child & youth wellbeing

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

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.

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Organisation Name:	Child Protection Clinical Network of the Paediatric Society of New Zealand
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?)	This submission is from the Clinical Reference Group of the Child Protection Clinical Network. Our main role is to provide leadership in child protection and family violence practice to child health services in NZ. Professor Dawn Elder, Paediatrician, Academic (Clinical Lead) Ms Miranda Ritchie, VIP programe manager, Faciltator Dr Clare Doocey, Paediatrician Ms Allie Fyfe, Nurse, Gateway Coordinator Ms Rachel Heteraka, Northland DHB Dr Vivience Hobbs, Paediatrician Ms Jenny Humphries. Midwife Dr Patrick Kelly, Paediatrician Dr Andreas Leinfellner, Paediatrician Ms Kathy Lowe, Nurse, VIP Coordinator Ms Susan Miles, Child Protection Coordinator Dr Teuila Percival, Paediatrician Dr Vili Sotutu, Paediatrician Dr Russell Wills, Paediatrician

Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	• Unlike conditions of childhood like cancer or diabetes, children experiencing abuse and neglect have no national parent advocacy bodies or research funds, yet have known, poor and costly long-term outcomes that affect childhood and adult wellbeing for many. • Health services for these children are fragmented, training and confidence of staff is variable and access to basic care such as for the mental health consequences of abuse and neglect is often poor. • There are however, clinicians with specialist expertise, services in NZ of very high quality, and a strong desire to assist in improving services to be nationally consistent and high quality. • The Child Protection Clinical Network of the Paediatric Society of New Zealand represents the specialist staff working in this challenging area in Health. • We support the first principle of the Child Wellbeing Srategy and make several suggestions for improvement of health services for children experiencing abuse and neglect. • These suggestions focus on staff training, child protection team organisation and further development of mental health services for children who have been exposed to maltreatment, especially very young infants.

Submission Content
We are very pleased that the government is taking the initiative on addressing child wellbeing. We also appreciate the efforts of both the previous and current governments in addressing family violence in New Zealand. Although we support a full range of measures to improve child wellbeing the expertise of our network group is in child maltreatment and family violence and so we will restrict our submission to this area. We represent the clinicians who work in child health services at the coal face in DHBs around the country, assessing risk, undertaking assessments, providing care and providing opinions and medicolegal reports for our most vulnerable infants, children and adolescents exposed to maltreatment. Sometimes the first time we have met our patients has been in a mortuary. In this work Oranga Tamariki—Ministry for Children and the NZ Police are our partner agencies and we value our association with them and the memorandum of understanding that sets out our way of working together. For all infants, children and adolescents to thrive they need to be free from exposure to physical and sexual violence and emotional abuse and neglect. To enable all infants, children and adolescents exposed to these forms of maltreatment to move through a management pathway to a place where they can once again thrive, there need to be appropriate assessment and diagnostic and management services, including follow-up, that are accessible, of high quality and close to home for those children. Data from the New Zealand Child and Youth Epidemiology Service demonstrates a sharp socio-economic gradient for child abuse presenting to hospital.[1] Our experience is that poverty also limits the ability of families to recover from exposure to abuse but this submission will focus on the health needs of children exposed to child abuse and neglect which for all of us in the Network is our core business and primary focus. In terms of the Child Wellbeing Bill this submission best comes under the sub-heading 'Improving the wellbeing of core populations of interest to Oranga Tamariki.' **Currently in New Zealand / Aotearoa it is our experience that:** • Although a lot of very well intended thought has been given to multi-agency planning and co-operation in regard to family violence there is still a very poor representation of expert practitioners in child protection in government agency groups and this means that an understanding of the child perspective is once more likely to be subsumed to the adult perspective. Just as the voice of children is critical when considering their welfare, so is the voice of experts who deal solely with the clinical care of children on a day-to-day basis important. • As an example three of the members of our committee, Dawn Elder, Patrick Kelly and Miranda Ritchie, have served terms on the Family Violence Death Review committee. There is currently no clinician with expertise in child abuse and neglect on this committee although the committee is charged with the review of child abuse and neglect deaths as well as adult family violence deaths. This is not tenable. • The role of health is underestimated in the management of family violence. In the MOJ consultation document 'A common approach to understanding Family Violence Risk Assessment and Management' in the list of agencies under the heading 'Who is responsible for conducting a risk assessment?"(p34), health is only included as "some

health providers". And yet family violence presents in pregnancy, in the perinatal period, to well child/ tamariki ora workers, in primary care, in emergency departments and adult wards and especially in child health in-patient and out-patient settings. Family violence risk assessments are being undertaken in the health system multiple times daily by the members of our network and by our DHB colleagues.

- In the same document there is a statement 'In 70% of intimate partner violence cases involving children, the children are being abused too. Even if the children are not physically abused, their exposure to violence can cause serious and sometimes permanent harm.' While this statement does have some balance there should more clarity that exposure to intimate partner violence is by definition child abuse as this type of exposure falls under the definition of emotional abuse used by Child Youth and Family / Oranga Tamariki for many years. Therefore 100% of children exposed to intimate partner violence have 'been abused' and a high proportion of those are likely to have been physically abused. These are areas where words are important and input from experts in child abuse and neglect and those who understand how family violence presents to health is critical.
- There is a lack of cohesion in the development of health services related to family and sexual violence in the Ministry of Health (MOH) and currently only limited attempts to seek advice from the available expertise in the development of services for children from the very committee (The Child Protection Clinical Network) that the MOH supports.

Research undertaken by our committee indicates that there are concerning limitations in the services in health available for the assessment of children exposed to maltreatment and referred to child health services in DHBs for assessment:

- Fifteen of 22 paediatric departments in 20 DHBs responded to our questionnaire. A third had no specified paediatrician with a leadership role in child protection and over half had no specific child protection clinic for non-acute referrals.
- In a survey of 79 paediatricians across the country, 32 (44%) paediatricians reported they avoid assessing child sexual abuse cases because of personal concern about their level of training.
- In the same survey just under half (47%) of the paediatricians responding reported that they avoid as least some types of child protection work because they do not feel well enough trained and supported.
- Around half of the paediatricians (53%) reported not feeling confident completing a routine inquiry for intimate partner violence.
- There were 43 (57%) paediatricians who agreed or strongly agreed that tertiary child protection assessments should be completed by specialist paediatricians with child protection training. This feeling was pervasive across all responding DHBs.
- There were 27 paediatricians (36%) who reported that they had on at least one occasion felt personally threatened or unsafe while involved in a child protection case. The general issues included verbal and physical intimidation, verbal abuse and aggression. A small number of paediatricians have had a Health & Disability Commissioner complaint made by the suspected abuser, or death threats made against them or family members.
- The majority of paediatricians (93%) who had experienced these adverse events were still willing to do child protection work. In connection with the other findings, this finding implies that it is concern about training and support rather than willingness to do the work that is the main issue.
- With regard to increasing confidence in child protection work a range of training

opportunities were selected with the most frequent one being supervision or support from a tertiary level child protection paediatrician (67%) followed by more training as a consultant (45%), peer review within their own DHB (44%), more involvement in child protection work as a registrar (28%) and more training pre-FRACP (Fellow of the Royal Australasian College of Physicians) (25%).

Data published in the family violence death review committees 5th report indicates that:

- In the 56 deaths from 52 child abuse and neglect death events between 2009-2015, 58 children < 18 years of age were normally resident in the home where the death occurred and 51 were present in the home at the time of the death.
- For 91 intimate partner death events between 2009 and 2015, 83 children < 18 years of age were normally resident in the home where the death occurred and 51 were present in the home at the time of the death.
- There are currently no guidelines as to how the after-death care of these children should be managed. It is very likely that the fatal event experienced by these children was similar to many non-fatal events they had witnessed in the past. The grief they feel for the family member who has died is therefore added to the traumatic effects of these past exposures to family violence.

We would like to outline some barriers to optimal recovery from exposure to maltreatment, that we have observed from clinical cases. These barriers are highly likely to affect ongoing child wellbeing:

- A young mother with a history of methamphetamine use and exposure to intimate partner violence is now caring for her two children who continue to have some behaviour problems, with the younger child having a lot of difficulty sleeping. She avoids her friends as they were part of her 'old life'. Her family are also not supportive and are part of her 'old life'. As part of the Oranga Tamariki plan for maintaining her children in her care she attends family violence counselling, attends drug and alcohol counselling and a parenting course. She is also having follow-up with a paediatrician for the child with sleep problems. She has appointments with another paediatrician because her other child has a diagnosis of Attention Deficit Hyperactivity Disorder. She also has to engage with her lawyer on Family Court matters. She is on a benefit and so cannot afford to live in a house in a better neighbourhood. She cannot afford to do anything extra for herself that might provide respite for her. She can only just afford to get to all her scheduled appointments and yet if she does not go she will be judged. There is nobody who can babysit her children because she does not trust anybody and she cannot afford to pay a babysitter. Therefore a parent who needs a break more than many other parents, because of her history of depression, her children with behavioural and developmental problems, her sleep deprivation and her solo parent status, does not get that support.
- A 4-month-old child is taken into care urgently by Oranga Tamariki and is with a temporary caregiver. The child arrives very distressed and cries most of the night and cannot be fed. The child has been exposed to violence and has been clasped tightly to the mother's chest while she has been agitated and distressed over the last few months. The child has been hard to feed initially but the behaviour has gradually settled over a couple of weeks. A paediatrician does a Gateway assessment. The report expresses concern about the initial behaviour of the child and what that means for their future especially as there will inevitably be at least one further change of caregiver and possibly more than one in this child's future. The paediatrician would like to refer the child to a local infant mental health service to assess the child's

attachment and support him over his ongoing journey until he is in a permanent placement. Unfortunately there is no such service.

- A paediatrician is referred a 7 year old child for a medical assessment by the Police. Oranga Tamariki are already involved. The child has disclosed historical abuse by an 18-year-old cousin that happened when the cousin was living with the family a year ago for 6 months. As part of the assessment it is revealed in the history that there is also intimate partner violence between the parents with some high-risk features. It is also noted that the child has significant sleep problems and does not get to sleep until midnight most nights. It is noted by the paediatrician that the abuse is alleged to have happened in the child's bedroom. There are also issues with inattention at school and the child is behind in her schoolwork. The paediatrician suspects the child has post-traumatic stress disorder. She recommends that the child's bedroom is changed but this is not possible to do for this household as some family members are already sleeping in the lounge. The paediatrician would like to refer to child mental health services because the child has symptoms and has been exposed to more than one form of maltreatment. The local mental health service refuses the referral because they are not funded for sexual abuse work. The paediatrician does not feel ACC supported sexual abuse counselling is appropriate as the situation is more complex. The family would need to pay for other mental health services and have insufficient funds to do so. If they do get support from an NGO who would be responsible for follow-up to ensure a successful outcome for this child?
- An 11-year old boy is seen for a Gateway assessment. He is on his third placement, now a temporary non-whānau placement. He has behavioural symptoms that suggest conduct disorder, he is getting more and more behind at school and there is concern that he may have Fetal Alcohol Spectrum Disorder (FASD). A referral to child mental health services is undertaken. They say his disability should be assessed first and that they would not address his behavioural problems until he is in a permanent placement. He is referred to the DHB developmental team. They say it is the responsibility of the Ministry of Education to arrange formal testing. There is nobody in the local Ministry of Education who can undertake an assessment to confirm the diagnosis of FASD. Five months have now passed since the Gateway assessment and the child has received no further services.

When the prevalence of exposure to maltreatment in New Zealand is considered the data are startling:

- In the five years from 2011–2015 there were 694 hospitalisations of 0–14 year olds for injuries arising from assault, neglect or maltreatment. The most common primary diagnoses for these hospitalisations were traumatic subdural haemorrhage, especially in 0–4 year olds, and head injuries. Infants in the first year of life had the highest hospitalisation rates for this type of injury.[1]
- The Christchurch Health and Development study reported in 1996 that in their cohort of just over 1000 18-year-olds, 10.4% reported sexual abuse before the age of 16 years (17.3% of females and 3.4% of males)[2]. The Dunedin Multidisciplinary Health and Development Study asked about a history of child sexual abuse at 26 years of age. In this cohort 20% of the group, 30.3% of women and 9.1% of men, reported some form of sexual abuse before the age of 16.[3]
- In the Christchurch Health and Development Study participants were asked at age 18 about their experience of intimate partner violence during childhood.[4] Overall rates were around 38% when verbal violence is included, with equal rates of violence reported as being perpetrated by mothers and fathers. Violence initiated by fathers was associated with an increased risk at 18 years of age of conduct disorder, anxiety disorder and property offending. Exposure to violence initiated by mothers was

associated with an increased risk of alcohol abuse or dependence.

- Also from the Christchurch Health and Development Study 7.6% of young people asked at age 18 reported that their parents had regularly used physical punishment and 3.9% reported that their parents use physical punishment too often or too severely or treated them in a harsh or abusive way.[5]
- In comparison less than 1% of New Zealand children have current diabetes or a new cancer diagnosis each year and yet it is never questioned that these children should have wrap around services and appropriate transition to adult care as they mature.
- These differences in service provision by primary diagnosis are inequitable.

Our recommendations to improve child wellbeing in relation to exposure to any form of maltreatment are that:

- Oranga Tamariki and NZ Police need to be very clear about the importance of health in recognising and managing family violence. Health is often where family violence presents first and there is a high risk of missed opportunities for prevention of serious morbidity and mortality if staff in Health are not ready to meet the challenge of providing care to those exposed to family violence.
- It is critical that Health, Oranga Tamariki and NZ Police maintain a close working relationship.
- While there has been significant progress over the last 5-10 years, child health professionals still need more training and support to undertake child protection work. The best way to improve standards in this area of clinical care would be through the development of multi-disciplinary teams in each DHB that can assess, manage and provide a robust opinion in regard to all forms of child maltreatment. Te Puaruruhau in Auckland provides an excellent model for large centres.
- For some DHBs these services will need to be supported as regional services in a hub and spoke model.
- While ACC could be in a position to support the development of these services, adding complexity to funding in an environment where funders are also time-poor will only delay implementation of multi-agency, multi-disciplinary teams.
- Primary care providers need to be provided with the tools and time to assess intimate partner violence and parenting concerns. NGOs with expertise in supporting parents with mental illness, addictions, violence and related issues are stretched beyond capacity and carry considerable risk. Increased training and support for these services is needed.
- Mental Health services for children need to be open to the assessment and management of the mental health consequences of all forms of maltreatment, including support of caregivers of children with moderate and severe attachment and trauma issues. This is likely to require significant investment and changes in culture so adult and child mental health services work more collaboratively with each other and with other services. The current ACC model of support is not a good fit for children who have experienced complex trauma that includes exposure to sexual abuse.
- Mental Health services need to be provided across DHB boundaries if that is in the best interests of the child.
- Infant mental health services need to be established in all DHBs so that our most vulnerable infants can be supported to have the best start in life.
- Undergraduate training of social workers and related disciplines must be strengthened so that graduates have a clear understanding of, and can competently assess for, child abuse, intimate partner violence, mental health and addictions, and the consequences of these issues on children. This is not currently always the case.

- While the information sharing provisions of s66 of the new Oranga Tamariki Act and the Family and Whanau Violence Bill clarify that sharing information to protect victims takes precedence over privacy, this remains poorly understood, particularly within Oranga Tamariki sites. The guidelines supporting both new Acts should be combined, co-constructed with the sector, widely shared and Ministers' intent that information be shared to improve safety clearly stated.
- Three-quarters of tamariki in care are Māori. Cultural competency must be strengthened alongside clinical competency for all disciplines involved in the care and protection of children. Mana whenua should be involved at all levels in the design, delivery and evaluation of local services for children and partnerships between iwi and providers encouraged and strengthened. Tikanga Māori should inform all aspects of assessment and care for tamariki Māori at risk and with substantiated abuse and neglect. Pacific cultural competency should also be strengthened.
- Finally if we are really going to put the needs of children first in planning services for children in the context of family violence, those with clinical expertise in this area through working solely with children, need to be around the table.

References

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2. D.M. Fergusson, M.T. Lynskey, & L.J. Horwood, Childhood sexual abuse and psychiatric disorder in young adulthood: I. Prevalence of sexual abuse and factors associated with sexual abuse, J Am Acad Child & Adolesc Psychiatr 1996;35: 1355–1364.
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4. Fergusson D, Horwood L. Exposure to interparental violence in childhood and psychological adjustment in young adulthood. Child Abuse Negl 1998;22:339-357.
5. Fergusson DM, Lynskey MT. Physical punishment/maltreatment during childhood and adjustment in young adulthood. Child Abuse Negl. 1997 Jul;21(7):617-30.

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