Contents

Editorial: The Green Paper on Vulnerable Children   3
News from the Office of the Children’s Commissioner  5
Towards better use of evidence in policy formation  7
Child abuse and neglect in New Zealand  10
Challenges to achieving equal and equitable outcomes in education for children  12
Addressing Inequalities in child health  15
Youth health in New Zealand  17
Safe as houses?  19
Tamariki Maori  21
New Zealand Pacific children  24
Children’s voices: shaping the future, by hearing them in the present  28
Strong partnerships to protect children  30
Universal and targeted services for children  32
Has the time come for a Children’s Act?  35
Information sharing and monitoring  39
Information, resources, conferences  43

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Please note: The opinions expressed by contributing writers for Children may be the opinion of the writer and/or their organisation. These opinions are not necessarily the views of the Children’s Commissioner.
This edition of “Children” takes as its focus the Government’s Green Paper on vulnerable children. A Green Paper is a “preliminary report of government proposals published to stimulate discussion”. Governments usually ask public servants to write a Green Paper in-house, release it for discussion, collate submissions and use these to inform policy. Green Papers are usually followed by a White Paper, which is a statement of government policy. A Green Paper allows a government to seek ideas to address an issue, and also to assess the mood of the electorate and potential political allies for policies that may be controversial or unpopular.

The New Zealand Government’s Green Paper on Vulnerable Children notes that while most children in New Zealand do well most of the time, a sizeable proportion (the paper estimates 15 percent) have significant risk factors and poor outcomes. The paper notes the Government’s existing investments for children, that children are primarily the responsibility of families and whanau, and the need for all of society to take responsibility for children. It states the Government’s vision as “Every child thrives, belongs and achieves”, reminds us of our commitment to children through the United Nations Convention on the Rights of the Child and notes the increasing evidence base on the importance of the early years.

The Green Paper proposes action in four areas; sharing responsibility, showing leadership, making child-centred policy changes and making child-centred practice changes. Within each area, suggestions are made and questions are asked to prompt feedback. The questions target real and important issues such as how much monitoring and supervision we would be prepared to allow to keep vulnerable children safe and what we are prepared to give up in order to invest in vulnerable children.

In this edition of “Children”, I have asked prominent New Zealand experts on children’s issues for brief papers on what they believe should be in the White Paper. The edition is in two sections; the first on problems and issues, the second on solutions. All papers demonstrate both the scientific rigour of some of our top minds, and their commitment to our children. I am very grateful to all those who have contributed.

From talking to politicians from both sides I believe there is now a shared understanding of the vulnerability of children and a consensus that we need to invest in the early years. It is not yet clear how government will choose services to invest in or how to decide what to stop funding in order to invest. There is some anxiety about how much monitoring and supervision the electorate will tolerate and uncertainty about the overarching framework for the government’s investment.

I believe New Zealand should have a Children’s Act and a Children’s Action Plan that commits government and the public service to specific and measurable reductions in child poverty and reducing inequalities in health and educational outcomes. I agree with the OECD that there should be an independent, broad-based annual report on the state of the nation’s children’s health and wellbeing, and progress on the agreed targets. I agree with Infometrics and Every Child Counts that New Zealand needs a consensus based on an investment approach to improving child wellbeing leading to a long-term funding commitment that is not subject to adversarial politics. I agree we need a commitment to investment based on the best evidence, research, evaluating and monitoring to ensure the investment achieves the greatest possible impact, including disinvestment from non-performing programmes and services. And I agree we need to fundamentally examine our tax and welfare systems to try to find a modern solution to the complex issue of child poverty.

Please take time to read the papers and consider how you can contribute to the Green Paper debate. You could encourage your organisation to make a submission, or participate in one of the many community hui and fono around the country, or send a personal submission via the Green Paper website [www.childrensactionplan.govt.nz](http://www.childrensactionplan.govt.nz).

I believe that the Green Paper on Vulnerable Children is a once-in-a-lifetime opportunity for New Zealanders to let government know just how much we value children. Kiwis love children, but we currently invest a shockingly small amount in them in comparison to other OECD countries and our investment is poorly targeted. We could invest more and differently, and we would reap the benefits for generations to come. This edition of Children describes some ways in which we might do this.

Dr Russell Wills
Children’s Commissioner
A poem by Karen McKechnie
Office of the Children’s Commissioner

When circumstances reach a point
And the facts are clearly seen
Then the way for change should be written down
And the paper should be Green

And where once the word referred to
A thing unlearned….naive
Now it means a fresh approach
With roots that will not cleave

It is easy to dismiss the talk
The meetings and discussion
But this united front has great intent
And will create a repercussion

The lesson in the storybooks
About the small red hen
Typifies how we became
Only interested in the end

To make the perfect loaf of bread
She called out far and wide
For each involved to do their part
To make the bread with pride
But it seemed to all the farmyard
If they just sat by and waited
Someone else would do the work
(How’s that for ignorance inflated)

There’s just one thing we need to grasp
So simple in its truth
The middle and the end of life
Are nothing without youth

If we don’t step up and grasp this chance
This paper of great portent
It won’t just be the economy
And our integrity that’s spent

It will be this sporting nation
That loses something dear
By dropping the most important ball
And not really playing fair

We have the opportunity
To take the path unseen
To set a brand new standard
In this paper we call Green
Submissions now are called for
Our children should not wait
For the vigilance that they deserve
And a future that is great
Introducing the Children’s Commissioner

On 1 July 2011, Dr Russell Wills began a five-year term as Children’s Commissioner, combining the Commissioner role on a part-time basis with his paediatric work. Dr Wills is a community and general paediatrician, and Head of Paediatrics at Hawke’s Bay District Health Board in Hastings. He attended Lindisfarne College in Hastings, trained at the University of Otago Medical School in Dunedin and Christchurch and was a house surgeon in Napier in 1998-99. He began his paediatric training as a senior house officer in Winchester and Southampton in England in 1990-92. Registrar training was in Newcastle between 1993-1996. He completed his subspecialty training in community paediatrics and Master of Public Health degree in Brisbane in 1997 and 1998.

From 1999-mid 2001 Dr Wills was National Paediatrician for Plunket, a senior lecturer at the Wellington School of Medicine and a Community Paediatrician at Wellington Hospital. He has been a general and community paediatrician at the Hawke’s Bay Hospital in Hastings since August 2001 and is currently Head of Department.

Dr Wills’ clinical interests are in general paediatrics, child protection and children with severe behaviour disturbance. He sees many children with autism, ADHD, foetal alcohol effects and the behavioural and developmental effects of abuse and neglect. At HBDHB he leads the Family Violence Intervention Programme, Before-School Check Programme and Child and Youth Mortality Review Committee. He is also involved in the Ministry of Education Positive Behaviour for Learning Programme implementation, Incredible Years strategic group and the Youth to Men governance group in Hawke’s Bay. He has co-authored papers on drug allergy in cystic fibrosis, detection of family violence and the Before-School Check and presented at many national and international medical conferences on these topics. He has held leadership roles in community paediatrics with the Paediatric Society of New Zealand and the Royal Australasian College of Physicians, and has contributed to national guidelines and projects on autism, family violence, child abuse and medical aspects of children in Child, Youth and Family care. He is married with two adolescent sons.

Introducing the Deputy Children’s Commissioner

Dr Jo Cribb started work as Deputy Commissioner on 5 September 2011. She came to the Office from the Families Commission where she was Group Manager – Policy and Research. Jo’s background is in social policy and research. Jo has a PhD and postgraduate qualifications from the University of Cambridge, UK and the University of Canterbury. She was recently seconded from her role with the Families Commission to lead the development of the Green Paper for Vulnerable Children. Jo is married with two children.

More emphasis on monitoring

One of the Office’s statutory roles is to monitor services delivered to children and young people under the Children, Young Persons and Their Families Act 1989. In the main, this has meant the Office has had a focus on Child, Youth and Family, visiting several of their sites and all of their residences every year. Visits to Child, Youth and Family sites include discussions with social workers, supervisors and managers and, importantly, a range of stakeholder groups who work alongside Child, Youth and Family. These include meetings with Police, DHBs, school principals, iwi groups, NGOs, Judges and lawyers and many others. Those we meet with have invaluable opinions and insights into the level of services being
delivered to children and young people in their area and help us form a view on what is going well and where the gaps are.

The Office is constantly looking at how to expand the scope and the depth of our monitoring work. With two dedicated staff concentrating on this role, we have achieved a great deal. But a decision has now been made to expand that small team to three and we have just welcomed our new senior advisor, Tom Ratima, into that role.

And a new appointment will be made to the health and disability role by late October.

**New YPRG are into their role**

Our new Young Peoples Reference Group (YPRG) members are well into their role. They participated in the national youth diversity forum in Hamilton on 21-22 August, run as part of the Human Rights Diversity Forum. The forum, now in its seventh year, is an opportunity for people involved in race relations, human rights and cultural diversity to come together to share ideas and good practice.

The YPRG then came to Wellington for the weekend of 2-4 September where they met with Office staff and worked on particular areas of interest to young people.

With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

**Advocacy work**

The Office’s other main role is to advocate for the best interests of children and young people. As well as giving advice at an individual case level, the Office takes every opportunity to make submissions to proposals for policy and legislative changes that affect children and young people. This is usually work led by the subject matter experts in the Office – the Principal Advisors – with input from their colleagues. The four Principal Advisors bring expert knowledge of areas of real importance to the best interests of children and young people – welfare, education, law and health and disability.

Our Principal Advisors are:

Dr Nicola Atwool – welfare

Dr Sarah Te One – education

John Hancock – law
Worldwide as governments have to deal with issues of great complexity, they are increasingly formalising the role of scientific advice in the policy formation process. Recognition has grown that in complex areas of policy formation, an unbiased perspective in generating the knowledge base is desirable if not essential.

Democratic governments make decisions and policy based on many inputs, including fiscal considerations, societal values, prevailing public views, and the ideals and vision of the government of the day. But underlying all of that is the observation that decisions made in the absence of informed background material are, by definition, made on the basis of belief and dogma and are less likely to be effective and less efficient and can entrench policies which may be of little value. Further, without evidence as to whether policies are working governments can become constrained by earlier policy decisions that are not easily reversible because there may be a popular or political perception that they are effective when in fact they are not. As we stated in our report on adolescence “Improving the transition”

“Our research suggests that many programmes have been introduced albeit with good intent, that are unlikely to succeed as they are not supported by the evidence base, whereas other approaches likely to be effective have not been implemented. A key challenge is to ensure that all programmes are appropriately monitored to ensure that they are effective and cost effective within the New Zealand context, allowing better use of scarce resources to support our young people”.

But in areas of complex science, science cannot have all the answers and it is certainly not the role of scientific advice to therefore try and determine the policy agenda. Rather the role of evidence in policy formation is to provide an unbiased and relatively value-free (and I will explain what I mean by that later) summary of the issues from a scientific perspective. In general, except when asked on a very specific basis, scientific advice is not about specific recommendations. That is not the purpose of scientific advice, rather the importance of scientific advice is that it provides base knowledge on which the other perspectives need to be overlaid as policy is formed.

The way science is incorporated into policy is complex. There are at least three distinct elements which I shall address generically before making some brief comments of particular relevance to children:

Does science and knowledge have a privileged place in policy formation?

I define science as the process by which reliable knowledge and reduced uncertainty about the world are obtained by a set of disciplines of hypothesis generation, testing and challenging, evaluation, and reformation. It is this set of processes of validation that allows scientifically derived knowledge to sit within the policy framework in a different way to other claimed forms of knowledge. Other forms of knowledge which are not empirically based can only be derived from belief of one sort or another. One must be wary of decision-making processes that make assumptions but are not prepared to look at the knowledge base before decisions are made.

But science and knowledge alone do not make for policy. There are perfectly valid other components to policy formation and these can lead to quite different outcomes. Those other components include societal values, public opinion, affordability and diplomatic considerations and must also accommodate political processes.

Does the changing nature of science affect the way in which science advice is achieved?

We are in danger of underestimating how much the nature of science has changed; it used to be dominated by linear questions, those aimed for reductionist precision. For example, what is the speed of light, how old is the earth, how much weight will this bridge take, are birds descended from dinosaurs, what are the side effects of this medicine? As a result science was authoritative, definitive and largely accepted by a very different public. In general, science advice on such matters is issue-specific, linear and can be provided by an expert without an interlocutor.

But much science has undergone radical change. Science now increasingly deals with complex non-linear phenomena where certainty is not possible, there remain unknowns, and answers are defined in terms
of probabilities and levels of uncertainty. Science in that sense is no longer authoritarian although it is still capable of being authoritative. These are issues of high public concern and political complexity and indeed the very matters on which governments turn to science advisors. Typical examples include food security, the use of genetic modification, dealing with the aging population and of course climate change.

Such science is intimately linked to and intertwined with the values and concerns of the public and body politic. Values have always played a role in what and how scientists choose to study, in research ethics, in funding decisions although of course the process of obtaining the results and interpreting any set of observations must be value-free. But an additional factor now arises, as the philosopher of science Heather Douglas makes clear in her book *Science Policy and the Value Free Ideal*¹ and this is the issue of how much uncertainty is acceptable when deciding whether the science should form the basis of an action or policy. Such decisions are never value free. Values do not compete with or replace evidence, but determine the importance of inductive gaps left by the evidence.

Thus the key question becomes: When is a particular body of scientific work adequately “sound” to serve as the basis of policy? One must ask how much evidence is sufficient, how reliable are the studies underpinning the evidence? How much uncertainty is acceptable? What are the risks associated with an erroneous conclusion in either direction? Failure to recognise the implications of this responsibility has generated deep tensions. This kind of science has been given the name ‘post-normal science’ and is defined as the application of science to public issues where facts are uncertain, values in dispute, stakes high and decisions urgent.

Because of this intertwining of values with knowledge a further complexity arises. Science can become the proxy for a values debate which is essentially independent of the science. The most current example is the apparent debate about whether or not there is anthropogenic climate change. Most of that debate is really a proxy for a public and political values debate about economics and intergenerational equity. As scientists get drawn into such a debate, they can lose their role as unbiased advisors and risk loss of public trust. Complicating the matter, complex science is based on variable data and advocates for any one position may choose selectively from this to make a point. The potential for values, beliefs and science to thus become conflated is almost inevitable and the public and policy debate becomes confused.

In these matters of post-normal science the role of the science advisor as a communicator with both the policy maker and the public becomes critical. Science advisors must be explicit about the assumptions, limitations and uncertainties underlying the evidence and present technological options in ways that allow the full range of their possible benefits or adverse effects to be appreciated. Remember no science advisor is expert in everything they must advise on, indeed that is not their role. They must act as a broker between the science community and the policy framework. It is how that brokerage is conducted that is itself a key issue.
Roger Pielke in his book *The Honest Broker* distinguished between two kinds of advice about complex science – that of being the issues advocate and that of being the honest broker. The former is what it sounds like – the advice is proffered with the scientist having the goal of getting a specific outcome – and that is an inappropriate role for a person like myself. The honest broker on the other hand takes another approach. The evidence is summarised in a values-free way, in so far as that can be achieved.

The science advisor must be honest in admitting the limits of knowledge but also be informative about the implications of what is known and unknown. This must include definition of the limits of knowledge and where biases could exist in evaluating and defining the range of options that arise from the analysis.

The science advisor must also acknowledge that many decisions that governments have to make are developed in an environment of limited available information or where the use of science is unable to resolve competing policy options.

**How should science advice be incorporated into the New Zealand policy and political framework?**

This is the focus of my discussion paper *Towards better use of evidence in policy formation* which is available at [www.pmcsa.org.nz](http://www.pmcsa.org.nz). A key point is that the use of evidence and its formal inclusion into the policy framework is very variable across ministries. Often evidence is not considered in isolation as a base knowledge but the evidence is considered from the outset in a values conflated manner in that scientific advice is not sought independent of the end-user. This risks issues advocacy rather than issues brokerage. There is a need for protocols that establish the basis for scientific advice. Few departments have a person responsible and with the brief to act as science advisor and whose role is to ensure the quality and independence of scientific advice. Yet overseas this is becoming an essential part of policy frameworks. Government is a significant purchaser of research both through its funding agencies and directly from departments and it is important processes are created that ensure quality and useful information is obtained.

**Relevance to children**

This discussion is highly relevant to the issues faced by the Children’s Commissioner. The community is rightly concerned about the high morbidity for our young people. A large resource of public and voluntary effort is put into this sector; there is a multiplicity of programmes. Opinions and advocates abound. Yet too many NZ children do badly. This is an area where is it is obvious that a better evidence base and a better use of the evidence base is needed to separate what we know and do not know from what our opinions are. I am delighted that in preparing the Green paper on Vulnerable Children, the Minister had an independent scientific group look at its content from the point of view of being clear on what we know and do not know. It is important to identify the questions that are being asked and get the community’s input on them. These are questions such as the role of targeting resources disproportionately to the most vulnerable families. But whatever we do we need to be sure that we monitor any intervention or programme – for both its expected and unexpected effects. If we want to do better by our children we must use evidence to chart our way ahead.

**References**

By Dr Nicola Atwool, Principal Advisor, Office of the Children’s Commissioner

The Evidence

New Zealanders are painfully aware of our high rates of death from child abuse and many are familiar with the names of small children whose deaths have been highlighted in the media. However, these are the tip of the iceberg and the full extent of the challenge facing this country is not well understood. Not all deaths are given extensive media coverage and there are children who have disappeared without leaving an imprint on our collective conscience. Between 2000 and 2008 on average seven children died each year as a result of maltreatment. These numbers contribute to a very bleak picture. Between 2003 and 2008, 68 children and young people under the age of 19 years died as the result of assault. Eleven of these children were aged less than one year and 12 were aged between one and four. It is often said that our youngest children are our most vulnerable but this is not the whole picture. Thirty-two young people aged between 15 and 19 also died as a result of assault in the same time period. The major difference is that most of the infants will have been killed by a family member or person closely associated with the family whereas our young people fall victim to a wider group of assailants including peers. It is possible that our attitudes to these deaths are different because we think that young people may have contributed in some way to their death. Many, however, are simply in the wrong place at the wrong time and we should be just as concerned about preventing these deaths.

Although our concern is often focused on death many more children suffer intentional injury. During 2010 the rate for admission to hospital demonstrates a slight decline with 20 per 100,000 children being admitted due to injuries arising from assault, neglect or maltreatment. There is considerable variation depending on deprivation rating with a rate of 4.2 for decile 1 (least deprivation) and 42.2 for decile 10 (highest deprivation). Admission rates are significantly higher for Maori and Pasifika than for European and Asian.

Reports of concern to Child, Youth and Family add to this picture. There has been a steady increase over the past five years and the 2009/10 figure of 124,921 is double the number for 2005/06. Further action was required in 55,494 cases and substantiated abuse was found in 26,169 (41 percent). It is important to acknowledge that these are findings and do not necessarily reflect numbers of children because there may be more than one finding for a child. Just over 5,000 findings related to behavioural or relationship difficulties and as such may not be considered to be related to abuse and neglect. They may, however, reflect situations where previously undetected abuse and/or neglect has contributed to the development of these difficulties in older children.

It is likely that greater awareness is a factor in the increased number of reports of concern. Sometimes this is interpreted as diminishing the extent of the problem. The threshold for intervention by Child, Youth and Family is, however, relatively high and many of these children may be experiencing significant levels of neglect even though they do not meet this threshold.

Another factor in the increasing rate of notification has been police reporting of family violence incidents at which children have been present. Although most New Zealanders are aware of high rates of family violence, not everybody is aware of the impact on children and young people living in these situations. The risk of child maltreatment is significantly higher but even when children are not the focus of the abuse their well being is significantly compromised by their exposure. In a survey of young people 10.4 percent reported witnessing adults hurting each other, 16.6 percent reported adults hurting children, 12.3 percent reported being hit or physically hurt, 48.2 percent reported adults yelling and swearing at other adults and 45.9 percent reported adults yelling and swearing at children.

In addition to evidence of intentional detrimental behaviour, data related to unintentional injury indicates that we are failing to protect our children and young people. Nine hundred and thirty-two children and young people aged from 0 to 19 died as a result of unintentional injury between 2003 and 2008. Of these 36 were under the age of one year and 140 were aged between one and four. Five hundred and sixty-five were aged between 15 and 19. Road accidents were the most common cause of death with drowning and suffocation accounting for significant numbers. Our response to these deaths is most often to regard them as terrible tragedies but we often overlook the fact that these are preventable deaths. They are a reminder that we are not as alert as we could be with our youngest children and we are not doing as well as we could in preparing our young people for the risks associated with adolescence.
Our high suicide rates are further evidence of this. Over the period from 2003 to 2008 327 children and young people took their own lives. The youngest was aged under nine years, 32 were aged between 10 and 14, and 294 were aged between 15 and 19. Although many factors contribute to suicide it is important to remember that each of these young people had arrived at a point where life was not worth living at that point in time and we have to ask what we could be doing better as a society to ensure that our young people do not reach this point.

The Consequences

There is a finality in death that may explain why it is highlighted in the media. Sadly, however, the consequences of maltreatment are life-long for the children and young people who survive and may be transmitted into the next generation. In the most extreme circumstances children suffer permanent brain damage as the result of assault. What is less well understood is that brain functioning may be impaired as the result of chronic neglect. There is robust evidence that child maltreatment impacts on cognitive, physical, and emotional functioning. Children and young people exposed to abuse and neglect experience difficulties relating to others and this increases their isolation. Boys are often identified as having behavioural difficulties and this becomes the focus for concern. Girls may shut down and be overlooked. By adolescence children raised in environments characterised by abuse and neglect are experiencing significant difficulty.

Given the overwhelming evidence of harm it seems extraordinary that we have failed to address this situation, especially given that there is overwhelming evidence that early intervention is the key to achieving positive outcomes. The Green Paper provides an opportunity to take a comprehensive approach to improving life for vulnerable children and young people. It will be important in taking up this opportunity to think about what has stopped us from taking action before now. There is an understandable reluctance to intervene in families and this has been viewed as the last resort. For children, this means the intervention is often too little and too late because the damage is already done. As a society we have to accept that it has been easier to stand back and wait until a situation is so bad it cannot be ignored. As long as our focus is on the identification of child abuse and neglect we will fall short.

If we shift our focus to ensuring that every child has the best start in life possible a different pathway opens up. Rather than assuming that most families have what they need to do a good job and looking for the exceptions our starting point can be an understanding that parenting is a challenging and demanding role for which we are not always well prepared. The emphasis can then be on working with parents to assess their situation and provide support at the earliest possible opportunity. If we truly value our children we need to set our sights high and be willing to invest in giving each and every one the very best start in life. In the process we will achieve significant reductions in the number of children exposed to abuse and neglect.

References

Challenges to achieving equal and equitable outcomes in education for children

By Dr Sarah Te One, Principal Advisor, Education, Office of the Children’s Commissioner

The Green Paper invites us to consider how to best redress educational inequalities and inequities for children, particularly our most vulnerable. The purpose of this paper is to provide a brief overview of some key issues.

Articles 23, 28 and 29 of the United Nations Convention on the Rights of the Child (UNCROC) establish entitlements for all children to an education that supports their development and fulfils their potential. Schools and early childhood education services are responsible for educating children and young people to participate and contribute to society based on a shared sense of identity about what it means to be a New Zealander. Our increasingly diverse population poses some very complex challenges to achieving educational equity and equality for all: there are increasing socioeconomic disparities, differences between rural and urban communities, cultures and genders. These differences are apparent in New Zealand’s record of educational achievement amongst countries of similar standing in the OECD.

Recent reports provide compelling evidence that not all New Zealand children reach their educational potential, and further, this failure is costly, now and in the future. So, while our literacy and numeracy standards are among the highest in the OECD, we also have what is called a ‘long-tail’ of underachievement particularly among students from low-socio economic areas and in Māori and Pasifika populations. Too many tamariki/mokopuna leave school without qualifications and consequently transition into adulthood disadvantaged. The question facing us now is how to address existing disparities? What factors improve quality outcomes for all children and for vulnerable children in particular?

Early Childhood Education (ECE)

The fundamental importance of the early childhood years is now widely recognised. What happens to children under-five impacts on their future well-being and because of this, prudent investment in the early childhood sector should be prioritised. Good quality ECE is known to make a significant long-term difference to children’s success at school, and thus, potentially enhances their well-being in society in the future. Research has established that participation in ECE services of good quality is beneficial for all children but is particularly beneficial for vulnerable children.

Some aspects of New Zealand’s ECE system measure up reasonably well against OECD benchmarks. However, Government investment in ECE totals $1.3 billion, less than half the OECD average for children under five. While New Zealand has high participation rates, particularly for four-year-old children, participation rates for Māori, Pasifika and children in low socio-economic areas is significantly lower with only 82 percent of new entrants in our lowest decile schools recorded as attending ECE services (see Figure 1). A lack of cultural responsiveness, feelings of isolation combined with costs, including transport, can be barriers to enrolment.

Figure 1: Prior participation in ECE of year 1 students by ethnicity, 2000-2010.

Artwork by the Littlefair Family
The biggest growth area in ECE is for under-two-year-olds. This age group requires special attention where partnerships between parents, employers and the State should be flexible, sensitive and supportive. There is a link between higher level qualifications and positive outcomes for infants and toddlers in ECE.

**Primary and Secondary Education**

The majority of New Zealand students achieve as well as or better than students from other countries of similar status. In fact, in some areas, our students achieve at the highest levels. The down-side is “the system serves some groups of students, in particular Māori and Pasifika students and students from low socio-economic communities less well”\textsuperscript{11}. While trends indicate that fewer students leave schools without qualifications, the differential between groups of students remains a challenge for educators (see Figure 2)\textsuperscript{12}.

**Figure 2: Percentage of school leavers with little or no formal attainment**

On-going projects such as Te Kotahitanga\textsuperscript{14} provide evidence that improved achievement for Māori is possible where the classroom milieu is receptive and responsive to Māori as Māori. Teacher professional development and whānau involvement are critical to success.

Currently there are 115,000 students in decile 1 and 2 primary, intermediate and secondary schools in New Zealand\textsuperscript{15}. The majority of students in these schools are from low-income Māori and Pasifika families. A recent report\textsuperscript{16} highlighted two issues for these schools: a lack of food, and the poor quality of food purchased. Research is now unequivocal: there is a direct relationship between positive learning outcomes, including improved concentration, better self-control and increased positive engagement with peers and a good quality breakfast.

Equally concerning are the increasing numbers of students stood-down, suspended, excluded and expelled over the last decade\textsuperscript{17}. Māori students are disproportionately represented in these figures. Over 50 percent of these students (aged 16 or over) discontinue with formal education\textsuperscript{18}. When asked, students themselves requested that their perspectives on learning be taken into account earlier rather than later\textsuperscript{20}.

Rates of bullying in our education institutions are very high by international standards. Internet and cell phones compound the problem\textsuperscript{21}. Research also linked bullying to school suspensions. Children with disabilities and special needs are reported to feel most vulnerable in our schools\textsuperscript{22}.

Children with special educational needs and disabilities risk missing out on an education with their peers. These children may be doubly disadvantaged if they come from a low SES background. Many have been denied access to ECE and schools if they are not accompanied by an Education Support Worker, or because their funding is limited. A lack of coherent information about entitlements, difficulty in defining what exactly a special need is, and incomplete data regarding numbers are barriers to accessing inclusive education. Limited or no support for some disabilities significantly disadvantages those children. Transitioning between sectors is complicated by fragmented funding entitlements that reportedly disrupt a child’s educational experience\textsuperscript{24}.

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With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants
Differences in morbidity and mortality between socioeconomic groups constitute one of the most consistent findings in epidemiological research.... In recent analysis we showed health behaviours... to explain a major proportion of the association of socioeconomic status with mortality in the British Whitehall II Study. However, whether health behaviours are equally important mediators in different cultural settings remains unknown... Material deprivation, financial insecurity, work stress and work environment, psychosocial factors such as job control or social support, or differential access to health care may be other possible mechanisms through which SES influences health (Stringhini et al. 2001).

In recent years, there has been much interest in health inequalities and the ways in which factors such as socioeconomic position, lack of control, stress and health related behaviours (e.g. smoking, alcohol) adversely impact on health outcomes, such as morbidity and mortality from cardiovascular disease.

While the focus of such research has often been on the cumulative effects of economic adversity across the life course, in New Zealand the available evidence would suggest that socioeconomic factors begin to impact adversely on health in utero, as evidenced by our social gradients in stillbirths, preterm births and small for gestational age. Similarly, during infancy, large social gradients are evident for many infectious and respiratory diseases. For example, during 2002-2006 (see Figure 1), infants living in the most deprived (NZDep decile 10) areas were admitted to hospital with bronchiolitis (a viral respiratory infection) at a rate six times higher than for those living in the least deprived (NZDep decile 1) areas.

The reasons for such early social gradients in child health are complex, and in the case of bronchiolitis may potentially arise from the social patterning of known risk factors such as exposure to second hand cigarette smoke and substandard housing / crowding, both of which have been shown to exhibit marked social gradients in New Zealand, with exposures being much higher for those living in the most deprived areas.

In terms of prevention, with bronchiolitis being a viral respiratory tract infection, and thus not amenable to early antibiotic intervention in primary care, it is likely that, for this condition at least, solutions beyond the scope of the health sector will be required, if we are to avoid hospital admissions occurring in future. For other conditions such as skin infections however, where early antibiotics may serve to prevent a hospital admission, or whooping cough where timely vaccination may prevent the condition developing in the first place, access to affordable primary health care may potentially play a significant role in mitigating the impact of the socioeconomic environment on children’s health and wellbeing.
While further research may provide us with better insights into the pathways linking the socioeconomic environment to children’s health and wellbeing, awaiting the outcome of such research should not delay us developing effective policy responses, as in a number of cases, there is sufficient evidence to guide future action. For example, in South Auckland a healthy housing programme which included housing modifications to reduce overcrowding, and to improve insulation and ventilation resulted in an 11 percent reduction in acute hospitalisations in children aged 0-4 years. Similar research in Wellington found significant reductions in night time wheezing and days off school for children, following a housing insulation program. In addition, research suggests that improving on-time delivery of immunisations may be expected to decrease admission rates for pertussis in New Zealand infants.

With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

Thus for New Zealand, the challenge no longer lies in adequately describing the impact of the socioeconomic environment on children’s health and wellbeing, or even in providing better descriptions of the pathways via which these associations occur, but rather in developing evidence based policy solutions which can begin to address the economic adversity experienced by many of our children, and the impact this has on their health and wellbeing.

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By Dr Simon Denny, School of Population Health, University of Auckland, and Dr Theresa Fleming, lecturer in youth health (Dept of Paediatrics) and clinical youth mental health social worker at Whirinaki (CMDHB Community Child and Adolescent Mental Health Service).

The adolescent years represents a period of human development with unique challenges and opportunities. Most adolescents are healthy when measured against traditional health status indicators such as incidence of disease, health care utilisation or morbidity rates. However, adolescence is a time of life when young people face significant threats to their current and future health from preventable factors, such as suicide, unsafe sexual activity, violence, alcohol use, risky motor vehicle use and substance use\(^1,2\). In fact many of the most urgent and expensive issues facing New Zealand’s health system, such as tobacco use, obesity and mental illness, originate during childhood and adolescence. For example, approximately 80 percent of young people who are obese during childhood and adolescence remain obese as adults,\(^3,4\) most people who start smoking do so during adolescence and rates of depression and other mental illness increase markedly during the adolescent period.

While the majority of young people navigate successfully through these issues, significant numbers of young people do not. In this respect, New Zealand has a poor record of youth health compared to other OECD countries. Rates of youth suicide, death from motor vehicle injuries, unintended pregnancy and drug and alcohol use are among the highest in the Western world\(^5\). In a recent national youth health survey, 15 percent of female secondary school students and seven percent of male students reported significant symptoms of depression and seven percent of female students and three percent of male students report attempting suicide in the previous year\(^6\). During adolescence, heightened risk-taking can lead to adverse health outcomes such as substance abuse, road traffic injuries and STIs. These risk behaviours can result in immediate consequences for young people (e.g. sexually transmitted infections) or result in consequences later during adulthood (e.g. infertility).

Adverse health outcomes among young people impact their wellbeing and often have wider long term social and economic implications. For example, mental distress and substance use in adolescence reduce school achievement and interfere in the development of positive peer and adult relationships. Disruptions to healthy development at this critical time result in lowered opportunities for young people and increased risk of a cycle of underemployment and marginalization. These adverse health outcomes are disproportionately experienced by young people living in poverty and impact on their ability to do well in school and contribute positively to their communities. For example, rates of suicide attempts among young people living in poor neighbourhoods are twice those of young people living in more affluent neighbourhoods\(^5\). Furthermore 22 percent of young people from poor neighbourhoods currently smoke cigarettes compared to 14 percent of young people from more affluent neighbourhoods\(^5\).

The most important influences on adolescent health and wellbeing are healthy families and communities that provide support and opportunities for young people. Adolescents who feel that they belong, that people care about them and that they have a future, typically overcome hurdles, achieve positive outcomes and are able to contribute positively to society. It is important to note that the health of adolescents and their families are influenced by wider economic factors, such as access to high quality employment, income inequality and poverty. Economic factors influence the ability of young people to transition successfully into meaningful employment, further their training and education, and form long-term relationships and start families\(^7\). Ultimately the health and wellbeing of adolescents growing up in New Zealand reflects how well we provide equitable and fair societies with opportunities for young people to grow and flourish.

Unfortunately, New Zealand’s young people have been largely overlooked in terms of national policy, age-specific health services and funding for youth development programs. Compared to other OECD countries, New Zealand has a low rate of investment in children and youth, and poverty in New Zealand disproportionately affects children and young people. Over the past 30 years, young people in New Zealand have had the lowest improvement in their health status compared with any other age group\(^5\). Current services are not meeting the
needs of the youth population. Compared to other age groups, young people in New Zealand have the lowest utilisation rates of primary care, are least likely to see the same primary care doctor consistently, and receive the least time with their primary care doctor. Furthermore, rates of forgone healthcare are high, particularly among vulnerable youth populations such Maori, Pacific and young people living in poverty. Recent initiatives in school-based health care have shown reductions in secondary school students engaging in high risk sexual behaviours and suggest opportunities to address youth health issues in primary care settings. However these services are under threat due to funding cuts and lack of support nationally.

A popular misconception is that little can be done to address youth health issues and that effective interventions need to happen during early infancy and childhood. While high quality early child care, high quality parenting and school engagement initiatives during childhood are all important for later adolescent wellbeing, adolescence is another important ‘critical period’ and there are a number of interventions that are effective during the teen years. Many of these interventions are as cost-effective as interventions during early childhood and have significant downstream savings.

To improve the health and wellbeing of young people in New Zealand requires the following coordinated efforts that cut across traditional silos of health, education and social services:

→ implementation of evidence-based interventions to support young people most in need
→ a holistic approach to youth wellbeing that recognises the fundamental importance of families, schools and communities in nurturing young people
→ ongoing and relevant information on the issues facing the current and future generations of young people
→ evaluations of the impact of economic, social and other policies on young people
→ adolescent health goals that are articulated and reported on
→ training and specialisation of clinicians in youth health.

New Zealand should prioritise being a place where young people can participate, belong and look forward to their future. To fail to do this fails young people and fails the broader community.

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Safe as houses?

By Professor Philippa Howden-Chapman, Director of NZ Centre for Sustainable Cities and He Kainga Oranga/ Housing and Health Research Programme.

There is no longer any argument that the health of New Zealand children and their families is largely determined by factors outside of the formal health care setting. Although access to quality and affordable medical care will always be essential when children are unwell, there is no doubt that a lot more work can be done at a policy and practical level on the widely accepted social and economic determinants of health. Effecting change at this level through public health measures is one of the best and most cost-effective strategies for targeting preventable illness and injuries and making a real difference to the health of children and their families.

Recent evidence that 200,000 New Zealand children are living in poverty due to the policies of successive governments over the past 25 years is a shocking indictment on a country that prides itself on being a good place to raise children. We need to take action now if we are to address child poverty and the damaging effects that such inequalities have on the whole of society. But rather than throw money at yet another innovation, or roll out an existing programme of dubious or unproven worth, there needs to be a thoughtful deliberative cross-party approach to child poverty and ill-health based on strategies which have been shown to be effective.

For the past ten years, the He Kainga Oranga/Healthy Housing research team at the University of Otago in Wellington has been examining the role of housing and its impact on health and injury. The focus has typically been on the most vulnerable and disadvantaged families and communities where practical interventions like improved heating and insulation have been put in place with significant success. Some of this research has influenced policy and prompted governments to retrofit insulation over recent years.

We know that many families are living in substandard, unsafe, and poorly heated housing, and that this can have a major impact on the quality of life and health of the occupants. New Zealand houses are known to be cold and damp, with the average indoor temperature below the World Health Organisation recommended minimum of 18°C. This situation has serious implications as there is evidence that cold indoor temperatures may at least be partly responsible for the higher death rate in winter when there is an increase in mortality of 18 percent, with children under five being particularly vulnerable.

However, simple measures like better heating and insulation can make a significant difference for children as our randomised controlled trials have shown. The Housing Insulation and Health Study found that children with asthma in the better insulated homes, had a significant improvement in self-reported health and wheezing, and parent-reported incidences of school absence.

A subsequent Housing, Heating and Health Study which installed effective, non-polluting heating into previously insulated, but under-heated homes, showed further improvements. Asthmatic children living in the homes with the better heating had significant reductions in self-reported poor or fair health, having had a dry cough, or their sleep disturbed by wheeze.

In addition, the collection of absence data from school registers for almost 70 percent of the asthmatic children in the study showed that more effective heating resulted in a significant reduction of 21 percent in the average number of days off school during the winter terms. This data supported the earlier study finding mentioned above of parents reporting less school absences for their children.

This confirmation of a reduction in school absenteeism through these cost-effective housing measures has significant implications. Findings both in New Zealand and internationally suggest that higher levels of absence may be detrimental to academic performance. If these children are to break free of deprivation, this is likely to be through the opportunities offered by regular school attendance and higher educational qualifications.

Safety in the home is similarly an important factor in the wellbeing of children. For example, in New Zealand between 1989 and 1998, 53 percent of deaths and 55 percent of hospitalisations for children under five years of age occurred in the home. Falls are a main contributor. Nevertheless, as the non-fall injury hazards included many that were specific to children, it was not surprising that strong relationships were observed for
this age group, showing steeply increasing home injury rates with increasing home injury hazard counts.

A focus on improving housing through these evidence-based and effective public health measures will not only benefit children, but can also make life easier and healthier for their parents. We call on the government to make healthy housing a policy priority for children and their families from 2011 and beyond.

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He Kainga Oranga/Housing & Health Research Programme
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www.healthyhousing.org.nz

With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

References

Dear Horiana: Letter to My Daughter

By Dr Kathie Irwin, Rakaipaaka, Ngati Porou, Ngati Kahungunu Chief Maori Advisor, Families Commission

Hey babe,

I decided to write this to you because I am at work, working on a response to the current Green paper on Vulnerable Children. The Green Paper process itself is an interesting one which I hope you and the organisations that you work with will consider participating in. We need your voice, babe, and those of your peers on this. The Green Paper opens up the opportunity for any New Zealander to communicate directly with the Government over the issue being addressed. As a solicitor, and a Board member of Te Hunga Māori Roia o Aotearoa, and Te Awe, I hope you will see this as an opportunity to speak out about vulnerability as a structural site of struggle and the possibilities of its transformation.

There’ll be lots of facts and figures in this process. I am trying to get centred and grounded in the whānau narratives, that sit outside the official parameters, where much of NZ’s most profound social change has come from. This issue cuts to the heart of who we are as a society. Your legal training has given you powerful insights into the structural and legal dimensions of issues like this, and tools to unpack them. Our whānau story has added cultural dimensions to this and grounded us in a history of social activism through the mahi of your tipuna, great grandparents and grandparents.

As you grew up I do remember occasions on which I suggested that I should perhaps have called you Susan, rather than Horiana, because I thought your behaviour at the time incongruent with the beautiful name you carried. I do shudder at that now. And laugh at the tipuna wickedness in bringing you a loving boyfriend whose mother’s name is Susan! She is a lovely woman who has been like a second mother to you and I am very grateful for her influence in your life. I only ever wanted your name to be a joy and a taonga to you, as it is to me. A beautiful way of honouring your great grandmother who also bore that name and who lovingly allowed you, and only you, of all her direct descendants, to carry it on to the future. Others from the Presbyterian Church took her name, but not her own descendants. She would not allow it.

She was born in Nuhaka in 1899, one of the Te Kauru whānau of nineteen children. When she was a child her name was used to taunt her, as a form of derision. Horiana was shortened to “Hori”, with the associated views about being dirty, second rate and second class. The creation of this vulnerability she felt was a direct result of the racism of the society in which she lived. She told me that she came to dislike her name because of this.

With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

She was my rock. Your grandmother died of breast cancer when she was 47, I was 17. In my devastation I turned to your great grandmother for solace and wisdom. I came to know her story intimately and to cherish it. She was a pioneer, long before her time. A Māori woman who challenged convention, who chose a future for herself not seen by anyone but herself. In 1915 she left the close community of Nuhaka, and the embrace of a large loving Mormon whānau, to become a Presbyterian and to go to Turakina Māori Girls College in search of a secondary school education. She was the 149th pupil to register at the school and became Dux in 1917. In the years that followed she became a teacher in the Presbyterian Mission Schools. After her marriage to Reverend John Laughton, originally from the Orkney Islands, she worked in the service of her faith through the church. On her 1921 marriage certificate she entered “School teacher” in the occupation section.

She worked tirelessly to support your great-grandfather in his work in Māori communities undertaken for the Presbyterian Church. They both drew on their faith to give effect to the vision of bilingualism and biculturalism that the late Sir Apirana Ngata spoke of throughout his career. His cherished words of encouragement to Rangi
Bennett, which started “E tipu, e rea” encouraged her to strive to live the fullest, richest life she could, drawing on the dual heritage the treaty of Waitangi offered this country. This is what your great grandparents wanted for all New Zealanders.

They led work in the church which would now be called transformative praxis: parallel development in the church in the form of a separate Māori Synod, confirmed as a full Synod in 1956; the creation of the position Māori Moderator to ensure kaupapa Māori based leadership in the church; and, the building of a marae in Ohope (Te Maungarongo) to enable the church to be located within the very heart of Māori society, the marae, so that the practices of the church were undertaken through te reo Māori me ona tikanga. These were all transformation initiatives. Strong, bold actions, long before they were the norm, taken by people who not only saw a different way forward. They had the courage and the determination to build it. Literally, with their own hands. They didn’t wait for anyone to give them permission, or power, or a model of how to create change. They gave themselves permission, drew on their own faith, passion and power, designed and built their own dreams.

So yes, in 1986 when you were born there was only one name I wanted for you babe: Horiana. We took you to meet your great grandmother and had photos with her. Aunty Karen asked grandma if we could name you after her. Grandma asked: What will her name be?”. Aunty Karen replied: Horiana, after you, Kathleen, after her grandmother and mother, Irwin, after her father, Kathie’s husband”. This was not without some sacrifice I might add. A card carrying feminist “marriage” was not on my agenda at the time. However, knowing your great grandmother as I did I knew that our case would have been weakened if we were unmarried. So, not only did I lose my waist for you but I also sacrificed a cherished feminist principle for you to carry your tipuna name as well!

We persuaded her that a time was coming when being called Horiana would be a wonderful thing. When “Horiana” would be part of the valued expression of Māori language and culture that was common place in NZ society. The name would call forth a heritage at once uplifting and inspirational. She agreed and named you with her blessing. The lessons our whānau have taught us are that we are all part of the change needed: reaching out beyond our own whānau to work with others in need; honouring the wisdom of our tipuna to provide solutions to the questions we face; requiring change to be embraced even from what seem the most intractable places: and, living every day purposefully dedicated to the vision of the new futures we seek.

Whānau don’t become vulnerable on their own. Vulnerable whānau don’t live in a vacuum. Vulnerable whānau are our whānau. There but by the grace of God could go any one us when life’s calamity strikes. As NZ’ers are now only too well aware of in the wake of the Christchurch earthquakes.

You, and the people you work with, are helping take our society forward babe. The Treaty settlement process enables us to address historical grievances with the hope that there can be new futures. Without this work, vulnerability caused by structural exclusion will plague our future as it has our past. We can do better than that. Our great grandparents would not accept anything less than their dream for us. Why should we for our mokopuna?
I’m off to the WAI 262 seminar at Victoria University tonight based on the Waitangi tribunal Report Ko Aotearoa Tenei4. Aroha Mead is organising it to ensure that we all have a chance to hear from leading experts about the role and status of traditional knowledge in our lives. She is so cool babe, someone else who won’t accept “what is” but who strives for “what could be” and generously shares with others her knowledge about the way to achieve it.

Arohanui,

Mum.

(PS. Don’t forget you said that you would give me a ride home after the seminar).

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New Zealand Pacific children

By Dr Teuila Percival, QSO, MBChB, FRACP. Consultant Paediatrician, KidzFirst Children’s Hospital, CMDHB. Director of Pacific Health, School of Population Health, University of Auckland.

Pacific children, like all children in New Zealand should expect the best in health, education and social supports to enable them to develop and thrive and achieve their best potential.

Our Pacific children and young people make up an increasingly important group in New Zealand. Pacific fertility and growth will see almost one in five New Zealand children being Pacific within two decades. Our Pacific community and its children will be significant contributors to the success of this country.

Pacific children are an increasingly heterogeneous group. The most common group is Samoan, followed by Cook Island and Tongan. However, over half of Pacific young people are now New Zealand born rather than new migrants and two thirds of Pacific young people are of mixed ethnicity identifying with more than one ethnic group.

New Zealand has made considerable progress over the past decades. Pacific children’s experience of New Zealand is mixed. Whereas our communities continue to value and encourage traditional beliefs and language, there is a stark and continuing disparity in the health, educational and economic outcomes for Pacific children and their families.

Low educational achievement, predominant “blue collar” jobs, high unemployment, together with the added burden of cultural obligations make Pacific families particularly vulnerable economically.

The effect of welfare reforms and market rents in the 1980s and 90s was to push more Pacific families and children into poverty. The recent global economic recession has also impacted on Pacific children both with measures of poverty and hardship and health.

Pacific communities have made gains in the retention of some of our languages, and increasing numbers of Pacific children enrolling in pre-school education. There have also been some positive health gains too. Pacific infants had the highest rates of meningococcal disease during the epidemic in the late 1990s and early 2000s.

Very high rates of MenZB immunization were achieved in Pacific with an associated dramatic fall in incidence rates. These gains, however, important as they are, continue to be overwhelmingly subsumed by poor Pacific health, less educational success and increasing economic hardship.

Whereas infant mortality has reduced for Pakeha and Maori in New Zealand over the past few decades, that of Pacific has not. Pacific mortality has essentially remained unchanged with current Pacific infant mortality just above 6 per 1000 live births compared with less than 4 for Non Pacific-Non Maori.

Low household incomes and the marked inequality between Pacific household incomes and other New Zealanders are the most important determinant of our health, educational and social outcomes.

Pacific median household income is lower than non-Pacific people. The additional cultural obligations of gifting to Churches and supporting extended family back home in the Islands result in Pacific families having even less money available for themselves. Essentials such as healthcare for children may take second place to the other priorities of rent and cultural commitments.

Pefi Kingi writes of Pacific families “The family is the cornerstone of personal life from birth to death, and identity can centre on one’s roles, duties and responsibilities within the family... it maybe that collective well-being is awarded a higher priority than that of the individual, particularly if that individual is a sick child.”

Financial stressors and increasing unemployment with the recent global recession has affected Pacific and Maori more than other New Zealanders. Pacific unemployment continues to be higher than other New Zealanders with the most recent Pacific rate being almost 14 percent.

(See Figure 1)
Poverty, particularly when it is sustained through childhood, is associated with poor health, educational and economic outcomes which extend into adult life. 40 percent of Pacific children are growing up in poverty. Benefit cuts, increased housing costs and high unemployment have contributed to this continuing poverty since 1990. See figure 2.

The Ministry of Social Development’s Living Standards report documents Pacific families with dependent children as being more likely to be living in hardship than other ethnic groups. The proportion of Pacific children that live in severe hardship at 30 percent has almost doubled between 2000 and 2004 (see Figure 3). With another 12 percent and 19 percent living in significant and some hardship, New Zealand has over 60 percent of Pacific families living in hardship. Hardship measures include children having to share a bed, not being able to afford to go to the doctor, being unable to afford shoes and wet weather clothing, and not going on school outings because of cost.

The health of families, in particular that of the adults who are Pacific children’s caregivers impacts on them directly and indirectly via household income and ability to access resources and healthcare. Pacific adults in New Zealand as a population group have poorer health than most New Zealanders with the double burden of high rates of non-communicable diseases and infectious diseases, together with continuing high rates of avoidable premature mortality.
The picture is of an adult Pacific population with poor health determinants of low household income and high unemployment, high prevalence of intermediate risk factors such as obesity and hypertension and high prevalence of diseases such as diabetes and ischaemic heart disease. Most notably, Pacific have not shown the same reduction in all age mortality seen with Maori and Pakeha. Effectively this has seen an increase in the disparity for Pacific life expectancy and other New Zealanders. This burden of disease and avoidable mortality in the adults who are the caregivers for our Pacific children impacts on children’s well being, and ability to access resources including healthcare.

Pacific children also experience poorer health than other New Zealand children. They have the highest hospitalization rates for acute respiratory and infectious illnesses such as pneumonia, cellulitis and rheumatic fever together with highest rates of chronic conditions like bronchiectasis and obesity. Pneumonia is one of the leading causes for hospitalising children. Pacific children’s rates are the highest in New Zealand, being twice that of Maori and four times that of Pakeha.

Acute rheumatic fever has recently gained some Government interest. Rheumatic fever for Pacific is twice that of Maori and fifty times that of Pakeha. This potentially preventable condition with serious long-term cardiac sequelae is associated with poverty and overcrowding.

Pacific children also present to hospital with more advanced or severe disease raising concerns about barriers to healthcare access. A similar pattern is seen in Pacific adults with more advanced disease presenting late to primary and secondary healthcare. The lack of health service co-ordination and the continuing financial costs involved are barriers for our low income Pacific households.

Maternal health is particularly important to child health. Notably high rates of obesity in Pacific women and poor antenatal care attendance affect Pacific infant morbidity and mortality and late foetal deaths. As with much of the morbidity seen with Pacific children, many of these deaths are preventable with access to effective healthcare and improved socioeconomic circumstances.

The most important determinant of Pacific children’s health status and continuing health inequality is poverty. A policy environment that addresses child poverty is a critical part of reducing health inequality for our children.

Appropriate healthcare can be an effective means to address inequalities. The New Zealand Healthcare sector has developed some programmes, which have been effective for Pacific children such as the Healthy Housing programme and the MenzB national immunization campaign. Both of these programmes were cogniscent of Pacific disparities and built into their design strategies to achieve specific Pacific targets. Mainstream Primary HealthCare and the Primary HealthCare strategy has failed to address child health inequalities and to effectively reach those most in need such as Pacific.

Education enrollment, retention and qualifications are important for the health and economic success of a population. Our Pacific children, along with Maori, are more likely to leave school without qualifications than other New Zealanders. The education sector is showing some improvements both with Pacific pre-school enrollments and NCEA 1 achievement in schools. In 2008, 76.3 percent of Pacific achieved NCEA 1 compared with 59.7 percent in 2005.

Pacific children are an important group for all communities in New Zealand. To reduce the disparities in their health and socio-economic circumstances requires a commitment from leaders in Government and Pacific Communities.

Health services certainly have a role but the most important strategies will need to affect determinants of child poverty, overcrowding and education.

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By Rebecca Blaikie, Advisor
Office of the Children’s Commissioner

There is no “youth problem”. There is a village problem of adults who have forgone their responsibility & capacity to join their neighbours and share the wealth of children. It is our greatest challenge and our most hopeful possibility. – John McKnight

The New Zealand government is a signatory to the United Nations Convention on the Rights of the Child (UNCROC). This puts an obligation on the Crown to be responsible for ensuring that the rights of children are upheld in New Zealand. UNCROC’s purpose is to maximize children’s positive life experiences. The Green Paper provides an opportunity for children and young people to participate in a decision-making process that will support them succeed and to make contributions that benefit themselves and others, now and in the future.

All children and young people under 18 have the right to political agency. New Zealanders need to stop viewing children and young people as unfinished, irresponsible or lacking in rational judgement, that they are the ‘problem’ instead of part of the solution. Children are citizens in their own right. They have a right to be consulted and to have their views given weight. Article 12 of the United Nations Convention on the Rights of the Child sets this out:

“State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

For this purpose the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13 recognises the right of children to seek, receive and give information and ideas of all kinds.”

There are 1,216,890 children (0-19 years) in New Zealand, a significant proportion of our society who need to be treated with respect and prioritised so they can thrive, belong and achieve. Society benefits from children being involved in decision-making because it:

→ Encourages co-operation between different age groups in society
→ Reinforces the benefits of participation and the value of contribution
→ Builds a positive, democratic society

Sharing power with children and young people and making child-centered decisions will shape New Zealand now and long into the future, and can only enhance our nation. If it is good for children, it is good for everyone.

Children are members of family/whanau, they move in educational spaces, and they are members of our communities. They have a vested interest in the development of policies and decisions that affect the environment they live in. Children and young people are high users of local services and programs, so good decisions and good policy contribute to the healthy development and wellbeing of all children and young people. Working alongside children and young people in decision-making roles is important:

→ as an issue of human rights;
→ in leading to more effective decision-making;
→ in recognition of young people’s ability to act;
→ in respecting young people’s full citizenship now;
→ as being about growing into citizenship;
→ in ‘capacity building’ in young people and their communities; and
→ in building connections between young people and their communities.

It is important to remember that children and young people have different life experiences and a different perspective than adults. “If our political leadership and our political and social policies are to truly reflect the views of all sections of our community, young people should have the opportunity to be part of that process.”

Both thinking about and including children and young people in the development of a country’s vision, leadership direction, legislation, policies, programs, and...
services ensures that these will meet their needs in a more efficient and effective way. All policy needs to be developed through a child centered lens to measure effects on children and young people as "even when policies are not primarily aimed at children, they may still have important consequences for children and young people in their daily living".

Participation in decision-making means "actively involving young people in all areas of our society – the family, school, workplace, place of worship, social group and wider community". It bridges the generation gap and builds mutual understanding around issues that affect everyone in the communities they live in. When children and young people are included in decision-making and policy development they are likely to be more connected with a ‘sense of place and belonging’ and take a pride in their country, and the community they live in.

Children and young people participating in decision-making is succession planning in action; it provides leadership opportunities and learning. It equips children and young people with tangible skills they can use throughout their life – skills like thinking critically, sourcing good information, teamwork, problem solving, planning, financial management, networking, writing and oral communication skills and time management.

The Green Paper is about children. They have the right to know it is happening and to be included in creating solutions for themselves and others. The Office of the Children’s Commissioner is interested in collaborating/partnering with, or supporting organisations that work alongside children and young people to get their voices, opinions and realities woven into the Green Paper process. It is critical that children and young people get to participate and have a say around the Green Paper – they have so much to offer in their own right as citizens and they will be directly affected by the outcomes of the child action plan, both now and in the future.

“There can be no keener revelation of a society’s soul than the way in which it treats its children.” – Nelson Mandela

There is a section at the back of this newsletter that provides information of why and how to include children and young people in effective decision-making.

References

By Miranda Ritchie, National VIP Manager for DHBs and Paul Nixon, Chief Social Worker, Child Youth and Family

We all have a role in protecting children; our individual and organisational responses have and will continue to make a difference. In this article we have outlined the principles of action we believe are fundamental for organisations who work together to safeguard and promote better outcomes for vulnerable children. Shared understanding of core principles strengthens relationships. The release of the Green Paper challenges us all to consider what we are doing to protect children; how we are doing it and what more we could be doing to improve their safety and wellbeing.

Being Child-centred

One of the central challenges for large organisations working in highly pressurised environments is remaining child-centred. Each child is unique and our responses should reflect the needs of the particular child and their family. The risk is that managers and leaders become preoccupied with processes and systems and they can lose sight of the child’s needs.

The Children, Young Persons and their Families Act 1989 requires all decisions to be made in the child’s best interests. Being child-centred means setting and leading a culture of thinking, attitudes and behaviour that is responsive to children’s voices, rights and needs. Embedding this can require an attitudinal and behavioural change that requires leadership at all levels that models this approach and supports others to focus on what is best for children.

Strong Partnerships

Children who are at risk or who have been abused often have needs that are multi-faceted. No single group or agency can meet their needs alone. Therefore it is vital that workers are effective in engaging the child’s family/whanau alongside other agencies to work collaboratively. An approach that brings together family/whanau, community and multi-agency systems around children are most likely to have the biggest impact.

Traditionally some interagency relationships were reliant on individuals and their personal commitment to working together. However, more formalised agreements have been developed, for example the 2011 Memorandum of Understanding between District Health Boards, Child, Youth and Family and the Police, and these agreements help improve interagency understanding and communication across the board. The discussion, consultation and engagement during their development directly impacts on the effectiveness of the end agreement. In practice, these agreements mean that staff now meet face-to-face to discuss safety plans and can contact colleagues in the other agencies more easily. They know they will get a more open response and their call, if not answered directly, will be responded to promptly.

Interagency relationships that recognise each organisation’s role and responsibility and appreciate any differences in organisational culture are more effective. In reality this impacts how change is managed. While both Child, Youth and Family and DHBs are large organisations, the approach to changing practice by policy is very different. Child, Youth and Family manages policy/procedure through a central system, while each DHB has its own policy and process for approval. Understanding these subtle but important differences is critical when we are working together to develop a joint strategy.

Integrated Strategy

We believe that strengthening the collaboration between agencies to bring together their collective resources will benefit children and families. The Ministry of Health Violence Intervention Programme (VIP) uses a systems approach to support health professionals to identify, assess and refer persons experiencing family violence (including child abuse and neglect and partner abuse). The elements of this systems approach include strong senior management/senior clinician support, community agency collaboration, policies, resources, clinical champions training and quality improvement activities. This approach in action is evident with the participation of Child, Youth and Family representatives on the programme’s governance group and on the programme’s training team so that interagency connections occur at governance and practice level.

The implementation of Child, Youth and Family Hospital Social Workers in all DHBs is another example; the role supports strategic planning and interagency information sharing. In practice, the Child, Youth and Family Social Worker, as a member of the multidisciplinary team, contributes to case review meetings by sharing relevant history and supporting safety plan development.
Practice

Early identification and excellent communication with appropriate information-sharing between services is essential to ensure the right services are available to the most vulnerable children and families. In practice, this means that the strategies outlined above are put into action. Staff training in child protection intervention includes a requirement for consultation with senior colleagues for example, senior clinician, supervisor or Child, Youth and Family Hospital Social Worker.

Another example of the integrated approach to assessment and planning is the Multi-agency Safety Planning process, a comprehensive assessment that considers the child in the context of their family/whānau, including information from health, Child, Youth and Family and the Police. In practice, the Paediatrician, Ward Social Worker, Charge Nurse, Child, Youth and Family Social Worker and Police meet and share their information to develop a full assessment. The subsequent plan focuses on how the agencies will work together with the family/whānau to achieve best outcomes for the child, and includes a process to review and update the plan as required.

Evaluation and feedback

Our collective commitment to addressing child protection inspires action, but how do we know the impacts of our efforts? Processes for evaluation, review and the establishment of strong feedback loops can inform subsequent actions and strengthen relationships. For example, the Child, Youth and Family evaluation of the Child, Youth and Family Hospital Social Worker role includes a survey with key stakeholders from both Child, Youth and Family and the DHB.

Another example is the VIP quality improvement activity that seeks feedback from community agencies. In practice this means the DHB asks the agency such as the local Child, Youth and Family office to identify the number and quality of referrals received, feedback that indicates that the right children are being referred and the interagency relationships are affirming for clinical and programme staff.

Evaluation is also important to monitor service capacity. For example, the number of notifications to Child, Youth and Family has nearly quadrupled in the last six years. It is expected that when interventions are implemented, the demand for services will increase. The challenge is to ensure capacity can meet demand and the services are matched to the child/family needs.

Strategies to address these challenges include regular reporting of data, including analysis of the referral trends and enhanced processes for sharing information across agencies. In addition, evaluation activities need to assess if the improvements are changing outcomes for children.

Conclusions

It is all about relationships – national, regional and frontline services working together with families and communities to change outcomes for children. The Green Paper asks us to propose strategies for “improving the workforce for children”. We believe that the principles that underpin many of today’s strategies can inform future actions. Cross sector planning is critical as integrated strategies are required to support our most vulnerable children. Strategies for children need to be child-centred, collaborative and practical. In addition, all strategies should be evaluated and findings reported that identify the impacts for children, their families and service providers.

References

Universal and targeted services for children

By Dr Pat Tuohy, Chief Advisor, Child Health, Ministry of Health

This article represents the personal views of Dr Pat Tuohy and does not necessarily represent current Government policy.

In New Zealand, as in many Western democracies, the state has a key role in ensuring the health and wellbeing of its most vulnerable citizens. Young children are arguably the most vulnerable population group in our society because of their physical and emotional immaturity, and their lack of social and political power. All New Zealand infants and young children require adults to act on their behalf, hopefully in their best interests, although the media continue to remind us that the adults in some children’s lives put their own interests first and may abuse, neglect or fail to care adequately for them.

In order to meet children’s needs and support their families we must develop a coherent way of working across agencies. This paper describes the rationale for the current Well-Child service for children and the needs based provision of additional services for children with higher needs.

The Context

The New Zealand universal Well-Child services are based on a child’s right to good health and wellbeing, and as such are a key component of New Zealand’s compliance with the UN Convention on the Rights of the Child (UNCROC), in particular Article 24.

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Further, with relevance to aspects of the current Well Child programme, Article 24 states that:

2. (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

2. (f) To develop preventive health care, guidance for parents and family planning education and services.

These universal services are provided because all children need support from their families, communities and the state. Examples of universal child health services include some screening programmes such as those for newborn metabolic disorders and congenital deafness, and a range of Well Child services such as the B4School check. These services are provided universally because it is accepted that all children stand to benefit from them.

With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

It is however justifiable and appropriate to provide some services in a targeted fashion. Some children have higher needs than others in a particular domain, and will require support or services which other children do not. We have institutional responses to this situation. For example, we have a range of services for the diagnosis and treatment of illness provided through a range of community and hospital based healthcare. These are usually termed indicated services, because there is an “indication” for their use in a particular condition. In the disability sector the Needs Assessment and Service Co-ordination (NASCO) process identifies and coordinates the provision of services to address child’s disability related needs. Similarly some children will have needs which require that services be provided to their families, parents and caregivers, such as children whose parents have disabilities, social needs or drug and alcohol difficulties.
The current New Zealand system of universal and targeted provision of child health and wellbeing services, also called progressive universalism (UK Department of Health 2009) provides a base level of support and services for all children, with a higher level of support available for those who need it.

The Well Child programme has been designed to deliver this mix of services with a core set of 11 contacts from birth to five years of age, and additional contacts based on assessed need. The major advantage of a targeted system nested within a universal service is that the “dose” of services and support can be adjusted to meet the changing circumstances of the child and family. A service model based on a true partnership between experienced health professionals and the family provides families with access to universal health education, clinical assessments, and illness and injury prevention programmes such as immunisation and car seats. Families with higher and more complex needs can be identified without stigmatisation and offered additional supports through the additional contacts available through the Well-Child programme or referred to other health or social services. The current programme provides every family with a doorway to further services, and if necessary, someone to assist the family to open that door.

**Vulnerability And The Risk Continuum**

Central to the provision of targeted services for children is the requirement that the targeting process is efficient and effective.

In order for targeting to work, it must be possible to accurately identify the sub-group of the population who will benefit most from a service or intervention. A high quality screening programme is designed to do this, and the criteria for such programmes are well described. (National Screening Advisory Committee 2003)

However, many of the conditions we are concerned about in childhood such as child abuse, developmental delay and other aspects of childhood vulnerability, are difficult to screen for. This is because these children may exist along a continuum of risk which does not have a clear cut-off between “vulnerable” and “not-vulnerable”. Mechanic and Tanner (2007) describe vulnerability as a subtle and complex attribute which is manifest at many levels including individual genetic endowment, personality and traits, through to family networks and social and community linkages. It also includes the broader societal factors such as neighbourhood quality, financial sufficiency and cultural affiliations.

Artwork by Millie Torbit

Early in the lives of vulnerable children, it is not always possible to predict which children are likely to have poorer outcomes as adolescents and adults. In these situations the only real option is to move away from a risk based model of targeting to a needs based model. At present we have a universal safety net for children based on the universal service. Admittedly, not all families engage with this service, but experience shows that the development of a long term trusting relationship is key to linking “hard to reach” families into services. Families are routinely monitored through the universal Well Child service, and vulnerable families who have needs which impact on a child’s health and wellbeing can be sensitively and accurately identified so that additional services can be offered and families facilitated to take them up.
The Way Forward

The Well Child programme is currently moving away from a risk assessment model towards a needs assessment model for targeting additional services to vulnerable families. Needs assessment can be complex, but the model is already used in many areas of health and disability services (e.g. the NASC process) and other social services (Family Start) to identify current and potential needs which could help improve their lives and general wellbeing.

Our current vision is to develop this new model over time into a multi-sectoral assessment framework, such as currently used in the United Kingdom Common Assessment Framework (Every Child Counts). This has a number of benefits for the family and the service providers, including greater consistency of assessment of family needs, better information sharing between agencies, and a greater opportunity for coherent and consistent service provision. Families expect agencies to work together to deliver seamless care. A multisectoral assessment framework will assist us to meet these expectations.

References

5. National Advisory Committee on Health and Disability (2003) Screening to Improve Health in New Zealand – Criteria to assess screening programmes NHC. Wellington
6. Ottawa Charter for Health Promotion First International Conference on Health Promotion Ottawa, 21 November 1986
Has the time come for a Children’s Act?

By John Hancock, Principal Advisor, Legal, Office of the Children’s Commissioner

One of the issues raised by the Green Paper is whether new legislation should be enacted that strengthens the obligations on government to address and meet the needs of vulnerable children. This article will briefly examine the implications of this proposition against the context of current legislation and overseas examples.

The Green Paper identifies a number of specific functions that such legislation could invoke. These include requiring the establishment of a Vulnerable Children’s Action Plan, creation of legislative mechanisms for monitoring and reporting government progress, changes to policy and practice requirements and recognition of both the specific needs of tamariki and partnership with iwi, hapu and Maori organisations in meeting those needs.

Such legislation, which we will refer to for the purposes of this article as a ‘Children’s Act’, would need to have a broad ambit and sit at the apex of the body of child-related legislation. Its enactment would be a significant step for the government to take.

Against this context, it is notable that in its third and fourth periodic Concluding Observations on New Zealand, the UN Committee on the Rights of the Child, issued on 4 February 2011, recommended that the New Zealand Government:

→ Ensure all existing domestic legislation relating to children is brought into compliance with the Convention
→ Establish a permanent mechanism to ensure high-level and effective co-ordination of the Convention’s implementation
→ Adopt a comprehensive policy and national plan of action to implement the Convention.

The Green Paper itself has responded to these concerns, through its identification of an action plan for children and new legislation as two areas for exploration. It also recognises the role of the UN Convention on the Rights of the Child, alongside the Treaty of Waitangi, as an underpinning set of rights, values and principles.

Current children’s legislation

While there are many statutes that affect children’s lives directly or indirectly, there are three pieces of legislation that give statutory expression to the principles and values that sit at the heart of New Zealand’s children’s law jurisdiction. They are:

→ The Children, Young Persons and their Families Act 1989
→ The Care of Children Act 2004
→ The Children’s Commissioner Act 2003

The Children, Young Persons and their Families Act 1989

The Children, Young Persons and their Families Act (“the CYPF Act”) is perhaps the most significant legislative statement regarding children. Enacted in 1989, it closely pre-dates the ratification of the UN Convention on the Rights of the Child.

At a functional level, the CYPF Act provides the legal framework that underpins the mechanics of the care and protection and youth justice jurisdictions. In doing so, it directly concerns New Zealand’s most vulnerable children and young people. It has been described as ‘world-leading’ legislation and through its establishment of the Family Group Conference as the central decision-making forum in both care and protection and youth justice jurisdictions, it has provided a template for inclusive, family-centred decision-making that has been emulated by many countries overseas.

Significantly, the CYPF Act is also underpinned by principles that must be applied in practice. These include principles that concern the child’s connection and relationship with their family, whanau, iwi or hapu, specific youth justice principles which recognise the vulnerability of the child in criminal proceedings and which are essentially therapeutic and diversionary and the over-riding principle that the interests and welfare of the child must be the determinative factor in decision-making under the Act.

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With thanks to the Human Rights Commissioner, Diversity Forum Youth Participants

The Care of Children Act 2004

As its title suggests, the Care of Children Act 2004 (COCA) governs New Zealand’s parenting and guardianship jurisdiction. Among its many functions, the Act defines the legal duties, rights and responsibilities of legal guardians, provides the legal mechanics for determining parenting (care and access) arrangements and establishes the guardianship powers of the Family Court. The operation of the Act can therefore have a profound influence on the lives of individual children.

At the centre of decision-making processes made under COCA lie two fundamental concerns. The first, set out under section 4 of the Act, provides that the welfare and best interests of the child must be the first and paramount consideration in the administration and application of the Act. This is further informed by section 5, which sets out a number of principles to be applied in the determination of a child’s welfare and best interests, including the primary responsibility of parents and guardians in the care, development and upbringing of a child, the child’s right to safety and protection from all forms of violence and the preservation and strengthening of the child’s identity, whether cultural, linguistic, religious or otherwise.

The second regards the right of the child to participate in proceedings under the Act. Section 6 provides that a child must be provided a reasonable opportunity to express views in the course of proceedings and that those views must be taken into account. This reflects the right of participation enshrined in Article 12 of the UN Convention, recognised by New Zealand’s Family Court judiciary as the ‘linchpin’ of the Convention and therefore of considerable significance to the operation of the family law jurisdiction.9

The Children’s Commissioner Act 2003

The enactment of the Children’s Commissioner Act 2003 (CCA) strengthened the role significantly and, importantly, expanded the Commissioner’s functions to include additional powers and functions to give better effect in New Zealand to the UN Convention on the Rights of the Child.

Of all New Zealand legislation, the CCA is the most directly charged with the implementation of the Convention, which itself is annexed to the Act’s second schedule. Its functions notably include advancing and monitoring the application of the Convention by departments of State and instruments of the Crown and raising awareness and understanding of children’s rights, interests and welfare and of the Convention generally. It follows that the CCA signifies the most direct legislative expression of the Crown’s commitments under the Convention.

The implications of a Children’s Act

Given the scope of the above legislation, two matters for consideration initially arise when considering the implications of a Children’s Act. The first regards whether a Children’s Act is required in light of existing legislative principles. The second regards the manner in which a Children’s Act would reflect and intersect with the statutory framework that is currently in place.

Turning to the first issue, there is certainly a strong case for enacting over-arching legislation that facilitates formal collaboration across the different sectors, as our current statutory framework does not mandate a joined-up approach to service delivery to children based on a common set of principles.

The UK Children Act 2004, referred to in the Green Paper, is a good example of legislation that sets in place a legal platform for co-ordinated government activity. It provides that children’s services authorities and their relevant partners (which include the police, probation, youth offending services, strategic health authorities and the Learning and Skills Council) must make arrangements to promote co-operation. Such arrangements must be made with a view to improving the well-being of children, insofar that it is related to the
child’s physical and mental health and emotional well-being, protection from harm and neglect; education, training and recreation; their contribution to society; and social and economic well-being.\textsuperscript{10}

Notably, Part 1 of the Children Act 2004 also establishes the UK Children’s Commissioner and the role’s functions, which are generally less detailed or wide-ranging as those set out in the New Zealand CCA\textsuperscript{11}. It also established the role of ‘director of children’s services’ with responsibility for health, education and social services delivered to children by local authorities.\textsuperscript{12}

Another overseas example cited by the Green Paper is Victoria’s Child Wellbeing and Safety Act 2005. The Act sets out a charter of principles, entitled ‘principles for children’, that apply to the development, design and provision of services to children\textsuperscript{13}. Without expressly referencing the UN Convention on the Rights of the Child, the principles are wholly consistent with its framework and include co-operation and co-ordination of services. However, the principles are for guidance only and cannot be legally enforced.\textsuperscript{14}

The Child Wellbeing and Safety Act 2005 also establishes three entities charged with co-ordination and oversight of its principles; the Child Safety Commissioner, the Victorian Children’s Council and the Children’s Services Co-ordination Board. The Council, which includes the Commissioner, is charged with providing the Victorian Premier and the responsible Minister with advice regarding policies and services regarding the health, development, well-being and safety of children\textsuperscript{15}.

The Co-ordination Board is a high-level government entity comprising the Secretaries of the Departments of Treasury, Human Services, Justice, Education, Victorian Communities, Premier and Cabinet and the Chief Commissioner of Police\textsuperscript{16}, and is charged with reviewing and reporting annually to the Minister outcomes of Government actions regarding children, particularly vulnerable children. The Co-ordination Board is also responsible for monitoring administrative arrangements and co-ordination of service delivery at local and regional levels\textsuperscript{17}.

The Rights of Children and Young People Measure passed in a unanimous cross-party accord by the Welsh National Assembly provides another, powerful overseas example of legislative action. The Measure will have the effect of passing the UN Convention on the Rights of the Child into law and, from 2014, will require Welsh Ministers and the First Minister to have due regard to the rights and obligations in the Convention and its Optional Protocols in the strategic and day-to-day functions of the Welsh Assembly Government.

Read together, the above overseas examples highlight the gaps that exist in New Zealand’s statutory framework, namely:

\begin{itemize}
  \item The lack of a high-level co-ordinating mechanism within the structure of government to co-ordinate cross-sector work programmes and accountability for outcomes (such as a Director of Children’s Services or Children’s Services Co-ordination Board); and
  \item The lack of a set of core legislative principles regarding children that apply across the relevant government sectors (such as the ‘principles for children’ under the Victorian legislation for example).
\end{itemize}

An over-arching Children’s Act would result in much greater levels of government accountability and cross-sector co-ordination. Its elevated status would also ensure that children’s interests are taken into account during the fiscal and economic considerations and priorities that occur at the heart of government decision-making and power. This, in turn, would provide a platform upon which cohesive policies for children can be developed and sustained across the various government sectors.

This raises the secondary question of how such legislation would interact and relate with other child law statutes. A Children’s Act would not necessarily require major changes to other legislation, such as the CYPF Act...
for example, as it is not designed to govern or prescribe a set of functions for a specific sector. It therefore would not necessitate large-scale subsequent amendments or new regulations. Of central importance will be ensuring that its principles complement or align with those already established.

However, if the overseas statutes referred to above were to be adopted as a template for New Zealand, this could mean the role of the Children’s Commissioner would become vested under a Children’s Act, rather than under its own legislation as is currently the case. Such a move would either enhance or dilute the role, depending on the extent to which the current functions and constitutional status are retained or modified. This is a critical issue given the important statutory function the Commissioner has in monitoring the government’s application of the UN Convention on the Rights of the Child.

In conclusion, the time has clearly come for an overarching Children’s Act to be considered for development and implementation in New Zealand. Both the Green Paper and the UN’s concluding observations reflect in different ways the current social concerns that exist about the circumstances of New Zealand’s vulnerable children. Our current legislation provides a good basis upon which to build an enduring statutory framework that delivers better outcomes for children.

References

3. ibid paragraph 13
4. ibid paragraph 15
6. Section 5, Children Young Persons and their Families Act 1989
7. Section 208, Children Young Persons and their Families Act 1989
8. Section 6, Children Young Persons and their Families Act 1989 – note this principle does not extend to youth justice proceedings undertaken under Part IV of the Act.
10. Part 2, Section 10, Children Act 2004 (UK)
11. ibid, Part 1 ss1-9
12. ibid s18
13. Section 5, Child Wellbeing and Safety Act 2005 (Vic.)
14. ibid, section 4
15. ibid, section 10
16. ibid, section 14
17. ibid, section 15
There are large inequalities in health outcomes for children in New Zealand\(^1\). The New Zealand Health Strategy commits health services to reducing these inequalities in health outcomes\(^2\), e.g., by reducing barriers to access to services. The families of vulnerable children often move, change cellphones frequently and do not notify health services that they have moved, making it difficult to ensure children receive preventive care and contributing to health inequalities.

Information systems are powerful tools to ensure those who most need a service receive it\(^3\). They are a key tool in reducing health inequalities for Maori and Pacific children. The information systems are governed by the twelve principles\(^4\) of the Privacy Act 1993\(^5\) and the Code of Health and Disability Consumer Rights\(^6\), which ensure that data is only used for the purpose for which it was collected, and service users must consent to the collection and sharing of data. Some systems have proven remarkably effective at improving access for Maori and Pacific, and allow funders to monitor the performance of service providers and health outcomes. Examples are given below.

Vulnerable families also have frequent contact with health providers who record families’ new details, but systems to share the new details within the health system are poor or non-existent. Systems also rarely update the details of other household members. Invitations for services are therefore sent to previous addresses, contributing to poor access and health inequalities.

Currently the Health Information Strategy for New Zealand does not include maintaining up to date contact details for patients as a priority\(^7\). I believe it should. For example, the strategy could prioritise linking databases of contact details within Health (e.g., Primary Health Organisations’ age-sex registers, hospital clinical information systems, Before-School Check Database, Oral Health Service database, National Immunisation Register) so all systems are automatically updated with each contact with a service. Family members usually resident together could also be linked (as they often are in primary care practice management systems) so that if one family member makes contact with a health service and their change of details is recorded, this data can be used to update all other household members.

**National Immunisation Register (NIR)**

Immunisation is the most cost-effective health intervention after clean water and sanitation\(^7\). Effective disease prevention depends on high immunisation rates producing herd immunity, e.g., eradication of Morbilli (Measles) requires a vaccination rate of 95\%\(^8\). The NIR was introduced in 2005 after successive national immunisation coverage surveys demonstrated very low coverage rates, particularly for Maori and Pacific\(^9,10\). Children were much less likely to be immunised if they moved twice since birth (OR 0.46) or if they were Maori (OR 0.46) or if they were Maori (OR 0.6), leaving these groups vulnerable to vaccine preventable disease.

Since implementing the NIR in 2005, immunisation rates have increased for all District Health Boards and for children of all ethnicities\(^12\). Some District Health Boards have achieved exceptional immunisation rates, e.g., in Hawke’s Bay, the immunisation rate at two years is 93 percent for NZE and 94 percent for Maori.

While enrolment on the NIR is voluntary and nearly universal, some children aren’t enrolled on the NIR until several weeks old. Many Maori and Pacific children are also enrolled late with General Practitioners (GPs) and Well Child/ Tamariki Ora (WCTO) providers. The child’s immunisations will often be given late, greatly increasing their chance of admission with a vaccine-preventable disease like whooping cough and increasing inequalities. Potential solutions include:
Before School Check (B4SC)

The Ministry of Health’s B4SC is a national programme available in all DHBs that “aims to identify and address any health, behavioural, social, or developmental concerns which could affect a child’s ability to get the most benefit from school.”13 In Hawke’s Bay the B4SC programme uses a sophisticated database and performance management system to ensure high access rates for Maori and Pacific children who live in poverty. Data is also analysed to examine referral rates by type and the proportion of referrals accepted and declined. This data is fed back to GPs to improve the quality of the programme and ensure that children who have not yet received their check do so, or are referred to an outreach service to find the child and offer the service.14 However B4SC performance is variable across the country.15 Data linkages to other databases within health (e.g., WCTO providers, Oral Health Service, NIR) are weak. It therefore takes longer for busy providers to look up information on children, so sometimes children miss out on a service they would have received if that knowledge had been available to the clinician.

Solutions to these issues could include:

→ The Ministry of Health use the available information from the B4SC database to support PHOs to improve performance of B4SC providers
→ The National Health IT Board prioritise connectivity between systems for children, e.g., WCTO, NIR, Oral Health and General Practice systems.

How can the possible negative consequences of increased monitoring be minimised?

The public must have confidence that their information will only be accessed and used appropriately. All the above systems have comprehensive processes to minimise inappropriate accessing and sharing of information, based on the twelve principles of the Privacy Act4. These include:

→ Policies on accessing and sharing of information are reviewed by experts on privacy and confidentiality to ensure they adhere to national standards that strictly regulate accessing and sharing of information
→ Staff receive training on and are required to adhere to these policies
→ Random audits to identify unauthorized access
→ There are strict penalties for unauthorised accessing or sharing information (termination of employment and referral to Police)
→ Access limits that prevent certain staff accessing information they are not entitled to.

These protections should not change.

Information sharing

We already have systems to facilitate sharing of information. Each system has its strengths and opportunities for improvement. Examples include:

→ All New Zealanders have a unique identifier (National Health Index (NHI) number) within Health that facilitates information sharing, e.g., transfer of care from GP to specialist is dependent on NHI.
→ All DHBs and most GPs now have electronic clinical records. These are accessible for approved clinicians who are required to abide by the provider’s privacy rules.

Information sharing is made difficult by systems that do not easily allow transfer of care, e.g., Electronic transfer of care systems such as electronic referrals (e-Referrals) and discharge summaries (eDS), or sharing of clinical information between primary and secondary care.

Regional Health Information Services Plans (e.g., the Central Region Information Service Plan – CRIS16) are currently working on e-Referrals, eDS and information sharing between primary and secondary care within the broad structure of the Health Information Strategy for New Zealand under the oversight of the National Health IT Board17.
Child Protection Alert System and Antenatal Child Protection Alert System

Child abuse is frequently missed in health services and further abusive events commonly occur. Abused children are frequently pre-verbal and families often move, making it difficult to connect events\(^1\). Death reviews frequently comment on how health services failed to share information adequately\(^2\). Child Abuse Alerts (CPAs) attached to the National Medical Warning System (NMWS)\(^3\) act as a warning to clinicians that information on a child exists and where to find it. The (NMWS) has been used to share critical information between health providers since 1977. Only children referred by health professionals to Child, Youth and Family (CYF) in whom a multidisciplinary team agree there is ongoing risk of abuse can have a CPA added, or ANCPA for pregnant women. The experience in Hawke's Bay and Auckland is that the CPA system has been very helpful in ensuring that clinicians concerned for a child had early warning of previous child protection concerns and appropriate action was taken to ensure the child's safety.

What else can the government do to make sure professionals and services have all the information they need to make the best decisions about services for vulnerable children and their families and whanau?

Information sharing between services is compromised by strict rules that require families to know before information can be shared. Information sharing from government services (Health, Police, schools) to Child, Youth and Family and Police is permitted under the CYP&F Act where there are child protection concerns, and between health services by the Health Act. However information sharing from Child, Youth and Family to other agencies, and between NGO social services, Health and schools are not covered. Sometimes this means information that could keep a child safe is not shared and children's outcomes are poor\(^4\).

The Law Commission has proposed changes to the Privacy Act\(^5\) to allow Orders in Council permitting information sharing between such government agencies where there are child protection concerns. We support this change.

Summary

Information sharing and monitoring of children already occurs and contributes to keeping children safe and improving access to services, reducing health inequalities. There is potential to improve these systems through the Green Paper, in particular by improving IT systems across the health sector to automatically update changes of address, making enrolment on the NIR and with a GP and WCTO provider an opt-off system and ensuring this happens before newborn infants are discharged from hospital, better use of available data to performance manage providers and ensure the most at-risk children receive services, better connectivity between systems, e.g., for transfer of care, use of child protection alerts and making information sharing easier between services concerned for a child's wellbeing.

References


Opportunities

A ‘Green Paper’ is a discussion document that outlines ideas a Government wants to test with the public before making decisions. The New Zealand Government is concerned about the number of children who have childhoods that make it unlikely they will thrive, belong and achieve. The Green Paper outlines a number of ideas on how to improve leadership for vulnerable children, some policy changes; and some changes to how services are delivered.


The Green Paper is available in English, Te Reo, Samoan and Tongan
To view the questions from the Green Paper visit http://www.childrensactionplan.govt.nz/home/consultation-questions


There is a Green Paper Facebook page – facebook.com/greenpaperonchildren

Let the Government know what you think – we can help you do this.

We encourage you to help New Zealand children and young people have a voice in the Green Paper process.

→ Ministry of Youth Development Keeping it Real, E Tipu e Rea http://www.myd.govt.nz/have-your-say/resources.html#ETipuERea7
→ Youth Development Strategy Aotearoa http://www.myd.govt.nz/have-your-say/resources.html#YouthDevelopmentStrategyAotearoaYDSA12

Further reading around children’s rights (birth to 18 years) and participation in decision making:

→ Arnstein, Sherry R A ladder of Citizen Participation
→ Hart R 1997 Children’s Participation: From Tokenism to Citizenship (Innocenti Essays No 4), UNICEF International Children Development Centre Italy
→ Hart, R (1997) Children’s Participation The Theory and Practice of Involving Young Citizens in Community Development and Environmental Care, Earthscan: UK

Submissions close 28 February 2012


Outward Bound course for people who work with youth

The Connect course combines support from experienced facilitators from the youth sector, outdoor adventures and key learning sessions, to help people who work with youth in New Zealand to be more equipped and feel more confident and connected in their role.

Course dates Saturday 5 November to Saturday 12 November 2011

Content

Through key partnerships with expert facilitators from the youth sector, the Connect course extends Outward Bound’s experiential programme to one that develops the professional skills and standards of people who work with youth in New Zealand.

As a member of Ara Taiohi, you will only pay $900 towards your total course fee ($2,560) which covers:

- food and accommodation
- activities and specialist equipment
- 2 Outward Bound instructors, 1 expert facilitator from the youth sector and special guests

Outward Bound sources funding for the rest of your course fee. To become a member of Ara Taiohi visit: www.arataiohi.org.nz

For more information about CONNECT visit http://www.outwardbound.co.nz/ Freephone: 0800 OUTWARD (688 927)

Reports Publications

‘Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence’ By Sir Peter Gluckman

Or visit www.pmcsa.org.nz/ for information around this report.

Effectiveness of the alcopops tax: Researchers’ opinion

A ‘For Debate’ piece in the latest issue of The Medical Journal of Australia (MJA) discusses the effectiveness of the 2008 tax on ready-to-drink spirit-based drinks (alcopops) and concludes that, although it appears to be working, more needs to be done to tackle teen drinking levels.

Download this report at http://www.acys.info/yfx/issues/number_179/july_s_news/effectiveness_of_the_alcopops_tax_researchers_opinion
Source: Youth Field Xpress, no. 179, July 2011.)

Australian and NZ teens highly ranked in computer literacy

An OECD report called Students On Line: Digital technologies and performance shows Australian and New Zealand students ranked second behind Korea among 70 countries.

Download this report at http://www.acys.info/yfx/issues/number_179/july_s_news/australian_and_nz_teens_highly_ranked_in_computer_literacy
(Source: Youth Field Xpress, no. 179, July 2011.)

Left Behind

A Child Poverty Action Group Monograph
Edited by M.Claire Dale, Mike O’Brien and Susan St John

For more information please visit www.cpag.org.nz/
Hunger For Learning

The Child Poverty Action Group (CPAG) has recently released the report, Hunger for Learning. It discusses the experiences of five Auckland schools which run breakfast programmes and outlines the real educational advantages that these programmes offer to their students.

Download this report at http://www.cpag.org.nz/assets/Publications/2-0%2025804%20Hunger%20for%20Learning%20Brochure.pdf

Children’s Perception of Violence

‘Children’s perceptions of violence: the nature, extent and impact of their experiences’ – this paper reports on a study that examined children’s perceptions of the prevalence, incidence, and impact of violence experiences witnessed by them, and factors that mitigated and reduced its impact. It was published in the June 2011 issue of the Social Policy Journal of New Zealand.


NZ Institute Report of Disadvantaged Youth

A report released by the NZ Institute states youth aged 15 to 19 in New Zealand are disadvantaged compared to youth in other OECD countries in nearly every way. The report ‘More ladders, fewer snakes’ proposes that accelerated roll-out of e-learning to low decile schools and improving the school-to-work transition will materially reduce youth unemployment and resulting social issues.

Download this report at http://www.nzinstitute.org.nz/index.php/ownershipsociety/paper/more_ladders_fewer_snakes_two_proposals_to_reduce_youth_disadvantage/

1000 days to get it right for every child – the effectiveness of public investment in New Zealand children.

A report by David Grimmond of Infometrics Ltd

Download this report at http://www.ncwznz.org.nz/assets/Uploads/1000-days-to-get-it-right-for-every-child.pdf


He Ara Hou Report 2011

Auckland University team led by Professor Manuka Henare, He Ara Hou: the pathway forward: Getting it right for Aotearoa New Zealand’s Māori and Pasifika children examines the statistics relating to our Māori and Pasifika children and shows that just over half of the 200,000 New Zealand children living below the poverty line, are Māori (59,651) and Pasifika (44,120).


For more information visit www.everychildcounts.org.nz/

The Children’s Social Health Monitor 2011 Update

Download this report at http://www.nzchildren.co.nz/

Kids Club Pilot Evaluation Report 2011

Written for Supporting Families in Mental Illness – Auckland by Jo Hazel


Parental divorce – outcomes for children

The paper Parental divorce and adult family, social and psychological outcomes, using data from the Personality and Total Health (PATH) Through Life Project, shows children from divorced families are more likely to experience long-term disadvantage.

The data used covers a broad range of adult outcomes relating to family, social and psychological factors and responses to 17 items on childhood family adversity factors experienced up to the age of 16. The results reinforce the pattern of earlier Australian and international research that children from divorced families experience long-term disadvantage compared with their peers from intact families. There are particularly strong associations with early transitions to adult roles.

“Adolescence – Beyond the Stereotypes”
This report reflects on the state of the world from a young perspective. The publication has been created by an editorial team of 12 adolescents and young people from all parts of the world, who were involved in collecting, editing and reviewing the content, shaping the design and illustrations, and planning for the launch and distribution of the publication.

Download this report at http://www.voicesofyouth.org/posts/adolescence-beyond-the-stereotypes

Training, Conferences, Hui, Wangana, Fono

WELTEC Bachelor of Youth Development
Interested in a career working with New Zealand’s youth? Want to make sure you have the skills and knowledge employers need most? Get the right start with WelTec’s new, cutting-edge Bachelor of Youth Development.

Developed in close collaboration with industry, and committed to a Treaty partnership approach, the Bachelor of Youth Development has been designed to develop confident and capable practitioners for modern youth services.

For more information visit http://www.weltec.ac.nz/SUBJECTAREAS/SocialServices/BachelorofYouthDevelopment.aspx

Or Email information@weltec.ac.nz; or Call 0800 WELTEC.

ARA TAIHOI

Ara Taiohi is a new national organisation to help people who work with young people become more connected, effective and accountable.

Two well-established national bodies, New Zealand Aotearoa Adolescent Health and Development and National Youth Workers Network Aotearoa, have joined forces to create Ara Taiohi.

As its name signifies, the health and well-being of young people at the heart of the new organisation. (‘Ara’ means ‘pathway to/for’, and ‘taiohi’ means ‘young people’).

Those in the youth sector are invited to Ara Taiohi’s AGM to be held on Thurs 27 and Fri 28 October 2011, to contribute to the implementation of the strategic plan and shape Ara Taiohi’s priorities. Discussions and formations of cacui and workshops on the Green Paper, dealing with the Media, and input in the Ara Taiohi website will also be covered.

Ara Taiohi has copies of the Youth Workers’ Code of Ethics 2nd edition available.

Now is the time to join this strong nationwide movement that represents a coming of age in a sector that will always be young at heart.

For more information go to www.arataiohi.org.nz.

Or you can phone (04) 802 5000 or email admin@arataiohi.org.nz

Jigsaw National Conference,
Te Papa, Wellington
2 – 3 November 2011
‘whanau ora – through children’s eyes’.

A conference for anyone interested in or working with whanau and families where children may be experiencing violence, abuse and neglect.

For more information see www.jigsaw.org.nz
The 8th Australian and New Zealand Adolescent Health Conference
9–11 November
Darling Harbour, Sydney

Paediatric Society of New Zealand 63rd Annual Scientific Meeting
Auckland
Tuesday 22nd – Friday 25th November 2011.
Further information at www.psnz2011.co.nz

New Resources
“Read & Rights”

November 20th marks the day in 1989 when the United Nations adopted the UN Convention on the Rights of the Child (UNCROC) ..., a historical landmark for recognising children’s best interests and that their protection and participation should be high on every government’s agenda.

UNICEF NZ is marking the occasion with a new publication for young children to learn about their rights. “Every Child” is a picture book with contributions from some of our well-known children’s illustrators, and simple text which will help children realise and understand the value of human rights. The Children’s Commissioner is supporting this publication.

The book will be launched during the week of November 21 2011 with readings at libraries throughout the country. You may want to be involved to support the objectives for children and adults to share the joy of reading together, to learn about human rights and discover the treasures in their local library.

Contact your library to find out if there is a Read&Rights event near you.

Link to more information http://www.unicef.org.nz/ReadAndRights

Or contact Barbara Lambourn 0800 243 575

Child Matters has recently relaunched its popular book ‘How Can I Tell?’. This book is a practical, easy-to-understand guide that not only educates people about the signs of child abuse, but also gives people the knowledge and confidence to know what to do next.

‘How Can I Tell?’ is in its fourth print run with 40,000 copies having already been distributed since 2009. The difference with this new edition is that it has been re-designed specifically for public readership, having previously been targeted more towards people working with children.

‘How Can I Tell?’ is available to purchase from the Child Matters website www.childmatters.org.nz, for $2 plus postage. Order your copy today – and why not order a few extras to give to other adults and community groups who you think may benefit from this valuable information.

The Childsafe Guide is a tool for organisations to help them evaluate how childsafe their organisation is and develop policies and procedures to ensure their organisation is childsafe in the future. A step-by-step guide to help you manage risk and keep children safe in your organisation that provides:

→ A process for evaluating how childsafe your organisation currently is, as well as for developing robust plans to protect the children in your care,

→ A framework to develop a comprehensive child protection policy that will ensure your organisation has:
  - Childsafe People
  - Childsafe Practices
  - Childsafe Training

→ Advice about important issues.

You can access this tool at: www.childmatters.org.nz/150/resources-info-centre/childsafe-guide
About Child Matters

Every child deserves to flourish in an environment safe from all abuse. Child Matters is determined to ensure that this happens.

Child Matters, a national charitable trust based in Hamilton, is the only organization in New Zealand solely focused on child abuse prevention.

Women’s Refuge new look and website

The website www.womensrefuge.org.nz has over 100 pages of up to date advice, tips, and legislation information on all matters related to domestic violence. For the first time it has a Youth micro site, targeted at young people 12 – 25. It offers youth a quiz to look for early warning signs of controlling relationships, key advice on where to go for help and a section for GLBTI (gay, lesbian, bisexual, transgendered, intersex) youth. “Three years in the planning and 12 months in the build, we now have a brand new updated website with a look that brings us firmly into the 21st century,” says CEO Heather Henare.

“Reaching out to young people is one of our overarching goals. Our statistics tell us that 56 percent of the women who reach out to us are under 35 years of age. Having information appealing and relevant to young people, fits with our emphasis on preventing domestic violence as early as possible.”

Please find us at www.womensrefuge.org.nz, Twitter.com/womensrefugenz, Facebook.com/womensrefugenz or Youtube.com/womensrefugenz

Youth and the Law 2010 edition

Email: enquiries@edresources.co.nz

Phone: 04 801 7066
Price: Youth and the Law – $35.50 + GST including postage and packaging
Enquiries about school sets are welcome

Legal Ages Posters – $26.80 + GST set of three including postage and packaging

Raising Children in New Zealand

Raising Children in New Zealand is a new ground-breaking parenting series, focusing on particular stages of the first three years of a child’s life.

Organisations or individuals who would like a copy of this information can order a copy of Raising Children via www.raisingchildren.org.nz or phone the Raising Children office on (09) 638 5515.

DVDs cost $25 plus postage and packaging, with significantly discounted rates for four or more DVDs.

Online training tool helps professionals to connect with young people

ReachOut Pro has produced a new online training tool called Connecting Our Worlds to assist healthcare practitioners, youth workers, and those working in health promotion to better engage with young people through the use of technology.

This four-part educational module provides users with a basic understanding of young people’s relationship with technology, popular programs, websites and technologies used by young people, how technology can be used as a clinical and therapeutical tool, and professional and ethical issues that arise from using technology in working with young people.

For further information, visit: http://www.reachoutpro.com.au/professional-development.aspx
(Source: YouthGAS email list, 25 May 2011.)

Lifeline Suicide Prevention Helpline: 0508 TAUTOKO

New Zealand’s first suicide prevention helpline.

For more information visit http://www.lifeline.org.nz/

Suicide Prevention Information New Zealand can be found at http://www.spinz.org.nz
VOICY

The Ministry of Youth Development's online youth engagement tool, VOICY, is a way for youth to contribute directly to policy making. MYD has set it up to help MYD understand what the real issues are for young people. VOICY is an online community where young people can join in conversations, share their vision for New Zealand and talk about the things that matter to them. Discussions from VOICY are summarised into reports and help inform policy advice that shapes. Visit VOICY at http://voicy.bangthetable.com and encourage the young people you work with to have their say.

Tikanga Whakatipu Ririki

Maori child advocacy organisation Te Kahui Mana Ririki had developed a strengths-based Maori parenting model called Tikanga Whakatipu Ririki. The model is informed by a literature review of historical Maori parenting practices. This knowledge has been distilled into a modern and practical positive parenting model.

Tikanga Whakatipu Ririki resources available are:

- A guide for whanau (a summary booklet of the model for whanau and parents)
- A5 flyers (a summary of Tikanga Whakatipu Ririki parenting beliefs and techniques for whanau and parents)
- Fridge magnets (Tikanga Whakatipu Ririki beliefs about tamariki)
- Trainer manuals and parent workbooks (for providers who have participated in the Tikanga Whakatipu Ririki training for trainers workshops)

Our beliefs about tamariki

<table>
<thead>
<tr>
<th>Tamariki are atahaua</th>
<th>Children are perfect. They are the face of God. Ata or atua is a reflection or a god. Ahua is aspect or nature. Babies are perfect and they are still perfect when they are children.</th>
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</thead>
<tbody>
<tr>
<td>Tamariki are wairua</td>
<td>Children are spirit. Wai is water or stream. Rua means two. Children are spirit. They are both male and female. Both sides need developing to be in balance. The female in the boys needs to be evident and the male in the girls. Boys have a tender and nurturing side and girls have a strong and directional side.</td>
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<tr>
<td>Tamariki are tapu</td>
<td>Tapu is special, sacred. Children are special because they come from the ones who have gone before, the tipuna, and they are the parents of the ones to come. They are sacred because they are whakapapa to the atua, the gods.</td>
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<tr>
<td>Tamariki have mana</td>
<td>Children have status and power. Respect them. Children have their own power. They are the face of god; they are wairua and they are tapu. This gives them mana.</td>
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<tr>
<td>Tamariki need aroha</td>
<td>Children need love. They need adults who are committed to them. Aroha is love and it is commitment. This is vital to children. They need love and they need adults who will commit to them totally and always.</td>
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<tr>
<td>Tamariki need turangawaewae</td>
<td>Children need to belong. They must trust their whanau and friends. Turangawaewae is a secure and safe place where tamariki know everyone. It means whakapapa and whanaungatanga; family relationships and connections.</td>
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<tr>
<td>Tamariki need hinengaro</td>
<td>Hinengaro is the mind – the place where problems and conflicts are solved. If tamariki are shown violent solutions, they will find it hard to learn non-violent methods.</td>
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These resources can be ordered from the Office of the Children’s Commissioner, PO Box 5610, Lambton Quay, WELLINGTON 6145. Email publications@occ.org.nz Fax (04) 4711418 Phone 0800 224 453, option 2
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<td>Setting the scene to encourage good behaviour</td>
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<td>Te whakatika i te whanua kia pai tonu te noho</td>
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<td>Some suggestions on how to help children behave</td>
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