Submission to the Mental Health Inquiry

5 June 2018

Royal New Zealand Plunket Trust

Atawhaingia te pa harakeke

Atawhaingia is to nurture, protect, cultivate and love. te Pa Harakeke is the Harakeke (flax) grove of the village, used as a metaphor for an intertwined community.

This whakatauki speaks to the essence of Plunket's submission. It is about nurturing whānau and bonds in the solidarity and unity of community.

The central shoot of the flax plant is likened to a tamariki/child. On either side of the child are its parents, and beyond them are extended whānau family members all of whom protect the budding child from the ravages of nature.

Introduction

Plunket's submission is guided by our vision that in the first 1,000 days we can make the difference of a lifetime. Our vision is underpinned by three strategic goals:

> **Healthy tamariki** – we make sure every child/tamariki has the opportunity to be as healthy and well as they can be.
>
> **Confident whānau** – we build the confidence and knowledge of whānau and families across New Zealand.
>
> **Connected Communities** – we make sure no family/whānau is left isolated, disconnected or unable to cope.

Plunket's submission is based on an understanding of health and well-being informed by Te Whare Tapa Whā model[1]. The four dimensions of well-being, Taha tinana (physical health), Taha Wairua (spiritual health), Taha whānau (family health), and Taha hinengaro (mental health) are equally important to the well-being of tamariki/children and their whānau and family.

Mental illness in one generation is frequently transmitted to the next. Our submission emphasizes the need for a whānau and family approach to mental health and well-being; it focuses on maternal mental health and tamariki, infant and child mental health and the strong relationship between the two.

[1] Durie, M.H. (1985). A Māori perspective on health. *Social Science and Medicine, 20*(5): 483-6

What's working well?

Growing up in supportive, nurturing whānau and family environments

Tamariki, infants, and children growing up in supportive, nurturing whānau and family environments are likely to develop into happy and secure children that can regulate their emotions, develop positive relations with others, and be healthy. This helps protect them from developing mental health problems.

The early years of life have a significant impact on mental health, development, and relationships throughout life. Secure infant and caregiver attachment is an important predictor of resilience in later life including higher self-esteem, reduced anxiety and reduced negative responses to stress.

We know tamariki/children's lifetime outcomes are better when they grow up in the context of caretaking relationships that are positive and warm, where there is responsiveness to emotional states, where caregivers guide their behaviour, and where infants are not exposed to toxic stress[2]. Tamariki, infants, and young children, need to express their emotions freely, know they can make what they need clear to their primary caregiver, know they are going to be responded to, and learn about their emotions and how to regulate them. They learn to have trust in the relationship, and see the relationship as their source of security and safety.

These are the environments that work well for tamariki, infants, children, and protect them for life. There is increasing evidence that sensitive responses from primary caregivers to their child's emotional and physical needs are the foundations for healthy outcomes in the long term[3]. Secure infant mental health is the path to mental health and well-being as an adult.

Early identification of children at risk of poor outcomes

Unfortunately some tamariki, infants, and children are exposed to adverse childhood experiences[4] and are not living in supportive nurturing environments. We know infants remember trauma in different ways to adults. Tamariki too young to use words, have bodily memory, so trauma is remembered in the gestures and what they feel in their body. In fact trauma in the early years can be more enduring than trauma later on[5]. Preventing tamariki, infants and children from being exposed to adverse childhood experiences, early identification of people who have experienced them, and providing evidence based support could have a significant impact on their long term health and well-being.

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[2] Toxic stress results from strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship. The risk factors studied in the Adverse Childhood Experiences include examples of multiple stressors (e.g., child abuse or neglect, parental substance abuse, and maternal depression) that are capable of inducing a toxic stress response.

[3] Wouldes, T., Mery, S., & Guy, D., (2011). Social and emotional competence: Intervening in infancy. In Gluckman, P. *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.

[4] Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

[5] Ogle, C. M., Rubin, D. C., & Siegler, I C. (2013). The impact of the developemntal timing of trauma exposire on PTSD symtoms and psychosocial functioning among odler adults. *Devleopmental Psychology, 49*(11):doi: 10.1037/a0031985.

Evidence shows that adverse prenatal, infant, and childhood experiences increase the risk of poor mental health later in life and that early intervention can improve outcomes later in life[6]. Plunket nurses routinely assess whānau and families to identify exposure to known adverse childhood experiences such as family violence, whānau family history of mental health issues, post-natal depression, and substance abuse. They also assess parents' exposure to adverse experiences in their childhood as they can critically impact on their parenting practices. In addition, they assess for child behaviour issues that may benefit from early intervention.

The universal Well Child Tamariki Ora (WCTO) service provided by Plunket and other providers is essential to identifying tamariki and children who are growing up in environments that expose them to experiences likely to have an adverse impact on their well-being including their mental health. Universal services that identify tamariki/children and their whanau and family at risk are important because risk factors exist across the socioeconomic spectrum.

This early identification is essential to initiating appropriate early preventative interventions, especially for those most at risk. The ability to assess whānau and families as a guest in their home or community, and have an ongoing relationship, facilitates the assessment and the opportunities to support whānau and family to be responsive and engaged with their tamariki despite their adversity. While early identification of at risk tamariki/children is critical, so is access to the interventions and support that can help them.

Providing all caregivers with support and information so they learn to be responsive to the needs of their tamariki, infants and children, and build confidence in their own abilities

All caregivers need some help, support, and guidance to provide supportive nurturing environments to their tamariki/children. This includes helping them to understand and respond to their child's cues and development. Services such as Plunket's Well Child Tamariki Ora and PlunketLine services, which are free and universally available, provide parents with support and information helping them to be responsive to their infants and young children.

We know however, some families such as Māori whānau, Pacific and migrant families find it harder than others to access the supports they need. Barriers can include language, culture, isolation, lack of knowledge of the health systems, and poverty (limiting people's access to transport and phones). Some service providers have responded to these access issues by employing and training staff who can speak a variety of languages, understand cultural beliefs and values about parenting and wellbeing, and can work with the diverse range of communities. Plunket is developing a workforce strategy to help address this issue.

Connected communities supporting whānau to raise tamariki

It takes a village to raise a child. The primary caregivers (whoever they may be – whether parent, grandparent, an auntie or an uncle) need the support of other whānau, family, and their community. Some communities have strengths through support structures such as marae, churches, sports clubs, play groups, and Plunket in the neighbourhood (PIN) groups that help to build resilience in the community.

[6] Gluckman, P. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.

But in some of our communities, some primary caregivers of young children are very isolated. That makes the family quite vulnerable. They need people supporting them to be able to support their tamariki/child. Enhancing well-being requires positive relationships with people in communities.

What's not working well?

Access to specialist maternal, tamariki, infant, child, mental health services

Plunket nurses identify early whānau, family and tamariki with mental health issues and refer them to mental health services where they are available. However a lack of services and long waiting times are putting mothers and their tamariki/children at risk.

One Plunket nurses story of supporting a suicidal mother highlights the problem:

> *"Currently the acceptance criteria for the perinatal team within our DHB has moved from moderate/severe to severe only. So, a mother must have suicidal ideas before she will be accepted regardless of her score on the Edenborough Postnatal Depression Scale. There is also a lack of co-ordination between perinatal and adult mental health services. When a mother is deemed not to meet the criteria for the perinatal team she is transferred over to the adult mental health service and she enters limbo. I had one mother attempt to commit suicide whilst waiting to be picked up by adult mental health. This was two weeks after my referral had been declined by the perinatal team because she did not meet their criteria. I then visited her a week later and she was still feeling suicidal and had no thoughts of living. We rang the crisis team but because she was still under the adult team and it was before 5pm they were unable to help. I spent the rest of the afternoon watching movies with this mum and waiting for her mother to come home from work. Very scary stuff when you are out in the field and feel helpless."*

There is a need to increase access to mental health and addiction services to meet current demand, especially in the areas of maternal, infant, and child mental health, and addictions.

Plunket staff are:

> *"seeing a lot more depression and anxiety within the community, and there are very few services I can refer to"*.

Perinatal depression

A mother's mental health is critical for the happiness and behaviour of her children[7]. It deserves high policy priority for the sake of both mother and child. Perinatal depression is a neglected health priority, affecting 10-15 percent of women. Approximately 60 percent of Plunket mother's assessed as having postnatal mental health issues have a history of mental health issues - this is consistent with the international literature[8].

Both antenatal and postnatal depressive symptoms have been associated with poor early child health and development. The high prevalence of postnatal depression in women with a previous history of

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[7] Clark, A. E., Fleche, S., Layard, R., Powdthavee, N., & Ward, G. (2018*) The origins of Happiness: the sicence of well-being over the life course*. Princeton Univeristy Press.

[8] Patton, G. C., Romaniuk, H., Spry, E., Coffey, C., Olsson, C., Doyle, L. W., Oats, J., Hearps, S., Carlin, J. B., & Brown, S. (2015). Prediction of perinatal depression form adolescence and before conception (VIHCS): 20 year propspective cohort study. *Lancet, 386,* 875-883.

mental health problems suggests greater attention should be given to identifying and targeting this group of women early in their pregnancy.

Pregnancy is an important time to support women who have suffered trauma in their own childhood. This may help prevent the intergenerational transmission of maltreatment and subsequent mental health difficulties[9].

Focusing on individuals outside the context of their whānau or family

It is critical that mental health services addressing the needs of adults carefully consider the needs of their tamariki. There are problems when adult mental health services address the needs of parents and their tamariki separately.

Services also need to focus on the importance of the child - caregiver relationship. The relationships a child builds with their primary-caregiver and other whānau members are critical to the development of social and emotional competence. In order for tamariki to be well, they need the whānau to be well.

Services also need to work in partnership with Māori, Pasifika, Asian and immigrant people to ensure that cultural attitudes and beliefs about mental health are responded to in ways that make people feel safe and respected.

The mothers' own history of abuse, mental illness, and substance abuse are key risk factors to the healthy development of secure relationships during pregnancy and early childhood. A number of epidemiological and longitudinal studies have shown that children who have a family history of violence, mental illness and abuse are more likely to have poor mental health in later life[10,11,12,13,14,15,16]. Specific family variables associated with poorer health outcomes are: having a parent with a psychiatric disorder, being abandoned by a parent, parental divorce, low levels of parental education, and family conflict. These risk factors tend to cluster together and can result in adverse childhood experiences that have a cumulative negative effect on the health and well-being of whānau, families and their tamariki children.

Plunket nurses regularly see this intergenerational pattern of mental health issues. They work with these whānau and families helping them to develop the knowledge, attitudes, and skills they need to provide tamariki children with secure relationships and connecting them with support in their

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[9] Pawlby, S., Plant, D., Pariante, C. M. (2018). Keeping the baby in mind: New insights into the link between matenral childhood trauma, mnetal health problems in pregnancy and outcomes for the child. In Leach, P. (ED). *Transforming infant wellbieng: Research, policy and practice for the firs 1001 criticial days*. Routledge: New Your.

[10] Plant, D. T., Barker, E.D., Waters, C.S., Pawlby, S., & Pariante, C. M. (2013). Intergenerational transmission of maltreatment and psychopathology: the role of antenatal depression. *Psychological Medicine, 43,*

[11] Chojenta, C.L., Lucke, J. C., Forder, P.M., Loxton, D. J. (2016) Matenral health factors as risks for postnatal depression: A prospectice longitudinal study. PLOS ONE 11(1): e0147246. doi:10.1371/journal.pone.0147246

[12] Biaggi, A., Conroy, S., Pawlby, S., Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders, 191*, 62-77.

[13] Graham-Berman, S. A., Seng, J. (2005). Violence exposure and traumatic stress symptoms as additional predictors of health problems in high-risk children. *Journal of Pediatrics, 146,* 349-354. 46.

[14] Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry & Clinical Neuroscience. 256,* 174-186. 48.

[15] Dube, S. R., Felitti, V. J., Giles, W. H., & Anda, R. F. (2003). The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Preventive Medicine, 37,* 268-277. 49.

[16] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, M. S., Spitz, A. M., Edwards. V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*, 245-258.

communities. However, funding is inadequate for our nurses to spend the time required to provide the level of support needed by some whānau and families.

We can improve mental health outcomes for tamariki/children and their whānau and families with a strategy that supports early social and emotional development through secure tamariki, infant, child, caregiver relationships. This would be taking a whānau and family approach and by intervening in the early years (from conception).

Family violence

A lot more needs to be done to prevent family violence. Plunket supports primary prevention initiatives which aim to stop violence before it occurs, by promoting respectful, non-violent relationships and changing social and cultural norms that support violence. Programmes designed to prevent violence against women must address prevailing beliefs and norms about gender and women's roles in society. Primary prevention efforts must include sexual violence and include men and boys as partners in primary prevention. This will require additional support and resources.

The prevalence of family violence in New Zealand is high. One in two (55%) women in New Zealand who have ever had a partner report having experienced physical, sexual, and or psychological / emotional abuse (Intimate Partner Violence (IPV)) in their lifetime. When psychological / emotional abuse is excluded, one in three (35%) report having experienced IPV in their lifetime[17].

Mothers with mental health problems are more likely to be a victim of family violence than the general population. Children tamariki exposed to family violence are more likely to develop mental health problems[18]. Plunket staff regularly identify and respond to family violence, one Plunket nurse describes the complex history of a woman who is a victim of family violence:

> *"Catherine (not her real name) is 26 weeks pregnant with her second child. Catherine grew up exposed to violence between her parents. Her father is a drug addict. She was sexually abused by a family friend as a child. She has had several abusive partners with the loss of a baby in utero from abuse. She has a history of mental illness with suicide attempts. Catherine and her baby received extensive assistance from a range of Plunket services which supported her to bond well with her first child, but she is not feeling well connected with this baby in utero."*

Measures to prevent excessive alcohol consumption

Alcohol abuse is a common factor in whānau and families where tamariki have early mental health and behavioural problems[19]. Excessive consumption of alcohol often leads to family violence and causes considerable harm to tamariki children and their whānau and families. Consumption of alcohol during pregnancy also has adverse effects on the foetus and can result in the child suffering the long term impacts of foetal alcohol spectrum disorder[20].

Plunket believes stronger measures are needed to reduce access to alcohol. Measures such as increasing the purchase price of alcohol, restricting its marketing and availability, and to more tightly

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[17] Fanslow, J. L., & Robinson, E. M. (2011). Sticks, stones, or words? Counting the prevalence of different types of intimate partner violence reported by New Zealand women. *Journal of Aggression, Maltreatment & Trauma, 20*, 741–759.

[18] Harold, G. (2011). Families and children: A focus on parental spearation, domestic violence and child maltreatment. In Gluckman, P. *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.

[19] Gluckman, P. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.

[20] Sokol, R. J., Delaney-Black, V., & Nordstrom, B. (2003).Fetal alcohol spectrum disorder. *JAMA, 290*(22), 2996-2999.

regulating drink-driving, would reduce the considerable harm that excessive alcohol consumption does to New Zealand's families and whānau.

Plunket staff frequently support families and whānau suffering as a result of excessive alcohol consumption, often in combination with other risk factors such as family violence.

> *"Anne (not her real name) is 30 years old and has given birth to seven children. Anne was raised in a single parent home. She does not know her father. Her mother is an alcoholic and had weekly binges for as long as Anne can remember. She states when her mother binged on alcohol it could be for a few days or 1-2 weeks. During her binges her mother would leave her mostly with strangers or occasionally her grandparents. Anne suffered physical and sexual abuse from the strangers she was left with and emotional abuse and neglect when she was with her mother. She does however state that her grandparents were good to her though extremely strict and harsh with discipline. She states that she has modelled her parenting more after her grandparents than her mother, though denies using physical discipline."*

What could be done better?

Addressing child poverty

A pervasive finding in Plunket's data and the research literature is that the prevalence of factors associated with poor mental health, tend to be higher amongst whānau and families living in poverty. The evidence shows poverty has implications for the quality of the life outcomes for all; especially children and especially in the early years[21,22]. Poverty and the effects of poor health outcomes have a flow-on effect that can span a lifetime and even inter-generationally.

Plunket strongly supports the intent of the Child Poverty Reduction Bill as a critical step toward creating a society where all children are able to get the best start in life. Accountability for meeting agreed consistent targets and reporting on progress towards eliminating poverty as proposed in this Bill, is a significant and welcome step towards a collaborative approach to reducing child poverty. However, we believe this Bill does not go far enough to protect every child from the impacts of poverty. 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.

A life course approach to mental health and well-being

Plunket recommends taking a primary prevention and 'life-course' approach to reducing mental illness and promoting mental health and well-being. A large body of evidence shows that adverse prenatal, infant, and childhood experiences increase the risk of poor mental health later in life, including anxiety, depression and substance abuse.

Many mental health and addiction problems are associated with a history of early neurological and biological factors, low cognitive ability, school failure, childhood antisocial behaviour, family violence, parental drug and alcohol use, physical abuse, neglect and poor parenting practices. Frequently, but not invariably, the worst outcomes occur in a minority of people whose early childhood and family life have been marked by multiple challenges.

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[21] Gluckman, P. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.
[22] Gibson, K.,, Abraham, Q., Asher, I., Black, R., Turner, N., Waitoki, W., & McMillan, N. (2017). *Child poverty and mental health: A literature review*. Child Poverty Action Group and New Zealand Psychological Society.

A focus on the early years, in particular the antenatal period and first five years of a child's life, are crucial as the harmful impact of many risk factors on mental health outcomes is greater during that time. Providing developmental assessments and support for tamariki, infants and young children experiencing multiple challenges before they exhibit problems in their behaviour or development, will increase their chances of achieving social and emotional competence.

It is urgent the Government acts now, committing to taking a life course approach to mental health and well-being, starting with New Zealand's current cohort of infants and young children. This will:

- maximise their chance of having strong mental health and well-being later in life.
- reduce demand on mental health and addiction services and improve mental health outcomes for New Zealanders in the long term.
- require long-term investment.

Prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over the life course. Early-life interventions designed to mitigate risk of poor mental health outcomes may also have positive effects on other outcomes such as reduced involvement with the Justice system.

Programmes for tamariki, infants, children, and their whānau families should be selected based on the evidence that supports their effectiveness, and implemented well. Such programmes require ongoing monitoring to ensure fidelity and continued effectiveness.

Services for tamariki and their whānau

It is a matter of high social and policy importance that the inequality in mental health outcomes for Māori are addressed. The rates of mental illness are higher for Māori than non-Māori. Māori are a young population who have a higher birth rate, and are at greater risk of being exposed to adverse childhood experiences that impact on future mental health.

There are at least three explanations for poorer outcomes for Māori. Firstly, differences in the distribution of underlying risk factors. Secondly, the incongruence between Māori cultural norms and understanding of well-being, and the biological and psychological view of mental illness dominant in the provision of many mental health services. Thirdly colonisation and racism whereby historical and on-going abuses of power manifest in poorer outcomes requiring major organisational and system change to address.

It is important that all general and universal health services specifically include Māori philosophies, responsive policies and practices within the provision of services in New Zealand. Plunket's Strategy is supported by the following Māori principles: Mana Atua, Mana Tūpuna, Mana Whenua, and Mana Tangata. Plunket also has a Māori Strategic Plan Whānau Āwhina Whānau Ora which provides a 10 year strategic direction to ensure Plunket is reaching Māori communities and families to effect the best possible start for every child.

We require increased investment and support of initiatives by Māori for Māori to ensure delivery of culturally acceptable and culturally appropriate programmes for Māori. These programmes need to be based on Māori-specific principles, have a high degree of Māori control, and acknowledge the historical impacts of colonisation, and institutional bias on mental health and well-being.

Plunket has established a Whānau Āwhina Whānau Ora service delivery team to support and promote better outcomes for vulnerable Māori whānau across the Hamilton (Kirikiriroa) area. The focus of this project is initially on clinical service delivery to high needs Māori whānau across Hamilton. It is about increasing the intensity of resources to deliver well child services for Māori within

this community, by supporting a by Māori for Māori approach that responds to the cultural needs of Māori whānau engaged with Plunket.

Māori require culturally relevant interventions and healing environments. Māori concepts of mental health and well-being are different than the concepts of mental illness that dominate our health services. The four dimensions of Te Whare Tapa Whā, Taha Tinana, Taha Wairua, Taha Whānau and Taha Hinengaro illustrate one model of Māori well-being. Evidence shows there is concern from within Māori communities and also from within mental health that some Māori who are diagnosed as mentally ill are actually having spiritual experiences, which in the Māori culture are called matakite (among other terms)[23].

There are examples of Kaupapa Māori models of healing making a difference to Māori[24], illustrated by the work of Wiremu Niania[25] and Diana and Mark Kopua[26]. Adequate resources need to be allocated to robustly evaluate Māori mental health services using Kaupapa Māori methodologies.

Whānau, hapu and iwi structures have strengths, supports and resiliency features which are advantageous for tamariki, so efforts to improve access to whānau, hapu and iwi must be encouraged.

A major focus should also be the development of policies, funding, services and interventions that address the issues that place Māori tamariki and their whānau at greater risk of mental illness.

Provision of services targeted at tamariki, infants, children, and their whānau and families who are most at risk

There is a need for more services and interventions that are targeted proportionately at those who are most at risk. There is a clear need for additional support for whānau and families with a history of inter-parental conflict, domestic violence and child maltreatment. Economic modelling in other countries has demonstrated the long term benefits of targeted programmes for high-risk families provided that those programmes meet certain criteria[27]. Evidence based programmes aimed at high-risk groups will be expensive in the short term but justifiable over the longer term, both economically and in terms of social outcomes.

Plunket supports the need for intensive home visitation programmes targeted at high risk infants and their families that are well-designed. Such programmes are associated with a wide range of benefits that extend into later life. To be effective these programmes need to be carefully implemented and require rigorous and continuous monitoring and evaluation. The intensive home visiting programme with strongest international evidence base is the Nurse Family Partnership (NFP) developed by David

[23] Ngata, Ronald Spencer (2014) Understanding matakite: A Kaupapa Māori study on the impact of matakite/intuitive experiences on wellbeing: a thesis presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Māori Studies at Massey University, Papa-i-ōea, Aotearoa.
[24] Wratten-Stone, Acacia. (2016). Kaupapa Māori models of psychological therapy & mental health services: a literature review.
[25] http://www.synergies-journal.com/synergies/2014/11/17/wiremu-niania-and-dr-allister-bush-a-collaboration-of-mori-healing-and-child-psychiatry
[26] https://www.stuff.co.nz/national/102115864/in-narrative-therapy-mori-creation-stories-are-being-used-to-heal
[27] Gluckman, P. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence*. A report from the Prime Minister's Chief Science Advisor.

Olds[28,29]. The intensive home visiting programme with the strongest New Zealand evidence base is David Fergusson's Early Start programme[30].There is also some evidence that the Family Start home visiting programme provides benefits in the New Zealand context[31].

While all children will benefit from interventions in early childhood, the evidence is compelling that targeting intensive but costly interventions towards those at higher-risk has a high rate of social and economic return.

There are marked differences in the mental health and well-being of tamariki, infants, children, mothers, fathers, whānau and family across New Zealand because of different exposure to social, economic, and cultural factors, and natural disasters.

It is important to note that it is common for multiple, interacting risk factors to be operating in families and whānau where children tamariki are at risk of early mental health and behavioural problems.

In fact the number, timing, and persistence of environmental risks operating prenatally and during infancy are a better indicator of the predictors of early childhood problems than any one risk factor[32]. The following groups of children are most at risk:

- children born with a biological or health problem such as chromosomal disorders, difficult temperament, or very low birth weight
- children born to teenage parents
- children born to parents who, for a variety of reasons, are unable to interpret their child's distress or be sensitive to their infant's cry, who have negative feelings toward the child, or who have a lack of parenting knowledge
- children born to parents who have a mental illness, a history of abuse, or parents who abuse alcohol, tobacco and other drugs. Of particular concern are mothers who continue to use alcohol, tobacco and other drugs during pregnancy
- children who are living in poverty, or living in neighbourhoods where there is a high incidence of violence.

Evidence based parenting interventions for parents of infants

There is a need for evidence based parenting programmes for infants and their parents that focus on early relationships, particularly the infant caregiver relationship. The *Circle of Security* programme is

[28] Asmussen, K., Feinstein, L., Chowdry, H., & Martin, J. (2018). Evidence-based intervention for the first 1001 days. In Leach, P. (ED). *Tranforming infant wellbeing: Research, policy and practice for he first 1001 critical days*. Routledge: New York.
[29] See https://www.nursefamilypartnership.org/about/proven-results/ for a list of international research publications related to the NFP.
[30] Fergusson, D. M., Grant, H., Horwood, L. J., & Ridder, E. M. (2005). Randomized trial of the Early Start program of home visitation. *Pediatrics, 116*(6), e803-809.
[31] Vaithianathan, R., Wilson, M., Maloney, T. & Bairds. S. (2016). The impact of the Family Start home visiting programme on outcomes for mothers and children: A quasi-experimental study. Ministry of Social Development Wellington.
[32] Sameroff, A. J., & Fiese, B. (200) Models of development and developmental risk. In: Zeanah, C. H. J., (ED). *Handbook of Infant Mental Health*. Vol. 2nd ed. New York: Guilford Press.

one of a small number of parenting programme that has a strong theoretical base for its effectiveness with infants[33] and some research to support its efficacy with toddlers[34].

The Circle of Security intervention provides primary caregivers, with a way of understanding a child's needs, both in the immediate moment and within the relationship as a whole. Through use of the circle, adults can develop the means to look beyond a child's behaviour and consider the underlying emotional needs. It would be useful to research the effectiveness of this and or other parenting programmes targeted at parents of infants in the New Zealand context.

Two parenting interventions, Triple P and the Incredible Years, have both been shown to be effective in other countries for children aged three to seven years. Te Whānau Pou Toru is a programme that has been culturally adapted from the Triple P programme and been shown to have positive outcomes in the New Zealand context[35]. It would be good to invest more in the cultural adaptation, implementation and evaluation of these programmes in New Zealand.

Taking a whole of sector approach to infant, child tamariki and family whānau mental health and well-being

We need a more comprehensive and integrated continuum of services if we are to solve the intergenerational problems of substance abuse, and mental illness that currently impact adversely on children tamariki throughout their lives.

Early childhood interventions should be available across the portfolio of social and health services. These include the Well Child Tamariki Ora (WCTO) services, near-universal services, such as childcare and early childhood education, as well as targeted interventions for a range of vulnerabilities, including economic hardship, childhood disabilities, child maltreatment and parental substance abuse, mental illness, and justice among others.

Research and evaluation of interventions aimed at infant, child and maternal mental health

More research and evaluation is needed of early intervention programmes particularly for New Zealand tamariki, infants, and toddlers at risk of longer term problems and mothers at risk of postnatal depression. It is important that any such research takes into account a Māori world view as well as perspectives from Pasifika and other migrant populations, particularly refugees who may have had significant adverse experiences in their country of origin.

Policy work on the optimal mix of universal and targeted interventions

Government agencies need to work together with NGOs on policy regarding the optimal mix of universal interventions and targeted interventions proportional to need in the early years that reduce mental illness and promote mental health and well-being.

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[33] Asmussen, K. Feinstein, L., Chowdry, H., & Martin, J. (2018). Evidence-based intervention for the first 1001 days. In Leach, P. (ED) *Transofrming infant wellbing: Research, policy and poractice for the forst 1001 critical days*. Routledge: London.

[34] Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: the Circle of Security intervention. *Jurnal of Consulting and Clinical Psychology, 74*, 1017-1026.

[35] Keown, L., Sander, M. R., Franke, N., & Shepard, M. (2017). Te Whānau Pou Toru: Findings from a randomised controlled trial of Te Whānau Pou Turu Whānau/Whanaungatanga Kōrero – a māori adaptation of the primary care Triple O Positive Whānau/Parenting discussion groups. Available from https://www.health.govt.nz/system/files/documents/publications/te-whanau-pou-toru-nov17_0.pdf

Invest in the capacity and capability of the infant, children and tamariki workforce

Additional capacity and capability is required in the Well Child Tamariki Ora and midwifery workforces in New Zealand. Specifically training in effective screening and interventions to prevent mental illness and promote mental health and well-being. Training should include knowledge supporting emotional and social competence in infants and child caregiver relationships so that it can strengthen their work with families and whānau.

Additional capacity and capability is also required in the mental health workforce for people to work with tamariki, infants, children, and their whānau and families, so as to provide targeted interventions to those most at risk or already showing signs that require treatment.

Educational pathways are required to ensure that multi-disciplinary workers from across the social sectors have the skills required to support tamariki, infants, children, and their whānau and families particularly where there are multiple risk factors. Such training will need to include cultural competence. Workers supporting these high risk whānau and families would benefit from formal programmes of supervision.

What sort of society would be best for the mental health of all of our people?

Communities that are connected, diverse, tolerant, safe (non-violent), and where the communities themselves are involved in providing supportive nurturing environments for children, tamariki and their caregivers.

An environment where people feel included, free to share their thoughts and emotions, know others will respond respectfully, and everyone has relationships which are a source of security and safety.

To get to such a society considerable investment is needed in primary prevention and early intervention.

Puritia mai rā te tika hei kōrero	Enfold the truth of mind to speak freely
Puritia mai rā te pono hei wananga	Enfold the truth of heart to learn
Puritia mai rā te aroha hei awhina i te ngākau ā tangāta	Enfold the love of humanity to be open to the opportunities
Kia tū , kia ātea, kia mārama!	So as we stand unencumbered and with clarity
Hui e!	Let us be one
Taiki e!	We have united in conscious thought