



The Paediatric Society of  
New Zealand

**THE PAEDIATRIC SOCIETY OF NEW ZEALAND**  
“Health of our children/tamariki: Wealth of our nation”

**Submission to the Ministerial Inquiry into Mental Health and Addiction**

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**1. Introduction**

- 1.1. Please find enclosed the Paediatric Society of New Zealand’s response to the questions proposed in the mental health and addiction inquiry consultation document. We thank you for this opportunity. A full list of recommendations is given at the end of this submission.
- 1.2. The Paediatric Society of New Zealand is a multi-disciplinary membership organisation of approximately 500 health professionals working to advocate for, and promote, the health and wellbeing of children/tamariki and young people/rangatahi throughout Aotearoa New Zealand. The membership has been consulted in the development of this submission.
- 1.3. The United Nations Convention on the Rights of the Child, Article 24, indicates that all children/tamariki and young people/rangatahi have the right to the best health care available – this includes mental health services and thus needs to be observed.
- 1.4. For the purposes of this document the term infant/kōhungahunga refers to those aged 0 – 3 years; child/tamariki refers to those aged 4 – 12 years; and young people/rangatahi aged 13 years – 24 years.
- 1.5. The words of Dame Whina Cooper have guided this document: "Take care of our children. Take care of what they hear, take care of what they see, take care of what they feel. For how the children grow, so will be the shape of Aotearoa."

**2. Inquiry Questions**

**2.1. What’s Currently Working Well?**

*What Do You Think Is Currently Working Well? Why Do You Think It Is Working Well? Who Is It Working Well For?*

For those infant/kōhungahunga, children/tamariki and young people/rangatahi presenting in crisis (active suicidal ideation with intent or active symptoms of psychosis), specialist mental health services are responsive and accessible.

For those families/whānau who have managed to access and engage with secondary mental health services, the system appears to work well. This is especially true for motivated, well-resourced and high functioning families/whānau.

Specialist services appear to work well for those children/tamariki and young people/rangatahi with “straightforward” mental health diagnoses that is not complicated by significant psychosocial stressors, environmental pressures or complex developmental difficulties.

A strength of Child and Adolescent Mental Health Services is the multidisciplinary team approach that can be offered with child and adolescent psychiatrists, clinical psychologists, mental health nurses, social workers, occupational therapists, kaiāwhina or kaitiaki (cultural support workers) and mental health support workers. Although the makeup of the teams will differ depending on District Health Board.

The medical treatment of Attention Deficit Hyperactivity Disorder in Aotearoa New Zealand appears to be working well under both paediatric service and mental health services with judicious use of prescription medication.

Gateway Assessments provided to children/tamariki and young people/rangatahi in care can provide an opportunity for a comprehensive multidisciplinary assessment. However, the disciplines involved varies District Health Board to District Health Board.

Schools are actively interested in the wellbeing of their students and use the resources that are available to them effectively. These systems work well for those with good, consistent engagement in schooling.

The B4 School Checks is an accessible comprehensive screen for developmental or health concerns and has an excellent uptake in the community of over 90%.

## **2.2. What isn't Working Well at the Moment?**

*What Mental Health And Addiction Needs Are Not Currently Being Met? Who Isn't Receiving The Support They Need And Why? What Is Not Being Done Now That Should Be?*

A recurring issue is the inconsistency in intake criteria of specialist mental health services across the nation. Additionally, the question of what is "behaviour" versus "mental health"? Behaviour should not be used as a reason to deny service without appropriate pathways for intervention.

There are differing age ranges for Child and Adolescent Mental Health Services (CAMHS) across the country. In fact, the age range for all services (health, disability, education, social) aimed at children/tamariki and young people/rangatahi vary. Specialist education services typically finish at age 15 years, Oranga Tamariki age 17 years, CAMHS 18 – 20 years depending on region, child health typically 15 year, child disability up to 18 years, and youth services up to 24 years, perinatal mental health typically only covers the pregnancy period and first year after delivery. This creates confusion for all with regards to referral pathways and transfers of care.

Infants/kōhungahunga, children/tamariki, young people/rangatahi, and whānau who present to services with a number of health concerns across different domains often find it hard to access a service that is able to meet their complex needs. This is compounded when there are social or educational adversities. Due to the fragmented nature of the Aotearoa New Zealand health system (physical health, disability and mental health), people fall through the gaps. Children/tamariki and young people/rangatahi may not reach "criteria" for one service, however, if their challenges and difficulties were viewed in a cumulative nature, then they would be identified as the most vulnerable of our population.

There are several clinical presentations that are becoming more common in today's society that are affecting the mental health of Aotearoa New Zealand's children/tamariki and young people/rangatahi with no nationally recognised pathway for assessment and intervention. Of note is fetal alcohol spectrum disorder, transgender or gender dysphoria.

The current mental health system focuses primarily on the needs of the individual. Relationships are considered important but the focus is on individual wellness. This is a Pākehā/Western model of health which does not necessarily work for Māori or Pasifika cultures. Research clearly indicates that Māori need services based on the whānau and that are holistic. Additionally, it is recognised that Māori (and other cultures) who have a strong identity and sense of belonging experience better well-being than those who do not. We need to focus on providing services to whānau and build identity.

There is a recognised overlap between disabilities (e.g., autism spectrum disorders, intellectual disability, specific learning disabilities, and speech language delay) and mental health, yet there are limited pathways for dual diagnosis assessment and intervention. More specifically currently assessments for specific learning disabilities such as dyslexia have to be accessed through private providers at the families/whānau cost. This group of children/tamariki and young people/rangatahi require multidisciplinary specialist intervention, with the intervention targeting the both the mental health and developmental needs of the person requiring service.

Services for infant/kōhungahunga mental health issues and attachment difficulties are lacking. Again, there are inconsistencies across the country about assessment and intervention. Perinatal Mental Health Services needs to focus on the mother/māmā and infant/kōhungahunga dyad and have the skills to assess the wellbeing of the infant/kōhungahunga through direct observation, rather than relying on parental report.

Our most vulnerable children/tamariki and young people/rangatahi are often under the care of Oranga Tamariki and therefore are eligible for a Gateway assessment to identify their specific needs. Many of these children/tamariki and young people/rangatahi who have faced significant trauma also have attachment difficulties due to the disrupted relationships with biological whānau. These children/tamariki rarely can access specialist services or there can be a significant wait-time which maintains the difficulties. Oranga Tamariki can access primary mental health services for them, however, the needs are often greater than can be addressed in brief intervention given the extreme backgrounds of trauma. The Gateway assessment process varies in terms of clinicians providing it, wait-times and follow-up of recommendations offered across District Health Board's and Oranga Tamariki sites.

Screening of mental health, developmental and behavioural concerns is recommended and commonplace through the education sector and primary and secondary physical health care. However, when screening identifies early indicators of mental health problems there are limited resources and services that these children/tamariki and young people/rangatahi can be referred to as they very rarely meet the inclusion criteria of specialist mental health services. Primary mental health contracts are not available for infants/kōhungahunga and children/tamariki under the age of 12, this is an obvious gap in service.

Helplines are useful option for children/tamariki and young people/rangatahi dealing with bullying at school, substance use or general social issues. However, resources are so limited that there are always people who cannot access this service.

If children/tamariki, young people/rangatahi, or whānau do not attend (DNA) appointments this is often perceived that they do not want or need a service. Potentially, these are the people that need a service most. Practical barriers to attendance, such as distance, travel, parking costs, timing, and environment need to be addressed so that service is accessible. A change of perspective from 'did not attend' to 'did not reach' would underpin an attitude that the health service has an important role in identifying and addressing barriers to treatment.

Mental health services cannot exist in a vacuum. There is a lack of connection between mental health and obstetric or paediatric medical services, these are all separate systems within individual District Health Boards which creates barriers and confusion. These three

services need to work together with integrated care pathways to best meet the needs of infants/kōhungahunga, children/tamariki, young people/rangatahi and their whānau. Saying that clinicians “need to collaborate” is not good enough when there needs to be processes and opportunities that facilitate collaboration and shared care.

### **2.3. What could be Done Better?**

*What Are Your Ideas About What Could Be Done Better Or Differently To Improve Mental Health And Wellbeing In New Zealand? What Could Be Done Better Or Differently To Prevent Addiction From Occurring? What Could Be Done Better Or Differently To Prevent People Taking Their Own Lives And Support Those Affected By Suicide? How Could Support Be Better Provided To Those Who Need It?*

Children’s/tamariki physical, development and mental health are inexplicably interlinked, yet this is not reflected in the provision of service to infants/kōhungahunga, children/tamariki or young people/rangatahi in Aotearoa New Zealand as outlined above. The following are recommendations to improve the mental health and wellbeing in Aotearoa New Zealand including the prevention of addiction and prevention of suicide. These recommendations are based on clinician feedback as well as national and international guidelines.

#### **2.3.1. Instigate a centralised triage system for mental health concerns at the primary care level with clear and consistent referral criteria across the country.**

Effective identification and triage to a range of mental health services is critical for managing demand (Mental Health Commission, 2012, p. 20). Users of mental health services often move between different primary and specialised health and care services, depending on their current concern, and this often leads to fragmentation of care, falling through gaps, or bottle necks being caused (Ådnanes & Steihaug, 2013; Joint Commissioning Panel for Mental Health, 2011). Complicating matters within Aotearoa New Zealand is that every District Health Board manages their child health services differently; for example, in some District Health Board’s child development services are integrated into mental health services, whereas others operate independent of each other requiring separate referrals with differing referral criteria. Paediatric medical services also operate independently. This means that services are unable to address complexities where several problems coexist.

To reduce inequities and ensure that the mental health needs of infant/kōhungahunga, children/tamariki and young people/rangatahi are met there needs to be clear and consistent pathways with agreed referral criteria and processes (Joint Commissioning Panel for Mental Health, 2011) across services and District Health Board’s. As stated by the Health and Disability Commission (2018) “overly restrictive criteria for acceptance into services will mean that many young people will miss out on early intervention” (p. 87) and distinguishing between behavioural and mental health needs can be artificial. Although many specialist mental health services within Aotearoa New Zealand have “single points of entry” these still can result in confusion for referrers and families/whānau, particularly if they do not meet “criteria”. Regardless of whether individuals or family members approach an individual or an organisation they need to be supported to get the help and support required.

Triage for mental health needs to be part of a network of services where there are opportunities for collaboration between primary and secondary care and advice and support can be sought from each other. There needs to be close working links between all aspects of health services (physical, developmental, and mental health) to facilitate easy, smooth transfer between the different services, as well as joint-working (Joint Commissioning Panel for Mental Health, 2011).

Effective triage and care planning can reduce the need for more costly services by preventing escalation of mental health difficulties.

### **2.3.2. Instigate the recommendations from the 2010 Alcohol Law Reform.**

Alcohol has the potential to cause serious harm including suicide. The recommendations from the 2010 Law Commissions Report still stand.

The neurological damage that occurs when an unborn child is exposed to alcohol in utero is permanent and increases the risk of emotion and behavioural difficulties (Popova et al., 2018). Prevention continues to be the only way to minimise the impact of fetal alcohol spectrum disorder (FASD Working Group, 2016).

Over a third of young people/rangatahi from Aotearoa New Zealand engage in binge drinking (Fergusson & Boden, 2011). For young people/rangatahi research indicates that harm from alcohol use can be long-lasting with neurological impacts including difficulties with learning and memory, academic achievement, and mental health problems (Bava & Tapert, 2010). Additional consequences for young people/rangatahi of alcohol consumption include suicide, unprotected and unwanted sex, violence, assault, and road crashes (Fergusson & Boden, 2011). Suicide is also related to alcohol use (Norström & Rossow, 2016) and within Aotearoa New Zealand over half of youth suicides involve alcohol or illicit drug exposure (Gluckman, 2017).

The Law Reform report provides comprehensive evidence-based recommendations. With reference to our younger population recommendations that will benefit young people/rangatahi of Aotearoa New Zealand include raising the purchase age for alcohol, increasing the cost of alcohol, taxing alcohol and making it harder to access (Fergusson & Boden, 2011; New Zealand Law Commission, 2010).

### **2.3.3. Ensure education settings are providing evidence-based resiliency programmes and introducing a skills-based approach to emotion regulation and suicide prevention.**

A safe physical and emotional environment in schools is expected within Aotearoa New Zealand (Te Pou o Te Whakaaro Nui, 2013) and is recognised as being a protective factor for mental health particularly in Māori, including suicidal ideation and self-harm behaviour (Simpson et al., 2017). The Health curriculum is also based on Durie's (1994) Te Whare Tapa Whā model of health including taha wairua, taha hinengaro, taha tinana, and taha whānau; thus incorporating mental health (Ministry of Education, n.d.).

There needs to be readily accessible mental health support including the development of emotion regulation skills within all education settings across all ages including early childhood, primary school, and secondary school (Gluckman, 2017a). Health is only compulsory in the Aotearoa New Zealand curriculum up until Year 10; however, mental health challenges continue well after this. Mental health education and skills for mental health improvement needs to be explicit and integrated into the school curriculum at all levels. Senior students facing formal examinations and social pressures including transition to employment or tertiary education may not receive appropriate pastoral support about emotional wellbeing or mental health.

A number of programmes have been piloted or implemented in some schools within Aotearoa New Zealand through the Positive Behaviour for Learning initiative by the Ministry of Education (Ministry of Education, 2015) and some are also supported by the

Youth Primary Care Mental Health programme. Core principles of the initiative are that positive behaviour can be learnt and that environments can be changed to foster learning and increase student well-being.

One evaluated example of a resiliency programme is My FRIENDS Youth (Barrett, 2012a; 2012b) which has been available in some Aotearoa New Zealand schools since 2013 as a pilot programme (MacDonald, Bourke, Berg & Burgon, 2015). The focus on the programme is to build resilience and help young people/rangatahi cope with difficult and challenging situations. The My FRIENDS Youth is part of a suite of programmes endorsed by the World Health Organisation (2004). Originally developed in Australia, it has been introduced and positively evaluated in Australian schools.

In the evaluation of the Aotearoa New Zealand pilot, MacDonald et al. (2015) state that the My FRIENDS Youth can be successfully implemented within Aotearoa New Zealand secondary schools. The programme was perceived as being positive by both students and teachers; additionally, Māori and Pasifika students also supported the use of the programme and that they used strategies from the programme.

The fact that well evaluated and effective programs have only been offered as pilots without national roll out further creates disparities. These programmes need to be made available nationwide.

#### **2.3.4. Ensure all paediatric chronic health services have access to psychological support**

Children/tamariki and young people/rangatahi with chronic illnesses or life-limiting conditions are at higher risk than the general population for mental health problems including internalising and behavioural difficulties (Pinquart & Shen, 2011; Royal College of Psychiatrists, 2010). There are several factors that make a person with chronic illness vulnerable to developing mental health concerns, these include real or perceived threats to life, physical discomfort, treatment side effects, reduction in quality of life, disruptions in social and peer relationships, and multiple demands on the individual (regardless of age) and their family/whānau. Yet access to mental health support is very limited. Some paediatric chronic health services within Aotearoa New Zealand have limited access to psychological support, this however is not sufficient to meet the need.

Chronic health conditions, including diabetes, chronic fatigue, pain, epilepsy, cancer, inflammatory bowel disease, arthritis, and cystic fibrosis, can have profound social and emotional consequences and can result in mental health problems which then impede management of physical health and increase mortality rates (Pinquart & Shen, 2011; Royal College of Psychiatrists, 2010). Conversely, mental health can impact social and cognitive function and decrease energy levels, which can negatively impact the adoption of health-promoting behaviours (Royal College of Psychiatrists, 2010), which are needed for effective management of any health condition.

Recognising the interactions between psychological factors and physical functioning is critical to positive health outcomes for children. Integrated health care has long been advocated for in chronic health and is defined as “a continuum of the extent to which mental health services are interwoven in the medical management of a child’s chronic illness” (Walders & Drotar, 1999, p. 119). Additionally, a goal of an integrated system is to facilitate communication and collaboration which is deemed a necessary component of providing optimal care.

Chronic illness does not just impact on the child/tamaiti or young person/rangatahi. Research has found that near 60% of parents report clinically significant depressive symptoms and 60% report clinically significant anxiety in the weeks following their child's diagnosis of type 1 diabetes (Streisand et al., 2008). Children and young people also report high levels of psychological distress at the time of diagnosis including symptoms of depression, anxiety, and social disruptions (Grey et al., 1995).

There is clear evidence that psychological support can have a major difference to the lives of people with chronic illness reducing morbidity and mortality and reducing the impact of illness on the child/tamaiti, young person/rangatahi and his/her whānau (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015; Delamater Guzman, & Aparicio, 2017; Eccleston, Fisher, Law, Bartlett & Palermo, 2015). Social and economic benefits of integrating emotional and psychological care with chronic health care have also been evidenced by the United Kingdom National Health Service Confederation (2012).

As stated by Bennett, Shafran, Coughtrey, Walker, & Heyman, (2015); it is inequitable that children who are already disadvantaged by their physical illnesses are not able to access appropriate mental health services (p. 308).

### **2.3.5. Introduce psychological resource in all paediatric medical clinics for the purposes of mental health assessment and interventions.**

A diagnosis of any medical condition during infancy, childhood, and adolescence can cause significant disruption to normal developmental processes which in turn increase the risk of emotional distress and mental health problems. Children/tamariki with medical conditions have an increased risk of adjustment difficulties, including emotional and behavioral concerns. A child's/tamaiti self-concept is also impacted (Lavigne & Faier-Routman, 1992).

Many children/tamariki or young people/rangatahi present to paediatric medical services with physical symptoms that are unexplained by a physical illness or disorder (Cottrell, 2016). Common symptoms reported are headache, abdominal pain, fatigue, swallowing difficulties, feeding difficulties, seizures, and motor weakness (Andresen et al., 2011; Ani, Reading, Lynn, Forlee, & Garralda, 2012). These "medically unexplained symptoms" often result in children/tamariki and young people/rangatahi moving between medical and mental health services, causing further distress to the individual and his/her family/whānau as well as costing the health system through hospital admissions and unnecessary medical procedures. It is now commonly accepted that there is an interaction between biological, psychological and social factors in the cause of medically unexplained symptoms, yet this is not reflected in the availability of interventions. Psychological interventions incorporating family/whānau have demonstrated to be effective in reducing both symptoms and emotional distress (McAllister, Markham, Coughtrey, & Heyman, 2017). It is important that interventions occur in childhood as anxiety, depression, and behavioural disorders are all linked with medically unexplained symptoms both in childhood and further in to adulthood (McAllister et al., 2017).

The transition process for children/tamariki to adult/pakeke health services is a challenging one, particularly as they often are also facing moves from education to employment and from the family environment to independent living. The process should be holistic in nature to address all of person's needs. Many health services transition their children/tamariki or young people/rangatahi at different ages dependent on the services available locally. Despite most health services desiring a smooth transition, the child/tamaiti or young person/rangatahi can be lost to follow up. This increases the risk of negative health outcomes including mental health concerns as

well as mortality and morbidity (Gray, Schaefer, Resmini-Rawlinson, & Wagoner, 2018).

### **2.3.6. Ensure national consistency in the provision of timely and effective care to infants and parents.**

There is a need for more resources to support mothers, fathers, and whānau early on. Adverse conditions in early life can have life-long consequences for health and wellbeing (Ministry of Health, 2015; New Zealand College of Public Health, 2017). The importance of the first 1000 days is compelling. A child's/tamaiti experiences during the first 1000 days are important and pervasive and there is strong evidence that that adult wellbeing depends on a healthy start to life (Moore, Arefadib, Deery, Keyes, & West, 2017). The Growing Up in New Zealand longitudinal study (Morton et al., 2014), has shown that Māori & Pasifika infants/kōhungahunga are exposed to a greater number of risk factors than New Zealand European or Asian children, further highlighting inequities. Exposure to these risk factors also means that infant/kōhungahunga will experience poor health outcomes during their first 1000 days. Providing increased access to mental health and social support services during pregnancy and early years is vital to support healthy pre and postnatal development. There is clear evidence that relationships between infants/ kōhungahunga and their caregivers in the first three years of life and of their impact on physical and mental health outcomes (Ministry of Health, 2015).

As highlighted in the “Healthy Beginnings” document by Ministry of Health (2011) research has established the importance of having effective interventions for infants and parents with self-regulation difficulties (emotional or behavioural), attachment problems, and mental health or substance use disorders. Additionally, services need to focus on the triadic relationship between the mother/māmā, father/pāpā, and infant/kōhungahunga as well as including other relationships within the whānau (p, 24).

For those parents who have mental health and/or addiction issues face additional challenges alongside that of raising a baby/pēpē. There is strong evidence that interventions with these families can prevent mental health issues and reduce the burden of mental health and addiction for future generations (Beardslee, Chien, & Bell, 2011; Ministry of Health, 2015).

There needs to be appropriate infrastructure around services to ensure that clinicians are appropriately trained and skilled to provide the specialist perinatal and infant mental health care. There also needs to be support for frontline workers working with vulnerable parents and infants/ kōhungahunga as this is often the first point of contact for whānau.

### **2.3.7. Increase accessibility to parenting programmes for all areas of the country.**

Behaviour difficulties in children are a significant risk factor for mental health difficulties, suicidal behaviour, substance use, violence, and physical health problems into adolescence and adulthood (Fergusson, Horwood, & Ridder, 2005; Fergusson, Boden, & Hayne, 2011). There is also increased prevalence rate in Māori children/tamariki (Fergusson et al., 2011). There are obvious implications for the health, social, education, and justice systems.

Evidence based interventions need to be introduced early in the life of a child/tamaiti and also target children/tamariki and families/whānau with identified risk factors for developing serious conduct problems (Church et al., 2007; Lees & Fergusson, 2015). To support this, there is strong evidence that early intervention programmes that focus

on the improvement of parenting practice and the enhancement of effective parenting promotes prosocial behaviour and thus reduces behavioural difficulties and future conduct problems (Michelson, Davenport, Dretzke, Barlow, & Day, 2013). Interventions that improve family/whānau interactions and quality of parenting being provided also can lessen the risk of harm and adverse outcomes for children (Ministry of Health, 2015).

Two programmes that have been evaluated positively for the Aotearoa New Zealand context include Triple P (Sanders, 1999) and Incredible Years (Webster-Stratton, Reid, & Hammond, 2004). Both programmes are designed to prevent and treat behaviour problems in children. Additionally, they have both been tailored for Aotearoa New Zealand context, with specific adaptations for Māori whānau, including the acknowledgement of Te Ao Māori and the engagement of whānau (The University of Auckland, 2017; Anstiss, 2012).

Unfortunately, these programmes are not readily accessible across the country or come with substantial cost and wait-times creating inequities for children/tamariki and families/whānau.

### **2.3.8. Develop nationwide policies on the reduction of bullying and implementation of anti-bullying programmes.**

A recent report from the Organisation for Economic Cooperation and Development (2017) indicates that Aotearoa New Zealand has the second highest rates of bullying in the OECD. Bullying is also an identified risk factor for mental health difficulties including suicide. This is of significant concern given Aotearoa New Zealand also has some of the highest rates of suicide in young people. Aotearoa New Zealand research (Gibb, Horwood & Fergusson, 2011) indicate higher mental health difficulties and adjustment problems in late adolescence and adulthood for those people who either bullied or were victims of bullying between the ages of 7 and 15 years. Digital media and cyber-bullying are also identified as having negative social, health, and academic consequences, with research indicating stronger impact on suicidal ideation than in-person bullying (Gardella, Fisher, & Teurbe-Tolon, 2017; van Geel, Vedder, & Tanilon, 2014). This is of significant relevance to children/tamariki and young people/rangatahi.

A protective factor against suicide is a supportive school environment (Simpson et al., 2017), thus the value of having school-based programmes targeting bullying. Evidence suggests that to effectively address bullying, a whole-school approach is required. This allows for bullying to be targeted a multiple levels, and also addresses the systemic nature of bullying (Murachver, 2011; Boyd & Barwick, 2011). This means involvement with the “whole school community”, involving students, teachers, parents, family/whānau as well as professionals from education, welfare, and health services.

Commitment from all parties has been identified as critical to the success of a whole-school approach (Boyd & Barwick, 2011), thus the need for nationwide policies.

### **2.3.9. Ensure that culturally appropriate models of care are implemented for Māori and Pasifika people that take a holistic view of health, thus incorporating Taha Tinana, Taha Hinengaro, Taha Whānau, and Taha Wairua.**

Mental health disorders are more common in Māori and Pasifika people (Oakley Browne, 2006). Māori children/tamariki and young people/rangatahi are more likely to be seen by mental health services (Simpson et al., 2017) and have higher suicide rates than their non-Māori peers. Māori and Pasifika people are also more highly represented

in paediatric medical clinics. It stands to reason then that Māori and Pasifika people with physical health concerns are even more at risk of mental health concerns.

The current health system focuses on the individual, which is a Pākehā/Western model of health and increases the inequities that we see in health. This does not necessarily work for Māori or Pasifika cultures. Research clearly indicates that Māori need services that are holistic in nature, come from a Māori world view, and particularly include whānau (Durie, 2001; Rochford and Signal, 2009).

### **2.3.10. Invest in an early intervention approach to emotional and behavioural difficulties to reduce development of mental health disorders and reduce the risk of suicide.**

Adverse events in the early years of a person's life and poor relationships with caregivers place a person at increased risk for a range of mental health and general health problems both in the short and longer term (Fergusson et al., 1995; Winston & Chicot, 2016). There is strong evidence that intervening effectively and early with infants, children and young people works and can avert serious issues in the future and is highly cost-effective (Wouldes, Merry, & Guy, 2011). Early intervention focusing on availability of resources, including social support and mental health services, building attachment, and enriching development will help support resilience in neurological systems that serve to protect against future health and mental health issues.

The Youth Primary Mental Health Care (YPMHC) initiative was introduced in 2012 for young people/rangatahi aged between 12 and 19 years in Aotearoa New Zealand (Ministry of Health, 2012) yet there continues to be inconsistencies across the country about access and quality. Providers of youth primary mental health services in all regions should be made readily available with clear and transparent referral processes.

Whānau Ora models of health practice strongly support Māori and Pasifika cultural values. The Whānau Ora model also highlights the importance of family/whānau when looking at the mental health needs of infants/kōhungahunga, children/tamariki, young people/rangatahi. Taking an individualised approach to mental health needs can be detrimental to all and increase the risk of further mental health challenges.

The Whānau Ora model of practice has been implemented in some primary care services, where health care is coordinated to comprehensively address the health and wellbeing needs of the entire whanau (Te Puni Kōkiri, 2017). The principles underpinning the Whānau Ora model should be applied in practice across all primary care practices rather than carrying out more pilot projects.

Collings et al. (2010) highlights that District Health Board's and Primary Health Organisation's should critically reflect within their own organizations and among primary care teams the effectiveness of primary mental health care.

Early intervention for emotional and behavioural difficulties through primary care can prevent mild cases from escalating at a later stage. For those infant/kōhungahunga and children/tamariki (under 12 years) access to primary mental health care is only possible if an infant/kōhungahunga, child/tamaiti, young person/rangatahi is in care and thus seen through the Gateway programme with Oranga Tamariki funding. The primary mental health programme needs to be extended to allow for psychology and counselling services for those aged 0 - 12 years and their family/whānau. Very rarely is medication used in this age group for mental health concerns and thus "talking therapy" is the recommended option.

An ongoing cause for concern is Aotearoa New Zealand's high youth suicide rate relative to other developed countries (UNICEF Office of Research, 2017). Māori young people/rangatahi are also particularly at risk. Youth suicide is more than simply a mental health issue, it is closely linked with psychiatric disorder, substance use, behavioural problems, and family/whānau, social and educational disadvantage (Skegg, 2011). Suicide among young people/rangatahi often represents a lack of resilience, diminished self-control, increased impulsivity, and exaggerated emotional responses in the face of inevitable stressors. Many young people have suicidal thoughts and some commit self-harm. For young people now, the world is very different from even a generation ago and continues to rapidly change (Gluckman, 2017).

Gluckman's (2017) discussion paper on youth suicide makes a number of key points that require careful consideration. The focus must also include an emphasis on primary prevention starting from very early in life. This means promoting resilience and emotion regulation skills to cope with the inevitable exposure to emotional stresses and building self-control skills in early childhood and primary school years, by using known approaches (Gluckman, 2017). Steps to remediate Aotearoa New Zealand's high rate of youth suicide also means promoting mental health awareness and ensuring that there are competent, well-trained, and fully functional adult- and peer-support systems in secondary schools (Gluckman, 2017). This also must be backed up by a capacity to find and rapidly support those children and young adults who are in mental distress and ensuring that the needed interventions and therapy are early and effective.

### **2.3.11. Implement national guidelines on the mental health assessment and support of transgender children and young people across all District Health Boards.**

Higher rates of mental health concerns are reported by transgender people, both internationally (Dhejne, van Vlerken, Heylens, & Arcelus, 2016; Strauss et al., 2017) and nationally (Clark et al., 2014). Specifically, the Aotearoa New Zealand Youth '12 study identified significant disparities in depression symptoms as well as suicide attempts. The mental health concerns may not be inherently related to being transgender, but also because of the stress associated with being a member of a minority group that faces a lot of stigma (Couch et al., 2007). It is also more common for individuals on the autism spectrum to identify as being transgender, which creates a further layer of complexity when providing holistic health care (Strang et al., 2018). This highlights the specialised need for mental health support for transgender children/tamariki and young people/rangatahi across the range of mental health presentations.

Family/whānau members also experience psychological distress when their child/tamaiti discloses that they are transgender (Strauss et al., 2017), and also require mental health support. Family/whānau support is critical to a transgender child/tamaiti and young person/rangatahi having healthy emotional wellbeing (Strauss et al., 2017). Currently within Aotearoa New Zealand access to mental health support for transgender children/tamariki and young people/rangatahi is limited, with the wider Auckland region having the only comprehensive pathway for gender diverse and transgender young people; although still lacking any dedicated psychological or psychiatric care.

These are significant inequities in service for transgender children/tamariki and young people/rangatahi. Given the high rates of mental health concerns in the transgender population, **all** transgender children/tamariki and young people/rangatahi and their family/whānau should have access to mental health support at both the primary and secondary care level. This should include a holistic psychosocial assessment to identify

any mental health concerns so that these can be appropriately addressed and incorporated into a holistic care plan.

### **2.3.12. Introduce nationwide systems that allow for the identification and management of neurodevelopmental impairments and neurodisability.**

Fetal Alcohol Spectrum Disorder, Speech Language Disorders (including specific learning disabilities), and Autism Spectrum Disorders are all complex presentations that require specialist support and early identification to reduce the risk of associated mental health concerns.

Children/tamariki and young people/rangatahi with Fetal Alcohol Spectrum Disorder have learning and behavioural problems which can be severe and difficult to manage (Streissguth et al., 2004). Many continue to have significant challenges into adulthood. In Aotearoa New Zealand most people with FASD are undiagnosed (FASD Working Group, 2016), in part due to the lack of appropriate multidisciplinary assessment services (medical doctor and psychologist). Currently, there are very few services available in Aotearoa New Zealand offering this service (Gibbs & Sherwood, 2017). Children/tamariki with FASD stand the best chance of a positive outcome if they are assessed and diagnosed before the age of 6 years (Streissguth et al., 2004) allowing for early intervention.

The Action Plan for Fetal Alcohol Spectrum Disorder (FASD Working Group 2016) is a starting point for the implementation of a nationwide approach and provides clear recommendations to ensure the appropriate prevention, assessment, and management of people with FASD.

Speech, language and communication needs are often precursors to mental health concerns and under recognised in children with mental distress or mental health concerns. Research from the United Kingdom indicates that close to 80% of children with emotional and behavioural concerns have significant language deficits (Hollo, Wehby, & Oliver, 2014; Lindsay & Dockrell, 2012). Just over one third of children/tamariki with learning disabilities also have a diagnosable mental health disorder (Emerson and Hatton, 2007). Specific learning disabilities (e.g., dyslexia) require specialist assessment, however, access to these is limited within the education system and is more commonly carried out by private organisations at the personal cost of the family/whānau.

For these children and young people interventions for mental distress or mental health are less likely to be effective unless the speech, language, and communication needs are integrated into the intervention provided.

There are relatively clear assessment frameworks for individuals with Autism Spectrum Disorders (Ministries of Health and Education, 2016). However, assessment pathways do vary by region and in some regions previous unilateral decisions by mental health relating to referral pathways have created significant challenges for paediatrics.

Mental health comorbidities are very common with Autism Spectrum Disorders and pose challenges to family/whānau as well as with health professionals (Mannion, Brahm, & Leader, 2014). Management encompasses a range of agencies including mental health, disability support services, education services and behaviour support agencies. The challenges inherent in managing individuals with significant disability and externalising behaviour is significant and the integration and collaboration between services and sectors often does not facilitate this. The availability of specialist

emotional and behavioural support needs to be increased to ensure that emotional wellbeing of these children/tamariki and young people/rangatahi. As the presenting issue is typically “behaviour challenges” accessing mental health services can at times be challenging and options around crisis management for these individuals are limited.

Mental health clinicians need to be supported to develop the skills and expertise to manage and treat common mental health comorbidities alongside developmental and educational services.

### **2.3.13. Instigate the recommendations of the Office of the Children’s Commissioner to reduce child poverty.**

Inequities in society are clearly identified as being a risk for poorer mental health and addiction outcomes (Lipman & Boyle, 2008; Pascoe et al., 2016) including suicide. This has been demonstrated by longitudinal studies within Aotearoa New Zealand (Fergusson, McLeod, & Horwood, 2015; Poulton et al., 2002). Māori and Pasifika are over-represented by child poverty (Perry, 2016). There is also a converse relationship, where mental health problems in childhood contributes to on-going poverty into adulthood (Boden et al., 2013; Welch & Wilson, 2010). Identified aspects of child poverty impacting mental health of infants/kōhungahunga, children/tamariki, young people/rangatahi include but are not restricted to inadequate housing, poor nutrition, parenting under stress, adverse events, poor neighbourhoods, and limited access to mental health services (Gibson et al., 2017). As outlined in the literature review by the Child Poverty Action Group and New Zealand Psychological Society (Gibson et al., 2017, p. 3):

*“incidence of mental health problems throughout the lifespan could be reduced through addressing the causes of child poverty and associated factors. Any mental health strategy for children should sit alongside a comprehensive programme to alleviate poverty.”*

Unless child poverty is addressed then change to mental health outcomes for New Zealanders are unlikely. The 78 recommendations made by the Children’s Commissioner’s Expert Advisory Group on Solutions to Child Poverty (2012) are key to ensuring to positive health outcomes for infants/kōhungahunga, children/tamariki, and young people/rangatahi of Aotearoa New Zealand.

### **2.4. From Your Point of View, What Sort of Society Would be Best for the Mental Health of All Our People?**

*If You Could Refresh How The System In Aotearoa Promotes Positive Mental Wellbeing, And Prevents, Identifies And Responds To Mental Health And Addiction Challenges, Including Suicide, What Would That System Look Like, How Would It Be Different From What We Have Today, Where Would You Start, And Where Would You Focus Your Efforts?*

If as a nation we are to improve mental health and wellbeing in Aotearoa New Zealand, we need to take a population approach and look at prevention and early intervention strategies. Research is clearly indicating that this approach works.

Within Aotearoa New Zealand specialist medical and mental health services function largely independently of each other and there are 20 District Health Board’s setting their own funding priorities. This undermines the provision of comprehensive, consistent and integrated mental health and physical health care. Closer alignment of physical and mental health services with clear accountabilities is required at a national level. Services need to work together with integrated care pathways to best meet the needs of infants/kōhungahunga, children/tamariki, young people/rangatahi and their whānau. An

integrated system also facilitates communication and collaboration which is deemed a necessary component of providing optimal care. This also aids in addressing the issue of physical health care being overlooked in mental health services and mental health needs not adequately being managed in physical health services.

Without addressing the mental health concerns of our infants/kōhungahunga, children/tamariki, and young people/rangatahi as well as their whānau, the implications will continue to be significant. These will include increased physical and mental health care use as well as individual, family/whānau, and societal costs.

## **2.5. Anything Else You Want to Tell Us**

*Is There Anything Else You Want The Inquiry To Know?*

Thank you for this opportunity to provide feedback in meeting the mental health needs of our infants/kōhungahunga, children/tamariki, and young people/rangatahi and their whānau.

We are happy to provide any further information and to work together in improving the mental health care in Aotearoa New Zealand.

## **3. Technical Matters**

As was requested in the Terms of Reference document, the following comments have been collated based on the suggested headings by the Inquiry Panel.

### **3.1. Funding**

As has been highlighted there needs to a nation-wide funding model for all levels of mental health so that you get the same services across the country rather than dependent on post-code. This is made particularly complicated by having 20 District Health Boards who set their own funding priorities.

High risk areas such as those with high numbers of Māori and Pasifika children/tamariki and young people/rangatahi and those living in rural areas should have additional dedicated funding.

Funding to address the mental health needs of Aotearoa New Zealand's youngest needs to be integrated between health, education, and social services.

### **3.2. Governance and Accountability**

There needs to be transparent and clear "clinical" governance across primary and secondary mental health care. A transparent and robust monitoring and reporting framework is established so we can better measure and manage mental health needs of Aotearoa New Zealand. This needs to include auditing to ensure that funding is being applied appropriately and contracts reviewable rather than permanent.

There needs to be an infrastructure at the primary mental health level on how to deal with children/tamariki and young people/rangatahi on where to seek support and how to prevent escalation of mental health distress or else rate of youth suicide is unlikely to change.

### **3.3. Workforce Planning**

Psychology service should be available and accessible in all paediatric medicine clinics. This will aid in identification of mental health concerns, formulation of needs, and then appropriate planning for intervention.

Psychologists should be an integral part of Gateway assessments to ensure comprehensive mental health screening and triaging of those most at risk.

There are varying levels of experience and training in primary and secondary mental health across clinicians and different services. This impacts on access to competent and experienced staff and creates marked discrepancies on service delivery depending on the person and the profession involved.

Acknowledging that GP's, Oranga Tamariki social workers, and school staff such as school guidance counsellors, RTLB's, and SENCO's are dedicated to the work they do and the children/tamariki and young people/rangatahi that they serve. They are not provided however with the appropriate levels of training, support, and supervision to deal with mental health concerns, including extreme behavioural difficulties, deliberate self-harm and suicidal ideation.

School counsellors should be readily accessible in all intermediate and secondary schools across the country.

### **3.4. Data Collection**

It is very difficult to collect data unless there is uniformity and service is accessible to all.

### **3.5. Design and Delivery of Services**

Integrated triage for primary and secondary mental health services so that service is provided based on need and is seamless. There are very few services available for infants/kōhungahunga or children/tamariki at the primary mental health level. This results in over-referrals to secondary mental health services. Just as with physical health if there was not primary health service, hospital paediatric medicine services and emergency departments would be overloaded with common ailments and minor illnesses.

The development of pathways using a traffic light system (similar to the child protection guide) where green, amber and red levels are divided into level of risk for harm and have prescribed pathways for action attached.

Develop "One Stop Shops" or "Health Hubs" in as many towns as possible based on agreed criteria (youth population, identified need). These clinics can bring together many services and agencies that meet the needs of young people/rangatahi such as nurse-led clinics, psychological help and therapy, support with benefits and youth workers. These hubs should be in a venue that is youth friendly, providing access to information, primary care and community health services as a minimum. Some of the highest risk areas do not have ready access to Family Planning Services without significant travel required.

### **3.6. How to Improve Coordination between the Health Sector and Other Areas.**

Have a shared electronic record between services for infants/kōhungahunga, children/tamariki, young people/rangatahi that can be accessed irrespective of where the individual and whānau live.

Paediatric medicine and child and adolescent mental health services should be co-located or easily accessible. This would allow for more easier communication between clinicians and also allow for coordination of appointments reducing stress and pressure for families and whānau.

Have a centralised triage system with clear referral processes for primary and secondary mental health issues.

**Maimoatia ngā pihinga, hei orange mō te wao**

*Cherish the seedlings, for the wellbeing of the forest*

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