Government Inquiry into Mental Health and Addictions

Submission of Child Poverty Action Group

Prepared for
Child Poverty Action Group (CPAG)
by Professor Innes Asher, Professor Tony Dowell, Associate Professor Nikki Turner, Professor Toni Ashton and Jessica Suri

June 2018

This submission is from:

Child Poverty Action Group Inc.

PO Box 5611,

Wellesley St,

Auckland 1141.

http://www.cpag.org.nz

Child Poverty Action Group (CPAG) is an independent charity working to eliminate child poverty in Aotearoa/ New Zealand through research, education and advocacy. CPAG believes that New Zealand's high rate of child poverty is not the result of economic necessity but is due to policy neglect and an ideological emphasis on flawed economic incentives. Through research, CPAG highlights the position of tens of thousands of New Zealand children, and promotes policies that address the underlying causes of the poverty they endure.

We would like the opportunity to present an oral submission.

Contact: admin@cpag.org.nz

Executive summary

There is a strong relationship between child and family poverty and adverse mental health outcomes, which may be life-lasting. Poverty is particularly damaging for young children from the antenatal period, young adolescents and for children growing up in persistent poverty. Any approach to improving mental health outcomes need a strong focus on reducing poverty and deprivation for pregnant women, young children and their families.

CPAG recommends that the Inquiry consider a twin-track approach to ameliorating the impact of poverty on mental health disorders and outcomes:

- **The Government should implement a comprehensive plan of general measures to reduce child and family poverty. This will reduce economic and other stressors from childhood deprivation, which are factors in the initiation and maintenance of mental health problems.**

- **The Government should improve mental health provision and access to health services.**

CPAG's full list of recommendations is given at the end of this submission.

Introduction

The lifelong and potential intergenerational ill-effects of early childhood adversity and toxic stress have been clearly articulated by The American Academy of Paediatrics:

> *Early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain architecture and long-term health. The report examines extensive evidence of the disruptive impacts of toxic stress, offering intriguing insights into causal mechanisms that link early adversity to later impairments in learning, behaviour, and both physical and mental well-being. ….many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by the alleviation of toxic stress in childhood.* (Shonkoff, 2012)

Child Poverty Action Group with the New Zealand Psychological Society published a report in 2017 "Child poverty and mental health: a literature review" (Gibson K et al. 2017) - which describes more fully this relationship. Some of that material is summarized in this submission, with additional sections.

In 1991 child poverty rates rose dramatically, and the number of children in very severe poverty has increased over the last 15 years. There is a consistent relationship (correlation) between poverty and poorer mental health outcomes, which is evident in rates of mental health problems experienced by children living in poverty.

The *Government Inquiry into Mental Health and Addiction* acknowledges that there are currently unmet needs in relation to mental health and addiction. Living in poverty is one of major determinants of negative mental health outcomes, and these may last life-long.

Other factors related to child poverty are also highly influential on mental health: poor housing circumstances, poor health with inadequate primary health care access, youth unemployment and underachievement in education.

These aspects, known as the determinants of mental health and addictions, have worsened following major policy changes in the early 1990s. They need to be urgently and adequately addressed to form the 'fence at the top of the cliff'. We make recommendations to the Inquiry which address particularly these determinants.

New Zealand has the highest rate of youth suicide in the OECD, which started to rise during the onset of the neoliberal reforms in the 1980s (Hassall, 1997). As well as the highest rates in Māori, suicide rates are also increased for Pasifika youth and those with lower socio-economic status.

The failure of all governments to fully enact the commitments of Te Tiriti o Waitangi, from the time it was signed in 1840, is the major 'upstream' factor in much of what has happened to Māori (Salmond, 2017) and why their outcomes are so much worse than Europeans. A greater proportion of Māori young people in New Zealand die from suicide than any other group of people in New Zealand, and all their health outcomes are worse than Pākehā. Since 2001 the Waitangi Tribunal has repeatedly found that the government has a continuing obligation under Te Tiriti o Waitangi to actively protect Māori from the adverse effects of settlement including "on the one hand, medical responses to the effects of ill health and, on the other, remedial action against its causes, both direct (medical) and indirect (environmental, social, economic, cultural, institutional)" (Waitangi Tribunal, 2001, p.53).

There are two ways that a focus on child poverty in this Inquiry is helpful; firstly that addressing poverty issues per se has the potential to reduce mental health problems in childhood and long-term, and secondly that a focus on child mental health within the context of socioeconomic disadvantage (child poverty) is important, particularly in relation to service access where children and their families from backgrounds of poverty are both more likely to need mental health services and more likely to have a range of financial, social and cultural barriers to appropriately accessing these services.

Front line services need to be strengthened to address the increasing demand from the increased numbers of people with need who have landed 'at the bottom of the cliff. We make recommendations for management of mental health and addictions particularly to give additional support particularly in primary and community care to extend and develop initiatives with a focus on children and families in poverty.

What is child poverty?

According to the United Nations Children's Fund (UNICEF) "children living in poverty are those who experience deprivation of the material, spiritual and emotional resources needed to stay alive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential, and participate as full and equal members of society".

The Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty in 2012 defined child poverty in New Zealand in this way:

> *New Zealanders like to believe that our country is a great place for children. For the majority of our children this is true. For a substantial minority, however, it is not. These children experience hardship or are excluded from the normal patterns of modern life, sometimes for long periods. We call this poverty. … It means, for instance, a much higher chance of having insufficient nutritious food, going to school hungry, wearing worn-out shoes or going barefoot, having inadequate clothing, living in a cold, damp house and sleeping in a shared bed. It often means missing out on activities that most New Zealanders take for granted, like playing sport and having a*

birthday party. It can also mean much narrower horizons – such as rarely travelling far from home. (Children's Commissioner's EAG, 2012)

How many children are in poverty in New Zealand?

The Child Poverty Monitor started in 2013 and has reported each year on poverty measures and associated outcomes (Duncanson et al., 2017). The main measures of poverty are summarised in Table 1:

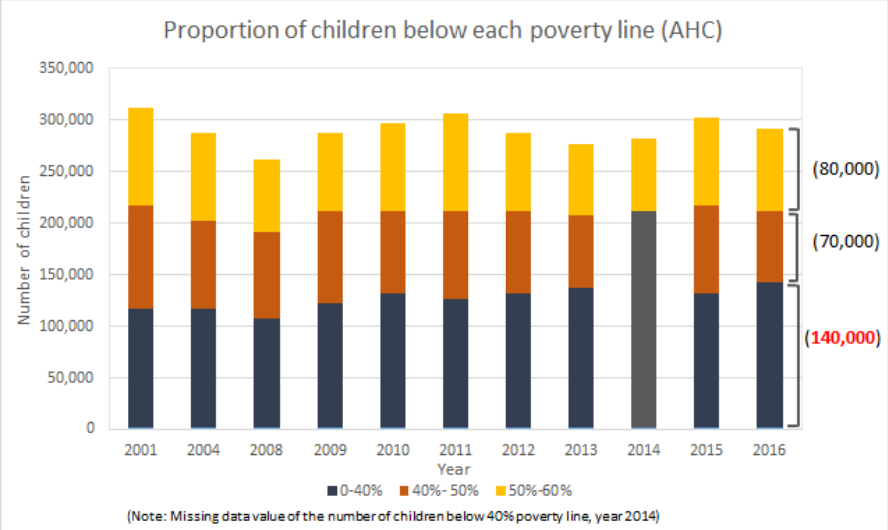
Table 1: Children 0-17 years in poverty 2016 using different measures [Perry 2017]

Child poverty measurements	**Number of children**	**% of children**
Total children	1,060,000	100%
INCOME MEASURES		
Income poverty (<60% median* after housing costs)	290,000	27%
Severe income poverty (< 50% 2015 median after housing costs)	210,000	19%
Very severe income poverty (<40% 2015 median after housing costs)	140,000	13%
MATERIAL HARDSHIP MEASURES		
Material hardship (children living in households that go without 7 or more things they need because of cost)	135,000	12%
Severe material hardship (children living in households that go without 9 or more things they need because of cost)	70,000	6%

*median means contemporary median ie for that year

Each of these definitions of poverty is annually measured, monitored, interpreted and published by the Ministry of Social Development (MSD). The household income measures give an estimate of the monetary resources available to support the child. The material hardship measures estimate the lack of necessities for the child's health and well-being because of cost. Both are important, and related. The most severely affected children have both income poverty and material hardship (nearly one in 10 children).

It is of grave concern that the number of children in the 'very severe income poverty' category has risen to 140,000. Those in severe income poverty are now half (48%) of all the children in income poverty whereas 15 years ago they were 37% of all the children in income poverty (St John & So, 2018), as illustrated in Figure 1.



How does poverty affect the mental health of children?

A child's social, physical and economic environment can impact their development and overall wellbeing. Children who live in households with low family income can experience lifelong damage, with proven effects on health, nutrition, brain development and educational attainment (UNICEF 2017, Expert Advisory Group on Solutions to Child Poverty. 2012a). Thus unsurprisingly there is a clear relationship between poverty experienced in childhood and a greater likelihood of mental health problems. The pathways linking low family income to long term outcomes are complex (Expert Advisory Group on Solutions to Child Poverty. 2012b), and in part may be influenced by other socioeconomic factors (Maloney 2004).

Poverty can impact children's wellbeing directly though lack of economic resources. Having adequate income is important for providing things which affect children's development, such as nutritious meals, access to learning resources, good quality education, childcare settings outside the home and living in a safe and stimulating neighbourhoods (Duncan & Magnuson, 2013).

The psychosocial aspects associated with poverty can also impact on children's development and wellbeing. Parents may be less available for consistent nurturing because of high hours of work necessitated by low paid jobs. Economic and financial stress is also associated with family turmoil, violence and relationship instabilities (Chandra, 2015). New Zealand has the highest rate of inter-partner violence in the OECD (Herbert 2014). Financial burdens can lead to conflict within the household, which in turn would produce a stressful environment for children and would directly impact their emotional development.

Among New Zealand secondary school students in 2012 14% had witnessed adults hitting or physically hurting another child in their home in the last 12 months and 7% had witnessed adults hitting or physically hurting other adults. Witnessing violence in the home was more common among students from neighbourhoods with high levels of deprivation (Clark 2012).

Child poverty is highly prevalent and so too are mental health problems (up to 40% of adults, and adolescents, and up to 20% of pre-adolescents with significant psychological symptom counts). Therefore effective strategies can have an impact on large numbers of the population. In order for strategies to be effective they need to have associated 'low cost',

brief interventions that can be accessed by large numbers of the population. Lifting families out of poverty will give them resources to access these services as well as the stress-reduction from poverty reduction itself.

The highest prevalence disorders and those with the most impact on children and their families in poverty are not of 'traditional' psychiatric concern. In particular the place of 'stress' style disorders, particularly 'anxious depression' should be recognised (Lam et al., 2012)

How do mental health disorders arise from poverty?

Living in poverty can have long lasting effects on a child's mental health. Experiencing poverty and hardship early on in life can impact mental health in many ways, and while the relationship between poverty and mental health is complex, studies show a correlation between childhood poverty and the development of mental health issues later in life.

Research shows that parents' socio-economic status is significantly associated with self-reported depressive symptoms, anxiety and substance abuse in adulthood (Schaefer et al., 2017). Similarly, results from the Dunedin Longitudinal Study also show a link between childhood stressors and the development of depression, anxiety and substance abuse (Poulton, Moffitt & Silva, 2015).

In terms of securing the wellbeing and happiness of future generations, action to reduce child poverty is likely to have an impact on a range of childhood mental health problems, particularly attention deficit hyperactivity disorder, and behavioural problems such as conduct disorder.

Other longitudinal studies have shown similar links between poverty and mental health. Findings indicate that the proportion of time spent in poverty in childhood is significantly associated with externalising mental health symptoms, such as learned helplessness (Evans & Cassells, 2014). Learned helplessness is also associated with development of maladaptive coping mechanisms as well having an increased risk for suicide ideation.

Experiencing stressors in childhood has been linked to exhibiting high risk behaviour in adolescence and adulthood. Engaging in high-risk behaviours such as substance abuse (using alcohol and drugs) is thought to compensate for their biological, emotional and social deficiencies which have occurred through being raised in a damaging home environment (Repetti, Taylor & Seeman, 2002).

While significant predictors of mental health disorder are a strong family history or previous history of disorder, the link is not inevitable. However intergenerational poverty itself may increase the chance of mental health disorder through epigenetic mechanisms, where the environment may cause permanent changes in the way genes are expressed. There are also socially determined links, such as a parent in poverty, where a mental health disorder increases the likelihood of the same for her /his child. While someone may be predisposed to developing a mental health illness, stress associated with poverty can increase the likelihood of developing illnesses.

Poverty and Addictions

Childhood adversity, including poverty and/or housing and/or racism stress, may lead to maladaptive coping mechanisms, which include turning to behaviours which lead to problem substance use or addiction – gambling, alcohol, smoking, methamphetamine use being among the more common ones in New Zealand. There is a clear correlation between poverty, mental health disorders and addictions.

Every young person will decide whether or not to use these substances, a decision that they will revisit many times. Many young people will try them. Some will have short term harm. A few will have long term harms. For those in poverty there is a double jeopardy of ease of access in the short term with consequent greater proportionate financial, emotional and psychological disadvantage in the future. Poverty reduction can help change this trajectory and offering appropriate support to young people can alter their decisions regarding substance experimentation.

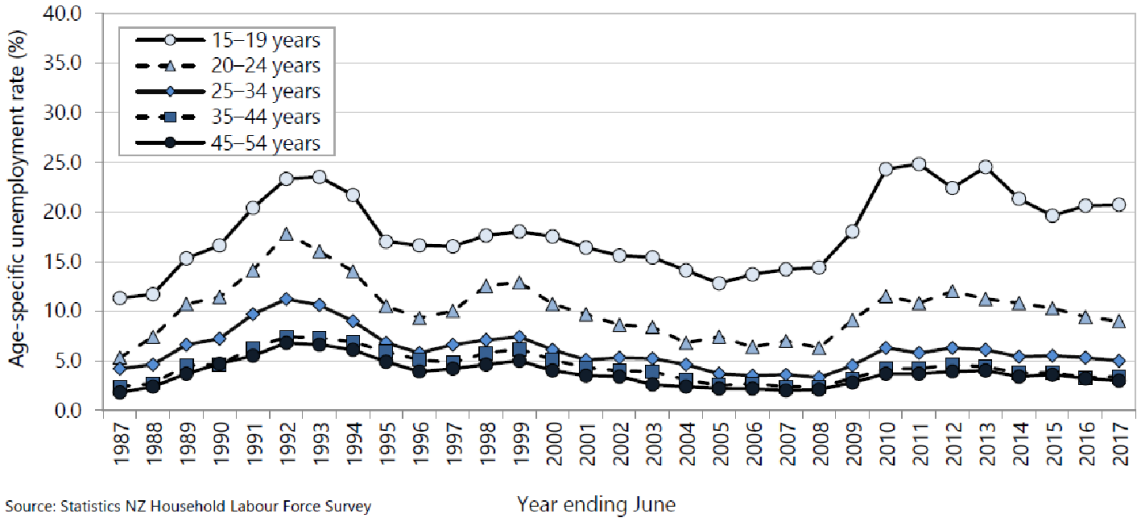
Poverty and Suicide

Between 2014 and 2016, there were a total of 238 suicides reported amongst young people aged between 12 to 24 years, with the rate of youth suicide for Māori being almost three times higher than that for non-Māori (Gluckman, 2017). Poverty, inequality and social fragmentation have all been identified as key determinants which affect rates of youth suicide.

It has been thought that depression and anxiety can potentially be mediating factors between socioeconomic deprivation and self-harm and suicidal ideation (Robinson et al., 2017).

New Zealand has one of the highest youth suicide rates in the developed world, and there are high rates of youth suicide in areas of high socio-economic deprivation. This is in the context of high and increased youth unemployment (Figure 2).

Figure 2 Unemployment rates by selected age groups. New Zealand 1987-2017 (Duncanson 2017)



The causal pathways leading to both suicidal ideation and completed suicide are complex. CPAG emphasizes the importance of the Inquiry considering the impact that poverty will have as a factor in increasing feelings of hopelessness which then lead to either ideation or a suicide attempt in a young person with an existing depressive episode.

What could be done better?

The incidence of mental health conditions among children and adolescents can be reduced by addressing severe and persistent poverty and related factors, particularly during the early years of a child's life. Child Poverty Action Group, in its reports, has made many recommendations on the measures required (St John & So, 2018), and these are summarised in CPAG's recommendations (see Briefing to Incoming Ministers)[1]. In short, there needs to be a comprehensive package of policies and initiatives to lift incomes so all children live in income adequacy, and to address the related factors of housing, education and employment.

Thus CPAG recommends that the Inquiry considers a twin track approach to ameliorating the impact of poverty on mental health disorders and outcomes.

In the first instance general measures to reduce child and family poverty will reduce economic and other stressors which are factors in the initiation and maintenance of mental health problems and addiction. Ensuring families are able to have time to spend together, have money to meet their basic needs, and are able to access support in their communities is essential.

Secondly we wish to highlight areas for improvements in **mental health provision and access to services.**

A life course approach is necessary to be considered to child poverty, but also to mental health problems. A focus on the early years, and in particular the antenatal period and first five years of a child's life, are crucial as the harmful impact of poverty is greater during that time in terms of mental health outcomes. Similarly a secondary focus on adolescent mental health in the crucial late childhood to early teenage years in the context of poverty reduction is likely to be beneficial.

1. ***Focus a strong attention of mental health resources on the antenatal services, early childhood and adolescent periods as the crucial times in the life course that need particular attention***

For adolescents, access to services that are considered safe and confidential are important. School-based services are the main important point of access for adolescents

2. ***Increase the number of primary and secondary schools with school-based health services, including mental health services specific to early detection***

Primary and community care themes are important; primary care is where 95% of all formalised health care takes place. It is responsible alone for diagnosis and management of more than 50% of mental health problems and partners with other services for a further 25%. Funding, investment and strategic thinking have not focused sufficiently on primary care. In particular, there is an important opportunity to improve access to psychological therapies for those in poverty.

1 See: A New Zealand where all children can flourish: Briefing paper to the incoming Government http://www.cpag.org.nz/assets/171026%20CPAG%202017%20election%20briefing%20paper%20V8_WEB.pdf

3. ***Further investment is needed in availability and access for children and their families to psychological support therapies in primary care***

The system is not 'broken'. There has been a tendency within the media, and among some politicians and lobby groups, to describe the mental health system as completely dysfunctional; it is not. While there are significant problems, particularly relating to acute secondary care, there is a platform of service provision currently which can be enhanced and developed. This is particularly true of service delivery initiatives that would have an impact on children and families living in poverty. There is for example a substantial platform of service delivery in primary care using Primary Health Organisation (PHO) support and for which the initial funding and introduction was developed with the intention of targeting of specific groups – i.e. Māori, Pasifika, and low income people. Despite this significant investment, access problems to care remain, and there are opportunities to strengthen service provision to children and young people (Dowell 2012).

4. ***The current platforms for service delivery need further enhancement, particularly with a focus on access to care, and increased service provision for antenatal, young children and adolescent services.***

Coordination between mental health and addiction services is complex and the most effective policy approaches are challenging to design. These were touched on by the Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty in 2012's working paper on Health Policy and Effective Service Delivery to Mitigate Effects on Child and Youth Poverty (2012a).

5. ***Provide clear, coordinated service pathways, especially for pregnant women, children and young people.***

Successful policy initiatives in the field of addictions and young people are challenging given the common tendency of young people to experiment with substance use and the difficulty of finding a balance between a health and harm minimization approach or a legal prohibitive stance. These challenges are compounded when substance use is accompanied by poverty.

6. ***CPAG recommends that first and foremost the inquiry adopts a health sector and humanitarian approach to substance use policy rather than a legal and criminal justice approach.***

The inquiry should also consider ways in which service coordination can be improved so that children, adolescents and families with substance use and addiction problems can access appropriate support.

7. ***Increase funding for community-based social services and mental health support programmes.***
8. ***Widen the criteria for free counselling and talk therapy so that it is universally available to all people in New Zealand.***
9. ***Provide properly funded social services based around the needs of children and their families/ whānau, not on whether they meet statistical criteria.***

CPAG supports the below recommendations on prevention, treatment and education for drug and addiction which are based on the comprehensive recommendations from the New Zealand Drug Foundation:

The Government should:

10. ***Escalate government-led actions to minimise exposure to opportunities for addictive situations/substances.***
11. ***Ensure that early detection of problems with drugs is assessed and age-appropriate support is provided.***
12. ***Ensure that young people and those around them can identify issues early and get developmentally-appropriate support. Young people have indicated that having access to 'check-ups' so they could either do a self-reflection or be responsible to get a check-up for their alcohol/drug use without needing to first identify it as a problem.***
13. ***Ensure a well-resourced range of responses are available to support young people to make changes to their alcohol and other drug use, including self-help, personal support, and also fast-response services when a young person is struggling or in crisis.***
14. ***Ensure therapeutic measures are used to address alcohol and other drug concerns, including when a youth comes into contact with the justice system, as a result of drug use and having therapeutic programmes in place in schools for responding to student drug use.***
15. ***Ensure children, youths and families are well versed in the risks and harms as well as safer use. Supporting the development of educational programmes to show how alcohol and other drugs affect people, their families, and their communities, and how to reduce negative impacts.***
16. ***Ensure children and young people develop the critical thinking skills to make informed choices that affect their outcomes, i.e. through effectively resourcing development and implementation of age-appropriate educational programmes in schools.***
17. ***Ensure well-resourced urgent response frontline services and funded age-appropriate long-term rehabilitation.***
18. ***Reduce barriers to young people accessing help in schools (e.g. parental consent should not be required).***

Conclusion

There is a strong relationship between child and family poverty and adverse mental health outcomes, which may be life-lasting. Poverty is particularly damaging for young children from the antenatal period, young adolescents and for children growing up in persistent poverty. In the early 1990s child poverty rates rose dramatically, and the number of children in very severe poverty has increased over the last 15 years.

Māori children are disproportionately affected. The failure of all governments to fully enact the commitments of Te Tiriti o Waitangi, from the time it was signed in 1840, is the major 'upstream' factor in much of what has happened to Māori (Salmond A 2017) and why their outcomes are so much worse than Europeans.

Any approach to improving mental health outcomes need a strong focus on reducing poverty and deprivation particularly for the crucial developmental periods for pregnant women, young children, adolescents and their families.

CPAG recommends that the Inquiry considers a twin track approach to ameliorating the impact of poverty on mental health disorders and outcomes. Firstly there is a need to

implement a comprehensive plan of general measures to reduce child and family poverty. Secondly there is a need to increase resourcing and focus in mental health provision and access to health services, particularly for the crucial developmental periods of pregnancy, early childhood and adolescent services. The areas that need the most attention include availability and access for children and their families to psychological support therapies in primary care, enhancement of existing services provision for these crucial age groups, improved coordination and clarity around service pathways and taking a health sector and humanitarian approach to substance use policy rather than a legal and criminal justice approach.

Recommendations

1. General measures to reduce poverty and related stress

Adhere to the principles of Te Tiriti o Waitangi in all national activities.

To reduce income poverty for children the Government should:

- *Instigate policy changes so that all children in poverty are lifted out of poverty, prioritising those in very severe income poverty.*
- *Ensure all families get their full income-support entitlements.*
- *Raise core benefits for all beneficiaries by 20%.*
- *Raise the minimum wage significantly.*
- *Index all aspects of Working for Families and social welfare benefits annually to average wages and prices along the lines of New Zealand Superannuation (NZ Super).*
- *Join the In Work Tax Credit of $72.50 per week to the first child Family Tax Credit payment.*[2]
- *Fix punitive design features of the benefit system by:*
    - *Stopping all sanctions in the benefit system for families with children*
    - *Allowing beneficiaries to work at least 10 hours at the minimum wage before any abatement e.g. $165 per week for singles and $165 for each person in a couple.*
    - *Aligning single and married rates of all benefits by lifting the married rate as part of the increase to benefits*
    - *Encouraging beneficiaries to use gifts and loans from family without penalty.*

[2] See "Progressive universalisation of Working for Families (WFF)" available here: http://www.cpag.org.nz/assets/180412%20CPAG%20IWTC%20backgrounder%20FINAL.pdf.

- *Toughening policy on loan sharks and institute a debt forgiveness programme for Work and Income debt.*

To improve housing affordability, availability, health and safety the Government should:

- *Increase social housing stock.*
- *Instigate a comprehensive Warrant of Fitness for all rental houses.*
- *Improve stability of rental tenure with increased tenure duration and tenant protections*
- *Implement strategies to contain property prices such as reform the taxation of housing to reduce speculation in housing and reduce rent and house prices.*
- *Build and rent more state houses at controlled rents of no more than 30% of before housing costs disposable income.*

To improve children's health and employment outcomes Government should:

- *Improve access to healthcare services by providing free primary healthcare to all children until they turn 18 years old.*
- *Increase youth employment and participation in training.*

2. Mental health provision and access to services.

- *Focus a strong attention of mental health resources on the antenatal services, early childhood and adolescent periods as the crucial times in the life course that need particular attention.*
- *Increase the number of primary and secondary schools with school-based health services, including mental health services and alcohol and drug support specific to early detection.*
- *Further investment in availability and access for children and their families to psychological support therapies in primary care.*
- *Further enhance the current platforms for service delivery, particularly with a focus on access to care, and increased service provision for antenatal, young children and adolescent services.*
- *Provide clear, coordinated service pathways, especially for pregnant women, children and young people.*
- *Adopt a health sector and humanitarian approach to substance use policy rather than a legal and criminal justice approach.*
- *Increase funding for community-based social services and mental health support programmes.*
- *Widen the criteria for free counselling and talk therapy so that it is universally available to all people in New Zealand.*
- *Provide properly funded social services based around the needs of children and their families/ whānau, not on whether they meet statistical criteria.*
- *Support the comprehensive recommendations from the New Zealand Drug Foundation for children and youth - with regard to prevention, treatment and education for drug and addiction.*

References

Chandra, D. V. (2015). Understand child poverty and its impact on the holistic wellbeing and education of children in New Zealand: What every early childhood teacher should know. *The Online Journal of New Horizons in Education, 5*(2), 79.

Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012.* Auckland, New Zealand: The University of Auckland

Dowell AC, Garrett S, Collings S, McBain L, McKinlay E, Stanley J. 2009.*Evaluation of the Primary Mental Health Initiatives: Summary report 2008*. Wellington: University of Otago and Ministry of Health. ISBN 978-0-478-31907-1 (print)ISBN 978-0-478-31908-8 (online)HP 4754

Duncan, G. J., & Magnuson, K. (2018). The importance of poverty early in childhood. *Policy Quarterly, 9*(2), 12-17.

Duncanson M, Oben G, Wicken A, Morris S, McGee M, and Simpson J. (2017). *Child Poverty Monitor, A Technical Report.* New Zealand Child and Youth Epidemiology Service, University of Otago, Dunedin. Retrieved from: http://www.nzchildren.co.nz/

Evans, G. W., & Cassells, R. C. (2014). Childhood poverty, cumulative risk exposure, and mental health in emerging adults. *Clinical Psychological Science, 2*(3), 287-296.

Expert Advisory Group on Solutions to Child Poverty. (2012a). Solutions to child poverty in New Zealand: Evidence for action. Wellington: Office of the Children's Commissioner. http://www.occ.org.nz/publications/child_poverty

Expert Advisory Group on Solutions to Child Poverty. (2012b). *Working Paper no.2: Lifecourse Effects on Childhood Poverty*. Wellington, August 2012.

Expert Advisory Group on Solutions to Child Poverty. (2012c). *Working Paper no 17. Health Policy and Effective Service Delivery to Mitigate Effects on Child and Youth Poverty*. Wellington, August 2012.

Gibson K, Abraham Q, Asher I, Black R, Turner N, Waitoki W, McMillan N. Child poverty and mental health: A literature review. ISBN: 978-0-9941132-7-6. Child Poverty Action Group and New Zealand Psychological Society May 2017

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

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

Herbert and Mackenzie (2014) http://theimpactcollective.co.nz/thewayforward_210714.pdf

T P Lam; D P Goldberg; A C Dowell; S Fortes; J K Mbatia; F A Minhas; M S Klinkman Proposed new diagnoses of anxious depression and bodily stress syndrome in ICD-11-PHC: an international focus group study. Family Practice 2012; doi: 10.1093/fampra/cms037

Maloney T. 2004. Are the outcomes of young adults linked to the family income experienced in childhood? . *Social Policy Journal of New Zealand,* 22 55-82. https://www.msd.govt.nz/documents/about-msd-and-our-work/publications

Poulton, R., Moffitt, T. E., & Silva, P. A. (2015). The Dunedin Multidisciplinary Health and Development Study: overview of the first 40 years, with an eye to the future. *Social Psychiatry and Psychiatric Epidemiology, 50*(5), 679-693.

Repetti, R. L., Taylor, S. E., & Seeman, T. E. (2002). Risky families: family social environments and the mental and physical health of offspring. *Psychological Bulletin, 128*(2), 330.

Robinson, K., Brocklesby, M., Garisch, J. A., O'Connell, A., Langlands, R., Russell, L., Kingi T., Brown, E-J.**,** Wilson, M. S. (2017). Socioeconomic deprivation and non-suicidal self-injury in New Zealand adolescents: The mediating role of depression and anxiety. *New Zealand Journal of Psychology, 46*(3), 126-136.

Salmond A. Tears of Rangi. Auckland University Press 2017.

Schaefer, J. D., Caspi, A., Belsky, D. W., Harrington, H., Houts, R., Horwood, L. J., & Moffitt, T. E. (2017). Enduring Mental Health: Prevalence & Prediction. *Journal of Abnormal Psychology*, *126*(2), 212–224. http://doi.org/10.1037/abn0000232

Shonkoff JP et al for American Academy of Pediatrics. The lifelong effects of early childhood adversity and toxic stress. Pediatrics 2012; 129: e232-246

St John S and So Y. An analysis of the effectiveness of policies for children in the worst poverty in 2018. Child Poverty Action Group May 2018

UNICEF. The State of the World's Children 2005. UNICEF 2005.

UNICEF Office of Research. 2017. Building the Future: Children and the Sustainable Development Goals in rich countries Florence: UNICEF.

Waitangi Tribunal (2001), *Wai 692 - Napier Hospital and Health Services Report* (Wellington, Legislation Direct) Retrieved from: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_68596252/Wai692.pdf