

# Survivors' experiences of abuse and neglect in mental health care settings

Summary and key messages



JUNE 2024



Abuse in Care  
Royal Commission of Inquiry

Developed by the Royal Commission of Inquiry into Historical Abuse in State Care  
and in the Care of Faith-based Institutions to assist accessibility

**ISBN 978-1-0670299-7-5 (online)**

Crown Copyright New Zealand 2024

# **Whakairihia ki te tihi o Maungārongo**

# He karakia

E tāmara mā, koutou te pūtake o ēnei kōwhiringa, kua horaina nei  
E tohe tonu nei i te ara o te tika  
E ngaki tonu ana i te māra tipu  
Anei koutou te whakairihia ki te tihi o  
Maungārongo, kia tau te mauri.

Rukuhia te pū o te hinengaro  
kia tāea ko te kukunitanga mai o te whakaaro nui.  
Kia piere ko te ngākau mahora  
kia tūwhera mai he wairua tau.

Koinei ngā pou whakairinga i te tāhuhu  
o te Whare o Tū Te Mauriora.  
Te āhuru mōwai o Te Pae o Rehua,  
kaimuru i te hinapōuri,  
kaitohu i te manawa hā ora,  
kaihohou i te pai.

Nau mai e koutou kua uhia e ngā hau kino  
o te wā, kua pēhia e ngā whakawai a ngā tipua nei,  
a te Ringatū kino rāua ko te Kanohihuna.

Koutou i whītiki i te tātua o te toa,  
i kākahu i te korowai o te pono,  
i whakamau i te tīpare o tō mana motuhake,  
toko ake ki te pūaotanga o te āpōpō e tatari mai nei i tua o te pae,  
nōu te ao e whakaata mai nei.

Kāti rā, ā te tākiritanga mai o te ata,  
ā te huanga ake o te awatea,  
kia tau he māramatanga,  
kia ū ko te pai, kia mau ko te tika.  
Koinei ko te tangi a te ngākau e Rongo,  
tūturu ōwhiti whakamaua  
kia tina, tina!  
Hui e, tāiki e!

– Waihoroi Paraone Hōterene

To you upon whom this inquiry has been centered  
Resolute in your pursuit of justice  
Relentless in your belief for life  
You have only our highest regard and respect,  
may your peace of mind be assured.

Look into the deepest recesses of your being  
and discover the seeds of new hope,  
where the temperate heart might find solace,  
and the blithe spirit might rise again.

Let these be the pillars on which the House of Self,  
reconciliation can stand.  
Safe haven of Rehua,  
dispatcher of sorrow,  
restorer of the breath of life,  
purveyor of kindness.

Those of you who have faced the ill winds  
of time and made to suffer,  
at the hands of abusers and the hidden faces of persecutors, draw near.

You who found courage,  
cloaked yourselves with your truth,  
who crowned yourself with dignity,  
a new tomorrow awaits beyond the horizon,  
your future beckons.

And so, as dawn rises, and a new day begins,  
let clarity and understanding reign,  
goodness surrounds you and  
justice prevails.

Rongo god of peace, this the heart desires,  
we beseech you,  
let it be,  
it is done.

– Waihoroi Paraone Hōterene



### **Pānui whakatūpato**

Ka nui tā mātou tiaki me te hāpai ake i te mana o ngā purapura ora i māia rawa atu nei ki te whāriki i ā rātou kōrero ki konei. Kei te mōhio mātou ka oho pea te mauri ētahi wāhanga o ngā kōrero nei e pā ana ki te tūkino, te whakatūroro me te pāmamae, ā, tērā pea ka tākirihiā ngā tauwharewarenga o te ngākau tangata i te kaha o te tumeke. Ahakoa kāore pea tēnei urupare e tau pai ki te wairua o te tangata, e pai ana te rongo i te pouri. Heoi, mehemea ka whakataumaha tēnei i ētahi o tō whānau, me whakapā atu ki tō tākuta, ki tō ratongo Hauora rānei. Whakatetia ngā kōrero a ētahi, kia tau te mauri, tiakina te wairua, ā, kia māmā te ngākau.



### **Distressing content warning**

We honour and uphold the dignity of survivors who have so bravely shared their stories here. We acknowledge that some content contains explicit descriptions of tūkino – abuse, harm and trauma – and may evoke strong negative, emotional responses for readers. Although this response may be unpleasant and difficult to tolerate, it is also appropriate to feel upset. However, if you or someone in your close circle needs support, please contact your GP or healthcare provider. Respect others' truths, breathe deeply, take care of your spirit and be gentle with your heart.

The Royal Commission of Inquiry examined the abuse and neglect of children, young people and adults in State care and in the care of faith-based institutions. This summary provides an overview of survivors' experiences of abuse and neglect in mental health care settings during 1950-1999.

# Contents

<b>Chapter 1: Introduction .....</b>	<b>2</b>
<b>Chapter 2: Executive summary .....</b>	<b>3</b>
<b>Chapter 3: Purpose and process .....</b>	<b>8</b>
Rights and identities .....	8
How the Inquiry framed its analysis and understanding of abuse and neglect.....	9
Survivors who experienced mental distress.....	10
<b>Chapter 4: Context for the Inquiry period .....</b>	<b>13</b>
Māori attitudes and approaches to health and disability .....	13
Pacific Peoples' approaches to health and disability .....	13
Pākehā settler approaches to mental distress.....	14
Eugenics influenced attitudes to mental distress .....	14
People who experienced mental distress often experienced lifelong poverty .....	15
Changing attitudes during the Inquiry period.....	15
Frameworks for State mental health care .....	17
Mental health settings.....	18
Health professionals and other care workers .....	20
How people entered mental health settings.....	20
<b>Data .....</b>	<b>21</b>
<b>General rates of admission.....</b>	<b>21</b>
Rates of Māori entering mental health care increased.....	22
Numbers of Pacific Peoples in mental health settings unclear .....	23
Entries into forensic mental health settings.....	24
<b>Chapter 5: Circumstances for people experiencing mental distress being admitted into care .....</b>	<b>25</b>
Trauma and disadvantage.....	26
Behaviour, neurodiversity and disability .....	27
Young people transferred from social welfare settings .....	28
Gender discrimination.....	30
Homophobia and discrimination .....	31

## **Chapter 6: Nature and extent of abuse in mental health care settings ..... 33**

Physical abuse.....	33
People were neglected, dehumanised and degraded.....	34
Emotional, psychological and developmental neglect.....	35
Medical abuse and neglect.....	37
Aversion techniques to punish and control.....	39
Abuse and neglect experienced by different groups.....	40
Extent of abuse in mental health care settings.....	41

## **Chapter 7: Impacts of abuse and neglect in mental health settings..... 42**

Physical health .....	42
Mental health and emotional wellbeing.....	42
Impacts on life after time in mental health care settings.....	43
Impacts on particular groups.....	45

## **Chapter 8: Factors that contributed to abuse and neglect of people in mental health settings..... 47**

<b>The people at the centre of abuse and neglect .....</b>	<b>51</b>
Abusers.....	52
Bystanders.....	52
<b>Standards of care were routinely breached.....</b>	<b>53</b>
Individual care needs were often not recorded or were ignored.....	54
Institutional environments and practices that breached standards.....	55
Solitary confinement, seclusion and secure care wrongfully used as punishment.....	57
Medical standards were frequently breached, at times unlawfully .....	57
<b>Poor employment policies, practices contributed to abuse, neglect.....</b>	<b>58</b>
Staff and carers were often compromised by under resourcing.....	59
Inadequate training and development to deliver care.....	61
<b>Few records were kept of complaints of abuse and neglect .....</b>	<b>63</b>
<b>Complaints processes were absent or easily undermined .....</b>	<b>64</b>
<b>People in care faced barriers and needed family, whānau, or advocacy support .....</b>	<b>65</b>
<b>Oversight and monitoring did little to change the experiences of people in care.....</b>	<b>65</b>
<b>The State's responsibility for care.....</b>	<b>67</b>
<b>Society's responsibility for care .....</b>	<b>68</b>
<b>Lessons identified and changes made.....</b>	<b>70</b>

# Chapter 1: Introduction

1. This summary describes the abuse and neglect experienced by survivors in mental health care settings during the Inquiry period (1950 to 1999).
2. Chapter 2 is an executive summary.
3. Chapter 3 summarises how the Inquiry approached understanding mental distress, including the experiences of survivors in mental health care settings who registered with the Inquiry.
4. Chapter 4 provides the historical and social context most relevant to mental health care settings during the Inquiry period, including traditional societal attitudes to care among Māori, Pacific Peoples and Pākehā.
5. Chapter 5 describes the circumstances that led to children, young people and adults entering mental health care settings during the Inquiry period. This chapter explains how discrimination and misdiagnosis played a particular role that led to many people entering these settings.
6. Chapter 6 discusses the nature and extent of abuse and neglect experienced by children, young people and adults in mental health care settings. It focuses on physical, psychological and emotional abuse and neglect, as well as medical abuse and neglect.
7. Chapter 7 describes the impact on survivors of the abuse and neglect they suffered in these settings, including the ongoing societal stigma associated with mental distress and time spent in mental health care settings.
8. Chapter 8 explains the factors that contributed to children, adults and young people being abused and neglected in mental health care settings. It focuses on the factors that had specific effects in these settings, including a lack of common standards, poor employment conditions and the lack of a comprehensive, independent oversight and monitoring system. It also summarises the lessons learned and the changes made to prevent and respond to abuse and neglect.

## Chapter 2: Executive summary

9. Mental distress means a mental or emotional state that disrupts daily life. How long the distress lasts and how intense it is can vary. People who experience mental distress include those who are seriously upset, people who are reacting naturally to a stressful situation, and people with mental illness (whether medically diagnosed or not).
10. Mental distress is common among survivors of abuse and neglect in State and faith-based care. Of the 2,329 survivors who registered with the Inquiry, 83 percent reported experiencing mental distress at some point in their lives. Some survivors experienced mental distress before entering care. Many others reported suffering mental distress during or after their time in care. This summary focuses on the experiences of people who were in mental health care settings.
11. During the early part of the Inquiry period, psychiatry was an emerging field, lacking many of today's diagnostic and treatment tools and an understanding of diversity and difference. Medical disciplines, including psychiatry, operated within a predominantly Western healthcare system, driven by a biomedical model that framed mental health and disability as problems to be fixed.
12. For those experiencing mental distress, placement in mental health care settings was often compulsory, mandated by court orders, emergencies, or the criminal justice system. Some entered voluntarily or on advice from family or clinicians.<sup>1</sup>
13. The Mental Health (Compulsory Assessment and Treatment) Act 1992 brought significant changes to New Zealand's mental health system, emphasising patient rights and recognising the role of cultural factors in diagnosis and treatment, along with the right to appeal treatment.<sup>2</sup>
14. Throughout the Inquiry period, people were admitted into mental health care settings for a variety of reasons, many of which were unrelated to psychiatric illnesses requiring hospital treatment. Factors such as societal prejudices, including sexist, homophobic, and racist attitudes, led to the inappropriate institutionalisation of people.
15. A misunderstanding of behaviours due to a lack of knowledge about neurodiversity and sensory or learning disabilities also resulted in unwarranted admissions. The Inquiry saw evidence of children and young people being transferred between social welfare and psychiatric institutions as punishment. Gender norms and expectations, as well as discrimination against diverse gender identities and sexual orientations, were also significant factors driving admissions.

---

<sup>1</sup> Mental Defectives Act 1911, section 39(1), Mental Health Amendment Act 1958, section 2.

<sup>2</sup> Brief of Evidence of Dr John Crawshaw (1 April 2021, pages 3-4).

16. Admissions to psychiatric hospitals surged in the 1940s and 1950s, peaked in the 1960s, and gradually declined in the 1970s. From 1960 to 1990, Māori first-time admissions to mental health facilities increased by over 200 percent, compared to a slight increase for non-Māori.<sup>3</sup> By the late 1990s, the high rates of mental distress among Māori were seen as a crisis of unprecedented proportions.<sup>4</sup>
17. In 1999, Pacific Peoples made up seven percent of forensic inpatient users and five percent of community-based service users, indicating overrepresentation in mental health settings compared to the general population.<sup>5</sup>
18. The Inquiry heard that mental health settings were environments of isolation, fear, violence and control. Almost all survivors of mental health care settings described abuse and neglect that stripped them of their personhood, identity, dignity, and autonomy. This abuse and neglect represented a disregard for the inherent human value of individuals, disrespect of their diverse identities and needs, and a failure to fulfil their rights to participation, inclusion and decision-making. It also represented a disregard for the collective whakapapa rights of survivors whānau.
19. Survivors of mental health care settings experienced long-term isolation, segregation and severe neglect, and were subjected to regular control and restraint. This impacted their relationships, created fear of change or intimacy, and reduced survivors' abilities to live independently or interdependently. For many, the medical abuse and neglect suffered resulted in long-term physical and mental conditions.
20. Their ability to fit back into whānau life and with their communities was impacted. These impacts were compounded by discriminatory societal attitudes relating to ableism and disablism which limited lifelong opportunities. Some never left care, and the Inquiry heard evidence of unmarked graves on the grounds of some of the old institutions.
21. Staff and caregivers in mental health care settings had almost total power and control over the lives of people in their care. Human rights were largely absent and the rights guaranteed to Māori under te Tiriti o Waitangi were not considered or upheld. The culture within mental health care settings discouraged intervention when abuse and neglect was happening, and in many places normalised abhorrent behaviour and practices. Serious abuse was almost never reported to police, and complaints and oversight processes offered little recourse or protection.

---

<sup>3</sup> Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry, Waitangi Tribunal (Wai 2575, B26), (Waitangi Tribunal, 2019, page 12).

<sup>4</sup> Māori Health Commission, Tihei Mauri Ora! Report of the Māori Health Commission (1998, page 14).

<sup>5</sup> Review of forensic mental health services: Future directions (Ministry of Health, 2010, pages 16–17, Table 2).

22. Overcrowding was common in mental health settings.<sup>6</sup> Many institutions had substandard physical environments. Buildings were outdated, poorly designed and inappropriate. Overcrowding often led to compromised daily routines like reduced or absent oversight, lack of individualised care and limited activities. Many people in overcrowded and unsuitable environments suffered abuse and neglect.
23. While many staff and carers in mental health settings genuinely approached their position to do the best they could for those in their care, poor employment policies combined with poor senior leadership and management practices made it difficult for individual staff and carers to safeguard people in care. This was summed up by staff from mental health settings who told the Confidential Forum for former in-patients of psychiatric hospitals about having "a lack of time for kindness".<sup>7</sup>

---

<sup>6</sup> Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 19).




<sup>7</sup> Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 32).

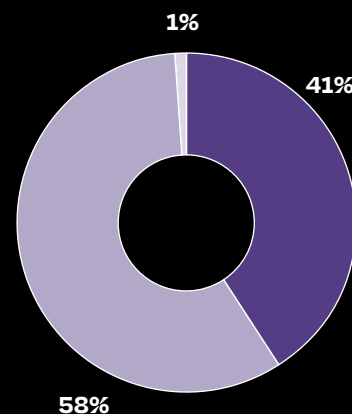
# Key facts about registered survivors who experienced mental distress




Total Number of Survivors: **1,921**

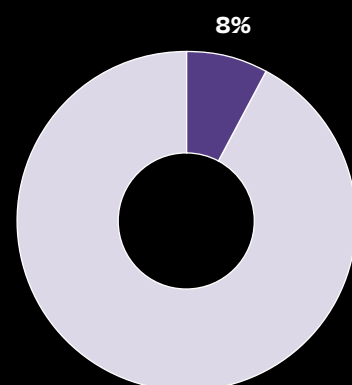
## Gender

	NUMBER OF SURVIVORS	PERCENT
 Female	784	41%
 Male	1,121	58%
 Gender diverse, Non-Binary, Other, Prefer Not to Say, No Data	16	1%



## Part of Takatāpui, Rainbow and MVPFAFF+ community

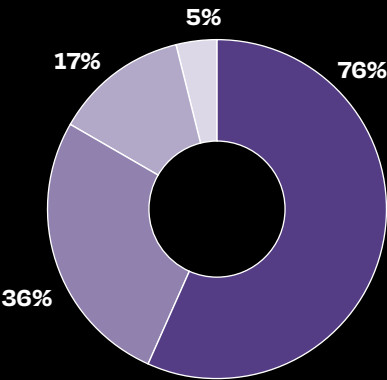
	NUMBER OF SURVIVORS	PERCENT
 Takatāpui, Rainbow and MVPFAFF+ community	148	8%



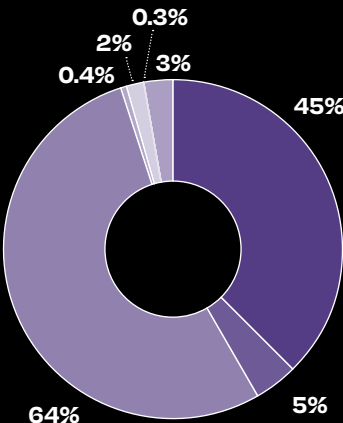
\* Survivors who experienced both State and faith-based care are counted in all three groups (State care, faith-based care, and State and faith-based care).

Age	
	YEARS OLD
Average age when entered care	9

Type of care		
	NUMBER OF SURVIVORS	PERCENT
State care	1,460	76%
Faith-based care	691	36%
State and faith-based care	327	17%
Unknown	97	5%



Ethnicity		
	NUMBER OF SURVIVORS	PERCENT
Māori	857	45%
Pacific Peoples	93	5%
Pākehā / European	1,242	64%
Asian	7	0.4%
Another ethnic identity	47	2%
Prefer not to say	6	0.3%
No ethnicity recorded	57	3%



# Chapter 3: Purpose and process

24. Part 1 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*, explains that the Terms of Reference directed the Inquiry to focus on the experiences of "those with ... mental illness" who suffered abuse and neglect in State and faith-based care.<sup>8</sup> The Inquiry uses the term mental distress instead of mental illness.
25. The Inquiry's approach to understanding the experiences of survivors who experienced mental distress was informed by the knowledge, expertise and work of its Mental Health Reference Group and what it heard from survivors, their families and communities.
26. The Inquiry acknowledges that people who experience mental distress and their communities have their own histories, worldviews and values. The Inquiry acknowledges that Māori, Pacific Peoples and those who identify as Takatāpui, Rainbow or MVPFAFF+ who also experience mental distress have their own unique experiences and perspectives.

## Rights and identities

27. How people who experience mental distress, their families and communities understand their identities depend on each person's perspective. This can vary widely and can change over time.
28. Mental distress means a mental or emotional state that disrupts daily life and that can vary in how long it lasts and how intense it is. People who experience mental distress include those who are seriously upset, people who are reacting naturally to a stressful situation, and people with mental illness (whether medically diagnosed or not).
29. The Inquiry acknowledges that many people who experience mental distress do not self-identify as disabled. They would, however, still be included within the definition of disability in the 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD). Discrimination against disabled people was not illegal in Aotearoa New Zealand until the introduction of the Human Rights Act in 1993. Disabled people's specific rights are described in the CRPD, but not all these rights have been incorporated into Aotearoa New Zealand's domestic law.
30. People with diverse impairments, including experiencing mental distress, continue to face barriers that non-disabled people take for granted. These include barriers to autonomy, participation, full citizenship and recognition as productive members of society. Disability communities continue to work towards addressing the gap between disabled people's rights and the realities of their daily experiences.

---

<sup>8</sup> Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clause 8.

31. Ableism and disablism contribute to the barriers experienced by disabled people by creating discrimination. They are belief systems that see value in people only according to their ability to have bodies or minds that fit social and medical definitions of 'normal' and are considered productive and desirable.
32. Ableism is the value system that results in attitudes and behaviours through which society privileges non-disabled people. Ableism is widespread and systemic, and often arises from ignorance rather than conscious intentional discrimination and harm. Invisibility of disabled people and disability issues in the public discourse contributes to ableism. Disablism is conscious, direct discrimination against people who are disabled, based on their disability.
33. The Inquiry heard from survivors who had experienced ableism and disablism related to their history of experiencing mental distress that affected their ability to access healthcare, employment and housing, and being believed when they reported abuse and neglect in care.

## **How the Inquiry framed its analysis and understanding of abuse and neglect**

34. Based on what survivors, their families and communities shared about their experiences, the Inquiry found these principles from the CRPD appropriate to help frame its understanding and analysis of the abuse and neglect suffered by survivors who experienced mental distress.
35. The CRPD principles are:
  - > Respect for inherent dignity, individual autonomy – including the freedom to make one's own choices – and independence of persons:
  - > Non-discrimination
  - > Full and effective participation and inclusion in society
  - > Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
  - > Equality of opportunity
  - > Accessibility
  - > Equality between men and women, and children

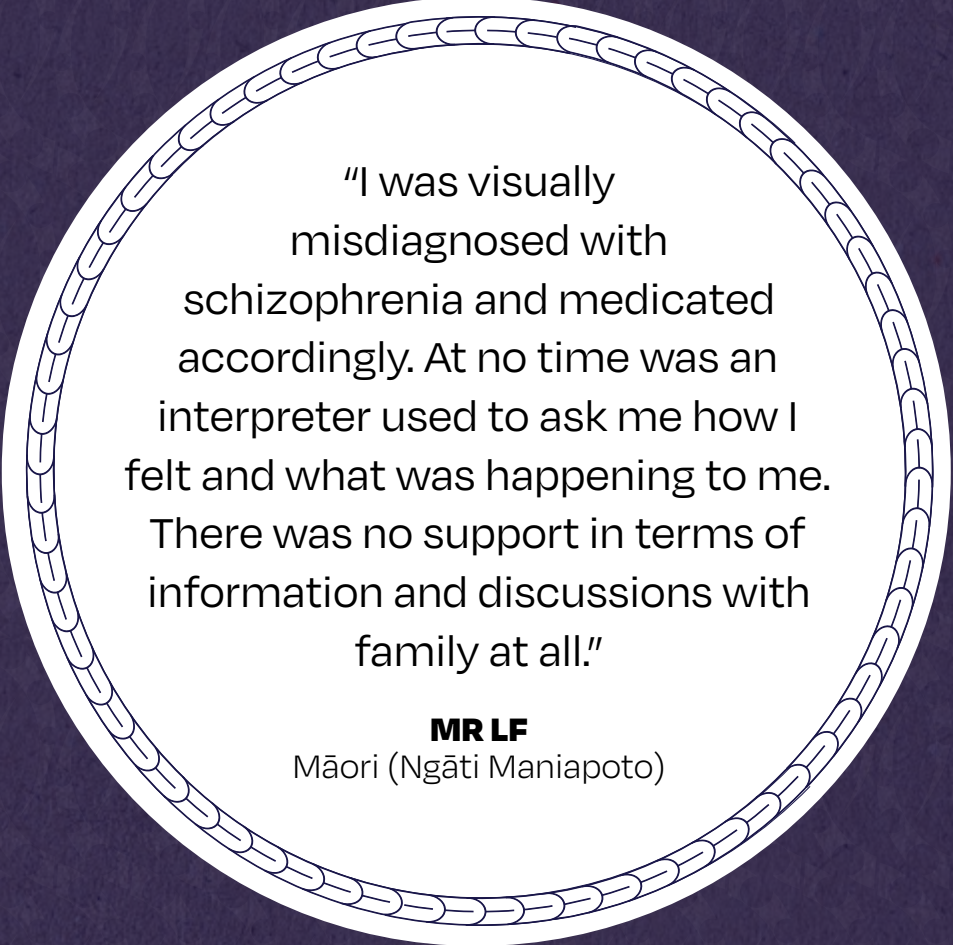
## **Survivors who experienced mental distress**

36. The Inquiry heard from approximately 321 survivors whose first entries into care were to mental health care settings. Of those:
- > 27 percent entered for troubled behaviour
  - > 15 percent entered due to mental distress
  - > 8 percent entered by State requirement due to unsafe environments, including abuse at home
  - > 4 percent entered due to neglect by parents
  - > 8 percent of survivors did not know why they entered.
  - > 8 percent were placed by their parents because they were unable to manage or care for them or for unknown reasons
  - > 4 percent of survivors entered following recommendation by authorities.
37. A small number of survivors said they had entered because they had disabilities and had no other options. Some survivors were placed into mental health care settings because of societal attitudes and discrimination based on their sexual orientation.
38. Most of the evidence the Inquiry has received from survivors relates more to experiences of entering mental health care during the 1950s to the 1980s, in the era of large-scale institutions. This pattern aligns with findings from a report the Inquiry commissioned into the size of care groups.<sup>9</sup>
39. The Inquiry has heard less about survivors' experiences of community-based mental health care and support services in the latter part of the Inquiry period, particularly the 1990s.

---

<sup>9</sup> MartinJenkins, Indicative estimates of the size of cohorts and levels of abuse in State and faith-based care: 1950 to 2019 (2020, pages 34–35), Table 10: Cohort of people within health and disability care settings and identified survivors of abuse, 1950 to 2019 and Figure 9: Cohort of people within health and disability care settings and identified survivors of abuse, 1950 to 2019.

40. Many survivors told the Inquiry that they engaged with mental health services as adults to address the impact of abuse and neglect they experienced in care when they were younger, such as experiencing mental distress. However, these survivors did not always go into detail about their subsequent pathways or experiences in these mental health care settings.
41. Just under half (45 percent) of survivors who experienced mental distress identified as Māori. These survivors experienced increased suffering through cultural abuse and neglect compared to others.
42. The Inquiry uses the term 'mental health care settings' to cover the different types of mental health services survivors spoke about. All these settings fall into the category of what would now be termed specialist services.
43. Specialist services cater to people with long term or complex needs. In the early part of the Inquiry period this meant large psychiatric hospitals and psychiatric wards attached to general hospitals. As services evolved in the 1980s and 1990s, specialist services came to include kaupapa Māori services, therapeutic groups, psychoeducational groups, and community support groups. District Health Boards (DHBs) and their predecessors were responsible for funding and delivering these services, which could be provided directly or through non-governmental organisations (NGOs).



"I was visually  
misdiagnosed with  
schizophrenia and medicated  
accordingly. At no time was an  
interpreter used to ask me how I  
felt and what was happening to me.  
There was no support in terms of  
information and discussions with  
family at all."

**MR LF**

Māori (Ngāti Maniapoto)

# Chapter 4: Context for the Inquiry period

## Māori attitudes and approaches to health and disability

44. Traditional Māori attitudes to hauora (health and wellness) had multiple dimensions, including hauora hinengaro (mental health and wellbeing), hauora tinana (physical health and wellbeing), hauora whānau (family health and wellbeing) and connection to whenua (land).
45. Wellness required a state of balance in all spiritual aspects of a person, including their tapu, mana, mauri and wairua. Traditional Māori healing operated within this broader holistic context. Tohunga (expert, healer) addressed the root cause and the symptoms rather than trying to treat a single underlying cause.<sup>10</sup>
46. The Western medical concept of disability had no equivalent within te ao Māori (the Māori world).<sup>11</sup> For example, Māori oral histories suggest that being kāpō (blind) was seen not as a disability but a source of greatness or special power to be shared with their hapū.<sup>12</sup> There is limited evidence about attitudes to disability and Deafness in te ao tawhito (the ancient Māori world).<sup>13</sup> Tāngata Turi likely experienced limited but functional participation in Māori society pre-colonisation.
47. The arrival of European missionaries and settlers disrupted Māori systems of health and wellbeing.<sup>14</sup>

## Pacific Peoples' approaches to health and disability

48. Before colonisation, Pacific cultures did not consider mental illness to come only from within a person. They viewed mental distress as 'spiritual possession' caused by the breach of a sacred covenant between people and their gods.<sup>15</sup>
49. Since colonisation and Christianity, some Pacific attitudes towards mental distress have changed. Christian perspectives tended to see disability as a punishment for sin and this may have influenced Pacific Peoples' views towards disabled people.<sup>16</sup> These beliefs express themselves in attitudes of cultural stigma and shame.<sup>17</sup>
50. Pacific Peoples still see mental distress as not just a medical issue with a physical cause but as an inseparable part of overall wellbeing involving "body, soul and spirit".<sup>18</sup>

10 Durie, M, Whaiaora: Māori Health Development (2nd edition, Oxford University Press, 1998, page 7), in Waitangi Tribunal, Ko Aotearoa tēnei: A report into claims concerning New Zealand law and policy affecting Māori culture and identity, Te taumata tuarua: Volume 2 (2011, page 602).

11 Kaiwai, H & Allport, T, Māori with disabilities (Part two): Report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Inquiry (Wai 2575), (2019, pages 17–18).

12 Tikao, K, Higgins, N, Phillips, H & Cowan, C, "Kāpo (blind) Māori in the ancient world," MAI Review, 2(4), (2009, page 11).

13 Smiler, K & McKee, RL, "Perceptions of Māori deaf identity in New Zealand," Journal of Deaf Studies and Deaf Education, 12(1) (2007, page 94).

14 Kaiwai, H & Allport, T, Māori with disabilities (Part two): Report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Inquiry (Wai 2575), (2019, page 18).

15 Suaalii-Sauni, T, Wheeler, A, Etuate, S, Robinson, G, Agnew, F, Warren, H, Erick, M & Hingano, T, "Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand," Pacific Health Dialog, 15(1), (2009, pages 18–27, page 19).

16 Ministry of Health, Pacific Peoples' experience of disability: A paper for the Pacific Health and Disability Action Plan review (2008, page 24).

17 Ministry of Health, Pacific Peoples' experience of disability: A paper for the Pacific Health and Disability Action Plan review (2008, page 24).

18 Ministry of Health, Pacific Peoples and mental health: A paper for the Pacific Health and Disability Action Plan review (2008, page 11).

## **Pākehā settler approaches to mental distress**

51. Before the mid-18th century in Britain, people who experienced mental distress were part of the community, cared for by a patchwork of family and Christian charity.<sup>19</sup> If they were thought to be a risk to themselves or others they might be cared for in a small hospital, or jailed. The State intervened sometimes in the case of landowners experiencing mental distress to protect the land title.<sup>20</sup>
52. Disruption to social structures from population growth and urbanisation meant that in the 18th and 19th centuries families were sometimes unable to care for their loved ones. This carried over to Aotearoa New Zealand. By the end of the 19th century there were gaps in Pākehā extended family networks due to people having fewer extended family members living nearby. This led the Inspector of Lunatic Asylums to complain that many patients were in the asylums only because they had no one else to look after them.<sup>21</sup> The 19th century was also when mental distress began to define a person as an identity.<sup>22</sup>
53. During the Inquiry period, ableism and disablism were strong societal attitudes. From the 19th century European settlers focused on the importance of physical and mental fitness. This drew attention to people whose bodies and minds were seen as different. These attitudes continued to influence views into the 20th century.<sup>23</sup>

## **Eugenics influenced attitudes to mental distress**

54. Eugenics was a social and political 19th and 20th century movement that believed unwanted genetic characteristics could be bred out of the human population. These characteristics included traits and behaviours considered undesirable, such as committing crimes, being poor, having sex outside of marriage and mental distress.<sup>24</sup>

---

19 Scull, A, *The most solitary of afflictions: madness and society in Britain, 1700–1900* (Yale University Press, 2005, pages 1 and 11).

20 Scull, A, *The most solitary of afflictions: madness and society in Britain, 1700–1900* (Yale University Press, 2005, pages 11–12).

21 Fairburn, M, *The ideal society and its enemies: The foundations of modern New Zealand society 1850–1900* (Auckland University Press, 1989, page 233).

22 Grinker, RR, *Nobody's normal – how culture created the stigma of mental illness* (WW Norton and Company, 2021, pages 18–19).

23 Guy, L, "'Straightening the queers' – medical perspectives on homosexuality in mid-twentieth century New Zealand", in *Health and History*, Volume 2, No 1 (2000, pages 101–120, page 108); Pratt, J, "The dark side of paradise: Explaining New Zealand's history of high imprisonment", *British Journal of Criminology* 46 (2006, pages 541–560, page 553).

24 Witness statement of Dr Hilary Stace to support evidence given at the Inquiry's Contextual Hearing (Royal Commission of Inquiry into Abuse in Care, 1 November 2019, paras 24–37); Moore, A & Tennant, M, *Who is responsible for the provision of support services for people with disabilities? A discussion paper commissioned by the National Health Committee* (1997, page 17).

55. Over the early decades of the 20th century, the eugenics movement influenced State measures to identify, classify, group and segregate disabled people and people who experienced mental distress from the rest of society.<sup>25</sup> Eugenics was condemned after the Second World War following the horrors of the Nazi regime, but its ideas still influenced laws, policies and attitudes during the Inquiry period. For instance, discussion of problem families from poor areas, the use of birth control without consent in care settings and the segregation of disabled people away from their communities all echo eugenics thinking about inherited traits and fitness for reproducing.
56. Society held a general fear of mental distress that was reinforced by the State, faiths and by widespread belief in the medical model of disability. The medical model of disability refers to disability being seen as “an individual's problem, something wrong or broken that could be cured or contained”.<sup>26</sup>

## **People who experienced mental distress often experienced lifelong poverty**

57. During the Inquiry period, people who experienced mental distress often experienced lifelong poverty that impacted their care options. They were generally excluded from mainstream work. When work was available, it was often low paid, part time or temporary, with poor working conditions and few career opportunities.<sup>27</sup>

## **Changing attitudes during the Inquiry period**

58. During the 1960s and 1970s, several groups, including Māori, human rights, gay rights and disability rights activists, placed the State's care and protection system under increased scrutiny and broadly challenged the status quo.
59. During the 1960s and 1970s, the disability rights movement challenged the government's policies and approach to the care of disabled people. Internationally, disabled people developed the social model of disability in response to the traditional medical model and attitudes.
60. The social model of disability, with its emphasis on removing attitudinal and physical barriers to participation, led to policy shifts that enabled the closure of large institutions. Deinstitutionalisation was first proposed in the third report of the Royal Commission into Hospital and Related Services in 1973. This report was highly critical of putting people into institutions and recommended community-based care.<sup>28</sup>

<sup>25</sup> Swarbrick, N, Care and carers: Care of people with disabilities (Te Ara – The Encyclopedia of New Zealand 2011, page 4), <http://www.TeAra.govt.nz/en/care-and-carers/page-4>.

<sup>26</sup> Sullivan, M & Stace, H, A brief history of disability in Aotearoa New Zealand (Office for Disability Issues, 2020, page 18).

<sup>27</sup> Beatson, P, “The seven impaired samurai: Life options for the disabled,” New Zealand Journal of Disability Studies, No 4 (1996, page 10).

<sup>28</sup> Third Report of the Royal Commission of Inquiry into hospital and related services, services for the mentally handicapped (1973, page 15).

61. From 1974, the State stopped building new psychiatric hospitals.<sup>29</sup> Existing institutions remained open and continued to be used. Closing psychiatric institutions took more than 30 years.
62. The Mental Health Foundation was established in 1977, at a time when mental distress was not generally spoken about openly. The Foundation had its roots in the belief that early developmental experiences are critical to people's lifelong mental health and was formed to promote the mental health and wellbeing of all New Zealanders.<sup>30</sup>
63. The public's fear of mental distress continued throughout the 1980s and 1990s. The 1988 Mason Report stated that:  
  
*"The general population appears to have a very distorted image of psychiatric patients. This image is influenced by a lack of education and knowledge of the major psychiatric disorders and a misconception that psychiatric illness is inextricably linked with dangerousness."*<sup>31</sup>
64. The 1980s and 1990s also featured increased recognition of the lack of appropriate care and resourcing for people who experienced mental distress. including inquiries into the mental health system in the mid-1980s and 1990s.<sup>32</sup>
65. The Aotearoa Network of Psychiatric Survivors was created in 1990 to support users of mental health services and improve the mental health system. It lobbied for deinstitutionalisation of care and community-based housing for former patients.<sup>33</sup>
66. In 1994 the State passed the Health and Disability Commissioner Act. As part of moves to ensure that consumers of health and disability services would have the right to be treated fairly, a Code of Health and Disability Consumer's Rights was produced. An independent commissioner was appointed, assisted by a free, independent national advocacy service to support people to make complaints under the code.<sup>34</sup>

<sup>29</sup> Millen, J, Breaking barriers: IHC's first 50 years (IHC New Zealand, 1999, page 81).

<sup>30</sup> Mental Health Foundation, Change in mind: Kia puawai a mua, a history of the Mental Health Foundation of New Zealand (2008, pages 12–13 and page 17).

<sup>31</sup> Mason, K, Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients (Ministry of Health, 1988, page 138).

<sup>32</sup> Mason, K, Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients (Ministry of Health, 1988); Mason, K, Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley – Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services (Information Centre, Ministry of Health, 1996).

<sup>33</sup> Sullivan, M, Disability and disability organisations (Te Ara – The Encyclopedia of New Zealand, 2018), <https://teara.govt.nz/en/disability-and-disability-organisations>.

<sup>34</sup> National Health & Disability Advocacy Service website, About us (accessed 2023), <https://advocacy.org.nz/about-the-advocacy-service/>.

67. The 1992 Mental Health Act established the Mental Health Review Tribunal, an independent body appointed by the Minister of Health to decide among other things, whether patients are fit to be released from compulsory status, investigate complaints about breaches of patient rights, and appoint second-opinion psychiatrists.<sup>35</sup>

## **Frameworks for State mental health care**

68. The Mental Defectives Act 1911 set out the conditions for admission into mental health settings until it was replaced by the Mental Health Act 1969. The Mental Defectives Act 1911 was the first legislation in Aotearoa New Zealand to categorise types of disability, long-term health conditions and mental distress. The Act arranged 'mental defectives' into six categories including persons of unsound mind.<sup>36</sup> This was extended by the Mental Defectives Amendment Act 1928 to include a seventh category: persons socially defective (defined as anti-social behaviour requiring supervision).<sup>37</sup>
69. Decisions about how the mental health care system operated were usually made at a national level by the Minister of Health or the Director-General of Health or the Department of Health.<sup>38</sup> Ultimate accountability for the mental health care system sat with the Minister of Health, who provided overall direction, oversight and control over the system.<sup>39</sup>
70. During the Inquiry period, decisions about what mental health care should look like and how it should be delivered and funded sat variously with the Department of Health (followed by the Ministry of Health from 1993 onwards) and Division of Mental Health / Mental Hygiene, the Director-General of Health and the Director of Mental Hygiene / Mental Health, and a range of devolved decision-makers including Hospital Boards, Area Health Boards and Crown Health Enterprises.<sup>40</sup>
71. The Director-General of Health was the chief administrative officer of the department, and the Ministry of Health from 1993. Reporting to the Director-General was the Director of Mental Hygiene, later Director of Mental Health, who had specific legislative obligations relating to people in disability and mental health care.<sup>41</sup>

---

35 Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 101 and 102(1).

36 Mental Defectives Act 1911, section 2, (I-VI).

37 Mental Defectives Amendment Act 1928, section 7.

38 Parliamentary Library, New Zealand health system reforms (Parliamentary Library research paper, 2009, pages 2–3).

39 Parliamentary Library, New Zealand health system reforms (Parliamentary Library research paper, 2009, pages 2–3).

40 Brief of evidence of Dr John Crawshaw (1 April 2021, page 7).

41 Mental Defectives Act 1911, section 5; Mental Health Act 1969, section 3; Mental Health (Compulsory Assessment and Treatment) Act 1992.

72. Until 1983, hospital services were provided by District Health Offices and Hospital Boards. From 1983 to 1993 there was a decentralisation of purchasing and provision of health care away from the Department of Health to Area Health Boards, and with further reform this changed again to Regional Health Authorities and Crown Health Enterprises and the establishment of Needs Assessment and Service Coordination agencies. In 1998, further reform created the Health Funding Authority and Hospital and Health Services.<sup>42</sup>
73. More localised decisions about how specific institutions or third-party providers should be run were made by individuals such as superintendents or medical officers, or devolved decision-makers such as Area Health Boards and Crown Health Enterprises.
74. In 1992 the Needs Assessment and Service Coordination system was set up after a review of the existing disability support services.<sup>43</sup> The funding and delivery of existing support services were redistributed across the four Regional Health Authorities.<sup>44</sup>
75. Under this system, disabled people (including people experiencing mental distress) needed to be assessed to see what funding they were eligible for. This funding then determined the support and resources they could access.<sup>45</sup>

## **Mental health settings**

76. By 1957, Aotearoa New Zealand had 11 psychiatric hospitals – Kingseat Hospital in Karaka, Carrington (later called Oakley) Hospital in Tāmaki Makaurau Auckland, Tokanui Hospital located south of Te Awamutu, Lake Alice Hospital in Rangitikei, Porirua Hospital in Te Whanganui-ā-Tara Wellington, Braemar Hospital in Whakatū Nelson, Sunnyside Hospital in Ōtautahi Christchurch, Seaview Hospital in Hokitika, and Seacliff, Wakari and Cherry Farm Hospitals in Ōtepoti Dunedin.
77. These hospitals largely offered an inpatient service, where people stayed for treatment. They also took disabled people as patients, largely people with a learning disability. The experiences of disabled people are detailed in the Inquiry's final report, Whanaketia – through pain and trauma, from darkness to light, the case study on the Kimberley Centre, Out of Sight, Out of Mind, and the summary on disabled survivors' experiences of abuse and neglect in care.

---

42 Brief of evidence of Dr John Crawshaw on behalf of the Ministry of Health at the Inquiry's Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 1 April 2021, para 3.24).

43 Shipley, J & Upton, S, Support for independence for people with disabilities – A New Deal (Ministers of Health and Social Welfare, 1992).

44 Sullivan, M & Stace, H, A brief history of disability in Aotearoa New Zealand (Office for Disability Issues, 2020, page 15).

45 Sullivan, M & Stace, H, A brief history of disability in Aotearoa New Zealand (Office for Disability Issues, 2020, page 15).

78. From the 1970s, psychiatric experts increasingly stressed the importance of community and outpatient care for people experiencing mental distress. As in the disability sector, the shift to the provision of community mental health care and services was slow.<sup>46</sup>
79. By 1999, almost all the large-scale psychiatric institutions had closed their doors. Cherry Farm Hospital in Ōtepoti Dunedin closed in 1992, Tokanui Hospital located south of Te Awamutu closed in 1998 and Kingseat Hospital in Karaka closed in 1999.<sup>47</sup> Mental health services were largely devolved to inpatient care in local hospitals, outpatient hospital services and a range of smaller-scale community providers, including support services provided by non-government organisations, offering residential care or specialist programmes.<sup>48</sup>
80. Inpatient teams, such as in psychiatric wards attached to general hospitals, made up a smaller part of the mental health system, undertaking close observation, intensive investigation or intervention.<sup>49</sup>
81. Given the multidisciplinary nature of the mental health and addiction sectors over time, a range of teams (including community mental health teams) may have been involved in an individual's pathway through the mental health care system.
82. While Māori mental health programmes and service providers began to emerge from the 1980s,<sup>50</sup> State mental health services were predominately Eurocentric and not culturally responsive to tāngata whaiora Māori.<sup>51</sup>

46 Warwick, B, Mental health services (Te Ara, 2022, pages 8–9).

47 Coleborne, C, "Preserving the institutional past and histories of psychiatry: Writing about Tokanui Hospital, New Zealand, 1950s–1990s," Health and History 5, No 2 (2003, page 111).

48 Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, page 10).

49 Warwick, B, Mental health services (Te Ara, 2022, page 11).

50 For example: The Māori mental health unit, Te Whai Ora, was established within Tokanui Psychiatric Hospital in the mid-1980s, Cram, F, Te Huia, B, Te Huia, T, Williams, M & Williams, N, Oranga and Māori health inequities 1769–1992 (Waitangi Tribunal, 2019, page 103). In the late 1980s, te Whare Paia was established as a Māori mental health unit in a large old villa on the Carrington Hospital grounds as the larger hospital institution closed down, Transcript of evidence of Ron Baker from the Kaupapa Māori Panel (20 July 2022, page 641).

51 Kaiwai, H & Allport, T, Māori with disabilities (Part two): Report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Inquiry (Wai 2575), (Waitangi Tribunal, 2019, page 27); Bathgate, M, Donnell, A & Mitikulea, A, The health of Pacific Islands people in New Zealand: Analysis and monitoring report 2 (Public Health Commission, 1994, pages 148–149); Cram, F, Te Huia, B, Te Huia, T, Williams, M & Williams, N, Oranga and Māori health inequities 1769–1992 (Waitangi Tribunal, 2019, page 103).

83. The monocultural nature of mental health services presented language and cultural barriers,<sup>52</sup> which meant that they were often not culturally safe for Pacific Peoples and their families. Cultural safety for Pacific Peoples could also include religious safety. One study published in 2000 on the experience of eight Pacific service users within a mental health setting found that religious safety was often not achieved, particularly in the context of inpatient services such as acute wards. Author Malo Vito described a cultural religious difference that contributed to incorrect interpretations:

*“Any type of religious or cultural behaviour which might be deemed over the top, delusional or psychotic in a psychiatric service would be just eccentric, or extreme within Pacific Islands communities. Pacific Islanders’ vocal praise and worship could be seen as ranting and raving within the confines of an acute ward.”*<sup>53</sup>

## **Health professionals and other care workers**

84. Day to day decisions about people in mental health care settings were made by medical professionals and other health care workers who made decisions about individual treatment, care and other daily activities. These decision-makers included doctors, psychiatrists, nurses and other health care workers.

## **How people entered mental health settings**

85. The Mental Defectives Act 1911 set out the conditions for admission of people who experienced mental distress into mental health care settings until it was replaced by the Mental Health Act 1969. Both Acts provided the legal authority for admission to an institution, either compulsorily (against the person’s will) or voluntarily (by choice).<sup>54</sup>
86. For people who experienced mental distress, placement in mental health care settings was often compulsory. People were placed in mental health care settings by order of the court, on an emergency basis, or through the criminal justice system. Sometimes people entered voluntarily or on the advice of their family or clinician.<sup>55</sup>
87. The Mental Health (Compulsory Assessment and Treatment) Act 1992 led to substantial changes in New Zealand’s mental health care system. It put more importance on the rights of patients, recognising the role of cultural factors in diagnosis and treatment and the right to appeal treatment.<sup>56</sup>

<sup>52</sup> Malo, V, Pacific people in New Zealand talk about their experiences with mental illness (Mental Health Commission, 2000, page 21).

<sup>53</sup> Malo, V, Pacific people in New Zealand talk about their experiences with mental illness (Mental Health Commission, 2000, page 22).

<sup>54</sup> Mental Defectives Act 1911, section 16(b).

<sup>55</sup> Mental Defectives Act 1911, section 39(1), Mental Health Amendment Act 1958, section 2.

<sup>56</sup> Brief of Evidence of Dr John Crawshaw (1 April 2021, pages 3–4).

88. The 1992 Act still enabled compulsory mental health assessment or treatment, if someone was judged to be a serious danger to themselves or others, or unable to take care of themselves.<sup>57</sup> Mentally distressed patients could also be compulsorily assessed and treated in the community.
89. The Director of Mental Health became responsible for administration of the Mental Health Compulsory Assessment and Treatment Act 1992.<sup>58</sup> The Director-General of Health could also appoint a director of area mental health care services for each region, to lead the mental health workforce for their area.<sup>59</sup>

## Data

90. The Inquiry found little reliable data about people with disability and mental distress before or during the Inquiry period. The most recent substantial dataset prior to the Inquiry period was the 1916 Census results, which documented a much narrower range of impairments compared to modern standards.
91. Of the total population of Aotearoa New Zealand in 1916, 6,359 people were recorded as having one or more of the following impairments: 206 people were recorded as deaf-mutes, 566 people recorded as blind, 4,275 people recorded as lunatics, and 1,312 people recorded as feeble-minded.
92. By 1996 out of a total of population of 3,618,303 people, 517,212 (14 percent) indicated they or their dependents were disabled. Of this, 411,477 indicated they or their dependents had a long-term disability.

## General rates of admission

93. Rates of admissions into psychiatric hospitals increased rapidly during the 1940s and 1950s, reaching a peak in the 1960s and falling gradually over the 1970s:
  - > in 1953, approximately 9,700 people (478 per 100,000 of NZ population)<sup>60</sup>
  - > in 1966, approximately 10,600 people (397 per 100,000 of NZ population)<sup>61</sup>
  - > in 1971, approximately 10,100 people (355 per 100,000 of NZ population)<sup>62</sup>
  - > in 1976, approximately 8,500 people (270 per 100,000 of NZ population)<sup>63</sup>
  - > in 1981, approximately 8,000 people (257 per 100,000 of NZ population).<sup>64</sup>

<sup>57</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 28 and 29.

<sup>58</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, section 91.

<sup>59</sup> Ministry of Health, Office of the Director of Mental Health Annual Report 2013 (Ministry of Health 2013, page 6).

<sup>60</sup> Stats NZ, The New Zealand Official Yearbook 1955 (page 68).

<sup>61</sup> Department of Health, Survey of occupied psychiatric hospital beds and psychiatric day and outpatients, 1976, Special Report No 55 (Government Printer, 1979, pages 2–3).

<sup>62</sup> Department of Health, Survey of occupied psychiatric hospital beds and psychiatric day and outpatients, 1976, Special Report No 55 (Government Printer, 1979, pages 2–3).

<sup>63</sup> Department of Health, Survey of occupied psychiatric hospital beds and psychiatric day and outpatients, 1976, Special Report No 55 (Government Printer, 1979, pages 2–3).

<sup>64</sup> Department of Health, Survey of occupied psychiatric hospital beds and psychiatric day and outpatients, 1981, Special Report No 66 (Government Printer, 1983, page 4).

94. The ethnic makeup of people who entered psychiatric hospitals fluctuated over this period.

### **Rates of Māori entering mental health care increased**

95. As with disability care, whānau Māori have traditionally preferred to look after family members experiencing mental distress at home, rather than placing them in mental health settings.<sup>65</sup> In 1909, Māori made up just over 1 percent of psychiatric inpatients nationwide, rising to 1.8 percent in 1938. Ten years later, in 1948, this had increased to 2.6 percent. This figure represented 20.8 people per 10,000 population for Māori, while for non-Māori the figure was 51 people per 10,000.<sup>66</sup>
96. From the early 1960s, both Māori and non-Māori rates of admission to mental health care settings increased.<sup>67</sup> Non-Māori admission rates stabilised in the mid-1960s and then declined during the 1970s and 1980s, but Māori rates of admission increased throughout the 1960s, stabilised in the 1970s, and rose again throughout the 1980s.<sup>68</sup>
97. From 1970 to 1987, tamariki Māori (10 to 19 years old) and rangatahi Māori (20–29 years old) were admitted to mental health care at a rate approximately one and a half times higher than non-Māori. The rate of rangatahi Māori admission was approximately double the non-Māori admission rate in the mid-1980s.<sup>69</sup>
98. By the mid-1980s, Māori made up 14 percent of all psychiatric admissions despite making up only seven percent of the population.<sup>70</sup> From 1960 to 1990, while “non-Māori first-time admissions to mental health facilities had only slightly increased”, the Māori rate increased by more than 200 percent.<sup>71</sup> By the late 1990s, the high rates of mental distress and conditions among Māori were described as a crisis of “unprecedented proportions”.<sup>72</sup> In 1999, for example, 50 percent of forensic inpatient service users and 29 percent of community-based service users were Māori.<sup>73</sup>

65 Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, pages 6–7).

66 Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, page 6).

67 Cram, F, Te Huia, B, Te Huia, T, Williams, M & Williams, N, Oranga and Māori health inequities 1769–1992, A report commissioned by the Ministry of Health for stage two of the Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B25), (Waitangi Tribunal, 2019, page 111); Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, page 8).

68 Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry, Waitangi Tribunal (Wai 2575, B26), (Waitangi Tribunal, 2019, page 8).

69 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 14).

70 Cram, F, Te Huia, B, Te Huia, T, Williams, M & Williams, N, Oranga and Māori health inequities 1769–1992, A report commissioned by the Ministry of Health for stage two of the Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B25), (Waitangi Tribunal, 2019, page 112).

71 Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry, Waitangi Tribunal (Wai 2575, B26), (Waitangi Tribunal, 2019, page 12).

72 Māori Health Commission, Tihei Mauri Ora! Report of the Māori Health Commission (1998, page 14).

73 Ministry of Health Review of forensic mental health services: Future directions (2010, page 16, Table 2).

99. The increase in Māori admissions was partly attributed to the worsening state of mental health among Māori, and Māori accessing mental health care at a later stage of distress. Scholars attribute the worsening state to a range of factors, including alienation from traditional whānau and hapū support systems, poor access to primary health care, a lack of culturally appropriate services, racism and poverty.<sup>74</sup>
100. Studies from the 1990s found Māori adults were more likely to be admitted to psychiatric units through the justice system, after coming to the attention of law enforcement agencies; Māori were about two to three times more likely to receive referrals from law enforcement agencies than non-Māori.<sup>75</sup>

### **Numbers of Pacific Peoples in mental health settings unclear**

101. During the Inquiry period there was limited data on the admission of Pacific fanau (children), tagata talavou (young people) and tagata matua (adults) to mental health care or the duration of their stay.
102. Data from 1984 showed that Pacific adults aged 15 years old and over were represented in psychiatric admissions at rates close to their proportion in the general population. Pacific tagata talavou and tagata matua comprised 2.3 percent of the national population but only two percent of admissions to psychiatric care.<sup>76</sup> However, research throughout the 1980s and 1990s found that Pacific patients who entered mental health care were more likely to be formally committed and were also more likely than non-Pacific people to be readmitted.<sup>77</sup> Leota Dr Lisi Petaia's evidence to the Inquiry notes that one of the first interactions that Pacific Peoples usually have with mental health facilities is through the justice system.<sup>78</sup>
103. In 1999, seven percent of forensic inpatient users and five percent of community-based service users were Pacific Peoples. These figures indicate an overrepresentation in these mental health settings compared with the general population.<sup>79</sup>

<sup>74</sup> Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, pages 17–18).

<sup>75</sup> Gassin, T, Māori mental health: A report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, B26), (Waitangi Tribunal, 2019, pages 8, 12); Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 14).

<sup>76</sup> Bathgate, M, Donnell, A & Mitikulena, A, The health of Pacific Islands people in New Zealand: Analysis and monitoring report 2 (Public Health Commission, 1994, page 146).

<sup>77</sup> Mason, K, Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients (Ministry of Health, 1988, page 29); Bathgate, M, Donnell, A, & Mitikulena, A, The health of Pacific Islands people in New Zealand: Analysis and monitoring report 2 (Public Health Commission, 1994, pages 146–147).

<sup>78</sup> Witness statement of Leota Dr Lisi Kalisi Petaia (12 July 2021).

<sup>79</sup> Review of forensic mental health services: Future directions (Ministry of Health, 2010, pages 16–17, Table 2).

## Entries into forensic mental health settings

104. During the 1990s regionally based forensic psychiatric services were developed which existed at the interface of the mental health and criminal justice sectors.<sup>80</sup> This pathway was significant for survivors experiencing mental distress, and / or with learning disability and / or neurodiversity, where it was relevant to their offending.
105. Entry into forensic services involves an individual being charged with a criminal offence and subsequently being referred to this specialised mental health setting for assessment and treatment.<sup>81</sup> Sometimes individuals were transferred from prison to mental health settings, including forensic wards, because they were considered unwell and in need of treatment.<sup>82</sup>
106. A 1999 review of forensic services found that most service forensic users have offences that are classed as 'serious' (violent or sexual). The review also found that the most common referral pathway into this setting has been through the courts, with prison being the second highest referral source.<sup>83</sup>
107. While forensic service users can be inpatients or community-based, forensic services remain more institutionally focused compared to other adult mental health services.<sup>84</sup>
108. The 1999 review found all but one inpatient service user was 'under legislation', such as the Criminal Justice Act 1985 or the Mental Health (Compulsory Assessment and Treatment) Act 1992.<sup>85</sup> While 41 percent of outpatients had informal or voluntary legal status, many had previously been inpatients under one of these Acts.<sup>86</sup>

---

80 Ministry of Health, Review of forensic mental health services: Future directions (2010, page 8).

81 Ministry of Health, Review of forensic mental health services: Future directions (2010, page 8).

82 See for example: Mental Defectives Act 1911, section 38, Mental Health Act 1969, section 43 and Mental Health (Compulsory Assessment and Treatment) Act 1992, section 46; Witness statement of Ms BU (4 October 2022, paras 8.12–8.15).

83 Ministry of Health, Services for people with mental illness in the justice system: Framework for forensic mental health services (2001, page 10).

84 Ministry of Health, Review of forensic mental health services: Future directions (2010, page 9).

85 Ministry of Health, Services for people with mental illness in the justice system: Framework for forensic mental health services (2001, page 10).

86 Ministry of Health, Services for people with mental illness in the justice system: Framework for forensic mental health services (2001, page 11).

# Chapter 5: Circumstances for people experiencing mental distress being admitted into care

109. In the early part of the Inquiry period, psychiatry was still an emerging discipline. Psychiatrists lacked some of the tools and understanding of today, not only to diagnose and treat conditions, but also of difference and diversity.
110. Medical disciplines, including psychiatry, operated within a predominately Western health care system, driven by a biomedical model of understanding and approach to health, including mental health and disability.
111. Prejudice and a lack of knowledge and understanding of different behaviours or conditions saw some people admitted to mental health care settings for reasons that would be viewed as inappropriate today, including admissions based on punitive, sexist, homophobic and racist attitudes and misunderstood behaviours.<sup>87</sup>
112. During the Inquiry's State Institutional Response Hearing, Director-General of Health Dr Diana Sarfati acknowledged:

*"Societal stigma against people with mental health conditions and learning disabilities was a contributing factor to people being placed in psychiatric settings during the 1950s-1970s, and I acknowledge that people (including children and young people) were placed in psychiatric hospitals and facilities for reasons that would not be acceptable today."*<sup>88</sup>

<sup>87</sup> Witness statements of Alison Pascoe (29 April 2022, paras 2.25–2.27) and Ms LV (14 February 2023, para 7); Private session transcript of Ms SD (1 December 2020, page 7).

<sup>88</sup> Transcript of evidence of Director-General of Health and Chief Executive Dr Diana Sarfati for the Ministry of Health at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 207).

## Trauma and disadvantage

113. Survivors told the Inquiry that, before entering mental health care settings or engaging with mental health care services, they experienced trauma and adversity, including in childhood and adolescence.
114. Māori survivor Ms LW had been experiencing mental distress from the trauma of sexual abuse and was 18 when her mother took her to a doctor who sent her for assessment at Wellington Hospital; that same day she was placed at Porirua Hospital.<sup>89</sup> Māori survivor Ms OF (Ngāti Kahungunu) became “depressed and angry” after being sexually abused by a friend’s father and struggling with her sexuality. She was sent to Ward 12 Southland Hospital in Waihopai Invercargill after attempting to take her own life when she was aged 16.<sup>90</sup>
115. Most survivors who talked to the Inquiry about mental health care pathways also had a history of State or faith-based care.<sup>91</sup> The majority of these survivors experienced trauma in these care settings.<sup>92</sup>
116. NZ European survivor Robert Donaldson experienced sexual abuse by Father Magnus Murray from age 7 to 17 years old, whom he had met through his family’s involvement with St Bernadette’s Church in Ōtepoti Dunedin.<sup>93</sup> After having a breakdown as an adult in the 1980s, Robert was admitted to Cherry Farm Psychiatric Hospital in Ōtepoti Dunedin, where he suffered further physical abuse.<sup>94</sup>
117. For some survivors admitted into mental health care, authority figures (including medical professionals) appear to have misdiagnosed their conditions due to a lack of understanding of the survivor’s experiences, behaviours, and emotions.<sup>95</sup> Māori survivor Terry King was admitted to Ngawhatu Hospital in Whakatū Nelson at 14 years old because he kept running away from his abusive home. He had suffered sexual and physical abuse from priests at St Joseph’s School in Waihi and St Mary’s School in Tauranga, as well as from his stepfather. His reports of abuse were not believed by medical staff, and instead Terry was diagnosed as “Feeble minded, with Schizoid Personality”<sup>96</sup> almost one month after being admitted.<sup>97</sup>

<sup>89</sup> Witness statement of Ms LW (27 June 2022, paras 1.14 and 1.15).

<sup>90</sup> Witness statement of Ms OF (21 November 2022).

<sup>91</sup> Witness statements of Mr SN (10 March 2021, para 7); Mr AA (9 March 2021, para 1); Mr II (21 March 2021, para 3) and Mr HH (24 March 2021, paras 7–10); Witness statements of Mr HZ (8 April 2021, para 7); Ms AV (13 September 2020, para 6); Steven Storer (24 May 2021, para 3) and Mr MM (11 August 2021, paras 86–88).

<sup>92</sup> Witness statements of Danny Akula (7 October 2021, paras 107–108); Robert Donaldson (24 August 2020, para 1.5); Tyrone Marks (10 March 2021, para 4); Mr SN (10 March 2021, para 7); Mr AA (9 March 2021, para 1); Mr II (21 March 2021, para 3) and Mr HH (24 March 2021, paras 7–10); Witness statements of Mr HZ (8 April 2021, para 7); Ms AV (13 September 2020, para 6); Steven Storer (24 May 2021, para 3) and Mr MM (11 August 2021, paras 86–88).

<sup>93</sup> Witness statement of Robert Donaldson (24 August 2020, para 1.5).

<sup>94</sup> Witness statement of Robert Donaldson (24 August 2020, para 3.10).

<sup>95</sup> Witness statement of Rodney Davis (23 November 2022, para 1.15).

<sup>96</sup> Appendix to the witness statement of Terry King (10 August 2021, para 42), Letter from medical officer to doctor at Wakefield (11 August 1967).

<sup>97</sup> Appendix to the witness statement of Terry King (10 August 2021, paras 40–42), Letter from medical officer to doctor at Wakefield (11 August 1967).

## Behaviour, neurodiversity and disability

118. Neurodiverse children and young people and people with sensory or learning disabilities, traumatic brain injury or foetal alcohol spectrum disorder, often came to the attention of authorities because of their behaviours. These behaviours could be wrongly labelled as naughtiness, delinquency or even contribute to diagnosis of a mental health condition, which could increase the likelihood of an individual being placed into a mental health care setting.<sup>98</sup> This was particularly the case for tamariki and rangatahi Māori, who were often placed into mental health care from home or social welfare residences where authorities took a racist approach and so were less tolerant with their behaviour. As described in the Inquiry's final report, Whanaketia – Through pain and trauma, from darkness to light, discriminatory and racist attitudes contributed to tamariki and rangatahi Māori being considered deviant and criminal.
119. Porirua Hospital set up a unit for autistic people in the 1970s as this diagnosis began to increase.<sup>99</sup> Tāngata Turi Māori survivor Mr LF (Ngāti Maniapoto) who had Asperger's syndrome was admitted to Sunnyside Hospital in Ōtautahi Christchurch when he was 21 years old. He stayed at the hospital on and off over a period of approximately 11 years:

*"I was visually misdiagnosed with schizophrenia and medicated accordingly. At no time was an interpreter used to ask me how I felt and what was happening to me. There was no support in terms of information and discussions with family at all."*<sup>100</sup>

120. In a paper prepared for the Inquiry, Dr Olive Webb explained that until around 1980, children and young people with autism were often diagnosed with a psychiatric condition, "childhood schizophrenia":

*"The expected mode of intervention was medical, and that means, during these times, antipsychotic, sedating medication. The intense anxiety experienced by people with ASD would not be recognised as such, and escalations of behaviour would be seen as manifestations of psychosis. In keeping with treatment of people with psychiatric conditions, restraint and seclusion would occur to manage out-of-control behaviour."*<sup>101</sup>

<sup>98</sup> See Royal Commission of Inquiry into Abuse in Care, Beautiful children, Inquiry into the Lake Alice Child and Adolescent Unit (2022).

<sup>99</sup> Witness statement of Dr Hilary Stace for the Inquiry's Contextual Hearing (October / November 2019, page 12, para 46).

<sup>100</sup> Witness statement of Mr LF (13 February 2020, para 3.2).

<sup>101</sup> Webb, OJ, The likely impact of prevailing conditions and environments on people now considered to be neurodiverse, between 1950 and 1990: A paper prepared for the Royal Commission into Abuse in State Care (25 November 2022, pages 8–9, para 3.a.iii).

## Young people transferred from social welfare settings

121. The State sometimes transferred children and young people from social welfare residences into mental health care settings. This was in response to actual or perceived mental, emotional, and / or behavioural issues. Sometimes this was for short periods of observation.<sup>102</sup>
122. Pākehā survivor Beverly Wardle-Jackson, who was placed into girls homes and experienced physical abuse in care, was later placed in psychiatric care. Beverly told the Inquiry:
- “Like a lot of girls who went into care, I ended up in psychiatric hospital care – first Ward 27 at Wellington Hospital and then Porirua Hospital, where I stayed on and off from 1967 to 1973, and later Oakley Hospital. In between admissions, I went to other places – often back to various girls homes. Each time, I was returned to Porirua Hospital when my behaviour was perceived to be ‘difficult’. I was just a lonely, isolated teenage girl.”*<sup>103</sup>
123. In the late 1960s between 20 and 30 percent of girls discharged from Fareham House in Pae-Tū-Mōkai Featherston were transferred directly to psychiatric hospitals.<sup>104</sup> Admissions of girls into mental health care settings were often influenced by gendered discrimination, including being demonised for not living up to societal expectations of girlhood and womanhood. This is discussed further in Part 4 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*.

<sup>102</sup> Sworn statement of Ernest Lester McCuish (31 March 1978); Witness statement of Sonja Cooper and Sam Benton of Cooper Legal relating to the inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (8 October 2021); Tollemache, EM, Letter from the acting deputy chair of the Welfare Office to the superintendent at Kingslea regarding the proposed admission of a patient to Kingslea (15 January 1966, page 2); Witness statements of Tyrone Marks (22 February 2021, para 52); Ms MC (9 June 2022, paras 2.54–57); Mr FP (10 March 2022, para 46) and Ms MV (28 July 2022, para 4.24); Private session transcript of Matthew Hohipa (4 March 2020, page 10); Private session transcript of Peter Saffill (20 July 2020, pages 50–51).

<sup>103</sup> Witness statement of Beverly Wardle-Jackson (7 November 2019).

<sup>104</sup> Stanley, E, *The road to hell: State violence against children in postwar New Zealand* (Auckland University Press, 2016, page 67).

124. By the 1970s, some social welfare residences had regular visits from psychological services, which could prompt assessment, referrals, and transfer of children and young people to other psychiatric or psychopaedic settings such as hospitals.<sup>105</sup> A 2006 Ministry of Social Development report, *Social Welfare Residential Care (1950–1994)* examined the departmental and institutional practices in social welfare residences. This report noted a small but significant group of children and young people in social welfare residences that had either come from, or went on to, a psychiatric hospital.<sup>106</sup> Examples given of this connection between social welfare and psychiatric institutions included:
- Hokio Beach School near Taitoko Levin, Holdsworth Boys' Home in Whanganui and Lake Alice Child and Adolescent Unit in Rangitikei
  - Allendale Girls' Home in Tāmaki Makaurau Auckland and the psychiatric ward at Auckland Hospital
  - Kohitere Boys' Training Centre in Taitoko Levin, Epuni Boys' Home in Te Awa Kairanga ki Tai Lower Hutt, Miramar Girls' Home in Te Whānganui-ā-Tara Wellington and Porirua Hospital.<sup>107</sup>
125. This pattern was also clear in the evidence survivors gave to the Inquiry. As discussed in the Inquiry's report, *Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit*, the Inquiry found the Department of Social Welfare paid insufficient attention to whether it had lawful authority to consent to the informal admission of children and young people to a psychiatric hospital.<sup>108</sup>
126. Survivors believed they were sometimes admitted from social welfare residences to nearby psychiatric or psychopaedic settings as punishment for unwanted behaviour, especially running away.<sup>109</sup> Survivor Alan Nixon, who had been running away from Kohitere Boys' Training Centre in Taitoko Levin, was sent to Lake Alice and placed into the adolescent ward for observation when he was aged 16. Alan told the Inquiry he received 'two jolts' of electric shocks without muscle relaxant or anaesthetic "as punishment for not telling the Lake Alice staff the reasons why I kept running away".<sup>110</sup> After a month at Lake Alice, where he experienced further abuse and neglect, Alan was sent back to Kohitere Boys' Training Centre.<sup>111</sup>

<sup>105</sup> Statement of Michael Ferriss (27 April 2021, paras 80–84).

<sup>106</sup> Parker, W, *Social Welfare residential care 1950–1994*, Volume I (Ministry of Social Development, 2006, page 56).

<sup>107</sup> Parker, W, *Social Welfare residential care 1950–1994*, Volume I (Ministry of Social Development, 2006, page 56–57).

<sup>108</sup> Royal Commission of Inquiry into Abuse in Care, *Beautiful children, Inquiry into the Lake Alice Child and Adolescent Unit* (2022, para 69).

<sup>109</sup> Royal Commission of Inquiry into Abuse in Care, *Beautiful children, Inquiry into the Lake Alice Child and Adolescent Unit* (2022, para 70).

<sup>110</sup> Witness statement of Alan Nixon (8 October 2021, paras 91–93).

<sup>111</sup> Witness statement of Alan Nixon (8 October 2021, para 97).

127. Former psychiatrist Dr Ken Bragan described how the courts sent “delinquent adolescents” to Sunnyside Hospital in Ōtautahi Christchurch.<sup>112</sup> Māori survivor Susan Kenny (Ngāti Apa) had already been labelled as delinquent due to her behaviour following sexual abuse and other trauma. She was placed at Sunnyside after a minor incident at Kingslea Girls’ Home in Ōtautahi Christchurch:

*“One day at Kingslea, I can remember exercising in the courtyard and a shuttlecock went on the roof. I got up on a chair to get it. A staff member came and grabbed me, and I kicked back. I remember getting an injection. I think it was after that I went to Sunnyside.”*<sup>113</sup>

128. The Inquiry also heard from a clinical psychologist, and former staff member at Holdsworth School in Whanganui, that boys were transferred from the school to Lake Alice Child and Adolescent Unit in Rangitikei as punishment for misbehaviour.<sup>114</sup>
129. Retired police aid youth worker Mr LX recalled a points system at Holdsworth School, which determined whether boys were sent home or released. He asked the principal what the negative points on the board meant and was shocked with the response: “Oh then that inmate goes to Lake Alice for treatment and let me tell you he comes back with a much better attitude.”<sup>115</sup>
130. Some former staff of psychiatric institutions told the Confidential Forum for former in-patients of psychiatric hospitals that, on occasion, people with no diagnosed mental health conditions ended up in psychiatric hospitals due to capacity pressures in other care settings, including social welfare residences.<sup>116</sup>

## Gender discrimination

131. Pathways into mental health care settings could also be gendered. Women and girls’ admissions sometimes reflected prevailing societal norms and attitudes about women’s gender roles, mothering, pregnancy, miscarriage, childbirth, sexuality and marital difficulties.<sup>117</sup> The Confidential Listening and Assistance Service found that young women admitted to psychiatric hospitals for post-partum depression often stayed for many years.<sup>118</sup>

<sup>112</sup> Witness statement of Dr Ken Bragan (19 February 2021, para 12).

<sup>113</sup> Witness statement of Susan Kenny (15 July 2021, para 91).

<sup>114</sup> Witness statement of John Watson (15 January 2021, para 17).

<sup>115</sup> Witness statement of Mr LX (20 October 2020, para 17).

<sup>116</sup> 108 Mahony, P, Dowland, J, Helm, A & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 31).

<sup>117</sup> Witness statement of Mary O’Hagan (14 October 2019, para 24).

<sup>118</sup> The Confidential Listening and Assistance Service, *Some memories never fade: Final report of The Confidential Listening and Assistance Service* (Department of Internal Affairs, 2015, page 29).

132. Discrimination against women and girls could also intersect with racism. Young girls at Fareham House in Pae-Tū-Mōkai Featherston, who were predominately Māori, were given medication in an effort to “establish acceptable patterns of behaviour.”<sup>119</sup> As discussed above, the Inquiry heard that 20 to 30 percent of girls at Fareham House went on to be admitted to mental health hospitals.<sup>120</sup>
133. The Inquiry’s summary report on the experiences of women and girls in State and faith-based care has more detail on the gendered reasons for entries into mental health settings.

## **Homophobia and discrimination**

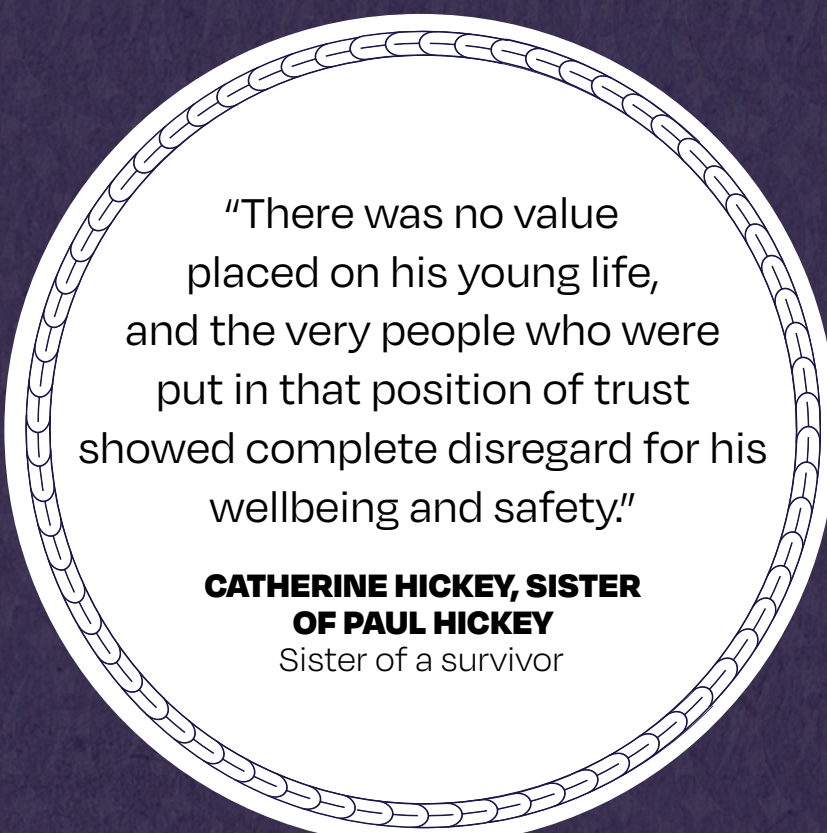
134. Discrimination towards people with diverse gender identities and/or sexual orientation resulted in people from the Takatāpui, Rainbow and MVPFAFF+ communities being admitted to mental health settings.<sup>121</sup> Until 1973, the Diagnostic and Statistical Manual of Mental Disorders categorised homosexuality as a mental health disorder. This, coupled with the criminalisation of homosexuality (until homosexual law reform was passed in New Zealand in 1986), established a pathway for Takatāpui, Rainbow and MVPFAFF+ communities into mental health care settings.<sup>122</sup>
135. Religious attitudes that conceptualised homosexuality as a mental health issue also forced Takatāpui, Rainbow and MVPFAFF+ to engage in mental health care and treatment, particularly for Pacific Peoples.
136. The Inquiry’s summary report on the experiences of Takatāpui, Rainbow and MVPFAFF+ people in State and faith-based care has more detail on homophobic and other discriminatory reasons for entries into mental health settings.

<sup>119</sup> Fareham House Annual Report 1968, “Temporal Lobe Epilepsy – Related to Difficult Behaviour” (n.d., page 6).

<sup>120</sup> Stanley, E, *The road to hell: State violence against children in postwar New Zealand* (Auckland University Press, 2016, page 67); Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J & Leonard, J, *Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999* (Ihi Research, 2021, page 207).

<sup>121</sup> Private session transcript of Joan Bellingham (29 April 2019, page 6); Private session transcript of Ms SP (n.d., page 14); Transcript of evidence of Paora Moyle from the Expert Panel at the Inquiry’s Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 18 March 2022, page 38).

<sup>122</sup> The Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and statistical manual: Mental disorders* (1st edition, American Psychiatric Association Mental Hospital Service, 1952, page 39).



"There was no value  
placed on his young life,  
and the very people who were  
put in that position of trust  
showed complete disregard for his  
wellbeing and safety."

**CATHERINE HICKEY, SISTER  
OF PAUL HICKEY**

Sister of a survivor

# Chapter 6: Nature and extent of abuse in mental health care settings

137. While all forms of abuse and neglect were experienced across most mental health settings, this chapter focuses on the most pervasive forms that the Inquiry heard about. The Inquiry heard that mental health care settings were environments of isolation, fear, violence and control for many survivors and witnesses. Features of these settings included:
- > strict regimented routines
  - > people in care experiencing depersonalisation, for example people in care being processed in groups according to a fixed timetable, without consideration for individual privacy needs
  - > a one size fits all approach. Institutional care follows a uniform approach, providing the same services to all children, young people and adults in care regardless of their age, gender, abilities, needs, or reasons for separation from parents / caregivers
  - > children, young people and adults in care in institutions are often isolated from their whānau, support networks, hapū and iwi, and communities, far from their places of origin, and unable to maintain relationships with parents, whānau and support networks.
138. Counsel for the Crown described the evidence presented at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing as "a shameful picture of inhumanity".<sup>123</sup> This is an apt description of what was experienced in these settings.

## Physical abuse

139. Children, young people and adults in mental health care settings experienced physical abuse that was violent, pervasive, and created a climate of fear for many survivors. Most of the abuse that occurred was perpetrated by staff, and in many instances the abuse was intentional. Survivors described being punched, kicked, held in painful restraint positions, dragged along the ground, sexually assaulted and raped by staff.<sup>124</sup> Chris Finan (Maori, Yugoslavian), who was diagnosed with ADHD as a child, spent time in mental health care settings as a child and young person in the 1980s and 1990s. As a child at Lake Alice in Rangitikei he received electric shocks from an electroconvulsive therapy (ECT) machine without anaesthetic:

*"I was given ECT to get rid of my behavioural issues. I remember being shackled to the bed and the pain of the electric shocks feeling like thunder or fireworks. I did not get anaesthetic."*<sup>125</sup>

<sup>123</sup> Transcript of evidence of the closing statement by the Crown at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in Care, 20 July 2022, page 699).

<sup>124</sup> See for example the witness statements of Ms OF (21 November 2022, page 7); Chris Finan (9 August 2021, page 6), Joshy Fitzgerald (25 February 2022, page 7) and James Packer (13 February 2020, page 4).

<sup>125</sup> Witness statement of Chris Finan (9 August 2021, page 3).

140. Many survivors told the Inquiry they were physically abused by other patients or residents at institutions. Peer abuse inside institutions was widespread, recurrent and often not dealt with by staff. Survivors described being hit in the head and knocked out by a cricket bat, bitten, stabbed in the stomach and thrown downstairs by their peers.<sup>126</sup> Some survivors described abuse by peers or others being allowed or facilitated by staff.
141. The Ministry of Health acknowledged the presence of physical abuse in mental health care settings from 1950 to 1999 and recognised that during this time, these care settings did not always adequately safeguard people from harm.<sup>127</sup>

### **People were neglected, dehumanised and degraded**

142. Society's devaluation of people experiencing mental distress was magnified within the confines of institutional settings. Staff viewed and treated individuals in their care as less than – many survivors talk about staff failing to provide residents with even a basic level of respect and dignity.<sup>128</sup> Survivors and whānau told the Inquiry that the most pervasive form of abuse in these settings was neglect,<sup>129</sup> with the denial of an individual's personhood being an insidious and damaging feature of all mental health settings. Personhood has been described as the "essence of being human" and includes "choice, a sense of autonomy, being part of a loving family, the chance to labour, love and consume".<sup>130</sup>
143. Survivor Carla Mann, who spent part of her pregnancy in Carrington Hospital in Tāmaki Makaurau Auckland said: "You weren't treated like a person there, you were treated like a 'thing'".<sup>131</sup>
144. Survivor Denise Caltaux similarly described the lack of dignity and care afforded to patients at Tokanui Psychiatric Hospital, located south of Te Awamutu, in the early 1990s, describing it as "horrendous".<sup>132</sup> Denise recalled that patients in the unit at Tokanui were "herded like animals" to be locked in a communal space during the day, showers were conducted communally by gender each morning, and there were no choices given around food and drink.<sup>133</sup>

<sup>126</sup> Witness statement of Catherine Hickey (2 August 2021, page 4); Mr LD (15 May 2021, page 5); Philip Banks (15 October 2020, page 10) and Alison Pascoe (29 April 2022, page 18).

<sup>127</sup> Transcript of evidence of Director-General of Health and Chief Executive Dr Diana Sarfati for the Ministry of Health at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 206, lines 6–12).

<sup>128</sup> Witness statement of Carla Mann (15 March 2022, para 66); Sunny Webster (18 December 2021, page 9) and Sidney Neilson and Cherene Neilson-Hornblow (20 May 2022, para 8.9).

<sup>129</sup> Witness statement of Ms Bielski (18 October 2021, pages 4–8, 9); Transcript of Commissioner Gibson at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in Care, 20 July 2022, page 702); Transcript of Counsel at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in Care, 11 July 2022, pages 3, 8).

<sup>130</sup> Mirfin-Veitch, B, Tikao, K, Asaka, U, Tuisaula, E, Stace, H, Watene, FR & Frawley, P, Tell me about you: A life story approach to understanding disabled people's experiences in care (1950-1999), (Donald Beasley Institute, 2022, page 117).

<sup>131</sup> Witness statement of Carla Mann (15 March 2022, para 66).

<sup>132</sup> Witness statement of Denise Caltaux (4 October 2022, page 22).

<sup>133</sup> Witness statement of Denise Caltaux (4 October 2022, pages 22–23).

145. In mental health care settings, people would live in pyjamas or dressing gowns issued to them upon arrival.<sup>134</sup> A report about Tokanui Psychiatric Hospital in 1985 concluded:

*“Residents live as paupers, with no personal possessions and often no personal clothing. They are frequently dressed / undressed in the middle of a day room, bathed in large groups, toileted in hallways on potty trolleys, and generally treated with little respect for the dignity and privacy of each person. Staff have become insensitive to the dehumanising aspects of these care procedures.”<sup>135</sup>*

### **Emotional, psychological and developmental neglect**

146. Across large-scale institutional settings, the Inquiry was told of survivors’ emotional, psychological and developmental needs being neglected. Aroha, care, emotional support and attention were withheld from survivors, and they were not given opportunities to grow and learn through meaningful activities and stimulation.
147. Survivors of some mental health care settings did not feel emotionally supported to process earlier trauma and adversity they had experienced in their life, including in other State and faith-based care settings.<sup>136</sup> They believe trauma and adversity probably contributed to their mental and emotional state at that time. Survivor Ms SD said she did not receive support from staff in Sunnyside Hospital in Ōtautahi Christchurch to help her process grief she was experiencing alongside other challenges, and instead, “it was all just sort of brushed under the carpet.”<sup>137</sup>
148. Catherine Hickey, whose brother Paul “suffered prolonged and premeditated abuse [at Porirua Hospital] at the hands of the very people who were entrusted to protect him”,<sup>138</sup> told the Inquiry that:
- “There was no value placed on his young life, and the very people who were put in that position of trust showed complete disregard for his wellbeing and safety.”<sup>139</sup>*
149. A 1979 letter from the psychiatric medical officer at Hawke’s Bay Psychiatric Unit to Porirua Hospital states: “I wish [Paul] better luck with his mutilation ... since the only real relief I can see for him is in his death.”<sup>140</sup> Paul took his own life nine months later.

134 Witness statement of Jane Castelfranc-Allen (31 March 2022, page 3).

135 Patricia McNelly, Report of consultation efforts regarding services for the intellectually handicapped at Tokanui Hospital August (October 1985, page. 6).

136 Witness statement of Robert Shannon (9 June 2021, paras 3.5–3.6); and Ms ON (11 May 2022, paras 101–106, 247).

137 Private session transcript of Ms SD (1 December 2021, page 15).

138 First witness statement of Catherine Hickey (2 August 2021, para 32).

139 Second witness statement of Catherine Hickey (15 February 2023, page 7).

140 Letter from psychiatric medical officer to the medical superintendent at Porirua Hospital re treatment (6 December 1979).

150. Antony Dalton-Wilson (Samoan, Gypsy, German) who was in several mental health care settings as a child, told the Inquiry that:

*"I sometimes went to Māngere Hospital in the holidays but I'm not sure why. I hated it and was treated really badly there. When I first went there, they put me straight in time out and told me to wait. I was yelling for somebody to get me out. I did not have any food or drink...The staff didn't come and get me out until night-time."*<sup>141</sup>

151. Chris Finan described his entry into Lake Alice in Rangitikei at the age of seven:

*"When I arrived, I was strip searched by the nurses...I was then hosed down in the communal shower area. The shower area was open and all sorts of people, of different ages, were in there."*<sup>142</sup>

152. The lack of activities within in-patient psychiatric units have been described by survivors as 'intolerable'.<sup>143</sup> People's need for meaningful activity and stimulation was neglected. Samoan survivor Rachael Umaga said that at Te Whare Ahuru at Hutt Hospital in Te Awa Kairangi ki Tai Lower Hutt:

*"There was nothing to do at the unit. We just sat there all day and smoked. I felt neglected because there was nothing to do, except wait for 10 o'clock, 12 o'clock, three o'clock and five o'clock for our pills or for a cup of tea."*<sup>144</sup>

153. Rachael told the Inquiry that while there was a craft room, music room and room where you could cook or bake under the supervision of a nurse, no one could do these activities because the facilities were not adequately maintained or resourced with staff to supervise: "It really felt like the staff provided us all these things to show they care but it was all just surface level and for show."<sup>145</sup>

154. Chris Finan told the Inquiry that he received no education or other activities as a child in Lake Alice and was medicated to control his energy levels.<sup>146</sup> He experienced a similar lack of meaningful activity at Kingseat (Karaka) in the mid-1990s:

*"I would wake up at 6am and have a shower and then breakfast. We would only wear pyjamas, which had 'patient' labelled on them. Each day I sat around doing nothing."*<sup>147</sup>

<sup>141</sup> Witness statement of Antony Dalton-Wilson (13 July 2021, page 12).

<sup>142</sup> Witness statement of Chris Finan (9 August 2021, page 2).

<sup>143</sup> Witness statement of Denise Caltaux (4 October 2022, pages 24, para 12.18).

<sup>144</sup> Witness statement of Rachael Umaga (18 May 2021, page 6).

<sup>145</sup> Witness statement of Rachael Umaga (18 May 2021, page 10).

<sup>146</sup> Witness statement of Chris Finan (9 August 2021, pages 2–3).

<sup>147</sup> Witness statement of Chris Finan (9 August 2021, page 6).

155. The 1985 report on Tokanui Hospital concluded similarly, that there were many residents who received minimal personal attention or effort to stimulate them and "these residents spend their days virtually ignored by staff except for foods, fluids and baths".<sup>148</sup>

## **Medical abuse and neglect**

156. Medication was used to control, subdue or 'manage' people's behaviours while they were in mental health care settings, often for the benefit of staff. 'Overmedicalisation' refers to the inappropriate application of medical analysis or diagnosis to non-medical situations, as well as the use of unnecessary treatments, which applies to many instances of medical abuse the Inquiry has heard about.<sup>149</sup>
157. The Inquiry heard evidence of medication being used in an experimental nature in psychopaedic and psychiatric settings. Former staff have used the term 'medical experiments' to describe the kind of trials that took place in these settings.<sup>150</sup>
158. Dr Enys Delmage, consultant in adolescent forensic psychiatry, told the Inquiry that caution should be exercised when "passing judgment on historical prescribing practices". He said clinicians in those days "would not have had the benefit of decades of research and innovation that followed".<sup>151</sup>
159. At the Inquiry's State Institutional Response Hearing, Ministry of Health Chief Executive and Director-General of Health, Dr Diana Sarfati acknowledged that:
- "Much of the nature and standard of care and treatment provided in historical psychiatric or psychopaedic institutions would be unacceptable today and are now, rightly, reviewed as neglect or abuse."***<sup>152</sup>
160. Survivors often used the term 'guinea pig' to describe how they felt being given different medications, typically without their informed consent. Samoan survivor Leota Scanlon, who was placed in Lake Alice Child and Adolescent Unit at 13 years old, described how he "just felt like a guinea pig there" as "the staff spent their time figuring out what drug worked best to settle us down and to shut us up".<sup>153</sup>

148 McNelly, P, Report of consultation efforts regarding services for the intellectually handicapped at Tokanui Hospital August (October 1985, page 6).

149 British Medical Journal website, Too much medicine (2023), <https://www.bmj.com/too-much-medicine>

150 Witness statement of Marleen Verhoeven (26 September 2022, page 5); Transcript of evidence of Dr Olive Webb at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in Care, 13 July 2022, page 226).

151 Expert witness report of Dr Enys Delmage (13 June 2022, page 15).

152 Transcript of evidence of Director-General of Health and Chief Executive Dr Diana Sarfati for the Ministry of Health at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 205).

153 Witness statement of Leota Scanlon (23 June 2021, pages 3, 6).

161. Chemical restraint is a type of restraint where medication is used to control a person's behaviour, typically to sedate, subdue and encourage compliance. Chemical restraints can be proactive and used to stop an anticipated behaviour occurring. When it is used in this way it is called overmedicalisation, as a regular dose of medication is being given to maintain control over the behaviour. At other times, medication is used reactively to control or curb unwanted behaviour. The Inquiry has heard evidence of chemical restraint being used in care settings such as disability and mental health settings, as well as social welfare residences and institutions.
162. Survivor Robert Shannon (8 years old) was placed in an adult ward at Palmerston North Hospital for eight months in the early 1960s. He told the Inquiry he was sedated throughout his time at the hospital, and that it:
- "Was only necessary because I was not in an appropriate facility and I was not receiving any treatment for my condition [paediatric behavioural challenges later diagnosed as Childhood Behavioural Disorder]."*<sup>154</sup>
163. In a letter to a charge nurse at Lake Alice Child and Adolescent Unit, Rangitikei, Dr Pugmire refers to both paraldehyde and Largactil (the brand name for antipsychotic medication, chlorpromazine) as "tranquilizers".<sup>155</sup> Not only was this kind of medication used as a chemical restraint in care, but paraldehyde injections were often used as tools to inflict aversive punishment.
164. Medical abuse in the form of chemical restraint and over-medicalisation enabled other types of abuse to occur, particularly sexual abuse. Sexual abuse sometimes occurred while survivors were physically or chemically restrained (including being heavily medicated) in settings such as psychiatric hospitals.<sup>156</sup> Survivors spoke about how they were intentionally taken advantage of while in these states.
165. The Inquiry has also been told about punitive medicating. Dr Olive Webb, clinical psychologist specialising in intellectual disabilities and autism spectrum disorder, gave an example of the ward doctor at Sunnyside Hospital in Ōtautahi Christchurch who increased a patient's medication as punishment. The patient had broken the antenna on his car in retaliation for something he had said that upset her.<sup>157</sup>

<sup>154</sup> Witness statement of Robert Shannon (9 June 2021, pages 9–10).

<sup>155</sup> Letter from Dr Pugmire to charge nurse, Villa 6 (19 September 1977).

<sup>156</sup> Witness statements of Christine Ramage (27 July 2021, pages 12, 18) and Steven Storer (24 May 2021, page 7).

<sup>157</sup> Witness statement of Dr Olive Webb (25 May 2022, page 12).

166. Medical neglect means the failure to provide or allow for adequate medical care that could be needed by children, young people and adults in any care setting. This includes injuries and illnesses being left unnoticed, untreated or caregivers or staff withholding access to medical treatment for any length of time.<sup>158</sup> Family members told the Inquiry that they brought injuries to the attention of staff, but they remained untreated.
167. Catherine Hickey told the Inquiry that when her family visited her brother Paul at Porirua Hospital they often found him with untreated injuries:
- "[Mum found him] cowering in a corner in the ward, with fresh bruises, black eyes, swollen lips and cuts on his body...this happened more than once."*<sup>159</sup>

### **Aversion techniques to punish and control**

168. Aversion therapy is a form of behaviour therapy where undesirable behaviour is matched with an unpleasant (aversive) stimulus and delivered in a measured, controlled way.<sup>160</sup> As unpleasant feelings or sensations become associated with that behaviour, the goal is for the behaviour to decrease or stop. Aversion therapy has been the focus of debate for many years among educators, medical professionals and practitioners.<sup>161</sup> Its use remains controversial on ethical grounds and because of concerns about its effectiveness and safety.<sup>162</sup>
169. The Inquiry has seen some evidence of aversion techniques being used on children, young people and adults across different care settings in an attempt by staff to reduce behaviours they viewed as 'problematic' or challenging. This was often done through the delivery of uncomfortable, sometimes intolerable medical stimulus such as electric shocks delivered through electroconvulsive therapy (ECT) machines and painful injections. Survivor Mr JJ said that he was given electric shocks on 12 occasions in one day after accidentally breaking a pot at Lake Alice Child and Adolescent Unit.<sup>163</sup> The Inquiry refers to these as aversive techniques, rather than therapy, as they represented medical abuse as a form of punishment and control.

158 Mirfin-Veitch, B & Conder, J, "Institutions are places of abuse": The experiences of disabled children and adults in State care between 1950–1992 (Donald Beasley Institute, 2017, page 26).

159 First witness statement of Catherine Hickey (2 August 2021, para 38).

160 APA Dictionary of Psychology website, aversion therapy (2023), <https://dictionary.apa.org/aversion-therapy>; APA Dictionary of Psychology website, behaviour therapy (2023), <https://dictionary.apa.org/behavior-therapy>

161 Letter from professor to detective superintendent re: Lake Alice allegations (2009, page 2).

162 Letter from professor to detective superintendent re: Lake Alice allegations (2009, page 2).

163 Witness statement of Mr JJ (23 March 2021, para 25).

170. The effects of medical abuse, such as electric shocks, could enable subsequent abuse to occur. As discussed in the Inquiry's report *Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit*, several survivors suspected they were raped while heavily sedated or unconscious after receiving electric shocks.<sup>164</sup> Survivor Malcolm Richards, said he had no idea how long he had been unconscious after electric shocks, but he "came to back in the cell with a sore, sticky rectum" and believed he had been raped.<sup>165</sup>
171. The Inquiry has seen evidence of paraldehyde injections being used as aversive punishment. Paraldehyde is a hypnotic and sedative with anti-convulsant (anti-seizure) effects, known to have an extremely offensive taste and smell.<sup>166</sup> Administration by way of injection is understood to be extremely painful.<sup>167</sup> Following administration, people report being unable to use the part of the body that received the injection over a long period, until the effects have worn off.<sup>168</sup>
172. Medical abuse in the form of aversion techniques also commonly occurred consequently to children, young people and adults in care who were impacted by other types of abuse and neglect. Caroline Arrell, a former worker at two large-scale disability and mental health institutions, Tokanui Psychiatric Hospital near Te Awamutu and the Kimberley Centre near Taitoko Levin, said young residents' 'challenging behaviour' was overwhelmingly caused by emotional and physical neglect and a lack of stimulus:
- "I believe [residents] as demonstrated in their behaviour, were also responding to a wide variety of abuse. I believe that they were behaving in perfectly understandable ways in very abnormal environments."*<sup>169</sup>

### **Abuse and neglect experienced by different groups**

173. For survivors who experienced mental distress, the most common abuse type in these settings was physical, which featured in 43 percent of accounts.
174. For Pākehā survivors of disability and mental health care settings, the most commonly experienced type of abuse was physical, at 44 percent.
175. Almost half of Māori survivors who went through disability or mental health care settings were physically abused (46 percent). There was also significant sexual (33 percent of accounts), and emotional abuse (31 percent of accounts) experienced by Māori.

<sup>164</sup> Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice Child and Adolescent Unit* (December 2022, page 127).

<sup>165</sup> Witness statement of Malcolm Richards (31 March 2021, para 33).

<sup>166</sup> New Zealand Formulary for Children, *Medicines for Children – information for parents and carers: Rectal paraldehyde for stopping seizures* (2019).

<sup>167</sup> Gallen, R, *Report on the Lake Alice incidents* (Crown Law Office, 2001, page 8).

<sup>168</sup> Gallen, R, *Report on the Lake Alice incidents* (Crown Law Office, 2001, page 8).

<sup>169</sup> Witness statement of Caroline Arrell (21 March 2022, page 15).

176. For wāhine Māori who spent time in disability or mental health care or care settings, physical abuse was the most commonly experienced type (44 percent).
177. Of the Pacific survivors time in disability or mental health care settings, 36 percent said that they were neglected while they were there. This is a high proportion compared to other groups or settings. The next most common abuse type was physical abuse, which was experienced by 29 percent of survivors.
178. Takatāpui, Rainbow and MVPFAFF+ survivors experienced homophobic abuse that was sometimes couched within religious abuse and justifications. Takatāpui, Rainbow and MVPFAFF+ children and young people were targeted due to their sexuality, gender expression or sex characteristics, and were more vulnerable to abuse. Some were subjected to conversion practices in mental health care that were psychologically and often physically abusive. These experiences are set out in detail in the Inquiry's summary of the experiences of Takatāpui, Rainbow and MVPFAFF+ people in state and faith-based care.
179. The Inquiry was told about forced and unconsented abortions happening in mental health settings. Mostly, the Inquiry heard of women who realised during or after the procedure that they had undergone an abortion. The Inquiry also heard that some of their pregnancies were a result of sexual abuse occurring while in care.<sup>170</sup>

### **Extent of abuse in mental health care settings**

180. MartinJenkins estimated a total of 183,489 people in the identified health and disability care settings during the Inquiry period. The MartinJenkins report further estimates how many people probably experienced abuse in health and disability care settings. Their analysis of available data from international studies provided a low estimate of 22,153 survivors (10.5 percent of survivors who were in these settings from 1950 to 2019), and a high estimate of 72,422 survivors (34.2 percent).<sup>171</sup>
181. There has been limited research on the extent of abuse and neglect in mental health care settings. The Ministry of Health has never kept centralised records. As part of its Notice to Produce response, the Ministry of Health reported that any complaints of abuse that could have come to the attention of the Ministry and its predecessors over the scope period would not be held in a central location and would instead be held among records for the relevant directorate or business unit. The Ministry stated it was not a health provider and so was unable to answer questions relating to records.

<sup>170</sup> Witness statements of Sunny Webster (18 December 2021, page 12); Christina Ramage (27 July 2021, pages 17–18) and Paul Milner (1 June 2022, page 5, para 2.8).

<sup>171</sup> MartinJenkins, Indicative estimates of the size of cohorts and levels of abuse in state and faith-based care – 1950 to 2019 (2020, page 36).

# Chapter 7: Impacts of abuse and neglect in mental health settings

## Physical health

182. Survivors placed in mental health care spoke of the immediate and ongoing physical impacts from receiving electric shocks as punishment, such as electrode burns, tinnitus and memory loss.
183. Medication was administered to many survivors in these settings to control their behaviour. Since then, these survivors have developed chronic health conditions related to direct physical impacts like bowel damage.
184. The neglect experienced by survivors in institutional care exacerbated other impacts of abuse. Some survivors who suffered physical abuse were medically neglected and their injuries not treated, which made the injuries they suffered worse and the damage lifelong.
185. Women were denied reproductive rights during and after their time in institutional care, meaning many were unable to have their own children.
186. Engagement with survivors and their whānau or support networks, during the Inquiry and previous inquiries, revealed that people died while in care. These deaths seemed more likely to occur in disability and mental health care settings where people experienced gross neglect.

## Mental health and emotional wellbeing

187. The Inquiry received evidence that solitary confinement (also referred to as seclusion) was prevalent in mental health care settings. Research demonstrates that solitary confinement can have lasting physiological impacts on survivors' intellect and behaviours, social and emotional regulation, mental and physical health, and memory, and on brain structure and function. This impact is especially likely when solitary confinement (seclusion) is experienced frequently, for longer durations, and at a younger age when the brain is still developing. Chemical restraint was also used in combination with solitary confinement (seclusion). Survivors remember this as a double form of punishment and that its impact was felt acutely.
188. Social isolation and separation had detrimental impacts on children, young people and adults in mental health care settings. Institutionalisation separated many survivors from their whānau, hapū, iwi, language, culture and wider communities for decades, and in some cases, for life. This separation had traumatic and far-reaching consequences for survivors and was particularly acute for Māori and Pacific survivors.

189. Research shows that placing people into institutional care – where they experience strict routines and restricted autonomy – has detrimental impacts to many aspects of their lives. For children, being placed into regimented institutional care impacts their intellectual, behavioural, social and developmental development, including their attachments.
190. Like many in residential institutions the experience for mental health residents was dehumanising. There are a number of impacts that are unique to these survivors. Many survivors of these institutions don't like locked doors or the sound of heavy keys. All survivors were prescribed medications while in an institution and many are still using similar regimes. Many survivors experience negative impacts of long-term use of these medications.
191. Survivors of mental health care settings experienced long-term isolation, segregation and severe neglect, and were subjected to regular control and restraint. These impacted their relationships, created fear of change or intimacy, and reduced survivors' abilities to live independently or interdependently. For many, the medical abuse and neglect suffered resulted in long-term physical and mental conditions.
192. Almost every survivor the Inquiry heard from still experiences stressful and disruptive anxiety disorder challenges and many continue to experience ongoing mental distress or live with diagnosed mental health issues. This includes suicide and suicide ideation and attachment disorders. Attachment disorders are mental health conditions that affect how people form and maintain relationships. They often develop in early childhood if the caregiver is neglectful, abusive, or not consistently available.
193. People with attachment disorders might struggle to trust others, manage their emotions, and build healthy relationships. They might seem withdrawn, anxious, or overly dependent on others.

### **Impacts on life after time in mental health care settings**

194. Survivors of mental health care settings were subjected to extreme abuse and severe neglect, including segregation and isolation. Many survivors were denied personhood and autonomy, independence, and were not given the opportunity to learn basic life skills. Their ability to fit back into whānau life and with their communities, having been in institutions with strict regimented routines, was impacted. These impacts were compounded by discriminatory societal attitudes relating to ableism and disablism which limited lifelong opportunities.

195. From 1988, large mental health institutions started closing down without infrastructure in place to support transition back into the community. No aspect of institutional care had prepared survivors for this and adjusting to community life was challenging. Survivor Sunny Webster, who was placed in a mental health institution, explained that she lacked the basic skills necessary for everyday life and had to teach herself "how to live from scratch."<sup>172</sup>
196. Another survivor, Toni Jarvis, said he cannot understand how the State expected him to "go to Cherry Farm and then at a later stage manage to fit back into the community".<sup>173</sup>
197. Māori survivor Sidney Neilson (Ngāpuhi, Ngāti Porou) was diagnosed with schizophrenia at 19 years old and told the Inquiry that he spent almost 50 years in and out of Porirua Hospital. In a joint witness statement with his sister, Sidney explained that he and his whānau felt unsupported in his pathway into community-based living, after he was discharged around 1989, due to deinstitutionalisation:
- "There was limited offer of help or support for me or my whānau, I felt like I just thrown into the community and told to survive. I moved from an open ward at the hospital to a halfway house. There were whānau hui, and meetings with a psychologist and psychiatrist in preparation for my release, but all my family knew was that the hospital wanted to discharge me."*<sup>174</sup>
198. Sidney initially had some negative experiences with community-based living, such as moving from flat to flat with different mental health community services, dealing with poor living conditions such as mould and being taken advantage of by a previous landlord. However, Sidney told the Inquiry that he now enjoys the independence:
- "I love my life. It is good living alone, cooking, shopping, keeping my flat clean and tidy, keeping myself clean and tidy and doing my own things".*<sup>175</sup>
199. Survivors of abuse and neglect in mental health care settings have also experienced difficulties with employment. Survivors said the emotional and psychological impacts affected their ability to retain employment in a range of ways including how they respond to or interact with others, feelings of inadequacy or unworthiness, and the impact of alcohol or substance misuse. Other employment difficulties stemmed from the prejudice and discrimination of having been in care, including being seen as less trustworthy than other people.

<sup>172</sup> Witness statement of Sunny Webster (18 December 2021, para 90).

<sup>173</sup> Witness statement of Toni Jarvis (12 April 2021, para 41).

<sup>174</sup> Witness statement of Sidney Neilson and Cherene Neilson-Hornblow (20 May 2022, para 5.1).

<sup>175</sup> Witness statement of Sidney Neilson and Cherene Neilson-Hornblow (20 May 2022, para 5.9).

200. Societal attitudes towards mental distress and people who have been in mental health care settings has meant that the negative impacts of abuse and neglect in care have contributed to further adverse outcomes for many survivors experiencing mental distress. This includes fewer employment opportunities, often meaning survivors require long-term income support that is often inadequate for their additional needs.
201. Some survivors of mental health care had no pathway after care. Some survivors have spent much of their lives in institutional care, shifting to smaller care settings where features of institutional care still exist. These include regimented routines, one-size-fits-all approaches to care, lack of individualised care responding to each person's unique needs and circumstances, isolation from whānau, depersonalisation and may be excluded from communities.
202. The Inquiry has not only received evidence of people dying in care, but also of people in care being buried in unmarked graves.

### **Impacts on particular groups**

203. Disconnection from te ao Māori was often compounded for survivors who were tāngata whaiora. Tāngata whaiora Māori in mental health care settings were denied opportunities to connect with their whānau and their Māori identities. The care and treatment they received often did not reflect holistic approaches to health and wellbeing, including kaupapa Māori models of care.
204. State and faith-based institutions generally denied tāngata whaikaha and tāngata whaiora Māori the ability to express themselves as Māori and become or develop their cultural competency. Many lost their identity as Māori and their connection to their whānau. Māori survivor Joshy Fitzgerald told the Inquiry that he wished he had more opportunity to learn te reo:  
  
*"[te reo Māori] would at least give me a feeling of belonging. I don't feel like I belong anywhere."*<sup>176</sup>
205. Separation and lost connection to kainga (family) impacted disabled Pacific survivors' ability to also keep connected with their ethnic and faith-based communities and maintain their cultural identity.

<sup>176</sup> Witness statement of Joshy Fitzgerald (25 January 2022, para 7.10).

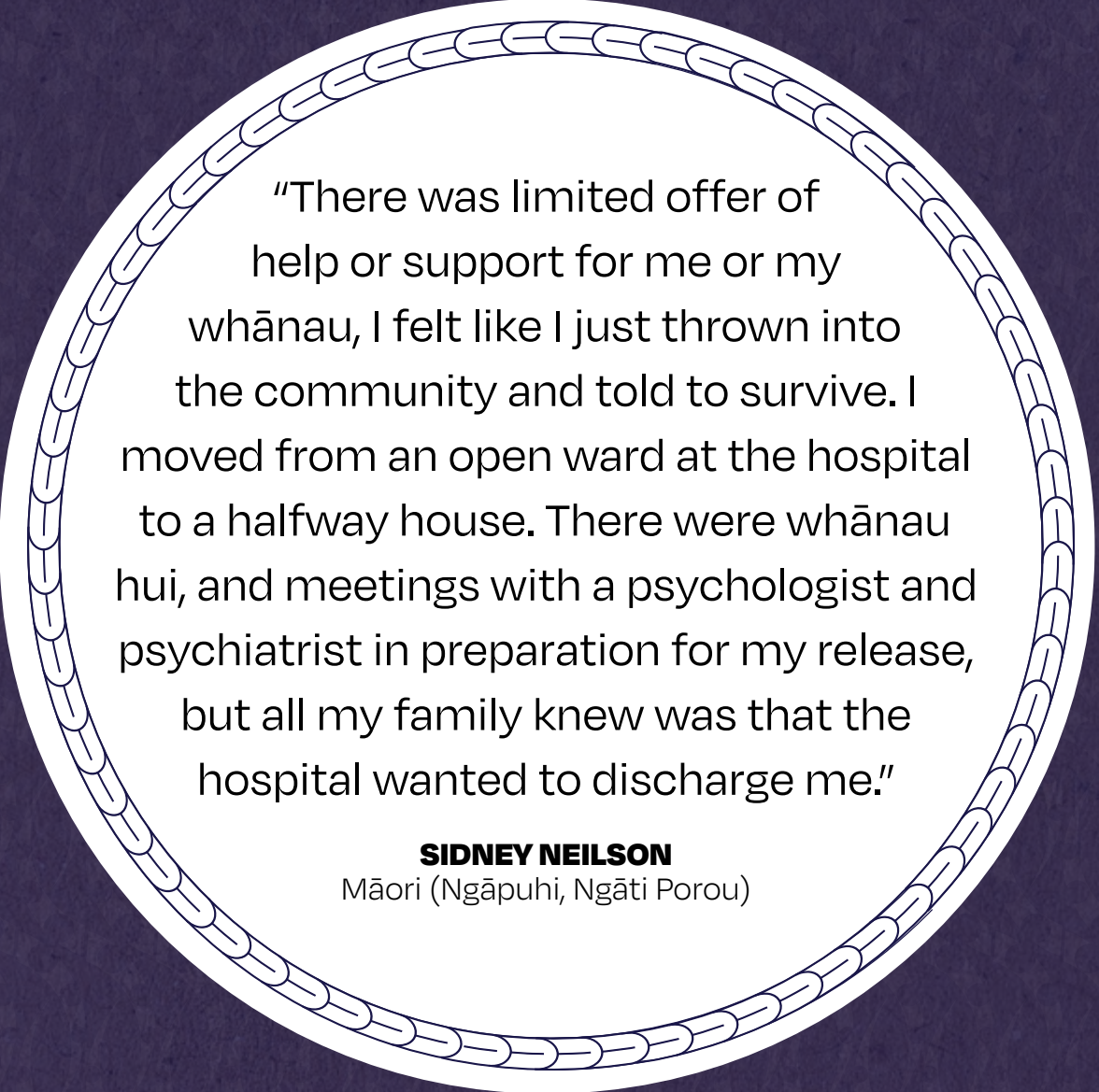
206. At the Inquiry's State Institutional Response Hearing, Geraldine Woods, then Acting Chief Executive of Whaikaha, said:
- "Between 1950 and 1999, Health and Disability care settings failed to consistently and meaningfully support the cultural needs of tāngata whaikaha Māori. I acknowledge that this caused tāngata whaikaha Māori to be disconnected from their culture, identity, language and communities. These impacts are ongoing and have impacted whānau, hapū and iwi."*<sup>177</sup>
207. The segregation of survivors in institutional care settings and restricted contact and separation from whānau caused acute pain and lifelong negative impacts. This separation also denied Māori and Pacific survivors access to their cultural beliefs, values and practices.
208. Survivors with diverse sexuality or gender identity spoke about how homophobic abuse impacted their self-worth, and feelings of safety about their identity.
209. Takatāpui, Rainbow and MVPFAFF+ survivors in disability and mental health settings were sometimes physically and sexually abused and neglected because of their gender orientation or sexuality. As well as the life-long impacts shared by many other survivors they experienced gender dysphoria and intimacy avoidance, struggling with emotional closeness and connecting on a deeper level.

---

<sup>177</sup> Transcript of evidence of Acting Chief Executive Geraldine Woods for Whaikaha – Ministry of Disabled People at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 215).

# Chapter 8: Factors that contributed to abuse and neglect of people in mental health settings

210. Part 7 of the Inquiry's final report, Whanaketia – Through pain and trauma, from darkness to light, describes the factors that the Inquiry identified as having caused or contributed to the abuse and neglect of children, young people and adults in State and faith-based care. In addition, Part 7 identifies the lessons learned and the changes made to prevent and respond to abuse and neglect. Part 7 concludes by setting out findings relating to:
- > breaches of relevant standards,
  - > factors that caused or contributed to abuse and neglect in care,
  - > fault
  - > lessons learned.
211. The Inquiry identified that four factors all caused or contributed to the abuse and neglect of survivors in mental health settings. These included:
- > factors relating to the people at the centre of abuse and neglect
  - > institutional factors
  - > structural and systemic factors
  - > societal factors.
212. During the Inquiry period, many whānau and communities needed support to care for their children, young people and adults at home or within their community. Without this support, many children, young people and adults were placed in State and / or faith-based institutions.
213. Many of the personal circumstances that made it more likely a child, young person or adult would enter care, often became the factors for why they were more susceptible to, or at an increased risk of, abuse and neglect in care. These factors were underpinned by societal attitudes, like discrimination based on racism, ableism, disablism, sexism, homophobia, transphobia and negative stereotypes about children and young people.



"There was limited offer of help or support for me or my whānau, I felt like I just thrown into the community and told to survive. I moved from an open ward at the hospital to a halfway house. There were whānau hui, and meetings with a psychologist and psychiatrist in preparation for my release, but all my family knew was that the hospital wanted to discharge me."

**SIDNEY NEILSON**

Māori (Ngāpuhi, Ngāti Porou)

214. These factors included:

- a. being raised in poverty and experiencing deprivation
- b. being disabled with unmet needs
- c. being Māori and racially targeted
- d. being Pacific and racially targeted
- e. being Deaf with unmet needs
- f. experiencing mental distress with unmet needs
- g. being Takatāpui, Rainbow, MVPFAFF+, gender diverse or transgender and being targeted
- h. having experienced significant or multiple adverse childhood events before entering care
- i. having a deferential attitude to people in positions of authority, including faith leaders and medical professionals
- j. other reasons such as age or gender.

215. Most survivors of abuse and neglect in State and faith-based care had or experienced many of these factors, which heightened their risk of abuse and neglect. For children, young people and adults in mental health care settings, this meant that they were more susceptible to abuse and neglect if they were raised in poverty, were Māori, Pacific, Deaf, disabled, Takatāpui, Rainbow, MVPFAFF+, or experienced mental distress, or multiple combinations of these circumstances.

216. People placed in care needed support, strong protection and to be safeguarded against abuse and neglect. Instead, many were placed in care facilities with institutional environments and practices that heightened the risk of abuse and neglect.

217. The systemic or institutional factors that contributed to abuse and neglect in care during the Inquiry period, which are described in detail in Part 7 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*, included:
- a. standards of care were inconsistent and routinely breached
  - b. complaints processes were absent or easily undermined, with few records kept
  - c. senior State and faith leaders prioritised the reputations of institutions and abusers over people in care
  - d. oversight and monitoring was ineffective
  - e. rights guaranteed under te Tiriti o Waitangi and human rights were largely absent
  - f. people in care were dehumanised and denied dignity
  - g. people in care were isolated from whānau, kainga, communities and advocates
  - h. there was little accountability for abuse and neglect.
218. All of the systemic or institutional factors that contributed to abuse and neglect were present in mental health care settings. Part 7 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*, describes these in detail. This chapter focuses on the factors that were particularly acute in mental health care settings.
219. The Inquiry examined the responsibility of the State and faith-based institutions in respect of the abuse and neglect in care that occurred during the Inquiry period. The failures of the State to uphold its responsibilities impacted children, young people and adults in care and are described in detail in Part 7 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*. This chapter focuses on the failures that were particularly acute in mental health care settings.

## **The people at the centre of abuse and neglect**

220. Children, young people and adults in State and faith-based care were diverse, with diverse care and support needs. Although each person in care was unique, every person needed support, strong protection, and safeguarding. Strong protection refers to a set of internationally-recognised factors that contribute to resilience because they promote healthy development and well-being and can reduce the risk of experiencing abuse and neglect. These factors are a combination of personal, parental, and environmental factors.
221. The rights guaranteed in te Tiriti o Waitangi reinforce many protective factors. For example, connection to whakapapa, whānau, hapū and iwi are taonga protected by te Tiriti o Waitangi.
222. Had these rights been upheld during the Inquiry period – such as the right to tino rangatiratanga over kāinga, and the right to continue to live in accordance with indigenous traditions and worldview guaranteed by the principle of options – these rights would have been amplified protective factors for tamariki, rangatahi, and pakeke Māori, reducing entry into care and the risk of abuse and neglect in care.
223. Human rights recognise that children, young people, adults, people with disabilities and Māori as indigenous to Aotearoa New Zealand are distinct groups that also require special measures, particularly protective measures. In care settings, this means special protection measures like comprehensive standards of care needed to be in place. During the Inquiry period, the lack of special protections or measures for people in care were factors that contributed to abuse and neglect.

## Abusers

224. Staff and caregivers in institutional and residential settings had almost total power and control over the lives of people in their care. Medical professionals and health care workers held positions that gave them coercive statutory powers to place people in care, at times without any consent, decide their treatment, including at times the use of compulsory orders, and decide what supports they could access. Some people misused the power and control that came with these positions to inflict certain types of abuse and neglect.
225. Abusers were rarely held to account for their abuse and neglect. Institutional and system failures made it easier for many abusers to conceal their actions, interfere with complaints processes and continue abusing often with a sense of impunity.
226. Some survivors were abused by others of a similar age, or those placed in the same setting, in what is known as 'peer-on-peer' abuse. In care settings, a culture of physical or sexual violence could be established through staff condoning or even encouraging peer-on-peer abuse between residents.

## Bystanders

227. For some bystanders, the care environment was a significant factor in whether they would intervene when they saw signs of abuse or neglect:

*“Quite aside from the issue of abusive people in positions of power within institutions, the institutionalisation of staff and residents led to an environment in which bad practices were not challenged.”*<sup>178</sup>

228. Bystanders consistently failed to intervene to stop or report abuse and neglect because:
- > the people in their care had become dehumanised in their eyes, so they no longer cared what happened to them
  - > they gave abusers “the benefit of the doubt” due to personal relationships, grooming, and cognitive bias
  - > they were reluctant to intervene due to fear of reprisals, or there was an institutional culture that discouraged or suppressed intervention
  - > they were not trained to identify signs of abuse or neglect
  - > they had become desensitised to abuse and neglect because it was commonplace and normalised in the care setting
  - > there was little consequence for not intervening or reporting (voluntary reporting was introduced in 1989 and reporting protocols for agencies and care providers in 1995).

---

<sup>178</sup> Brief of Evidence of Dr John Crawshaw on behalf of the Ministry of Health for the Investigation into State abuse in psychiatric care (1 April 2021, para 3.5).

## Standards of care were routinely breached

229. Before and throughout the Inquiry period, mental health care settings had common legal standards to prevent ill-treatment, later called abuse and neglect. These common standards were all similar to this standard for institutional care which had been in place since 1911.

*“Every Superintendent, licensee, officer, nurse, attendant, householder, or other person having the oversight, care, or control of any mentally defective person, or employed in any institution, house, or place in which any such mentally defective person resides, who strikes, wounds, or ill-treats, or wilfully neglects, any such mentally defective person is guilty of an indictable offence.”<sup>179</sup>*

230. Before and throughout the Inquiry period, across all State and faith-based care settings it was a criminal offence to sexually abuse or indecently assault a person in care (consent was not a defence),<sup>180</sup> with special provisions for women and girls, regardless of age, in institutional care.

*“Every person is guilty of an indictable offence who has or attempts to have carnal knowledge of any female who is detained under the provisions of the Act, or is otherwise under oversight, care, or control as mentally defective [consent is no defence].”<sup>181</sup>*

231. Between 1950 to 1992, it was left to government agencies and institutions to decide whether and how they would protect the rights of the people in their care. From November 1992, the basic rights of people subject to compulsory mental health treatment orders were protected in legislation.<sup>182</sup> They had:

- > the right to know their rights while in care and have a copy in writing;
- > the right to an interpreter, including for te reo Māori or to meet their communication needs
- > access to independent legal and psychiatric advice
- > the right to company
- > the right to send and receive mail and make phone calls.

<sup>179</sup> Mental Defectives Act 1911, sections 126–127; Mental Health Act 1969, sections 112–113; Mental Health (Compulsory Assessment and Treatment) Act 1992, section 114; Child Welfare Act 1925, section 24; Child and Young Persons Act 1974, section 103; Children, Young Persons, and Their Families Act 1989, section 453; Children, Young Persons, and Their Families Amendment Act 1994, section 2; Industrial Schools Act 1882, sections 48, 75; Offences of the Person Act 1867.

<sup>180</sup> See Crimes Act 1908 sections 208–219; Crimes Act 1961, section 195.

<sup>181</sup> Mental Defectives Act 1911, section 127; Mental Health Act 1969, section 113.

<sup>182</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 64–75.

232. A complaints process was also included which provided important protections including the requirement for directors of area mental health care services to rectify matters and rights of appeal.<sup>183</sup> There was also a general emphasis on family connections and cultural identity and connections to support protective factors while in care.
233. There was a legislated requirement in the Health and Disability Services Act 1993 for standards of services (rather than care or preventing and responding to abuse or neglect in the care of a provider), and general objectives to secure the best health, care and greatest independence for people receiving the services. The Department of Health's 1992 Child Abuse Guidelines for Health Services set standards for preventing and responding to abuse.<sup>184</sup>
234. From 1996, most people in the care of health and disability service providers were also entitled to services that met the standards in the Code of Health and Disability Services Consumers' Rights. There were limitations on the right to informed consent for some people who were considered unable to do so or where compulsory mental health treatment was ordered.<sup>185</sup> The standards in the code focused on the rights of people in care, including:
- > the right to be treated with respect
  - > the right to be free from discrimination, coercion, harassment and exploitation
  - > the right to dignity and independence
  - > the right to make an informed choice and give informed consent (although people subject to a compulsory order were specifically excluded from this right).<sup>186</sup>

### **Individual care needs were often not recorded or were ignored**

235. Some care settings had record keeping and data management policies regarding individual care needs in place,<sup>187</sup> however the Inquiry heard evidence that these policies were not always followed and did not require the ethnicity or cultural identity of people in care to be recorded.
236. Several survivors told the Inquiry that their ethnicity was misidentified, incorrectly recorded or not recorded at all.<sup>188</sup> This primarily affected Māori and Pacific survivors. Research has found evidence of "insufficient, patchy and poor-quality ethnicity data collection across State care institutions".<sup>189</sup>

<sup>183</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 6, 64–75.

<sup>184</sup> Department of Health, Child abuse guidelines for health services (June 1992, page 5).

<sup>185</sup> Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996.

<sup>186</sup> Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, regulation 2.

<sup>187</sup> Record Keeping History of the Ministry of Social Development and its Predecessor Agencies: Part One – Agency Structure, Records Systems, and Procedures (n.d., pages 52–54).

<sup>188</sup> Witness statements of Joanna Oldham (2021, para 11); Mr CE (8 July 2021, para 117) and Rachael Umaga (18 May 2021, paras 21, 51, 64).

<sup>189</sup> Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, Leonard, J, Hāhā-uri, hāhā-tea: Māori Involvement in State Care 1950–1999 (Ihi Research, 2021, page 373).

237. From the late 1980s, failures to accurately identify and record individual care needs often meant services or funding were not provided to the person in care despite their care needs and eligibility.
238. In 1994, the State introduced the Needs Assessment and Service Coordination service. The purpose of this service was to identify the needs of disabled people and people experiencing mental distress and match these to standardised funding and services.<sup>190</sup> The foundational policy for the Needs Assessment and Service Coordination service identified that it should not treat disabled people as being sick, it should be culturally sensitive and be flexible and innovative.<sup>191</sup> However, during the Inquiry period the service was based on a medical approach to treating impairments rather than the holistic the needs of the person and their whānau.
239. While some people were provided with the right supports and care through the Needs Assessment Service Coordination service, some were not which increased their risk of abuse and neglect. Several reports were published in the late 1990s and early 2000s highlighting problems with the service, particularly for Māori and Pacific Peoples.<sup>192</sup> In 2003, the National Advisory Committee on Health and Disability would recommend the service be fundamentally redesigned because of its shortcomings in identifying and meeting the needs of disabled people and people experiencing mental distress.<sup>193</sup>

### **Institutional environments and practices that breached standards**

240. During the Inquiry period, many children, young people and adults were placed in large-scale mental health care settings. Institutional models of care, which included institutional environments and practices, were a feature of these care settings.
241. Despite the diversity of people in settings and their different needs, they experienced a heavily regimented one-size-fits-all model of care with the same form of care applied to everyone regardless of their age, gender, abilities, culture, needs and reasons for being in care.
242. Conformity with rules and discipline and order were prioritised over the needs of people in care, described as an approach of “rules, power and control”.<sup>194</sup> Conformity was often enforced through harsh and abusive discipline.<sup>195</sup>

<sup>190</sup> Te Whatu Ora, Needs Assessment (2023).

<sup>191</sup> Shipley, J, & Upton, S, Support for Independence for People with Disabilities – A New Deal (Ministers of Health and Social Welfare, 1992, page 10).

<sup>192</sup> Health Funding Authority, Disability Support Services: Strategic work programme: Building on the New Deal (Ministry of Health, 1998); National Advisory Committee on Health and Disability, To Have an ‘Ordinary’ Life Kia Whai Oranga ‘Noa’ (September 2003).

<sup>193</sup> National Advisory Committee on Health and Disability, To Have an ‘Ordinary’ Life Kia Whai Oranga ‘Noa’ (September 2003, page 49).

<sup>194</sup> Witness statement of Helen Porter (26 August 2022, page 5).

<sup>195</sup> Witness statements of Mr GV (27 July 2021, paras 56–57, 78) and Jonathon Stevenson (29 March 2022, paras 72–73, 84).

243. For some larger institutions, a strict one-size-fits-all routine meant they could rely on smaller staff numbers. The Inquiry heard that smaller staff numbers led to people in care losing their independence and individuality.<sup>196</sup>
244. An emphasis on conformity over individual needs resulted in standards of care being overlooked or ignored and people in care not receiving the level of care they needed, increasing the risk of abuse and neglect. For example, in its report to the Minister of Health in 1986, the Department of Health said:
- "In most psychiatric hospitals in New Zealand the range of treatment options available is inadequate so that patients with very different needs are often treated in the same ward with the same programme ... the lack of individualised assessment, treatment and rehabilitation programmes tends to lead to undue reliance on drug therapy and various forms of custodial care; and to seclusion."***<sup>197</sup>
245. In that same report, the Minister of Health was told there was a widespread lack of formal recognition of the cultural needs of people in mental health settings, such as access to te reo Māori interpreters, rongoā practitioners or cultural support groups.<sup>198</sup>
246. Overcrowding was common in mental health settings.<sup>199</sup> Many institutions had substandard physical environments. Buildings were outdated, poorly designed and inappropriate. Overcrowding often led to compromised daily routines like reduced or absent oversight, lack of individualised care and limited activities. Many people in overcrowded and unsuitable environments suffered abuse and neglect, including:
- > sexual abuse
  - > a lack of privacy and dignity through open toilet, washing, and sleeping areas
  - > compromised personal hygiene and dental and medical care
  - > no access to clean personal items like clothes and shoes
  - > limited warm clothing and bedding
  - > generally unsanitary living conditions.<sup>200</sup>

196 Transcript of evidence of Dr John Crawshaw, Director of Mental Health and Addition Services, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 212)

197 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 6–7).

198 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 10–11).

199 Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 19); Parker, W, Social Welfare Residential Care 1950–1994, Vol 1 (Ministry of Social Development, October 2006, page 49); Grant, JW, Acting Director-General Department of Social Welfare, Circular Memorandum re: Numbers of children and young people in family homes (Department of Social Welfare, 23 October 1981).

200 Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 19, 31–32); Witness statement of Te Aroha Knox (16 August 2021, paras 25–31).

247. Geographically isolated facilities could increase the risk of abuse and neglect by creating opportunities and cultures of total control with limited outside influence.<sup>201</sup> Isolated facilities could also lead to staff focusing on control and surveillance, which contributed to them becoming desensitised to the needs of people in their care.<sup>202</sup> Isolated areas within facilities could become areas where abusers would have unsupervised access to people in care and their abuse hidden from sight.<sup>203</sup> Isolated facilities could also make it difficult for families and whānau to connect with and visit their loved one in care, a critical protective and safeguarding factor.
248. Secure units were an unsuitable physical environment that contributed to the abuse and neglect of children, young people and adults in care.

### **Solitary confinement, seclusion and secure care wrongfully used as punishment**

249. Some settings had standards that limited the use of solitary confinement, seclusion or secure care. For example, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 it was only to be used if necessary, where necessary, and for as long as it was necessary, for the care or treatment of the patient or the protection of other patients.<sup>204</sup>
250. Despite these limits on the use of solitary confinement, seclusion and secure care, the Inquiry found survivors commonly reported the wrongful use of solitary confinement in mental health facilities.

### **Medical standards were frequently breached, at times unlawfully**

251. Despite a range of medical standards being in place, the Inquiry found some children, young people and adults in care experienced over-medicalisation, lobotomies, sterilisation, invasive genital examinations, experimental psychiatric treatments without informed consent, electric shocks and injections of paraldehyde as punishment, which exposed some patients to unreasonable medical risks.

201 Beyer, L, Higgins, D, & Bromfield, L, Understanding organisational risk factors for child maltreatment: A Review of Literature (Australian Government Department of Families, Community Services and Indigenous Affairs, 2005, pages 46–47).

202 Green, L, "Analysing the sexual abuse of children by workers in residential care homes: Characteristics, dynamics and contributory factors", *Journal of sexual aggression* 7(2) (2008, page 17).

203 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, pages 177–178); Mathews, B, Child Sexual Abuse in Institutional and Non-Institutional Context, in Mathews, B & Bross, DC (eds) (2019, pages 162–163).

204 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 71.

252. Many people in care were medicated for long periods without the necessary medical reviews.<sup>205</sup>

*"Significant numbers of patients continue to be given drugs for lengthy periods without review. Such lack of review of individual treatments is of particular concern as many of the drugs, if given over prolonged periods, are capable of producing serious side effects."*<sup>206</sup>

## **Poor employment policies, practices contributed to abuse, neglect**

253. Many staff and carers in mental health settings genuinely approached their position to do the best they could for those in their care. However, poor employment policies combined with poor senior leadership and management practices could undermine or make it harder for individual staff and carers to safeguard people in care.<sup>207</sup>

254. Generally, employment policies and practices were left to each setting to decide what was needed from 1950 through to the late 1980s. Some departments would set broad, process-based requirements through service contracts.<sup>208</sup> From the late 1980s, different settings had different legal obligations.

255. During the Inquiry period there were no mandatory vetting requirements or policies for mental health settings. At times there was a deference to membership of professional bodies like the New Zealand Medical Council, the regulatory body for doctors.

256. The Medical Council could not register people who had been convicted of any offence punishable by imprisonment of two years or more or who were "otherwise not of good fame or character".<sup>209</sup>

---

205 Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 29); Witness statement of David Newman (31 May 2022, page 8).

206 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 7).

207 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, pages 158–159, 166–172); Historical Institutional Abuse Inquiry (Northern Ireland), Report of the Historical Institutional Abuse Inquiry (2017, pages 25–27); Independent Inquiry into Child Sexual Abuse (United Kingdom), The Report of the Independent Inquiry into Child Sexual Abuse (2022, page 124).

208 New Zealand Community Funding Agency, Standards for Approval Level One: Child and Family Support Services (November 1995, Standards 13–16, pages 31–34).

209 Medical Practitioners Act 1950, section 16; Medical Practitioners Act 1968, section 22.

257. The Medical Practitioners Act 1995 tightened restrictions on registration. Doctors who had been convicted of any offence punishable by imprisonment for a term of three months or longer had to satisfy the Medical Council that the offence would “not reflect adversely on his or her fitness to practice medicine”.<sup>210</sup> The Medical Council could also decline registration if an individual was “not fit to practice medicine by reason of any mental or physical condition”,<sup>211</sup> if they had been the subject of professional disciplinary proceedings,<sup>212</sup> or were otherwise “not fit to practice medicine”.<sup>213</sup>
258. However, as the Medical Council acknowledged at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing in June 2021, it did not always act to ensure that people in care were safe from doctors who should not have been practicing.<sup>214</sup>
259. The Nursing Council of New Zealand decided who could become a registered nurse. Throughout most of the Inquiry period the only restrictions outlined in the governing legislation were that the nurse had to be a certain age and “of good character and reputation”.<sup>215</sup>

### **Staff and carers were often compromised by under resourcing**

260. Understaffing in mental health settings contributed to abuse and neglect in care through staff being overworked, tired and under pressure. This affected their ability to provide individualised care, and contributed to emotional, physical, and educational neglect of people in care. It also contributed to abuse and neglect through inadequate oversight or supervision of staff which provided abusers with opportunities to abuse or neglect people in their care.<sup>216</sup>

---

<sup>210</sup> Medical Practitioners Act 1995, section 13 (b).

<sup>211</sup> Medical Practitioners Act 1995, section 13 (c).

<sup>212</sup> Medical Practitioners Act 1995, section 13 (d).

<sup>213</sup> Medical Practitioners Act 1995, section 13 (g).

<sup>214</sup> Transcript of evidence of Aleyna Hall and David Dunbar, New Zealand Medical Council, at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing (Royal Commission of Inquiry into Abuse in Care, 23 June 2021, page 652).

<sup>215</sup> Nurses and Midwives Act 1945, section 16; Nurses Act 1971, section 19; Nurses Act 1977, section 19.

<sup>216</sup> Witness statements of Johnny Nepe (10 December 2021, page 16) and Mr HN (7 May 2022, page 6).

261. Understaffing in mental health settings was a common problem.<sup>217</sup> Many staff said they felt overworked, under pressure and tired due to understaffing.<sup>218</sup> A 1986 review of psychiatric and psychopaedic hospitals made a direct link between understaffing and neglect of patients, noting that insufficient staff numbers led to “deficiencies in dignity and in the basic elements of appropriate care”.<sup>219</sup> The review also found that:
- “Staff shortages and low morale seriously affect patient care and ... lead to lack of awareness and general acceptance of substandard conditions ... staff often appear defeated and convey an air of resignation.”***<sup>220</sup>
262. Some staff from mental health care settings told the Confidential Forum for former in-patients of psychiatric hospitals about having “a lack of time for kindness”.<sup>221</sup> The 1996 second Mason inquiry into mental health care services found that “multi-disciplinary staff shortages have resulted in lower standards of care.”<sup>222</sup>
263. Throughout the Inquiry period care work was not valued by society. This inadequate recognition contributed to conditions where staff and care workers were not appropriate or appropriately trained, were underpaid, experienced poor working conditions, and were otherwise not supported to provide safe and therapeutic care. These factors contributed to environments in which abuse was more likely to occur.
264. Poor supervision or performance management contributed to abuse and neglect because it became accepted and staff and carers were not held to account for abuse or neglect.
- “A culture of using physical violence against children, young people and adults in care was so normalised in some care settings that staff found it difficult to intervene when they witnessed abuse or were ostracised if they complained.”***<sup>223</sup>

<sup>217</sup> Prebble, K, Ordinary men and uncommon women: A history of psychiatric nursing in New Zealand public mental hospitals 1939-1972 (The University of Auckland, 2007, pages 58, 99, 240); Witness statement of Mr El (20 February 2021, page 4); Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 11-12).

<sup>218</sup> Prebble, K, Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals 1939-1972 (The University of Auckland, 2007, page 58); Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, pages 120-121); Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 11-12).

<sup>219</sup> Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 8).

<sup>220</sup> Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 12).

<sup>221</sup> Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 32).

<sup>222</sup> Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, page 123).

<sup>223</sup> Witness statements of Allison Campbell (15 February 2022, paras 2.48, 3.15); Caroline Arrell (21 March 2022, para 2.61); Ken Bragan (19 February 2022, para 21) and Enid Wardle (3 October 2021, para 3.25).

## **Inadequate training and development to deliver care**

265. Many staff and carers did not have the training and development needed for their roles and the demands they faced in care settings, particularly in overcrowded and under-resourced facilities. For regulated care professions like medical professionals, training, development and vetting could form part of their registration requirements.
266. In mental health care settings there were numerous reports of a lack of training of both clinical and non-clinical staff and concerns about how that affected children, young people and adults in care.<sup>224</sup> The second Mason inquiry into mental health services in 1996 found a lack of trained staff, particularly in child and adolescent mental health.<sup>225</sup> Where training was provided, it sometimes taught techniques that were not appropriate for a supportive care environment.<sup>226</sup>
267. Referring to the recommendations on patient rights in the 1983 Gallen Inquiry, the Mason Inquiry said the changes in the Mental Health (Compulsory Assessment and Treatment) Act 1992 that provided better protection for patients, and should have reduced inpatient admissions, required significant staff training and resourcing to be effective. That training and resourcing had not happened. The necessary community-based services had not been set up and as a result hospital admissions were still seen as the mainstay of crisis response.<sup>227</sup>
268. Before the 1980s, there was limited training and development of staff and care workers to identify signs of abuse and neglect in care.<sup>228</sup> From the 1980s onwards, most care settings began developing their own guidance and training, initially focusing on sexual abuse.
269. The Department of Health issued Child Abuse Guidelines for Health Services in 1992 to supplement area health boards' own policies and processes on identifying and responding to signs of abuse and neglect:

***“The safety of the child is paramount. Health service providers must therefore ensure that staff are provided with a basic knowledge and understanding of the indicators of child abuse, and the appropriate reporting procedures to follow.”<sup>229</sup>***

<sup>224</sup> Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 12–13); Behrens, MJ, Report on Inquiry pursuant to section 58 (1) of the Mental Health Act 1969 (4 October 1983, page 43)

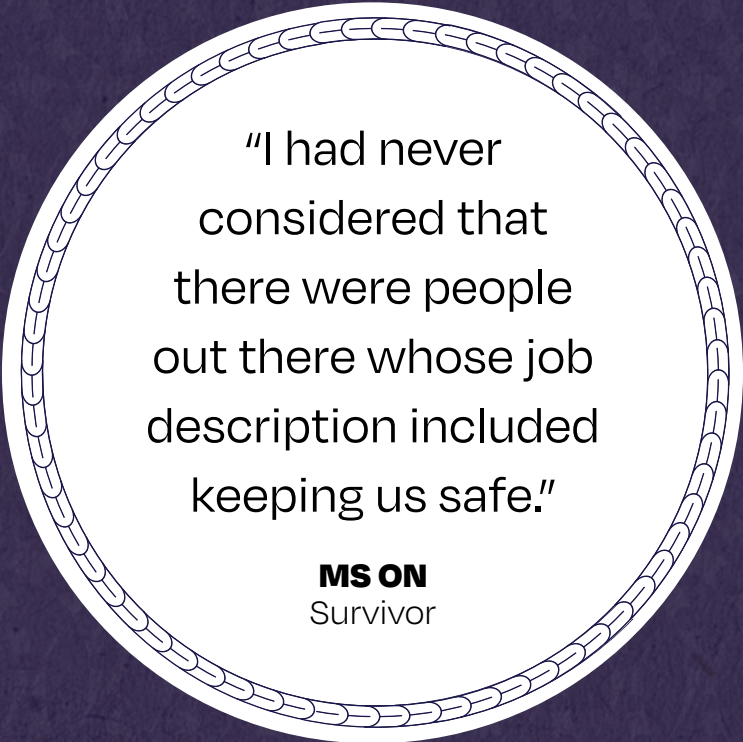
<sup>225</sup> Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, (May 1996, page 133).

<sup>226</sup> Witness statement of Caroline Arrell (21 March 2022, para 2.10–2.14).

<sup>227</sup> Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, page 22).

<sup>228</sup> Daly, K, Redress for historical institutional abuse of children, in Deckert, A & Sarre, R (eds), The Palgrave Handbook of Australian and New Zealand Criminology, Crime, and Justice (2017, page 7); Witness statements of Denis Smith (15 December 2021, para 19) and Patricia Williams (12 July 2022, paras 12, 29); Ministry of Social Development, Practice review for [survivor] (April 2011, para 41).

<sup>229</sup> Department of Health, Child abuse guidelines for health services (June 1992, page 14).



"I had never  
considered that  
there were people  
out there whose job  
description included  
keeping us safe."

**MS ON**  
Survivor

## **Few records were kept of complaints of abuse and neglect**

270. Although mental health care settings were subject to the record keeping requirements of the Archives Act 1957 (detailed in Part 2 of the Inquiry's final report, *Whanaketia – Through pain and trauma, from darkness to light*), few records were kept of complaints of abuse and neglect in mental health care settings. Before 1992, complaints were routinely not recorded in mental health care settings. When recorded, they were often not reflective of what had happened, and were dismissive of the abuse and/or neglect reported. There are limited records regarding complaints made to relevant professional bodies.<sup>230</sup>
271. The 1983 Gallen Inquiry found that incidents and allegations of ill treatment at Oakley Hospital in Tāmaki Makaurau Auckland were not recorded on patient files. Instead, an incident book was used to record altercations on the ward, including between patients and staff. The Gallen Inquiry indicated that this was done out of a desire to protect staff from any disciplinary action that might result from an allegation of mistreatment.<sup>231</sup>
272. The Gallen Inquiry noted that the proper process was for complaints and violent incidents to be recorded on patient files and properly investigated, including referring matters to the official visitor as soon as possible after they occurred.<sup>232</sup>
273. There was also a failure to report complaints to the appropriate authorities. The Inquiry heard evidence that across multiple institutions there was a reluctance by staff to involve NZ Police in complaints of abuse and neglect.
274. Pākehā survivor Alison Pascoe (deceased), who was in Kingseat Psychiatric Hospital in Karaka, reported that she was sexually assaulted by a male patient when she was 12 years old, around 1954. After she disclosed the incident to staff, there were some repercussions for the patient, but there was no police involvement. Alison told the Inquiry that staff:

***"...should have called the Police. I don't know why they didn't. Patients had no rights."***<sup>233</sup>

230 Affidavit on behalf of the Medical Council of New Zealand for Notice to Produce No1 (10 June 2020, pages 3–5); Affidavit of Associate Professor John Allan on behalf of the Royal Australian and NZ College of Psychiatrists, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No 1 (11 December 2020, pages 3–5).

231 Gallen, R, Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, (January 1983, page 87).

232 Gallen, R, Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, (January 1983, pages 97–98).

233 Witness statement of Alison Pascoe (29 April 2022, paras 2.69–2.73).

## Complaints processes were absent or easily undermined

275. Until the 1990s, the primary mechanism for people in care to raise concerns or make complaints was through district inspectors and official visitors. Unlike district inspectors, official visitors did not need to be highly qualified but have "impartiality, respectability and social concern".<sup>234</sup>
276. In the early years, there were too few district inspectors, only two in the whole country in the 1960s, increasing to 27 by 1997.<sup>235</sup> Their role was poorly defined, and many patients were not aware of them or how to speak to them. While the official visitor role was retained under the Mental Health (Compulsory Assessment and Treatment) Act 1992, in 2014, 14 years after the Act was passed, no official visitors had been appointed.<sup>236</sup>
277. After 1992, there was a legislated complaints process for people in care who were subject to compulsory assessments and treatment orders.<sup>237</sup> It was limited to complaints about breaches of their statutory rights, but did ensure patients had access to advocacy, and that all complaints were to be independently investigated by either the district inspector or official visitor.<sup>238</sup>
278. From 1996, the Code of Health and Disability Services Consumers' Rights made it clear that anyone in the care of a service provider had the right to complain.<sup>239</sup>

---

234 Prebble, K, Gooder, C & Thom, K, New Zealand's Mental Health District Inspector in historical context: "the impartial scrutiny of a citizen of standing", the Journal of Law, Medicine & Ethics 22(2) (2014, page 417).

235 Professor Michael Taggart, Report to the Ministry of Health on District Inspectors (20 May 1997, pages 3, 11).

236 Prebble, K, Gooder, C & Thom, K, New Zealand's Mental Health District Inspector in historical context: "The impartial scrutiny of a citizen of standing", the Journal of Law, Medicine & Ethics 22(2) (2014, page 424).

237 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75.

238 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75(1).

239 Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, regulation 2, right 10

## **People in care faced barriers and needed family, whānau, or advocacy support**

279. In many mental health settings, families were actively discouraged from visiting their loved ones in care and other forms of family contact were restricted.<sup>240</sup> At times, care was taken to ensure the abuser's reputation was protected.
280. In mental health settings, it was left to each setting to develop its own policies on reporting to police. The Inquiry heard evidence that across multiple settings there was a reluctance by staff to involve police in complaints of abuse and neglect.
281. Prior to 1992, complaints were not routinely recorded in mental health care settings. When recorded, they were often not reflective of what had happened, and were dismissive of the abuse complained of. There are limited records regarding complaints made to relevant professional bodies.<sup>241</sup>

## **Oversight and monitoring did little to change the experiences of people in care**

282. The Mental Defectives Act 1911 set out the monitoring and oversight of people experiencing mental distress. The Act provided for an Inspector-General of Health, District Inspectors and Official Visitors as necessary.<sup>242</sup> These three roles represented the entire oversight and monitoring mechanism for mental health hospitals until the establishment of the Human Rights Commission, Children's Commission, and the Health and Disability Commission in the 1990s.
283. The Inspector-General of Health was responsible for the general administration of the Mental Defectives Act.<sup>243</sup> District inspectors were acknowledged in a 1983 policy proposal as "one of the few legislative safeguards available to patients in the mental health system."<sup>244</sup> This safeguard was applied inconsistently and with little direction from the Department of Health.

---

240 Mirfin-Vietch, B & Conder, J, Institutions are places of abuse: The experiences of disabled children and adults in state care (Donald Beasley Institute, 2017, page 40).

241 Affidavit on behalf of the Medical Council of New Zealand for Notice to Produce No1 (10 June 2020, pages 3–5); Affidavit of Associate Professor John Allan on behalf of the Royal Australian and NZ College of Psychiatrists, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No 1 (11 December 2020, pages 3–5).

242 Mental Defectives Act 1911, section 41(1).

243 Mental Defectives Act 1911, section 42 (1).

244 Ministry of Health, New policy proposal – New initiative, (1983, page 1).

284. The Inquiry saw evidence that when district inspectors raised concerns these were not always taken seriously.<sup>245</sup> Patients were not always aware of the role of district inspectors or how to access them.<sup>246</sup> Survivors confirmed the lack of awareness regarding district inspectors. Ms ON, who spent time at Claybury House at Kingseat Hospital in Karaka, explained:
- "I had never considered that there were people out there whose job description included keeping us safe."*<sup>247</sup>
285. At the beginning of the Inquiry period, the role of official visitors in monitoring mental health hospitals was already well-established, having been provided for in legislation since 1846.<sup>248</sup> Official visitors could visit any hospital in the area they were responsible for, without previous notice, as often as they thought fit, but had to do so at least once every three months and this increased to once a month for inpatients in 1992.<sup>249</sup>
286. Official visitors' reports highlighted issues to hospital management like neglect and inadequate facilities, including no privacy in the toilets and poor-quality food.<sup>250</sup>
287. There were various issues with the effectiveness of official visitors, like patients being unaware of their existence or viewing them as part of the hospital system. Hospitals' management sometimes took a hostile approach to official visitor's reports and recommendations.
288. The lack of independence, definition and direction for both the district inspector and official visitor roles reduced the potential effectiveness of these roles and contributed to abuse in care.
289. In 1994, the Health and Disability Commissioner Act was enacted to establish the role of an independent Health and Disability Commissioner, an independent advocacy service, and to provide for a Code of Health and Disability Services Consumers' Rights.<sup>251</sup> The Health and Disability Commission provides nationwide, government-funded, independent advocacy through the Advocacy Service for consumers of health and/or disability services who want to make a complaint regarding a breach of their rights under the Code of Health and Disability Services Consumers' Rights.<sup>252</sup>

<sup>245</sup> Letter from the District Inspector of Tokanui Hospital, David Bates, to the Minister of Health (22 December 1994, page 1).

<sup>246</sup> Letter from the Deputy Director-General of Health to Chief Executives of Health Boards (29 November 1979, page 2).

<sup>247</sup> Witness statement of Ms ON (11 May 2022, para 500).

<sup>248</sup> Lunatics Ordinance 1846; Mental Defectives Act 1911, sections 70-78; Mental Health Act 1969, sections 5 and 56-65; Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 94-98; Prebble, K, Gooder, C, & Thom, K, New Zealand's Mental Health District Inspector in historical context: "The impartial scrutiny of a citizen of standing", the Journal of Law, Medicine & Ethics 22(2) (2014, page 416).

<sup>249</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, section 96 (1)(a).

<sup>250</sup> Letter from Official Visitor to Tokanui Medical Superintendent re: Concerning official visits 9 October 1985 and 22 October 1985 (23 October 1985).

<sup>251</sup> Report of the Social Services Committee, Inquiry into the quality of care and service provision for people with disabilities – Presented to the House of Representatives (September 2008, page 35); Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

<sup>252</sup> Nationwide Health & Disability Advocacy Service, About us – The Advocacy Process (webpage, n.d.).

## The State's responsibility for care

290. Throughout the Inquiry period, specific State officials had statutory responsibilities to and were accountable for the treatment of people in their care, including in mental health care settings.
291. Many of the people in policy leadership roles lacked diversity and lived experience of what it was like to be in care.<sup>253</sup> Most leaders within the State in the Inquiry period were Pākehā, non-disabled men. This lack of diversity and lived experience of care in the State's leadership contributed to discriminatory policy and legislative design and decisions that did not meet the diverse needs of people in care.
292. The State often failed to provide concrete support or special measures to families, whānau or parents in need, which affected their ability to care for their loved ones at home.<sup>254</sup> The State often failed to adequately explore other community or family-based options that prevented the need for out-of-whānau care.<sup>255</sup>
293. Discriminatory legislation, policies and practices reflected the views and attitudes of the people who designed them.<sup>256</sup> By and large, decision-makers lacked diversity and lived experience of care.<sup>257</sup> The perspectives of children, young people and adults in care were largely not considered in the design of legislation, policies and practices that affected them.
294. The Inquiry saw that the State attempted to make some changes to prevent and respond to abuse in care. However, despite changes to legislation and policies, instances of abuse in care have persisted, in part due to the ongoing discrimination towards those with care needs.
295. Some changes, like the closing of large institutions, took decades to achieve and had a marked impact in reducing rates of abuse and neglect. However, a switch to community-based care did not address the continuing discrimination and stigma within the mental health sector.

253 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, pages 274–283).

254 Brief of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, August 2022, para 43); Further Acknowledgements made by Geraldine Woods on behalf of Whaikaha Ministry of Disabled People for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 2022, para 8).

255 Brief of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, August 2022, para 43); Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8); Further Acknowledgements made by Geraldine Woods on behalf of Whaikaha Ministry of Disabled People for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 2022, para 8).

256 Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8 (5)); Crown Closing Statement for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, para 17); Crown Closing Statement for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, para 13);

257 Transcript of evidence of Peter Hughes, Public Service Commissioner, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, pages 1064–1065).

296. In settings like mental health care there were successive calls for change from families, whānau, communities and advocacy groups. The State, however, was slow to implement change and generally left decision-making powers to institutions themselves. It was not until 1992 that the State set legislative protections for people subject to compulsory treatment.
297. While deinstitutionalisation of care was an important step taken in the Inquiry period, there many years of institutionalising people suffering mental distress away from the families, whānau and communities. The push for deinstitutionalisation began in the late 1950s but it was not until the 1970s that these ideas finally began to take hold. Even then, the State was slow to make real change.

## **Society's responsibility for care**

298. The Inquiry heard that attitudes of ableism have directly contributed to people experiencing mental distress entering care and suffering abuse and pervasive neglect in care during the Inquiry period.
299. At the Inquiry's State Institutional Response Hearing, the Director-General of Health Dr Diana Sarfati acknowledged "that institutional and societal ableism in legislation, policy and systems has contributed to the abuse of disabled people and people with mental health conditions in health and disability care settings."<sup>258</sup>
300. Ableism underpinned the views of disability throughout the inquiry period, and disablism was inherent within all care settings.<sup>259</sup> Throughout the Inquiry period limited understandings of neurodiversity, traumatic brain injury and foetal alcohol spectrum disorder (FASD) contributed to survivors entering and suffering abuse and neglect in care.
301. The Inquiry heard that ableism and disablism was embedded in Aotearoa New Zealand society,<sup>260</sup> and that ableist attitudes contributed to policies of institutionalisation that resulted in the invisibility of disabled people, including people experiencing mental distress, throughout the inquiry period. The Inquiry also heard that the whānau of disabled people were not adequately supported with resources and investment to ensure they could care for disabled family members, and that communities were not reasonably or adequately funded to provide supports and deliver programmes. This included the whanau of people experiencing mental distress.

<sup>258</sup> Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8(5)).

<sup>259</sup> Brief of evidence of Dr Brigit Mirfin-Veitch for the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in Care, June 2022, para 73).

<sup>260</sup> Transcript of evidence of Dr Brigit Mirfin-Veitch at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in care, 20 July 2022, page 642).

302. At the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing, expert witness Dr Brigit Mirfin-Veitch explained that:

*“understanding how social structures impact on and shape disability, violence and abuse also requires recognition that the way society works is framed by privilege and power, which is embedded in our economic and political and social policies and practices, that focus on the dominant and most productive members of society.”<sup>261</sup>*

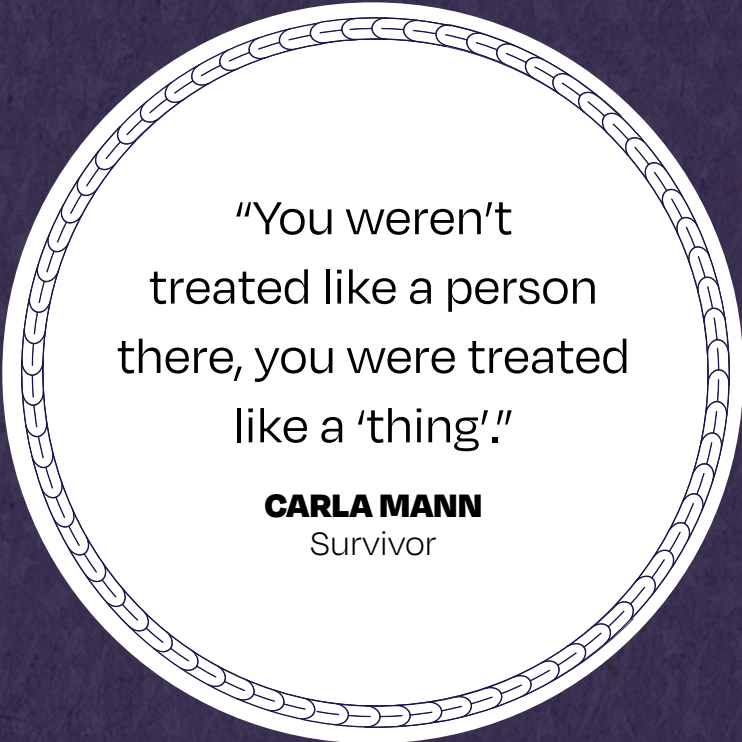
303. Segregating and congregating people experiencing mental distress in care institutions, away from their whānau, where they continued to be stigmatised demonstrated that they were not valued equally with able-bodied people. People experiencing mental distress in care were denied inclusion and participation. Education opportunities were limited and neglected. People in mental health care settings were generally unable to develop their independence or their unique gifts and strengths. Being kept away from their whānau and community exacerbated this.
304. Congregating people on perceived disability also led to assumptions of similarity between individuals, and people were not treated and cared for as individuals. This resulted in society continuing to disempower children, young people and adults in care who were experiencing mental distress from participating in decision making processes.

---

<sup>261</sup> Transcript of evidence of Dr Brigit Mirfin-Veitch at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (Royal Commission of Inquiry into Abuse in care, 20 July 2022, page 642).

## **Lessons identified and changes made**

- 305. During the Inquiry period, the State attempted to make some changes to address problems identified in different care settings and to prevent and respond to abuse and neglect in State and faith-based care.
- 306. Most changes were specific to certain care settings. These changes included the creation of new legislation, policy, rules, standards and practices to prevent and respond to abuse and neglect in care as well as subsequent tweaks to these regulations, as new lessons were learned. Several of these changes had a positive impact on people in care, while some had intentions that were not achieved in practice.
- 307. Legislative and policy changes can largely be seen as a good faith attempt by the State to address lessons identified and to respond to and mitigate abuse and neglect in care. With hindsight, much more abuse and neglect could have been prevented if changes had been applied consistently across all settings and implemented differently. The changes often reflected discrete elements of a lesson, which limited their potential impact for preventing and responding to abuse and neglect in care.
- 308. Implementation repeatedly frustrated successful change. Common failures of implementation included funding and resourcing constraints, and lack of diversity in leadership positions, policy design and service delivery.



"You weren't  
treated like a person  
there, you were treated  
like a 'thing'."

**CARLA MANN**  
Survivor

# He waiata aroha mō ngā purapura ora

Kāore te aroha i ahau mō koutou e te iwi i mahue kau noa  
i te tika  
I whakarerea e te ture i raurangi rā  
Tāmia rawatia ana te whakamanioro  
He huna whakamamae nō te tūkinō  
He auhi nō te puku i pēhia kia ngū  
Ko te kaikinikini i te tau o taku ate tē rite ai ki te kōharihari o tōu  
Arā pea koe rā kei te kopa i Mirumiru-te-pō  
Pō tiwhatiwha pōuri kenekene  
Tē ai he huringa ake i ō mahara  
Nei tāku, 'kei tōia atu te tatau ka tomokia ai'  
Tēnā kē ia kia huri ake tāua ki te kimi oranga  
E mate pūmahara? Kāhorehore! Kāhorehore!  
E ara e hoa mā, māngai nuitia te kupu pono i te puku o Kareāroto  
Kia iri ki runga rawa ki te rangi tīhore he rangi waruhia ka awatea  
E puta ai te ihu i te ao pakarea ki te ao pakakina  
Hei ara mōu kei taku pōkai kōtuku ki te oranga  
E hua ai te pito mata i roto rā kei aku purapura ora  
Tiritiria ki toi whenua, onokia ka morimoria ai  
Ka pihi ki One-haumako, ki One-whakatupu  
Kei reira e hika mā te manako kia ea i te utu  
Kia whakaahuritia tō mana tangata tō mana tuku iho nā ō rau kahika  
Koia ka whanake koia ka manahua koia ka ngawhā  
He houkura mārie mōwai rokiroki āio nā koutou ko Rongo  
Koia ka puta ki te whaiao ki te ao mārāma  
Whitiwhiti ora e!

– Paraone Gloyne

# A Love Song for the Living Seeds

The love within me for you, the people, remains unchanged

Left alone, abandoned by justice and order

Subjected to the silent suffering of mistreatment

A heaviness in the core, silenced into stillness

The gnawing of my heart cannot compare to the anguish of yours

Perhaps you are hidden in the depths of the night, Mirumiru-te-pō

A night dark and dense

Where there may be no turning in your memories

But here's my thought: 'Do not push open the door to enter'

Instead, let us turn to seek life and well-being

Is memory dead? No, certainly not!

Arise, friends, let the truth resound loudly from the heart of Kareāroto

To ascend to the clear skies, a sky washed clean at dawn

Emerging from the troubled world to a world of promise

A path for you, my flock of herons, to life

So, the precious core may blossom within you, my living seeds

Scattered across the land, cherished and growing in abundance

Rising in One-haumako, in One-whakatupu

There, my friends, lies the hope to fulfil the cost

To restore your human dignity, your inherited mana from your ancestors

Thus, it will thrive, flourish, and burst forth

A peaceful feather, a treasured calm, a serene peace from Rongo

Emerging into the world of light, into the world of understanding

A crossing of life indeed!

– Paraone Gloyne



**Abuse in Care**  
Royal Commission of Inquiry