



Abuse in Care
Royal Commission of Inquiry

Research Report

What we know about the numbers of people in care
and the extent of abuse in care

Royal Commission of Inquiry into Abuse in Care
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Executive summary

This research report summarises what the Royal Commission of Inquiry (the Inquiry) into abuse in care currently knows about indicative numbers of people who were in certain state or faith-based care settings in Aotearoa New Zealand from 1950 to 2019 and, of those, the number who may have experienced abuse or neglect while in care. Further, it summarises what is currently known about the proportional representation of three different groups in care: Māori, Pacific people, and disabled people. Finally, it examines the number and profile of people who have registered with the Inquiry.

Indicative estimates of people in care and their abuse in care

In examining the indicative numbers of people who were in certain state or faith-based care settings and, of those, the number who may have experienced abuse or neglect while in care, the present research report draws on a report by MartinJenkins (see Indicative estimates of the size of cohorts and levels of abuse in state and faith-based care - 1950 to 2019).

The indicative estimates of how many people were in care, and rates of abuse in care, developed by MartinJenkins for the Inquiry,¹ estimate that from 1950 to 2019 around 655,000 people passed through care in the settings that were examined, which represent a subset of the full range of settings in the Inquiry's terms of reference.²

While there are substantial gaps in the data available for this cohort analysis, it is clear that more people have passed through the care settings examined than was previously known or, in some cases, estimated before the establishment of the Inquiry. Even on the most conservative indicative estimates, there has been more abuse in care than previously thought. On any assessment this is a serious and long-standing social problem that needs to be addressed.

MartinJenkins estimate that of the 655,000 people who passed through care:

- 254,000 passed through social welfare care settings
- 102,000 passed through the educational care settings
- 212,000 passed through health and disability care settings
- 254,000 passed through faith-based care settings.

These numbers total more than 655,000 reflecting the estimated overlap between settings – that is, the fact that many individuals passed through two or more settings. The size of the

¹ For a full explanation of the methodology used to estimate these numbers, see MartinJenkins. (2020, October 1). *Indicative estimates of the size of the cohorts and levels of abuse in state and faith-based care – 1950 to 2019*. Final report for the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions.

² The care settings included in the MartinJenkins indicative estimates are: social welfare, education, health and disability, and faith-based institutions.

cohort, defined as the number of new admissions to a care setting each year, peaked in the 1970s at 122,000 people, before falling to around 70,000 in the 2010s.

Of the estimated 655,000 who passed through care, MartinJenkins estimate that between 17% (n=114,000) and 39% (n=256,000) experienced abuse while in care. Due to the lack of Aotearoa New Zealand research on the prevalence of abuse in care, MartinJenkins' indicative estimates on this are based largely on international studies. International studies are, however, more heavily weighted towards some types of abuse than others (eg, physical and sexual abuse) and mostly exclude neglect. This means the indicative estimates of abuse provided by MartinJenkins would almost certainly be higher, and possibly significantly higher, had they included all forms of abuse within the scope of the Inquiry.

Representation of cohorts in care and their abuse in care

In summarising what is currently known about the proportional representation of Māori, Pacific people and disabled people in state and faith-based care, and as victims of abuse in care, the report draws mostly on Aotearoa New Zealand literature that has explored this topic.

The report examines two key pathways by which children and young people came into care: through the youth justice system and the welfare system.³ It also examines disabled people in disability-specific care settings. It does not examine broader contextual factors, eg, colonisation, institutional racism, policy settings, which may have influenced decisions made in these pathways. This is the subject of ongoing work by the Inquiry, including through our investigations and broader research and policy work.

Māori in care

There is clear evidence that Māori have been over-represented in the care system from at least the 1960s, if not earlier. For example, statistician Len Cook estimates that by the late 1970s, 7% of all Māori boys and 2% of all Māori girls were living in state institutions. Across 2,027 children and young people resident in six Department of Social Welfare institutions in Auckland during 1983, 62% (n = 1,250) were Māori.⁴ Māori also grew as a proportion of the general population over this time and as a proportion of the youth (0 to 19-years) population.

While overall numbers of children and young people in care has fallen substantially since the 1980s, rates of tamariki and rangatahi Māori in care have remained high and even grown. For example, in 2013, Māori comprised 63% of all 'out of home' care placements and 71% of all youth justice residence admissions (which includes those on remand and serving orders in residences) yet comprised only 22% of the Aotearoa New Zealand youth population. By 2018

³ This report uses terms as cited in the studies used. As such, various terms are used throughout this report including welfare system, social welfare system, care system, and care and protection.

⁴ This report provides numbers (n=), where available in the source material.

the proportion of Māori was 69% for all 'out of home' placements and 78% for all youth justice residence admissions, while comprising 25% of the national youth population.⁵

While ethnicity is a factor in rates of abuse in the community, and reports from Australian and Canadian Royal Commissions show that ethnicity can be a factor for suffering abuse in care,⁶ little is known about ethnicity as a factor of abuse in care in Aotearoa New Zealand. A recent Oranga Tamariki report shows that 81% of children abused in care are Māori, while 69% of the children in care are Māori. Māori survivors are also more likely to report racial and cultural abuse while in care.

Pacific people in care

While significant information gaps exist across all three cohorts examined, the gaps are particularly pronounced for Pacific people in care, particularly for the period 1950 to 1999. Sporadic and inconsistent reporting of ethnicity is, in part, the reason for these gaps.

Recent Oranga Tamariki data suggests that Pacific children and young people (aged 0 to 17 years) are proportionally over-represented in youth justice care settings and 'out of home' care placements, though not to the same extent as Māori. In 2013, Pacific children and young people comprised 15% of all 'out of home' placements and 19% of all youth justice residence admissions, while comprising only 11% of the Aotearoa New Zealand youth population. In 2018, these proportions had increased to 16% for all 'out of home' placements and 23% for all youth justice residence admissions, while comprising 13% of the youth population.

A 2019 cohort study of involvement in child protection services by ethnicity, found that Pacific children had elevated rates of abuse notifications (27%), substantiations (11%), and placements (2.4%) compared to all other ethnic groups except Māori (42% of notifications, 20% of substantiations, and 7.1% of placements respectively).

Disabled people in care

Very limited historical data is available on the number and proportion of disabled people in institutional care in Aotearoa New Zealand. What is currently known suggests that disabled people resided in a wide range of care settings including: disability-specific care, such as psychopaedic and psychiatric hospitals; as well as children's homes, youth justice settings, and other types of institutional care. Further, many of this cohort moved between settings.

Disabled people, particularly those with a learning disability, were more likely to be in care, and for longer periods, than non-disabled people. In 1971, for example, 40% of people with a learning disability were housed in psychopaedic facilities. Rates for those over 30-years were 56% to 60%.

⁵ References for sources of information are provided in the body of the report, not in the Executive Summary.

⁶ See Royal Commission on Aboriginal Peoples. (1991); National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. (1997).

While the number of people being institutionalised began to fall from the late 1970s, psychopaedic institutions only began to close in 1994 and the last, the Kimberley Centre in Levin, did not close until 2006. Today, the focus of disability-specific care has shifted to providing options that support disabled people to live in the community or their own homes. Note, though, that many people in these community or home settings still may be in care, and thus within the scope of the Inquiry.

A recent study, using linked data in the Integrated Data Infrastructure, shows that disabled children and young people are proportionally over-represented in Oranga Tamariki involvement: 35% of all disabled children in Aotearoa New Zealand compared to 17% of all non-disabled children. They are also over-represented in ‘out of home’ placements (14% compared to 10% of all children with Oranga Tamariki involvement). The majority of disabled children with Oranga Tamariki involvement have a learning disability (62%).⁷

International studies show that as a population, disabled children and adults experience abuse at far higher rates and for more prolonged periods than non-disabled people, and that disabled children living in care may be more vulnerable to abuse.

Registrations with the Royal Commission of Inquiry

As of late August 2020, 1,756 survivors and witnesses (nearly all survivors) were registered with the Inquiry. Nearly half of all survivors (47%) reported abuse in state care settings, with another 11% reporting abuse in faith-based care settings. A further 5.7% reported abuse in both settings. Reported abuse in care does not total 100% as the setting in which abuse occurred is unknown for 36% of survivors.

Of these survivors, 59% are male and 41% are female. They range in age, with just over a quarter (27%) aged 50 to 59, and nearly a fifth (19%) aged 60 to 69. Younger survivors under age 30 comprise a minority at 4.2%. For those whose ethnicity is known, just over a quarter (28%) identified as NZ European/Pākehā, a quarter (25%) as Māori, and only 0.9% as Pacific. Several people also reported multiple ethnicities, that is, identification with three or more ethnicities. Nearly a third of survivors (31%) reported some form of disability.

⁷ In this paper we use the contemporary community-preferred term ‘learning disability’, for example see <https://www.peoplefirst.org.nz/your-rights/language/>. Terminology has also changed significantly over time. For example, persons properly classifiable under the Mental Defectives Act 1911, included “idiot”, “imbecile”, “feeble-minded”, “epileptic” or “socially defective”.

1. Introduction

This research report presents a summary of what is currently known about:

- demographic changes in Aotearoa New Zealand from 1950 to present;
- indicative numbers of people who were in the care settings in the Inquiry's terms of reference from 1950 to 2019;
- the proportional representation of three groups in care: Māori, Pacific peoples, and disabled people;
- Indicative estimates of the numbers of people who may have been abused in care within the scope of the Inquiry;
- registrations with the Inquiry to date.

The demographic changes described in Section 2 are largely based on publicly available census data. The focus in this section is on changes that provide context, or have implications, for the analysis in subsequent sections, particularly analysis of the proportional representation of Māori, Pacific, and disabled people in care.

The indicative estimated numbers of people who were in care presented in Section 3 are based on a report prepared by MartinJenkins for the Inquiry. Indicative estimates of the prevalence of abuse in care included in Section 5 are also based on the MartinJenkins report. The full version of the MartinJenkins report is published separately.⁸

Section 4 discusses the proportional representation of Māori, Pacific people, and disabled people in a variety of care settings. Section 5 provides indicative estimates of the extent of abuse in care in Aotearoa New Zealand from 1950 to present, as well as the extent of abuse specifically among Māori, Pacific people, and disabled people in care.

While we discuss representation in care, and abuse in care, of Māori, Pacific people, and disabled people separately in this report, we recognise that some people belong to more than one of these groups. Indeed, there is a correlation between ethnicity and rates of disability. For example, Māori have a disproportionately higher rate of disability.

Section 6 concludes by summarising the profile of people who have registered with the Inquiry to date, and includes those who are survivors and witnesses of abuse in care.

Limitations

Due to substantial gaps in the data available for the cohort analysis, the indicative estimates of the number of people who were in care, and numbers who may have been abused in care, developed by MartinJenkins are high-level indicative estimates only. While the researchers used

⁸ MartinJenkins, 2020.

various techniques to fill data gaps where possible, the limitations in the indicative estimates must be acknowledged.

Due to the lack of Aotearoa New Zealand research, MartinJenkins' estimations of numbers of people abused in care are based largely on international studies. MartinJenkins mainly used international studies to formulate the uppermost indicative estimates of numbers abused in care and used local studies to develop their lower-range indicative estimates. The use of international studies has two key limitations. First, most of the studies focus on sexual and/or physical abuse. The Inquiry's scope, by comparison, is much broader and encompasses physical and sexual abuse, as well as emotional and psychological abuse, and neglect. MartinJenkins' indicative estimates of prevalence may, therefore, not reflect all forms of abuse within the scope of the Inquiry.

Second, caution is required when applying overseas studies to Aotearoa New Zealand. Differences in context may not account for differing social, cultural, policy, and legislative factors, or different models of care delivery. And, overseas studies do not account for cohorts unique to Aotearoa New Zealand. MartinJenkins' method of estimating cohort size also does not account for instances of individuals experiencing abuse on multiple occasions and being subjected to multiple forms of abuse. Keeping in mind these limitations, and MartinJenkins' assumption that rates of abuse of those in care are constant over time, is important when considering the indicative estimates produced by MartinJenkins. It is likely that these cohort sizes and abuse rates are higher than the highest indicative estimates provided.

The other data presented in the rest of this report are not exhaustive; due to COVID-19 restrictions, sources have largely been limited to those publicly available online. Significant gaps in knowledge have been identified across all three cohorts, but particularly for Pacific people. There are also gaps in particular care settings, such as faith-based institutions and schools. Further research, including a deeper dive into archival material, is needed to address these gaps and to develop a more comprehensive understanding of the proportional representation of all three groups in care, and their abuse in care.

For much of the period covered by the Inquiry (1950 to 1999), the government did not systematically or appropriately collect ethnicity data. Available ethnicity data has limitations. Any use of subjective methods by agency staff members, such as visual identification to assign ethnicity, means that ethnicity data may be seriously flawed. Also, lack of uniformity across government approaches in defining or reporting ethnicity makes comparisons between different agencies, and over time, challenging.

At a general population level, the definitions of ethnicity used in the census also changed over the period 1950 to 1999, with the shift from "blood quantum" methodologies to the current

method of self-identification of ethnicity.⁹ This has had consequences in terms of determining the proportional representation of these groups in care, and their abuse in care.

Before 1996, when the New Zealand Disability Survey was carried out, governments did not collect official data on the number of people in Aotearoa New Zealand who have a disability. Most of the statistics on disability from before this period are based on administrative data produced by various government agencies involved in the provision or funding of care for disabled people. As with ethnicity, definitions of disability have changed considerably over time, thus this data also has limitations.

⁹ In 1951, previously separate European and Māori censuses were integrated into a single Census of Population and Dwellings (Statistics New Zealand, n.d.[a]). Between 1926 and 1971, ethnicity was based on a racial 'blood quantum', which categorised non-Europeans in terms of their quantum of non-European blood, such as 'full blood' or 'half-blood' (Statistics New Zealand, 2001, p. 2). In 1971, the ethnicity census question was changed to refer to ethnic origin, with respondents asked if they were of full European descent and, if not, what their descent was, calculating fractions (Cormack, 2010, pp. 13-14). Legislation in 1974 defined Māori as 'any person with Māori ancestry' as opposed to the census definition of Māori as anyone with half or more Māori descent (Statistics New Zealand, 2001, pp. 2-3). The next census reflected this change, with respondents asked a two-part question about 'fractions of blood' and ethnic and Māori ancestry (Statistics New Zealand, 2001, pp. 2-3). The 1981 census returned to the traditional race-based approach, where respondents were provided with nine tick boxes to report their self-identified ethnicity and respondents were counted as Māori, for example, if the boxes ticked added up to more than half of 'ethnic origin' (Cormack, 2010, p. 14). In 1986, the census question on ethnicity became, "What is your ethnic origin? Tick all boxes that apply to you" (Cormack, 2010, p. 15). In 1991, the phrasing changed from 'ethnic origin' to 'ethnic group' and in 1996, Māori was placed at the top of the list of ethnic groups (Cormack, 2010, p. 17). "New Zealand European or Pākehā" was included as an option, and there was a significant increase in the numbers of people reporting multiple ethnic identities (Cormack, 2010, p. 17). In this report, Māori, Pacific people, and NZ European/Pākehā are used throughout.

2. Demographic change in Aotearoa New Zealand 1950 to present

Population trends

From 1950 to the present, the Aotearoa New Zealand population has more than doubled. The 1951 Census counted almost two million New Zealanders and in the 2018 Census the population had increased to nearer five million.

Populations of ethnic groups have also increased. In 1951, Māori comprised 6.0%¹⁰ of the total Aotearoa New Zealand population. From 1996 to 2018, the proportion of Māori increased by 21% (from 14% of the total population in 1996 to 17% in 2018). The population of Pacific people grew from 0.2% of the total Aotearoa New Zealand population in 1951 to 5.5% in 1996. Post-2000 census, Pacific people continued to increase as a proportion of the population, from 6.2% in 2001 to 8.1% in 2018.

Geographic and migration trends provide some context for understanding increases in the proportion of Māori and Pacific people in Aotearoa New Zealand. In 1936, just over 11% of Māori lived in urban areas.¹¹ By 1966, the figure was 62%. By 1988, 83% of the Māori population lived in Aotearoa New Zealand's towns and cities. In the space of a few decades, Māori had become "a predominately urban people".¹² This shift is recognised as one of the most rapid internal population migrations in the world.¹³

There are constitutional ties between the Cook Islands, Niue and Tokelau, and Aotearoa New Zealand, although waves of migration have been different from different Pacific Island nations. The significant growth of Pacific peoples in the Aotearoa New Zealand population in the second half of the twentieth century was due to an increase in migration from the Pacific Islands, higher birth rates among Pacific people, and a higher proportion of Pacific women of childbearing age.^{14 15} It was also, in part, due to the census question on ethnicity changing to reflect the community desire for self-identification, rather than "blood quantum" calculations of "ethnic origin".¹⁶

¹⁰ All percentages over 10 are rounded to zero decimal places. All percentages under 10 are rounded to one decimal place.

¹¹ Anderson, Binney and Harris, 2014, p. 395.

¹² Belich, 2001, pp. 471-472.

¹³ Ryks, Pearson, & Waa, 2016, p. 78.

¹⁴ Bathgate, Alexander, Mitikulena, Borman, Roberts, & Grigg, 1994; Bedford, 1994; Bedford, 2009.

¹⁵ Statistics New Zealand, 1998.

¹⁶ Cormack, 2010; Statistics New Zealand, 2001.

Despite this growth, Pacific people were undercounted in the 1976 Census. This was largely due to the fears of deportation felt within Pacific communities, as the efforts of immigration officials and police to identify and deport Pacific people - due to concern over illegal immigration, or “overstaying” on certain visas – increased during this time.¹⁷

Pacific people are geographically concentrated in the major urban area of Auckland. In 2000, for example, 67% of Pacific people in Aotearoa New Zealand lived in Auckland.¹⁸ The geographic concentration of Pacific people in Auckland has implications in terms of understanding the proportion of Pacific children and young people in care; a regional analysis will provide a truer understanding of proportional representation compared to a nationally-based analysis.

Population trends among Māori and Pacific 0 to 19-year olds

From 1950 to 1999, the proportion of young people in the general population decreased. In 1951, young people aged 0 to 19 years comprised over a third (36%) of the total population. While the numbers of young people rose in 1996, the proportion of young people in the general population decreased by 17% to sit at just under a third (30%). This proportional decrease has largely been attributed to the aging profile of the Aotearoa New Zealand population.¹⁹

Māori and Pacific people have more youthful population profiles than NZ European/Pākehā, and have, as a result, increased as a proportion of the 0 to 19-year-old population. In 1986, 1991 and 1996 census, the proportion of young people identified as NZ European/Pākehā fell from 77% to 67%, while the proportions of Māori and Pacific young people increased.²⁰ From 2001 to 2018, the proportion of Māori aged 0 to 19 increased by 18% (from 21% in 2001 to 26% in 2018). In 2001, 10% of the population aged 0 to 19 identified as Pacific people; by 2018, this proportion had increased to 14%. Population changes in Aotearoa New Zealand, particularly in the 0 to 19 cohort provide context for analysis in subsequent sections.

¹⁷ Bedford, 1994.

¹⁸ Gagné, 2000, p. 48.

¹⁹ Statistics New Zealand, 1998, p. 14.

²⁰ Ibid, p. 14.

3. Indicative estimates of people in care from 1950 to 2019

The Inquiry's terms of reference 35.1(b) states that the substantive interim report will include "an analysis of the size of the cohorts for direct and indirect state care and care in faith-based institutions".²¹ The Inquiry contracted MartinJenkins to estimate the size of these cohorts, including:

1. the numbers of people who were in the various settings of state care (as defined in the Terms of Reference 17.3) from 1950 to now;
2. the equivalent number of people placed in the various settings of faith-based care from 1950 to now; and
3. the numbers of people who suffered abuse in state and/or faith-based care, to the extent known.

This section provides a summary of findings of indicative estimates of how many people were in care from 1950 to 2019, the latest year for which data is available.

The full limitations of this analysis, and its methodology, are included in the MartinJenkins report, which is published separately.²² Notably, there are substantial gaps in the data available for analysis, no new research was undertaken, and the results present an indicative high-level estimate of abuse only.

The MartinJenkins report did not seek to quantify the numbers of people passing through every setting within the terms of reference. In some cases, the numbers would be of limited practical assistance: for example, all schools are in scope so every person who went to any school from 1950 to now is within the terms of reference. In other cases, the numbers would be impossible to obtain without primary research – for example, the number of people within the 'pastoral care' category in faith-based settings. The report focuses on a subset of the settings in scope.

MartinJenkins estimate that from 1950 to 2019 around 655,000 people passed through the care settings that were examined: social welfare, faith-based, health and disability, and education. The latter three categories are partial counts for the reasons described below.²³ The size of the

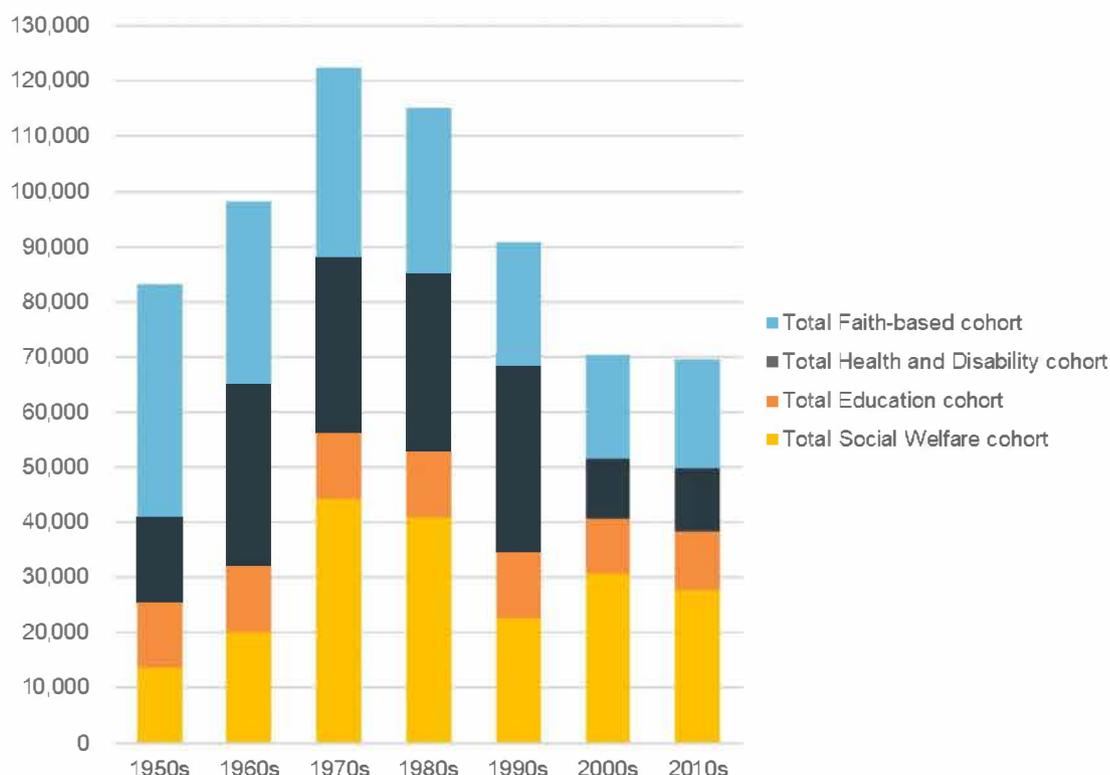
²¹ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, *Terms of Reference*, p. 16.

²² MartinJenkins, 2020.

²³ For health and disability care setting data, MartinJenkins (2020, p. 3) were unable to obtain data on the numbers of children attending health camps. They were also unable to obtain sufficient useable data on the numbers of people attending non-residential psychiatric facilities. In terms of residential and non-residential disability facilities, they included a small number of children from this cohort within the education (special schools) setting. They also found some data within the Statistics New Zealand Disability Surveys of 1996, 2001, 2006 and 2013.

cohort, defined as the number of new admissions to a care setting each year, peaked in the 1970s at 122,000 people, before falling to around 70,000 in the 2010s. The cohort peak was influenced by many factors, including the social, education, and health policies of the day, and practices in state and faith-based organisations at that time.²⁴ Figure 1 below outlines MartinJenkins' estimations of these cohort sizes by major care setting, from 1950 to 2019.

Figure 1: MartinJenkins' indicative estimates of total cohorts by major care setting, by decade, 1950 to 2019²⁵



Data from these surveys is insufficient to reliably estimate the size of the cohorts across the period 1950 to 2019. For education settings, they were unable to find suitable data on the numbers of disabled students in the mainstream school system. For faith-based care settings, they were unable to find data on the numbers of people involved in wider faith-based settings (for example, Sunday Schools and youth camps).

²⁴ MartinJenkins, 2020, p. 6.

²⁵ Cohorts represent the number of new admissions to a care setting each year. For example, if a child enters a boarding school for 5 years, he or she is counted once, in the year they first started that school. The decades shown in this chart sum the new admissions over each 10-year period (MartinJenkins, 2020, p. 6).

Social Welfare (youth-justice and other state wards, including care and protection and foster care)

From 1950 to 2019, it is estimated that 258,000 people were in social welfare care settings, with 95,000 in youth justice settings, and 163,000 in social welfare care settings. The cohort of people in social welfare care settings peaked in the 1970s at around 56,000 people.²⁶

Education (residential special schools and regional health schools, non-residential special schools, and non-religious boarding schools)

It is estimated that 102,000 people were in education care settings from 1950 to 2019, with 83,000 (82%) in non-religious boarding schools, 17,000 (17%) in non-residential special schools, and 1,600 people (1.6%) in residential special schools and regional health schools.²⁷ Due to large data gaps, these indicative estimates are more uncertain than those of other care settings.

Health and disability (psychiatric hospitals or facilities)

From 1950 to 2019, it is estimated that 212,000 people were in health and disability care settings.²⁸ Of these, almost 160,000 people were inpatients in health and disability care settings from 1950 to 1993, while nearly 20,000 were inpatients from 2004 to 2017. Around another 33,000 people were estimated as being in some form of health and disability care.²⁹

Faith-based (faith-based children's homes, orphanages, foster homes, residential disability care settings, and boarding schools)

MartinJenkins estimate that 254,000 people were in faith-based care settings from 1950 to 2019, with:

- 143,000 people (56%) in faith-based children's homes, orphanages, and foster homes
- 109,000 (43%) in faith-based boarding schools
- 1,600 (0.6%) in faith-based residential disability care settings.³⁰

In the 1950s, MartinJenkins estimate that 53,000 people were in faith-based care settings, reducing to around 25,000 people by the 2010s.³¹

²⁶ MartinJenkins, 2020, p. 26.

²⁷ MartinJenkins, 2020, p. 29.

²⁸ MartinJenkins, 2020, p. 34.

²⁹ MartinJenkins, 2020, Table 10: Cohort of people within health and disability care settings and identified survivors of abuse, 1950 to 2019, p. 34.

³⁰ MartinJenkins, 2020, p. 37. These figures have been rounded due to being estimations, and may not add to the total number stated.

4. Representation of cohorts in care

This section summarises what we know about the proportional representation in care of three groups: Māori, Pacific people, and disabled people. Over-representation is where the number of people from these groups are higher than we would expect based on their proportion in the general population. Under-representation is where the number of people from these groups is lower than we would expect based on their proportion in the general population.

The population of people in care grew over the second half of the twentieth century. From the late 1940s to the early 1970s, the number of state wards rose by about two thirds (n = 3,616 to n = 5,515) as the numbers of children and young people coming to the attention of welfare authorities grew at rates that far exceeded growth in the youth population.³² At its peak in 1977, 7,214 children and young people were in the guardianship of the state.³³ At any one time, only a minority of state wards lived in institutions, with most living in their own home, with extended family, or in foster homes. In 1962/1963, 23% (n = 810) of state wards were living in some form of institution.³⁴ At the height of institutionalisation, in the late 1970s and early 1980s, 33% of state wards (n = 2,306 individuals) were in some form of institutional care.³⁵

Māori in care

The historical and contemporary over-representation of tamariki (children) and rangatahi (young people) Māori in the care system is now well evidenced. Until recently though, government did not systematically collect data on the representation of Māori in care. Nevertheless, by piecing together the available sources, a clear picture of Māori over-representation in care emerges.

³² Dalley, 1998, p. 172; Statistics New Zealand, 1975. The term state ward is used by Dalley to describe children and young people in residential institutions or fostered out (Dalley, 1998, p. 172). The term state ward was generally used to refer to children and young persons removed from the care of their families and placed in the care of the state (as evident in Department of Social Welfare historical documents).

³³ In 1988, there were 2,000 children and young people in the Department of Social Welfare's residential institutions. By 1992, there were just 79 (Human Rights Commission, 1992, p. 6). However, this number excluded around 700 children and young people in 'out of family' care in a variety of state-run homes (such as family homes), as well as an unknown number living in private institutions registered as Child, Youth and Family Services (ibid, p. 180). Measured by annual admission rates, the number of individuals admitted to institutions fell from 1,295 individuals in 1989/1990 to 655 in 1992/1993 (Dalley, 1998, p. 316).

³⁴ Statistics New Zealand, 1964.

³⁵ Figures relate to children in the care of the Department of Social Welfare in any form of institution, including residential institutions, special schools, private institutions, psychiatric institutions, hospitals and boarding schools (Craig & Mills, 1987, p. 36). The figure of 2,306 is from 1980 (ibid). By 1985, the percentage of state wards in institutional care had fallen to 31% (1,807 individuals) (ibid). The number of children and young people in the Department of Social Welfare's residences was 709 at the end of 1972, and 680 by the end of 1981 (Dalley, 1998, p. 292). See also: Garlick, 2012, p. 65; Statistics New Zealand, 1982.

Pathways into care: the youth justice system

One method of measuring the representation of Māori in the care system over time is by looking at the pathways by which groups of individuals entered care. For significant numbers of children and young people, the point of entry into care was through the youth justice system.

The over-representation of tamariki and rangatahi Māori in apprehensions by police and the court system since the Second World War is well documented. From 1940 to 1970, Māori were, on average, three times more likely than non-Māori to appear before the children's courts.³⁶ From 1964 to 1974 the rate³⁷ that Māori males aged 10 to 16 came to notice for offending,³⁸ increased by 176% compared to 80% for non-Māori males. The rate Māori females aged 10 to 16 came to notice for offending increased by 235% compared to 120% for non-Māori females.³⁹ Of Māori males who turned age 24 in 1981, nearly half (47%) had appeared in court at least once in their lifetime, compared to less than a quarter (22%) of non-Māori males.⁴⁰

The number of court cases involving children and young people dropped sharply from the late 1980s as, with the passage of the Children, Young Persons, and their Families Act 1989 (later renamed the Oranga Tamariki Act 1989), the Family Group Conference⁴¹ became the primary means of addressing offending by young people. The number of court cases involving young people decreased by almost a third following the passage of the 1989 Act, from 8,193 in 1989 to just 2,352 in 1990.⁴² Nevertheless, rangatahi Māori remained significantly over-represented in youth offending statistics during the 1990s and up to the present day.⁴³ By 2015, Māori made up 25% of the population aged 10 to 16 years, yet made up around 60% of those involved in the youth justice system.⁴⁴

³⁶ Garlick, 2012, pp. 56-57.

³⁷ Rate per 1,000 population, see Fifield & Donnell, 1980, pp 6-7.

³⁸ A person who came to notice for offending is defined as a person between 10 and 16 years who either appeared before the Children's Court or who was referred to the Youth Aid Section for offending or misbehaviour (Fifield & Donnell, 1980, p.5).

³⁹ Fifield & Donnell, 1980, pp. 5-7.

⁴⁰ Lovell & Norris, 1990, pp. 24, 60.

⁴¹ A Family Group Conference is a mediated formal meeting between family/whānau members and officials, such as social workers and police, about the care and protection or offending of a child or young person.

⁴² Department of Social Welfare Information and Analysis Group, 1999, p. 56.

⁴³ By the early 1990s, Māori were estimated to make up half of all young people in the youth justice system, with the disparities particularly marked in some areas, including Auckland (Dalley, 1998, p. 277). During the mid-1990s, police apprehended Māori youth aged 16 and under at population rates of 107 per 1,000, compared with 42 per 1,000 for Pacific youth and 28 per 1,000 for other youth (Department of Social Welfare Information and Analysis Group, 1999, p. 56). Māori aged 10 to 13 were almost six times more likely to be apprehended by police than non-Māori the same age (Morrison, 2009, p. 18). For Māori aged 17 to 20, the rates were three times higher than for non-Māori (ibid).

⁴⁴ Ministry of Social Development, 2016, p. 49.

Pathways into care: the welfare system

Another way tamariki and rangatahi entered state care was through the welfare system including, for example, for suspected or proven cases of abuse or neglect. Studies of child abuse from the 1960s and 1970s note high numbers of tamariki Māori among both alleged and proven abuse cases. A 1972 study, based on a survey of 363 abuse cases, noted that in 1967 the rate of abuse of tamariki Māori was six times that of NZ European/Pākehā children.⁴⁵

The number of investigations carried out into alleged child abuse or neglect rose by a third during the late 1980s alone, from 2,131 in 1988 to over 6,500 in 1989, due to rising public awareness of child abuse.⁴⁶ In 1998, tamariki Māori made up 42% of care and protection cases, yet only a quarter (24%) of the child population.⁴⁷ In 2002, the rates of children assessed as abused or neglected were 10 per 1,000 population for Māori children compared to 6 per 1,000 population for non-Māori.⁴⁸ From 2006 to 2011, nearly half (46%) of care and protection notifications requiring further action involved tamariki Māori, compared with just under a third (31%) involving NZ European/Pākehā.⁴⁹ A 2015 expert panel estimated that 2 in 10 young people in any birth cohort would be known to the Child, Youth, and Family Service (CYF) by age 17.⁵⁰ Of this group, around six out of ten were expected to be Māori.^{51 52}

Tamariki and rangatahi Māori in state care

The longstanding over-representation of tamariki and rangatahi Māori across these key pathways into care – the justice and welfare systems – has resulted in the over-representation of Māori in care. This conclusion is supported by studies showing that once Māori are in these systems, they are more likely to experience outcomes involving removal from the home or some form of custodial care.⁵³ In response to complaints by the Auckland Committee On Racism and

⁴⁵ Fergusson, Fleming, & O'Neill, 1972.

⁴⁶ Dalley, 1998, p. 342.

⁴⁷ Department of Social Welfare Information and Analysis Group, 1999, p. 52.

⁴⁸ Ministry of Social Development, 2004, p. 70.

⁴⁹ 43,845 notifications required further action in 2006 (Ministry of Social Development, 2012, p. 183). In 2011, 57,949 notifications were assessed as requiring further action (ibid). In this context, 'further action' could include entering a 'family/whānau agreement', holding a Family Group Conference, or taking the matter to Court (ibid, p. 186).

⁵⁰ Ministry of Social Development, 2016, p. 43.

⁵¹ Including both care and protection or youth justice referrals (ibid).

⁵² Tamariki and rangatahi Māori were more than twice as likely as children and young people in the general population to be notified to CYF, and 57% of children known to CYF by age 5 were Māori, despite Māori making up only 30% of all children in this age group (ibid, p. 41).

⁵³ Not only were Māori boys and young adults significantly more likely than non-Māori to come before the court, they were also more likely to be placed under state guardianship or to receive a custodial sentence than were non-Māori members of the cohort (Lovell & Norris, 1990). Of 1,799 cases that received outcomes 'implying removal from home', 51% were Māori (ibid). Of 229 cases that resulted in borstal sentences that year, 61% were Māori (ibid). Analysis of 2014 CYF data by the 2015 Expert Panel found that while around five of every 10 CYF referrals were for Māori children and young people, Māori made up six in ten of those placed into statutory care (Ministry of Social Development, 2016, p. 43).

Discrimination (ACORD), the Chief Ombudsman found that of a total of 13,604 cases brought before the children's courts in 1973, 42% were Māori.⁵⁴

The over-representation of tamariki and rangatahi Māori in state institutions, from at least the 1960s, is confirmed by reports from specific institutions.⁵⁵ In the Owairaka home, the proportion of Māori was said to have increased from around 25% in 1959 to 70% 'Polynesians' in 1969, and to '80% Polynesian, mainly Māori' in 1978.⁵⁶ Across 2,027 children and young people resident in six Department of Social Welfare institutions in Auckland during 1983, 62% (n = 1,250) were Māori, 22% (n = 447) were NZ European/Pākehā, and 16% (n = 330) were Pacific people.⁵⁷ Two-thirds of admissions at the Cornwall Park Reception Centre in Auckland in 1981 were Māori or Pacific children, and the ethnic breakdown of admissions to Hokio was similar.⁵⁸ Thus, by the 1980s Māori made up a majority of the care population in state residences, at least in the Auckland region.

Of the 239 girls aged 15 and 16 years involved in Von Dadelszen's (1987) study, who had been under the guardianship of the Director-General of Welfare in 1985, just over half (51%, n = 122) were Māori, over a third (37%, n = 88) were NZ European/Pākehā, and 12% (n = 29) were of either Pacific, or Māori and Pacific origin.⁵⁹ Statistician Len Cook estimates that by the late 1970s, 7% of all Māori boys and 2% of Māori girls were living in state institutions.⁶⁰

While overall numbers of children and young people in care have fallen substantially since the 1980s, the rates of tamariki and rangatahi Māori⁶¹ in the care population have remained high,

⁵⁴ Chief Ombudsman, 1977, p. 76.

⁵⁵ ACORD's investigations into four Auckland state welfare residences in 1978 reported that "Māori and Pacific Islanders comprise 70 to 80% or more of the inmate population" (ACORD, 1979, p. 143). A Ministerial Advisory Committee found that 62% of children in Department of Welfare residential homes in 1985 were Māori (Craig & Mills, 1987, p. 86).

⁵⁶ Human Rights Commission, 1992, p. 219.

⁵⁷ Women Against Racism Action Group, 1984 (revised edition, 1985), p. 21.

⁵⁸ Dalley, 1998, p. 293.

⁵⁹ Von Dadelszen, 1987, p. 33.

⁶⁰ Cook, 2020, p. 15.

⁶¹ Since its establishment in 2017, Oranga Tamariki has shifted from reporting 'primary' ethnicity to recording multiple ethnicities for each child, as applicable. Recording only the 'primary' ethnicity was more likely to undercount the number of children with Māori or Pacific ethnicity and was also inconsistent with Statistics New Zealand standards. Oranga Tamariki now reports the following ethnic groups: Māori (children who have Māori recorded as one of their ethnicities, but not Pacific); Māori-Pacific (children who have both Māori and Pacific recorded as any of their ethnicities); Pacific (children who have Pacific recorded as one of their ethnicities, but not Māori); NZ European/Other (children who do not have either Māori or Pacific recorded as any of their ethnicities, or 'not specified'). To get the total number of Māori children you add the total Māori group and the total Māori-Pacific group. Similarly, to get the total number of Pacific children you add the total Pacific group and the total Māori-Pacific group (Oranga Tamariki, personal communication, 22 September, 2020).

even growing over time. From 2013 to 2018, the percentage of young people in ‘out of home’⁶² care who were Māori grew from 63% (n = 2,425 of 3,844) to 69% (n = 3,499 of 5,038).⁶³ A 2019 cohort study of 56,904 children born in Aotearoa New Zealand in 1998 found that 7% of the Māori cohort had been placed in care by age 18, compared to 2% of the NZ European/Pākehā cohort.⁶⁴ The Office of the Children’s Commissioner found that, in 2019, Māori babies up to the age of three months were five times more likely than non-Māori to be taken into state care.⁶⁵ As at 30 June 2020, Māori made up 68% of children and young people in care and protection custody.⁶⁶

Māori tamariki and rangatahi are also over-represented in youth justice admissions (which includes those on remand and serving orders in residences), and this over-representation has increased over time.⁶⁷ In 2013, Māori comprised 71% of the population of residences yet comprised only 22% of the Aotearoa New Zealand youth population; by 2018 the percentage was 78% of youth justice residence admissions compared to 25% of the youth population.⁶⁸ In June 2020, 74% of those in youth justice custody were Māori.⁶⁹

Tamariki and rangatahi Māori in residential education

From the nineteenth century onwards, a small proportion of tamariki and rangatahi Māori attended private Māori boarding secondary colleges run by various faith-based organisations. By 1950, there were ten such Māori denominational schools in existence, catering for a total roll of 654 pupils, of which 385 were fee-paying, and 269 had government-funded places.⁷⁰ The rolls of Māori denominational colleges declined after the Second World War, as increasing numbers of Māori attended their local high school. By the 1980s, the last Māori denominational boarding schools had either closed their doors or had integrated into the state system.⁷¹

⁶² ‘Out of home’ placements include non-family/whānau placements, family/whānau placements, Child and Family Support Services placements, CYF Family Home placements, residential placements, and other supported accommodation.

⁶³ Oranga Tamariki, personal communication, 22 September 2020; Statistics New Zealand, n.d. (c).

⁶⁴ Rouland, Vaithianathan, Wilson, & Putnam-Hornstein, 2019. This study ‘followed the 1998 New Zealand birth cohort of 56,904 children through 2016. We determined the cumulative childhood prevalence of reports to child protective services (CPS), substantiated maltreatment (by subtype), and out-of-home placements, from birth to age 18 years, by ethnic group. We also developed estimates stratified by maternal age and community deprivation levels.’

⁶⁵ Office of the Children’s Commissioner, 2019, Infographic – Pēpi Māori 0-3 months and the care and protection system.

⁶⁶ Oranga Tamariki Quarterly Report, June 2020, Infographic – Care and protection – statistics.

⁶⁷ Some people may have more than one admission in a year due to transfers between youth justice residences; more than one court appearance within the year that resulted in a remand order; or more than one court appearance within the year that resulted in a residential order. This means that total youth justice admissions will be higher than the number of distinct individuals admitted.

⁶⁸ Oranga Tamariki, personal communication, 22 September 2020, Statistics New Zealand, n.d.(c).

⁶⁹ Oranga Tamariki, 2020a, Quarterly Report June 2020, Infographic – Youth justice – statistics.

⁷⁰ Department of Education, 1950, p. 7.

⁷¹ Calman, 2012.

Māori in psychiatric care

Both Māori and non-Māori rates of admission to psychiatric institutions increased from the early 1960s.⁷² By 1974, Māori rates of first admissions to psychiatric institutions had surpassed non-Māori first admission rates for all age groups.⁷³ From 1977 to 1984, the rate of Māori admissions to psychiatric hospitals increased from 1,317 (50 per 10,000 population) in 1977 to 1,184 (62 per 10,000) in 1984, a period in which overall rates of admission for the general population actually fell from 13,614 (44 per 10,000) to 13,521 (41 per 10,000).⁷⁴

Several inquiries in the 1990s found that Māori were not only over-represented as users of mental health services but were also more likely to be in secure care and subject to compulsory treatment orders.⁷⁵ Today, Māori experience higher rates of mental illness and access mental health services at rates higher than any other ethnicity in Aotearoa New Zealand, and remain subject to greater use of compulsory treatment and seclusion.⁷⁶

Pacific people in care

While significant gaps in knowledge exist across all three cohorts, the gaps are particularly pronounced for Pacific people in state and faith-based care, especially for the period 1950 to 1999. Sporadic and inconsistent reporting of ethnicity is, in part, the reason for these gaps. Where ethnicity is recorded, it is often restricted to simply Māori and non-Māori. Where Pacific ethnicity is recorded, it is frequently in combination with Māori making it difficult to distinguish the exact proportions for Pacific. In more recent times, the reporting of ethnicity has changed and/or is inconsistent across government agencies, making comparison difficult.

Much of the data publicly available were aggregated at a national level and could not be broken down by ethnicity at a regional level. National reporting is likely to misrepresent the proportion of Pacific young people in care, due to the concentration of Pacific peoples in certain regions.⁷⁷ Further regional analysis is needed to develop a better understanding of the true proportional representation of Pacific young people in state care.

It is noteworthy that recent Oranga Tamariki data suggest that Pacific children and young people are over-represented in the welfare and youth justice systems, though not to the same extent as Māori.⁷⁸

⁷² Cram, Te Huia, Te Huia, Williams, & Williams, 2019, p. 111; Gassin, 2019, p. 8.

⁷³ Durie, 2001, p. 19.

⁷⁴ Craig & Mills, 1987, pp. 18-19.

⁷⁵ Gassin, 2019, pp. 16, 14, 52; Durie, 2001, p. 19.

⁷⁶ Baxter, Kingi, Tapsell, & Durie, 2006, Te Rau Hinengaro – Chapter 9, Māori, pp. 176-178; Government Inquiry into Mental Health and Addiction, 2018, p. 11.

⁷⁷ Bathgate et al., 1994; Bedford, 2009.

⁷⁸ Oranga Tamariki, personal communication, 22 September 2020, Statistics New Zealand, n.d.(c)

Pathways into care: Pacific young people in the youth justice system

One method for measuring representation in the care and protection system is to examine the pathways by which people enter care. Most children and young people entered state care through the youth justice system either for offending or welfare reasons. It is noted at the outset that recorded crime statistics do not account for factors such as institutional racism in youth and criminal justice system decision-making.

Rates of youth offending among Pacific people have increased over time. For example, from 1978 to 1990, the proportion of Pacific youth offenders increased by 133% (from 3% to 7%). This was, however, largely representative of the proportion of Pacific people in the Aotearoa New Zealand youth population at the time (7.7%).⁷⁹ The increase in Pacific youth offending rates can, in part, be explained by the growth of the Pacific youth population. This was due to immigration, higher birth rates among Pacific people, and the higher proportion of Pacific women of childbearing age.⁸⁰

After the implementation of the Children, Young Persons and their Families Act 1989, the number of court cases involving children and young people dropped significantly. However, like Māori, Pacific youth offending rates continued to increase. In 1995, the rate of offending for Pacific young people was 244 per 1,000 among 14 to 16-year olds, and 232 per 1,000 for 17 to 20-year olds; higher than all other ethnic groups except Māori.⁸¹

Research in the late 1990s on the youth justice system in Aotearoa New Zealand shows that “young Pacific people offend at approximately twice the rate of NZ Europeans/Pākehā but at half the rate of young Māori”.⁸² A 2004 study found evidence that Pacific youth were being brought before the Youth Court more often than their NZ European/Pākehā counterparts for similar offending, although there was no evidence of unequal treatment in terms of severity of outcomes, especially those involving supervision with residence.⁸³ Pacific youth in Aotearoa New Zealand are, however, over-represented in rates of violent offences.⁸⁴ In 2008, for example, over a third of Pacific young people (35%) appearing in the Youth Court received proved outcomes⁸⁵ for violence offences, compared to a quarter of Māori (24%) and nearly a fifth of NZ European/Pākehā (18%).⁸⁶

⁷⁹ Maxwell & Morris, 1993; Statistics New Zealand, 2001.

⁸⁰ Statistics New Zealand, 1998.

⁸¹ Statistics New Zealand, 1996a.

⁸² Maxwell, Kingi, Robertson, Morris, & Cunningham, 2004, p. 19.

⁸³ Ibid.

⁸⁴ Ioane & Lambie, 2016.

⁸⁵ A charge ‘proved’ and finalised in the Youth Court is recorded as a Youth Court proved outcome not a conviction (Ministry of Justice, 2010, p.6).

⁸⁶ Ministry of Justice, 2010.

The over-representation of Pacific youth in the offending pathway, also translates into available data on youth justice-related care settings. In 1983, Māori and Pacific children and young people were over-represented in six Department of Social Welfare institutions in Auckland. Of the 2,027 residents (who were there for both welfare and offending reasons), 62% (n = 1,250) were Māori; 22% (n = 447) were NZ European/Pākehā; and 16% (n = 330) were Pacific people.⁸⁷ This compares to 75% NZ European/Pākehā, 19% Māori, and 6.1% Pacific people in the Aotearoa New Zealand youth population from the 1986 census.⁸⁸ These figures would likely appear less over-represented, though, if based on the proportion of Pacific young people in the Auckland population alone, where they constitute a larger proportion of the population.

More recent Oranga Tamariki data also shows that Pacific⁸⁹ youth are over-represented in youth justice residences, though not to the same extent as Māori. In 2013, Pacific youth comprised 19% (n = 164 of 850) of all youth justice residence admissions, while comprising only 11% of the Aotearoa New Zealand youth population. In 2018, this proportion had increased to 23% (n = 183 of 797) compared to 13% of the general youth population.^{90 91}

Pathways into care: Pacific children and young people in the welfare system

Historic information on Pacific children's pathways into care for welfare reasons is more limited than for youth offending. However, a study in the late 1990s found that Pacific young people were "somewhat less likely to have been involved in the care and protection system [than they were] to have been involved in the Youth Court".⁹² This finding is supported by subsequent studies. In 1998, for example, Pacific children made up 9% of care and protection cases and 10% of youth justice cases.⁹³ The care and protection figures are roughly proportionate to the Pacific youth population in the 1996 census (9.1%) while the youth justice figures are marginally over-represented.⁹⁴

In 2013, Pacific children and young people were over-represented in 'out of home' care placements - 15% (n = 572 of 3,844) while comprising only 11% (n = 130,470 of 1,161, 384) of the Aotearoa New Zealand youth population.⁹⁵ By 2018, the proportion of Pacific young people

⁸⁷ Women Against Racism Action Group, 1984 (revised edition, 1985), p. 21.

⁸⁸ Statistics New Zealand, 1987-1988 Yearbook; Statistics New Zealand, 1996b

⁸⁹ As noted above, the total number of Pacific children is the sum of the Pacific group and the Māori-Pacific group (Oranga Tamariki, personal communication, 22 September 2020).

⁹⁰ Oranga Tamariki, personal communication, 22 September 2020, Statistics New Zealand, n.d.(c)

⁹¹ As noted above, some people may have more than one admission in a year meaning that total youth justice admissions will be higher than the number of distinct individuals admitted.

⁹² Maxwell et al., 2004, p. 68. This study focused on five geographical areas: Henderson, Kapiti-Mana, Christchurch City, Lower Hutt and Masterton.

⁹³ Department of Social Welfare Information and Analysis Group, 1999.

⁹⁴ Ibid; Statistics New Zealand, 1996b.

⁹⁵ Oranga Tamariki, personal communication, 22 September 2020; Statistics New Zealand, n.d.(c).

in 'out of home' care placements had increased slightly to 16% (n = 824 of 5,038) while comprising 13% (n = 157,818 of 1,225,227) of the youth population.⁹⁶

A 2019 cohort study of 56,904 children born in Aotearoa New Zealand in 1998 found that Pacific children had elevated rates of abuse notifications (27%), substantiations (11%), and placements (2.4%) relative to all other ethnic groups except Māori (42% notifications, 20.4% substantiations and 7.1% placements respectively).⁹⁷

Pacific children in special residential schools

In 1984, Māori and Pacific children were reportedly over-represented in special residential schools for children with a learning disability,⁹⁸ although no breakdown is provided specifically for Pacific children.⁹⁹ For example, at two such South Island special residential schools for children, Campbell Park School and Salisbury Girls School, half of the residents were Māori and Pacific children (57% for Campbell Park and 51% for Salisbury). Reasons for this over-representation are, however, not clear.¹⁰⁰ Māori and Pacific Island children were also, reportedly, over-represented in Health Camps, which provided a temporary change of environment for children with social, emotional, or psychological difficulties.¹⁰¹

Pacific people in psychiatric care

In psychiatric care, Pacific adults aged 15 years and over are represented in psychiatric admissions at rates close to their proportion in the general population. For example, in 1984, Pacific adults comprised 2.3% of the national population but only 2% of admissions to psychiatric care.¹⁰² A 1994 study found that Pacific patients who were admitted to psychiatric care were more likely to be 'committed' and, were also more likely than NZ European/Pākehā, to be readmitted.¹⁰³

⁹⁶ Ibid.

⁹⁷ Rouland et al., 2019, p. 1256. This study uses IDI data and maternal ethnicity. These figures may be under-representative because paternal ethnicity was not recorded. The study states the 'final birth cohort consisted of 56,904 births, with 59% classified as of European origin, 23.1% as Māori, 10.1% as Pacific, 6.7% as Asian, and 1.1% as 'other' ethnicity. Overall, 13.2% of Māori and 6% of Pacific children were born to adolescent mothers, compared with 1.3% of Asian and 3.2% of European children. Maternal birth date was missing for 0.3% of our birth cohort.'

⁹⁸ In this paper we use the contemporary community-preferred term 'learning disability' rather than intellectual disability.

⁹⁹ Craig & Mills, 1987, p. 45.

¹⁰⁰ Ibid.

¹⁰¹ Ibid, pp. 47-48.

¹⁰² Bathgate et al., 1994.

¹⁰³ Ibid.

Disabled people in care

While disabled people may enter the care system for welfare or youth offending reasons, they may also enter disability-specific care settings. While it is relevant to estimate the proportion of disabled people in care for welfare and youth offending reasons, it is not relevant to do so in disability-specific care settings where the total population is disabled.

The category of disability is conceptually and definitionally complex and contested, both nationally and internationally, and across time, making measuring who is disabled challenging.¹⁰⁴ Also, very limited historical data is available on the number and proportion of disabled people who were in institutional care in Aotearoa New Zealand.¹⁰⁵ While the reporting of ethnicity has been sporadic and inconsistent, the reporting of disability has, by comparison, been mostly absent. Even today, disability continues to be under-reported in population demographics, compared to sex and ethnicity.

Disabled people in care from 1950 to 1999

Disabled people, particularly those with a learning disability,¹⁰⁶ resided in a range of care settings, including psychopaedic¹⁰⁷ and psychiatric hospitals, children's homes, youth justice settings, residential group homes, foster care, and often moved between settings.¹⁰⁸

Before the Mental Defectives Act 1911, mental health issues and learning disabilities were not officially acknowledged as separate conditions.¹⁰⁹ The Mental Defectives Amendment Act 1928 subsequently enabled children with a learning disability and neurodiversity¹¹⁰ to be removed from their families and placed in care. This Act also sparked the development of increasing numbers of separate residential care institutions for disabled people, including psychopaedic facilities.¹¹¹

For much of the twentieth century, parents of disabled¹¹² children, therefore, faced considerable pressure from governments to place their children into state institutions by the

¹⁰⁴ Palmer & Harley, 2012; Molden & Tøssebro, 2012.

¹⁰⁵ Before 1996, national data on disabled people in Aotearoa New Zealand was not systematically collected.

¹⁰⁶ In this paper we use the contemporary community-preferred term 'learning disability'.

¹⁰⁷ Psychopaedic is an Aotearoa New Zealand term used to refer to institutions established for the care of people with learning disabilities.

¹⁰⁸ Mirfin-Veitch & Conder, 2017; People First New Zealand, 2010.

¹⁰⁹ Brunton, 2011.

¹¹⁰ In this paper we use the contemporary community-preferred term 'neurodiversity' to refer to a broad range of neurological conditions (or 'differences') including Autism Spectrum Disorders, Foetal Alcohol Spectrum Disorders (FASD), ADHD, and dyspraxia. These terms are themselves broad and refer to a range of common traits (Graby, 2015; Owren & Stenhammer, 2013; Kenny, Hattersley, Molins, Buckley, Povey, & Pellicano, 2016). Note that some, but not all, people who are 'neurodiverse' may also have a learning disability or other impairment.

¹¹¹ Mirfin-Veitch & Conder, 2017; People First New Zealand, 2010; Human Rights Commission, 2016.

¹¹² Definitions of disability have, as noted above, changed considerably over time. What was considered disabled in the mid-twentieth century may, for example, be contested in a contemporary setting.

age of five, because it was ‘better’ for them and their families.¹¹³ Those who entered institutions were likely to remain in care for much or all of their lives.¹¹⁴

Following the 1953 Intellectually Handicapped Children (Aitken) report, and until the early 1970s, large-scale institutions became the State’s preferred option for housing disabled people, particularly those with a learning disability.¹¹⁵ From 1952 to 1972, beds in psychopaedic hospitals alone rose from 549 to 2,017. People with learning disability were also placed in psychiatric hospitals, specialist wards in general hospitals, and community organisation homes.¹¹⁶ The number of beds in psychiatric hospitals and psychiatric wards, or units in general hospitals, peaked in the late 1960s and early 1970s at 10,100 beds, housing people with psychiatric or psychological disability, and people with learning disability. In 1971, it was estimated that almost 40% (n = 4,329) of people with learning disability were housed in psychopaedic or psychiatric institutions.¹¹⁷ The same study also found that the likelihood of residing in such institutions increased with age, with over 60% of those aged 30 years and over, and 80% of those aged 60 years and over living in hospitals as at 1971.¹¹⁸

The number of people with learning disabilities being institutionalised began to decrease from the late 1970s, with a shift towards community support and smaller residential homes.¹¹⁹ By 1984, the numbers of people in institutions with a learning disability had decreased from 4,329 in 1971 to 3,621 in 1984, a decrease of 16%.¹²⁰ However, psychopaedic institutions only began to close in 1994. Mangere psychopaedic hospital in Auckland closed in 1994, Templeton Centre in Christchurch in 1999, Braemar Hospital in Hamilton in 2004, and the last, the Kimberley Centre in Levin, closed in 2006.¹²¹

Disability survey

In 1996, the first Disability Survey was released by Statistics New Zealand.¹²² These have since been released in 2001, 2006, and 2013.¹²³ Table 1 below outlines the population of disabled

¹¹³ Aitken et al., 1953; Swarbrick, 2011.

¹¹⁴ Lambie, 2016.

¹¹⁵ King, 2019.

¹¹⁶ N.Z. Royal Commission of Inquiry into Hospitals and Related Services, 1973.

¹¹⁷ Craig & Mills, 1987, p. 27.

¹¹⁸ Craig & Mills, 1987, p. 28.

¹¹⁹ Brunton, 2003.

¹²⁰ Craig & Mills, 1987, p. 27.

¹²¹ Gates, 2008.

¹²² The New Zealand Disability survey collects data on disability, which is defined as a “long-term limitation (resulting from impairment) in a person’s ability to carry out daily activities”. The Disability Survey therefore estimates the total number of people in Aotearoa New Zealand who self-identify as having a disability.

¹²³ Statistics New Zealand has not released information on data collected during the 2018 Census on disabled people. There are no recent statistics on the population of disabled people in Aotearoa New Zealand as a result. There are also no recent statistics on ethnicity of disabled people in Aotearoa New Zealand.

people estimated by the Statistics New Zealand Disability Survey from its census years 1996 to 2013.

Table 1: Population of disabled people estimated by Statistics New Zealand Disability Survey, 1996, 2001, 2006 and 2013

Survey Year	Total Population (NZ)	Population of disabled people	Percentage of disabled people in total population	Number of disabled Māori	Number of disabled Pacific people
1996	3,618,302	702,000	19%	84,230	Unavailable ¹²⁴
2001	3,737,280	743,800	20%	106,500	27,700
2006	4,027,947	660,300	16%	96,600	24,800
2013	4,242,048	1,062,000	25%	176,000	51,000

In 2013, the age-adjusted disability rate¹²⁵ for Māori was 32%, 26% for Pacific people, and 24% for the NZ European/Pākehā population.¹²⁶ Of the 89,000 with a learning disability, 8,000 adults (9%) lived in a residential facility.¹²⁷

Disabled people in care post ‘deinstitutionalisation’

‘Deinstitutionalisation’ refers to the shift from disabled people being primarily placed in institutional care settings to being cared for in the community. Post ‘deinstitutionalisation’, the focus of disability-specific care has shifted to providing options that support disabled people to live in the community and their own homes.¹²⁸ While residential care services still exist, they are typically much smaller (frequently housing 4 to 6 people).

The Ministry of Health is one of the main funders of disability-specific care in Aotearoa New Zealand.¹²⁹ Of disabled people receiving care through the Ministry of Health’s Disability Support

¹²⁴ In 1996, Statistics New Zealand provided an ethnic group breakdown by Māori and non-Māori only. Thus, information on the numbers of disabled Pacific people are not available in the 1996 survey.

¹²⁵ Age adjustment can make different groups in a population more comparable. The age-adjusted rates are rates that would exist if a sub-population (in these cases Māori and Pacific) had the same age distribution as the total population.

¹²⁶ Statistics New Zealand, 2014. Statistics New Zealand calculated the age adjusted disability rate; the method for how this was done is available in the report referenced.

¹²⁷ Ibid.

¹²⁸ Ministerial Committee on Disability Issues, 2012.

¹²⁹ Not all disabled people receive or require disability support (Ministry of Health, n.d.). To qualify for the Ministry of Health’s Disability Support Services, a person must have a “physical, intellectual, or sensory disability (or a combination of these), which is likely to continue for at least six months, and was acquired before the age of 65 years” (ibid). Some people with neurological and developmental impairments, such as autism, may be funded; while others, such as those with FASD, are not (ibid). Across the range of support services, some are means tested, while others are not (ibid). The Ministry of Health does not fund disabled people who acquired their impairment through injury or after the age of 65 (ibid). These groups may be funded through ACC (injury) or District Health Board (age-related disability) (ibid). We do not currently have figures from ACC of the number of disabled people receiving care from them, or the number living in residential services. Aged care is excluded from this Inquiry.

Services (DSS) in 2013, Māori were over-represented (17% compared 14% of the population) and Pacific people were slightly under-represented (6% compared to 7% of the population).¹³⁰

Of disabled people receiving DSS in 2013, 21% (n = 6,475) were living in residential facilities.¹³¹ People with learning disability accounted for 74% (n = 4,798) of those in residential care.¹³² A further 2,797 disabled people received ‘supported living’ care, with significant support from staff in and outside of their homes, including overnight care.¹³³ Māori disabled people were proportionally represented in residential facilities (15% compared to 16% of DSS service users)¹³⁴ while Pacific disabled people were under-represented (3% compared to 6% of DSS service users)¹³⁵. Thirteen percent (13%) of people receiving supported living services are Māori (compared to 16% of DSS service users), while Pacific disabled people make up 3% of supported living clients (compared to 6% of DSS service users).¹³⁶

Disabled people in psychiatric care

In 2013, approximately 242,000, or 5% of people in Aotearoa New Zealand, had a psychiatric or psychological impairment – with Māori identifying a higher rate of psychiatric or psychological impairment of 7%, totalling 51,000 people.¹³⁷ Psychiatric and psychological care is now almost entirely based on outpatient community care, with very limited short-term admittance to mental health units. In 2013, 7,146 people spent time in mental health units, for a total of 199,142 nights, at an average of 28 nights.¹³⁸

Coercive practices such as restraint and seclusion remain possible under current mental health legislation. Of people who spent time in mental health units, 11% experienced seclusion during their stay – with Māori 3.7 times more likely to experience seclusion than non-Māori.¹³⁹ A 2017 independent review, funded by the United Nations Office of the High Commissioner for Human Rights, found rates of restraint and seclusion practices in health and disability settings in Aotearoa New Zealand to be extremely high, despite a substantial reduction in seclusion practices since 2009.¹⁴⁰

¹³⁰ Ministry of Health, 2015.

¹³¹ Ministry of Health, 2015, pp. 7 -8.

¹³² Ministry of Health, 2015, p. 42.

¹³³ Ministry of Health, 2015, p. 44.

¹³⁴ Ministry of Health, 2015, pp. 10, 39.

¹³⁵ Ministry of Health, 2015, pp. 10, 39.

¹³⁶ Ministry of Health, 2015, pp. 10, 45.

¹³⁷ Statistics New Zealand, 2014.

¹³⁸ Ministry of Health, 2014, p.34.

¹³⁹ Ministry of Health, 2014, pp. 28-31. ‘Seclusion’ was defined by the Office of the Director of Mental Health as “where a consumer is placed alone in a room or area, at any time or for any duration, from which they cannot freely exit”. See *ibid*, p. 26.

¹⁴⁰ Shalev, 2017.

Disabled children and young people in care and protection

Until recently, the proportion of children and young people in care and protection with a disability was unknown.¹⁴¹ An Oranga Tamariki report¹⁴² used linked data from the Integrated Data Infrastructure (IDI)¹⁴³ to provide an overview of disabled children and young people in ‘out of home’ care, or with Oranga Tamariki involvement.¹⁴⁴

The study showed that while disabled children comprised 5% of all children aged 0 to 17 years, they were over-represented in Oranga Tamariki involvement. Of those children aged 0 to 17 known to Oranga Tamariki (n = 202,600), 10% (n = 20,000) were disabled.¹⁴⁵ Disabled children were also over-represented in all placements in ‘out of home’ care (14%) and particularly so for disabled children aged 15 to 17 years (25%).¹⁴⁶

The majority of disabled children with Oranga Tamariki involvement have a learning disability (62% compared to 31% Autism Spectrum Disorder, and 7% physical, sensory, neurological, or other disability).¹⁴⁷ Children with a learning disability are also four times more likely to be placed in ‘out of home’ care than any other children with current or past Oranga Tamariki involvement.¹⁴⁸

¹⁴¹ While age, gender and ethnicity data are frequently collected, disability status is not.

¹⁴² Oranga Tamariki, 2020b.

¹⁴³ The IDI is a large research database managed by Statistics New Zealand. It holds microdata about people and households. The data is about life events, such as education, income, benefits, migration, justice, and health. It comes from government agencies, Statistics New Zealand surveys, and non-government organisations (NGOs). Oranga Tamariki matches IDI data with receipts of Ministry of Social Development Child Disability Allowance, Ministry of Health Disability Support Services funding, and Ministry of Education Ongoing Resourcing Scheme funding – all of which (at minimum) require medical conformation of disability.

¹⁴⁴ Disabled children were identified as those receiving one or more of: a Ministry of Social Development Child Disability Allowance; Ministry of Health Disability Support Services funding; or, Ministry of Education Ongoing Resourcing Scheme funding. Oranga Tamariki, 2020b, pp. 4-5.

¹⁴⁵ Oranga Tamariki, 2020b, pp. 10, 35.

¹⁴⁶ Oranga Tamariki, 2020b, pp. 10, 37.

¹⁴⁷ Oranga Tamariki, 2020b, p 48. These statistics are based on indicators of diagnosed disability. See *ibid.*, pp. 4-5.

¹⁴⁸ Although there are no comprehensive figures available in Aotearoa New Zealand of the number of disabled people in the youth justice system, Lynch (2016) has noted a few local studies that indicate high rates of prevalence of neurodisabilities among youth offenders and large amounts of anecdotal evidence suggesting significant overrepresentation of neurodisability within the youth justice population. Internationally, the lack of identification and support for people with neurodisabilities (including interpretation of the behaviour of people with neurodisabilities as hostile, delinquent or guilty) has been understood as significantly contributing to the criminalisation and overrepresentation of disabled people in youth justice settings (Lynch, 2016); McCausland & Baldry, 2017; Baldry, McCausland, Dowse, & McEntyre, 2015; Hughes, Williams, Williams, Chitsabesan, Walesby, Mounce, & Clasby, 2015.

5. Indicative estimates of the number of people who may have been abused in care

We will probably never know for certain how many children, young people, and vulnerable adults were abused in care in Aotearoa New Zealand in the period 1950 to 2019. We can, however, make indicative estimates and continue to develop our knowledge of the size of these cohorts, throughout the life of the Inquiry. We can also say that despite some data limitations, it is clear that the abuse of children, young people, and vulnerable adults in care in Aotearoa New Zealand is a significant problem.

Overseas inquiries into institutional care have found that abuse was a common, even routine, part of institutional life.¹⁴⁹ In Aotearoa New Zealand, studies have found that abuse was systemic in institutional care, and included physical, sexual, emotional, psychological, educational, and cultural forms of abuse as well as neglect.¹⁵⁰ The culture of abuse that pervaded these institutions affected all who lived in them, whether they experienced abuse directly, witnessed abuse, or were aware of abuse occurring.

There are many issues associated with estimating the extent of abuse in care, particularly the historical extent of abuse in care. Under-reporting, or delayed reporting of abuse, lack of agreement over definitions of abuse, changes in definitions of abuse, and lack of reliable records on abuse in care all make it a challenge to estimate the extent of abuse in care. While survivors' accounts give an indication of the scale and routine nature of abuse in care, they do not tell us the exact numbers of people who may have been abused in care.¹⁵¹

In this section, we first provide an estimate of the numbers of children, young people, and vulnerable adults in care in Aotearoa New Zealand from 1950 to 2019, who may have experienced abuse or neglect in care. One way of estimating the extent of abuse in care among these groups is by taking what we know from the research from Aotearoa New Zealand and overseas on the rates of people who are abused in care and then applying those percentages to the cohorts of individuals known to have passed through care in this country.

¹⁴⁹ Royal Commission into Institutional Responses to Child Sexual Abuse, 2017, p. 78; Commission of Inquiry into Abuse of Children in Queensland Institutions, 1999; Commonwealth of Australia, 2004; Fernandez, Lee, Blunden, McNamara, Kovacs, & Cornefert, 2016; Commission to Inquire into Child Abuse, 2009; Historical Institutional Abuse Inquiry, 2017.

¹⁵⁰ Roguski, 2013; Mirfin-Veitch & Conder, 2017; The Confidential Listening and Assistance Service (CLAS), 2015; ACORD, 1979; Von Dadelnszen, 1987; Stanley, 2016; Oranga Tamariki, 2019b; Gallen, 2001; The Confidential Forum for Former In-Patients of Psychiatric Hospitals, 2007.

¹⁵¹ Radford, Dodd, Barter, Stanley, & Akhlaq, 2017; Timmerman & Schreuder, 2014.

Studies have found that the risk of abuse differs between care settings. For this reason, it is necessary to obtain indicative estimates of the likelihood of abuse in each care setting, before establishing an overall total of people estimated to have experienced abuse in care in Aotearoa New Zealand from 1950 to 2019.

Of the estimated 655,000 who passed through care, MartinJenkins estimate that between 114,000 and 256,000 experienced abuse while in care.¹⁵² In social welfare settings,¹⁵³ it is estimated that from 17% to 39% of children and young people experience some form of abuse in care.¹⁵⁴ For boarding or residential schools (excluding faith-based residential schools), it is estimated that rates of abuse range from 24% to 44%.¹⁵⁵ As explored further below, being disabled is related to a higher risk of abuse. For health and disability settings, it was found that from 11% to 34% of disabled people may experience abuse in care.¹⁵⁶ For children and young people in faith-based homes, the likelihood of abuse ranges from 21% to 42%.¹⁵⁷ Table 2 below outlines low and high indicative estimates by MartinJenkins of the numbers of survivors in state and faith-based care, 1950 to 2019.¹⁵⁸

Table 2: MartinJenkins' estimated numbers of people abused in state and faith-based care, 1950 to 2019¹⁵⁹

Setting	Estimation (low and high)
Social welfare	34,373 to 79,008
Residential education	19,471 to 35,359
Health and disability	17,570 to 57,438
Faith-based	42,342 to 83,841
Total	113,757 to 255,646 ¹⁶⁰

¹⁵² MartinJenkins, 2020, p. 8.

¹⁵³ Including care and protection and youth and justice residences and foster/kin care.

¹⁵⁴ The range of 18.5 to 40% is for care and protection and youth justice residences, and for foster/kinship care, the estimated prevalence range was from 15.9 to 37.6% (MartinJenkins, 2020, p. 52).

¹⁵⁵ MartinJenkins, 2020, p. 31.

¹⁵⁶ MartinJenkins, 2020, p. 36.

¹⁵⁷ MartinJenkins, 2020, p. 39.

¹⁵⁸ For the purposes of providing indicative estimates, MartinJenkins (2020, p. 12) 'defined abuse at the more serious end of the abuse spectrum so that the results hold more weight and reflect the purpose of the work.'

¹⁵⁹ MartinJenkins, 2020, Table 15: Estimated numbers of survivors of abuse in State and faith-based care, 1950 to 2019 (showing the low and high end of the ranges of abuse), p. 43.

¹⁶⁰ An alternative measure of prevalence, based on identifying the total number of people (n=6500) known to have made claims of abuse while in state and faith-based care, multiplied by the likelihood (based on Aotearoa New Zealand and international crime surveys) that a crime goes unreported, gives a low range of 36,000 and a high range of 65,000 for estimated number of individuals abuse in care in Aotearoa New Zealand 1950 to 1999, which is around 5.5 to 5.9% of the cohort when the overlap between settings is adjusted for (MartinJenkins, 2020, p. 45). This methodology of calculating incidence was considered less reliable by the authors of the MartinJenkins (2020) research than the cohort-prevalence method described in greater detail in the above text. This is because it is likely that only a minority of victims of abuse have, thus far, lodged an abuse claim.

These indicative estimates must be treated with caution. The projected figures provided above are based on limited data. Applying overseas findings to the Aotearoa New Zealand context may also not account for differing social, cultural, policy, and legislative factors, or for different models of care delivery.

Defining and measuring prevalence of abuse is methodologically difficult, due to inconsistencies in definitions of abuse across jurisdictions and time. Definitions of abuse vary between the different studies MartinJenkins relied on to estimate the prevalence rates, and are more heavily weighted towards some types of abuse than others. For instance, most of the existing literature focuses on sexual and physical abuse; less is known about the extent of emotional abuse and neglect. The indicative estimates in the table above would almost certainly be higher, and possibly significantly higher, had a broader definition of abuse been used to estimate prevalence.

Also, the methodology used by MartinJenkins assumes that rates of abuse have remained relatively consistent over time, yet little research has been undertaken on this. Finally, the method of estimating the prevalence of abuse also does not account for the fact that one individual may experience multiple or repeated experiences of abuse, or that abuse may have occurred over a prolonged period. These are important methodological considerations when it comes to understanding prevalence of abuse.¹⁶¹

Abuse and neglect are known to be prevalent in the community in Aotearoa New Zealand.¹⁶² While ethnicity is a factor in rates of abuse in the community, we know little about ethnicity as a factor in abuse in care. Some Māori survivors, who have given accounts of their abuse in care, report having experienced racial abuse and being treated more harshly by staff because they were Māori.¹⁶³ Experiences of 'cultural abuse', whereby the cultural needs of Māori in care were neglected, also appear to have been commonplace. Māori in care consequently experienced alienation from te reo and tikanga Māori, whakapapa, and iwi affiliations.¹⁶⁴

International studies show that disabled children and adults experience abuse at far higher rates and for more prolonged periods than non-disabled people. This, in part, can be explained by the

¹⁶¹ Mathews, Walsh, Dunne, Katz, Arney, Higgins, Octoman, Parkinson, & Bates, S, 2016.

¹⁶² Kotch, Chalmers, Fanslow, Marshall, & Langley, 1993; Human Rights Commission, 2016; Fanslow, Robinson, Crengle, & Perese, 2007; Fleming, Watson, Robinson, Ameratunga, Dixon, Clark, & Crengle, 2017; Clark, Robinson, Crengle, Grant, Galbreath, & Sykora, 2009; van Roode, Dickson, Herbison, & Paul, 2009; Ministry of Women's Affairs, 2012; Clark, Fleming, Bullen, Denny, Crengle, Dyson, Fortune, Lucassen, Peiris, John, Robinson, Rossen, Sheridan, Teevale, & Utter, 2013.

¹⁶³ CLAS, 2015, pp. 28-29; ACORD, 1979; Marks, 2017.

¹⁶⁴ Kaiwai & Allport, 2019, p. 28; National Advisory Committee on Health and Disability, 2004; CLAS, 2015, pp. 28-29; Kopu, 2017, p. 2.

fact that disabled people are more likely to spend time in institutions, and for longer periods, than non-disabled people.¹⁶⁵

Of particular risk are people with a learning disability.¹⁶⁶ Sullivan and Knutson (2000) studied over 50,000 student records in Nebraska and found that over a third (31%) of disabled children had abuse and/or neglect records with a government agency, compared to less than a tenth (9%) of non-disabled children. Disabled children were almost four times more likely than non-disabled children to experience physical abuse and neglect, and over three times more likely to experience sexual abuse.¹⁶⁷ More recent meta-analyses of disability and abuse conducted by the World Health Organisation found that disabled children were four times more likely to be abused than non-disabled children. Disabled adults also experience higher rates of violence than non-disabled adults.¹⁶⁸

These figures are, however, likely to be under-estimates of the extent of abuse among disabled people. While abuse is under-reported across the population, disabled children and adults face particular barriers to reporting, as people with higher support needs or communication barriers may find it difficult, if not impossible, to report abuse or to escape from it, due to fear of retribution or withdrawal of support from carers who they depend on for daily living needs.¹⁶⁹ Overseas literature has also found that disabled children in care may be more vulnerable to abuse.¹⁷⁰

¹⁶⁵ Milner, Gates, Mirfin-Veitch, & Stewart, 2008; Llewellyn, Wayland, & Hindmarsh, 2016; Westcott & Jones, 1999; Young, Nosek, Howland, Chanpong, & Rintala, 1997; Sullivan & Knutson, 2000; Briggs, 2006; Jones, Bellis, Wood, Hughes, McCoy, Eckley, & Officer, 201; Ward & Rodger, 2018.

¹⁶⁶ Sobsey & Doe, 1991; Sullivan & Knutson, 2000; Wissink, Van Vugt, Moonen, & Stams, 2015.

¹⁶⁷ Sullivan & Knutson, 2000.

¹⁶⁸ Jones et al., 2018; Hughes, Bellis, Jones, Wood, Bates, Eckley, McCoy, Mikton, Shakespeare, & Officer, 2012.

¹⁶⁹ Young et. al., 1997; Cockram, 2003; Roguski, 2013.

¹⁷⁰ Westcott, 1999.

6. Registrations with the Royal Commission of Inquiry

As at late August 2020, 1,756 survivors and witnesses were registered with the Inquiry. Table 3 below shows survivors registered with the Inquiry by registration type, care setting, gender, ethnicity, and age. Nearly all (99%, n = 1,744) are survivors of abuse in care, while 12 (0.7%) are witnesses of such abuse.

Nearly half of all survivors and witnesses (47%, n = 827) reported abuse in state care, with another 11% (n = 193) reporting abuse in faith-based care. Another 5.7% reported abuse in both settings. The setting in which abuse occurred is unknown for 36% (n = 636), hence reported abuse in care does not total 100%.¹⁷¹

Of the 1,756 people who have registered with the Inquiry, 59% (n = 1,027) are male, and 41% (n = 723) are female. One (0.1%) person is recorded as being gender diverse, while the gender of five people (0.3%) is unknown.

Survivors and witnesses who have come forward to the Inquiry range in age. Just over a quarter (27%, n = 479) are aged 50 to 59 years, while nearly one fifth (19%, n = 331) are aged 60 to 69. Another 16% (n = 279) are aged 40 to 49, while 11% (n = 188) are aged 30 to 39. Survivors and witnesses aged over 70, account for 9% of registrations, with 7% (n = 129) aged 70 to 79, and 2% (n = 28) aged over 80. Younger survivors and witnesses comprise a minority of registrations, totalling 4.2% (n = 74). Of these, 3.8% (n = 67) are aged 20 to 29, while 0.2% (n = 4) are aged 10 to 19, and another 0.2% (n = 3) are aged 0 to 9. Younger survivors tend to be registered by their parents or caregivers. The age of survivors and witnesses is unknown for 14% (n = 248) of registrations.

In terms of ethnicity, just over a quarter (28%, n = 495) identified as NZ European/Pākehā, with a quarter (25%, n = 442) identifying as Māori. When those who reported multiple ethnicities are included, nearly a third (31%) identified as Māori, including those who identified as Māori, Māori and NZ European/Pākehā, and Māori and Pacific. For NZ Europeans/Pākehā, when multiple ethnicities are included, 34% (n = 591) identified as NZ European/Pākehā, and Māori and NZ European/Pākehā. For Pacific people, when multiple ethnicities are included, 1.6% (n = 29) identified as Pacific, and Māori and Pacific. Of the remainder, 8.7% (n = 153) identified as 'other', 5 (0.3%) identified as unknown multiple ethnicities, and one (0.1%) identified as Asian.

¹⁷¹ The Royal Commission is continuously improving its processes and systems for reporting and recording data, to help ensure that gaps in data are remedied.

Under 1% (0.5%, n = 8) preferred not to say. The ethnicity of survivors and witnesses is not recorded, i.e., is unknown for 30% (n = 527) of registrations.

Table 3: Registered survivors and witnesses by registration type, care setting, gender, ethnicity, and age

Registration type	Count	Percentage
Survivor	1744	99.3%
Witness	12	0.7%
Total	1756	100.0%
Care setting	Count	Percentage
State	827	47.1%
Faith	193	11.0%
State and faith	100	5.7%
Unknown	636	36.2%
Total	1756	100.0%
Gender	Count	Percentage
Male	1027	58.5%
Female	723	41.2%
Other	1	0.1%
Unknown	5	0.3%
Total	1756	100.0%
Ethnicity	Count	Percentage
NZ European/Pākehā	495	28.2%
Māori	442	25.2%
Pacific people	16	0.9%
Māori and European	96	5.5%
Māori and Pacific people	13	0.7%
Asian	1	0.1%
Multiple ethnicity (more than three)	5	0.3%
Other	153	8.7%
Prefer not to say	8	0.5%
Unknown	527	30.0%
Total	1756	100.0%
Age at time of registration	Count	Percentage
0 - 9	3	0.2%
10 - 19	4	0.2%
20 - 29	67	3.8%
30 - 39	188	10.7%
40 - 49	279	15.9%
50 - 59	479	27.3%
60 - 69	331	18.8%
70 - 79	129	7.3%
80+	28	1.6%
Unknown	248	14.1%
Total	1756	100.0%

Nearly a third of survivors and witnesses (31%, n = 539) reported some form of disability, while 69% (n = 1,217) reported no disability.

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