Abuse in Care Royal Commission of Inquiry
Contextual Hearing on Wednesday,
6 November 2019 at the Rydges Hotel, Auckland

Commission Members:
Sir Anand Satyanand - Chair
Commissioner S Alofivae
Commissioner A Erueti
Commissioner P Gibson
Commissioner C Shaw

TRANSCRIPT OF PROCEEDINGS

OPENING ADDRESSES

CHAIR: Mr Mount, good morning.

MR MOUNT: I am joined today by Chris Merrick who will lead the witnesses. We have three witnesses, the first two of whom are already in place, Michael Tarren-Sweeney and Charlene Rapsey. We also have Tracey McIntosh today. As I say, Mr Merrick will lead the evidence today.

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PROFESSOR MICHAEL TARREN-SWEENEY - AFFIRMED
DR CHARLENE RAPSEY - AFFIRMED
EXAMINED BY MR MERRICK

MR MERRICK: I acknowledge everyone here today and if I could start by saying a little bit about how we might commence with these two witnesses, Sir.

10.03 **CHAIR:** And then I'll ask them for their initial statements.

MR MERRICK: Yes. So, the proposal is that we have both Professor Tarren-Sweeney and Dr Charlene Rapsey seated at the witness table, as you can see. What we will start with, is Professor Tarren-Sweeney will read portions of his brief of evidence. We will then turn to Dr Rapsey who will read her brief of evidence and we will allow for questions at the

10.04 end, so that we can essentially - where there's overlap, there might be ability to comment one with the other. That is the proposal. No difficulty if, Mr Chair, you propose to deliver the affirmation to both of them at the outset.

CHAIR: All right, I will do that. (Witnesses affirmed). I will now leave Mr Merrick initially to ask you the questions that he wishes.

MR MERRICK: Thank you, Sir.

Q. We will start, as I've outlined, with you, Professor Tarren-Sweeney. Can I just confirm that in the open

10.05 volume of documents which is just in front of Dr Rapsey there, behind tab 21 you have sighted a copy of your brief of evidence?

PROFESSOR TARREN-SWEENEY: Yes, I have.

Q. And you've signed that?

PROFESSOR TARREN-SWEENEY: I have.

Q. And it's true and correct?

PROFESSOR TARREN-SWEENEY: Yes, it is.

Q. Thank you. What we propose to do is have you begin by reading your brief of evidence. If you could commence doing that now.

PROFESSOR TARREN-SWEENEY: Thank you. First, I'd like to thank the Royal Commission for giving me the opportunity to talk today on a topic that's been my
10.06 life's work and my curriculum vitae is annexed in full, annex 1 to this brief.

I am a clinical child psychologist, psychiatric epidemiologist and child developmental theorist and I work as a Professor of Child and Family Psychology at the University of Canterbury in Christchurch, where my family and I have lived since 2006.

My earlier research focused on identifying various mental difficulties experience by children in State care, using epidemiological and clinical research methods,
10.07 including development of new psychometric measures. And this was mainly based around a longitudinal study that I ran in NSW called the Children in Care study between 1999 and 2011.

Since then, I have advised statutory child welfare ministries and national health services on how to provide services for children in care in New Zealand, in Scotland, Ireland, England and Wales and South Australia and NSW, bearing in mind that in Australia Child Welfare is a State jurisdiction.

10.07 Following on from that, my work has been referred to in the 2008 Special Commission of Inquiry into Child Protection Services in NSW.

CHAIR: Excuse me intervening, if I could ask you to be mindful of the stenotyper in front of you and

equally the signers who are working at high speed with technical material, so if you could keep your eye on both and pace the delivery of what you say, that will be greatly appreciated by everyone.

PROFESSOR TARREN-SWEENEY: If I keep an eye on the screen, okay.

MR MERRICK:

Q. I think you were at paragraph 6.

A. Yes. And the Royal Australian and New Zealand College of Psychiatrists submission to the 2017 Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

10.08

The realisation that these children's mental health difficulties and their life circumstances are poorly matched to generic Child and Adolescent Mental Health Services led me to work on the design of specialised Mental Health Services for these populations.

But in the latter half of my career, my focus has shifted from clinical research to measuring and understanding how these children develop over time in the midst of what are often unnatural childhoods.

10.09

So today I want to provide some insights from developmental science on how the State should respond to the plight of children growing up in statutory care. In particular, my evidence will focus on those who have suffered abuse, trauma, or neglect prior to their entry into State care.

Because my work has not been focused on the New Zealand context, my evidence refers to the developmental needs of children growing up in statutory care generally, without addressing the specific aspects of the New Zealand care system, or the specific cultural context in which it exists.

10.10

Such children leave their parents' care with

neurobiological systems that are adapted to cope with neglectful or abusive environments, but which are poorly adapted to normative social environments.

This translates as heightened risk for various developmental, social and mental health difficulties that are often persist in adulthood, and what a colleague of mine, Eamon McCrory describes as latent vulnerability.

If there's any good news from this story, it is fortunately neurobiological development is not fixed. 10.11 Children can experience psychological and neurobiological recovery in response to consistently sensitive, loving care, as well as other experiences that foster felt security.

In thinking then about how society should tend to these children's care and wellbeing, I propose three priorities.

The first is restoring to them the opportunity to experience and enjoy what remains of their childhood in much the same way as do other children.

10.12 The second is restoring the social and familial conditions that are necessary for healthy human development, and which are also the pre-conditions for these children's developmental recovery.

And the third is ensuring that they and their caregivers are provided specialised clinical and developmental services, as well as intensive caregiver support.

In this first part of my evidence, I will describe the psychological development of children placed in 10.12 statutory care, focusing mainly on the effects of severe maltreatment, and their mental health.

Firstly, when I use the word maltreatment, I am using it as a collective term to describe child abuse and neglect. It's a term that's mostly used in the research

field to describe both.

The toxic effect of maltreatment on children's psychological development and wellbeing, particularly when this is done by children's parents or other primary caregivers, are well established.

We know considerably more about these effects now than we did 20 years ago, and this is largely due to advances in neurodevelopmental science and other research advances.

10.13 A range of neurobiological and psychological processes in early childhood that are critical to human social functioning are impaired by early and prolonged exposure to traumatic maltreatment. These include behavioural and emotional regulation, executive functioning, intellectual abilities, language and memory.

Similarly, severe and chronic maltreatment profoundly alters children's attachment development, affecting their interpersonal relationships; how they understand and value themselves and others; the meanings

10.14 children attribute to social relationships; and how they understand the minds of others, which has implications for the development of empathy.

The effects of maltreatment on children's development vary somewhat depending on children's ages and stages of development at the time they are harmed.

In particular, maltreatment in the first 3-5 years of life has more adverse effects on children's development than maltreatment at older ages. That's because most of the important parts of our human

10.15 development occur in those first 3-5 years of life.

There is also evidence that, whilst children's development is seriously compromised by maltreatment, some of these effects can be reversed over time in response to optimal care, including the development of

attachment security, while other effects tend to persist.

So, for example, inner-tension hyperactivity and intellectual disability tend to persist, despite changes in the quality of care.

In this next section, I want to talk a little about the effects of pre-care maltreatment on the development and mental health of children in statutory care.

The protection, psychological development and wellbeing of a large majority of maltreated children is
10.16 best served through varying levels of family support services, including specialised parenting interventions, and parental drug and alcohol treatments. It goes without saying that providing effective family supports earlier, rather than later, is the key to arresting and preventing further developmental harm for such children.

However, a relatively small proportion of children who are maltreated by their parents or other guardians have an ongoing need for care, and in modern times, these children are mostly placed into statutory care following
10.17 severe and chronic maltreatment.

In terms of terminology, in New Zealand, Australia and North America, statutory care is referred to as out-of-home care. Whereas, in the UK and Ireland the preferred term is "looked after children".

And out-of-home care includes placements with families, which collectively is referred to as family based care. And placement in residential facilities which can range from small group homes to large institutions.

10.18 There are, in turn, two types of family based care. Namely, foster care and kinship care. In New Zealand, the term for kinship care is whanau care and this refers to placements with extended whanau, such as grandparents, uncles and aunts, and even more distant relatives.

Foster care refers to placements with families who are not biologically related to the child.

Whereas residential care was once the predominant form of State care, last year in Australia only 6% of children in State care were in residences, and they were predominantly adolescents with more serious behavioural difficulties. By comparison, in Australia 51% of children are in whanau care and 39% in foster care.

Q. Can I pause you there, Professor, and just ask a question about the use of residential care and why nowadays it's less used? Are you able to comment on what the research is? You've talked about the detrimental effects of maltreatment on children. Is there a link between the impact of residential care on children and its lesser use over time, so historically it was used very frequently, we've heard that over the last few days. Can you comment on that?

PROFESSOR TARREN-SWEENEY: The extent to which residential care is developmentally harmful, is somewhat linked to the age of the child. And so, the younger the child is, the more that they are in need of being nurtured by parental figures. The more it is that residential care is manifestly harmful for their development.

When I first started working in Child Welfare in the mid 80s, I was also working in Youth Justice at the time, New South Wales still had large residential services that included family groups, including infants. And over time, and I imagine New Zealand had the same, but over time as the harmful effects of residential care had become better known, and in particular for younger children, it's been increasingly reserved for those older children and adolescents who are seen to be not placeable with families.

Q. Thank you. If we can return now to your brief, I think we were at paragraph 30 and moving on. Can I also check in with our stenographer to check with the pace?

PROFESSOR TARREN-SWEENEY: I think it's important that we differentiate between these children and a much larger number of maltreated children who remain in their parents' care.

So, these children are not a random cross-section of children that are known to Oranga Tamariki. Generally speaking, western jurisdictions, these are children who are found by the Courts to be in need of care and are involuntarily removed from their parents and have experienced the highest levels of harm.

They are more likely than other maltreated children to have experienced more severe, more chronic, more pervasive and more diverse maltreatment.

This is important because, whereas all maltreatment is developmentally harmful, research has confirmed that the level of developmental harm is proportionate to the severity, chronicity and pervasiveness of the maltreatment they have experienced.

Q. So, what you are saying there is we need to acknowledge at this stage there are the varying degrees we're talking about?

PROFESSOR TARREN-SWEENEY: Yes.

Q. You are talking about the higher end of severity when it comes to maltreatment?

PROFESSOR TARREN-SWEENEY: That's right. There are two implications for that. One is that it is the most severely maltreated children that tend to come into care through the Courts.And it's those very children who have had the most adverse developmental experiences.So, in other words, the children that are coming into care are the most

vulnerable.

Q. To be clearer still in the context of this hearing, we're talking international research currently or the current state, correct?

PROFESSOR TARREN-SWEENEY: Yes, that's right. This is not, what I'm talking about is now, and so historically children came into care for many other reasons historically.

Q. We have heard a lot about that. We won't dwell on that now. We will carry on with your brief of evidence.

10.23

PROFESSOR TARREN-SWEENEY: The most illustrative point I can make about this is the strongest independent predictor of the mental health of children in care is the age that they are when they come into care, with earlier placement in family-based care being a strong protective factor. And this is in spite of what I'm going to talk about in a minute, about all of the harmful effects that care actually excerpts on children's development. In spite of that, the younger a child is when they're placed into care, the better the mental health generally is throughout their childhood, at least when we examined this across the entire care populations.

10.24

I think it is important not to interpret this statistic as an endorsement of statutory care as being generally reparative or therapeutic for these children. Later I will explain how out-of-home care also compromises many children's development, limiting their recovery from effects of serious maltreatment and sometimes leading to further deterioration in mental health.

10.24

But the reason why I want to emphasise this, is that this statistic refutes a commonly held belief that some children are better off remaining with families who

persistently maltreat them than being placed in statutory care, at least in the modern context.

Q. I suppose, what you're saying there is that runs against any proposition that might say we won't act for this reason?

PROFESSOR TARREN-SWEENEY: Yes. Within the field because people are exposed to all of the problems that statutory care has and they can see the various harms caused by the statutory care system, a lot of people working in the field have a crisis of confidence and start to believe that children may be better off if they remain in severely maltreating homes. And the evidence that I've just given you refutes that. In spite of all the harm that care does, it is a less harmful option than remaining in families where they are being severely and persistently maltreated.

Q. And you're going to come on to this later?

PROFESSOR TARREN-SWEENEY: Yes.

Q. One of the big questions you've pointed out is what form does that care take?

PROFESSOR TARREN-SWEENEY: Yes. I am not suggesting we need to choose between two bad options. I am suggesting that we need to be thinking about what the better option is, yes.

Q. Pick up again from, I think, paragraph 40 now.

PROFESSOR TARREN-SWEENEY: Yes. Let me know if I'm taking too long and I need to move on.

In this next part of my evidence, I want to talk about the mental health of children in long-term statutory care.

Over the past 30 years, numerous population studies carried out in countries with comparable care systems to New Zealand have mentioned the mental health of children

and young people in care.

Most of these studies were carried out in the United States, Canada, the United Kingdom, Europe and Australia.

These include the study that I conducted that I spoke about earlier.

What's really interesting about this research, is just how consistent the estimates are. So, around the world, studies are finding much the same results.

10.28 Whilst no comparable research has been carried out to date in New Zealand, this consistency of international research suggests that New Zealand children in care are likely to have comparable mental health problems, at least as understood and measured within western epistemologies.

It is important to note that children experience mental ill-health within the context of broader developmental impairments, as well as physical health problems and physical disabilities.

10.28 And to address that, New Zealand has introduced, within the last 5 or 6 years I think, a cross-government health screen procedure for children entering statutory care, called the Gateway Assessment. This screening assessment seeks to identify not just mental and emotional difficulties, but also learning difficulties, physical ill-health resulting from maltreatment, social disadvantage and poverty.

Several population studies, including my own, have estimated around a quarter of children in care have some

10.29 level of intellectual disability, and similar rates of language difficulties.

However, the most important developmental difficulties experienced by these children, as measured by the number of affected children, their felt

experience, the impact on their present wellbeing and social functioning, the impact on their caregivers, and their future lives are their mental health difficulties.

Q. Before you move on, at paragraph 47 you said that across these population studies the estimates, as you've described, have been quite consistent but that around a quarter of children in statutory care have some level of learning disability or language difficulty. How did that compare to the population of children at large?

10.30 **PROFESSOR TARREN-SWEENEY:** That compares to around 2% of children at large.

Q. So, 25% for children in care across these studies and 2% for children at large?

PROFESSOR TARREN-SWEENEY: Yes. Yeah, I skipped some of the details there.

Q. That's fine. I think we were at paragraph 51, thank you.

PROFESSOR TARREN-SWEENEY: With regards to mental health, international research consistently indicates around half of children in long-term

10.31 statutory care have mental health difficulties that require clinical intervention or support. And around another quarter have difficulties approaching the need for clinical support. So, that means there's only a quarter of children who are travelling well and otherwise we don't need to be continuing to monitor them.

So, for a population, from a public health perspective, this is one of the highest risk populations for mental health difficulties that we have in our

10.31 society.

Also, in addition to the numbers of children that have these problems, what's very pertinent is the types and culminations of symptoms that children in care experience differ somewhat from that of other children

that may have need for clinical services.

And this is also the case for severely maltreated children who remain with their parents. So, in other words, the mental health problems that I'm talking about are not specific to children in care as such. They're specific to maltreated children.

Firstly, the mental health difficulties that children experience whilst growing up in care are mostly trauma related and attachment related. And they are also
10.32 developmentally based, which means they develop over long periods of time.

In particular, difficulties with social and interpersonal relatedness linked to attachment development are hallmark features that differentiate this population from other children with clinical-level difficulties.

I am sorry for all the big words.

Other characteristic difficulties include relationship insecurity, inattention/hyperactivity, Post
10.33 Traumatic Stress Disorder symptoms, disassociation, conduct problems and oppositional-defiance, self-injury, food maintenance behaviours, which means hoarding, gorging and storing food, abnormal responses to pain and sexual behaviour problems.

However, the most defining feature is not the forms or types of difficulties, but their complexity and severity.

In my longitudinal study of 347 children in long-term care in New South Wales, 20% had complex
10.34 attachment and trauma-related problems that are not adequately explained or classified in either the Diagnostic and Statistical Manual of Mental Disorders, what they call the DSM, the Psychiatric Classification Manual, or the World Health Organisation's International

Classifications of Diseases.

And this is one of the reasons why these children require specialised clinical services.

In the context of children entering long-term care with seriously compromised psychological development, it is understandable that their mental health difficulties persist whilst growing up in care. That's because these difficulties are developmentally-based and thus tend to follow a long-term developmental course.

10.35 So, these are not like simple problems like anxiety and depression that may arise over a short period of time and can be treated quickly, where the course of the problem can be changed fairly quickly.

Q. That's because the developmental problems that have taken a course of time in the child's development which is what we spoke about earlier?

PROFESSOR TARREN-SWEENEY: Yes. An analogy might be that problems that are not developmentally based, it's like steering a speedboat on the water. But

10.36 developmentally based problems is more like trying to change the steering or the course of a big ocean ship, you can't just change it very quickly, it's very slow to change over time.

Q. And I think now you're going on to talk about the conditions of a child's development which lead to a child's development at paragraph 61.

PROFESSOR TARREN-SWEENEY: So, the conditions are slow to change but without improvements in a child's developmental conditions, these more serious

10.36 problems are likely to become increasingly fixed or trait like, which is a psychological term, having lifelong implications for social, educational and occupational functioning.

On the other hand, even with optimal conditions

where the child's care, life circumstances and their care changes dramatically for the better, that recovery tends to be slow and this often tests their foster parents' commitment and strength. Even in the best of worlds when they do recover, it occurs over long periods of time.

I will now move on to canvass what I believe are the most important things that children need if they are unable to remain in their parents' care.

At the start of my evidence, I proposed that
10.38 severely maltreated children can experience psychological recovery in response to consistently sensitive, loving care, as well as other experiences that engender felt security.

I also expressed my belief that the State, by which I mean the government at large and civil society, not just the statutory Child Welfare department, that the State has a duty of care to do three things for these children.

The first was to restore to them their right to
10.38 experience and enjoy what remains of their childhood in much the same way as do other children.

The second was to restore the social and familial conditions that are necessary for healthy human development.

And the third was with regard to providing specialised clinical services and support.

Although costly, this third priority is perhaps the simplest, it is the most straightforward to achieve, because unlike the first two priorities, we can do this
10.39 without reforming the statutory care systems.

So, here I'm talking about Governments providing specialised clinical services for children in care.

Q. And that's because, as you described earlier, in terms of the complex range of factors which are present in this

population of young people, some of the tools which are available within the mental health setting aren't necessarily addressing those; is that the point?

PROFESSOR TARREN-SWEENEY: Yes. And it's not specific to New Zealand, this is a problem all around the world and I might just talk because there's a fair bit to get through here and I think we wanted to get to the other parts, make sure we get to that.

If I can just summarise what I say from paragraphs 68-81.

10.40

Q. Thank you.

PROFESSOR TARREN-SWEENEY: No government has managed to get this right yet. The government that's done - where it's been done the best is in the United Kingdom and in this part of the world New South Wales has shown the most progress, in terms of not just the Child Welfare Department but particularly the Health Department developing specialised clinical services.

10.40

Q. We with pause there? We are both conscious of the time but there's a point about what's happened in New South Wales which might be worth touching on very briefly. That's the extent to which they have tried to change the way that they look at their system in terms of Care and Protection and Youth Justice; is that correct?

PROFESSOR TARREN-SWEENEY: They have done a number of things. Firstly, early in the early years when I was first working in the Ministry, they separated out Youth Justice from Child Welfare, for the

10.41

reason being that the institutional approaches to running Youth Justice services cross-contaminate the way that they care for children in residential services because the same agency is doing both. It's difficult for them to care for children in

residential care in the manner in which a parent would be thinking about a child, when at the same time they are running equivalent institutions for young offenders.

Q. So, two separate departments effectively?

PROFESSOR TARREN-SWEENEY: Yes, in different ministries, yes.

Q. Thank you.

PROFESSOR TARREN-SWEENEY: The second thing they did, was in the 90s they did a very radical move, it was the Usher Inquiry led to the closure of every residential service in NSW, including small group homes, every single one was closed. That had some negative consequences, in terms of children that were difficult to place with foster families sometimes winding up living in youth refuges\and things but it was a revolution in terms of forcing the government to confront how do we care for difficult to place children with families? I think it was largely successful.

Q. If we can return to its summary, the four points?

PROFESSOR TARREN-SWEENEY: I will go through the four points very quickly. The first is, we know these children actually consume a disproportionately large amount of generic State run Mental Health Services. In spite of that, many of them don't get the services that they need. So, there is a problem with capacity.And so, New Zealand, as with other places in the world, doesn't have enough Mental Health Services to meet the needs of this population, let alone the population at large.

Secondly, the existing Child and Adolescent Mental Health Services, partly because they're so stretched, operate under an acute care model, which means that

they're focusing on getting clients in and out as quickly as possible, using brief therapies and brief interventions. And these children need long-term interventions.

Q. And that's the point you've made around the cruise liner and the speedboat, developmental versus other more acute -

PROFESSOR TARREN-SWEENEY: Yes. The irony is they don't necessarily need treatment services that are as
10.44 intensely provided as the acute care services. Sometimes an over the horizon approach is a better one where the children aren't even aware that they're receiving Mental Health Services. It's mainly provided through their carers. So, they don't need as intensive services all the time but they need a service that their caregivers can access that are available. In other words, they can't - presently they have to join queue and then wait and then fall off and again join the queue
10.44 again and then wait and then fall off.

The other problem, as I mentioned, these children have difficulties that are not well understood within existing diagnostic classifications, and that points to the need for, well that points to a bigger challenge or problem, which is we don't have a clinical workforce that is sufficiently skilled in terms of understanding - speaking too fast?

COMMISSIONER ALOFIVAE: No, I'm appreciating the point.

PROFESSOR TARREN-SWEENEY: We need more specialised
10.45 clinicians and the best way to do that is to train them and to employ them within specialised services.

Q. And on that point, earlier you've talked about western approaches to this and later on you talk about cultural

parameters, in terms of relationships. On this point around specialised clinicians, would you support the proposition that a diverse range of clinicians with different cultural backgrounds would add to the workforce in that area?

PROFESSOR TARREN-SWEENEY: I think in New Zealand currently around half, or a little more than half, of children in care are Maori. And so, I think it's self-evident that, the work that I've done has been voiced internationally, so I've not talked specifically about this, but I think it's self-evident that if you were to develop specialised Mental Health Services for children in State care in New Zealand, then there has to be, not only the model of treatment models in ways of delivering services, but trying to recruit more clinicians from the cultural backgrounds that reflect the population of children in care.

I think I've covered that enough. I guess the last part of my evidence, I'm really wanting to talk about present statutory care systems, the extent to which they meet the needs of children and specifically focusing on what I see as being systemic factors that compromise children's lives.

Q. Just so we can follow along, we're now at paragraph?

PROFESSOR TARREN-SWEENEY: 82. I am seeing how far I've got to go.

A recent review that I carried out of studies that measured longitudinal changes in children's mental health in family based care found no consistent evidence that care excerpts a general population wide effect on children's mental health. In other words, at least in terms of measuring children's mental health over time, there is no evidence that foster and kinship care are

either generally harmful or generally therapeutic.

Instead, several longitudinal studies have found that sizeable proportions of children show meaningful improvement in their mental health over time but similar proportions show deterioration in their mental health over time.

And if I can refer to my New South Wales study again, around 35% of those children around 9-11 years of time, had good mental health at the start and good mental 10.49 health at the end. A quarter of the children showed meaningful improvement in their mental health. Another quarter showed meaningful deterioration, things got worse for them. And the final 15%, their difficulties, they had difficulties at the beginning and difficulties at the end, that stayed much the same.

And so, what this kind of draws our attention to, I think, is not asking whether or not carers itself is generally harmful or generally therapeutic, but what are the characteristics of care that foster children's 10.50 healthy development and what are the aspects of care, the care system, that either impede their development or recovery or actually cause further harm?

I am just going now to paragraph 92.

Q. To 92, thank you.

PROFESSOR TARREN-SWEENEY: Within a family preservation framework, the designated purpose of statutory care shifted in the 1980s and 1990s to temporary protective care with restoration, meaning restoring the child to their birth family, being the ultimate 10.50 goal.

This reflects the belief that foster care should serve as a support intervention in the aid of family preservation, not as a means for effecting family break up.

The problem is, however, if we look at the reality of what has happened since then, today statutory care increasingly serves a very different function. I don't have the equivalent statistics for New Zealand but, for example, in Australia there is an increasing trend for children to enter statutory care at a younger age and to spend the remainder of their childhood in care. And based on current trends, the majority of children placed into care will effectively grow up in care.

10.51 Children experienced statutory care through the lens of their previous experiences of harmful care. Harmful, insensitive and inconsistent parenting adversely affect children's attachment style and how they understand and interpret adult caregiving behaviour. Attachment theory predicts that the developmental effects of statutory care should vary according to the characteristics of a child's attachment development prior to their entering into care.

And so, I've written some technical terms here but basically, what I'm saying is that if as a young child 10.52 you were raised by parents where your relationships are very distorted and maladaptive, then when you are subsequently placed with other families you still perceive those people and understand relationships through that lens that developed earlier.

Whereas, the attachment styles of very young foster children tend to match their foster mother's attachment styles, children who come into care at older ages are more resistant to change, despite receiving markedly improved care.

10.53 Many such children are thus prime for insecurity when they enter care, due to their compromised attachment development, as well as the loss of their parents and being placed with unfamiliar carers.

Therefore, even with optimal reparative conditions,

and with specialised support, children's recovery tends to be slow.

Whilst growing up in statutory care is preferable to ongoing exposure to maltreatment, there is good evidence that it systemically compromises children's development and wellbeing.

There is accumulating international evidence that the quality of caregiving provided to children in statutory care, caregivers' motivations for fostering
10.54 children, their commitment and bonding to children placed with them; and of course maltreatment of children in care all influence children's felt security and psychological development and these factors regulate their recovery from their mental health difficulties.

Q. At this stage, if we could move down to paragraph 112 because it would be good to talk about this idea of a qualified commitment to care and then go on to talk about the impact of familial love.

PROFESSOR TARREN-SWEENEY: Maltreatment and care, we'll
10.55 skip that, 105?

Q. I think if we can direct ourselves now to 112.

PROFESSOR TARREN-SWEENEY: Okay, yep. The accumulating research challenges a myth embodied within western statutory care systems, that children can be adequately nurtured for the remainder of their child hoods by caregivers who have a qualified commitment to them, so long as those children receive good or adequate day-to-day care.

By that, what I'm saying is that there was a belief,
10.55 at least within the care system that I've worked in, that it didn't matter whether caregivers and children had bonded to each other as if they belonged to each other. All that was essential was that children were loved and nurtured on a day-to-day basis. But this kind of

misunderstands what the concept of love is, which I will talk about now.

While children may not initially understand or respond positively to loving care, over time familial love is the most important therapeutic mechanism that we have for repairing these children's lives.

But familial love, and the close relationships that underpin it, are not momentary transactions of nurturance or affection. So, it's not transactional and it's not
10.56 something that we can provide on a time limited basis as something that we do in terms of behavioural nurturing of children on a day-to-day basis.

Q. At this point, I think it's a good point to jump now to paragraph 117 where you talk about relational permanence.

PROFESSOR TARREN-SWEENEY: Put simply, children with only truly feel secure when they acquire relational permanence. Familial love and relationships are not time limited, they are unending.

At this stage, I should also emphasise that
10.57 relational permanence and the associated felt security that flows from it, is experienced and shaped within cultural parameters and shared belief systems.

For example, for Maori, felt security does not flow exclusively from close, permanent, familial relationships. It also flows from having a secure connection with and a sense of belonging to one's whakapapa and connection to whanau, hapu and iwi.

Based on my understanding, the practice of Whangai operates within the strengths of that cultural framework.

10.58 I also believe that the practice of Whangai provides a vehicle for facilitating relationship permanence and felt security for Tamariki who otherwise cannot or should not be raised by their parents.

Almost all aspects of present statutory care systems

work against children acquiring relationship permanence and associated felt security, even in cases where foster parents and whanau are strongly motivated to permanently care for a child.

Children's felt security is constrained or undermined by the legal, philosophical and historical bases of statutory care systems throughout western jurisdictions.

To illustrate this, I was going to provide some
10.59 examples but I won't but I will just mention, I should mention that, I should refer the Commission to the TVNZ1 documentary "I am a survivor of State care" which provides an historical example in which Daryl Brougham and his former foster parents recount his involuntary removal from their care and the long lasting effects this had on all of them.

My experience has been that children growing up in long-term care begin to fully understand their legal and care status from about age 6 or 7. In my clinical work,
10.59 I have observed this growing awareness is often accompanied by increasing insecurity about the possibility of that child losing or being taken from their caregivers.

In my NSW longitudinal study, one of the clearest predictors of children's mental health problems was foster parents' perceptions of placement security. Within the confines of family relationships, felt insecurity of one family member impacts on the felt security of others.

11.00 Thus, foster parents' own concerns about a child's tenure with them can raise anxiety within the family system. This can be quite detrimental when children are already highly anxious about their placement security.

Statutory care systems add here to the myth that

caregivers can simultaneously nurture and love children "as much as any child might need" but that those caregivers should also be able to readily let go of those children if it the agency decides they should be returned to their parents or moved to another placement. In practice I believe that this is rarely achieved, and that there is an inevitable trade-off between the level of nurturance and expressed love, and a caregiver's ability to let go. I will move now to paragraph 147. Let me know if I'm taking too long.

11.01

By and large, out-of-home care services are staffed by very caring and emphatic professionals and yet, complex systemic factors deny these children the possibility of enjoying the same standard of care and the same experience of childhood that most children enjoy.

The most intractable problem within our system of legally impermanent statutory care is placement disruptions and placement instability.

Q. At this stage, can I ask you to summarise some of the points you've made about placement disruption and placement instability, starting on page 16, paragraph 149?

11.02

PROFESSOR TARREN-SWEENEY: I can skip a lot of this, okay. There are two main problems. First of all, placement instability is very common in statutory care. Some of it occurs because children are moved in a planned way. When they're moved from placement to placement in a planned way, it may be because a child is being moved from a supposedly temporary placement to a permanent placement. But not enough thought is given to how that affects children. The most common reason children move is because placements disrupt or breakdown. And the most often stated reason for that is foster parents

11.03

or whanau carers not being able to cope with children's behavioural difficulties or their unusual or problematic interpersonal relatedness difficulties, so their attachment behaviours.

And we haven't had enough research to definitively map out and show exactly what the psychological toll is on children when their placements breakdown, and the reason for that is, it's technical reason. But numerous qualitative studies of children growing up in care, children describe the devastating effects of placement moves and placement breakdowns.

Q. As a matter contributing to placement breakdown, would you add, if the level of mental health support is deficient or not adequate, that would be a factor which would contribute to placement breakdown?

PROFESSOR TARREN-SWEENEY: It is. And so it works in the other way as well, and that is that placement breakdowns incur a toll in terms of children's mental health. So, we see a spiral, what we typically see is a spiralling pattern, after the first placement breakdown the likelihood of another one increases because the children's distorted views of themselves and of others, the breakdown confirms their distorted views. So, they're living in a dangerous rejecting world, they see themselves as being unlovable and they see the placement breakdown as being inevitable.

And so, over time you get this reverberating cycle, that we see this pattern with older children/adolescents, where eventually they are placed in residential care.

But the biggest, I think the biggest cost of placement breakdowns is that every time one happens, the clock is reset for this child actually developing a permanent relationship. That's actually a bigger cost

because whilst when a child is moving from placement to placement, they are adrift and they are alone. And the more chance it is that when they reach adulthood as a 17 or 18 year old, they are literally alone in the world.

And so, Mental Health Service, in terms of the specialised special approach for these children, the number one goal is not to bring about some improvement in their mental health in the short-term. The number one goal is to maintain children's placements because if you
11.06 can do that early on and keep placements that are at risk viable, so that caregivers and children become closer to each other and they develop stronger bonds to each other, and foster parents and whanau carers are adequately supported to deal with the problems that children have, then we reduce the risk of placement breakdown. And the placement breakdown is the catastrophe, more than the mental health problems getting worse, if that makes sense.

Q. Shortly we're going to take a break but before we do
11.07 that, I just wondered if you had any final points that you wanted to make in closing, Professor Tarren-Sweeney?

PROFESSOR TARREN-SWEENEY: I have probably spoken too long.

Q. No.

PROFESSOR TARREN-SWEENEY: I can read my conclusion? Today's I've presented evidence that I believe supports the case that statutory care systems are not able to restore to children their right to experience and enjoy what remains of their
11.08 childhood in much the same way as do other children.

And that an impermanent care system cannot provide children with the social and familial conditions that are necessary for healthy human development and are also

preconditions for their developmental recovery.

I believe that the experience of growing up in statutory care in the western world constitutes an unnatural childhood, one that exposes our most vulnerable children to unique developmental risks that other children do not encounter.

Furthermore, there is good evidence to show that these developmental risks are systemically interconnected. It involves a complex interaction of
11.08 Child Welfare practices, caregiver motivation, the child's experience of impermanence and felt insecurity.

The core problem is that this system sees many children growing up without acquiring permanent relationships. In other words, without enjoying unconditional, lifelong commitment by a loving family.

My present research focuses on designing and testing a developmental theory which I call a permanence theory, and I should skip that because we are running out of time. The theory proposes felt security is the core
11.09 psychological state that underpins developmental recovery and that it can't be fully attained without close permanent familial relationships.

Q. It would be interesting to hear about how some of the work you've done to try and test that theory in term of your research?

PROFESSOR TARREN-SWEENEY: It's still in its early stages but partly what I've been doing is unusual for a psychologist but I've been doing historical work to test - well, humans are a social species
11.10 that evolved such that close and enduring familial relationships are essential for their psychosocial development.

In other words, if that part of our lives is approximately non-negotiable, that all of us do this,

then that provides evidence for it having an evolutionary basis. The in other words, what I'm looking for is any evidence historically or cross-culturally where children are raised in a similar way to how we raise children in care would potentially provide evidence that we can, as a species, cope with this.

And so, I've searched as far back as pre-Christian Europe and the Roman Empire, as well as ethnographic accounts of traditional societies throughout the world, and so far I have not found any such precedent.

What this tells us is the absence of such precedents infers this experience lies outside the boundaries of human adaptation as determined by our DNA.

In other words, being raised without a semblance of a permanent family is both developmental harmful and contrary to human evolution.

Thank you.

Q. Thank you. First, Mr Tarren-Sweeney, a big acknowledgment to you. I will just turn to the Chair now to see whether that might be an appropriate time, although slightly early, Sir?

CHAIR: Yes, I think I speak for all my colleagues, this would be a good time to take the morning break. When we resume, counsel if they wish can ask Professor questions. Is that the way in which you're going to do it or are we going to hear from Dr Rapsey first?

MR MERRICK: We will hear from Dr Rapsey first and then have questions to round off.

CHAIR: Very well. We will take the break and then we will receive the evidence of Dr Rapsey.

Hearing adjourned from 11.12 a.m. until 11.30 a.m.

MR MERRICK:

Q. We will now turn to you, Dr Rapsey, and we will follow the same process as we did with Mr Tarren-Sweeney.

At tab 22 of the folder in front of you, if you can open to tab 22, can we see there a signed copy of your brief of evidence?

DR RAPSEY: That is correct.

Q. Do you confirm that that is true and correct?

DR RAPSEY: I do.

11.33 Q. With the proviso that at paragraph 23 there is something, a point you would like to clarify around the brief at that point. We can do that in your oral evidence.

DR RAPSEY: Yes, correct, thank you.

Q. I will invite you to start by reading your brief of evidence, thank you.

DR RAPSEY: Thank you. Tena koutou. I am a lecturer in the Department of Psychological Medicine, University of Otago, and a Registered Clinical Psychologist. My research interests include mental

11.33 disorder and the effects of childhood adversity. While in practice, I have worked as an ACC approved clinical psychologist; and at times this has included working with incarcerated men who were victims of sexual abuse, as well as with children in foster care.

This work also included working with those where the abuse occurred in State care and so I bring an understanding of the issues faced by survivors of abuse in State care.

11.34 My current research projects include: the World Health Organisation World Mental Health Surveys project. This is a unique international collaboration with over 30 countries focused on epidemiology and the prevention of mental disorder.

The Otago Women's Health Study, a 25-year longitudinal study investigating associations between childhood abuse and outcomes across the life course.

And the Foster the Whanau project which investigate the costs, benefits and long-term out comes for children when the mother participates in an intensive, residential intervention as an alternative to foster care.

First, I am proud that our government has chosen to Commission this Royal Commission into abuse in care.

11.36 Today, the evidence I am presenting is based on my summary of the research field, primarily addressing the question posed by the Commission: what are the effects of abuse?

In this brief, I have used the word "maltreatment" as a term that includes physical, emotional and sexual abuse as well as neglect.

I am going to discuss evidence addressing the following four questions:

What are the effects of childhood maltreatment?

11.36 What are the effects of time in out-of-home care, that is foster care or institutional care? And specifically, what are the effects for children in Aotearoa New Zealand?

What is the effect on the family and the likelihood of family reunification when a child has been removed into care?

And what evidence supports alternatives to out-of-home care?

So, beginning with the first question, what are the

11.37 effects of child maltreatment?

There is strong and robust evidence that all forms of child maltreatment are associated with an increased risk of deleterious outcomes across the life span of the individual.

Q. By deleterious?

DR RAPSEY: Bad, poor, reduced.

Q. Thank you.

DR RAPSEY: The magnitude of risk of poor outcomes increases with increasing exposure to maltreatment and/or the increasing severity of the abuse. So, that is cumulative maltreatment and/or higher levels of abuse harm are associated with increasingly greater risk of poor outcomes.

11.38 The effects of child maltreatment are pervasive, with disruption of multiple interacting systems - biological, psychological, relational and social. This pervasive disruption influences development in multiple ways with long-term implications across the life-course.

Psychological effects of maltreatment includes an increased risk of meeting diagnostic criteria for all types of mental disorder.

As an example, the WHO World Mental Health Surveys, which is the largest international survey of mental

11.39 disorders, conducted an analysis of the relationship between childhood adversity and adult mental disorder which included almost 52,000 participants from 21 countries, including Aotearoa New Zealand. They assessed diagnosis of 20 commonly occurring mental disorders, so that includes depressive disorders, bipolar disorder, anxiety disorders, including Post Traumatic Stress Disorder, phobias, generalised anxiety disorder, behaviour disorders, examples of behaviour disorders are conduct disorder, ADHD, as well as substance abuse

11.40 disorders, so alcohol and drug. They did this using a clinical interview. They found that childhood maltreatment increased the risk of meeting criteria for all types of mental disorder at all ages.

In this survey, in this study, they also analysed

the extent to which childhood adversity contributed to the prevalence of mental disorder in a country. They reported that eradication of childhood adversity would lead to a 23% reduction in mood disorders, 31% reduction in anxiety disorders, 42% reduction in behaviour disorders, and a 28% reduction in substance disorders. So, overall, eradication of childhood adversity would lead to a 30% reduction in all mental disorders.

So, this study, the World Mental Health Surveys, did
11.41 not assess psychosis but other research has found that childhood maltreatment increases the risk of psychosis.

Childhood maltreatment increases the risk of death by suicide and suicidal behaviours.

This increased risk of mental disorder persists across the life course of an individual.

In addition to an increased risk of mental disorder, child maltreatment affects physical health. Child maltreatment is associated with an increased risk of a number of chronic diseases and the associated disability
11.42 and loss of quality of life. For example, there is an increased risk of a range of physical health problems including pulmonary, cardiovascular, gastrointestinal disease, musculoskeletal problems, chronic pain and cancer specifically, in the WHO surveys, child maltreatment was associated with an increased risk of all of the measured physical health conditions. They were heart disease, asthma, diabetes mellitus, arthritis, chronic spinal pain and chronic headache.

Childhood physical and emotional abuse is associated
11.43 with an increased risk of all-cause early mortality for women.

Maltreatment in childhood also has implications for relational and social outcomes. Effects include increased risk of sexual and physical re-victimisation, a

greater likelihood of developing insecure attachment styles which are associated with later relationship difficulties, and diminished educational and employment opportunities.

This diminished social and economic capital also has implications for reduced mental and physical health.

There are a number of proposed mechanisms that contribute to understanding why child maltreatment increases the risk of poor physical and mental health.

11.44 Research focused on biological mechanisms finds that there are neurological changes that can occur in adverse environments. In particular, there is evidence that child maltreatment can lead to altered hypothalamic-pituitary-adrenal stress response networks, the HPA network.

The HPA axis is involved in the fight or flight response. Fight or flight is a useful system to get us out of danger quickly. It is a complex system that also regulates immune functioning and inflammatory processes.

11.44 One theory suggests that child maltreatment alters the HPA system so that it is more sensitive to stresses, to dangers in the environment. While the physiological mechanisms involved in a stress response are valuable and useful for short-term dangers, persistent and chronic exposure to stress is associated with a range of poor outcomes.

So, coming to the question, what outcomes are associated with time in out of home care, foster care or institutional care?

11.45 We would expect that removing children from adverse home environments and placing them in out-of-home care should improve outcomes for children who have experienced maltreatment. However, when children are removed from parental care due to maltreatment, they remain at

increased risk of experiencing a number of poor outcomes, including mental and physical illness, poorer educational outcomes and greater contact with Justice and Child Protection Services.

When compared with children from similar backgrounds, taking into account the extent that's possible, that children in care are at greater risk of poor outcomes because they come from backgrounds of adversity, some studies suggest that outcomes are not 11.46 improved and may even deteriorate for some children in care.

So, for example, children who go into unfamiliar foster homes can experience a greater increase in mental and behavioural problems than children who remain in maltreating homes, but maltreating homes that are not at a level for the children, to the extent that the children would be removed into foster care.

This is the point I wanted to clarify, that children in severely maltreating homes should be removed from that 11.47 harm. The point to take from this research is that foster care is not reparative for many children.

One factor that contributes to poorer outcomes in placement instability. When in care, New Zealand children typically experience 7-8 placement moves by the time they are 8 years of age.

There is evidence from a number of studies that placement instability is associated with a greater risk of mental distress and symptoms of mental disorder. Attachment theory and research present a compelling 11.48 argument for the necessity of consistent, loving, and responsive caregiving, and thus the likelihood that placement disruption will have devastating consequences for a young person's development.

In support of the argument that placement

instability contributes to an increase in problems, children who go into foster care with average levels of mental and behavioural health problems are most likely to experience an increase in problems following placement stability. So, that is it's not just that children with pre-existing difficulties are more likely to experience placement disruption at first.

Children placed in residential care, so group homes and institutional care, have worse mental and behavioural 11.49 outcomes than children placed in family based foster care. And by family based foster care, I mean unfamiliar based foster care, not kinship care.

When children and young people are asked their perspectives ongoing into care, many children reported missing their mothers and reporting that their lives would have been better or the same if they had stayed with their families.

Young people report preferring family based foster care to residential care.

11.49 Specifically, in Aotearoa New Zealand children who were in the care of Child, Youth and Family, now Oranga Tamariki, are at greater risk of experiencing a number of adverse outcomes, including higher engagement with Youth Justice and Corrections, poorer educational achievement and poorer mental health when compared to children who have no contact with Child, Youth and Family.

Women with contact with Child, Youth and Family as children are nearly three times more likely to be parents before age 25, and as parents are three times more likely 11.50 to have their child referred to Child, Youth and Family.

So, a set of analyses of a cohort of children born in 1990-1991, found those children who were ever placed in Child, Youth and Family care were:

Twice as likely to fail NCEA level 2; 78% left

school with less than NCEA level 2 compared with 36% of children with no contact with Child, Youth and Family.

They were ten times more likely to have been in prison before age 21. So, 18% compared to 2% of all children.

They were more than twice as likely to have a mental disorder. Five out of ten had identified mental health issues compared to two out of every ten who did not have contact with Child, Youth and Family.

11.51 Maori children are particularly affected. Maori children were significantly more likely to have a hospital admission arising from assault, neglect or maltreatment.

6 out of 10 children in foster care are Maori.

Intervention practices within a narrow focus on child removal do not address structural barriers, systemic racism and can further perpetuate harm through a placement that does not ensure cultural continuity.

Moreover, a focus on risk and individualistic child
11.52 protection policies conflicts with ways of knowing embedded in indigenous identity and values of Maori within Aotearoa New Zealand.

My research most often focuses on statistics and the increased probability of risk but mind these numbers are the stories of individuals. I have also worked as a clinical psychologist and heard, and read in their files, some of the stories of individuals who grew up in care.

Some historic files contain accounts of boys who spent time in multiple group homes until the State
11.53 relinquished responsibility for them when they turned 15, leaving them with few resources. At the time that I was talking with them, these men were incarcerated.

It has seemed to me that as a society we failed in our care of these men when they were children in our

state mandated children's homes. We placed these children in institutional care, failed to provide adequate care, and then again placed them in the institutional control of prisons when they went on to commit crimes that hurt others.

My third question, what is the effect on the family and the likelihood of family reunification when a child has been removed into care?

In addition to research finding poor outcomes for
11.54 children removed into foster care, there is evidence that removal of children into care has poor outcomes for the mother, which ultimately has implications for her children.

Qualitative evidence describes mother/child separation as a traumatic event that involves the devastating grief of losing a child, loss of identity as a mother, and the added assault of stigma and the societal invalidation of such a loss. Not only does a parent experience the loss of a child but they experience
11.55 guilt and marginalisation at being blamed for that loss.

Internationally, quantitative evidence finds that compared with mothers in the general population, mothers whose children were taken into care had higher rates of mental disorder, housing instability, and poverty prior to having their children removed, which is what we would expect. But this inequity increased in the two years after having a child taken into care.

So, when mental health and structural factors that contributed to the initial removal of a child are
11.56 intensified following the removal of a child, family reunification and thus, ultimately, the child's welfare, is undermined.

My final question, what evidence supports alternatives to out of home care?

In Aotearoa New Zealand, the recent government commissioned review of, then, Child, Youth and Family, modernising Child, Youth and Family, concluded that the current system of foster care provision was failing to provide adequate Care and Protection of our most vulnerable children.

Therefore, to improve outcomes for children and mothers in the context of Child Welfare concerns, effective alternatives to our current out-of-home
11.57 placement system are needed.

Broadly, there is some international evidence that interventions to reduce child maltreatment broadly can be effective. Larger effect sizes, that means that the most impact was seen for interventions that provided social and emotional support.

Consistent with this research, focused on the importance of attachment relationships, the modernising Child, Youth and Family report identified that supporting families to care for their children was a key principle
11.57 that should underpin interventions.

So, a family preservation intervention is an intervention that aims to reduce child maltreatment and other Care and Protection concerns in order to avoid an out of home placement.

In Aotearoa New Zealand, at least two organisations, the Anglican Trust for Women and Children and the Merivale Whanau Development Centre, offer residential, family preservation interventions that aim to avoid parent/child separation. These two similarly structured
11.58 services, offer an intensive 6-18 month support programme, whereby the mother and the children in her care are placed in residential care together. During the intervention, the mother and her children participate in a therapeutic and parenting skills focused programme

aimed at changing the factors associated with Care and Protection concerns.

A qualitative evaluation of one of these Aotearoa based family preservation services was undertaken by my team. We found that service users and staff provided hopeful stories that included the centrality and importance of relationships, the development of practical skills and psychological resources through participation in a wrap-around, holistic programme, described by many of the participants and the staff as being like a family. 11.59

The reports from these women and from the staff contrasted markedly with qualitative reports of women's experiences with Child Welfare services.

The stories told in our study suggest that a relational and skills based programme within a supportive residential community environment has the potential to change the lives of women and children.

Internationally, few studies have investigated longer term, residential programs and so we have minimal robust evidence to be able to comment or determine effectiveness. 12.00

Robust research directly assessing the effect of family preservation interventions is limited but indicates some components may reduce out of home placements for some children.

Further research, in particular qualitative research, is necessary to investigate whether participation in this Aotearoa based family preservation programme results in reduced risk of future out of home placements, along with improved outcomes for children. 12.00

It is time to change the focus of Child Welfare interventions from one that focuses only on the child and the child's risk, to a new paradigm that understands that parent and child wellbeing are inter-related.

The stories of service users and of staff suggest that there is some value in pursuing a paradigm that supports and fosters family resilience.

Q. Kia ora, thank you for that.

MR MERRICK: Mr Chair, I have had discussions with counsel about possible questioning. I have a couple of questions to put, I will put on behalf of Ms McCartney. As I understand it, Mr Stone may or may not have questions, in light of Dr Rapsey's evidence but we can confirm that. I will put these questions first.

Q. They are to you Professor Tarren-Sweeney. The first question relates to briefly what happened with children in New South Wales who were moved out of residential homes into the community as a result of that shutting down of residential homes?

PROFESSOR TARREN-SWEENEY: That occurred in the 1990s following the Usher Inquiry, Usher report, Father John Usher was the man who did that, led that Inquiry. Every residential facility from the largest residential institutions to the smallest group homes were closed. There were no exceptions. And so, with such a radical change, there were, of course, some negative outcomes from that for specific children but in the main it was a brave and positive move because it forced cultural change and it forced a way of thinking afresh around how to care for difficult to place children.

New South Wales at the time had a funded, parallel funded service for young people, teenagers, who had run away from home or homeless, there was a youth refuge system. And so, for a time, for several years, many of those young people, they were mostly adolescents that were very difficult to place, found themselves living in

the youth refuges for periods of time.

Over time, there was a very small number of young people that could never be successfully placed with families and over time the government relented and gradually started to reintroduce funded residential placements.

And so, I think it was in the 2000s that happened, and so particularly organisations like Life Without Barriers, who I think work here in New Zealand as well, started to be allowed to provide small group homes for those most difficult to place kids.

Q. Was that monitored by the child protection?

PROFESSOR TARREN-SWEENEY: It was oversight, they were licensed by the State Child Welfare authority but there was also oversight by the children's guardian. But I think the important thing is that even though residential care has been reintroduced in New South Wales, the numbers of children in residential care of young people is far, far lower than it was previously. And so, on the positive side, it effected positive side because it forced the State to think about how could we place young people, mostly young people, mostly adolescents, and some children, who historically and traditionally were seen as being unfosterable, how can we make that happen?

And so, I think in the process of being forced to do that because of this quite radical change, the State had to learn ways of doing this, in terms of training particular caregivers, foster carers, to be able to take specific, very difficult to care for, young people and children.And off then those were placements where there was only one person, one child or one young person placed. And there was definitely a financial cost to

this because the level of resourcing and the level of support and training and ongoing assistance required to support these placements is quite expensive but bearing in mind that we're talking about a relatively small number of children in care that this applies to.

Q. Thank you. I'll move on to the other bigger question that I have been referred, and that's seeking some clarification or reconciling your earlier evidence that statutory care exposes children and young persons to
12.06 developmental risks, alongside this tension that you both talked about, that it's against the interests of children to remain in environments involving serious maltreatment. And so, the question was, how do you reconcile the two? It may have something to do with what you talked about, being two bad choices but I will leave that to you to answer.

PROFESSOR TARREN-SWEENEY: There are two solutions, and they are not mutually exclusive and they shouldn't run in conflict with each other or be seen as
12.07 opposing choices. In other words, there is a kind of perception there is a false dichotomy between family preservation and permanent placements, and there doesn't need to be. It's not paradoxical that the State could both be investing more efforts into family - the State should be at the same time investing more efforts into not only funding family's parenting interventions but I think, more importantly, funding research into finding effective family parenting interventions. In other
12.08 words, developing interventions that work to reduce maltreatment to the point where children don't need to come into care.

At the same time, we have to recognise that even if we got to that Utopian point where we were able to

develop interventions that dramatically reduced children's exposure to harm, there would always be some children that need to come into care.

And so, the other point is that for those children, for those small number of children who cannot be raised by their parents, the point that I'm trying to emphasise is that they need to be raised by someone else, not by the State.

And so, I see statutory care or State care as
12.09 really, it should only exist for strictly temporary, for children who need temporary care. It shouldn't, no child should grow up in statutory care in this situation that's extremely unnatural and harmful for their development.

So, I don't actually see that those two endeavours as being contradictory. I see them as being complementary.

However, I think in practice, if we look around the world, the bigger difficulty is social workers being able to be able to simultaneously, philosophically be able to
12.10 be comfortable with those two positions. In practice, it's very difficult. People tend to, we see for example in Scandinavia which has the strongest and highest level of family preservation resourcing and the strongest commitment to family preservation resourcing, that because the philosophy is so strong, that those social workers that work in that system find it very difficult then to raise their hand and say, "These children need to be in care".

In other words, it becomes difficult for people who
12.10 were investing from a philosophical and from their hearts into a system of supporting and improving families, so that children can remain with their families, it's very difficult for those people to simultaneously be the person that says, "Look, these children's experience of

maltreatment is ongoing, it is severe" and what happens sometimes in Scandinavia is social workers then become complicit in children being maltreated and not being responded to.

Q. That covers that group of questions, I think. I'll leave it now to you, Mr Chair, to see if Mr Stone has some questions.

CHAIR: Thank you, Mr Merrick. Now, Professor and Dr, I am going to ask if any of the other counsel wish to address questions to you. Mr Stone?

MR STONE: Yes, I'd like to.

CHAIR: Please come forward.

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DR CHARLENE RAPSEY
PROFESSOR MICHAEL TARREN-SWEENEY
QUESTIONED BY MR STONE

Q. I act for Dr Lynn Russell, she is the main claimant for a claim currently with the Waitangi Tribunal. Her WAI
12.12 number is 2684.

In her claim, she says that Maori who are entering into prisons actually have mental health issues and that a large number of them are going into prison because they're not getting their healthcare met before they enter and then once they're in prison, they're not getting the care they need there either. And then when they're released, again they're not receiving the mental healthcare that they need and they subsequently reoffend and enter back into prison again. So, they are on this
12.13 perpetual merry-go-round. I was interested in your evidence because it reinforced a report I read regularly which said that entering into State care is a gateway to criminal offending.

Professor, you said before that a quarter of children, I think you used the term travel well and don't need monitoring. That means then that there's 75% of them don't travel well that need help?

PROFESSOR TARREN-SWEENEY: Yes.

Q. And you said that the Crown has three duties, the last of
12.13 which was to provide specialised clinical support, and that they're not really getting that. That process IS to get them in and to get them out as quickly as possible?

PROFESSOR TARREN-SWEENEY: Yes, the existing Mental Health Services are not designed for children in

care or maltreated children. They are designed for the community at large. Because the demand for services is so high and the waiting times are so high, there's such a long wait list, the government prioritises psychological treatments that are relatively brief and rapid, rather than longer term, so that they can get more throughput, so more children can access the services. But that very approach doesn't work well for these children.

12.14 Q. We can say then that the Crown is failing these people at every level? It is failing them as children placed in care? It's failing them as young adults? It's failing them as adults and as inmates? And failing them once they get out?

PROFESSOR TARREN-SWEENEY: This is a really good example of how, if the State, if the Crown were to address the core problems of these children's development in lives at the earliest possible times in their lives, not only would they save those children's

12.15 lives and save future generation's lives, but they would prevent so many consequential effects that affect everyone and which add to the cost for society, in terms of provisions of services.

So, this is a really clear example of where early decisive intervention, doing the right thing even if it's costly, saves many things, not least of which is that we don't have as many lives destroyed.

Q. If the Minister of Corrections were here today and he said to you, "Look, I'd like to build bigger prisons",

12.16 what would you have to say about that?

PROF TARREN-SWEENEY: I'm not sure that that's an area I'd have expertise in but I think that - I think what this kind of puts a light on, is the idea that this is actually something that requires a whole of

government approach because, you see, the Minister of Corrections is only thinking about the particular concern that the Corrections Department has. It doesn't necessarily make sense that Corrections goes into the business of children's social work or Mental Health Services. But a government at large can be thinking about this strategically. For example, in New South Wales one of the things I didn't say that actually led to
12.17 increased revision of Mental Health Services for children in care, was that that government introduced a thing called best endeavours legislation or a best endeavours law. And what the law said was that children in State care, by virtue of the fact that not only was those children's guardianship legally transferred to the State but as a society when we remove children from their parent's care, we as a society then have to take on a duty of care and a degree of responsibility for
12.17 children's lives that other families don't share.

So, best endeavours legislation says that if a child is in care, they go to the top of the queue for the waiting list for any government service, whether it be educational services, social work services, mental health services or even services that may prevent young people from offending and coming into Youth Justice.

And so, that was actually, that became law. And because the law says you have to do that, it's like submitting a freedom of information request. Social
12.18 workers would submit a best endeavours request to a local, to their child Mental Health Service, which places that child at the top of the queue.

MR STONE: Thank you.

CHAIR: Thank you, Mr Stone. Any other counsel? There

being none, I'll then ask my colleagues if they have any questions of either Professor Tarren-Sweeney or Dr Rapsey?

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DR CHARLENE RAPSEY
MICHAEL TARREN-SWEENEY
QUESTIONED BY COMMISSIONERS

COMMISSIONER ERUETI: I have a couple of questions. It relates to your research, Professor Tarren-Sweeney, which would suggest the need for early intervention if there's a notification, say, which would seem to create a heightened sense or heightened level of anxiety, I suppose, around children at that young age.

12.19

I'm curious about whether that has the potential of creating an environment that might be hard hitting of particular groups? And there's some tension here between that heightened intervention and the possibility of groups being stigmatised and targeted, as we've seen in history.

12.19

Professor Stanley yesterday talked about even benign interventions having long-term detrimental effects. I suppose it's a type of intervention you were talking about earlier that's important, right?

PROFESSOR TARREN-SWEENEY: Yeah. The developmental science is unequivocal. The more severe maltreatment that children experience and the longer that experience happens over time, the greater the harm that's done to them. So, we can't kind of will that away, that's just a fact.

12.20

And so, if we then think about, you know, what is our responsibility as a society or even within family, within whanau? Then when we know that children are experiencing, I am not talking about the large number of

New Zealand children that are known to Oranga Tamariki, I'm talking about the most serious cases here. It's about being able to have the means to more clearly identify which of these children we need to be focusing on the most.

The problem that you allude to around institutional abuse of power, to some extent, racism, bias, that is problems I don't have any expertise in or I don't have an answer to, other than the fact that in identifying a
12.21 policy, a policy need like I have done here, it's important not to believe that it's a straightforward matter of achieving that.

And so, we can say more clearly that developmental science says we need to find the children who have been harmed the most as early as we can and to work out whether we're providing enough support or services for their family in order for those children to be able to remain with their family or whether, in fact, they need to come into care.

12.22 And one of the problems, one of the larger problems that, one of the larger impacts that happens for these children, is when we don't do that because children that experience really severe maltreatment for long periods of time, coming into care for example at age 8 or 9 or 10, are in such poor shape psychologically that it's really asking a lot of us to be able to work out how we can then repair that within the short space of time that's left of their childhood.

But I think what you're talking about is a really
12.22 important point, and that is we can have a clear idea, this idea to me is crystal clear, but when you go to try to kind of implement that idea, just as I've alluded to all sorts of systemic problems within the care system, there are potentially systemic problems within the child

protection system which is within the same ministries but child protection remember is a different part of Oranga Tamariki as distinct from out of home care.

So, I don't have an answer for you but I think it's a valid concern.

COMMISSIONER ERUETI: Thank you. I did wonder too if you could elaborate some more about the specialist services that should be provided to children in statutory care which you've referenced also the
12.23 cultural needs that they might have. To what extent do we have those services available here in New Zealand? Are there models or are we forced to look to Australia like NSW for inspiration?

PROFESSOR TARREN-SWEENEY: There's nowhere in the world that does it very well. There is a very - there are some examples that I can refer to but what's really interesting, is even in the United Kingdom where they seem to have done the best, this never came out of a central government policy change or
12.24 an issue. Most of these services arose from the ground up because dynamic clinicians, you know, visionary clinicians decided we needed this. In Glasgow, for example, I believe there were five or six Child and Adolescent Mental Health Services, government ones within the National Health Service, and a group of clinical staff that specialised themselves individually in work in this area came together and said, "Look, we want to do this better". And so, they managed to do a restructure
12.25 within the Glasgow services, so that one of them was setup just for children in care and maltreated children. And then the clinicians that work in the six services that specialise in that work all came to that one service. Not only that, we're finding

with this service and others, they are best if they are co-located with Child Welfare services. So, they then move that new specialised service into a building with, in one of the most impoverished parts of Glasgow, so it was not fancy, and they co-located with the Child Welfare service. And the reason for that is, a lot of the nature of this specialised work is not just about the clinical work, it's about how those specialised services can
12.26 shape casework.

And so, it's realising that some of the best ways that we can use this specialised knowledge is to guide social workers and what they're doing, rather than providing some kind of magic treatment that will fix this problem. There is no magic treatment.If there is one, it's just really stability and love. And so, it's helping social workers work out how to do that and to kind of try to ward off things like moving children from one place to another.

12.26 **COMMISSIONER ERUETI:** Thank you, Professor, I really appreciate that. Me and my colleagues have spent a lot of time in private sessions hearing about in foster care our children being moved from dozens of homes to the next.And hearing about the long-term effects that has had on the survivors.

One last question for Professor Rapsey, it's about the comment you were describing as family preservation intervention, I was really fascinated by that. It seems there's very little research to that, quantitative
12.27 research you said?

DR RAPSEY: That's right, yes. So, we can theorise that family stability is optimal and if you can intervene sufficiently with that family of origin to ameliorate those Care and Protection concerns

that would have otherwise led to those children going into foster care. And you can prevent that additional harm that goes from the initial separation, then that will have better outcomes for children and for their families. But we don't have any actual evidence to support that.

COMMISSIONER ERUETI: Is that research that you're undertaking?

DR RAPSEY: I am, yes. I'm not sure if you are familiar with the IBI integrated data, yes? So, I'm waiting, I'm on the list to use that data to investigate - the children whose mothers have gone through these services, what were their "outcomes" in terms of this really big imprecise measurement. We can't measure their developmental outcomes but we can measure their outcomes in terms of did they go on and end up in foster care anyway? Did this intervention just stall the process or did those children, and potentially additional children that that mother might go on to have, were they then protected from going into a system that might then have involved multiple placements? So, that's the first step in terms of the effectiveness of this programme and looking at the health, other outcomes as well, as much as we can with this clunky data that we have.

COMMISSIONER ERUETI: Kia ora, thank you.

COMMISSIONER SHAW: Thank you both for your evidence. I've got two questions that arise from what my colleague has just referred to, and that's the private sessions which the Commissioners have been undertaking, speaking with individual survivors. We've heard from currently up to this stage from about 200 individuals and we have over the last

days of this hearing heard from individual survivors. One of the horrifying things that many of these say, is that they did not feel as though they were treated as humans, they were not being treated as human beings, and they say that in many ways but I think that just summarises what they felt.

Listening to your evidence today seems to me to suggest maybe why they felt that. For you, Professor 12.30 Tarren-Sweeney, you spoke of loss of attachment of love, loss of a permanent family. Could this be why they felt as though they were not being treated as human?

PROFESSOR TARREN-SWEENEY: Perhaps many of the people that you've been speaking to privately were in residential settings but perhaps also with families as well. Sometimes we can over think this but for me, I often just try to imagine myself, you know, or the thing that I keep saying to try and shift people's thinking, is what is it that you would 12.31 want for your own child or for your own grandchildren? Does it meet that standard?

And the first thing is, no-one would ever want their own child or grandchild to be raised in an institution, not because an institution has a bad reputation or bad name but because institutions, as good as they can be in terms of the absolute best types of institutions that ever existed, the childhood or the experience a child has in growing up in an institution, as I said right at the end of my evidence, I think goes beyond the limits of 12.31 human adaptation, goes beyond the limits to which we've evolved as a species, which is at its very core we are a social species and at the very core of that social aspect is family.

If you read between the lines, my way of thinking

about family is quite fluid. You know, it's not necessarily tied to blood but it's certainly about how we feel and the strength of relationships.

And so, that really is - that's why institutional care, there are almost no chances, there are very rare cases where children may have bonded very closely to a residential care worker but if they're working shifts, you know - and then for foster care, I think the experiences of growing up in foster care are much more
12.32 varied than what I have explained today. There's a risk in reading my evidence that you would go away thinking that all foster care is bad. In fact, I've worked for many years of my life working with foster carers and some of the foster carers I have worked with are amongst the best people I have ever met in my life and quite inspirational and their capacity for love and for giving love to children and their commitment to them is phenomenal. But by and large most foster carers' commitment to the children that they raise is conditional
12.33 and it's conditional by virtue of this contract. So, we can have a situation where foster parents can be as good as any parents that exist, and yet the nature of the relationship and the longer term commitment is qualified.

COMMISSIONER SHAW: So, when survivors say, was it my fault that I wasn't treated as a human being; what would you say to them?

PROFESSOR TARREN-SWEENEY: Well, first of all, I would say I can understand why they believe that, even though it's not true.

12.34 **COMMISSIONER SHAW:** Yes. And that's the important thing, it's not true, is it?

PROFESSOR TARREN-SWEENEY: It's not true. There but for the grace of God go us.Every one of us is born the same and equally. I believe that the vast

majority of negative feelings that people have for themselves are acquired after birth, not because of genetics or other things like that. And so, in that respect, children in care are as a result of two things; one, the experiences that they had before they came into care; and secondly, the experiences they have in care, they often have very, very negative self-image. They see themselves sometimes as being essentially
12.35 unlovable. And then they also have similar distortion this is how they recognise and perceive the people that are trying to care for them.

And so, on the one hand, sometimes the care that they're getting is not good enough or it's qualified but also, how they perceive that and understand it and reconstruct it is often distorted. And so, it's definitely not their fault.

COMMISSIONER SHAW: I think it's important that you say it is definitely not their fault.

12.35 **PROFESSOR TARREN-SWEENEY:** Yes. And one of the reasons, the problem with placement breakdowns and placement instability, is that it's typically constructed in terms of the placement breakdown because this child's behaviour was too difficult. Now, at the face value that may be the case, that the foster parent says, "I can't care for this child because their behaviour is so difficult". But the way the child then reflects on that and perceives that, is this is confirmation of my own belief of myself as
12.36 being unlovable and bad, and they don't have the ability, and neither do the foster parents, of actually understanding and making sense of how it came to this.

COMMISSIONER SHAW: Thank you for that and that leads me

directly into Dr Rapsey's evidence because you listed in paragraph 10 all of the commonly occurring mental disorders that were suffered by children. Again, just bringing it back to a survivor perspective for a moment, so many say I was a naughty kid, I was being naughty, they punished me because I was being naughty. And it just struck me that what they felt was in a blaming way their own fault, in fact could well be
12.37 explained by the matters in your paragraph 10 and probably other things as well?

DR RAPSEY: Yes, absolutely. And I think we all try to make sense of our world and one of the ways that children in care can do that, is to make it, how do I understand why I'm in this situation? It must be something that I have done. Children will do that, even if that's not told to them explicitly. But certainly in the historical files that I have reviewed, there is that impression - well, that
12.37 explicit message that comes through from workers at the time, that it is naughty behaviour which is be a abhorrent sort of interpretation to us now or to myself because whatever that outcome is, whether it is a greater likelihood of experiencing depression or anxiety, whether it's a greater likelihood of becoming incarcerated, those things are a result of a person adapting to the best of their ability to the situation that they are in, in a way that any of us would adapt if we were in that situation.
12.38 It's quite clear what the drivers of - what it is that leads a person to that end outcome and it's certainly not because of any fault or inherent capacity of that individual.

So, yes, both that experience of mental disorder is

likely a normal and a person doing the best that they can do to survive in an impossible situation, as well as contributing to their impression, it's something that's also going on at the time, if they're experiencing a mental disorder then that's going to contribute to their behaviour.

COMMISSIONER SHAW: Thank you for that answer. I have a quick question of detail for you from your paragraph 32, where you're talking about the
12.39 Aotearoa New Zealand experience and particularly Maori children.

There you say that Maori children were significantly more likely to have a hospital admission arising from maltreatment than European children. You say that in the context of - you start by talking about New Zealand children who were in the care of Child, Youth and Family. Is your statement there in paragraph 32, does that relate to all Maori children or only those who have had contact with or were in the care of Child, Youth and Family or
12.40 Oranga Tamariki?

A. I understand that that applies to all children but that isn't - that's part of why they come into contact with Oranga Tamariki.

COMMISSIONER SHAW: New Zealand children in the care of Child, Youth and Family were at greater risks of experiencing more adverse outcomes. That's you saying children in contact with the authorities basically. Then when you go on and talk about Maori children, does that refer to Maori children
12.40 who were in contact with the authorities?

DR RAPSEY: No, I don't think, I think it's the general population. That's my remembering of that research.

COMMISSIONER SHAW: Okay, all right, thank you. And

then I have one more question of a sort of higher order, and it came through the evidence of both of you. And that was the cost of providing care, particularly you, Professor Tarren-Sweeney, in New South Wales, the intervention at that very early stage, the very high cost of that, and the cost to our society of mental disorders. I know that either of you is an economist and I think we will be looking for economic evidence in the course of
12.41 our Inquiry over the negotiation few years but do either or both of you want to comment on what you perceive as the best spend for New Zealand in this area, beginning with the start of the early intervention or the outcome end?

PROFESSOR TARREN-SWEENEY: Colleagues of mine at Oxford University have developed a tool actually that can be used for this. It's a cost calculator that can be used in Child Welfare services and you can actually pop in different numbers into this
12.42 calculator and it can actually show you how much money interventions cost, for example for a child with high levels of mental health needs in care at a certain age, and what you actually gain in terms of economic benefits to the State through that person's lifetime.

So, their research has shown using real examples and using this calculator, has actually provided practical proof, I guess, that intervening early with effective, I think the emphasis is on effective, effective
12.43 interventions, effective services, not only does it save lots of money for the State but, you know, there is an incalculable savings in terms of the human side.

COMMISSIONER SHAW: Did you want to add anything to that, Dr Rapsey?

DR RAPSEY: My understanding is that there is, Treasury has already calculated the cost of care, so I can provide you, I can't remember what the numbers are but you can, of course, draw conclusions from what we have presented, that the cost of later incarceration, the cost of later involvement with Child Protective Services, that there is a substantive cost associated with care. So the former Governments focused on a social investment
12.44 model done at that time, which did generate an estimate of what being in care cost compared to not. And part of the work that we're planning in terms of looking at these intensive family preservation interventions, which are costly interventions, do they work out cheaper in the long-term?

And the other piece of evidence that I could direct you to, is to that 2015 investigation into Child, Youth and Family. I am fairly sure they have a table that
12.44 details the cost benefit of particular interventions early on to prevent child maltreatment. And certainly significant savings can be achieved by intervening early and intensively.

COMMISSIONER SHAW: Thank you both very much. I am sorry to have ended on that rather, on the economic note which I hope doesn't take away from the fact that your evidence has been very powerful in terms of showing us the dramatic and negative effects of children in care, of the treatment that they have
12.45 received. Thank you both very much.

COMMISSIONER ALOFIVAE: Thank you for that. That might be a nice segway into the question I would like to ask you both, if I may.

I think, Professor Tarren-Sweeney, there would be

many NGOs and clinicians who would be feeling very victoronic at your comments that actually, often the answers lie, it comes about through the practice that can then inform how they should be restructuring their programs but it doesn't always fit the contract that they might have actually landed in terms of delivering a particular resource.

My question really is around, in paragraph 35, Professor Tarren-Sweeney, you refer to the strongest 12.46 independent predictor of mental health is the age that the young person enters into care. And I know you referred to this too, Professor Rapsey.

Regrettably for us, one of the things that we've come to know very well through the Inquiry, is that a lot of kids come in as infants and age out in care. And so, the issue of placement then becomes very critical because in terms of looking at the systemic barriers, so we have lots of language in our different bits of legislation and health legislation, MOE, social services, around the 12.46 child focus, doing things in the childhood of a child. Do you have any comments around actually where the nubs are that actually in that pipeline, that actually need particular attention?

PROFESSOR TARREN-SWEENEY: When you were talking about nubs, do you mean with the -

COMMISSIONER ALOFIVAE: There are some critical points. When you talked about your nature versus nurture theory and talked about attachment, the timeframes around actually when babies need to really be 12.47 placed either back with whanau or into a kinship or a permanent caregiver?

PROFESSOR TARREN-SWEENEY: First of all, what I'm illustrating with this point about age of entry into care, it's not particularly pertinent to the

idea that children are in care, children who come into care at an earlier age are in better shape. It's more illustrative of the harm that happens cumulatively for children severely maltreated over time. So, all this, this is not an endorsement of out of home care. It's really shining a light on the fact that Child Protection Services are increasingly focused on identifying severely maltreated as early as possible. And despite all
12.48 of the current controversies, I believe that's the right approach.

So, that doesn't mean, however, that those children should come into care as infants and then grow up in care. I think pretty much everything that I'm saying suggests that either they need to be quickly returned to their families, if they can safely care for them, or they should be raised by another family or by extended family, by whanau, or by unrelated family. But they shouldn't be spending their entire childhood as a case. Right?

12.48 So, in terms of what your question is around what we're talking about, the developmentally sensitive timeframes and such. I mean, there's a different, a range of different opinions on this. All I can say is that the research tends to suggest that the incremental effects of maltreatment are linear. In other words, it's not like a particular - and that the first 3-5 years of life is when most of it happens. So, if children are severely maltreated for more than 5 years and they're going into school, then often, even if they come into
12.49 care, it's very difficult for those children to come back onto a normal life path.

In terms of at what age should be returned to their families, I think that's partly what you're referring to as well.

COMMISSIONER ALOFIVAE: Yes.

PROFESSOR TARREN-SWEENEY: I think this is where we need to be guided mainly from attachment theory and very good assessment, individual assessments, rather than rules of thumb. So, I don't know if you saw "I am a survivor of state care" documentary of Daryl Brougham but there was a particular placement that he had with a family and he was moved from them and he was still fairly young and he had
12.50 endured some terrible, dreadful maltreatment in care prior to that. But for whatever reason, he had bonded to that family. So, I think the important thing is not so much time but it's the significance of the relationships.

And so, I think it's fundamentally wrong for us to be dragging children away from caregivers where they have bonded together very closely.

That said, the younger children are, attachment theory tells us, the more malleable they are, the more
12.51 capable they are of forming new attachments and it's also driven partly by the amount of contact that they've had. So, if they've been returned to their mother, then if they'd been seeing their mother a lot, so an existing relationship has been preserved, then they're not returning home to a stranger. And in turn, that's partly determined by memory. So, the younger a child is, the shorter their long-term memory is. And so, relationships, ultimately relationships are held in memories. So, if you don't know who someone is, right,
12.51 then you can't really have had a continuing relationship. As you get older in your mind you can kind of construct what appears to be a relationship but in terms of a real relationship, carrying someone in your mind in memory is important. That's why older children retain much, much

longer memories of relationships then. I am not sure if I've answered that.

COMMISSIONER ALOFIVAE: You have. The systems issue that I'm referring to that our survivors have been referring to throughout the stories that we've heard and what we've heard in our private sessions, is exactly what you're describing. It's the inconsistent, there's just no attention paid actually to how they feel, to the removal, they say
12.52 they like a caregiver but they're removed anyway. This is the policy work that's going on behind the scenes that is incongruent to I think -

PROFESSOR TARREN-SWEENEY: If you can imagine for a moment that your child or grandchild had to live with someone else but you were still concerned who they were going to live with, you can imagine all the things you would be thinking about. But the State is a poor corporate parent, right? This is notwithstanding the fact that we have so many
12.53 wonderful social workers. The people that work in this field are so wonderful and yet, they're working within a system that shapes their thinking in ways where they intervene and make decisions that don't reflect what they would do if this was their own child or grandchild.

In terms of funded services and funded agencies, I think if you read between the lines or maybe it's even more explicit than that, I'm not advocating for services necessarily to be funded with more money, I'm advocating
12.53 for the whole system to be basically closed down. And I know that privatisation of foster care services has actually led to an increasing powerful industry. And so, what I'm proposing actually would be opposed by that privatised fostering services. What they would rather do

is approach this from the point of view that it can be remedied.

What I'm trying to argue, is that the system, this system can't be remedied, it needs to be replaced.

So, people, there are funded services that, again, they're doing all of this for the right reasons. Their motivations are pure. But they will argue against what I'm arguing for because the ultimate end point of this would be that we would eventually replace care, the care
12.54 system with something else.

COMMISSIONER ALOFIVAE: Thank you, that's what I was after.

And, Professor Rapsey, just your comment around the RDI, and really the big dots that we look at but obviously the qualitative data you were referring to, the small dots, the colour, the journey that tells us.

Is it about scale? Is that what you're referring to, in terms of being able to explain the stories of the different cohorts, the different groups of families
12.55 you're working with?

DR RAPSEY: Is the question, why do we need that additional evidence?

COMMISSIONER ALOFIVAE: I know why we need it. It's about to tell the picture more clearly but is it about scaling services? I just want you to unpack it a bit more, if you are able to, please?

DR RAPSEY: I don't think I understand the question yet, sorry.

COMMISSIONER ALOFIVAE: You have talked about your ADI
12.55 and you're waiting for that data but you've got some qualitative work you're wanting to match it up with or tell a story in those big dots. Can you explain what you two would like to see come out of that, is what I'm asking?

DR RAPSEY: We have qualitative data, we've analysed that, done that part of the study but that's only a small, a certain type of evidence and only a small part, only the people who are in the service right now. And so, ideally, we want to know what the outcomes are of all of the children who have participated over time. But actually, what's really required is a bigger study which actually assesses the outcomes of the children going into
12.56 the future, yeah. So, assesses their mental health, assesses their behaviour, assesses their attachment, and measures accurately how things are when they go in and how things are when they go out and over time.

COMMISSIONER ALOFIVAE: Thank you, no further questions.

COMMISSIONER GIBSON: Thank you both for your evidence. I will start with a question to Professor Tarren-Sweeney. The first part of it, you talked about 25% of those going into State care were
12.57 people, children with intellectual disabilities and language disabilities, and that's 2% of the general population, so it's not just an over representation, it's in the order of 12 times what you'd be expecting.

I suppose, first I imagine it's complex what's going on but what's your sense of what's going on for that scale of these people who will be coming into State care? And second to both of you, is there any difference in the evidence of the journey to recovery wellbeing for this
12.57 group of people that have gone through care?

PROFESSOR TARREN-SWEENEY: There hasn't been, to my knowledge, good research in trying to drill down and identify the reasons for this. We know that the type of intellectual difficulties is much more

likely to be verbal difficulties and language based difficulties. And there's a fairly simple causal mechanism that accounts for that for maltreatment children and that is social neglect and under-stimulation in infancy. So, children acquire verbal intelligence and acquire language, learn to speak, because they're spoken to and it's through our social discourse and social interactions that we acquire language.

12.58 And so, you see for example, extreme examples of this if we look at research on children, infants that are raised in orphanages in eastern European countries, the very famous study of the English Romanian adoption study, study of children that were experiencing very profound neglect in orphanages where they were left in their accounts for most of the time. Almost all of those children had some level of intellectual disability and yet, there was no kind of underlying genetic or biological reason for that. In other words, the evidence
12.59 suggests it was almost entirely due to their social developmental experiences.

The other reason that I suspect again there's not a lot of research done on this but I suspect the other main, a contributing factor to this is pre-natal exposure to alcohol and other substances. Particularly foetal alcohol effects, we know there are quite well-known effects on children's intellectual development.

That's the only two main ideas that I have.

COMMISSIONER GIBSON: Is there any difference in the
13.00 journey to recovery, the evidence around that for this group?

PROFESSOR TARREN-SWEENEY: In my study, intellectual disability was one of the independent predictors of children's mental health. So, in other words, we

know that children in care with intellectual and language difficulties are more likely to have mental health problems than other children in care. But we don't know how to explain that relationship. It may just be that children that experience the most severe maltreatment manage to get doubly disadvantaged in terms of more likely having mental health problems and having language problems.

DR RAPSEY: And I don't know whether to add to that with
13.01 a story. It's not research based. I assessed a young person or seeing them, spending time with their foster parent, they'd been in foster care for the first 2-3 years of their lives and they were developing typically and doing well and then they were returned to their maltreating environment and I got to see them again when they were 7 or 8. At that time, they had lost all of the language they were developing. They are almost not able to communicate and had developed a number of
13.01 behavioural and extensive difficulties that were now irreparable.

So, there are, yeah, crucial periods where remaining in a maltreating environment, that sets the course for the rest of the life of that young person.

COMMISSIONER GIBSON: Would it be right to assume that there's, I suppose, strong evidence, fertile ground, that there should be a lot more early support pre-State intervention, whether it's clinical or social or other, for this group of
13.02 people in particular who so many to be over-represented in coming into the system?

DR RAPSEY: Yes, I would certainly argue for that. I think keeping in mind what Professor Tarren-Sweeney said about the need for intervention - sitting

there alongside the need for intervening and keeping families together there is the need for both of those but certainly to intervene with families to address Care and Protection concerns would be invaluable.

PROFESSOR TARREN-SWEENEY: I think it's pretty clear if we look at Scandinavia, for example, if you apply a population-wide family support and family preservation approach, in other words across the 13.03 larger number of families where children are known to Child Protection Services, that that has effects, positive effects, in terms of not just family preservation but children's wellbeing and development.

So, that's kind of like a public health approach, you know, where basically across the board we up the ante in terms of providing support and interventions that can improve family functioning and reduce the need for Child Protection Services.

13.04 But I think with this particular population of children in care, as I said before, these are the kids the most, at the top of the pyramid. In this situation, generic family support services and generic interventions are not going to work. We are not even, at this stage we don't really have good confidence yet that we have interventions that do work for those families. My colleague at Canterbury University, Sarah Whitcombe-Dobbs is finishing a doctoral study on this topic and one of the things she has done is quite a detailed review of the 13.04 effectiveness of parenting interventions for the highest risk families and measuring effectiveness in terms of reduced child protection notifications after the intervention.

And the review doesn't really provide or yield many

promising studies yet. So, that's not to say we should be giving up on this. I think if society has - if there is a big goal for governments, rather than shooting for the moon and trying to land a man on the moon, if we could solve this problem of how to repair families, the highest risk families so children don't come into care, then that should be something the Noble Prize is given to.

So, this is, you know, the problem, the human
13.05 condition we're trying to deal with, this problem.

So, we have a situation there, I think, of simultaneously trying to - I think one of the problems that Governments have got is just referring every family to whatever the service is that's available. And we know that for our highest risk families that's not going to work. They actually need very, very targeted, very specific services. And even in that situation, there's no guarantee that it will work but at least if we try it, we can - for the ones where it works, then it works. And
13.06 for the ones where it doesn't work, we know what we have to do in terms of protecting the children.

COMMISSIONER GIBSON: Thank you both.

CHAIR: Thank, you Professor Tarren-Sweeney and Dr Rapsey. This is bleak territory but if I may say so, your written briefs, which have been well integrated by Mr Merrick, and the generous and frank way in which you answered the many questions we've put, have put considerable clarity to what we have in front of us. That doesn't diminish in any
13.07 way the bleak picture that we look at regarding our family. The Commission is very grateful for the evidence that both of you have given. Thank you.

Madam Registrar, could you please adjourn the sitting?

Hearing adjourned from 1.08 p.m. until 2.15 p.m.

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PROFESSOR TRACEY MCINTOSH - AFFIRMED

EXAMINED BY MR MERRICK

MR MERRICK: Thank you, Sir. I'll call our next witness, which is our last witness for the day, Professor Tracey McIntosh who's already seated.

Q. Tracey, welcome this afternoon.

CHAIR: Professor, just as we start, there is a requirement of the Inquiries Act 2013 that as Chair I ask you - (witness affirmed).

MR MERRICK:

Q. Professor McIntosh, behind tab 23 I think you've got in front of you a signed copy of your brief of evidence for this hearing?

A. That's correct.

Q. And can you just confirm that's true and correct?

A. I can confirm that.

Q. Thank you. With that done, just start with some introductions?

A. (Speaks in Te Reo Maori). I would just like to take this opportunity to acknowledge the Commissioners, recognise the importance and significance of this work and wish you great strength and great wisdom in what you are doing. I would like to acknowledge specifically the survivors, through your strength, through your knowledge, through your expertise, through your insight, it will help us navigate the path we need to go forward.

I would also like to acknowledge those who did not survive the system and with a very heavy heart recognise the damage and the devastation that the system has done. I recognise those who for a range of reasons why remain silent and for those that have been silenced. In terms of my own work, I want to recognise all of those who are

the people that have shaped and informed and enlightened me and educated me under conditions of incarceration. They are the experts of their own condition, they are the experts that I will be drawing on in regards to this brief summary.

Q. (Talks in Te Reo Maori). Those that have passed away. To bring us back to those of us who are here today present, I acknowledge your acknowledgments in full.

That being said, it's probably not a natural
14.23 conclusion to start, the step to start with, what some would describe as a korero to talk about yourself. I'll lead you through that.

A. Thank you.

Q. Can we just confirm for those who may not know you, those who are watching, for example, on the livestream, that you're currently a Professor of Indigenous Studies and Co-Head of Wanaga o Waipapa, the School of Maori and Pacific Studies at the University of Auckland?

A. Yes, that's correct.

14.24 Q. Formally a Co-Director of Nga Pae o te Maramatanga, New Zealand's Maori Centre of Research Excellence hosted by the University of Auckland?

A. Yes, that's correct.

Q. Previously, you've held roles as Head of Sociology at the University of Auckland?

A. Yes.

Q. And relevant to some of the evidence that we've heard, you were in 2018 and 2019 a member of the Independent Welfare Expert Advisory Group established by the Minister
14.24 of Social Development?

A. That's right.

Q. Before moving on, I wonder if we might just pause on that experience that you had because we've heard over the last few days around one of the core failures, being the

failure to address, I think, what some described as the antecedents to safe care, namely Powhiri House and Addiction.

Given that experience, I leave it open to you to make comment around firstly the role that the welfare system may have to play in that State care cycle, if you like.

A. Yes.

Q. And over the page at paragraph 8 you have talked about your role on ropu Te Uepu Hapai it te Ora, Safe and Effective Justice Advisory Group. And the reason why I'm asking this, is because you've spoken about the hui that you went to around the country for both of those kaupapa, so how has State care played out in those context, can I ask?

A. If I can just look at the Welfare Expert Advisory Group, particularly the report Whakamana Tangata: Restoring Dignity to Social Security in New Zealand which was publically released in May this year, I think that's a very important -

CHAIR: Professor, can I intervene a moment to ask you as you speak, to keep your eye on the stenotyper but also to be aware of the signers. So, if you look towards both of them, you will get the sense of the pace at which you will need to keep so that they can keep up.

A. Aroha. So, in thinking about the report Whakamana Tangata, I think that report is of great significance to this Commission, both in terms of its content but also in terms of its recommendations. Largely that is because when we're looking at the many people who churn through our welfare system, churn seamlessly between the welfare system and our Criminal Justice System. So, it's a really important element to look at where in many parts

of this country and many parts of our State agencies we do transitions poorly, it is of great concern that that particular transition between those two systems can be so seamless.

So, certainly what we recognise is that when we look at our people who are living in deprivation, in scarcity, who encounter far greater levels of social marginalisation and whose contact with the State is nearly continuous but often a poor encounter, and where
14.28 the operating mechanism both within the State system of the prisons and often through particularly an increasing level of sanctions within the welfare system, means that you have an operating mechanism that can often be characterised as coercive control.

What this does to those that sit within the system. So, I think that's a very significant area. As you noted, we travelled, I was a member of both the Welfare Expert Advisory Group and ropu Te Uepu Hapai it te Ora, the Justice Advisory Group, both of those groups
14.29 travelled throughout the country meeting with thousands of people. We had fono, we had forum, hui, throughout the country, both in main urban areas, as well as small areas and rural and quite isolated areas.

And the overwhelming sentiment that we got, certainly out of those that we met from the Criminal Justice System, was the emotion of grief. Interestingly, probably the overwhelming emotion we got from those that we encountered as a part of the welfare group, was anger. And I think these are very powerful emotions in regards
14.29 to very significant numbers of our people going through the system.

What it means to not - the need for the restoration of mana was clear in our workings, whether it was working with the welfare group or whether it was working through

the justice group.

The recommendations that we see in Whakamana Tangata are really significant, as I said, in terms of the Commission work as well, in terms of the way that we don't just uplift members of our communities but actually how we uplift the nation.

Q. In the course of those hui, fono and other forums, was anything said about the State of children in care?

A. So, it was probably one of the most talked about
14.30 elements, certainly within the justice one with ropu Te Uepu Hapai it te Ora but also with the welfare one. So, we heard, the very first hui that we went to was in Hastings and the very first person who spoke to us in a public forum spoke to us about, first talking about the release from prison and the incredible difficulties that they encountered but also in speaking to that, also then spoke their history in terms of being in care. And so, that was our very first encounter under the Welfare Expert Advisory Group. Throughout the country, that
14.31 grief that I spoke about, I talked about it that what we saw was a landscape of devastation, in terms of the Whangai and the intergenerational reach of the disruption of whanau, of the loss of children and that many of us who talked about the loss of children had themselves experienced State care. So, their anxiety was far more heightened around their children because of what they had experienced.

Q. In your brief at paragraph 11, you outline some further relevant experience about work done in the Auckland
14.32 region correction facility, can you tell us a little bit about that at this stage?

A. Yes, I've been going into the Women's Prison for well over a decade now. I go in on a weekly basis. Though Maori indigenous incarceration is a research area me in

terms of my professional life, it is an important area of research, this work is, while it informs my professional life, it has been, I guess, of the most significance to me personally. So, I go in as a volunteer and I run a range of programs, including a creative writing programme and education programs within the prison. But really what it is, you know, we call it these names, it's about human work.It's about what it means to be human together. And I think that is the most significant part
14.33 of the work.

And without a doubt, all of my own work has been informed and shaped and enlightened by working with particularly Wahine Maori and particularly young Maori women.

I have worked with some of those women since the day they entered the prison, in some cases at the age of 16 into the adult prison, with some of those 12 years later I'm still seeing the same young women who have yet to be released.

14.34 Q. You alluded to it in your early acknowledgments about bringing that korero to us today and we are privileged to have that. And so, at this stage I just want to flag for those that have the brief of evidence, that we will depart from the order of the brief of evidence because you bring real life experience of people you've worked alongside and to that end, I think we could pick up our korero at paragraph 60 where you talk about the life of Stan.

A. Yes, and I'd just like to recognise and acknowledge Stan
14.34 Coster in this moment. Stan and I worked together for 6-7 years and Stan is unable to be here today. So, what I will be drawing on here, he gives as a koha to all of us.

Q. By that, you've spoken with Stan?

A. I have spoken with Stan.
Q. He has given his approval for you to speak about his story?
A. Yes. I am hoping that he will be watching it.
Q. If you are Stan (speaks in Maori). And you're drawing on work that you've previously published also?
A. That's right.
Q. In conjunction with Stan?
A. We published together, we've actually published quite a
14.35 bit together and also with Dominic Andrae who has also been an author on the work that we have done together. And to recognise that Stan is far more than a research participant. He is both author and auteur of this work.
Q. I leave it with you.
A. While Stan's experience is a unique experience, it is one that's much more collective shared, so I speak about that.

So, Stan's most ongoing intimate relationship has been with the State. I think that's a really significant
14.36 space for him to imagine the world without the State absolutely at the centre is very difficult for him. When I say it's the most intimate relationship he had, it doesn't mean that encounter and that relationship has been a good one but it's certainly been the most prolonged and sustained relationship that he has had.

So, Stan is -

MR MERRICK: If we can pause the hearing, please?
CHAIR: We will take an adjournment.

14.37 **Hearing adjourned from 2.37 p.m. until 3.13 p.m.**

CHAIR: Thank you, Mr Merrick, please continue with Professor McIntosh's evidence.

MR MERRICK: Thank you.

Q. Professor, we were beginning to talk about the narrative about Stan. I just wanted to ask a question. We have heard the different life stories of people in this hearing. Can you comment on what some of the common events in Stan's journey through State care might have been or some of the common threads to that?

A. I think some of the areas where you see really high levels of commonality for many people who have
15.14 experienced State care, is that often the whanau, even prior to the birth of the child, has been under a level of scrutiny or surveillance by the State and the State has often had quite high levels of intervention already within the family.

Like many others, gang characterised, by living under conditions as I said earlier of degradation and scarcity, and that a particular event in this case in terms of the death of the mother which meant that the children, through a change of processes were then placed
15.14 into State care.

As I said, there had already been the Department of Social Welfare, as it was at the time, the family was already very well-known to them, so that would not be an uncommon feature.

So, I think we've heard this morning around placement and stability, for example, and that certainly is a feature of Stan's life as well.

There were a number of children involved. In the beginning there was an attempt to keep those children
15.15 together, given that they had suffered, you know, one of those most significant and profound losses that children can have, in terms of the death of their mother. So, there were some attempts made to keep those children together, though within weeks that approach was

abandoned, largely due to the difficulties of placing children into foster care together.

So, very high level of placement instability. So, in that first year he experienced, and this was 1969, and so in that first year he experienced five placements in three different geographical regions, two of those in the North Island and one in the South Island. So, that was also the level of movement that he experienced during that time.

15.16 Q. How did the progression through residential homes impact, for example?

A. It's interesting when we look at the reports. What we did to try to better understand his own story, was through the Official Information Act applied, given his very close relationship with the State, applied for all documents that had been held on him. This was a huge amount of documentation.

So, one of the things that you can really see there, and again so characteristic of this period, 1969, by 1975 15.17 he's a 15 year old/16 year old. So, if we follow that documentation through, we see this movement into foster care, sometimes into group homes, into the larger ones, Epuni, Owairaka, those homes, sometimes in foster care, and we see really this incredible constant escalation from those homes.

So, the reports are interesting because they're reports, nearly formulaic. In the beginning when there is the placement, there's usually a quite hopeful report, that this person is shy but is settling in. That's sort 15.18 of the nature of the first report. Then you start to see the second and third report where there are concerns around either behaviour, a range of different things, not outgoing, not talking, not doing those sorts of things, until you start to get these final reports before

movement saying not settling in, disruptive either to the family life of the foster home or disruptive in the larger home, and then moving on.

In one case, there was documentation where a foster family, a Pakeha foster family who had been optimistic that they would be able to not so much care because that's not really the language that's used in the report but they would be able to control this young child that had been placed with them. They seemed to be optimistic
15.19 that they would be able to do that.

The second report, not settling in.

Third report, finding it very difficult.

And the concern that they raised was, whilst they did not wish to continue with the placement, they were concerned that other people in the community in which they lived would think they were not able to control a Maori child.

And the Department of Social Welfare response to that in the report written was that they understood those
15.19 concerns and that the placement would be out of the community. And so, there we got the sense that the concerns of the foster family were more important than the concerns around a 9 year old child.

And so, we have heard about the sort of dehumanising element of children not really having their rights as children to be children and cared for, and where the adults and adult needs were much more likely to be met than the needs of the children. And so, we see this movement through into different forms of care facilities
15.20 and with higher levels of constraint and surveillance being a characteristic of those movements.

We've heard over the Contextual Hearing about the use of Secure Units and this is also a characteristic of Stan's story, so much so that by the time he had moved up

through into the prison system, Secure Units were by far the most familiar, and indeed - familiar places for him and indeed the places that he sought.

So, within the brief of evidence, it does talk about that first time going into Epuni Boys' Home, for example, into the secure unit, the types of induction practices, particularly the cleansing rituals that he went through which again has been characteristic of many of the stories that have been heard and I'm sure will be heard as the Inquiry continues.

Q. Just one final topic, if you like, before you move on to your work with women in prison. How has that system played a role in gang affiliation, gang membership, from that narrative that you were talking about just then?

A. So, here particularly looking at my research, which looks at the State's role in gang formation and just how significant the role the State has played, particularly in the early formation of the gangs. So, if we think about 1975 as a particular, sort of, apex year in regards to you've got within the youth resident system 80% of the young boys are Maori during that time, you know, you see how important, particularly Epuni Boys' Home but certainly not only that boys' home, how significant that was in terms of gang formation. The very early members, the vast majority had gone through that home or through other homes. And certainly, again, with Stan's narrative, that is a significant feature as well.

The roles of being alienated, of being marginalised, of being in what, you know, were called forced association with others, in many cases completely removed from their own whakapapa, completely removed from their own place, their own whenua, and the types of solidarity that we have. There is a brief of evidence what that means in terms of the new forms of collective that were

formed during that period.

So, I think that the State's role in gang formation, particularly in early gang formation, is incredibly significant and cannot be overstated.

Q. Can we now turn to paragraph 89 of your brief of evidence, unless there was anything under that heading that you wanted to touch on before you go there?

A. What I guess I'd just like to stress, is around this transition. So, from a child who was put formally into
15.24 State care as a 9 year old in 1969, that the next 30 years, the next 30 years would be characterised by being totally institutionalised, either through the home system or through the prison system. And in fact on the day where the State extinguished their obligations as guardian and as parent, was the day that he entered into the adult prison system. That's how seamless that State engagement was.

And so, this is someone who has then spent 25 years within the prison system, often for relatively short
15.25 lags, though there have been some significant ones in there as well. And so, you think of that child, that 9 year old child, experiencing the most profound loss, having already suffered significant hardship prior to being put into State care, and that any aspiration that he had, in terms of the qualities that had been identified and recognised, you do see some of those in the reports, that they were quashed and they were squandered. It has completely marked the trajectory of not only his life but the broader whanau life and there
15.26 has been intergenerational impact.

Q. In your brief of evidence, you talk about an intergenerational impact, particularly as we should discuss it around the role that gender has to play and the reach, and that's probably a good point to pick up

your korero about the work that you do with women in prison, and so, if we can move to that topic.

A. Yes. Just looking at the brief in paragraph 89, I just note that the really distinguishing feature of incarcerated women is this really strong common histories, common characteristics. One of those very common characteristics is around trauma, certainly much, much higher than you'd find in the general population.

Our men who are also incarcerated have extremely
15.27 high levels of trauma as well, much higher than the general population but for women it's very marked. Very high levels of victimisation particularly around violence and sexual violence, that is an international trend we see. Also, just to note that incarcerated women are much more likely, much, much more likely than the general population to have been in State care and to have suffered abuse within the environment of State care.

In terms of the intergenerational reach, what we have seen in New Zealand is incredibly, as we know, we
15.27 have a very common social statistic that we're very familiar with, which is on the one hand very high incarceration rate and particularly the gross proportionality of Maori within our prison system. And what we've seen over the last 10 years is the incredible increase in terms of Maori women's incarceration.

So, while, for example, Maori men make up around 51% of the male prison population, women make up, Maori women make up around 63% of the women's prison population. If you disaggregate that for age, particularly looking at
15.28 from say 16-25, it is far higher.

So, the intergenerational reach of that, the impact of having such high numbers of Wahine Maori in prison is incredibly significant.

There is much less research done, there's quite a

lot of research on the impact of having a father in prison for children. There's much less research on having a mother in prison. But what research has been done, and my own research would support this, is that the impact on children is so immediate.

So, certainly it is not a good thing to have a father in prison, the damage is severe and sustained. Having your mother in prison, as I said, the impact is much more immediate. Women are much more likely to be
15.29 the sole carers or the primary carers of children and so, on an arrest, for example, it is much more likely that there will be disruption for those children immediately. It's much more likely that they will be uplifted if they are unable to find family members to take them. So, you have a much more immediate impact with women being in prison.

Because I've had a particular focus on young women or young Wahine Maori in prison, many of them who have yet to be mothers, then there's some other really
15.30 interesting work around what that means and the impact of those people who become mothers after they've already experienced incarceration. As I noted, in most cases they've also experienced high levels of State care.

Q. You've talked about the impact of having a father in prison. Do you have some experience to draw on with those you have worked with, other women for example, around the disruption to internal whakapapa?

A. That has been a really significant feature, is how many of the young women I've worked with. It's an interesting
15.31 thing. Most of the women I've worked with, in fact nearly all of them, they know their whakapapa, they know where they come from. Some of them actually have been quite involved in their marae life. Many of these very young women come from small town New Zealand.

But when we have done whakapapa work, when we're sort of doing that as part of the work that we do, very often they're not able to - they don't have the same sort of access to their whakapapa through their father's side, and this is when a lot of those issues actually come out, when they realise because their father was absent, that their father was in and out of prison, that they had not really had an ongoing sustained relationship with their father.

15.32 And sometimes this was most apparent in regards to their names because when they came in, they know their name. Often had the most beautiful whakapapa names, both first names and in their last names. Often I would talk about that name and a very common response was, "Yeah, that's my Dad's name, I don't know much about that side of my family". And so, that disruption, so that part of their whakapapa has yet to be revealed to those women.

Q. A parallel korero about disruption, actually no it links to whakapapa because that ties you to a place. Has there

15.33 been some experience that you've had around disruption of place as a result of State care and prison context?

A. Yes, particularly for where young girls are placed. As we've seen, a vast majority of people who have been put into care have largely been young boys, often there are far less placements for young girls, so they're much more likely to be at some geographical distance. It's the same with the prisons, we only have three women's prisons, so that continues that same continuum.

So, that loss of place has come up as really

15.34 significant in terms of the women's lives.

One of the things, if you will allow me to - one of the things that we often do when the young women come in, is I'll have a map of New Zealand, I tell them show me all the places that you've lived on this map. And it's

an interesting one because it allows, if there is any sort of issues around whakapapa, often if they sort of say I was here, that's where my Nan was, you know, you're able to get that sort of sense, usually they know that, so they're able to show where they're from in terms of where their whakapapa lines are from and also where they've lived. In some cases, you might see a high alignment from where they live to where they whakapapa to.

15.34 One of the really interesting things, is because due to placement, State care placement, just where they are, all over the place. So, for some very young people who come to prison under 18, when you see how many places they've been placed in, nearly all of them excluded from the compulsory education system, as I note in my brief of evidence, by 13 and yet have been to up to 25 schools and yet have been excluded from the compulsory education system by 13.

The first time it happened to me, yeah, it really
15.35 marked me. We were doing this particular piece of work and there was quite a number of young women who I was doing it with. We were doing it as a piece of group work.And one of the young ones was explaining all of her places that she had lived. And they were in common with many of the other girls because they'd been in the same homes together. And I noted, we were in Wiri, at the Women's Prison in Wiri, and I noted that she hadn't put Auckland or even Manukau, she hadn't put a mark on it. And I said to her, "You haven't put Auckland on it?"
15.36 and she just looked at me and she went, "Oh no, I've never lived there" and yet here we were on that whenua in Auckland and that young girl was going to be there for quite a number of years and yet she had never lived there, and it really made me think about what it means to

live.

Q. You've also talked about some Maori women who experienced abuse in State care and their thoughts to their own children. Did you want to comment on that?

A. So, certainly one of the most pervasive narratives that I've heard from the women who are incarcerated is around their stories of abuse in State care and the level of anxiety for those that are now mothers who have, in turn, their children in State care, the level of anxiety and
15.37 stress and ongoing trauma that that produces. And the reason that it produces such a high level of trauma, is because of their fears and their expectations that their child or children will be harmed in State care.

And unfortunately, because I've been going in there such a long time, there have been far too many cases where that has been confirmed, where their children have been harmed in State care.

Q. As part of that, what have you come to know for some about the role State care has had to play in their
15.38 parents' or grandparents' lives?

A. As noted in the brief of evidence, in many cases their parents of the young women that I've had, their parents have experienced State care and in some cases their grandparents have experienced State care.

And so, what that means, in terms of their own expectations around family, their own understandings. It's interesting because their desire to have flourishing, beautiful family life is constantly articulated and that is constantly against the idea of
15.39 the real fear that that is impossible to realise.

Just very recently, only in the last week, I spoke to a young woman who will be released some time in the relatively near future, who is hoping to be able to, from her point of view, rescue not her own children, she has

not had children yet, but that she hopes to be able to rescue, using her words, her whanau members, in one case her sister's child, in one case her first cousin's children, from State care.

Having to talk about the very significant difficulties she's likely to encounter in trying to take those children into her care was quite a difficult conversation to have.

Q. Before we - I have a couple of questions left around this korero that we're having about the work you've been doing with Wahine Maori in prison. The first is, I understand you've brought a piece of creative writing that you would like to share with us?

A. Yes.

Q. I think this might be an appropriate time to do that before I ask the last question about this subject.

A. If I could just give some context for this work. Again, I did speak to the young woman prior to coming in here, saying that if the opportunity was afforded, would it be all right for me to read one of her poems, and again she gave that she really would love and really wanted to be able to bring some element of her experience to this place. That at the moment she's not in a position to be able to speak directly to the Commissioners and to others, and so that is really important to bring that lived experience within this group.

Again, to give context of someone who entered into the system, both the State care system and into the prison system at a very young age, who has done her growing up within that environment, so she has grown up under conditions of confinement, containment and incarceration. I've chosen one, it was very difficult to choose which one, an incredibly talented poet and this poetry has been read in a whole range of places and she

goes under the pseudonym of Maia. It was difficult for me to choose one that I thought for the Commissioners that would capture it. You can see there is a significant amount of work here. There's two lines in this one that I think are really significant for the Commission.

So, again, someone who early, real characteristics of this young woman's life, very unique and specific to her but certainly part of a much more collective
15.42 experience as well, excluded very early from the compulsory education system, experienced great levels of social harm and the tragedy of then going on to perpetrate harm against others. And in no way wanting to trivialise or underestimate the harm that she recognises that she has caused herself.

So, I've chosen this poem she gave me, I've chosen this poem. The poem is entitled "Misery so pure". I also read this poem at the Maori Justice Hui Inaia Tonu Nei in Rotorua for some of the same reasons.

15.43 "Broken hearts fear the loudest.

A prisoner in tears.

A scene surround us.

Broken bones can always heel but words seep in, painful to feel.

Trapped souls struggle in the arms of hell but in this cell the walls never tell.

Broken dreams reveal a forgotten call, yet a scream doesn't seem to be heard at all.

Surrendered in the heart of hate, the Devil inside
15.44 never turns up late.

Broken roads lead to a complete end, a prisoner's journey is always just around the bend.

Living life only to die inside the broken and tainted heart I hide.

The worse thing in life that you will never see, is being captured, having never been free.

The deepest and the darkest places to be. Waiting for the system to release me.Killing all innocence and hope but not the pain or the mess devastation caused with only me to blame. No-one to love. No-one to hear. The passion and the addiction to fear. Awaiting for life to begin and start, this was the journey of my heart. In the end, what more is left? To live in hell, what then
15.45 next? To re-create the cell whenever I'm near but I'm still breathing and I'm still here".

Q. Kia ora. That leads me to my last question which is two things; one relating to resilience and the other talking about hope. Do you have some comment from your observation about the resilience of the people that you've worked with?

A. An incredible level of resilience, a resilience that has been borne out of struggle and torment. An incredible potential to flourish. For me, in many ways, it is a
15.46 social indictment that the incredible potential that I've been able to recognise, to see within the prison, is recognised, it goes behind the wire.

What types of intervention, and we have heard some of that this morning and certainly the Inquiry has heard of it, the Whakamana Tangata report speaks to it, the He Waka Roimata report speaks to it, as those early interventions, the way at the community level, at the hapu level, the types of things that we're able to do to allow lives to truly flourish.

15.46 So, the potential, certainly these women have real aspirations but they're also social realists. They recognise just how difficult their path on release will be but they have hope, and I think that we have an obligation, a cultural obligation, and a moral

obligation, and a social obligation, and a political obligation, to ensure, through the work of the Inquiry and through the work of all sections across government, that this work is not just the work for those that have been damaged in State care, it is the work of the nation.

Q. Whilst speaking about obligations, do you have any comment to add Te Tiriti o Waitangi as forming part of that or not?

A. I think it's incredibly significant and certainly when we travelled up and down the country, that was also one of the - we heard that wherever we went, particularly in smaller communities, small town communities, around the need to really recognise. And my brief of evidence and of course Moana Jackson and Kim Workman and others have spoken to this far more eloquently than I can around the ongoing impact of colonial policies, the need for a true partnership, we saw that in the Inaia Tonu Nei report, the really important need for that. So, I think that does have to be absolutely central. The restoration of mana and the ability to live life of dignity, a life of knowing who you are. And, as I often say, the right to not only know who you are but to know why you are, where you are.

Q. Finally, did you have by way of summary any hopes to share for this Inquiry?

A. And in this one I would like to read from the brief of evidence, if I may.

I believe the work of the Royal Commission of Inquiry into abuse in care is of critical importance in acknowledging the harm that was done to children and the intergenerational reach of that harm.

Recognition of that harm and the validation of the lives of those that experienced it, is needed as determining the appropriate redress.

Restoration of mana, of the people who have been harmed through emotional, physical, psychological, sexual, verbal, institutional and cultural harm is crucial.

While the Royal Commission of Inquiry into abuse In Care has a specific time-span, many of the young women in prison who have experienced abuse in care sit outside of this time period. There needs to be recognition of the ongoing damage that is being caused.

15.50 As noted elsewhere in the brief, in too many cases those who experience State care follow in the footsteps of their parents and even their grandparents.

In order to ensure that harm is not repeated, we need to be honest with ourselves and understand the critical role that colonisation and racism have played in establishing systems which in turn have allowed abuse in State care settings to continue.

In listening to and understanding the voice of survivors and their whanau, there must be a development 15.50 of strategies and an implementation that safeguards the rights and the mana of the child, that recognises how valuable they are, that cherishes and upholds the concept of mokopuna tangata, that ensures connection to whakapapa are revealed and nurtured, that understands whanau and hapu settings and works towards collective security and flourishing of all whanau.

The abuse of our children in State care is one of the darkest, one of our darkest chapters. In bringing it to light and not turning away from the devastation that 15.51 was caused, we can seek to restore those lives and ensure that future generations thrive. Whether a child is in the care of their immediate whanau or in the care of others, that child should benefit from the knowledge that they are loved, wanted and vital for our collective

future as a nation.

I think just one thing that I'd like to add here, is with Stan we collected his story from his own recollections obviously but also from the incredible level of documentation that was held by the State about him. When he read through those documents, he saw rationales about his placement, the shifts, his transitions, that he had never, as a child, had access to or been afforded of. He never knew why things happened
15.52 to him when they happened to him when he was very young. So, I think it is very important as a part of the Inquiry, that we see the absolute need for people who have been placed in State care to be able to access all of their records and that that access to those records is without financial cost and the support is in place to allow them to be able to navigate what is often very difficult systems.

MR MERRICK: Thank you for that.

CHAIR: Thank you, Mr Merrick, thank you, Professor.
15.53 Have you been given notice by any counsel?

MR MERRICK: No, I haven't, Sir.

CHAIR: I take it then, there is no wish to address any questions by counsel to Professor. Can I then invite my colleagues, if they wish to ask any questions of Professor McIntosh.

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PROFESSOR TRACEY MCINTOSH
QUESTIONED BY COMMISSIONERS

COMMISSIONER GIBSON: No questions, thanks for your evidence.

COMMISSIONER ALOFIVAE: I have a number of questions but you have so elegantly actually framed a lot of the responses in your brief.

15.54

If I could just ask you a question around the early interventions, what would those look like practically? I think as a nation we're very good at describing what the problem is and so to move to the next level of what could possible solutions look like, any comments on that?

A. Commissioner, I really think that the solutions are very much within our communities. I believe, having travelled around the country, I have listened to many of them. And many of them are very much place based. One of the big issues, and we have heard it in other parts of the Inquiry as well, is around what resourcing would need to look like, what the shift would need to look like.

15.54

At the moment, I think that many of our State agencies' resourcing and contracting of these things; one, often they're near colonial in terms of the particular practice of them. The sorts of KPIs that are important to the State may not actually produce really strong outcomes.

15.55

One of the really important elements of early intervention where the need is necessary, is it's ongoing engagement. I think that's a really important element. We often have contracts that are for 6 weeks, 12 weeks.

Mr Taito the other day talked about 501, for example, and that's an excellent example of people returning from Australia back into New Zealand, often with very, very few familial or social financial connections here and contracts that allow between 3-6 weeks of work with them. They're criminogenic.If we think about something like steps for freedom, what people are released with, $350 if they meet the very difficult criteria, you think if you're released into Auckland, Hamilton, Wellington, but
15.56 frankly if you're released into our smaller towns, again I believe they're criminogenic.

What we heard was around the types of interventions, particularly if I'm speaking within Maori settings, around the need for the hapu particularly, their ability to identify those that can make the most sustained positive engagement in their broader whanau's lives.

In some cases, certainly what we're looking at is, rather than really individualised care, the importance of collective care. But, you know, the issue of poverty,
15.57 the issue of insufficient income, is a very significant one. It's not enough all on its own but it is significant. People are living lives of real desperation out there and the impact on our children is incredibly marked.

So, I do have confidence that we do actually have much of it. I think that, here I'm speaking in much more my policy sort of space, that we do look for collective impact and that's a really important element. That we do need to recognise, we do need to truly test things and
15.58 that there will be failures. I believe in a fail fast philosophy where you have high accountability, high transferability and a high trust environment. Trust our people and resource them.

COMMISSIONER ALOFIVAE: Thank you very much,

Ms McIntosh.

CHAIR: Thank you.

COMMISSIONER ERUETI: I just want to ask about the numbers of Maori women in prison and how did it escalate so quickly over recent decades? Professor, Dr Jackson was here just recently talking about crimes of poverty, are you able to help us unpack that to explain what has happened?

A. Certainly what we see here does follow international
15.59 trends, which is also very concerning. And I can remember having this question asked about 12-14 years ago in the United States with a very well-known international criminologist, American criminologist, and he was explaining the incredible increase of African American women in the prison system there. Someone asked a very similar question, you know, why is this happening? And he answered very off-the-cuff, in some ways taking light, he says they're running out of men.But then he did, he said, no, there is something in that, in regards to when
16.00 you have a group that is targeted and marginalised, that it's likely to expand and that there is some escalation.

I think we do have to recognise, I talked about the State's role in gang formation and to recognise that many of these young women have grown up certainly in conditions of deprivation but also often within strong gang associated whanau. Here, I am in no way doing a blame the gangs one. I am just more broadly saying about when you marginalise fathers and mothers and where the gang member becomes an important space of collectivism
16.01 and then children are brought up in that, then they're likely also to experience sometimes even harder level of marginalisation that others had. So, that is another feature.

The exclusion from the compulsory education system

is just such an incredible feature common characteristic. So that, of all of the women that I've seen between 16 and 18 entering the prison in the last decade, I've only had one that wasn't excluded, only one that wasn't excluded by 13. Some had been excluded as young as 6 from our compulsory education system. So, that's an incredible characteristic. It shows the strength of the schools to be able to mitigate issues around poverty and marginalisation but it also shows that the exclusion from 16.02 that is important.

The other thing is the incredible care to custody pipeline. So, we often talk about the soft pipeline and the hard pipeline, and the care to custody pipeline is certainly a part of the hard pipeline. So, 83% of all young Maori who come into prison young have been in State care. The vast majority at the time of arrest, the State was the parent. So, those sorts of features. I mean, we still have, you know, so we've got a statistical absolute blowout, you know. Overwhelmingly, our prison population 16.03 is still male. Men make up 92% of the prison population. But in talking about that 8%, you know, when you think about when Moana Jackson wrote in 1988 about how many women were in prison there compared to now, it's an astonishing, astonishing increase and that they're so young, the vast majority under 30, very, very young.

COMMISSIONER ERUETI: Kia ora, we were struck by that exclusion from compulsory education at such a young age and young women coming through the prison system. I wondered too whether because we're 16.03 hearing so much about stigmatisation and stereotyping of people with disabilites, Pasifika Maori and children generally and about whether you can see that having a role here with Maori women too about them being stereotyped and about them internalising stereotypes and that having a role

the way that the State sees them, whether the schools or Police or Child Welfare Officers?

A. Certainly one of the things I mention in the brief is that for the women their first experience of incarceration is not their first experience of confinement or of the prison. So, the experience of prison has largely been through other whanau members, i.e. the fathers and mothers. But that experience of confinement, that line in that poem which came through, "The worse thing in life that you never see is being captured having never been free". Incredibly high levels around confinement and other elements.

So, the stigmatisation at the broader whanau level and the particular stigmatisation on young women, particularly those who have experienced high levels of violence, including sexual violence, some of that violence and sexual violence being under conditions of State care. There is a high level of internalisation and recognition of each other.

I've sat at tables when we're sitting around and people are sharing, these are young, young women, for me as an older women they're children, sharing stories of real horror and no-one reacting to them, no-one reacting to them, because these are the common stories that they've heard.

And, in fact, I remember one woman, actually she was an older woman, and in all of these times when we were working together, working on a creative piece actually, she kept talking about the terrible things that had happened to her when she was 9 years old, she kept repeating around, and in saying in some detail what had happened to her at 9 years old. And one of the other woman just became frustrated by it and she said, "We've all had a 9 years old". You know, that experience that she

was saying, you think it's unique to you, it's not.

So, I think that's a very significant feature when you see such high levels of victimisation within the group that you're working with.

The issue around health, healthcare, around living with disability, it is also much more heightened and marked with this group of women.

COMMISSIONER ERUETI: Kia ora, Professor. You also spoke about, my colleague Sandra Alofivae asked about solutions and interventions, you talked about a localised response and that seemed to be a common theme that came through the criminal justice first reports.

In tandem with that, there's also that high level, Maori working in partnership with the State, in terms of the framing policy and law. Is that part of, do you see that as part of this package, if you like?

A. I do think this is the work of the nation, I absolutely think that's an important thing. You know, the need for a really, you know, about what mokopunatanga means for us as a nation. The belief that our children's children will flourish. That we have to have confidence in believing it. I think that one of the things that I'm sure as Commissioners that you constantly come against is, you know, when I was listening to Dr Sutherland's evidence last week, how could we treat our children like this? How could we treat our children like this? Children should not be vulnerable.Children should be valuable. And I think there's something as a nation. One of the things when I was with Professor Jonathan Boston who Co-Chaired the Expert Advisory Group on solutions to child poverty in 2012, one of the things in the forum and the hui and those other things that we did for that work over that year, was the incredible high

tolerance we found amongst good people for children to live in poverty. That people were frightened that in supporting our Tamariki, that we would reward bad parents and that they were willing to let children suffer, rather than to address the issues of poverty because of a particular frame that they had around poor parenting.

So, there's something that we need to, in the psyche of the nation, we can't keep saying this is a great place to bring up children until every child in this country says it was a great place to grow up.

So, I think that's at that much broader level. That's why I talk about the deep profound honesty that we need to have, that this was systemic, that it has gone across decades and continues today, and that it is sustaining this incredible negative legacy. That we have the power. I believe as a nation we can be absolutely global leaders in regards to our policies in terms of our child and childcare. And the will is there and the people are good but we just, you know I used to say we have a high incarceration rate. It's not just that we are tolerant of having such a high incarceration rate but we have an enthusiasm for it.

I think that enthusiasm is waning. I think we're truly in a time where people are looking for shifts and changes, that we recognise 4.5 million people we're the excellent pilot study for the rest of the world. This Inquiry can show real leadership in terms of how we want to see ourselves as a nation and truly, I believe that our children, and it's not just that they're our future but it's the mark of the nation and the way that all children are treated, and particularly those children who live on the margins. Kia ora.

COMMISSIONER ERUETI: Kia ora, Professor.

COMMISSIONER SHAW: I just want to ask you about one

area of our work. I am very grateful for what you've just said about the high level systemic matters. The Commission is also required to look into redress and what we have also been referring to as restoration, and that comes to - there two levels of that, of course there's the higher level and then the individual level.

I'm struck deeply by your reference to the lack of access to education, the denial of education, the denial
16.12 of health, the denial of security. I don't expect you to answer this right now, unless you are already on top of it, but speaking to your women, your Wahine, do you have a sense of what the State could do, even in a small way, to give some redress for the individual hurts that they have suffered and the damage that they have suffered?

A. I mean, one, I'm always taken by the generosity of the women I've worked with given the difficulty of their lives and they truly are already thinking of that next generation. They do not want the next generation to
16.12 experience the things that they've experienced. That shows the generosity of spirit.

Certainly education, without a doubt, has been - I said the work that we do is human work but it is around learning together. And whilst the women, they're excluded from schools so early, and often their schooling experience was not a good one, and yet I see that flourishing, the opportunities, when those opportunities are provided.

So, I think education is an incredibly important
16.13 element of thinking about as part of the redress.

There will need to be an Inquiry as part of this, the education for the nation that this is happening. I think there is that redress.

In broader sense of compensation, whatever that

might look like, the restoration of mana seems to be central in all of the korero that I've had with people individually and in groups.

And in some ways, I think that compensation will probably be most beneficial at the collective level, though there will be instances where the individual redress is seen as important.

If I think about things like ACC sensitive claims, for example, I'm not saying that is the model but it is a
16.14 model that could be reflected on and thought about.

COMMISSIONER SHAW: That is a model that has monetary compensation but also provides ongoing support and counselling, whatever is required?

A. That's right, yes. And also, and the other thing, I guess, with the ACC model, which is at the moment different than what we would see in terms of say with WINZ, is that the ACC model, in terms of injury, provides access back into workplace support for getting types of work, all of those things. So, sustainable livelihoods
16.15 is a very important part of a redress system, education, sustainable livelihoods, the ability to live one's life as Maori, as Pasifika, as whatever we are, be able to live our lives as that, to live lives that allow dignity and allow full participation in your community. I think those are very significant areas and these are complex ones for us as a nation to deal with.

When I think about the $1.2 billion that we presently spend on incarceration, we heard this morning around if you had early intervention, particularly around
16.16 a range of issues, you know, what this would do for adult and adolescent engagement, and I think we can see the same things here.

We spend $1.2 billion every year. Think about what the Treaty settlements are. You know, supposed to be

full and final. That's redress and supposed to be flourishing of an iwi. Think about what their quantum is compared to what we're spending every year in locking up our people and largely locking up Maori.

So, it's not that we don't have the levers. It's the need to have the courage, conviction, consciousness and the will, including the political will, to make those changes.

COMMISSIONER SHAW: I apologise for saying that you might not have been prepared for the question. You plainly are. Just to let you know that the Commission will of course be diving deeply into the issue of redress into the future and if you want to continue thinking about it, we would be very interested to hear from you perhaps at a later stage in our deliberations. Thank you very much for your evidence.

CHAIR: Professor, I am the last of the Commissioners to have an opportunity to ask you a question. I'm grateful for the wide furrow that's been created by my colleagues. I find the last five paragraphs of your statement and the poem which you read both provocative and compelling. And I have listened carefully to the answers you have given to my colleagues. And there is, surely, a huge challenge in front of the New Zealand community to deal with the problem you have laid out so eloquently.

My mind can't get over the unhappy juxtaposition that there is when one drives out of Trentham and you go past the mothball Central Institute of Technology which is not being used, a multi-storeyed education facility, and you drive on to Rimutaka Prison with its razor wire and electronica, where hundreds of people, many of them Maori, are incarcerated. That juxtaposition has, for a

long time, sat unhappily with me and I think that your challenge about needing to educate those people who are in care and in custody is one of the things which ought to be a legacy of this Royal Commission. I hope I make it obvious that I join my colleagues warmly in thanking you for your evidence.

A. Thank you.

CHAIR: Madam Registrar, that brings us to the end of the day. I see our representatives from Ngati Whatua are with us.

16.20

Hearing adjourned at 4.20 p.m.