Children's Rights Report - UPR 3 AOTEAROA NEW ZEALAND

Introduction

This report was prepared by ACYA[1], CPAG[2], Save the Children NZ[3], and IHC[4] in consultation with a wide range of civil society organisations and individuals.[5] It is based primarily on the United Nations Convention on the Rights of the Child (UNCROC), particularly the 2016 Concluding Observations of the Committee on the Rights of the Child (UNCRC)[6].

About one quarter of Aotearoa New Zealand's (Aotearoa/NZ) population is aged under 18; just over 1.1 million children[7]. Approximately 71% identify as European or other (including NZer); 25% as Māori; 13% as Pasifika; 12% as Asian; and 1% as Middle East, Latin, American or African[8]. Half are adolescents[9]. Māori and Pasifika populations have a younger age profile.

While most children in Aotearoa/NZ enjoy positive childhoods, the rights of a significant number are regularly compromised.[10]

[1] Action for Children and Youth Aotearoa (ACYA) is the coalition of non-governmental organisations that co-ordinates reporting on children's rights under the United Nations Convention on the Rights of the Child (UNCROC) and other international human rights instruments. ACYA is New Zealand's UNCROC country focal point.
[2] Child Poverty Action Group (CPAG) is an independent charity working to eliminate child poverty in New Zealand through research, education and advocacy. Through research, CPAG highlights the position of tens of thousands of New Zealand children living in poverty and promotes public policies that address the underlying causes of that poverty and its impact on children's economic, social and cultural rights
[3] Save the Children New Zealand is a non-governmental organisation working to give children a healthy start in life, the opportunity to learn and protection from harm
[4] IHC advocates for the rights, inclusion and well-being of all people with intellectual disabilities and supports them to live satisfying lives in their communities.
[5] A list of all those supporting this report is attached as Appendix 1.
[6] CRC/C/NZL/CO/5.
[7] In this report we use the term children to refer to all those aged under 18. We recognise that this classification encompasses many ages and diverse circumstances. We also recognise that many young people do not regard themselves as children.
[8] http://www.occ.org.nz/assets/Uploads/StatsOnKids/demographics2016.pdf
[9] Statistics New Zealand. Subnational population estimates by age and sex, at 30 June 2017 http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7502
[10] http://www.occ.org.nz/our-work/statsonkids/

Overall comment about Pēpē[11], Tamariki[12] and Rangatahi Māori[13] [14]

Individual and collective human rights under international rights instruments such as UNCROC and United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), develop and support inherent tāngata whenua[15] rights of pēpē, tamariki and rangatahi Māori[16]. These rights are also inherent in Te Tiriti o Waitangi of 1840[17].

In Aotearoa/NZ, especially for Māori, children's rights are understood within the context of whānau[18] and family.

Pēpē, tamariki and rangatahi Māori experience significant and pervasive inequities[19]. These inequities arise from inequitable access to the determinants of wellbeing, inequitable access to and through services and care, and from the differential quality of services and care received.[20] This maldistribution is the expression of colonisation, [21] coloniality [22] and racism [23] whereby the determinants of health and wellbeing continue to be differentially distributed in Aotearoa/NZ by ethnicity and specifically, by indigeneity.[24]

The inequities that occur for pēpē, tamariki and rangatahi Māori compared with Pākehā[25] are thereby considered an end-result of the disproportionate impacts of the socio-political and economic environments that drive poor health and wellbeing outcomes in Aotearoa/NZ.[26]

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[11] Baby, see Appendix 2 Glossary

[12] Children, see Appendix 2 Glossary

[13] Younger generation, see Appendix 2 Glossary

[14] See Appendix 2 *Health inequities for pēpē, tamariki and rangatahi Māori* . Prepared by Dr. Paula Thérèse King for Aotearoa/NZ Children's Rights report: UPR 2019

[15] People born of the whenua/land. See glossary, Appendix2.

[16] The Oranga Mokopuna model, set out in Appendix 2, provides a conceptual frame of reference within Te Ao Māori for the realisation of tamariki Māori rights.

[17] Te Tiriti o Waitangi/The Treaty of Waitangi imposed obligations on the Crown to protect the rights of Māori to the possession of their own taonga (i.e. whatever is precious in Māori culture) and to enjoy the same rights as British subjects.

[18] Extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members.
http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&keywords=whanau

[19] Simpson, J., Duncanson, M., Oben, G., Adams, J., Wicken, A., Pierson, M., … Gallagher, S. (2017). Te Ohonga Ake The Health Status of Māori Children and Young People in New Zealand Series Two (Health Status of Children and Young People). New Zealand Child and Youth Epidemiology Service. Retrieved from http://hdl.handle.net/10523/7390

[20] Jones CP. Systems of power, axes of inequity: parallels, intersections, braiding the strands. Med Care 2014 Oct;52(10 Suppl 3):S71-5.

[21] Robson, B.,& Harris, R. (Eds.). (2007). *Hauora: Māori Standards of Health IV. A study of the years 2000-2005*. Wellington:Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

[22] Grosfoguel, R. (2011). Decolonizing Post-Colonial Studies and Paradigms of Political-Economy: Transmodernity, Decolonial Thinking, and Global Coloniality. *TRANSMODERNITY: Journal of Peripheral Cultural Production of the Luso-Hispanic World,1*(1),1-38.

[23] Harris RB, Stanley J, Cormack DM. Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLOS ONE 2018;13(5):e0196476.

[24] Reid, P.,& Robson, B. (2007). Understanding Health Inequities. In B. Robson & R. Harris (Eds.), *Hauora Māori Standards of Health IV:A study of the years 2000-2005* (pp.3-10). Wellington:Te Rōpū Rangahau Hauora A Eru Pōmare, University of Otago

[25] Foreign, see glossary Appendix 2.

Developments since previous review (2013)

Since 2013 there has been increased focus on children, particularly those considered at risk of abuse, offending or in poverty, providing many opportunities to advance children's rights: Parliament is considering legislation[27] that will require Governments to adopt, publish and review a child wellbeing strategy covering all children, with a focus on measures and targets to reduce child poverty; the education and health systems are being reviewed; and changes are being made to the care, protection and youth justice systems.

For the first time Aotearoa/NZ has a Minister for Children. The Prime Minister is responsible for the Child Wellbeing Strategy and poverty reduction.

Changes to the Oranga Tamariki Act 1989, due to come into force in 2019, will require consideration of the UNCROC and UNCRPD[28] rights of children in the Oranga Tamariki system[29]. This means that some children, but not others, will have their rights included in domestic legislation.

The increased focus on children in a number of Government departments underscores what has been a perennial challenge for Aotearoa/NZ; lack of coordination and cohesion on child policy and regulation across Government. For example the social service and health systems remain distinct.

Children's Commissioner

A review of oversight of the Oranga Tamariki system and of children's issues in New Zealand, is currently underway[30] and focusses mainly on the role and functions of the Children's Commissioner. The review is an opportunity to address UNCRC recommendations that the Office be: well resourced; equipped to receive, investigate and address complaints from children; and have its independence strengthened and powers to act in the best interests of children.[31]

Mechanisms to uphold and implement children's rights

In its April 2018 report *Building Blocks: Building the foundations for implementing the Children's Convention in Aotearoa* the Children's Convention Monitoring Group (CMG)[32] called on the

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[26] Simpson, J., Adams, J., Oben, G., Wicken, A., & Duncanson, M. (2016). The Determinants of Health for Māori Children and Young People in New Zealand (Determinants of Health for Children and Young People No. 2). New Zealand Child and Youth Epidemiology Service. Retrieved from http://hdl.handle.net/10523/6384

[27] Child Poverty Reduction Bill 2018

[28] United Nations Convention on the Rights of Persons with Disabilities

[29] The term 'Oranga Tamariki system' is being used within Government to describe not only the statutory care and protection and youth justice system in the Oranga Tamariki Act 1989, but also the system for responding to children with early risk factors for future involvement in the statutory care and protection and youth justice system, and young people transitioning from care. See, for example, the cabinet paper on "Consultation on options to strengthen independent oversight (children's issues and Oranga Tamariki system). https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/oversight-for-children/cabinet-paper-consultation-on-options-to-strengthen-independent-oversight.pdf

[30] http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/oversight-for-children/children-s-oversight-consultation-document.pdf

[31] Relates to UNCRC Concluding Observation recommendation 11 (2016)

[32] The Children's Convention Monitoring Group (the Monitoring Group) monitors the New Zealand Government's implementation of the UN Convention on the Rights of the Child (the Children's Convention), its Optional Protocols and the Government's response to recommendations from the UN Committee on the Rights of the Child (the Committee). In addition to a monitoring role, we advocate for the adoption of processes that embed the Children's Convention across

Government to invest in the infrastructure needed to ensure the Children's Convention is embedded in Aotearoa. The CMG identified ten areas where improvements need to be made to enable implementation of the UNCRC, including children's rights awareness raising and training, data collection, budgeting for children, planning, and legislative and policy development[33].

Recommendations

1. Ensure the Child Wellbeing Strategy is based on children's rights and Te Tiriti o Waitangi[34], and developed in close cooperation with children, their whānau, hapu and iwi, families and communities, to
    a. improve understanding and implementation of children's rights, particularly the rights of pēpē, tamariki and rangatahi Māori as tāngata whenua
    b. promote children's best interests and respect for the inherent dignity of each child, including participation in their communities and wider society
    c. encourage more co-ordinated and cohesive work for children across government through
        i. systematic use of children's rights to analyse and monitor laws, policies and practices and their impact on all children's lives
        ii. increased training on children's rights and child impact assessments
2. Ensure any moves to strengthen the Children's Commissioner advance all rights of all children, be based on wide consultation with those working with and for children, and children themselves, and strengthen the Office's independence[35]
3. Address the recommendations of the Children's Convention Monitoring Group[36] [37].

A Cross cutting issues

Equity and non-discrimination

Inequities and discrimination remain significant issues, particularly for Māori children, Pasifika children and children with disabilities. In 2016 The Committee made a priority recommendation regarding children belonging to minority and indigenous groups and identified issues of discrimination or inequities in numerous separate recommendations[38].

The Committee made several recommendations specifically about children with disabilities[39] and remained "seriously concerned about the structural and systemic disadvantages Māori and Pasifika children face…"[40].

Examples of inequities include:

- 50% of babies uplifted at birth and taken into State care are Māori[41]

Government, such as collecting good information, listening to children, raising awareness of the Convention and planning to advance children's rights

[33] See Appendix 3 for the full list of recommendations made by the CMG

[34] Consistent with children's rights, the Child Wellbeing Strategy should be developed in close cooperation with children, their whānau, hapu and iwi, families and communities.

[35] Relates to UNCRC Concluding Observation recommendation 11 (2016).

[36] See Appendix 3

[37] Relates to UNCRC Concluding Observation recommendations 5-12 (2016).

[38] Relates to UNCRC Concluding Observation recommendations: 10(a), 15(a)(b), 16, 17, 19(a)(b)(c), 23(c)(g), 24(a), 26, 27(a)(b), 28(a)(b), 30(a)(b)(c)(d)(e)(f)(g), 31(a)(b), 33,34,36(a), 37(d), 38(a)(b),42, 45(e)(2016).

[39] Relates to UNCRC Concluding Observation recommendation 30 (2016)

[40] Relates to UNCRC Concluding Observation recommendation 41 (2016).

- In the year ended 30 June 2017
    - 3,518 of the total 5,708 children in State care were Māori
    - 2,895 of the 4,716 children in out-of-home placements were Māori
    - 78 out of the total 118 children admitted to Care and Protection residences were Māori
    - 658 of the 889 admitted to Youth Justice residences were Māori[42]
- Disproportionately high numbers of Māori and Pasifika youth appear before the Youth Court[43]
- Between 2014/15 and 2016/17, the Youth Court appearance rate for Māori increased by 23%; the rate for non-Māori reduced by 12%[44]
- In 2016, 11% of Māori children/adolescents in mental health units had been put into seclusion at least once, and 7% of Pasifika children/adolescents[45]
- Suicide rates for rangatahi are disproportionately high and overall, Aotearoa/NZ has the highest rate of adolescent suicide in OECD[46]
- 15% of people under 16 and 19% of people under 28 who receive Disability Support Services have had a finding of abuse and neglect[47]
- Pasifika children are nearly 50 times more likely than New Zealand European children, and twice as likely as Māori children, to be admitted to hospital with acute rheumatic fever[48]
- Pasifika children are three times more likely to witness violence and five times more likely to die from abuse or neglect[49]
- In a recent consultation many children said they experience racism at school and are treated unequally because of their culture[50].
- In 2016
    - School exclusion rates for Māori were around twice the national rate.
    - Boys are excluded three times more than girls. [51]
    - Exclusion rates for children with disabilities are not recorded.
- Youth with disabilities aged 15 – 24 are four times more likely than their non-disabled peers not to be in employment, education or training (NEETS). For Māori the rate is 22.4% compared to 9.1% for the non-Māori population[52]
- Queer[53] and gender diverse students are at higher risk of being subject to violence[54]

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[41] https://www.stuff.co.nz/national/102575309/hundreds-of-newborns-taken-from-mothers-over-last-three-years

[42] All ethnicity statistics are from: http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care-national-and-local-level-data-jun-2017.xlsx

[43] Ministry of Justice *Youth Justice Indicators Summary Report April 2018.* https://www.justice.govt.nz/assets/Documents/Publications/Youth-Justice-Indicators-Summary-Report-201804.pdf

[44] Ibid

[45] https://www.stuff.co.nz/national/health/104612267/pasifika-mori-put-in-seclusion-at-double-the-rates-of-pkeh

[46] https://www.unicef-irc.org/publications/pdf/RC14_eng.pdf

[47] Ministry of Health 2016 – *Characteristics of Disability Support Service (DSS) recipients.* Minister of Disability Issues Forum, December 2016.

[48] http://archive.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress-health/overall-health.aspx

49http://www.pasefikaproud.co.nz/assets/Resources-for-download/PasefikaProudResource-Understanding-family-violence-infographic.pdf

[50] *Education matters to me: Key insights,* Children's Commissioner's Office and New Zealand School trustees Association. 2018. Available at http://www.occ.org.nz/assets/Uploads/OCC-STA-Education-Matters-to-Me-Key-Insights-24Jan2018.pdf

[51] https://www.educationcounts.govt.nz/statistics/indicators/main/student-engagement-participation/Stand-downs-suspensions-exclusions-expulsions

[52] New Zealand Household Labour Force Survey 2017 – June quarter

[53] "Queer" is a reclaimed word that serves as an umbrella term encompassing diverse sexualities and those who are not sure. This word is used by many people in Aotearoa/NZ but is not the preferred term for everybody. https://www.ry.org.nz/friends-whanau/useful-words/

[54] https://www.bullyingfree.nz/about-bullying/lgbtqia/

- The In-Work-Tax-Credit discriminates against around 230,000 children whose parents are beneficiaries[55].

Recommendations

4. Uphold Te Tiriti o Waitangi
5. Ensure the Child Wellbeing Strategy
    a. is comprehensive, cross sectoral and holistic, covering all rights of all children, including affirmative action where necessary
    b. include measures to
        - combat negative attitudes and prevent discrimination
        - urgently address disparities in education, health and standard of living for Māori and Pasifika children and children with disabilities
6. Provide all low-income families with equitable income support.

Environmental issues

Climate change is impacting children's rights in Aotearoa/NZ. Children who are Māori, Pasifika, have a low standard of living, and/or experience discrimination and disadvantage will carry a greater burden [56] [57] [58] [59].

The Government's consultation on proposed legislation to lower greenhouse gas emissions is to be commended[60].

Recommendations:

7. Place children's rights at the centre of climate change adaptation and mitigation, particularly those most vulnerable to climate change effects[61]
8. Undertake health impact assessments, particularly child health, to inform climate change legislation and policies.

B Civil and political rights

Right to life, liberty and security of the person

Children living in the poorest areas are three times more likely to die[62] [63].

[55] The In-Work-Tax-Credit (IWTC) discriminates against some 230,000 children whose parents are beneficiaries, including those who are studying full-time and receiving a student allowance. They are denied assistance given to others. In June 2013 (*CPAG v Attorney-General* [2013] NZCA 402.) the Court of Appeal found that the IWTC discriminated against children of beneficiaries, but the discrimination was justified by social and economic policy which the Court regarded as the purview of Parliament. (Refer to Max Harris "Justified Discrimination" [2013] NZLJ 363.)

[56] http://www.acya.org.nz/uploads/2/9/4/8/29482613/uncroc_orataiao_submission_on_climate_change_.pdf

[57] Metcalfe S. Fast, fair climate action crucial for health and equity. NZ Med J [Internet] 2015; 128(14250:14-23.

[58] Bennett H, Jones R, Keating G, Woodward A, Hales S, Metcalfe S. Health and equity impacts of climate change in Aotearoa-New Zealand, and health gains from climate action. N Z Med J. 2014;127(1406).

[59] Appendix 4

[60] Zero Carbon Bill 2018 https://www.mfe.govt.nz/have-your-say-zero-carbon

[61] Such as the children of Tokelau, and the rights of children in the future

Between 2002 and 2016 there were 1,758 deaths due to suicide, making it the leading cause of death in adolescents[64].

In the year ended June 2017, there were 14,802 substantiated findings of child abuse[65].

Seven percent of children have witnessed adults at home hitting or physically hurting another adult; 14% have witnessed adults at home hitting or physically hurting children[66].

Aotearoa/NZ continues to lack child's-rights based health-care protocols for intersex children, which means surgery and other treatment of intersex infants, and the denial of treatment and surgery to young people who want to make their own decisions about their gender, remain an issue[67].

Similarly, there is not a legal framework that protects children with disabilities from sterilisation without their free, prior and informed consent, and ensures they have independent advocacy[68].

Rates of bullying are high compared with other countries[69]. Each school has its own processes for reporting, recording and responding to bullying, which allows for responses suited to particular school communities but can also result in inconsistency[70].

The Historical Abuse in State Care Royal Commission[71] excludes abuse within religious institutions[72] and children currently in State care need immediate protection.[73]

For children who have suffered violence, trauma or abuse, access to child-friendly reporting channels, physical and psychological rehabilitation and health services, including mental health services, remains limited.

Recommendations

9. Prioritise efforts to address and prevent youth suicide.
10. Build on existing initiatives[74], to develop a strategy to combat violence, abuse and neglect of all children in all settings[75], that:

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[62] Child and Youth Mortality Review Committee 13th data report 2012-16. Prepared by the New Zealand Mortality Review Data Glroup, University of Otago. 2018. https://www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC-13th-data-report-FINAL-Apr-2018.pdf

[63] Medical conditions are the leading cause of death for children and young people at 39% of deaths. This is followed by unintentional injuries at 28%, intentional injury at 25% of deaths, and SUDI at 7% of deaths. Medical conditions include tumours and congenital disorders, unintentional injuries include transport-related deaths and drownings, and intentional injuries are made up of deaths due to suicide and assault

[64] https://www.hqsc.govt.nz/our-programmes/mrc/cymrc/news-and-events/news/3285/

[65] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/findings.html

[66] https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012-overview.pdf (page 26)

[67] Relates to UNCRC Concluding Observation recommendation 25 (2016).

[68] Relates to UNCRC Concluding Observation recommendation 30(f) (2016

[69] There is more information on bullying in New Zealand Schools on the bullyingfreenz website https://www.bullyingfree.nz/about-bullying/bullying-in-new-zealand-schools/

[70] For example, recent media reports illustrate an obvious discord between parent's views of addressing bullying and the school's. *https://www.stuff.co.nz/southland-times/news/104706752/southland-school-fight-club-claims-fended-off-by-principal*

[71] http://www.abuseinstatecare.royalcommission.govt.nz/

[72] Unless the State had transferred responsibility of children to the religious institution.

[73] See Appendix 5 Children deprived of their family environment, which indicates the problem of abuse and harm of children in the State care system is on-going.

[74] For example, the development of the Child Wellbeing Strategy, establishment of Oranga Tamariki, BullyingFreeNZ, Guidelines on restraint and seclusion in schools, and family violence prevention

[75] Families, schools and institutional care.

i. pays particular attention to Māori, Pasifika and disabled children, and children under five years
ii. provides better data on violence against children
iii. strengthens awareness raising and education programmes to prevent and combat child abuse
iv. monitors and evaluates initiatives to address violence against children.[76]

11. Uphold the rights of all children to bodily integrity, autonomy and self-determination by
    a. Developing and implementing a child rights-based health care protocol for intersex children, that provides for counselling and support for families and training for professionals
    b. Adopting legislation that prohibits the sterilization of children with disabilities without their free, prior and informed consent, and provides for independent advocacy.
12. Welcome the Historical Abuse in State Care Royal Commission.
13. Begin to eradicate the use of violence and abuse in State care immediately, including the use of restraints and detention, through
    i. training and supervision of those working with and for children in care
    ii. establishing child-friendly reporting processes
    iii. prompt investigations and responses to violence.
14. Ensure all children who suffer trauma and violence receive rehabilitation in addition to core health interventions.

Administration of justice, including impunity and the rule of law

There has been progress on youth justice issues, such as the inclusion of most 17 year olds in the Youth Court jurisdiction (as from 1 July 2019) and a significant fall in Youth Court appearances since 2009. However, significant problems remain.

The age of criminal responsibility (ten years) is low, and for serious crimes such as murder and manslaughter, children as young as ten can face a High Court jury trial and an adult sentence.

Between 2015 and June 2018, nine children were killed, and 36 seriously injured, in Police chases.

Although 80% of young people[77] are granted bail, the proportion of young people held on custodial remand has doubled since 2012[78]. Detention of children in Police cells has increased. One percent of youth were detained in Police custody at initial hearing in 2014/15 and 3% in 2015/16[79]. Of those who are held, up to 70% are rangatahi Māori[80]. Alternatives are urgently needed to both prevent Police cell remands and to significantly reduce the number of young people held on remand in youth

[76] Relates to UNCRC Concluding Observation recommendation 23 (2016).
[77] Under section 2 of the Oranga Tamariki Act 1989, a young person means a person over the age of 14 years but under the age of 17 or 18
[78] https://www.orangatamariki.govt.nz/assets/Uploads/Research/Youth-Justice/Youth-remand-trends-F2012-to-F2016.pdf. This increase is most likely due to changes to the Bail Act in 2013.
[79] https://www.orangatamariki.govt.nz/assets/Uploads/Research/Youth-Justice/Youth-remand-trends-F2012-to-F2016.pdf (page 12)
[80] Correspondence with JustSpeak http://www.justspeak.org.nz/

justice facilities because there is nowhere else for them to be held (i.e. not because their offending was serious enough to warrant a lengthy remand).

Policing strategies are not always appropriate for children. For example, bail checks and conditions can be onerous for young people, increasing the likelihood of breaches.

Recommendations

15. Address discrepancies in the age of criminal responsibility and sentencing provisions for children charged with serious crimes such as murder or manslaughter
16. Urgently invest in alternative remand options
17. Urgently review Police pursuits to prevent further deaths or serious injury of children
18. Take a more targeted approach to reduce the number of Māori and Pasifika young people in the Youth Court, including in the provision of culturally specific diversion programmes and changes to Family Group Conference process to ensure these are appropriately delivered for all families
19. Consider lifting the age of youth justice to include those aged under 21, consistent with evidence on effective responses to offending by young people.

Fundamental freedoms and participation in public and political life

Increasing recognition is being given to the views of children.[81] The Children's Commissioner has made a significant contribution through their *Mai world* project.[82]

Recommendations

20. Build on growing recognition of children's voice to;
    a. make including children's views the norm
    b. ensure all children can actively participate in decision-making affecting all aspects of their lives, including within families, communities and wider society
    c. create opportunities and mechanisms so all children can raise issues themselves
21. Accede to the third UNCROC Optional Protocol on a Communications Procedure[83].

Prohibition of all forms of slavery

In April 2018 a mother was convicted of slavery for selling her daughter for sexual services an estimated 1000 times[84]. The young woman fell under Aotearoa/NZ's general reservation to UNCROC and her abuse was discovered by chance.

Work underway on digital child protection is welcome[85].

Recommendations

22. Remove the general reservation to UNCROC
23. Take all other necessary measures to prevent and respond to the sale of children.[86.]

[81] Recent examples include Oranga Tamariki establishment and education reform.
[82] http://www.occ.org.nz/4youth/maiworld/
[83] UNCROC Optional Protocol on a Communications Procedure
[84] https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12011269
[85] This work is on the proposed UNCROC work programme and is being led by the Department of Internal Affairs.

Right to privacy and family life

Privacy and data

Legislation has been passed allowing collection and sharing of data on children[87] [88] [89].

It is unclear when children's data should be destroyed, whether this happens automatically or on request when the child turns 18.

Care is needed to prevent genuine, useful data collection becoming surveillance of specific populations, leading to individual or group discrimination, stigma and predictive privacy risk, undermining the trust and purpose for collection[90].

Recommendations

24. Regulate to protect the data and privacy of children, including children in the Oranga Tamariki system
25. The Privacy Commissioner monitor and report on children's privacy
26. Children be made aware of their privacy rights[91].

Family life

A high and increasing number of children are deprived of care in their own family[92]. In the year ending 30 June 2017, 5,708 distinct children and young people were in State care[93] [94]. A disproportionate number are Māori.

In 2017, 225 new-born babies were taken into State care - 38 more than in 2016 and 63 more than in 2015[95]. More than half of these babies are taken from young Māori mothers.

Oranga Tamariki reports having approximately 3,800 caregivers[96]; a shortfall given the number of children in State care. This means some children are not having their care and welfare needs met within a family environment and places stress on the State care system, undermining options and quality.

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[86] In accordance with the Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography
[87] Especially those children identified as vulnerable to harm or poor life outcomes
[88] Privacy (Information Sharing Agreement for Improving Public Services for Vulnerable Children) Order 2015
[89] The interest in data collection is due to the (perceived) need for data on individuals for protection purposes and to guide Government investment on how best to allocate targeted funding, particularly in the social sector; education, health, justice, housing migration and welfare.
[90] Ballantyne, A., & Style, R. (2017) Health data research in New Zealand: updating the ethical governance framework. NZMJ, *130(1464),* pp 64-71
[91] That agencies hold information about them, they can request this information, and that it can be deleted (either automatically or on request) at 18 years of age.
[92] See Appendix 5
[93] Children in State care are legally in the custody of the Chief Executive of Oranga Tamariki (Ministry for Children), New Zealand's State child welfare agency
[94] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html
[95] https://www.stuff.co.nz/national/102575309/hundreds-of-newborns-taken-from-mothers-over-last-three-years
[96] https://www.radionz.co.nz/news/national/353938/record-number-of-children-in-state-care-more-than-6000

The Historical Abuse in State Care Royal Commission is positive[97]. However, the problem of abuse of children currently in the care of the State requires urgent attention.

Recommendations

27. Provide effective and culturally-appropriate support services to families, in particular whānau Māori, to ensure positive child, family and whānau outcomes[98]
28. Monitor the number of babies being taken into care and ensure it is truly an option of last resort and does not reflect unconscious bias or structural discrimination
29. Take urgent measures to eradicate abuse, harm and violence against children in State care, and provide training and ongoing support to carers[99]
30. For all children in State care, translate the principles of the best interests of the child and the importance of the child's views[100]
31. Ensure that every child in State care can make complaints which are addressed[101]
32. The State and community-based NGO care providers work in closer partnership for the benefit of all children in State care, including tamariki Māori
33. All carers undertake children's rights training to support their State-delegated care responsibilities
34. All children in care have age-appropriate, regular and ongoing opportunities to learn about their rights.

Economic, Social and Cultural Rights

Right to work and to just and favourable conditions of work

Aotearoa/NZ's reservation to UNCRC Article 32(2), covering protections for children who work, is based on young workers being adequately protected by existing law.

There is very little recent research about young workers. However, there is enough to call into question the adequacy of existing protections, which are contained in a wide, relatively complex, array of statute law, regulations and codes of practice. There are inconsistent standards and no clear principles underpinning the regulation of children and young people's work or recognising their particular vulnerabilities in the workplace. For example, there is no minimum wage for those aged under 16 and no minimum working age.[102] During 2012 and early 2013 an Independent Taskforce on

[97] http://www.abuseinstatecare.royalcommission.govt.nz/
[98] Relates to Concluding Observation recommendation 26 (2016).
[99] Relates to Concluding Observation recommendation 23 (2016).
[100] Relates to Concluding Observation recommendation 28(a) (2016).
[101] This will require making sure that all children in State care are aware they can make a complaint about their care experience, and they know how to make such a complaint, to Oranga Tamariki itself and/or to an appropriate external agency, and that the complaints of children in State care will be appropriately investigated and addressed in a timely and child-centered manner.
[102] Research has found that secondary school students in employment have low levels of awareness surrounding their employment rights, low rates of union membership and a 50% likelihood of having a formal written employment agreement. Schoolchildren employees have reported trusting their employers to the extent that they will do work that they consider unsafe, while a small proportion will do an unsafe task because they are afraid they will lose their job if they do not. Injuries are a relatively common and occasionally serious occurrence for child workers. In one study, one sixth of secondary school students in part time work reported being injured at work in the previous year, of these injuries half were relatively minor but about one fifth were serious enough to warrant a visit to a medical professional or hospital. http://www.mbie.govt.nz/publications-research/research/labour-market-and-skills/schoolchildren-in-paid-employment.pdf

Workplace Health and Safety identified young people as one of the groups particularly vulnerable to injury and harm [103].

A large number of children work, mostly by choice and safe from harm and exploitation. They must be a part of determining the adequacy of protections.

Recommendations

35. Ensure young workers are adequately protected from harm and exploitation [104]
36. Collect data on the experiences of young workers, including their views
37. Remove the reservation to UNCROC Article 32(2).

Right to social security

In 1991, child poverty increased significantly following cuts of up to 25% to social welfare. This reduction in social security has never been fully restored.

Tax credits are not well indexed, which means their impact on living standards diminishes over time.

Recent family tax credit increases are expected to lift 64,000 children out of poverty on the Government's primary measure of 50% Before Housing Costs median income. They apply to all low income children. Households in low-paid work benefit from a realistic increase in the amount they can earn before abatement of the tax credits begins. However the abatement rates for those earning over $42,700 increased to 25% from 1 July 2018, so that the extra is more quickly lost. Those families on benefits or with insufficient hours of work are still denied an important part of the tax credit package.

Benefit sanctions mean children of beneficiaries can have their household income reduced by up to 50%, or even cancelled, if certain requirements are unmet. For example, when children live in sole parent families and the father is not named on the welfare application, the welfare recipient's weekly income may be reduced by up to $28 per week.

Although the Welfare Expert Advisory Group (WEAG)[105] will suggest improvements to welfare accessibility and provision, evidence is available to support immediate changes.

Recommendations

38. Improve children's wellbeing by
    a. Giving all low income families the full tax credits for their children
    b. Immediately abolishing benefit sanctions
    c. Legislating for annual tax credit adjustments[106]
    d. Reducing abatement rates so low-income families can earn without compromising their overall household income and therefore children's wellbeing
    e. Building a fair, compassionate welfare system where everyone receives their entitlements.

[103] *The report of the Independent Taskforce on Workplace Safety and Health He korowai whakaruruhau* (2013) p 13.
[104] Relates to Concluding Observation recommendation 44 (2016)
[105] https://www.beehive.govt.nz/release/expert-group-established-provide-independent-advice-welfare-system-improvements
[106] The tax credit threshold should be adjusted to be consistent with wage inflation (as happens with New Zealand Superannuation)

Right to an adequate standard of living

Poverty

In 2018, there are more than 140,000 children going without many of the things they need and 28% children experiencing income poverty[107]

Children with disabilities and Māori and Pasifika children are disproportionately over-represented in low-income households. Household with disabled children are 43% more likely to experience income poverty than all households with children. [108]

Forty five percent of children in income poverty are from working households.[109]

The Child Poverty Reduction Bill will require Governments to develop a Child Wellbeing Strategy and set child poverty reduction targets.[110]

Access to nutritious food

Many families cannot consistently afford healthy food. Food security concerns are most frequently experienced by Pasifika and Māori young people. In 2012, approximately two out of three Pasifika young people and half of Māori young people reported food security concerns occasionally or more often. Teenagers whose families worry about money for food are more likely to be overweight, have poor mental and physical health, and miss school. [111] In 2017 the Ministry of Social Development reported that "*food has remained the main reason for needing hardship assistance ... grants for food assistance have increased from 98,076 in the December 2015 quarter to 137,079 in the December 2017 quarter*".[112] On 14 February 2018, the Salvation Army reported a 13% increase in food parcel distribution in 2017 compared to consistent numbers over the six years prior.[113]

Drinking water safety

A 2016 outbreak of gastroenteritis from drinking water in Havelock North affected 5,500 of the 14,000 residents and raised serious concerns about drinking water safety[114].

Housing

Nearly 70% of children in poverty live in State housing or private rentals. The price of housing and rents is high compared to wages[115]. For families who are renting, the problem is threefold: house rents are high and increasing, the quality of many rental properties is substandard and deteriorating,

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[107] Based on the measure of 60% of the national median income after housing costs

[108] Based on the 60% of household median income before housing costs, analysis by CCS Disability Action of unpublished 2013 Disability Survey data provided by Statistics New Zealand.

[109] http://www.childpoverty.co.nz/sites/default/files/IncomePoverty_2016.jpg

[110] See Appendix 5 - joint children's sector submission setting out high level, collective views on the Bill.

[111] Rising food security concerns among New Zealand adolescents and association with health and wellbeing (2018) Kōtuitui: New Zealand Journal of Social Sciences Online, 13:1, 29-38, DOI: 10.1080/1177083X.2017.1398175

[112] Ministry of Social Development, 2017 *Hardship Assistance -December 2017 quarter* (refer Figure 3) The Salvation Army, 2018, *Kei a Tātou - It Is Us State of the Nation Report* http://www.salvationarmy.org.nz/sites/default/files/uploads/20180214tsastateofthenation2018.pdf

[113] The Salvation Army, 2018, *Kei a Tātou - It Is Us State of the Nation Report* http://www.salvationarmy.org.nz/sites/default/files/uploads/20180214tsastateofthenation2018.pdf

[114]. Havelock North Drinking Water Inquiry reports. 2017. Retrieved from: https://www.dia.govt.nz/Government-Inquiry-into-Havelock-North-Drinking-Water-Report---Part-1---Overview ; See also https://www.health.govt.nz/publication/annual-report-drinking-water-quality-2016-2017

[115] The International Monetary Fund's house price-to-rent ratio shows New Zealand has one of the widest gaps between prices and incomes.

and the rental market provides few rights and protections for renters[116] For the whole of Aotearoa/NZ, rents increased by around 11% between 2009 and 2014 (similar to Consumer Price Index inflation) but Christchurch rents increased by 20% to 30%, with almost all of this increase since the 2011 earthquakes. In Auckland, rents are rising faster than incomes, increasing by 17% between 2009 and 2013.

Recommendations

39. Align policies and services with children's rights and the Sustainable Development Goals (SDGs) to ensure all children have equitable access to and outcomes from:
    a. an adequate standard of living
    b. quality housing
    c. free, quality, public education
    d. good health (nutritious food, safe drinking water, and quality healthcare when needed)
    e. timely, flexible and integrated social support services.
40. Update the reference year for measuring poverty at least every five years
41. Legislate to protect families who rent[117]
42. Establish a social housing plan that is aligned with children's rights, based on realistic forecasts for future demand for social housing, targeted to areas of high need, and allocate budgets to fund this plan over at least a ten-year period.

Right to health

There are significant inequities in availability, accessibility, acceptability and quality of health, especially for children already marginalised by poverty, indigeneity, ethnicity and disability.

A child living in poverty is nearly three times more likely to end up hospitalised than a child from a more affluent household, and over eight times more likely to be hospitalised for assault, neglect or maltreatment. Children living in poverty are also significantly more likely to end up hospitalised for conditions such as asthma, pneumonia, bronchiolitis, bronchiectasis, gastroenteritis, skin infections, road traffic crashes, drownings, falls, neglect and violence. Highly prevalent yet preventable diseases such as serious skin infections and pneumonia, as well as less common by highly preventable damaging diseases rheumatic fever and bronchiectasis are directly related to unhealthy housing, and are virtually unknown in other OECD countries such as Sweden, the UK and the USA. [118]

Pasifika children and young adults are nearly 50 times more likely than New Zealand European children, and twice as likely as Māori children, to be admitted to hospital with acute rheumatic fever. The top three barriers to primary health care for Pasifika peoples are identified as cost, transport and language.

Expensive general practice primary health costs (GP) visits create barriers to healthcare for children in poverty. In July 2015, the National Government introduced free GP visits and prescriptions for

[116] Our children, our choice (2014). Child Poverty Action Group. see: https://www.cpag.org.nz/assets/Publications/140812%20CPAG%20OurChildrenOurChoice-Part4Housing%202014.pdf

[117] The Residential Tenancies Act needs to be overhauled to ensure more secure tenure, access to effective advocacy, support in disputes with landlords, protections against excessive rent increases and guarantees to decent quality housing through a comprehensive warrant of fitness programme.

[118] Left further behind (2011). Child Poverty Action Group. https://www.cpag.org.nz/assets/sm/upload/g4/gp/1n/xu/111010%20FINAL%20%20Left%20Further%20Behind%20Brochure.pdf

children under 13, extended to under 14 under Labour in 2018. However, 14-17 year olds must pay the full fees for the GP and prescriptions. The rate of unmet need due to cost is high from the age of 13-14 (8.8% compared to 2.7% for 6-12 year olds, 2016-17 data)[119].

Adolescent health

'We are always told make the most of our lives, achieve highly, do great things, be great, always be striving. But this makes us feel like we have a lot of pressure to do these things, we never achieve enough, we never do enough, we never have enough, we never are enough. It stops us from being happy with our lives, our situation, ourselves. We don't know if enough is enough and worry too much about this instead of being happy with what we do, what we have and who we are.'
Young person, Mental Health and Addiction Youth Hui, 25 May 2018[120]

Overall there have been improvements in the health and wellbeing of adolescents[121], but significant issues remain. Sexual and reproductive health, bullying, obesity, mental health and access to primary health care are all issues for adolescents. Participants in the Youth 2000 survey also reported not getting enough time with parents, struggling with food affordability and lack of access to part-time employment impacted on their wellbeing.

For some girls, cultural and cost barriers to menstrual management products adversely impact their health and education.[122]

Dental caries

Dental caries remains the most common chronic preventable childhood disease in New Zealand, with Māori and Pasifika children experiencing greater prevalence and severity than other groups. While dental services for children are free, there is a maldistribution of services, variable access to fluoridated water supply as well as a lack of monitoring to ensure children in need are receiving adequate services.

Breastfeeding

A lack of facilities in public spaces and workplaces creates barriers to breastfeeding[123]. Breastfeeding initiation rates are relatively high but decline rapidly in the first months of life[124] due to multiple structural barriers to breastfeeding such as a lack of facilities in public spaces and workplaces. The most recent National Strategic Plan of Action for Breastfeeding covered the period 2008-2012 and has not been renewed.

Preventing Neural Tube Defects

The addition of folic acid to bread is a safe and effective way to prevent the neural tube defects (NTDs), a major contributor to infant mortality and morbidity[125]. Mandating folate fortification of

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[119] https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_6a7d866d/#!/explore-indicators
[120] Save the Children New Zealand, *Youth submission to the mental health and addiction inquiry* (2018).
[121] Based on findings of Youth 2000 Survey series. https://www.fmhs.auckland.ac.nz/en/faculty/adolescent-health-research-group/publications-and-reports/overview-of-health-and-wellbeing-findings.html#par_pagetitle It should be noted that the latest data available is from 2012 and the next survey is due to be completed this year, 2018.
[122] https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2018-02%20Proposal_Mens_Mgmnt_Pdcts_NZNO.pdf
[123] Personal correspondence between ACYA and members of the Child Wellbeing Network
[124] Royal New Zealand Plunket Society. Annual breastfeeding statistics [Available from: https://www.plunket.org.nz/news-and-research/research-from-plunket/plunket-breastfeeding-data-analysis/annual-breastfeeding-statistics/
[125] http://www.moh.govt.nz/notebook/nbbooks.nsf/0/19C76A786D58C8D6CC256DA4008038A6/$file/ImprovingFolate.pdf

bread, as recommended by the Chief Science Adviser[126], would lower the incidence of NTDs, especially for at-risk groups.

Recommendations

43. Ensure the health system provides services that are available, accessible, acceptable and of high quality to all children, especially those already marginalised by poverty, indigeneity, ethnicity and disability[127]
    a. Extend free primary health care and prescriptions for children up to the age of 18[128]
    b. Promote healthy environments and lifestyles for children
    c. Improve sexual and reproductive health services for adolescents
    d. Update the National Strategic Plan of Action for Breastfeeding.

Right to education

Education review

The education system is under review creating opportunities to realise children's rights to quality education that supports them to reach their fullest potential. [129].[130]

The repeal of National Standards, which had the effect of narrowing or limiting the taught curriculum, is consistent with children's rights .[131]

Early Childhood Education

Concerns about the quality and safety of Early Childhood Education (ECE) are growing. In the 2016 Early Childhood Education Complaints and Incidents Report, a total of 331 complaints about early learning services. Of these 245 were investigated and 165 were upheld. The complaints upheld found that standards had not been met or the investigation found the service was required to improve. Tragically one child died due to an accident at their centre.

Inclusive education

Students with disabilities are excluded from New Zealand's education system, face barriers to equitable access to education and are over-represented in school disciplinary processes, particularly exclusions both formal and informal. There are barriers to enrolment, accessing the curriculum and required resourcing. Initial teacher education and ongoing professional development in inclusive practice also remains a problem. Long delays continue for students in access to early intervention and specialist services, including communication and behaviour support.

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[126] http://www.pmcsa.org.nz/wp-content/uploads/The-role-of-evidence-in-policy-formation-and-implementation-report.pdf (p 15)

[127] More intensive effort is needed to close equity gaps in health services for different cultural groups, including developing culturally appropriate services for Māori and Pasifika communities.

[128] Including prescriptions, oral health, vision and hearing care.

[129] UNCROC, Article 29.

[130] Article 29; New Zealand has signed up to the Sustainable Development Goals and therefor is committed to achieving Sustainable Development Goal 4, to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

[131] NZCER (2016) National Standards in the Seventh Year. NZCER: Wellington

Despite over thirty years of special education policy development and review it is unknown how many children and young people with disabilities are enrolled, where they go to school or the type, extent and true cost of the supports they need to learn.

Students with disabilities do not enjoy an enforceable right to education and have no access to an independent review of decisions made. IHC (the New Zealand organisation providing support and care for people of all ages with intellectual disabilities) lodged a complaint under the Human Rights Act in 2008 based on the continual systemic, unjustified discrimination against students with disabilities requiring accommodations to learn. This claim is still to have a full hearing in the Human Rights Review Tribunal.

Recommendations

44. Ensure the education system upholds Te Tiriti o Waitangi and realises, respects and promotes children's education rights[132], especially the rights of
    a. children with disabilities to an inclusive education and reasonable accommodations, using accurate prevalence data about children requiring additional supports to inform education policies, resource frameworks, plans and programmes
    b. minority groups to an education that diverges from that preferred by the majority.
45. Improve quality and safety in ECE by, amongst other things, improving teacher to child ratios, lifting ECE teacher qualification requirements and monitor provision of home-based care.

Rights of specific persons or groups

Children with disabilities

Children with disability are more likely to live in low income families. Data from Statistics New Zealand's 2013 Disability Survey[133] shows:

- 34 % of disabled children living in families that earn under $50,000 a year, compared to only 24 % of non-disabled children
- 17% of carers of children with disability were unemployed[134]
- 30% of disabled children lived in one parent households, compared to 17% of non-disabled children.

Estimates from 2013 Disability Survey also found that children with disability were less likely, in the previous four weeks, than non-disabled children to have had music, art, or other similar lessons; played a team sport; done other physical activity such as swimming or gymnastics; visited friends; or been away on holiday in the past 12 months.

Children with disability are disproportionately impacted by wider systemic issues associated with poverty such as housing and household income levels.

[132] Articles 23, 28 and 29 UNCROC; Articles 7 and 24 Convention on the Rights of Persons with Disabilities
[133] Statistics New Zealand. (2014). *Disability Survey: 2013.* Wellington: Statistics New Zealand.
[134] CCS Disability Action *Submission on the Child Poverty Reduction Bill* 2018. Page 9. Retrieved from https://www.ccsdisabilityaction.org.nz/assets/resource-files/Submission-on-the-Child-Poverty-Reduction-Bill.pdf

Children with disability are also over-represented in the care and protection system[135]. At the same time, children with disability are sometimes left in placements when other children are removed for protection purposes[136].

Recommendations

46. Include an explicit focus on children with disabilities in the Child Wellbeing Strategy
47. Strengthen efforts to combat the marginalisation and discrimination of children with disabilities in their access to and outcomes from health, education, care and protection and justice services[137]
48. Ensure the Disability Action Plan addresses issues for children with disability[138].

Specific regions or territories

There are regional variations in the realisation of children's rights. For example, children in post-earthquake Canterbury and those living in economically deprived areas (such as Northland and the East Coast of the North Island), do not enjoy their rights equitably.

Recommendation

49. Address regional variations in the enjoyment of children's rights, in consultation with children, their whanau, hapu and iwi, families and communities.

[135] Ministry of Health 2016 – *Characteristics of Disability Support Service (DSS) recipients.* Minister of Disability Issues Forum, December 2016.
[136] IHC Submission on the Children, Young Persons and Their Families (Oranga Tamariki) Legislation Bill. (2017). Retrieved from https://ihc.org.nz/sites/default/files/IHC%20CYPF%20OT%20Bill%20Submission%203%20March%202017.pdf
[137] Relates to UNCRC Concluding Observation recommendation 23(c) and 30(b)(2016).
[138] Relates to UNCRC Concluding Observation recommendation 30(a) (2016).

Appendix 1 – List of organisations endorsing Children's Rights Report - UPR 3 Aotearoa New Zealand

Action for Children and Youth Aotearoa (ACYA)

Barnardos

CCS Disability Action

Child Matters

Child Poverty Action Group (CPAG)

Christian World Service

IHC

JustSpeak

New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO)

NZEI Te Riu Roa

OMEP Aotearoa New Zealand

Peace Movement Aotearoa

The Public Health Association of New Zealand

Royal New Zealand Plunket Trust

Safeguarding Children Tiakina ngā tamariki

Save the Children NZ

Stand Children's Services Tu Maia Whanau

UNICEF New Zealand

University of Otago Children's Issues Centre

Wesley Community Action

YouthLaw

Appendix 2 - Health inequities for pēpē, tamariki and rangatahi Māori

Prepared by Dr. Paula Thérèse King for Children's Rights Report: - UPR Aotearoa New Zealand

The relationship between colonisation and health inequities for indigenous peoples is well described both internationally [139], [140] and in Aotearoa/New Zealand (Aotearoa/NZ), [141] as is the association between racism and health in Aotearoa/NZ. [142]

The significant and pervasive health inequities experienced by pēpē, tamariki and rangatahi Māori compared with Pākehā babies, children and young people in Aotearoa [143] arise from inequitable access to the determinants of health, inequitable access to and through health care and from the differential quality of the care received.[144] At the same time this maldistribution is the expression of colonisation, [145] coloniality [146] and racism [147] whereby the determinants of health and wellbeing continue to be differentially distributed in Aotearoa/NZ by ethnicity and specifically, by indigeneity.[148]

The inequities that occur for pēpē, tamariki and rangatahi Māori compared with Pākehā are thereby considered an end-result of the disproportionate impacts of the socio-political and economic environments that drive poor health and wellbeing outcomes in Aotearoa/NZ.[149]

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[139] Czyzewski, K. (2011). Colonialism as a Broader Social Determinant of Health. *The International Indigenous Policy Journal,2*(1). Available at https://ir.lib.uwo.ca/cgi/viewcontent.cgi?referer=https://www.google.co.nz/&httpsredir=1&article=1016&context=iipj

[140] Paradies, Y. (2016). Colonisation, racism and indigenous health. *Journal of Population Research,33*(1),83-96.

[141] Reid, P.,& Robson, B. (2007). Understanding Health Inequities. In B. Robson & R. Harris (Eds.), *Hauora Māori Standards of Health IV:A study of the years 2000-2005* (pp.3-10). Wellington:Te Rōpū Rangahau Hauora A Eru Pōmare, University of Otago.

[142] Harris RB, Stanley J, Cormack DM. Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLOS ONE 2018;13(5):e0196476.

[143] Simpson, J., Duncanson, M., Oben, G., Adams, J., Wicken, A., Pierson, M., … Gallagher, S. (2017). Te Ohonga Ake The Health Status of Māori Children and Young People in New Zealand Series Two (Health Status of Children and Young People). New Zealand Child and Youth Epidemiology Service. Retrieved from http://hdl.handle.net/10523/7390

[144] Jones CP. Systems of power, axes of inequity: parallels, intersections, braiding the strands. Med Care 2014 Oct;52(10 Suppl 3):S71-5.

[145] Robson, B.,& Harris, R. (Eds.). (2007). *Hauora: Māori Standards of Health IV. A study of the years 2000-2005*. Wellington:Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

[146] Grosfoguel, R. (2011). Decolonizing Post-Colonial Studies and Paradigms of Political-Economy: Transmodernity, Decolonial Thinking, and Global Coloniality. *TRANSMODERNITY: Journal of Peripheral Cultural Production of the Luso-Hispanic World,1*(1),1-38.

[147] Harris RB, Stanley J, Cormack DM. Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLOS ONE 2018;13(5):e0196476.

[148] Reid, P.,& Robson, B. (2007). Understanding Health Inequities. In B. Robson & R. Harris (Eds.), *Hauora Māori Standards of Health IV:A study of the years 2000-2005* (pp.3-10). Wellington:Te Rōpū Rangahau Hauora A Eru Pōmare, University of Otago

[149] Simpson, J., Adams, J., Oben, G., Wicken, A., & Duncanson, M. (2016). The Determinants of Health for Māori Children and Young People in New Zealand (Determinants of Health for Children and Young People No. 2). New Zealand Child and Youth Epidemiology Service. Retrieved from http://hdl.handle.net/10523/6384

This is particularly so for a number of preventable conditions such as acute upper respiratory tract infections, bronchiolitis, asthma, pneumonia, bronchiectasis, pertussis, otitis media, gastroenteritis, skin infections, rheumatic fever, dental problems, [150] and obesity.[151]

It is also evident in all-cause mortality for children less than eighteen years of age, where although higher mortality rates are more common for those living in areas of high deprivation, there is a disproportionate impact on pēpē, tamariki and rangatahi Māori with substantial increases in mortality rates with increasing deprivation.[152] This is seen in mortality rates from sudden unexpected death in infancy which are seven times as high for pēpē Māori compared with Pākehā babies.[153]

Significant inequities in mortality also occur in intentional injuries which are twice as high for Māori compared with Pākehā, with 83% of all these deaths due to suicide in tamariki and rangatahi Māori. Between 2012-2016, all intentional injury deaths for tamariki Māori between the ages of 10-14 years were due to suicide.[154] Of maternal suicides between the years 2006-2015, Māori mothers were three times more likely to die from suicide than Pākehā with just under half of all Māori maternal suicides occurring in Māori mothers under the age of 17 years.[155]

One in six tamariki Māori are reported to be living with disability,[156] and are more likely to be living with a disability (15%) than Pākehā children (9%), [157] with inequities occurring in hearing impairment and loss, [158] psychological and psychiatric impairments, difficulty with learning, difficulty with speaking, and intellectual disability.[159]

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[150] Simpson, J., Duncanson, M., Oben, G., Adams, J., Wicken, A., Pierson, M., … Gallagher, S. (2017). Te Ohonga Ake The Health Status of Māori Children and Young People in New Zealand Series Two (Health Status of Children and Young People). New Zealand Child and Youth Epidemiology Service. Retrieved from http://hdl.handle.net/10523/7390

[151] Craig E, McDonald G, Adams J, Reddington A, Oben G, Simpson J and Wicken A. (2014). Te Ohonga Ake The Health of Māori Children and Young People with Chronic Conditions and Disabilities in New Zealand Series Two. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago. Retrieved from https://ourarchive.otago.ac.nz/handle/10523/6134

[152] New Zealand Mortality Review Data Group. (2018). Child and Youth Mortality Review Committee 13th Data Report 2012–16. Dunedin: University of Otago. Retrieved from https://secure-www.otago.ac.nz/nzmrdg/

[153] Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi. (2017). Sudden unexpected death in infancy (SUDI): Special report. June 2017. Wellington: Child and Youth Mortality Review Committee. Retrieved from https://www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC_SUDI_Report.pdf

[154] New Zealand Mortality Review Data Group. (2018). Child and Youth Mortality Review Committee 13th Data Report 2012–16. Dunedin: University of Otago. Retrieved from https://secure-www.otago.ac.nz/nzmrdg/

[155] PMMRC. 2017. Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015.Wellington: Health Quality & Safety Commission.

[156] Craig E, McDonald G, Adams J, Reddington A, Oben G, Simpson J and Wicken A. (2014). Te Ohonga Ake The Health of Māori Children and Young People with Chronic Conditions and Disabilities in New Zealand Series Two. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago. Retrieved from https://ourarchive.otago.ac.nz/handle/10523/6134

[157] Stats NZ. (2013). Disability Survery 2013, Wellligton: Statistics New Zealand. Retrieved from https://www.stats.govt.nz/information-releases/disability-survey-2013

[158] Craig E, McDonald G, Adams J, Reddington A, Oben G, Simpson J and Wicken A. (2014). Te Ohonga Ake The Health of Māori Children and Young People with Chronic Conditions and Disabilities in New Zealand Series Two. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago. Retrieved from https://ourarchive.otago.ac.nz/handle/10523/6134

[159] Stats NZ. (2013). Disability Survery 2013, Wellligton: Statistics New Zealand. Retrieved from https://www.stats.govt.nz/information-releases/disability-survey-2013

Though daily smoking in 14-15 year olds for Māori and Pākehā 14-15 year olds have continued to decrease over time whilst rates of 'never smoking' have increased, Māori rates of daily smoking are over five times higher than for Pākehā, with Māori girls reporting the highest daily smoking rates. [160] Māori mothers compared with Pākehā were also more likely to smoke before (up to 47%) and during pregnancy (up to 32%), and were more likely to be exposed to second hand smoke.[161]

In the perinatal period, inequities exist for pre-term birth and low birth weight, [162] and the rate of neonatal deaths for pēpē born under 28 weeks gestation to Māori mothers is one and a half times higher than for Pākehā.[163]

Experience of racism occurs more commonly for tamariki and rangatahi Māori in Aotearoa and has been found to be associated with a range of adverse health outcomes.[164] A report published earlier this year has described the multiple ways tamariki and rangatahi Māori have experienced racism within the education system.[165]

Oranga Mokopuna – A tāngata whenua rights to health and wellbeing model [166]

Oranga Mokopuna is a tāngata whenua rights to health and wellbeing model for pēpē, tamariki and rangatahi Māori. Based on the mātauranga Māori model of whānau, Oranga Mokopuna model provides a conceptual frame of reference within Te Ao Māori for the realisation of tāngata whenua rights to health and wellbeing.

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[160] ASH (2017). Year 10 ASH Snapshot. Auckland: ASH-Action for Smokefree 2025. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/ashnz/pages/70/attachments/original/1521962541/2017_ASH_Y10_Snapshot_Topline_DRAFT_27Mar18.pdf?1521962541

[161] Humphrey G, Rossen F, Walker N, & Bullen C. (2016). Parental smoking during pregnancy: findings from the Growing Up in New Zealand cohort. NZMJ, 129: 1442. 60-74. Retrieved from https://www.nzma.org.nz/__data/assets/pdf_file/0014/51440/Humphrey-FINAL.pdf

[162] Craig E, McDonald G, Adams J, Reddington A, Oben G, Simpson J and Wicken A. (2014). Te Ohonga Ake The Health of Māori Children and Young People with Chronic Conditions and Disabilities in New Zealand Series Two. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago. Retrieved from https://ourarchive.otago.ac.nz/handle/10523/6134

[163] PMMRC. 2017. Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015.Wellington: Health Quality & Safety Commission.

[164] Crengle, S., Robinson, E., Ameratunga, S., Clark, T., & Raphael, D. (2012). Ethnic discrimination prevalence and associations with health outcomes: data from a nationally representative cross-sectional survey of secondary school students in New Zealand. BMC Public Health, 12(45), 1-11. Retrieved from http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-45

[165] OCC. (2018). He manu kai mātauranga: He tirohanga Māori. Wellington: Office of the Children's Commissioner. Retrieved from http://www.occ.org.nz/assets/Uploads/Experiences-of-Maori.pdf

[166] King P, Cormack D & Kōpua M. (2018). Oranga Mokopuna - A tāngata whenua rights to health and wellbeing model (in press).

Inherent tāngata whenua rights derive from and are nurtured by whakapapa – traversing generations through tīpuna/tūpuna to beyond the origins of the universe, are grounded in Tikanga Māori – a constitutional framework and system of laws that Māori have observed in Aotearoa/NZ for at least a thousand years, and affirmed by the two internationally recognised instruments, he Wakaputanga o te Rangatiratanga o Nu Tīreni (1835) and te Tiriti o Waitangi (1840). Individual and collective human rights depicted under international rights instruments such as the United Nations Convention on the Rights of the Child, and the Declaration on the Rights of Indigenous Peoples then develop and support inherent tāngata whenua rights.

Oranga Mokopuna can be applied in the designing, delivery and evaluation of health systems, policies, services and interventions. However, there are a number of considerations for use. Critically, the model highlights that pēpē, tamariki and rangatahi Māori cannot be considered as existing outside the context of their whānau. In addition, the realisation of tāngata whenua rights to health and wellbeing are fundamentally informed by Tikanga Māori first and foremost. Tikanga will vary between whānau, hapū and iwi, and thus is dependent on context. Oranga Mokopuna cannot be employed in a way which disrupts whakapapa or be co-opted in a way that does not align with tāngata whenua rights. Nor can it be fragmented – the model must be applied in its entirety.

Oranga Mokopuna supports the respect, protection and fulfilment of tāngata whenua rights so that pēpē, tamariki and rangatahi Māori thrive and flourish as our rangatira of today.

Glossary

Aotearoa – Māori name for New Zealand

Hapū – Kinship group, sub-tribe, sub-nation, to be pregnant

He Wakaputanga o te Rangatiratanga o Nu Tīreni – Declaration of Independence

Iwi – Extended kinship group, tribe, nation, people, bone

Mātauranga – Knowledge, wisdom

Nu Tīreni – New Zealand

Pākehā – Foreign

Pēpē – Baby

Rangatahi – Younger generation

Rangatira – Chief / Chieftaness

Tamariki – Children

Tāngata Whenua – People born of the whenua/land

Te Ao Māori – The Māori world

Te Tiriti o Waitangi – Māori version of The Treaty of Waitangi

References for Appendix 1.

King P, Cormack D & Kōpua M. (2018). Oranga Mokopuna - A tāngata whenua rights-based approach to health and wellbeing (article in press).

King P. Rights to Health: An Indigenous Model for Children and Young People in Aotearoa/NZ. In: Proceedings of 15th World Congress on Public Health, Melbourne Convention and Exhibition Centre; Melbourne, Australia. April 2017. Retrieved from https://wcph2017.entegyapp.com.au/Page/28/802/26/2855

Appendix 3 – Recommendations of the Children's Convention Monitoring Group*

Building Blocks: Building the foundations for implementing the Children's Convention in Aotearoa (April 2018)

1. Incorporate the UNCRC in law
2. Develop an overarching children's rights strategy or plan that covers all children and
3. Coordinate to ensure consistently good (rights-based) policy for children across Government and equitable access to, and outcomes from, public services
4. Training and tools, such as child impact assessments, to implement children's rights
5. Generate high quality disaggregated data on children to inform policies, legislation and practices
6. Budget to track and measure spending on children's rights and wellbeing and the impact of that investment
7. Fund and resource the Children's Commissioner to effectively fulfill its mandate and functions to monitor and advance child rights
8. Establish systems to seek out and consider children's views in decision making using a child-centred, rights based approach
9. Raise awareness of the Convention for children and adults alike, including adults working with and for children, and Government officials responsible for decision-making
10. Withdraw reservations and accede to the Third Optional Protocol.

* *The Children's Convention Monitoring Group*

The Children's Convention Monitoring Group (the Monitoring Group) monitors the New Zealand Government's implementation of the UN Convention on the Rights of the Child (the Children's Convention), its Optional Protocols and the Government's response to recommendations from the UN Committee on the Rights of the Child (the Committee). In addition to a monitoring role, we advocate for the adoption of processes that embed the Children's Convention across Government, such as collecting good information, listening to children, raising awareness of the Convention and planning to advance children's rights.

Read the recommendations in full *Building Blocks: Building the foundations for implementing the Children's Convention in Aotearoa*

Available on http://www.occ.org.nz/publications/reports/getting-it-right-building-blocks/

Appendix 4 - Table 1: Expected impact of climate change on physical and mental health of Māori children in Aotearoa NZ

Source: Children's rights and climate change in Aotearoa New Zealand: supplementary information for the UN Committee on the rights of the Child. Prepared by OraTaiao: The Aotearoa NZ Health and Climate Council on behalf of Action for Children and Youth Aotearoa. August 2016. Available here: http://www.acya.org.nz/uploads/2/9/4/8/29482613/uncroc_oratataiao_submission_on_climate_change_.pdf

Injury and illness from extreme weather events (flooding, storm surges, drought, etc.)	Most Māori now live in urban areas, but many Māori communities, and Māori cultural, social, economic and recreational activities are in coastal areas vulnerable to sea level rise and extreme weather events. Many Māori rural and remote settlements have vulnerable infrastructure and lack resilience to cope with and recover from extreme events. Extreme events can worsen chronic disease and access to health services. This will disproportionately affect Māori children who already have higher rates of chronic disease and worse access to health services than Pākehā children.
Mental health	Loss of Māori land, urupā (cemeteries), marae (traditional Māori meeting places), and other places of cultural importance will add to the existing burden of mental illness and higher rates of self-harm among Māori children.
Vector-borne disease	New mosquito vectors carrying diseases like Dengue could become established in Aotearoa NZ, especially in the North Island where Māori are concentrated in coastal areas that are at higher risk for the establishment of exotic mosquito populations.
Respiratory disease	Māori children have higher rates of respiratory illness, including asthma (see also *Allergic conditions including asthma*). These rates may increase for several reasons, including temperature changes, air pollution, and inadequate housing. Māori children are already more likely to be living in overcrowded housing. They are more likely to be living in traditional settlements in many coastal areas or flood plains vulnerable to extreme weather events. Changes in weather may lead to greater use of heat sources that produce indoor air pollutants. Dwellings may become damper, colder and mouldy. The reduction in habitable dwellings, climate-related displacement of people, and reduced family income may increase overcrowding and homelessness, and thus increase infections. The respiratory effects of increased outdoor air pollution will also fall disproportionately on Māori children.
Nutrition and food security	As local sources of food gathering production are affected by climate change, and food prices rise globally, the higher burden of food insecurity and poor nutrition experienced by Māori children is likely to increase.
Allergic conditions including asthma	Changes in pollen dispersal and the distribution of plants and flowering could increase allergic conditions including asthma. Rates of asthma are already higher among Māori children than Pākehā children.
Effect on parents, grandparents and other family members	The wellbeing of Māori children cannot be separated from the wellbeing of their wider family. Māori children will also be affected by the disproportionate effects of climate change on Māori adults.

Box 2: Current impact of climate change on Ngāti Hine children [30,35]

Ngāti Hine is a Māori tribe in northern Aotearoa NZ. Ngāti Hine has a close relationship with their lands and waterways, a relationship that has survived the impact of colonisation. Ngāti Hine ancestral lands are inland and away from urban centres. Most people on these lands live a lifestyle that values traditional ways of life.

Ngāti Hine are renowned for their relationship with tuna (eels). Their customary fisheries are in their rivers and wetlands. The tuna breed and spawn once a year–during a time that has specific climatic requirements–in the Pacific Ocean and return to the land, migrating back up the rivers.

Ngāti Hine have been able to maintain their autonomy in part because of the tuna in their waterways. The whole of Ngāti Hine culture depends on the lifecycle of the tuna. Tuna are essential kai (food) and a major source of protein. Ngāti Hine have a reciprocal relationship with tuna, which are revered as kai and a measure of caring and hospitality.

Ngāti Hine have adapted their traditional practices to protect the sustainability of the tuna despite Government agendas of deforestation and the draining of wetlands. Now Ngāti Hine elders observe that climate change is also depleting the tuna.

Ngāti Hine children learn their culture and heritage in an experiential way from their kaumatua and kuia (older people, especially grandparents), who pass on their deep knowledge about tuna to their mokopuna (grandchildren). Thus tuna are central in the bringing up of children and the relationship between generations.

Climate-related disruption of the lifecycle of the tuna has profound implications for Ngāti Hine children to enjoy the rights guaranteed to them by the CRC, including their rights to family, health, food, standard of living, education, culture and being indigenous.

And, of course, the impact on tuna is only one of the ways in which climate change will impact the rights of Ngāti Hine children.

Appendix 5 – Addressing youth suicide in New Zealand

A submission by Dr. Ian Hassall to the Government Inquiry into Mental Health and Addiction, 9 April, 2018.

Ian Hassall is a paediatrician and child advocate. He was New Zealand's first Children's Commissioner (1989-2004) and the recipient in 2010 of the Aldo Farina Award for child rights advocacy.

Introduction – our obligation to all children and young people

We must see that all children have the best chance in life. That way lies humanity, prosperity and the best of New Zealand traditions. As it happens, our Government signed up to just such a commitment, the U.N. Convention on the Rights of the Child in 1993. Especially relevant are Articles 2, 24 and 27. The alternative to striving to meet this commitment is to view certain children and classes of children as writeoffs who are destined to give way to children better adapted by reason of inheritance and good fortune to a narrowly-conceived dominant culture. There is some public support for this view often implied but rarely made explicit. It is a recipe for social division a waste of potential and a threat to life. It accepts inequality, a potent determinant of reduced life chances.[167]

The personal and social dimensions of mental health

Through one pathway, inequality links to poor life outcomes through impaired mental health. If children are to have their best chance in life we must give what help is needed to their parents and families to ensure their individual mental health and well-being. That is the issue as seen from a young person and their family's perspective. Equally, we, as a society must offer them a place of dignity and promise. Mental health is a duality. It is personal and it is social. It depends on the integrity of the individual mind which in turn depends upon the social milieu, which is, in infancy the intimate caregivers and, as time goes by, a widening cast of neighbours, friends, community, school, actors and musical idols, fictional characters and the national society and wider world.

Mental health and suicide

Suicide is widely understood in New Zealand as a consequence of mental ill-health. It is sometimes equated with depression although this is not a simple cause-and-effect association. Clinically diagnosed depression can lead to suicide but depression is common and suicide relatively uncommon. Other factors must be sought in understanding the path to suicide. In seeking a preventive strategy a focus on depression can obscure the role of social factors as well as the wider range of intermediate steps that lead to suicide.

[167] a. National Health Committee. (1998) *The social, cultural and economic determinants of health in New Zealand: Action to improve health.* Wellington: The National Health Committee.
b. Wilkinson, R., Pickett, K. (2010) *The spirit level: Why equality is better for everyone*. London: Penguin.
c. Rashbrooke, M. (Ed.) (2013) *Inequality: A New Zealand crisis*. Wellington: Bridget Williams Books.

The personal and social dimensions of suicide

The same duality of origin as applies more generally to disordered mental health applies also to suicide. The social contribution to suicide is apparent if we consider the widely differing prevalence among different populations and at different times. Emile Durkheim, the father of sociology studied these differences in his famous research of more than a hundred years ago.[168]

> Since suicide is an individual action affecting the individual only it must seemingly depend exclusively on individual factors, thus belonging to psychology alone. Is not the suicide's resolve usually explained by his temperament, character, antecedents and private history? (Durkheim, p xliv)

but

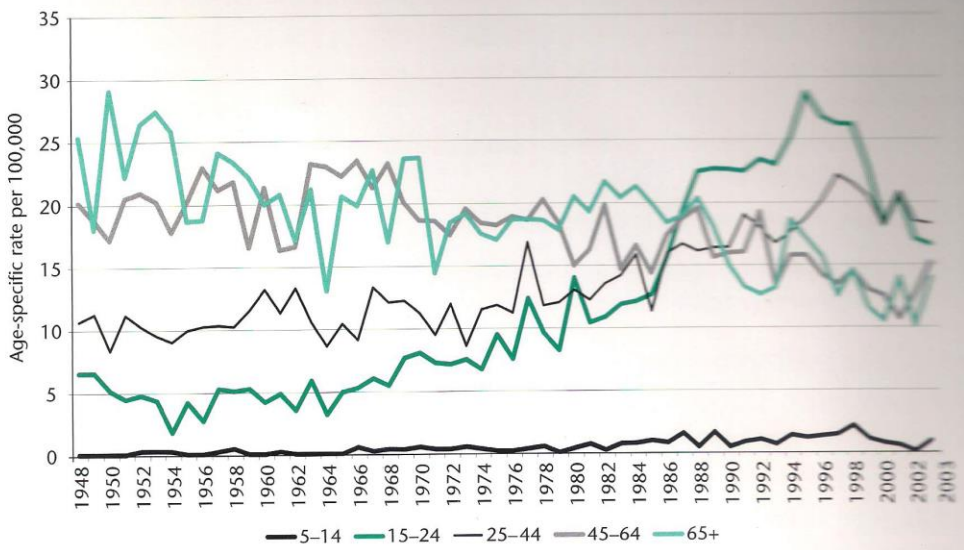
> If…. the suicides committed in a given society during a given period of time are taken as a whole, it appears this total is not simply a sum of independent units, a collective total, but is a new fact *sui generis*, with its own unity individuality and consequently its own nature – a nature furthermore dominantly social. Indeed, provided too long a period is not considered, the statistics for one and the same society are almost invariable, as appears in Table 1 (which compares suicide numbers among six European countries – 1841-1872). This is because the environmental circumstances attending the life of peoples remain relatively unchanged from year to year. To be sure, more considerable variations occasionally occur but they are quite exceptional. They are also clearly always contemporaneous with some passing crisis affecting the social state. Thus around 1848 there occurred an abrupt decline in all European states (The 1848 revolution in France, was the first of a revolutionary movement which subsequently affected most European countries). (Durkheim, p xliv)

New Zealand's particular youth suicide problem

In our own country, the spectacular doubling of the youth suicide rate between 1985 and 1989 (Figs. 2[169],[170]) can only be explained by a change in the conditions of life among young people as understood by them at that time.

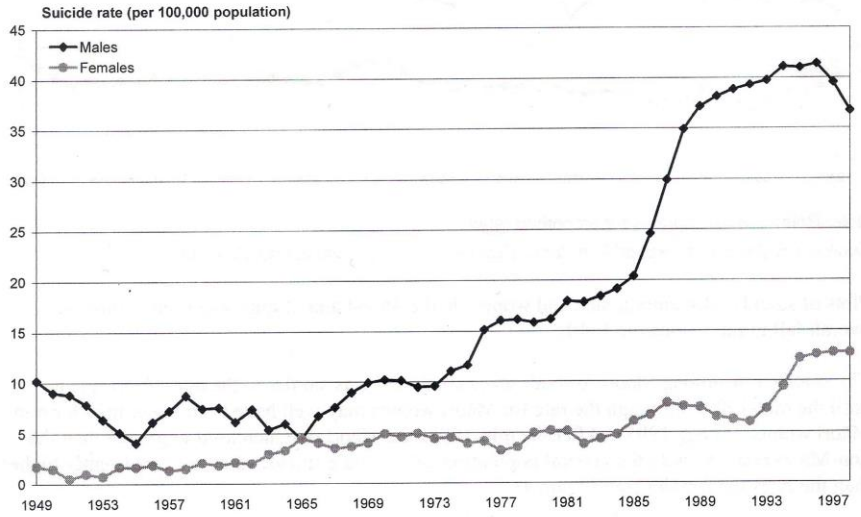
[168] Durkheim, E. (1897) *Le Suicide: Etude de sociologie.* Paris. English translation (2002) *Suicide: A study in sociology.* London and New York: Routledge Classics. p. xliv.
[169] Associate Minister of Health. (2006) *The New Zealand suicide prevention strategy 2006-2016.* Wellington: Ministry of Health. p.4
[170] Collings, S., Beautrais, A. (2005) Suicide prevention in New Zealand: A contemporary perspective. Wellington: Ministry of Health. p.3

Figure 2: Age-specific suicide rates, 1948–2003



Note: 2003 data are provisional; rates are age-standardised.
Source: New Zealand Health Information Service.

Figure 2: Age-specific rates of suicide in the 15–24-year-old age group, by sex, 1949–98



Note: Rates used are three-year smoothed rates.
Source: Ferguson et al (Report 2 in *Social Explanations for Suicide in New Zealand*).

A study of coroners' reports on suicides during the 20th Century discusses this rise in the youth suicide rate in some detail.[171]

> The explanatory argument is that rising rates of youth suicide are best studied in relation to deep changes in the culture and economy which coalesced in 'a perfect storm' bearing down directly and suddenly on young people. New Zealand, along with many 'Western societies' had moved toward consumerism after World War II. Where materialism had strengthened but the economy was faltering, the moral disorientation and nihilism of some young people is understandable. The increase in youth suicide, that alarmed so many people at the time, provoked public controversy and advanced the medicalization of suicide, was a particularly cheerless summary of epic cultural and economic changes. (Weaver, p 254)

> Advocates of the clinical approach inverted relationships between social stresses and disorders. "Life events in the year before death", asserted the authors of one study, "must be examined with caution: separation, change in habits and moving can all be attributed to personality disorders, depression or substance abuse. They may even be helpful at the clinical level, serving as possible suicide risk indicators." If suicide stems from disorders of an autonomous or biochemical origin why was there a sudden change in age rate late in the century? Moreover most motives that we identified could not be deemed mental illnesses by any stretch of the Diagnostic and Statistical Manual. It is possible to argue that self-destruction is *ipso facto* a sign of mental illness, but such a simplification obscures the meditative processes undertaken by many suicidal people and removes from scrutiny the conduct of people around the deceased. (Weaver, p 255)

The sudden increase in suicides among young people in New Zealand was superimposed on a more gradual increase dating from the sixties and seventies that was more widespread throughout the countries we regard as peers. It seems likely that the slow rise in youth suicide among Western countries and the sudden rise confined to New Zealand have arisen from different processes or one as an exaggeration of the other. They can be expected to have a cumulative effect – 'the perfect storm'. In any event the New Zealand tragedy requires its own explanation.

My interest in and analysis of the excess of youth suicide in New Zealand

I have, first as Children's Commissioner and subsequently on my own account, looked for such an explanation.[172],[173] (See Appendix). Logic suggests suicide comes from despair as to future prospects and detachment from customary constraints against suicide. Such despair and detachment may be internally generated and unjustified or based on objective reality or a mix of the two. What "passing crisis affecting the social state" (in Durkheim's words) was impacting on New Zealand youth or at least a section of New Zealand youth from 1985? There was a revolution at that time beginning in 1984. It has been given a number of names but is most widely referred to as the economic reforms.

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[171] Weaver, J. (2014) *Sorrows of a century: Interpreting suicide in New Zealand, 1900-2000. Ontario: McGill-*Queens University Press and Wellington: Bridget Williams Books.

[172] Hassall, I., (1997) Why are so many young people killing themselves? *Butterworth's Family Law Journal*, 2, 7, 153-158.

[173] Hassall, I. Yes, it hurts, but we have to sort it. *NZ Herald, 31 July, 2017*, p. A12.

Little was done to measure and analyse the impact of the reforms on children and young people, particularly at sub-population level but such information as was available suggested a negative impact.[174]

Similar reforms were taking place in other OECD countries at the time but it is widely acknowledged that changes were swifter, more extensive and thus more brutal in New Zealand with closure of businesses, loss of employment prospect and a sense of undermining of social norms. 'No pain, no gain' was a popular refrain. Aggressive, divisive words like 'loser' and expressions like 'kick arse' crept into our language and became commonplace. Perhaps pre-existing conditions and population expectations had been more benign in New Zealand than in many other countries as well and perhaps protective factors such as civil society institutions that offered support and identity, were not as developed and effective. Whatever the detailed explanations there is no doubt that a revolution was in progress and its effect on at least some of New Zealand's children and young people was traumatic.

Why has the youth suicide rate remained high for the last thirty-three years?

Why, though, has New Zealand's high youth suicide rate persisted when we might have expected it to fall when stability returned in the nineties and beyond? It is, after all, now thirty-three years since the uptick in rate. The reason is unclear although it may be that suicide became embedded as an option in youth culture and needed a more positive message to youth rather than the mere removal of the original trauma.

Despite a) the dramatic events of the late eighties in New Zealand, b) the known association of sudden increases in suicide rate with social and economic turmoil and c) the evidence for other negative impacts on children and young people, there has been an official lassitude which has impaired the development of an effective preventive and ameliorative strategy.[175]

> The increase in male suicide rates in the 1970s and especially the 1980s could relate to the rapid social changes in New Zealand society over this period – but there is no strong evidence for this hypothesis. (Ministry of Health, p 175)

The Prime Minister's Chief Science Advisor in a 2017 discussion paper acknowledges the contribution of social circumstances to youth suicide but in discussing the epidemiology fails to acknowledge the specifically New Zealand 1985-9 surge in rate.[176] Although it includes references to potentially useful family and community-based preventive strategies, the paper is primarily oriented to individual-based solutions rather than interventions that view society as an entity in its own right.

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[174] Blaiklock, A., Kiro, C., Belgrave, M., Low, W., Davenport, E., Hassall, I. (2002) *When the invisible hand rocks the cradle: New Zealand children in a time of change: Innocenti Working Paper No. 93.* Florence: UNICEF Innocenti Research Centre.

[175] Ministry of Health. (1997) Progress on health outcome targets: The state of the public health 1997. Wellington: Ministry of Health.

[176] Gluckman, P. (2017) Youth suicide in New Zealand: A discussion paper. http://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf

> Suicide prevention is complicated because we do not understand the causes well enough at the individual level. (Gluckman, p 8)

A whole-of-society approach to prevention to match the whole-of-society effect of the reforms

If New Zealand's ongoing high youth suicide rate is a result of an embedded suicide option in youth culture and a failure to address the poisonous message that the turmoil of the late 1980s sent to youth, how can an effective prevention strategy be made to work? A good starting point would appear to be to signal to all young people that there is a credible present and future place for them. If this is to be more than lip service it must be underpinned by:

- pastoral care programmes in secondary schools and tertiary institutions which overcome young people's reluctance to confide in adults and professionals[177]
- active job creation for youth including adequate training, and apprenticeships
- access to tertiary education
- an active programme of poverty reduction and housing
- attention to young people's spiritual needs
- recognition and support for diversity
- efforts to end bullying and harassment

For such a programme to be effective it must be sincere and high profile and not only the responsibility of Government but of us all. The understandable fear that young people will be induced to commit suicide as a result of the accompanying publicity should be handled judiciously but it should be noted that our high rate of suicides occurring in diverse communities suggests that there is already widespread knowledge of the issue within youth culture.[178]

Conclusion

The social and economic turmoil of the late eighties coincided with a sharp rise in youth suicide rate. It is plausible that these events were related as cause and effect. In the absence of credible alternative explanations and in view of our failure so far to reduce the youth suicide rate we should base our preventive efforts on hypotheses of process that accept this cause and effect relationship. One such hypothesis is that some young people found during the reforms that their society could not be relied upon to help them find a place of dignity and purpose according to their expectations and a number of them ended their lives. Suicide spread in the youth culture as a response to a loss of hope from this and other causes.

Having failed as a country to take into account the impact of the eighties reforms on young people or to take effective steps to support and protect them subsequently it is incumbent on us to strive to reverse the poisonous messages of the eighties that left young people without hope. There is a rational programme that promises to do this.

END

[177] Gibson, K., Wilson, J., Le Grice, J., Seymour, F. (2017) Resisting the silence: The impact of digital communication on young people's talk about suicide. *Youth and Society, p. 1-20, DOI: 10.1177/0044118X17720986*.
[178] Ibid.

Appendix 5 – Information on children deprived of their family environment

A high number of children are deprived of being in the care of their own family in New Zealand. Official Government statistics for the year ending 30 June 2017 show that 5,708 distinct children and young people were in the custody of the Chief Executive of Oranga Tamariki (Ministry for Children), New Zealand's State child welfare agency.[179] This compares with 5,312 in the year ending 30 June 2016, representing an increase of 7%.[180] However, media have reported that at the end of January 2018, 6,100 distinct children were in the custody of the Chief Executive.[181] This is the highest number of children ever to be recorded as in the care of the State in New Zealand.

From 2016 to 2017 a 7% increase also occurred in the number of distinct children in out-of-home placements (increasing from 4,394 to 4,716).[182] 118 children and young people were admitted to Care and Protection residences in the year ending 30 June 2017, representing a 9% decrease from the previous year, and 889 children and young people were admitted to Youth Justice residences in the year ending 30 June 2017, representing a 2% reduction in admissions from the previous year.[183]

Tamariki Māori are disproportionately overrepresented amongst children deprived of their family environment. Of the total 5,708 children in the custody of the Chief Executive in the year ending 30 June 2017, 3,518 were Māori. Of the total 4,716 children and young people in out-of-home placements in the same year, 2,895 were Māori. Of the children and young people admitted to Care and Protection residences in the year ending 30 June 2017, 78 out of the total 118 were Māori, and of the 889 admitted to Youth Justice residences in the same year, 658 were Māori.[184]

There has been an increase in the number of newborn babies being taken into State care. Media have reported that 225 babies were taken into State care in 2017 - 38 more than in 2016 and 63 more than in 2015.[185] It is also reported that more than half of the newborns are uplifted from young Māori mothers.

Oranga Tamariki reports having approximately 3,800 caregivers to support the care of children in the care of the State.[186] There is currently a shortfall in numbers of caregivers available to care for children and young people in need of care through the State. This means that not only are some

[179] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html
[180] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html
[181] https://www.radionz.co.nz/news/national/353938/record-number-of-children-in-state-care-more-than-6000
[182] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html
[183] http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html
[184] All ethnicity statistics are from: http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care-national-and-local-level-data-jun-2017.xlsx
[185] https://www.stuff.co.nz/national/102575309/hundreds-of-newborns-taken-from-mothers-over-last-three-years
[186] https://www.radionz.co.nz/news/national/353938/record-number-of-children-in-state-care-more-than-6000

children being deprived of a family environment to meet their care and welfare needs, but it is adding stress to the State care system, with a lack of options resulting in limited respite relief for caregivers when they need it. Children with challenging behaviours in particular face challenges in securing placements with caregivers.

Despite significant reform of the Oranga Tamariki system being ongoing, systemic issues continue to have a detrimental effect on children in the State care system. This includes the problem of abuse and harm of children in the State care system.[187] An Oranga Tamariki study published in 2017 found that of a sample of case files of children and young people in Oranga Tamariki care during 2015-2016, 12% of children and young people had experienced at least one incident of harm during that time in care.[188] Of the children and young people involved in the study who experienced harm during this time, tamariki Māori experienced harm at a significantly higher rate than non-Māori children (73% compared with 23%).[189] It is notable that the report only recorded one incident of harm where a child or young person had experienced multiple incidences of harm during their time in care 2015-16.[190] While it is positive that a Royal Commission of Inquiry into Historic Abuse in State Care has been launched,[191] the problem of abuse of children currently in the care of the State requires urgent attention, so that children in the care of the State are safe and are cared for in a family and whānau environment so they can thrive.

[187] The UN Committee on the Rights of the Child raised this as a concern its most recent Concluding observations on New Zealand (see para 22(a).
[188] https://www.orangatamariki.govt.nz/assets/Uploads/Research/Safety-of-Children-in-Care/Safety-of-children-in-care-full-report.pdf at p.13.
[189] https://www.orangatamariki.govt.nz/assets/Uploads/Research/Safety-of-Children-in-Care/Safety-of-children-in-care-full-report.pdf at p.14.
[190] https://www.orangatamariki.govt.nz/assets/Uploads/Research/Safety-of-Children-in-Care/Safety-of-children-in-care-full-report.pdf at p.12.
[191] http://www.abuseinstatecare.royalcommission.govt.nz/

Appendix 6: Children's Sector Joint Submission on the Child Poverty Reduction Bill

"He kai tahu me kikini, he kai tahu me tīhore, mā te tamaiti te iho"

"Pinch off a bit, peel off a bit, the inside is for the child" (said of the potted bird) – we save the best for the child

There is a significant opportunity right now to achieve real change in the lives of Aotearoa's children; to do so we must work collaboratively and urgently.

For nearly three decades, too many children's lives and outcomes have been compromised by deep-seated disparities, including prevalent and persistent child poverty with high rates of very severe income poverty (140,000 children) and severe material hardship (70,000)[i]. Rather than treating children as the taonga they are, children's wellbeing has historically been given low priority in public policy and decision-making.

The Child Poverty Reduction Bill (the Bill) aims to reduce child poverty by setting measures, which will be monitored according to agreed targets, and reporting on progress as part of a strategy to improve the wellbeing of all children. The Bill is a significant, welcome step forward and an opportunity for Government and non-government organisations, communities, children, whānau and families to work together, to create a society where all children live safe and fulfilling lives, and are supported to reach their potential.

This submission sets out the high level, collective views on the Bill of many who work with and for children in Aotearoa. It is supported by individuals and organisations as listed below.

As a collective, united in the same cause, we are committed to working together to hold this and future Governments to account so there is significant progress on the wellbeing of Aotearoa's children.

This legislation is important for all children in Aotearoa
We support the Bill's definition of a child as a person aged under 18 years. Within that definition, the diversity of children's rights and needs must be recognised, including those of older children and children in their early years.

The Bill needs to uphold the principles of Te Tiriti o Waitangi and respect tamariki Māori as tangata whenua.

Actions to enhance the wellbeing of different groups of children must take their particular needs and rights into account, so no child is left behind. Children with disabilities, for example, are more likely to live in low-income households and face greater costs, resulting in higher rates of material hardship. Yet children with disabilities are largely invisible in child poverty data. Other groups of children that will require specific attention include: tamariki Māori, Pasifika children, refugee and migrant children, children living in rural areas, as well as those already specifically mentioned in the Bill – children in care, at risk of abuse or neglect, and those involved in the youth justice system.

Working in partnership towards realistic and enduring child poverty measures and targets
In aiming to reduce poverty within a normal period of economic activity, the Government is signalling an intention to set its targets realistically – given the depth of child poverty, it will not be an easy task to bring the numbers down.

However, realism must not become an excuse for inadequate action. A broad and strategic approach is needed to ensure the targets are met, and to ensure that a reduction in child poverty is sustained long-term and that it makes a real difference to children's wellbeing.

Policies and actions to reduce child poverty need to be developed transparently and in partnership with the children's sector to support community-led development and to enable whānau, families and children themselves to contribute to identifying problems and shaping solutions.

Effective planning and policy-making for children requires good information
Robust, disaggregated data and other evidence such as qualitative research and children's views must be used to inform decision-making affecting children.

The United Nations Convention on the Rights of the Child (the Children's Convention) provides an existing framework for planning to promote and protect children's wellbeing and should underpin the Child Wellbeing Strategy, as well as cross-Government approaches that affect, and give effect to, children's rights.

We suggest that a set of rights-based principles be incorporated in the Bill to encourage coordinated, child-centred and whole family and whānau approaches to policies across Government.

These principles should help define child wellbeing and what it will take for all children to have good childhoods where they can holistically exercise and enjoy their rights to, amongst other things: be treated with respect and dignity; be cared for by their parents and whānau, with support where needed; live free from violence; have an adequate standard of living; timely access to quality healthcare and education; opportunities to play and be with friends; and be connected to their own culture.

We recommend principles similar to those set out in section 5 of the Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017be used so that the Bill embeds children's rights, is mana enhancing and gives effect to the principles of whakapapa and whanaungatanga.

Being child-centred across Government
Measures to reduce child poverty will potentially be undermined unless the way children's rights and interests are taken into account across all of Government is improved. In addition to sectors traditionally associated with children's wellbeing, such as health, education, housing and social services, decisions about transport, justice, the labour market, climate change, privacy and data protection and collection also impact on children.

Quality universal services are essential for all children
Reducing child poverty and mitigating its impact on children depends on all children being able to access and benefit from quality universal public services, such as health, education and social services.

A Ministry for Children should be for all children
We welcome that the Vulnerable Children Act 2014 is to be called the Children's Act 2014, in line with the Ministry's name change to Oranga Tamariki – Ministry for Children. We urge Government to be transparent about how Oranga Tamariki will focus on all children. We are concerned that many children who fall outside current risk criteria will have difficulty accessing services, support and interventions that are critical to their wellbeing.

The importance of getting the measures and data collection right
To accurately measure child poverty and its reduction, it is crucial that fixed line low-income after housing costs accurately represent current average housing prices and incomes. The fixed line

measure takes income at a point in time (currently 2007) adjusted annually by the Consumer Price Index as a baseline. However, real incomes change over time, and while the median income may fluctuate, a reference year that is too outdated (as this one is) becomes out of touch with the reality of surviving on a low income.

The data collected by the Household Economic Survey (HES) is out of date by the time it is publicly reported on. For example, the latest income information for the 2018 Household Incomes report was collected between July 2016 and June 2017, and based on income information from the 12 months prior. This means that by the time the next report is released in July 2018, data on incomes for some families may be two years out of date.

Information in the HES is also drawn from an insufficient sample range and size. The survey is generally conducted on 3000-3500 private households, including only 1000 with children. A bigger sample size is needed, to provide an accurate representation of the population. To provide a more representative picture of the economic circumstances of Aotearoa's children, the sample needs to include a sufficient number of children with disabilities, tamariki Māori, Pasifika and Asian children, and a sample of children who are homeless. Poverty lines should be validated based on knowledge - gained through consultation with those living on low incomes - of what level of income is required to ensure a minimum adequate standard of living for children, and what is needed for them to thrive.

We support the Bill's intent and recommend:

1. The development and implementation of the Child Wellbeing Strategy, including action to reduce child poverty, be consistent with and uphold the principles of Te Tiriti o Waitangi.

2. Principles similar to those set out in section 5 of the Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017 be included in the Bill to embed children's rights and ensure the Bill is mana enhancing and gives effect to the principles of whakapapa and whanaungatanga.

3. Poverty reduction targets and measures should be realistic and, most of all, backed by policies that will be effective in achieving them.

4. The Child Wellbeing Strategy:
   - take a child rights approach encompassing all children in Aotearoa New Zealand and all areas of their lives, as required under the Children's Convention; and
   - be developed, designed and monitored
     - in consultation with children; and
     - in partnership with iwi and Māori organisations, non-government organisations and communities; and
   - be adequately resourced and budgeted for, have clear time frames and transparent processes for review, monitoring and reporting on progress.

5. Actions under the Child Wellbeing Strategy to reduce child poverty and improve the wellbeing of children should align public policies and social service delivery with children's rights so that all children and young people, at all stages of their childhood and adolescence, have access to and equitable outcomes from:
   a. sufficient income and an adequate standard of living;
   b. quality housing;
   c. free quality public education;
   d. good health, including nutritious food, and quality healthcare when needed; and

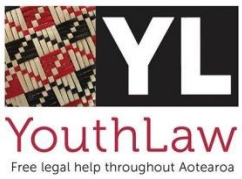
e. timely, flexible and integrated social support services when they need them.

6. The reference year for the fixed-line after housing costs poverty measure be updated at least every five years.
7. More resourcing should be allocated to the collection of and reporting on data so that it can be captured, disaggregated and analysed as promptly as possible and based on a larger sample than currently taken by the Household Economic Survey (HES), from which the Household Incomes Report is drawn.

"Take care of our children
Take care of what they hear
Take care of what they see
Take care of what they feel
For how the children grow
So will be the shape of Aotearoa"

Dame Whina Cooper ONZ

This submission is endorsed by the following organisations and individuals committed to building a better Aotearoa-New Zealand for children:



Full list of supporters below:

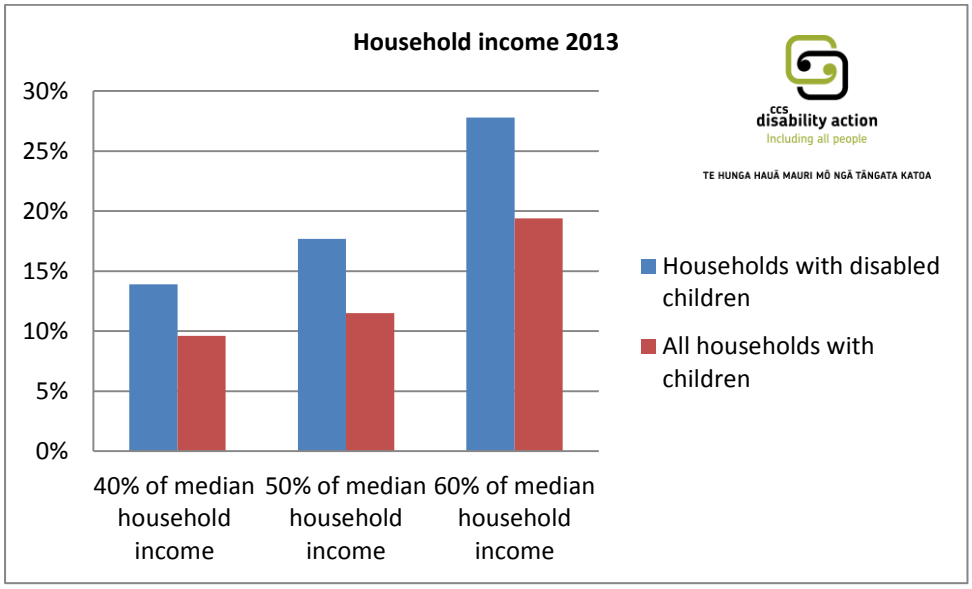
Action for Children and Youth Aotearoa (ACYA)
Auckland City Mission
Barnardos
Child Poverty Action Group
Child Matters
CCS Disability Action
Department of Public Health, University of Otago, Wellington
Department of Paediatrics and Child Health, University of Otago, Wellington
Disabled Persons Assembly NZ
Dr Emily Keddell
Dr Ian Hassall
Dr John Garrett
He Whanau Manaaki A Tararua Free Kindergarten Association
IHC New Zealand
KidsCan

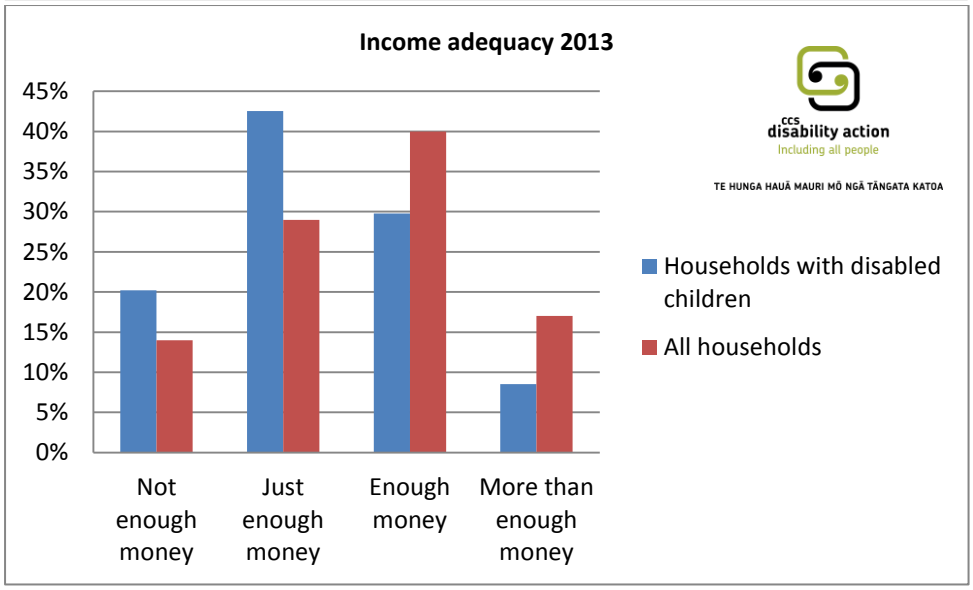
Medical Students for Global Awareness
New Zealand College of Public Health Medicine
New Zealand Council of Christian Social Services (NZCCSS)
New Zealand Council of Trade Unions Te Kauae Kaimahi
Ngā Tangata Microfinance
NZEI Te Riu Roa
OMEP Auckland Chapter
OMEP Aotearoa New Zealand
OMEP Otago Chapter
Paediatric Society of New Zealand
Parent Help
Peace Movement Aotearoa
Public Health Association of New Zealand
Royal New Zealand Plunket Trust
Save the Children New Zealand
Social Service Providers Aotearoa
Stand Children's Services Tu Maia Whanau
Te Awakairangi Health Network
True Colours Children's Health Trust
UNICEF New Zealand
University of Otago Children's Issues Centre
Variety -The Children's Charity
Wesley Community Action
Whakaora Ngangahau Aotearoa - Occupational Therapy New Zealand
Women's International League for Peace and Freedom Aotearoa Section (WILPF)
Youth Law Aotearoa

Appendix 6 –Children with disabilities

Children with disability are more likely to live in low income families. Data from Statistics New Zealand's 2013 Disability Survey shows:

- 27.8% of disabled children living in families that earn under $40,000 a year, compared to only 19.4% of non-disabled children.[192]
- 17% of carers of children with disability were unemployed.[193]
- 30% of disabled children lived in one parent households, compared to 17% of non-disabled children.
- 63% of households with disabled children say they earn just enough or not enough money, compared to 43% of all households.[194]





[192] This is 60% of median household income before housing costs in 2013 analysis by CCS Disability Action of unpublished 2013 Disability Survey data provided by Statistics New Zealand.
[193] CCS Disability Action *Submission on the Child Poverty Reduction Bill* 2018. Page 9
[194] Analysis by CCS Disability Action of unpublished 2013 Disability Survey data provided by Statistics New Zealand.

Estimates from 2013 Disability Survey also found that children with disability were less likely, in the previous four weeks, than non-disabled children to have had music, art, or other similar lessons; played a team sport; done other physical activity such as swimming or gymnastics; visited friends; or been away on holiday in the past 12 months.

Children with disability are disproportionately impacted by wider systemic issues associated with poverty such as housing and household income levels.

Inclusive education

Students with disabilities are excluded from New Zealand's education system, face barriers to equitable access to education and are over-represented in school disciplinary processes, particularly exclusions both formal and informal. There are barriers to enrolment, accessing the curriculum and required resourcing. Initial teacher education and ongoing professional development in inclusive practice also remains a problem. Long delays continue for students in access early intervention and specialist services, including communication and behaviour support.

Despite over 30 years of special education policy development and review it is unknown how many children and young people with disabilities are enrolled, where they go to school or the type, extent and true cost of the supports they need to learn.

Students with disabilities do not enjoy an enforceable right to education and have no access to an independent review of decisions made. IHC (the New Zealand organisation providing support and care for people of all ages with intellectual disabilities) lodged a complaint under the Human Rights Act in 2008 based on the continual systemic, unjustified discrimination against students with disabilities requiring accommodations to learn. This claim is still to have a full hearing in the Human Rights Review Tribunal.

References for Appendix 6.

CCS Disability Action *Briefing to incoming Coalition Government*. 2017 Retrieved from https://www.ccsdisabilityaction.org.nz/assets/resource-files/Briefing-to-the-incoming-Coalition-Government2.pdf

CCS Disability Action *Submission on the Child Poverty Reduction Bill* 2018. Retrieved from https://www.ccsdisabilityaction.org.nz/assets/resource-files/Submission-on-the-Child-Poverty-Reduction-Bill.pdf

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