

Under the Inquiries Act 2013
In the matter of the Royal Commission into Historical Abuse in State Care and in
the Care of Faith-based Institutions

Brief of Evidence of Dr Diana Sarfati on behalf of the Ministry of Health for Institutional Response Hearing

17 August 2022

Solicitor

Julia White

General Counsel, Crown Response to the
Abuse in Care Inquiry
Julia.White@abuseinquiryresponse.govt.nz

Counsel

Rachael Schmidt-McCleave

Kate Sheppard Chambers
PO Box 5606, Wellington 6140
www.katesheppardchambers.co.nz
Rachael.Schmidt-
McCleave@kschambers.co.nz

Max Clarke-Parker

Meredith Connell
PO Box 24546, Wellington 6140
Max.Clarke-Parker@mc.co.nz

Brief of Evidence of Dr Diana Sarfati on behalf of the Ministry of Health for Institutional Response Hearing

1 Introduction

- 1.1 My name is Diana Sarfati. I am the Director-General of Health and Chief Executive of the Ministry of Health. I took up this position on 30 July 2022 and will hold it until a permanent appointment is made.
- 1.2 I have been the Chief Executive of Te Aho o Te Kahu, Cancer Control Agency since May 2020. Prior to this I was National Director of Cancer Control at the Ministry of Health, to oversee the implementation of the agency in late 2019. Between 2015 and 2019 I was co-head and then head of the University of Otago's Department of Public Health.
- 1.3 I hold a Doctor of Philosophy, Master of Public Health and Bachelor of Medicine and Bachelor of Surgery degrees from the University of Otago, and am a Fellow of the New Zealand College of Public Health Medicine. I am a public health physician, cancer epidemiologist, and health services researcher. I am registered with the New Zealand Medical Council.
- 1.4 As Director-General of Health, I am the administrative head (Chief Executive) of the Ministry of Health. I have a wide range of responsibilities, including being responsible to the Minister of Health for the stewardship of the Ministry, including its medium and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to successive governments, as well as assets and liabilities on behalf of the Crown that are used by or relate to the Ministry, and legislation administered by the Ministry. I also have a large number of functions, duties and powers set out throughout the legislation that the Ministry of Health administers.
- 1.5 I am joined in giving evidence before the Royal Commission by my colleagues:
 - (a) Dr John Crawshaw, Director of Mental Health and of Addiction Services. These are statutory roles that Dr Crawshaw holds under the Mental Health (Compulsory Assessment and Treatment), and Substance Addiction (Compulsory Assessment and Treatment) Acts. He will be speaking to the deinstitutionalisation of mental health and psychiatric services in New Zealand since the 1970s, as well as the current measures in place to reduce instances of abuse and neglect in an inpatient context. Dr Crawshaw is a forensic psychiatrist.
 - (b) Dr Arran Culver, the acting Associate Deputy Director-General, Mental Health and Addiction Services. Dr Culver is the Group Manager Mental Health and Addiction in the Ministry's System Performance and Monitoring Directorate, which includes Dr Crawshaw and his team, as well as the mental health strategy and policy and clinical advisory teams, and the Suicide Prevention Office. Dr Culver can speak to mental health policy, and ongoing mental health reform. Dr Culver is a child and adolescent psychiatrist.

(c) John Whaanga, Deputy Director-General, Māori Health. Mr Whaanga leads the Ministry's Māori Health Directorate. The Māori Health directorate partners with Te Aka Whai Ora Māori Health Authority, Te Whatu Ora Health New Zealand and other directorates within the Ministry to develop high quality insights, advice and perspectives from policy development through to operational delivery. At a Government level, it leads Māori engagement and relationships with Māori stakeholders, has responsibility for Māori Crown relationships including treaty settlement relationships, responsibility for ensuring the Ministry meets all-of-government Māori Crown relationships commitments and along with the Te Aka Whai Ora, has responsibility for leading policy and setting the strategic direction for Māori Health; monitors and reports data insights. Mr Whaanga can speak to the Ministry's ongoing work in these areas.

1.6 I am also joined by representatives from Whaikaha, the Ministry of Disabled People, Geraldine Woods, Hannah Kerr and Amanda Bleckmann. Whaikaha came into effect on 1 July 2022. This has meant that Disability Directorate within the Ministry of Health has now transitioned into Whaikaha, taking with it functions of operational disability policy, coordination of disability support services and responsibility for strategic disability policy progression. This means knowledge about current disability support services and associated matters such as funding and monitoring, as well as most historical knowledge (to the extent it might exist), would now sit within Whaikaha. This shift has further limited the knowledge (including historical) within the Ministry of Health as it relates to disability care.

1.7 I have been in this role at the Ministry for only a short period but will provide to the Royal Commission some context around structural changes at the Ministry of Health. I will also speak to the Ministry's response to the experiences that have been shared by survivors and whānau in this inquiry.

1.8 Collectively, the Ministry of Health witnesses will be able to talk to the current health system. We appreciate that the relevant period of the Commission's work is 1950–1999, and while we will endeavour to answer questions relating to matters that pre-date not only our time in our current positions, but also our personal knowledge, experience, and expertise, the Commission will appreciate that there are clearly limits to this. Dr Crawshaw's brief of evidence covers deinstitutionalisation and changes in mental health care from the 1970s to today.

2 The Ministry's response to the Commission

2.1 I firstly want to acknowledge the survivors who have come before this Commission to share their experiences, and their whānau, and other supporters. As Ms Schmidt-McCleave stated at the start of this hearing, your voices throughout this inquiry are the very heart of the Commission's work, and without you, it cannot succeed. It is also important to acknowledge all survivors, including those who have not, or are no longer able to, participate in this inquiry.

2.2 Representatives of the Ministry have listened to and reviewed testimony by survivors at each of the hearings held by the Commission. We have heard of various types of abuse in health and disability settings – for example, physical,

sexual, and psychological abuse by staff and other patients, overmedication, the inappropriate use of restraint and seclusion, and neglect.

- 2.3 We have listened to the stories of survivors, and have carefully reviewed the Commission's findings and recommendations to date. The Ministry will continue to do so as the work of the Commission continues, including as it makes further findings and recommendations over the coming months. I attach as Schedule A a document identifying the Notices to Produce issued by the Commission that the Ministry has responded to.
- 2.4 Past abuse cannot be justified. The effects of abuse on people and their families have been long-standing, often unheard, and devastating. Today the way services are provided is appropriately very different.
- 2.5 As Dr Crawshaw addresses in his brief of evidence, over time there has been a significant shift in attitudes towards disabled people and people with mental health conditions, which has gone hand in hand with the formal changes Dr Crawshaw can talk to. Standards of care have improved, including in response to reviews and inquiries, such as the Mason reports.
- 2.6 Much of the nature and standard of care and treatment provided in historical psychiatric or psychopaedic institutions would be unacceptable today, and are now rightly viewed as neglect or abuse.
- 2.7 It is also undeniable that treatment, historically within normal practice and now viewed as inappropriate, does not excuse behaviour that, then as now, was abusive.
- 2.8 In respect of health and disability care settings (being psychiatric and psychopaedic facilities) during the relevant period of 1950-1999, I reiterate the acknowledgements made by Ms Schmidt-McCleave in the Crown's opening statement. While one of the functions of this Commission is to make findings, I also want to make some additional, specific acknowledgements on behalf of the Ministry of Health:
 1. I acknowledge that there were people in health and disability care settings between 1950-1999 who experienced abuse and other forms of harm, such as physical, sexual, and psychological abuse by staff and others in care, cultural neglect, and a failure to fully and appropriately meet the needs of all of those in care. The impacts of this abuse and neglect are ongoing for survivors, and their families.
 2. I acknowledge that health and disability care settings between 1950-1999 did not always ensure that people in the care of those settings, including children, Māori, Pacific people, people with mental health conditions, and disabled people, were safe from harm, when they should have been. I acknowledge that health and disability care settings did not have adequate policies, processes and practices in place to always detect and facilitate the reporting of abuse and other forms of harm, or to safeguard people in the care of those settings.
 3. Record-keeping issues, such as ethnicity not being recorded, and the loss of some records, have meant that the number of Māori and Pacific

people in health and disability care settings during the relevant period is unlikely to ever be known. However, from what we do know, Māori, Pacific people and disabled people were particularly negatively impacted, either by being overrepresented in these settings, or through these settings not meeting their distinct needs, including because of abuse.

4. I acknowledge that institutional racism in legislation, policy and systems has contributed to the abuse of Māori and Pacific people in health and disability care settings.
5. I acknowledge that institutional and societal ableism in legislation, policy and systems has contributed to the abuse of disabled people and people with mental health conditions in health and disability care settings.
6. I acknowledge that health and disability care settings between 1950-1999 did not consistently and meaningfully ensure the cultural needs of all Māori were met, including providing culturally appropriate health care options, causing disconnection from their culture, identity, language, and communities. I acknowledge that these impacts are ongoing, and have also impacted not just those individuals, but also their whanau, hapu, and iwi.
7. I acknowledge that health and disability care settings between 1950-1999 did not consistently and meaningfully ensure the cultural needs of all Pacific people were met, including providing culturally appropriate health care options, causing disconnection from their culture, identity, language and communities. I acknowledge that these impacts are ongoing, and have also impacted not just those individuals, but also their wider aiga as well.
8. I acknowledge the evidence heard before this Commission that institutionalisation resulted in disabled people being placed in settings where many experienced abuse, and the detrimental impacts of this. In doing so, I acknowledge that health and disability care settings between 1950-1999 were ableist, and did not always meet the needs of disabled people and people with mental health conditions.
9. I acknowledge that societal stigma against people with mental health conditions and learning disabilities was a contributing factor to people being placed in psychiatric settings during the 1950s-1970s, and I acknowledge that people (including children and young people) were placed in psychiatric hospitals and facilities for reasons that would not be acceptable today.
10. I acknowledge that when people were in health and disability care settings between 1950-1999, there was not always input from other agencies that would have been beneficial to achieving a better outcome for the person in care.

11. I acknowledge that between 1950-1999 there was not the legislative or policy settings to ensure sufficient emphasis was put on considering alternatives before placing disabled people and people with mental health conditions into health and disability care settings. This included not always providing adequate support and resourcing to families, or exploring family or community based care options.
12. I acknowledge that the Third Report of the Royal Commission of Inquiry into Hospital and Related Services of 1973 recognised that the policy of large-scale institutionalisation in the 1950s – 1970s (which implemented the main conclusions of the 1953 Aitken report) were the opposite to international best practice at the time.
13. I acknowledge that any form of abuse is completely unacceptable, and that a suite of significant measures have been implemented that should ensure that patients are much better protected, and cared for appropriately.
14. I acknowledge that Māori are more likely to experience compulsory assessment and treatment than non-Māori, and are also more likely to be secluded.
15. I acknowledge that there was inappropriate use of seclusion and restraint in psychopaedic and psychiatric settings.
16. I acknowledge that disabled people and people with mental health conditions have not always been supported to make decisions about their own lives.

3 Changes to the health and disability system

- 3.1 The provision of mental health and disability care in New Zealand, and the associated regulatory framework, has been one of ongoing evolution. This has reflected transformations in society about the type and standard of care that should be provided, and advances in care reflecting improved understanding (whether clinical, scientific or social services).
- 3.2 It has also reflected the ongoing and improved recognition of the rights of persons in care, including the New Zealand Bill of Rights Act 1990, Human Rights Act 1993 and international instruments (such as the United Nations Convention on the Rights of Persons with Disabilities). This does not only reflect changes in society at large, but is also as a result of reviews (including inquiries) over time into care provided and the need for change. The Mason Report in 1988 and the subsequent response, including the enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992, is an example of this.
- 3.3 Four broad trends can be observed.

Regional service providers

- 3.4 Between 1950 and 1993, the structure of the New Zealand public healthcare system comprised individual regional service providers (the predecessors of District Health Boards, and now Te Whatu Ora Health New Zealand).
- (a) By 1950 a number of psychiatric institutions had already been established for the detention of mental health patients under the Mental Health Act 1911;
 - (b) In 1957, 29 Hospital Boards were established under the Hospitals Act 1957, and by 1972, nearly all psychiatric and psychopaedic institutions had been transferred to the Hospital Boards, with Lake Alice the exception;
 - (c) Between 1983 and 1993, 14 Area Health Boards were established, replacing the Hospital Boards as well as receiving devolved responsibilities from the Department of Health.
- 3.5 The Ministry is not aware of any systematic response to claims of abuse from this time. However, I understand that mechanisms for investigations and inquiries did exist. This is evidenced by a range of reports into mental health services that were commissioned throughout the period. These include the 1971 Report of the Commission of Inquiry into Psychiatric Services at Oakley Hospital, which was produced pursuant to the Commissions of Inquiries Act 1908, and the 1988 “Mason report”, which was produced pursuant to the Hospitals Act 1957, the Area Health Boards Act 1983, and the Commissions of Inquiry Act 1908.

1992–1996 - Philosophical system change

- 3.6 Between about 1992 and 1996 the public healthcare system significantly changed its structure and care philosophy in a way which shifted the previous practice of bringing patients into state residential care or custody for treatment towards greater community-based care options, with greater recognition of patient rights.
- 3.7 In 1993, four Regional Health Authorities (designed to purchase services from a range of providers in a competitive health market), and 23 Crown Health Enterprises (to provide services, and which were to be run on a commercial basis) were established. The Department of Health was succeeded by the Ministry of Health.
- 3.8 In 1998, the Health Funding Authority was established to replace the Regional Health Authorities, and Crown Health Enterprises were reconfigured as Hospital and Health Services.
- 3.9 On 1 January 2001:
- (a) District Health Boards were established to replace the Hospital and Health Services; and
 - (b) the Health Funding Authority was disestablished and its responsibilities transferred to the Ministry.

- 3.10 This structure remained in place until the most recent reforms on 1 July 2022, which I will address in due course.

1990s to early 2010s

- 3.11 From the late 1990s onwards the central health government agency known as the Crown Health Financing Agency (**CHFA**) started to receive increasing numbers of historic claims of abuse in public healthcare which were dealt with by litigation or settlement processes. This resulted in the set-up of various forums to hear claims and offer assistance. In mid-2012, a large scale settlement of court proceedings that had been lodged and foreshadowed occurred.

July 2012 – Present

- 3.12 On 1 July 2012 CHFA was disestablished and its property and liabilities were transferred to the Ministry including responsibility for historic abuse claims for events occurring prior to 1993.
- 3.13 The Ministry assumed responsibility from CHFA for historic abuse claims relating to Area Health Boards, and their predecessors, and established a Historic Abuse Resolution Service (**HARS**) administered by the Ministry. This remains the current mechanism for receipt and redress of historic claims of abuse occurring before 1993 in public healthcare.
- 3.14 As can be seen from this explanation, New Zealand's health and disability system has undergone a number of major structural transformations – and is currently going through another, with the establishment of Health New Zealand, the Māori Health Authority, and Whaikaha – Ministry of Disabled People on 1 July this year.
- 3.15 From 1 July 2022:
- (a) Te Whatu Ora Health New Zealand is responsible for the planning and commissioning of hospital, primary, and community health services, consolidating the 20 District Health Boards into one entity.
 - (b) Te Aka Whai Ora Māori Health Authority has shared responsibility for decision-making, planning and delivery, and working in partnership with Te Whatu Ora and the Ministry, is responsible for ensuring the health system works for Māori.
 - (c) Whaikaha provides disabled people with a dedicated agency that will support a whole-of-life approach to disability, rather than considering the community's needs through a health lens alone.
 - (d) The Ministry of Health continues to act as chief strategic advisor and kaitiaki of the country's health sector.
- 3.16 These reforms aim to create a more equitable, accessible, cohesive and people-centred system that will improve the health and wellbeing of all New Zealanders. These goals are:

- (a) People-centred: a system that brings together the voice of all communities
- (b) Equitable: a system that focuses on working in partnership with Māori and honouring Te Tiriti o Waitangi
- (c) Accessible: a system that offers more equitable, convenient and integrated access to services for all New Zealanders
- (d) Cohesive: a national health system that delivers locally, supported by co-ordinated planning and oversight.

4 Concluding remarks

- 4.1 The Ministry looks forward to continuing to work with the wider Crown as the Commission progresses, and is cognisant of how important the Commission's work is.
- 4.2 Finally, I want to once again acknowledge the survivors who have shared their experiences with this Commission, and the work of this Commission to help avoid such experiences being repeated.

Signed:
Diana Sarfati

Date:

Schedule A – responses to Notices to Produce issued to the Ministry of Health

Notice to Produce number	Date of issue	Date of response(s)
1	22 October 2019	29 November 2019
5	7 February 2020	14 February 2020
6	11 March 2020	Various
8	31 March 2020	Various
11	27 July 2020	17 September 2020
14	14 August 2020	22 October 2020
15	21 August 2020	28 September 2020
18	7 October 2020	9 November 2020
20	12 October 2020	5 November 2020
25	11 November 2020	13 January 2021
29	24 November 2020	8 March 2021
30	12 May 2021	21 May 2021
50	24 May 2021	Various
199	11 June 2021	21 June 2021
202	2 June 2021	5 July 2021
223	1 July 2021	16 July 2021
227	14 July 2021	28 July 2021
264	18 August 2021	16 September 2021
327	11 November 2021	Various
331	1 November 2021	Various
342	23 November 2021	24 November 2021
360	11 February 2022	Various
416	5 April 2022	11 May 2022
420	7 April 2022; 29 June 2022	Various