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

Proactive Release

Submissions on the Child and Youth Wellbeing Strategy

August 2019

The Department of the Prime Minister and Cabinet has released the following submission received during its public consultation on the child and youth wellbeing strategy.

Some of the information contained within this release is considered to not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act).

- Where this is the case, the information has been withheld, and the relevant section of the Act that would apply, has been identified.
- Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes and their reference to sections of the Act:

- **9(2)a** – Section 9(2)(a): to protect the privacy of natural persons, including deceased people.

https://dpmc.govt.nz/contact-us
Dept of Prime Minister & Cabinet
Parliament, NZ

9(2)(a)

11 December 2018

Submission on Child, Youth, Wellbeing 9(2)(a)

Introduction from my relevant background experiences

9(2)(a)

You will receive submissions with updated academic research and of NGOs and Community services. I will summarise early interventions and therapeutic relationships for "what worked" across silos, as in my Submissions for Mental Health, Child Poverty, Family Justice Reforms, and Criminal Justice.

Broader concepts and specific clinical approaches needed across ages and "silos" -
"We all do the best we know how at the time." "Society gets the child (and adults) it deserves". "It takes a Village to raise a Child". A child needs unconditional love from at least one person before starts school (to feel lovable) and, had at least one achievement before leaves school (to maintain hope when struggling)- (Ref-Sir Michael Rutter, "Resilience in Adversity", UK). "We all need a sense of belonging, of purpose, someone who cares, and something that we do not want to lose."
Therapeutic relationships are vital for positive changes, *to motivate* listening, hope, trying, caring. Neuro-plasticity permits positive experiences and new information to "edit" our brain's circuits. "Relationship traumas require relationships repair" (Karen Treisman, UTubeTED), caring connections.

NEURO-SCIENCE RESEARCH - Pregnancy - child's first 1000 days - pre-school - school - trauma effects
Epigenetics - **Nature & Nurture** -shows daily positive and negative effects from conception to death.
-eg-N*ature* - Birth ability to speak, *Nurture* - speaks first language & accent heard; religion taught
- eg -nutrition in pregnancy can affect daughter's and grand-daughter's risks for vascular disorders;
- anxiety in grandmother can affect mother's, then can affect baby's feeding, sleeping, attachments;
- trauma in pregnancy in Christchurch 2011 earthquakes showed child's DNA trauma brain effects;
- repeated Domestic Violence witnessed by children can affect brain areas, circuits, and reactions.
(see several TED talks on UTube, &, research by Brainwave Trust, & Institute in Canberra, and re "Adverse Child Experiences", and "Trauma Informed" therapy programmes, & PTSD).
Many youth offenders had trauma and Child Welfare histories, and ignored mental health symptoms
- Brain maturity can take till age 25 years, and longer if suffered developmental arrest experiences.
-Judge Becroft and Office of Commissioner for Children reported vital evidence across ages & "silos".

Early Interventions - for Individual Child and Youth, and for Safer Communities & Wellbeing.

1) Decision if to continue pregnancy - Assess anxiety, mood, health, effects, stress, supports, have therapeutic info re all options, and non-judgemental counselling then, and if has follow-up needs. Margaret Mead, Anthropologist, reported (in 1970s) that "an unwanted child is born to slow suicide", and, said that the parents now need to do what the whole clan used to do". If to be adopted out, give options of Open Adoption, desired info to child, from "parents", if future contacts. (I was certifying Abortion Consultant Psychiatrist, and, visited single pregnant girls in Hosp for DSW. Some opted to keep baby but at aged about two years, baby was removed, and had a grief reaction).

2) Antenatal and Postnatal Care- What mother eats, feels, experiences, does, affect foetus- baby. Baby & mother's health (physical, mental) can benefit from GP's screenings (eg for Depression), info, care, supportive Plunket visits, supports, Play Groups, Community / Cultural Groups, avoid Poverty

3) First 1000 days -Mother & Child *to receive financial incentive to attend local supportive parenting educational centre, at least on half-day/week, aged 3 months to 3 years,* assessed, needs referred. Pilot programmes provided for three years in cross-section of contracted centres could be evaluated. Professor Fraser Mustard, Canada, reported evidenced of such benefits to child's school progress health, wellbeing, and, World Bank assessed his programmes as very cost-effective.
Single teenage mothers receive bonus if she and child attend NZ parenting courses, and, all benefit. *Home carers* should be as continuous as possible and with warm positive safe caring interactions. *Referral affordable resources available* - free GP consults, Plunket, Family Help Trust, Early Start, Cultural supports, Child Psychotherapists, Family Therapists, other local relevant NGOs. Children need a positive trusting attachment to a continuous carer, and to learn to self-regulate emotions.

4) All pre-schoolers - at age 3 & 5yrs, to receive *free GP examinations, treatment, referrals* for wellbeing, and Child abuse and neglect checks to be mandatory during GP's examinations, & Specialist referrals if suspected, eg ADHD, Autism Spectrum, Dyslexia, "not ready to learn" .
In-home carers could reduce stress and health infections for parents in full-time work, and children, but with minimum changes of home-personal, and, full tax-deduct ability for qualified "nannies". (My son, 3-5 yrs, enjoyed Nursery full-time, for hospital staff at my work-place 9(2)(a)
Entry required to be talking, and out of naps. Older sibs and teacher joined them in school holidays).

5) Schools -need multi-disciplinary staff to provide case-management for pupil's health & wellbeing for physical, emotional health, child development, ADHD, Autism, anxiety, poverty, family wellbeing. 1 in 3 NZ children reported to have witnessed Domestic Violence, 1 in 4-5 reported sexual abused. Staff pathways if needed - teacher, mental health nurse, GP, school Counsellor, Play Therapist, registered psychotherapist, Family therapist, community/cultural support family worker/social worker, ACC, & protocols to share sensitive ethical information, risk assessments, and feedback. School Dental Clinics to be re-established, or free dental care? Hot lunches to be supplied in schools? *Much after-school care* is done by grand-parents. Could school communities liaise to assist all?

6) Child in State Care or Supervision - Each needs case-manager for *distressed child* to contact direct (I was Consultant Psychiatrist 9(2)(a)).
Staff Social Workers became familiar with our work and we shared new info. I visited staff and their referred residents in 9(2)(a) Group Homes, Foster Homes, and attended Courts, Child Protection Committee, Family Group Conferences, and Hospital liaison. Families could benefit from whole family help in a *supportive employed carer's home.* Children show

sad, scared, angry grief behaviours with repeated foster-care changes. "It takes two years to finish saying goodbye and to start saying hallo", following a loss of significant relationships, places. *Negotiations* were needed often between me 9(2)(a) , Hospital staff -local/ NZ , Dept Directors. Many local services lacked beds and staff, argued re Welfare, Health or Justice, and "moved on".. Oranga Tamariki needs to *re-introduce Specialist Health Services multi-disciplinary staff Units,* for referrals from Dept Senior Social Workers, Dept Solicitors, School Counsellors, GP, cultural, NGOs. In mid-1970s, a Govt Survey of young females in Welfare and Prison Custody, reported that 70% disclosed previous sexual or physical abuse. Trauma informed awareness and therapy was unknown

7) Youth Hubs -as planned in Christchurch by Dr Sue Bagshaw, with all services on site, ie transition accommodation, free GP, counselling, supported access to employment/training, Welfare Benefits , to multi-disciplinary specialist mental health resources, cultural supports, ACC Sensitive Claims.

8) Family Court Reforms - Solicitor be appointed for Child in all disputes, Family Court Counsellors, referrals of child & youth to free Grief Counselling after separations/deaths, if required. (I saw those in Adult Prisons with unresolved early family grief causing sad, scared, angry reactions, reoffending). (9(2)(a) 1979 IYC Law & Rights of Child Committee, who recommended Family Courts in NZ, and, 9(2)(a) , and retained by Child's Solicitors).

9) Hospital Boards- Mothers & Babies Units, &, Child & Adolescent Mental Health Services, to have adequate staffing - Nurses, Child Psychologists, Play Therapist, Family Therapists, Psychiatrists, Registered Psychotherapists, and, 24 hour MHS acute beds attached to Hospital A & E Emergency Depts, with mental health staff liaison. Their staff could assist paramedics and Police call-outs.

10) Treatment programmes for addicted and/or suicidal youth - adequate early interventions, with therapeutic relationships, supports, and medications for clinical mood and psychotic disorders. There is a high co-morbidity of psychosis and addictions, and all have similar brain circuit pathology. If take cannabis under aged 20, it can "turn on" a genetic risk of schizophrenia (O.U. Cohort Study). Many youth started on illegal drugs and excess alcohol to "drown" derogatory "voices" of abusers. Prof Adams in 1970s reported suicidal attempts into Christchurch A & E, as often following "a double grieving" , from unresolved parental loss before aged 7, plus a recent relationship breakup.

11) Youth Justice & Adult Offenders- Need mental Health & Wellbeing Assessments when charged, Community & Prison programmes- child development, trauma informed psychotherapy, addictions, literacy, job skills, case-management for therapeutic relationships, and team liaison. (I told prisoners I did not accept excuses, but explored explanations, and assisted changes. There were no prison suicides in my 15 years 9(2)(a) . I started weekly offenders therapy group in Protection Wing, got stake-holders support, 9(2)(a)).

12) Connections, self-worth, hope - to say no, to escaping into excess alcohol, drug abuse, assaults. There are too many sad, lonely, scared, angry, hostile, immature children and youth in adult bodies.

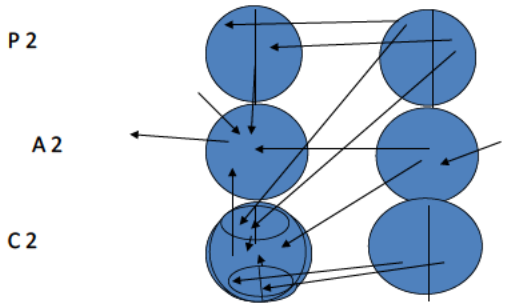
13) Volunteers- Various professional Health workers retire next decade, who may volunteer a few hours/week, but, Annual Practice Certificate/Continuing Professional Development requirements cost money and difficult. I suggested amendment to Acts for "Limited Registration" for limited scope of practice, IF a Volunteer, physically alongside NGO or GP, who accept overall clinical responsibility.
14) Costs of all above will **save costs**-Health, Welfare, Justice, ACC, and, for **Community Wellbeing.**

9(2)(a)

See References /Diagrams below - Young Offenders & Erickson's Stages, 9(2)(a)
Transactional Analysis, Development of Child to Adult, by influences of Parent, culture, others

Transactional Analysis

Child - Parent Transactions



+ve P = nurtures,
-ve P = power, fear

A- neutral info

+ve C creative,play
-ve C = hurts, neglect

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Young Offenders – Erickson's Stages

Age	Stage	Parenting Needs	Offenders say
0-1 ½ yrs, infancy	Trust v Mistrust	avoid harm, secure, 'good enough' mother, OK, loved	too many hurts, run, nobody cares, nothing to lose, do it
1 ½ - 3 yrs,	autonomy v shame Independence v dependence	praise achievements (talk, walk, feelings) boundaries, rules avoid harm, fear	I'm shit, nobody I can't change, all expect too much
3 ½ - 6 yrs Pre-school	Ini iative v guilt	praise efforts, self, support for problems, socialise	I've failed, unwor hy, avoid others
6 – 12 yrs school	Industry, competent v inferiority	praise efforts, talk, teach & model skills, joint activities	no good, why try? no use listening, I'm a hopeless case
12 – 20 yrs	Identity v Diffusion	limit setting for age mutual respect, trust	need group always, adults put us down
21- 34 yrs	Isolation v intimacy	good role models, support if requested	I can't trust, push off, too scared to be close
35+ yrs	Generativity v stagnation	good role models, support as requested	bored, want money, sex, drink, drugs, food

11 December 18

To whom it may concern.

I am a registered psychotherapist who worked nine years until recently in a CAMHS service in an area of high need.

It was apparent that the mental health services for infants, children and young people had become so run down and under resourced that services developed protocols to attend to short term risk over efficacious treatment.

CYF/Oranga Tamariki remains under resourced in terms social worker with sufficient training and experience and options for safe placement, care and treatment of children at risk.

The infant child and adolescent mental health, and child protection work force needs to be increased substantially e.g. as much as 300%.

Training for the work force needs to be made more substantial. Specifically there is a great need for more training in child development for social workers.

Development of the capacity for parenting assessments for social workers

Increase resources and options available for fostering children. Whanau placements are not always appropriate or available.

More residential group homes, with significant therapeutic input, are required for the cohort of children that require more engagement than a foster home can provide to reduce the number of harmful (to the child) foster placement breakdowns.

Increase the support for foster families, both financially and practically/emotionally. Improve payments to foster families whether whanau or not. The foster carers are often struggling before taking on foster children.

Improve training for foster families and the support available to them in handling traumatised children.

Maintain diversity in CAMHS services and increase resources for great availability of resources across the country.

Improve training of all workforce around assessing and treating complex developmental neglect and trauma.

Need at least 200 infant, child and adolescent psychotherapists of psychodynamic/play based/ attachment based orientation to serve CAMHS and Oranga Tamariki teams - assessing and treating children who present in complex ways and have developmental deficits as a result of neglect and trauma. These staff to complement psychologists, nurses, and social works who bring other skills and paradigms.

Psychodynamic psychotherapists are also required to treat adolescents and parents.

There is a significant shortage in Aotearoa/New Zealand of clinicians to do the work required and no one profession can fill the gap. Different clients need different help at different times and international experience is that CAMHS series are best when staffed with multiple disciplines. This will require government support to university departments/other training providers to ensure the availability of the necessary training places which universities have been reluctant to offer without guaranteed enrolments. Distance learning needs to be made available.

Yours faithfully,

9(2)(a)

Registered psychotherapist

Submission also included the following article which was not attached to the release of the submission for copyright reasons:

Katehakis, A. (2009). Affective Neuroscience and the Treatment of Sexual Addiction. Sexual Addiction & Compulsivity (16), 1-31.