DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

Submissions on the Child and Youth Wellbeing Strategy

August 2019

The Department of the Prime Minister and Cabinet has released the following submission received during its public consultation on the child and youth wellbeing strategy.

Some of the information contained within this release is considered to not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act).

- Where this is the case, the information has been withheld, and the relevant section of the Act that would apply, has been identified.
- Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes and their reference to sections of the Act:

- **9(2)a** – Section 9(2)(a): to protect the privacy of natural persons, including deceased people.

child & youth wellbeing

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Child and Youth Wellbeing Strategy – Submission Template

This document is intended for individuals or groups who wish to make a formal submission on the child and youth wellbeing strategy.

Please complete this template and email it to: childandyouthwellbeing@dpmc.govt.nz

A guide to making a submission is available on the DPMC website https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Submissions will close on **Wednesday 5 December**.

Please provide details for a contact person in case we have some follow up questions.

Contact Name:	Patrick Kelly
Email Address:	9(2) (a)
Phone Number:	
Organisation Name:	Te Puaruruhau, Auckland District Health Board
Organisation description: (tell us about your organisation – i.e. who do you represent? How many members do you have? Are you a local or national organisation?)	Te Puaruruhau is the multi-disciplinary child protection team which is part of Starship Children's Health, but is co-located in a multi-agency "Child Advocacy Centre" (Puawaitahi) with the Auckland City Police child protection team, the Evidential Video Unit for central, west and north Auckland and Oranga Tamariki Clinical Services for central, west and north Auckland (a team which provides psychological services to some Oranga Tamariki clients). Te Puaruruhau consists of 28 health staff (administrative staff, nurse specialists, family violence advocates and trainers, paediatricians, psychologists and social workers). There are more than 60 staff in the building of Puawaitahi as a whole, including forensic interviewers, police detectives, Oranga Tamariki psychologists and psychotherapists (including one therapy dog) and administrative support. Te Puaruruhau sees about 700 new patients (tamariki and rangatahi who have experienced abuse and neglect) every year, from all over metropolitan Auckland and New Zealand. We consult on approximately 3000 such cases every year. We work closely with the MOH Violence Intervention Programme (which for the Auckland DHB is based in our building), hold the child and adolescent Sexual Abuse Assessment and Treatment Services (SAATS) contract for metropolitan Auckland and deliver the Gateway assessment service for tamariki and rangatahi who have been referred to a Family Group Conference or are in the custody of Oranga Tamariki for abuse and/or neglect. We provide training in child protection and intimate partner violence to undergraduates (medical, nursing and social work students), postgraduates (primary health care providers, junior

	resident medical officers, nursing staff, paediatricians from New Zealand and Australia, social workers in the health and education systems and Oranga Tamariki, school counsellors) and police officers regionally and nationally. We provide the only dedicated full-time research and training positions in New Zealand for doctors seeking postgraduate child protection training. Te Puaruruhau has taken a lead role in developing some key aspects of effective multi-agency practice in New Zealand: • The DHB / Oranga Tamariki liaison social worker • The national Memorandum of Understanding between DHB, Oranga Tamariki and police and its associated schedules • The National Child Protection Alert System • Power to Protect (national shaken baby prevention program) • Puawaitahi, our multi-agency “Child Advocacy Centre” We do not presume to speak on behalf of tamariki and rangatahi who have experienced abuse or neglect, or their whānau. However, we have considerable experience of how “the system” does or does not work for them, and have stood alongside many of those who have suffered the consequences of its failure. For our entire professional careers, the NZ health system has largely chosen not to prioritise the health and wellbeing of children and young people who experience abuse and neglect - and still chooses not to prioritise violence as a health issue. This submission should be read in conjunction with our parallel submission to the Commission of Enquiry to the Government Enquiry into Mental Health and Addiction. This submission was circulated within Te Puaruruhau for feedback on Tuesday December 4. Due to limitations of time, I have not had the opportunity to consult more widely about this submission. Subject to the limitations of that time-frame, this submission represents a distillation of our experience of working in the New Zealand health system with the victims of abuse, neglect and intimate partner violence for the past 25 years.

Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	This submission focuses on the first requirement of the outcomes framework: all tamariki and rangatahi should be "loved, nurtured and safe" and "homes are safe and nurturing." We agree. However, this is not the case for between 10 and 20% of New Zealand children and young people. We are health professionals and our focus is on the health system response. This is appropriate, because to date the health system has been a weak link in prevention and intervention The key points of our submission are as follows: 1. Child abuse and neglect (CAN) and intimate partner violence (IPV) are profoundly important health issues. 2. Early intervention and effective response to these issues should therefore be a priority for the health system. 3. The Police and Oranga Tamariki cannot and should not be the lead agencies for a "proportionately universal" response. The health system could be. 4. The biggest challenge to overcome to make this a reality is the challenge of health workforce development. 5. Key elements of a basic DHB infrastructure to support "proportionate universalism" in the area of CAN and IPV already exist and could be developed further with less investment than has been wasted on past strategies.

Submission Content

1. **Child abuse and neglect (CAN) and intimate partner violence (IPV) are profoundly important health issues.**

   Current prevalence data are well summarised in the MOH Family Violence Assessment & Intervention Guideline (Second Edition, 2016). For NZ children and young people, the most dangerous place in the country is their own home. Up to 1/3 of females will have been exposed to some form of sexual abuse by the age of 18 years and approximately 14% of 13 to 17 year olds have experienced and/or witnessed physical abuse in their home in the previous 12 months. The prevalence in preverbal children (the first 1000 days) is unknown, but we do know that approximately 60,000 children every year are notified to Oranga Tamariki because they were in the home when the police were called to attend at an incident of intimate partner violence.

   The data analysed for the Interim Report of the Expert Panel into Modernising Child Youth and Family do not include health outcome data. However, it is very clear that the mere fact of notification to Oranga Tamariki is a pointer to multiple adverse future outcomes – regardless of what Oranga Tamariki does next. From the literature on Adverse Childhood Experiences, there is no doubt that many of these children and young people will experience lifelong effects on their mental and physical health. Childhood adversity increases the risk of poor health outcomes in conditions as disparate as obesity, diabetes, smoking, cancer, heart disease, respiratory disease, sexual risk taking, mental ill health, drug use, alcohol use and interpersonal and self-directed violence. Sadly, the negative health outcomes most strongly associated with childhood adverse experiences also represent risks for the next generation.

   In most cases, Oranga Tamariki will have no involvement with these children and young people once they turn 18. In most cases, the police will have no ongoing involvement with them except for that group who progress into criminal behaviour.

   In contrast and in all cases, the health system will be involved with the graduates of Adverse Childhood Experiences and intimate partner violence for the rest of their lives. The health system carries the can for the enormous long-term cost, but puts very little specific resource into prevention, identification or early intervention.

2. **Early intervention and effective response to CAN and IPV should therefore be a key priority for the health system.**

   There is a limited evidence base for what works and what does not work in prevention and early intervention. Programmes that do have some evidence for efficacy (such as David Olds' program of nurse-led home visiting in the United States or David Fergusson's Early Start program in Christchurch) have usually been developed and tested using rigorous models of multi-disciplinary feedback and outcome evaluation that are regarded as routine quality improvement practice in the health system.

   The health system has made great strides in prevention and treatment of many health conditions in the past 25 years. It has made this progress because it has devoted considerable resource to research, training and system improvement. The NZ health system is currently (and appropriately) devoting very large resources to issues such as obesity, smoking, immunisation, emergency department stays and cancer treatment. It is expected that this investment will in due course lead to better outcomes.

In contrast, with the sole exception of the minimally-funded Violence Intervention Programme and a small contribution to the SAATS contract, the NZ Ministry of Health has never made a priority of child protection or partner violence intervention. Most DHB in New Zealand do not regard these as priorities and do not strategise for improvement. It is therefore not surprising that we have made so little progress.

3. **Police and Oranga Tamariki cannot and should not be the lead agencies for a proportionately universal response to CAN and IPV. The health system could be.**

   By definition, a notification to the police or Oranga Tamariki is evidence that someone is concerned that a threshold of harm has been crossed. Typically, that notification will receive a response that the threshold either has been crossed, or it has not. The outcome is binary – investigate (prosecute or substantiate), or not.

   However, in many of these families a much more graduated and intensive response, that evolves naturally out of existing universal services, perseveres over time and has an internal escalation pathway, is what is actually needed. Since “Hunt for the Wilderpeople” it has become a running gag in New Zealand that “no child is left behind”, but Oranga Tamariki is in fact usually a revolving door of “investigate, refer, close the file”. The logical response is not to redesign Oranga Tamariki, but to reconsider the allocation of responsibility for ensuring that no child is left behind.

   One obvious solution is to provide a graduated infrastructure of expertise and intervention within the health system, where home visitors (such as Well Child services and midwives) are properly trained and given access to supervision and support by those who have expertise in child abuse and neglect and intimate partner violence; and where along with other primary health professionals they have easy access (when required) to appropriate secondary and tertiary forms of assessment and intervention.

   At some point, for some families, there will always have to be an option for prosecution of an adult or placement of a child or young person outside the home. At that point, there is obviously a role for statutory action. But there is no reason why the entire graduated proportionate response up till then could not rest within the health system – or why that structure would not continue to support the family thereafter.

   Everyone accepts that for every health disorder there is an appropriate hierarchy of health response – primary, secondary and tertiary. Only for abuse and violence is the intervention and response routinely delegated to the “statutory authorities”. The inevitable result is that the health system is disconnected from that response, takes no responsibility for the outcome and has little investment in improving it.

4. **The biggest challenge to overcome to make this a reality is the challenge of health workforce development**

   There is no point in pretending that the health system has the capacity to undertake this task, right now. But it has the capacity for the capacity.

   There are approximately 1100 front-line Oranga Tamariki social workers in New Zealand. There are at least 10 times that number of front-line health professionals, from multiple disciplines, who devote part or all of their time to the health of children and young people – at all levels of intervention (primary, secondary and tertiary). However, the vast majority are relatively untrained in CAN and IPV.

Many of these professionals are otherwise highly-trained in their own field, and in many those fields of expertise (maternal and child health, mental health, child development and behaviour etc) are directly relevant to the kinds of assessment and intervention needed by families where children are unsafe and poorly nurtured.

Many of these professionals are dedicated and enthusiastic, are used to working with families and have a repertoire of skills in gaining informed consent, empathy and communication. Many work in multi-disciplinary teams. Many of them chose their professional pathway in response to families or mentors that they encountered relatively early in their careers.

Tragically, the very fact that most health professionals have almost no undergraduate or postgraduate training in CAN or IPV and most DHB fund no services dedicated to CAN or IPV, means that such professionals are deprived of the very experiences that build a trained and committed workforce.

We do a lot of training. In our experience, when health professionals are properly trained in child protection and partner violence intervention, the vast majority have both the desire and the capacity to do very good work.

What is currently lacking is the secondary and tertiary infrastructure within the health system to provide training and day-to-day support and the funded services within DHB in which both the trainers and the trained can be embedded in a sustainable clinical framework. However, it would not be difficult to get the ball rolling (see point 5).

5. **Key elements of a basic DHB infrastructure to support "proportionate universalism" in the area of CAN and IPV already exist and could be developed further with less investment than has been wasted on past strategies.**

In every part of New Zealand, there are existing health services dedicated to child health which already follow "proportionate universalism": contracts for universal services with provision to escalate if certain criteria are met. These contracts should be weighted emphatically in favour of children who are being left behind (especially those "lost to follow-up"), or where there are concerns about IPV and/or CAN.

Every DHB has at least some of the bare bones of a secondary service which could (given the appropriate capacity) provide training, supervision and support to primary services. Professionals who could be assembled into such secondary services include paediatricians and (in some DHB) psychologists who contribute to Gateway assessments; the Oranga Tamariki Liaison social worker; nurses, GPs and (in many DHB) paediatricians who provide sexual abuse services through the SAATS contract; the Violence Intervention Programme Co-ordinator and (in some DHB) the Child Protection Co-ordinator; experienced health social workers; crisis support services and family violence advocates or support workers funded by community groups.

However, many of these professionals currently operate in silos fragmented by their different contracts. For most, child protection and violence intervention are merely a sideline to their primary responsibilities. Few DHB have organised these services or contracts into dedicated multi-disciplinary child protection and violence intervention teams, with a mandate to expand workforce capacity and service provision.

Typically, infant and child mental health services operate in another silo, and their funding structure often actively works against their participating in interventions for children who have experienced abuse or neglect. Indeed, childhood trauma is often used as a criterion to exclude children from mental health services.

If the Ministry of Health is serious about the idea that children and young people should be “loved, nurtured and safe”, then it is about time it put its money where its mouth is. Any expectation that DHB will recognise this issue as a priority and devote resources to it has turned out – in many cases – to be merely a pious hope. Every DHB in New Zealand should be specifically funded to develop comprehensive multi-disciplinary services devoted to child protection and violence intervention, with strategic objectives for those services against which they are required to report.

Please note that your submission will become official information. This means that the Department of the Prime Minister and Cabinet may be required to release all or part of the information contained in your submission in response to a request under the Official Information Act 1982.

The Department of the Prime Minister and Cabinet may withhold all or parts of your submission if it is necessary to protect your privacy or if it has been supplied subject to an obligation of confidence.

Please tell us if you don’t want all or specific parts of your submission released, and the reasons why. Your views will be taken into account in deciding whether to withhold or release any information requested under the Official Information Act and in deciding if, and how, to refer to your submission in any possible subsequent paper prepared by the Department.