Options to Strengthen Independent Oversight of Children's Issues and Oranga Tamariki System

Submission to the Ministry of Social Development

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Contact

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About the New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over **52,000** nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is Freed to care, Proud to nurse.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation *Tōpūtanga Tapuhi Kaitiaki o Aotearoa* (NZNO) welcomes the opportunity to comment on the *Options to Strengthen Independent Oversight of Children's Issues and Oranga Tamariki system*, and appreciates the extended submission time allowed.

2. NZNO has consulted its members and advisory nursing, policy and research staff in the preparation of this submission, including members of the College of Child and Youth Nurses Aotearoa, College of Primary Health Care Nurses, Cancer Nurses College, Neonatal Nurses College, Mental Health Nurses Section, Women's Health College, the Pacific Nurse Section, and Te Rūnanga o Aotearoa, which comprises 3,600 Māori nurses, midwives and nursing support workers.

3. Nurses are the largest group of health professionals who work with children and young people at every level of care and in all areas of service provision throughout Aotearoa New Zealand, ie in the community, GP practices, schools, clinics, hospitals, corrections, disability, oral health, mental health, addiction, rehabilitation, residential care, family planning and sexual health services, etc. In most service areas nurses routinely liaise with social and community workers, as well as with family and whānau, medical colleagues and relevant agencies including Oranga Tamariki.

4. As well as direct care, nurses provide a wide range of health education and promotion programmes, including parenting and family violence programmes, community education, and undertake screening and coordination of care for children and young people at risk, and those acutely at risk.

5. Nurses and midwives are the regulated practitioners who see **95%** of children in their homes with family and whānau ante and post birth, deliver the preschool (B4 school) checks, immunisation, and screening that provide frontline monitoring of the health and wellbeing of children to prevent and reduce harm.

6. In addition to our responses to the consultation questions below, largely based on the College of Primary health Care Nurses' submission, we ask you to consider the following **brief general comments**, reflective of those we have made in innumerable submissions, analyses, and engagement with government departments[1] since publication of the original green paper on

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[1] See for instance:

https://www.nzno.org.nz/resources/submissions/articletype/articleview/articleid/1154/green-paper-for-vulnerable-children (2012)

https://www.nzno.org.nz/LinkClick.aspx?fileticket=_MfEG1ntvDc%3D&portalid=0 (2012)

https://www.nzno.org.nz/resources/submissions/articletype/articleview/articleid/1573/vulnerable-childrens-bill (2013)

https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2_2014-12%20CAP%20Information%20sharing_NZNO.pdf (2014)

https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2014-11%20Child%20Protection%20Guidelines_NZNO.pdf (2014)

https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2014-11%20Children%20at%20Risk.pdf

https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2_2016-09%20Common%20Approach%20Family%20Violence_NZNO.pdf (2016)

https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/1_2016-04_Chdns_Wkfce_competencies_NZNO.pdf (2016)

Vulnerable Children in 2011 and the policy and regulatory settings which followed.

7. Fundamentally, we submit that strengthening the oversight functions of the Office of the Children's Commissioner, in whatever form, is meaningless if the systemic problems with State services for children and young persons are not addressed. As these are not identified or referenced in the consultation document, we fear that yet another opportunity to make the necessary, vital structural changes to services needed to prevent, reduce and mitigate harm, will again be missed.

8. *Relationship between health and child protection services:* Firstly, there is a **significant disconnect** between social, youth justice and health services, including referral and reporting systems, beginning with the almost complete absence of reference to core health services in social service and youth justice legislation and regulation. In practice this means that the most vulnerable tamariki and rangatahi, who need, and are entitled to, extra care and support, frequently miss out on basic public health care available to all other citizens – ie they are doubly disadvantaged.

9. We have appended some *confidential* cases presented in an oral submission to the Social Services Committee in 2016 that evidence this disconnect, but also draw your attention to the significant and ongoing issues nurses have experienced in relation to their role as lead co-ordinators of interdisciplinary teams for acutely at risk children established under the Children's Action Plan, and screening and vetting requirements. These have been articulated and discussed with Ministers, the Ministry of Social Development, the Children's Action Plan lead and the Ministry of Health, with scant progress or adherence to agreed processes going forward.

10. Health is the only public service that is mandated and responsible for providing programmed interventions to optimise the health and wellbeing potential of citizens over their lifespan: ie ante and post-natal care, enrolment with a primary health care provider, B4 school checks, immunisation and screening programmes, and oversight of infectious disease prevention and control, pandemic, emergency care, sanitation.

11. Health is the obvious central starting point forall government services for children and rangatahi; assessment, referral, reporting and information-sharing systems of child protection, and justice services should be consistent with, and relate to, health service systems in the first instance. Currently, assessment and referral systems between health, justice and social services have little in common, leading to wasteful duplication and, more onerously, significant service gaps and omissions, which exacerbate entrenched health and socio-economic disparities.

12. Centralising health in this way would remove the ambiguity and confusion around universal and/or targeted child rights and services that exists between health, justice and social service workers operating under different systems, but with the same underlying goals of optimising the health and wellbeing of children and tamariki – all of whom are 'vulnerable'.

13. *Workforce*: Secondly, it is axiomatic that the quality of services is dependent on the quality of the workforce, but core, frontline health workers are both 'invisible' and generally powerless under the current system.

14. Moreover, while we are confident that the Health Practitioners Competence Assurance Act 2003 provides for robust assurance of health professionals competence and fitness to practice, the same cannot be said for the regulation of social workers.

15. The concerns expressed in our submission to the Social Services Committee on the Registration of Social Workers Bill earlier this year[2], that job titles would be changed to avoid employers having to comply with registration requirements has been borne out.

16. This is a good example of a structural barrier not only to quality service provision, since it undermines regulated social workers and their education and practice, but also to the robust oversight and monitoring of services, as it prevents the collection of accurate data on social workers. The legislation needs to be amended accordingly.

17. *Structural discrimination*: Thirdly, despite a reference to "cultural capability"[3] and vague mumblings about the need for a culture change, the reality of the **structural discrimination and unconscious bias** that is demonstrably inherent in child, youth justice and indeed health services, is not acknowledged as a causal factor/contributor to family disruption. Nor it being robustly addressed by embedding the bicultural partnership and enacting te Tiriti o Waitangi articles.

18. The outrageous, grossly disproportionate overrepresentation of Māori tamariki and rangatahi in social and youth justice services and negative health statistics because of systemic discrimination in public services was identified in the 2012 Human Rights Commission Report: *A Fair*

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[2]https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2018-01%20Regn_Social_Workers_Bill_NZNO.pdf (2018)

[3] Clause 44 bullet point 5 *"to demonstrate high levels of cultural capability – including capability to engage with tamariki Māori, their whānau, hapū and iwi*" (p 9, Cabinet paper on this Consultation)

Go for All? Rite tahi tātou katoa? Addressing Discrimination in Public Services[4]. It is not clear what action has since taken, but more than a name change is necessary to address the historic and systemic lack of knowledge, skills and cultural safety and competence that privileges mainstream above indigenous interests and drives inequity.

19. *Critical periods: Preconception to three years and Adolescence*: We take this opportunity to suggest these two critical periods as potential target areas for the prevention and mitigation of harm to children and young people and draw your attention to:

    - The Health Committee's report on its *Inquiry into improving child health outcomes and preventing child abuse* (18 November 2013)[5], focused on preconception until three years of age for the internationally evidenced reason that that is the critical period where there is most potential to influence lifelong outcomes; and

    - *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence* A report from the Prime Minister's Chief Science Advisor [6] (2011).

20. These two reports were very well received in the health sector, but do not appear to have been widely read elsewhere, or their findings acted on. We suggest the latter is particularly relevant to the complex timing issue of transition from childhood to adulthood, which the arbitrary legal age of 18 years does not capture. The Māori word "rangatahi" encompasses this period of youth/adulthood more generally, and it is recognised in the extended support for children in care up to age 21 now available. NZNO supports having a broader timeframe for child and youth services, including child protection services.

21. Finally, NZNO agrees that there is a need to strengthen independent oversight of the fairness, efficiency and effectiveness (ie outcomes) of public services for children and young people under 18 years, particularly in view of:

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[4] https://www.hrc.co.nz/files/2914/2409/4608/HRC-Structural-Report_final_webV1.pdf (2012) Retrieved July 2018.

[5]https:/www.parliament.nz/en/pb/sc/reports/document/50DBSCH_SCR6007_1/inquiry-into-improving-child-health-outcomes-and-preventing

[6] http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf (2011)

- historic systemic abuse of individuals in State care;
- marked regulatory change in relation to the Vulnerable Children Act and the ill-considered Children's Action Plan; and
- the current change in direction signalled by the establishment of the Child Wellbeing Unit, and focus on reducing child poverty and enhancing child wellbeing.

22. NZNO **strongly supports** the latter, which is consistent with definitive international evidence[7] (Marmot, 2008) and the WHO Alma Ata Declaration[8] and welcomes other strategies which address the determinants of health and inequity (housing, in particular). We also look forward to more robust and meaningful monitoring of wellbeing across government departments, with the introduction of indicators to support Treasury's Living Standards Framework.

23. NZNO **supports** the Children's Commissioner's view that there must be a focus on all children alongside those in the Oranga Tamariki system.

24. We are less certain with the need for "systemic advocacy" unless it is in the form provided, for instance, by the Health Quality and Safety Commission's Mortality Review Committees - statutory committees that review particular deaths, in order to learn how to best prevent these deaths. We note that there are currently four ongoing committees dedicated to reviewing the deaths of children and young people, babies and mothers where death is caused by pregnancy or childbirth, deaths resulting from family violence and deaths associated with surgery, and one temporary committee established to ascertain the feasibility of suicide mortality review.

25. Of the options offered we generally prefer Option 1b.

26. NZNO wants to be involved in the work of the Child Wellbeing Unit and has a number of expert and experienced nurse members and nurse advisers in child and youth services, and has a broad Māori membership base.

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[7] Marmot, M. (2008). Closing the gap in a generation. *Health Equity Through Action on the Social Determinants of Health*, 246. http://doi.org/10.1080/17441692.2010.51461

[8] http://www.who.int/publications/almaata_declaration_en.pdf

27. We recommend that you:

- **Note** our support for the current direction of government policy that aims to prevent and reduce harm by acting on the social determinants of health;
- **Agree** that health is fundamental to wellbeing and that the most vulnerable children are missing out on core health services which increases demand for higher level health and social services;
- **Agree** that health and health services must be embedded at the centre of all child and youth services;
- **Recognise** the core role of public health workers as the primary frontline mechanism for universal prevention of harm to children and young persons, and subsequently, in specialist services to reduce and mitigate harm and optimise health which underpins wellbeing ;
- **Amend** legislation to protect the title of social service worker;
- **Identify** and address structural discrimination in public services;
- **Note** our advocacy for *Preconception to three years* and *Adolescence* to be considered as critical target periods for preventing and mitigating harm to tamariki and rangatahi;
- **Note** our preference for **Option 1B**; and
- **Note** NZNO's strong interest in being involved in the Child Wellbeing Unit's work and the experience and expertise we have to draw on in members and staff.

CONSULTATION QUESTIONS

Is any part of your response confidential? *(Please tick)*

Yes Appendix 1.

1. Are there any issues or things you want to provide a view on that are not covered in the questions below? Please tell us about them.

Please note all of the above especially with regard to our recommendations. In this instance NZNO agrees with a targeted consultation but is concerned with the inadequate timeframe and that the document did not identify **nurses** as a core workforce for Oranga Tamariki (ie only cites "social workers, care givers etc.")

NZNO had only three weeks to respond – many of these children come to the attention of nurses, their welfare, their health, their well-being, including providing care under the Vulnerable Children's Act, Children's Action Plan etc. Nurses do Reports of Concern, attend Family Group Conferences, become involved in processes regarding warrants uplifting children, and yet have not been approached by employers, eg DHBs, Ministry, Plunket etc. to be part of this consultation. The time period was not sufficient for robust consultation, we urge you to adhere to:

- the Ministry of Health consultation guidelines for District Health Boards relating to the provision of health and disability services (2002)[9];
- The Cabinet Manual[10] which advises that "effective and appropriate consultation is a key factor in good decision making, good policy, and good legislation" and requires "realistic time frames"; and

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9 http://www.moh.govt.nz/notebook/nbbooks.nsf/0/7DA9155B78CF5A05CC257A990002EE58/$file/consultation-guidelines-links.pdf

10 https://www.dpmc.govt.nz/our-business-units/cabinet-office/supporting-work-cabinet/cabinet-manual

- Section 7 of the Local Government Act which stipulates a minimum of four weeks and a maximum of three months.

NZNO strongly recommend that nurses are included as a key workforce for Oranga Tamariki.

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2. What are the benefits of independent oversight for all children and young people, and those in the Oranga Tamariki system?

Which of these are the most critical / important?

Independent oversight for all children and young people provides checks and balances for: staff, processes, decisions. If thorough, it can guard against lack of competence or capability- faulty logic, poor judgement, and unconscious bias, and lack of capacity and capability that may lead to injustice, discrimination and poor outcomes.

Provides basis for overall and independent review and evaluation and policy advice for improved systems and management.

Guardianship of systems caring for infants and toddlers, or those with disabilities who cannot speak, report or complain.

Which of these are the most critical / important?

While there are benefits with both broad and targeted oversight, the history of successive iterations of 'exclusive' siloed systems that are a barrier to coordinated, efficient delivery of integrated social health and justice services for children and young people indicates the need for comprehensive oversight. NZNO supports the Children's Commissioner being tasked with that oversight.

3. So far four independent oversight functions have been identified - monitoring, complaints and investigations, and systemic advocacy. Have we identified the right ones? Are all oversight functions equally important?

All have value that will vary with each child's situation, developmental stage, and circumstances leading to them coming into Oranga Tamariki service.

Advocacy

We note that advocacy is part of regulated practitioners' scopes of practise and responsibility, but this is not recognised in the document (see p7) or, indeed, in the case of nurses, in practice. Regulated qualified practitioners have the knowledge education, training, and experience to advocate for individuals, families and whānau *and* for efficient and fair systems from an evidence–informed base, yet frontline practitioners are frequently overlooked (as in this case) at every stage of system development: design, operation and evaluation (when the latter actually happens). Often they have little choice but to comply with systems that effectively undermine effectiveness, efficiency and equity, and are generally powerless to intervene.

We suggest that indicators for the Living Standards Framework with regard to child poverty and health would be useful and the model of having a broad range of indicators, with the ability to focus more deeply on particular areas of interest as they merge is a good one. In general therefore we believe that the commissioner should not be constrained as to the oversight of the wellbeing of Aotearoa's tamariki and rangatahi.

While NZNO strongly supports the right of children to have an independent advocate, we *did not support* the way this was introduced under the umbrella of philanthropic agencies, and without any consultation

not excepting the Families Commission. We are not sure how well VOYCE is achieving its purpose, but that could be one area that the Children's Commissioner could also oversee.

As it stands, the distinction between independent advocacy and systemic advocacy roles is not clear. Note that considering current research and evidence should be added to the functions of systemic advocacy described in clause 40 (p9) ie "...identify patterns of issues, undertake thematic reviews, and then advocate for change [*if necessary*]".

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4. An oversight body could operate at a number of levels – at system and strategy level, at policy level, or operational. It might also act for individuals. For each of the four functions, where can an oversight body add greatest value?

For advocacy:

By zoning in, focussing, on aspects that have been issues identified from monitoring process or in complaints – advocating aspects that need change, processes that need modifying.

For monitoring:

From complaints received, aspects can be identified that need close monitoring or more frequent monitoring.

However significant attention must be paid to monitoring both short and long term outcomes.

For complaints review:

Results from complaints can inform areas that need monitoring or advocacy for changes in processes, funding, education, and so on.

For investigation:

Independent (child-centred) investigation is probably the most valuable role.

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5. Taking each of the four oversight functions in turn, what is important in terms of how each function is carried out (ie what principles or ways of working are important) for:

- being child-centric and child-facing

Decisions made for an infant may last for years – positively or negatively - in some cases until they are 18years old. There is a life-course effect from these decisions. The rights of children must be understood and paramount.

- providing a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)

Governance and decision-making *at all levels* must reflect Te Tiriti values - the specific needs of Māori, and kaupapa Māori solutions must be factored into all decision making about the wellbeing of children and young people. A bicultural governance should be

developed for Oranga Tamariki and an equity lens applied to all policies and strategies to enact the five articles of Te Tiriti and deliver *partnership, protection, and participation* for Māori in all aspects of life in Aotearoa – access to health care and information, health literacy, clothing, food, recreation, rest, education.

- recognising mana tamaiti (tamariki), whakapapa, and the practice of whanaungatanga for children and young people

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- driving and supporting system or policy improvements

- building public trust and confidence?

Intergenerational issues will take some time to resolve unless there is demonstrable improvement in joined up services and a clear reversal of the structural discrimination and inequity that is the root cause of public distrust and lack of confidence. The previously referenced WHO Report: "Closing the Gap in a Generation" provides a comprehensive evidence base and recommendations for improving equity and thus health and wellbeing.

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6. What are the key skills, knowledge and capabilities required for each function?

Robust training and education and a qualified, well-regulated and integrated workforce, that is supported, culturally competent, and able to meet the needs of tamariki and rangatahi.

Aligned child protection education.

Appropriate police vetting.

Professional Development and Supervision.

Maturity, judgement, insight to ability and limitations.

Fairly employed by credible, appropriately resourced organisation providing safe staffing (ie appropriate skill-mix) and healthy workplace.

Robust, integrated long term workforce planning.

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7. How could the oversight system balance the focus on children and young people in the Oranga Tamariki system, and on all children?

As above. The relationship between universal and targeted/specific services is not difficult to grasp, but identifying degrees of vulnerability and risk, and levels of child protection interventions is. Separating oversight of general, at risk and acute services risks introducing new disparities (eg children who *almost* meet the threshold for Oranga Tamariki intervention, may be structurally 'invisible') since the factors affecting risk and vulnerability are so widely variable given the complexities of age, circumstance, context, individual characteristics.

For that reason, Oranga Tamariki should be an integral part of the universal, *cross agency system* that assures, enhances and protects the health and wellbeing of children and young people. Established, programmed health promotion opportunities and

interventions, provide a useful central framework for the development of specialised child protection, youth justice, school–based and mental health and addiction services, all of which could be within the purview of the Children's Commissioner.

8. How regular and systematic should monitoring of Oranga Tamariki be? And children's wellbeing and poverty?

Probably biennially. We note that there are a number of relevant indicators reported by various agencies with different time frames eg DHBs have to report on Key Performance Indicators monthly, and various poverty and standard of living statistics are reported annually. Two years would be sufficient to allow analysis of those data, and register change, including short term policy outcomes, and would remove Reports from the three yearly political cycle.

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9. Do you think systemic advocacy sits well with a broad monitoring/regulatory mandate? What are the challenges and opportunities of having these together?

We do not think they are incompatible and the advantages outweigh the disadvantages.

10. What is your view of which of the functions fit best together?

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11. When separating functions is there a risk of silos that needs to be managed? If the functions were to be separated what would need to be the connectors?

We advise against separating functions. Once a silo always a silo and it is generally inefficient managing multiple. Separate assessment and reporting functions for child protection, child health and youth justice, family and domestic violence etc. remain the biggest barrier to efficient integrated child and youth services.

12. So far we've thought about some options for how independent oversight functions could be organised:

- What do you think of those proposals? Is there any option you prefer over another?

Option 1 B.

- How can these or other options be developed to be relevant and responsive to the needs of children and young people who are Māori and their parents, whānau, families and caregivers?

- Do you see other options for strengthening oversight arrangements?

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13. We will be asking children and young people about their views on what child-centric, child facing, and timely complaints, monitoring and investigations system would work best for them (primarily with a view to Oranga Tamariki).

Do you have knowledge or experience of this? What help and stops children and young people from saying what is not working for them, and what does that mean for design and principles?

Nurses have a primary role in both specialist and general health and protection services for children and young people, including co-ordination, assessment and referral and have statutory duties in healthcare and advocacy for the health and wellbeing

of children and young people and their families and whānau.

Children with disabilities - physical and intellectual or those who are unable to speak, using Makaton sign language – have difficulty speaking up.

There are cultural barriers to speaking up, including, for example, expectations, cultural norms around responsibility, shame, behaviour, sexuality, kinship, etc. are different from, and unrecognised/rejected/or unable to be dealt with appropriately by mainstream workers within the existing systems.

Structural discrimination prevents recognition of unconscious bias, racisms etc. There is so much work, including public dialogue and training that needs to be done to even start to combat this.

Information needs to be available in multiple languages and utilise all social media platforms, including print.

Substantially increasing the role and resourcing of the Health Promotion Agency (HPA) (currently mainly funded through alcohol levies) to improve health literacy that affects lifestyle choices especially in the vulnerable transition period of adolescence would deliver the best results. Early intervention for mental health and addiction services, expanding health services in schools etc. a positive focus on health literacy and education/ training to enhance wellbeing and optimise the health potential of every child will also help inculcate a safe, transparent culture that invites trust and confidence.

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14. Beyond being child-centric and child-facing, what else is important, eg procedural fairness, cost effectiveness, prioritisation?

All of the above.

How would you measure or evaluate this? And when?
An infant taken into care today may be in care for 18 years before you find out that decisions made now, were flawed. For an example; the Royal Commission of Inquiry into Historical Abuse in State Care.

Must be measured by outcomes – ie a substantial drop in health and socio economic disparities in number children taken into care etc. within a generation.

Child Poverty Advisory Group has made a number of recommendations regarding indicators for equity – see also the living standards dashboard which should include some of these measures.

15. If we consider Oranga Tamariki as a system, should the complaints review mechanism sit across the system, or have common features across all agencies? What would be the challenges and opportunities?

Human rights should form the basis of complaints systems and review.

16. An independent complaints mechanism could potentially operate at many levels. Is there a need for a complaints triage function, for

independent review of individual complaints, or for oversight of how effective agency complaints mechanisms are? What would have greatest value in the next few years?

Difficult to say, and premature. Start by listening to the views of current frontline professional staff working with children and young people to reduce the number of complaints.

17. How well do the current oversight arrangements - the different independent bodies as well as internal arrangements - work as a collective? What are the priority improvements to make?

There are some good models such as the mortality Review Committees, and some social and community agencies, including for example the Salvation Army, UNICEF, and collaborations like CPAG and Tick for Kids make valuable contributions. The issue is with translating recommendations into actions and, in our view, the fundamental barrier of child protection services being not only at arms distance from health services but often an obstacle to ensuring child safety and health and wellbeing.

18. It is more likely than not that legislative change will be required to strengthen independent oversight. Legislative changes that are associated with each of the options we would like you to consider are listed (see 'Possible options in detail' on pages 16 to 22). Are there other changes that should be considered?

Yes. Health must be at the heart of child welfare legislation, ie the right to guaranteed access to core and appropriate specialist health services in all circumstances, at every level of State intervention.

CPHCN notes the former opportunity to create an Ombudsman for Children as in Norway with concurrent legislation; the then government chose to have a Children's Commissioner with a limited role. It could be argued we would not be in this situation today if decisions made then had been different.

Note the Appendix which follows

Nāku noa, nā

Marilyn Head

Senior Policy Analyst

APPENDIX 1

NZNO Oral Submission to Children, Young Persons and their Families (Advocacy, Workforce and Age settings) Amendment Bill, Oral submission.

Note that because of the sensitive nature of the cases referenced by nurses, and the potential for children and families to be identified because of the small, close communities they live in, we have withheld the name and employer of one nurse, of three who spoke to the bill, each of whom highlighted a situation where the disconnect between child protection and child health services prevented timely, safe and appropriate care .

Case 1

Kia ora,

I am a Paediatric Community Nurse Specialist working in a remote rural area. I am an NZNO member and a committee member of the College of Child & Youth Nurses.

I face many challenges working with families, particularly those living in remote areas where cell phone coverage is next to none, add to this their lack of reliable transport, if any, to attend doctors or hospital appointments and you can imagine how difficult it can be at times to keep my finger on the pulse of vulnerable families.

Here is just one example: I have a four year old child on my case load who has cancer and was deemed palliative last year with an undetermined life expectancy. Amongst other medical issues she has had three heli-med transfers in last two years to Starship, for life threatening infection. Her parents are young and Dad also has medical issues of which he has been non-compliant with treatment. There are two younger siblings and up until March this year they all lived with Mum's father. They have always been a challenging family to work with but until the beginning of this year I believed they were doing the best they could in their circumstances

- At the beginning of March this year the child missed a paediatric appointment and an Oncology specialist appointment The Family knew about both as I had reminded them.
- In Mid-March after three attempts to get them there they bought the child to the GP with badly infected sores.
- A week later Family Violence and alleged methamphetamine ('P') use was identified. I personally cited strangulation marks on Mum's neck.
- Nana took the children to another part of the country.

This was when I lodged my first report of concern and family violence documentation to CYFS. The first of three reports I have made about this whānau, not to mention many phone calls to both CYFS social workers and the district health board liaison CFYS co-ordinator, and numerous emails and phone calls to those involved.

I contacted the community nurse and social worker in the area Nana lives and they made contact with her and did a home visit. The property is remote with no road access when wet, and no cell phone coverage. There is a caravan and make shift lean-to with open fire for heat and cooking. Three other grandchildren are also in Nana's care. My opinion, and theirs, was that this was not a satisfactory environment for a palliative child to be living in, and all the children were clearly at risk of developing respiratory and skin infections not to mention rheumatic fever due to overcrowding and inadequate warm, insulation and ventilation in the dwelling. It was decided that if it became a permanent situation, they too would have to lodge a report of concern.

A couple of weeks passed, I heard nothing from CYFS, I asked our liaison worker, what CYFS had done so far she told me they had contacted Nana by phone and had closed the case as the children were safe.(I'm not quite sure how you can deem a child safe from a phone conversation!).

A second report of concern was lodged

At the beginning of June Mum retrieved the children and returned home.

I lodged the third report of concern and having heard nothing back I contacted CYFS twice to see what was happening. I was told the child was not in imminent danger therefore there was nothing they could do!!

The only contact I have had was from one social worker wanting to arrange a family meeting but not being able to contact them, made no further attempt.

There have been more missed appointments. Right now the child, siblings and Mum and Dad are all staying with Nana…. four adults, six children, mid-winter remote rural location.

And so it goes on… you can see how difficult it is but also how difficulties are compounded by having various assessment and management processes and quite different ideas about what health, safety, and wellbeing mean. This case also highlights how very difficult it is to keep track of children, who are being moved all the time even for paid professionals with access to internet and phones etc.

What we desperately need is aligned services, including nationwide children's teams using a connected communications system so children like this don't fall through the gaps, there are consistent quality and safety expectations, assessment and standards throughout the country, including standard safe procedures for nurses, social workers etc. entering homes.

Case 2

Hilary Graham-Smith

Thank you for the opportunity to meet with you to discuss Children, young people and their families. I am Hilary Graham-Smith, PSM NZNO – here with nurse members, Ramona Dillon an urban based Plunket nurse and JS a rural paediatric nurse. NZNO is the leading professional and union nursing organisation of Aotearoa New Zealand, representing 48, 000 members.

Please note that we support the three objectives - independent advocacy services, extending age settings, and more effective workforce utilisation – and that, as our submission has pointed out, we have concerns with the first two, in particular the methodology for developing the independent advocacy service through selective (opaque?) consultation with the philanthropic sector.

However, we want to use this (short, precious!) time to focus on the workforce and other issues arising from both the current and proposed new structure of care and protection services for vulnerable children and young people. We do not think the new structure will be any more effective in preventing abuse or meeting the needs of all at- risk children, because it is based on a flawed assumption that there is a discrete, identifiable group of vulnerable children for whom these services can be exclusively developed. In fact **all** children are vulnerable (as is recognised by the UN declaration on the rights of children) and the degree to which they are at risk depends on numerous circumstances that can change very quickly. Similarly, abuse comes in many forms. Being able to respond quickly and flexibly to risk, requires an open and inclusive structure that allows skilled health, social, education and justice workers to collaborate. That requires a shared vision.

A universal primary health care approach aimed ensuring the health and safety of all children and young people, must be the starting point for both health and social services for children and young people.

The Bill refers to enabling a wider range of professionals to have core roles in discharging functions under the CYPF Act. However there is no reference in the Bill to the makeup of the workforce required for a holistic approach which includes taking into consideration, without limitation, the child's or young person's age, identity, cultural connections, education, and health. I would call your attention to paragraph 64 of the NZNO submission which says
Without a common purpose/vision, opportunities for early intervention and efficient use of workforce resources will be impeded. Social workers are not clinicians and cannot be expected to recognise, assess, or manage health conditions and health risks that are often not visible or apparent. Conversely, health practitioners cannot address the broader range of social issues - family violence, housing, employment, drug and addiction, transience etc. - that social workers manage.

In practice, this often means that the opportunity to treat and manage health conditions may be missed, compounding the disadvantages that highly vulnerable C&YP are subject to.
Recent attempts to 'bridge the divide', for instance with the Children's Teams, have, in fact, highlighted the division and exemplified the extent of unmet health need in children and young people that come to the attention of social services. Public Health and Well Child Nurses are frequently appointed as the lead professional in the children's team BECAUSE **the most acute presenting concerns are health related**. We have expressed our serious concern with the gross underestimation of the capacity required to undertake this lead [professional role the naïve expectation that no extra resourcing was required for what is essentially an entirely new service and way of working. While the children's teams are part of the $60m (2013-2019) implementation of the Vulnerable Children's Act, the example set and the prospect of an equally unknown future in the Investing in New Zealand's Children and Their Families programme of CYFS reform, is acutely concerning.

Case 3

Ramona Dillon

- As registered nurses, we are concerned health doesn't feature in this CYF amendment bill, as intrinsic to child and family outcomes? We ask the reference to "other professional" be specific to Registered nurse professionals and embedded in this Bill.
- Health services as a contributor to improvement in vulnerable children outcomes must be included. Nurses make clinical assessments and the assessment of risk criteria is different to those practicing within

MSD child protection services. Nurses see all children as potentially vulnerable and assess all children using the **Manitoba scale of risk**. This basic difference highlights an area of both a gap and risk for children

- Of those registered nurse professionals practicing within the scope of child, youth and family many have post graduate qualifications.
- I represent WC nurses at the coal face and the biggest gap in advocating for vulnerable children is the paucity in the sharing of information. There must be a two way sharing of information to ensure the voice of every child is heard and understood. As nurses we understand health in a holistic way encompassing psychosocial needs as well as the physical and the family environment
- Well Child nurses and other nurses caring and advocating for vulnerable children share their assessments, complete reports of concerns to Child Youth and Family and this is imperative.
- If MSD want to see outcomes for vulnerable children then it is imperative there must be both transparency and reciprocity with the sharing of information to optimise decision making for those practicing in the MOH domain.
- When the WC nurse has open reciprocal discussion with MSD SWs we can mutually agree on supporting children and families, when this occurs it is noted to be so beneficial
- As Well Child nurses we are predominantly practicing in the dark, when the stakes are at their highest
- An example of a case which stays in our hearts and our minds.
- A new mother who herself had been a ward of Child Protection services. Charlotte, not her real name, was living with her so called “friend” an older man. Through the media later we learnt, he had prior convictions of paedophilia. As it turned out, she herself was being groomed along with her new born child and the two children who followed. WC nurses repeatedly raised the issue and asked for information from CYF because what we assessed in this home environment was not intuitively and assessed as safe.
- The information was not forthcoming. We made referrals to CYF on the grounds of what we saw, what was forthcoming was scant. The so called friend, has since turned out to be the father of the children, and has recently been sentenced to a lengthy prison term. Sadly and frustratingly the damage has been done to this young mother of just eighteen at the time. We were not privy to information sharing then and even now, even though the children are still enrolled with WC services. The young mother will continue to be a risk to herself and her children.
- If there had been sharing of vital background information the outcomes most likely would have been different.

- Nurses are a regulated body of professionals. We are well placed to be at the frontline of every child youth and family decision making. Please let us do what we do well and let MSD and MOH align themselves.

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