

Mental health education in *The New Zealand Curriculum*

NZHEA position statement



November 2019

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Provided with each section of this resource is a PLD discussion activity for HPE middle leaders and teachers.

These questions could form the basis of a professional learning discussion at a faculty/department meeting, or a regional cluster meeting/workshop.

Summary

The World Health Organization defines mental health *'as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'* The emphasis here is on quality of life considerations, not deficits and disease. In the New Zealand context, students learn about mental and emotional wellbeing as part of a holistic understanding of health and wellbeing, described by the concept of hauora, and explored through Durie's te whare tapa whā model.

Mental health education includes many different topics such as: Wellbeing (as a holistic concept); Identity and self-worth; Building strengths/capacity (or building resilience) by enhancing protective factors and reducing or mitigating risk factors; Personal management (goal-setting, decision making, problem solving, stress management, relaxation) and interpersonal communication skills (effective listening, assertiveness, negotiation and compromise); Friendships and relationships (qualities of and skills for) and challenges to these (bullying, harassment, discrimination and stereotyping, break ups); Managing stressful situations; Alcohol and other drugs; Change, loss, disappointment, and grief; Digital citizenship - social media use, cybersafety; Body image; (and at senior level) some understanding of common mental health conditions like depression and anxiety, the factors that contribute to these conditions, prevention and help seeking.

While we believe in the importance of mental health education, and that education may make a *contribution* to wellbeing outcomes for *some* students *when* it is part of a whole school approach to the promotion of wellbeing, our effectiveness as teachers requires *all* of our students to benefit from our teaching. Those educational benefits, first and foremost, are learning outcomes, in accordance with the Teaching Council *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession*.

We need to make a clear distinction between the purpose and outcomes of:

- Mental health education as a key area of learning in health education, based on the HPE learning area in *The New Zealand Curriculum*, the outcomes of which are learning outcomes, as is the case for all other subject learning in the NZC.
- A whole school approach to the promotion of student wellbeing (or mental health) where some wellbeing benefits may result for some students, and
- School systems that respond to individual students requiring some form of support for their mental health and wellbeing, which often requires access to specialist services in the community.

The recent Goldberg, et al.¹ meta-analysis of whole school approaches to enhancing children and young people's social and emotional development (ie. a coordinated set of activities across curriculum teaching, school ethos and environment, and family and community partnerships), which included 45 studies involving 496,299 participants, concluded that these whole school approach-type interventions *'demonstrated significant but small improvements in participants' social and emotional adjustment, behavioural adjustment, and internalising symptoms. Interventions were not shown to impact on academic achievement. The inclusion of a community component as part of a whole school approach were found to be significant moderators for social and emotional outcomes'*.

We note particularly the findings of an OECD² report that states that social and emotional skills do not play a role in isolation. They interact with *cognitive skills* which further enhance children's likelihood of achieving positive outcomes in life. As teachers, teaching students to think critically about issues that impact their lives, to develop deep understanding of the economic, political and cultural factors that influence health and wellbeing, and how to take individual and collective action to promote wellbeing, is a key purpose of health education in the NZC.

¹ Goldberg, J.M., Sklad, M., Elfrink T.R. Schreurs, K.M.G. Bohlmeijer, E.T. & Clarke, A.M. (2019). Effectiveness of interventions adopting a whole school approach to enhancing social and emotional development: a meta-analysis. *European Journal of*

² OECD. (2015). *Skills for social progress: the power of social and emotional skills*. Paris: OECD Publishing.

<https://doi.org/10.1787/9789264226159-en>

Introduction

Purpose

The views expressed in this position statement are the perspective of the NZHEA executive. As experts in health education in *The New Zealand Curriculum* this position statement describes our understandings of our expected teaching practice, which includes education about mental health related topics.

In addition, we also acknowledge the role we play as teachers - irrespective of the subject matter we teach - and our professional responsibility to promote the wellbeing of students, as stated in *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession*³.

November 2019.

This position statement has been developed in response to persistent misunderstandings reported in news media about the nature and outcomes of mental health education in New Zealand schools. This media focus targets secondary schooling in particular, and much of this position statement reflects that. However, most of this material is equally applicable to primary schools.

Our purpose at this time is to make a clear distinction between the purpose and outcomes of:

- **Mental health education as a key area of learning (covering many different topics) in health education, based on the HPE learning area in *The New Zealand Curriculum*,**
- **A whole school approach to the promotion of student wellbeing (or mental health), and**
- **School systems that respond to individual students requiring some form of support for their mental health and wellbeing.**

The need for greater clarity is to **support and protect the professionalism of teachers - as teachers**. As a matter of policy (and law) the relationship between teacher and student is about teaching and learning, that is, it is a *teacher-learner relationship*, not a doctor (or other health practitioner) and patient, nor is it a counsellor or social worker and client relationship.

IMPORTANTLY, we need to **support the learning achievement and progress of all students, and protect their interests in relation to their health and wellbeing**. These different forms of support and protection require suitably qualified adults in designated roles and positions, who know the extent and limitations of their professional responsibilities within the jobs they are employed to do, and who know how to practice within their professional codes of responsibility.

While we believe in the importance of mental health education, and that education *may* make a contribution to wellbeing outcomes for some students when it is part of a whole school approach to the promotion of wellbeing, our effectiveness as teachers requires *all* of our students to benefit from our teaching. Those educational benefits, first and foremost, are learning outcomes.

³ *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession*, Teaching Council of Aotearoa New Zealand <https://teachingcouncil.nz/content/our-code-our-standards>

We are NOT saying that...

We shouldn't waste our time teaching about mental health issues.

- If any of us is to take action to support ourselves or others, and contribute to the wellbeing of our communities, **none of us can act in a knowledge vacuum**. There is still a strong case to be made for health education teaching students knowledge *about* mental health and wellbeing (which includes knowledge of skills that may support their wellbeing).

Teaching and learning about mental health is all about preventing mental illness.

- **We need to shift the public discourse around mental health.** Mental health is about wellbeing, not mental health problems, illness, disease and deficits. About 20 percent of people experience mental health issues of clinical significance at some point in their lives. Most people do not experience mental health illness themselves. Everyone experiences stressful and distressing events at some time in their lives that they need to manage. Consequently, everyone can learn something about mental health whether it's about their own mental health and wellbeing, or that of others. Within current teaching and safety guidelines, we may include learning about specific mental health problems when there is an identified learning need to do so and where this adds depth and understanding to a learning programme.

Mental health education makes no contribution to health and wellbeing outcomes.

- **Collecting health and wellbeing data**, and the quality and rigour of the data needed as evidence to show how education may contribute to health and wellbeing outcomes for some students, **is methodologically and ethically highly problematic**, not only for teachers, but also for organisations that deliver mental health programmes in educational settings. Showing causal relationships between 'education for all' approaches and actual improved (mental) health outcomes for individuals or populations is a known and persistent limitation for research in this field. Meta-analyses and systematic reviews of this research suggest that mental health education may have some impact on wellbeing outcomes, when it is combined with other actions as part of a whole school approach to the promotion of wellbeing.

We should all be teaching a standardised mental health programme.

- We believe that all schools should, and have the right within current education policy, to **design their own school curriculum** to meet the **learning needs** of their students and school communities. In order that (assumed or claimed) impacts of standardised programmes can be measured, requires the one-size-fits-all programme to be delivered without adaptations - regardless of its appropriateness for the group it is being delivered. Educationally we regard this as being an unsound and outdated practice, and inconsistent with our job as teachers. Such programmes are seldom culturally responsive, nor do they respond to diverse learner needs.

Teacher and schooling effectiveness can be judged on the outcomes of mental health education (only) programmes – either own curriculum design, or a prescribed programme.

- The complexity of some people's mental health issues far exceed the reach, resources and expertise of people employed in educational roles in schools. Even school counsellors are limited in their practice. **Health outcomes for young people are a cross-sector consideration**, and significant health issues experienced by young people require health sector expertise to manage the situation.

All teachers are teachers of (mental) health education.

- The long held claim that 'all teachers are teachers of health (or wellbeing)' needs to be challenged - at least in secondary schools. For starters, a distinction needs to be made between the promotion of wellbeing - being the responsibility of all teachers regardless of what they teach - and deliberately planned and taught health education subject matter.

Would an English teacher say that you were teaching English when your health education students happen to read and comprehend a newspaper article about a health issue? Would a maths teacher say you were teaching

maths if your students happen to be discussing some health statistics from a research report? Would an art teacher say you were teaching art if your students choose to present their work using a range of visual imagery?

To suggest that the promotion of wellbeing, that all teachers (should) be doing as they create safe, supportive, inclusive classrooms, is the same as deliberate and purposefully designed teaching and learning in health education based on achievement data and knowledge of student learning needs, marginalises and undervalues the place and importance of health education in the NZC, and where **learning is 'about' health and wellbeing**.

The complexity of many wellbeing-related contexts and the importance of being able to think critically and understand the situation deeply, and the critical action to be taken, requires detailed and deliberate learning. Developing these deep understandings is not incidental. Without consideration of the way all of the underlying concepts shape health and wellbeing knowledge, without critical thinking *about everything*, and without constructing new meaning as a result of applying conceptual ideas to health education topics - it's not health education in the NZC.

We are saying ...

In relation to mental health education, our success and effectiveness as teachers, and as schools, is judged on the basis of learning outcomes.

- *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession* makes clear our role as *teachers*. Our success as *teachers* is not measured in terms of health behaviours or health outcomes.

Mental health education, and the many topics that derive from this key area of learning, provide valuable, authentic and engaging learning contexts for students that help them to understand themselves, other people, their communities, the country, and the world they live in.

- As a key area of learning, mental health is a major learning context and forms much of the foundation learning of knowledge and skills in health education.

All teachers are responsible for promoting student wellbeing (in accordance with Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession).

- However, deliberate and purposeful teaching and learning about mental health is not the same as the whole school approaches for promoting mental health and wellbeing. It is important to distinguish between the purpose and actions for 'education' and the 'promotion' of wellbeing.

To give authority to the specialist subject knowledge, and validate the educational purpose of health education in the NZC, the old saying that '*all teachers are teachers of health education*' needs to be reframed (in secondary schools at least) to be '*all teachers promote the wellbeing of students*'. (In primary schools where teachers teach across the curriculum, this old saying still works.)

Whole school approaches (WSA) to the promotion of student wellbeing may lead to improved mental health and wellbeing outcomes for some students.

- A WSA combines a range of policy considerations, curriculum education, school wide actions, and engagement with community to act in a variety of ways to 'promote' wellbeing, (where 'promote' means to support or actively encourage, and to further the progress or improve something). A WSA to the promotion of student wellbeing is supported by specialised and targeted school systems and processes that can *respond* when individual students, or groups of students, are experiencing distress.

‘Mental health’ as a matter of definition

There are many definitions of mental health. Contemporary understandings, like those expressed below by the New Zealand Mental Health Foundation and the World Health Organization, favour a focus on wellbeing or wellness, not a biomedical (only) focus on disease, disorder and problems.

Mental Health Foundation

The NZ Mental Health Foundation defines mental health as the capacity to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice and personal dignity.⁴

World Health Organisation

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.⁵

These wellbeing or ‘quality of life’, rather than biomedical health (ie illness) understandings, are promoted by education through a wide range of education sector literature (references to which feature across this statement).

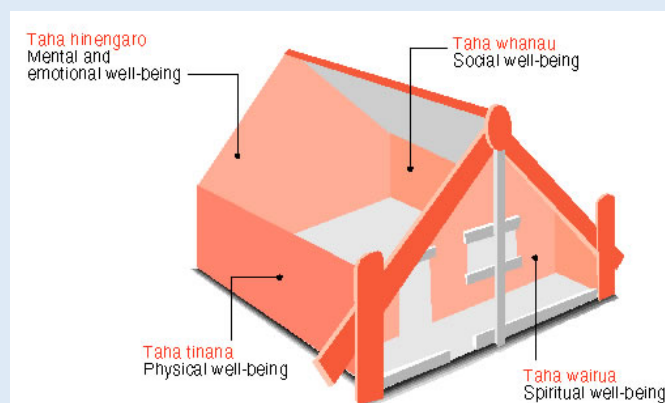
Also, these ‘wellbeing’ oriented definitions are important for understanding the nature, purpose and outcomes of mental health education in the NZC, and the roles, responsibilities and professional authority of teachers as they engage in practices and processes to promote student wellbeing.

Hauora and wellbeing

As New Zealand teachers continue to develop their knowledge and capacity to be able to validate and give authority to aspects of mātauranga Māori, understanding in detail the intent of the now familiar and widely used whare tapa whā model of hauora (a holistic model of health and wellbeing) is as important now as it ever was. In addition, consideration of Pasifika knowledge and other indigenous and cultural models and concepts of health and wellbeing are gradually being included as part of this learning.

The whare tapa whā model that frames the concept of hauora used in Health and Physical Education (HPE) in the NZC includes consideration of **taha hinengaro** that is, ideas related to mental and emotional wellbeing.

Hauora – a Māori philosophy of well-being that includes the dimensions taha wairua, taha hinengaro, taha tinana, and taha whānau, each one influencing and supporting the others. NZC (1999) after Durie (1994) in *Whaiora: Māori Health Development*.



⁴ Mental Health Foundation definition <https://www.mentalhealth.org.nz/home/glossary/>

⁵ World Health Organization definition https://www.who.int/features/factfiles/mental_health/en/

The following extract from *Whaiora: Maori health development*⁶, focusing on te whare tapa whā dimension of taha hinengaro, is included here to illustrate how Western academic knowledge about health and wellbeing may potentially share some similarities, but importantly many differences, about the nature of mental and emotional wellbeing. As a holistic model this text should of course be read alongside an explanation of all of the dimensions, but given the mental health focus of this resource, just the paragraphs specifically referring to taha hinengaro have been included.

Taha hinengaro is about the expression of thoughts and feelings. In Māori nomenclature, thoughts and feelings derive from the same source, located within the individual. The notion that they are vital to health is a well-recognised concept among Māori. Western authorities have reached similar conclusions though through circuitous routes that have traverses psychological and psychiatric observations, a path that other cultures have not needed in order to finish at the same point. Māori thinking can be described as holistic. Understanding occurs less by division into smaller and smaller parts, the analytical approach, than by synthesis into wider contextual systems so that any recognition of similarities is based on comparisons at a higher level of organisation.

Consistent with this style of thinking, health is viewed as an interrelated phenomenon rather than an intra-personal one. Health thinking from a Māori perspective is integrative not analytical; explanations are sought from searching outwards rather than inwards; and poor health is typically regarded as a manifestations of a breakdown in harmony between the individual and the wider environment. There are several expressions that bind the individual to the outside world. Whenua, for example, can mean both placenta and the land, rae is either the forehead or a land promontory, iwi refers equally to a bone (kō-iwi) or to a nation of people, while hapū can denote pregnancy and a section of a large tribe. The word for birth is whānau, the same term used to describe a family, and wairua, spirituality, can also be used to refer to an insect, just as a kōpō can mean blind or a species of eel. Whakapo is to darken (as in approaching night) and, as well, to grieve, waimate is a hereditary disease but also polluted water, kauae can be the jawbone or a major supporting beam in a building, a tāhuhu refers to both the vertebral column and the ridge pole of a meeting house.

A further distinctive feature of taha hinengaro is its relevance to both thoughts and feelings. While western thinking distinguishes between the spoken word and emotions (and generally encourages the word more than the feeling), Māori do not draw such a sharp distinction. Communication, especially face-to-face, depends on more overt messages. Māori may be more impressed by the unspoken signals conveyed through subtle gesture, eye movement, or bland expression, and in some situations regard words as superfluous, even demeaning. Emotional communication can assume an importance which is as meaningful as an exchange of words and valued just as much. Condolences, for example, are frequently conveyed with tears; infrequently with words. So, when Māori children who are chided by their teachers for showing what they feel, instead of talking about their feelings, they are not only made to feel unworthy (of their feelings) but must also contend with a sense of frustrated expression. (Durie, 1994, p70-71).

PLD activity for HPE middle leaders and teachers:

- What are the dominant discourses around the term 'mental health' among your students? Your HPE teachers? Your whole staff? Your school community?
- Does mention of 'mental health' direct the talk toward matters of wellbeing, or illness and disease? If the latter, how could you change this focus?

⁶ Durie, M. (1994). *Whaiora: Maori health development*. Auckland, N.Z: Oxford University Press

Mental health education as a matter of curriculum policy

The current health education statement in the NZC is dominated by considerations of mental health education.

Health education statement in the NZC (2007, p23)

In health education, students develop their understanding of the factors that influence the health of individuals, groups, and society: lifestyle, economic, social, cultural, political, and environmental factors. Students develop competencies for mental wellness, reproductive health and positive sexuality, and safety management, and they develop understandings of nutritional needs. Students build resilience through strengthening their personal identity and sense of self-worth, through managing change and loss, and through engaging in processes for responsible decision making. They learn to demonstrate empathy, and they develop skills that enhance relationships. Students use these skills and understandings to take critical action to promote personal, interpersonal, and societal well-being.

Although the 1999 curriculum document is no longer 'policy', it is still a useful resource for considering what is intended to be the focus when learning about mental health. This 20 year old statement now needs updating to include more contemporary ideas, such as the knowledge and skills for building resilience (previously framed in relation to ideas about change and loss), cybersafety, digital citizenship, and responsible use of social media, and making more explicit the focus on inclusiveness of diversity. However, the scope of what constitutes mental health education remains consistent with this statement.

HPE in the NZC (1999) Key Area of Learning: Mental Health (p36-37)

Mental health is a broad area, influenced by diverse factors.

"At the personal level, mental health refers to the quality of a person's psychological, social, and behavioural functioning in the world" (The Mental Health Foundation, 1995).

Positive mental health is a prerequisite if students are to reach their highest academic, physical, and social potential. The implementation of programmes in this key area of learning will contribute to the development of a safe emotional environment in classrooms and the wider school, as required by National Administration Guideline 5 (i).

In this key area of learning, students will have opportunities to explore the ways in which the physical, mental and emotional, social, and spiritual dimensions of hauora contribute to mental health.

Students will examine social, cultural, economic, and environmental factors that influence people's mental health, including the effects of media messages. Students will use critical-thinking and problem-solving skills to develop strategies and safety procedures for avoiding, minimising, or managing risk situations.

A supportive classroom environment is necessary for quality learning in mental health. In supportive classroom situations, students can acknowledge diverse points of view, accept a range of abilities, and show concern for one another. Teachers should use a range of teaching and learning strategies that encourage all students to participate fully in the programme.

School-wide policies and practices that promote equality, fairness, and non-violence will support classroom programmes and help to develop a school environment that enhances students' mental health.

Students require a range of learning opportunities in mental health. These include opportunities to develop:

- knowledge, understandings, and skills to strengthen personal identity and enhance a sense of self-worth for example, through learning about self-awareness, self-reflection, self-appraisal, and self-advocacy, and about personal characteristics, relationships, and contexts that contribute to a sense of identity
- knowledge, understandings, and skills to examine discrimination and stereotyping, and to evaluate their impact on people's mental health for example, when recognising instances of discrimination and stereotyping, acknowledging individual differences, respecting the rights of other people, and responding constructively to discriminatory practices and behaviours
- understandings and personal and interpersonal skills to enhance relationships for example, through learning about the range and nature of relationships and the factors that influence them, learning to use a range of communication skills effectively, working co-operatively to achieve common goals in a range of settings, and examining options, consequences, and positive responses to challenges and changes in relationships
- knowledge, understandings, and skills to support themselves and other people during times of stress, disappointment, and loss for example, when expressing their own ideas and feelings and listening to those of other people, managing change, implementing practical strategies for supporting themselves and other people, accessing support, and understanding cultural differences associated with loss and grief
- knowledge, understandings, and skills to make informed, health-enhancing decisions in relation to drug use and misuse for example, through learning about the effects of drugs on all dimensions of hauora, becoming aware of choices and consequences, using communication and problem-solving skills effectively, developing strategies for protecting themselves and other people, examining their own rights and responsibilities and those of other people and society, accessing support in problem situations, learning about policies and laws, and critically analysing ways in which society influences people in relation to drugs and the impacts that drug use and misuse have on society
- knowledge, understandings, and skills to recognise and respond to situations of abuse and harassment for example, through learning about causes and effects, learning about their own rights and responsibilities and those of other people, using communication skills effectively, identifying and using strategies and safety procedures, and becoming aware of policies and laws
- knowledge and understanding of the benefits of physical activity, relaxation, and recreation in relation to mental health
- values and attitudes that support the enhancement of mental health for the students themselves, other people, and society such as a positive and responsible attitude to their own well-being, respect for the rights of other people, care and concern for other people, and a sense of social justice

Although the list below is by no means an exhaustive account of mental health 'topics' considered to be part of mental health education, popular units of learning across New Zealand secondary schools include:

- Wellbeing (as a holistic concept)
- Identity (and self-worth)
- Building strengths/capacity (or building resilience) – enhancing protective factors and reducing or mitigating risk factors
- Personal management (goal, setting, decision making, problem solving, stress management, relaxation, etc) and interpersonal communication skills (effective listening, assertiveness, negotiation and compromise, etc)
- Friendships and relationship (qualities of and skills for) and challenges to these (bullying, harassment, discrimination and stereotyping, break ups, etc)
- Managing stressful situations
- Alcohol and other drugs
- Change, loss, disappointment, and grief

- Digital citizenship - social media use, cybersafety etc
- Body image
- (Usually more at senior level) some understanding of common mental health conditions like depression and anxiety, the factors that contribute to these conditions, prevention and help seeking.

PLD activity for HPE middle leaders and teachers:

- 'Audit' your school health education programme for coverage of mental health contexts. What can you conclude about the range of topic coverage in relation to the (wide) scope of what is possible - as noted by the material in this section?
- What has decided the focus for your current programme? Is it.... historic (*'we've always done it that way'*)? Aligned with certain resources? Makes use of an external provider? Required by senior leadership or directed by a schoolwide initiative? Designed anew each year to respond to identified student learning needs and interests? Directed by a connected or integrated curriculum theme?
What are the implications of the reasons for your mental health education being the way it is when thinking about high quality educational outcomes and learning pathways across school for all of your students?
- How do you judge whether or not mental health education aspects of your health education programme are 'meeting students learning needs' and responding to the principles of your local school curriculum?
- How and where do you incorporate considerations of hauora and te whare tapa wha, and other models of health and wellbeing, in your teaching and learning programme?
- What meaning do you give to mental health and wellbeing? Is it more aligned with the academic knowledge of the curriculum, indigenous understandings or other cultural understandings?

Teaching ‘about’ mental health as a matter of outcomes

Teaching in health education, as a learning area in the NZC, is **learning ‘about’ health and wellbeing**. That is the measurable and required outcomes - as a matter of education policy - are learning outcomes, not health and wellbeing outcomes.

The National Education Goals (NEGs)

NEG 5 “A broad education through a balanced curriculum covering essential learning areas. Priority should be given to the development of high levels of competence (knowledge and skills) in literacy and numeracy, science and technology and physical activity.” <https://www.education.govt.nz/our-work/legislation/negs/>

The National Administration Guidelines (NAGs)

NAG 1: Each board of trustees is required to foster student achievement by providing teaching and learning programmes which incorporate The National Curriculum, as expressed in The New Zealand Curriculum 2007 or Te Marautanga o Aotearoa. Each board, through the principal and staff, is required to:

- (a) develop and implement teaching and learning programmes:
 - (i) to provide all students in years 1–10 with opportunities to progress and achieve for success in all areas of The National Curriculum;

NAG 5: Each board of trustees is also required to:

- a) provide a safe physical and emotional environment for students;
- b) promote healthy food and nutrition for all students; and
- c) comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees.

<https://www.education.govt.nz/our-work/legislation/nags/>

To assume that health and wellbeing (behavioural) outcomes will result from health education teaching and learning alone is **unethical and flawed** in several ways.

- Prevention (as a goal of the teaching and learning) while a claimed intention of health education, is very difficult to prove, especially when statistics show that most students will not develop mental health problems anyway.
- Intervention in response to known or perceived health needs of some students in the class is potentially risky when the teacher is not likely to have full knowledge of the situation, and it may draw undue attention to students with certain mental health issues, exacerbating the problem. This would generally be considered unsafe practice. Any intervention approaches (that aimed to improve student behaviour or health outcomes) should be with individual students or a targeted group of students impacted by the situation, be conducted in a safe and secure environment, and be led by an adult with the appropriate expertise and authority to ‘intervene’.
- New Zealand teachers are required to ‘teach in ways that ensure all learners are making sufficient progress, and monitor the extent and pace of learning, focusing on equity and excellence for all’ (see the following discussion on teacher standards). An effective teacher therefore is required to show that, as a consequence of their teaching, students have reached a level of achievement in the NZC and have made progress with their learning over time (refer to NAG1). If a student already has a ‘good’ state of mental

health, where do they progress to? Or for students whose cognitive abilities make the expected learning (and therefore learning into action) inaccessible, how can these students make progress?

- Teaching students about aspects of mental health, with the intent that they will use that knowledge to take personal action, assumes individuals have control over their life circumstances - that is, control over their access to money and other resources, their family and home circumstances, their relationships with others, their genetic predisposition, and so on. The life circumstances of young people, just like many adults, is substantially influenced (and controlled) by other factors that individuals (in isolation) are often powerless to change.
- Philosophically, the approach to teaching that simply gives students (mental) health knowledge and tells them how to act as individuals to have healthy lives, make healthy decisions that prevent disease, and makes them healthy citizens, reflects a predominantly westernised, neoliberal, individualised, **healthism** approach that is rejected by HPE in the NZC.
- The evidence from MANY education-for-all prevention programmes around the world (e.g. related to health behaviours such as alcohol and other drug use, eating behaviours, safer sex practices etc) indicate that education alone is not enough to change behaviours and measure sustained improved health outcomes. Even programmes that claim such outcomes are regularly challenged with many studies using self-report measures and no rigorous and defensible clinical health or observed behavioural measures, and claims often only cover modest time frames. Longitudinal studies - of which there are relatively few - cannot demonstrate the role education (alone) plays in health outcomes because of the multiple and complex factors that impact health behaviours across the life span.
- A teacher cannot ethically 'measure' students' health behaviours like they can measure learning outcomes. Only a doctor or other designated health professional gets to carry out these sorts of measures, interpret the data and recommend a course of action based on the evidence.

However, just because (curriculum) health education alone doesn't result in measurable health outcomes across student populations, it does not mean we give up teaching about health and wellbeing. After all, how can anyone act in a knowledge vacuum? **The point is that we don't claim health and wellbeing outcomes as a result of our teaching, or have our teacher effectiveness measured on the basis of student health and wellbeing outcomes.**

We do acknowledge that some teachers will have anecdotal evidence of positive health and wellbeing outcomes for a small number of students that can be reasonably attributed to their teaching. This is great BUT remember, that *as teachers*, ALL of our students must achieve and make progress with their learning. Isolated accounts of improved health and wellbeing outcomes for individual students are not the measure of an effective *teacher*.

PLD activity for HPE middle leaders and teachers:

- How do you like to express the contribution that your health education teaching makes toward outcomes for young people?
- How (un)comfortably does this material in this section sit with you? Why is this?
- What are you prepared to have your effectiveness as a teacher judged on when teaching young people about mental health education topics? And what are you not prepared to have your effectiveness judged on? Why is this?
- Do you think a few hours of your teaching can 'rescue' students from the mental health impacts of the grief experienced from: significant (death) losses of friends and family members, the impact of sexual violence by partners or adults/other family members, persistent cyberbullying and highly problematic social media use, genetic predispositions to mental health issues, substance abuse from inadequate control of drugs, conservative cultural and/or religious values and beliefs that don't recognise and support diverse identities, dispositions and ways of being in the world ... and so on...

A matter of expertise and authority – the Standards for the Teaching Profession

A founding premise of this position statement is that as teachers, we have no qualifications nor professional authority (based on our professional codes of practice) to diagnose or treat students experiencing mental health problems. Our professional responsibilities as teachers are:

- *For those of us teaching in the HPE learning area*, teaching about mental health (knowledge skills and understanding across a range of mental health related contexts); and
- *For all teachers*, work in the best interests of learners by promoting the wellbeing of learners and protecting them from harm. The range of educational materials expanding this specific aspect of the code suggests that this is about teachers creating safe, supportive, and inclusive learning environments. This includes eliminating bullying, developing digital citizenship, respectful communication, designing learning programmes that are inclusive of diverse identities (cultural, sexual, gender, and physical and cognitive abilities).

Our professional code of practice *as teachers* does not give us authority to act as (mental) health professionals - for which we would require medical qualifications and be registered practitioners who work within the required medical codes of practice. However, our teacher's code of practice does require us to 'meet relevant regulatory, statutory and professional requirements' which, if extended to consider documents such as the *Preventing and responding to suicide: Resource kit for schools*,⁷ means we need to **know how systems work in our school** so that we know how we are expected to respond to these regulations.

Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession

This section uses extracts from *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession* and the accompanying *Examples in Practice* document from the New Zealand Teaching Council, to highlight the role and responsibility of teachers – and the limitations of a teacher's practice. Although these practices apply to all teachers, the nature of the subject matter we deal with in health education gives heightened importance to most of these requirements. **Added emphasis** and **annotations** have been added.

The code of professional responsibility (p10)

2) Commitment to learners: Teachers work in the best interests of learners by:

(2.1) Promoting the wellbeing of learners and protecting them from harm.

Harm is defined as any detrimental effect on the learner's (physical, emotional, social, intellectual or spiritual) wellbeing. This includes neglect, deprivation, abuse, discrimination, exclusion, threats of physical harm and harassment. It does not include accidental harm that does not involve negligence or misconduct.

The Code of Professional Responsibility: Examples in Practice (p11) expands on this by stating the following.

*Examples of behaviour that **promotes learners' wellbeing** and **protects them from harm** include:*

- creating learning environments (including online spaces) that are safe and inclusive, and that promote the dignity and emotional wellbeing of all learners
- fostering trust, respect and cooperation with and among learners
- fostering a learning environment that actively promotes community support

⁷ Preventing and responding to suicide: Resource kit for schools

<https://www.education.govt.nz/assets/Documents/School/Traumatic-incidents-and-emergencies/SuicidePreventionOCT2013.pdf> (Note that as part of a cross sector response to the prevention youth suicide, the Ministry of Education is currently in the process of revising this document.)

- showing respect, for example, using a respectful tone of voice, showing an interest in learners as individuals and learning names quickly
- demonstrating empathy and responsive care when learners are unwell, hurt or upset
- **being familiar with the indicators of, and risk factors for, abuse and neglect and taking appropriate action where there is reason to believe a learner may have been, or may be at risk of being, harmed (including self-harm), abused or neglected**
(This must be done as a coordinated approach, led by someone in the school in pastoral role that the school authorises to act on behalf of students.)
- advocating for a learner's right to access the educational institution and to receive additional support for their development and learning where this is needed
- **working collaboratively with other agencies that may be involved with a learner's wellbeing**
(Again, this should be done as a coordinated approach, led by someone in the school in pastoral role that the school authorises to act on behalf of students. It is not recommended that teachers act in isolation and take matters into their own hands.)
- using care and sound judgement when discussing a learner's personal information with others, either within the learning environment or outside of it
- **informing learners of the extent of confidentiality and the situations where information may be disclosed**
(Any cause for concern about student safety and health status should be reported to a designated person in the school e.g. school counsellor.)
- using established procedures for out-of-school or out-of centre activities in order to reduce risk of harm
- fostering an environment of trust and respect where learners feel it is safe to take risks
- using digital communication with diligence and care to protect privacy and confidentiality.

*Examples of behaviour that **does not promote learners' wellbeing and may cause harm include:***

- inappropriate handling such as physically grabbing, shoving or pushing, or using physical force to manage a learner's behaviour
- using verbal or body language that is unreasonable and inappropriate (for example, using aggressive, threatening or humiliating language, or using an intimidating stance and demeanour)
- inappropriate or unreasonable exclusion (for example, from a physical space, an activity, an opportunity or attention)
- **failing to take reasonable steps to protect a learner from harm**
(Reasonable steps means not overstepping professional boundaries as much as it means not taking, or taking an inadequate level or type of action.)
- disclosing a learner's personal or confidential information beyond those who have a legitimate need to know
- permitting, supplying or encouraging a learner to use a controlled drug.

The code of professional responsibility (p10)

2) Commitment to learners: Teachers work in the best interests of learners by:

2. 2 Engaging in ethical and professional relationships with learners that respect professional boundaries.

We recognise that :

- teachers are in a unique position of trust, care, authority and influence over our learners
- the teacher–learner relationship is not equal, and there is always an inherent power imbalance
- teachers have a duty of care to ensure that the physical and emotional wellbeing of learners is safeguarded
- teachers have the responsibility to ensure and maintain professional boundaries with their learners.

Examples of behaviour that demonstrates ethical and professional relationships with learners include:

- being careful to manage professional boundaries both within and beyond the learning environment
- **taking steps to establish and maintain positive and professional relationships focused on their learning and their wellbeing**
- (Noting that this is where the distinction between biomedical (mental) health and wellbeing becomes important - see the promoting and responding triangle later in this resource.)
- taking steps to ensure that my learners understand the limits and boundaries of the teacher–learner relationship
- being transparent about actions that could be interpreted as blurring professional boundaries, by informing, and seeking authorisation from, my professional leader.

Examples of behaviour that may breach the boundaries of ethical and professional relationships with learners include:

- fostering online connections with a learner outside the teaching context (for example, ‘friending’) or **privately meeting with them outside the education setting without a valid context** (Valid context here would imply learning related. The teacher-student relationship is that of teacher and learner, not health professional and patient. Co-curricular activities in this context are still taken to be part of the education setting.)
- encouraging a learner to develop an inappropriate emotional dependency on me (In health related situations this is a known and common consequence.)
- adopting a role with a learner that is inappropriate and beyond the scope of my teaching position, such as treating the learner as a friend
- (As above, avoid treating the learner as a ‘patient’ - someone who has health and wellbeing problems and who requires help beyond referring them to a designated person in the school.)
- communicating with them about very personal and/or sexual matters without a valid context
- (When we teach sexuality education, what constitutes a valid context should be curriculum related.)
- engaging in a romantic relationship or having sexual or intimate contact with a learner or with a recent former learner
- making jokes or innuendo of a sexual nature toward a learner, or making inappropriate comments about their physical appearance.

When health education teachers collect evidence to show that they have met the standards for the teaching profession, this evidence should be able to be drawn from teaching about mental health, as much as any other aspect of their teaching. Consider these elaborations of the ‘learning focused culture’ and ‘teaching’ standards, in relation to the previous section which focuses on the outcomes of mental health education.

Standards for the teaching profession (p20)	Elaboration of the standard
Learning-focused culture Develop a culture that is focused on learning, and is characterised by respect, inclusion, empathy, collaboration and safety	<ul style="list-style-type: none"> • Develop learning-focused relationships with learners, enabling them to be active participants in the process of learning, sharing ownership and responsibility for learning. • Foster trust, respect and cooperation with and among learners so that they experience an environment in which it is safe to take risks. • Demonstrate high expectations for the learning outcomes of all learners, including for those learners with disabilities or learning support needs. • Manage the learning setting to ensure access to learning for all and to maximise learners’ physical, social, cultural and emotional safety. • Create an environment where learners can be confident in their identities, languages, cultures and abilities. • Develop an environment where the diversity and uniqueness of all learners are accepted and valued. • Meet relevant regulatory, statutory and professional requirements. (This includes knowing how to use school systems for supporting students with health and wellbeing needs.)

<p>Teaching Teach and respond to learners in a knowledgeable and adaptive way to progress their learning at an appropriate depth and pace.</p>	<ul style="list-style-type: none"> • Teach in ways that ensure all learners are making sufficient progress, and monitor the extent and pace of learning, focusing on equity and excellence for all. • Specifically support the educational aspirations for Māori learners, taking shared responsibility for these learners to achieve educational success as Māori. • Use an increasing repertoire of teaching strategies, approaches, learning activities, technologies and assessment for learning strategies and modify these in response to the needs of individuals and groups of learners. • Provide opportunities and support for learners to engage with, practise and apply learning to different contexts and make connections with prior learning. • Teach in ways that enable learners to learn from one another, to collaborate, to self-regulate and to develop agency over their learning. • Ensure learners receive ongoing feedback and assessment information and support them to use this information to guide further learning.
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PLD activity for HPE middle leaders and teachers:

- How confident are teachers in the HPE faculty/department to collect data from a range of mental health topics or units to use as evidence that a relevant section of the teaching standards have been met? How could this confidence to collect data from mental health-related teaching be improved? What do teachers need to learn to do in relation to data collection and what constitutes evidence that the standards have been met?
- Which aspects of the code do teachers of health education find particularly relevant for their practice, given the subject matter they deal with? What issues do the extracts in this section raise about teacher professionalism when teaching mental health education? Are there any aspects of practice teachers are less confident about? Who (or what resource) can help to sort out areas of uncertainty?

The educational case against prescribed one-size-fits-all education (only) programmes

In the face of public concern about young people's health and wellbeing issues, non-education or non-school-based stakeholder groups are often able to secure funding to develop and implement education (only) 'programmes' in schools that aim to improve health and wellbeing outcomes in response to these claimed 'crises' and concerns. These sorts of programmes have existed for decades and a persistent outcome of (almost all of them) is that they 'don't work' - which is to say they cannot provide convincing evidence of the health/wellbeing/behavioural change goals that the provider claims that the programme will achieve.

Evaluations of such programmes - where they exist - predictably show increased knowledge (after all they are 'educational'), but the pre- and post- self-report measures typically adopted by these studies lack rigour and convincing evidence of actual improved health and wellbeing outcomes that are sustained over time. Consequently, there is a poor evidence base as to 'what works' when the focus is on 'education only' programmes.

With a lot of evaluation research now available around programmes that aim to improve mental health and wellbeing outcomes for students - of variable quality, as noted - it has allowed researchers to carry out systematic reviews and meta-analyses to better judge the impact of such programmes across populations. Meta-analyses allow researchers to factor in a wide range of considerations, including the robustness of the data collection methods, the evaluation process, as well as the claims to improved outcomes.

One recent meta-analysis of whole school approaches to enhancing children and young people's social and emotional development (ie. a coordinated set of activities across curriculum teaching, school ethos and environment, and family and community partnerships), by Goldberg, et al.⁸, included 45 studies (30 interventions) involving 496,299 participants. The study concluded that these whole school approach-type interventions '*demonstrated significant but small improvements in participants' social and emotional adjustment, behavioural adjustment, and internalising symptoms. Interventions were not shown to impact on academic achievement. Origin of study and the inclusion of a community component as part of a whole school approach were found to be significant moderators for social and emotional outcomes*' (p755). The study went on to say that further research is required to determine the 'active ingredients' of whole school interventions to better understand the components necessary to achieve successful outcomes.

Targeted intervention programmes (which are still 'educational' but include specific behaviour change goals and activities) may more convincingly show improvements among smaller groups with an existing and identified health or wellbeing need, and where the programme provider can ethically use clinical measures. In these situations the programme can be more rigorously evaluated for the impact of the activities on health outcomes.

The NZHEA position

NZHEA supports the use of external providers where they provide highly specialist knowledge or unique perspectives, and add value to a health education teaching and learning programme designed and planned to meet student learning needs. We are less supportive of one-off events or performances that claim to have educational value, but instead offer little more than 'edutainment'.

We also support the practice of teachers accessing PLD offered by external providers who can help them develop health education specific knowledge and pedagogical expertise.

⁸ Goldberg, J.M., Sklad, M., Elfrink T.R. Schreurs, K.M.G. Bohlmeijer, E.T. & Clarke, A.M. (2019). Effectiveness of interventions adopting a whole school approach to enhancing social and emotional development: a meta-analysis. *European Journal of Psychology of Education*, 34(4), 755–782. Open access to this article is at <https://link.springer.com/article/10.1007/s10212-018-0406-9>. This article references a number of other similar studies from the past decade.

However, we do not typically support the provision of externally developed and facilitated programmes. The programmes referred to here are those that require the teachers to hand over their class to the provider for a succession of lessons so that they can deliver their pre-designed (usually one-size-fits- all) programme of activities.

There are exceptions to this, typically where:

- the teacher and provider **work in partnership** to deliver the programme,
- there is room to **adapt** the programme to meet student learning needs, and
- the programme in essence becomes a **‘resource’** within a more broadly focused unit of learning.

We believe that the best person to be delivering teaching and learning programmes in health education is the teacher employed by the school, and who has an ongoing learning relationship with the students. The external provider may facilitate PLD for the teacher that enables them deliver the programme, but on the understanding that for a teacher, a programme is just a resource and they will modify the activities to meet the learning needs of their students. Unless the teacher is able to adapt the programme in a way that it builds on prior learning and leads to future learning, and produce learning artefacts that show learning has occurred (and at a specified level of the NZC), it is not meeting expected education practice for curriculum delivery. Modifications to programmes are also necessary to attend to broader learning considerations for students like literacy or digital fluency needs, and to reflect the principles of the school’s local curriculum.

Becoming critical consumers of externally provided programmes

We are aware that many teachers are, or are becoming more critical of the various offerings of externally provided health education programmes, insofar as teachers are deciding for themselves whether or not the provider can show the programme is a good fit for their students at their school, and that it is somehow better than, and adds value to, what they already do (or know to do).

Many teachers are asking that prospective providers adapt their programmes to better meet the learning needs of their students, and complement their planned teaching and learning programme. However, many providers are reluctant to do this as to evaluate programme effectiveness providers need to maintain the integrity or ‘fidelity’ of their programme which requires the one-size-fits-all approach.

Teachers are also often aware of the impact that a lack of provider knowledge about the unique learning needs of the students in context of their school community can have. For example we have heard teachers talk about programmes that:

- Are pitched too high or too low for the year level,
- Are seldom (genuinely) culturally responsive,
- Don’t have time or capacity/opportunity to develop a safe supportive learning relationship between facilitator and students,
- Can disrupt what the teacher has already established,
- Lack connections with prior and future learning, and
- Often don’t add more educational value than what they teacher could have done themselves.

In relation to the teacher standards, handing over a class to an outside provider means that the teacher is absolving themselves of responsibility and neglecting many expectations around programme design and teaching. This approach also contradicts the expected teaching as inquiry approach whereby teachers use data about student learning to decide learning programmes and how to best teach their students to achieve identified *learning* needs. A one-size fits all programme designed by a provider with no knowledge of the students is not going to achieve this.

At a time when all manner of mental health programmes that purport to inoculate young people against the detrimental effects of health and wellbeing issues are being offered to schools, we believe that (among many other considerations) it is a teacher’s role to be a critical consumer and reviewer of such programmes.

For example, consider the globally popular variations of mindfulness programmes that are being adopted by schools as the panacea for all mental health and wellbeing issues (which research suggests can have some positive benefits for some students, although this research also needs to be read with a critical eye as some claims are hard to substantiate). We're not opposed to mindfulness programmes per se, but if its assumed that a bit of 'skill and drill' around some personal relaxation and other self-management techniques is all it takes to support wellbeing - but nothing is done by the school about developing respectful communication and eliminating (cyber)bullying and harmful social media use, creating a safe inclusive environment for students with diverse ethnic and cultural, sexual and gender identities, (etc) then some personal skills with little knowledge foundation to them, and no consideration of the skills needed to work and live with others and be part of a community, will have little sustainable impact.

The opening paragraph in the Goldberg, et al.⁹ article cited previously makes some points that are highly relevant for health education:

*Children and adolescents need a balanced set of **cognitive**, social and emotional skills in order to achieve positive outcomes in school, in work, and in life more generally (OECD, 2015)¹⁰. Social and emotional skills such as understanding and managing emotions, navigating social conflicts effectively, and making responsible decisions have been shown to influence numerous measures of social outcomes, including improved health, life satisfaction, subjective wellbeing, and reduced odds of engagement in anti-social behaviours (Goodman, 2015)¹¹. **Social and emotional skills do not play a role in isolation**, they interact with **cognitive skills** which further enhance children's likelihood of achieving positive outcomes in life (OECD, 2015). (Goldberg, et al., p.755)*

The mention of 'cognitive' skills is emphasised here, which are in addition to learning (and having) social and emotional skills. The importance of cognitive processes for learning 'about' health and wellbeing goes back to the previous point made in this position statement that none of us can understand mental health and wellbeing issues, or take action, without knowledge - which requires cognitive learning.

Cognitive skills are what the brain uses to:

- think - especially to think critically and creatively - to analyse and evaluate, infer and deduce, recognise different perspectives, imagine and create
- read, interpret, and comprehend
- learn and understand
- remember
- reason, rationalise, and justify
- take notice and pay attention.

In being a critical consumer of mental health education (and other) programmes, we encourage teachers to:

- Resist pressure from school leadership or the school community who see these programmes as a response to a perceived 'crisis'.
- Investigate, in detail, what students will learn and look to the quality of the cognitive skills and health education knowledge, not just the mental health or social and emotional skills, and what evidence will be available to show this learning has occurred.
- Be clear about the 'value' that will be added to your teaching and learning programme.

⁹ Goldberg, J.M., Sklad, M., Elfrink T.R. Schreurs, K.M.G. Bohlmeijer, E.T. & Clarke, A.M. (2019). Effectiveness of interventions adopting a whole school approach to enhancing social and emotional development: a meta-analysis. *European Journal of Psychology of Education*, 34(4,) 755–782. Open access to this article is at <https://link.springer.com/article/10.1007/s10212-018-0406-9>

¹⁰ OECD. (2015). *Skills for social progress: the power of social and emotional skills*. Paris: OECD Publishing. <https://doi.org/10.1787/9789264226159-en>.

¹¹ Goodman, A., Joshi, H., Nasim, B., & Tyler, C. (2015). *Social and emotional skills in childhood and their long-term effects on adult life*. London: Institute of Education.

- Question the appropriateness of the programme content and delivery when considering the diversity, and diverse learning needs, of the students at your school.
- Avoid the temptation to see such programmes as a quick fix to make up for lack of teacher confidence for teaching about the subject matter.
- Use school data that shows the programme being offered will respond to known cognitive learning and social and emotional (mental health) needs.
- Ask for evaluations reports that show evidence of impact that the programme claims will be achieved.

PLD activity for HPE middle leaders and teachers:

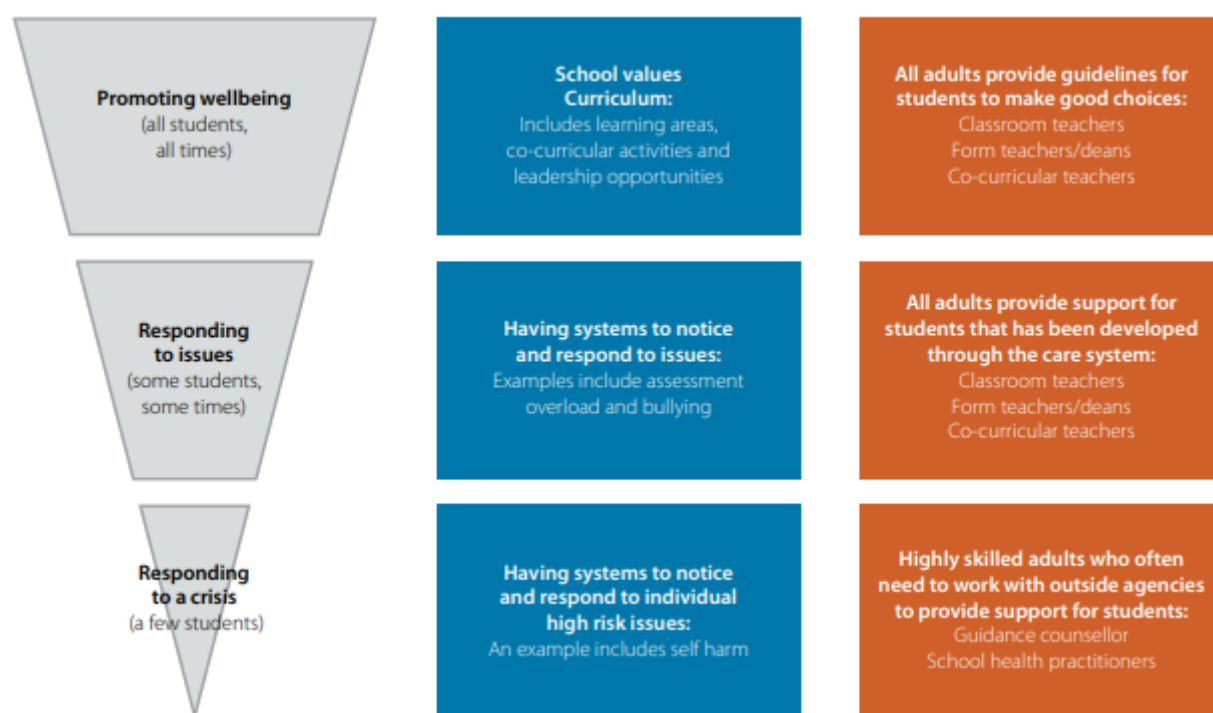
- If you use external providers for a one-off lessons, what value do they add to your programme? What's your evidence for this?
- If you use an external provider to deliver as aspect of your programme (over several lessons), what value do they add to your programme? What's your evidence for this?
- How are you going to feel IF in future you are asked to deliver (or give over your class to an external provider) to deliver a one-size-fits-all programme that purports to inoculate young people against mental health problems, or pick them up if they are in distress. And IMPORTANTLY that your teacher effectiveness - and your school's effectiveness - is going to be judged on the health outcomes this programme claims will be achieved?
- What is your position and justification if you are put under pressure by senior leadership, others in your department and/or external providers to allow a 'programme' or group into your health education time?
- How confident do members of your department feel with planning and teaching units relating to mental health, and facilitating classroom activities/discussions such as from the NZCER mental health or NZHEA mental health resource? How can you develop confidence within your department in this area?

A matter of process: Teaching and learning 'about' mental health vs promotion of wellbeing 'for' mental health

Whole School Approaches to the promotion of student wellbeing

With increased focus on the promotion of wellbeing at schools, the place of curriculum teaching and learning requires careful and considered understanding. Curriculum teaching and learning emphasises **learning 'about' wellbeing** where outcomes are 'measured' as learning outcomes. This is a part of but not one and the same as **learning 'for' wellbeing** which may come from school wide promotion of wellbeing and whole school approaches that bring together many school systems and practices.

The promoting and responding triangle following (reproduced from ERO¹² and originally called the intervention triangle) is a model that has been in use for decades for mental health and wellbeing promotion. It is regularly redesigned and repurposed for different projects and application. In New Zealand, ERO and NZCER have been using this model to frame the promotion of student wellbeing in NZ schools.



Based on CASEL. (2008). Social and Emotional Learning (SEL) and Student Benefits: Implications for the Safe Schools/Healthy Students Core Elements. Washington DC: National Center for Mental Health Promotion and Youth Violence Prevention, Education Development Center. In Wellbeing for success: a resource for schools. As presented by ERO March 2016.

Note that the emphasis in this model is on 'wellbeing'. A definitive understanding of 'wellbeing' - as distinct from 'health' - remains elusive among our current education literature as it does internationally, despite the frequent use of the term 'wellbeing'. ERO¹³ and NZCER¹⁴ documents reference te whare tapa whā as a model of hauora framing

¹² Education Review Office (2016). Wellbeing for success: a resource for schools. NZ: Crown.

<https://www.ero.govt.nz/publications/wellbeing-for-success-a-resource-for-schools/>

¹³ Between 2013 and 2016 ERO published the following reports related to student wellbeing: Guidance and Counselling in Schools: Survey Findings (July 2013); Improving Guidance and Counselling for Students in Secondary Schools (December 2013); Wellbeing for Success: Draft Evaluation Indicators for Student Wellbeing (November 2013); Wellbeing for Children's Success at

the concept of wellbeing. However, the specific and considered application of the concept to whole school contexts is not explicitly and deliberately reported (like, for example, the way students may apply the concept of hauora, using te whare tapa whā, to a range of learning contexts).

By default what is clear from the documentation produced by these agencies is that the schooling focus on wellbeing is NOT about biomedical understandings of 'health'. On the occasion that schools may need to support a few students to access specialist medical support for health conditions, this framed in relation to 'intervention' activities, not actions (for all) that focus on the promotion of student wellbeing.

Promoting (the top part of the triangle):

What is often not as clear as it could be, or should be, in these diagrams is the place of purposefully designed and planned teaching and learning units focused on topics drawn from the mental health key area of learning in the HPE learning area. A useful addition to this diagram is to situate HPE learning in the **top part of the triangle** to show how HPE teaching and learning contributes knowledge and skills to the promotion of wellbeing. As previously noted, promoting wellbeing cannot occur without knowledge of the situation and knowing how to act. This is not saying that all learning in health education will contribute to the promotion of (health and) wellbeing, but there is the potential for this to happen.

Different ways of promoting wellbeing in schools includes:

- Teachers' everyday practice as they create safe supportive classroom communities that support learning.
- Inquiry based processes as part of schooling improvement, where data is used to identify areas of student wellbeing need, and new learning (for staff and students) leads to action to bring about change.
- Student led health and wellbeing promotion as a feature of learning in health education, or through the activities of student action groups.

Responding – early intervention (the middle layer of the triangle):

Students who require early intervention-type support for identified health and wellbeing needs can usually be responded to by a school's pastoral support team and within established school systems. Although teachers may provide a form of support for students as part of actions in this early intervention layer, it is under the guidance of designated school leaders working in response to a planned and organised system of support.

Responding – students in crisis (the apex of the triangle)

Those few students with highly specific health needs can be connected with health specialists in the community who have the qualifications and authority to manage such situations.

Evaluative capability

The evaluative capability for collecting data and 'measuring' the outcomes of whole school approaches to the promotion of student wellbeing is still growing in New Zealand schools. ERO's (2016) *Wellbeing for success: a resource for schools* document lists many indicators of effectiveness for school wide promotion of wellbeing - almost all of these are systems level or process oriented considerations and monitoring that systems are working.

Although student wellbeing outcomes could be a feature of these indicators, the use of procedures and tools to measure this, and in ways that are ethical for schools to measure, are limited, often to self-report measures. Data such as reduction in bullying incidences or stand-downs and exclusions, increased or active use of student-led

Primary School (February 2015); Wellbeing for Young People's Success at Secondary School (February 2015); Wellbeing for Success: Effective Practice (March 2016); Wellbeing for success: a resource for schools (March 2016)

¹⁴ Lawes, E. and Boyd, S. (2018). Making a difference to student wellbeing—a data exploration. NZ: Crown.

<https://www.nzcer.org.nz/research/publications/making-difference-student-wellbeing-data-exploration>

support groups, adherence with digital citizenship protocols, and other such behavioural measures, should be possible.

It is also acknowledged that counsellors will hold confidential information about the health and wellbeing status of some students. However, this is seldom available to members of the school community for self-evident reasons.

Teacher wellbeing

The focus of this position statement is on the promotion of student wellbeing, as a teacher and schooling responsibility.

Promotion of staff wellbeing is an employment¹⁵ issue under the Health and Safety Act. Although considerations of staff wellbeing may be included alongside the promotion of student wellbeing, in a schooling improvement context it is the improved outcomes for students that are key, along with evidence of the changes to teacher and leader practice that contributed to these improvements.

PLD activity for HPE middle leaders and teachers:

- If you haven't already done so, and perhaps building on a similar task completed by the students, map out all of the actions that occur in your school that contribute something to the promotion of student wellbeing.
- Further annotate this map with the ways the health education programme contributes to these actions through the learning of knowledge and skills. Which aspects of this student learning are purposefully noted in the school's documentation as contributing to these activities to promote student wellbeing? Which could be - or should be?
- If your school or Community of Learning/Kahui Ako has wellbeing focused goals, how is your health education programme positioned within the CoL/KA plan? If it's 'lost', consider trying to get it formally included as part of the actions for achieving school goals and/or the CoL/KA achievement challenge.
- What health (or wellbeing) promoting actions do your students engage in, as part of their learning in health education, that could be documented as part of a whole school approach to the promotion of wellbeing, that warrants being recorded in annual school reporting to the Ministry or the community?

¹⁵ Ministry of Education statement about staff wellbeing as a health and safety employment matter
<https://www.education.govt.nz/school/health-safety-and-wellbeing/student-and-staff-health/staff-wellbeing/>

Safety considerations when teaching about aspects of mental health

Reproduced and adapted from the NZHEA resource: *Mental Health and Resilience: Teaching and learning activities for NZC Levels 6-8*¹⁶ by Jenny Robertson (2018).

A focus on mental health contexts in health education frequently results in the issue of suicide and self-harm being raised by students. This is especially so when these issues are receiving attention in the media through news and current affairs programmes reporting recent statistics, or entertainment media depicting these themes in film and TV programmes. Similarly, a focus on body image inevitably piques interests in eating disorders or body dysmorphic disorder, images and accounts of which are readily found in a variety of online sources.

Teachers can't stop students raising these issues. How teachers respond to student questions and comments about suicide and self-harm, is guided by school policy.

The issue of suicide and self-harm - a health education position on the matter.

What's going on for young people who attempt or commit suicide is often highly complex and a *teacher's* training doesn't begin to prepare them, much less provide them with a professional mandate, to make decisions about a young person's mental health status (see the Education Council teacher standards and code of professional responsibility). It requires a guidance counsellor and/or community-based mental health professional's expertise, working within their codes of professional practice, to manage these situations.

To support student safety, schools will have policy and protocols for what they expect teachers to say and do when:

- students raise the issue of suicide or self-harm in conversation,
- making decisions about what is and isn't appropriate to include in lessons, and what students can focus attention on in research/investigation/inquiry based learning,
- they have concerns about the wellbeing of students e.g. *If you think (or know) a student is self-harming or maybe about to cause harm to themselves, or they have told you they are thinking about committing suicide, what do you do - if you're at school? - After school hours? - If you come to know of this via social media?*

Knowing when to refer.

If teachers are at all concerned about the wellbeing of a student they need to report this as soon as possible to the guidance counsellor or other person in the school or school community with the designated responsibility for student welfare. Even if it is a concern without tangible evidence, teachers are still encouraged to talk with the school counsellor about their concerns and not to 'write it off' as being overly cautious, or that 'the student is having a bad day and they will snap out of it'.

The school counsellor is able to make contact with students without the student knowing where the referral came from if need be. They often do this by stating to the student that their teachers (in general) are concerned about the drop off in their school work and would they like to talk about that (for example). Alternatively, teachers can offer to take students (with their permission) to see the counsellor, acting briefly as a go-between and making it the teacher's 'problem' and not the student's. For some students this takes the onus off them making contact ('*I'll go because the teacher wants me to*') especially if there is a negative stigma about help seeking in the school. The counsellor will then act accordingly.

¹⁶ Robertson, J. (2018). *Mental Health and Resilience: Teaching and learning activities for NZC Levels 6-8*. NZ: New Zealand Health Education Association (NZHEA). Available from <https://healtheducation.org.nz/resources/>

As a teacher of health education it is important that you understand and adhere to your school's policy and protocols on this matter.

These procedures have been decided by those people in the school with the leadership role and authority to make decisions like this, and who have to take responsibility in such situations. It is irresponsible of teachers who are not trained to deal with these situations (nor have the professional role and responsibility to act in such situations in their *role as teacher*) to disregard the professionalism of those with the designated role to act, and who have to follow a range of ethical and legal protocols as part of their own practice. *If you have issues with the way your school manages these matters, talk with the guidance counsellor or a senior leader to develop understanding about why the school requires you, as a teacher, to respond in the ways described. If it can be demonstrated that the school needs to change its policy and practices, this needs to happen in agreement with school leadership.*

The Ministry of Education has guidelines about suicide prevention and school policy related to this.

- Ministry of Education (2013). *Preventing and responding to suicide: Resource kit for schools* <http://www.education.govt.nz/assets/Documents/School/Traumatic-incidents-and-emergencies/SuicidePreventionOCT2013.pdf>
- The Ministry of Health is responsible for New Zealand's suicide prevention strategies. This site provides statistics and other resources that schools and students can access for reliable information: <https://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide>
- See also the Mental Health Foundation suicide prevention strategy: <https://www.mentalhealth.org.nz/home/our-work/category/34/suicide-prevention>

Health education is about the promotion of wellbeing, and learning knowledge, skills, and understandings to be able to engage in health promotion processes.

Suicide prevention isn't 'talking about suicide' as such - it's about promoting wellbeing. A teacher teaching *all* students can contribute to a whole school approach (WSA) to the promotion of wellbeing by providing learning opportunities to develop knowledge, skills, and understanding related to the following contexts:

- Quality friendships and relationships that support wellbeing.
- Eliminating bullying and cyberbullying (and addressing other power imbalances in relationships).
- Developing a safe, supportive and inclusive culture at school, especially for students identifying as same sex-attracted, transgender, or other sex/sexuality/gender identity, or students who are marginalised because of physical, cognitive or behavioural disabilities.
- Teaching skills that support students to manage change and deal with disappointment - and how alcohol and drugs are not a solution.
- Understanding who can help and in what ways – including people in students' own social networks and people in organisations and agencies who can help (and how to contact these people).
- Changing school culture around help-seeking, and that it's okay to seek help when feeling down.
- Providing opportunities for diverse expressions of masculinity, and developing a culture that is accepting and inclusive of this diversity.
- Providing learning opportunities and experiences that make connections with culture, family, ancestors and places.
- Providing learning opportunities and experiences that consider a diversity of identities.
- Reducing stigma about mental health issues such as depression and challenging some conservative cultural/religious attitudes that continue to see mental health issues as shameful, or a sin and something to hide from view.
- The contribution of physical activity, and sleeping and eating well to positive mental health.
- Knowing about, participating in, and contributing to, community activities.

Teachers can make a **positive contribution** to all of this *but they need to be backed up by all other teachers and school leadership*, as well having effective school systems. Schools also need to be able to enlist the support of other sectors, like mental health and social development/welfare to do their job.

Teachers need to teach students to be critical of headline grabbing media reports hyping up the focus on suicide and pointing out the problems and the statistics. Ethical reporting will seek to show understanding of the source of the problem, and highlight what needs to change in order to prevent people self-harming. As a matter of practice, much of the work mental health professionals do requires privacy and protecting individuals from the public or social/family problems that are contributing to the situation, and unethical and uncritical media interference, or schools drawing attention to students in distressing situations, can compromise this work.

Eating disorders (and body dysmorphic disorders)

In past (pre-internet) decades, the message to health education teachers was to avoid an extended, overt and explicit focus on eating disorders. In principle we still support this but, in response to new knowledge about these conditions, and the way the internet and social media have changed the way we view bodies and share information, we are aware this position needs revisiting and clarification.

Using information from the EDANZ¹⁷ website we know that:

- Eating disorders are serious, biologically influenced illnesses.
- Clinically, eating disorders are now categorised in several ways - the familiar anorexia nervosa and bulimia nervosa, as well as binge eating disorder, avoidant/restrictive food intake disorder (ARFID), and other eating and feeding disorders.
- It is still not fully understood what causes eating disorders.
- Latest research is revealing that a combination of genes and environment are involved with studies showing that 50-80% of the risk for developing an eating disorder is genetic.
- The aspect of the issue that has persisted over time, and arguably been made more acute with the rise in internet and social media use, is around the high value that society places on appearance, where criticisms about excess weight and admiration of extreme thinness is common, and weight reduction (or muscle building) forms of dieting are normalised behaviours.

Teaching in health education needs to engage students in learning that:

- Avoids glamourising and normalising eating disorders, patterns of disordered eating, and body dysmorphic disorders, and similarly avoids perpetuating the fascination that some students have about these issues.
- Critically analyses societal attitudes about body appearance and how this impacts on body image (a person's thoughts, feelings and perceptions of their body) and wellbeing - and recognising what we can do about it.
- Critically analyses messages about dieting behaviours.
- Enables them to take individual and collective action to challenge social norms about body appearance - for (biological) males and females, and across a diversity of gender identities.
- Promote self-acceptance and a positive body image (a person's thoughts and feelings about their body).

We are NOT suggesting that it is appropriate to focus a whole unit or an investigation on eating disorders. The stipulation that eating disorders is not a suitable topic for *assessment* purposes, as stated in the explanatory notes of the Achievement Standards, remains. However, in assessments, eating disorders may be *mentioned* as one example of a consequence for health and wellbeing, where evidence shows it is relevant and meaningful to do so.

As topic matter about eating disorders is seemingly unavoidable when students are learning about body image and the impact of social media on mental health and wellbeing, it is suggested that a small amount of information about eating disorders is appropriate to include in a teaching and learning programme (in accordance with the teaching points listed above). The purpose of this learning is to dispel myths and make clear the scope of what is meant by

¹⁷ EDANZ (Eating Disorders Association of New Zealand) <https://www.ed.org.nz/> (note that EDEN - Eating Disorders Education Network - no longer exists)

'eating disorders', how to recognise concerning behaviours, and where to seek help for self, or for a friend or family member.

We are not suggesting that detailed biomedical and clinical information about the various disorders and the treatment of these is appropriate learning for health education. This is the same message we would give about any health issue - that an extensive biomedical only emphasis does not reflect the nature and purpose of learning in health education, as described by the underlying concepts of the HPE learning area. It is expected that a unit of learning would give most focus to those broader considerations of challenging societal norms, promoting self-acceptance, ways to resist dominant societal messages, and ways to take action.

PLD activity for HPE middle leaders and teachers:

- What guidance does your school give teachers about the way issues of self-harm and suicide is to be managed in classroom teaching and learning?
- What are you expected to do if a student discloses to you suicidal feelings, or says or does something that causes you to be concerned about their wellbeing?

Consider asking your school counsellor(s) along to a HPE department or faculty meeting and establish clear understandings about your role and responsibilities as HPE teachers:

1. In consideration of the mental health-related subject matter you teach, AND
2. As a teacher at your school who contributes to the promotion of wellbeing of students at your school.

*In late 2019, this area of educational practice was under review. **Look out for revised guidelines and policy in this area.** Take most notice of Ministry of Education endorsed materials, as these consider the roles and responsibilities of teachers and schools, as a matter of policy.*

Concluding questions

What do you believe your job is **as a teacher** when it comes to:

- **Teaching and learning 'about' mental health in HPE?**
- **Promoting student wellbeing 'for mental health'** as a part of a whole school approach?

When the focus shifts to mental health disorders and problems experienced by some students, often highlighted and given focus in the media:

- What do you have control over and can therefore be held accountable for?
- What do you have authority to act on and therefore be expected to do?
- What does your school expect of you when you encounter students experiencing mental and emotional distress?
- Where does your role as teacher stop (as a matter of policy) and where must you rely on the school pastoral care systems (and services in the community) to support your students?

Resources

Teaching and learning resources

We acknowledge that there are many New Zealand relevant materials for teaching and learning in the area of mental health. This list is not exhaustive and prioritises those materials that are clearly aligned with the NZC.

Fitzpatrick, K., Wells, K., Webber, M., Tasker, G. & Riedel, R. (2018) *Mental health education and hauora: Teaching interpersonal skills, resilience, and wellbeing* Wellington: NZCER <https://www.nzcer.org.nz/nzcerpress/mental-health-education>

Mental Health Foundation (2009). *Mental Health Matters*. NZ: Mental Health Foundation. <https://www.mentalhealth.org.nz/assets/ResourceFinder/Mental-health-matters-a-health-education-resource-for-junior-secondary-school.pdf>

Ministry of Education (2000). *The Curriculum in Action: Change, Loss and Grief Years 1-8*. Wellington: Learning Media. <https://health.tki.org.nz/Key-collections/Curriculum-in-action/Change-loss-and-grief>

Hedges, K. & Robertson, J. (2018). *Wellbeing and relationships: Learning Workbook Level 5*. Auckland: ESA.

Robertson, J. (2018). *Mental Health and Resilience: Teaching and learning activities for NZC Levels 6-8*. NZ: New Zealand Health Education Association (NZHEA). Available from <https://healtheducation.org.nz/resources/>

Robertson, J. and Dixon, R., (2017), *Alcohol and other drugs: A resource of teaching and learning activities for teachers of students in Years 9-11*. New Zealand: NZHEA.

Pastoral and other support for student wellbeing in schools

A range of information and resources produced by the Ministry of Education for supporting, mentoring and counselling students, keeping them safe physically and online, and help for dealing with bullying can be found at <https://www.education.govt.nz/school/health-safety-and-wellbeing/pastoral-care-and-wellbeing/>

For guidance around the role and responsibilities of pastoral care specialists (specifically counsellors) and teachers in schools, see *Te Pakiaka Tangata Strengthening Student Wellbeing for Success Guidelines to Assist New Zealand Secondary Schools and Wharekura in the Provision of Good Practice in Pastoral Care, Guidance and Counselling* (MoE, 2017) <https://www.education.govt.nz/school/health-safety-and-wellbeing/pastoral-care-and-wellbeing/guidelines-for-the-provision-of-pastoral-care-guidance-and-counselling-in-secondary-schools/>

An overview of the education contribution to the **Vulnerable Children Act** (which has relevance for people in schools who support vulnerable children) can be found in *Vulnerable Children Act 2014 A practical guide for Early Childhood Education Services, Ngā Kōhanga Reo, Playgroups, Schools and Kura* <https://www.education.govt.nz/early-childhood/licensing-and-regulations/childrens-act-2014-early-learning-sector-requirements/>

For an example of a whole school approach to promoting wellbeing (in an alcohol and other drug context) see Tūturu - 'Supporting New Zealand schools to take a whole school approach to student wellbeing that prepares students for a world where alcohol and other drugs exist' <https://www.tuturu.org.nz/>

Research and evaluation of the promotion of wellbeing in NZ schools

Education Review Office (2015). *Wellbeing for Children's Success at Primary School*. NZ: Crown. <https://www.ero.govt.nz/publications/wellbeing-for-childrens-success-at-primary-school/>

Education Review Office (2015). *Wellbeing for Young People's Success at Secondary School*. NZ: Crown. <https://www.ero.govt.nz/publications/wellbeing-for-young-peoples-success-at-secondary-school/>

Education Review Office (2016). *Wellbeing for Success: Effective Practice*. NZ: Crown.
<https://www.ero.govt.nz/publications/wellbeing-for-success-effective-practice/>

Education Review Office (2016). *Wellbeing for success: a resource for schools*. NZ: Crown.
<https://www.ero.govt.nz/publications/wellbeing-for-success-a-resource-for-schools/>

Lawes, E. and Boyd, S. (2018). *Making a difference to student wellbeing—a data exploration*. NZ: Crown.
<https://www.nzcer.org.nz/research/publications/making-difference-student-wellbeing-data-exploration>

PLD activity for HPE middle leaders and teachers:

Review your department/faculty collection of resources used to support teaching and learning about mental health.

- Which resources are clearly aligned with the NZC?
- Which are responsive to the diverse learners in your school – (and which ones do you really need to get rid of)? What is the basis for your claims about the suitability of these resources for your students?
- Which resources include wider school considerations such as ideas for ways to assess learning, developing students' literacy skills etc?
- What resources have you developed yourselves?
- Where do you see the resource 'gaps'? Are there other known resources that could be accessed? What could you develop as a department?

Turning to the research and policy resources:

- How familiar are all of your health education teachers with the policy documents listed throughout this resource?
- How familiar are your health education teachers with the Teaching Council *Our Code Our Standards Code of Professional Responsibility and Standards for the Teaching Profession*?
- How familiar are your health education teachers with the evaluation indicators in the Education Review Office *Wellbeing for success: a resource for schools* (2016).