADS-25-P T-scores and clinical bands are calculated only for participants aged 8 and over.

^aFull data was not available for the MoH⁶ sample, these results are the only published rates. Missing values represented by -.

Predictors of treatment

Binary logistic regression was employed to identify factors predicting whether a child had (or had not): received a professional recommendation for assessment; undergone an assessment; received a diagnosis or received treatment. Predictor variables were the same for all four models, and included demographic factors (age, gender, and ethnicity of child) and parent-rated symptom scales. Preliminary analyses using Tolerance and VIF statistics determined that multicollinearity may be an issue with the SDQ Emotion subscale and the RCADS-25-P Depression and Anxiety subscales, so the SDQ Emotion subscale was omitted, given the RCADS-25-P scales offer greater specificity.

Appendix G presents the results of the four regressions. Boys were more likely to be recommended to seek assessment, as were those with higher SDQ Impact scores. Predictors of the child undergoing assessment were higher age, and higher scores on SDQ Hyperactivity, Impact and RCADS-25-P Anxiety subscale. As predictors of a diagnosis, higher age, and higher scores on the SDQ Hyperactivity and Impact subscales were all statistically significant. Being male, older, and having higher Anxiety and Impact scores predicted whether treatment was obtained. Finally, factors predicting interest in school-based treatments were the SDQ Peer Relations and Impact subscales, and the RCADS-25-P Anxiety subscale.

Access and barriers to treatment

Approximately 32% of children had been recommended for assessment by a doctor or teacher, with 33.7% in total having been assessed. For children who received psychological assessment, most consulted general practitioners (37%), private psychologists (36%), others such as paediatrician or occupational therapist (30%), and community mental health providers (25%; see Appendix H). Almost all

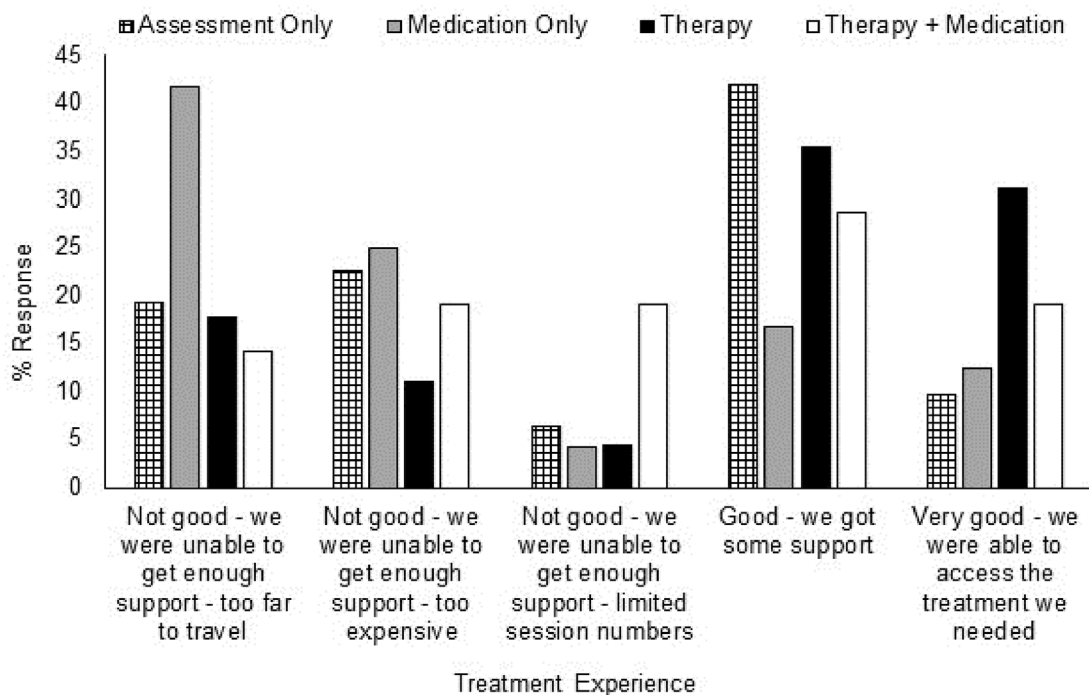
(95%) parents reported difficulties seeking assessment and treatment for their child. The most common barriers were waitlists (53%) and cost (43%). Notably, 36% of parents were unsure who to contact for help. For children who received intervention (n=127), 51% of parents reported an improvement in child symptoms. Additionally, 23% of all parents were dissatisfied with their experience in accessing support, reporting issues such as cost, travel and session limits, while 17% reported the experience as either good or very good. There were significant differences between intervention types (assessment only, medication only, therapy only or therapy plus medication) and treatment experiences ($\chi^2(12, n=121) = 20.2$, one-sided $p < .05$). Those who received therapy were more likely to report “good” or “very good” intervention experiences. Those who received only medication were more likely to report difficulties with travel or expense (see Figure 2).

Discussion

Parents in NZ reported high rates of psychological distress among primary-aged children. Children are reportedly experiencing clinical levels of psychological symptoms including emotional and behavioural problems, at much greater levels than previously reported. In a country with serious mental health difficulties in adolescence,³ it is important to also understand the difficulties experienced by younger children. We must address the needs of younger children both to improve their psychological health now, and to mitigate the escalation of symptoms into adolescence.

Our findings are comparable to a study of Australian children during COVID-19, which also showed elevated emotional and behavioural problems.⁴⁰ However, while the Australian study was conducted during the peak of the pandemic during lockdown conditions, our participants reported elevated distress in early 2023 – when

Figure 2: Intervention type by intervention experience.



pandemic restrictions had ended and the acute COVID-19 situation had eased. No other research was found for children in NZ since the pandemic, however, clinical-range symptoms were markedly higher in this sample than previous NZ estimates.⁶ Notably, our oldest children were 10-11 years old, whereas the earlier NZ sample encompassed 10 to 14 year-olds, including adolescents likely to experience higher rates of psychological symptoms. Thus, our rates may be even more concerning, as younger children generally have lower rates of symptoms than adolescents. Our findings are consistent with reports of increased demand for psychological treatment and may suggest ongoing impacts from the disruption and stress of the pandemic.

Older children were more likely to experience emotional symptoms, according to their parents, with higher scores on depression, anxiety and emotion scales, however these did not vary by gender in multivariate analyses. Conduct, hyperactivity and peer problem scores did not vary with age, but all were more common among boys. Only the prosocial (positive) subscale was higher for girls. Recent data from the Growing Up in New Zealand study shows an increase in mental health engagement in older children, as well as increases in both depression and anxiety symptoms among 12-year old children.⁴³

Children from European backgrounds had higher reported emotional symptoms than those who were Māori, according to their parents. This is not in keeping with the significant wider research reporting higher rates of mental health difficulties for Māori,^{44,45} and may be a false negative finding. Interestingly, being Māori predicted lower SDQ impact scores, with parents reporting lower rates of disruption associated with children's psychological symptoms. While explaining this difference is beyond the methodology of this study, historical trauma and systemic racism have resulted in significant health inequities and increased barriers to treatment for Māori.⁴⁵ It may be that whānau in this study have not sought assessment or treatment for these reasons. Additionally, this could highlight cultural differences in attitudes to child behaviour and expectations, whereby Māori traditionally embrace a child's 'spark' and see this as tapu (sacred) vs. the more colonial view of child raising⁴⁶ which may pathologise this behaviour and consequently see it as distressing.

When referred for assessment, most parents attended, with most children then receiving a diagnosis and treatment. However, the majority of parents reported significant difficulties accessing psychological assessment and/or treatment for their children. Consistent with common barriers to mental health help-seeking in NZ,^{45,47,48} the most endorsed difficulties included waitlists, cost, not knowing who to contact for help or finding no services nearby. Similarly, parents reported difficulties accessing sufficient treatment, with travel, expense and limited session numbers noted. In addition, parents described additional difficulties such as their children "not being severe enough to get help", COVID-related delays or not feeling their concerns were heard. This is consistent with findings for other childhood difficulties such as autism.⁴⁹

These findings echo reports from the NZ public health system, where approximately 60,000 children had an unmet need for professional mental health care annually, with this rate double among Māori and 1.44 times higher for the most deprived communities.⁴⁷ Notably, 81,000 children reportedly consulted a teacher regarding their mental health in the prior 12 months, a substantial demand on professionals without mental health training.⁴⁷ Just over half (57.6%) of Growing Up in New Zealand (GuiNZ) respondents reported receiving what they needed from mental health services,⁴³ similar to the 51% of our

respondents who felt their children had improved since treatment. The GuiNZ study reported similar barriers to treatment.⁴³ Insufficient numbers of child psychiatrists,⁵⁰ psychologists¹⁹ and increases in demand³ for services have been reported in NZ. Counselling is rarely available in NZ primary schools, unlike Australia, the UK and US where school counsellors are a major source of psychological care for children.⁵¹⁻⁵³ The recent Counselling in Schools initiative has only covered 140, or 5.5%, of the primary schools in NZ so far,⁵⁴ and thus, there remains a large unmet need. Parents in our study overwhelmingly endorsed treatment through schools (78% would access it), with this interest associated with higher children's anxiety and peer problem rates.

Widespread, accessible, and evidence-based psychological services are clearly needed across the NZ population. Comparable Organisation for Economic Cooperation and Development (OECD) countries offer large-scale access to evidence-based psychological services, and have all been shown to be both clinically and cost-effective (e.g., "Better Access" in Australia; "Improving Access to Psychological Therapies" in the UK; "Expanding Access" in Canada). Mental health has been a prominent issue in NZ political discussions in recent years. The He Ara Oranga report proposes a shift toward community-based mental health care,²¹ however as parents report in the current study, it remains extremely difficult to access adequate, high quality mental health care. The recent introduction of the "Integrated Primary Mental Health and Addiction Service" placed Health Improvement Practitioners or Coaches in medical practices, however the efficacy of this programme remains unknown, and these practitioners rarely have training or experience working with children. Arguably, what is needed is a population-level approach to evidence-based intervention, with free-or-low-cost access to funded psychological services made available to all. In addition, school-based support should be evidence-based and offered by psychologists with expertise in emotional, behavioural, and learning difficulties, and available to all tamariki across NZ.

Limitations and future directions

Parents self-selected to complete this survey, in response to invitations in social media groups. Although invitations directly requested that parents of children without psychological difficulties participate too, a self-selection bias is possible. However, our sample was bimodal—we had a large number in the clinical-range, as well as a large number with normal-range symptoms. Regardless, for those children represented in this sample and undoubtedly many others, rates of psychological difficulties are high, and treatment barriers are significant. Norms used for the RCADS-25-P were from the US, as provided by the scale's creators.²⁸ No normative data could be found for NZ children; however, the comparisons made with recent Australian data for the RCADS-25-P and previous NZ data for the SDQ allowed us to note the high level of clinical and abnormal symptoms in this sample, relative to others.

Previous research suggests that if parents themselves experience mental health difficulties, they may over-inflate their child's mental health concerns.⁵⁵ As the focus of this study was on the children, we did not investigate parents' mental health. However, children with the highest parent-reported symptoms were also those referred to treatment by professionals—so arguably, these parents were not inaccurate in their reporting, their children experienced independently recognised challenges.

Many parents were unable to report the type of professional they consulted for assessment, so for the purposes of this community sample, broader questions about “type of support” were asked (see Appendix B). Our findings indicate that treatment experiences vary by intervention received, however, further research should pursue this question in detail—exactly what type of intervention was received, profession involved, costs, public vs private, waitlist, number of sessions and so on—to better understand the provision of mental health services to children, and outcomes in Aotearoa.

Further research is underway to investigate the impact of the COVID-pandemic on children’s mental health in NZ, to consider a larger range of difficulties and to expand community sampling. Given the difficulties reported by families seeking psychological support for their children, this is an urgent priority for researchers and clinicians. With many children talking with their teachers about mental health, and the vast majority of primary-aged children enrolled in public schools, increasing support through schools seems a logical avenue.

Conclusion

A great many primary-aged children in NZ are experiencing heightened levels of psychological problems, according to parent-report. Many of these children are referred for assessment and treatment; however, parents report significant barriers including cost, availability, and waitlists. There is a pressing need for increased access to psychological care in this crucial age range, given the established rates of serious mental health difficulties and outcomes among NZ adolescents.

Ethics approval

Ethical approval for this study/case/case series was obtained from Auckland University of Technology Ethics Committee (AUTC reference 22/308) on 29th November 2022. Informed consent was received from all participants before completing the survey.

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Conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.anzjph.2023.100120>.