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.
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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 and Youth Wellbeing Strategy

Submission to the Department of the Prime Minister and Cabinet

Date: 5 December 2018

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About the New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO)

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 52, 000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation *Tōpūtanga Tapuhi Kaitiaki o Aotearoa* welcomes the opportunity to comment on the Child and Youth Wellbeing Strategy.

2. Nurses and midwives work with tamariki and rangatahi, and families, schools, and communities delivering health care in many different service settings and at all levels of care. They strongly support the holistic child/youth focus of the proposed outcomes framework which is consistent with the comprehensive nursing scope of practice.

3. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the College of Child & Youth Nurses, College of Primary Heath Care Nurses, Mental Health Nurses Section; Pacific Nurses Section; midwives and nurses working in child and youth health centres, Te Rūnanga o Aotearoa (Te Rūnanga), and professional nursing, policy, and research advisers.

4. NZNO belongs to the Child Poverty Action Group and Tick for Kids networks and is a member of the Action for Children and Youth Aotearoa (ACYA) Coalition; we warmly support submissions from these expert groups, who are broadly representative of experienced frontline professional and community organisations focused on child and youth wellbeing.

5. We appreciate the constraints involved in consulting on, and developing, a comprehensive wellbeing strategy for children and young people following so soon after the narrowly focused Vulnerable Children's legislation and restructure, and alongside several concomitant service reviews and inquiries.

6. A decade's talk and consultation and a plethora of papers, research, and reports etc. have unsurprisingly clarified strong consensus around the outcomes that New Zealanders want for all tamariki and rangitahi, and the principles upon which services should be designed and delivered. These include embedding the biculturalism implicit in Tiriti o Waitangi and ensuring universal rights of access to the essentials for health to assure equitable outcomes.

7. It has not, however, delivered the resources, planning or workforce needed to address what's wrong - ie systems barriers and structural discrimination - or to implement what is 'right' – ie proven and efficient strategies to empower people, improve equity and effect intergenerational change.

8. Accordingly, this submission will focus on what our expert and experienced members – nurses, midwives, and kaimahi hauora who are at the frontline of the delivery of child and youth health services in all health and community settings – would like to see implemented, rather than 'wordsmithing' the proposed outcomes framework[1].

9. Wellbeing and health are intertwined. Optimising the health potential of individuals through the prevention, management and treatment of disease, illness and injury on the one hand, and the promotion of health on the other, enhances the wellbeing, resilience and social cohesion of families, whānau, communities and society as a whole. Both parts of this equation are encompassed by the term "primary health care (PHC)" and demonstrate the intrinsic connection between the medical and social determinant drivers of health.

10. Primary health care encompasses a broad range of professional health care received in the community, including health education, counselling, screening, disease prevention and management, and also services that contribute to health, such as those centred on employment, community development, environmental protection and voluntary work[2].

11. NZNO is guided and informed by the international evidence which underpins the Declaration of Alma-Ata 1978 (World Health

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[1] https://dpmc.govt.nz/sites/default/files/2018-11/appendix-b-proposed-outcomes-framework.pdf

[2]https://www.nzno.org.nz/Portals/0/publications/New%20Zealand%20Nurses%20Organisation%20Manifesto%20Elections%202011.pdf

Organization, 1978) [3], that identifies PHC as the key to attaining the UN goal of "Health for All" and the Report of the Committee on the Social Determinants of Health *Closing the Gap in a Generation* (Marmot, 2008). We are also cognisant of the urgent need to progress the United Nations' Sustainable Development Agenda 2030 in the next decade remaining.

12. However, it is the specific day-to-day experiences of our members working in GP practices, hospitals, Māori and iwi providers, schools, prisons, police stations, and social services for example, . that we draw on to identify changes needed to improve the child and youth wellbeing in the following areas:

    - Regulatory reform to remove systems barriers to integrated accessible services;
    - Cultural reform to remove structural discrimination;
    - Workforce planning and utilisation;
    - A separate strategy for rangitahi; and
    - A focus on coordinated planning for incremental, rather than 'disruptive', progress.

13. We'd be happy to elaborate on the above, but do not intend to duplicate the detailed examples and rationale we have already provided in numerous previous submissions[4], workshops, meetings, hui, and public commentary.

14. We tautoko the truth and wisdom of King Tawhaio's words *Ki te kahore he whakakitenga ka ngaro te iwi*, and warmly acknowledge the bold vision, articulated by his descendant Te Puea that this coalition government has committed to.

15. Substantive action on housing, climate change, pay equity, lifting wages, extending school based health services and the government-wide introduction of the living standards framework are as fundamental

[3] Note that the World Health Organization calling for a recommitment to the Declaration http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

[4] EG in response to the Green and White papers (2012), Children's Commissioner's Solutions to Poverty (2012), Vulnerable Children's Act (2014), United Nations Committee to the Rights of the Child (2015), Oranga Tamariki Bill (2016), Family and Whānau Violence Legislation Bill (2017 the Child Poverty Reduction Bill and other related submissions on housing, education, family violence and justice consultations.

to improving child and youth wellbeing, as the repeal of section 59 in 2007 was to fostering cultural norms that reduce violence at all levels[5].

16. NZNO seeks further engagement with the Child and Youth Welfare Strategy Team so that the experience and expertise of our members and staff can be utilised in the design and delivery of integrated public services that improve, support, and protect the wellbeing of our young people.

DISCUSSION

Regulatory Reform to remove systems barriers

17. The lack of provision in legislation and regulation for core health services to be connected to social, youth justice and health services, including alignment of assessment, referral and reporting systems, means that the most vulnerable tamariki and rangatahi, who need, and are entitled to, extra care and support, frequently miss out on basic health care available to all other citizens - ie they are doubly disadvantaged, with the inevitable lifelong consequences.

18. A striking example is the lack of alignment between health and child protection assessment systems for children who are acutely at risk. An experienced public health nurse may identify and refer a highly vulnerable child needing immediate care, without any result because it doesn't meet the threshold for intervention under the child welfare system. Often the nurse is not informed either way and there is little opportunity for collaboration. Similar disconnects can be found between health and justice although the connection between poverty, poor health, and antisocial, criminal behaviour are well known.

19. Legislative provision for engagement/ oversight of health practitioners in public services other than health, is usually in relation to special circumstances eg referral for psychiatric assessment, or reference to particular roles eg Medical Officer of Health. There is little to ensure a routine health check is done as part of any intervention by a State service involving children and young people, and yet we know this is the very group that has high rates of unmet need and the greatest potential to benefit from PHC ie vaccination, treatment of minor infections, education - including management of prevalent chronic disease such as asthma and diabetes, screening and access to appropriate aids such as glasses and hearing aids, referral to medical and specialist services for addiction, sexual health and mental health issues.

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[5] https://www.savethechildren.org.nz/assets/Files/Reports/STC-Childrens-Report-DIGITAL.pdf

20. Regulation should **mandate** rather than assume the provision of core health services to children and young people that come to the attention of State in any situation, and services must be designed to align with health to ensure coordinated oversight and care.

21. Nurses are scientifically educated and trained to assess and refer appropriately, to deliver PHC and medical treatment and to advocate for patients consistent with the holistic scope of the nursing profession. They provide a link not only to the medical profession and essential clinical information, but also to families, whānau, social workers, police and corrections officers, community leaders etc. Nurses are embedded in communities in many capacities and, not surprisingly, many were appointed as lead coordinators of the children's teams responsible for at risk children and young people, a vulnerable children's initiative.

22. However their ability to access, convey, and coordinate clinical and social information is often stymied by systemic barriers with predictably adverse outcomes for tamariki and rangatahi. These include:

    - siloed information between Ministries and funders and providers;

    - nurses (and others) not being consulted about the development and implementation of strategies doomed to fail because of inadequate information;

    - disparate or non-existent training when new processes are introduced, inadequate resourcing (the children's teams, for example, were introduced with *no additional funding* though the assessed workload was double);

    - sluggish and/or non-existent responses to identified problems at every level of service; and

    - a lack of understanding of the importance of clinical input at grass roots level.

23. We submit that the **health system** must be the starting point for wellness planning and strategies, not only because health and wellbeing are so closely connected, but also because the Ministry of Health is the government agency responsible for public health interventions which affect people, both directly and indirectly, throughout their lives, eg with sanitation, water quality, disaster and emergency response, programmed immunisation and screening programmes, and at critical stages of birth death, illness, exposure to risk etc. It is essential that other agencies' systems (social welfare, child protection, justice, and education) are aligned with health's to enable timely, efficient and coordinated actions to improve wellbeing.

24. Ironically, however, another systemic barrier lies at the heart the heart of the health system itself. Possibly the single biggest impediment to equitable access to basic health information and services, is the overwhelming focus on private medical practice for the delivery of PHC. The fees barrier is inherently discriminatory, as is the discretionary location of practices, which leave high deprivation and rural areas poorly covered[6].

25. Moreover, it does not take account of significant advances and changes in the delivery of modern multidisciplinary health care or utilise the potential of a broad range of regulated health practitioners, or allied workers and experts (social workers, families, kaumātua, counsellors, scientists, advocates etc.) to provide cost effective, culturally appropriate, integrated clinical and social services that empower individuals, whānau and communities.

26. **Alternative funding models** to capitation-based subsidies to private GP practices are urgently required.

27. A further systemic issue is the significant reduction of the public health workforce and fragmentation and contracting out of public health services to the point at which we can no longer be confident about the safety of drinking water, 'swimability' of our rivers[7] or capacity to meet health demand in times of crisis.

28. As articulated in *Nursing matters - Priorities for health* (NZNO, 2017)[8] "Secure, long-term funding for public health, must be sufficient to maintain current service, facility and workforce levels, meet increased population and health demand, and pay for new initiatives. … In particular, the decades-long decimation of the public health workforce must be reversed to ensure appropriate prevention, preparedness and emergency response to public health risks, due to natural disasters, climate and environmental change, AMR, and pandemic."

Addressing structural discrimination

29. This has been well canvassed by the Human Rights Commission 2012 report *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services* and continues to be evidenced by avoidable and unacceptable outcome disparities, attributable to

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[6] Recent efforts to address access issues by extending the range of funded services and medications pharmacists can deliver are predicated on the same commercial, medical model of PHC, and will not address the unmet need.
[7] https://www.radionz.co.nz/national/programmes/sunday/audio/2018653679/michael-baker-nz-s-drinking-water-may-not-be-our-biggest-worry

[8]https://www.nzno.org.nz/Portals/0/publications/2017%20NZNO%20Manifesto%20-%20Nursing%20Matters.pdf?ver=2017-08-03-150331-707

discrimination based on ethnicity, disability, poverty and circumstance, across a number of key indicators for child and youth wellbeing.

30. We see no evidence of a **government-wide strategy** to address structural discrimination within public services or throughout the country, yet this is a fundamental public health and PHC issue that privileges or disadvantages children from the outset.

31. It is difficult to address unintended structural discrimination – and we are confident that in Aotearoa it *is* unintended; but like any other form of ignorance, it can and must be addressed with good information, education and planned approach to raising awareness of and removing structural discrimination in public services and beyond. Progressing cultural change and ensuring the **cultural competence** of essentially the same staff, needs to be properly resourced.

32. Structural discrimination and the inequity it gives rise to, is hazardous to health and wellbeing and consequently to creativity, productivity, prosperity and sustainability. It needs to be addressed with a health promotion/education campaign as other public health risks are.

33. The higher profile this government has given to the importance of, and commitment to enacting, te Tiriti o Waitangi, is very welcome. We take this opportunity to reiterate comments made in our submission on the Child Poverty Amendment Bill[9] which gives further context to our recommendations above.

34. "*The Māori term tamariki for children does not specifically link to any particular age group, rather it overlaps with other terms, for example; tamariki (young, youthful, children), taitamariki (to be young, youthful), and rangatahi (younger generation) (Māori dictionary, 2016).*

35. As health professionals, we understand why it is necessary to be proactive in addressing health inequity and know from the evidence-base (Russell, Smiler, Stace, 2013) that ensuring free access to culturally appropriate primary health care services for all tamariki is an essential first step in promoting better health outcomes for our tamariki.

36. *Te Rūnanga agrees that disparities in child health status signal the need for universal health services responsive to the needs of Māori children - and this needs to start with good antenatal and maternity care and societal change to focus on the health and wellbeing of our future generations*."

[9] https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2018-04%20Child%20Poverty%20Reduction%20Bill%20Final.pdf

Workforce

37. The quality of services is essentially dependent on the quality of the workforce and having the adequate staffing levels and skill-mix.

38. We submit that there has been the same serious lack of long-term workforce planning for professional workforces, as is starkly evident with trades as apprenticeships were abandoned in the 1990s. In addition, immigration has been used as the recruitment tool of choice by a number of industries and corporations, assisted by the low demands of the recently expanded Employer Accreditation Scheme. Few efforts have been made to retain migrants or alter the staggeringly low long term gain we get from immigration. Eg “Between 1955 and 2004 New Zealand’s net population gain from 2.3 million migrants was just 208,000 people” (Hawthorne, 2014)!

39. What has this to do with child and youth wellbeing? It is part of the mix of factors that influence wages, job security, cultural competence, career development, leadership and workforce sustainability. It deprives some of the benefits of good work[10] , relegates others to precarious work, and is destabilising for migrants. Moreover, it enhances inequity within and between countries in contravention of the SDA 2030 and leaves Aotearoa hugely at risk of not having, or being able to compete globally for, the workers it needs to meet their needs.

40. For example, we continue to be more dependent on immigration for its health workforce than any other OECD country (Head, 2017; Ministry of Health, 2016; Zurn & Dumont, 2008) and, ironically for nurses, this has increased alongside new graduate unemployment, and changes to immigration policy which make it harder for internationally trained nurses to gain residency. Pacific nurses, who are too few in number, face other remediable barriers to registration here.

41. Moreover, **underrepresentation of Māori i**n *all* professional workforces reflects, and perpetuates, structural discrimination. This has been brought to the attention of the Waitangi Tribunal in the Wai 2575 claim and, by Te Rūnanga to the United Nations Forum of Indigenous Rights (2016-18).

42. The situation may be different for social workers who do not appear on the essential skills in demand lists, but this may be due to the heavy caseload that social workers carry, rather than actually there being sufficient social workers. Even so, the unaccountable decision to protect the title but not the job description of social workers, undermines the value of regulating the profession.

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[10] Consensus Statement on the Health Benefits of Good Work https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=baab321a_14

43. What is desperately needed is **sound long-term workforce planning** and **coordinated immigration, education and employment policy and regulation** across all government agencies, not just within them.

44. The Report of the WHO High Level Commission on Health Employment and Growth (Horton et al., 2016) recommended secure commitment to inter-sectoral, national and regional engagement and the development of specific strategies to prevent all forms of discrimination, prevent decent jobs transitioning into informal jobs etc. and improve global equity in the distribution of health workforce resources. Importantly, the report also recognised that to build capacity to develop and regulate and preserve decent jobs, States require: "…a suite of appropriate long term planning policies and regulatory frameworks that must be coherent across education, health, labour, international relations, and immigration and trade sectors".

Adolescence

45. We warmly welcome the specific inclusion of "youth" as distinct from "child" in the Strategy.

46. The seminal report on adolescence from the Office of the Chief Science Adviser provided a sound rationale for the forty recommendations made in respect to how we could make it easier for rangatahi to transition from childhood to adulthood, as safety and healthily as possible (Office of the Prime Minister's Science Advisory Committee, 2011).

47. There are a number of reasons why this period – possibly longer and different from previous generations - is so important for the remainder of life, and why we need specific strategies and services for adolescents within the framework of the UN Convention on the Rights of the Child.

48. Apart from dealing with physical and cognitive changes some of which, like puberty and the onset of menarche, are occurring earlier (Karapanou & Papadimitriou, 2010), young people are also exposed to more risks, and have to make decisions about a wide range of things, with a lower level of adult input, than at any other time.

49. Those decisions, as the Chief Science Adviser's report makes clear, often "have their antecedents in early childhood" which is why many of the recommendations focus on primary prevention and early intervention. (The Health Committee took the same well received approach in their report on child health outcomes and preventing child abuse (Health Committee, 2013).)

50. However, it notes that: *There has been increasing investment in a series of early intervention programmes in New Zealand, but with a few*

> *randomised trials to evaluate their efficacy in a New Zealand context. Of those programmes that have been evaluated, many have been shown to be ineffective.* ***A matter of high priority is to set up a consistent programme of research and evaluation to develop high-quality early intervention programmes*** *(and to cull ineffective and, in some cases, potentially harmful programmes) for New Zealand children at risk of longer term problems and difficulties. It is important that any such programme of research takes into account both Māori and Pasifika perspectives.* (Office of the Prime Minister's Science Advisory Committee, 2011, p11) [NZNO emphasis]

51. NZNO agrees that there are significant knowledge and policy gaps, particularly those specific to the New Zealand context, in relation to what intervention and prevention programmes are effective, what the key influences on adolescents are, and how to improve outcomes for at- risk groups. A rigorous approach is needed to ensure evidence, rather than advocacy, policy.

52. NZNO supports the recommendations of both reports and is at a loss to understand why so few have been properly resourced and implemented, and subjected to ongoing evaluation.

53. Clear evidence supporting the effectiveness of school based health services (SBHS), particularly for adolescent mental health (Denny et al., 2014) should have prompted immediate action, given New Zealand's appalling rate of youth suicide, but didn't.

54. It is of huge concern, therefore, that funding for the "nurses in all schools" election promise still only covers decile 1-4 schools, and it is not at all clear when, or even if, it will be extended to all schools in the 2019 budget, and what it will encompass. The potential for SBHS to connect and utilise the skills of a range of health and social service professionals and those of the wider school community, to deliver measurable improvement to the wellbeing of rangitahi and more equitable outcomes for disadvantaged youth are significant.

55. Our understanding is that a comprehensive scheme has not yet been developed, certainly not to the point at which there is a clear and supported framework and standards for school nurses, rather than the hotch potch of disparate employment arrangements and contracted services with DHBs, schools, NGOs, churches, ACC, that currently fund nurses in schools. Some are even funded through school donations.

56. It is disappointing that there has been no comprehensive engagement or consultation with nurses and other clinicians who will be expected to deliver SBHS, nor what those services should encompass for the best outcomes. Nor has there been school or community engagement. Without a clear understanding of what SBHS are expected and able to deliver, aligned with transparent resourcing, contracts, training and

standards, there is a real risk that they will be subject to unrealistic expectations. It is essential that those delivering the services are involved in the design of them.

57. We strongly advise that **resourcing and implementing SBHS** is prioritised.

Planning for balanced incremental progress

58. Finally, we note that numerous "high level" restructuring and reforms within health and other government agencies over the past few decades have not delivered better or more equitable outcomes. Most have been accompanied by a strong, negative feeling of "déjà vu".

59. We advocate to carefully planned, "bottom up", incremental transition to integrated holistic services to improve wellbeing.

CONCLUSION

60. In conclusion, NZNO welcomes and **supports** the proposed outcomes framework for the Child and Youth Wellbeing Strategy and agrees that each of the numerous (16) focus areas are worthy of attention.

61. We recommend that you note our **support** for the recommendations made in submissions by the Child Poverty Action Group, Tick for Kids Action for Children and Youth Aotearoa (ACYA) Coalition.

62. We further **recommend**:

- All agencies working with tamariki and rangatahi are health-focused and have assessment and reporting systems that align with national health systems;
- All interventions affecting children and youth should prompt a health check to enable early and repeated opportunities for intervention if necessary;
- Alternative funding models to ensure universal access to PHC;
- A government-wide strategy to address structural discrimination in public services and beyond;
- Long term workforce planning, to ensure that we have the workforce, including proportional Māori workforces, needed to meet child and youth needs;
- The development of coordinated immigration education and employment policies and regulation to improve equity and

- A consistent programme of research and intervention to develop high quality early intervention programmes;
- Prioritising the resourcing and implantation of SBHS in all schools;
- A focus on coordinated planning for incremental, rather than ‘disruptive’, progress;

63. Finally, please note that we seek further engagement in subsequent development of the Child and Youth Wellbeing Strategy utilising the depth of knowledge, experience and nursing of our members and staff.

Nāku noa, nā

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