Preventing Child Poverty: Barriers and Solutions

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Although child poverty rates in New Zealand are about average when compared with other developed nations, they are still unacceptably high given the negative outcomes they create. Childhood poverty is associated with a range of negative health, social and psychological outcomes, all of which can place a considerable burden on the individuals, their families and their communities. The negative impacts are arguably largest when poverty coincides with a child's early years. There are therefore strong humanitarian, social and economic grounds for policy that makes eradication of child poverty a priority, as well as increased investment in children's early years. Differences in child poverty rates between developed nations are determined largely by government policy. However public attitudes towards the poor, particularly beneficiaries, can be a barrier to changing government policy. Research and practice psychologists therefore have an important role to play in influencing public attitudes towards poverty and shaping policy through active engagement in the policy-making process.

Practising psychologists, counsellors and other human service workers are often faced with providing individual treatment for conditions which either directly or indirectly trace back, at least in part, from child poverty. Therefore, psychologists and other human service workers arguably need to understand more about this underlying condition in order to appreciate their clients' experiences better and help to change the social situations that are barriers to children living fulfilling lives today and reaching their potential in the future.

Although child poverty rates in New Zealand are about average when compared with other developed nations, too many of our children suffer both short-term and longer term social and psychological consequences. Examining changes in the extent of child poverty over time indicates that the level is, at least to some extent, shaped by government policy. This article focuses on what child poverty looks like 'on the ground', and what impacts child poverty is having on our society. Child poverty is shaped by a variety of factors and it affects particular types of households more severely. Child poverty has short term, long term and very long term consequences, some of which will come to the attention of practising psychologists for remediation, while other (often cumulative) effects will lurk undetected. In addition, since active social engagement with this issue seems warranted we analyse the circumstances under which people's attitudes might be mobilised to support appropriate government policy to reduce child poverty and therefore minimise its effects.

Extent of Child Poverty in New Zealand

The overall picture painted by economists and statisticians is clear, although the details blur with the complexities of measurements and individual circumstances. Child poverty is the extent to which children live in poor households and is a specialised aspect of poverty studies more generally. Some New Zealand studies into child poverty have been carried out (and will be referred to below), and a figure for the proportion of children in low income households (i.e. those below the poverty threshold) is included amongst the set of key indicators in the authoritative annual Social Report regularly produced by the Ministry of Social Development (MSD 2009). MSD broadens and contextualises these figures on child poverty through its frequent (annual) income reports (e.g. Perry, 2009) and its less frequent Reports on Living Standards (MSD 2008). The Children's Social Health Monitor, produced by the New Zealand Child and Youth Epidemiology Service, quotes these reports and adds a breadth of health data that fills out the sad picture for poor children. This monitor published its first set of indicators in 2007: see Craig (2007) and http://www.nzchildren.co.nz/introduction.php. For more rapidly appearing, but not specifically child-relevant indicators of the economy and its effects, information is provided by the Council of Christian Services Vulnerability report (http://www.justiceandcompassion.org.nz/uploads/publications/vulnerability_report5.pdf)

Although there is no official poverty line in New Zealand, households in poverty are taken to be those falling below a particular threshold set in

relation of the average household equivalised income, with that threshold being validated by the New Zealand Poverty Measurement study (e.g. Waldegrave at. al., 2003). This type of measure has been adopted by MSD in their annual Social Report (MSD 2009). Since housing costs loom large in any family's finances it is better to have a measure of after-housing cost disposable income rather than not controlling for this. However, proxies to this measure are used in various research studies. Other studies (in particular the ELSI scale developed by MSD: e.g. Perry, 2009) have moved into the wider framework of living standards and have supplemented income-based measures with wider measures of economic standards and also behaviours which lead to social exclusion.

Child poverty over time: 1980-2009

Child poverty in New Zealand increased dramatically during the 1980s and 1990s in the wake of social and economic policies that left many families struggling to make ends meet. It was a time of high unemployment and low wage growth, a time of benefit cuts and the imposition of market rentals on state house tenants which all differentially negatively affect households with children. Between 1984 and 1994, the rate of child poverty more than doubled, so that by 1994 one in three New Zealand children were living in poverty (Stephens et al 1995, Perry, 2009a, p. 98).

During the same period, the gap between the rich and poor widened considerably—more so than in any other of the 24 OECD countries for which data is available (Barclay 1995, Perry, 2009a). New Zealand was becoming an increasingly unequal society, with children the least equal of all since poorer households contain more children (Perry, 2009a: p. 93).

It was not until 2004 that a major policy was announced with the specific aim of reducing rates of child poverty: the *Working for Families* package introduced by the Labour-led coalition government (1999-2008). This multi-stranded initiative was targeted at "low-to-middle-income families with dependent children" (Perry, 2004, p. 19) and was progressively rolled out between 2004 and 2007. Expressed aims of the package were to "make work pay" and to reduce child poverty (Perry, 2004) by supplementing the income of working families in particular. Since 2004, the package (together with the effect of other trends) has had some impact on child poverty rates (Perry, 2009a).

Importantly, between 2004 and 2008, 30% of poor children were lifted above the poverty line (Perry, 2009a, p. 105). A further review of the experience of poverty in New Zealand updated until 2007 (Stephens and Waldegrave, 2009) shows broad improvements in poverty reduction. Nonetheless, in 2008, with the *Working for Families* package nearing full implementation, child poverty rates were still too high. After a brief dip to 16% in 2007, the rate rose again to 20% in 2008—nearly double the rate recorded before the economic restructuring in 1986 (Perry, 2009a, p. 98). The situation is likely to have worsened since 2008, because of the effects of the global recession and rising unemployment which will increase child poverty, undoing to some extent the gains of the past few years[1]. Indeed, the December 2009 Household Labour Force quarterly survey (Statistics NZ 2010) showed the unemployment rate at 7.3%, the highest level in ten years although by the March quarter 2010 it had dropped to 6%..

Children's experiences of hardship

While family income helps to measure resources available to households, it is an imperfect measure of living standards more generally (Friesen, 2008) as they are determined by a range of factors over and above income, such as existing assets, material assistance from people outside the household and extra demands on household income such as health and disability costs (Perry, 2009b). In the 2008 Standard of Living survey, based on face-to-face interviews with 5000 households, hardship is defined as living in a household where there was enforced lack of four or more of the 14 basic items—the sorts of things which, "…the majority would consider that 'no one should have to do without'" (Perry, 2009b, p. 21), such as being able to keep the main rooms in the house warm or having a good bed. Using this measure, 23% of children in New Zealand were living in hardship in 2008, compared to 15% for the whole population and 4% for people over 65 years of age.

Families move in and out of poverty (Ballantyne, S., Chapple, S., & Maré, D. C. 2003) so that over time more may be exposed to poverty than the extent measured in a particular cross-section.

This survey also includes a set of measures relating specifically to children, thus giving a clearer picture of what hardship means in children's lives. For the 130,000 children (12%) living in severe hardship in 2008—that is, living in households that lack six or more of the 14 basics—that picture is bleak (see Table 1 from Perry, 2009b, p. 25). Nearly 40% of these children did not have a raincoat; one in five did not even have their own bed or a full school uniform. In over 40% of cases, at least one child in the household had had a serious health problem in the previous year; 58% were living in homes where heating was a major problem in winter and just under half were in homes where dampness or mould was also a major problem. Sixty-five percent were living in homes where doctor's visits were often postponed because of the cost. The survey also shows the potential impact of poverty on children's opportunities to make and sustain friendships: 31% could not invite friends to a birthday party, 37% went without music, dance, kapa haka, art, swimming and the like, while for 32% involvement in sport had to be limited.

Children's own stories of poverty help to complete the picture. The Children's Commissioner's project "This is How I see it" enabled some eighty eight children and young people to document their experiences and offers a qualitative picture of the lived realities of child poverty in 2007/8 (Egan-Bitran, 2010). The findings mirror those above and those of qualitative studies conducted elsewhere (e.g., Ridge, 2002):

> *"Of particular significance is the impact poverty and the economic hardship associated with it have*

Table 1: Restrictions on children depending on the deprivation score of their family (from Perry, 2009b, p.25)

Deprivation Score	All	0 Well Off	1	2-3	4-5	6+ Severe
Distribution of children across the DEP scores	100	41	18	18	10	12
Average number of children per family		2.2	2.3	2.5	2.7	2.7
Enforced lacks of children's items Percentages						
friends to birthday party	6	-	-	5	9	31
waterproof coat	8	-	2	8	11	39
seperate bed	5	-	-	3	13	20
seperate bedrooms for children of opposite sex (aged 10+)	8	2	3	6	14	24
all school uniform items required by the school	5	-	-	2	9	19
Economising 'a lot' on children's items to keep down costs to enable other basic things to be paid for						
continued with worn out shoes/ clothes for the children	8	-	-	5	15	39
postponed child's visit to doctor	2	-	-	-	5	13
did not pick up prescription for children	1	-	-	-	3	7
unable to pay for school trip	3	-	-	-	6	17
went without music, dance, kapa haka, aret, swimming, etc	9	2	4	8	18	37
involvement in sport had to be limited	8	-	4	6	17	32
Multiple Deprivation						
4+ of the 11 children's items above	6	-	-	2	11	35
5+ of the 11 children's items above	4	-	-	-	7	29
6+ of the 11 children's items above	3	-	-	-	2	24
Serious health problems reported by respondent						
serious health problems for any child in the last year	28	22	25	31	35	43
Enforced lacks reported by the respondent in child's family						
keep main rooms warm	9	-	3	8	18	37
meal with meat, fish or chicken t least each second day	3	-	-	-	6	18
cut back or did without fresh fruit and vegetables ('a lot')	14	-	-	15	32	63
postponed visit to doctor ('a lot')	14	-	4	18	38	65
one weeks holdiay away from home in last year	33	14	28	42	52	73
home computer	8	3	6	8	13	25
internet access	9	-	7	9	18	28
Housing and local community conditions						
overall physical condtion of the house (poor/ very poor)	7	-	3	7	15	28
difficult to keep house warm in winter (major problem)	22	9	13	27	38	58
dampness or mould (major problem)	17	5	13	18	37	49
crime or vandalism in the area (major problem)	11	6	6	11	13	31

> *on children and young people's social relationships, social inclusion, school experience, sense of self and future prospects. Deep emotional costs were evident as many of the children and young people struggled to cope with the negative consequences of difference and disadvantage" (Egan-BItran, 2010, p. 28).*

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Which children are poor?

In terms of income poverty, children are more likely to live in poverty than adults[2], but the risk for some children is higher than others:

(1) In 2007 and 2008, the child poverty rate in workless homes was seven times higher than in homes where at least one adult had a full-time job (Perry, 2009a, p. 99). Yet, despite Working for Families' emphasis on making work pay, a third of poor children were living in households where at least one adult worked full-time (Perry, 2009a).

(2) Poverty rates are higher in single-parent households than in two-parent households, yet nearly half of poor children come from two-parent homes (Perry, 2009a, p.100).

(3) Rates are higher for larger families with three or more children (Perry, 2009a, p. 100).

(4) Updated results on the ethnic composition of child poverty are not available; however in 2003/2004, while the rates for Pakeha/European children stood at 16%, rates for Maori children were substantially higher at 27%, and higher still for Pasifika children (40%) (Fletcher & Dwyer, 2008, p. 25)[3]. Perry (2009a: 54) indicates that in terms of median household incomes more generally all ethnic groups have increased their income compared to the mid-1990s (measured on a 2008 basis) and the spread across ethnic groups has not widened.

(5) The rates were highest among beneficiary families, where 58% of sole-parent and 54% of two-parent households were in hardship (Perry, 2009b, p.23). Further, since a disproportionate number of children with disabilities live in beneficiary families, hence they too are likely to be overrepresented among poor children (Fletcher & Dwyer, 2008, p. 27 ; Krishnan et al., 2002, MSD, 2004).

How does New Zealand compare internationally?

Comparing New Zealand's performance in addressing child poverty with that of other developed nations provides little comfort. Across developed nations, child poverty rates range from under 3% in Denmark to nearly 25% in Turkey with an OECD average circa 2005 of 12.4% (OECD, 2009: p35). Despite recent improvements, in the mid-2000s, child poverty rates in New Zealand are still about average in relation to most comparable developed nations (Perry 2009a, p118-119). Recent comparative international figures are not yet available. However, as Fletcher and Dwyer note in 2008 "...it is unlikely our ranking relative to other OECD countries will have improved much over that period."

As for measures of living standards, again, New Zealand compares not particularly favourably with other developed countries. Using an EU measure which assesses hardship as the enforced lack of three or more of nine basic items, the rate of child material hardship in New Zealand was 18%:

> *"This ranks New Zealand at the 'low' (i.e. more deprived) end of the old EU for hardship rates for children, the same as Italy (18%), but better than Greece (20%). The New Zealand hardship rate for children is higher than that for the UK (15%) and Ireland (14%), and well behind countries like Norway (6%), the Netherlands (6%) and Sweden (7%)" (Perry, 2009b, p. 33).*

But such high rates are not inevitable, even for a country of modest means such as our own. Given the more even distribution of economic cycle effects, most of the difference in child poverty rates between developed nations is determined by government policy designed to alleviate it (Unicef, 2005) and government policy can be changed (as we discuss further below).

Correlates, Concomitants and Long-lasting Consequences

Major influences on the overall level of child poverty are demographic processes, family formation, unemployment rates, benefit and retraining levels, childcare services and housing costs, all of which are shaped broadly by the economy and/or government social policy.

Low family income (the exact definition varies across studies) is associated with a range of negative health outcomes including low birth weight, infant mortality, poorer mental health and cognitive development, and high rates of hospital admissions from a variety of causes; negative social outcomes include leaving school without qualifications, economic inactivity, early parenthood, hunger and food insecurity, reduced life expectancy, and debt and criminal activity (Hirsch, 2006). The effects are not linear (but particularly accrue to households in more extreme poverty) and parental education and other mediating factors affect the magnitude of associations (OECD, 2009).

The relationship between poverty, neighbourhood deprivation, overcrowding and poor health is well documented (Fletcher & Dwyer, 2008). For example in New Zealand, a child growing up in a low-income household has on average a 1.4 times higher risk of dying during childhood than a child from a high-income household. Children born into poverty are more likely to be born prematurely, to have a low birthweight and to die before the age of one (Turner and Asher, 2008). A poor child is three times more likely to be sick, and hospitalisation rates for children from low income areas are significantly higher than for those from wealthier areas (Turner and Asher, 2008). Infectious diseases also spread more easily in overcrowded and difficult household conditions (Baker et al., 2000). Some of the effects of child poverty last into adulthood; poverty during childhood is associated with higher rates of heart disease, alcohol and drug addiction and worse oral health at age 26 (Poulton et al., 2002).

According to results compiled from the General Social Survey (Statistics NZ 2008) the social psychological

Table 2: Satisfaction with Life: Households with Dependent Children Source Statistics NZ, General Social Survey, 2009: Compiled by authors

	VS	S	N	D	VD	
"very restricted"	.0%	15.0%	25.6%	39.8%	19.5%	133
"restricted"	2.0%	22.4%	30.3%	40.8%	4.6%	152
"somewhat restricted"	.7%	41.2%	33.7%	23.3%	1.1%	279
"fairly comfortable"	8.1%	56.2%	24.8%	10.6%	.2%	480
"comfortable"	10.7%	69.9%	14.2%	5.1%	.0%	745
"good"	26.0%	69.5%	3.9%	.7%	.0%	917
"very good"	82.5%	17.5%	.0%	.0%	.0%	291
Total	20.1%	55.0%	14.5%	9.2%	1.2%	2997

effects are also considerable. Table 2 shows that the life satisfaction of (adult) respondents in households with dependent children is highly related to their deprivation level. Below the 'fairly comfortable' level (on a modified ELSI scale) very few household respondents are very satisfied, especially in the three most deprived segments, whereas in the 'very good' category almost all respondents are very satisfied and the remainder 'satisfied'.

Inequalities are associated with life dissatisfaction, a range of mental health problems (Wilkinson & Pickett, 2009) and rates of violent offending (Smith, 2007). Child physical abuse and neglect, for example, is estimated to be 22 times more frequent in poverty-stricken families than in families above the poverty line (Sedlak & Broadhurst, 1996, cited in Tyler et al., 2006). Child abuse and neglect occurs in all socioeconomic classes, but substantial evidence shows a strong relationship between poverty and child maltreatment (Connell-Carrick, 2003; Pelton, 1978; DiLauro, 2004). Deprived neighbourhoods also appear to exacerbate the conditions under which child physical abuse and neglect can flourish (Coulton, Korbin & Su, 1999; Drake & Pandey, 1996). For example, children born to mothers 17 years of age or younger who lived in high poverty areas were 17 times more likely to have a substantiated case of neglect than children born to mothers who were 22 years of age or more in low poverty areas (Connell-Carrick, 2003).

Higher rates of child physical abuse and neglect are associated with poverty via the stress (Gephart, 1997, cited in Tyler et al., 2006) of inadequate income to meet children's needs for food and adequate shelter, and inadequate income to meet the needs of parents for space away from children through alternative care arrangements. Poverty signals low social status and rejection and can be socially isolating. These factors are conducive to neither positive parenting nor the mental health of either parent or child.

As with many other factors which may damage child well-being, poverty has a greater impact on the very young, although there is some emerging evidence of negative effects of low-income on middle childhood development too (Votruba-Drzal, 2006). Income has the greatest effects on family dynamics in poor households (Mistry, Biesanz, Taylor, Burchinal and Cox, 2004). The OECD (2009) has summarised recent research thus:

> *Poverty has a significant effect on well-being. The mainly United States literature suggests the following broad consensus conclusions…:*
>
> - *After controlling for covariates (for example, parental age) the effect of income on child well-being is small compared to other child-outcome-related factors like parents' education.*
> - *Effects in early childhood are typically larger than in late childhood.*
> - *Income effects on child well-being are stronger for children in poorer families.*
>
> (OECD, 2009, page 168)

Similar findings for New Zealand are also available. Analysis of the longitudinal data from the Christchurch Health and Development study (Fergusson et al 2008; Marie et. al., 2010) shows that socioeconomic status at birth:

- was strongly related to the extent of educational achievement at age 25 (explaining over 35% of the variance in this outcome);
- mediating factors including family educational aspirations, family economic circumstances, child's cognitive ability and child's classroom behaviours, but not school factors or material deprivation.

Social difficulties and psychopathology connect

The relationship between social difficulties and psychopathology is now well-documented (Read, Mosher & Bentall 2004; Wilkinson & Pickett, 2009). The data presented earlier in this paper reinforces the view that reducing child poverty is part of the picture of reducing child abuse and neglect and various mental health problems[4].

Neurobiological and longitudinal research highlights the importance of focusing particular attention on the early years of life (Shonkoff & Phillips 2000; OECD, 2009). Not all children in poverty or all children living in deprived areas will have poor, limited adult lives or experience family dysfunction or violence. However, children whose infancy is marked by inadequate or overcrowded housing, unpredictability and violence are likely to fill New Zealand's hospitals with recurrent health issues and struggle to keep up at school. Young children who lack food, warmth and stimulation, live in uninspiring empty neighbourhoods and are deprived of frequent positive human interaction, have much of their life's potential stolen. Some traumatised and neglected

children may become aggressive; others may dissociate and shut down; some truant from school. Some end up incarcerated in New Zealand's prisons at increasingly alarming rates: there were up to 4,000 people in prison in 1990; 6,000 in 2003, and just over 8,000 in 2007. By September 2011, the number is likely to be approximately 9,000. Māori are persistently over-represented in the prison population, as are Pacific people to a lesser extent, with the root causes of both clustering around socio-economic factors and the long term effects of colonisation (Fergusson & Boden, 2006; Smith, 2007).

Poverty hugely increases stresses on communities, families and children and increases the probability of poorer health, income and employment in adulthood. This leads to an increased inter-generational risk of poverty and hardship. This has a toll not just for individual children and their families, but for New Zealand as a whole, both in terms of negative social spending (for example on special education, youth justice, prisons, health and mental health services), and lost opportunity, because these children are not able to achieve their full potential, socially, culturally or economically (see Poulton et al. (2002) for an extensive review of the relationship between social mobility and chronic poverty).

Thinking about Solutions

> *"Countries should invest more resources during the period from conception until entry into compulsory schooling when outcomes are more malleable and foundations for future success are laid. If interventions are well designed, concentrating them into early childhood can enhance both social efficiency and social equity."*
>
> *(OECD, 2009, p. 179)*

Measures to increase family income will be most effective in improving child outcomes if they are targeted to the poorest families, very early in the life of the child (OECD, 2009). This reflects the convergence of thinking in the last fifteen years or so in the academic domains of neuroscience, sociology, psychology, criminology, paediatrics and longitudinal studies of human development emphasising the critical importance of the early years. The structures and functions of the brain are affected by the environment and vice versa, particularly in early critical periods of brain development. While we still have a lot to learn about these critical periods and the specifics of the interactions, the fact that children's immediate social environment affects fundamental brain development is unequivocal (Shonkoff & Phillips 2000).

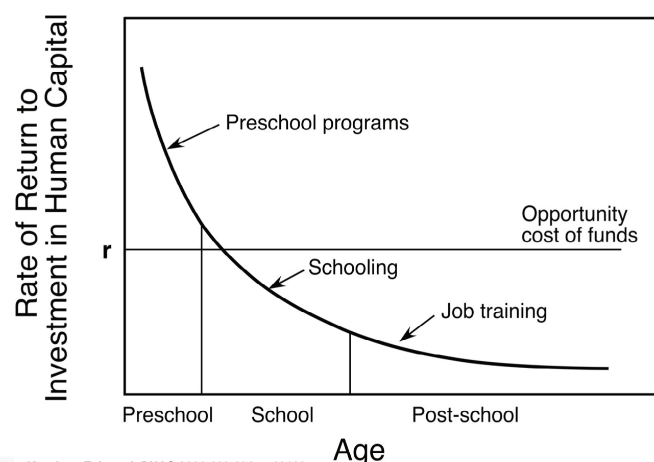
There is, therefore, increasing recognition by governments, scientists and economists on the need to invest early in the lifecycle to enable people to reach their full potential (Elizabeth & Larner, 2009; Ministry of Health, 2008; Ministry of Social Development, 2008). The rate of return on investment is expected to be many times the size of the investment made long-term (Irwin, Siddiqi & Hertzman, 2007). Rates of return are highest when interventions focus in the early years because competence builds competence and because society has the longest time to recoup the investment.

Figure 1 depicts an estimated rate of return as a function of the age at which the investment was originated (Knudsen, Heckman, Cameron & Shonkoff, 2006). Expenditure in education is primarily focused on children, but even with New Zealand's increased expenditure on early childhood education, the majority is focused later in the lifecycle. Expenditure in health services is almost the mirror opposite with the vast majority of expenditure occurring on acute adult conditions and the last few years of life.

Effective early childhood interventions can substantially enrich children's social attachment, social skills and motivation to engage constructively in their worlds thus also contributing to New Zealand's social capital. Social capital is defined by Robert Putman (1993) as connections between individuals, trust, networks and norms of reciprocity. However, if people don't experience this reciprocity and trust through healthy attachments in infancy, it is much harder to experience them in adolescence and adulthood. This is one reason why the growth of the infant mental health movement in recent years is such an important development.

Successive New Zealand governments have invested in child health, family income, social support services and early childhood education, although arguably not early enough in the life cycle. The Working for Families package and investment in early childhood education are legacies of Hon Helen Clark's Labour-led government. In its first year the present National-led coalition government sustained the Working for Families

Figure 1: Rate of return to investment in human capital as function of age when the investment was initiated



package although efforts to improve access to early childhood education were limited by a funding reduction. The development of "Early Years Hubs[5]" to coordinate service delivery is encouraging. Nevertheless, a year into their three year term, the National-led coalition government's strategy to systematically promote healthy child development and reduce child poverty is unclear. The Whanau-Ora policy currently being developed could possibly contribute to the reduction of the intergenerational nature of the disproportional high rates of Maori child poverty. This fund is to enable agencies to become more responsive to whanau, hapu and iwi aspirations, by focusing more attention on service cohesion with not to whanau, and on relational rather than transactional contracting with service providers. It remains to be seen the extent to which the principles will enhance service competence and capability and will assist New Zealand's poorest Māori children.

However, even the best and most effectively integrated health and social services cannot fix poverty by themselves. Services of any kind, aimed at individuals and families are unlikely to create the level of change required to seriously reduce the intergenerational nature of some child poverty, the numbers of people that experience significant emotional problems or indeed the number of people that commit violent crimes. There is therefore wisdom to putting as much effort into changing the social structures that keep groups of people powerless, as into initiatives that help nurture attachment, and help people to cope better with the status quo (Albee 1985, 1996). To do the latter without the former is to grow a prevention system that has the potential to exploit the very people it is trying to help (Rappaport 1992), by encouraging them to merely adjust to, rather than also challenge, a situation which has caused and is maintaining their distress. Realistic policy options to reduce the number of poor young children are not on the political agenda. In a global recession, this isn't surprising. But it is not inevitable[6] and it is certainly short-sighted.

The huge disparity in incomes between single and two-parent households invites a focus on the child support system. The considerable difficulties faced by poor children whose parents do not live together need to be addressed. Fletcher and Dwyer (2008) recommended building on the strong foundations of the current child support system by passing on child support to sole parents in New Zealand, as happens in Australia.

The unequal distribution of poverty between neighbourhoods makes it harder for families and services in deprived areas to ensure children's well-being. Improving access to good transport, quality health housing (including social housing), affordable quality childcare, adequate nutrition (e.g. free school lunches) and health services in these areas would enable more children to have their needs met. Organisationally, the changes in local government in Auckland offer some real possibilities in the future to improve some of New Zealand's most disadvantaged areas (Davies & Rowe, 2009).

Such measures could reduce the incidence of these experiences of disadvantage, but they will, however, do little to reduce the factors which underlie them. The ability of the Working for Families package to protect children from income poverty is heavily dependent on a strong labour market (Fletcher & Dwyer, 2008). Insufficient income to meet basic needs can result in medical neglect, because of the high cost of after-hours services, failure to provide adequate housing, and failure to provide sufficient food. Fletcher & Dwyer (2008) have argued that the structure of current benefit payments could be simplified and benefit rates could be tilted towards people with babies and young children, rather than teenagers, without extra expense (Fletcher and Dwyer, 2008). Moreover, Fletcher and Dwyer (2008) suggested that Working for Families could be realigned to work better in times of weak labour demand.

New Zealand needs an integrated focus to strengthen the foundations of human development with a concrete strategy to reduce child poverty, particularly in the early years (Davies et al., 2002). Approaches that align across local and central government and integrate services across health, education and family support sectors are showing promise in the developed world (Halfron, Russ, Oberklaid, Bertrand & Eisenstadt, 2009). These approaches can usefully include the collation of detailed child development data across a range of measures, including physical health and wellbeing, social competence, language and cognitive development and communication skills as in the Canadian Early Childhood Development Index, developed by Clyde Hertzman and colleagues, to help communities plan and monitor their performance on promoting healthy early child development.[7] In the words of the New Zealand Prime Minister's Chief Scientific Advisor, Professor Peter Gluckman:

> *"The scientific logic is clear. The humanity and equity of the approach is obvious. We will have to devote a greater proportion of our resources to promoting optimal conditions for the early years of our lives." (Gluckman & Hanson, 2006)*

Barriers to Overcoming Child Poverty

The social, economic and humanitarian case for eliminating child poverty and investing in children is clear enough, but there is no clear evidence that these are priorities for the current government. Arguably, there are significant barriers to doing so. It would require not only strong political will but also significant spending in the shorter term for benefits which would not be fully realised for many years to come. It would be a brave government that made the sort of financial commitment required without strong voter support. Yet public attitudes are not always conducive to sympathy or a sense of collective responsibility for the plight of the poor and their children (see NZ Listener, May 1-7, 2010).

However attitudes can be changed. In the mid-2000s, British researchers spent a day with 24 "middle England voters," exploring their views on child poverty. Over the course of the day, these voters went from poverty sceptics (that is, they didn't even believe there was any child poverty in Britain) to poverty

warriors, ready to personally contribute an extra £20 in income tax per month to eliminate child poverty and increase government investment in children's early years. Their initial attitudes towards the poor were blaming of the individual: child poverty was because of "'poor parenting' or 'runaways, big families, alcohol and drugs'" (Toynbee, 2005)—and the examples they gave were almost invariably from the media. However those attitudes shifted markedly over the six hours of discussion. While statistics and relative poverty left these voters unmoved, some types of information hit a nerve: examples of the hardships faced by poor children (no warm clothing in winter, no birthday parties, no school trips), the higher likelihood of poor children dying in childhood, that poor parents tend to spend any extra money they have on their children and *not* on drugs and alcohol, and importantly the fact that child poverty *can* be dramatically reduced. The former sceptics became enthusiastic, "If it really works, then of course it should be done!" (Toynbee, 2005).

Confronting the participants' scepticism and stereotypes with the right sort of factual information worked with this small group of voters. However, as Toynbee points out, "…alas, you can't take the whole population to a hotel room for six hours to tell them all this." The main forum for wider debate is of course the media, but it was in large part from the British media that the study participants' negative stereotypes were drawn in the first place.

There is no reason to believe that the New Zealand media is much different. For example, examining news coverage during the economic upheavals of the 1980s, Leitch (1990, cited Barnett, Hodgetts, Nikora, Chamerlain, & Karapu, 2007) illustrated how the media depicted the unemployed as lazy individuals scrounging off the hardworking, taxpaying public. In 2004, initial media reports of the *Working for Families* package made a clear distinction between the deserving (working) poor and the undeserving (beneficiary) poor (Barnett et al., 2007). The dominant frame drew on easily digested images of irresponsible parenting:

> *"Coverage took for granted 'common sense' ideas from contemporary society, including the notion that poor people purchase cigarettes or gamble instead of feeding their children. Primary emphasis was on the stereotypical notion that poor people often neglect their children and that children are innocent victims of neglect—resulting in child poverty … Coverage is constructed to appeal to the 'scroungerphobic' fears of middle New Zealand." (Barnett et al., 2007, pp. 305-306)*

Of course other images of poverty and unemployment are evident in the media, such as the recent article in The *New Zealand Herald* describing the thousands queuing for hours in hope of securing one of 150 supermarket jobs[8], an article which highlights barriers to employment and the lengths people go to in order to find work.

So what is the New Zealand voting public's attitude towards the poor? There is scant research which systematically investigates attitudes towards the poor in any depth. However data from the 2007/8 New Zealand Election Survey compiled by authors gives us a glimpse. Thirty-eight percent of those surveyed believed people live in need because they are lazy; 21% blamed social injustice; 40% did not know. But no matter how the data was split (i.e. by age, gender, urban-rural, educational level, home ownership, number of benefits, income, household size, or occupation) the proportions remained the same: a higher percentage of respondents believed people in live in need because of individual failings (laziness) rather than systemic failings (unfair society)[9].

The picture in Sweden was rather different: in 1990, there were twice as many Swedes who blamed poverty on factors *beyond* the individual, such as social injustice, than Swedes who blamed the individual (Van Oorschot & Halman, 2000). Needless to say, Sweden's policy approach to poverty among its youngest citizens is vastly different from our own, as is the incidence: 4% of Swedish children lived in poverty compared to 15% in New Zealand in 2005.[10]

The New Zealand Election Survey data suggests that public attitudes in New Zealand are not at the point where heavy investment in alleviating child poverty, including among beneficiaries, would be as palatable as it was to the 24 Britons in the UK study. On the contrary, policy that penalises "lazy" beneficiaries, with their children as the lamentable but unavoidable victims, is likely to fit neatly with those attitudes.[11] If the New Zealand government is to be encouraged to end all child poverty (not just among the deserving poor) and to invest heavily in children's early years, they need to be assured that they will not be penalised by voters for doing so. Therefore a key step must be to challenge those stereotypes and to highlight the relationships between childhood poverty and childhood/adult outcomes at every level, but especially in the very forum that has helped to construct them—the media.

The place of psychologists: Public Policy and Public Debate

Many clinical, forensic and educational psychologists see more human pain in a week than most of us see in a lifetime[12]. Paradoxically, these societally-ordained witnesses seem paralysed into silence about the source of the pain flowing over them. To ask a human being to sit day after day with often frightened and sometimes frightening survivors of the worst that life can throw at people, and to find the energy, and hope, to simultaneously try to plug the source, seems unfair. Nonetheless, this expertise is an invaluable part of the picture of poverty, pain and deprivation that needs to be better known if realistic policy options are to be implemented. The educational psychologist understands the humiliation of the child who cannot afford the things his peers have. The forensic psychologist can talk about early childhood deprivation evident in some clients she sees in prison. Indeed, effective actions to reduce child poverty will likely do more to prevent a variety of widely publicised violent crimes in the long-term than increasing custodial sentences.

Practising psychologists offering

anonymous stories into media discourse showing the connections between social and psychopathology would assist the development of robust policy. The media has considerable influence on policy. The media does report child abuse and neglect and other violent crimes regularly and such violence appears to be an issue of concern to many in the community, as seen by the number of people who report family violence as a significant social concern. In 2008 and 2009 surveys commissioned by the Ministry of Agriculture and Forestry, 86% respondents marked reducing family violence as the top priority for New Zealand (Ministry of Agriculture and Forestry, 2009). Thoughtful and populist public dissemination of the psycho-social root causes of issues that the media reports on and the public seem concerned about (e.g., child abuse and violence) would put pressure on decision makers to develop meaningful solutions. At the time of writing, the lock-'m-up-and-throw-away-the-key brigade appear to have captured a disproportionate amount of space in media discourse (Elias, 2009). Rational well-founded psycho-social theories, told through stories, are largely absent.

Research and practice psychologists, including developmental psychologists, also need to more directly engage with the policy making process. Maton and Joseph (2006) identified the following four directions in the USA:

1. Psychologists need to make more effort to communicate directly with policymakers about the implications of their practice and research findings

2. Research and practising psychologists need to become more involved with interdisciplinary research terms so that their research becomes increasingly policy relevant.

3. Psychologists need to become more involved with high quality public policy evaluations

4. Psychologists need to develop more strengths-based research including the strengths and resilience of those living in poverty.

These recommendations have merit for the New Zealand psychologists' community. To them we would add the need for greater coordination between the psychological practice and research communities. Clinical psychology's over-emphasis on distressed individuals may be inadvertently preventing us focusing more on what we mean by mental health, healthy families, healthy communities and just societies. If we focus more of our debate on these latter areas, we might learn more about how to enhance their development.

Our responsibility as a community of psychologists is to generate a body of relevant findings and practice knowledge, over time, related to pressing social issues and to help ensure that active channels of social influence that facilitate communication of these findings to policymakers are in place. This will greatly enhance the possibility that we will be able to have a substantial national influence on the well-being of society's citizens and communities (Maton and Bishop-Josef, 2006, p. 144)

Final Word

Concern with child poverty is heightened partly because children are dependent and unable to look after themselves (so society takes a broader 'duty of care' attitude - looking over the shoulders of parents) and partly because adequate investment in their development is needed for the longer term good of themselves and the wider society. This viewpoint has gathered momentum in New Zealand policy circles since the turn of the millennium, although it has yet to be fully accepted and institutionalised, and certainly needs to be further enhanced.

Psychologists - including clinical, forensic, developmental and educational psychologists - have important roles to play in promoting this discourse in the media and more directly with policy makers. This may assist to put genuine strategies to child poverty on the political agenda, and thereby deal with a root cause of some of New Zealand's social problems. The costs to reduce child poverty may well be high short-term; the costs of inaction for New Zealand's children and grandchildren would likely be even higher. In the words of John F. Kennedy:

> *"There are risks and costs to a programme of action. But they are far less than the long-range risks and costs of comfortable inaction."*

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Footnotes

[1] This seems as an inevitable consequence of the Working for Families emphasis on supporting working families although it may in fact technically improve because the median will have dropped: thus the percentage figure will probably reduce even though more will have low incomes

[2] That is, while 20% of New Zealand's children lived in poverty in 2008, the rate for the whole population was 14%; the rate for the over-65s was the lowest of all at 9% (Ministry of Social Development, 2009, p. 63). These figures are based on a constant-value (1998) measure using 60% of median equivalised household income, after housing costs.

[3] Constant value 60% of median equivalised household income, *after* housing costs.

[4] Albee (1985) recognised this when he proposed a model of primary prevention to reduce the incidence of emo-

tional illness. Whether or not George Albee had child poverty in mind when he developed his model, the equation offers a useful way of conceptualising the relationship between child poverty and psychopathology. Reducing child poverty will likely reduce stress and exploitation.

[5] Thirteen Early Years Service Hubs were established, and funded from 2006 through 2010, in high need areas to provide a central point where families can access a range of services including ante-natal care, Well Child health checks and immunisation programmes, and quality childcare and education for under fives, and have served some 2500 families per year (Source: Family and Community Services website).

[6] For example, throughout the fraught economic times of the 1990s, Norway reduced its child poverty rate from 5.2% in 1991 to 2% in 2000 (using the 50% poverty line). The most significant factor in reducing the rate was government support (UNICEF, 2005, pp. 19-20).

[7] See Early Child Development Index as part of the Early Child Developing Mapping Project www.earlylearning.ubc.ca.

[8] Orsman, B., & Eriksen, A. M. (2010, 22 January). Thousands Queue for 150 Jobs. The New Zealand Herald.

[9] Detailed tables available from the authors

[10] Based on the 50% measure of equivalised median household income (see OECD, 2009).

[11] The authors who analysed the 1990 European Values Study suggest a hypothesis for future research that, “a relatively high level of individual blame explanations [for poverty] combine with anti-poverty policies, emphasizing highly selective, means-tested income protection, low benefit levels, and a workfare type of reinsertion strategy as a way of controlling and disciplining the undeserving, allegedly irresponsible, and work-shy poor” (Van Oorschot & Halman, 2000, p. 21).

[12] Most unfortunately, the distress of psychologists coping with other’s stresses seems a unresearched topic with an extensive literature review finding no studies directly on the topic. However, see Waldegrave (2009).

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