ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
FOSTER CARE INQUIRY 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) Ali'imuamua Sandra Alofivae Dr Anaru Erueti
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton QC, Dr Allan Cooke and Ms Aroha Fletcher for the Royal Commission Ms Rachael Schmidt-McCleave, Ms Julia White and Mr Max Clarke-Parker for the Crown
Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
Date:	14 June 2022

TRANSCRIPT OF PROCEEDINGS

INDEX

Hearing opens with waiata 'He Hōnore' by Ngāti Whātua Ōrākei

[Waiata He Hōnore]

KAUMATUTA: E te Atua kaha rawa, tae mai nei o teenei wā, e manaakitia mai i ō tātou i tēnei kaupapa. Kia kaha mai te kōrero nei i tēnei wā, āwhinatia mai ō koutou kei te haere mai nei, o tātou te kōrero, i māuiui te kōrero. He piki te kaha, te māramatanga me te rangimārie. Heavenly father, we ask you on this day that you give blessings to all, their kōrero and the kaupapa. We ask all these things that we come together as one, in life and our kōrero, in light and understanding. We ask all of these things in your name. Āke tonu āke, āmine. Nā reira, tēnei te mihi atu ki a koe, ki a koutou. Aroha mai ki te paepae kia mihi ki a koutou mō tāu mahi, nā reira, tēnā koutou, tēnā koutou, ā kia ora hui mai āno tātou.

[9.37 am]

CHAIR: Ata mārie koutou, nau mai, haere mai, piki mai ki tēnei tūmatanui. Welcome to everybody for the second day of the hearing. We hope that you stay well and that the evidence that you hear today will not be too upsetting, but we just point out that these are stories that need to be told and that we need, as a nation, to hear. So, thank you for your attendance today, whether you are here in person or watching online. Nō reira tēnā tātou katoa. Mōrena Dr Cooke, mōrena Dr Calvert, welcome back.

DR COOKE: Tēnā koe Commissioners. We're going to commence with Dr Calvert this morning, her evidence will conclude at 10.30. Just a couple of housekeeping matters, we're going to hear secondly from Mr EC who's going to be led by Ms Fletcher. He will be followed by Kath Coster, again led by Ms Fletcher. We're scheduled to have a break at 11.30 am and it's intended that Mr EC would conclude his evidence after that and then 15 minutes later we would commence with Ms Coster at 12 noon. We may have some flexibility around that, just to avoid having a break during the course of the evidence from Mr EC. This afternoon we have two expert witnesses, Dr Tania Cargo and Dr Alayne Mikahere-Hall.

CHAIR: Yes, that's fine. I just wanted to say that you take the breaks according to what our witnesses require. We have a run sheet, but it's not written in stone, and we will do whatever is necessary to accommodate the wellbeing of our survivors and our experts indeed who we rely on, so we'll just see how it goes through the day.

DR COOKE: Thank you. Is it the practice here to get Dr Calvert to re-affirm?

CHAIR: No, I think we just say you remain on the affirmation you took yesterday, Doctor.

DR SARAH CALVERT (on former affirmation)

QUESTIONING BY DR COOKE CONTINUED: Dr Calvert, we spoke yesterday about drift in care for children, and there are some issues around that, that I want to address. First is dealing with the number of Māori children who are in care now, they are going to be in non-kin placements, which are ostensibly safe placements, and they're going to be in a situation where that child cannot be returned to his or her parents and you would be familiar, I'm sure, with that situation.

A. Yes.

Q. The dilemma often is that the ideal would be if the child cannot be returned to Mum and Dad, then that child should go back and be placed with whānau. That's, - you accept that?-

A. That's correct.

Q. And we know that often it can be a time-consuming process to find whānau for a particular child?

A. That's correct.

Q. For example, there may be reluctance on the part of parents of children to give detail of where they come from for all sorts of reasons?

A. That's correct.

Q. So, for example, social workers may not know that Mother or Father may have a connection to, say, Rotorua or Gisborne or wherever the case may be?

A. And sometimes the parents themselves do not know.

Q. So, Oranga Tamariki has over the years put in place teams from time to time using different names, to try and assist in locating finding whānau members?

A. That's correct.

Q. That in itself takes time, doesn't it?

A. Yes.

Q. In your experience, are you able to give us some assessment of the implications for children who have been taken into care. This is against the background, of course, of what we spoke about yesterday, and the time that is taken in locating a possible whānau placement for them, on the one hand, and on the other the fact that this child's in a safe placement where he or she is being safely looked after, nurtured and presumably possibly forming attachments?

A. Well, I'd like to say that the latter is a hopeful position, but the reality is that as children remain in care there's a greater likelihood that they will move placements, they may move in and out of the more institutional type of placements like family homes and go into a care

situation, and regrettably the older the child and the more placements a child has, the less likely placements are to sustain. So that becomes a sort of cycle.

In my experience I think in the, -with the passage of the current, or with the original passage of the current legislation, so in the early 1990s Oranga Tamariki, then Child, Youth and Family relied very heavily on staff who were nominated as community social workers. They were usually social workers who did indeed in most places have a very good linkage into their local communities and were often reasonably able to -track, - this- is not the words that would have been used by many of them, —but certainly to track what we would now call whakapapa and make links through their connections with the communities.

As the structural changes have devolved in Oranga Tamariki, they have sometimes set up separate systems for tracking whakapapa. They have had varying degrees of success and there's a new system that has come in in the last couple of years. In my experience none of the newer systems have been any more effective than the community social workers once were, and in many cases they're less effective because they're often, -they- don't have the training to think about how to use community linkages to find things out.

So, if it's very clear what, for example, a Māori child's whakapapa is like, then that is a reasonably easy straightforward process, perhaps not as straightforward as people might think. And then, –but if there is not an easy quick link, then the lack of that kind of community basis means it's much harder for people to kind of find ways into the information.

On the converse, those systems are now, I think, quite heavily reliant on iwi-based systems for, –on the other end starting that process, and there is, in my experience, a vast degree of difference between how those services will respond. Some are very child focused and therefore work very quickly to try and establish links, and some are less child focused, or perhaps have other priorities, and so it becomes much harder.

COMMISSIONER ERUETI: There must be a capacity issue too, wouldn't it, I assume?

A. Yeah. That's what I mean, smaller iwi's, in particular, smaller Māori-based organisations have many demands on them and so trying to track down and converse with whānau is a very time-consuming process, rightly so, and so that's a capacity issue.

On the other end of drift is also that, this is perhaps, – I don't mean to be impolite in saying this, but many whānau are avoidant of these processes because on some level they are not going to offer placements for children, especially older children. I think it is still generally easier to find people who will take on, say a child under five, but as children age

and they come with perhaps a more problematic history, it becomes more difficult, and certainly in my work in the Family Court, I have a number of cases where the difficulty has not been Oranga Tamariki making the connections and getting the information, the difficulty has been then how to manage the negotiations with whānau and hapū, and the difficulty that people have in saying "no."

So, this is in certainly a number of my cases a significant cause of drift in that it, – I've certainly got one case currently where it's taken five years for a true "no" to be given, we are not able to find a place for these children. So, it's taken a long time, a lot of discussion, a lot of meetings, some toing and froing of those children before finally that was acknowledged that that was not going to be possible. It's a very painful thing for people to say we can't do this.

CHAIR: Can I just ask, and without revealing anything at all, of course, about the identity of this family, what has happened to the child in that five years?

A. There are three children, they currently remain in non-kin care, two of them in a placement that was supposed to last six weeks and one of them has had a number of placement changes in that time but has now been settled in a non-kin placement position for about 18 months. But they've been in care for, -on and off there are some complexities in the situation in terms of where they went and who with, but they've been in non-kin care effectively for five years.

Q. But I'm inferring from what you say that they have not been, the three of them, in stable one placement non-kin care through that time?

A. No.

QUESTIONING BY DR COOKE CONTINUED: Just on that point, if the children had been in a stable non-kin placement and are then moved, transitioned appropriately to a whānau placement, does the fact that it's been a stable placement, is that in itself a positive factor for the transition of those children from one placement to the other?

A. We would generally say, leaving aside children who are presenting, -who have now developed out of all of their life circumstances significantly maladaptive ways of dealing with the world, that's a broad description. If children are in a safe, stable, secure situation, that may give, other than that group of children, that may give children the capacity to move. As I said yesterday, attachment is not kind of some concrete thing that happens, it's very malleable. So, - children can take useful experiences from here and translate them over here.

I think that in general caregiver social workers often find there isn't the resource to help the receiving family to get used to the ups and downs. So, all the years that I've trained foster parents, I've always said, you know, look you're going to have a period at the beginning when things go well, children work very hard to make placements work and adults work hard to make placements work. So, in the beginning it goes well, it's somewhere predictably around six months to 12 months it all goes to custard, sometimes very dramatically, and at that point you need some really steady resources to help contain and maintain that process.

For example, if we look at the traditional support order, that's just at the point at which the support order almost is coming to an end. So, there's that problem. Many of these children come with frank trauma, particularly in the area of family violence. Mr Cooke knows what I'm now going to talk about. And this is one of my real bugbears because I've been talking about this for over 20 years since we did the research.

At that point the Ministry is reliant in terms of services for these children on the Ministry of Health, to some extent on the Ministry of Education, but primarily on the Ministry of Health, that is how services to the children in State care are delivered, other than if they have been sexually abused, in which case they, regrettably to say, they are the lucky ones because there is a service that is immediately available for them and can be accessed. But for most children in care, the trauma and the distress that they experience can only be attended to through the Ministry of Health and its service provision.

CHAIR: So, is that because it's viewed as a mental health issue? Why the Ministry of, – for a complete ignoramus in this area, why the Ministry of Health?

A. My understanding from the work that we did in the 1990s is that's a longstanding agreement at some kind of public service level. So Oranga Tamariki did in -the as- a result, well, really actually it's bizarre to say, as a result of the Whakatāne earthquake in 1987 the Ministry set up some services of its own to meet the needs of children who were traumatised and had difficulties, that's what I worked for, it was called "specialist services." It set them up in Auckland where there still is one, in Hamilton, in the Bay of Plenty, in Wellington, in Christchurch and in Dunedin. So, – these were intended to provide actual services both to children and to social workers and families.

Slowly over the years, apart from a full unit, or two full units in Auckland, one of which is primarily orientated towards addressing abuse issues for children in partnership with the Police, well they both are that, and some staff in Christchurch there are none of those services anymore.

COMMISSIONER ERUETI: Just briefly, sorry Sandra, so when you were writing about this 20 years ago, was that, you identified the problem, what was the solution that you recommended? Was it this specialist service within OT-?

A. I'm looking meaningfully at Dr Cooke, because in fact my team did research on this and ultimately that research led to some funding shift from the Ministry of Health to Oranga Tamariki which became what is called high and complex needs. High and complex needs is now a pale shadow of what it was ever intended to be and is, I understand, to be restructured again.

But there was a recognition that Health was not providing core services to the children that Oranga Tamariki had in its care. That then became the gateway assessment. - I'm an upfront person so I'm just going to say it how I think it. The gateway is primarily a complete waste of time and resource because they do not provide information that is helpful to social workers in understanding and meeting the needs of children. They are a paediatric assessment, and actually, fairly few children who come into care need medical intervention, they need other kinds of intervention, and they need other kinds of assessment, and they need culturally appropriate interventions and assessments, and gateways provide for virtually none of that. Most of the gateways I read do not even record children's whakapapa.

CHAIR: You had a question?

COMMISSIONER ALOFIVAE: I did, thank you, and it was borne out of what our Chair had started. So, you've identified actually that the ministries continue to work in silos. So, is it fair to say that even today, or if I could ask what your impression is over the last 40 years in which you've worked in this arena, have they gotten better to understanding the trajectory of a child so that they're actually stitching it up, – that's my phrase, at a regional level which is where service provision should actually be really clear and accessible?

A. No, and I think last week in The Herald it noted that child and adolescent mental health services, which is primarily where Oranga Tamariki children get funnelled if they get funnelled at all, you know, have been massively underfunded. I started my career working at Greenhill Child and Family, Adolescent and Child Mental Health Service in Tauranga and it was massively underfunded then, and when I went on the Hospital Board, we reviewed this across New Zealand and those services were massively underfunded then and that's back in 1986. And now The Herald is reporting these services are massively underfunded. They are very western medically orientated.

So, you're more likely to get a service if you had an eating disorder than if you have what we would call developmental psychopathology, that is the adversity of your life experience has impaired your development as a child or young person. There are very few services that have anyone that is an expert in that kind of area, and so realistically they find Oranga Tamariki children very difficult to deal with because then, they're not used to dealing with children who come with really severe trauma.

Western medicine has only really in the last 20 years woken up to what trauma does to children, so they don't see it, they don't see how the child, –yesterday I was describing how children will go inside themselves and they just don't respond and, or they respond by throwing their chairs around and breaking the television, and health services find all of that quite difficult to deal with. Their expectation is that you, the individual client or patient, as they call them, is pleased to have the service and therefore will cooperate. Social workers and people like me know. I don't expect kids to cooperate, and their behaviour is what I'm looking at to learn about how they are experiencing the world.

So, in general, I trust myself to be able to contain children, but once they're in my room pretty much they're going to get to do what they need to do for us to develop the relationship. I'm not going to, –they're not going to have to sit in a chair on the other side of a desk, they're going to be allowed to kind of just become comfortable enough to be with me in the room so that we can start to talk and sometimes draw or whatever about what has happened to them. That's not how health works.

CHAIR: I'm going to hand you back to Dr Cooke because I know he's got a large list of questions, but I'm going to plant this idea in your mind, and it may well be something that he's going to raise with you. I think we would all, we're all hanging out here to hear your ideal. If you were the queen of the world, what would you set up in order to mitigate this? I'm not going to ask you to do it now, it may be... –

DR COOKE: It may well be given the discussion that we've had, and my questions are slightly more narrow in their focus at this stage, it may be appropriate in fact to have Dr Calvert address that question, because I'm mindful we've got half an hour of her time.

CHAIR: Well, we're in your hands, Dr Cooke.

DR COOKE: Yes, and we have her report, of course, so why don't we address that particular issue, which is the question that...-

CHAIR: I think it is, because what we are doing here is looking forward, isn't it, I mean we're hearing from our survivors of the horrors of the past, but every one of our survivors asks us

"make it better, don't let it happen again." And we can only do that by hearing of good ideas, so if you're prepared to do that, we're all ears.

QUESTIONING BY DR COOKE CONTINUED: Are you able to do that? The question would be is it within your area of knowledge and expertise to opine, express an opinion, on what would work better for the children who come into care and with whom you have come into contact with and worked with over a number of years.

A. I can only really talk directly from my experience, and I mean I'm very well read in the intense literature and there's a lot of literature around children in care. But, –

Q. Sorry, is it also worth bringing it back into from the trauma perspective and discussing it in relation to the ACES literature, for example?

A. The first thing I would say is that Oranga Tamariki has been very badly served by the constant change of focus and structure and that has damaged, -it's- a strange word to use, – but the professionalism of the service. So, in my view, the work has got worse and worse, and I see a lot of it, and I don't hold social workers responsible for it getting worse and worse. What has happened is resources have not been put in to ensure that the service can maintain a particular level and quality, and get better, which was certainly the intention of the Act originally, you know, the Act grew out of Pūao-te-Ā-ta-t-ū.

COMMISSIONER ERUETI: Are you talking about CYFS?

A. Yes, CYFS.

Q. The '89, yeah.

A. Yeah, the '89 Act grew out of a document that is, I read it recently because I wanted to use some of it in a report. It's as relevant today, and that is just a tragedy that it's as relevant today as it was when it was written. So, we had a good piece of legislation, but it was never properly resourced and successively during the 1990s both social work practice and resourcing were diminished.

So, the first thing I would say is that whatever structural changes occur, people have to be prepared not to muck around with them for a while but to let people make them work. Second thing I would do is ensure that the people who have a role in the lives of children who come to notice, because it's not just children in care but children who come to notice, are properly supported in a professional manner to do their work.

I will give you an example. Child, Youth and Family, as it was, spent a lot of money developing a risk model for New Zealand. It was culturally consulted, it was a very good model that had robust research supporting it from overseas, and they don't use it, and most social workers don't even know what it looks like anymore. And so, what do we

have? I'm not being facetious, but we have a picture of a triangle with different colours and different words on it and that is a risk assessment tool. It's not. Risk assessment is thinking about data, which means you have to have a proper robust way of gathering the data, you have to be able to think about it in terms of, if you like, a matrix of ideas and then you have to come out with a kind of conclusion. You know, that is not how social workers now are able to assess risk. So social workers have been denied tools to enable them to do a good job, and yet they're still expected to make these decisions.

Q. I see in your brief of evidence you talk about this risk model, is that the one that's based on the Canadian model?

A. Yes, the...

Q. When did that stop being used?

A. It sort of stopped sometime in the between- 2003 and 2012 primarily. The Department has tried to develop resources, so myself and Philippa Wells, who used to work for the Ministry, we developed a resource for social workers around parents with mental illness, because mental illness is actually universally- known to be one of the primary reasons why children move into care and why they drift in care.

So, social workers need a tool for both assessing which mental illnesses we should be concerned about and then a tool for how to think about that in terms of social work practice. Most social workers don't even know that that document exists. And part of that is, again, not a criticism of social workers, the computer system was designed in the 1990s to monitor social workers, that's what it was designed for, it was not meant to manage children in care or to manage children who came to notice, it was designed to monitor social workers and what they did.

It is a most appalling system. There is no way a social worker, for example, can quickly and easily track data around, say risk, it's just not possible. So, the system is full of half completed assessment tools that are repeated endlessly over and over.

So overall what I'm trying to say is the professionalisation needs to be brought back, regardless of whether we have two organisational structures, one for Māori or one for Pākehā. Māori children are as entitled as Pākehā children to a professional social work service, culturally appropriate, of course, but a professional service. And Pākehā children are entitled to that, and at the moment the Ministry doesn't have the tools, and it doesn't have the, I suppose, the capacity to ensure that that happens.

It tried in the 1990s, there was an attempt called the Competency Programme, which was supposed to up-skill all social workers, and had, for example, some excellent

aspects around culture. For example, at least noticing what a child's whakapapa was, where they had generally lived in their life, that was all part of that programme. That all just disappeared into some kind of 1990s hole.

So, there are lots of things that would be quite easy to quite quickly do to improve these kind of processes. A much better joined up approach with other ministries that, you know, social workers still endlessly tell me they're on the phone to Kāinga Ora all the time, "I desperately need better housing for this family", you know, "there are rats in the roof of this house and that's really bad for these children", you know, and they spend hours and hours having those kinds of conversations that go nowhere. And that takes them away from the interventive part of social work, which is what many of them went into social work to do, to work with families to help them not have their children taken away.

CHAIR: Can I just ask, that joined up approach makes, at first glance, great sense, but not just Kāinga Ora, I would have thought health, education, anybody else to put in that?

A. Well, I think MSD in terms of funding is, you know, I mean I know they have a different view, but the reality is, you know, if your best resource is someone who's in private practice or as a community service agency that has good Māori social work staff but wants to be paid for the Ministry to use them on an individual family basis, there should be a way to do that. But it's too difficult.

COMMISSIONER ALOFIVAE: Dr Calvert, so basically the systems in place currently as they are, don't enable that collaboration effectively?

A. No, they don't at all.

Q. So, there should be, or is it your proposition that someone should drive that?

A. Well, I think Oranga Tamariki should be, you know, whatever the structures look like, should be given the authority to drive that. But, you know, the Ministry of Health, for example, is a really powerful Ministry in New Zealand and its focus is perhaps very different from the focus of an agency like Oranga Tamariki which is orientated towards children. Children don't have a voice, they don't go and talk to their local MP, they don't write letters, they don't generally go to the media and so their voices don't have that weight when a Ministry is looking at how to deliver services.

Q. In terms of our nation's child and wellbeing strategy, which cuts across all agencies, I suppose, it's something that could possibly, or probably, or actually should fall under that strategy, right?

A. It should.

Q. And just one other question. So, there is a large focus on Māori but increasingly over the decades we've seen more Pacific kids come into the system and other ethnicities, we've got a growing diverse nation. Where do you see them fitting into when you're talking about your models of Māori and Palagi?

A. So, in my view I can understand, because it – flows from the Treaty that Māori want the right to, if you like, I don't like the word "control" because it kind of has a, to me, an unfortunate ring, but to have independence of autonomy of, if you like, kaitiaki over their children. I think that is then complicated because many children themselves hold in their own sense dual identity and they feel disrespected in having to make a choice one or the other, and, as you say, there are many other ethnicities now that Oranga Tamariki has to meet the needs of –.

And so, I think we can all continue to learn best from one another and that whatever service develops, it's going to be really important that something that works well here is available for working well somewhere else. Someone else's ability to negotiate a better, a more child-focused service provision here has something to teach someone somewhere else about how they got there.

So, I would hate it if what we ended up with is a very siloed service, I don't think that will help. And the reality is that many of the things that statutory welfare has to do are well -understood and they apply across the board. They're not, –they're not ethnically defined, for example, or defined by gender, they're, you know, risk assessment is risk assessment and, you know, if you do a good risk assessment you have to talk to lots of people and you have to think about the context in all of those things, how an individual service might do some of that might look different, but the overarching principles are going to be the same. So, it's kind of like if we have separate systems, how are they joined up so that everybody, everybody benefits from that process.

COMMISSIONER ERUETI: I imagine when we get to the accountability, our hearing when the Crown is here, that they will say well we've got the Public Service Act, this new legislation and it's about joining up the agencies and there's efforts afoot for cross-agency work with iwi and so forth. Can you see evidence of movements, real tangible movements towards trying to join the agencies up?

A. Well, I think, you know, in a completely different system the Covid response and the criticism of, for example, the Ministry of Health demonstrates how, you know, difficult it is for people who are not on the ground to think about how you join these things up. People revert to what they're used to. You know, when I went to university apart from the fact that

Jim and Jane Ritchie were lecturers and so we learned a lot about Māori just intrinsically in their lectures, I never saw, as a clinical practice, asking about whakapapa. But I went to Greenhill and that was a unique service, five Māori and five Pākehā, and, you know, on day one it was "what's the whakapapa, where are they from?" And I went oh okay, this is a really good way to learn about the people I'm going to be working with. And so, it just became part of my practice because it was from the very beginning.

If you don't have those kinds of systems that require that, or there's not a commitment to those systems, and we've certainly seen that, in my view around the health response under Covid, then people, vulnerable people fall by the wayside and at the bottom of the vulnerable people list will be children and adolescents.

CHAIR: So, your message here is that what you learned was more by good luck than by good management, in a way, it was fortunate you went to Greenhill, you got that experience, but not every social worker has that?

A. No.

Q. So, it needs to be embedded, embedded into the training and the systems that this is the air you breathe, this is fundamental to the way it works. And I put that as a proposition to you. The second proposition is, you've referred earlier to something that I'm very interested in, that's the trauma approach. I just wondered, first you can comment on what I've just said, but then if you'd like to talk about getting trauma-focused approaches?

A. So, I mean an example is CYRAS, the computer system, it does not require the social worker to list whakapapa.

Q. So, there's no box to tick?

A. There's a box to tick but you don't have to tick it. It's you know, a simple thing to require right at the beginning, certain information, and then you can't advance in the system without doing it. And so, you know, but it was never designed for that, so you know, that's not a criticism of social workers, it was never designed to gather this kind of information, it was designed to keep track of how many clients they had on their list and how those clients were moving through the system and whether they went out visiting on Tuesday, you know, that's what it was designed for. It was a control of social workers, not a gather data for the benefit of the clients of the service. So that would be the first thing.

Again, I mean trauma-informed practice is about professional understanding, and I use that word in a broad sense. So, it is about recognising -involvement in statutory welfare is an indication always, 100% of the time, that trauma is somewhere and often front and centre of what you are dealing with. And recognising that and working with usually, in

my view, generations of trauma. So, you know, when I write reports, I write about what colonisation creates generational trauma. So, it's not just looking at a mum who's been the victim of family violence, it's also looking at the perpetrator and where that violence has started to develop-.

But it's also looking much further back and thinking about, you know, for example the loss of land. Land is really intrinsic in the Māori world to your sense of identity, like your felt and internalised identity, and so to lose that is in some ways like losing a parent. And so that is a trauma in and of itself, that a professional approach, a trauma-focused approach would incorporate. That you would be looking and plotting all of- the forms of trauma and how they have fed into the difficulties the family has, and then you are also looking at how you relate to people, how you meet them, how you,- and again, western models and Ministry officers, for example, they're not very good at this, they're not very good- at starting with, - I don't start with a karakia unless somebody that is clear it will be comfortable for them, but it's always "would you like a cup of tea?" In all my private practices we've always had biscuits and for kids we have animal biscuits with hundreds and thousands on the top and things like that. Always that sense of –

Q. Manaaki.

A. Manaaki, let me meet you first as human beings and recognise how you might feel coming into this space. That isn't how the Ministry currently operates. It does at a family group conference, you always get at least a cup of tea, but when you walk in there's not that sense that you are being acknowledged but also what you might be bringing your fear, your anxiety, your distress, all of those things.

So, a trauma-informed practice is about thinking every single person that I'm going to be in contact with today is a victim of trauma and I need to think about that, and half my colleagues might be and things that go wrong may be because of their personal experiences. It's always having that in the front of your mind. Again, to me that's having a professional approach.

Q. Do you know if that's written into any practice or policy or guidelines or principles in Oranga Tamariki at the moment?

A. It is currently supposed to be much more a focus for social workers, but –

Q. How is that sold? Is that just people talking about it, or is there a diktat from above that says you must do it, how does that work?

COMMISSIONER ERUETI: Or part of the degree.

A. I won't talk about social work training. It's not, it's- seen as part of the practice that you recognise that trauma is there, but that's sort of like what I call a talking head. You know, and so it's- really,- people need quite a lot of training to understand how to be in that space, especially with children. -I mean I'm lucky, in my career I ran an evidential interview unit and at the time probably people would have said it was one of the best in New Zealand, and I had two wonderful interviewers, one of whom was Māori, –and still is, -and we would spend a lot of time before these interviews working out how to meet this child so that what they had to talk about, which could be truly horrifying things like truly horrifying things, how they could best tell what was needed and not be further diminished by that experience. And I would spend hours with the interviewing team while we would plot how to do that. And I was also very aware of the damage being done to the interviewers in those circumstances and so they would know when they came out, if it was nine o'clock at night, I would be there, and we would have a process for managing them once we'd got the child and whoever had brought the child out of the building.

CHAIR: Can I bring this back to foster care, because we're talking about social workers here and who are a vital part of it. What about the foster parents themselves, to what extent should they and are they getting anything of this information about how to deal in a trauma-informed way etcetera?

A. They do get training and they do have a specialised social worker who is their social worker. But again, you know, the diminished quality of professionalism means that has diminished, and truly I think most foster parents, especially a proportion of foster parents who are in certain types of foster care organisations, they have no real experience themselves of severe trauma and they come to foster care often out of a very good place to want to help and care for children, but their assumptions are a complete divergence from what the child is going to need. Until you've seen a child who's highly traumatised, who's actually lost all capacity to think and manage their own behaviour and is having what people call a meltdown, but like a serious meltdown, until you've seen that and then had to think about how you're going to manage it, you're not on the page.

Q. Is the answer no actually?

A. The answer is basically no.

Q. Conscious of time and my colleagues. I've got one more question I want to ask you and it's a bit of an elephant in the room. Are you aware if there's a system in social workers' practice of incentivising them to have certain numbers, caseloads, children in and out of the system etcetera? Are you aware of that?

A. I'm not sure I would say there was a system for incentivising, but I would certainly say that there is intense pressure on social workers, and it differs. So that's one of the things social workers tell me, last year it was this, and now it's this. There's a definite significant pressure to meet perspectives from, often, in my view, outside the Ministry itself even around what Oranga Tamariki should be doing, how many children should be in care, how they should be codified, if you like, like what are the issues. We can see that with a much starker differentiation between Youth Justice and Care and Protection now. So, in the past, kind of much greater recognition that most YJ [Youth Justice] kids, even they weren't formerly Care and Protection kids would have been Care and Protection kids if somebody had had a look at them before they started on YJ.

So, there's much stronger requirements on those kind of higher-level requirements to appear certain ways. At the moment I understand it, I might be completely wrong, but I understand there's a complete ban on even talking about the removal of children from parents at the moment. So, you know it's – not incentivised.

Q. But it's an imperative of some sort that's coming. I'm going to stop talking because I'm conscious of time and I want my colleagues to be able to ask questions as well.

COMMISSIONER ERUETI: I just want to bring it back to talking about drift and you talking about whānau and avoidance. Given what you've told us in the last 10, 15 minutes you can understand the hesitation they might have to, and why the negotiations take five years and drag and drag and drag. I really appreciated that, thank you very much Dr Calvert, thank you.

COMMISSIONER ALOFIVAE: No further questions, lots of thoughts, but I'm sure there'll be another mechanism for us to be able to pick it up with you Dr Calvert, thank you.

CHAIR: Now I'm going to hand it right back to you. If you want to take more time, or if you feel that we haven't covered things feel free.

DR COOKE: Thank you, I think we've covered everything I would want to cover that has come out of the report and in terms of looking forward.

CHAIR: Yes.

QUESTIONING BY DR COOKE CONTINUED: I did want to cover just one aspect which is really talking about the journey through care that these kids can have, which is from Care and Protection into possibly foster homes, family homes, residences and the kind of care that they would receive. And you've addressed that at page 19 of your report.

Can you just tell us, you do say in paragraph(sic) 19 in the first paragraph there that residential care is less than optimal and carries inherent risks.

A. That's correct, residential care in and of itself carries risks. Residential care with children means that children absolutely do not get the opportunity to build and develop stable relationships with caregiving adults because that's the very nature of residential care. The adults are not stable, they're not there 24/7, they're a forever revolving group of people that come and go in the child's life.

Q. Residences are established for the purposes of care and control, and they are there ostensibly, aren't they, in this situation for control of children, do you accept that?

A. I don't think all the residences were clearly for control. I think they were for, I- think there was often a hope that better services could be provided to very distressed children if they were in a setting that was more containing. And there's some good psychological, if you like, psychological thinking that that is the case, that there are children who are better, at least for a period of time, being in an environment where the environment is the boundary and there is no possibility of getting outside that boundary, providing that is within a therapeutic kind of process-.

So, I think what happened was that, and this is again the research that we did, our residences, well, I used to call them our residences, Oranga Tamariki's residences became in fact the de facto mental health hospitals for children and adolescents, and if they were in any large numbers still here today, that's what they would be. And indeed, family homes became the residential services for children with severe mental health difficulties, because Health had decided we're not going to have residences for children, we're going to do away with all our institutions, which is fine, but then you have to provide the services in another way.

And Dr Cooke knows I've spent a lot of time seeing children in Oranga Tamariki residences, even since I left Oranga Tamariki, the majority of those children in western terms meet diagnostic criteria, most of them have really severe mental health difficulties, most of which could be fixed, but there's no service for them. Oranga Tamariki, there isn't a city in New Zealand where even the gateways now are done by public health nurses who have no knowledge, no background in seeing Oranga Tamariki type children.

So, the residences then become a holding pen and the staff become jailers trying to manage these children. It's a vicious cycle for which, in my view, Oranga Tamariki is not responsible.

Q. I use the phrase "care and control", but that's in the sense of protection and containment because of course we know that if they were not in a residence many of these young people, children, young people, would take off and place themselves and others at risk.

A. As they do now.

Q. As they do. Of course we know as well that when we think about a young person's mind, and I can think of numerous young people who I've,- we've both worked with, who may be placed in a family home or whatever, but they're in the custody of the Chief Executive and there may be a Youth Justice framework, where being in custody and the consequences of running away are not appreciated, because that could create, that could result in them escaping custody in a sense in terms of criminal offending-.

A. That's correct.

Q. And their mind, the way in which their mind operates because they're going to have possibly intellectual disability, FAZ(?), any of those things?

A. Frank's(?) brain injuries.

Q. They've got no idea of the consequences of what's going to occur, are they?

A. No, and to be fair, most of the time the social workers understand that. So again, Dr Cooke will be aware of some of these cases, my role has really been to say to the Family Court, I need you to order a neuropsychological assessment of this child, or I need you to get a decent psychiatrist who understands these kinds of children to see this child and write a report so that the social worker has some authority to go and require a service. The Family Court's fairly amenable to that process, thank goodness, but to try to get a neuropsychic assessment on an Oranga Tamariki child pretty much anywhere in New Zealand out of a Ministry of Health service, it just doesn't happen.

Q. Just on that, and let's look at the current situation in Auckland, for example, where we have child and adolescent mental health units at three DHBs. What's your experience of a child who may be in Oranga Tamariki care receiving assessments from one of the CAMHS [Child and Adolescent Mental Health Services] in the Auckland area?

A. Virtually never happens. One is particularly bad, two are what I would say to managers of sites shall we do some arm twisting and sometimes that is successful. But it's not just they don't want to see the children, they don't have people who understand the, you know, the huge complexity, culture, maybe refugee status, frank trauma, parents with mental illness, all of these things, poor housing, you know, children who may have actually had long periods of time with just insufficient food. So, they don't have a matrix in their way of thinking about their clients, who they call patients, in the way that is necessary for the kinds of children who are coming into care.

COMMISSIONER ERUETI: Just briefly I think we need to unpack CAMHS just for the uninitiated.

A. CAMHS, so there's two kind of acronyms that are used for services, mental health services for children and adolescents and it's either CAFS, which is Child and Adolescent Family Services, or CAMHS which is Child and Adolescent Mental Health Services.

CHAIR: I think we'll wrap this up at this point, but this is, I suspect, the beginning not the end, it might be the beginning, –the end of the beginning. Can I just, as a conclusion, note a few things. Number one, your single repeated mantra is more resources.

A. **[Nods]**.

Q. Second one is to be more,– is for government services to be more joined up?

A. **[Nods]**.

Q. And those have become very apparent and obvious to us. And I think you'll find that we're going to come back to you, if you are willing, you're certainly able, but if you're willing to assist us further beyond this hearing I think we would appreciate that.

The last observation I make, and it comes out of what you've just been saying recently, that seems to be the complete lack of consistency of service provision across the motu. So that if you're in Riverton or if you're in Auckland, or if you're in Dannevirke, or Te Awamutu, it's going to be different for the children who, for one reason or another, can't stay with their families; is that correct?

A. That's correct.

Q. That's a crying shame, isn't it?

A. It's terrible.

Q. So, it's a lottery of where you live in a way?

A. It's a lottery of where you live and whether you are lucky enough to find one or two people who will make a difference, whether it's a schoolteacher or a caregiver or your social worker or somebody else, the person at the local dairy. If you find somebody, kids are magnets for people who are going to make life better for them, so, you know, if they can find somebody they will, but it is a lottery.

Q. I think that's a good note to end on. Thank you so much, Dr Calvert, and as I said, I'm sure this won't be the last time we talk to you if not in this environment, then certainly in other ways. Thank you so much.

A. Thank you.

CHAIR: We'll take the morning adjournment.

Adjournment from 10.58 am to 11.03 am