Image from *Photovoice: This is how I see it, OCC 2008*

Improving the mental health and wellbeing of children and young people

SUBMISSION FROM THE OFFICE OF THE CHILDREN'S COMMISSIONER
TO THE GOVERNMENT INQUIRY INTO MENTAL HEALTH AND ADDICTION

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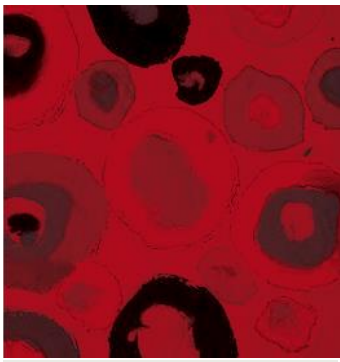

PURPOSE

1 This paper describes the key areas of opportunity that I believe we need to focus on in order to improve the mental health and wellbeing of our children and young people. Many of these areas are inter-related.

2 We have included in this paper quotes from children and young people who talked to us about their emotional and mental wellbeing and related experiences as part of our *Education matters to me* series[1].

DEFINITION OF MENTAL HEALTH AND ADDICTION ISSUES USED IN THIS PAPER

3 In this paper, I use the term mental health and addiction issues in their broadest sense, encompassing behavioural, emotional, mental health, neurodevelopmental, and alcohol and other drug (AOD) problems and disorders

SUMMARY OF OUR RECOMMENDATIONS

Rec 1: Provide more therapeutic support for children and young people and their families and whānau

1a Provide more therapeutic support in the community

1b Provide more therapeutic residential care

Rec 2: Update the specialist mental health service specifications to include behavioural disorders

Rec 3: Address system and organisational barriers that prevent effective treatment of mental health and addiction issues

3a Address funding barriers

3b Remove barriers to collaboration

3c Provide clear, coordinated service pathways, especially for children and young people with neurological disabilities

3d Improve continuity of mental health and addiction services, especially for children and young people and families who move outside their local community

Rec 4: Take direct action to address the over-representation of tamariki and rangatahi Māori

The Children's Commissioner represents the **1.12 million people** in Aotearoa New Zealand under the age of 18, who make up 23 percent of the total population.

The Commissioner has the statutory role to advocate for their interests, ensure their rights are upheld, and help them have a say on issues that affect them.

The UN Convention defines 'children' as everyone under the age of 18. When we talk about 'children' we include this whole group.

When talking about children and young people who are Māori, we use the terms tamariki and rangatahi Māori.

[1] See: http://www.occ.org.nz/publications/reports/education-matters-to-me-key-insights/

Rec 5: Ensure services operate in child-centred ways

Rec 6: Address the underlying causes of mental health and addiction issues

6a Create environments that nurture relationships

6b Invest more in prevention - Antenatal and Wellchild Tamariki Ora Services

6c Address the environmental stressors that contribute to youth suicide

6d Reduce child poverty

BACKGROUND

4 The Office of the Children's Commissioner wants Aotearoa New Zealand to be a place where all children can thrive. The Children's Commissioner is independent from Government. He have a broad role to advocate for the best interests, rights, health and wellbeing of all of New Zealand's 1.12 million children and young people aged 0-17 inclusive. They make up 23 percent of New Zealand's population. The Children's Commissioner's role also involves ensuring children have a say and can be heard on issues that affect them. He is also mandated, via the Children's Commissioner Act 2003 and the Crimes of Torture Act 1989, specifically to monitor the policies and practices of Oranga Tamariki, the Ministry for Children.

5 The Children's Commissioner and his Office are committed to honouring Te Tiriti o Waitangi and have a duty to advocate for, and ensure meaningful engagement with, Māori as tangata whenua. We also recognise that New Zealanders made a promise to ensure certain rights to tamariki and rangatahi of Aotearoa (children and young people of New Zealand), as outlined in the United Nations Convention on the Rights of the Child (UNCROC) in 1993.

6 During the course of the Office's monitoring, we have interviewed health staff, Oranga Tamariki staff and children and young people all around the country. As a result, we have learnt much about the key mental health-related system and practice issues facing children and young people, particularly those in the care of Oranga Tamariki. We hear about complaints and concerns related to systemic issues affecting children's mental health and wellbeing.

7 We also regularly hear about mental health from children and young people through our 'Mai World', child and youth voices engagements. We have found in recent years that children and young people raise concerns about mental health, suicide, and lack of timely services or supports.

Key areas of opportunity to improve children's and young people's mental health and wellbeing

1 PROVIDE MORE THERAPEUTIC SUPPORT FOR CHILDREN AND YOUNG PEOPLE AND THEIR FAMILIES AND WHĀNAU.

1a Provide more therapeutic support in the community

8 There is a large gap in both primary and specialist community-based therapeutic services that address children's and young people's behavioural, emotional and mental health problems. By therapeutic support, we mean a wide range of services that have expertise in engagement and working with a wide variety of families and whānau who are struggling and want and need help. Therapeutic support helps children and young people and their families and whānau to address their behavioural, emotional and mental health needs and includes cultural support.

9 The lack of community-based therapeutic support for children and young people and their families and whānau is a key barrier to the effectiveness of Oranga Tamariki's work. Firstly it makes it more challenging for Oranga Tamariki to keep children and young people safely with their families and whānau. Secondly, in the event a child or young person needs to be removed from their families or whānau, it makes it more challenging to provide a safe, stable placement. The lack of therapeutic support is also a reason that transitions to different placements often fall over and that young people end up committing offences and spending time in secure youth justice facilities.

10 While primary mental health services have grown in recent years, it is still too difficult for children and young people and their families and whānau to access: family therapy; cultural support; parenting support; or talking therapy for any issues they may have. There is inherent structural bias because services do not adequately respond to the needs of clients, particularly Māori and Pacific peoples. Supporting and developing culturally responsive services will reduce disparities in accessing services.

"I would like our school to put more effort into recognising mental and emotional issues that some students have, our school seems to only want our attendance to look good. Mental health isn't something our school focuses much on, which isn't good considering how much changes teenagers go through. I want our school to be more understanding about LGBT+ people, give us a unisex uniform." *(Secondary school student, NZ European)*

11 Organisations and professionals who do have responsibility for children with behavioural issues frequently themselves say they don't have the necessary expertise, the result being that many children and young people with behavioural issues fall between the cracks.

12 To address these service gaps, we need more community funding to increase access to therapeutic services through: schools, non-government organisations, Māori social service organisations and primary and specialist mental health care settings.

1b Provide more therapeutic residential care

13 There is also a significant shortage of secure child and adolescent mental health beds. This gap in facilities and resources leads to young people being detained in the company of adults in mental health units. This is contrary to the United Nations Convention on the Rights of the Child (UNCROC), article 37(c). The lack of specialist mental health facilities also results in children being detained in secure care and protection residences for unacceptably

long periods, e.g. 9 months. According to Dr Russell Wills, the previous Children's Commissioner and consultant paediatrician, there are between 100-200 young people in New Zealand with very high and complex needs for whom there are quite inadequate facilities. We see this as an urgent issue.

14 Specialist mental health and AOD services often refuse to treat children and young people who are not in stable placements. There is frequently tension between specialist mental health services and Oranga Tamariki. Oranga Tamariki staff are frustrated that specialist mental health services often say they cannot accept children and young people into treatment if children and young people are not in a stable, long-term placement. We frequently hear that Oranga Tamariki staff struggle to access specialist mental health services for children and young people whose living circumstances are unsettled. We have come across several cases of young people in secure Oranga Tamariki residences who were suicidal but receiving only limited support from specialist mental health services because they were not in long-term placements.

"It was terrifying to transition because I knew nobody, so I would not go to school because it was too scary." *(Student in alternative education, Pākehā))*

15 While we understand the significant challenges associated with successfully treating children and young people who are not in stable placements, we believe that specialist mental health and addiction services take this argument too far, with the result that many children and young people who could benefit from some level of treatment are denied access. There is evidence that short term interventions can make a difference. We believe that children and young people in short term placements should have access to specialist mental health services when needed.

16 There is a lack of a suite of suitable placement options for children and young people in contact with Oranga Tamariki. Specialist mental health and AOD services are also frustrated with Oranga Tamariki's lack of placement options. Oranga Tamariki is currently working to increase the level of whānau searching and to expand the range of placement options for young people (including those on remand), but this process is likely to take some time to reach fruition. In the meantime, Oranga Tamariki staff will continue to struggle to find safe, stable placement options for children and young people.

2 UPDATE THE SPECIALIST MENTAL HEALTH SERVICE SPECIFICATIONS TO INCLUDE BEHAVIOURAL DISORDERS

17 The service specifications for specialist child and adolescent mental health services (CAMHS) explicitly exclude children and young people with predominantly behavior problems from receiving services. This is a particular issue for children and young people in the care of Oranga Tamariki, an over-representative proportion of whom have behavior problems due to their family backgrounds and complex trauma experienced earlier in life. These young people's behaviours are often driven by their inability to regulate their emotions.

18 The artificial distinction that specialist mental health services make between behaviour and mental health disorders significantly reduces vulnerable children's and young people's access to mental health and addiction services. This undermines the ability of Oranga Tamariki to find stable placements for children and young people. Caregivers are dealing with traumatised children who often have very challenging behaviour. When caregivers and young people do not receive appropriate therapeutic support, placements are more likely to fail. Multiple placements result in further trauma and behavioural and emotional issues for children and young people.

19 We believe Mental Health's policy to treat only those people with mental health issues (or comorbid behavioural and mental health issues) should be revised, with appropriate

resources given to grow core mental health and AOD services and increase vulnerable children's and young people's access to specialist support.

20 We realise removing the exclusion from the service specifications has the potential to overwhelm CAMHS with referrals. Primary mental health services also have a key role to play in addressing behavioural problems early, as does Oranga Tamariki, Education, Police and Justice. What is also needed is an interagency strategy to design and align the services needed to address the behavioural (and emotional) problems of children and young people. This work has started many times in the past but keeps stalling due to competing priorities.

3 ADDRESS SYSTEM AND ORGANISATIONAL BARRIERS THAT PREVENT EFFECTIVE TREATMENT OF MENTAL HEALTH AND ADDICTION ISSUES.

3a Address funding barriers

21 Funding for mental health and addiction issues is currently siloed through District Health Boards. But if we are to address the underlying causes of mental health and addiction problems, then we agree with Mary O'Hagan, a previous mental health commissioner, that we need growth in a wide range of community support services, including: cultural and spiritual services; education support; income and employment support; community based crisis support; wellbeing promotion and self-management; advocacy and navigation; psychiatric treatments; talking therapies; stable housing; and physical health care.

22 To achieve growth in these areas, we need multi-sector planning, funding and accountability. To avoid the effects of agencies working in siloes, we could either top slice funding or alternatively pool funding from different agencies after the funding is allocated to enable resources to be moved more flexibly to where they are needed and to address mental health and addiction issues in a much more holistic way.

3b Remove barriers to collaboration

23 There is a lack of effective collaboration and joint planning between specialist mental health and addiction services and Oranga Tamariki. We frequently hear stories about how both specialist mental health services and Oranga Tamariki take a step back once children and young people are in the care of the other service. A more coordinated, joined-up approach is needed. Currently the degree of true team work between the two different agencies is dependent on individual relationships. These vary in quality across the country, leading to young people in contact with Oranga Tamariki having different levels of access to specialist mental health and AOD services around the country. This is not good enough.

24 The lack of collaboration and joint planning means there is a lack of understanding of each party's roles and responsibilities in supporting children and young people at times of vulnerability. This can result in both agencies being complacent about their role in children's and young people's plans. We have heard both agencies shift responsibility for a lack of progress in children's and young people's outcomes, rather than just sitting down together and working out what is needed to improve outcomes for children and young people.

25 When one agency is letting a plan down or young people are falling through the gaps between agencies, this should be escalated quickly to find a solution. Currently there is no consistent way of resolving or escalating issues when one agency is letting the plan down. We need a system that holds agencies accountable for not working together in child-centred ways.

"Money affects what children can do at school, their education and their ability to participate in sports."

(Young person, Our Views Matter. OCC)

26 Some barriers to collaboration are related to a lack of resources, but the fact that there are pockets of good practice suggests that better, more consistent collaboration is possible.

3c Provide clear, coordinated service pathways, especially for children and young people with neurological disabilities

27 For many children and young people with neurological disabilities [such as attention deficit hyperactivity disorder (ADHD), Autistic Spectrum Disorder (ASD), foetal alcohol spectrum disorder (FASD), and brain injury], the treatment pathway is unclear. As a result, children with complex presentations may end up being 'ping-ponged' between different services – paediatric services, CAMHS, child development teams, and disability services, with no one taking overall responsibility. This is particularly so for children with FASD for which there is no specific service response in place. For example, a young person with FASD and associated intellectual disability may get specific health issues, such as auditory problems, attended to by a District Health Board's (DHB) paediatric services. However, there is no agency taking responsibility to develop a coordinated plan that addresses these children's intellectual, behavioural and educational challenges. Such a young person would only be eligible for specialist mental health services if they also have a severe mental health disorder.

28 Addressing neurological disabilities early can prevent later behavioural, emotional and mental health disorders. Yet many young people who offend have undiagnosed neurological disabilities. Parents may fail to take a child or young person who has received a potential brain injury to a health practitioner because they are worried about getting into trouble. Without support, these young people go 'off the rails' at school and often end up committing offences and ending up in the youth justice system. Children should not have to commit offences to end up receiving support for their neurological issues.

29 Children with neurological disabilities have difficulty reaching their educational potential for a range of reasons. Many experience adverse discipline processes in school (suspension, part-time attendance, and so forth). The development of greater expertise, diagnosis, and collaboration between government and community agencies is a crucial challenge.

"I'd make sure everyone had a friend to be with throughout the day because being alone makes you sad sometimes."
(Secondary school student, NZ European

30 A specific example of a gap in services – Child Development Services see children and young people up until the age of 16 years. This includes children and young people with autism. However, when a young person with autism is dropped by the Child Development Service, they are often not picked up by CAMHS (who usually see children and young people between the ages of 0-19 years). These children and young people therefore don't receive further services until they reach adulthood at about 20 years of age.

3d Improve continuity of mental health and addiction services, especially for children and young people and families who move outside their local community

31 It is common for children and young people, especially those in the care of Oranga Tamariki, to move or be placed outside of their local communities. When such moves occur, there is an expectation that another DHB will pick up the provision of mental health and/or AOD services. However, too frequently this does not happen, for a variety of reasons: sometimes because of the lack of a permanent placement; at other times because of a lack of collaboration between different DHB services or between Oranga Tamariki and DHBs; and sometimes because of a lack of consistency between DHBs in their thresholds for acceptance. Parents or caregivers often do not understand how to best advocate for their children or young people or navigate the system.

32 For all these reasons, the specialist services many children and young are receiving start and stop again, with a lack of continuity across different placements and locations. This is a huge barrier to effectively supporting young people to heal and recover over time. For children and young people in the care of the state, it is the responsibility of Oranga Tamariki and Health to ensure they receive the appropriate mental health and addiction services. Health and Oranga Tamariki must work more effectively together to improve the continuity of services for this cohort of children and young people.

4 TAKE DIRECT ACTION TO ADDRESS THE OVER-REPRESENTATION OF TAMARIKI AND RANGATAHI MĀORI

33 This year the Children's Commissioner has made improving outcomes for tamariki and rangatahi Māori one of his priorities. Whānau Māori, including tamariki and rangatahi Māori, are over-represented in measures of mental health ill-health or addictions. This is largely due to the ongoing impacts of colonisation. Māori are tangata whenua and should be engaged in all levels of decision making.

34 To make a difference to the rates of ill-health, it is vital to hear the views of tamariki and rangatahi Māori and their whānau, hapū, and iwi. We acknowledge there is no one Māori, tamariki Māori or rangatahi Māori voice, perspective or experience. The experiences of people who whakapapa Māori are informed by their own lives, their connections to culture and their whānau, hapū, iwi, rohe and community they have grown up in. Listening to the views and experiences of rangatahi and tamariki Māori will inform how to meet their needs better.

35 Improving mental health outcomes for tamariki and rangatahi Māori means doing things differently. Importantly there must be a valuing of tikanga Māori as a key avenue of healing and recovery. There is a big need to work in relationship with iwi and urban Māori social services and organisations to improve outcomes for tamariki and rangatahi. Frontline practitioners need access to high quality cultural advice and support and regular cultural supervision.

36 There is also a large need for more kaupapa Māori services that focus on enhancing young people's sense of identity, belonging and connection to their culture. Children and young people with a clear sense of identity who are proud of their culture are less likely to suffer from mental health and addictions problems.

37 Kaupapa Māori services need to be adequately resourced. It is not enough to develop legislation, policies or services designed to improve outcomes for Māori, without resourcing them to fulfil their potential. If we want different outcomes for Māori, we have to change the way we do things.

38 To progress this work, we need to have a clear understanding of the desired outcomes for Māori from Māori. This requires meaningful engagement and consultation with Māori, and adequate resourcing of iwi and Māori organisations, to design the measures needed to assess performance towards achieving those outcomes.

39 Improving the mental health outcomes for tamariki and rangatahi Māori also means progressing the child poverty work to address the social determinants of health (elaborated on further under point 6d below).

"Since I am Māori, and have an anger problem, I would get into fights easy because people would say racist things to me." *(Student in alternative education unit, Māori)*

"At other schools we're judged like 'typical Māori girl'. We were labelled at other schools. [They] already decided who we were. Like 'oh there's a brown girl, she is going to beat us up. Stay away from them [Māori]'. Makes us mad and feel down." *(Student from teen parent unit, Māori)*

5 ENSURE SERVICES OPERATE IN CHILD-CENTRED WAYS

40 Mental health and addictions services and organisations need to become more child-centred. This means operating in a way that enables the best interests of children, young people and their whānau to be put first, rather than organisational imperatives, such as budgets and other priorities. Putting the best interests of children and young people first means seeing them in the context of their families and whānau and providing better services to not only children but to their families and support networks as well. At its heart, child-centred practice is about nurturing relationships within families and whānau.

41 It is children's and young people's right under the Children's Convention (article 12) to be heard in respect of matters that affect them. Mental health and addiction and other services should always listen to children and young people with mental health and addiction needs, both to maximise the quality of the service provided to individual children and young people, and to foster a culture of learning for the whole organisation. Hearing and incorporating the views of children and young people delivers better and more robust decisions.

> **"Listen to the community and children. Make fair decisions that are good for communities and children. Find solutions that are good for everyone"**
>
> *(Young person, Our Views Matter , OCC)*

42 When children and young people are not the main client, then being child-centred means always asking if the client has children, considering how children are affected, listening to children's views if possible, and basing practice on the needs of the client in the context of their relationships with children and whānau. See our website for more ideas on how to be child-centred: www.occ.org.nz/listening2kids/child-centred.

43 It is also important that children's and young people's views are included and heard as part of the mental health inquiry. Our office has provided advice and guidance on how to engage children and young people in the Inquiry to ensure this happens. Hearing and incorporating the views of children and young people helps to develop their capacity to act independently, make their own choices and actively participate as New Zealand citizens. Our website also contains many ideas for how to engage effectively with children and young people: www.occ.org.nz/listening2kids/how-you-engage.

> **"Make it that people see me rather than doing nothing and treating me like a nobody."** *(Secondary school student, undisclosed ethnicity)*
>
> **"Just talk to us, don't see us as too hard."** *(Student in learning support unit, Samoan)*

6 ADDRESS THE UNDERLYING CAUSES OF MENTAL HEALTH AND ADDICTION ISSUES

6a Create environments that nurture relationships

44 While providing more services that address mental health and addiction issues is likely to help more individuals, other solutions are needed at the community level to reduce the population prevalence of mental health and addiction issues. Something central to recovery appears to be missing in the social

> **"My family made me happy by giving me everything I want and supported but also my friends helped me along the way."** *(Primary school student, Māori/ NZ European/Pacific Peoples)*
>
> **"Get rid of bullying and theft because it makes people feel sad and angry."** *(Student in supported learning centre, Pākehā/Māori)*

fabric of developed countries, including New Zealand. We need to focus more on factors outside the delivery of good clinical practice. That is, we must address the underlying causes of mental health and addiction issues.

45 When we ask children and young people about what is important to them, relationships emerge as being of central importance. When we look into the history of people with behavioural, emotional, or mental health issues, it is common to find problems stemming from early disruptions to attachment and relationships in childhood. When experiencing adverse experiences, the thing that makes the biggest difference to wellbeing is the quality of relationships we are surrounded by.

46 A key implication is that we need to create and promote environments where positive relationships can flourish throughout the lifespan. Starting in infancy, the environment must enable sound bonding and attachment between parents and children. At schools, the environment should enable meaningful friendships to develop and be maintained. School environments, and later work environments, should offer protection from bullying. During transitions, children's and young people's environment should enable them to stay connected and feel cared for. In adulthood, we are healthier and likely to live longer if we are in safe, loving relationships.

47 Mental health and addiction services and other organisations should therefore focus on creating environments where children and young people feel a sense of belonging, where relationships are valued, and where connections are nurtured.

6b Invest more in prevention - Antenatal and Wellchild Tamariki Ora Services

48 There has been too little emphasis on reducing the incidence of mental health and addiction issues via prevention. We have known for many years that prevention and early intervention are much more effective in addressing mental health and addiction issues than later interventions. Yet the bulk of our tax payer dollars goes into these later interventions which have only modest effect sizes at best.

49 Improving children's mental health and wellbeing requires more support for parents and whānau right up front. As is suggested above (under point 6a), more support is needed to create environments that enable sound bonding and attachment between parents and children. Antenatal and Well Child Tamariki Ora services have a key role to play here, as universal services alongside targeted mental health services, in preventing children's behavioural, emotional and mental health problems and responding effectively.

"Attitudes come from how you are raised. Someone can come from a violent or caring family. How you are raised.

I was suspended from school. I used to take the violence from my home to school. The course is a good space for now. I'm going through a heap at home – divorce and violence."

(Student in alternative education unit, Tuvaluan/Samoan/Rarotongan)

50 A key point here is that given the determinants of behavioural, emotional and mental health problems, mental health and addiction services cannot do it alone. Services other than mental health services need to be supported to do more to prevent behavioural, emotional and mental health problems in the first place.

51 As a vital antenatal service, midwives have a key role to play. At a recent one day conference on child-centred practice, a keynote speaker, Dr Johan Morreau (a paediatrician at Lakes DHB), recommended that midwives, Family Start, Oranga Tamariki and Health need to work much more closely together to ensure that no vulnerable mothers or babies fall through the gaps in services. We agree. We believe there is real potential in these groups

integrating their services better to conduct home visits that support vulnerable babies to receive the best start in life. This requires adequate resourcing.

52 Plunket also conduct home visits and we have seen the data about enrolment in Well Child Tamariki Ora (WCTO) programmes. We understand that we need more home visits than the current policy allows. We are interested in the future direction of WCTO services, particularly for Māori children, as advocating for tamariki Māori to have equal opportunities to fulfil their potential is one of my Office's priorities.

53 In our view we also need to deepen and widen the B4 School Check, paying more attention to neuro-developmental issues and to widen the coverage – currently 92% of four year olds. There is also an unresolved issue as to the inability of health to share the B4 School Check data with Education, unless there is specific parental permission to do so. This is counterproductive and denies the education sector crucial information about a child's neurodevelopment and any psychosocial or disability issues.

6c Address the environmental stressors that contribute to youth suicide

54 In some communities the devastating impact of New Zealand's staggeringly high youth suicide rate is regularly on display. It hasn't always been this way. The suicide trends show that youth suicide rates went from the lowest in all population groups in 1985 to the highest in 1995. In fact, the youth suicide rate tripled over this period. While rates have improved since the statistical high points in the mid-90s, youth suicide rates have remained among the highest by age group for the 20 years since. These levels of youth suicide are not inevitable or intractable. We need to understand what has happened in the past few decades to cause young people to act in such a devastating way, in such numbers, so rapidly.

55 Professor Sir Peter Gluckman, the Prime Minister's Chief Science Advisor published a very carefully researched report on exactly this topic in July 2017. His report, *Youth Suicide in New Zealand: A Discussion Paper*, is a sobering review of this complex and uncomfortable topic. The report is helpful in emphasising that it is wrong to see youth suicide as purely a mental health issue. While this may be one driver, the other risk factors are an array of inter-related issues, and often difficult to isolate.

56 As Gluckman noted, rapid increases in youth suicides can't be explained by increases in diagnosable mental illnesses among young people – it happened too quickly for that. Neither do coroners' reports seem to signal any increase in mental health disorders associated with suicide, such as schizophrenia or severe bi-polar disorder. A number of key factors seem to interplay. These include socio-demographic factors, poor family relationships, impulsivity, low self-esteem, hopelessness, loneliness, drug and alcohol misuse, and a history of suicidal behaviour amongst family and friends. All these factors need careful attention.

57 In youth suicide statistics, as in so many other child measures, Māori are drastically overrepresented. Past attempts to address this over-representation from a deficit-based, Western worldview have failed. I encourage more efforts to draw on the wisdom of Te Ao Māori for positive, strengths-based solutions. Gluckman helpfully concludes that working closer with communities in co-designing solutions, particularly with Māori perspectives, will be crucial to making a difference.

"Reduce stress levels? Why do you think we have such a high youth suicide rate? I'm in a situation where if I fail my exam I cannot get a career in science, therefore having nothing to do when I leave school, fix this, it's absolutely ridiculous."
(Secondary school student, Māori/ NZ European)

58 It is not enough to carve out a few specific elements to tackle youth suicide – in doing this in the past we have failed to take account of the whole young person and all of their needs. We need to address the many challenges and environmental stressors that face children and young people, including poverty and ethnic disadvantage. This means prioritising things like adequate family income, suitable housing, and fostering connections with community, family and culture. It means listening and talking to young people about the issues that affect them.

"Really my biggest concern is that the counsellors are always booked up. I once put in a booking that said "very urgent" and they only got to me a month and a half later. Imagine if I was bordering on suicide and they didn't get to me on time. Thats what's wrong. No one cares enough."

6d Reduce child poverty

59 We need strategies to reduce child poverty. It is clear that, for the 30% of children that experience the most disadvantage, "all roads lead back to child poverty" – in that virtually all bad life outcomes are association with deprivation and material disadvantage. The "tentacles of poverty" are far-reaching. Children who grow up in poverty are much more likely to develop behavioural, emotional and mental health problems that put so much pressure on different agencies later on. The Child Poverty Action Group with the New Zealand Psychological Society published a report in 2017, 'Child poverty and mental health: A literature review' (Gibson et al., 2017), which describes this relationship more fully.

[What puts me off being at school is] "Family circumstances like I can't afford to do things or when I need to do things for my family and church." *(Secondary school student, Tongan)*

60 Children are impacted by the stress their families, whānau and caregivers experience as they work to cope with living and parenting with limited resources. Financial and other stress means adults have reduced capability for developing strong connections with children and undertaking the key tasks involved in laying children's cognitive foundations and the ground work for their psychological and mental wellbeing.

61 Children who grow up in settings with insufficient resources experience significantly more stress than their peers and it can be very toxic. Researchers have found that toxic stress associated with living in poverty has impacts on children's immune and biological symptoms. The negative cycles of disadvantage, discrimination and internalised stress are repeated over subsequent generations.

62 So, we must reduce child poverty. We need to improve the general circumstances of those living in hardship, including the provision of basic necessities of everyday living. Tackling poverty will reduce family stress, and make it easier for families and whānau to create environments that nurture relationships. Tackling poverty is also likely to reduce youth suicide rates. It will improve not only children's and young people's mental health but child and family wellbeing overall.

"We need love. We need adults who don't just see us now, but what we can be in the future"

(Rangatahi, Engaging with tamariki and rangatahi at Ngā Manu Kōrero, OCC)