Waipapa Taumata Rau University of Auckland

Growing Up in New Zealand

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Now We Are 15

Young People's Experiences of Self-Harm and Thoughts of Suicide at Age 15 Snapshot

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Self-care note

This report discusses young people's mental health and wellbeing and experiences with some detail. The report includes references to thoughts of suicide, self-harm, and other potentially adverse life experiences. If you or your whānau are struggling with any of these issues, please consider whether reading this report is right for you at this time. The report also examines and discusses the likelihood of experiencing these factors. While some contextual factors may increase the average risk of mental health challenges in the population, this outcome is not inevitable for individual people.

- Free text or call 1737 any time for support from a trained counsellor or peer support worker.
- In an emergency, call 111.
- Suicide crisis helpline
- Other free tools and services are available here.

Foreword

This report is about young people from the *Growing Up in New Zealand* Study cohort at 15-years old. More specifically, it is about those who have reported experiences of self-harm and thoughts of suicide. While a majority of the cohort young people reported positive wellbeing outcomes, we as a study cannot overlook the stories of those whose journey through adolescence has been more difficult.

As a study, our contribution to the wellbeing of children and young people requires us to report on the data that we collect from young people and their whānau. However, these reports are more than simply numbers and statistics. Every data point represents a story, the experiences of a young person who exists within a whānau, school, and community. Our hope is that by presenting these findings, we can inspire change across the various tiers of decision making.

The data that are reported here will highlight that the ability for young people to flourish is, in many ways, informed by the broader social, political, and economic determinants of health and wellbeing. The findings speak to the importance of early intervention, accessible and appropriately tailored services, housing quality, education, material wellbeing, and the policy landscapes that shape our day-to-day realities. Addressing these structural determinants is essential if we are to move toward our collective goal of Pae Ora.

I would like to mihi to all of the study participants who were courageous enough to share their experiences, and to trust us with their stories. It is our hope that this report can capture your experiences in a way that influences decision-makers and policy writers to strive to do better for all young people who call Aotearoa New Zealand home.

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Introduction

Suicide and self-harm among young people affect every community in Aotearoa New Zealand (NZ). Behind each statistic is a young person with dreams and a place within their family and communities. When a young person contemplates suicide or engages in self-harm, it reflects on the pressures, experiences, and environments that have not supported their wellbeing. By locating suicide and self-harm behaviours within broader structural determinants such as economic systems, health systems, and sociopolitical systems, it is possible to move beyond reducing distress to individual diagnoses and instead situate these experiences within their full social and environmental context, allowing for a systems-level understanding. It is important to reframe it this way because it shifts the burden of explanation and responsibility away from individuals themselves, and recognises that experiences of distress and suicidality may reflect broader societal and cultural conditions rather than an individual problem.

Suicide prevention is often envisioned as the domain of professionals, but non-clinical actors such as family members, peers, and community leaders, play an equally critical role. In Māori contexts, for example, whānau connections are recognised as a protective factor against suicidal behaviours amongst rangatahi (1). Across cultures, strong family support is one of the most robust protective factors against suicidality amongst young people (2, 3). Therefore, alongside structural support, it is vital to also equip families and communities with knowledge and resources to support their young people and ensure a wraparound approach.

structural[1] drivers of harm in relation to self-harm and suicidal behaviours amongst young people.

In line with ethical frameworks and guidelines when reporting on self-harm and thoughts of suicide, this snapshot will utilise free text responses collected during the 15Y data collection wave to highlight both the struggles, and the hopes and dreams of young people in the *Growing Up in New Zealand* cohort. This will ensure that the reasons young people might experience suicidal thoughts and engage in self-harm are understood as complex and cumulative over time, rather than brought on by any one event or experience. These quotes were selected to highlight both the challenges and strengths that 15-year-olds describe in their everyday lives. They are presented as insights that give depth and context to the statistical patterns, not as representative.

What do we know about self-harm and thoughts of suicide?

Self-harm refers to an act of deliberately harming oneself, regardless of the presence of suicidal intent. While reasons for engaging in self-harm are multifaceted, some young people may self-harm as a coping mechanism when they have difficulty understanding, managing, and responding to their emotions (6). Thoughts of suicide refer to experiences of thinking about ending one's life, which can range from fleeting considerations to more persistent or distressing ideation. These thoughts can arise for a variety of reasons, but for some young people, they can reflect responses to overwhelming emotional distress shaped by ongoing stressors, adversity, and circumstances, particularly when access to support or protective resources is limited (7, 8).

> *If you ever feel like the world is crashing on you, I'll always be here no matter the circumstance*

The results in this snapshot are reported by self-identified ethnicity. This approach reflects the reality that ethnicity is a core organising principle in Aotearoa New Zealand's data systems, policy settings, and equity commitments (4) . Reporting outcomes by ethnicity allows patterns to be seen clearly across groups, aligns with Te Tiriti o Waitangi obligations to monitor inequities, and ensures that the experiences of Māori and other priority populations are visible (5). This enables the identification of

Population-based research in NZ suggests that self-harm are common experiences among young people, although prevalence estimates vary depending on study design and measurement (9). Consistent with this, findings from the Youth2000

1 In this snapshot, structural determinants are broader social, economic, and political conditions that shape how resources and opportunities are distributed, influencing people's lives and outcomes long before individual choices come into play.

survey series showed a marked increase in thoughts of suicide among adolescents, increasing 15.3% in 2012 to 20.8% in 2019 (10). Together, these findings highlight that experiences of self-harm and thoughts of suicide are widespread among young people in NZ and represent a substantial public health concern during adolescence.

While this snapshot does not examine suicide rates directly, patterns of self-harm and serious thoughts of suicide among adolescents are important to consider within the broader context of youth suicide in NZ. Young people aged between 15 and 19, and young adults aged between 20 and 24, consistently have the highest age-specific suicide rates among developmental groups in NZ (11). These rates account for a significant proportion of deaths in this age group, with over one-third of all deaths among 15 to 24-year-olds attributed to suicide (12). While not youth-specific, national suicide prevention initiatives acknowledge that early intervention, community-based responses, and culturally appropriate support are crucial to addressing these issues (13).

For this snapshot, we present the number and of young people who responded "Yes" to self-harm and to serious thoughts of suicide for each of the major ethnic groupings separately and by gender, disability, area-level deprivation, rurality, and longitudinal trajectories of material hardship. It is important to note that this snapshot does not present how common self-harm or thoughts of suicide are in the wider population. Rather, it reports on the young people in the *Growing up in New Zealand* cohort who reported self-harm or serious thoughts of suicide, helping us to understand who is affected.

For this snapshot report we used the prioritised ethnicity[2] method for classifying young people into one of the following mutually exclusive broad ethnic groupings (in this order): Māori (N=962), Pacific (N=490), Asian (N=569), Middle Eastern/Latin American/African (MELAA; N=48), Other (N=17), European (N=2059). Due to small numbers, young people who identified as MELAA or Other were combined with European young people (N=2124) for reporting purposes only.[3]

> *I'm smart and I think I can get through tough situations*

Methods and measures

For full details of the methods and measures used, please see the NWA15 Mental Health and Wellbeing Snapshot Supplementary Material and Material Hardship technical document.

Here we report young people's experiences of self-harm or thoughts of suicide in the *Growing Up in New Zealand* cohort at age 15. Young people were asked: '*During the last 12 months have you deliberately hurt yourself or done anything you knew might harm you (but not kill you)?*' and '*During the last 12 months have you seriously thought about killing yourself (attempting suicide)?*'. Tables 25 and 26 in the Supplementary Material document present the number of young people who responded to each question, their response type, and the level of missingness.

Young people's longitudinal experience of material hardship between 9 months and 15 years of age is described in the [Material Hardship technical document]. In brief, the material hardship trajectories were categorised into four distinct clusters: No material hardship, Some exposure to material hardship over time, Persistent hardship, and Increasing material hardship.

For Table 1, cell counts fewer than 10 were suppressed and replaced with 'S', and random rounding to base 3 was applied to the "I don't want to answer" and "Missing" categories. Random rounding was not applied to other rows in Table 1. For tables 2 to 6, cell counts fewer than 10 were suppressed and missing response rows were removed to preserve confidentiality. Random rounding was not applied. Random rounding to base 3 (RR3) is an unbiased statistical disclosure control method used by Stats NZ to protect confidentiality by ensuring all table cells are multiples of 3 while maintaining the original expected value of the data.

2 Using prioritised ethnicity allows for comparisons between groups, but young people who identify with multiple ethnicities will only be counted once. As such, this approach but may under-represent ethnic groupings, such as Pacific and Asian communities when young people identify with multiple ethnicities. Please note, other snapshots use total response ethnicity, where individuals are counted in all groups they identify with, so results may not be directly comparable. Please see the Introduction and Methods paper for more details.

3 Please see the NWA15 Introduction and Methods Paper for information on the total cohort

Results

Self-harm

Overall, 77.2% (n=3228) of young people in the *Growing Up in New Zealand* cohort said they had not self-harmed in the last 12 months (see Table 1). However, 1 in 6 (16.6%, n=693) young people reported engaging in self-harm behaviours, and 6.2% (n=259) of young people who had reported self-harm, reported having self-harmed three or more times in the previous 12 months (see supplementary paper for more information).

Table 1 suggests that European/MELAA/Other young people were most likely to report self-harm (18.6%), followed by rangatahi Māori (16.5%), Asian (13.9%) and then Pacific young people (11.4%). See Supplementary Paper for further details. We note that the number of young people who responded "I don't want to answer this question" was similar but not the same across the ethnic groups, which may contribute to some of the ethnic differences observed.

Serious thoughts of suicide

Most young people reported no serious thoughts of suicide in the last 12 months (80.1%, n=3352). However, approximately 1 in 10 (10.8%, n=452) of young people in the *Growing Up in New Zealand* cohort reported that they had.

Table 1 suggests the percentage of young people within the *Growing Up in New Zealand* cohort who reported serious thoughts of suicide was similar between ethnic groups (10.9% of rangatahi Māori, 8.0% Pacific young people, 9.7% of Asian young people, and 11.8% of European/MELAA/Other young people). There were different levels of missingness across different ethnic groups, and between 6.7% (Asian young people) and 9.3% (rangatahi Māori) said "I don't want to answer this question".

> *I worry about a lot of things, mainly just what im going to be though, what im going to amount to, I just want to have a good life and do something but I don't quite know what, and that makes me worried I will become insignificant*

Table 1. The number and percentages of young people who reported self-harm or serious thoughts of suicide in the last 12 months by ethnicity and in the total cohort

Self-harmed	**Māori N = 962**	**Pacific N = 490**	**Asian N = 569**	**European/ MELAA/Other N = 2124**	**Total Cohort N = 4183**
No, never	732 (76.1%)	398 (81.2%)	473 (83.1%)	1617 (76.1%)	3228 (77.2%)
Yes	159 (16.5%)	56 (11.4%)	79 (13.9%)	396 (18.6%)	693 (16.6%)
I don't want to answer	63 (6.5%)	30 (6.1%)	15 (2.6%)	99 (4.7%)	213 (5.1%)
Missing data (self-harm)	S*	S*	S*	12 (0.5%)	51 (1.2%)
Serious thoughts of suicide	**Māori N = 962**	**Pacific N = 490**	**Asian N = 569**	**European/ MELAA/Other N = 2124**	**Total Cohort N = 4183**
No	761 (79.1%)	413 (84.3%)	474 (83.3%)	1696 (79.8%)	3352 (80.1%)
Yes	105 (10.9%)	39 (8.0%)	55(9.7%)	250 (11.8%)	452 (10.8%)
I don't want to answer	89 (9.3%)	36 (7.3%)	36 (6.3%)	168 (7.9%)	330 (7.9%)
Missing data (thoughts of suicide)	S*	S*	S*	12 (0.5%)	48 (1.1%)

**Cell counts fewer than 10 were suppressed and replaced with 'S'. RR3 was applied to the "I don't want to answer" and "Missing" categories. Suppressed and missing values are included in column totals.*

Examining how ethnicity intersects with factors such as gender, disability, rurality and material hardship helps us to consider who within our communities has the greatest need for support and care. Therefore, the remainder of this snapshot has been designed to explore the distribution of a range of different sociodemographic variables to experiences of self-harm and serious thoughts of suicide for each of the main ethnic groupings represented in the *Growing Up in New Zealand* cohort. It is important to note that the small number of young people who reported serious thoughts of suicide limited the extent to which we were able to examine these intersections, particularly for Pacific and Asian young people. As a result, our presentation and discussion focus primarily on patterns observed among rangatahi Māori, with comparisons made to European/MELAA/Other young people, where numbers allow. Care should be taken when interpreting the findings presented in the report as they do not represent prevalence or increased risk of self-harm or serious thoughts of suicide by each factor. However, the findings do provide some indication of where burden may be higher. Finally, all findings should be considered in the context of the underlying distribution of factors amongst the *Growing Up in New Zealand* cohort, which itself is not representative of the NZ population.

Gender

The top half of Table 2 presents the distribution of gender identities[4] among Māori, Pacific, Asian and European/MELAA/Other young people who reported self-harm by ethnicity.[5] These data help us to consider whether differences in gender identities within an ethnic group contribute to reported experiences in self-harm at 15-years of age. Remember that this information is provided to help us understand where care and support may be required, rather than how common these behaviours are in the wider population. For this reason, the data in Table 2 should not be interpreted as indicative of the likelihood or risk of self-harm or serious thoughts of suicide.

Table 2. The distribution of gender-identity within Māori, Pacific, Asian and European/MELAA/Other groups who reported self-harm or serious thoughts of suicide in the last 12 months.

Among those who reported self-harm	**Māori N = 159**	**Pacific N = 56**	**Asian N = 79**	**European/ MELAA/Other N = 396**
Cisgender boy	28 (17.6%)	14 (25.0%)	13 (16.5%)	92 (23.2%)
Cisgender girl	64 (40.3%)	22 (39.3%)	31 (39.2%)	184 (46.5%)
Trans-Non-binary/ Unsure	41 (25.8%)	10 (17.9%)	29 (36.7%)	102 (25.8%)
Among those who reported serious thoughts of suicide	**Māori N = 105**	**Pacific N = 39**	**Asian N = 55**	**European/ MELAA/Other N = 250**
Cisgender boy	17 (16.2%)	S*	17 (30.9%)	68 (27.2%)
Cisgender girl	45 (42.9%)	16 (41.0%)	24 (43.6%)	97 (38.8%)
Trans-Non-binary/ Unsure	27 (25.7%)	S*	13 (23.6%)	72 (28.8%)

**Cells with counts fewer than 10 have been suppressed and reported as 'S' to protect confidentiality. Suppressed and missing values are included in column totals.*

> *Despite the rough patches in my life, I know who I am and I am happy to say I am proud of who I am, who I become and who I think I will turn into...*

4 Gender identities were measured at the 12Y DCW unipolar gender identity question asking participants whether they saw themselves as a boy, a girl, or somewhere in between and sex assigned at birth categorisation. For more details see the methods paper

5 The 15-Year questionnaire included the NZ Population Census ethnicity questionnaire which enables respondents to identify with as many different ethnic groups as they wish. For this snapshot report we have used the "prioritised ethnicity" method for classifying young people into one of the following ethnic groups (in this order): Māori, Pacific, Asian, European/MELAA/Other. Due to small numbers, young people who identified as MELAA or Other were included with European young people for reporting purposes only.

For example, among the n=159 rangatahi Māori who reported self-harm in the previous 12-months, 40.3% identified as cisgender girl, 25.8% identified as trans/non-binary/unsure and 17.6% identified as cisgender boy. A similar pattern was observed within the Asian and European/MELAA/Other groupings, with the largest number of those reporting self-harm identifying as cisgender girl, followed by trans/non-binary/unsure and then cisgender boy. Interestingly, a slightly different pattern was observed among Pacific young people, with the largest percentage of those who reported self-harm behaviours in the previous 12-months identifying as cisgender girls (39.3%), followed by cisgender boys (25.0%) and then those who identified trans/non-binary/unsure (17.9%).

The bottom half of Table 2 presents the distribution of gender identity for Māori, Pacific, Asian and European/MELAA/Other who reported serious thoughts of suicide in the last 12-months. Note that the small number of reports of serious thoughts of suicide among Pacific and Asian young people limits exploration of patterns within these two ethnic groupings.

Our findings show that amongst Maori who reported serious thoughts of suicide 42.9% were cisgender girls. For European/MELAA/Other ethnic groupings who reported serious thoughts of suicide 38.8% were cisgender girls. Whilst we note the percentage of cisgender boys who reported serious thoughts of suicide was lower for rangatahi Māori (16.2%) compared with European/MELAA/Other (27.2%), it is unclear how much the level of missingness for gender identity amongst the Māori group and European/MELAA/Other group may influence this.

The challenges that cisgender girls, transgender young people, and those who identify as non-binary face are shaped by the structural influences around them that decide how gender is regulated, who is seen as legitimate, and who is pushed to the margins (14). Many minoritised young people are navigating systems that weren't built with them in mind. Sexism, gender expectations, and transphobia surface in classrooms, online spaces, health services, and in the everyday interactions that either affirm who they are or make them feel unsafe (15-17).

The cumulative impact of stigma and discrimination is substantial and operates at both an individual and a structural level (18). Transgender and non-binary young people persistently report high levels of misgendering, harassment, and exclusion (15, 19), while cisgender girls commonly experience emotionally targeted bullying or online harassment that undermines their confidence and sense of belonging (20, 21). These experiences are closely tied to increased risks of self-harm and suicidality. Table 2 presents the distribution of gender identity among young people who reported self-harm and serious thoughts of suicide in the last year, stratified by ethnicity.

Disability

Table 3 presents the distribution of disability status among Māori, Pacific, Asian and European/MELAA/Other young people who reported self-harm and serious thoughts of suicide in the previous 12-months. These data help us to consider whether differences in disability status within an ethnic group contribute to reported experiences in self-harm and thoughts of suicide at 15-years of age. Remember that this information is provided to help us understand where care and support are needed, rather than how common these behaviours are in the wider population. For this reason, the data in Table 3 should not be interpreted as indicative of the likelihood or risk of self-harm or serious thoughts of suicide.

The top half of Table 3 presents the distribution of disability status among Māori, Pacific, Asian, and European/MELAA/Other young people who reported self-harm in the last 12 months by

Table 3. The distribution of disability status amongst Māori, Pacific, Asian, and European/MELAA/Other young people who reported any self-harm or serious thoughts of suicide in the last 12 months.

Among those who reported self-harm	**Māori N = 159**	**Pacific N = 56**	**Asian N = 79**	**European/ MELAA/Other N = 396**
No disability identified	96 (60.4%)	45 (80.4%)	54 (68.4%)	255 (64.4%)
Disability identified	63 (39.6%)	11 (19.6%)	25 (31.6%)	141 (35.6%)
Among those who reported serious thoughts of suicide	**Māori N = 105**	**Pacific N = 39**	**Asian N = 55**	**European/ MELAA/Other N =250**
No disability identified	57 (54.3%)	29 (74.4%)	46 (83.6%)	136 (54.4%)
Disability identified	48 (45.7%)	10 (25.6%)	S*	114 (45.6%)

**Cells with counts fewer than 10 have been suppressed and reported as 'S' to protect confidentiality. Suppressed and missing values are included in column totals.*

ethnicity. Our findings show that among those young people who reported engaging in self-harm behaviours, most did not have a disability[6].

The bottom half of Table 3 presents the distribution of disability status among Māori, Pacific, Asian, and European/MELAA/Other young people who reported serious thoughts of suicide by ethnicity. Note that the small numbers of reports of serious thoughts of suicide among Pacific and Asian young people limit exploration of patterns within these two ethnic groupings. Nevertheless, among those who reported serious thoughts of suicide, the number of those who identified as having a disability was similar within the Māori and European/MELAA/Other groupings.

The challenges that disabled young people face arise from an accumulation of distress across structural domains. As such, difficulties in wellbeing are not caused by disability itself, but often result from societal stigma and unequal access to opportunities and support; outcomes shaped by pervasive ableism. In other words, it is society's failure to include and accommodate them - not their bodies or minds - that can push them into distress (22, 23).

Interpersonal experiences may then be reinforced by institutional practices. For example, school systems may fail to provide adequate support, meaning young people with learning disabilities, autism, or behavioural differences are more likely to be suspended or excluded (24). These patterns accumulate and shape how young people see their futures. Concerns about the future, such as higher education, employment, and independent living, can become a source of distress, especially if they foresee limited opportunities. Factors like high youth unemployment, lack of workplace accommodations, and discrimination in hiring mean disabled school-leavers often struggle to find stable, meaningful work (25, 26).

Area-level deprivation

Table 4 highlights important differences in the distribution of socioeconomic deprivation among young people who report self-harm (top-half of the table) and serious thoughts of suicide (bottom-half of the table) when comparing rangatahi Māori and European/MELAA/Other young people in the *Growing Up in New Zealand* cohort.

Table 4 shows that among rangatahi Māori who reported self-harm in the previous 12-months 27.0% lived in the most deprived areas of NZ (Quintile 5) and 15.1% lived in the least deprived areas (Quintile 1). For European/MELAA/Other young people who reported self-harm, 8.8% lived in Quintile 5 and 30.1% lived in Quintile 1.

Amongst rangatahi Māori who reported serious thoughts of suicide, 26.7% lived in the most deprived areas of NZ (Quintile 5) and for European/MELAA/Other 7.6% lived in Quintile 5.

It is important to note that the interpretation of these patterns is limited by the number of observations, and the underlying ethnic distribution of young people across deprivation levels. Therefore, these data should not be interpreted as prevalence or risk. While Māori are more likely to live in areas of higher deprivation, research shows that Māori often experience poorer outcomes than Pākehā within the same level of deprivation, and in some domains, disparities widen with increasing deprivation, suggesting that deprivation may operate differently for Māori than for European/MELAA/Other populations (27).

Patterns of area-level deprivation are shaped by wider structural influences that determine how resources, opportunities, and services are distributed (28). Young people who grow up in more deprived areas are exposed to a range of environmental stressors that can relate to mental health over time (29). These may include overcrowded or poor-quality housing, neighbourhood crime, limited access to safe open spaces, fewer recreational opportunities, and reduced availability of local health and youth services (30). Repeated exposure to these conditions can contribute to higher levels of stress, a reduced sense of safety, and fewer opportunities for positive social connection, all of which are potentially linked to poorer mental wellbeing (29).

Having to worry about getting a good job to afford petrol, a house, food etc.

6 Disability status was measured using self-reported Washington Group Short-Set of Questions on Functioning (WG-SS); see the NWA15 Mental Health and Wellbeing Snapshot Supplementary Material and NWA15 Education Snapshot Supplementary Material for more details

Table 4: The distribution of area-level socioeconomic deprivation amongst Māori, Pacific, Asian and European/ MELAA/Other young people who reported self-harm or serious thoughts of suicide in the last 12 months

Among those who self-harmed	**Māori N = 159**	**Pacific N = 56**	**Asian N = 79**	**European/ MELAA/Other N = 396**
Quintile 1 (least deprived)	24 (15.1%)	S*	17 (21.5%)	119 (30.1%)
Quintile 2	20 (12.6%)	S*	20 (25.3%)	101 (25.5%)
Quintile 3	25 (15.7%)	S*	12 (15.2%)	72 (18.2%)
Quintile 4	34 (21.4%)	S*	16 (20.3%)	59 (14.9%)
Quintile 5 (most deprived)	43 (27.0%)	29 (51.8%)	12 (15.2%)	35 (8.8%)
Serious thoughts of suicide	**Māori N = 105**	**Pacific N = 39**	**Asian N = 55**	**European/ MELAA/Other N = 250**
Quintile 1 (least deprived)	11 (10.5%)	S*	12 (21.8%)	59 (23.6%)
Quintile 2	11 (10.5%)	S*	10 (18.2%)	74 (29.6%)
Quintile 3	23 (21.9%)	0 (0.0%)	11 (20.0%)	49 (19.6%)
Quintile 4	24 (22.9%)	S*	13 (23.6%)	38 (15.2%)
Quintile 5 (most deprived)	28 (26.7%)	21 (53.8%)	S	19 (7.6%)

**Cells with counts fewer than 10 have been suppressed and reported as 'S' to protect confidentiality. Suppressed and missing values are included in column totals.*

Rurality

The majority of young people who reported self-harm or serious thoughts of suicide at 15-years of age lived in urban areas; a finding which is likely due to the fact that most young people in the *Growing Up in New Zealand* cohort live in urban rather than rural areas (please see the NWA15 Introduction and Methods paper).

Internationally, there is an elevated risk of suicide and self-harm amongst young people in rural settings, compared to those living in urban settings (31, 32). In NZ, the differences are less marked but there has been a significant increase in young people presenting to emergency departments with self-harm in rural settings, particularly for rangatahi Māori (33).

Rurality shapes access to services, exposure to environmental stressors, and whether help is accessible at the moment it is needed (34). In NZ, rural communities continue to face structural barriers such as limited local services, long travel distances, shortages of trained staff, restricted options for youth-specific or crisis support, and small populations that can make anonymity and privacy difficult (35-37). These contextual constraints mean that help-seeking often happens outside formal clinical settings (e.g. through whānau, community, or informal networks), and that standard service models may deliberately or inadvertently exclude rural young people whose needs don't match the policy frameworks that deploy resources (35).

Broader structural barriers can also limit what help is realistically available (35). Underfunding, workplace shortages, and inflexible service models make it unlikely that standard interventions will meet the needs of rural young people when they are most vulnerable (35). Because of these realities, rurality remains an important structural factor to include in analyses of suicide and self-harm amongst young people, even when this snapshot found similar patterns across the experiences of urban and rural groups. What matters is whether the systems surrounding them are capable of responding when distress arises, and conditions that protect young people long before distress escalates.

Table 5. The distribution of urban/rural status for Māori, Pacific, Asian and European/MELAA/Other young people who reported any self-harm or serious thoughts of suicide in the last 12-months.

Self-harm	**Māori N = 159**	**Pacific N = 56**	**Asian N = 79**	**European/ MELAA/Other N = 396**
Urban	121 (76.1%)	49 (87.5%)	72 (91.1%)	313 (79.0%)
Rural	26 (16.4%)	S*	S*	73 (18.4%)
Serious thoughts of suicide	**Māori N = 98**	**Pacific N = 38**	**Asian N = 54**	**European/ MELAA/Other N = 239**
Urban	86 (81.9%)	34 (87.2%)	51 (92.7%)	198 (79.2%)
Rural	12 (11.4%)	S*	S*	41 (16.4%)

**Cells with counts fewer than 10 have been suppressed and reported as 'S' to protect confidentiality. Suppressed and missing values are included in column totals.*

Longitudinal experiences of material hardship

Table 6 presents the distribution of material hardship experiences[7] for Māori, Pacific, Asian and European/MELAA/Other young people who reported self-harm or serious thoughts of suicide in the last 12-months.[8] As in previous sections, here we focus on patterns of distribution for rangatahi Māori and European/MELAA/Other young people who reported these behaviours due to small numbers reported for Pacific and Asian groupings. Care should be taken when interpreting these data.

For example, Table 6 suggests 72.2% of European/MELAA/Other young people and 45.9% rangatahi Māori who reported self-harm had not experienced material hardship in their lives. Among rangatahi Māori who reported self-harm, approximately 14.5% experienced "some" material hardship, 16.4% experienced "increasing" hardship, and 8% had experienced "persistent" material hardship. In contrast, among European/MELAA/Other young people who reported self-harm, 3.8% experienced increasing hardship, 9.6% some hardship, and 4.3% persistent material hardship.

Among rangatahi Māori who reported serious thoughts of suicide, 18.1% experienced increasing hardship whereas for European/MELAA/Other young people who reported serious thoughts of suicide, approximately 4% experienced increasing hardship.

At a population level, longitudinal trajectories of material hardship, from 9 months through to 15-years of age, are not randomly distributed, but reflect structural inequities: unequal distribution of resources, inadequate social supports, and generations of systemic[9] underinvestment in whānau and communities. Young people who grow up in homes where essential needs are unmet, where housing is insecure, food is uncertain, or where neighbour deprivation is high, absorb these pressures in ways that can affect how safe they feel. Material hardship functions not merely as an individual or household-level stressor, but as an expression of deeply embedded social disadvantage that accumulates over time.

For rangatahi Māori and Pacific young people, structural disadvantage is part of a broader web of inequities which include systemic racism, discrimination in access to healthcare, reduced social support, and the intergenerational consequences of colonisation and economic exclusion (38). These may be experienced as a secondary layer of factors that can push back against individual efforts toward recovery; possibly further perpetuating distress via a cycle of mistrust/misbelief in

7 Please see Material Hardship technical document for more information

8 The 15-Year questionnaire included the NZ Population Census ethnicity questionnaire which enables respondents to identify with as many different ethnic groups as they wish. For this snapshot report we have used the "prioritised ethnicity" method for classifying young people into one of the following ethnic groups (in this order): Māori, Pacific, Asian, European/MELAA/Other. Due to small numbers, young people who identified as MELAA or Other were included with European young people for reporting purposes only.

9 In this context, systemic refers to the impact of multiple interconnected social systems that work together to shape experiences and outcomes.

oneself, structural supports, and systems.

When whānau have enough income to meet their needs, when housing is stable, when communities are well-resourced, young people's distress eases: their sense of connection strengthens; their capacity to imagine a future expands; their risk of self-harm

of separate but related national-level documents that speak to issues around child and youth wellbeing (41) and mental wellbeing (42). Collectively, these national strategies serve as a guiding vision into the future while also providing standards against which the government of the day can be held accountable.

Table 6. The distribution of material hardship trajectories for Māori, Pacific, Asian and European/MELAA/Other young people who reported any self-harm or serious thoughts of suicide in the last 12 months

Self-harm	**Māori N = 159**	**Pacific N = 56**	**Asian N = 79**	**European/ MELAA/Other N = 396**
Not in material hardship	73 (45.9%)	19 (33.9%)	55 (69.6%)	286 (72.2%)
Some exposure to hardship	23 (14.5%)	S*	S*	38 (9.6%)
Persistent hardship	13 (8.2%)	10 (17.9%)	S*	17 (4.3%)
Increasing hardship	26 (16.4%)	S*	S*	15 (3.8%)
Serious thoughts of suicide	**Māori N = 105**	**Pacific N = 39**	**Asian N = 55**	**European/ MELAA/Other N = 250**
Not in material hardship	47 (44.8%)	13 (33.3%)	39 (70.9%)	169 (67.6%)
Some exposure to hardship	16 (15.2%)	S*	S*	26 (10.4%)
Persistent hardship	S	S*	0 (0.0%)	14 (5.6%)
Increasing hardship	19 (18.1%)	S*	S*	10 (4.0%)

**Cells with counts fewer than 10 have been suppressed and reported as 'S' to protect confidentiality. Suppressed and missing values are included in column totals.*

decreases (39, 40). These changes don't occur because young people have suddenly become more resilient. They occur because the environment has stopped working against them. And this is the point: suicide and self-harm prevention in the context of material hardship is about addressing poverty, investing in whānau, and ensuring the systems surrounding them enable safety, dignity and hope.

Policy Implications

A range of key documents outline Governmental commitments to addressing suicide and self-harm; for example, the establishment of the Suicide Prevention Office in 2019 and the recent publication of the *Suicide Prevention Action Plan 2025-2029* (13). Another system-level mechanism includes the Mental Health and Wellbeing Commission (Te Hiringa Mahara), tasked with independent monitoring functions including holding the Government to account for the actions outlined in the 2025-2029 Action Plan (13). These strategies sit alongside a range

We invite readers to reflect on the experiences of reported thoughts of suicide and self-harm within the GUiNZ cohort at 15-years, and to consider how the multiple interconnected factors that young people are navigating can be addressed through national policy settings. We hope that these findings provide those in positions of decision making with the evidence necessary to ensure resources, interventions, and programmes are developed and deployed to support those most in need, for the wellbeing of all young people who call NZ home.

Experiences of self-harm and thoughts of suicide were concentrated in a small subset of the GUiNZ cohort. Reported outcomes varied by broad ethnic groupings. These findings highlight that experiences of self-harm and serious thoughts of suicide vary between ethnic groupings and differ by gender identity and socioeconomic context. By examining these patterns together, the analysis shows how social and structural contexts influence experiences within ethnic groupings, rather than assuming uniform experiences across ethnicities. This paper suggests

that differential distribution of socioeconomic conditions may be contributing to ethnic differences in self-harm and thoughts of suicide at 15-years of age. These findings are not new (43) and serve as a reminder that young people who reported thoughts of suicide and self-harm would benefit from appropriately tailored and responsive support. At a service provision level this looks like upholding the rights of young people to available, accessible health, and other social service care (44). At a systems-level, it requires that we consider appropriate resourcing, training, workforce, and deployment pathways, to ensure access to services is appropriately available.

In the context of a rapidly changing data environment, data that capture the experiences of young people and their families are essential to ensure interventions are designed appropriately (45) . This report demonstrates the importance of adequate data quality. The ability to disaggregate data brings to light patterns of inequity that otherwise risk being hidden among population averages (46). Efforts to address youth mental health and wellbeing, to build toward Pae Ora, as outlined in the *Pae Ora (Healthy Futures) Act 2022* (47) must be informed by contextually rich data representative of our diverse population, with policies committed to utilising data appropriately to identify the various pathways through which inequities are operating.

The rights of children and young people to good health, including mental health, are laid out in both national and international instruments. For example, the United Nations Convention on the Rights of the Child asserts the rights of children to "the highest attainable standard of health" and outlines the responsibilities of states to ensure an adequate standard of living for the "physical, mental, spiritual, moral and social development" of children (48). New Zealand ratified this convention in 1993 (49). Locally, *The Child and Youth Strategy 2024-2027* outlines focus areas to improve outcomes for children, identifying key dimensions to support a "good life now and into the future." (41). Against this backdrop, that a small portion of cohort young people are reporting experiences of thoughts of suicide and self-harm is an indication that there is still work to do to ensure that all young people who call NZ home are supported to thrive.

The report also highlights that actions to address experiences of thoughts of suicide and self-harm must look beyond the health system, addressing the broader determinants of wellbeing in a coordinated effort across all relevant agencies and ministries. This is reflected in the *National Suicide Prevention Action Plan 2025-2029* which asserts that a "whole-of-government, whole-of-society" response is necessary, with interventions needed to address "housing, discrimination, and violence." (13). Efforts to bring attention to social determinants of health are not new, and are widely published in the academic literature (50, 51) and governmental reports (52). Report findings lend their weight to this discussion, asserting the importance of addressing these social determinants if we are to achieve Pae Ora (47) and if we are to reach the aspirational vision of "New Zealand being the best place in the world for children and young people." (41).

Available services

If you think you, or someone you know, may be experiencing mental health challenges, there are several **free** tools or services that can help.

- From a trained counsellor (or text or call 1737)
- In an emergency, call 111.
- Suicide crisis helpline

See the Ministry of Health website for a list of resources, or click below for information or support:

- Wellbeing support
- Support for rangatahi for hauora, identity, culture, and mental health
- Healthcare providers near you
- LGBTQIA+
- Depression
- Anxiety

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This Snapshot is part of a collection that make up the *Growing Up in New Zealand* 15-Year Checkpoint

Additional Snapshots in the series, along with supporting documents, can be found here or at growingup.co.nz/now-we-are-fifteen

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Statement of Approval:

This study has received ethical approval from the Health and Disability Ethics Committee (Ref NTY/08/06/055). Ethical approval means that experts who are not involved with *Growing Up in New Zealand* have checked all of our information and activities, and are happy that there is nothing that would be harmful for you or your family, that information will be kept private, that this study will be helpful for New Zealand families.

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