



The Paediatric Society of New Zealand Te Kāhui Mātai Arotamariki o Aotearoa

Thank you for the opportunity to provide feedback on the NZ submission on the UNCROC.

The Paediatric Society of New Zealand, Te Kāhui Mātai Arotamariki o Aotearoa, is an incorporated society with a multidisciplinary membership predominantly of clinicians (nurses, doctors and allied health) working in child health.

Specific feedback has been received from leaders of the Injury Prevention and Epidemiology Special Interest Group, the Child Protection Clinical Network and the Child Development and Disability Clinical Network.

Do you agree or disagree with what the Government has been doing to uphold the rights of children in the Children's Convention?

Overall, the Paediatric Society of New Zealand supports the direction and efforts of the government and its agencies to uphold the rights of children. However, the health system has not yet delivered equitable health outcomes for Maori and Pacific children, compared with NZ European.

Increased effort and resource are required to meet the needs of all tamariki and rangitahi in New Zealand and to meet our obligations to Te Tiriti o Waitangi and the Convention on the Rights of the Child.

How we define "children" in New Zealand. (Q8)

Children are currently defined as 0-17 inclusive in the UNCROC.

In health data, tamariki / children are defined as 0-14 inclusive and rangatahi / young people as 15-24 inclusive. This is consistent with the UN statistical standards.

There is overlap for an individual child / young person due to their developmental stage and depending on the clinical service.

The Paediatric Society uses the terms tamariki for children and rangatahi for young people.

Wellbeing and health care (Q 9, 11.)

As child health professionals in public practice, we have noticed the impact on children's wellbeing throughout the response to the pandemic. In particular we have been struck by the following:

1. The increase in children living in temporary accommodation has deteriorated access to preventive care. Temporary accommodation (living in motels) has made provision of primary and preventive care more challenging, which is reflected in deteriorating rates of on-time interventions such as enrolment of pregnant women with a midwife, immunisations, well child-tamariki ora assessments and the Before-School check.
While we welcome increased investment in iwi-mandated social service organisations, we are concerned that there appears to be no plan or additional resource to support District Health Board-funded services to address this change in need.
2. Children living in temporary accommodation has also deteriorated their access to education in particularly early childhood education (3-5) and primary school (5-10). Māori and Pasifika children are the highest ethnic groups affected.

3. The deployment of the child health workforce away from their core roles into contract tracing and vaccination roll out has impacted on prospective surveillance of child development and on childhood vaccination rates.
4. Mental health and wellbeing of children and parents has deteriorated and overwhelmed services. We have also been struck by the impact of the pandemic and response on the mental wellbeing of children and their families.

We have observed publicly funded Child and Adolescent Mental Health Services (CAMHS) and Neurodevelopmental-Behavioural paediatric services, social services and Ministry of Education services becoming overwhelmed by demand for support for children in whom concerns have been raised for mental health and behavioural issues. Waiting time has increased or the threshold for acceptance has been raised above what is clinically acceptable. Access through fee for service providers further increase ethnic disparities.
5. Parents are reporting increased mental health symptoms but across the country, access to community-based mental health services for both children and their parents is increasingly challenged by fixed budgets and a significant increase in demand. Despite a recent comprehensive review of publicly funded mental health and addictions services, we can see no evidence of collection of data to demonstrate this demand and no plan to meet it.
6. The capacity of secondary health care services for children does not meet demand. Respiratory syncytial virus has demonstrated our limited surge capacity. RSV is a common respiratory virus causing irritating but not serious upper respiratory infections in adults and older children, but serious respiratory infections (bronchiolitis) in infants. The usual winter epidemic of RSV did not occur in 2020, as COVID lockdown restrictions had the effect of reducing all respiratory virus infections. This winter however, possibly due to reduced immunity and ongoing household crowding, the epidemic has been the worst we have seen in 20 years. Our children's wards, emergency departments and intensive care units have been overwhelmed at times with infants with RSV. This epidemic has been a salutary reminder of the vulnerability of the New Zealand health system to an epidemic, more so than COVID, as admissions and deaths from COVID were rare, while RSV admissions have tested our surge capacity and stretched both clinician and bed resources to their limit.

The children's voice (Q15)

1. Agencies are addressing that children's voices are heard. The Office of the Children's Commissioner has led a number of initiatives particularly related to the voice of children in care and the practice of removing newborns from their whānau. These highlight the need to investigate and review government agencies' progress on a regular basis as children themselves have limited ability to affect government decisions.
2. However, it also must be remembered that not all children's voices can be heard. Some children are preverbal, some disabled and some are too frightened to speak out. Therefore, it is important for whānau to have a strong voice about what needs to be working well to enable them to provide for their tamariki. This is especially important for Māori and Pasifika families. We need to understand from them when access to care and support is difficult.
3. There is also an important place for the voices of those with expertise in the care of children whether it be health care, or education or some other aspect of their care. Too often the voices of those with expertise in child health care are missing or appear to be undervalued. For example, the Family Violence Death Review committee reviews the deaths of children and youth as well as adults but has not had a paediatrician with expertise in child protection as a member for some years. The Family Violence and Sexual Violence Work programme has focused more on adults than children and has not addressed the issue of service provision in health for those children and youth affected by family violence.

Protecting children from violence (Q27)

1. Rates of harm to children from physical, sexual and emotional abuse remain too high and are yet to see any impact of initiatives the government has introduced.
2. Multidisciplinary, multi-agency Children's Teams (CTs) are being replaced with new initiatives, whose impact is yet to be seen. CTs were introduced in partnership with 10 District Health Boards (DHBs) to provide comprehensive assessment and interventions for whānau with complex needs. These struggled with recruitment of suitably skilled staff, complex bureaucratic mechanisms including information-sharing, community engagement and relationships between sectors. Now they have been disestablished, new initiatives are occurring in those sites. Success will require learning the lessons from Children's Teams so previous mistakes aren't repeated. Even if the new mechanisms are clinically successful, changing population-level outcomes will depend on equitable provision of whānau support to ensure the wellbeing of pēpi, tamariki and rangitahi.
3. Responsibility for Child and Youth Mortality Review Committees (CYMRCs) will be devolved to DHBs from December 2021. Previously funded and managed by the Health Quality Safety Commission, CYMRCs will become the responsibility of financially challenged DHBs to ensure ongoing collection, analysis and action on child and youth mortality data. Given the ethnic inequity in the data with very high mortality in Māori, we are concerned that devolution of responsibility for CYMRC from HQSC to DHBs may compromise efforts to reduce mortality for tamariki Māori.

Children with disabilities (Q35)

What more could the Government be doing for disabled children and their families?

1. Children with disabilities do not have their right to an education upheld to the full extent possible by the State. To uphold the rights of disabled children in education, schools should be audited regularly regarding their disability-related support services. Improved funding for mainstream school support services would allow schools to employ teacher aides, provide in-school consultation with therapists and special equipment (e.g. modified trikes) to enhance participation.
2. Improve funding for child and family support services based on their needs and to the level of the true cost. For example, respite care should be funded to a living wage, rather than a "contribution", as is currently the case.
3. Address the widespread inequities for Māori and Pasifika with disabilities and in the provision of support. We recommend recruitment of more Māori and Pasifika into the disability clinical workforce and options for kaupapa Māori disability support services.
4. Fund and support a meaningful and collaborative interagency approach across Ministry of Health, Child Development Services, mental health services, Ministry of Education services, social services, e.g., Oranga Tamariki. For example, the cost of practitioners attending interagency hui (meetings) should be recognised in contracts, rather than solely provision of face-to-face care.
5. Adopt a child and whānau centred approach - support of the child and caregivers/ parents/ whānau is essential, as support of the adults needs to be addressed to increase capacity and skill to enable best support their children.
6. Provide equal opportunity for children with disabilities to facilitate play, including provision of disability sports across New Zealand. Support physical activity by improving opportunity for inclusive sports and modified sports with specially trained PE teachers in mainstream schools. Address existing inequities in barriers to access parks, playground equipment and beaches for children with disabilities by incorporating disabled-friendly playground

equipment (i.e., Universal design principles) and walkways to encourage leisure activities of all children including children with disabilities.

7. Include Fetal Alcohol Spectrum Disorder (FASD) as an eligibility criterion for Ministry of Health-funded disability services and fund diagnosis and support services in all 20 DHBs. Currently, FASD diagnosis and support is a “postcode lottery”, available in a few proactive DHBs but not in most. Even if diagnosed and severely disabled, children with FASD are not eligible for MOH-funded disability services unless they have a co-morbid diagnosis of an intellectual, physical, or sensory disability, which most do not. It is likely that FASD disproportionately affects tamariki Māori, so failure to provide assessment and support for tamariki with FASD is, in our view, an example of systemic racism.

Financial support for children and young people? (Q36)

There have been many initiatives and investments made to ameliorate the impact of the pandemic and its response on children and young people, to the Government’s credit, e.g., increasing baseline benefits by \$25/ week and provision of resources to students without access to online learning.

The data lag in official statistics reporting means that it is not yet possible to tell if these measures have led to a reduction in child and family poverty levels or improved child and youth wellbeing. The plan to collect child-specific data in a more planned and rights-centred way and to regularly publish these data is particularly welcome.

What are the three things covered by the Report that you think are most important for the Government to make more progress on?

1. Gather and report annually data on children across health, education and social outcomes and set targets to improve equity of access and outcomes

Government has committed to report annually on wellbeing outcomes for children. We recommend this reporting is comprehensive, dis-aggregated by ethnicity and reported to a local level, with an expectation that there be inter-sectoral local planning. See also disability inequity issues below. Timely reporting and provision of data is essential to gauge impact of policy on outcomes for children and whānau.

2. Collaboration across sectors and sufficient funding for child protection

Current policy has significantly increased funding for and emphasised improvement by the national statutory child protection authority, Oranga Tamariki, to the exclusion of other organisations with a clear role in child protection. For example, there has been no commensurate increase in funding or policy work for District Health Boards to improve services, the model of care or cultural competence for children at risk of abuse or neglect.

3. Address inequities for tamariki with disabilities across the health, education and social sectors.

Many disabilities are more common in Māori and Pacific children, whose families are more likely to be poor, have insecure or crowded housing and less likely to access services across all three sectors. There is minimal reporting on access to services for children with a disability and few requirements on services to do so. It is our view that national and local reporting of such data should be mandatory, with targets set for organisations across all three sectors, and informed by consultation with whānau, communities and practitioners in the sector. For example, the Ministry of:

- Health could report on access to respite care
- Education could report on educational outcomes
- Social Development could report on access to the Child Disability Allowance
- Children (Oranga Tamariki) could report on stability of placements for children with disabilities,

dis-aggregated by ethnicity, at both a national and local level.

Thank you for the opportunity to have input to the rights of the child review process. We would appreciate feedback on this in due course.



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