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.

child & youth wellbeing

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Child and Youth Wellbeing Strategy – Submission Template

This document is intended for individuals or groups who wish to make a formal submission on the child and youth wellbeing strategy.

Please complete this template and email it to: childandyouthwellbeing@dpmc.govt.nz

A guide to making a submission is available on the DPMC website https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Submissions will close on **Wednesday 5 December**.

Please provide details for a contact person in case we have some follow up questions.

Contact Name:	9(2)(a)
Email Address:	
Phone Number:	
Organisation Name:	[Please include if you are submitting on behalf of an organisation]
Organisation description: (tell us about your organisation – i.e. who do you represent? How many members do you have? Are you a local or national organisation?)	I represent myself as a child, youth and family Mental Health nurse working in schools in predominantly rural settings. I work for 9(2)(a) however these are my views as a rural nurse and are not endorsed by my employer.
Executive Summary: (Please provide a short summary of the key points of your Submission - 200 words)	In summary the framework needs to acknowledge that; We first need to put on our own oxygen mask and tidy our own house before we attend to children, youth and families, in this way we will do our best to first DO NO HARM We need to acknowledge and include grandparents and carers in parent roles Attachment is the work of a lifetime and can be enhanced or adversely affected by agencies Government agencies anxious responses to politics can harm children, youth and families and appetite for brave, kind, rigorous accountability and reflection is required Government agencies and NGOs require considerable ongoing expertise coaching to deliver bold ideas Developmental approaches are a fundamental requirement,

	Sen's Capability Approach fundamentals of actual capacity and opportunities and social justice can illuminate our pathway Adverse Childhood Experiences informed practice helps families reframe what was previously thought of as deficit and heal together and communities have a place in that Communities can do far more with support to lead local initiatives Child and youth and family should learn and contribute to research about things that effect them Existing design processes are biased to adults Knowledge economy and digital addition need consideration

Submission Content

My whakaaro is from the perspective of a rural mental health nurse working in 9(2)(a) . I work for the government but my views are not representative of my employer, they are my own professional views as a nurse, based on my nursing ethics and also as a local, someone with connection to whenua and whakapapa.

The framing of wellbeing has gone some way to bring reality, aspiration and rigor together, it is a bold and refreshing approach. I have provided some suggestions and comments for consideration based on my own experience practicing in my own community.

I see a rise in anxious children and families, however I connect this to the way our country has been governed up till recently. The anxiety goes all the way up through schools, NGOS, local and National Government. Everyone is worried about money, funding, change, and many respond with reactivity. This can mean KPI's and other indicators can become the main goal but the methods to achieve them are not necessarily going to improve outcomes for children and family however meeting them eases anxiety of those responsible for them. The global and national focus on wellbeing sets off a domino effect of reactivity in agencies, however not all of it is considered or in the interests of children, youth and their families.

ACES

Some time ago I learnt about the Adverse Childhood Experiences study and have engaged in ongoing self-directed learning whilst folding the learnings into my practice to enhance the experiences of the families I work for. I consider ACE informed practice to be one of the most significant steps to turn our most shameful and damning statistics around. I see that predominate causes of mental illness that children and youth experience in 9(2)(a) are multiple childhood adverse effects. ACEs are pernicious and rarely are they not intergenerational. Working with an understanding of "what has happened to you" instead of "what is wrong with you" creates a space for healing, this becomes a whanau journey rather than a focus on fixing children and young people. When I start this journey with a family which usually starts with someone identifying what is wrong with a child, we come to what happened to you, and then you, and you, and you as we carefully and respectfully hold space for each family member as we gather together the whanau narrative. This work is significantly based in Taha wairua, the Taha lest acknowledged by government agencies in their understanding and application of Te Whare Tapa Wha. My vision is for my community, 9(2)(a) to be one of the first ACES informed communities and that this will start a nationally spreading fire. This will mean at every level from local government to commerce to social, health and education and at a layperson level we put our collective hearts, minds, resources and determination to sustainably create a local environment of healing, where we do not do further damage to whanau through our processes, designs and interactions.

However, holding fast to this vision can put me out of step with my employer as I serve within an environment of paradox. I see government agencies ready and willing to respond to new approaches in relation to trauma but they often race ahead to want to "teach teachers" to do this work or "educate parents". However, our failure to first inspect our own practice reflectively and rigorously as services before we start creating new pilots, projects, frameworks etc means that currently our agencies unintentionally collectively do harm whilst trying to do good. We continue to successfully and dogmatically design failure

into our systems in the way we locate our services, our appointment systems, the way we communicate. Agencies like the 9(2)(a) continue to use terms and policies like “failed to engage”, “non-compliant” which release them from obligation, written and digital communication is corporatized, services are located in city centric fashions in a few buildings filled with most of the specialist trained staff.

To extricate ourselves from this cycle of harm we need to focus on leadership as vision, plans and measures are not enough to change ingrained behaviours in government and government funded agencies. I have seen this in the creation of first the school based mental health team and now Mana Ake, two showcase projects for governments that have taken very different approaches but feature many of the same problems that reflect the dearth of leadership and particular types of expertise in developing systems that not only improve health but are healthy in themselves. We also need to drop our city centric tendencies and put the majority of the workforce into communities so that they not only support children, youth and families but they strengthen the practice of their community colleagues. In this way our government services need to reflect the character and culture of the local communities and not be allowed to maintain developing multiple barriers to access.

Rural child and youth mental health nursing

Rural child and adolescent and family nursing is not seen as a priority for my service, which makes much of my day to day nursing awhi for other colleagues in primary care, NGO’s and other government agencies unseen and undervalued. Rural nurses can have a cohering effect, working fluidly across many interfaces, we seek to develop sustainability in people and practice and we are the swiss army knives and number 8 wire of not only child, adolescent and family mental health but all other aspects of health. We constantly seek to connect in the absence of the official pathways to do so, so for us integrated health is what we do, it’s not new.

Children youth and families in post disaster politics

The unofficial nature of much of our work in community due to the lack of vision for it means that our communities can be vulnerable after a disaster. The recent 2016 earthquake in North Canterbury and Kaikoura has demonstrated the lack of child and youth voice in our approach to post disaster recovery. The lack of accountability due to no rigorous review of post-disaster response ensures that the same mistakes can be made again and again. The response was incoherent, fumbled, poorly communicated and close to a disaster itself yet is unlikely to gain more than a superficial cursory review that will not have the appetite for any uncomfortable findings.

Children, youth and families have been adversely affected by health and educations anxiety about politics in post disaster recovery. The nature of the politics is again based on our weakness to reflect and take our learnings forward with a positive growth mind-set. The findings of the Ombudsman’s investigation into the short comings in educations’ post disaster response for schools has created anxiety that has led to political contagion with health becoming concerned about upsetting education. This is experienced as reactivity about controlling post disaster or crisis environments such as after the earthquake, after suicide deaths of students and the Port Hills fires as creating a “nothing to see here move along, get back to learning” mantra that post 2011 EQ research showed us is harmful to children and the people working with them. This speaks to the top down political culture of

fear, and if we are even thinking about looking at discussing culture of children and families we also need to address the influences of broader cultures. The post disaster response has also been a flourishing incubator for personal and professional ambition and significant changes to service delivery have occurred in secretive ways in vulnerable communities.

Furthermore local approaches to develop local models of care have weak consultation mechanisms with children and little with youth. 9(2)(a) the proposal for the new proposed model of care for health had a few local public meetings 9(2)(a) . The documentation was filled with health jargon, whilst this was modified (after complaints) the actual lack of child and youth voice was concerning. I believe we need to appraise our research approaches and train our children, youth and communities in participatory approaches of qualitative research to compliment the quantitative research that government undertakes. We also need to include mobile methods and photo voice to capture children's perspectives.

Funding and design bias in favour of adults

As I complete my thesis 9(2)(a) I have found that our funding approaches and designs whilst seemingly for children can be inherently biased to adults. We do not fund playgrounds in schools, however play is upheld as a right of children by the UN. We design school spaces for children not with them, we are consumed with innovation and cultural landscaping when research tells us that children want natural spaces, wild areas of play and areas to have fun. We prioritise funding for learning spaces but do not fund space that enhances the wellbeing of the adults who care for children, this means at play time that children can play in the space left around modern learning spaces whilst teachers are cramped in aged leaky buildings.

Incoherence in policy and vision

The increased focus on wellbeing in schools is contrasted by the contention and mixed views in government about responsibility of feeding children in the food in schools bill, therefore schools reflect this lack clarity and meet the needs of hungry students predominantly at their own cost in varied ways. There has been no unifying vision of wellbeing that coherently links all aspects of wellbeing for schools, this adhoc approach to way elements of wellbeing focus have been inserted into curriculums' over time, characterised by a "set and forget" approach. Therefore governments approach to wellbeing in schools has been incoherent. Te Whare Tapa Wha is confined within its location in the Physical Health Curriculum and is under-utilised and often misunderstood. Values are inserted into the curriculum but do not reflect the significant value of care that the focus groups constantly identified as important. Wellbeing is becoming shackled to achievement and success, reflecting much of the OECDs ideology for education and wellbeing but less of Sen's Capability Approach that reflects the passion for social justice that many primary school principals hold.

Sticky tape solutions at the coal face

The privileging of funding means that money rarely trickles down to local grass roots initiatives. As a nurse I often spend significant time sticky taping solutions together for

families. Currently I am working with grandparents who have the care of two children who have come from another regional area suddenly after being taken from their mother. They are not under a statutory response so have no funding. 9(2)(a) . No referral was made by the treating DHB to ours. The principal, myself and others are running to support the grandparents and children so that no one falls over, this means food parcels, free uniforms, scraping funding from anywhere and everywhere for trauma support and hours of advocacy, cup of tea making, listening and practical help. A wellbeing policy for children needs to reflect the increasing number of grandparent carers. This year alone I have worked with rural schools to do this same process over and over again, as sibling groups of 2, 3, 4 arrive from all over NZ to grandparents. The children typically have multiple childhood experiences including witnessing violence, experiencing physical abuse, sexual abuse, food insecurity and withholding, material deprivation, parent/s mental illness and substance abuse, parental incarceration. Therefore they arrive with nothing and yet with everything, we have no funding and few local services. Some grandparents are the parents who were historically responsible for the harm of their children that these children belong to yet they have little support to grandparent/parent in a new way. They also often experience mental illness and struggle to cope. The important point is we can do it, we do, do it but we could do it better if we had access to urgent discretionary funding at a local, micro level, believe me it's not much money and we are very frugal.

Children WITH Disabilities

We are just supporting a parent led support group for families of children with special needs, it would be very helpful if your wording could be 'children with disabilities' not 'Disabled Children', youth also have disabilities and therefore it should be children and youth with disabilities. Ideally you would consult young people to see how they want to be identified. Principals constantly struggle to provide appropriate care for students who have disabilities. Students can sit in modern learning environments with access to modern technology but not have adequate teacher aid support so when their hearing aid back in when it frequently falls out or they choke the one teacher of 40 + children has to attend. The rigidity of funding and high thresholds creates a grey area of significant numbers of students with disabilities who struggle to access learning who have no support as they are not severe enough. I am currently trying to plant the seed with a local church to partner with a city based native plant charity to create a regular social working group for local people experiencing disabilities and mental illness as there is currently nothing. If you ask my managers if this is within my scope and boundaries they would say no, they would also less likely agree with the support I give my colleagues in other areas of health like paediatric oncology and diabetes. They don't have the ability to travel out to young people in rural areas, I am here, it makes sense, we work together, it works, its just unofficial, similarly I support GP's and school nurses, school counsellors, police, school attendance officers. The paradox is that we meet the need, we get viewed as working outside our scope by our service yet lip service is paid to not working in silos and working in integrated ways.

Knowledge economies and digital addiction

I support the Rock On process of school attendance which is an initiative involving police, school attendance advisors, mental health consultants and schools. Last week six of the cases of non attendance were related to gaming issues which are probably gaming addiction. Many of the consults I do for schools involve digital harm. The OECD is pursuing the knowledge economy and this is seen in New Zealand education as BYOD and technology studies, many parents provide infants use devices to distract, entertain and soothe, parents are off line to children and youth in online pursuits on phone and devices, many young people and adults are addicted to technology and digital media. I see this as being one of the fastest growing form of harm to infants, children and youth and believe that we need to weigh the push for progress and economic development with the responsibility to first do no harm. Currently we have limited treatment for digital addiction, I believe we need to prioritise prevention and treatment urgently, working with children, youth and families as communities need to develop visions with government in this area. Similarly a decade or so after the focus on co-existing disorders there is still a lack of capacity in knowledge and experience and service design to fluidly support child and adolescent substance use and abuse child and adolescent mental health workforce and systems.

LGBTI

As a rural school nurse who is openly gay I am often contacted by other members of my service to consult around young people who present with mental health challenges who may have sexuality and gender related needs. There are very good community based NGOs who are providing specialty training and I believe they need funded support to help our combined government and non-government agencies develop confidence in language and responses for children, young people and their families' sexuality and gender needs. Any support to these good services to increase the ability for rural families and students to access these service will also be very appreciated. I am currently discussing digital potential for a city based NGO and funding for semi regular transport so rural young people can meet face to face and attend the strengths based peer run sessions they offer.

Politics of youth suicide

In relation to child and youth suicide, over the past 6 years I have seen an increase in self harm and suicidal ideation in younger children, this reflects the Gluckman report on the same. 9(2)(a) we lost two young people under the age of 17 in 2017, the ripples are far reaching and create further risk for a considerable time. We have not current data to hand every day of how many young people have had suicide attempts the day prior, what areas they came from and what schools they attend. 9(2)(a)

there was concern about who should be in a school first, our team or the MOE, evidently the thought of going in together was a difficult one. The work is continuing and is very heartening. I created and facilitated a hui with my team for schools who had lost a student by suicide and we captured the experiences of the school counsellors and leadership teams as they shared their experiences. We shared the report back to them, the process itself was designed for healing and it was the only time schools had the opportunity to connect in this way. The continuous development of guidelines and resources that do not reflect the experiences of children, youth, families and schools keeps laying more bricks in the foundations of new silos. The patch protection, distrust and desire for intense formality

in government agency response needs to be explored. We need to be in a shared process of healing not managing, fixing or herding.

Barriers to locally led change

In rural areas youth are hampered by transport and confidentiality/privacy in help seeking. 9(2)(a) a school and community connectors to create a youth led research pilot to establish a youth designed and led hub in a rural area school where support agencies can see young people. Likewise I am supporting the strengthening of our local Alternate Education where some of our most vulnerable youth attend education. After facilitating a session with the small team I approached an official to ask what the best AE was and could this team get release time and funding to visit for inspiration. I was told there was no known best AE and that AE staff get paid poorly and it's unwise to get involved as while people are aware AE is not good they accept it as no one else wants to do it. The irony is that across the road a multi-million dollar ILE sits within a high school yet our highly vulnerable youth are in a decrepit underfunded facility with a handful of underpaid staff who are at the edge of burnout. Time and time again the funding model is taking a big lend of skilled yet exhausted people to the detriment of vulnerable children youth and families. The sad thing is there is a huge waiting list for children and youth to go to AE.

Mild to Severe discourse of obscuration

The conversations about mental health that feature the use of the terms mild to moderate to severe need to be addressed. They were developed to support diagnostic formulation in the DSM, they should not be used solely when looking at divisions of child and youth mental health care between community NGOs and DHB's. A child may have moderate mental health needs but live in a family or care system with very little capacity to support them. If these terms remain in use for funding we need to inspect and discuss them.

I could say much more but have so much more work to do this weekend, my apologies for the rough read, I have so little time. Whilst I raise significant issues I am an active part of significant solutions. I am in favour of the framework you propose yet I question the capacity of government agencies and larger NGO's to break out of their handmaiden of policy roles to bring the vision into a reality in a way that helps the workforce, children, youth, families and communities get stronger. I think these changes require accessible specialist coaching across many areas of expertise and multiple check in points for progress, qualitative research methods including mobile methods that include child and youth voice. The people affected by the processes changes should have the loudest voice in appraising them.

Please note that your submission will become official information. This means that the Department of the Prime Minister and Cabinet may be required to release all or part of the information contained in your submission in response to a request under the Official Information Act 1982.

The Department of the Prime Minister and Cabinet may withhold all or parts of your submission if it is necessary to protect your privacy or if it has been supplied subject to an obligation of confidence.

Please tell us if you don't want all or specific parts of your submission released, and the reasons why. Your views will be taken into account in deciding whether to withhold or release any information requested under the Official Information Act and in deciding if, and how, to refer to your submission in any possible subsequent paper prepared by the Department.