

**ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
STATE INSTITUTIONAL RESPONSE HEARING**

Under The Inquiries Act 2013

In the matter of The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions

Royal Commission: Judge Coral Shaw (Chair)
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Mr David Stone for the New Zealand State Abuse Survivors Charitable Trust

Venue: Level 2
Abuse in Care Royal Commission of Inquiry
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TRANSCRIPT OF PROCEEDINGS

INDEX

MINISTRY OF HEALTH

Questioning by Mr Clarke-Parker	212
Questioning by Ms Thomas	218
Questioning by Ms McCarthy	240
Questioning by Ms Thomas	269
Questioning by Ms McCarthy	303
Questioning by Ms Thomas	308
Questioning by Commissioners	311

1 **Hearing opens with waiata Whakataka Te Hau and karakia tīmatanga by Ngāti**
2 **Whātua Ōrākei**

3 **[9.08 am]**

4 **CHAIR:** Ata mārie ki a koutou katoa, nau mai hoki mai ki tēnei tūmatanui. Welcome, everybody,
5 to this morning's session. Today we are dealing with our health system and we have a
6 parade of our senior officials from the Health Department, grateful for your attendance.

7 I'll ask Ms Thomas just to open, thank you Ms Thomas.

8 **MS THOMAS:** Tēnā koutou katoa, ko Mrs Thomas tōku ingoa. I am a nondisabled Pākehā
9 woman wearing a blue suit jacket, pink shirt, with glasses and blonde hair. I am the
10 Counsel Assisting today with my friend Alice McCarthy who will also be questioning later
11 in the day and I will hand over now to Ms Schmidt-McCleave to start the evidence in chief.

12 **CHAIR:** Tēnā koe Ms Schmidt-McCleave.

13 **MS SCHMIDT-McCLEAVE:** Tēnā koutou ano ki ngā Kaikōmihana, tēnā koutou katoa. Ko
14 Rachael Schmidt-McCleave tōku ingoa. For those listening who may not have heard from
15 me already this week and who cannot see me, my name is Rachael Schmidt-McCleave, I'm
16 the counsel for the Crown, I'm accompanied by my co-counsel, Mr Max Clarke-Parker,
17 who will be doing some of the questioning today as well. I am a Pākehā middle-aged
18 woman with dark brown hair and brown eyes. Tēnā koutou katoa.

19 In the box today, Commissioners, this morning we have the Director General of
20 Health, Dr Diana Sarfati, with Dr John Crawshaw from the Ministry of Health to her left, to
21 Dr Sarfati's right is Geraldine Woods who is the acting Chief Executive of Whaikaha, the
22 Ministry of Disabled People, and she is accompanied to her right by Amanda Bleckmann,
23 who is the acting Deputy Chief Executive of Whaikaha, Operational Design and Service
24 Delivery.

25 So I'm going to be leading the health witnesses evidence this morning and
26 Mr Clarke-Parker will follow and lead the evidence of the Whaikaha witnesses.

27 Can I just also explain to the Commissioners that we have in the courtroom today
28 behind the Crown table and to the left, Dr Arran Culver who is the acting Deputy Director-
29 General, Mental Health and Addiction Services, and he will be giving evidence later today
30 in one of the later sessions, and also Amanda Kerr from Whaikaha who will also be giving
31 evidence in one of the later sessions.

32 We were hoping to have John Whaanga from the Ministry of Health but he is
33 unfortunately self-isolating and unwell, but if there are any issues that he typically would
34 have covered then we're very, very happy to follow up that with the Commission in writing.

1 **CHAIR:** Thank you.

2 **MS SCHMIDT-McCLEAVE:** So if Madam Chair would like to take the oaths.

3 **CHAIR:** Yes, I will, and as I have forgotten to do before, I will introduce myself to those who
4 cannot see. My name is Coral Shaw, I'm the chair of the Royal Commission, I am an
5 elderly woman, I have white chin length hair and I wear glasses and today I'm wearing a
6 greenish jacket.

7 Good morning to all of you and I include in that the other two people who aren't
8 sitting in the witness box.

9 **MINISTRY OF HEALTH.**

10 **DR DIANA SARFATI, DR JOHN CRAWSHAW, MS GERALDINE WOODS,**
11 **MS AMANDA BLECKMANN (Affirmed)**

12 **MS SCHMIDT-McCLEAVE:** I'm going to start by leading the evidence of Dr Sarfati, who is, as
13 I mentioned, the Director General of Health and the Chief Executive of the Ministry of
14 Health and has been in the role two and a half weeks since the 30th of July 2022 with the
15 recent health changes and the departure of the former Director General.

16 So Dr Sarfati is going to give an introduction first and then I will return her to her
17 written brief to highlight some key points.

18 **DR SARFATI:** Tēnā koutou katoa, tāku mihi tuatahi ki ngā mana whenua ko Ngāti Whātua
19 Ōrākei e manaakitia mai, tēnā koutou. Nei rā āku mihi ki ngā Kaikōmihana, i tā koutou
20 mahi whai tikanga, tēnā koutou. He mihi māhaki ki ngā whānau purapura ora ki ā koutou
21 mahi rangatira, tēnā koutou.

22 Ko wai au? No Koterangi aku tīpuna, no Ngāti Hūrae aku tīpuna, he tāngata Tiriti
23 ahau. I tipu ake au i Te Whanganui a Tara i te rohe o Te Atiawa rāua ko Ngāti Toa, ko Te
24 Whanganui a Tara te moana, ko te Matarangi te maunga, ko Diana Sarfati taku ingoa. Nō
25 reira, tēnā koutou, tēnā koutou, tēnā tātou katoa.

26 My name's Diana Sarfati, I am the Director General of Health. For those who can't
27 see me, I'm a short woman, my children would call me middle-aged, and I have somewhat
28 unruly curly light coloured hair to shoulder length. Thank you.

29 **MS SCHMIDT-McCLEAVE:** Tēnā koe, Dr Sarfati.

30 Commissioners will have received Dr Sarfati's written brief of evidence and in
31 particular the first paragraphs which set out her extensive experience, I'm not proposing to
32 take her through those, but Dr Sarfati would like to read some introductory comments and
33 also to give some acknowledgments. So I'll pass over to Dr Sarfati to read from paragraph
34 two of your brief.

1 **DR SARFATI:** Thank you. I firstly want to acknowledge the survivors who have become before
2 this Commission to share their experiences, and their whānau and their supporters. As
3 Ms Schmidt-McCleave stated at the start of this hearing, your voices throughout this
4 Inquiry are at the very heart of the Commission's work and without you it cannot succeed.

5 It is also important to acknowledge all survivors, including those who have not or
6 are no longer able to participate in this Inquiry.

7 Representatives of the Ministry have listened to and reviewed testimony by
8 survivors at each of the hearings held by the Commission. We have heard of various types
9 of abuse in Health and Disability settings, for example, physical, sexual, and psychological
10 abuse by staff and other patients, over-medication, the inappropriate use of restraint and
11 seclusion, and neglect.

12 We have listened to the stories of survivors and have carefully reviewed the
13 Commission's findings and recommendations to date. The Ministry will continue to do so
14 as the work of the Commission continues, including as it makes further findings and
15 recommendations over the coming months.

16 Past abuse cannot be justified. The effects of abuse on people and their families
17 have been long-standing, often unheard, and devastating. Today the way services are
18 provided is appropriately very different.

19 As Dr Crawshaw addresses in his brief of evidence, over time there has been a
20 significant shift in attitudes towards disabled people and people with mental health
21 conditions, which has gone hand in hand with the formal changes Dr Crawshaw can talk to.
22 Standards of care have improved, including in response to reviews and inquiries such as the
23 Mason reports.

24 Much of the nature and standard of care and treatment provided in historical
25 psychiatric or psychopaedic institutions would be unacceptable today and are now, rightly,
26 reviewed as neglect or abuse. It is also undeniable that treatment historically within normal
27 practice and now viewed as inappropriate does not excuse behaviour that then, as now, was
28 abusive.

29 In respect of Health and Disability care settings, during the relevant period of 1950
30 to 1999, I reiterate the acknowledgments made by Ms Schmidt-McCleave in the Crown's
31 opening statement. While one of the functions of this commission is to make findings,
32 I also want to make some additional specific acknowledgments on behalf of the Ministry of
33 Health.

1 I acknowledge that there were people in Health and Disability care settings between
2 1950 and 1999 who experienced abuse and other forms of harms such as physical, sexual
3 and psychological abuse by staff and others in care, cultural neglect and a failure to fully
4 and appropriately meet the needs of all of those in care.

5 The impacts of this abuse and neglect are ongoing for survivors and their families.

6 I acknowledge that Health and Disability care settings between 1950 and 1999 did
7 not always ensure that people in the care of those settings, including children, Māori,
8 Pacific people, people with mental health conditions and disabled people were safe from
9 harm when they should have been.

10 I acknowledge that Health and Disability care settings did not have adequate
11 policies, processes and practices in place to always detect and facilitate the reporting of
12 abuse and other forms of harm, or to safeguard people in the care of those settings.

13 Record-keeping issues such as ethnicity not being recorded and the loss of some
14 records have meant that the number of Māori and Pacific people in health and disability
15 care settings during the relevant period is unlikely to ever be known. However, from what
16 we know, Māori and Pacific people and disabled people were particularly negatively
17 impacted, either by being over-represented in these settings or through these settings not
18 meeting their distinct needs, including because of abuse.

19 I acknowledge that institutional racism in legislation, policy and systems has
20 contributed to the abuse of Māori and Pacific people in health and disability care settings.

21 I acknowledge that institutional and societal ableism in legislation, policy and
22 systems has contributed to the abuse of disabled people and people with mental health
23 conditions in Health and Disability care settings.

24 **MS SCHMIDT-McCLEAVE:** I'm loathed to interrupt you, but if you could slow the pace just a
25 little for the signers, thank you.

26 **DR SARFATI:** Sure, of course. Apologies. I acknowledge that Health and Disability care
27 settings between 1950 and 1999 did not consistently and meaningfully ensure that the
28 cultural needs of all of Māori were met, including providing culturally appropriate
29 healthcare options, causing disconnection from their culture, identity, language and
30 communities. I acknowledge that these impacts are ongoing and have also impacted not
31 just those individuals, but also their whānau, hapū and iwi.

32 I acknowledge that Health and Disability care settings between 1950 and 1999 did
33 not consistently and meaningfully ensure that the cultural needs of all Pacific people were

1 met, including providing culturally appropriate healthcare options, causing disconnection
2 from their culture, identity, language and communities.

3 I acknowledge that these impacts are ongoing and have also impacted not just those
4 individuals but also the wider aiga as well.

5 I acknowledge the evidence heard before this Commission that institutionalisation
6 resulted in disabled people being placed in settings where many experienced abuse and the
7 detrimental impacts of this. In doing so, I acknowledge that Health and Disability care
8 settings between 1950 and 1999 were ableist and did not always meet the needs of disabled
9 people and people with mental health conditions.

10 I acknowledge that societal stigma against people with mental health conditions and
11 learning disabilities was a contributing factor to people being placed in psychiatric settings
12 during the 1950s to 1970s and I acknowledge that people, including children and young
13 people, were placed in psychiatric hospitals and facilities for reasons that would not be
14 acceptable today.

15 I acknowledge that when people were in Health and Disability care settings between
16 1950 and 1999, there was not always input from other agencies that would have been
17 beneficial to achieving a better outcome for the person in care.

18 I acknowledge that between 1950 and 1999, there was not the legislative or policy
19 settings to ensure sufficient emphasis was put on considering alternatives before placing
20 disabled people and people with mental health conditions into Health and Disability care
21 settings. This included not always providing adequate support and resourcing to families or
22 exploring family or community-based care options.

23 I acknowledge that the third report of the Royal Commission of Inquiry into
24 Hospital and Related Services of 1973 recognised that the policy of large-scale
25 institutionalisation in the 1950s to 1970s, which implemented the main conclusions of the
26 1953 Atkin report were the opposite to international best practice at the time.

27 I acknowledge that any form of abuse is completely unacceptable and that a suite of
28 significant measures have been implemented that should ensure that patients are much
29 better protected and cared for appropriately.

30 I acknowledge that Māori are more likely to experience compulsory assessment and
31 treatment than non--Māori and also more likely to be secluded. I acknowledge that there
32 was inappropriate use of seclusion and restraint in psychopaedic and psychiatric settings.
33 I acknowledge that disabled people and people with mental health conditions have not
34 always been supported to make decisions about their own lives.

1 **MS SCHMIDT-McCLEAVE:** Ngā mihi ki a koe, Dr Sarfati.

2 Commissioners, in the remainder of the brief, Dr Sarfati speaks about the changes
3 over time to the Health and Disability system and we're happy to take that as read. I am
4 aware that the extensive acknowledgments that have just been given are not contained in
5 the copy of the briefs you have, so we'll ensure that is followed up after this session so you
6 have a copy of that.

7 I'd now like to briefly lead Dr Crawshaw's evidence. And I understand he has some
8 introductory remarks to make to the Commissioners and the public.

9 **CHAIR:** Thank you.

10 **DR CRAWSHAW:** Tēnā koutou katoa. Nō Kōtarani, nō Airani nō Ingarani ōku tīpuna, ko John
11 Crawshaw taku ingoa. Nō Ōtautahi ahau, kei Te Whanganui a Tara au e noho ana.

12 I'm John Crawshaw, I'm the Director of Mental Health and Addiction at Ministry of
13 Health. For those of you who might not be able to see me, I'm the older man with the grey
14 hair in a dark suit with a light blue shirt and a gold tie.

15 **MS SCHMIDT-McCLEAVE:** Thank you, Dr Crawshaw. And you have since 1 July 2022
16 assumed responsibility for the statutory and regulatory functions for the Intellectual
17 Disability (Compulsory Care and Rehabilitation) Act under the delegated authority of the
18 Director General?

19 **DR CRAWSHAW:** That is correct.

20 **CHAIR:** Just slow down. You are part of the speed limit as well.

21 Just repeat that because it's a big long title that is hard to translate.

22 **MS SCHMIDT-McCLEAVE:** Yes. Since 1 July you have assumed responsibility for the
23 statutory and regulatory functions for the Intellectual Disability (Compulsory Care and
24 Rehabilitation) Act 2003?

25 **DR CRAWSHAW:** That is correct.

26 **MS SCHMIDT-McCLEAVE:** And that's under the delegated authority of the Director General
27 of Health.

28 **DR CRAWSHAW:** That's correct.

29 **MS SCHMIDT-McCLEAVE:** And as Director of Mental Health and Addiction Services, you are
30 also responsible for administering New Zealand's Mental Health, Substance Addiction and
31 Intellectual Disability legislation.

32 **DR CRAWSHAW:** That's correct.

1 **MS SCHMIDT-McCLEAVE:** And just for the benefit of those listening, you have previously
2 given evidence to this Commission, particularly in the investigation into State abuse at
3 Lake Alice, that hearing, and you rely on portions of that brief of evidence you've given.

4 **DR CRAWSHAW:** I do.

5 **MS SCHMIDT-McCLEAVE:** And your brief of evidence that you have provided for this
6 hearing also draws from the Ministry's responses to Notice to Produce 420.

7 **DR CRAWSHAW:** That's correct.

8 **MS SCHMIDT-McCLEAVE:** If you could, for the Commission and those listening, please read
9 paragraphs 1.6 and 1.7 of your brief.

10 **DR CRAWSHAW:** Please slow me if I go too fast.

11 **CHAIR:** I will put the hand up, yes.

12 **DR CRAWSHAW:** My background is in forensic psychiatry, I graduated from Otago University
13 Medical School in 1978 and since 1986 I have been a Fellow of the Royal Australian and
14 New Zealand College of Psychiatrists.

15 My previous experiences include practices of forensic psychiatric, lecturing in
16 psychological medicine, involvement in developing major changes to mental health and
17 addiction legislation and policy frameworks in New Zealand and Tasmania.

18 I have had a number of senior management positions, including a general manager
19 of Mental Health, Elderly and Disability Services for Capital Coast Health, a Crown Health
20 Enterprise, between 1993 and 1998, during which time I was responsible for the closure of
21 Porirua Hospital.

22 I note that in the course of my career, in a private practice capacity I have provided
23 expert evidence on behalf of claimants bringing claims against the Crown and religious
24 institutions, including issues related to limitation issues, or statute of limitation issues. In
25 this capacity and in my clinical work, I know all too well, the depth of pain and anguish
26 that the complainants recounted and the long-lasting impacts their experiences in care have
27 had on their lives.

28 I also know how hard it was for them to recount their experiences and bring them to
29 notice. I extend my sympathies to them.

30 **MS SCHMIDT-McCLEAVE:** Just turning the page, Dr Crawshaw, if you could outline at
31 paragraph 1.9 what your brief covers.

32 **DR CRAWSHAW:** In this brief I outline some of the key structural changes in the health system
33 and to the provision of mental health and psychiatric care in New Zealand since 1978.

1 I also explain the measures that exist in the current environment to reduce instances of
2 abuse and neglect in inpatient settings.

3 There have been changes in the statutory landscape, the organisational structures of
4 the public health system, and the culture of both mental health care providers specifically
5 and also society at large.

6 **MS SCHMIDT-McCLEAVE:** Thank you, Dr Crawshaw.

7 And Commissioners and those listening, Dr Crawshaw's written brief covers
8 extensively the changes to mental health care in New Zealand, so he is happy to have that
9 evidence taken as read. Specifically it covers deinstitutionalisation, the impact of the
10 New Zealand Bill of Rights Act, and international legal instruments, the Mental Health
11 (Compulsory Assessment and Treatment) Act 1992, which is the regulatory framework for
12 mental health, the public health sector restructures that have taken place in the time period,
13 the Code of Health and Disability Services Consumers Rights, the Mental Health
14 Commission and Blueprint, quality improvement systems, the role of the Children's
15 Commissioner, the Inquiry He Ara Oranga from 2018, the Mental Health and Wellbeing
16 Commission, and the Ministry's Guidelines under the 1992 Mental Health (Compulsory
17 Assessment and Treatment) Act, and those topics make up the bulk of Dr Crawshaw's brief,
18 but he would like to read his segment of the brief on lessons learned, so Dr Crawshaw, if
19 you could read from part 3 of your brief.

20 **DR CRAWSHAW:** The provision of mental health and disability care in New Zealand and the
21 associated regulatory framework has been one of ongoing evolution. This has reflected
22 transformations in society about the type and standard of care that should be provided and
23 advances in care reflecting improved understanding whether clinical, scientific, or social
24 services.

25 It has also reflected the ongoing and improved recognition of the rights of persons
26 in care, including the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993,
27 and the international instruments such as the United Nations Convention on the Rights of
28 Persons With Disability.

29 This does not only reflect changes in society at large, but also is a result of reviews,
30 including inquiries over time into care provided and the need for change.

31 The Mason report in 1988 and the subsequent response, including the enactment of
32 the Mental Health (Compulsory Assessment and Treatment) Act 1992 is an example of this.

33 More recently, we have seen the publication of the 2018 Inquiry into Mental Health
34 and Addiction. The publication of the Inquiry report and the Government response to that

1 Inquiry recognises that the ongoing evolution of a rights-based approach to care and
2 seeking elimination of abuse in care, which is an acknowledgment of what historically
3 occurred, and is recognised in the report of the 2005 Confidential Forum for Former
4 Inpatients of Psychiatric Hospitals, (the Forum). This was succeeded by the Confidential
5 Listening and Assistance Service, (the Service), in 2008. Participants in this Forum and the
6 Service highlighted abuse they have suffered while in care of the State run psychiatric
7 hospitals and facilities.

8 These actions also reflect where failures in care, including abuse or outdated
9 practices, have been identified, as well as the need for changes. It also means that the
10 current Health and Disability system has had significant change over the years, as well as
11 the staff within it.

12 In the 1950s through to the 1970s, people, including children and young persons,
13 were placed in institutions for reasons that would not be acceptable today. This shift in
14 attitude is consistent with an increasing societal focus on a rights enhancing environment
15 that has gone hand in hand with the formal changes which together makes it more difficult
16 for abuse to occur at a systemic level.

17 While those formal changes have established measures for reducing incidents of
18 abuse and neglect, the impact of changes in societal norms since the 1970s should not be
19 underestimated. Historically, society has displayed significant stigma towards people with
20 mental illness and intellectual disabilities and while that stigma has improved, it continues
21 to be a problem today.

22 The shifts in attitude have been enormous. Significant portions of the community
23 strongly opposed the idea that mental health care should be provided in the community in
24 the past, which at times created significant obstacles to change.

25 The emergence of the mental health consumer rights movement was instrumental in
26 challenging the prevailing health beliefs and practices in psychiatric institutions and
27 advocating for the rights of service users. Advocacy groups such as the Mental Health
28 Foundation, which was established in 1977, were also influential in changing public
29 attitudes towards mental illness and promoting the rights of service users.

30 In the mid-1980s I established a group representing the region's psychiatrists called
31 The Wellington Regional Psychiatrists. In response to the calls for changes, one of our
32 core activities was advocating for the shutting of Porirua Hospital. I experienced first-hand
33 the resistance of some parts of society and key agencies which did not always accept that
34 institutionalising people for mental health reasons was unacceptable.

1 That is the backdrop against which large-scale psychiatric and psychopaedic
2 institutions were situated and, just as significantly, it was the context within which
3 measures to prevent the abuse had to be introduced.

4 Related to the societal changes is the distinction between staff behaviour that was
5 inappropriate and abusive at times on the one hand, and clinical practices that would not be
6 acceptable today, but were consistent with practices at the time. The nature and standard of
7 care and treatment provided in historical psychiatric or psychopaedic institutions would be
8 unacceptable today and might extend to neglect and abuse in today's environment.

9 These institutions, because of the large numbers of patients and often low staff
10 numbers, operated a more regimented and standardised system of care than would be
11 acceptable today. This meant that people often lost independence and individuality.

12 While, of course, not all people involved in such institutions were problematic and
13 many were motivated by a desire to help people, the reality is that these institutions had
14 many negative consequences. For that reason, there was a big push to shut the institutions,
15 including by psychiatrists of my generation and other health professionals. There is,
16 however, a distinction between that treatment historically within normal practice and now
17 viewed as inappropriate and behaviour that was then, as now, abusive.

18 Treatments are another area where there has been significant change over time. In
19 the 1950s to 1970s there were limited psychotropic medications available. Although able
20 to provide positive effects in some cases, these agents often had significant side effects and
21 limited effectiveness by today's standards.

22 By the 1980s and 1990s, more effective medications had been introduced with a
23 lesser side effect profile. The advent of these new medications combined with a move
24 towards community care to enable discharge back into the community and the whole
25 deinstitutionalisation movement occurred. Thankfully, we have a greater range of
26 pharmacological and other psychological treatments available for us now.

27 **MS SCHMIDT-McCLEAVE:** Thank you, Dr Crawshaw. And you both will be asked to remain
28 there to answer questions from Counsel Assisting, but before that occurs, Mr Clarke-Parker
29 will lead the evidence of Whaikaha. Thank you, Commissioners.

30 **CHAIR:** Tēnā koe Mr Clarke-Parker.

31 **QUESTIONING BY MR CLARKE-PARKER:** Tēnā koe.

32 Tēnā koutou katoa, ko Max Clarke-Parker ahau. For those listening, I am Pākehā, I
33 have brown hair and a beard, and today a blue striped tie. Tēnā kōrua Whaikaha witnesses.

34 Ms Woods, may I please begin by having you introduce yourself.

1 **MS WOODS:** Tēnā koutou katoa. Ko Takitimu ngā maunga hī, ko Aparima tōku awa, ko [Nō]
2 Ōrieti ahau. Kei Te Whanganui a Tara tōku kāinga noho, ko Woods tōku whanau. E ngā
3 mana, e ngā reo, tēnā koutou. E ngā mōrehu me ā koutou kōrero mō tēnei kaupapa. Tēnā
4 koutou katoa. Ko Geraldine Woods tēnei e mihi ana.

5 I am a nondisabled 58-year-old Pākehā female with short greying hair. I wear
6 glasses and today I am wearing a grey dress.

7 **MR CLARKE-PARKER:** Thank you, and you have prepared a brief of evidence for this Royal
8 Commission which has been filed, and largely will be taken as read, but you have particular
9 sections of that that you will be taking us through today. Please begin.

10 **MS WOODS:** My name is Geraldine Woods, I am the acting Chief Executive of Whaikaha,
11 Ministry of Disabled People. I have had this role since July 2022 when Whaikaha was
12 established.

13 It is important to note that my contract is only expected to be for two months to
14 allow the finalisation of the permanent appointment of the new Chief Executive.

15 I have over 20 years experience in executive and senior management roles in the
16 Public Service. Most of this experience has been in roles working with the disability
17 community, including as Deputy Director-General, Disability, in the Ministry of Health,
18 and as Executive Director in Queensland, Australia supporting the establishment
19 of- the-- National Disability Insurance Scheme.

20 As acting Chief Executive, I am responsible for establishing the Ministry as a new
21 Public Service Department agency, building the confidence of and partnering effectively
22 with the disabled community and working with service providers to ensure delivery of
23 Disability Support Services without service disruption for disabled people.

24 The predecessor agencies for Whaikaha are the Office of Disability Issues, ODI,
25 previously housed in MSD, and the Disability Directorate from the Ministry of Health,
26 MOH. Whaikaha will be responsible for driving better outcomes for all disabled people,
27 leading cross-government strategic disability policy, delivering and transforming Disability
28 Support Services, leading cross-government work to address accessibility barriers once the
29 accessibility legislation is passed, which is expected to be enacted by 1 July 2023, which
30 will be guided by a Ministerial Accessibility Committee made up of and representing
31 disabled people.

32 Whaikaha is in its early establishment and is developing internal processes and the
33 ongoing work programme and priorities.

1 Whaikaha is committed to leading a true partnership between the disability
2 community, Māori and Government, and to help transform the disability system.
3 Achieving these important overarching goals is an important step to ensuring that the errors
4 of the past do not continue today. The United Nations Convention on the Rights of Persons
5 with Disabilities and Te Tiriti o Waitangi are critical underpinning documents in that
6 mission.

7 The purpose of the UNCRPD, the Convention, is to promote, protect and ensure the
8 full and equal enjoyment of all human rights and fundamental freedoms by all disabled
9 people and to promote respect for their inherent dignity. The Treaty and the Convention
10 work together as the whāriki and korowai of disability policy and the full realisation of
11 human rights and disabled people in Aotearoa.

12 Although Whaikaha was newly established on 1 July 2022, staff within the agency
13 have been involved in the response to the Commission and have been aware of the evidence
14 given by survivors. In previous hearings we have heard stories of the traumatic experiences
15 of disabled people in care. This has included stories from both disabled people and their
16 whānau of physical, sexual and emotional abuse, violence and cruelty.

17 We have heard of institutions which did not -provide adequate care and oversight
18 for individuals. We have heard of staff members who did not treat individuals with care,
19 compassion and respect. We have heard of staff members who attempted to improve
20 environments of care institutions and improve the attitudes of other staff but- struggled
21 within a system that made improvements very challenging.

22 The abuse that people experienced in these settings is completely unacceptable. We
23 would like to acknowledge the bravery and fortitude of survivors. You shared the stories of
24 hurt --caused you to, to your whānau and to others. I would also like to make the following
25 acknowledgments on behalf of Whaikaha, Ministry of Disabled People.

26 It is likely that Māori, Pacific and disabled people were disproportionately
27 represented in care. It is likely that Māori, Pacific and disabled people were
28 disproportionately abused in care. Between 1950 and 1999 the Health and Disability care
29 settings were ableist. They did not always meet the needs of disabled people and disabled
30 people often experienced discrimination and unfair treatment as a result of their disability.

31 I acknowledge this means disabled people experienced higher levels of abuse and
32 neglect than other people in care.

1 Deaf people, in particular, were denied access to their language and their place in
2 their community. These impacts are ongoing and have always impacted on whānau of
3 disabled people and Deaf people.

4 Between 1950 and 1999 Health and Disability care settings failed to consistently
5 and meaningfully support the cultural needs of tāngata whaikaha Māori. I acknowledge
6 that this caused tāngata whaikaha Māori to be disconnected from their culture, identity,
7 language and communities. These impacts are ongoing and have also impacted whānau,
8 hapū and iwi.

9 Between 1950 and 1999 Health and Disability care settings failed to consistently
10 ensure that Pacific disabled people had adequate access to their culture, identity, language
11 and communities. This contributed to isolation and cultural disconnection. I acknowledge
12 that the impacts are ongoing and have impacted individuals as well as the wider aiga.

13 I acknowledge that there has not always been coordinated input from other agencies
14 when people have been in Health and Disability care settings. This probably would have
15 been beneficial to achieving better outcomes for people in care.

16 I acknowledge the evidence heard before this Commission that many disabled
17 people placed in care settings experienced abuse and other forms of harm. The nature of
18 the abuse described in the evidence included physical, emotional, and sexual abuse
19 perpetrated by caregivers, staff and others in care. Disabled people also experienced
20 neglect, including cultural neglect.

21 I acknowledge that the impacts of this abuse and neglect are ongoing for survivors
22 and their whānau. Whaikaha regards any form of abuse as completely unacceptable.

23 I acknowledge that some of the operating practices within the Health and Disability
24 care settings between 1950 and 1999 did not always ensure whānau care arrangements were
25 considered before disabled people were placed in Health and Disability care settings.
26 I acknowledge that families in need were not always provided with support and extended
27 family, whānau, hapū and iwi were not always supported to care for their disabled people
28 safely in their communities.

29 Whaikaha accepts the findings of the Third Report of the Royal Commission of
30 Inquiry into Hospital and Related Services of 1973. This report recognises that the policy
31 of large-scale institutionalisation in the 1950s to 1970s, which implemented the main
32 conclusions of the 1953 Aitken Report, were not consistent with policies being followed
33 elsewhere in the world.

1 I acknowledge there was inappropriate use of seclusion and restraint in
2 psychopaedic settings.

3 Historically, Deaf and disabled people have not always been supported to make
4 decisions about their own lives.

5 Whaikaha will work in partnership with disabled people, tāngata whaikaha Māori
6 and their whānau with Te Tiriti o Waitangi, Te Tiriti, at the forefront. This will be a unique
7 relationship between the Crown, disabled people and tāngata whaikaha Māori that allows
8 disabled people and tāngata whaikaha Māori to have a voice and an opportunity to input
9 into the future of whaikaha.

10 Whaikaha's leadership of the disability system will build on the existing Enabling
11 Good Lives and Whanau Ora approaches. The Enabling Good Lives approach is person-
12 centred with a whole-of-life focus that supports disabled people to determine and tailor
13 their everyday lives, goals and needs. The Whanau Ora approach is a whānau-centred way
14 of working to achieve transformational change that focuses on the strengths of tāngata
15 whaikaha Māori and their families participating in Te Ao Māori and Pacific disabled people
16 and aiga.

17 Disability system transformation is about fundamentally changing the purpose of
18 the disability support system from being about provision of services to giving disabled
19 people, tāngata whaikaha Māori and Pacific disabled people choice and control over their
20 own lives. A fundamental aspect of the transformation is the implementation of the
21 Enabling Good Lives approach across the system. The Enabling Good Lives vision and
22 principles and disability support system transformation emerged from several significant
23 inquiries and initiatives.

24 In 1921, -sorry in 2021, get my dates right, Cabinet agreed to implement the EGL
25 a-pproach to Disability Support Services nationally. Feedback from disabled people and
26 whānau whaikaha Māori involved in the EGL demonstration sites has been positive. Those
27 who have access to the new system report a greater ability to manage their own lives and to
28 choose service providers that work within a culturally responsive context, aligning with
29 disabled people's cultural continuity and tino rangatiratanga of tāngata whaikaha Māori.

30 As the EGL approach is rolled out nationally, disabled people will have greater
31 choice over their living arrangements, including living in the community. Evaluations have
32 found that many have an increased sense of choice and control, social connectedness and
33 have benefitted from the use of flexible approaches to funding to improve their lives and
34 well-being.

1 Whaikaha has developed a monitoring evaluation analysis and learning strategy
2 with the community for the transformation of the Disability Support Services. This strategy
3 aims to ensure a developmental approach to monitoring and evaluation, providing stronger
4 opportunities for safeguarding responses.

5 A safeguarding framework was developed as part of Mana Whaikaha in the Mid-
6 Central region in 2018. Connectors of Mana Whaikaha have been trained in the
7 safeguarding framework.

8 Whaikaha has also recently taken on responsibility for Action 28 of Te Aorere
9 Kura, the national strategy to eliminate family violence and sexual violence. Action 28 is a
10 pilot in Waitemātā that focuses on the development and implementation of a safeguarding
11 framework and inter-agency safeguarding approaches to prevent, report, investigate and
12 respond to alleged family harm and other forms of abuse, neglect or harm -of- disabled
13 adults.

14 Whaikaha will also be developing a comprehensive disability workforce strategy
15 and implementation plan to support a transformed disability support system and the
16 ongoing development of the disability workforce.

17 There needs to be significant improvement of data collection for disabled people.
18 The Office of Disability Issues has been working with other Government agencies on this.
19 Work to date includes encouraging disaggregation of data by disability and other
20 demographics including ethnicity, as well as working with disabled people to understand
21 how we can better monitor outcomes, particularly from a Te Ao Māori lens.

22 Work is also underway to develop a disability indicator to inform future data
23 collection. This work will further allow Government agencies to better identify gaps in
24 data and apply key considerations for disabled people in terms of data collection analysis
25 and dissemination.

26 In this brief I have shared the reasons that Whaikaha was established and its goal in
27 driving better outcomes for disabled people. We are an agency that seeks to uphold the
28 articles of Te Tiriti o Waitangi and the UNCRPD to support disabled people, tāngata
29 whaikaha Māori, Pacific disabled people, whānau and carers. Using the framework of
30 Enabling Good Lives approach to transform Disability Support Services, we aim to give
31 disabled people more choice and control over their lives and the supports they receive,
32 leading to better outcomes for disabled people and their families.

33 We have monitoring oversight and safeguarding mechanisms to ensure the safety of
34 disabled people and we are continuously working to improve our complaint procedures to

1 ensure the process is accessible to all. We are committed to the ongoing development of
2 the safeguarding framework. Ultimately, we believe this will support the prevention of
3 abuses such as those shared with us in these hearings.

4 We acknowledge how difficult this process will have been for survivors and their
5 whānau, and the difficulty in sharing these very personal and distressing stories. Terrible
6 stories of abuse, and from Whaikaha's perspective, in particular the abuse of disabled
7 people highlight the importance of our agencies' work in the future.

8 We will be very interested in the Royal Commission's findings and
9 recommendations and again thank the Royal Commission and the survivors for sharing
10 their stories with us all and creating this opportunity for change.

11 **MR CLARKE-PARKER:** Thank you, Ms Woods. Now.

12 Turning to you Ms Bleckmann, I may have to ask you to just pull that microphone
13 towards you. We won't be leading any evidence from you, but may I please have you
14 introduce yourself.

15 **MS BLECKMANN:** Thank you. Tēnā koutou katoa. Ka nui ngā mihi ki a koutou. Ko
16 Maungawhau te maunga, ko Ngāti Pākehā te iwi, ko tōku Bleckmann te whanau, ko
17 Amanda tōku ingoa, nō Tāmaki Makaurau ahau. Ko Whaikaha tōku wāhi mahi. Nō reira e
18 ngā iwi, tēnā koutou, tēnā koutou, tēnā koutou katoa.

19 For those of you who can't see me, I am a 50-year-old female, I am Pākehā, I am
20 blonde with mid-length hair. I wear glasses and I am 178 centimetres tall. Today I am
21 wearing a multicoloured dress and a black jacket.

22 I am the interim Deputy Chief Executive at Whaikaha, Operational, Design and
23 Delivery. I am responsible for the commissioning of Disability Support Services. It is also
24 my job to oversee the transformation of Disability Support Services.

25 I have read every single witness statement and I have listened. I have been
26 profoundly affected by what I have read and heard and I extend my deepest respect to
27 survivors.

28 **MR CLARKE-PARKER:** Thank you very much to all four of you and I will now hand you over
29 to Counsel Assisting for questioning.

30 **CHAIR:** Thank you, Mr Clarke-Parker.

31 **QUESTIONING BY MS THOMAS:** Thank you, Dr Sarfati and Ms Woods, thank you for your
32 significant acknowledgments that you have both made to this Royal Commission of Inquiry
33 this morning. We appreciate those and we will go through all of those acknowledgments

1 very carefully and they may also assist us today to make some of these questions go more
2 smoothly as I go through some of the questions for you today.

3 The first question I have is for Dr Sarfati. Please correct me if I'm pronouncing
4 your name incorrectly.

5 **DR SARFATI:** Perfect.

6 **MS THOMAS:** I would like you to confirm for us, please, the role of the Ministry of Health in
7 the State care system. Is it accurate to say that the Ministry of Health is the steward and the
8 kaitiaki of the Health and Disability system?

9 **DR SARFATI:** That's correct.

10 **MS THOMAS:** And the Ministry sets the expectations around accountability requirements, it
11 funds national services and ensures that New Zealand's international Health and Disability
12 obligations are also met?

13 **DR SARFATI:** That's mostly correct. You'll be aware that there has been very recent reforms, so
14 the role of the Ministry shifted on 1 July so that now we have Te Whatu Ora Health
15 New Zealand which is responsible for the delivery of care and managing the distribution of
16 funding to those services.

17 **MS THOMAS:** So the Ministry of Health is not the provider of health services.

18 **DR SARFATI:** No, that's correct.

19 **MS THOMAS:** But the Ministry does fund health providers?

20 **DR SARFATI:** Not currently, no.

21 **MS THOMAS:** But prior to 1 July were funding health providers?

22 **DR SARFATI:** So prior to 1 July, the funding went through the Ministry to DHBs who then
23 determined what services to provide to their populations, and then there were some services
24 that the Ministry contracted with directly.

25 **MS THOMAS:** Right. So the Ministry is not the provider of the health services, but the Ministry
26 does accept that it comes within this Royal Commission of Inquiry's definition of providing
27 State care?

28 **DR SARFATI:** I can't comment on that definitional issue, I don't think.

29 **MS THOMAS:** I'm happy if it would assist to put up on our Trial Director just the paragraph, or I
30 can paraphrase it for you, but the provision of State care within our terms of reference,
31 whether it's directly or indirectly, includes assuming responsibility when passing on its
32 authority or care functions to a service provider.

33 **DR SARFATI:** So the role of the Ministry of Health as a kaitiaki and, as you pointed out earlier,
34 providing an accountability for the health system, that is part of that role, but there is

1 another layer of accountability that sits with what were the DHBs, now Te Whatu Ora, in
2 terms of the direct contracting and quality of services that they are providing. So there's
3 sort of layers of accountability there.

4 **MS THOMAS:** But would you accept through that, though, the Ministry of Health still sits at a
5 point where it does indirectly provide care within that definition.

6 **DR SARFATI:** Yes, the "indirectly provides care", I think "has responsibility for care that is
7 provided".

8 **MS THOMAS:** We'll accept that, thank you.

9 Does the Ministry of Health also accept that by acknowledging you come within
10 this definition, the Royal Commission of Inquiry definition of State care, that this includes
11 being accountable for its obligations to Māori under Te Tiriti o Waitangi?

12 **DR SARFATI:** Yes.

13 **MS THOMAS:** I'm going to start my questioning today on the topic which is some words that
14 I've taken actually from the Crown acknowledgment at Ūhia te Māramatanga where the
15 Crown there said, in that survivor focused public hearing, this showed a shameful picture of
16 inhumanity.

17 What I'd like to do now is put up some quotes on the Trial Director and we'll go
18 through those quotes to read them into the record and then I may ask you some questions at
19 the end.

20 **CHAIR:** Ms Thomas, I'll just explain for those who are in the audience and watching, that these
21 documents will not be displayed to you on the screens nor shown on the live streaming but
22 relevant parts will be read out. The reason for this is there are parts of these documents
23 which can't be shown for reasons of privacy of individuals.

24 So I hope you will bear with us for that and counsel will read the parts that she's
25 referring to.

26 **MS THOMAS:** Thank you. On the screens before you here, the first quote that we can see is
27 from a report of consultation efforts regarding services for the intellectually handicapped at
28 Tokanui Hospital and this was in October 1985. I will just read the words that are in bold
29 on the screen here:

30 "The need to recognise the personal identity and basic rights of each resident.
31 Residents live as paupers with no personal possessions and often no personal clothing.
32 They are frequently dressed or undressed in the middle of a day room, bathed in large
33 groups, toileted in hallways on potty trolleys and generally treated with little respect for the
34 dignity and privacy of each person. Staff have become insensitive to the dehumanising

1 aspects of these care procedures. They rarely work within a unit for extended periods and
2 do not form attachments and close personal relationships with the residents. They remain
3 task-orientated and impersonal in providing basic care to the residents."

4 I'll just move on to read through the next quotes and then ask my questions at the
5 end. This next quote is taken from a 1985 report by a medical officer regarding a review of
6 the psychiatric and psychopaedic hospitals on a visit to Tokanui in 1984. I'll just read the
7 full quote. It's not too long:

8 "I still rarely see toys and staff using toys with the residents. Too often residents are
9 seen in a bare environment with perhaps a TV set, either sitting apathetically, rocking back
10 and forth or indulging in some purposeless and/or destructive activity."

11 If I move on to the next quote, this is a Department of Health internal memorandum
12 and it's dated April 1976 regarding the Tokanui Hospital Shigella isolation facilities. Just
13 for everyone's benefit, Shigellosis or Shigella is a bacterial infection and the symptoms of
14 Shigella are significant diarrhoea and sometimes vomiting. This is quite fuzzy, this quote,
15 but I'm going to read it, the highlighted parts into the record:

16 "Shigellosis or Shigella has been present in wards 5 and 6 off and on since 1969."

17 Bearing in mind this document is dated 1976:

18 "Together these two wards provide accommodation for about 90 children."

19 I'll just move to the end of that quote where it says:

20 "Four children have been permanently in isolation for more than one year. Periods
21 of isolation vary from about 6 to 24 weeks."

22 Moving on to the next document, which is a 1986 letter to a chief nurse at a
23 Hospital Board regarding some nursing tutors speaking about the conditions at Templeton.
24 And I will read into the record the highlighted parts:

25 "Another is that many staff demonstrate lack of respect for the dignity of the people
26 who are placed in their care by trusting relatives. Verbal abuse is common, and on
27 occasion, physical abuse is stooped to. We query the need for people to have their evening
28 meal at 15:30,- so 3.30 hours in the afternoon-, -when breakfast is 17 hours away and the
29 residents' supper is just a snack. Communal combs or hairbrushes are in use. Individual
30 toilet items would reduce the risk of Pediculosis and Scabies. Toothbrushes are cleaned by
31 scrubbing them against each other. Drugs have been administered to all residents using one
32 spoon and one bowl of porridge, risking the spread of infections, for example hepatitis.
33 Residents are often spoken to in a derogatory manner, example egg--head. Routines in

1 villas appear to be totally organised with staff needs in mind and with little thought given to
2 the needs of the residents they purport to care for."

3 And I'll just move on to the last document, the last quote that is taken from
4 documentary evidence that we've received, and this is a 1969 letter from the Medical
5 Superintendent at Tokanui to the Director of the Division of Mental Health. I'll read out the
6 highlights:

7 "Our staff is now aware of the need to get our children out of their beds and
8 considerable improvement has been made in this respect. Because of lack of training,
9 nursing staff have not come to appreciate the potential of these children or what effective
10 nursing care constitutes. The attitude 'you are wasting your time, these children will never
11 do anything' still lingers."

12 Those are all quotes from documents. However, I do have one further quote that
13 we'll just go through which is taken from a transcript of the evidence given by a witness at
14 Ūhia te Māramatanga. This is the witness Paul Milner who did spend a number of years as
15 a researcher for the Donald Beasley Institute during the closure of Kimberley. And he's
16 referring here to the report that was written by the Donald Beasley Institute. I'll just read
17 this into the record:

18 "In the report we ultimately wrote there is a sentence that goes 'a pervasive
19 acceptance of the reality that many residents had entered Kimberley speaking but would
20 leave silent represented a quiet but distressing everyday denial of personhood. It captures
21 staff's reflection on a comment made by B's mum that when he first went into Kimberley he
22 spoke, but when he came out, he didn't.'"

23 Now Dr Sarfati and Ms Woods, we've just gone through what could be described as
24 a shameful picture of inhumanity and we've done this based on documentary evidence in
25 addition to what we all heard at the survivor public hearing a few weeks ago.

26 Do you both agree that this evidence we've referred to does demonstrate pervasive
27 neglect within these institutions?

28 **DR SARFATI:** I think those accounts paint an extremely disturbing picture of the practice in
29 those institutions at that time. Practices that were dehumanising, disrespectful to the people
30 being provided with care, showing a distinct lack of concern about people's fundamental
31 needs and including unsafe, unhygienic practices.

32 So absolutely accept that those were harmful and disrespectful practices.

33 **MS THOMAS:** Thank you. Ms Woods, would you like to add anything.

1 **MS WOODS:** Just that it goes to the acknowledgments I made earlier, that any form of abuse is
2 completely unacceptable, and the evidence that's been provided has shown that that's
3 occurred.

4 **MS THOMAS:** And that these documents we've reviewed also demonstrate a failing on behalf of
5 the institutions here, the State-run institutions, to provide adequate care in these settings?

6 **DR SARFATI:** Those reports clearly describe care that certainly by today's standards would be
7 absolutely and utterly unacceptable.

8 **MS THOMAS:** I'm going to ask some questions now in relation to the standards of the day topic,
9 and I'll just start my questioning here by reflecting on another point that the Crown made at
10 Ūhia te Māramatanga, which was "The Crown's responsibility is not to deny or diminish, it
11 is to accept and to acknowledge that abuse has occurred", which you have both done this
12 morning with your significant acknowledgments.

13 And I'd actually like to ask Dr Crawshaw a question here because it relates to a part
14 of your brief and you've already gone over this this morning in your evidence in chief
15 today, but in your written brief to the Commission, this is actually the one that was filed
16 back in 2021, at paragraph 2.5 there you've said that:

17 "The nature and standard of care and treatment provided in historical psychiatric or
18 psychopaedic institutions would be unacceptable today and might extend to neglect or
19 abuse in today's environment."

20 And you've gone on at paragraph 2.6 of your brief to say:

21 "There is, however, a distinction between that treatment historically within normal
22 practice and now viewed as inappropriate and behaviour that then and, as now, was
23 abusive."

24 And Dr Sarfati, I acknowledge you've made a similar comment in your brief of
25 evidence. Can I just ask, Dr Crawshaw, in these sentences that are in your brief, are you
26 making a distinction between two options? So, the first option being a
27 treatment about-- treatment or practices that historically would be normal practice for the
28 day, but are now viewed as inappropriate, and the second option being treatment or
29 practices that both historically and today would be considered abusive?

30 **DR CRAWSHAW:** What I was trying to convey is that as the Commission has heard, there were
31 very abusive practices, such as amounting to assaults and criminal behaviour, quite frankly,
32 which certainly, even then, would not have been acceptable, but was not challenged.

33 **MS THOMAS:** And an example of that, a relatively easy example to illustrate, would be
34 something like electric shocks on a person's genitals, for example.

1 **DR CRAWSHAW:** Yes, that's right, that wouldn't have been acceptable practice in the day, let
2 alone now.

3 **MS THOMAS:** I'm now going to ask you a question about an example that's potentially not as
4 clear-cut, and this comes from some evidence that Dr Olive Webb provided at the Ūhia te
5 Māramatanga hearing, where she described a regime at Sunnyside in 1974 and I will ask for
6 that document to be put up on the screens before you. This is from her transcript. For the
7 record it's number ending 00481, lines 5 to 14. We'll just zoom in on the relevant -
8 sorry-- it's lines 5 to 14. And I'll read this into the record:

9 "The first day that I spent there I was there early in the morning and these men
10 were - got up from their beds, shuffled into that lobby, stripped naked, they were then
11 marched, or sort of herded really, through the main villa and through the end of the day
12 room, into this large bathroom that had multiple shower heads. They were showered
13 en--masse by nursing staff who were wearing rubbers and gumboots. They were then taken
14 out and dried and then herded back to the lobby where their clothes were.

15 "Question: So they were herded back naked after the shower?"

16 Answer: Herded back naked, yes, yeah. And that was their morning routine.

17 Question: What did it remind you of?"

18 And Dr Webb responded:

19 "Concentration camps come to mind."

20 Dr Crawshaw, what one of the two categories would you place that behaviour in?

21 **DR CRAWSHAW:** I find that disturbing and distressing firstly, and I think most of the people
22 here would find that disturbing and distressing. Secondly, it is what I was referring to in
23 my brief in terms of institutionalisation and institutional practices which can be harmful.

24 It is difficult for me to form a judgment as to why people assumed that that was
25 acceptable then. It's certainly not acceptable now.

26 **MS THOMAS:** So you're acknowledging it's clearly not acceptable now but are you in a position
27 to acknowledge at the time this was not acceptable behaviour.

28 **DR CRAWSHAW:** It would not have been acceptable to me, but I can't answer to the people who
29 thought it was reasonable.

30 **MS THOMAS:** Is that because of another point that Dr Olive Webb went into that things were
31 happening in these institutions that were the norm of the day?

32 **DR CRAWSHAW:** I think very much so and that of course is, again, what we refer to as
33 institutionalisation.

1 **MS THOMAS:** But that doesn't mean they were right at that time, just because everyone was
2 doing it and behaving in that way?

3 **DR CRAWSHAW:** Not necessarily, and not in my opinion.

4 **MS THOMAS:** I will look at just one more example on this point, which is another one that was
5 given by Dr Webb at the previous hearing, and this is document number ending 00481. If
6 we could bring that up, please. And if we could zoom in on lines 9 to 21. I'll read this
7 paragraph into the record:

8 "Question: I understand that the bathrooms at Templeton would have six to eight
9 toilet pans without partitions between?"

10 "Answer: Yes, I remember one day in particular where I was taking a person who
11 was a very senior community person, I was sort of hosting her really, and we went, we were
12 in Totara Villa and the bathroom doors were flung open in order to show this dignitary the
13 bathrooms and there were six, six and six toilets going directly out from the wall and there
14 were 18 guys all sitting on these toilets, and then one leapt up to change the radio station
15 which was going, and sat down again, and we were told with an element almost of
16 embarrassment 'Oh, we call this the milking session', and we went on.

17 "Question: So that is indicative of the views that the staff had towards the patients?"

18 "Answer: Well, I think even that makes it too concrete, this was just what was done.
19 It was the way things happened. And I suspect that a whole lot of people never even asked
20 the question if this is the right or the wrong thing to do, this is just the way it was."

21 Dr Crawshaw, again, which of the two categories or the distinction that you make
22 would you put this example into?

23 **DR CRAWSHAW:** Again, this is very distressing reading, and I just can't imagine what it would
24 have been like for those poor people. That, I think, is just not acceptable.

25 **MS THOMAS:** Sadly, it may not have been unusual, but that doesn't mean it was right.

26 **DR CRAWSHAW:** No, and if I could just help the Commission with a bit of context. As a
27 teenager I was working at Sunnyside Hospital putting myself through Med School and this
28 practice was not something which I witnessed at Sunnyside Hospital.

29 **CHAIR:** Sorry about the noise, I see people have rushed off to try and do something about it, so if
30 we could just bear with it in the meantime, thank you.

31 **MS THOMAS:** Thank you. We'll now move on to the next topic which is, I'd like to have a
32 discussion around what constitutes systemic abuse. Once again Dr Crawshaw, this is
33 something that was in your brief of evidence provided to the Royal Commission back in
34 2021.

1 **DR CRAWSHAW:** Yeah.

2 **MS THOMAS:** You've made a statement there, a sentence that says:

3 "There is an inherent likelihood of deviation from acceptable social norms in the
4 psychiatric institutions and other institutions as they previously operated."

5 In that sentence that I've just read out, when you refer to "the other institutions", are
6 you referring to psychopaedic institutions?

7 **DR CRAWSHAW:** I was actually referring to all institutions, and the literature, bearing in mind
8 that this- was part of the literature that challenged me and caused my practice to change, it's
9 very clear that institutions of any form actually have an inherent likelihood to create its own
10 social norms. So- I wasn't necessarily talking psychopaedic, I was talking other institutions
11 at the time.

12 **MS THOMAS:** And at that time, or looking back between 1950 to 1999, you would accept there
13 were many psychiatric institutions in New Zealand at that time and four large psychopaedic
14 institutions?

15 **DR CRAWSHAW:** Yes, I know that from the literature not personally.

16 **MS THOMAS:** We have a document that's already gone up on the screen which is the full
17 paragraph from your brief of evidence which, just for the record, is number ending 757001.
18 This is paragraph 3.5. What I would actually like to do is, we're going to go through this
19 paragraph and look at it in terms of a table referring to a definition of systemic abuse that
20 was provided by Dr Brigit Mirfin-Veitch, if that's all right.

21 What I would like to do is --zoom in on the highlighted words on the lefthand
22 column of the table, and I'll read those into the record, and once I've done that,- I'll zoom in
23 on the highlights on the right-hand side of the table, which are the words from your
24 paragraph in your brief.

25 So, I'm now reading the definition of systemic abuse that was provided in the brief
26 of evidence from Dr Mirfin-Veitch which comes from document ending 41002:

27 "Systemic abuse (also referred to as institutional abuse) refers not only to the direct
28 physical abuse but violence inherent in a system. Systemic abuse has a range of features,
29 including to routinely prioritise order of a place over an individual's needs."

30 If we could now please zoom into the highlighted part on the corresponding side of
31 this table from Dr Crawshaw's brief. I will read into the record that highlighted sentence:

32 "The institutional environment affected both staff and residents, both sets of people
33 became institutionalised."

1 Dr Crawshaw, do you see there is a correlation between those two highlighted parts
2 from your brief and from Brigit Mirfin-Veitch's definition?

3 **DR CRAWSHAW:** I certainly see the parallels and if I may help the Commission, I deliberately
4 included that paragraph in my brief to assist the Commission in its decision-making. As to
5 what might or might not constitute systemic abuse, I think that's for the Commission to
6 decide, not me.

7 **MS THOMAS:** Thank you. We'll just work through the remaining factors that Dr Brigit Mirfin-
8 Veitch has highlighted, if we could zoom in on the next paragraph and I'll read into the
9 record the highlight here from the definition that:

10 "Power dynamics where staff are dominant, and vulnerability is created for
11 residents."

12 And moving over to the paragraph from your brief, I'll read into the record the
13 highlight that:

14 "The issue of abusive people in positions of power within institutions..."

15 Again, do you see the parallels between those highlights?

16 **DR CRAWSHAW:** Yes, both of us are probably referencing the same literature.

17 **MS THOMAS:** Thank you. The next paragraph down, sorry, this might be on the next page of
18 this document if we could zoom in on the highlighted aspect here from Dr Brigit Mirfin-
19 Veitch stating that:

20 "For example, one aspect of systemic abuse is allowing abusive interactions."

21 And in your paragraph, you state:

22 "The institutionalisation of staff and residents led to an environment in which bad
23 practices were not challenged."

24 Do you agree there are parallels?

25 **DR CRAWSHAW:** Yeah, as I say, I think we're probably referencing similar literature.

26 **MS THOMAS:** I've just got two more aspects of this definition that we'll go through. Dr Brigit
27 Mirfin-Veitch said:

28 "Finally, sustained and pervasive prejudice that considers disabled people's bodies
29 and minds as deviant from the norm and in need of intervention to adapt to the order of
30 society."

31 And you have said here in your brief that this arises from very significant level of
32 paternalism and control over a vulnerable person's life that characterise such institutions.

33 It's not the exact words but do you agree, again, there's a parallel?

1 **DR CRAWSHAW:** There's similar sentiment, although my comment is much more about
2 institutions in general and I would certainly recommend people read Goffman's 'Asylums',
3 which is a seminal work in terms of challenging the thinking that led to the asylums.

4 **MS THOMAS:** Thank you. And the final box that we will draw out from the brief from Dr
5 Mirfin-Veitch is a quote at the top:

6 "Systemic abuse refers not only to the direct physical abuse but violence inherent in
7 a system."

8 And to your final sentence at your brief of evidence which says:

9 "This dynamic was part of the rationale behind closing psychiatric institutions
10 completely. It was not sufficient just to introduce new policies or to remove problematic
11 individuals."

12 **DR CRAWSHAW:** Yes.

13 **MS THOMAS:** Do you agree, Dr Crawshaw, that your evidence acknowledges that what was
14 happening within these historic psychiatric and psychopaedic institutions constituted
15 systemic abuse?

16 **DR CRAWSHAW:** I am reluctant to comment on something which is the decision-makers'
17 purview. I have included evidence in my brief which I thought would be helpful for the
18 Commission when it's making its decision with respect to that provision in its brief.

19 **MS THOMAS:** Given your own knowledge and expertise, and you are here today from the
20 Ministry of Health however, and we've gone through what you have suggested in your
21 brief, compared it to another expert's definition of systemic abuse, are you prepared to
22 accept the similarities there and that systemic abuse occurred in these institutions?

23 **CHAIR:** I wonder if I could help, I don't know if I help or hinder, Dr Crawshaw. I appreciate
24 what your dilemma is here and in an ordinary court of law you possibly are right. But can
25 I just suggest that you're here as an expert and you're here to assist the Commission and we
26 would value your expert opinion. So we're not asking you for your personal opinion but
27 your expert opinion, whether we choose to take it or not is a matter for us, but it would be
28 helpful, in saying that I don't want to push you into a corner where you feel you're obliged
29 to say something that you feel will compromise you in any way.

30 **DR CRAWSHAW:** So my dilemma is that you've given me some quotes, I've given some quotes.
31 What I can't really say for certain, because I haven't done the historical analysis, is what
32 happened in each of the institutions in New Zealand, was it the same, was it different, were
33 the same dynamics at play. So it's difficult to reach a firm conclusion without an evidential
34 basis.

1 However, the literature and my personal experiences talk about the perils of
2 institutionalisation, and the need for that to be addressed, not simply by changing the rules,
3 but actually changing what's inherent sitting behind institutions. And it certainly was my
4 personal motivation to start shutting Porirua Hospital, I felt that there was no other way but
5 to shut the institution.

6 **MS THOMAS:** So it was a major contributing factor to shutting Porirua and in fact to the
7 deinstitutionalisation of all of the institutions in New Zealand?

8 **DR CRAWSHAW:** Certainly, there are others of my generation who had similar views and
9 I'm-- not unique, who took a similar attitude and set about shutting institutions.

10 **MS THOMAS:** So, would you accept, then, the fact of the decision to shut the institutions, one
11 aspect of that was the concern felt by yourself and many others about the systemic abuse in
12 those institutions?

13 **DR CRAWSHAW:** I think I would say, you know, I'll leave to the Commission the issue about
14 systemic abuse, I would just say that institutions inherently have the perils which I've listed
15 in my brief and for that reason simply changing, as it were, people within it would not
16 change the impact of institutional care on individuals, so therefore shutting the institutions
17 was the only rational response.

18 **MS THOMAS:** So are you saying the action of closing those institutions is a reflection of an
19 acceptance that it was a system-wide abusive situation in these institutions.

20 **DR CRAWSHAW:** I would say that each of us reach their own conclusions with respect to the
21 institutions that we were responsible for. Because it wasn't like a -- I'm going back in time
22 now, but -different - so-- there was a slow shutting or a slow emptying out of the
23 institutions that had occurred, so that by the time I was made responsible for Porirua
24 Hospital, in fact I wanted to become responsible to so I could shut it, we moved 400, 450
25 people safely back into the community because that's what was necessary.

26 Was it a movement? It was a movement. Was it a - -it happened not just in
27 New Zealand, it happened in Australia, and other parts of the Western world. So,- the ethos
28 at the time was that institutional care was no longer appropriate and needed to be dealt
29 with.

30 **MS THOMAS:** And it needed to be dealt with more than in just one institution it, needed to be
31 dealt with across the board.

32 **DR CRAWSHAW:** I think that most of the psychiatrists; --well, actually, having said that, I faced
33 considerable resistance and considerable dispute as to whether what I was doing was the

1 right thing. But as I say, I felt it was the only reasonable response given the information
2 that I had.

3 **MS THOMAS:** And can we take from your final sentence, which I think is still highlighted on the
4 screen here, that it simply was not sufficient just to introduce new policies or to remove
5 some problematic individuals, this was not a situation of a few bad apples in various places,
6 this required the institutions to be closed down, didn't it.

7 **DR CRAWSHAW:** In my opinion.

8 **MS THOMAS:** Thank you. I'd now ask for a quote to be placed up on the screen which is from
9 this transcript of the evidence from Dr Brigit Mirfin--Veitch at the Ūhia te Māramatanga
10 hearing, and this is document ending 0482. I will just read into the record the highlighted
11 aspect of this transcript. Dr Mirfin-Veitch said it was fairly stark;- --this is in relation to a
12 piece of research that the Donald Beasley Institute conducted by engaging with and
13 conducting research, gathering stories from survivors, or from storytellers who had been in
14 care settings prior to 1999 within New Zealand. She said that:

15 "We said from survivor testimony it is clear the systems put in place by the state to
16 support and protect children and young people catastrophically failed many of them
17 repeatedly and we said that that constituted systemic abuse."

18 Dr Crawshaw, this is another expert's opinion based on the research that that
19 institution has conducted. Do you have any comment to that conclusion that is being made
20 on the screen there that the State catastrophically and repeatedly failed to protect and
21 support children and young people?

22 **DR CRAWSHAW:** So, I have read the witness statements, but again, I'm getting into a situation
23 where I'm asked to comment on---

24 **CHAIR:** Sorry, counsel.

25 **MS SCHMIDT-McCLEAVE:** Ma'am, excuse me, I am sorry to interrupt, but I do feel this
26 question has been put to Dr Crawshaw in a number of ways now and he has addressed it in
27 the way he feels it can and I feel it's being repeated, ma'am. I just wanted to raise that.

28 **CHAIR:** It is getting to that point. All right, perhaps we'll leave it. We have Dr Mirfin-Veitch's
29 clear statement, we have all of what you've said as well, and you are right to this extent,
30 Dr Crawshaw, it is for us to decide, and I think we're good enough to make a decision on
31 that one. So, thank you.

32 **MS THOMAS:** Thank you, and I will move on. That document can be moved down now.

1 In terms of where the State has previously recognised and acknowledged systemic
2 abuse, do you agree that that has been conceded previously in terms of the Lake Alice
3 Child and Adolescent Unit?

4 **DR CRAWSHAW:** I understand that that is the case.

5 **MS THOMAS:** And I'm happy to summarise here, there is, if it would assist, I can put up on the
6 screen the transcript from the redress hearing, otherwise I can read out, if it's fine with you,
7 what was said there by the Chief Legal Advisor in terms of redress for the Lake Alice Child
8 and Adolescent Unit, that:

9 "The redress scheme offered by the State to survivors from the Lake Alice Child
10 and Adolescent Unit was that every person who met certain criteria, so being at the unit
11 between '72 to '77, and people who were under the age of 17 at the time they were in that
12 unit, were eligible to receive a redress payment for the fact of being in that unit as the State
13 acknowledged in that situation that there was systemic abuse at the unit."

14 So, we've had a discussion around systemic abuse, and you have outlined for us in
15 your brief of evidence and today the factors that, based on the literature and your own
16 expertise, particularly your expertise from the closure of Porirua, around what constitutes
17 systemic abuse.

18 The people, the disabled people in New Zealand and people who experience mental
19 distress who were in other institutions, so any institution that was not the Child and
20 Adolescent Unit at Lake Alice, they have never received a global apology or
21 acknowledgment about systemic abuse and widespread issues within all of those other
22 institutions.

23 Do you agree with that, that that hasn't been forthcoming as yet?

24 **DR CRAWSHAW:** I'm assuming that that is the case, I don't have knowledge of all of ---

25 **MS THOMAS:** That's all right. You can take it from me that the particular apology that did come
26 from the Prime Minister in 2001, that was directed specifically to the people that came
27 within the criteria that I just read out that were at Lake Alice in the Child and Adolescent
28 Unit.

29 And so, do you have any comment in terms of what could be seen as an
30 inconsistency here? We have one particular unit that has received an acknowledgment of
31 systemic abuse and yet we have a significant number of other institutions in New Zealand
32 that were also closed down, partly because of the problems, the systemwide problems in
33 those institutions. Do you have any comment on that inconsistency?

1 **MS SCHMIDT-McCLEAVE:** I'm sorry, ma'am, to be on my feet again. I wonder whether this is
2 another way of the same question and I do point to Dr Sarfati's acknowledgments made this
3 morning and wonder whether perhaps they address some of the answers to that question.

4 **CHAIR:** The question was, does he have any comment? I think it's for Dr Crawshaw to say yes
5 or no to that one.

6 **MS SCHMIDT-McCLEAVE:** Thank you, ma'am.

7 **DR CRAWSHAW:** That was what I was about to say, which is Dr Sarfati on behalf of the
8 Ministry has made some very significant acknowledgments, and insofar as the work of this
9 Commission, I think we await your decisions as to what you have heard in depth across the
10 country.

11 **CHAIR:** Thank you.

12 **MS THOMAS:** Thank you. I would now like to move on to a topic to focus on how abuse and
13 neglect happened in Aotearoa New Zealand in these institutions and given the
14 acknowledgments that have been made to this Royal Commission this morning, I may be
15 able to streamline these slightly more.

16 Again, sorry, Dr Crawshaw, you're in the hot seat because it was a point that was
17 made in your brief of evidence, and you've raised it again this morning, that there was
18 societal views historically that underpinned entry into care for many disabled people and
19 people with mental health conditions, there was displayed significant stigma towards
20 people.

21 **DR CRAWSHAW:** Mmm-hmm.

22 **MS THOMAS:** And you've said that stigma continues to be a problem today. But the shifts in
23 attitudes have been enormous, I think your brief said, that things have changed.

24 **DR CRAWSHAW:** Yes.

25 **MS THOMAS:** Would you agree that it is not only people historically in society that displayed
26 significant stigma towards disabled people and people experiencing mental distress, but
27 those societal attitudes were mutually reinforced by government legislation and policy and
28 equally the policy reflected the attitudes of the day, but the attitudes of the day were also
29 shaped by the legislation that was enacted?

30 **DR CRAWSHAW:** I sort of feel like I'm being asked a chicken and egg question. I think that the
31 legislation which we get in this sort of area is very much a reflection of societal attitudes
32 and societal beliefs in how they tolerate the passage of certain pieces of legislation. My
33 experience, personally, is that I experienced extreme societal backlash trying to shut
34 Porirua Hospital and was personally vilified in the process. So I can only imagine what the

1 politicians of the day might have experienced if they started to push legislation beyond
2 what society could tolerate.

3 So, I think that it's very difficult for us, sitting here now, to go back 30, 40, 50 years
4 and say, well, what was in the minds of politicians and what was in the minds of the
5 decisionmakers when all we've really got is the written accounts of what society would or
6 would not accept.

7 **MS THOMAS:** You've used the word "stigma" in your brief. Would you accept another way to
8 describe society's attitudes historically looking back, in addition to the word "stigma" could
9 be "prejudice"?

10 **DR CRAWSHAW:** Prejudice is just one part of stigma, it's the- term, and I've seen it in some of
11 the briefs of evidence, is very much that for a lot of people it was out of sight, out of mind.
12 And is that prejudice? Is that non---acknowledgment of people who are different from
13 them? I think you'd have to look at individual differences.

14 People who have studied stigma would say there is actually a multitude of factors
15 which actually end up with stigmatisation.

16 **MS THOMAS:** We are grateful for the acknowledgments that have been given this morning from
17 Dr Sarfati on this, that I think you said that the Health and Disability care settings were
18 ableist, and you acknowledged that institutional and society ableism existed and contributed
19 to the abuse in these settings.

20 So, what I'm now going to do is ask for a document to go up on the screen which
21 are some quotes from the Aitken Report that you both also referred to this morning, that
22 was tabled in 1953 to the Government.

23 Just by way of background, this Aitken Report came from a committee of people
24 made up of both the Department of Health and Department of Education, and that is --it
25 was put before the Government and as a result of the recommendations being taken on
26 board from that report, it did set New Zealand on a pathway of large-scale
27 institutionalisation.

28 I will read through some of these quotes that are on the board. This is document
29 ending 08195 and as I do so, just --- I'm reading directly from this obviously historic
30 document which are the words of that time and would be seen as disrespectful today, but
31 just to read into the record, this is paragraphs 39 and 40 of the Aitken Report:

32 "The lowest grade of mental defective is the idiot, a being in human shape who
33 lacks the power and often the instinctive desire to protect himself against common physical
34 dangers. He cannot learn to clothe or feed or clean himself or to control his excretions or,

1 at most, he can acquire these habits only very imperfectly. He may learn to walk but often
2 cannot. He makes meaningless sounds and purposeless movements. He responds to only
3 the simplest commands or to none at all. He may be apathetic, or he may be restless,
4 excitable or destructive. Many idiots are physically deformed, sometimes grotesquely.

5 Most idiots are readily yielded by their parents to the custody of an institution,
6 where they are nourished and cared for. The task of doing so is extremely laborious and the
7 great majority of people would reject it as too distasteful. It is possible, fortunately, to find
8 men and women who are willing to do it, but it is always difficult, for it can bring little
9 emotional satisfaction."

10 I think in terms of that quote and particularly the acknowledgements that have been
11 made this morning already, Dr Sarfati, would you agree that the words just there reflect
12 ableist thinking and intent at the time?

13 **DR SARFATI:** Categorically.

14 **MS THOMAS:** Thank you. And if we could move on to the next quote. I'll just read out the
15 highlighted parts of this aspect of the Aitken Report where there's some recommendations
16 that the Aitken Report made. The first one is that:

17 "The Government adopted the policy of providing good residential institutions
18 under the mental hygiene provision of the Department of Health, but independent of mental
19 hospitals, for the majority of intellectually handicapped children and adults in the
20 community."

21 The second recommendation is that:

22 "Each institution accommodate 400 to 500 mental defectives in separate residential
23 units taking about 30 each."

24 And I'll just read the fourth recommendation there that:

25 "Parents be encouraged to place intellectually handicapped children in these
26 institutions at about the age of 5."

27 Dr Sarfati, looking at those recommendations, do you agree that by the Government
28 at that time implementing those recommendations, the Government effectively adopted a
29 policy for the majority of all intellectually handicapped children and adults in the
30 community, so this was very widespread, to be housed in institutions?

31 **DR SARFATI:** Assuming the Government followed those words, that would imply that that's
32 what they would be doing and very much following a policy of institutionalisation.

33 **MS THOMAS:** And these were large institutions. Here, the report says, between 4 to 500 people
34 in one institution.

1 **DR SARFATI:** Indeed.

2 **MS THOMAS:** And also, just finally here, obviously the particular report that was in
3 New Zealand and recommended and taken on board, said that parents really ought to be
4 encouraged to place their children there, in these institutions, by about the age of 5.

5 **DR SARFATI:** Yes.

6 **MS THOMAS:** Thank you. Just finally on this Aitken Report, if we could pull up the last quote
7 on that document. This says:

8 "The motive for providing good mental defective institutions is partly economic
9 (since they liberate the energies of parents) but largely humanitarian."

10 Looking at that particular highlighted aspect of the report, is it fair to say that
11 finances or economics may have had a part to play in the decision to provide
12 accommodation for children here, as it says, to liberate the energies of parents?

13 **DR SARFATI:** I can't comment the extent to which that was the case on the basis of that quote
14 alone. Certainly, that quote suggests that those factors were considered. Some of the
15 earlier material that you quoted suggests there were much broader issues as well and a
16 fundamental belief and commitment to the ideas of institutionalisation.

17 **MS THOMAS:** Absolutely. But this may have been just one factor that we could infer from that
18 quote there potentially.

19 **DR SARFATI:** Potentially, yes.

20 **MS THOMAS:** In terms of the quotes we've just been through, particularly the comment around
21 all disabled people and people with mental health conditions from the community to be
22 placed in these institutions, do you agree that to place on a large scale this whole cohort of
23 individuals into these places is an act of segregation, to remove them from the community?

24 **DR SARFATI:** Well, it's certainly an act of separation of disabled-- people who met these
25 criteria, from their family, whanau, their communities, so in that sense, yes.

26 **MS THOMAS:** Thank you. I'm now going to move on to the Burns report, which was a report
27 that was dated in 1959. This was, just by way of background, a report that was written by
28 the New Zealand branch of the British Medical Association, it's really a critique of the
29 Aitken Report because they had concerns about the overemphasis of the large-scale
30 institutionalisation.

31 If this could go up on the screen. We have a number of quotes here and I might just
32 read out some of them rather than all of them and then get to some questions on this. Just
33 for the record, this document is ending 0816.

1 The first quote we can see from this Burns Report is titled "The dangers of
2 institutionalisation" which I think has been acknowledged today already and even
3 Dr Crawshaw referred to it as "the perils of institutionalisation".

4 So, I will just try and summarise some of the points from this Burns Report here
5 where they are listing what they see as some of the dangers:

6 "The noxious influences include an unfavourable social environment and therefore
7 in addition to the well-known psychological risks incurred by separating the child from its
8 family, placing it in an institution may blight its intellectual development."

9 Another thing they've mentioned here is:

10 "The decision to place a child in an institution on account of mental defect is almost
11 never taken in the interests of the child itself."

12 And then this Burns Report recommends that:

13 "The payment of extra child allowances to the mother or the encouragement of
14 some foster home care by proper and realistic payment to foster mothers..."

15 And they recommend "the development of community services to be outlined".

16 If we can move on, the next quote here, and again, I'll just try and summarise this
17 because I acknowledge, Dr Sarfati, you have already acknowledged this morning that the
18 policies that were undertaken were out of step with what was happening around the world.
19 And here, we're looking at a document which clearly in black and white says that the World
20 Health Organisation's expert subcommittee report, this is back in -we're- back in 1959 here,
21 said that:

22 "With adequate economic aid to parents if there was skilled social case work and a
23 properly organised and comprehensive social services, as a general rule home care is to be
24 recommended. Generous financial and practical assistance to parents is still cheaper than
25 hospital care."

26 So that is really an acknowledgment in the Burns Report that following the World
27 Health Organisation recommendations at that time, home care was the preferred option.

28 And if we could go to the last quotes from this Burns Report, where they really just
29 list out some of the critique of what was happening in New Zealand at that time as
30 recommended by the Aitken Report, if you could zoom in on that first paragraph there, the
31 highlights state that educational and training facilities are severely inadequate --this is in
32 relation to institutions, that institutions are too socially isolated, and too custodial, that the
33 current three centres- this is in relation to the psychopaedic, three psychopaedic institutions
34 in New Zealand at that time, means that parts of the country have no suitable local

1 provision for residential accommodation, so these-- - a- lot of people were split in terms of
2 family being geographically split from their children.

3 And just finally the last quote which is titled "Official policies and plans", this is the
4 Burns criticism of the Aitken Report that that report was out of touch with contemporary
5 ideas, it was erroneous with its extreme overemphasis on institutional care, and that:

6 "The official policy has a misguided emphasis on extending residential
7 accommodation and a mistaken preference for large institutions, both are opposite in
8 direction to modern opinion and trends elsewhere".

9 I think you have already agreed this morning that this report was a clear critique of
10 the Aitken Report and out of step, and just for everyone to understand, this came about in
11 1959 and was tabled in Parliament at that point.

12 I'm now going to move on to the final document which you've also referenced this
13 morning, which is the 1973 Royal Commission of Inquiry into the Services for Mentally
14 Handicapped, the third report of the Royal Commission of Inquiry into Hospital Related
15 Services, that's what it was called back then. And this is document number ending 08131.

16 And I've just got three particular quotes from this 1973 Royal Commission of
17 Inquiry, which I will read into the record. And the first highlighted quote states that the
18 Aitken Committee, which made up the Aitken Report, made up of medical and teaching
19 professions:

20 "It is not known to what extent administrative convenience, educational influence or
21 medical opinion shaped these decisions. But what is known is that the main conclusions
22 were the opposite of those even then being followed as a basis for policy elsewhere in the
23 world."

24 And in terms of the next quote, from the Royal Commission of Inquiry in 1973, I'll
25 just emphasise the last sentence there, because it shows the numbers of beds which
26 expanded. So:

27 "From 1952 through to 1972, occupied beds in psychopaedic hospitals alone
28 increased from 549 to 2,017 and in addition facilities for mentally handicapped persons
29 were built in psychiatric hospitals."

30 And the last quote from this 1973 Royal Commission of Inquiry states there that:

31 "From the evidence submitted to us, we believe that the disproportionate emphasis
32 put on care in large psychopaedic and psychiatric hospitals in the past 20 years is wrong."

33 And correct me if I've misheard this this morning, but I understand from your
34 acknowledgments today, that you would agree with that statement on the screen.

1 **DR SARFATI:** Correct.

2 **MS THOMAS:** Thank you. Would you also agree that if we're looking at the timeframes of
3 events here, 1953, the Aitken Report came out and was followed; we then have 1959 where
4 there's a critique of that policy tabled in Parliament; 1973, the Royal Commission of
5 Inquiry is clearly stating the past 20 years of policy have been wrong. Would you agree
6 that the Government of those times were on notice about the misguided policy, they were
7 aware that there was significant criticism?

8 **DR SARFATI:** I think we'd all agree that the Aitken Report sent us down a path which resulted in
9 policies which were damaging to people who were institutionalised at that time and that
10 certainly by the end of that decade the Government had been provided with a contrasting
11 view. I guess where I'm not able to comment is the extent to which those two views at the
12 time were considered balanced or the extent to which those were seen as reasonable
13 disagreements by experts or the extent to which the second one, the more recent one, was
14 seen as a more expert report.

15 **MS THOMAS:** And what we do know, though, just from history, is that in terms of the
16 timeframe again, 1973, there is this clear comment here about the policy is wrong, but the
17 final psychopaedic institution in New Zealand, the Kimberley institution, didn't close until
18 2006. So that is 33 years later and just to put that, I guess, into the context of real life for a
19 survivor, the first survivor that we heard at our Ūhia te Māramatanga hearing gave evidence
20 with her sister and this lady was in Kimberley from 1962 through to 2004.

21 So if you think about from this point here of 1973 when the Royal Commission of
22 Inquiry said the policy is wrong, that particular survivor then spent another three decades of
23 her life in an institution. Are you able to make any comment about that in the timeframe as
24 a result?

25 **DR SARFATI:** I can only really make general comments. Dr Crawshaw may be able to make
26 more comment. What I would say is, first of all, I saw that evidence and acknowledge both
27 the sister, both of the people involved, and the impact that that had on their lives. I think
28 deinstitutionalisation of the scale that was required in the 70s is a very complex and
29 difficult thing to achieve.

30 De-institutionalisation in every country took long periods of time, and there were
31 many complex aspects of that that needed to be in place. For example, ensuring that there
32 are adequate supports available in the community, adequate workforce to provide the care.
33 That's not--- that shouldn't necessarily be read as a justification for that particular

1 timeframe, but just in a general sense these sorts of changes in policy inevitably take a
2 substantial amount of time to implement.

3 **MS THOMAS:** And here, we're talking about 33 years of time.

4 **DR SARFATI:** Yeah, as I say, I can't comment on that specific amount of time or what would be
5 expected to be a reasonable amount of time, but certainly that shift is complex. You would
6 expect it to take time. Whether 33 years is a reasonable amount of time, of course a lot of
7 de-institutionalisation had occurred over that period, so we're talking about the absolute
8 last.-

9 **MS THOMAS:** Which was much later, I acknowledge that, I think it was from 1985 onwards
10 where there was a real shift in focus to start the deinstitutionalisation process and many
11 places were closed within the 80s and 90s and Kimberley was the last in 2006.

12 But even from 1973, when the Royal Commission of Inquiry have said this is wrong
13 to that real shift in focus in 1985, that's 12 years. Are you able to comment, or do you have
14 a view on the Government's inaction, effectively, from 1973 and as a result of that inaction,
15 potentially thousands of disabled people in New Zealand and people with mental distress
16 spending time in institutions where the Government were on notice that the best policy
17 would be in the community?

18 **DR SARFATI:** Unfortunately, I can't give you any insight as to what happened over that period.

19 **MS THOMAS:** Thank you. I think that may be an appropriate time to take the morning tea
20 adjournment.

21 **CHAIR:** All right. We'll take 15 minutes and resume again about 25 to 12. Thank you.

22 **Adjournment from 11.18 am to 11.40**

23 **CHAIR:** Mr Clarke-Parker.

24 **MR CLARKE-PARKER:** Thank you. I'm just here to very briefly have Ms Kerr introduce
25 herself.

26 **CHAIR:** Yes.

27 **MR CLARKE-PARKER:** So, Ms Kerr, can you please introduce yourself to the Commission.

28 **MS KERR:** Tēnā koutou, ngā mihi nui ki a koutou katoa. Ko wai au? Ko Buccaletiv mō te
29 maunga, ko Lough Lene te roto, no Ingarani no Kōterana hoki ōku tīpuna, kei te
30 WhanganuiaTara e noho ana ahau, ko Hannah Kerr tōku ingoa.

31 My name's Hannah Kerr, I'm the Group Manager Strategy and Policy at Whaikaha,
32 the Ministry of Disabled People. For those of you who can't see me, I'm a nondisabled
33 Pākehā woman, I'm 40 years old, I will leave you to decide whether that means that I'm
34 middle-aged. I have long dark hair, I'm wearing a grey jacket and a white blouse.

1 I have listened to and read the survivor testimonies. I would like to extend my deep
2 appreciation for your bravery in coming forward and sharing your stories with the
3 Commission, the Crown and the public.

4 The experiences that you described are terrible. They were terrible to listen to, they
5 were terrible to read about, but unimaginably worse to experience. And so important to
6 share. I extend my deepest sympathy for what you suffered.

7 I also acknowledge those who are no longer here to share their stories.

8 Along with my colleagues, I welcome the Royal Commission's Inquiry and the
9 critical contribution that you will make to the continuing work to ensure that disabled
10 people in Aotearoa no longer suffer abuse. Thank you.

11 **MR CLARKE-PARKER:** Thank you very much, and I just note that halfway through this
12 session we will have a brief swap to have Ms Bleckmann resume into the witness box in
13 Ms Kerr's place, but for now I will hand you over to Counsel Assisting.

14 **CHAIR:** Kia ora, thank you.

15 **QUESTIONING BY MS McCARTHY:** Tēnā koutou e ngā rangatira o te pae. Good afternoon,
16 Ms Kerr, Ms Woods, Dr Sarfati and Dr Crawshaw. I'm Alice McCarthy, I'm one of the
17 Counsel Assisting the Royal Commission. I am a Pākehā woman with blonde hair, I'm
18 wearing a navy dress and a black blazer and I have single-sided Deafness.

19 For this next session I'd like to ask you some questions about the experiences of
20 Māori within the Health and Disability system and then focus on looking at what steps both
21 ministries are taking to uphold Te Tiriti o Waitangi today.

22 I'm conscious that there are diverse conceptions of disability and mental health, so
23 today I'm going to use the terms "tāngata whaikaha Māori" and "tāngata whaiora Māori" to
24 refer to Māori with lived experience of disability and mental distress.

25 I would also like to thank you for your significant acknowledgments this morning
26 and also note my questions may be slightly shorter as a result of that.

27 I'd like to begin by understanding a bit more about the experience of tāngata
28 whaikaha Māori and tāngata whaiora Māori within the Health and Disability systems. So,
29 you acknowledged this morning that there was systemic ableism within these systems, and
30 you also acknowledged that there was institutional racism within these systems.

31 I'd just like to put a quote up on the screen, please, from a report from the Human
32 Rights Commission released on 21 December last year, which is document number
33 MSC0008205 and the report is entitled Whakamanahia Te Tiriti, Whakahaumarutia Te
34 Tāngata (Honour the Treaty, Protect the Person).

1 If we can just zoom into the highlighted quote on page 17, I'll read it out:

2 "The intersection of multiple inequities tāngata whaikaha Māori experience,
3 including colonisation, disability, racism and poverty can increase the risks of violence and
4 abuse. Although the inequities tāngata whaikaha Māori face are diverse, all sit within the
5 broader context of colonisation. Tāngata whaikaha Māori have lived experience and
6 challenges that non-indigenous persons do not, compounded by the intersecting effects of
7 colonisation and systemic racism."

8 Dr Sarfati and Ms Woods, do you both accept that tāngata whaikaha Māori and
9 tāngata whaiora Māori historically were at heightened risk of abuse while in State care?

10 **DR SARFATI:** I would tend to take that question back a step and just acknowledge that certainly
11 in recent decades the way that, not only the health system but systems in general have been
12 organised in New Zealand have disproportionately privileged non--Māori and we see the
13 effects of that today in the statistics relating to employment, education, health, across the
14 board.

15 Within the health system, if you look at statistics relating to Māori, there is clear
16 evidence that Māori have poorer access to many aspects of the health system and in some
17 areas- have worse quality of care once they've accessed the health system. That's generally
18 true across the health system and also- true for mental health services specifically.

19 In terms of the particular question as to whether that put Māori at higher risk of
20 abuse within those settings, I'm not sure I can make a statement specifically on that because
21 I don't have that specific information, except inasmuch as we know that Māori were
22 over-represented in institutions and therefore are likely to have had a high likelihood of
23 experiencing abuse as a result of that.

24 **MS McCARTHY:** Thank you, Ms Woods.

25 **MS WOODS:** Just really referring back to the acknowledgments that I've already made, is that it
26 is likely that Māori Pacific and disabled but Māori in particular were disproportionately
27 represented in care, and they were also disproportionately abused in care is likely. And
28 also, just acknowledging that in the period of this Commission that is looking at the Health
29 and Disability care settings failed to consistently meaningfully support the cultural needs of
30 tāngata whaikaha Māori.

31 **MS McCARTHY:** Thank you. I'll turn now to look historically, acknowledging that you have
32 made a lot of acknowledgments, but I just wanted to tease out a little bit more about how
33 these large-scale institutions operated. And so you'll be aware we're assisted in our
34 discussion today by research that's already been Commissioned by the Waitangi Tribunal

1 and I'd like to take you first to one of these reports by Dr Paula Toko King which is called
2 "Māori with lived experience of disability", and this is document number MSC0008208.

3 I won't take you to the first reference but at page 149, Dr King says that disability
4 services, including large-scale institutionalisation have generally been Pākehā centric and
5 conflicted with Māori world views of health and wellbeing.

6 So, to help tease this out, we've got a table here that's got two extracts from
7 Ms King's report. So, on the left there's her description of Te Ao Māori conception of
8 disability and on the right is contrasted with Western models of disability.

9 So, to begin on the left side, she says:

10 "Historically perceptions in treatment of Māori with lived experience of disability
11 were based on valuing their abilities and strengths they possessed. In Te Ao Tawhito Māori
12 concepts of disability were diverse and continue to be so in contemporary times."

13 Ms Woods, I'll initially direct this question to you. Would you accept that this
14 shows a positive mana-enhancing conception of disability?

15 **MS WOODS:** Yes.

16 **MS McCARTHY:** And is it fair to say that tāngata whaikaha Māori would have been a valued
17 and important part of whānau in the wider hapū and iwi?

18 **MS WOODS:** I assume so, yes.

19 **MS McCARTHY:** Then if we turn to the right, Dr King says that:

20 "Crown policy and legislation in contrast have also embedded various models of
21 disability such as the medical model, favoured in the Health and Disability sector, or the
22 economic model, within the labour sector. The Crown's imposition of a series of colonial
23 Western models and systems of thought, for example the tragedy/charity, medical and
24 rehabilitation models, have also undermined Māori holistic world views of health and
25 well-being."

26 I won't ask you to go into detail on those models, but would you accept that they
27 show a very much medical and deficit model of disability?

28 **MS WOODS:** Yes, by my reading of what that says, I'm just not sure, it says "undermined Māori
29 holistic world views of health and well-being" which is much broader than necessarily
30 tāngata whaikaha Māori. But certainly, for tāngata whaikaha Māori, those Western models
31 have--- it didn't embody the previous expectation of Māori life.

32 **MS McCARTHY:** So, is it fair to say that that practice of removal of children or young people or
33 adults from their whānau and the placement in psychiatric and psychopaedic institutions
34 was contrary to Māori world views?

- 1 **MS WOODS:** As I understand Māori world views, yes.
- 2 **MS McCARTHY:** Is it also fair to say that that removal was contrary to the ability of Māori to
3 determine support for tāngata whaikaha Māori and tāngata whaiora Māori within their own
4 homes?
- 5 **MS WOODS:** Sorry, can you repeat that question?
- 6 **MS McCARTHY:** The question is whether the practice of large-scale institutionalisation was
7 contrary to Māori making decisions about that support in care within their own homes and
8 communities.
- 9 **MS WOODS:** Well, the removal of children or adults into those institutions is not how Māori and
10 whānau and certainly Whanau Ora approach would operate.
- 11 **MS McCARTHY:** Thank you. Now, I was going to turn to look at the institutions themselves,
12 but if I can just run through the concessions that you made earlier. So, you've conceded
13 that Māori were overrepresented in those institutions?
- 14 **MS WOODS:** Yes.
- 15 **MS McCARTHY:** You've conceded that the laws, policies and systems within the Health and
16 Disability settings were institutionally racist?
- 17 **DR SARFATI:** Yes.
- 18 **MS McCARTHY:** You've conceded that these did not meet the cultural needs and disconnected
19 people?
- 20 **DR SARFATI:** Yes.
- 21 **MS McCARTHY:** And that includes that there was a provision of culturally inappropriate
22 healthcare.
- 23 **DR SARFATI:** Yes.
- 24 **MS McCARTHY:** The only point I just want to clarify is the last one about culturally
25 inappropriate healthcare. Are you talking in that instance about where mātauranga Māori
26 would adopt a different approach to, say, mental health than Western psychiatric care
27 might?
- 28 **DR SARFATI:** So I think it speaks to the issues that Dr King was highlighting in her evidence
29 around the conceptualisations of health and healthcare in Te Ao Māori and how they
30 contrast with those, particularly those of the time, which were very different and much
31 more narrow, and so by definition, if the care was provided within that narrow construct, it
32 would not be culturally appropriate according to the views of health within Te Ao Māori.
- 33 **MS McCARTHY:** Just to help us tease out that point with an example, at our Disability Deaf and
34 Mental Health hearing we heard from a survivor who was in Porirua Hospital, and his

1 sister, and I'll just take you to the transcript which is TRN0000539. And at page 14 the
2 survivor's sister, -I'll just paraphrase it for you,- -she talks about the care that her brother
3 received,- and she says:

4 "Pretty much because the systems are built on the policies, the legislation, all of
5 those systems are built on Pākehā knowledge. What I'm saying is that those systems need
6 to be more mātauranga."

7 Then she shifts down to say:

8 "Because I think that if we use our own medicines or if we use our own source of
9 well-being, that's going to make us feel better, then we can't go wrong."

10 So, would you accept that still today there is a need to adopt culturally responsive
11 approaches in the same way that there was historically that they're describing in Porirua?

12 **DR SARFATI:** I absolutely accept that we'd need to be delivering culturally appropriate care now
13 and that should have always been the case.

14 **MS McCARTHY:** If I shift to the situation today, now we are slightly hampered in this
15 discussion by the lack of data that we have, and you have acknowledged that's already an
16 issue. I just wanted to confirm, can either Ministry currently measure or understand the
17 rates of abuse in care experienced by tāngata whaikaha Māori and tāngata whaiora Māori?

18 **DR SARFATI:** Sorry, currently?

19 **MS McCARTHY:** Yes.

20 **DR SARFATI:** I can't comment on that. John?

21 **DR CRAWSHAW:** I don't know whether we can comment on abuse because that's not
22 specifically recorded in our systems, but as you would be aware, since the 2011 year, I have
23 been deliberately publishing data about Māori experiences in respect of care and actually
24 trying to demonstrate that those rates, the rate differential is not acceptable and have been
25 challenging services to change and in fact have required that they start to put in
26 programmes to make changes.

27 **MS WOODS:** I'm sorry, I actually don't know if we can do that, but I'm happy to find out and
28 provide that information in writing.

29 **MS McCARTHY:** Thank you.

30 **CHAIR:** Could I just ask a question about that Dr Crawshaw. So, there are no- --there's no
31 record, centralised record of abuse?

32 **DR CRAWSHAW:** The unfortunate thing is that now, today, thankfully, abuse occurs in very
33 limited experiences and examples. So that is a positive thing, but it does mean that it
34 actually ends up in individual records. It usually is within the DHB system when they

1 capture it, but those DHB systems of what we call serious incident records are not
2 something that I can interrogate from the Ministry. So, it's been one of the challenges that
3 we've had is actually getting a uniform description of it. That's also one of the challenges
4 which I had in terms of actually getting national data on restraint which we are now starting
5 to get.

6 **CHAIR:** We've heard in other contexts, not just the health one, but that when abuse was reported
7 it often landed in the employment folder or the HR folder belonging to the staff member
8 who was alleged to have done the abusing, sometimes not at all on the records of the person
9 who is alleged to have been abused, so that was one of the contributing factors to the
10 segregation of the data.

11 **DR CRAWSHAW:** It may well be, but equally, it is one of the things that I require the district
12 inspectors to report in their monthly reports, and they have ability to actually scan the
13 incident reports. So that is why I have some reasonable confidence that we're not seeing
14 significant abuse.

15 However, I would expect if a patient was severely affected, particularly injured, that
16 it would appear in both systems, and my experience is that it sometimes- -the examples
17 which I know of is that it does, and I also expect that there is going to be a serious incident
18 investigation not just for the staff member, but actually what were the systems that actually
19 allowed- that to occur. And that's often the reports which I will then require from the
20 services, but more importantly what are they going to do about it.

21 **CHAIR:** And you're phrasing that in the future, that's what you will be going to require?

22 **DR CRAWSHAW:** No, sorry, that's what happens at the moment.

23 **CHAIR:** All right, thank you.

24 **MS McCARTHY:** Continuing with the situation today and what we know, you did talk about
25 systemic institutional racism in the past. Would you accept that that continues today within
26 the Health and Disability sector?

27 **DR SARFATI:** Yes, and there is a lot of effort and focus on addressing the issues that that
28 creates. Most recently that's reflected in the Pae Ora Act, which, as you're undoubtedly
29 aware, centralises the importance of the five principles of Te Tiriti as articulated in Wai
30 5275 and the importance of achieving equity. So --

31 **MS McCARTHY:** Excuse me, Ms Sarfati, can you please bring your microphone slightly closer.

32 **DR SARFATI:** Sorry. It's like an alien.

33 Yes, so those elements are reflected in legislation and there is now a requirement on
34 health services to deliver against those five principles.

1 **MS McCARTHY:** Thank you. I'm just going to check with the Chair as to whether we need to
2 take a short break.

3 **CHAIR:** Yes, due to, just- by way of explanation, due to a very sad bereavement, we have lost
4 one of our signers and so I've insisted that she go, that means that our current signer is on
5 her own and she needs to take a break. We have another signer coming on their way. And
6 I -think what-- are we going to do? We said we'd discuss what was going to happen now.
7 Will we take an early lunch now or?

8 **MS THOMAS:** If everyone's happy, we could take the luncheon adjournment now and just
9 reconvene to allow the next signer to arrive for a 1 o'clock start perhaps?

10 **CHAIR:** I think if-- that suits, does that suit you?

11 **INTERPRETER:** Yes.

12 **CHAIR:** Is there anybody else who's important who is seriously inconvenienced by that? And,
13 first of all, our witnesses, is that all right with you? Counsel, does that affect anything
14 here? All right, let's take the lunch adjournment and we'll reconvene at 1 o'clock.

15 **Lunch adjournment from 12.04 pm to 1.03 pm**

16 **CHAIR:** Good afternoon, everybody, and welcome back, and welcome back especially to our
17 four witnesses and I'll leave them with you, Ms McCarthy.

18 **MS McCARTHY:** Thank you.

19 **CHAIR:** Just a small note, we still don't have our extra signer, and this one is nobly offering to
20 carry on on her own but I'm refusing to allow her to get into a health and safety scrap so if
21 you could be really careful about speed, please, for her and we won't go any more than half
22 an hour then we'll wait for the new one to come, thank you.

23 **MS McCARTHY:** I'd like to, in the next session, talk about the steps that both ministries are
24 taking to uphold Te Tiriti o Waitangi.

25 Ms Sarfati, you referred earlier to the five principles identified in the Hauora Report
26 and that these have now been adopted. Is it by both ministries?

27 **DR SARFATI:** It's actually in the Pae Ora Act, so it's a requirement under legislation, yeah.

28 **MS McCARTHY:** Thank you. I'll just ask that those five principles set out in Dr Crawshaw's
29 brief be placed on the screen. That's witness number 757002 at subparagraphs (a) to (e) of
30 paragraph 2.47.

31 I'll just come, as we go to each principle, I'll read them out, but they're there for
32 now. At a general level, you'll be aware that the Commission is very focused on
33 safeguarding against abuse, and we've heard from multiple survivors, from Māori survivors
34 who experienced significant abuse, often in Pākehā institutions or care settings. Do you

1 think it would be fair to say that having a Treaty Consistent disability and mental health
2 system would be a strong form of safeguarding against abuse?

3 **DR SARFATI:** Yes, I think there's, going back to the earlier discussion about Māori
4 conceptualisations of health and the broad approaches to that, that's part of it. But also
5 those other elements of the Treaty as articulated in those five principles of the Tino
6 Rangatiratanga Act of protection, achieving equity, providing options and partnership,
7 yeah, all of those are really important in order to deliver care that is appropriate for Māori.

8 **MS WOODS:** I think I'll just say "yes".

9 **MS McCARTHY:** Thank you. I'd like to talk now really about how we achieve that and what a
10 Treaty consistent system might look like.

11 **DR SARFATI:** Sure.

12 **MS McCARTHY:** So if we begin with the principle of tino rangatiratanga and I'll just read from
13 the extract here. This is often translated as self-determination or sovereignty, it means that
14 Māori are guaranteed self-determination and mana motuhake in the design, delivery and
15 monitoring of health and disability services. This means the right to be Māori and to live
16 on Māori terms in accordance with Māori philosophies, values and practices.

17 Ms Kerr, I might direct the next question to you. Do you think it's a fair
18 characterisation to say that the principle of tino rangatiratanga is fundamentally about
19 redressing a power imbalance between the Crown and Māori?

20 **MS KERR:** I think that's certainly a significant component of it, yes.

21 **MS McCARTHY:** I just wanted to explore that concept of power a little bit more. You will have
22 watched during our Disability, Deaf and Mental Health hearing we had a Māori panel and
23 one of the panel members was Dr Tristram Ingham who is the chair of Te Ao Mārama of
24 Aotearoa and he is also a professor of public health at Otago University. This is document
25 number TRN0000535.

26 And I'll just paraphrase the beginning, but he talks about power as a contributing
27 factor to abuse, and in his words, he says that while the bricks and mortar of those
28 institutions no longer exist, that the power structures that underpin those do.

29 And then if I can just take you to the middle of page 9, he says:

30 "I see nothing even to the present hour of the present day that gives me any
31 confidence that the power basis has shifted or that there is a genuine willingness to partner
32 with tāngata whaikaha Māori communities, tāngata whaiora communities to actually lead
33 the development or change in this space."

1 Ms Sarfati, would you acknowledge that addressing this power imbalance is really
2 fundamental to both ministries giving effect to their Treaty obligations?

3 **DR SARFATI:** Yeah, I think broader than that the health system as a whole, so to the extent that
4 the Ministry is acting as steward of the system as a whole, and I think, again, what we're
5 seeing with the reforms is a genuine step towards tino rangatiratanga with the Māori Health
6 Authority Te Aka Whai Ora being implemented which was a step further than Wai 5275
7 recommended, and Te Aka Whai Ora has the power to both commission kaupapa Māori
8 services but also, and perhaps more importantly, a role in holding the entire system to
9 account in terms of the way that it delivers to Māori. And that's not just within the services
10 themselves, how that engagement happens, whether the engagement's appropriate, Te Aka
11 Whai Ora also holds the function of liaising and being a point of contact with Iwi Māori
12 Partnership Boards which is the mechanism through which localities, so local areas are
13 required to engage with Māori at a local level.

14 So, these are new aspects to the health system which aim to, at least in part, -take
15 account of tino- rangatiratanga.

16 **MS WOODS:** I'd like to say something too. I think the uniqueness of Whaikaha is that we do
17 want to work in partnership with tāngata whaikaha Māori and disabled people. It's a three-
18 way relationship. And it is about ensuring that the Ministry is there and is working to
19 support everybody who-,- all disabled people,- but in particular that we ensure that the
20 needs of Māori and tāngata whaikaha Māori are met in the processes, and that's part of the
21 reason for it being established, it includes and is built into the Enabling Good Lives
22 approach but, more importantly, for Māori, probably, the Whanau Ora approach and it's
23 about the transformation including both of those components that both individually and
24 through family and whānau that the services will become more relevant and more effective.

25 **MS McCARTHY:** Thank you, Ms Kerr. And sorry to labour the point, but as chair of Te Ao
26 Mārama o Aotearoa, you'll appreciate Mr Ingham has a very good insight into the actions
27 currently being undertaken in this space. Would you agree with his comment that to date
28 there hasn't been a fundamental shift in that power balance?

29 **MS WOODS:** I can only talk about the last six to eight months, and we, for the establishment
30 of - well- no actually, I can talk a little bit longer than that. The work to, on what was
31 called the Machinery of Government Working Group, which provided advice, supported
32 the advice going to Cabinet around what eventually meant that the Ministry was created,
33 and the transformation of Disability Support Services and towards an EGL, -Enabling Good
34 Lives approach was supported by Cabinet. That was done in partnership with disabled

1 people and tāngata whaikaha Māori. In fact, Tristram was party to the conversations. And
2 then the establishment of the Ministry included a partnership or a governance arrangement
3 that included a governance group which was three officials, three tāngata whaikaha Māori,
4 three disabled people, and that was supported by two steering groups, one official's one,
5 and one community one in terms of the establishment.

6 So, we have attempted to start that process and we wish to continue that.

7 **MS McCARTHY:** And would you accept, as Mr Ingham has been involved in these and still
8 doesn't think that enough is being done, there is significant more progress that needs to be
9 made in upholding the principles of tino rangatiratanga?

10 **MS WOODS:** I'm not sure that I can comment on that because from my perspective he's been
11 fully involved and he's been helping in terms of trying to make that process work.

12 **MS McCARTHY:** I'd like to now turn to partnership, if we can put the extract with the principles
13 back up on the screen, please.

14 **COMMISSIONER ERUETI:** Can I just check, Alice, about these principles, Ms Sarfati, are they
15 in the Act itself or are they in the health action plan?

16 **DR SARFATI:** They're actually within the Act itself, they actually talk about the five principles
17 in the Act itself, I believe.

18 **COMMISSIONER ERUETI:** I just can't find them; do you know the provision?

19 **DR SARFATI:** No, and I'm not a lawyer, so now I'm feeling slightly nervous that maybe they're
20 not in the Act itself.

21 **COMMISSIONER ERUETI:** I don't think they are. Yeah, there is a Treaty clause in Section 6.

22 **DR SARFATI:** Perhaps what they do is in the Act they outline those- five elements are reflected
23 in the Act, albeit they may not be referred to as those elements, I would have to go back
24 and have a look at specifics of the wording-, h--appy to come back to you on that, though.

25 **COMMISSIONER ERUETI:** Thank you.

26 **MS McCARTHY:** If we turn to look at partnership. It says here that:

27 "Partnership requires the Crown and Māori to work in partnership in the
28 governance, design, delivering and monitoring of Health and Disability services. Māori
29 must be co-designers, with the Crown, of the Health and Disability system for Māori."

30 We've already been talking about how we've got reform under both whaikaha and
31 with EGL and also in the mental health space. Are you confident that both of these reforms
32 have been co-designed with Māori? That is EGL and the new mental health reforms of the
33 Act?

34 **MS WOODS:** I'll get Hannah just to talk about the development of the EGL approach.

1 **MS KERR:** So, the development of the Enabling Good Lives vision and principles actually came
2 from the disability community. I can't speak to the exact composition of the group that
3 developed those vision and principles, but my understanding is that tāngata whaikaha were
4 involved in that process and certainly, as Geraldine has just been discussing, the more
5 recent work that led to the announcements at the end of October last year about the national
6 rollout of the Enabling Good Lives approach and the work that has been done since then to
7 take that forward have been done in partnership with tāngata whaikaha as well as other
8 representatives of the community.

9 **MS McCARTHY:** And when you say partnership, do you think that reaches a level of co-design?

10 **MS KERR:** That has certainly been our intention.

11 **MS McCARTHY:** Ms Sarfati,-- Dr Sarfati, sorry.

12 **DR SARFATI:** In terms of the whole health reform process as you may be aware the reform
13 process came out of a report that had- --there was a committee that led that work and there
14 was a Māori equity group that worked alongside. So, at the high level that was how that
15 report was put together, and then the subsequent work in terms of operationalising the way
16 that the recommendations from that report would be operationalised, those were decisions
17 really of Government and subsequently operationalising Government policy.

18 But I think what you're asking is really how at a service level those are going to be
19 delivered, and that's really the work that's happening now, and so I think the importance of
20 the right structures being in place is a first step towards that, the tāngata whaikaha and the
21 Iwi Māori Partnership Boards being examples of that.

22 In terms of the way that mental health services have been designed specifically, I
23 can't comment on that. John may be able to.

24 **DR CRAWSHAW:** I'll start, but my colleague Arran Culver could probably give more
25 information about that. But to give an example, we're currently involved in the repeal and
26 replacement of the Mental Health Act. As part of the consultation process which was
27 extensive, there were separate Māori caucuses or hui, which were led by Ms Phyllis
28 Tangitu, and the intent was to truly capture the views of Māori as to what they wanted to go
29 forward. The analysis of all of those consultations is now on the Ministry website and
30 includes a significant section which deals significantly and principally about the views of
31 Māori.

32 Now, we still have the policy work to go through, but as we move forward, we're
33 constantly engaged with and indeed when I did the guidelines for the Mental Health Act we
34 were engaged with Māori and had extensive consultations at that point.

1 **MS McCARTHY:** Excuse me, Dr Crawshaw, if you could just slow your pace, please.

2 **DR CRAWSHAW:** My apologies, I get excited sometimes.

3 And our system and services framework we again have had significant consultation
4 with Māori. Because we recognise that actually, if it works for Māori it's likely to work for
5 all New Zealanders.

6 **MS McCARTHY:** Thank you. Just picking up on that final comment, Dr Crawshaw, would you
7 say that that's a general approach across the health sector that if something works for Māori
8 it's probably more likely to be beneficial for everybody?

9 **DR CRAWSHAW:** I think you're asking me to go beyond my area of specific expertise, I might
10 pass to the DG.

11 **DR SARFATI:** That's certainly--we can't demonstrate that, but that is certainly assumption that
12 if we have models of care that centralise families that put people in the centre of it that
13 empower people, so some of those general principles that would be inherent in models of
14 care that were centred around Māori whānau, they would almost certainly work very well
15 for others as well.

16 **MS McCARTHY:** Thank you. I'll just touch on one more principle briefly, if possible, looking at
17 options now. So, this requires the Crown to provide for and properly resource kaupapa
18 Māori Health and disability services and also ensure that there are culturally appropriate
19 mainstream services, which you touched on previously in terms of health delivery.

20 I'm conscious this is a very big topic, but in terms of the steps that both ministries
21 are taking to ensure that there are well-resourced kaupapa Māori services and a culturally
22 responsive mainstream service, can you just talk to me a little bit about that, please.

23 **DR SARFATI:** Yeah, so I guess the first thing to note is that there has been substantial
24 investment both in the 2019 budget and the 2021 budget for kaupapa Māori mental health
25 services. So, in 2022, for example, \$14 million specifically for kaupapa Māori mental
26 health services. Te Aka Whai Ora, one of their roles is to commission specific kaupapa
27 Māori services, so there is a commissioning capacity within the system being set up.

28 And so that is one element of it, that's the kaupapa Māori element of it at a high
29 level, and then in terms of strengthening mainstream services, there are several elements in
30 there to consider, partly that's around the structure, the process, the system how it works, as
31 a service in the community for example, so those things are important. But also important
32 is that the workforce reflects the community that it serves. And there's a lot of work going
33 on to improve the diversity of our workforce.

1 The other thing is working with Te Pou, for example, whose role it is to extend the
2 capability of current and future mental health workforces in relation to their cultural
3 competence. And there's a lot of other elements of cultural competency that are being built
4 into training of health professionals.

5 In addition, the Ministry of Health is in the process of doing a piece of work called
6 Ao Mai te Rā which is anti-racism kaupapa which is designed to support the health system
7 and the health workforce in terms of delivering services that are not systemically racist.

8 **MS McCARTHY:** And in terms of these, which sound like really positive programmes, do you
9 have a way of measuring whether they're being effective and whether that's actually
10 effecting cultural competency on the ground?

11 **DR SARFATI:** That's a really challenging question, as you can imagine. It's relatively easy to
12 measure some things like, has someone been to a course? But what we really want to know
13 is, are the services delivering better, more effective and more appropriate care? And so,
14 one way of measuring that is to measure outcomes. So, looking at whether, where there
15 were differences in outcomes, particularly where Māori were doing worse, whether that
16 difference is reducing, or --ideally being eliminated, and so that is another way of
17 measuring that. But it is a difficult thing to confidently measure in all its dimensions.

18 **MS McCARTHY:** My final question for this section of questions relates to the process that we're
19 going through today. So obviously the Royal Commission is looking into these issues and
20 the Waitangi Tribunal has current ongoing inquiries into both disability and mental health.
21 I won't put it up on the screen, but again, Dr Ingham, his concern from the panel was that:

22 "The findings will not be timely and will not be binding in a way that will actually
23 inform the generational transformation of the system that is currently proceeding without
24 their recommendations."

25 I was hoping you could tell me what steps you have planned to ensure both the
26 Commission's recommendations and the Tribunal's recommendations are meaningfully
27 incorporated and implemented.

28 **DR SARFATI:** I think some of the processes, systems and structures that I've described are those
29 that will provide us with the foundations to enact those recommendations, and certainly the
30 aim of those things and the way that the health system is being reformed aims to deliver
31 care more consistent with what will likely be the recommendations from the Waitangi
32 Tribunal and maybe this Commission as well.

1 Certainly, the recommendations from Wai 5275, the three general ones are
2 already--have already been accounted for and being dealt with already. So,- I think we're
3 showing really good progress albeit that of course we've still got a long way to go.

4 **MS McCARTHY:** And you do acknowledge that if either the Commission or the Tribunal did
5 recommend transformational change that perhaps goes beyond the current mental health
6 and disability reforms, there would need to be space to consider those and whether those
7 can be further implemented after the spate of recommended reform.

8 **DR SARFATI:** Of course, all recommendations from both the Tribunal and this Commission will
9 absolutely be considered. Exactly how they are responded to I don't think I can comment in
10 the absence of those recommendations.

11 **COMMISSIONER ERUETI:** Alice, do you mind if I ask a question just on funding. For the
12 Māori Health Authority, Dr Sarfati, are you able to give- do-- you know what the budget is
13 in the last Budget for the health authority for the next four years?

14 **DR SARFATI:** I would just want to double-check that before I gave you a number.

15 **COMMISSIONER ERUETI:** Yeah, even-- a rough figure?

16 **DR SARFATI:** I have a rough figure in my mind, but I just want to check, I'm happy to come
17 back after the next break.

18 **COMMISSIONER ERUETI:** Yeah, great.

19 **DR SARFATI:** If I can just check that for you.

20 **COMMISSIONER ERUETI:** Appreciate it, thank you very much.

21 **MS McCARTHY:** I think Ms-- Woods, did you want to respond to that?

22 **MS WOODS:** No, not to the money one, I can't answer that one, sorry. I've lost the train of
23 thought now, let me...

24 **MS McCARTHY:** Was this to my previous question about implementing the recommendations?

25 **MS WOODS:** Yes, sorry, thank you. Yeah, I mean from a Whaikaha perspective, we always
26 watch what is happening in these forums and discussions and we take note of the things that
27 people are saying and I would be a little bit horrified if we were working towards a
28 transformation that was not considering the things that this Commission is hearing, and we
29 ended up in a position where we were trying to implement something that was either
30 counter to or did not encompass sufficiently the recommendations that came through. But
31 then there will be additions that the Commission is likely to have and, of course, we then
32 work out how we roll those into the transformation as it's happening.

33 So, of course, we would hate- --we're not going to sit and wait; we're going to try
34 and be progressive in the way we do things.

1 **MS McCARTHY:** Thank you.

2 Madam Chair, if we could take a brief adjournment to reconfigure the witnesses,
3 please.

4 **CHAIR:** I don't think you mean reconfigure the witnesses, I don't think they would enjoy that at
5 all. But I know sorry--, I'm just pulling your leg, no, to give them a chance to change
6 around will be fine, okay, we'll take a brief break, thank you.

7 **Adjournment from 1.30 pm to 1.32 pm**

8 **CHAIR:** I have to say it doesn't look any different from when we left. Sorry, I've now seen you.

9 **MS McCARTHY:** We're going to talk now about seclusion and just to orientate people listening,
10 we're talking about--- there's a range of definitions, but we're just talking really about
11 restraint where a person is placed alone in a room or area from which they cannot really
12 exit.

13 Dr Crawshaw and Ms Bleckmann, I understand I'm directing these questions to you
14 in the first instance. So, you'll be aware I'm sure that the practice of seclusion or calls to
15 eliminate seclusion have been made both internationally, by UN Treaty bodies for example,
16 and domestically as well and we'll be talking about the zero-seclusion project a little bit
17 later on.

18 Do you acknowledge that the practice of seclusion has the potential to cause
19 significant harm, both psychological and physiological, and to increase risks of self-harm
20 and suicide?

21 **DR CRAWSHAW:** So, you will probably find some public statements from me on that point.
22 So, there is no evidence base that it is therapeutic. However, in certain circumstances it is
23 unfortunately a necessity. And if we're talking now as distinct in the past, because there is
24 quite a big and marked difference, the challenge is when it is necessary is how to do it in a
25 way which is least traumatising, and how do you debrief people and how do you actually
26 ensure that it is for the minimum period possible, or necessary rather, and how do you
27 actually support the person post that. So, there's quite a lot of work on that point.

28 I am mindful, and maybe we'll get into it later, that I don't want to see by
29 eliminating seclusion other practices which could also be traumatising. So, when faced
30 with people who are very, sometimes unfortunately violent, we do have to find a way to
31 keep everyone safe in the least traumatising way possible.

32 **MS McCARTHY:** Thank you. The Royal Commission has heard a lot about seclusion from
33 survivors and their whānau, particularly for our inquiry on the particular impacts of
34 seclusion on disabled people and people experiencing mental distress. For example, during

1 our Disability, Deaf and Mental Health hearing, which is transcript number TRN0000479,
2 and I'll just paraphrase this, we heard from the sister of a survivor with a learning disability
3 who described how her sister was secluded for a period of eight hours and 13 times was
4 secluded because she got out of bed early. And the sister of the survivor said that her sister
5 was like a toddler and to put somebody who is claustrophobic, or was in seclusion, where it
6 wasn't even a safe environment is reprehensible.

7 Do you acknowledge that disabled people and people experiencing mental distress
8 are at particular risk of harm from seclusion?

9 **DR CRAWSHAW:** I'll perhaps start, but as you will be aware, that was part of the, --some of that
10 was part of the original acknowledgments this morning, and as I recall that particular
11 transcript, or actually I think I watched it, they were talking about something which was
12 some time back, but however, that's why from my point of view we actually have to drive
13 and eliminate seclusion, because anyone who's in a distressed state, particularly someone
14 who has other challenges in their life, need to be as well protected as possible.

15 **MS WOODS:** I just refer back to the acknowledgment that we said this morning, that there was
16 inappropriate use of seclusion and restraint in psychopaedic settings, so yes.

17 **MS McCARTHY:** Thank you for those acknowledgments. I probably won't dwell a lot on the
18 historic aspects given those acknowledgments. But what I did want to do is just go through
19 some of the factors that did arise historically in relation to seclusion, and talk about whether
20 those still exist today.

21 So, we've got a table which is just being brought up now. So, on the left-hand side
22 we've got historical excerpts and on the righthand side we've got excerpts from reports that
23 have been undertaken either by the Ombudsman or for the Human Rights Commission over
24 the last couple of years. So, if we could talk about --- there's- three different aspects that
25 I wanted to talk through today.

26 The first one is looking at the survivors' time spent in isolation. So, we've heard
27 historically, as you will acknowledge, that disabled people and people experiencing mental
28 distress often spend long periods of time in seclusion. So the example here is a survivor
29 who was in seclusion for a week.

30 Now, the excerpt on the right, the first one is from Dr Sharon Shalev's 2020 follow-
31 up report for the New Zealand Human Rights Commission entitled "Seclusion and
32 Restraint: Time for a paradigm shift" which specifically looked at seclusion within Health
33 and Disability facilities. And she notes that in instances today people are still being
34 secluded for a period of over two days.

1 The second report there is from an Ombudsman report called "Oversight: An
2 investigation into the Ministry of Health stewardship of hospital level secure services for
3 people with an intellectual disability" from July 2021. And it similarly notes that people
4 within these facilities were in de-escalation and seclusion areas for lengthy periods of time.

5 So, my question is, from these excerpts and quite detailed reports, would you
6 acknowledge that the length of time spent in seclusion remains an issue today?

7 **MS BLECKMANN:** So, I'll start by saying that the Ombudsman's position was accepted in
8 relation to the placement of young people- of- people in seclusion. At the time and
9 immediately before the report was published, planning was underway for specialist
10 individualised service units and those service units were being set up or established to
11 better accommodate people who needed specialist or -hospital level care and in those
12 specific situations there -are people-- are now living in individualised service units.

13 **CHAIR:** I think you are going to need to speak a bit closer to your microphone.

14 **MS BLECKMANN:** Sure. Would you like me to repeat it?

15 **CHAIR:** Just tell me, it was called "specialist individualised" what?

16 **MS BLECKMANN:** So in July this year the specialist individualised service units were opened.

17 **MS McCARTHY:** Dr Crawshaw?

18 **DR CRAWSHAW:** So, we get to the issue of there are one or two outliers and yes, for some of
19 them, despite the efforts of staff to move them out of seclusion, there are occasions when
20 they remain extremely aggressive and it's not safe for other people on the unit for them to
21 be on the floor. And that's very challenging for all. As I said before, I don't want to see
22 some of the other options deployed, which could even be more traumatising.

23 However, if we start to look at some of the data which is flowing through, and we
24 do publish this regularly and it is on the Ministry's website, over time we have seen a
25 reduction in the amounts of time that people are spent in seclusion as well as some of the
26 frequency of events, and it remains a piece of work which we have a constant focus on, as
27 you've referenced one of the projects to actually drive it down.

28 However, there is quite a marked difference between what was in the past almost an
29 automatic practice sometimes, which, as we've acknowledged, was inappropriate, and what
30 we're now seeing today, when we're dealing with some individuals who are extremely
31 challenging to work with, and unfortunately make everyone unsafe, and as much as staff
32 are trying to minimise and, you know, there are some units which will go almost up to a
33 month or so without any seclusion events, which is quite markedly different. In fact, one
34 unit said to me they got to 90 days, which I was quite surprised, and then they had an

1 individual come in who was just simply not only too unwell but too violent to let on to the
2 ward.

3 So I feel for the staff facing what can be a very violent and unsafe situation, I feel
4 for the patients and other people in the unit who would otherwise be exposed to a very
5 unsafe and potentially abusive environment if we did not do something to contain them,
6 and I certainly do not want to see people being in a rolling maul type physical restraint as
7 an option to avoid seclusion nor do I want to see people excessively sedated, is the other
8 option.

9 It remains a fact that we sometimes are dealing with people who are extremely
10 unwell, extremely unsafe, and we have an obligation to keep everyone safe.

11 **CHAIR:** Could I ask for clarification, without going into too much detail, because I know we're
12 dealing with systems here, but this notion of the specialist individualised service units, Ms
13 Bleckmann, are they alternatives to seclusion or a type of seclusion? What exactly are
14 they?

15 **MS BLECKMANN:** So, it's what we would describe as more optimal environments and they are
16 individualised, so people are not living in a group arrangement where they need to be
17 secluded.

18 **DR CRAWSHAW:** If I could add, there are unfortunately some people who get quite distressed
19 by others around them and forcing them to have company can increase that distress, and
20 sometimes they display that by actually aggressively pushing people out of their space. So
21 our response is to actually retreat, which is I think perfectly acceptable, because they've
22 indicated they do not want people in their space.

23 Technically, that may result in them being secluded because they're off by
24 themselves. But however, it is something that they have demonstrated through their
25 behaviour is what they feel they need at this point in time. It's one of the challenges that I
26 have in terms of how do we count events where someone,- is it voluntary, because really I
27 don't know they're making a cognitive or rational choice, but they're actually needing space
28 in order to actually ground- themselves and re-settle.

29 **CHAIR:** Are those people in that particular category, the "I want to be alone" category, are they
30 free to come out when they feel like it?

31 **DR CRAWSHAW:** That's the intent of staff, and one of the designs of the new unit is so that they
32 can retreat to their personal space.

33 **CHAIR:** So it's a retreat rather than being told you must go there, they can choose to go there, but
34 they can choose to come out if they wish?

1 **DR CRAWSHAW:** Yeah, but technically, because they don't have company and they don't want
2 people around them, they are secluded.

3 **CHAIR:** Thank you. But the other situation you're talking about where --

4 **DR CRAWSHAW:** There's the other type where it's needed in order to keep the whole unit safe
5 as well as, you know, I've had some people explain to me after the event that they don't
6 know what went through their mind when they were sometimes actually aggressively
7 hitting out at people who they actually cared for. It's an extremely distressing state for all.

8 **CHAIR:** Of course, but for those people, just to make the distinction if we can, or if it is possible,
9 those people, who determines when they leave that secluded space? Do they decide it or do
10 staff, medical staff do it?

11 **DR CRAWSHAW:** So that is the difference between the past and now. We now require staff to
12 enter the room and to see if they can de-escalate the situation before the person can come
13 out, that's sometimes challenging and sometimes an unsafe situation. And we're going
14 through a process at the moment-- to- a project to review and redefine the guidelines
15 around seclusion and restraint to actually further make it very clear that this is not an
16 everyday event, but it is an exceptional event. And so, the intent is that you go back
17 in,- and they are under constant observation and staff are constantly trying to engage with
18 them to see if they're settled enough to come back out.

19 **CHAIR:** Thank you for that explanation.

20 **COMMISSIONER ALOFIVAE:** Can I just ask a follow-on question from that, just to help us
21 with the visual. So that's every hospital has, or not necessarily hospital or placement, has
22 the seclusion units, no?

23 **DR CRAWSHAW:** So, it's usually in the acute units, and the forensic, some of the forensic units,
24 not all of the forensic units. But the ISU, which is what we were talking about before, is a
25 national unit, based in Wellington, and that's for a very limited number of people who, if
26 we did not do that, we would have a situation which is intolerable for everyone.

27 **COMMISSIONER ALOFIVAE:** Thank you.

28 **MS McCARTHY:** Just to clarify, so we've been talking about the use of seclusion in instances
29 where you consider that's necessary. If I can refer you to Dr Shalev's 2020 report, for
30 completeness the reference is MSC0008137 at page 45, and I'll just read this excerpt. She
31 says that:

32 "Seclusion is meant to only be used where necessary, for the care or treatment of the
33 service user, or for the protection of other service users."

34 Which is what we were just discussing:

1 "However, one of the issues highlighted was that seclusion rooms were not always
2 used for their intended purposes, but instead were used as overflow bedrooms when the
3 wards or units were at capacity or as a longer-term housing for individuals who are
4 perceived as high-needs or challenging."

5 So, in your understanding that-- was two years ago, but does that practice still exist
6 today?

7 **DR CRAWSHAW:** So, the latter part is part of the reason why we developed the ISU, because
8 we had some individuals who, in the facilities that we then had, we could not safely look
9 after other than for periods of spending long periods in a de-escalation suite. The new ISU
10 has outdoor space, it has a living room, it has a bedroom, it has a space that this person can
11 call home which is quite a different environment.

12 In terms of the challenge of capacity- challenge, that's part of the reason why the
13 Ministry has engaged in a significant rebuild of its mental health facilities to actually
14 address- some of these issues. And my colleague Arran Culver can talk to the Commission
15 about that later.

16 **MS McCARTHY:** Dr Crawshaw, can you tell me, or maybe Ms Bleckmann, how many ISUs are
17 currently in New Zealand?

18 **MS BLECKMANN:** So, there are six units in New Zealand.

19 **MS McCARTHY:** And is that enough for the number of people who you would put in that
20 category as needing that more long-term support?

21 **MS BLECKMANN:** There are four people in the six available beds.

22 **MS McCARTHY:** Just picking up on your point, Dr Crawshaw, about refurbishing, sorry, that
23 wasn't the word you used, the settings, if we go, sorry, scroll up on this table, the last point
24 that I wanted to raise in terms of historical issues, that may still exist today, is in terms of
25 the physical attributes of the facilities themselves.

26 So, on the left there's a quote from a report which is MOH0001913, which was a
27 1986 report by the Minister of Health for the Department of Health entitled "Review of
28 psychiatric hospitals and hospitals for intellectually handicapped", and at page 9 he refers
29 to those historical seclusion facilities as Dickensian.

30 If we then shift to Dr Shalev's 2020 report, I'll just read out her description of some
31 of the seclusion facilities she saw:

32 "They were a stark environment with limited or no natural light and no fresh air, the
33 furnishings were comprising of no more than a bed base and a mattress, often just a
34 mattress. There was no means to tell the passing of time of day or date. Windows without

1 curtains or conversely with blinds that are kept shut and not working. Seclusion rooms
2 have no toilets, and instead service users need to use cardboard bedpans for urinating and
3 defecating and no access to running water."

4 Would you acknowledge that description also seems relatively Dickensian.

5 **DR CRAWSHAW:** That are aspects of that description which are contrary to our policy but just
6 leaving it as that, yes, there are one or two very older facilities which I'm not happy with,
7 which is, again, going back to why we have got a significant infrastructure rebuilding
8 programme, to address precisely that. And it might interest the Commission that the
9 Ministry undertook an audit of all of its acute facilities for that very purpose to develop the
10 infrastructure rebuilding process.

11 **CHAIR:** Was that audit in response to the Shalev Report?

12 **DR CRAWSHAW:** No, it was probably an audit in response to both myself and the OPCAT
13 people raising repeated concerns and wanting a proper process to deal with it.

14 **MS McCARTHY:** Another concern that Dr Shalev raises is concerns around data collection. So,
15 when you did that audit and actions taken since 2020, can you tell me if data collection
16 around seclusion has improved?

17 **DR CRAWSHAW:** We have always had a requirement for tight reporting on seclusion, it's a
18 requirement under the Act. There are exceptions where some of the hospital systems have
19 problems communicating with our national data collection, which can lead to issues with
20 reporting to seclusion, but we have always insisted in those circumstances that we get
21 manual data rather than just relying on electronic data. That's why we go to some bother to
22 actually make sure that there is accuracy in the data that you see reported in the annual
23 tables that we publish, -for that very reason to, make sure that we have captured the data
24 correctly and that it actually reflects- the reality on the ground.

25 I might add that one of the requirements that I have for my district inspectors is that
26 they look at the seclusion records- at least monthly when they visit the services and on
27 occasions those district inspectors have come back to me and said there are problems with
28 the data,- and they've worked with the services to get it accurate.

29 As with any data capture mechanism, it's only as good as the recording that occurs.
30 However, with the oversight of the district inspectors who are quite vigilant in this space, as
31 well as our insistence in getting the manual data correct, I think that while we may
32 miss- - well-, rather I hope we do not miss any of the data, but it is something which I have
33 been very focused on getting accurate.

1 **MS McCARTHY:** And can you please briefly describe what happens with that data, so the
2 process for analysis and how that feeds into future change?

3 **DR CRAWSHAW:** So, one of the things that we have been increasingly doing is drilling into that
4 data and in our publications publishing it in a way that hopefully makes it more meaningful
5 and we're about to do another publication in the next month or so. The intent is to help the
6 services on the ground understand where they sit with respect to that data, and if you look
7 at the website you will see that we publish it in a way that enables individual, what was
8 District Health Boards, understand where they sit in relation to their peers.

9 We also have increasingly focused on what is it that is happening for Māori and
10 Pasifika, for the simple reason that I want to know whether this- is an equity issue, from my
11 point of view, it's also a Te Tiriti- issue, that's why we publish the break-down of the data
12 we do.

13 It was my concern and the concern of a number of people within the sector that
14 actually we weren't making as much progress as we would like, which led to the
15 development of the zero seclusion programme of HQSC where we determined that we were
16 going to use a quality improvement methodology to actually help services learn from each
17 other and learn from tāngata whaiora and others about what could make a difference, how
18 could things be different.

19 And HQSC has been running that with the partnership with the services really since
20 2019.

21 So, it's an ongoing programme, it was set an ambitious goal of zero seclusion, it was
22 an aspirational goal, but that is still running, and they're refocused in terms of safety for all.
23 We're very clear that we need to continue to make progress. And it is-- I don't know that
24 the word's "pleasing", it is encouraging I think is a better way to put it, that we are seeing
25 services having significant periods where they have no seclusion, and that they have
26 thought through and have used different processes which might actually mean- that we
27 don't have to use seclusion.

28 A real focus in that and also a safe practice and effective communication, which is
29 how we are trying to avoid the use of restraint, is around alternatives at a very early stage to
30 de-escalate and diffuse situations so we don't get to the situation whereby seclusion is the
31 only answer.

32 **CHAIR:** Doctor, I haven't looked at the website so help me here. If I were to look at the website
33 and look at the data that you're presenting, would that show the trends, the downward
34 trends that you're talking about?

1 **DR CRAWSHAW:** That's what I have been trying to do, is to actually help people. One of the
2 things that worried me about Covid was would there be a situation of perhaps increased use
3 of seclusion with the staff challenges, when staff went off on Covid. So I actually asked
4 my district inspectors to have a much more close observation as to what was happening,
5 bearing in mind that I wasn't actually able to do much travelling and visit the services.

6 **CHAIR:** Definitely, yes.

7 **DR CRAWSHAW:** So, they were my eyes and ears to actually know what was happening on the
8 ground.

9 Pleasingly, in the first round there was actually much reduced use of actually
10 hospitalisation as well as seclusion, not so much as we've continued to progress, but the
11 services have continued to maintain that focus.

12 **CHAIR:** It would be very useful just to have the figures.

13 **DR CRAWSHAW:** We can certainly give counsel the link to our reports, they've been published
14 since the early, sorry-, mid---2000s.

15 **CHAIR:** They may have them already but if they don't I'm sure they'd be grateful.

16 **DR CRAWSHAW:** So we're happy it's- a public database so -that- because--, for me, it's about
17 accountability and transparency.

18 **COMMISSIONER ERUETI:** And data is disaggregated, is that right?

19 **DR CRAWSHAW:** When I came back to the country at the end of 2011, I asked for us to start
20 looking at for Māori and then for Pasifika, so we've been doing the disaggregated data.
21 We've even gone to the extent of trying to look at that in terms of rate per population, and
22 disaggregating that, bearing in mind it's a wee bit challenging in terms of age structure of
23 population. And you'll see if you look at the data, we do it with confidence intervals, so we
24 know whether we're seeing real changes versus just simple changes in numbers.

25 **COMMISSIONER GIBSON:** Can I ask if you're collecting on secondary disability, autism, for
26 example, in terms of seclusion rates, etc?

27 **DR CRAWSHAW:** I'm not sure we've got that data in our system. I'm looking at my colleagues.

28 **MS BLECKMANN:** The question was whether we reported on it or whether it was available?

29 **COMMISSIONER GIBSON:** Yes.

30 **MS BLECKMANN:** The information would be available but we're not reporting on it.

31 **COMMISSIONER GIBSON:** And that's both in disability services and mental health services
32 where there might be a secondary diagnosis or a secondary disability?

33 **DR CRAWSHAW:** Unfortunately, in terms of mental health the diagnostic part of our database is
34 probably the least reliable part of our database, because that relies heavily on how

1 clinicians choose to make and register and enter their diagnosis, and often it just ends up
2 with a principal diagnosis, which is the diagnosis that is under focus for treatment, so that is
3 more challenging, and that's of course part of the work that Whaikaha are doing in terms of
4 actually disaggregating disability data.

5 **MS McCARTHY:** In relation to the zero-seclusion policy, do you envisage that there would be
6 any issues with self-reporting in that staff might be reluctant to report on seclusion as they
7 might be seen to be not complying with the aspiration of the policy?

8 **DR CRAWSHAW:** One of my pieces of triangulation, if I can put it like that, particularly now
9 within the Ministry where we've got a Director of Lived Experience, is that we triangulate
10 what we hear from the services with what we hear from the lived experience community
11 and when I was doing sector visits one of the things that I would always do is set aside time
12 to talk to lived experience to actually hear their story and their account, because for me that
13 was extremely valuable information in terms of not just anecdote but actually what it was
14 like for them within the services.

15 The difficulty will be- is actually trying to make sure that we're not double-
16 counting. But I'm always open to any new suggestions in terms of getting the accuracy up
17 to standard.

18 **MS McCARTHY:** I think this is probably my last question, but just in relation to the
19 disproportional rates experienced by Māori, you have noted, Dr Crawshaw, in your brief
20 that DHBs are required to address this disparity. Can you tell me a little bit more about
21 how that works?

22 **DR CRAWSHAW:** So, bearing in mind this is when we had District Health Boards, as part of the
23 annual plans of the District Health Boards we- -in particular this was focused around- the
24 rates of the use of the Act, because of course you can't get into seclusion if you're not
25 placed under the Act, so if we can drive down the disproportionate number, use of the Act
26 for Māori, then that actually helps the whole situation.

27 So, they were required to have action plans as to how they were doing it. It's a
28 challenging space, because the use of the Act is a final common pathway of a whole lot of
29 other factors. So, there's a lot of disadvantage, a lot of late presentation, a lot of other
30 factors which actually lead to people--- potentially factors which will lead to increased use
31 of the Act.

32 But that said, my challenge to them was: I want to see the disproportionality
33 addressed. And some services have made significant headway, others are finding- it more
34 challenging. One of the issues is often factors outside of the health system, which is why

1 part of our transformation of the mental health services is around cross--sectional and
2 whole of system, which is whole of health system----- whole of Government system to
3 address that.

4 So, for instance, if you've got poor housing that can actually lead to significant
5 distress if you've got other factors which are affecting your life. But services have been
6 focusing on that and trying to address some of the inherent factors which are under their
7 control, but also working with partners to actually relieve it.

8 So there has been action plans on it, and we continue to monitor it, that's why
9 I continue to report on it.

10 **MS McCARTHY:** Thank you, Dr Crawshaw and Ms Bleckmann. If there are no questions on
11 seclusion I'll pass over to Mrs Thomas now.

12 **CHAIR:** Just a general question sorry-, I won't take too long on this. As you are well aware, and
13 we are too, that you are the Health- Day today. Seclusion arises in other aspects of care of
14 children, of young people and of vulnerable adults. I'm thinking perhaps Youth Justice as
15 an area, an obvious area where that might happen.

16 To what extent, if any, are you sharing your expertise and your experience with
17 other agencies of the State?

18 **DR CRAWSHAW:** So, if I could just pick up on the youth space and my colleague Arran Culver
19 might want to expand on that when he is here. Our workforce centre for child and youth
20 has assisted other agencies in developing some of their programmes, particularly in terms
21 of trauma- centred care. I know personally I was involved and engaged with the situation,
22 people may remember some years ago in terms of time-out for education to try and stop
23 that, and supported the then Secretary to actually introduce new policy and changes with
24 respect to that.

25 In some of these spaces it's not just what's in Health or what's in Education or
26 whatever, it's about actually working collaboratively together to achieve better outcomes.

27 **CHAIR:** Yes.

28 **DR CRAWSHAW:** Kia Manawanui which is our ten-year vision for where things should be,
29 heavily emphasises the need for cross-sector engagement.

30 **CHAIR:** How are you going on that? Because you're looking aspirational, I don't know if you're
31 looking completely satisfied.

32 **DR CRAWSHAW:** I will never be satisfied. Seriously, Health is a place where you can never
33 rest and you have to keep working hard and you can never drop your vigilance.

1 **CHAIR:** I really appreciate that statement. My question, though, is to what extent are you
2 satisfied about the degree to which you and your colleagues and other aspects of the care
3 regime are able to collaborate and maybe come up with some joint aspects?

4 **DR CRAWSHAW:** I might pass to the DG.

5 **CHAIR:** She's probably the one where the buck stops there.

6 **DR SARFATI:** I think that is a very, very good point and I think it is one of those things where
7 there is unanimous agreement that that collaborative approach is important. I'm not just
8 thinking about seclusion here, I'm thinking about health and well-being more broadly. And
9 I think there's some really good activity moving towards that.

10 I think as in other areas, Covid taught us some things. So, for example, the care in
11 the community approach to looking after people with Covid, which was not just Health, it
12 included other agencies, and looking at the services that an individual needed rather than
13 Health and, you know, whatever else.

14 And there is a real commitment and interest in learning from that and thinking about
15 how we can incorporate those ways of doing in a much broader sense. And again, going
16 back to the reform process, the idea of localities is very much attached to that.

17 **CHAIR:** Community based responses.

18 **DR SARFATI:** Community based responses, communities identifying what they need and then
19 agencies working together to deliver those things.

20 **MS WOODS:** Yeah, I just wanted to add that it is one of the points of Whaikaha and one of the
21 responsibilities is to have cross-governance strategic disability policy and it's to get that
22 linked-in coordinated approach. So that's at a strategic level but it would go down to an
23 operational level.

24 **CHAIR:** That's very good, it sort of echoes what Commissioner Coster said yesterday about going
25 to the community level. Because the Police have these challenges as well, don't they?

26 **MS WOODS:** They do.

27 **CHAIR:** That's something on the radar, let's put it as high as that.

28 **COMMISSIONER ERUETI:** It's interesting that you're gathering, Dr Crawshaw, disaggregated
29 data on Māori and Pacific but not disability, but you turned to your colleague, "I think you
30 are gathering that data on segregation and those with disability", so it just demonstrates this
31 theme of disconnection that we see.

32 **DR CRAWSHAW:** I think the challenge has been to actually get our systems to record it. It's not
33 that it's not important, it's about how do we consistently code data and consistently get that
34 shared across multiple systems. So, it's not simply about what's in the mental health

1 system, it's also what's in the other databases and get those brought together. That is not a
2 trivial exercise in IT connectivity.

3 **COMMISSIONER ERUETI:** I'm sure. Can I just follow up on your comment about the action
4 plans about Māori in seclusion, are they in the public domain those action plans?

5 **DR CRAWSHAW:** I don't know that they are. So just to correct you, it's about action plans in
6 terms of the use of restrictive care particularly the application of the Mental Health Act.

7 **COMMISSIONER ERUETI:** Okay. Those action plans, they're not in the public domain,
8 they're just- --

9 **DR CRAWSHAW:** So, I don't know to what extent the DHBs publish their annual plans, I'm
10 sorry I just don't know.

11 **COMMISSIONER ERUETI:** Okay, well, I don't know who has responsibility for those now
12 anyway, but where would you find them and who is monitoring them to ensure that they're
13 complied with?

14 **DR CRAWSHAW:** So, the district annual plans that used to be sent were monitored by the
15 Ministry, and we had a separate directorate which would monitor that as part of the ongoing
16 implementation of the funding agreements on a yearly basis, and so it wasn't just about
17 mental health, it was about a whole number of other actions which they were required to
18 take in that year.

19 **CHAIR:** We're going to be moving on to some new topics now, I believe, Ms Thomas; is that
20 right?

21 **MS THOMAS:** Yes, that's correct, if you're happy we might just use the next 15 minutes to do
22 one more topic.

23 **CHAIR:** Yes, absolutely.

24 **DR SARFATI:** Can I just ask whether you'd like me to address the questions that were addressed
25 to me before that I was unable to answer before we leave the previous, --which is the just
26 the two quick questions about the legislation and the funding for Māori Health Authority.

27 **CHAIR:** Please do.

28 **DR SARFATI:** So, in relation to the legislation, if you read the section under the Health Sector
29 Principles, they align with equity partnership tino rangatiratanga options and active
30 partnership although those are not the terms that are specifically used.

31 **COMMISSIONER ERUETI:** What section was that?

32 **DR SARFATI:** I think -it's at- 7? The heading is "Health Sector Principles" under the Pae Ora
33 legislation.

34 **COMMISSIONER ERUETI:** Yeah, Section 7.

- 1 **DR SARFATI:** If you read those principles, they describe those elements.
- 2 **COMMISSIONER ERUETI:** Yeah, they do, but there's no reference to tino rangatiratanga and
3 so forth.
- 4 **DR SARFATI:** No, that's right. In relation to the funding for Te Aka Whai Ora, the funding was
5 over four years and it included 168 million for commissioning, 20 million for Iwi Māori
6 Partnership Boards, 30 million for Māori primary and community care services, and
7 39 million for Māori workforce development.
- 8 **COMMISSIONER ERUETI:** Thank you.
- 9 **COMMISSIONER STEENSON:** Hi, kia ora.
- 10 **DR SARFATI:** Kia ora.
- 11 **COMMISSIONER STEENSON:** Do you know what that make-up is of the entire budget?
- 12 **DR SARFATI:** You mean the entire Health budget?
- 13 **COMMISSIONER STEENSON:** Mmm.
- 14 **DR SARFATI:** The entire health budget-- I couldn't tell up the actual proportion, it's a relatively
15 small proportion of the overarching budget, being mindful of the fact that the majority
16 of- the health services that Māori access are not funded through this mechanism, so there's
17 a lot of services that are, most health services are funded through the rest of the budget, so
18 this is the budget specifically for Te Aka Whai Ora.
- 19 **COMMISSIONER STEENSON:** So it comes through Health New Zealand?
- 20 **DR SARFATI:** That's right. So Health New Zealand, for example, funds screening services,
21 hospital services, those sorts of things, which the majority--- so Māori access those
22 services, those would be likely the majority of services that they would access. This is
23 specific funding for kaupapa Māori services and specific Māori--centred care.
- 24 **COMMISSIONER ERUETI:** Coming back, I didn't add up those figures, do they add up to
25 about 220 million or so?
- 26 **DR SARFATI:** I haven't actually added them up, so I'll trust you on that.
- 27 **COMMISSIONER ERUETI:** Okay, but I think it might be a bit more, but that's spread over four
28 years.
- 29 **DR SARFATI:** Over four years.
- 30 **COMMISSIONER ERUETI:** When I look at Pae Ora, the legislation, and I look at what they're
31 required to do, there's long list of functions that they have, they're not just a commissioning
32 agency. They have a major advisory role, they participate in a lot of what the Ministry is
33 doing.
- 34 **DR SARFATI:** That's right.

1 **COMMISSIONER ERUETI:** Do you think that is sufficiently- - is- that enough funding to
2 support the sort of mahi that they're required to do?

3 **DR SARFATI:** I think that's probably a question for Government, but what I would say is Te Aka
4 Whai Ora and Te Whatu Ora, so that's the Māori Health Authority and Health
5 New Zealand, are working in very close partnership. So one of the roles of Te Aka Whai
6 Ora is to ensure that the services that are being delivered by Te Whatu Ora are appropriate
7 for Māori, and are focusing on the areas that are of particular interest to them. But there's a
8 very close partnership forming there.

9 **COMMISSIONER ERUETI:** Yeah. But that means there's a lot of work that they have to do
10 including this work and working in conjunction with the Ministry, but there's that question
11 about whether, you know, that amount of money spread across four years and we've heard
12 the criticisms, comments made in the press about that not being sufficient to support the
13 Māori Health Authority.

14 **DR SARFATI:** Yeah, and as I say, that's probably a question for Government. Part of that
15 discussion was kind of a conversation about the proportion of the population that was
16 Māori and the proportion- but actually that would assume that all services that Māori were
17 accessing were funded through this mechanism which is, of course, not the case.

18 **COMMISSIONER STEENSON:** So, sorry, I just have a clarification as well, just understanding
19 the different, because you've got the Māori Health Authority, the Ministry of Health,
20 Whaikaha and Health New Zealand.

21 **DR SARFATI:** That's right.

22 **COMMISSIONER STEENSON:** So, in terms of who funds who, so Ministry of
23 Health- - who- apportions the funding to these organisations?

24 **DR SARFATI:** Basically, the funding for services now goes through Te Whatu Ora primarily,
25 that's the biggest funder of- - that's where most of the budget goes. So,- they then deliver
26 the health services.

27 **COMMISSIONER STEENSON:** And they get allocated their funding from?

28 **DR SARFATI:** Through Government, through Vote Health.

29 **COMMISSIONER STEENSON:** So it's not through the Ministry of Health.

30 **DR SARFATI:** Nominally, but it goes straight to Whatu Ora and then Te Aka Whai Ora gets its
31 own budget, as we've been discussing.

32 **COMMISSIONER STEENSON:** And that's through the Health New Zealand?

33 **DR SARFATI:** No, it's through the same mechanism, through Government.

34 **COMMISSIONER STEENSON:** Through Ministry of Health?

1 **DR SARFATI:** That's right, through Vote Health, yeah, that's right.

2 **MS WOODS:** I just need to clarify that Whaikaha is not part of the health system, so it's a
3 departmental agency that is through the Ministry of Social Development. The previous
4 Disability Support Services prior to 1 July were part of the health system, so that's part of
5 that change is that they've been moved, and they're now separated.

6 **COMMISSIONER STEENSON:** And your funding therefore comes through the Ministry of
7 Social Development?

8 **MS WOODS:** Well, we have our own vote, but yes, it comes through the Ministry, yes.

9 **COMMISSIONER STEENSON:** Thank you.

10 **CHAIR:** I think we should let Ms Thomas get on with her 15 minutes which we've eaten into, you
11 take as much time as you need, please.

12 **QUESTIONING BY MS THOMAS:** We're moving on to the topic of support for whānau and
13 families. This may take less time than it would have prior to the concessions and
14 acknowledgments that were made by both agencies through Ms Woods and Dr Sarfati this
15 morning, and I appreciate those.

16 As I think you've both acknowledged and have watched and reviewed the evidence
17 from the previous hearing Ūhia te Māramatanga, it was a consistent theme throughout that
18 survivor voice hearing around the lack of support for whānau to be able to look after their
19 family within the family home unit, historically, and there was pressure to place a disabled
20 child or a child or adolescent in mental distress into an institution.

21 There was a quote in Dr Brigit Mirfin--Veitch's brief of evidence for that hearing
22 that she said that often the mothers -made the final decision about care, and they carried the
23 burden of that decision. But Dr Mirfin---Veitch noted:

24 "While it is clear that they made those decisions due to an acute and systemic lack
25 of support, it was often perceived as being as a result of them, the mum, being unable to
26 cope."

27 But I think you've acknowledged this morning from both ministries, it was--- there
28 was inadequate support provided to families throughout those decades in New Zealand's
29 history. You're both nodding there.

30 **MS WOODS:** Yeah, I was just saying, all I can really say is they were not always provided that
31 support because there may have been circumstances where some people were, but certainly
32 the survivor evidence shows that those people didn't, they were not provided that support,
33 yes.

1 **MS THOMAS:** Thank you. I was going to put some quotes on the screen from some survivors,
2 but I think we can move on from that.

3 I imagine you'll also agree that as a result of that lack of support and therefore more
4 children, particularly disabled children, going into institutions, this did have a significant
5 impact and lifelong impact on these whānau and family members, both the people in the
6 institutions and the family at home.

7 **MS WOODS:** Yes.

8 **MS THOMAS:** Thank you. As the Crown at that hearing said that, "the Crown is here to identify
9 the lessons learned and to make good on our commitments to address them", what I would
10 like to do now is consider the situation today, 2022 and ask whether families today receive
11 adequate care and support from the State, acknowledging this needs to be a whole of
12 government response, not just Health and Disability, but particularly for disabled whānau
13 members today, is there sufficient support to the families.

14 I'd like to do this by putting up another table on the screen, which is the table of
15 factors contributing to the pathway into institutions in the 1950s, and when that comes up
16 that will be on the left-hand side column. And then on the right-hand side of this table
17 there's some quotes taken from a report that was authored in 2022 by the Donald Beasley
18 Institute, and it was really a literature review of the situation that's called "Good Practice
19 for Disabled Tamariki and Rangatahi in Care".

20 I might just go through this table one by one, but it won't take too long, to look at
21 the factors raised on the column which are the historical factors that were identified by Dr
22 Mirfin-Veitch as to reasons that contributed to families placing children into institutions,
23 and then I'll go through some quotes from the very recent report that are current day factors
24 that do contribute.

25 So, if we highlight or zoom in on the first box, it states a commitment- "-there was a
26 commitment to maintaining the family unit". So,- in general, the families were committed
27 to try and maintain that family unit, and if we go to the lefthand column of this table, and
28 I appreciate these are certainly not -word-for-word- comparisons but just a parallel to be
29 drawn, that here it states that "the final event tipped the balance from a family that was
30 coping to no longer being able to manage."

31 So would you accept the parallel there is a family were coping, were trying to
32 maintain that unit, but then the balance was tipped and that was no longer possible.

33 If we move to the next box, historically one of the factors that was suggested is
34 to- - a contributing factor to placing a disabled child into an institution was the futile search

1 for community-based- services, and if we could zoom in on the highlighted sections of the
2 right-hand column, I'll read these highlighted portions into the record:

3 "When considering the reasons why tamariki whaikaha might go into care, the lack
4 of Health and Disability support services provided to both the individual and their whānau
5 was cited as the main reason for relinquishment."

6 Then further down:

7 "More specifically, reviewed literature indicated that a lack of financial support,
8 whānau carer psychological distress, concerns for sibling safety, and the absence of regular
9 periods of respite were major contributing factors in relinquishment decisions and thus
10 OOHC."

11 Which I think stands for out of home care:

12 "There was an acute shortage of quality respite even though respite requests and
13 usage was escalating. Parents reported a lack of support from schools due to children being
14 suspended and expelled which generated additional demands."

15 And if we just briefly move to the last points, if we highlight the box 'C' on the left
16 hand side, historically one of the factors contributing to being placed in an institution was
17 seen as "the ongoing challenges to caring", and on the right hand side of this table, we've
18 mentioned this already, but the highlight there talks about the financial pressures:

19 "Struggling to accommodate the costs and time associated with day-to-day care of
20 their disabled family member. Retaining employment was reported as being challenging."

21 So that is a comment from the 2022 report

22 This next one is historically categorised as "The Influence of Professionals", and in
23 terms of current day acknowledging this is not as -the- correlation is not as clear with this
24 point, but there was a point made in the 2022 report saying that:

25 "Finally, engaging with Government agencies together with feeling conflicted over
26 how to respond to and resolve their support requirements and those of their tamariki
27 whaikaha were reported as factors contributing to whānau carer stress within the support
28 context."

29 And the last point on the historical side of this table that we're highlighting, this is
30 from the 1950 perspective, that the "the catalyst for permanent out of- home placement was
31 you just cracked up", and that's in relation to---- that was related to often a mother of the
32 child just went beyond the tipping point, and the child was then placed in an institution

33 And in terms of the 2022 report:

1 "...with research indicating that a deterioration of parental psychological well-being
2 can lead families to place their children in the care of others, albeit reluctantly, the
3 importance of tending to the psychological well-being of the whole family or whānau is
4 evident."

5 Dr Sarfati and Ms Woods, when we look at that comparison table from the factors
6 that contributed to children being placed out of their homes and into institutions,
7 particularly disabled children or children in mental distress, historically, and when we
8 consider the points raised from this literature review that was compiled this year, do you
9 agree, can you see the parallels in terms of those contributing factors then and now?

10 **MS BLECKMANN:** I'll -yeah- I think that it would be useful to provide some context, because
11 some of those paragraphs are over quite some time. In 2008 there was a select --Social
12 Services Select Committee Inquiry. At that time there were approximately 200 people
13 using individualised funding arrangements.

14 The Government response to the Select Committee Inquiry was to increase and
15 expand arrangements like individualised funding. There are now over 8,000 people using
16 individualised funding and therefore can make decisions and have increased choice and
17 control about the types of disability supports they get and there are over 26,000 people now
18 who access direct funding for respite.

19 So there are a whole range of things that Ministry of Health through the disability
20 directorate has done to expand the range of options for families supporting disabled
21 children, so that they're not placed in care.

22 In 2018, there was the repeal of Section 141 which means that children can't
23 voluntarily be placed in care. And the Ministry of Health, through the disability
24 directorate, also introduced intensive wrap-around services for children who were at risk of
25 being placed in care.

26 **MS THOMAS:** So, the comments in this 2022 report that a major contributing factor to an out of
27 home care placement being a lack of Health and Disability support, do you disagree with
28 that conclusion?

29 **MS BLECKMANN:** There are far more range of options to support families that were available
30 previously in the earlier reports.

31 **MS THOMAS:** Sorry?

32 **MS WOODS:** I think that what we're looking at is our understanding of what those references are
33 is that the dates that those quotes came from, because this is a literature review, I
34 understand, is that even though the report came out in 2022, they are quoting from things

1 that occurred in, for example, 2016 and 2012 and so subsequent to those dates, things have
2 been put in place to improve the services that are available.

3 **MS THOMAS:** Right. So, the 2008 select committee report, so you're saying since then things
4 have improved?

5 **MS BLECKMANN:** Yes, I am. Dramatically.

6 **MS THOMAS:** Even though, I think it is the 2016 comment here from the researcher Milner
7 around the inadequate respite care facilities or insufficient respite care, that was dated 2016,
8 I think.

9 **DR SARFATI:** I'll just jump in here with my academic hat on. That's a citation of a paper that
10 she's written in 2016 which will be citing stuff that happened prior to 2016. So even
11 though the date is 2016, that doesn't mean that those conclusions relate to that time, they
12 relate to sometime prior to 2016.

13 **MS THOMAS:** So, are you satisfied currently that there is sufficient Health and Disability
14 support available and sufficient respite care available to families and whānau to avoid
15 getting to a breaking point in their lives where they may then end up placing their child in
16 out of home care?

17 **MS BLECKMANN:** So in my experiences there is often a range of reasons that a family will
18 seek an out of home placement, and it won't just be because of a lack of disability support.
19 I think it's important to say that we are always wanting to improve Disability Support
20 Services, and there have been changes at specific points over time, and during Covid the
21 Ministry of Health introduced much more flexible arrangements about how people could
22 use their funding and what type of supports they could buy or purchase.

23 So yes, we will still have feedback that there is insufficient respite. On the flip-side,
24 there is far more choice for families about how they choose to access respite and what
25 respite means for a particular family.

26 **MS WOODS:** I think it also goes to the transformation of DSS towards an EGL approach will
27 enable that flexibility to be available to a lot more people. So that is the part of the point of
28 the transformation.

29 **MS THOMAS:** In terms of the point being made about the parental psychological well-being and
30 the stresses on families and the deterioration of that being a factor, is that a health question
31 or a disability question in terms of are you satisfied that's being addressed today?

32 **MS BLECKMANN:** I think it's both, and back in 2005 families would be--- a child aged under 5
33 would be far less likely to get disability supports, whereas we would absolutely expect now
34 that the NASCs are allocating support to children under 5.

1 So, back in 2005 disability supports tended to be for children over 5 and we have
2 made quite some change in that area.

3 **MS THOMAS:** Just one final question on this topic before we take an afternoon tea break. The
4 Chief Executive of Oranga Tamariki has set out a brief of evidence for this Royal
5 Commission stating that Oranga Tamariki is working to implementing recommendations
6 made in a report from the Ombudsman about the respective supporting disabled parents.
7 She also stated in her brief of evidence, I could put it up on the screen but if you're happy,
8 I might just read that out. This is, for the record, witness statement 2009001, paragraph
9 103:

10 "However, funding and provision of services and support to enable parents with
11 disabilities to retain care of their children relies heavily on the Ministries of health, the
12 Ministry of Education, Whaikaha, Ministry of Disabled People, Work & Income, the
13 Disability Rights Commissioner and the Disability Support and Advocacy Services, as well
14 as with Oranga Tamariki."

15 So, in relation to that point raised by the Chief Executive, what is the Ministry of
16 Health and Whaikaha doing to support retaining disabled children within the family
17 together with Oranga Tamariki and the whole of government?

18 **MS BLECKMANN:** We're doing a range of things. At a national level we meet at least monthly
19 with National Office of Oranga Tamariki; at a local community level in the prototype in the
20 Mid-Central there is a very close relationship between disability and Oranga Tamariki. The
21 evidence is showing that no children have entered care in the prototype since 2017 and we
22 are working with Oranga Tamariki to better understand what's happening in the prototype
23 so that we can extend that to other parts of the country.

24 **MS THOMAS:** Sorry, can you just confirm which--was this the Enabling Good Lives?

25 **MS BLECKMANN:** The Enabling Good Lives and in MidCentral, Mana Whaikaha.

26 **MS THOMAS:** Thank you. Those are all my questions on that topic, and if it suits everyone,
27 we'll take the 15 minute adjournment.

28 **CHAIR:** All right. We'll take the adjournment and there might be questions about that from
29 Commissioners, which we'll take after the adjournment, thank you.

30 **Adjournment from 2.38 pm to 3.03 pm**

31 **CHAIR:** Welcome back. Thank you, Ms Thomas.

32 **MS THOMAS:** Thank you, Madam Chair. We will now move on to the next topic of the
33 workforce. And I will ask the for a table that we have provided in relation to some

1 workforce issues to go up on the screen now. This table is titled "National Crisis Staffing
2 Shortages". And it is a collation of some quotes.

3 Once again, on the left-hand side of this table there's a number of historic quotes, on
4 the right-hand side there's some quotes that are more recent. I will just go through the
5 highlights and then ask some questions as we move through the pages on this table.

6 On the left-hand side there is a letter from the PSA to the Minister of Health in July
7 1983 and that is titled "PSA Hospital Group National Crisis" and the highlight on that letter
8 says:

9 "There is a staffing shortage of qualified and registered psychiatric nurses."

10 And the quote below that is dated 1986 and that's from the Askew report which
11 says:

12 "There is a shortage of professional staff. There are major shortages of professional
13 staff throughout the mental health services, in varying degrees different hospitals
14 experience serious shortfalls of psychiatrists, qualified nursing staff, physiotherapists,
15 occupational therapists, social workers, speech therapists, particularly in the hospitals for
16 the intellectually handicapped, and psychologists."

17 So those are two documents from the 1980s and if we move on to the quotes on the
18 right-hand side, this is taken from the Ombudsman's report 2021 called "Oversight". And
19 just for reference, the document of this report is MSC0008114.

20 This shows a quote, I'll just read that sentence in the middle there:

21 "We believe statutory obligations under the IDCCR Act are not being met
22 nationally and the population intended to benefit from this legislation are being poorly
23 served that we are now at a crisis point."

24 And the final quote in this right-hand side column from this 2021 report says:

25 "I have observed a reluctance by the Ministry to take leadership role in addressing
26 workforce issues and in my view, this has contributed towards a fragmented approach to
27 workforce development."

28 So, in relation to this table, Dr Sarfati, do you accept that staff shortages, historical,
29 from the past, are relevant in today's health system as well?

30 **DR SARFATI:** I think it's really useful in relation to this issue to consider some important
31 context. So, the first thing I would say is that when we're thinking about staff shortages
32 from a long time ago, 1950s, '60s, '70s, compared with those today in the context of mental
33 health services, we're talking about somewhat different things.

1 So, I'm slightly quoting my colleague Dr Culver, who's unfortunately not up here
2 with us right now, but we were talking yesterday as an example where in the '50s, '60s you
3 might have one psychiatrist for 300 patients, now you'd be considering it a problem if you
4 were at one psychiatrist for 15. So, what we would define as a workforce shortage now is
5 different to what they would have been defining then.

6 So, whilst we use the same language, we are talking about different scale, I guess
7 I'm saying, the scales are very, very different, which doesn't mean to say it's not a problem
8 now. But just in terms of context.

9 The second issue relating to health workforce is that health workforce capacity is a
10 general issue across the health system in New Zealand and globally. So, this issue of health
11 workforce development is a major issue for health systems in every part of the world and
12 New Zealand is no exception, and the mental health services are no exception to that.

13 In relation more specifically to the mental health services that we're talking about
14 today, there are clearly problems with workforce, and the Government has recently invested
15 substantial amounts specifically for mental health workforce both in the 2019 and 2021
16 budgets. In addition to that, there's some more recent work coming through. So, Te Whatu
17 Ora, for example, has a workforce task force which is one of its earlier pieces of work or
18 projects that it's put in place to address the issue of shortfalls in workforce across the
19 system, but mental health is one of their priority areas.

20 Thirdly, there is work going on actively at the moment within the Ministry of
21 Health on a workforce strategy. So again, it's a very broad-based consideration of how we
22 improve the pipeline into our health workforce in general.

23 **MS WOODS:** I think it's also important that we just note that the past material probably is quite
24 health related. The present is actually about intellectually disabled people in secure units
25 under an Act that is part of Whaikaha in terms of what we fund, and Amanda was just
26 going to talk to that.

27 **MS BLECKMANN:** Thank you. So, I'm going to just restate that the Ombudsman's 2021 report
28 was accepted, and the Ministry took a number of steps in response to the investigation and
29 to the report. So, one of the recommendations of the Ombudsman's report was to develop a
30 strategic framework for the IDCC&R, the Intellectual Disability (Compulsory Care) Act.
31 We have done that, or that is underway, so we have set up a specialist services group within
32 Whaikaha and previously within the Ministry of Health, and that team, the person leading
33 that team, is developing a strategic plan in response to the Ombudsman's report.

1 **MS THOMAS:** Thank you. If we could pull up the next table, please, called "Continuity of
2 staff". And I will read out the summarised quotes from the past on this topic of continuity
3 and then we'll move on to the present. The first comment or quote comes from a report to a
4 medical officer regarding the review of the psychiatric and psychopaedic hospitals back in
5 1984 on a visit to Tokanui, and there the comment says that:

6 "Staff numbers available and continuity remain inadequate."

7 In terms of the 1986 quote on the screen, again from the Askew report, the comment
8 is that:

9 "Low staff levels resulting from both low establishment and failure to recruit
10 leading to overwork, low job satisfaction and low standards, and a lack of status for
11 psychiatric hospitals."

12 It says that:

13 "These factors adversely affect the recruitment and retention of high calibre staff
14 and until this cycle is broken, the problems are self-perpetuating."

15 It also states that the constant turnover and lack of continuity of nursing staff often
16 compromise patient care by inhibiting the development of individual patient and ward
17 programmes.

18 And moving to some evidence from a survivor's sister that was given at our recent
19 public hearing on this point of continuity of staff, so this is transcript number ending 0479,
20 this witness stated:

21 "In order to have happy residents we need to have a stable workforce. In order to
22 have a stable workforce we need to have a career path."

23 This witness also went on to say:

24 "I've had experience with caregivers and at one stage seven out of my sister's eight
25 caregivers resigned in a period of seven to eight months. I can't remember exactly, that was
26 because of a very poor middle manager, so it's not enough to have caregiver training, you
27 must also have middle management training as well."

28 And just finally on this topic of continuity of staff, I'll read the quote from the
29 Health and Disability system review, which was a report that came out in March 2020:

30 "Despite recent regulatory changes that include in between travel- - sorry, it's hard
31 to read this one-- - pay equity for care and support workers and provisions for guaranteed
32 hours, workers are still faced with irregular hours and a lack of job security. In addition,
33 the current system is complex and bureaucratic-- as different top---up rates exist for travel
34 times, guaranteed hours and pay equity. Having secure salaried contracts is expected to

1 help grow a skilled workforce by improving staff retention and attracting new people to the
2 sector. This would help to meet future demand."

3 So perhaps if we could focus on the quotes from the present day, which go to this
4 point of the need for continuity of staff, the need to recruit and retain staff who want to be
5 in this workforce, and then that final quote around the need for good contracts with regular
6 hours so that people can rely on their jobs and their incomes coming in. Perhaps, Ms
7 Woods or Ms Bleckmann, do you have any comments to respond to these points?

8 **MS BLECKMANN:** Yeah, so I think that there are quite a few questions in there and I'll respond
9 to each of them. I think for the second quote, around a very poor middle manager and the
10 number of caregivers that had resigned, in that transcript the sister, [GRO-B]'s sister goes
11 on to say that there was a significant improvement.

12 **MS THOMAS:** Yes.

13 **MS BLECKMANN:** And that some significant changes were made within that organisation. It's
14 fair to say that the carers, the support workers do need to be in a right relationship.

15 **CHAIR:** Sorry.

16 **MS SCHMIDT-McCLEAVE:** Sorry, ma'am, there was just a name mentioned there.

17 **MS THOMAS:** I think we've got that covered.

18 **CHAIR:** You've got that covered? Thank you.

19 **MS BLECKMANN:** We would all agree on the need for continuity of support and that it is about
20 relationship. And then my third point to the third quote is around the home and community
21 support workforce rather than support workers who work in a care setting. But we would
22 still agree that there is a need for a regularised workforce and a well-supported, well-trained
23 workforce.

24 **MS THOMAS:** Sorry, can you just clarify for me that distinction that you made between the
25 workers who work in a care setting versus --

26 **MS BLECKMANN:** So the third quote is around, includes things like in between travel for
27 support workers, so that is about the home and community support workforce rather than
28 the workforce supporting people who are living in residential care arrangements.

29 **MS THOMAS:** But it's still a workforce supporting disabled people but in their homes?

30 **MS BLECKMANN:** [Nods].

31 **MS THOMAS:** Which Whaikaha still looks after, that workforce?

32 **MS BLECKMANN:** Yes.

33 **MS WOODS:** Whaikaha funds those services for disabled people. The health system funds for
34 aged care.

1 **MS THOMAS:** So you would agree though that that workforce- so the residential care workforce
2 but also the care workforce that works with people who are supporting people in their own
3 home equally need that continuity of staff, and do you think that is currently available? Are
4 you satisfied that that's operating in a continuity- of- -staff way today?

5 **MS BLECKMANN:** I mean, there'll be different--- there are different issues in the workforce,
6 including Covid, that we know that there are issues around service continuity and service
7 disruption.

8 I'd just like to also add that there is also a care and support workforce qualification.
9 So in response to the carer training, there are carer pathways and qualifications.

10 **MS THOMAS:** Yes, and we will get to that very shortly, I think there's another slide that talks
11 about particular qualifications.

12 **CHAIR:** Could I clarify please. This is about caring for disabled people, either in a residential
13 situation or at home. Residential people have contracts and work on rosters and there's a
14 continuity of service, is that what you're saying?

15 **MS BLECKMANN:** Yes.

16 **CHAIR:** The home ones, are they like contract workers, so they're on-call or how does that
17 operate?

18 **MS BLECKMANN:** It's a far more transient workforce. So they may be employees, or- they are
19 likely to be employees, but they-- - yeah-.

20 **MS WOODS:** I think your question is partly about what those workers do, so they provide- - they
21 might come in and provide housekeeping services, they might help-- --

22 **CHAIR:** No, I do understand what they do, they come in and support in the home. What I'm
23 interested in is their employment status, their contractual arrangements. Are they on a
24 contract that says you will be available, I don't know, 10 hours a week or 20, whatever
25 hours, and you will get this amount of money?

26 **MS WOODS:** It's highly dependent on the employer.

27 **CHAIR:** On the employer?

28 **MS WOODS:** There'll be a contractual arrangement with an entity and the home and community
29 service workers work through that organisation.

30 **CHAIR:** And to what extent is Whaikaha responsible for regulating those down? Or do you leave
31 them entirely up to the contracting agencies?

32 **MS WOODS:** Sorry, in terms of the- - it's not a regulated workforce like the health workforce is a
33 regulated workforce, there are standards which we would expect individuals to be working

1 to and there are standards that the contracts with those entities would-- -we would- have
2 written into those contracts.

3 I'd need Amanda to explain that a little bit more but --

4 **CHAIR:** Does that include continuity of care, because that's what this is about, isn't it? Does it
5 say, "and part of this contract is you will provide continuity of care"?

6 **MS BLECKMANN:** To the degree that's possible, I think a better way of describing this is in a
7 residential service there will be a team of people supporting a, or working in a home, and
8 there is a need for continuity of care, whereas in the home and community support services
9 it's more likely that a person will be moving from home to home, and again, there is a need
10 for continuity of support worker.

11 **CHAIR:** So, at the very best what we've established is that there's quite a difference between the
12 arrangements between those two.

13 **MS BLECKMANN:** Yes.

14 **CHAIR:** Thank you.

15 **MS THOMAS:** Just one further question on that situation where there is in-home care, so
16 someone comes into the home, they could be doing home housework, but they could also
17 be assisting someone to have a shower. So, in terms of continuity, the person who comes in
18 and does those personal cares, every week that could be a different individual depending on
19 the staffing situation in that third party that Whaikaha funds; is that correct?

20 **MS BLECKMANN:** Well, it could be, and one of the reasons that I mentioned individualised
21 funding and personal budgets is that people now have the opportunity to employ people
22 directly and choose who provides that support, they can choose when the support's
23 provided, who provides it and how it's provided. So, there is far more opportunity through
24 Whaikaha and Disability Support Services to ensure continuity of care, and choice about
25 who provides that care.

26 **MS THOMAS:** And that's available not just in situations of residential care, someone who
27 currently is at home but needs someone twice a week to come in and assist them with
28 showers, they can choose who they want when they want that under the new system?

29 **MS BLECKMANN:** Absolutely.

30 **MS THOMAS:** Do you feel assured that we have enough staff to make that available?

31 **MS BLECKMANN:** Well, the numbers of people who are choosing that option would show that
32 there are. So, there are around about 8,000 people using those arrangements. It does
33 extend to people who could otherwise be accessing residential care, so people could choose

1 to live in their own home and have a high level of support in their home and access a
2 personal budget.

3 **MS THOMAS:** Thank you. If we could move on to the next page of this workforce slide which
4 is titled "Staff shortages leading to bad culture, stress and then increased risk of
5 neglect/abuse." There is a historical document on the left-hand side, this is minutes of a
6 Hospital Board Dismissal Committee from 1985 regarding a psychopaedic student nurse at
7 Kimberley Hospital. And I'll read out the quote from this:

8 "The Committee considered the written reports on this staff member and the
9 recommendation of the Superintendent. There was also a letter from the staff member who
10 admitted to having struck a patient four times on the buttocks with a lavatory brush. It was
11 noted that there were exceptional circumstances at that time. The staff member was in a
12 villa with 43 handicapped patients. He was looking after 21 patients by himself; the staff
13 member was tending to one patient and was called out to the lavatories where a patient was
14 urinating on the floor. In the written statement from this staff member, he said he regretted
15 the circumstances and his striking a patient. He stated that he was under extreme stress and
16 reacted inappropriately."

17 So that was a historic situation.

18 And I'll now move on to the righthand column, which is from a witness statement,
19 survivor's sister, document ending 400001:

20 "On one occasion I was at a place and heard another resident crying and found them
21 on the floor bleeding. I called for help and the support worker at issue came but she broke
22 down and she said that she had requested stress leave. She also said that the other support
23 workers were blaming her for her sister's head injury."

24 This is the witness's sister's head injury.

25 "This whole incident was very concerning, not only because it was evident the
26 support worker was in no position to look after the visibly distressed resident but also
27 because it seemed like she had some involvement in [my sister's] injuries."

28 Just in terms of these quotes, would you agree as a global proposition that when a
29 person is in a workforce, an extremely stressed workforce with inadequate staffing, that
30 could increase and does increase risks of abuse or neglect occurring?

31 **MS BLECKMANN:** I'd say that it's really important that these organisations ensure the staff are
32 well supported, and my recollection of this transcript is that that is related to a period where
33 there was a high turnover of staff and refers to poor middle management and that there,
34 again, was a significant improvement.

1 **MS THOMAS:** Yes, on the present, this was I think, it was certainly post 2000 this situation, so
2 it's more current-day situation.

3 **MS BLECKMANN:** Yes.

4 **MS THOMAS:** What does Whaikaha have in its action plan to address these situations in terms
5 of when you are contracting this work to third parties? Do you have any specific aspects of
6 your contracts that you raise to try and prevent situations like this?

7 **MS BLECKMANN:** Absolutely, there are a range of mechanisms set out in the service spec to
8 prevent this type of situation. The contract sets out the Ministry's expectation that the
9 support is being provided in line with the vision and principles of Enabling Good Lives.
10 And the contracts set out the Ministry's expectation that providers deliver supports in line
11 with relevant legislation, such as the Human Rights Act and international instruments such
12 as the UNCRPD. And that there is appropriate supervision of staff.

13 **MS THOMAS:** Is Whaikaha made aware of care providers when they are in a state of
14 under-staffing or they're stressed, does that filter up the chain? Is there a requirement for
15 that information to be fed back to Whaikaha to understand this particular service, we
16 haven't got enough staff in these three houses, for example, we're stretched to the limit.
17 Does that get fed up; is that a requirement?

18 **MS BLECKMANN:** Yes, and there are a number of ways that Whaikaha would hear about these
19 types of situations, either through family members, from the provider directly, from people
20 living in the service. So there are a number of mechanisms we would hear about situations
21 like this.

22 **MS THOMAS:** When you do hear about that, what do you do?

23 **MS BLECKMANN:** We act immediately.

24 **MS THOMAS:** Can you tell us an example what would you do?

25 **MS BLECKMANN:** So, if there was a situation where we heard that there was a lack of staff,
26 that people were not getting the support that they need, we would be making contact with
27 the provider. We would send in a Ministry staff member to have a look at the service and
28 we do that often, or when we hear about these types of situations. We can do a no notice
29 audit.

30 So, there are a range of mechanisms and responses depending on how serious the
31 situation is and what type of response we get from the provider.

32 **MS THOMAS:** Thank you. If we could move to the next slide of this workforce table which is
33 titled "Inappropriate Interventions Resorted to", and we have discussed seclusion in detail

1 today already, but on the left-hand column of this table is a reference to the 1986 Askew
2 Report which states that:

3 "Hospital staff agreed with review team members that seclusion would often be
4 unnecessary with improved staff numbers and staff training."

5 And this OPCAT --report, sorry, dated January 2022, reference number ending
6 8132, states that:

7 "Staff and mokopuna told us that this unit is unsafe when occupancy levels are high,
8 and this occurs often."

9 It goes on to say:

10 "This is exacerbated by ongoing issues with unsafe staffing levels."

11 The final quote says:

12 "This is a significant increase in the use of seclusion and restraint since our last
13 monitoring visit. Staff said this increase is due to unsafe staffing levels, high occupancy
14 and acuity, the physical environment and a lack of de-escalation spaces."

15 So this may be more of a question directed for Health and Dr Sarfati and Dr
16 Crawshaw, but do you have any response to the issues mentioned in this recent OPCAT
17 report around an inpatient service with, as it says here, inadequate staffing which then leads
18 to higher risk of seclusion?

19 **DR SARFATI:** Yeah, so yes, in short, we are concerned about that, and responses have been
20 made and Dr Crawshaw can detail the actions that are currently underway, perhaps.

21 **MS THOMAS:** Thank you.

22 **DR CRAWSHAW:** One of the things that my office and, before the movement to Te Whatu Ora,
23 the group responsible for specialist services do is that we monitor the OPCAT reports, and
24 we'll follow up on particular issues. A lot of the reports actually had positive aspects as
25 well as particular issues.

26 This has been followed up by us and the service has already started to make
27 changes. People may not be aware of it, but within the health sector there is a process
28 called Care Capacity Demand Management, which is an agreement between the services
29 and the unions about how do they actually look at the appropriate staffing levels. Arising
30 from this report, the particular service leadership has agreed that they need to significantly
31 increase their staffing levels to deal with the issue, although there was some dispute about
32 what was the actual occupancy on the day that the visitors came.

1 That said, they're doing two things. One is to try and increase the staffing, but also,
2 they're taking the opportunity to increase the number of Māori staff within the unit, because
3 it gives them an opportunity to address some of the cultural aspects of care.

4 So, as I say, when we see these sorts of things we do follow through and check what
5 is actually happening on the ground and what is the service actually going to do in response
6 to the concerns raised. And as I say, in this case the service has responded.

7 **CHAIR:** You're no doubt familiar with this report and we haven't seen -- I know it's in the bundle
8 but I haven't read the whole thing. This is one report of one unfortunate situation, which
9 you say you've responded to. Are you familiar with this report?

10 **DR CRAWSHAW:** Yes.

11 **CHAIR:** How many incidents of this sort were listed? You said there were some good things.

12 **DR CRAWSHAW:** Yeah, so often these reports will comment on the caring nature of the
13 services that the staff are providing. There will be sometimes issues with particular aspects
14 of the service, and I think we noted before issues of using the seclusion room as overflow,
15 for instance.

16 One of the things I do on a regular basis is that I meet with both the Children's
17 Commissioner inspection teams as well as the Ombudsman's inspection teams because
18 what I'm looking for is patterns and patterns that need to be addressed.

19 **CHAIR:** That's what I'm really asking about, are these reports showing patterns or was this the
20 only incident in this report or were there other incidents?

21 **DR CRAWSHAW:** There are times when the service is, particularly in the last- -through Covid,
22 where they may have enough staff on the roster, but actually a number of staff are off with
23 Covid and needing to -self isolate which then places significant pressure on the services to
24 actually safely- staff.

25 There's also been the challenge of actually recruiting through Covid, bringing staff
26 in.

27 **CHAIR:** Dr Crawshaw, I understand all that.

28 **DR CRAWSHAW:** No, I'm just trying to get to- --

29 **CHAIR:** It's really the question of the volume of the incidents. --

30 **DR CRAWSHAW:** This would not be a usual situation.

31 **CHAIR:** That's where I wanted to hear.

32 **DR CRAWSHAW:** So, typically, services will prioritise the staffing of inpatient units, even to
33 the extent of not--- of bringing people in from the community to support it and they
34 certainly have done that through Covid.

1 I might add, services are also thinking quite innovatively about some of the options
2 that they've got in terms of who are the staff on the units.

3 **CHAIR:** That's right, it's not just the quantity, it is the quality and the nature, diversity.

4 **DR CRAWSHAW:** And for some units they're taking the opportunity, for instance to use peer
5 support on the wards which actually improves the response of the services.

6 **CHAIR:** Thank you.

7 **MS THOMAS:** I'd just like to move on to the next slide which is about career pathway and lack
8 of training because it does come back to the point that Ms Bleckmann raised before. The
9 quote on this screen on the left-hand side is again citing the 1986 Askew Report and it just
10 says that:

11 "Hospitals are hampered by inadequate staffing, limited funding and the perceived
12 marginal relevance of course topics in terms of opportunities to attend educational
13 programmes."

14 So that is a historic point, but in terms of the current day and going to the
15 qualifications currently available to people working in particularly in the disability sector,
16 the witness who gave evidence at our hearing, and this is taken from the transcript, talked
17 about the National Certificate qualifications being available, and her understanding, which
18 I'm sure you'll correct me if this is not correct, but her understanding that there was a level
19 3 and a level 4 National Certificate available, but there was not the next level up, so level 5,
20 and I think she,- in this situation the care support worker had asked in her regular reviews
21 to be able to do more training, and the survivor--,-- the witness at this hearing said that to get
22 a level 5 qualification that had to be found and done by correspondence from Ireland.
23 New Zealand does not have that level 5 training for people here to complete.

24 And then she just reiterates further down in this quote:

25 "To have a stable workforce we need a career path, and we need to professionalise
26 the sector."

27 Do you have any comments on this point around the need to make this sector and
28 this workforce, to really value this workforce with the opportunity for further education and
29 to professionalise the sector?

30 **MS BLECKMANN:** Yes, I do have comments to make. So, in 2020 the Ministry of Health
31 recognised the need for level 5 qualifications, and we took a joint initiative with the
32 New Zealand disability support network to develop the level 5 qualifications in particular
33 areas, and that work's been underway for the last year and a half.

1 I need to come back to you to let you know how far that's progressed, but we
2 absolutely recognise the need for career pathway and qualifications beyond level 4.

3 **MS THOMAS:** So, the work's in progress, so for example this support worker couldn't start that
4 qualification today but it's coming?

5 **MS BLECKMANN:** I'd need to come back to you, it may be in place now, but we've all agreed
6 on the need for level 5 qualifications and career pathways.

7 **MS THOMAS:** And just finally on this point of workforce before we move on to the next topic, if
8 we could look at the final page, which I think is called "Most Need Least Resource." I may
9 not actually go through all the quotes on the lefthand column, it is a summary from the
10 1986 report, of the Askew Report just detailing the problems with--- historically the
11 problems with the funding formula, I think, stating that -they-- were looking backwards:

12 "The cost data proportion of expenditure was used as the basis then to determine a
13 weighting for mental illness/mental handicap bed days, so these weightings that they used
14 are to be used in the formula, it could be more appropriate to use the various categories of
15 patient."

16 So, effectively, they're saying they were looking back to work out what the funding
17 would be for the next year or so, and if we look at the present quotes coming from the
18 Health and Disability System Review on the right-hand column, that says that:

19 "Rather the funding path has been informed largely by spend in the previous year
20 with some adjustment for inflation."

21 It then goes on to say:

22 "This work should be completed before Disability Support Services are rolled into
23 the DHB baseline and funded via the population-based funding formula."

24 Perhaps before I go on to my next questions around the current funding, are you
25 able to comment on that funding formula, is that from-- that quote of the Health and
26 Disability System review.

27 **MS WOODS:** The recommendation was actually, -was changed. So Disability Support Services
28 is not part -of - was not integrated into DHBs, DHBs were clearly not carried on with and
29 we have a Health New Zealand, the -population-based formula, I'm not sure what the health
30 system use, but for Whaikaha- there is a need to assess the budget and make sure that we
31 have an arrangement to ensure that there's sufficient funding coming in for both inflation
32 and for population increases.

33 **MS THOMAS:** Just looking at the quote from Dr Webb in the transcript here, I'll just read out the
34 highlighted part there, because this is also related to funding:

1 "For Christ's sake there must be another" ---just to contextualise this, this is a
2 conversation that Dr Webb has heard someone say on the phone:

3 "For Christ's sake there must be another four or five of these people around. Can't
4 we lump them together and bang them in a house?"

5 And Dr Webb said, "and that's the risk.

6 Question: And it's almost the reality?

7 Response: Mmm. Because that really goes to the--

8 Sorry, I can't quite see, we need to go to the next page, there's an extract from a
9 current care provider's response to this Commission in July this year and that extract says:

10 "As noted earlier, residential services funding creates unavoidable imperatives to
11 maintain certain group sizes and minimise vacancies and this means the options available to
12 people may not be what they would choose. We would like funding methodologies to
13 expand choice."

14 Can you please talk us through this situation, this has come obviously as a recent
15 response to a notice from a current provider. Can you comment on this and how will EGL
16 change this?

17 **MS BLECKMANN:** Yes, so I'll make several comments. If we go to the first statement on the
18 earlier page, that looks to me like that must be a very old statement because it refers to
19 [GRO-C] and Child, Youth and Family.

20 **MS THOMAS:** Yes, I think it was Dr Webb referring to a situation she had been involved in and
21 had heard.

22 **MS BLECKMANN:** We don't expect people to be "lumped together in a house", we expect
23 people to make choices about where they live, and that there are options for them, including
24 options other than residential care.

25 **MS THOMAS:** And in light of the July 2022 comment from a current provider saying that, if you
26 could, sorry, go back up to the next page, please, that residential services funding creates a
27 situation where there is a need to maintain certain sizes of homes, so that goes against what
28 you just said about choice and control. Do you have any comment to respond to that?

29 **MS BLECKMANN:** I'm disappointed to read that, because that's not how we would want people
30 to be supported. There are several pieces of work underway around residential services
31 which includes resetting pricing. There are various funding tools for residential services
32 that we would like to streamline so that we have the right incentives for paying for
33 residential services.

1 In some funding arrangements if there is a vacancy or somebody leaves a home then
2 the funding gets reset and I suspect that this particular arrangement is a historical funding
3 arrangement that we want to change.

4 **MS THOMAS:** Can I ask a question in terms of the now. If a disabled person would like to live
5 in a home by themselves right now but they currently live maybe with eight others or four
6 other people, are they entitled to say, "I want to live in a house and I would like support for
7 that to happen"?

8 **MS BLECKMANN:** The expectation is very individualised so somebody may have an option if
9 they are looking, if they're needing residential service and want to live in a residential
10 service then they would look at what services are available, and it is also possible for
11 people to live independently with support.

12 So just to extend on that there are examples where people might combine their
13 support funding, there are arrangements where people have described, and the Ministry has
14 written about Four Go Flating, for example, there are various arrangements where there are
15 family-governed services that are not like residential care, but people can combine their
16 funding, so there are far more options available to people.

17 **MS THOMAS:** Thank you. I'm going to move on now to access to complaint mechanisms. I'd
18 like a document to be put up on the screen which is ending 01453. This is a letter that was
19 dated August 1993 to the Director of Mental Health from a District Inspector. And if you
20 could enlarge the quotes there, I will try and read through these highlighted parts.

21 So the District Inspector is writing this letter which says that:

22 "There appears to be a rash of reports of assaults by staff upon residents. The way
23 that they are being dealt with continues to worry me. There is a continued tension between
24 internal inquiries on the one hand and the possibility of Police inquiries on the other. The
25 management are being pressure by the union, the PSA, which believes that Kimberley has a
26 duty as an employer to deal with these matters internally and thus not put staff's jobs at risk.
27 It faces a difficulty if matters are reported to the Police after an internal inquiry because the
28 Police take the view that the complaint has been too long in being laid and that the
29 witnesses have already been well worked over and in an internal inquiry they may be
30 regarded as having been tampered with in terms of evidential value."

31 The District Inspector goes on to say:

32 "I am exerting a pressure on them as the patient's representative to say that their
33 primary duty is not to be a good employer but to be a good carer and that residents at
34 Kimberley Centre have equally as much right to have persons who assault them prosecuted

1 or at least investigated for the purpose of prosecution, as do people who are living in the
2 wider community."

3 The letter goes on, but I don't think I need to read it all today. I think that last
4 paragraph we get the major point of the letter.

5 Ms Woods, do you agree with the opinion of the District Inspector sent to the
6 Director of Health raising his concerns that disabled people have the same right as any
7 other citizen to access the criminal justice system if someone has assaulted them?

8 **MS WOODS:** Absolutely.

9 **MS THOMAS:** Can you please take us through the requirements- what-- are the requirement on a
10 disability support service today if there is a situation where a staff member is alleged to
11 have assaulted a resident in that service and that's either been complained about, potentially
12 by the complainant, or maybe witnessed by someone else. What is the disability support
13 service provider required to do to ensure that that disabled person has the same right to
14 access the criminal justice system as everyone else?

15 **MS BLECKMANN:** So, the Ministry's expectation is that the Ministry is notified within 24 hours
16 of the incident occurring, and that the Police are involved.

17 **MS THOMAS:** So, the Ministry gets, I think it's called a Critical Incident Report, is it?

18 **MS BLECKMANN:** That's right.

19 **MS THOMAS:** And that was sent previously to the disability but- that's now been sent to
20 Whaikaha, I would---

21 **MS BLECKMANN:** Yes, that's right.

22 **MS THOMAS:** So Whaikaha receives that within 24 hours, what does Whaikaha do to check
23 whether anything is then also progressed to the Police?

24 **MS BLECKMANN:** So, there's an expectation in the notification of the incident of what actions
25 the provider has taken, so there would be a check that the Police have been involved.

26 **MS THOMAS:** And if Whaikaha receives this critical incident report and the box is not ticked
27 saying Police, what does Whaikaha do?

28 **MS BLECKMANN:** Then a portfolio manager would contact the provider and follow up
29 immediately.

30 **MS THOMAS:** Okay. And in terms of what level or situations would you expect, or can you
31 perhaps define for us what is a critical incident? What's an example of a critical incident?

32 **MS BLECKMANN:** So, we have a guideline that-- sets this out and it's referred to in the contract
33 and it's all forms of abuse and neglect.

34 **MS THOMAS:** So even a lower-level assault, for example?

1 **MS BLECKMANN:** Absolutely.

2 **MS THOMAS:** And in that situation there's an expectation of reporting to Whaikaha within 24
3 hours and a report to the Police?

4 **MS BLECKMANN:** Definitely within 24 hours, but I don't know what you mean about a lower-
5 level- assault, if somebody has been assaulted, then there's an expectation that --

6 **MS THOMAS:** I mean common assault as opposed to grievous bodily harm.

7 **MS BLECKMANN:** We'd expect to be notified.

8 **MS THOMAS:** And the Police would always be notified.

9 **MS BLECKMANN:** Yes.

10 **MS THOMAS:** In terms of support for a disabled person to make a complaint of abuse, or a
11 critical incident or an adverse event, you would agree that there are some people who
12 would need some more additional supports in order to speak out and be heard?

13 **MS BLECKMANN:** Yes.

14 **MS THOMAS:** The Ministry of Health webpage has comments on the implementation of the
15 Putting People First Report which came out in 2013 and one of the recommendations from
16 that report stated:

17 "To work with the sector to identify how a support role could help people stay safe
18 and speak out where needed."

19 And the Ministry of Health website said that that recommendation is complete.

20 Can you take us through, please, the specifics of that support role?

21 **MS BLECKMANN:** So, there were 36 recommendations in the Putting People First review and
22 all of those recommendations bar two have been completed and those two refer to the
23 residential pricing, that work has started, and a contract management system. So, in respect
24 to the support that needs to be put in place for somebody who may need support with
25 making a complaint, is set out in the Ministry's guideline that I just mentioned and is
26 referred to in the contract.

27 **MS THOMAS:** What does the support role look like? Can you take us through, is this an
28 independent support role?

29 **MS BLECKMANN:** No, it's not independent, but there are expectations around how people are
30 supported through making a complaint. I just need to say there are a number of ways
31 people can make a complaint that can be outside of the service provider.

32 **MS THOMAS:** So, it's the service providers who then support a person who may need to be
33 making a complaint about another employee or staff member of that service provider; is
34 that the situation?

1 **MS BLECKMANN:** That's one way, and there are independent ways through the Health and
2 Disability Commission, there is an 0800 number for Whaikaha, there are-- you can make a
3 complaint online, there are a number of- mechanisms.

4 **MS THOMAS:** All of those mechanisms, you'd agree in terms of accessibility, the individual
5 needs to take a proactive step to reach out or to make a complaint to the Health and
6 Disability Commissioner, don't they?

7 **MS BLECKMANN:** Again, the requirements, there are requirements around how the provider
8 supports a person to understand how they can make a complaint and it doesn't have to be
9 described as a complaint. And we expect providers to encourage feedback, that people are
10 not afraid of retribution, and that providers develop a positive complaints culture.

11 **MS THOMAS:** Now, this--- I'm going to move on to the Ombudsman report from 2020 which
12 was called "Off the record"?

13 **MS BLECKMANN:** Yes.

14 **MS THOMAS:** Just by way of introduction of this report, I will just summarise for everyone in
15 the room part of the foreword from that report which stated that:

16 "Concerns had been raised with the Ombudsman about the deaths of people with
17 learning disabilities receiving full-time residential support and a lack of visibility around
18 these deaths."

19 The foreword says:

20 "There was a sense that the deaths of these people were not seen as important and
21 had been overlooked, including by the Ministry of Health."

22 And I'm now going to ask for some of the conclusion from the Ombudsman report
23 to be put up on the screen and I'll read those into the record.

24 For the transcript, this is document ending 08399. The first paragraph there states:

25 "The Ministry of Health funds, purchases and monitors Disability Support Services,
26 including full-time residential support for more than 6,000 people with intellectual
27 disabilities. It is responsible for leading New Zealand's Health and Disability systems.
28 This gives rise to certain obligations and responsibilities.

29 Overall, in my opinion, the Ministry's arrangements in relation to the collection, use
30 and reporting of information about the deaths of people with intellectual disabilities
31 receiving Ministry funded residential support were unreasonable.

32 Recordkeeping was deficient and not consistent with the requirements of the Public
33 Records Act. There was no evidence that the information the Ministry collected or should

1 have collected, was used to inform its own service or policy development, or shared with
2 providers in ways that might support their quality improvement efforts."

3 I've just had a wee note to say that one of the witnesses for the Ministry of Health,
4 Dr Arran Culver, would like to be able to answer some of these next batch of questions.

5 **CHAIR:** So, does this require more reconfiguring, and do we need to go? Does one drop off and
6 the other comes on, or can we squeeze another person in?

7 **MS THOMAS:** I think we'll play musical chairs and swap Dr Crawshaw for Dr Culver, if that's
8 all right.

9 **CHAIR:** We don't have to leave the room if that's all right with you, Dr Crawshaw.

10 **DR CRAWSHAW:** We might have a bit of a tag team going on.

11 **CHAIR:** Tag team, good.

12 **MS THOMAS:** Dr Culver, would you like to take the opportunity to introduce yourself to the
13 Commissioners.

14 **DR CULVER:** Certainly, tēnā koutou e ngā rangatira mā, ngā mihi mahana ki a koutou katoa. Ko
15 wai au? Ko Kahurānaki te maunga, ko Tukituki te awa, Ngā Hau e Whā ngā iwi. Nō
16 Ahuriri ahau, e noho ana ki Whanganui a Tara ahau. He tākuta mate hinengaro mō ngā
17 tamariki me ngā rangatahi ahau. He whakahaere ki te rōpū Hauora Hinengaro o te Manatū
18 Hauora ahau.

19 Kia ora koutou, I'm Arran Culver, I am the Acting Associate Deputy Director-
20 General for Mental Health and Addictions at the Ministry of Health and I'm a child and
21 adolescent psychiatrist. I'm a Pākehā male of average height and thin build with brown
22 hair, and I'm wearing a charcoal suit, light grey shirt, and a dark tie.

23 **CHAIR:** We better get you truly on-boarded by just asking you: Do you solemnly and sincerely
24 truly declare and affirm the evidence you will give will be the truth the whole truth and
25 nothing but the truth?

26 **DR CULVER:** I do.

27 **CHAIR:** Thank you.

28 **MS THOMAS:** Thank you. Now, I've read through some concluding paragraphs of this 2020
29 Ombudsman report, and I would like to acknowledge that the Ombudsman did go on to
30 commend the Ministry of Health for efforts that had been made to remedy some
31 deficiencies in the systems. And then the Ombudsman went on to make some further
32 recommendations.

33 One of those recommendations was recommendation number 9, and I'll just read
34 that out. It was to:

1 "Consider what actions can be taken to develop and implement an improved
2 information management system that better supports Disability Directorate staff to capture,
3 store, access and utilise relevant information in compliance with the Public Records Act."

4 Can I ask, and I may actually ask this to Ms Woods, given your previous role at the
5 Disability Directorate prior to 1 July if that's appropriate for you to respond, given this was
6 a recommendation to support the Disability Directorate of this information, is this in place
7 now this system?

8 **MS WOODS:** I will ask Amanda to talk to it. Yes, I was in the Ministry of Health looking after
9 Directorate but that was over 15 years ago, so it wasn't the most recent one. There's been a
10 bit of form change in between times so I'll ask Amanda to answer the question.

11 **MS THOMAS:** Ms Bleckmann, is this information management system now in place?

12 **MS BLECKMANN:** Yes.

13 **MS THOMAS:** And in relation to recommendation 8 from the Ombudsman, which stated:

14 "Confirm arrangements for undertaking in-depth analysis of information about the
15 deaths of service users, when and how often this will occur, and information from Critical
16 Incident Reports and utilising that analysis to inform future policy and practice."

17 Would you agree that that recommendation 8, particularly the "utilising the analysis
18 to inform future policy and practice", is an important recommendation from the report?

19 **MS BLECKMANN:** Yes, and to add to that, there are a number of recommendations from that
20 report, as Dr Crawshaw had said earlier, around the need to triangulate information, so
21 there are a number of steps that Whaikaha undertake now to triangulate information, and
22 that includes a regular extract from the National Mortality Collection to ensure that we
23 don't miss a death and that we are receiving data on the official cause of death and the
24 coroner's findings.

25 **MS THOMAS:** But what about this extra aspect of this recommendation where in addition to all
26 those things that you've just said, the "utilising and analysis of the information to then
27 inform future policy and practice", is that something that the Ministry of Health, or now
28 Whaikaha, has progressed?

29 **MS BLECKMANN:** Yes. And including making-- so there are a number of other things in
30 addition to that, including regular reviews and revision of the operating procedure, and
31 within Whaikaha- we've got additional opportunities where we're partnering with disability
32 community to implement additional actions.

33 **MS THOMAS:** And in the Notice to Produce that the Commission received on 17 June from the
34 Ministry of Health, there were comments around the Ombudsman's recommendations

1 acknowledging- that this was a Notice to Produce that was received from the Ministry of
2 Health,- but this was before 1 July.

3 **MS BLECKMANN:** Yeah.

4 **MS THOMAS:** It gets a bit tricky with this cut-off, but the Commission had asked for a response
5 to what had been implemented or changed, but there -was- this-- recommendation 8 was
6 omitted from the Ministry's response and I'm just wanting to check, was that just an
7 omission in error, or are you satisfied that this recommendation has been implemented?

8 **MS BLECKMANN:** So, I would have to check, but I do know that we want to improve the
9 recordkeeping system where we want things more automated, so I know that we have a
10 system in place, we're doing regular reviews, we're analysing data, we're triangulating data,
11 but we want to have a more sophisticated and automated management system.

12 **MS THOMAS:** So, when you're doing that, you're receiving that information, are you taking the
13 next step of providing the benefit of that information back to the service providers for
14 future prevention?

15 **MS BLECKMANN:** I'd have to come back to you.

16 **MS THOMAS:** Do you agree that the recommendations from this Ombudsman report which dealt
17 with obviously the most serious outcome here for a person in care, because this ended in
18 death, do you agree that the collection of data, reviewing that data, learning from the
19 adverse events or the near misses, is not only important for the prevention or avoidable or
20 premature deaths, but it's equally important for a central collation of information about
21 complaints of abuse or neglect of disabled people in care.

22 Would you agree there's an equal need for a similar system for any complaints of
23 abuse?

24 **MS BLECKMANN:** Yes.

25 **MS THOMAS:** And it's equally important to analyse that information, review what the
26 complaints say, look at the trends, the risks in order to then be able to inform future policy
27 and practice and provide that information back to the service providers in the community?

28 **MS BLECKMANN:** Absolutely. I just want to highlight that if there was a very serious incident
29 of abuse, we would take additional steps and it's likely that we would have an investigation
30 with a 'lessons learned' and an expectation that the provider implements and makes
31 changes to their service.

32 **MS THOMAS:** But does that information from that individual provider get shared with all
33 providers nationwide through Whaikaha?

34 **MS BLECKMANN:** It doesn't at the moment.

1 **MS THOMAS:** So all the other providers are not benefitting from that 'lessons learned,' are they?
2 Not yet.

3 **MS BLECKMANN:** Not yet.

4 **MS THOMAS:** When can we expect that to happen?

5 **MS BLECKMANN:** So there are a number of areas of work that we've got underway for
6 Whaikaha, including a 90day plan and then longer-term priorities, and this is one of the
7 priorities.

8 **MS THOMAS:** Just in terms of this collation of information about complaints of abuse, and this
9 may be a question for Dr Sarfati or Ms Woods, because we received the Ministry of
10 Health's Notice to Produce on 17 June and at paragraph 6.1, the Ministry of Health stated:

11 "The Ministry of Health and its predecessors was aware of some complaints of
12 abuse in care. It would become aware of complaints of abuse in a variety of ways. Most
13 recently this may arise from service users, district inspectors, communications from
14 members of the public such as from ministerials, or contact with the call centre and
15 referrals or notifications such as from the Health and Disability Commissioner and other
16 agencies."

17 And it went on at paragraph 6.2 to say:

18 "Given the manner in which complaints may come to the Ministry's attention, they
19 are not held in a central location and would usually be held among records for the relevant
20 directorate, or business unit. Historic abuse claims are recorded by the Ministry's historic
21 abuse resolution service."

22 Dr Sarfati or Ms Woods, this question is for either of you, but do you have a
23 comment in relation to the evidence in that Notice to Produce that the complaints about
24 abuse in care come into the Ministry of Health but because they come in in multiple
25 different ways, they're not held in a central location?

26 **MS BLECKMANN:** I'll answer. If they're about abuse in care in a disability support service, it
27 will absolutely be centralised and come to Whaikaha or the then Disability Directorate.

28 **MS THOMAS:** Right. The brief of evidence that we received from Whaikaha on that point, and
29 this is from your brief of evidence, Ms Woods, talked about a repository, so this is at
30 paragraph 6.14:

31 "Whaikaha acknowledges the importance of open and transparent complaint
32 processes and the need for multiple complaint avenues. When a complaint relating to abuse
33 is made to Whaikaha, the Ministry handles the complaint in its entirety, responding and
34 storing information in a repository."

1 Can you explain to us what is meant, what do you mean that it is handled, "this
2 complaint of abuse in care is handled in its entirety" by Whaikaha?

3 **MS WOODS:** Well, I'm assuming what it means is all aspects of it are looked at by the staff of
4 Whaikaha and we don't pass on part of that to somebody else and then not check what's
5 happening with it. So, it goes to the point being made about we may go back to the
6 provider to expect that they are doing something about it, but we would require information
7 to come back to round that off.

8 **MS THOMAS:** When you say it's handled "in its entirety", you're not meaning- it-- doesn't just
9 stay there, if necessary, it would also be referred to the Police?

10 **MS WOODS:** Absolutely.

11 **MS THOMAS:** You've said here, can you explain what you mean by "stored in a repository"?

12 **MS BLECKMANN:** Yes, so it's stored centrally.

13 **MS THOMAS:** Once it's stored here, what happens to those complaints?

14 **MS BLECKMANN:** So, there are a number of things. So, in terms of analysing the data, the
15 complaints, we have monthly reports that are provided to the senior management team that
16 shows the themes, the serious incidents, the responses. So, it's an infographic around the
17 things that we need to be knowing about.

18 **MS THOMAS:** Is this the situation that I think you accepted before, that information happens,
19 and you do that at Whaikaha but that is not shared for lessons to be learned across the
20 service providers?

21 **MS BLECKMANN:** Not in a regular way. There are times that we would do presentations or
22 engage with the sector, but we are not currently doing that in a systematic way.

23 **MS THOMAS:** Right. I've now got some questions that I'd like to ask following on from the
24 complaints to the point of safeguarding and I acknowledge the acknowledgments that both
25 ministries made this morning in relation to care that was provided to disabled people and
26 people in mental distress between 1950 to '99 that did not ensure people in care settings
27 were safe from harm when they should have been safe.

28 At paragraph 6.1 of Ms Woods' brief of evidence, it's titled "Monitoring, oversight
29 and safeguarding", you've stated there that:

30 "Whaikaha has co-developed a monitoring evaluation analysis and learning strategy
31 with the community. This strategy aims to ensure a developmental approach to monitoring
32 and evaluation, providing stronger opportunities for safeguarding responses."

33 Is this strategy available in writing?

34 **MS BLECKMANN:** Yes, it is.

1 **MS THOMAS:** Would it be possible for us to receive a copy of that perhaps after this hearing or
2 is that on the website or...

3 **MS BLECKMANN:** It's not on the website but yes, we can absolutely provide that.

4 **MS THOMAS:** Thank you.

5 Sorry, I've just had another note to say it's a musical chairs moment and we need to
6 move- -request that Ms Kerr and Ms Bleckmann- might switch out here.

7 **MS WOODS:** We just think it's important we get the right information through to you.

8 **CHAIR:** I'm happy this is happening, the right person in the right place at the right time.

9 Welcome back.

10 **MS THOMAS:** So, Ms Kerr, this question is probably directed at you. In terms of the
11 safeguarding strategy, can you please expand on the "providing stronger opportunity for
12 safeguarding responses" aspect of the strategy?

13 **MS KERR:** Sorry, could you just remind me which strategy are we talking about?

14 **MS THOMAS:** It's mentioned in Ms Wood's brief of evidence at paragraph 6.1 that:

15 "Whaikaha has co-developed a monitoring evaluation analysis and learning strategy
16 with the community and this strategy aims to ensure a developmental approach to
17 monitoring and evaluation, providing stronger opportunities for safeguarding responses".

18 **MS KERR:** So, my understanding is that the strategy involves working alongside the community.
19 There's a very strong emphasis in this strategy of the Crown working with the community
20 and with providers to identify within practice what is working well, what needs to be done
21 more often, and sharing that best practice, and identifying the areas where things need to be
22 further strengthened, and then acting on that.

23 **MS THOMAS:** I'm sure we will benefit from having an opportunity once we've read through this
24 strategy in writing.

25 Your brief of evidence, Ms Woods, notes that Whaikaha, and you mentioned it
26 today, has recently taken on the responsibility for Action 28 of the national strategy to
27 eliminate family violence and sexual violence, and Action 28 of that national strategy is a
28 pilot that focuses on the development and implementation of a safeguarding framework,
29 and interagency safeguarding approach, so the SAFA approach to prevent, report,
30 investigate, and respond to alleged family harm and other forms of abuse, neglect or harm
31 of disabled adults.

32 So, I think that's a recent development that Whaikaha has taken on that
33 responsibility. Can you confirm that Whaikaha has been adequately funded from the
34 Government to do this work in terms of the safeguarding?

1 **MS KERR:** So I can speak to that. Yes, this is a recent development as you would expect, given
2 that Whaikaha is so new. This, I think, is a really good example of the opportunity that
3 Whaikaha creates to join up different pieces of work for disabled people across
4 Government. There is a lot of synergy between Action 28 and the safeguarding work that
5 is absolutely central to the Enabling Good Lives approach.

6 As you may be aware, the Government announced funding in Budget 2022 to begin
7 the national implementation of the Enabling Good Lives approach. There are some
8 foundational elements that will be prioritised with that funding, safeguarding is one of
9 those.

10 So Action 28 coming under Whaikaha really gives us an opportunity to bring those
11 things together and maximise the effectiveness of that funding.

12 **MS THOMAS:** Staying on the topic of safeguarding, and particularly here safeguarding for adults
13 at risk, so just for everyone's benefit, I'll just read out the definition of what is an adult at
14 risk, what does that definition mean. It's:

15 "An adult who needs care and/or support and is experiencing or is at risk of
16 experiencing harm, abuse or neglect, and because of their needs for care or support they are
17 unable to protect themselves against harm or abuse, neglect or the risk of it."

18 In terms of safeguarding adults at risk, there was a recommendation back in the
19 2013 Putting People First report, that was recommendation 12, that there should be a
20 support role or group of people who build strong and trusted relationships with disabled
21 people and support them to stay safe and speak out when needed, but the point I'm
22 interested in is the explanation behind that recommendation, because that report said -- in
23 terms of an explanation it said:

24 "This is important because at present there are no roles whose purpose is to oversee
25 the wellbeing of disabled people. This contrasts with the oversight provided by the Child,
26 Youth and Family" so- this was back in -2013, "--and the Ministry of Social Development
27 where a social worker visits each child or young person in care every two months to access
28 their wellbeing and provide support as necessary."

29 So, my question really is, currently if there is a child or adolescent who is at risk of
30 experiencing harm, abuse or neglect, that situation currently could be reported to Oranga
31 Tamariki and if a person is over 65, and is at risk of experiencing harm or abuse or neglect,
32 then that situation can be reported to Age Concern, for example. But for adults who are
33 adults at risk aged between 18 to 65, there doesn't appear to be a national agency or anyone
34 with a statutory responsibility that is looking after that age bracket of adults at risk.

1 Do you see this as a gap, Ms Woods?

2 **MS WOODS:** I'm sorry I don't actually-- I don't know particularly very much about this.

3 I suspect that Amanda might, but I'm sorry, I'm really not sure. But I'm happy to -provide
4 to-- find out and provide you with information in writing following the hearing, this hearing
5 here.

6 **MS THOMAS:** Or perhaps does your colleague Ms Kerr have a response in terms of --

7 **MS WOODS:** Unfortunately, the differentiation of material that both Amanda and- -that she
8 knows versus what we -know what-- we've got here, we've had to sort of split expertise on
9 that and we keep flipping between them unfortunately.

10 **MS THOMAS:** I think if Ms Bleckmann does know the answer, I'm pretty sure the
11 Commissioners would like to hear.

12 **CHAIR:** Absolutely. Just because she's not sitting there --

13 **MS WOODS:** Can she do it from there?

14 **CHAIR:** Of course she can. Just stand there, there is a microphone, you don't have to trudge back
15 into the witness box unless you especially want to.

16 **MS WOODS:** Thank you, sorry, it was just a bit tricky, and because I've such limited time in the
17 role I've kind of crunched my expertise to quite a small space.

18 **CHAIR:** Please don't be apologetic, we understand, and we're grateful you've provided so many
19 human beings to help you. Have you been following the question? It's about oversight of
20 the sort that's provided to children and young people by the- - under the Oranga- Tamariki
21 system social workers and indeed independent monitor.

22 **MS BLECKMANN:** So yes, I did understand. So, the best example of this is in the prototype in
23 Mid-Central where there's the Enabling Good Lives approach. So, while it's not a statutory
24 function, there is an expectation that there are people who attend or meet and see people in
25 residential services.

26 **MS THOMAS:** We'll just have a- - I just would like to follow up on that question, because we
27 have received evidence through submissions and community hui where there is a
28 submission that there is a real gap in terms of safeguarding adults at risk between the ages
29 of 18 to 65 and I'd just like to know whether Whaikaha- agrees with that.

30 **MS BLECKMANN:** We agree in the sense that we've picked up Action 28 in the last-- since
31 Whaikaha was established on 1 July, so Whaikaha- has agreed to lead out Action 28, which
32 is ensuring that there is a safeguarding framework for disabled adults.

1 **MS THOMAS:** And so that is a safeguarding framework, but in terms of the point of looking
2 bigger longer term and potentially an actual agency or -- is this something that Whaikaha
3 thinks more could be done?

4 **MS BLECKMANN:** So it won't -- the approach won't be that it's an agency, the approach is that
5 there will be a person, and we call them a kaituhono or a connector, and there are already
6 instances in other places outside of the prototype where if we become aware of a serious
7 concern we can send people in and there can be eyes and ears or people connecting in with
8 people living in a residential service.

9 **MS WOODS:** Perhaps if I can just add, I think that the transformation of Disability Support
10 Services into an EGL approach will need to consider these in a much more expanded way
11 and one of the considerations is what sort of- - to- what extent do we make that framework
12 around safeguarding and to what extent should it be held within the system or going
13 broader, but that work has not been done yet.

14 **MS THOMAS:** But it's in your planning consideration when you're looking at this overall?

15 **MS WOODS:** The safeguarding is, yes.

16 **MS BLECKMANN:** And it's a key feature of the Mid-Central prototype. So, it has already been
17 demonstrated in Mid-Central, and that is the expectation when there is a rollout of the
18 prototype or the EGL approach that that approach will be available across the country.

19 **MS THOMAS:** Will that end in a situation where, just as an example, if I was concerned about
20 something that I thought might be happening to my neighbour who potentially was an adult
21 at risk, and I'm just a member of the public, where do I go to raise those concerns?

22 **MS BLECKMANN:** So, as I said earlier, there is an 0800, there's the Health and Disability
23 Commission, there are a number of ways of notifying Whaikaha.

24 **MS THOMAS:** It's slightly different though, isn't it, from knowing that there's an organisation set
25 up with the intention of safeguarding or protecting a group of people?

26 **MS BLECKMANN:** So, in the example you just used, if you were a neighbour and you were
27 concerned about abuse or neglect, one of the options is calling the Police.

28 **MS THOMAS:** Yes. There's also in terms of the analogy, though, if I wanted to make a report of
29 concern to Oranga Tamariki, that's an option that I currently could, that doesn't exist today
30 if I want to make that similar report in relation to an adult at risk, does it?

31 **MS BLECKMANN:** It exists in that there is an 0800 number for Whaikaha and we would act
32 immediately if there was a concern from a member of the public.

1 **MS WOODS:** I think the point you're making is that we haven't yet got anything as formal as
2 Oranga Tamariki have and that would be something that would need to be considered and
3 that might be something the Commission would be considering.

4 **MS THOMAS:** Thank you. I'll move on to some questions about oversight, I'm not sure if
5 I should be directing those at --

6 **CHAIR:** Take a seat there and if you're needed you can pop up again should you be required.

7 **MS THOMAS:** This is really just to look at what currently exists for disabled people particularly
8 today in terms of oversight. There's a range that we've heard a number of options discussed
9 already the Health and Disability Commissioner is-- doesn't really monitor,- but people can
10 actively complain, there's the IMM, so the Independent Monitoring Mechanism, which
11 monitors the CRPD, and implementation of the Human Rights Convention.

12 We've heard a bit about district inspectors from the mental health aspect who
13 obviously monitor people who are under compulsory treatment orders. There's the Mental
14 Health Wellbeing Commission that has a monitoring role for the Mental Health and
15 Addiction Services. And there's also Health Cert, that is another organisation that monitors
16 residential homes, home standards where there are more than five people, I think, I
17 understand.

18 So, there are a lot of options out there in terms of monitoring systems and checking
19 the systems, but can you please- - I'll direct this at Ms Woods and then we'll find out who
20 needs to answer this. But is there an independent oversight available specifically for an
21 individual disabled person who is currently in a State- care funded disability setting?

22 **MS WOODS:** I thought that's what we were just talking about but in terms of --

23 **MS THOMAS:** I was talking previously more just about the need for safeguarding as a good
24 thing to have that we need to safeguard and that was the implementation of the pilots, but
25 that's slightly different from oversight. They're related but different.

26 **MS WOODS:** I'm not sure that I can provide advice on that.

27 **MS KERR:** When Cabinet made decisions about the establishment of Whaikaha there were a
28 range of functions that are envisaged for Whaikaha. When you're setting up a new Ministry
29 it is a big job, so the two immediate priorities for Whaikaha are around ensuring continuity
30 of existing services and then leading the transformation of those services.

31 Over the longer term, there are some decisions to be made about other functions that
32 Whaikaha might take on, including a more active oversight and monitoring of the cross-
33 government disability system and how it is supporting disabled people who are accessing
34 Government funded services as well as the wider population of disabled people.

1 As I say there, is still some advice to be prepared around what the scope of those
2 functions might look like. I will say that there is additional resourcing that has been held
3 for standing up new functions within Whaikaha and we're awaiting the arrival of the
4 permanent Chief Executive to progress advice and seek decisions on what those might look
5 like.

6 **MS THOMAS:** So is it fair to say this is arguably a gap but it may be addressed and may become
7 a priority in the future of Whaikaha?

8 **MS KERR:** Yes, and I think Government has recognised in establishing Whaikaha that there is a
9 gap in the sort of cross-government taking ownership of improving outcomes for and
10 ensuring that disabled people are safe.

11 **MS THOMAS:** Just to finish on this point, I would like to read to you a quote from Dr Tristram
12 Ingham, who spoke at the panel hearing of Ūhia te Māramatanga, and he said, in terms of
13 safeguarding:

14 "Firstly, an improved service, oversight, monitoring and safeguarding processes.
15 None of the existing processes for service oversight, monitoring and safeguarding are
16 sufficiently robust, all encompassing or with sufficient teeth to provide timely and
17 appropriate safeguarding for tāngata whaikaha Māori."

18 He went on to say:

19 "I think a critical element of the service oversight, monitoring and safeguarding
20 processes is that they need to be embedded in tikanga, designed, implemented, monitored
21 and evaluated by tāngata whaikaha Māori and our whānau to meet diverse aspirations for
22 wellbeing and balance, both individual and collective rights."

23 Do you have any response to that suggestion from Dr Ingham?

24 **MS WOODS:** Given Whaikaha wishes to work in partnership with tāngata whaikaha Māori
25 disabled people then clearly aspirations like that would be part of that consideration and
26 that work in partnership, so we would be absolutely considering it together.

27 **MS THOMAS:** Thank you. We just have two more brief topics and I'm going to move to allow
28 my colleague Alice McCarthy to ask this next topic in relation to mental health.

29 **QUESTIONING BY MS McCARTHY:** Kia ora. This next set of questions is solely focused on
30 mental health reform. I'm not sure if Mr Crawshaw would like to join or are we happy with
31 Mr Culver? Okay, thank you.

32 I would just like to focus on really looking at forward-looking how the Ministry
33 intends to safeguard against abuse in care. And would like to begin by acknowledging the
34 significant reform that is underway in response to He Ara Oranga. So, as you're aware,

1 there's the establishment of the Mental Health and Wellbeing Commission, we've got the
2 reform of the Act and we have got the Te Tiriti and rights based guidance that we referred
3 to earlier.

4 So really my questions are around the implementation of these new reforms and
5 how you can be sure that these are going to effect meaningful change on the ground.

6 **DR CULVER:** That's quite a broad question, I'll do my best to give a wide-ranging response.

7 I think it is a matter of building on current safeguarding. So, we still retain a
8 devolved system and the monitoring and reporting of adverse events and episodes of abuse
9 take place within what were District Health Boards and are now District Health Services,
10 and they retain a central repository, severity assessment code 1 and 2 events are reported
11 through to the Health Quality and Safety Commission who in turn report through to the
12 Ministry of Health.

13 In terms of the implementation in relation to the reforms, those -- all of those
14 monitoring functions will continue, including all of the other entities that occur, that are
15 involved in those processes, and we've discussed what those are.

16 The performance and monitoring function of the Ministry is strengthened and those
17 functions are currently being developed, particularly in terms of the Ministry's monitoring
18 role of the entities and that includes Te Whatu Ora and Te Aka Whai Ora, as well as other
19 health related entities.

20 So that is at necessarily a higher level than monitoring individual services. That
21 monitoring takes both a quality assurance approach in terms of the exception-based
22 reporting that occurs with adverse events, areas of risk, as we've covered, workforce issues,
23 infrastructure issues. But also seeks to take a more proactive approach in terms of
24 monitoring for quality and monitoring for improvement, that is ensuring that the entities
25 have structures and processes in place for quality improvement and quality assurance and
26 that there is a focus on continuous improvement.

27 Effective quality and safety governance is a part of that, there are a range of other
28 areas that are being considered, but this is part of a new directorate called the System
29 Performance and Monitoring Directorate within the Ministry of Health that is focused on
30 that function.

31 **MS McCARTHY:** Thank you, and I appreciate that was a very broad question. Just in terms of
32 talking about monitoring for quality and outcomes, this new team, unit that you were just
33 referring to, does it set targets and timeframes in terms of how it will measure those,
34 particularly when the new regime comes in?

1 **DR CULVER:** Those functions are still being developed. As I say, the existing functions will
2 continue. I'm not able to talk to exactly what those frameworks will look like at this stage.

3 **MS McCARTHY:** Thank you.

4 **CHAIR:** But do you have a sense of when they're going to be--- have they started, is there an end
5 point or an aspiration as to when there'll be the transition into the new system?

6 **DR CULVER:** I don't have a clear sense of when that will be. I think this will be a work in
7 progress over time that new approaches will be built on on top of each other rather than,
8 you know, a defined release date.

9 **CHAIR:** Yeah, I see, thank you.

10 **MS McCARTHY:** Turning now to some more, slightly more specific questions, we talked about
11 co-design earlier in terms of co-design with Māori, and one of the purposes I understand of
12 the reform of the Act is to give a greater voice to individuals and their whānau. Can you
13 just explain to me what the co-design -- if there's a co-design process and what that looks
14 like for ensuring the individuals and their whānau are involved in developing the new
15 system?

16 **DR CULVER:** The new Mental Health Act?

17 **MS McCARTHY:** Yes, please.

18 **DR CULVER:** So, there was a robust process of consultation and submission in relation to
19 the defining- the policy advice that will form the new legislation. There was a co--design
20 phase of that which included Te- Ao Māori world views and input. The consultation itself
21 included over 60 face-to-face or virtual consultations and around 500 submissions. I don't
22 recall exactly how many of those consultation hui- were with Māori organisations and
23 entities, but it was a significant portion.

24 That fed through to the consultation document- which has recently been released.
25 All of- that wider consultation material informs the development of policy advice. That is
26 being operated with an expert advisory group. There are 12 members of that expert
27 advisory group, seven of whom are Māori and form a Māori caucus. Five of the members
28 of the advisory group are from a lived experience background and have formed a lived
29 experience caucus.

30 So, all of the consultation feeds into the development of policy advice which is
31 being actively tested and developed in partnership with the expert advisory group to ensure
32 that the new Act is grounded in Te Tiriti and that it meets the needs of Māori and that it
33 addresses the significant equity issues that exist under the current legislation.

1 That policy advice will then go to Cabinet for decision, be drafted in the
2 Parliamentary Council Office and then come back for a Select Committee process where
3 there will be further opportunity for input.

4 **MS McCARTHY:** Thank you, and did that consultation process and the expert advisory group
5 involve engagement with Pacific people?

6 **DR CULVER:** Yes, it did.

7 **COMMISSIONER STEENSON:** Sorry, can I just confirm, are we talking about the Mental
8 Health (Compulsory Assessment and Treatment) Act 1992?

9 **MS McCARTHY:** Yes.

10 **COMMISSIONER STEENSON:** Thank you.

11 **MS McCARTHY:** If we now turn to look at some of the specifics of the reform of that Act, Dr
12 Crawshaw's brief talks about how the enactment of new legislation can provide an
13 opportunity to consider further structural protections against abuse.

14 If we're hoping to devise or you're hoping to devise a system that enhances the voice
15 of individuals and their whānau, would it be reasonable to expect those legislative
16 protections to include provisions around supported decision making?

17 **DR CULVER:** That is a commitment that has already been made that there will be a supported
18 decision making basis to the new legislation.

19 **MS McCARTHY:** Will that have robust provisions around instances of substituted decision
20 making is required?

21 **DR CULVER:** I'm not able to speak to the detail of that because the policy advice is still in
22 development and I am not the decisionmaker, so can't prejudge what Cabinet may decide in
23 that respect. There will be a range of options around how supported decision making will
24 function, how advanced directors will be incorporated into determining people's care, and
25 that also intersects with the issue of capacity, which will also be considered in that policy
26 advice.

27 **MS McCARTHY:** And apologies if I'm not aware of this, but has there been a similar
28 commitment that Te Tiriti and human rights will be incorporated into the new legislation?

29 **DR CULVER:** Yes, there has.

30 **MS McCARTHY:** In terms of incorporating Te Tiriti, does the Ministry intend to partner with
31 tāngata whaiora Māori to determine what that incorporation should look like?

32 **DR CULVER:** That is the function of the expert advisory group and also in conjunction with the
33 Māori Health Directorate within the Ministry of Health, and we're also working with Te
34 Aka Whai Ora who have a strong interest in the development of the new legislation as well.

1 There are certain restrictions in the process of developing legislation, however, in terms of
2 how we can consult at the stage of development of policy advice.

3 **MS McCARTHY:** Thank you. We also touched on earlier with Dr Crawshaw about
4 implementing these changes in terms of the workforce, and you'll appreciate there's a
5 concern that while there might be these great reforms, the people implementing them are
6 the same people. And so that maybe some of the same practices may continue. I
7 understand you've got Te Pou and there's training going through that, but can you just talk
8 me through what confidence you have in that these changes will be systemwide?

9 **DR CULVER:** That is something that we're currently building and Dr Crawshaw was involved in
10 developing guidance around supported decision making in relation to the current Act,
11 because there's nothing in the current Act that excludes supported decision-making as a
12 framework. So, we know these things are practice based. We've also looked at
13 implementation of new supported decision making based legislation in overseas
14 jurisdictions, and there have been some important lessons in that legislation itself, as he
15 suggests, does not change practice or culture. And so there needs to be a robust
16 implementation around improving practice, training, adequately supporting the
17 implementation, otherwise the new legislation may not have the impact that we hope for.

18 **MS McCARTHY:** This is my final set of questions and just kind of stepping back, picking up on
19 what you said, you'll be aware, I'm sure, of the criticism that New Zealand goes through a
20 cycle of mental health reviews and that while some things change and some things do
21 improve, fundamentally today there are still people out there with experience of mental
22 distress who are in unsafe situations and experience abuse in State care.

23 Can you please talk me through the lessons maybe that have been learned from
24 previous reviews and how the Government intends to combat those things that maybe failed
25 in the past?

26 **DR CULVER:** Well, I think we build from review to review, and I think it's important to
27 remember that when the 1992 Mental Health Act was developed, that broke new ground in
28 terms of being more rights based, having greater protections built in, having the opportunity
29 for legal challenge through Section 16 of the Act and through requiring consideration of
30 cultural needs in consultation with family and whānau.

31 If we've learned something it's possibly that we have too long between reviews,
32 because I think it would be fair to say that the current legislation is no longer
33 transformative, and that there is more we can do in terms of new legislation to realise those
34 goals.

1 There are a large range of continuous quality improvement activities that happen,
2 though, and in an ideal world we wouldn't require reviews to be continuously improving
3 and learning.

4 **MS McCARTHY:** Yes, I absolutely acknowledge that point that that should be a continual
5 review and analysis and learning lessons from information the Ministry's receiving. I think,
6 taking a step back again, with this new reform, how, and I guess when will you know that a
7 new rights-based Te Tiriti-based approach has been successful?

8 **DR CULVER:** I wish I had a clear sense of that. I think it will take some time for the new
9 structures to be embedded, to develop their own ways of operating and, importantly, there
10 is a strong direction of interagency collaboration, Kia Manawanui which is our long-term
11 ten-year population level mental wellbeing plan is very clear that health cannot achieve
12 these outcomes on its own, it does require work across all of the agencies in terms of
13 improving the wellbeing of the entire population but particularly those who have higher
14 levels of need.

15 We're also working on the system and services framework which will focus more on
16 what services need to be provided in order to meet those goals and I know that both Health
17 New Zealand and Te Whatu Ora and Te Aka Whai Ora Health New Zealand and the Māori
18 Health Authority are working on their interim plan in relation to how they will deliver
19 services.

20 So, I think it's a very exciting time, it is difficult to say when all of this will come
21 together in a very noticeable shift.

22 **MS McCARTHY:** Thank you for answering that question, and just a final point, in terms of
23 accountability, so can you just explain to me how the Ministry holds itself to account for
24 achieving these reforms?

25 **DR CULVER:** There are a number of accountability mechanisms. We are monitored by the
26 Mental Health and Wellbeing Commission, we are also monitored by the implementation
27 unit from the Department of Prime Minister and Cabinet, and there is also an assurance
28 group that oversees the implementation of Budget 19 and Budget 2022 initiatives who are
29 keeping track of our progress on that implementation and we're required to report to all of
30 those entities.

31 **MS McCARTHY:** Thank you. I have no more questions on this topic, so I'll pass over to
32 Mrs Thomas.

33 **QUESTIONING BY MS THOMAS:** Thank you. We're almost there, I promise. This is the
34 final topic and it's really a future focused question directed at Whaikaha in terms of a piece

1 of evidence that Dr Mirfin-Veitch gave at the public hearing where she spoke about the
2 good news, the benefit of Whaikaha and the national rollout of EGL having the ability to
3 transform the way we care and potentially to reduce some of the systemic abuse. But she
4 was quite clear in her evidence that the establishment of Whaikaha and the rollout of EGL
5 alone will not fix the systemic problems in her view and she drew quite heavily on the
6 United Nations Convention on the Rights of Persons with Disabilities, and particularly
7 Article 12 and I'll just summarise what she said on that point, that what still needs to
8 happen is for Aotearoa New Zealand to make a real commitment to the legislative and
9 policy change required to fully implement Article 12 of the United Nations Convention on
10 the Rights of Persons with Disabilities.

11 She went on to say that if disabled people were recognised as having legal and
12 mental capacity as per Article 12, and were supported to make decisions according to their
13 own rights, will and preference, the violence and abuse in care that we have heard about
14 over the course of the Royal Commission and this hearing, which was the public hearing a
15 few weeks ago, would not have been able to continue unchecked.

16 So, my question, Ms Woods, is in addition to the establishment of Whaikaha and
17 the national rollout of EGL, do you agree that for true accountability there is a need for a
18 real commitment to the UNCRPD and the Convention to be made into domestic law in
19 New Zealand, in particular Article 12?

20 **MS KERR:** Yes, is the simple answer. Some of us are actually off to Geneva on Friday for the
21 second UN examination of New Zealand's implementation of the Convention on the Rights
22 of Persons with Disabilities, and we are looking forward to the feedback from the UN on
23 the progressive realisation of the Convention in Aotearoa. But yes, it is absolutely essential
24 that Article 12 in particular is fully realised in New Zealand.

25 You may be aware that the Law Commission is currently undertaking a review of
26 supported decision making and issues around the ability to give consent, which Whaikaha
27 and the Ministry of Health are engaging with, and we look forward to the outcome of that
28 review, which will also make, I'm sure, recommendations for how we continue to fully
29 implement that article in the Convention.

30 **MS THOMAS:** Do you happen to know when that review will be finalised?

31 **MS KERR:** I think it's a reasonably long process, because there's a lot of legislation to look at. I
32 believe that it will be ongoing through next year.

1 **MS THOMAS:** You've mentioned, obviously, Whaikaha's role in attending Geneva, to attend
2 there. Is there anything else that Whaikaha does or can do to progress the implementation,
3 for example, of Article 12 into domestic law?

4 **MS KERR:** So I would say that the implementation of the Convention isn't solely the
5 responsibility of Whaikaha and it is a cross-government delegation that is going, including
6 representatives from the Ministry of Education, the Ministry of Social Development and
7 Te Puna Awanui, the joint venture business unit, and so every agency across Government
8 has responsibility for implementing those aspects of the Convention that fall within their
9 particular purview. So the Ministry of Justice, for example, would have a particular role in
10 relation to Article 12.

11 **MS THOMAS:** Thank you. This is my final set of questions. Just prior to this public hearing
12 starting this week we were all pleased to hear Minister Hipkins announcing that the
13 Government has decided they are working on an apology to all survivors of abuse in care
14 and also working to create a new independent redress system, and as part of that
15 announcement that we heard last week, Minister Hipkins said that:

16 "The first step is developing options for the collaborative design progress and that
17 targeted engagement with members of survivor communities is helpful to identify how this
18 design process might work. These options will go to Cabinet in September, and then
19 following this work we will start on putting the agreed collaborative design process in
20 place."

21 So, my question is in terms of that creation of the developing the options for the
22 collaborative design progress, can you confirm, Ms Woods, that the engagement with
23 members of survivor communities has included engagement with members of disabled
24 communities? You may or may not know that.

25 **MS WOODS:** I'm sorry, I don't know that, I'm not sure where that piece of work is actually
26 happening from.

27 **MS THOMAS:** This is just the announcement that was --

28 **MS WOODS:** I appreciate that, I'd need to go and find out, but we can investigate and provide
29 this.

30 **MS SCHMIDT-McCLEAVE:** I can possibly help with that, that work is based in the Crown
31 Response Unit.

32 **CHAIR:** It resides in the Crown Response Unit.

33 **MS THOMAS:** Excellent, I can check with them.

1 There was one final document I'd just like to go up on the screen to end today, and
2 this is from the transcript of the Ūhia te Māramatanga public hearing, document ending
3 00496. It's a piece of evidence from Paul Milner, and I will just read out this quote.

4 To give some context, this is a quote where the researcher Paul Milner described his
5 last day at this Kimberley institute where he was saying goodbye to the people that he had
6 spent time with for a number of years, and he went to see this individual who Paul had
7 thought maybe had locked-in syndrome and on this last day Paul Milner approached him to
8 say his final goodbye, and he described how this disabled man looked at him, and he said:

9 "It was with a look that said 'You absolute arsehole, you've seen, I've revealed
10 something of myself and you just walked away.' That is the habit of institutional care and it
11 ought not to be a habit, the knowing but walking away."

12 And my question to both Dr Sarfati and Ms Woods is, can you reassure the
13 survivors and the whānau members who have revealed themselves to this Royal
14 Commission of Inquiry that the Government will not just know that the abuse and the
15 neglect and the shameful part of our history has occurred, and then walk away?

16 **MS WOODS:** On behalf of Whaikaha I can say we will not walk away.

17 **DR SARFATI:** On behalf of the Ministry of Health, we will also not walk away.

18 **MS THOMAS:** We all agree that apology and redress are very important, and we've heard that
19 that's happening now within Government, progressing those aspects. Do you both also
20 accept that without an investment in systemic change and a paradigm shift in the societal
21 attitudes and the way that the State cares for children and adults at risk, the pervasive abuse
22 and neglect of the past could prevail again without that systemic change?

23 **MS WOODS:** I think from Whaikaha's perspective we are in the middle of transformational
24 change which is deliberately to try and ensure that the abuse of the past never happens
25 again.

26 **MS THOMAS:** Thank you.

27 **DR SARFATI:** Yes, I would agree we are well on a journey of systemic change such that the
28 abusive past, I would genuinely hope could never possibly happen again.

29 **MS THOMAS:** Thank you. I'll just leave you with the Commissioners who may have some
30 questions.

31 **CHAIR:** Thank you very much. I know the Commissioners, some of them at least, are bursting
32 with questions, we'll keep them as crisp as we can because I'm conscious it's been a long
33 and exhausting day. We'll start with Sandra Alofivae.

1 **COMMISSIONER ALOFIVAE:** Tēnā koutou katoa, faatalofa atu i le pa'ia ma le mamalu o le
2 tou matagaluega. (Greetings to distinguished members of the ministry). And for those who
3 haven't heard from me today, I was going to make up some stuff but I won't, I'll tell the
4 truth because the Chair's looking at me. I have short curly hair, I wear glasses and I think,
5 like Dr Sarfati, my children would probably say I'm middle-aged as well.

6 It's been a long day and we're very, very grateful for the way you've responded to
7 the questions that have been put to you. One of the recurring themes that we hear from our
8 survivors is: It takes such a long time. And you've been asked throughout the day to see if
9 you can quantify time, can you give us some ballpark figures, and we appreciate that you're
10 both ministries, the enormous reforms that you're under and you're going through, but
11 whispers in the community are placing a two-year ballpark figure just for the Ministry of
12 Health and those reforms to kind of stabilise. They're not even putting a ballpark figure yet
13 on Whaikaha.

14 We've heard how long it took to shut down the institutions- 20 years, 33 years or
15 was it 36 years at the longest? The question is, Covid was a wonderful example of how
16 esteemed leaders in our Public Service, of which you're very much a part of, you were able
17 to turn it around just like that. So,- something happened that forced you and your
18 colleagues to work quite differently.

19 I guess I'm just wanting to ask on behalf of the survivors that are listening on the
20 livestream, those that are present here, can we expect something within a reasonable
21 timeframe, reasonable being not the 36 years that it took, but maybe giving it to you to try
22 and give some assurance to the public around the urgency that the ministries are taking.

23 **DR SARFATI:** I think as you've said, we can't give you specific assurance. What I can say is
24 there is a very clear commitment both at the level of the Government and the legislative and
25 structural processes that they've put in place and also among my colleagues who are very
26 committed to seeing change. I think genuinely, though, all the change within the context of
27 a system as huge and complex as the health system will always be iterative.

28 One of the difficulties is it's a little bit like watching someone grow. Sometimes
29 that change isn't all that obvious until you think back, what was it like five years ago, what
30 was it like ten years ago, sometimes you'll look back and go it wasn't very different;
31 sometimes you'll look back and go, actually it's changed. I expect what we'll see from
32 hereon is iterative change and obviously we all want to see that change happen as quickly
33 as possible.

1 **COMMISSIONER ALOFIVAE:** Thank you. Another question that I had really arises out of the
2 pathways into care. So fully appreciating the difficult and the different pieces of legislation
3 that the ministries are working with, so we've heard about the IDCCR Act, we understand
4 about the CP(MIP) Act and also the interaction both those Acts have with Oranga Tamariki
5 and our young people in care.

6 We've heard evidence in previous hearings that neurodiversity and that whole
7 continuum is one of the new pathways into care. So one of the difficult decisions that our
8 courts are having to grapple with is when assessments are being called for around the
9 definition of disability, intellectual disability, does a young person meet the criteria, then
10 what is the pathway, and I've heard comments this afternoon around the support services
11 that are being formed, but one way of being able to keep our children and vulnerable adults,
12 but children in this particular instance, out of the care system, is for those services to be
13 developed and to be given some form of priority given what we know and have seen have
14 been big patterns in the past.

15 **MS KERR:** We are very aware that our eligibility criteria for Disability Support Services is
16 overdue a review. At the moment eligibility criteria doesn't include neuro developmental
17 disabilities. Having said that, our Child Development Services, which is a really critical
18 early intervention support within Disability Support Services, is open to any child with
19 global neuro developmental delay.

20 In the Cabinet papers that set up Whaikaha, Government explicitly recognised the
21 opportunity that Whaikaha has to look carefully at not just DSS eligibility criteria but
22 definitions of disability across Government and that there's an opportunity to harmonise
23 those, and considering neuro developmental disability and the supports and pathways that
24 need to be provided for people with those sorts of disabilities is absolutely a fundamental
25 part of that work.

26 **COMMISSIONER ALOFIVAE:** So, it's iterative but a work in progress?

27 **MS KERR:** Yes.

28 **COMMISSIONER ALOFIVAE:** One of the things that I've also heard this afternoon and I'm
29 just reflecting back is that language, every sector has a particular language. So, when we
30 talk about health and in Whaikaha, you talk about adverse events, whereas in Oranga
31 Tamariki they'd be calling them allegations of abuse. So, you've got the difference in
32 language, we've got the difference in thresholds as to what constitutes risk, what constitutes
33 eligibility, and just your comments on whether not having a more streamlined language and

1 perhaps a risk matrix, is that contributing to the traffic jams in being able to provide
2 appropriate services to those who really need it?

3 **DR CULVER:** I acknowledge we all do use different language and processes, there is room for
4 streamlining. I think one thing I'd also say is that there is an increasing focus on what are
5 the things that allow things to go well, because where the focus is purely on what's gone
6 wrong, we're missing the opportunity to share what are the factors that make things go
7 right. And that is certainly something that is happening across mental health and addiction.

8 Increasingly, particularly with programmes like the key performance indicator
9 programme, which uses data and service users and service providers to look at how can we
10 share information about what works, and disseminating outcomes of pilots, not just within
11 our own Ministry but across the ministries, so I think there is some work in that area,
12 absolutely there is more that we could do to be speaking the same language there.

13 **COMMISSIONER ALOFIVAE:** And just coming to the issue of accountability, so we heard I
14 think yesterday, on our first day of hearing we heard from your colleagues in MSD, we
15 heard from the General Manager of Te Kāhui Kahu which is an accreditation service, they
16 look after six agencies of which Whaikaha and the Ministry of Health are not within that
17 group.

18 So just a point of clarification so that our survivors are clear; the Ministry of Health,
19 you have your own accreditation processes for your providers?

20 **DR CULVER:** That's correct.

21 **COMMISSIONER ALOFIVAE:** So, you're responsible for monitoring the performance of those
22 providers as well as the quality of the services of those providers.

23 **DR CULVER:** Yes, although it's possibly not quite that simple after 1 July because Te Whatu
24 Ora also has a responsibility in monitoring the quality and service provision of its providers
25 and we have a responsibility to monitor Te Whatu Ora in that process.

26 **COMMISSIONER ALOFIVAE:** And who does- - is there another body, because I know, Dr
27 Culver, you referred to, I think it was Health and Safety Commission, there was a
28 department within DPMC and there was one other group that -monitors- the budget-- -- that
29 monitors, almost like a risk an audit and assurance, is that right?

30 **DR CULVER:** They monitor our implementation of the Government's response to He Ara
31 Oranga, so the implementation of both the Budget 19 funding and Budget 22 funding for
32 responding to all of the recommendations that were fully or partially accepted.

33 **COMMISSIONER ALOFIVAE:** Because one of the things that we've heard very clearly from
34 our survivors is what's not clear, or has ever been clear, is if they want to bring a complaint,

1 who is accountable, where they can they go to on your website? So some really practical
2 basic things that would go a long way to helping these psychosocial stressors would be very
3 helpful. I think sometimes we get caught up in the big stuff, whereas it's the real practical
4 day-to-day stuff that makes a difference in their lives, it goes a long way.

5 The last point I really wanted to ask you about, and you've all commented on this,
6 it's around the integrated collaborative response, so we've heard a lot about family harm, so
7 it's a sensitive indicator so everyone's responsible, which makes really nobody accountable,
8 we're all only responsible for your little bit, and it's still quite difficult to be able to pin
9 someone or an organisation or a Ministry down to be responsible.

10 There would be a number of crosscutting issues, and Dr Sarfati you mentioned a
11 couple, there's child and wellbeing, and I think Dr Culver you mentioned, there's wellbeing
12 generally across the board. I think another one is investing in services, and another would
13 be, like, workforce development.

14 You can't hold other agencies responsible for their core business, but you have
15 accountability documents, you've got your statement of intent, you've got your SPE. I'm
16 just socialising an idea. Is that another vehicle to be able to speak into how there is a
17 collective responsibility, because you all talk a good game, but it's not always played out in
18 public for the consumer in the communities who are the users of the services.

19 **DR SARFATI:** So, within Health there are some mechanisms which hold the entire system to
20 account, one of those is the Government Policy Statement which basically says: This is
21 what we want the system to deliver and you are all accountable for delivering these things.
22 And then I guess under that there is in development New Zealand Health Plan, which is a
23 plan which is put collectively together by Te Whatu Ora and Te Aka Whai Ora and which
24 the Ministry will monitor them by, which again determines some collective priorities which
25 the system is then held to account to deliver on, and some of those actions that will be
26 identified in that plan will relate to the areas that we're talking about today, including
27 workforce mental health services, etc.

28 **COMMISSIONER ALOFIVAE:** But Health being such a huge leader in the game, because
29 really at the end of the day you're responding to the social determinants that the other
30 agencies aren't able to meet in one respect. Do you think it's a leadership role?

31 **DR SARFATI:** Do you mean, do you think Health has a leadership role? Yes, yes, I think it does.
32 I think when we're looking at especially at high-level cross--government complex
33 intersectoral intersectional activity, it inevitably gets complex, and there are ways in which
34 government departments are aiming to work together. One example of that is a social

1 wellbeing board where the Chief Executives of relevant organisations, including Health and
 2 Justice and Education and various other ones, come together to discuss those sorts of issues
 3 which have that cross--government----

4 **COMMISSIONER ALOFIVAE:** Responsibility.

5 **DR SARFATI:** - responsibility, and that's chaired by the Public Service Commissioner who then
 6 sort of holds accountability for the Public Service as a whole. Of course, those issues are
 7 inherently complex and difficult to shift, those really difficult issues, and they do require
 8 that cross--government focus in- a sustained way.

9 **COMMISSIONER ALOFIVAE:** Thank you.

10 Dr Culver, I think you wanted to offer some comments.

11 **DR CULVER:** I was going to talk about a role on the Social Wellbeing Board, but also that there
 12 is a lot of good collaborative work occurring, and of the \$1.9 billion funding from Budget
 13 19 for mental health and wellbeing, \$835 million went to other agencies and there is a lot of
 14 collaborative work in terms of particularly between Health and, for instance, Education,
 15 Oranga Tamariki, in rolling out their parts of that programme. So, while the Social
 16 Wellbeing Board sits above all of those actions, there is a lot of direct contact between the
 17 ministries to support those initiatives.

18 **MS WOODS:** Can I just add there that Whaikaha will be responsible for driving better outcomes
 19 for all disabled people, and particularly about leading cross-government strategic disability
 20 policy. So that is about trying to get that the connectedness.

21 **COMMISSIONER ALOFIVAE:** And I'm sure the Police would love your support, and we heard
 22 from them yesterday. So, thank you very much.

23 **CHAIR:** Julia Steenson.

24 **COMMISSIONER STEENSON:** Tēnā koutou katoa. Nga mihi nui ki a koutou. For those who
 25 have joined today, I'll describe myself. I am a Māori woman in her 40s with a blue jacket
 26 and a white shirt and I have brown hair and brown eyes.

27 So, questions, I just want to pick up on or start where my colleague has left off
 28 around accountability. I just wanted to understand whether there are any mechanisms for
 29 the Ministry of Health to be accountable with regards to Te Tiriti and outcomes for Māori
 30 to Māori.

31 **DR SARFATI:** Well, maybe the first part of that question going back to the earlier discussion in
 32 the new Pae Ora Act, Te Tiriti is clearly stated as a core element of that. In terms of the
 33 Ministry of Health's role in its responsibility to Māori, Te Aka Whai Ora has a role in
 34 establishing the extent to which the sector as a whole is responding to Māori and delivering

1 according to Māori aspirations, and so whilst they don't have an explicit role in holding the
2 Ministry of Health as an organisation to account, it does have a role in holding the whole
3 health system to account. So, we will be partnering with Te Aka Whai Ora in that role
4 and so-- I think that's where that accountability will sit and that's where it will be held and
5 monitored.

6 **COMMISSIONER STEENSON:** So, they will have a sense of a monitoring role in terms of
7 outcomes.

8 **DR SARFATI:** Absolutely, yes.

9 **COMMISSIONER STEENSON:** Yes, and the next area I just want to focus on is around the
10 Mental Health (Compulsory Assessment and Treatment) Act 1992, because just looking at
11 how patients can be placed in compulsory care. Now, we know historically that has been
12 used in a way that hasn't had great outcomes particularly for Māori. At the moment the
13 current Act is that a health practitioner, which has always seemed to have been the process,
14 a health practitioner makes an assessment, decides what can be treated and whether or not
15 they can be treated as an outpatient, if they can't be basically.

16 Now the data, 2011 data that is in Dr Crawshaw's evidence says that they found that
17 Māori are more likely to experience compulsory assessment in treatment than non--Māori
18 and also more likely to be secluded.

19 So, in finding that, the DHBs, which is now Health New Zealand, has been tasked
20 with addressing that disparity, is that correct? Yes, that's what it says in there, I know I'm
21 speaking to somebody else's evidence.

22 **DR CULVER:** That's correct.

23 **COMMISSIONER STEENSON:** So, I guess my question is twofold. Understanding why that
24 was not addressed by Te Aka Whai Ora is the first part to that question.

25 **DR SARFATI:** Te Aka Whai Ora only came into existence on 1 July.

26 **COMMISSIONER STEENSON:** Yes, and Health New Zealand's also very new as well.

27 **DR SARFATI:** That's right, Te Aka Whai Ora is a very new organisation, but that would be, I
28 imagine, of substantive interest to them.

29 **COMMISSIONER STEENSON:** So, you're anticipating it may shift.

30 **DR SARFATI:** Yes, this is the new, under the new reforms, this is a new process under the new
31 reforms.

32 **COMMISSIONER STEENSON:** What I'm trying to understand really is, or perhaps get your
33 comment on, do you think that it's more effective and appropriate that ultimately Māori

1 would decide, or a Māori organisation would decide who should be placed, whether Māori
2 should be placed in compulsory care?

3 **DR SARFATI:** I feel like that might be beyond my level of expertise, that sort of a technical
4 question. I don't know if my colleagues could perhaps comment.

5 **DR CRAWSHAW:** So perhaps I can just help you. Firstly, my colleagues who transferred across
6 to the Māori Health Authority were actually working with us in terms of where we needed
7 to go in terms of this process, so it's not something that Māori have not been engaged with,
8 they certainly have been. Secondly, there's two parts to it. You talk about the health
9 practitioner but there's also the application process, and there's nothing to stop that, which
10 is the, we call the 8A, that's where someone has to apply for the Act to apply. And there is
11 nothing to stop that person being Māori, and in fact nothing to stop them being whānau
12 members.

13 However, for a lot of Māori they would not want to take that step, and so sometimes
14 it is better for them that other people step in.

15 It's challenging, and as I said in my main evidence, the real issues sit not so much in
16 terms of when the Act is applied, but actually how do people get to that point, and in fact
17 that's the difficult untangling task that we've been doing.

18 That said, in the 2020 guidelines we made a real effort to try and help people
19 understand the obligations under Te Tiriti, and in fact currently in the Act under Section 5
20 there is an obligation for anyone who is using the Act to it's- not mana- enhancing but it
21 talks about having to apply the Act in a culturally appropriate way taking into account- that
22 person's culture.

23 So, it doesn't just apply for Māori, but this especially applies for Māori in my view,
24 and there is a right under Section 65 of the Act that actually reinforces that. That's what's
25 given me the ability to give very clear guidance as to what we expect.

26 **COMMISSIONER STEENSON:** Thank you. So, if I could just ask another follow-up question
27 rather than have you---- yeah. So then, that would mean the cultural competency becomes
28 very important, of all the players.

29 **DR CRAWSHAW:** It does, and in fact if you look at most of the registered practitioners under
30 the HPCA Act, I haven't looked at all of them, but I know that for my own profession,
31 cultural competence is actually one of the expectations of our registration body.

32 **COMMISSIONER STEENSON:** And so, are you comfortable that there is a good level of
33 cultural competency currently?

1 **DR CRAWSHAW:** I think it's been more challenging for people who come from overseas to
2 understand the cultural context in which they deliver care, that's something which we're
3 providing, wanting to provide through Te Pou, some extra understanding of the cultural
4 competence, it's also part of the ongoing process we have been trying to lead from the
5 Ministry. As I said earlier, what we see is not acceptable in the sense of the marked
6 differential application for our indigenous folk, ie Māori. So, things have to change.

7 **COMMISSIONER STEENSON:** Sorry, then one last question, it may be for yourself or Dr
8 Sarfati, so feel free to decide. It is around, so earlier you talked about the measuring the
9 effectiveness of those cultural competencies is not easy, which I was a little bit surprised at
10 because are there any initiatives that are in- the commercial world you ask those who
11 receive services whether or not- things are being --

12 **DR CRAWSHAW:** Certainly, there are initiatives to measure the people who receive the
13 services, perception of the care, and there was and- there's been various attempts at getting
14 that. In terms, some services are actually using -real-time feedback which actually gives it
15 in -real-time. Other services have developed cultural assessment tools to see if that will
16 make a difference. Ultimately, of course, what really matters is what is the outcome. So
17 that is what Dr Sarfati has been---- was alluding to, we need markers of the outcome.
18 That's why I have been publishing the data, disaggregated data around Māori, that's why I
19 have been focusing on it because that's a very clear difference that we can actually measure
20 whether there is change.

21 **DR SARFATI:** To maybe expand on that, I wasn't implying there aren't ways of measuring, but in
22 terms of being really able to understand that construct well, and asking people is a really
23 important part of that. It's a necessary but not sufficient part and the reason for that is, for
24 example, for many years there's been a, for example, a patient survey for people that have
25 been admitted to hospital, this is general hospital and, generally speaking, what you will
26 see, this is for Māori patients and non--Māori patients, that actually they'll report that level
27 of care being about the same. At the same time, we know that outcomes for Māori are
28 worse. So that by itself is not enough to say the system has responded adequately.

29 **COMMISSIONER STEENSON:** Okay, yeah. As opposed to looking, drilling into a cultural
30 competency.

31 **DR SARFATI:** Exactly.

32 **COMMISSIONER STEENSON:** Are you receiving a cultural- - it's a separate-- --

33 **DR SARFATI:** That's right, that's right.

34 **COMMISSIONER STEENSON:** Okay, that's helpful.

1 **DR SARFATI:** So, it gets quite complex, I guess there's many elements that need to be - to- make
2 sure that we are measuring what we think we're measuring, I guess.

3 **COMMISSIONER STEENSON:** Thank you. Then I just have a couple of questions now around
4 the Whaikaha services, if I may. So, in the evidence it talks about Enabling Good Lives
5 approach working with the Whanau Ora approach, but then it sort of parks it. So is
6 somebody able to please unpack that a little bit more for me, because it would appear that
7 the Enabling Good Lives approach is the dominant approach.

8 **MS WOODS:** I think the intention, and I mean we're basing this off a very short span of
9 knowledge, but I think the intention is that Enabling Good Lives is about ensuring that
10 disabled people, tāngata whaikaha Māori have much more control over the supports
11 themselves. If you then overlay Whanau Ora on to that, then you get family and whānau
12 context around it. And so it would be probably down to those individuals and those
13 families as to which particular aspect they would want to work with. In Māori clearly the
14 Whanau Ora approach is quite important as it is for Pacific people.

15 **MS KERR:** When Mana Whaikaha, which is the prototype in Mid-Central, was established in
16 2018, one of the things that there was a really strong desire to test was how to ensure that
17 an Enabling Good Lives approach and a Whanau Ora approach could work together. Both
18 approaches, actually they share a whakapapa, they both came from the time when Tariana
19 Turia was the Minister, and so in Mana Whaikaha there was a whānau ora interface group
20 established that involves community members and whānau from both the Māori and Pacific
21 communities, and they did a piece of work looking at how the Enabling Good Lives
22 principles, the whānau ora principles, Te Tiriti and the UN Convention could all be
23 complementary.

24 The evaluation of Mid-Central has shown that there are some good outcomes being
25 achieved for tāngata whaikaha. We know there is more work to do in that space to ensure
26 that tāngata whaikaha, whānau whaikaha and Pacific disabled people can move seamlessly
27 between the systems and that will be a key part of the national implementation.

28 **COMMISSIONER STEENSON:** Okay, thank you. Then my last question is around, I think you
29 may be able to help me with this one, it's around Ngā Paerewa, the strategy, service
30 standards. So when I look at the service standards as they're outlined in the statement, it
31 talks about a shift, which we've just been talking about, to more whānau-centric, which is
32 great, and empowering tāngata whaikaha to make their own decisions about their own care
33 and support.

1 And then there are service - supervision and monitoring of service providers and
2 there's things that happen around oversight and audit and evaluation. I'm just wondering
3 whether these checks include a focus on mana motuhake, so ensuring that that self--
4 d-etermination element, freedom of choice and how a disabled person lives their lives, are
5 not restricted by, you know, there's obviously a compliance element.

6 **MS KERR:** I'm afraid I don't know the detail of the new Ngā Paerewa standard, but that's
7 something that we can come back to you about in writing.

8 **MS WOODS:** I think the other thing is that there is a shifting of systems, so this is the existing
9 system,- and we're wanting to move towards the EGL Whanau Ora approach and that will
10 have potentially different standards associated to it which could include the sorts of things
11 you're talking about. So,- we're possibly in the middle of that but we'll ensure we get you
12 the correct information.

13 **COMMISSIONER STEENSON:** OK. So, that would possibly be the same for my cultural
14 competency question as well.

15 **MS WOODS:** Absolutely, yes.

16 **COMMISSIONER STEENSON:** Thank you very much, ka kite.

17 **COMMISSIONER ERUETI:** Kia ora koutou katoa, I'm Anaru Erueti, I'm 53, Māori, greying
18 hair and wearing a suit.

19 Thank you for staying on after the time, we appreciate it. My question follows from
20 my colleague Julia's, I wonder with Whaikaha, with the Ministry, there's no legislation
21 establishing this, right, it's a Governmental agency, I don't think there's any statute?

22 **MS KERR:** There is no legislation at the moment. There is a legislative bid for a Disability
23 System Bill, there is policy work happening at the moment about what the scope of that Bill
24 could include. It may provide an opportunity to progress some of the things that we've
25 discussed today.

26 **COMMISSIONER ERUETI:** Because I wonder about the role of the Treaty and something that
27 hasn't been mentioned yet, but I think you should take this to Geneva, is the UN
28 Declaration on the Rights of Indigenous People. So I've noticed from both Dr Crawshaw's
29 brief but also yours, Ms Woods, about the idea that the policy is underpinned, I think the
30 korowai you called it by Te Tiriti and by the UNCRPD and something similar is said by
31 Dr Crawshaw in relation to the Mental Health Act reforms, but the declaration is absent in
32 both of your briefs and, of course -- I'll stop. I won't do a speech about the declaration, but
33 I wonder why that -- anyway, making that point, I wonder where the direction is coming

1 from in terms of Treaty and indigenous rights obligations for the Ministry. If you don't
2 have a code, if you don't have legislation, where are the directives on those matters?

3 **MS KERR:** We're working with the community on developing the Tiriti approach for the
4 Ministry. I would say the Declaration on the Rights of Indigenous Peoples should have
5 been in the brief, it isn't absent from the discussions that we're having, and I just
6 acknowledge what Dr Ingham said about that in the kaupapa Māori panel, and that's
7 certainly something we will be taking to Geneva.

8 But the establishment unit had ongoing discussions, and Geraldine may be able to
9 speak more to this, with tāngata whaikaha Māori and those discussions are continuing,
10 because we're absolutely committed to ensuring that Whaikaha is a Tiriti grounded
11 organisation.

12 **MS WOODS:** I don't think I've got anything more to add, it probably was something that was
13 missing in the brief, it happened so quickly.

14 **COMMISSIONER ERUETI:** Ka pai.

15 **CHAIR:** Dr Crawshaw, did you wish add to that?

16 **DR CRAWSHAW:** Certainly, in terms of the work that we've been doing in terms of the repeal
17 and replace of the Mental Health Act, that declaration in terms of indigenous people was
18 actually part of our policy work as we were working through and going through the
19 consultation document. So it's not absent.

20 **COMMISSIONER ERUETI:** That's good. I think about the discussion on Article 12, was it, and
21 how the declaration can imbue that with collective dimensions and form of consent and so
22 forth.

23 But then I think -- my other questions is following from Julia's question about
24 Enabling Good Lives, because I wonder why that collective dimension is not contained in
25 Enabling Good Lives, because if Enabling Good Lives is for Māori and non-Māori, and
26 certainly it seems a lot of Māori who are disabled identify strongly with their whakapapa,
27 why that collective dimension wasn't embodied in the development of Enabling Good Lives
28 and why it's come along later, it seems -- or maybe it was parallel, with the development of
29 Whanau Ora, but why is it not emerging from within Enabling Good Lives?

30 **MS WOODS:** I'm not sure, I think the two emerged together. The Enabling Good Lives came
31 from the community and from the- disabled community, so maybe it was just that it was
32 more particularly coming from non---Māori community, I'm not sure, but certainly Whanau
33 Ora was kind of around the same time and I think it's about making sure that the two are
34 connected for the future transformation.

1 **COMMISSIONER ERUETI:** It does seem that there is this disconnect in the international
2 movement with the disability movement and the indigenous rights movement that they're
3 not properly joined up, and I wonder whether this is also happening at the domestic level as
4 well, that it's not kind of really cohering sufficiently.

5 **MS WOODS:** I think from Whaikaha's point of view is from a partnership perspective we want it
6 to be connected so we are trying to do a partnership with tāngata whaikaha Māori with
7 disabled people, so non-Māori disabled people and with the Crown. So it is trying to make
8 sure that there is that connectedness.

9 **COMMISSIONER ERUETI:** Okay. This is the last question, it is about -- for Oranga Tamariki
10 we all spend time talking about the idea of enabling Māori communities as providers, and
11 we haven't got time to go into this in detail now, but I'm wondering with these changes
12 afoot, whether there's a potential for that to scale up within all your ministries, actually, to
13 grow the number of Māori providers across the various ministries.

14 **MS WOODS:** I think my expectation for Whaikaha is that with the transformation means that
15 family and whānau and tāngata whaikaha Māori can choose their own services. Therefore,
16 by definition they will be choosing services that work for them, that's probably an
17 emergence of quite different and quite new organisations and services.

18 **COMMISSIONER ERUETI:** We hope so. Dr Sarfati?

19 **DR SARFATI:** I think again with Te Aka Whai Ora and the specific funding that's been put into
20 Budget 19 and Budget 21, my expectation would also be that there would continue to be an
21 increase of kaupapa Māori services, I think we've already seen an expansion but we'd
22 expect to see more.

23 **COMMISSIONER ERUETI:** Kia ora. And in the mental health space?

24 **DR CULVER:** Absolutely, I think that will continue to be a main priority. I think there's also the
25 Iwi Māori Partnership Board approach of working communities. One thing we learned
26 from Covid was it was the communities who delivered and it was the communities who
27 were able to innovate and the best thing that the ministries could do was support them and
28 keep out of their way. So I think there is a lot of promise in an Iwi Māori Partnership
29 Board and locality-based approach and the expansion of kaupapa Māori service provision,
30 especially in the mental health space.

31 **COMMISSIONER ERUETI:** Kia ora.

32 **CHAIR:** Paul?

1 **COMMISSIONER GIBSON:** I'm a 6-foot tall Pākehā male, I'm legally blind, I'm sitting here
2 with one headphone over my ear and checking into a computer occasionally. Three years
3 ago, at the start of this Inquiry, I had brown hair and now it's gone grey.

4 Can I start by acknowledging the concessions, thank you for those and also
5 acknowledging some of the good things that are happening, the establishment of Whaikaha,
6 the beginnings of Enabling Good Lives.

7 But I think there's a general theme of that this group of ministries and successors
8 have been slow to learn and slow to act and I'd say even slow to take accountability,
9 responsibility for what's happening.

10 Also, across all the ministries we've seen, it would be fair to say the response to the
11 request to produce from Ministry of Health was by far the least thorough, and also the
12 least-- was actually almost denying of responsibility around historic abuse in care. That
13 doesn't give me a lot of assurance going forward that the struggles to actual-y- --the
14 slowness to learn, the slowness to act and the slowness to take accountability.

15 There was a phrase, I think, in your evidence Ms Woods about not to repeat errors
16 of the past, I think "errors" is just such an understatement. This was absolutely horrific
17 what happened under the watch of the Ministry of Health and its departments, successive
18 agencies over time: overmedicalisation, developing tools designed to shock and torture
19 people, extreme use of seclusion, and the slowness even when these have been brought to
20 the attention through the Burns report, through the Commission of Inquiry, the number of
21 years it has taken to respond. And today the role of EGL has been so slow, it seems, that
22 the changes to the, the proposed changes to the Ministry of the Mental Health Act.

23 I've been involved in this Independent Monitoring Mechanism processes as well
24 going to Geneva and the recommendations for change around legislation, I think since last
25 time only one piece of legislation has changed around the Oranga Tamariki Act.

26 Other legislation which has been identified since 2007 and the 2008 CRPD hasn't
27 changed.

28 I think people have acknowledged the legislative and policy settings up to 1999
29 enabled ableism and abuse, I don't think, apart from that one piece of legislation, there
30 hasn't been any other legislation change in the area.

31 Just some of the things that we heard; I would like some more genuine
32 acknowledgment about what has happened. Was it genuine horror, and going back to our
33 first contextual hearing, when Sir Robert Martin, apart from his own abuse, talked about
34 witnessing boys who had toileting accidents hosed down using fire hydrants, hosing their

1 private parts so that they couldn't even stand up, and what he witnessed was this was
2 punishment, and it was a message to him don't do this.

3 Do you accept that punishment occurred in these places in psychopaedic psychiatric
4 institutions?

5 **DR SARFATI:** Well, first of all, of course I was utterly appalled, listening to the evidence that
6 has been given by survivors and reading their briefs, you know, there's not really words
7 strong enough. It's heart-breaking and, you know, it's awful and, as my colleague said
8 earlier on, absolutely awful to read and really hard to even imagine what it would be like to
9 live through, that's not something that I have personal experience with and I can't even
10 imagine what that would be like for the person or their whānau, the people who love them.

11 So that's utterly appalling. As you've heard, we've read a series of
12 acknowledgments which are absolutely genuine, I apologise for your sense of the response
13 of the Ministry of Health in relation to the request for- -sorry-, I'm losing my voice now, it's
14 getting to be a long day, you know. But absolutely, those acknowledgments are genuine,
15 and to the survivors, their experience was inexcusable and awful.

16 **COMMISSIONER GIBSON:** Do you accept the places that were supposed to provide care
17 actually punished people for accidents that were beyond their control?

18 **DR SARFATI:** I've heard that evidence and that evidence is appalling and yes, I accept that
19 evidence, yeah.

20 **COMMISSIONER GIBSON:** Do you accept the levels of pain, emotional and physical, were
21 severe?

22 **DR SARFATI:** Yeah, as per our acknowledgments, absolutely, appalling, and lifelong effects
23 from that.

24 **COMMISSIONER GIBSON:** And across this time period we've seen experimentation, extreme
25 ECT, lobotomies, all of these things.

26 **DR SARFATI:** All of those things yes.

27 **MS WOODS:** Geraldine here, I just reiterate what Dr Sarfati as said, that any form of abuse or
28 neglect is totally and completely unacceptable, the stories are heart wrenching.

29 **COMMISSIONER GIBSON:** There's a comment, I think this is from Dr Crawshaw about the
30 institutions, the scale of them promoted almost a deviation from social norms all of their
31 own. Does this happen in large providers today? Can it happen in large providers, that
32 deviation from social norms?

33 **MS WOODS:** I would hope not. I think that we have more checks and balances in place that
34 should stop it, but I think that there's always continuous improvement. I think that there

1 are I-- think with big providers they in themselves need to be checking that the way they
2 operate isn't in the nature of an institution, but I think that, well, one of my colleagues
3 probably can answer better in terms of the checks and balances that the Ministry have put in
4 place are hopefully ensuring that the abuse that we've seen in the big institutions is not
5 occurring.

6 **DR CULVER:** I think, it's Arran Culver here, I think that it is a very important reminder of why
7 the institutions were closed, and an absolute imperative that we never go back to the age of
8 institutionalisation.

9 In terms of current provider frameworks, I think that there is a risk that institutional
10 behaviour can arise even in small services, and that is where the checks and balances need
11 to be applied, but also there is a responsibility and an accountability for establishing a
12 culture that does find that conduct abhorrent and that does seek to accord people their rights
13 to provide choices and to treat people with parity of esteem.

14 **COMMISSIONER GIBSON:** Going back to Ms Woods, I hope not, too, in terms of -- but the
15 fundamental question, are disabled people safe, for example, in residential care today?

16 **MS WOODS:** I think Amanda is standing to say something.

17 **MS BLECKMANN:** Amanda speaking. I'm going to make a couple of comment. In my
18 experience when things go wrong, I look to the top of an organisation and how the Chief
19 Executive is responding. When I hear about a situation of abuse or neglect, I call the Chief
20 Executive and I ask them how they are responding and in the most recent example the
21 Chief Executive and his senior managers were horrified. They drove to the centre, or out of
22 town to where that incident had occurred, they immediately contacted the Police, they
23 immediately did an investigation, they did everything we could have expected, and they
24 were shocked that their systems had let them down.

25 Earlier in my time at the Ministry when things have gone wrong, we've had
26 different experiences from Chief Executives who haven't taken responsibility, and it is my
27 experience that the Chief Executives in the bigger organisations take their responsibilities
28 very seriously and can expect to have a conversation when we hear about things.

29 **COMMISSIONER GIBSON:** It's good to hear there was that response, it's not so good to hear
30 that the abuse occurred.

31 Sitting behind the transformation of Enabling Good Lives, what is the - lots of
32 changes of funding models, how do we dismantle what's not working, what's the thinking
33 behind funding, the inequity between Whaikaha- funded- Disability Support Services and
34 ACC, what's the future around the resource allocation methodology?

1 **MS BLECKMANN:** There are two more things I'll respond to, and one is that I'm always
2 concerned when I hear providers talk about funding being a reason for abuse or neglect. It
3 doesn't cost for people to be kind and compassionate, and provide support. It's about the
4 values and the beliefs and the culture of the organisation. It's about the way things are
5 done, how decisions are being made and who makes those decisions.

6 So, for Enabling Good Lives it's about shifting the power and it's about disabled
7 people and their families making decisions about how they are supported and how they
8 want to use the support that they have access to.

9 **COMMISSIONER GIBSON:** Thanks. We heard from so many of the witnesses that sitting
10 behind abuse and neglect is power and control, both at the individual level, at different
11 levels, relational level, community level, societal level, and I think- can-- I thank those of
12 you who acknowledge their disability status or they're a non-disabled person. Just my
13 reflecting back, and I think for the disability community this is important, I'm not seeing yet
14 that significant shift in power and control as you're making decisions at the society level,
15 and at the Ministry level.

16 What's your reflections on how to change the structure so that power and control
17 does move to disabled people, their families, at different levels at the individual
18 relationship level where service and support is provided and at the strategic systems level?

19 **MS BLECKMANN:** So, in my view, the shift in power is when disabled people and families
20 have the funding themselves and they decide what's important to them, and they choose the
21 way they want to be supported, who supports them, when they're supported.

22 **COMMISSIONER GIBSON:** There's a comment that providers are expected to align with
23 Te Tiriti, with CRPD, with a range of relevant standards. What happens when they don't?
24 What does the Ministry do when they don't? Does residential housing, residential services
25 align with Article 19 of CRPD?

26 **MS BLECKMANN:** I think there's more work to be done. In the future I'd expect to see far less
27 residential services. In the meantime, there are currently 7,500 people accessing residential
28 support. We have in- the last month Whaikaha is initiating a piece of work to update the
29 contract for residential services so that there is a far more -rights based- approach to
30 supporting people. That needs to happen immediately.

31 You asked what we would do if providers are in breach- or not following things like
32 the UNCRPD. We will exercise the full extent of the contractual levers, and we will work
33 with providers to shift their practice and it could mean that we would not renew contracts,
34 or we would end contracts.

1 **COMMISSIONER GIBSON:** More broadly, Whaikaha has a responsibility across Government
2 for a range of things impacting on disabled people's lives. In the bodily integrity area there
3 are a range of rights issues, there had been the disability action plan work on nontherapeutic
4 non-consensual sterilisation, which I think Government walked away from, there are areas
5 like screening for Down Syndrome, what's the future of those issues, what's disabled
6 people's input into screening programmes?

7 **MS BLECKMANN:** I'm looking at my Health colleagues.

8 **DR SARFATI:** I can't give you a lot of detail on that specific issue. I do know that in relation to
9 the prenatal screening programmes there have been discussions with disabled people and
10 there are obvious issues there in relation to differing views, let's say, on the value of that
11 screening programme. I can't give you any more information on that, or the specific
12 information around that.

13 I think it's fair to say that there's more work to be done more generally in relation to
14 screening programmes to ensure that they are accessible to disabled people.

15 **COMMISSIONER GIBSON:** That wasn't the question. I'll just move on because I know we
16 don't have much time.

17 Were institutions designed to keep disabled people throughout their whole lives,
18 was there any exit plan to get disabled people out of there? What was intended for disabled
19 people who lived in institutions once they died?

20 **MS WOODS:** It's Geraldine here, I'm not sure, I don't know if there was a plan around that. I
21 don't think there was a rehabilitation component, which is possibly how it would have been
22 described at the time. But from the survivors' stories, people did seem to come and go from
23 those institutions, but I don't know on what basis that occurred. I don't know if any of my
24 colleagues can answer.

25 **COMMISSIONER GIBSON:** Some questions focusing around mental health and psychiatry. It
26 seems that over time what we might have expected the focus of psychiatry extended
27 towards social deviants, the pathologisation of social deviants, homosexuality; to what
28 extent is a critical analysis of psychiatry relevant historically and today, do psychiatrists
29 play the right role in the lives of people with mental health conditions and others? Because
30 we've heard stories of conversion therapies and other such things.

31 **DR CULVER:** It was certainly very distressing and disturbing to read those accounts. It's hard to
32 comprehend, looking back, in terms of what might have, what the thinking may have been
33 that led to some of those actions and behaviours. It certainly feels quite shameful to be part
34 of a profession that was engaged with those activities.

1 I guess my hope is that there has been very substantial change in terms of not
2 psychiatry in isolation, but all of the mental health clinical professional network in terms of
3 how we see ourselves and our role, and that is of enabling and of working as a team,
4 because the core unit of support in health delivery is the team, it's not one person on their
5 own and should never be seen as that.

6 I think team-based approaches do also mitigate some of the risks of -abuse
7 not- always, because you can get a group think process as well, but also -provides
8 a-- multidisciplinary approach provides a more complete set of supports. So,- I would not
9 see this, our current mental health service response as being a psychiatry response, I would
10 describe it as a mental health response.

11 **COMMISSIONER GIBSON:** I'm getting lots of hurry up messages. I've been asked to put
12 things in writing. I feel we haven't got the scale of the responses necessary given the scale
13 of what happened, and the assurance about the pictures going forward.

14 So, I'll just leave a final comment that when we look at what's come out of the
15 World Health Organisation, the CRPD, at the moment, just as we look back with horror
16 about the mistakes that were made then, can we fully recognise that we won't be looking
17 from- a generation's time looking back and saying that we haven't fixed this, abuse is still
18 going on and we're not recognising it. So,- thank you for your answers.

19 **CHAIR:** I'm sorry we've had to hurry, and I'm going to invite my colleagues and counsel if there
20 are other matters arising, do put them in writing because it's important we cover all of these
21 things.

22 I have no questions, just a comment. It appals me that, with my colleagues, that
23 there was a Royal Commission in 1973, and we're here now. And I ask the question: will
24 we need another one in 20 years' time? God forbid.

25 Can I thank you all sincerely. You have done the hard yards today because of the
26 time and we started at 9, it's now 6 o'clock, and I appreciate that you have put a massive
27 amount of time and energy into preparing, I really appreciate that, we all appreciate that.
28 I hope that you can now go and sigh a big sigh of relief that this is over. But we do look
29 forward to your continuing cooperation, because, as you understand, the full importance of
30 this matter, perhaps- we haven't-- - we've- only scratched the surface.

31 So, on that note, and our kaikarakia has been patiently waiting and we are going to
32 invite him to provide us with a blessing and a quiet ending to a long day.

33 **MS WOODS:** I wonder if I could make one final statement. To the survivors and to your
34 whanau, as myself and my colleagues we have said today, we have listened and heard your

1 experiences. We acknowledge that much of the care you received was not the level of care
2 you expected and deserved. On behalf of Whaikaha --

3 **MS KERR:** On behalf of Whaikaha I would like to convey our heartfelt thanks and gratitude for
4 your bravery in finding the strength to share your experience with the Royal Commission
5 both publicly and privately. I would also like to pay my respects to survivors who are no
6 longer with us, who never had the opportunity to have their experience heard or
7 acknowledged and, more importantly, did not have the opportunity to live the life they
8 deserved.

9 Experiences of all disabled, Deaf, tāngata whaikaha Māori in care will feed into the
10 way Disability Support Services are provided today and into the future. Whaikaha is
11 committed to working in partnership with disabled people and tāngata whaikaha Māori to
12 drive better outcomes for all disabled people.

13 **CHAIR:** Thank you very much.

14 **KAUMATUA:** I must apologise to Paora, Paul, I haven't met you before and I'm sorry that I
15 didn't get a chance but hei aha, tēnei te mihi ana ki a koe. Now I understand why people
16 are saying that they are 6 foot tall, 3 foot tall. And I just want to express to myself, I'm a 5
17 foot 6 Māori, the handsomest one you could ever see, three missing teeth, I've had them for
18 50 years, but hei aha, tino pai, kei te mihi ana ki a koe.

19 Ki a koutou ō tātou taumata te mihi ana, tēnei te mihi. Aroha mai, ki te whakarongo
20 mai te kōrero ana o tēnei kaupapa, tangi te ngākau, kia kaha, kia māia, kia manawanui.

21 Ki a koe, ki a koutou o te Ministry Hauora, Whaikaha, āe, e mihi ana ki a koe tae
22 mai ko tēnei wā, tangi te ngākau e tō mahi, he mahi pae ora o koutou iho o te tāngata.

23 Just to express to you that what we're hearing today is for the benefit of our people
24 for tomorrow and it's very hard from an outside point of view to come in and hear the
25 kōrero that's happening in here today. And what I want to do really is to bring back the
26 wairua, bring back the heart of this space here, back to the norm, and unfortunately
27 tomorrow the same thing's going to happen. But, however, with us here today we can bring
28 that together in our little prayer, in our little coming together as one here. So tonight, we're
29 going to sing, Te Aroha is our waiata, Te Aroha is our love, whakapono is the faith,
30 Te Rangimarie is to bring this coming together, tātou tātou, all of us. So that will be our
31 waiata.

32 I'm sure we've all heard it somehow, some time ago, that will be the beginning of
33 our waiata. Then I'll just say a quiet prayer for us, to soothe us, the pathway, open the
34 pathway for tomorrow. Kia ora mai nō tātou, ka pai.

1 **CHAIR:** The bad news is we start at 9 o'clock in the morning again. Pō mārie.

2 **Waiata He Hōnore and karakia mutunga by Ngāti Whātua Ōrākei**

3 **Hearing adjourned at 6.11 pm to Thursday 18 August 2022 at 9 am**