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

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

TRANSCRIPT OF PROCEEDINGS

OPENING ADDRESSES

MR MOUNT: This morning we have three witnesses scheduled. They are Dr Brigit Mirfin-Veitch, Dr Hilary Stace and this afternoon via videolink, fingers crossed our technology works from Sydney, Mary O'Hagan. I am joined today by Mrs Ruth Thomas and Hanne Janes. 09.33

CHAIR: As we start at the end of our first week, I would like to greet everyone and make a particular reference to the ancillary staff that assist the Royal Commission in its operation, and I refer to the signers, to our stenographer, to our wellbeing staff who are quietly here throughout the proceedings and to make the Royal Commission function. I want to acknowledge that and to register the thanks of all Royal Commissioners.

09.34 **MRS THOMAS:** I would like to call the first witness, Dr Brigit Mirfin-Veitch.

***

BRIGIT MIRFIN-VEITCH - AFFIRMED
EXAMINED BY MRS THOMAS

CHAIR: Once you are settled, I would like under the terms of the inquiries Act to ask you to confirm the following, Dr - (witness affirmed).

MS THOMAS:

Q. Do you have a brief of evidence before you in the folder?

09.35 A. Yes, I do.

Q. And can you confirm that is your brief of evidence that you have signed and dated?

A. Yes.

Q. You confirm that is correct?

A. I do.

Q. Thank you. Do you also have on the table before you the document "Institutions are places of Abuse"?

A. Yes, I do.

Q. And that is a report that you have co-authored with
09.36 Dr Jenny Conder?

A. Yes.

Q. I would ask you now to produce that document as Exhibit 6 in this hearing.

A. Yes.

Q. Just before we begin your evidence today, I understand you would like to make an acknowledgment?

A. Yes, I would. Tena koutou katoa. Before I begin, I
would like to acknowledge the disabled children and
adults who have formed and shaped my own understandings
09.36 of abuse. It is their stories that underpin the brief I
am speaking to today. Many of these individuals are no
longer with us and were therefore unable to support the
call for an Inquiry into an abuse in care, sadly these
men and women will also never know that thousands of

New Zealanders joined together to demand an Inquiry and an apology on their behalf and that demand was ultimately successful. It is these people I acknowledge today, along with those who are yet to tell their stories.

Q. Thank you. Can I just ask - just a reminder, we will be speaking slowly because everything we are saying is being typed up, so we will just pause if necessary.

Can you please tell us briefly who you are and your area of expertise? 09.37

A. Sure. As you know, my name is Brigit Mirfin-Veitch I am a Director of the Donald Beasley Institute which is a position that I've held since 2007 but I've been a member of the DB I staff since 1994.

The Donald Beasley Institute is an independent charitable trust that conducts research and education in the area of disability and we have a specific focus on learning disability.

I am also a Senior Research Fellow with the Centre 09.38 For Postgraduate Nursing Studies University of Otago and Adjunct Associate Professor of Deakin University. I am a sociologist, I have a strong interest in understanding the social lives with learning disability and I am committed to initiating and achieving social change through research.

My research has explored deinstitutionalisation from the perspective of family members, of people with learning disability who were moving from Templeton Centre.

09.38 **CHAIR:** It may be helpful if you keep in your sight the stenographer who is functioning at high speed but will be assisted if you keep an eye on the pace.

A. Sure thing. I was just noting that I've done research around deinstitutionalisation that focused on the

Templeton Centre, a large institution for children and adults with learning disability located near Christchurch.

I was also part of a team of researchers from the Donald Beasley Institute who explored the deinstitutionalisation or closure of Kimberley Centre, one of New Zealand's last or New Zealand's last large institution to close.

I was also engaged with institutionalisation and 09.39 deinstitutionalisation more recently as a co-author of *"Institutions are places of abuse": The experience of disabled children and adults in State care*, which was published in 2017 and which was an exhibit that I showed earlier.

I will note that the title of that piece of work, we acknowledge Robert Martin who will be speaking next week as the person that provided the inspiration for that title.

In addition, throughout my 25 years as a disability 09.40 researcher with DB I, I have conducted research in the area of parenting by people with learning disability, health and wellbeing, the justice system and more recently around sexuality and relationships, and all of this research has included a significant number of people with learning disabilities who have reported that they experienced abuse in care during research institutes, despite the fact that the research was not specifically about abuse.

Q. Thank you. You've been asked to give evidence at this 09.40 hearing today about the nature and extent of abuse and neglect that has occurred to people with learning disabilities in State care between the 1950s and 1990s?

A. Mm-Mmm.

Q. And you've drawn on the report "Institutions are places of abuse", as part of your brief?

A. Yes.

Q. Just before we get into the detail of your evidence, there's various terminology that you've used in your brief, can you please take us through that, just to explain the terms?

A. Sure. I've been asked to give evidence about the nature and extent of abuse and I'm going to talk about the impacts of such abuse on individuals. But one of the 09.41 things that I did note in my brief, that I am not a clinician, so as a first parameter around the evidence that I'm giving, is that I'm a researcher. I hear a lot about people's, I research people's experiences and what I'm going to talk about today is are those experiences and how people have felt, what they've told me about them, though I do note I am not a clinician, so I'm not making a clinical judgement about the impacts that people have experienced when they're talking about abuse in care.

09.42 I think the other part of your question is related to how we did the research?

Q. Yes but also perhaps just in terms of the - if you turn to paragraph 10 of your brief.

A. Sure.

Q. You refer to the terminology to be used when referring to someone with a learn disability, if you could take us through that?

A. Sure. I will take a step back and note that the research that we're talking about today was undertaken in 2007 09.42 (sic) 2017 during the campaign for a Commission of Inquiry into Abuse in Care. The research was contracted by the Human Rights Commission and with detailed research so that we could capture the voices and experiences of disabled people as part of this conversation that was going on.

I note that I use the term learning disability throughout the brief. People first New Zealand, which is a Disabled Persons Organisation promote the use of the term learning disability instead of intellectual disability. They feel the term is more respectful, reflective of the difficulties they experience and easier to say. So, therefore, learning disability is the term that I'm using today but in doing so, I acknowledge that intellectual disability, mentally retarded or mentally 09.43 subnormal were commonly used terms during the period 1950-1992.

Q. You've said your research responded to a concern that disabled people, including people with a learning disability, comprise a significant part of the silent majority who have not told their stories of abuse?

A. Mm-Mmm.

Q. Can you tell us what are the reasons why people with learning disabilities have not told their stories of abuse?

09.44 A. I think there are a number of reasons that create the silence. First and quite simply, people with learning disability have often not been asked. Second, they have told their stories and no-one has listened or responded. And thirdly, it's possible that abuse is so expected and pervasive that people have not recognised that they have been abused.

Other reasons relate to the fact that sexual abuse can be a taboo topic and when coupled with disability, it becomes even more taboo.

09.45 Another reason that people may not have told their stories of abuse, is that we, researchers and others, are often afraid to open up a space for them to do so. People with learning disability can be seen as too vulnerable to talk about abuse, they can be seen as lacking the capacity to do so. But in our experiences, researchers in this area simply by creating an ethically and emotionally safe space to talk, such as we do in research, people have felt able to talk about the abuse they've experienced. And we have noted many times that when research is not focused on abuse, that that's simply been provided with a safe and non-judgmental space for discussion where people are presumed to have capacity, appears to empower people to disclose abuse in all its 09.45 forms.

So, fundamentally, we need to make sure that people with learning disability know that it's okay to talk about abuse if we want to ensure that abuse is challenged. The historical evidence we drew on showed that people were scared to talk about the abuse, abuse that they'd experienced when it happened to them, because of further ramifications. And we will talk about that later.

Because they knew they wouldn't be believed or 09.46 because there was no mechanism for them to take their complaint.

So, it could be argued that people with learning disability might continue to experience these attitudinal and systemic barriers and we need to ensure they don't.

Q. In terms of your research particular to the document, the Institutions are places of abuse, what were the aims and purpose of that research?

A. One of the concerns was that as the conversation and the discussion grew around the call for an Inquiry into abuse 09.47 in care, that disabled people weren't part of the conversation. And so, the sort of - the motivation, I guess, for the research that we did, was to show that disabled people did have a place in this conversation and had experienced abuse in care and actually were high users of care, State care at the time, when they set out to do this research.

So, our aims were to determine what is known or what was known about the abuse of disabled people, particularly those with a learning disability, and particularly to think about systemic abuse and whether there was evidence that that was at play.

To identify gaps in the available evidence about abuse of people, disabled people in care.

09.48 And at that time we were thinking about what sort of research pathway had the potential to address gaps in knowledge around this area, which was another aim of the work.

Q. Were there any limitations or constraints to your research?

A. Yes, considerable ones. We had a very, very short timeframe and obviously limited resources. So, we had to think, you know, yeah, think carefully about how we approached this piece of work and how we could bring the 09.48 voices of disabled people to the fore within the timeframe and resources that we had.

Q. Were you able to - did you have resources to look into psychosocial disability?

A. That is one of the areas that we didn't delve into too deeply. They are a group of people, disabled people, that could have been included in this research but we did have quite a strong focus on learning disability. And in noting that we didn't draw on a great deal of evidence relating to people with psychosocial disability, people 09.49 who have experienced mental distress, that we were definitely not saying that they were not part of the experience of abuse that other disabled people who we were able to capture in the research were also part of.

Q. Just for clarity, can you tell us what is a psychosocial disability?

A. A psychosocial disability is the terminology used in the UN Convention on the Rights of Persons with Disabilities to refer to people who experience mental distress or psychological conditions. These differ from learning disabilities, in that they're generally episodic, can sometimes be alleviated by medication and don't necessarily involve cognitive impairment but it's really important to note that people with learning disability can also experience psychosocial disability as well. 09.50

Q. What was your research methodology when you undertook this research?

A. So, I think this question speaks back to your question about the constraints and how we thought about approaching this work. So, the approach that we used was to conduct an integrated literature review which is a very well recognised way of doing research where you draw on the literature to see, you know, what is available around the topic that you're interested in.

09.51 We did it this way because there wasn't time or resource to do primary research where we went and worked directly with the people who had experienced abuse. So, essentially, what we did was looked to the literature, looked to resources and publically available documents of all types that contained evidence of abuse experienced by people with disabilities and primarily learning disabilities. That was already available, that contained stories and evidence of abuse that we had possibly overlooked.

09.52 Q. The stories you drew on already existed in the public domain and you brought them to light?

A. Yes.

Q. As part of your research design, were you required to define what constituted abuse?

A. Yes, we did.

Q. How did you do that?

A. Yeah, we did that in two ways. The first was by utilising pre-existing definitions or types, categories of abuse as codes to begin with. And we did the - the second way we did it was by being responsive to the content and recurring issues raised in the data as other less well recognised forms of abuse came forward.

One of the additional categories that we developed 09.52 or included in the research, was, for example, one of restraint, a category of restraint, and we did this because it featured really heavily in the stories told by individuals.

Arguably though, we could have categorised restraint as falling into psychological abuse or physical abuse categories. So, it's noted in our work, abuse categories were not neatly delineated. People often experienced abuse across a spectrum of categories and some categories of abuse share common features. So, any emotional, 09.53 psychological element to all physical elements across categories of neglect and physical and sexual abuse.

Q. I think you've defined at least 7 different types of abuse in your brief which we'll come to shortly.

A. Yep.

Q. Just turning now to paragraph 27 of your brief, your research has referred to personal accounts of 13 men and 5 women?

A. Mm-Mmm.

Q. Would you have preferred to have a bigger sample than 09.54 that?

A. Yes but I think those 13 men and 5 women told us a lot about abuse in care but from a technical point of view, in qualitative research there's no specified or required number for sample size. The intent of qualitative research is to acquire a depth of understanding of the lived experience of an individual or a group of individuals. So, the quality of qualitative research is not determined by how many people said something but by the authenticity of the account and its transferability.

That said, of course we would have liked further accounts but the size of the body of data is not surprising, given the nature of the individuals. And it's also noted and we'll probably talk about it later, 09.55 that in all of the individual stories were with a trusted person or researcher. So, there is no question that many people with learning disability could have told their story but would struggle to do so without this assistance.

Q. We've heard evidence earlier in the week from Judge Henwood in relation to the Confidential Listening service, and she commented about despite reaching out to groups of people with learning disabilities, that service really struggled to have people come forward. Are you 09.55 able to comment on that at all and offer any solutions?

A. Yes. I think I spoke to it slightly earlier, that because people with learning disability often don't receive the same level of value as others, that in situations like this their stories aren't sought out as much or they're not seen as part of this particular context or situation.

But, as I said earlier, our experience has been in providing a really safe place for people to tell and to talk, that they often do and often when we don't expect 09.56 them to.

So, my advice would be to think about ways to provide supported approaches to people telling their story but thinking very carefully around who might be involved in that with people, a trusted person is particularly important, not simply expecting people to turn up to something where they don't necessarily understand the process or have a relationship with the people that are delivering the intended support or opportunity to tell their story.

Q. The accounts that you drew on for your research, can you tell us the types of disabilities that the people in that research group experienced?

A. Most people were identified as having a learning 09.57 disability. Others had a combination of disabilities, including a learning disability, being blind, having physical disability, a learning disability as well. One person was deaf and another described as having a traumatic brain injury from a childhood illness. Others had cerebral palsy and one other person had been misdiagnosed, came up in the literature that we drew on that had been misdiagnosed with learning disability as a young child which led to him being institutionalised for a very long time in a psychopaedic hospital.

09.58 Q. Just on that point of this person who was misdiagnosed, can you tell us what happened there or how that would have happened?

A. Because we were drawing on, you know, secondary literature resources that had already been put together, we weren't working with people directly. Our understanding is the person had come from a situation of family hardship and ended up being placed in an institution and then not getting out of that placement for a very long time.

09.58 Q. What types of State care were these people that part of your research, what types of State care were they placed in?

A. The critical thing to note is that in the accounts and the evidence that we drew on, people had been in a range of State care or care placements across a really long period of time. So, people had spent time in psychopaedic hospitals or institutions, psychiatric hospitals or institutions, they'd been in residential homes, educational placements and faith-based institutions for some and foster care, only a small number had experienced foster care within the time period we were looking at.

However, that is not surprising, given that most 09.59 people with learning disability or other disabilities would likely have been placed in the larger scale institutions rather than foster care at that time.

Q. You've referred to the word psychopaedic hospitals, can you clarify for us what is a psychopaedic hospital?

A. Psychopaedic is a uniquely New Zealand term that was developed by a linguistic in the 1960s and applied to hospitals or large institutions for people with learning or intellectual disability only. Psychopaedic nursing became a nursing specialty for staff who worked in those 10.00 hospitals and institutions and the term translates to mind of a child. That's the kind of translation of that term.

Q. So, these institutions were purpose built in New Zealand at that time for these people with learning disabilities?

A. There were four psychopaedic institutions in New Zealand, two in the North Island and two in the South Island. They existed for longer than the terminology of psychopaedic but which came in later. So, psychopaedic or institutions that were only for people with learning 10.01 disability were the Templeton Centre, Kimberley Centre, Braemar and Mangere.

Q. What was the ethnicity of the people in your research group?

A. In terms of ethnicity, because again we were drawing on secondary sources, so we had to go with what we could see in the literature, in that data. It was often not clearly stated but we knew that three people whose stories we drew on identified as Maori and another identified as Pasifika Cook Islands decent, and the rest we assumed to be Pakeha, New Zealand.

Q. What was age or roughly the ages of people in your group when they were placed in care?

A. Again, because we were drawing on secondary sources, we 10.02 could only go with what was in people's stories or, you know, what was included in those but without exception they'd all entered State care in childhood and had often remained in State care or in care into adulthood and many had remained in some form of care for their entire lives.

Q. I'd just like to move now to paragraph 35 in your brief where you mention case studies. Your research included case studies about abuse that happened to an individual person but also about being abused by being exposed to maltreatment of others and being powerless to stop that?

10.03 A. Yes.

Q. Are you able to give us an example of that?

A. Yes. What we were able to do, was from some of the sources that we were able to utilise, there was a lot of information about people's experiences in care. And from those we could kind of pull together a case study of the person's whole life in those kinds of environments and then with other sources we drew on we saw snippets of experience that we could use to gain an understanding of the types of abuse that people with learning disabilities and other disabilities were experiencing. 10.03

In terms of the case studies, for some people, and I won't go into a lot of detail because I think Robert Martin will speak to this next week, but certainly Robert's experience that he has bravely shared with the world showed the really complex interplay of experiencing abuse himself but also being deeply conscious of the abuse that others were experiencing around him and feeling concerned about that too. So, having - and he wasn't the only person that expressed how difficult it was to be experiencing this yourself but also seeing others and being powerless to do anything about that.

Q. If we move now to the different kinds of abuse that you focused on in your research. Which one of those featured 10.04 more frequently than any other?

A. Within our research, so as I said before, we did more detailed case studies which could show people what life was like on a daily basis but then we also did an analysis to go what were we seeing frequently for a lot of people? And within our research, we found that neglect featured more frequently across the different life stories in comparison to any other form of abuse. And arguably, being in State care could be read as synonymous with neglect due to the fact that even if 10.05 people aren't being overtly abused, they were generally exposed to an extremely impoverished relational environment, that is most of the stories we engaged with people talked about feeling as though no-one cared for them or knowing that no-one cared for them.

Q. I think you've mentioned a range of different areas of neglect, could you just give us some examples of those?

A. So, I think in general we found that people frequently and consistently described living situations or being in living situations where they didn't feel loved, that they 10.06 had no special person in their lives who was there to love and support and nurture them.

Other experiences of neglect could be seen in the lack of emotional support and connection that people received, particularly at times of distress.

One person whose life story that we drew on, a
person who I know very well personally or a knew very
well personally, she is no longer with us, said “I was
scared a lot in institutions, I would scream a lot, I
would get in the corner and put my hands over my face and
no-one ever came to comfort me.” So, here's a person, a
young person at the time, describing living in a series
of institutions all over the South Island, absolutely
recognising that her behaviour was an expression of
10.07 distress and that no-one ever came to help her feel
better or to check why she was feeling that way.

Rather, some of the things which leads from that
quote, was that people did recognise that rather than
staff being attuned and responsive to their emotional
needs and the way that they were trying to manage them,
that people were actually punished for challenging or
non-compliant behaviour.

Other things that we saw were in terms of neglect
were survivors' self-esteem being affected, with a number
10.08 of people linking their experiences in care with lifelong
feelings of being unwanted, feeling an acute absence of
affection or emotional support and some survivors
attributed this to a difficulty they had as adults to
show affection and trust other people, things that we've
probably heard in other survivor accounts over the last
week.

Q. What did you note in terms of lack of stimulation?

A. What was interesting, is that obviously a lot of the
people whose accounts and stories we drew on were able to
10.09 articulate their experiences. They could communicate and
share their story with another person and have it told.
What's noteworthy, is they talked about, you know, the
fact that they didn't experience a lot of stimulation and
there wasn't much to do but they were also concerned

about others who may have had a greater degree of impairment who really, really were left to their own devices and, you know, when they were totally reliant on other people for care or being engaged with some activity were left for long periods of time with no-one attending to their needs.

Q. As a result of that, were basic needs not met?

A. Yes. One survivor recalled the smell of people who needed assistance to go to the bathroom and were not 10.10 provided and said there were people who couldn't move and they just, would just stay where they had been left in the morning after breakfast, most of these people were non-verbal and were trapped until someone got around to attending to them.

Q. Can I ask you now to talk to us about the emotional and psychological abuse that you researched?

A. Yes, and I think as I noted earlier, there's a lot of cross-over between these sort of arbitrary categories of abuse and certainly, this category could also be placed 10.11 or has significant cross-over with neglect as well. But emotional and psychological abuse was also really apparent. The life stories and other sources of data we analysed conveyed a sense of deep fear, of hostility and distress, of experiencing hostility towards themselves and of feeling distressed which I think most people would agree are all strong indicators of emotional and psychological abuse.

As we noted earlier, this kind of abuse could be seen in both personal maltreatment that people 10.11 experienced and also due to their repeated and ongoing exposure to the maltreatment of others.

Some of the people with learning disability and other disabilities who told their stories in the body of data we were able to work with, interpreted some of their own behaviour as a tangible expression of distress and they saw self injurious behaviours as other people were engaging in, as their way of communicating distress. And they also recognised that there was a failure to respond to those self injurious behaviours and talked strongly about that.

Q. Your report mentions survivors living in constant fear, what impact did that have on their lives long lasting?

A. Again, that pattern of people reporting feeling fearful, 10.13 feeling that no-one was there for them, was a repeated frame coming through with them talking about their later lives. You know, particularly noting a difficulty in trusting people and making relationships. But in the moment, for some people that fear of being physically hurt while they were in the environments that they were in meant that they put their own protective mechanisms in place and for one person she reported that she simply chose to stop talking. Talking got her into trouble and the response to people's perceptions about her and her 10.14 behaviour meant that it was safer for her to not talk.

Q. You've said at paragraph 58 that survivors left State care with an entrenched understanding that people in positions of power could hurt them if it they failed to comply with expectations?

A. Yeah.

Q. Can you explain that?

A. Sure. The point that we were making was that the individuals who told their stories of abuse at the time all talked about the fact that nothing could be done 10.14 about it or that no-one helped them address it. Asking for help or assistance led to no action or negative action.That is, that there was some kind of negative ramification for them. So, it's not surprising that that was the learnings that people carried with them for their life.

Q. I'd like to ask you now some questions about power and abuse. At para 61, you've quoted there the statement that, "Abuse is the overt representation of an imbalance of power relations"?

A. Mm-Mmm.

Q. Can you explain that to us?

A. Sure. I think I'd like to draw on the work of Professor Dick Sobsey at this point and perhaps just make a personal comment before I explain his particular model of 10.15 abuse and people with disabilities. It was interesting when we'd been exploring this topic and preparing for today's hearing to draw on this particular book by Professor Dick Sobsey who is a Canadian researcher. He is an extremely well respected researcher and this would be seen as the most important text on abuse and people with disabilities. Some interesting historical context, is that Dick, Professor Sobsey wrote a lot of this manuscript in 1991 when he was a visiting Professor at the Donald Beasley Institute. And the other interesting 10.16 thing to note, is that the foreward to this book, which is an international text which is circulated the globe now for 25 years, it was published in 1994, it has the foreward in this book has the story of a New Zealand survivor of institutional abuse, Mavis May, and Professor Sobsey met or came across May during his time here in New Zealand. So, I think in terms of thinking how we can miss people with disabilities in this story, we have done so for 25 years, we have had evidence sitting in front of this book about a personal account of abuse provided by a 10.17 New Zealand woman, as I say, has circulated the globe because many, many people draw on this book to understand abuse in the lives of people with disabilities. But I digress a little bit there.

So, what - I am not sure, do we have the slide?

Q. If we could ask for the slide to be put up there now, thank you.

A. So, what we thought would be a useful way to think about the abuse that disabled people may have experienced or have experienced in care, is by drawing on Professor Sobsey's model as a way of helping people to understand the sort of power dynamic that's at play when people experience abuse.

So, Professor Sobsey draws on a very famous 10.18 ecological model or way of understanding the world that was developed by another researcher. He uses it to explain how abuse was able to occur. Very briefly, what he does is highlights the abusive context reflect inequities in power at a relational and environmental and cultural level. This can really usefully explain why abuse occurred and why it remained unchecked in institutional and other care environments.

In short, he says that abuse occurred in the context of power inequities. So, what you can see in the model 10.19 is that in the middle there is a circle which highlights relationship and it shows the dynamic between offender and victim or perpetrator and survivor, whatever language you want to use. And notes that what starts to happen is that there's a developing power and equality or equity and there is a weakened bond between the two.

He then looks at the environment that this happens in and notes that there aren't counter-controls. There's no way or process for stopping inequities happening, in fact they're magnified.

10.19 Around the outside he uses the term "culture" to say there's something at play that provides the support and rationale for the power and equities and the abuse to occur.

The reason that I was thinking about this and thought it would be useful to present, is when I was thinking about, after sort of listening and watching Keith Wiffin earlier in the week who talked about the kingpin system, that model is a pretty good way to explain how such a system could happen. And I would also like to note that while they didn't use the same terms and words that Keith Wiffin used earlier in the week, that people's stories that we drew on were quite clearly describing the same system, that there were more powerful 10.20 people than them and that you had to be careful of these more powerful people within the situations that you were in.

So, people with learning disability and other disabilities were not unaware of that system in operation, even if they did not use that terminology.

Q. Can I ask you now to talk to us about control and restraint?

A. Mm.

Q. As a form of abuse.

10.21 A. Yes. As I said earlier, that was something or an area or a theme that came through very clearly and strongly and was really expressed in a distress that people had about being confined to the institution itself, to their bedrooms or specially constructed seclusion rooms.

This practice could also be considered to fall into the abuse category of psychological and physical abuse as well, just noting that cross-over. We view these practices of control and restraint as comprising such a significant component of the data that we analysed it as 10.22 a separate and distinct form of abuse. So, being locked up was a prominent experience with many of the survivors describing that in detail and being very distressed by it. Being locked up was sometimes due to perceived challenging behaviours but sometimes it was just the practice of that institution.

In addition to noting the physical confinement to particular rooms and spaces, people also reflected on the highly regulated and regimented spaces and activities within the institution, including being told but not limited to when to shower, when to shave, when to eat, when to dress, when not to dress. Others described the process of establishing and forcing routine and physical confinement as excessively harsh, with some survivors 10.23 sharing evidence of control and psychological restraint created by staff restricting the space people were allowed to be in, and by restricting their ability to interact with friends.

I would like to draw on a quote which evidences this. "They used to put you in pyjamas, that was a horrible thing, they used to have a square table by the kitchen which was the really bad table. If you run away they put you in pyjamas, you had to stay in pyjamas all day while others had their clothes on. You had to sit in 10.23 one corner by yourself and you don't have your friends around you".

Overall, this particular theme conveyed a strong sense of being trapped in State care literally and figuratively, and confined and restricted on a daily basis in a manner that people perceived as hurtful, as excessive and as humiliating, as the previous quote evidences.

Q. Can you also talk to us about physical abuse and what the research found in relation to that?

10.24 A. What was interesting and possibly worrying to find, was that across the body of data, the evidence, the testimonies from people that had made their way into the public domain, physical abuse wasn't talked about as much as some of the other categories. So, I think it's really important to note, for example, that a lot of what people did talk about in these accounts was the neglect and the psychological and emotional abuse that they experienced. The control and restraint was a big area. And physical abuse was kind of of like a given and people didn't talk about it as frequently. I'll come to sexual abuse in a moment.

But what they did talk about was really quite extreme physical abuse. So, people talked about being 10.25 beaten by peers frequently and severely. They also clearly identified physical assaults carried out by staff. One survivor describing dragged down a corridor by either feet or hair as punishment. Sometimes small misdemeanours were met with excessive force, such as being kicked or accidentally breaking something.

And I have, I will illustrate with a quote, "When I was 13 one of the big boys picked me up by the back of the collar, lifted me off my feet, punched me in the nose, on the side of the nose and made it bent. I went 10.26 up to the nurse and told her that my nose was broken, she said she wouldn't do nothing about it".

So, significant experiences of physical abuse.

Q. Can you talk to us also about sexual abuse and what was discussed there?

A. So, in keeping with the Crimes Act and with more contemporary definitions, we define sexual abuse as any form of sexual contact that was not consensual or any form of sexual contact that happened within two children. And on both of these elements of the definition were 10.27 identified within the personal accounts we explored. We found that both children and adults were sexually assaulted. We found that the assaults occurred in large institutions, residential schools and within the family homes of their foster carers.

I have a quote here before moving on with some more information. Someone who lived at Templeton Centre for many years described sexual abuse, said “sexually abused, sodomised, you know, I suppose you could say that it continued on, not just only me but I think a lot of other people too.”

So, while sexual abuse was frequently divulged or talked about in the narratives, often people touched on it briefly, we know it's fairly graphic. This is likely 10.28 to be because many of the resources that we pulled the information from were not really designed by way of method or in thinking about the ethics of them to respond to disclosures of abuse. So, often we were finding this information in resources that had been written about deinstitutionalisation as things move into the community, about their life story etc. But that said, it was clear from the evidence we drew on that sexual violence was a seemingly inescapable and unchallenged reality for a significant number of both boys and girls and men and 10.29 women in State care. Some of the narratives included graphic experience of the person's abuse, including when it happened, where it happened and who the perpetrator was.

Q. Did the people that were part of your research talk about what happened if they did tell someone about the abuse?

A. There didn't seem to be a lot of evidence in people's stories that people had ever had any redress. For example, one survivor was sexually assaulted at knife point by an older peer when she was 11, despite being 10.29 able to point him out, there was no sense in her story that the perpetrator was punished, kept away from her or she received any psychological support for that sexual violence.

Similarly, and also shockingly, another male survivor raped by older peers appeared to go unchallenged. And others also described similar situations, again seemingly unchallenged. I am noting here we are using secondary sources, we weren't talking with people directly, but essentially there was little evidence to suggest there was ever any follow-up and evidence to suggest that the reverse, in fact.

COMMISSIONER SHAW: Could I ask a follow-up question on that? I appreciate you're working from secondary 10.30 sources. Was there any evidence to acknowledge that these people were telling authorities, were able to tell you? Because the answer could be, well, nobody did anything because they didn't know?

A. I think that might have been the case for some people but for other people it seemed to be clear that they knew that they had taken complaints to people and hadn't had a response or had had a negative response. So, I think, again, I'm qualifying my response but we saw evidence of both situations there.

10.31 **COMMISSIONER SHAW:** Thank you very much.

MS THOMAS:

Q. Just on that point, turning in your brief to paragraph 81, is that an example where someone -

A. Yes.

Q. - that you could tell us a bit more about?

A. Sure. One of the - yeah, so can I go back a couple of points to give some context? So, I noted in my brief that survivors consistently echoed the same sentiment in response to permeated trauma they experienced, commenting 10.32 they would keep quiet and hoped it wouldn't happen again. Similarly to reports of physical abuse, there was this deep-seated understanding that complaints would go nowhere and could even make your situation worse.

This view is echoed in a judgement that we located as part of the research for this piece of work that related to someone who had been in a couple of different institutions. And the judgement evidenced that this complainant felt devalued by staff, thus leading to the dismissal of complaints within State care and some subsequent revictimisation. So to this end the judgement reported the position and said, "Despite the complaint, the plaintiff says that sexual acts continued to be forced on him by that and another nurse for several 10.33 months. The plaintiff says that he did not complain to other staff because he thought it would be dismissed and he was scared of what could happen…. He says he did not report the events of witnessing sexual assaults on others because he was scared of the consequences of the charge nurse not believing him".

Q. Can I ask you to touch on the next heading of abuse that you've covered there, spiritual abuse?

A. Again, spiritual abuse was something that we didn't draw a lot of evidence about but we thought it was important 10.33 to include because it was significant for a number of people. So, while less recognised, spiritual violence featured heavily in the accounts of a person with a learning disability who was Maori, whose experiences in institutions conveyed a sense of loss with regard to being disconnected from his culture as a child. State care facilities in which this survivor was placed were both Pakeha centric in culture and lacked cultural competence for Maori and Iwitanga. He was denied access to his culture as a Maori man and more specifically to 10.34 his iwi which he noted in his story.Other Pakeha survivors noted their heritage was ignored. I am sure Robert will speak to this next week and people recounting a sort of broader disconnection from New Zealand and the world and historical events.

And then at a more individual level, people talked about being able to - being unable to pursue their own interests and their passions, despite expressing them, not being given the opportunity to pursue them. So, living a life very devoid of that individuality that makes us all the people that we are.

Q. The last type of abuse that you've covered in your research, financial abuse?

A. We noted this. Only a few survivors referred to their 10.35 financial material deprivation. However, we did note that people experienced such a significant lack of education or support to develop the skills required for meaningful employment if they did escape this environment as perhaps evidence of long-term financial abuse. But probably more prominently in their stories, financial abuse could be seen as illustrated through the experience of, you know, yep, compromised access to education and the erosion of people's ability to be employed. But it could also be seen in people being denied opportunities 10.36 to have possessions, to enjoy the money they potentially could have earned if their forced labour in institutions and other state sanctioned care environments had been recognised.

So, a number of the accounts talked about they made you a slave when I was 6 years old I had to help, I never went to school, they wanted me to work because I was good at it, you didn't get any money, that's for sure, you didn't get any money. Restrictive environments of care also denied opportunities to get work, as I've just 10.37 mentioned, and have any level of financial autonomy. Someone said “I'm disappointed that I've never had a job, I never got the chance, money is not everything in life but I would have liked to have been able to buy clothes.”

So, briefly touched on in these comments a little considered aspect of life in care, one that I hadn't thought about until I was reading people's stories, was that survivors were forced to undertake manual labour, both in institutions and foster homes, and this surprising finding featured quite heavily. One person described immediate and long-term injuries she suffered as a result of heavy lifting she was forced to do and others described their time as unpaid labourer for a foster family.

10.38 In that situation, the person, the family she was in was also a staff member of the institution she had been living in which suggests an abuse of power of a different kind.

Q. I would like to ask you briefly about other evidence that you gathered as part of your research that came from third parties. We may not have the opportunity to go through it into too much detail but can you tell us where you sourced some of this information?

A. Yes. So, the evidence that we drew on from third parties 10.38 was because we knew from some of the research that we'd done in our own institution and other work of colleagues in the disability research area, that we would - it would be useful to find information or data evidence that supported the stories that survivors had told. So, we drew on some of those accounts.

And so, some of them included eye witness accounts from relatives that were reported in particular stories, literature, resources and other eye witness accounts from researcher observation and from staff reports in some of 10.39 the institutions.

So, it's not about proving or disproving the survivors' stories. We believed in those but we thought it was useful to provide some more evidence if we could find it.

Most notably, the process of deinstitutionalisation has provided an opportunity for both staff and families to talk about neglect and abuse that they witnessed in various institutions. Within the New Zealand research was explored the process of institutional closure, for example, staff members have reported that abuse was an issue at Kimberley Centre, that they witnessed abuse of practice or actions themselves. For example, some research that focused on deinstitutionalisation of
10.40 Kimberley, staff members said, "I've been here for over 10 years all up and these people were brought up in fear here and I've seen this, when you look at the things that went on in this place it was horrific, they were cruel, very cruel people, we had men out in the courtyard here, do you know how they got showered, with fire losses. You rush up to one of these people very quickly, they will, that's when they have hidings at a very young age, the Kimberley Cringe, that's what they call it".

The staff quoted there were largely employed at
10.41 Kimberley Centre prior to its closure, so outside of the timeframe for this Inquiry. The quotes have been included to illustrate two important points. That abuse was occurring at the Institute beyond the focus of this research and the physical fear exhibited by the people that lived there and observed by staff and families actually labelled as the Kimberley Cringe was understood to be the result of a long-term pattern of abuse within the institution. It is acknowledged that both staff and residents may have been involved in abuse of practice or
10.41 actions that led to the development of the Kimberley Cringe or people's physical withdrawal away from people that came close to them.

Q. I'd like to move on now to the topic, this is from paragraph 107 onwards of your brief. The question, was what you've described institutional abuse?

A. Sure. One of the things that we considered in our research was whether the abuse that we saw when we pulled across a number of survivor stories, whether it showed or we could call it institutional abuse. And again, drawing on Professor Dick Sobsey's work, Professor Sobsey defined institutional abuse as neglectful, psychological, sexual abuse that takes place in managed institutional care of Human beings. He identified the key features as extreme 10.43 power relations between residents and staff, collective nature of abuse, that abuse is covered up or knowledge of it is not shared outside of the institution and that clearly defined patterns of environmental influence are at play.

I'd just like to note, and possibly if I've got time, to read out. Just to extend on the points that I've just made -

Q. Just while you're reading a quote, can you speak slightly more slowly.

10.43 A. Just to extend on that point and to pick up on a question I think from the Commissioners yesterday, that he goes on to say, "Institutional care is not necessarily restricted to large custodial institutions. It includes an array of living arrangements and related programs paid for with government or other public funds that would be normally provided through less formal family and community resources. Thus, institutional abuse can take place in group homes, foster care, hospitals, residential schools, prisons and a variety of other environments and 10.44 anyone can become the victim of institutional abuse, including people with disabilities".

Q. I'd now like you to talk to us about systemic abuse. Can you tell us about the definition of systemic abuse?

A. Yeah. So, in our study of survivor accounts provided by

people with disabilities, and particularly people with learning disability, we drew on the testimony characterised by participants who were describing long-term, immediate and long-term impacts as a result of their abuse. And given the evidence, we really wanted to consider whether their abuse could be defined as systemic. We drew on the work of Sally Robinson who is an Australian researcher who defines systemic abuse as having causal roots that are located in organisational
10.45 systems or policy, despite sometimes being perpetrated by a person.

So, in this definition, abuse can't be categorised as systemic due to prevalence alone, instead, abuse must be attributable or able to be attributable to system factors or failures that have worked actively or passively to enable or to facilitate abuse under the particular system. That is in more lay person's terms systemic abuse takes us beyond the notion of bad things being done by bad people independent of the system to a
10.46 recognition that the system has operated in ways that has both provided the opportunity for abuse to occur or for it to continue unchallenged. And I think that's what we've heard in people's stories.

Q. If you turn to paragraph 119 with the bullet points listed in your brief there, can you just take us through those?

A. Yeah. So, what we did against that definition of systemic abuse, is create a series of points that we could or key themes core findings that we could see in
10.47 the data that we had gathered in the survivor stories. So, we noted that the personal accounts detailed neglect in the form of people not having their basic needs met, possibly due to under staffing or inadequate training which constitutes systemic abuse. We saw

institution-wide failure to attend to the emotional and psychological development of children, potentially through under staffing, inadequate training and abusive or allowing an abusive culture to continue unchecked.

We saw the use of control and restraint practices, whether environmental, physical or chemical, for reasons of punishment rather than for therapeutic reasons which constitutes systemic abuse.

We saw repeated exposure to physical violence 10.47 resulting in injuries being left untreated and no meaningful attempt being made to stop the assaults which constitutes systemic abuse.

And people being repeatedly sexually abused or exposed to sexual very violence and the absence of any ability to achieve meaningful redress in the form of a person being held to account or counselling for psychological trauma and a care system that allowed staff and foster carers to abuse the children and adults in their care.

10.48 This is all suggestive of systemic abuse.

Q. This systemic abuse existed that you've described, do you have any comment or any thoughts on what can be done to avoid this in the future?

A. So, what we saw, yep, we were able to draw on secondary accounts that had been sitting unexplored really. So, when we go back to the beginning of this session, when you asked a question about why are disabled people invisible, the stories were there and the stories are there. We hadn't 10.49 looked hard enough and I think some of that speaks to the value that we place on disabled people and where we see them fitting in this issue.

But the evidence on record about the experiences of abuse has largely been collected within the context of research with an alternative focus, both in terms of the nature of the data that's collected and the way it's been able to be analysed. So, we need to do further exploration to really be able to learn from our mistakes from the past but my thoughts are that in doing this, we need to examine the context in which abuse occurred and the policies and processes and procedures that were there or were not there to assess the likelihood of similar abuses permeating future systems, that speaks to the question I was asked before, did people complain, did 10.50 they not complain, we need to know more about what people understood, did they understand there was a process for complaining or was there not?

It's also important to look closely at organisational culture at a broader level, again to generate important learnings to ensure we don't let down another generation of vulnerable children and adults.

Yeah, I think people who experience the trauma deserve the opportunity to learn how this abuse was able to happen, so really getting to the heart of why is an 10.51 important step towards that.

Q. Coming near the end of your brief, one of the headings is, "Gaps in the evidence".

A. Mm-Mmm.

Q. I'd just like to ask you briefly about the comments that you've made at paragraph 132 where you've described that people telling their stories were clear about what happened but they were not able to unpack the circumstances that led to such practice or actions.

A. Mm.

10.51 Q. Can you comment on that for us?

A. Yeah. I think we saw a range of - there were a range of stories told and for some people they were able to give extensive detail and, you know, to have a real understanding of the power dynamics that were at play, while others were simply reporting these terrible things that happened to them which they knew were wrong and should not have occurred but didn't have that context around them.

So, I'll step back to your previous question. We haven't got a full understanding of how these things were able to occur in this system of care, so it's not surprising that individuals with learning disability who had often not even experienced any kind of life in the 10.52 community, had lived whole lives in those institutions, weren't able to provide complex details or really comprehensive understandings of why and how things had happened, and even when they'd happened, because if you've lived a whole period of life with no typical signposts of times in your life, then you're not going to be able to give a lot of detail about this happened when I was this age, around this time etc., yeah, you don't have those things, life experiences to hand that detail on, contextual details on.

10.53 Q. Just in terms of the reference to the Askew review in 1980s where you stated it was unethical to explain away the high incidents of abuse in State care as being reflective of "the time". Can you comment on that for us?

A. Yes. The Askew review supported the individual stories that we explored. So, the review was a Ministry of Health review of psychiatric and psychopaedic hospitals. And Askew described the conditions despite institutional reform that occurred through the '70s and '80s and went 10.54 on to say that some staff in institutions reported to the review team that time outboxes and cupboards in some wards for the intellectually handicapped were used more for punishment than any therapeutic effect which was deemed to be more appropriate for practice for modifying behaviour. Further, they found deficiencies in dignity and in basic elements of appropriate care. For example, that some units in psychopaedic hospitals had toilets of a bench type in nature and communal showers.The report went on and said other things about what they saw there and concluded that staff shortages and low moral seriously affect patient care and the availability of alternative methods of treatment and led to a lack of awareness and general acceptance. So, it could be argued 10.55 that this review conducted in the 1980s has long provided evidence that neglect and abuse in care did indeed occur.

CHAIR: Ms Thomas, I will leave it to you to suggest an appropriate time at which we might take the morning adjournment.

MS THOMAS: I only have two more questions.

CHAIR: All right.

MS THOMAS: Perhaps we finish those and then take the break.

Q. Just turning to the end of your brief there where at 10.56 paragraph 140, statement that abuse and neglect are not in the past. Can you perhaps expand on that for us?

A. Yes. I think Hilary Stace is going to do that in the next session but I would just note that more recent research, as it has identified abuse and neglect are not in the past, that various approaches have been used to audit and otherwise assess quality of care and that it's clear that gaps remain that make it possible for neglect and abuse to go undetected. But I will leave it to Hilary to cover off on that.

10.57 Q. Finally, your final paragraph of your brief, do you have any final conclusions you would like to make to the Commission today?

A. Just further to the notion of the intention of the Inquiry to look to the future, I think it is important to conclude by mentioning the ongoing story of abuse in care that can be seen in some of our current research. We had done qualitative research with individuals in the justice system in recent years and found that over half of our 40 participants have been in and out of placement in childhood, these are all people with learning disability. Some of these people reported that they'd experienced abuse in these placements. Abuse in care has been seen again in a soon to be released piece of research which 10.58 includes the story of a young person with a learning disability who, in very recent years, has experienced multiple foster placements, including an unacceptably high number of placements and some abuse in some of those settings.

So, unfortunately, this suggests very strongly that we are a long way from being able to confidently assert never again and it reminds us why this Royal Commission of Inquiry is so critical to disabled people who have experienced abuse in care, whether it be past, present or 10.58 in the future. Thank you.

MS THOMAS: Thank you.

CHAIR: Thank you, Dr, thank you, Ms Thomas. I think we'll take the morning adjournment, following which I shall ask counsel whether they have any matters to raise by way of cross-examination and then I'll provide an opportunity for Commissioners to ask questions if they wish. Madam Registrar, could you adjourn the sitting of the Royal Commission.

11.05 **Hearing adjourned from 11.00 a.m. until 11.20 a.m.**

CHAIR: We were at the point where you had concluded, Ms Thomas. I now want to ask if any other counsel wishes to exercise the right to cross-examine the witness? There is none.

***

BRIGIT MIRFIN-VEITCH
QUESTIONED BY COMMISSIONERS

COMMISSIONER GIBSON: Kia ora, Dr Mirfin-Veitch. Even having heard it before, I still can't help feeling deeply moved and saddened every time I hear something. Our Terms of Reference include looking 11.20 to make future recommendations, so my questions cover all of that.

Outside of that institutional context, what protections, looking at the 1989 Act, were available to disabled children? Were they the same as for other disabled children? What legal safeguards were there?

A. I'm probably not the best person to comment on this and Hilary will speak to some of this later, I think. The area that I can talk to in terms of the safeguards around disabled children, relate to section 141 and 142 of the 11.21 Children, Young Persons and Their Families Act, just noting that the Donald Beasley Institute has done a very small piece of research in that area on the basis that those two particular causes could be seen as treating disabled or did treat disabled children differently who were - so, children who were unable to be cared for at home had a different route into care and treated differently while they're in care. And what we have done, is talk to some people who have been subject to section 141 who have left their family home, gone into 11.22 care and disability services and then talked about how that felt for them. So, that's a more recent experience of care that we've been able to capture in research.

COMMISSIONER GIBSON: You talk about people with learning disabilities in the justice system. If I was to extend that, not just to that group of people but with neurodisabilities, dyslexia, ADHD, head injury, autism spectrum, I know there's a growing global picture of these people in the justice institutions, what is your knowledge and experience of these people through youth justice and the journey into youth justice?

A. So, in New Zealand, we have quite a strong recognition that a significant proportion of young people in youth 11.23 justice are people who would fall under that broad umbrella term of neurodisability. It's an area of research that I'm involved in in a range of ways. I think we have been drawing on international research to give us a sense of the kind of scale or the numbers of young people who may fall under that particular umbrella term that are in youth justice. We are just embarking on some research to try and get a New Zealand prevalence bigger around that but essentially I think we can be fairly confident, based on the knowledge of legal 11.24 professionals, including very, very experienced Judges who are reflecting their experience and their belief that this is a big proportion of the people who we are seeing enter into youth justice. I think once we have done the research, I think it will confirm that a good number of those individuals have probably come through a pathway of care.

COMMISSIONER GIBSON: A final question, we've heard from previous witnesses about the context of adoption and the need for families to stay together. In the 11.25 context of disabled parents, what do we know what happens, what support and safeguards are there for disabled parent and child?

A. Very few. Again, another area of research that I've worked around in the Institute, is work around in sort of

decade periods from the late 1990s, and we are just about to embark on another piece of research to explore the experiences of parents who have a learning disability. What we have continued to see for the last 20 years but earlier, are that parents with a learning disability frequently have their children removed at birth or soon after. They sometimes have their children removed before they have proven that they weren't good parents. They are assumed to lack capacity and, yeah, continue to
11.26 experience child removal at a very significant rate. We tend not to see family reunification within families that include a parent with a disability, a learning disability at least, and we also tend to see access being eroded, so that the sort of attachment and the family relationship within those families isn't able to be maintained because they don't receive enough access and support around the access to keep that relationship going. This is an area that I feel that I can speak reasonably confidently about, hence my strong answers to this question.

11.26 **COMMISSIONER GIBSON:** Thank you.

COMMISSIONER ALOFIVAE: Good morning, Dr Mirfin-Veitch. Thank you very much for the way your evidence was presented and in particular the reference to your research. I suppose as a non-academic or non-research background but really appreciating the complexity. One of the questions I often ask is, at what point do we say we've got enough evidence there to actually put forward some concrete recommendations in this particular space,
11.27 appreciating the limitations that you've spoken to?

A. Yeah. I think or my perspective is we've got a lot of evidence that we've ignored or overlooked and as a deinstitutionalisation researcher, I put myself in the category of people who have sometimes overlooked these experiences. One of the things that I didn't talk about but that I noted in my brief, was that often we've heard the experiences, a lot of the data that we collected was around research that had occurred around deinstitutionalisation or life histories or oral histories that people had undertaken when they'd been moving out or soon after they'd moved out of an institution. So, while we, the collective community, disability community, were congratulating ourselves about 11.28 a job well done, we were often ignoring these stories and these voices that were coming through as we were asking people to tell us about what's good about living in the community outside of these institutional systems and structures.

So, I think we have evidence that we can certainly assure ourselves that abuse did occur for people with learning disability and other disabilities. What I think needs to occur, is primary research with people. Our work has drawn on published accounts. I will note that 11.28 some of those published accounts have originated from my organisation, the Donald Beasley Institute, so I actually did some of the research, I did know some of those people. So, there was a mix of me having done primary research that I then drew on for the work that I've presented here.

What we need to do is to do more of that kind of work with people and it needs to be carefully done, it needs to be slowly done, it needs to be ethically done. It's not something that you rush into without a lot of 11.29 thought.

I will say really strongly, however, that when the context is right, people will tell those stories and people do tell those stories. So, as I said earlier, even when we're not researching abuse, we are constantly hearing about it.

COMMISSIONER ALOFIVAE: Thank you. And just a final question around the collation of perhaps your ethnicity rating. Do you have a sense around the different ethnic groups?

A. Yes. So, in terms of the work that I presented today, are you asking me a question in relation to? We noted and talked about ethnicity where we could but, again, it speaks to your previous question, carefully planned work 11.30 allows us to explore all elements, all the intersectionalities of people lives, whereas where we're working with secondary data we're just taking what we can from it.

COMMISSIONER ALOFIVAE: Thank you very much.

CHAIR: Dr Mirfin-Veitch, other people giving evidence to the Royal Commission have referred, not all of them but many, to companion pieces of work occurring in Australia, Canada, United States for example. Is that aspect of companion work also to 11.31 be thought of in regard to people with learning disability?

A. I think by companion work, you're meaning a parallel process where a slightly different process is put around particular groups?

CHAIR: Yes.

A. That would be a really appropriate pathway. Again, what we need to be careful not to do, is to treat disabled people differently or think that they've had a vastly different experience because I think, in listening to 11.31 some of the evidence this week, that I can see such strong parallels. But what is important, is to think about how we do work with people with learning disability and to make the process accessible and sometimes that might take a companion process to achieve that in the best possible way.

CHAIR: Thank you.

COMMISSIONER SHAW: I have no questions but thank you for your evidence.

COMMISSIONER ERUETI: Dr Mirfin-Veitch, thank you for your evidence. It is a concern, isn't it, there's so little research that's been carried out into abuse and neglect in these institutions and very primary research so far. And it seems also that 11.32 there's still research that needs to be done in the post institutionalisation phase about abuse and neglect. I am assuming a case we heard in evidence relating to mental health institutions, despite the bricks and water, the large institutions that abuse and neglect continues and you referred to cases in the context of foster care. My question is about, it seems that there's even less research that's been carried out in relation to Maori and Pasifika and other minorities; is that the case?

11.33 A. That is the case.

COMMISSIONER ERUETI: Yes, yes. I wonder, in your evidence you talked about the abuse and neglect experienced in institutions but is there further work that needs to be carried out too on oversight and standards and recruitment and training, systemic factors that led to abuse and neglect occurring in the institutions?

A. Absolutely. In one of the elements of our work that we have skipped over today, was to sort of identify the 11.34 areas of research, the gaps that we thought were there, and I'm probably unable to find that particular section very quickly and probably didn't focus it completely, this brief, on that. But essentially, some of the things that we identified were the need to really explore this notion of systemic abuse more fully. I think we've got a reasonably good, some good frameworks to work from, but to be exploring it in the context of this Inquiry, we noted that we only had a small number of participants who told stories, their stories of being in foster care, and that's largely to do with the age and the time but we know that, from more recent research, that that's a real area that we need to do some - there's gaps in the research around. Obviously, working from the perspective 11.35 of Maori and Pasifika. The other area that we identified was a lot of people talked about leaving their families to go into these systems of State care and for a number of people that's because they were in difficult family situations. So, I think there's some gaps there, in terms of really exploring how we're supporting families right now and what we are - yep, how we're supporting and certainly that was, you know, a conduit to some of the placements for people that we talked with.

COMMISSIONER ERUETI: In the context of institutions but 11.36 also in the post institutional phase, including foster care?

A. Absolutely, yes.

COMMISSIONER ERUETI: My last question relates to Maori again. You referred to the impact on individual patients and cultural disconnect and I wonder also whether there's also the bigger, broader question about whanau, hapu and iwi, Maori involvement in the setting of policy, laws and practices, the institutions themselves, so historical as well as 11.36 contemporary angle and the need for work in that area too?

A. Yes, certainly need for work and no-one would argue that there are gaps and deficit in that area, in terms of disability, policy services supports etc. but also the wider system, you will have more experience and knowledge around.

COMMISSIONER ERUETI: To your mind, that work still needs to be developed?

A. Yes.

COMMISSIONER ERUETI: Still a lot of work to do?

A. Yes, definitely.

COMMISSIONER ERUETI: Thank you, Dr.

CHAIR: Thank you, Dr Mirfin-Veitch, your evidence is 11.37 now concluded and the Royal Commission is grateful for it, thank you.

A. Thank you.

MS JANES: May it please the Commissioner, we call Dr Hilary Stace.

***

HILARY STACE - AFFIRMED
EXAMINED BY MS JANES

CHAIR: May I ask you as follows, in terms of the Inquiries Act 2013 (witness affirmed).

MS JANES:

Q. Is your full name Hilary Janet Serena Stace?

11.38 A. Yes.

Q. And you have prepared a statement for the Commission?

A. Yes.

Q. Have you found it at tab 12 in the folder in front of you and you've signed and dated it?

A. Yes, I have. Can I start?

Q. Yes, that would be good, thank you. Dr Stace, you have a PowerPoint that you would wish to use as you read your statement.

May it please the Commission, we will produce that 11.39 as an exhibit as it has some additional material not in the written brief.

A. Yes but most of it is just summaries of my points, it makes it easier for me to go through my presentation.

Q. That will be Exhibit 7.

PowerPoint produced as Exhibit 7

A. Is it going to work? Yes.

Q. Dr Stace, just before you start reading, you've asked to read your brief of evidence, so just before you start that, can you confirm please that any third parties that 11.39 you refer to are either sourced from public or you have the consent of the people to speak about them?

A. Yes, yes.

Q. Thank you. If you'd like to start reading at paragraph 1, thank you.

A. Kia ora everybody. It's been a long road to get to this point. For many of us, it's been a long, long journey of advocacy to get here, so it's a great privilege.

I wanted to start with my own expertise in this area. I am a mother of a disabled adult son and he's from the first generation not to be institutionalised and the first to have the right to an inclusive education. I was trained as a historian and librarian and I did Honours Research on Eugenics in New Zealand. My 2011 PhD 11.40 was in public policy at Victoria University and the subject was The Policy Challenge of Autism.

In 2013-2014, I had two short contracts with the Human Rights Commission to work on historic abuse in State care and as a result, organised a round table of interested parties on this topic.

I am a writer, a teacher, an activist in disability rights, history, ethics, research and advocacy. And my current status is actually a Professor of the Health Research Centre at Victoria University, it is an honorary 11.41 role. It doesn't actually mean much.

Q. Can I ask you to perhaps slow down a little bit, thank you.

A. Yes.

Q. According to Te Ao Maori, we walk backwards into the present and future bringing those who came before us, their battles, knowledge and suffering. We honour them and learn from their stories. In previous work at the Human Rights Commission we used the whakatauki: Titiro whakamuri, haere whakamua (ask the old path for 11.42 directions to the new path).

We need to know our history in order to address it and help us understand why certain groups were locked away from communities and families for who they were rather than anything they had done. As disability advocate Robert Martin asks, how can humans treat other humans like that?

This paper mainly covers 2.1 of the Scope of Investigation but also addresses 2.2, 2.4 and 3.1. It covers the background to the development of the psychopaedic institutions, the political, scientific and social environment that encourages extreme discriminatory practices against certain groups of people and the legacy of that.

11.43 Q. Dr Stace, we might skip paragraph 3 because that's repetition, and if you can go to paragraph 4.

A. Yes. The Royal Commission's focus is 1950-1999 but this paper reviews the social and the legal, medical and attitudinal context in New Zealand since the mid 19th Century that enabled such abuse to happen. And it also looks at ongoing disability abuse and restorative processes required.

There were two official inquiries in the 1950s that sought to control the 'defective', the 'deviant' and the
11.44 'delinquent' which were the interchangeable fears of conformist New Zealand in the 1950s when this Inquiry time period starts.

When I was a baby, my father was appointed to the Government's Special Committee on Moral Delinquency in Children and Adolescents which produced what was known as the Mazengarb report in 1954.

In an era of 'moral panic', the intention was to control this potentially deviant phenomena of teenagers in the new state housing suburbs such as Naenae near
11.44 Wellington.

The Committee rushed its hearings so that the report could be sent to each household for the National Government's re-election campaign. My father was head of the Jaycees, the Junior Chamber of Commerce. Judge

Mazengarb told Prime Minister Sid Holland that the Committee members didn't need to be paid, so my father attended the full-time Committee while parenting his growing family and keeping his small business going. Meanwhile, my sister shared the evidence presented to the Committee - such as Mickey Spillane novels - with her school friends.

The Committee decided that the best way to prevent such deviants was to keep young people ignorant, so we 11.45 got new censorship laws. And one recommendation that took decades to overturn was that under 16 year olds must not have access to information about contraception.

This fear of young people and their potential delinquency also led to the rise of state boys' and girls' homes. A few years after the Mazengarb report, the Epuni Boys' Home was opened in Naenae in the heart of the new suburbia where the Committee had located such threat. In this Royal Commission we are hearing a lot about the long-term effects of abuse from such homes.

11.46 But more significantly for disabled people and families, was that the previous year, 1953, another government report responded to the fear of deviance by recommending that disabled children should be locked away from their families and communities in larger numbers than ever before.

The 1953 Aitken Report, or the Consultative Committee on Intellectually Handicapped Children, recommended extending the existing psychopaedic institutions such as Templeton, Levin, Kimberley, 11.46 Braemar, Ngawhetu and Mangere into large 'mental deficiency colonies" with parents encouraged or coerced into sending their disabled children to them by the age of 5. These recommendations were despite pleas from the newly formed Intellectually Handicapped Children's

Parents Association, the IHC, founded 70 years ago this month, I honour those parents, and the World Health Organisation advice for community facilities and support for disabled children and adults, not locking up.

But the Aitken Report is a significant reason why we have a Royal Commission today.

As a result of this report, the institutions were extended and numbers of residents rapidly increased. By 1972, and the establishment of the Royal Commission on 11.47 Psychiatric and Psychopaedic Hospitals, which would eventually recommend their closure, each institution was home to hundreds of disabled children, young people and the few adults who had managed to survive.

A 1964 documentary estimated that one in a thousand children had an impairment which required their institutionalisation.

Smaller units were attached to some local hospitals, while other children ended up in adult psychiatric hospitals. To deal with these growing numbers, the new 11.48 profession of specialist psychopaedic nurse, you heard about before, was developed in New Zealand with in-house training. The first cohort graduated in 1964.

The normalisation of institutionalisation of disabled children was hard for individuals to fight. I heard of a mother who had a baby with Down Syndrome in the 1960s. The family doctor and her husband suggested the baby be put into an institution. The mother resisted until one day the father came home with the GP and an attendant from Kimberley, they forcibly took the toddler 11.49 off his mother, told her not to visit for at least 2 years and to forget about him. Terrified and confused by such instruction, the mother didn't hear about him again until after his death a few years later. This powerlessness by mothers was hard, is hard for us maybe to understand now.

As noted already, this topic is also personal to me as I have an adult son with autism and learning disability. Christchurch film maker Gerard Smyth has made two powerful documentaries about the closure of Templeton institution. The residents he filmed were much like older versions of my son's Special Olympics friends. So, most of the interviewees in his documentaries were estranged from families and puzzled as to why they were there. 11.50

My son was born in the 1960s (sic) 1980s when institution closures were already underway. So, as I mentioned, we are the lucky first generation of parents for whom an institution was not suggested as a suitable place for him. I wasn't told he would be better off in one. He wasn't forcibly separated from his family or community. His impairment is not blamed on me or a cause of shame for the family.

Both assumptions were common only a few decades ago. 11.50

The 1953 Aitken Report, it didn't come out of anywhere. New Zealand has a - in New Zealand, we have a toxic, a long and toxic mix of colonisation, racism and eugenics in which many poor Maori or disabled people had no chance of equal citizenship. The antecedents of institutional abuse in State care developed over many decades and I will attempt to explain why disability was, and still is, viewed negatively.

19th Century New Zealand was settled by immigrants 11.51 mainly from Britain and Europe who endured a lengthy sea voyage for a chance of a better life in a new country. Two groups which threatened that vision were disabled people and people from Asia.

Although infectious illness and accidents were common, disability was unwelcome as it challenged the ideal of a new society and was a burden on others at a time when hard physical work and self-reliance were highly valued. Support was left to the benevolence of family or charitable aid.

The immigration acts that restricted the entry of
Chinese in the late 19th Century, also sought to deter
disabled people. One was the 1882 Imbecile Passengers
Act attempted to ban 'cripples, idiots, lunatics, infirm,
blind, deaf and dumb ' and required a bond from the
11.52 ship's captain for each of those 'undesirables' and the
1899 Immigration Restriction Act banned the 'idiot', the
insane and contagious.

In 2019, we still have immigration restrictions against disabled people.

Mental illness, as now, was generally feared and
misunderstood. The 1846 Lunatics Ordinance provided
incarceration of the mentally ill, initially in jails.
The first public 'lunatic' asylum was opened in Karori in
1854, followed by Porirua in 1887. The Porirua asylum
11.53 mixed several categories of these undesirables, those
with mental health issues, intellectual impairment,
alcoholics as well as elderly and homeless people.
Physically disabled people were often also housed in the
so-called ‘chronics wards’ in ordinary hospitals. For
decades, all these inmates also provided large captive
communities for doctors and specialists to practice
theories and treatments.

As New Zealand society developed, children came to
be regarded as more than little adults. The 1877
11.54 Education Act provided free, secular, primary school
education. The Act's aim was an educated workforce while
enabling State surveillance of children. Rules and
inspections were rigid.

Segregated residential schools developed at this time too for those with vision and hearing impairments. But deaf children were forced to be oral and punished for signing for most of the next century.

The rise of the pseudo-science of eugenics and Social Darwinism became very influential. In 1859 Charles Darwin published his best seller on the origin of species by natural selection or the preservation of favoured races in the struggle for life. The ideas of evolution, genetics, heredity and the potential of 11.55 selective breeding in humans, not really what Darwin was talking about, to breed out these undesirable characteristics. These were taken up by his cousin, Francis Galton, who named the new science eugenics. The application of 'Social Darwinism' found fertile soil in New Zealand as well as other countries. Here, these ideas were embraced by liberals and conservatives concerned about the white middle class birth rate which had started to decline in the late decades of the century and consequent fears of losing their racial and moral 11.55 supremacy. Improving racial 'fitness' was vital.

By the turn of the 20th Century, many of New Zealand's leading politicians, doctors and academics believed the scientific validity of eugenics. It was cutting edge science. We were also, as New Zealand, proudly part of the British Empire and its mother country or home, as a lot of people called it.

Their eugenic targets of this population, the white population, were those considered immoral and dangerous who threatened racial fitness. In New Zealand, disabled 11.56 or mentally unwell people and Chinese people were the main targets, hence the poll tax and immigration restrictions which I mentioned earlier.

In 2002, Prime Minister Helen Clark formally apologised to Chinese New Zealanders; disabled people are still waiting.

Two influential Social Darwinists were Duncan MacGregor and Robert Stout. MacGregor from Scotland was Professor of Mental and Moral Science at Otago University and advocated in the 1870s for extension of the definition of insanity to include 'hopeless drunkards, hopeless criminals and hopeless paupers', so that these dangerous classes might be 'made to work for their support, and deprived of liberty until they die, in order 11.57 to prevent their injuring society either by their crimes or by having children to inherit their curse'.

In the 1880s Premier Robert Stout, a former student of MacGregor who believed moral failings caused poverty, warned of an emerging class of permanent paupers, poor people, which would pollute the new society. His wife Anna was a prominent suffragist. Many feminist writings of the era reflected strong eugenic beliefs particularly as a means to rid society of undesirables such as alcoholics.

11.58 In 1903, WA Chapple, who was a respected politician and doctor, published his influential booklet, "The Fertility of the Unfit". The problem he saw was a decline in the fertility of the "fit" and the increasing birth rate of the "unfit".His solution lay in encouraging the "fit" to have more children and by sterilising the "unfit", and those included those with mental, moral and physical defects.

I remember when I was a young librarian at the Turnbull Library coming across the book, and it was in a 11.59 big collection of books and pamphlets, and I was shocked because I didn't know that opinion basically was so popular in New Zealand. It is a shocking book and yet he is a very, very influential book publisher.

The Eugenics Education Society was founded in

Dunedin in 1910 with a leadership of politicians, public servants, scientists, doctors, ministers of religion and academics, one of whom was Truby King, the Medical Superintendent of Seacliff Asylum. They linked intellectual impairment and some physical impairments like epilepsy with inferiority and moral degeneracy.

A note here about positive and negative eugenics. Negative eugenics sought to limit fertility while positive eugenists supported interventionist policies to
12.00 increase population 'fitness'. In this context, Truby King founded Plunket in 1907. He was a positive eugenist who believed that teaching mothers the strict rules of 'scientific' mothering would increase the fitness of the race. Committees of middle class women then took the idealogy to the breeding populace.

But surveillance of those deemed dangerous and deviant required legislation.

So, one of the most significant of these new laws was the 1911 Mental Defectives Act which classified
12.00 groups of 'other' into six categories. "Persons of unsound mind", "mentally infirmed", "idiots", "imbeciles", "feeble-mind" and "epileptics", and each category had a description and what should happen to each one of those groups.

And then the 1914 Education Act required parents, teachers and Police to report mentally defective children to the Department of Education and the School Medical Service was founded to identify defective children so they could be subject to surveillance. Health camps
12.01 developed to temporarily remove children from their families and instill ideals of health and fitness. The new science IQ testing provided a valuable classification tool.

By 1922 Committee on venereal disease was led by

William Triggs, a Member of the Legislative Council. His
concluding remarks expressed concerns with the role of
feeble-minded women infecting men, causing debauchery and
corruption. So, here we had another era of moral panic
and it was high. So, Mr Triggs was appointed to Chair a
Committee of Inquiry into Mental Defectives and Sexual
Offenders.

The 1925 report reinforced the links between intellectual
impairment, moral degeneracy and sexual offending in the
12.02 public mind. I have a little quote from that report, the
recommendations, "The unchecked multiplication of the
feeble-minded and epileptic is leading to a continually
growing addition to the sum of human misery and ever
increasing burden on the State and the serious
deterioration of the race". That was a government
report.

Theodore Gray was a Scottish clinician influential
in New Zealand psychiatric hospital administration. He
advocated villas instead of old multi-storey hospitals.
12.03 In 1927 he succeeded Truby King as Head of the Department
of Mental Hospitals. To protect this white racial
fitness he wanted segregated farm colonies for those with
intellectual disability or mental illness, registration,
screening and sterilisation. These were all proposed in
the 1928 Mental Defectives Amendment Bill.

After much political debate, sterilisation was
rejected under the leadership of opposition Labour MP
Peter Fraser who would become Prime Minister a decade
later. He was a rare voice against eugenics, possibly
12.03 because of his own family experience of mental illness.
As a compromise, a Eugenics Board was set up to keep
lists of mental defectives. Peter Fraser's wife, Janet,
one of the first women JPs, was appointed to this board
and I like to think she quietly sabotaged it as it didn't

last long.

French-born nun Suzanne Aubert who had personal experience of disability was another component of eugenics. She founded her first Home of Compassion for needy or disabled adults or children in Wellington.

So, even though eugenic sterilisation was never legal in New Zealand, we know there is a lot of evidence and anecdote that they were widespread and they were diagnosed and operations such as appendectomies and 12.04 witnesses, a lot of anecdotal information about that happening. Something that we need to do more research on.

Under the 1928 Mental Defectives Amendment Act children could be taken off families. A mother provided a rare voice of protest against Dr Gray's proposed travelling clinics which would examine intellectually impaired children. There is this rhyme/poem that I found that was apparently also a nursery rhyme. Anyhow, I'll read it:

12.05 "Oh Mother, save me from Dr Gray
'Cause teacher says he's coming today
And if I'm stupid he'll take me away.
Oh, Mummie, save me from Dr Gray!"
"I cannot save you, my little child."
His Mummie said and her eyes were wild.
"You belong to the State, you're no more my child!
But oh, my darling don't stupid be
Or he'll say we've tainted heredity.
And must be eradicated - you and me!"

12.06 This overview has shown how and why over several decades, intellectual impairment and disability came to be linked with 'immorality'. Reproduction of these so-called 'degenerates' threatened the dominant white, fit society but there was still the legal requirement for education so in 1908, Otekaiki (Campbell Park School) near Oamaru was opened as a residential school for 'feeble-minded' boys and in 1916 a residential school for 'feeble minded girls', Salisbury, was opened near Nelson. These special schools were run by the Education Department.

The overall effect of these influential beliefs was exclusion of the unfit from -

CHAIR: Dr Stace, can I intervene simply to ask you to 12.07 speak just a little more slowly, the signers are finding your pace quite difficult.

A. Sorry. The overall effect of these influential beliefs was exclusion of these groups from mainstream society. Girls and boys' homes, farm and residential schools and other institutions were developed to keep the sexes apart and importantly, prevent reproduction. Some were built on the sites of orphanages or industrial schools as more permanent placements for those who threatened racial fitness.

12.08 The 1928 Mental Defectives Amendment Act led to the establishment of our first psychopaedic institution, Templeman Farm mental deficiency colony, in 1929 under the authority of Dr Gray and his Mental Hospitals Department.It was near Christchurch but not too close. The first residents were boys but soon girls were sent there too, although sections were strictly segregated inside the institution. Christchurch filmmaker, Gerard Smyth, recorded stories of the residents before it closed in 1996 and caught up with some of the residents again in 12.09 2004. Some had been in Templeton for decades but didn't know why. Some had arrived by bus as small children. Dr Gray personally signed some of the admission forms.

Featured in the 1996 documentary, was an older man who had been a Templeton resident from the 1930s. I recently talked to his nephew about the ongoing impact on their family history. 80 years later this younger man wonders why it all happened. In the documentary, the Templeton resident said he was sent away from where he lived with his mother in the 1930s because he stole two pies. He was only a small child.He was initially sent to Otekaike and then Templeton. He describes regular sexual abuse by the "big boys" and lack of any accountability by authorities.He and another boy ran 12.10 away and for punishment were beaten then forced to spend several hours a day in a small dog kennel.

As a child, the nephew remembers occasional visits home from Templeton by the older man but the boy was warned to keep away because the older man was rumoured to be, without any evidence, a pedophile. The younger man remembered his uncle would flinch if someone came too close as if to avoid punishment and this reflects the reported Kimberley cringe of patients, residents of Kimberley, that Brigit mentioned.

12.11 In relating this story, the man expressed anger at the older man's mother, his grandmother, for not only sending her son away as a child but also refusing to accept him home when the institutions started emptying. But thinking of that poem I read earlier, the poverty of the 1930s, the mother would have had little power to fight the authorities when they came for the young shoplifter. As well as, mother blaming for conditions like autism remained strong into the 1970s and even beyond. Institutionalisation and the consequent shame 12.11 and fear that the family experienced has affected this whanau for generations.

Over time, more psychopaedic hospitals were established, including Braemar, Kimberley (Levin) and Mangere (Auckland). Residential units were established in hospitals such as Dannevirke, or in psychiatric hospitals, such as Porirua, which setup an autism unit in the 1970s when that diagnosis started increasing. Many disabled children spent time in mainstream psychiatric hospitals and some examples can be found in the DBI report that was mentioned earlier.

And Pukeora, which was an Institute for children and young adults with physical impairment, opened in Dannevirke in the 1950s.

12.12 So, support for eugenic policies was widespread globally and it was in this context in 1939 that a German father asked the State authorities in Germany to kill his disabled child. That was the start of the euthanasia policies of the Nazis and it is estimated that over 200,000 disabled people were killed in what was known as the 'silent Holocaust'.

But support for eugenic policies dimmed in New Zealand and elsewhere but did not die with the Nazis.

As mentioned earlier, children with impairments, 12.13 including intellectual learning disability, founded the forerunner to the IHC. They wanted schools and community facilities for their children so they could keep them at home and out of institutions, but they faced much discrimination. Oriental Bay residents petitioned against the planned school that the IHC had organised there. The residents of Oriental Bay lobbied the new National Government for support, they petitioned against the planned school and the residents lobbied the new National Government and the - I have lost my place there. 12.14 But the discrimination, the school never went ahead. The whole idea went away because the residents of Oriental Bay didn't want the idea of having a school for children with intellectual disability.

These parents kept lobbying and what happened is that they wanted these community facilities but what happened instead, is they got the Aitken Committee which was setup in 1954 that I mentioned earlier on and it was called the Consultative Committee under Dr Aitken who was himself at the Otago Medical School and he was also the father of a disabled child.

But instead of the - instead of what the parents want, which was community facilities, schools, occupation centres and all those sorts of things, what happened 12.15 instead is that the Aitken Report recommended expanding the institutions and for parents to send their children there by the age of 5. And then we had this huge expansion of institutionalisation over the next two decades, even though in 1959 another report by Dr Burns of the British Medical Association supported the parents and their call for community facilities but it was hard to turn the juggernaut around.

The 1964 National Film Unit documentary 'One in a Thousand' I mentioned earlier, it shows well dressed 12.16 children participating in a variety of interesting activities at Kimberley, although the voiceover is chillingly ableist.However, this official view contradicts that of Robert Martin who was at Kimberley around that time. His memory is of, despite some good staff, boredom, rigid routines, lack of education, denial of identity, including clothes, possessions and culture and neglect and frequent abuse.

This documentary illustrates how easy it was to spin a good news story, to reassure parents and the public and 12.17 why even official visitors didn't notice carefully hidden abuse.

Years later, the Confidential Forum for Former Inpatients of Psychiatric Hospitals heard about the 'back wards' of the institutions as places of horror and threat of adults and children living together in distressing conditions and unconsented sterilisations.

So, by the 1970s, thousands of children, young people and adults, were locked up in a network of psychopaedic and psychiatric hospitals, residential schools and youth justice homes throughout the country.

Robert Martin's biography, 'Becoming a Person', which is here, and he will be speaking next week, he has more valuable insights into institutionalisation. He 12.18 will talk himself but his experience, soon after he was born in 1957 he was labelled retarded and he was sent to Kimberley. He also had time in other institutions and also extremely abusive foster care. And also had a stint in Lake Alice.

Robert remembered some kind staff at the places he was sent to but the harsh institution life was frequently abusive. But, as he says, at least he could walk, talk and fight back, unlike some of the others.

And when Robert reached 15, the State tossed the 12.19 angry teenager out of care. He had been denied not only human rights but culture and identity.

In 2009, a 60 Minutes documentary called Shock Treatment told the sad story of a group of unlucky girls placed in residential State care who were suddenly all apparently diagnosed with epilepsy and put on an experimental cocktail of strong drugs with ECT as punishment, all without their consent or even knowledge. This was at Fareham House in the Wairarapa. Eventually the management changed and treatment ceased but the 12.20 long-term effects remained severe for many of them, as reported in the documentary.

There are also rumours of unconsented LSD trials at Ngawhatu. I would not be surprised as institutionalised children and adults have long been used for drug and medical experimentation, such as with polio in the US. Unconsented cadavers from Seacliff were provided to the Otago Medical School. It would be really good if the Commission could research these rumours of egregious breaches of medical ethics.

Meanwhile, truant or misbehaving children, mostly boys and often Maori, as young as 7 and many having what we would probably now recognise as learning or neurological disabilities could be picked up by
12.21 authorities and deposited in one of the many children homes such as Epuni and we've heard how that was often the first step through lifelong incarceration.

But many disabled children did not live long enough to become adults.

While doing my PhD research, I heard from an elderly man who told me his sister who was Down syndrome was sent away and not spoken about because if anyone found out about the family's bad genes other family members would not be able to find partners. A woman told me that those
12.22 with autistic children faced significant discrimination as popular theories blamed refrigerator mothers for their autism. They found it hard to get community acceptance or fundraise.

The deinstitutionalisation movement started in the 1970s but only in 2006 did Kimberley, the last one, close after a march on Parliament.

I urge people to visit the old Porirua Hospital villa which is now a museum. There are displays of innovative "treatments" such as ECT and insulin. The
12.22 seclusion room where young people were often held and a straightjacket are still terrifying. I hear it's under threat of closure, something else that the Royal Commission should stop as it provides vital evidence of what happened.

Now, the next part of my evidence is on Maori Pasifika but it's not an area of expertise of mine and others have covered it and will do so. Anecdotally, Maori children were disproportionately affected by disability abuse, we know that. There is also a need for more research about disabled Pasifika children in the institutions.

Changing tact a bit, getting onto what constitutes abuse that has already been mentioned. It takes many 12.24 forms and it includes physical, any behaviour threatening physical safety or bodily integrity. Sexual, anything non-consensual, illegal or inappropriate. Emotional or psychological, including threats or bullying or undermining.

Segregation from friends or partners.

Neglect, such as lack of access to medical treatment.

Control and restraint, including medical restraint or medical experimentation.

12.24 Financial, stealing or withholding money.

Cultural, exclusion from ethnic family or culture.

Demeaning, for example photographs of institutionalised residents without their consent.

Witnessing abuse and silencing, so that victims are unable or unwilling to complain.

A 2013 report by Michael Roguski provided evidence of abuse of disabled people living in the community. So, not in institutions, either in residential homes or similar. This is just one area. He examined disability 12.25 support in the Gisborne area and talked to disabled people, families and advocates. He found a number of structural issues including:

A low level of societal awareness of disability abuse;

A variety of silencing processes;

A lack of appropriate monitoring;

Poor management practices;

Inadequate reporting;

Inadequate legislation including no protection or support for the disabled person during an investigation of abuse.

The silencing he found was particularly worrying. For the disabled person, it meant pressure not to report, 12.26 not to report the abuse because for various reasons. And also, the sad reality that an abusive care worker is better than no care worker.

Disabled people feeling they were unworthy of good care or deserving of abuse.

Normalisation of poor treatment.

Difficulties in communication, for example the disabled person non-verbal or minimally verbal.

Undermining of the disabled person's testimony.

And collusion by authorities to protect the 12.27 perpetrator.

A 2012 survey of disability abuse in California showed a similar picture. The authors of that survey conclude that abuse is prevalent and pervasive and happens repeatedly to victims with all kinds of disabilities.

I would like the Royal Commission to recommend a similar New Zealand wide survey in which disabled people receiving services are free to answer anonymously with independent support without providers present.

12.28 Some recent examples, this is post again, out of the post institutions. This is hard. This is Ashley. The 1992 Mental Health (Compulsory Care and Assessment) Act was supposed to end abuse with new processes. Instead, the Act provided a new catchall diagnosis of mental disorder which was the justification for locking up a young autistic man, Ashley Peacock, for over a decade. After many long stretches of months in seclusion, mysterious injuries, including the one in the photo, and years and years of parental advocacy, he was finally released into community care in 2018. Media attention got him out but the years of incarceration have had a negative effect on him and his parents.

But he's not an isolated case. I have a friend who 12.29 has a high needs daughter and she's often told even by family members to put her daughter in an institution. Not that there are any institutions or even any respite care that are appropriate for her. And her mother wants to keep her at home. So, untrained, unskilled carers come regularly into the house and I have seen and heard from her how some bring demeaning ableist attitudes. One-to-one care can mean allegedly no spoken interaction, locking the young woman in one room for hours without food, drink or toilet breaks. Deleting her favourite 12.30 television programs. Taking her possessions. And even hitting her dog.

So, that's recent. Nothing in so-called disability support shocks me now or in the past.

Disabled people are still suffering abuse despite a whole series of reports. We have a 2008 Select Committee Report, a big long Inquiry for a couple of years. We had a 2013 Ministry of Health report, the Russell report. We have ongoing media stories, Health and Disability Commission investigations.A 2011 Ministry of Health 12.31 report, reported life expectancy for people with intellectual and learning disability was about 20 years less than for those without.The Donald Beasley Institute did a whole lot of work around 2003 to have An Ordinary Life Report about how we could improve things.

So, New Zealand, as it's obvious, has a much longer history of disability abuse than just 1950-1999.

A fully restorative approach, including an official and unconditional apology from the top, may help heal and ensure no more are harmed. This is a good example of an apology. It is the 2001 from Prime Minister Helen Clark to some of the victims of abuse at Lake Alice and what she said was, "Whatever the legal rights and wrongs of the matter, and whatever the state of medical practice at 12.32 the time, our government considers that what occurred to these young people was unacceptable by any standard, in particular the inappropriate use of electric shocks and injections".

And what I like about this one is it challenges the common arguments here that what happened was norm for the time, well it wasn't. And it happened a long time ago so it's no longer relevant. It's still relevant.

I will just skip over the next part which is the best practice for an official apology but I don't think 12.32 we've quite got to that point yet. And the restorative practices are only just beginning.

So what I'd like to talk a bit more about is how care can be transformed and what for me is - I want the one of ableism. What we have to do is address ableism. Disability academic, Fiona Campbell, she's described ableism. She says it projects a particular kind of self and body as essential to be fully human, one that is fit, active and healthy. Disability is thus cast as a diminished state of being human and should the 12.34 opportunity present itself, be ameliorated, cured or eliminated.

Under these circumstances, persons with severe impairments often trigger responses such as fear, revolution or confusion and assumptions that the disabled person's life must be terrible and not worth living.

And you can see in that description, it's really eugenics, that's where it's come from and also, yeah, the other thing we need is some urgent attention to workforce development.

I want to say a bit about structural and systemic ableism, just a couple of examples, because it is - any data about deprivation or social, economic, disabled people are the bottom. So much of our physical, 12.35 political or other information environments are not accessible to everybody.

Any support that is out there is rationed, whether it's in schools or in the community, everything is rationed. It's not there as a right.

And there's a lack of interest and representation of disability anywhere. If it's, theoretically, 24% of New Zealanders identify as having a long-term impairment, where are they? Where are they in all these processes? We don't have data, apart from that. The census 12.36 questions have changed, so we're going to get worse information. We disrespect disability everywhere and that is structural systemic ableism.

It's not for lack of trying particularly by disability advocates themselves.

We have the aspirational, the New Zealand Disability Strategy 2001 which "Underpinning the New Zealand disability strategy is a vision of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in:

12.36 'A society that highly values our lives and continually enhances our full participation'".

The UN Convention on the Rights of Persons with Disabilities, which New Zealand has ratified in 2008, you can't read these but here are some of the articles. The

Convention describes what these look like in real life. I think we would be pushed to actually meet any of them. Maybe we've had attempts at some of them. So, I think we really need that apology from the top for this whole over a century of eugenic state policies targeting disabled children, young people and adults. It was wrong, it was unjust and its legacy lingers in ongoing reports of disability, discrimination and abuse.

I want to leave the last word to Robert who is a 12.37 hero. This is a picture of him at the United Nations during the drafting of the Convention on the Rights of Persons with Disabilities where he spoke on behalf of Inclusion International where I think he was a Vice President. His quote is:

"Though it's great that New Zealand closed its last institution (Kimberley Centre), being institutionalised is not just about the buildings, the bricks and mortar. It is also about values, beliefs, actions and activities. It's about the way things are done, the decisions that 12.38 are made, who makes them and who has the control. In New Zealand, we still need to work hard to ensure that people with disabilities do not continue to be institutionalised even though they live in community settings."

So, I'll stop there, thank you.

MS JANES: I have some additional questions for Dr Stace.

I don't know if you want to take a break now, we are just about at 90 minutes or we can continue?

12.39 **CHAIR:** I think probably we should take a break so as to keep within the 90 minutes that we set out and we will return a bit early after lunch has occurred.

MS JANES: Thank you, Sir.

Hearing adjourned from 12.40 p.m. until 2.00 p.m.

MS JANES:

Q. Dr Stace, going back to first principles, is there a shared understanding of disability? Can you describe that?

A. A shared understanding, we have definitions but the language has definitely changed over time. I would say there probably isn't a shared understanding. The 14.03 language has changed a lot over time. In New Zealand, we use the definition from the disability strategy that I mentioned about that people are disabled by their environments and attitudes, so disability is political basically. The UN Convention using persons with disabilities because that's people first language, so that's another way. A shared understanding, there are a lot of different diagnoses and they change over time.

So, yes, it's quite hard at this time and place, we probably have quite different understandings than we 14.03 would have had in 1950 what disability is and there's new diagnoses happening all the time.

Q. And would a shared understanding or definition assist work in the - would a shared understanding or definition of disability assist in research and understanding of disability?

A. Definitely social model, which is the disabled person, the person disabled by their environment, that is really our official New Zealand interpretation.

The other model, what it replaced was the individual 14.04 model, where disability or impairment was located in the individual and was an individual problem.

So, the social model approach, regardless really of the language used, is what we really need so people are not individually deficient. Society is deficient but not including them.

Q. You speak quite a lot about eugenics in your evidence, is there still a residue or impact in society today?

A. Yes, definitely. I heard Boris Johnson say the other day that poverty is caused by bad genes, we hear a lot of the language of certain groups not allowed to breed on talk-back radio. That sort of language is quite common around the place, certain groups. The hints are they are genetically a problem, it is the ableist attitudes and 14.05 ableism is eugenics that I mentioned before being widespread that really provides that basis for eugenics, or whatever we call it, stills thrive in various attitudes and just basic things like disability support is rationed, so there's nothing as of right really.

So, disabled people using the social model of disability definition are still seen as not fully human basically, and that's a eugenic attitude.

Q. So, moving from that to education at paragraph 50 of your brief, you talk about abuse and neglect in education. Is 14.06 there anything that you would like to say further about that? And is there an article that you would like to produce as an exhibit?

A. I did co-write an article for the Policy Quarterly a few years ago about special education and how schools are almost penalised financially and otherwise for being inclusive.So, although we have a 1989 Education Act, section 8, which legislates for all children to be able to attend their local school from 5-19 years, full day, it is the reality for many, many children that's not the 14.07 reality. They are either persuaded to go to another school down the road or they're only allowed to attend a couple of hours a day. But the schools that are trying hard to be inclusive, it costs more to support those children properly than the funding allows, so we have these magnet schools, so-called, because they've got a nice inclusive environment and philosophy of belonging but it's hard for a lot of those schools. It's easier for schools to quietly persuade families to enrol their family in another school. That's so widespread, there's social media, Facebook pages of parents every day facing discrimination against their children.

Q. Thank you. Sir, if I may produce as an exhibit, "Education is for everyone unless you are special", as Exhibit 8. 14.08

Document entitled "Education is for everyone unless you are special" produced as Exhibit 8

You spoke about education and seclusion rooms, are they still a part of the system?

A. After families finding that schools were using them, I think it was about three years ago, and again the media exposed that, the law was changed I think early in 2017, maybe 2016, to outlaw seclusion rooms as such. Also, there were a whole lot of new guidelines brought in about what you could do about restraint. 14.09

So, theoretically we have no seclusion rooms. I suspect that time-out rooms of all sorts of styles are still being used. And I note some teachers are complaining about the restraint guidelines as being too prescriptive.

So, I think all these things, there needs to be a lot more transparency in schools about what's actually happening, ERO to look a bit deeper, because the seclusion rooms in those schools were there for years without anybody knowing or saying that they were there. 14.10 So, I think with all these things, ongoing vigilance is required.

And I think it was quite sad that in, I think I'm right about this, in the seclusion rooms, they were mainly in the special schools already, so we already have the schools where the children are almost, they're not in their local communities, they go somewhere else for a special environment and that's where the seclusion rooms mainly turned up. So, again, it's vigilance, inclusion, transparency, it's really important to not let those things creep back in.

Q. And following on from those recommendations or suggestions, are there any other changes that you think 14.10 New Zealand should be considering in terms of disabled persons' inclusion in the community and to prevent abuse?

A. In not just education?

Q. No.

A. There's just so many ways it can be approached. I mean, you know, it's again - it's resourcing, it's having a system whereby parents or - you know, parents are pretty savvy, they know when there is something different about their children quite often and they seek help. Huge waiting lists if there is any help. Everything is 14.11 rationed.

So, it's a slow, slow process to get the support, if support even exists.

So, I would suggest some system whereby children, when they have something identified even before the diagnosis because a diagnosis can take ages, parents know, they know, they need extra help with their child. It might not be something that's actually clinically diagnosed but they need help with their child. Just like the Karitane nurses when mothers got a bit stressed, 14.12 there needs to be something in the community that can help with families going through that stress. And if it's - if the child does end up with some kind of diagnosis, some wraparound system that probably goes with that child for their whole life throughout all the transitions, change the personnel but something that is unique to that child, not fashioned. You know, there's been some ideas and principles and attempts at doing these things over the years but they don't seem to last or be funded properly.

Q. I think we just need to slow down a little bit. Thank you for that.

And you've heard that Judge Carolyn Henwood spoke on Tuesday about how the Confidential Listening Assistance 14.13 Service had tried to reach out to include the disabled community and felt they had failed, not many stories had been heard. Do you have any suggestions that this Royal Commission could consider in light of trying to be inclusive?

A. Yes. Considering that a lot of the people who were experiencing abuse in the psychopaedic hospitals are no longer with us, we really have to make an effort to find those who are survivors and still with us.

Realistically, that could be a group home of 14.13 Kimberley ex-residents, maybe minimally verbal, living in a place where their provider may know nothing about their past. So, it's no good just telling provider organisations this Royal Commission exists. It has to be something that goes and finds people, takes time to build that relationship of knowledge and trust, to get the stories in an environment that suits them.

And I think there's some examples in the Extraordinary Stories book by Spectrum Care a few years ago that Brigit referred to. They did actually find some 14.14 stories, even people who they had no sort of history. There is an example in the Templeton work of Jabbot, I think his name is, who was one of the survivors from Templeton who is very able to tell his story. If somebody went to Christchurch, went to his group home, built a relationship, he would have a wealth of information to tell but it has to be person-centered, suit him, through intermediaries. It can be done but it's time consuming for each one but it really needs to be done, otherwise they just won't go and knock on the door of the building in Featherston and say "I'm here, listen".

Q. Thank you. A question, you've talked about some things that have happened post-institutionalisation but if you 14.15 were to characterise the state of the nation now, what would you say?

A. We have had lots of good intentions. We've had endless, endless reports into the health system and education system, things come and go. There is a good - I'm quite heartened by the latest programme under development, it is a prototype called Mana Whakahai in Mid Central Health and it's based on the enabling good lives principles developed by disabled people themselves a few years ago. It's governed and run by disabled people. Their trouble 14.16 is though that once you provide something really good, a lot more people come out of the woodwork and want it, so therefore you have a funding constraint, it falls over again, and it's only one area. It might be years til it's rolled out but there are good intentions and there are good people trying to do good things but it really has to be systemic and wraparound and be individual.

Q. And a final area of my questioning is, at paragraph 3 of your brief you talk about having had two contracts with the Human Rights Commission in 2013 and 2014. Can you 14.17 elaborate on what they involved and any reports that emanated from that work?

A. I think there's been concern in the Human Rights Commission for decades about this work and I think Ros Noonan is coming to speak next week and she was involved as Commissioner for one of those reports. It didn't ever get published.

Then in 2013, there was - that had all come under OPCAP, so it didn't come under UCRPD. In the business plan 2013, there was one line saying, "Ensure there is a review of historic abuse in State care to inform State care and welfare services delivered in New Zealand today" and I had a small part-time job more or less doing a stocktake of what had gone on, what the state of 14.18 everything was. There was an idea that there were a whole lot of files that MSD had that could be looked at to say systemic abuse and that was the initial thing but I think that was ruled out because we knew that was abuse. And too, the abusers won't say in the file I abused X last night, write it down, for somebody in 30 years to find.

So, I did a bit of a stocktake. I started with what I call a kaitiaki group of Robert Martin, a survivor, Robin Hunt who was an ex-Commissioner, who else was on 14.18 that? Anyhow, it was - Anne Hill on was that too. We decided what we could do in a very short time. And we had a round table in June 2014 where all sorts of people were invited, government agencies, individuals who were working in the area, psychiatrists who had been working, lawyers. We had this great round table of about 50 people and the idea was to spark something because that contract was ending, to spark something that would be ongoing.

So, there was - yeah, it wasn't popular with the 14.19 government, shall I say that. So, yeah, nothing much happened afterwards.

Q. And that report that you've talked about which was "Project: Ensure there is a review of historic abuse in State care, to inform State care and welfare services delivered in New Zealand today", could we please produce that as an exhibit which will be Exhibit 9 but I will take Dr Stace through a couple of the issues before turning you over to the Commissioners.

Report produced as Exhibit 9

In that report -

MS JANES: Would the Commissioners like a hard copy?

CHAIR: Yes, please. (Copy of report handed to Commissioners).

MS JANES:

Q. Just very briefly, just to highlight some aspects of the report. So, the first thing that you did in your report was to set out a timeline from the 1990s through to October 2013 about actions that had been taken in relation to historic abuse claims?

A. Yes.

Q. And you then have some conclusions on page 5 of your report?

A. Yes, they were from March 2014 and after that there are 14.21 just some appendices. I don't have any written material after March 2014, although the round table didn't take place until June.

Q. And can you just go through the appendices which are on page 6 and outline the purpose of collecting that data?

A. Well, it was just to, we wanted to know, well I was employed in a very part-time capacity to find out really what had happened over the decades. The then Chief Human Rights Commissioner had some questions about what had happened and so we dug up correspondence and there were 14.22 various other things like the Broad report, Howard Broad's report had been useful, various emails from people who had been - I mean, this work has been, the push for this work has gone on for decades, so there was a long history, including in places like the Human Rights

Commissioner. Am I allowed to say, really Commissioner Gibson, he did a lot of work to try and get a focus on historic abuse and he was at the Human Rights Commission at this time.

Q. And the correspondence that you collected that's annexed to this report, how would you characterise the views of the Human Rights Commission versus those of the government of the day?

A. Well, there is a letter there from the Attorney-General 14.23 who is quite disrespectful of the earlier work that had been done. I mean, yes, I don't know how the government works but I think it's quite hard to go on with a project once you've been almost shutdown by your superiors.

Q. And can you just describe what involvement, if any, you had subsequent to producing this document?

A. When I finished with this contract, I didn't really, apart from continuing to promote the work in this area, I met quite a few people as a result of that round table and worked out, you know, what they were doing and their 14.24 interests. So, I sort of had some informal conversations with people but, from then on, it was just a push for advocacy for a Committee, a Royal Commission, something to look at historic abuse. So, it was constant, the push for this, as it had been for decades and I think it was announced actually by Jacinda Ardern at Lizzie Stanley's book launch in 2015, she said if they were finally in government they would have one. The government of the day thought what was already there was sufficient, there were no new cases, there wasn't Legal Aid but the 14.25 processes were existing already, it wasn't needed to do anything. They did extend CLAS for another couple of years but they took money from the Ministry of Health to do that.

Q. And the view that you've just outlined, that everything was fine and working well, is captured in the documents in that report?

A. Yes.

MS JANES: I would like for an interim section 15 order for this report, primarily because there is some litigation that is named. I don't know the status of whether there are any suppression orders that may attach to that. So, on balance of caution, I would ask that any litigation or proceedings' names are given a non-publication order? 14.26

There are also names of staff members who are not in senior roles, as I understand it, within the organisations and so would not have had an expectation that they would be named in public, and so I would also ask for a non-publication order for staff members in non-senior roles within the organisations mentioned throughout the report.

CHAIR: Thank you. I have been looking at the document as Dr Stace has been speaking and referring to it, 14.26 and I can see the thrust of the application that you make. Can I ask if there is any objection to a section 15 order being made by the Commission? There isn't. Well, in that event - my colleague, Judge Shaw, has just intimated to me a slight reservation about the term "not senior roles". It seems to be a rather broad and vague definition. Is there any other formulation of words that would cover the position?

MS JANES: What the order seeks to do is one is not 14.27 seeking non-publication of people in Chief Executive or senior leadership roles. So, people within the Claims Unit or operational roles would not expect - normally an OIA application, their names are redacted.

COMMISSIONER SHAW: If it I could make it clear. It's just being able to, I get the point and I support the notion of non-publication to protect those people. It's just the way it's described. You've just said it, I think, people other than Chief Executive and what was the other?

MS JANES: Senior leadership roles.

CHAIR: That seems to cover it in a better way.

MS JANES: Thank you.

14.28 **CHAIR:** Having regard to the application that you make, can I enter into the record as follows:

The Inquiry has been asked by Counsel Assisting to make an interim order under section 15 of the Inquiries Act 2013 to prohibit publication of the names of legal proceedings. This is to avoid any inadvertent breach of suppression or other orders, as well as the names of any staff members to protect their privacy where the roles they are or were employed in were other than that of Chief Executive or senior leadership roles. In other 14.29 words, being people who had a reasonable expectation that they would not be publically named.

MS JANES: I am obliged, Sir, thank you.

CHAIR: Having considered the application and reviewed the matters the Inquiry ought to consider under section 15(2) of the Act though, the order that you seek is made.

MS JANES: I have no further questions.

CHAIR: I am now going to, first of all, ask counsel whether anyone wishes to exercise a right of 14.30 cross-examination of Dr Stace? I will then ask my colleagues if there are any questions. And in the middle, there is a little thing that I would like to say. First of all, counsel? There are no questions.

The thing that I wish to say, Dr Stace, is that in addition to your brief which runs to 22 pages, there is what I consider to be a prestigious bibliography of material which itself runs to five pages. I just want to record in public the usefulness that that material is and will be for the Royal Commission as it considers your evidence, along with other matters, and I want to thank you for that.

A. Thank you.

14.31 **CHAIR:** Can I then ask if any of my colleagues wishes to ask you any questions?

***

HILARY STACE
QUESTIONED BY COMMISSIONERS

COMMISSIONER GIBSON: Kia ora, Dr Stace. Thank you for the amazing presentation. My first question is about, I suppose, the current cultural backdrop, whether it facilitates abuse and neglect, and just 14.32 comparing, I suppose racism and ableism falling out of something historically eugenics and I think everybody understands and finds racism appropriately abhorrent. Ableism, I suppose, manifests itself in different ways.

To what extent should we find it abhorrent and to what extent is it pervasive today?

A. Well, discrimination is bad whatever you label it and whatever the target group is, and there's often, you know, racism and ableism will go together.

14.32 I don't think there's a big understanding of ableism. I don't think people reflect on maybe some ableist attitudes that we all have. I think, yeah, I just think it's all abhorrent because all those discriminations, isms, see other humans as not fully human, not fully deserving of rights, agency, dignity, all those sorts of things. I am not sure if that's what you meant.

COMMISSIONER GIBSON: Yes, thanks. I know some of the things that have been happening in Australia, I'm 14.33 looking for your comment on those. They've undergone quite a huge transformation of their support system, a huge increase in resources. To what extent does New Zealand require that or not to ensure people are safe from abuse and neglect in

care?
A. Do you mean - sorry?
COMMISSIONER GIBSON: That first.
A. Do you mean the NDIS?
COMMISSIONER GIBSON: Yes.
A. The NDIS, their ideas came from their government I guest about a decade ago and we thought how wonderful, they came to New Zealand and we all talked to them. The trouble with it, which this was going to be sort of an 14.34 ACC-type system with levies, I think. But the trouble is each State could make their own priorities and do it their own way. As time has gone on, the eligibility criteria has got much tougher, it's harder, it doesn't do under 8 year olds which seems ridiculous. And there's I think widespread disappointment that the promise hasn't met much - I mean, some people, okay, but actually it's still flawed and it's because it's subject to rationing and funding again, which is what the problem is.
I think personally what I would like to see in 14.34 New Zealand, is some alignment of ACC, Ministry of Health and Ministry of Social Development to have one universal equitable fair system of disability support and income support. And I think we could lead the world in doing that.
So, yeah, the NDIS, great idea. A bit of a disappointment.
COMMISSIONER GIBSON: Secondly, I am aware Australia had institutional responses to the Child Sexual Abuse Commission, much bigger resource-wise than what 14.35 we're doing here, $373 million. One of the outcomes of that was increase awareness of sexual abuse of children wasn't appreciated prior to that. A few years down the track, there's an even bigger Inquiry in terms of disability, violence abuse,

exploitation and neglect, $AUS427 million, on a scale bigger than the child sexual abuse. What lessons do you take from what's gone on in Australia in the last years about violence and abuse against disabled people?

A. The last Royal Commission, the people, some of them came to New Zealand was it last year, and told us about it. And the man I talked to said they didn't really think about disability when they started talking about sexual 14.36 abuse. But then one volume out of whatever they had, 40 volumes, was on disability and they thought there's a problem there. Well, we know that! I really like the one they're doing now. They've just started. They're live streaming some of the hearings, they've only just started doing some public hearings. I really, really like that focus on disability only because if nothing else, no reflection or disrespect to anybody, we know disability is sidelined, it's not interesting, people don't really relate to it, they feel uncomfortable, 14.36 unless there is a primary focus on disability and disability abuse, it is always at risk of being sidelined. Abuse, support for disabled kids, support for disabled adults, support for disabled aged people, it's always going to be sidelined unless there is a primary focus, unless people are really, really concerned to make it a strong focus of whatever work is underway.

COMMISSIONER GIBSON: Thank you.

COMMISSIONER ALOFIVAE: Good afternoon, Dr Stace, and thank you very much for the considered and 14.37 meticulous way in which you've presented your evidence.

My question really arises out of what really struck me was the systemic issues that constantly compound and actually leads to the deterioration really of the journey of the disabled persons through the system.

Earlier on in the week, Judge Carolyn Henwood spoke about a separate independent entity or an authority of some sort that would actually - that could actually receive the complaints specific to that, so that people could feel they could come forward to actually kind of get some grievance or to get some redress around some of those grievances. And I like what you're saying about the lack of alignment because that's what continues to compound. Any views on that? 14.38

A. Yes. When we had the Select Committee 2008, I think one of the recommendations was for a Disability Commissioner which would actually do some of those things. I remember the Cartwright Inquiry of the '80s and we thought hooray, the Health and Disability Commission is going to be the answer. Well, two years to get a - it's not working as we thought it might. Again, I think some sort of, Mm, a Disability Commissioner as well as the one on the Human Rights Commission, so one with its own office that can do investigations, that can hold government to account, 14.39 independent of the Office of Parliament, all those things, I would like. And it was a recommendation in 2008, and it said if other things don't work we'll look at it again, I think it might be time to look at it again.

COMMISSIONER ALOFIVAE: Thank you.

CHAIR: Thank you. I don't have any further questions of you myself but I now ask my colleagues, Judge Shaw and then Dr Erueti?

14.39 **COMMISSIONER SHAW:** Thank you, Ms Stace, I am very grateful for your evidence but I have no other questions for you.

COMMISSIONER ERUETI: I was going to ask the same question but I have another question.

I wanted to, thinking in the post-institutional environment about are we still seeing the features of institutionalisation in effect? I wondered whether there's been an increased burden or responsibility, is a better way of putting it, placed on whanau and family? Could you just describe for me that?

A. I think there is. I think any parent or family or whanau trying to support a child, particularly one who might have quite high needs, is really, really hard. There are 14.40 different mechanisms, you can be a fund holder, but the work really needs some concentration on the workforce, and the workforce has to be very professional, it has to have high status which it doesn't have now. It has to be a career, so you can be whatever you call it, personal assistant or carer. It needs to be something that people want to do and has career development, Code of Ethics, good union, all those sorts of things, and highly professional. I think that would be a start.

So that, when parents need support to have their 14.41 child at home or they are in a residential placement of some kind, they can have confidence that that child, who is an adult, who will be an adult when they die, which is a huge worry for parents of my generation, that they can have confidence there is that professionalism of the career of disability support worker, so you don't have to be constantly vigilant. You don't have to constantly worry about, you know, are they getting fed? Do they go and do anything in the community? Are they just getting barely babysat and that's all? You know, I think a 14.42 workforce, a huge strong focus on workforce would be a really good thing to do and I don't think anybody is actually doing it. I mean, of all the other work programs, but that I think would help because there are a lot of people living with their parents or not too far away. We don't really have - we hardly have any residential options in the old institution sense, there's a few but not many, mostly people living in group homes or one-on-one homes, single person homes.

COMMISSIONER ERUETI: One last question about the redress schemes, Dr Stace. I wonder about accessibility of people with disabilities to the redress schemes offered by MSD, Ministry of Health and Ministry of Education. You did mention 14.42 something earlier about the need for a Commissioner on Disabilities and perhaps that could provide that service?

A. Do you mean going through the current processes that you can go through, through the -

COMMISSIONER ERUETI: Yes, through the MSD historical claims.

A. I think education.

COMMISSIONER ERUETI: And health?

A. Yes. Certainly, support is required, yeah, I think 14.43 that's just a matter of people won't know that they can do. People don't know that their experience might have been abusive because it was the norm. Families, we need to, and this is the thing I want to say, I wish the Royal Commission hears from staff from families. Survivors are important but in disability a lot of them are no longer with us but there are still scarred families, still staff members horrified at what they saw and had to do. I think you have expertise here at the Commission to know how to do that in a very respectful way. It is a matter 14.44 of finding people, walking with them, building a relationship and going through that process.

COMMISSIONER ERUETI: Thank you.

CHAIR: Thank you, Dr Stace, thank you for your evidence and your willingness to answer questions.

A. Thank you.

MS JANES: Thank you, Dr Stace, you are excused.

Commissioners, we now enter a slightly challenging phase, we're going to see how we go with our next witness who is Mary O'Hagan. She's in Australia. We have done some road testing on the technology with some speed bumps, so with your indulgence, we will start the process, if it all collapses we may adjourn, with your permission, for 14.45 5 minutes and see if we can resurrect things. So, we're in your hands and the technology's hands.

CHAIR: My colleagues and I discussed what was in front of everyone at the luncheon adjournment and the way that you suggest seems to be the sensible way. Let's try and make the hook up and we will work with whatever emerges, thank you.

MS JANES: Thank you very much. If the worse happens, this witness can always be recalled at a later stage, so the evidence is not lost to the 14.45 Commission.

CHAIR: Thank you.

***

MARY ANNE O'HAGAN - AFFIRMED

EXAMINED BY MS JANES

(Via telephone)

Q. Hello, Mary, can you hear me?

A. Hello.

Q. Hello. Have you got your brief of evidence with you that you prepared for the Royal Commission? 14.46

A. Yes, I do.

Q. Can you state your full name for the record?

A. Yes, my full name is Mary Anne O'Hagan.

CHAIR: Mary, it's Anand Satyanand speaking. Can I, in order to comply with the Inquiries Act, first of all obtain an affirmation from you? (Witness affirmed).

MS JANES:

Q. Mary, can you provide some background information to the Commission about what has led you to give expert evidence today? 14.47

A. Yes. Well, I initially came into the area because I was a user of Mental Health Services for a number of years in my 20s and I was a prolonged patient of the hospital and I was given a pessimistic prognosis about my future which was totally wrong.

But after I came out of that experience, I was one of the initiators of the Psychiatric Survivor Movement in New Zealand. Then I went on to become the first Chair of the World Network of Users and Survivors of Psychiatry 14.48 and through that role I became an advisor to the WHO in the United Nations and also had a hand in the United Nations Convention on the Rights of Persons with Disabilities. That was while I was a Commissioner, New Zealand Mental Health Commissioner, I held that role for 6.5 years. Since then, I've run a social enterprise and I've now just taken on a role as programme lead for the Like Minds, Like Mine programme to uphold the mana and human rights of people with mental distress.

I want to say, in some of the publicity it says I am an abuse survivor. I've never called myself an abuse survivor. But I have witnessed abuse, I have heard stories of abuse and I have, you know, researched about 14.49 abuse and so on, so I'm very familiar with the whole territory.

Q. Thank you. And in your introduction, you've talked about your view of abuse and whether it's widespread in Mental Health Services and whether there are some good aspects. Do you want to just briefly comment on that?

A. Yes. So, yes, I believe that abuse is widespread and continues to be widespread. I think it changes its spots over time. But, on the other hand, I think we - I want to acknowledge that, you know, people who have been 14.50 abused, they have had experience of compassion and kindness and some people say they have benefitted from Mental Health Services. But this doesn't take away the gravity of the abuse that has gone on.

Q. And when you talk about mental health or mental illness, what perspective do you use that term from?

A. Well, the concept of mental illness is used in - it comes from western medicine and really it's only been around for 200 years and it didn't exist in traditional Maori society, and I think it's really important to acknowledge 14.51 that. And it was really, you know, the idea of mental illness as a whole sort of psychiatric apparatus was imported as part of the colonial infrastructure of New Zealand. And I just want to add that, this psychiatric apparatus or structure, from the 1840s on was an institutional environment. In New Zealand psychiatric hospital numbers peaked in 1944, so they stopped planning for new psychiatric hospitals in 1963 and they capped their numbers in 1973. At the same time, there was an expansion of community based treatment in the inpatient units attached to general hospitals and by 1999 all the large psychiatric hospitals had closed or been severely downsized.

Q. And if you were summarising - sorry, carry on.

14.52 A. No, you keep going.

Q. If you were summarising that move from institutionalisation to deinstitutionalisation , and subsequent events I've talked about inquiries and law changes, can you just expand on that?

A. Yeah. So, as the hospitals began to close in the early '90s, the money did not always follow the new services, in fact the health services took the money and a crisis led to the Mason Review in 1995-1996. And as a result of this review, and the establishment of the Mental Health 14.53 Commission, the government increased funding for community mental health services over the next decade.

And New Zealand, it is a little bit ahead of many other countries, in that about 25% of our services are community based support services and 75% of the funding goes into the traditional, you know, psychiatry hospitals.

And in anticipation, there was also a law change because in anticipation of the closure of a lot of state hospitals, New Zealand passed the current Mental Health 14.54 (Compulsory Assessment and Treatment) Act in 1992 . Now, this introduced the compulsory community treatment and I believe this has been a kind of new area for abuse but it also entitled the criteria and developed legal procedures for appeal to be released from the Act which has proven to be equivalent.

Q. In your introduction, you mentioned that you had been part -

A. Are you there?

Q. I am. I'm having my own technology problems. In your introduction, you mentioned that you were one of the people who started the survivor movement in New Zealand. Can you talk about the survivor movement, how it came to New Zealand and what it meant?

14.55 A. Right. So, the survivor movement began with a whole lot of other liberation movements in North America and parts of Europe in the 1970s. And many people who participated in the movement had experience of psychiatric abuse - actions that had harmed their bodies, minds, spirit, self-worth and their standing in the world.

Many of these actions were done lawfully and within the boundaries of acceptable practice, so I think this is really, this is a key point. And they ranged from seclusion, forced medication, locked hospitals, physical 14.55 force, emotional neglect, degrading conditions, the pathologising of human distress, prognoses of doom and the crushing invalidation of lived experience insights. And all these forms of abuse continue today.

So, the movement didn't reach New Zealand until the mid 1980s and over a short time survivors setup local networks that provided support and advocacy, and the first national network was established in 1990. And since the mid 1980s the movement has done quite a number of things which I outlined in my statement but I just 14.56 want to highlight a couple of them today.

They put pressure on the government to establish the Confidential Forum for inpatients in psychiatric hospitals.

CHAIR: Can I intervene for a moment, Mary, to ask you to speak a little more slowly? The evidence that you are giving is being stenotyped at very high speed but not sufficiently to cope with your speed at the moment.

A. Okay.

CHAIR: Thank you.

A. Good, I will slow down. One of the activities of the survival movement was to put pressure on the government to establish the Confidential Forum for former inpatients of psychiatric hospitals and subsequently to make a public apology, which has not yet happened. 14.57

There was the 'End Seclusion Now' campaign in 2014 and participation in system-led projects to reduce and eliminate seclusion. We have had a reduction in seclusion but no elimination.

Research and raising awareness of the harm caused by psychotropic drugs.

And also the development of the Wellbeing Manifesto in 2018 which called for an end to health-led services.

MS JANES:

Q. Mary, you know that the Royal Commission's Terms of Reference has a definition of abuse but in your paper you've used a different definition; can you outline why that is and what your definition that you use in the paper is?

A. So, it's not really - it's just a definition. It includes all those elements but it also includes the abuse by, you know, the Royal Commission definition conceptualises abuse by the type of impact it has on the person but it doesn't really capture the many different contexts or forms of abuse that are part of the institutional services. 14.58

And so, I sort of stretched it out a bit and talked about environmental, procedural, legislative treatment, psychological, critical, sexual, cultural property and narrative forms of abuse.

Q. Before we turn to looking at each - carry on.

A. You carry on.

Q. Before turning to look at each of those forms of abuse, is there anything that you would like to say about the underlying dynamics of abuse?

A. Yes. So, there's a question about why has abuse in the Mental Health Services been allowed to happen so often 15.00 and for so long? And why does the community accept abuse for several and not for others?

I think there's a profoundingly simple answer to this question, and that is that extreme states of mental distress have zero status as a human experience. And this taints most human responses to it.

The response might be fear, hostility, a desire to control, incomprehension, paternalism or pity. And they might be well intentions or not well intentions. But they all trace back to the ancient thing of stigma. 15.00 Stigma strips people of their human status and sets the stage for discrimination, human rights abuses and social exclusion.

Throughout history and across cultures, the way and means of expressing stigma has varied. Over the last 200 years in the west the official expression has been four things; institutionalisation, compulsory intervention, the dominance of medicine, and for Maori the process of colonisation.

I want to go into a little bit more detail about the 15.01 process of colonisation. As I said before, the Mental Health System has been part of a colonising infrastructure which has imposed additional harm on Maori. Prior to the 1960, few Maori were admitted to Mental Health Services. However, between 1959 and 1987 the number increased significantly. Throughout the 1990s and into the 2000s, Maori continued to be disproportionately represented in statistics for mental health admissions and involuntary treatment and seclusion.

Maori are 15% of the population but make up over 25% of people who use mental health services. Maori experienced increased rates of admission and involuntary treatment after the 1960s. While these increases are in
15.03 part reflected by Maori urbanisation, evidence indicates that colonisation and systemic racism were ultimately responsible.

And of course there are other groups that have been somewhat over represented or have been more prone to abuse than some others.

Women and girls, their admissions appear to have reflected prevailing norms about women's gender roles and some were sent following experience inside the social welfare system and many young women were admitted to
15.03 psychiatric hospitals with postpartum depression and often stayed for many years.

There are dynamics in play for young children who were sent to psychiatric hospitals sometimes in response to families. Men and boys who were often sent in response to anti-social behaviours. And disabled people and people with physical health conditions were subjected to forced treatment. And people with gender identity and sexual orientation that did not meet the norm, that also was led to diagnosis and forced treatment.

15.04 Q. Thank you. Moving on to the various abuse categories you outlined earlier, what do you define as environmental abuse?

A. That includes institutionalisation, locked wards, solitary confinement and separation from family and whanau. And the Confidential Forum reported that the physical environments of psychiatric hospitals were bleak and depressing. For instance, a former staff member from Tokanui Hospital described how people were housed in large, mixed age and gender dormitories. Hospital buildings were sterile, barren, bleak, lifeless, institutional and often neglected by health authorities. Families too spoke of forbidding buildings, dirty, noisy, smelly environments, smoke filled rooms, lack of privacy 15.05 and of patients not wearing their own clothes.

"I worked as a Co-ordinator of Psychiatric Services and Advocacy Services in Carrington Hospital in 1988 and I observed most of the wards at Carrington were shaped like a big T with a long corridor running down towards the dormitory. First there was the nurses station, then came the little kitchen which was locked most of the time so the patients couldn't make a mess or burn themselves. The drug room was opposite. Then came the dining room which always smelt of overcooked cauliflower. Next up 15.06 the corridor was the patients' living room which usually had a ripped pool-table in the middle and people sitting on chairs, chain smoking and looking blankly at the wall. Next were the bathrooms with no shower curtain or door lock. They faced the laundry, the property rooms and the seclusion rooms.At the end of the corridor came the dormitory".

Alasdair Russell talked to Julie Leibrich about the prison like conditions in Oakley Hospital in the early 1970s where he was a patient.

15.07 "In the five years I was in Male Three I went through 22,000 locked doors. Every door I went through was locked. I mean your cell door was locked. The door up to the stairs to the cell rooms was locked, the door at the bottom of the stairs was locked. The tearoom door was locked. The dayroom door was locked. The kitchen door was locked. The dining room door was locked. Every door you went through was unlocked before you and locked after you."

Q. Mary, just before we carry on, we're going to get into the area of your evidence where there are a number of quotes. Can you confirm, please, that any quotes in your evidence are either from public sources or that you have consent to use them?

15.08 A. Yes, I have got consent to use them and they are all from public sources but I sought consent from the people who are still alive but they are all published.

Q. Thank you. You then go on to talk about solitary confinement.Having gone from all of those locked rooms, there was an additional layer, can you talk a bit about that and why they were used?

A. Yes. Solitary confinement, otherwise known as seclusion, which is a term I tend not to use. It is the placing of a person in a bare room without the ability to make an 15.09 exit. It continues to be routine practice in institutional settings. And there are still seclusion rooms being built in modern acute patient units today.

Survivors at the Confidential Forum and Confidential Listening and Assistance Service talked about solitary confinement as extremely frightening and retraumatising. Threats of solitary confinement were also routinely used to instill fear and control people.

Denise Caltaux in a publication talked about her experiences of physical restraint and solitary 15.10 confinement in the early 1990s, and I quote:

"They committed me to Tokanui and that was the worst, worst, worst thing. For a start, I was taken straight into an isolation unit, and I was strapped down until I was in a side room."

I think a side room here is a solitary confinement.

"Of course we were going through the rigmarole of having to strip naked, and if you don't they'll do it for you sort of thing - and not being allowed to be left with your knickers or your socks or anything like that, and being left in this place. Nobody came to speak to me for ages. There was some interesting graffiti on the wall like 'motel hell' or something like that, and I thought afterwards, that's not wrong".

15.11 Egan Bidois talked recently on a podcast about the over-medication and abuses that led him to being put into solitary confinement in 1990 and I quote:

"A couple of orderlies would pick me up from my room and shuffle-drag me to the dayroom. They would sit me in a chair and pretty much leave me there to drool all over myself. I couldn't move. I couldn't speak. If you're unable to ask someone to help you go to the toilet, it eventually happens and someone notices the smell. If you're lucky they take you to the showers, get you 15.12 cleaned off and take you to the dayroom again. A couple of times you would be dragged out to the front yard. You would be stripped down, hosed and given a bit of a kicking for being a filthy mongrel and tossed into a seclusion room as a punishment."

Q. There's also the issue you talk about of separation from family and whanau?

A. Yes. According to the Confidential Forum, survivors were often forcibly parted from whanau, parents, partners or siblings. Contact with families and whanau was 15.12 infrequent. Some whanau were told by staff that it would be best to stay away. Separation from whanau left survivors more vulnerable to abuse.

Anne Helm was incarcerated in several psychiatric hospitals in the 1970s and she said:

"Remember, these were places where outsiders in the form of visitors were rarely seen."

Q. The Royal Commission heard the other day from Arthur Taylor that he had been put into a psychiatric unit without a diagnosis. In your evidence, you talk about procedural abuse, what do you mean and what examples would you like to share with the Commission?

A. I can't comment on Arthur Taylor's story but by procedural abuse, we mean processes such as admission, assessment and the administration of treatment. 15.13

Many survivors talked to the Confidential Forum and the Confidential Listening Assistance Service about forceful, cruel and brutal admission processes. They often had no idea why they had been admitted to hospital. They were subjected to decisions made by others, not informed of their diagnosis and received treatment without informed consent. Survivors reported rarely seeing a doctor or seeing multiple different doctors over time. They also recalled being routinely observed and 15.14 written about, in clinical records, based on nurses and psychiatrists' judgments rather than their own experiences. Survivors used terms such as terrified, alone, abandoned and confused to describe their experience of psychiatric hospitalisation. Many survivors spoke of a general lack of communication, interaction and interest from staff. They also described widespread lack of care and compassion, ranging from indifference to overtly violent behaviour.

The Confidential Forum reported that people's 15.15 experiences of trauma or adversity were usually disregarded in the assessment and treatment process. Survivors often said they were not listened to and their experiences were disbelieved. Sometimes staff did not know important details about survivors, for instance that they had children. Institutional procedures were especially harmful for Maori who have talked about having indigenous knowledge, values and experiences pathologised and medicated, resulting in a loss of Maori identity.

Q. Just to note for the Commissioners, the paper has a large number of quotes. We won't be going through each of the quotes but they are there and we would absolutely invite anyone to read those.

Mary, on that basis, can we turn to legislative
15.16 abuse, please.

A. Yes. So, legislative abuse includes the use of legal coercion. I say particularly beyond the scope of the law but I believe that the law itself is abusive.

And so, survivors talked extensively about being forcibly placed in psychiatric hospitals. While many were subject to mental health legislation, others were subjected to coercive practices despite their voluntary status. Forced detention and treatment were often experienced as torture, traumatising, inhuman, degrading
15.17 and cruel. Survivors on admission were often stripped, bathed without privacy and had their clothes taken away and forced into solitary confinement.

Maori with lived experience, who were more likely to be sectioned than non-Maori, have also talked about the violations they experienced under the Mental Health Act. And I quote:

"I have been degraded by people in positions of authority who are funded by the tax paying government to serve and protect us - not abuse and mistreat those in
15.18 the community who are treated worse than dogs under the mask of New Zealand's Mental Health Act ... I felt ashamed and fearful. My mental state of mind further deteriorated due to their response. I felt traumatised and felt that my basic human rights as a woman had been

blatantly violated."

Q. You've also spoken about treatment abuse and you particularly talk about the effects of psychotropic drugs and also ECT, can you summarise your views on those?

A. So, in the period 1950-1999, psychotropic drugs came in in the 1950s and electroconvulsive therapy was being used before 1950. There were other treatments but these were the mainstay. Some very drastic, terrible treatments in the earlier part of the period were insulin shock therapy 15.19 and lobotomies.I will be talking a little more about ^ went into the 70s.

The use of psychotropic drugs caused a condition called tardive dyskinesia, permanent involuntary movements that included grimacing, sticking out the tongue, or smacking of the lips. And of course the hospitals prescribed Paraldehyde until the 1970s and there's a graphic description of how horrible this was for the people who were administered it in the Gallen report.

15.20 Survivors who spoke at the Confidential Forum and the Listening Assistance Service described the use of these drugs in high doses and the use of polypharmacy. They rarely gave informed consent. Medications were sometimes given to sedate and control, rather than to produce therapeutic benefit. Some survivors reported the administration of Paraldehyde, many survivors as well as their family members reported that their mental health deteriorated significantly as a result of treatment.

And I want to add that the second generation 15.21 antipsychotics that have been around since 2000, also have a very poor effect on people's physical health and they are known to be life shortening.

Q. And you said you'd come back to deep sleep therapy. At paragraph 50 there's a quote that you wanted to share?

A. Yeah, so Anne Helm wrote about her experience of deep sleep therapy at Cherry Farm Hospital in the 1970s and I quote:

"I was placed on a six-week deep-sleep programme where the main concern was the constant taking of blood pressure because of the huge amounts of medication coursing through my body could potentially paralyse and stop fundamental physical functioning. At the end of this 'treatment', my legs atrophied from complete bed 15.22 rest. I could not support my bloated weight, I was barely able to lift my head from the pillow".

Q. And you spoke earlier about Lake Alice and Gallen J's report, what else would you say about electroconvulsive therapy?

A. So, psychiatric hospitals routinely administered unmodified ECT until the mid-1950s when modified ECT, using anaesthetics and muscle relaxants, became recommended practice.However, Sir Rodney Gallen's report on Lake Alice Psychiatric Hospital gives clear 15.23 evidence that the use of unmodified ECT went through to the 1970s at least. It also documents the use of ECT as a punishment, administered on children and young people's legs and genitals. He described these ECT practices as a regime of terror and they were reported to the United Nations Committee on the Convention Against Torture.

Q. And then at paragraph 54, there was a quote about the length of ECT treatments administered.

A. Yes. So, Egan Bidois talked about his experience of ECT and torture and I quote:

15.24 "I received", this was in 1990, "I received 27 courses of ECT, 27 times being carried off, strapped down to a table and having the national grid pumped through my skull. I distinctly remember being strapped down and had one of the orderlies lean over me and abuse me and tell me unless I play the game they will keep doing this. They basically fried me until my head was smashing against the table. That wasn't treatment for me. It was torture."

Q. And another form of abuse you speak of is psychological abuse, how do you define that and what would you like to say?

A. Psychological abuse includes bullying, threats, cruelty and put-downs.

15.25 The Confidential Forum and the Listening Assistance Service reported that survivors talked about many kinds of psychological abuses by staff. This included the demeaning jokes, emotional abuse and cruelty.

Q. And then we go on to physical abuse?

A. Yeah, yeah, okay. Physical abuse includes hitting and physically forcing people.

According to the Confidential Forum, survivors recalled many kinds of physical abuses by staff, such as being punched, thrown on the floor, pushed up against the 15.25 wall or being given unmodified ECT. The institutional milieu was punctuated with screaming and yelling, physical violence and manhandling people into ECT or solitary confinement.

In the 1980s, I interviewed Gerald about his time in Oakley Hospital and I quote:

"Oh sure, I've been beaten up by staff. At the secure hospital there was a rule you had to strip naked in the corridor, leave your clothes out, go into your room totally naked, get your pyjamas on and go to bed. I 15.26 found that really hard to do because of my physical disability so I took my clothes off in my room. I had three buttons undone on my shirt and they literally ripped my clothes right off me, pants and all, testicles squashed. It was standard practice."

Q. From paragraph 62, you talk about sexual abuse and where that abuse came from. Can you describe further what you would want to say?

A. Yes. Sexual abuse includes non-consensual sexual contact or harassment.

These Confidential Forum and Listening Assistance Service both reported that survivors talked about sexual abuse by staff, including rape. Survivors also reported sexual physical abuse by other residents within the 15.27 context of high levels of distress, and unsafe, mixed age and mixed gender facilities.

Debbie Peterson wrote by her experiences. Are you there?

Q. Carry on. Can you hear me?

A. "During one hospital admission when I was 26 ... I was sexually abused by a male nurse. I reported it and eventually the Police were called. I was taken to the Police Station, gave my statement and returned to the ward. Naively, I thought I'd be okay there. Instead I 15.28 was put in the same seclusion room the incident happened in, told I wasn't to talk to anyone and was 'looked after' by some very angry nurses. It was apparent they didn't believe me ... I was terrified."

Q. You've spoken about Maori experience and you talk about cultural abuse and a Waitangi Tribunal proceeding -

CHAIR: At this point, Ms Janes, we are approaching 3.30 which might be a good time to take the afternoon adjournment. Would this be a suitable time?

MS JANES: It certainly would, Sir.

Hearing adjourned from 3.30 p.m. until 3.45 p.m.

MR MOUNT: Mr Chair, perhaps during this brief moment, I can advise those watching through you that the witness Rosslyn Noonan who was scheduled for Monday will no longer be on Monday next week because of some logistical reasons outside everybody's control and we will have an update on Ms Noonan's evidence on Monday, I expect, if not sooner and we will let people know by means of the website.

CHAIR: Thanks very much. We will be keen to hear as soon as may be convenient.

MR MOUNT: Thank you, Mr Chair.

15.49 **MS JANES:** Just while we're recovering the witness, I want to check with the Commissioner about time constraints, it may affect what I do with the witness.

CHAIR: My colleague, Judge Shaw, I think there is an expectation that we will finish at 5.00.

MS JANES: Thank you, Sir.

Q. Welcome back, Mary, I hope you managed to have a cup of tea. We were at paragraph 66 of your evidence, talking about cultural abuse, and you were going to explain what you meant by that and the Waitangi Tribunal proceedings? 15.49

A. Right. Cultural abuse includes colonisation, racism and denial of access to cultural world views and supports.

The WAI 2575 report on Maori health inequities states that colonisation in the form of assimilation of policies and practices and institutional racism have marginalised Maori knowledge, ways of knowing and values. Maori experiences of psychiatric abuse are compounded by the impact of colonisation and alienation from whenua, whakapapa and whanau, which are the key ingredients for wellbeing. 15.50 The Confidential Forum reported that Maori survivors experienced a violation of their cultural values, beliefs and experiences within the Mental Health System; their experiences were routinely pathologised and this caused significant harm.

Q. And it wasn't just the Maori who were impacted by this, is it?

A. No. I want to quote a young Pacifica woman who talked about racism in hospital in the 1990s and I quote:

"When I was in hospital I found all the Pakeha nurses used to treat their race better. We were looked at like underdogs, like they always got their dinner served first. They got special privileges. Us Islanders didn't. We were just chucked in there, had breakfast, lunch and tea and that's about all." 15.51

Q. And another aspect of abuse is property abuse and you talk about something called an interest scandal, can you outline what the abuse is and what happened with that scandal?

A. Yes. So, by property abuse, I mean withholding or stealing money or goods. So, the hospital admission process usually involved the - what paragraph? Here we go.

So, I'll just start by saying that the process 15.52 involved the removal of clothing and personal property. People didn't have free access to their money. Many smoked cigarettes and staff controlled access to them as part of a reward and punishment regime. In the 1970s and 80s, in what became known as the interest scandal, the hospitals kept the interest money from individuals' welfare benefit payments that were paid into hospital trust accounts. The practice was stopped in 1987 when the Department of Health was advised that withholding interest money from welfare benefit claimants was 15.53 probably illegal.

Q. And when you talk about narrative abuse, what does that mean to you and had you had personal experience of that?

A. Yes. So, narrative abuse includes the prognosis of doom and a focus, pretty much a whole focus on people's deficits.

Before I go on to my own experience, I want to talk about survivors and the Confidential Forum who recalled how staff often viewed them with a deficit lens and gave them a bleak narrative about their future.

And these narratives led to hopelessness and contributed to negative consequences across the spheres of survivors' lives.

My own personal experience, at the age of 21 I was 15.54 given a prognosis of doom by my psychiatrist and I quote:

"Dr Pilling is standing at his desk sorting through a large untidy stack of files. He sits down, opens my file and his face turns serious.I think it's timely for me to tell you about the impact your illness is likely to have on you. You have a chronic condition which will recur for the rest of your life".

And I say:

"Do I really?"

And he said:

15.55 "The medication can help but you need to reduce stress and lower your horizons. A big career or full-time work probably aren't options, I'm afraid. And you need to think very carefully about having children, in case they inherit your illness".

"Does anyone recover?" I asked.

"Not usually", he says, "I'll see you next week". He looks up and smiles then starts writing his notes as I close the door behind me.

My eyes fill with tears."

15.55 Q. I'm delighted you proved him wrong. In terms of then moving on to impact of the various abuses that you've spoken about, can you just describe those starting from paragraph 80 and the quotes that you want to share in the following paragraphs?

A. Right. So, survivors at the Confidential Forum and listening and Assistance Service reported that they continued to experience lifelong psychological stress, they recalled living with low self-esteem, frightening memory, frequent nightmares, hypervigilance, shame, grief, sadness and loss, anger and rage because of abuse within the services. Many described their overwhelming struggle to make sense of multiple abuses.

Survivors suffered losses in many areas of life. 15.56 They lost connection to whakapapa, whanau and whenua. For many survivors, the damage to identity, the loss of human status and the violation of human rights permanently damaged their roles and status as citizens.

Q. And you interviewed a number of survivors in the 1980s and reached some collusions, what were they?

A. I wrote:

"Many had never talked about their experience in one sitting before, to someone who took them at their word. Some cried as they talked about all the pain they had 15.57 endured. So much of it was not due to the experience of madness itself but about their experiences in hospital, their lost opportunities, about once promising young lives that had fallen into unemployment, poverty and loneliness. They talked again and again of hospital staff who took their dignity away or never talked to them, the overuse of drugs, of seclusion, the trauma of compulsory treatment, the lack of psychotherapy and support, and the lack of information about drugs and side effects. So much of their suffering could have been 15.58 avoided if the Mental Health System and the rest of society had genuinely responded to them."

Q. And you also quote from Anne Helm about the trauma that went unattended which is a feature particularly of those with disabilities?

A. Anne wrote:

"Denial of experience also deeply buried the evidence traumatic memories of some institutional experiences and invalidated healthy reactions of natural grief and anger. Earlier losses - the death of my mother, the loss of a singing career, the removal of my first-born daughter to others' care - lay unattended. No-one had deemed these events important enough to support me to talk about them."

15.59 Q. And can you briefly summarise the impact of abuse on poor life and health outcomes?

A. Yes. So, many survivors talked about trauma from abuse leading to addictions, self-harm, suicidality and physical health conditions. Some died prematurely, while others died by suicide. Many survivors lived in poverty and had lost opportunities for education, secure employment and stable housing. Many relied on Income Support or ACC and had to deal with the Work and Income or ACC staff whose processes often mirrored the abuse in 16.00 Mental Health System - of being monitored, misjudged and incorrectly written about after sharing intimate details of their lives. And that was to the Confidential Forum.

Q. We've spoken about broken whanau community connections and the impact on Maori but is there anything further that you would like to say about those before we move on to another topic?

A. Yes. The stigma of being admitted to a psychiatric hospital, coupled with routine medical advice at the time often meant long-term separation from families and 16.01 whanau. Most whanau visited infrequently or stayed away. For some survivors, disconnection from families and whanau resulted in a lifelong sense of abandonment and feeling of not belonging. Sometimes ashamed families and whanau avoided Contact with survivors or constructed narratives about survivors that were themselves abusive. Many survivors described their struggle in trusting others, developing and maintaining relationships, and sustaining a sense of connection. And this was again through the Confidential Forum.

Q. And you've got a quote at paragraph 92 where Kaimahi Maori told the addiction Inquiry something that may resonate with many. Can you share that with the Commission, please?

16.02 A. Yes. This was from - so, this Kaimahi Maori said:

"Whanau are fearful of our ministries, fearful of mental health, fearful of Oranga Tamariki taking our children. Fearful of Police who take away their Dads. Whanau are on the back foot before anything that happened, just because they are Maori."

And I have another quote here from the whanau of a person with lived experience who talked about the corrosive impact of colonisation and alien systems on Maori:

16.03 "These alien systems denied (and still do) the harm that had been wrought in the collective body, mind and heart of Maoridom, while at the same time demonising Maori people and culture for the outcome of these harms. Alongside widespread economic, physical and spiritual deprivations from the erasure of conditions necessary for life, and also our spiritual and wellbeing institutions and practitioners, systemic denigration of Maori began to carve into my grandfather and grandmother's hearts and minds, the notion of their superiority and fated 16.04 impairment. They began to despise themselves in all things Maori as they internalised and acted out colonial induced systemic self-hate. The echoes of this hate infestation continue to resound throughout our personal and collective hearts and minds."

Q. Mary, we then turn to Mental Health Services after 1999 and you've quoted from the Mental Health and Addiction Inquiry. What would you like to say about what could or should happen into the future?

A. So, there have been some good developments in Mental Health Services since 1999, particularly the growing of community support services but we still have a system where clinical approach is dominant. There is still continuing institutionalisation and we have rising rates of compulsory treatment. 16.05

I want to focus a bit on compulsory treatment. Many submitters to the Government Inquiry into mental health and addiction spoke of their experience of compulsory detention often for long periods of time, being forcibly treated and being denied the right of self-determination and participation without treatment.

They also described the trauma associated with compulsion, the adverse impact of forced medication and the harm caused by solitary confinement.

16.06 And I quote from the Inquiry report:

"Throughout this Inquiry, many people shared their experiences of being held and compulsorily treated under mental health legislation and prolonged use of the Mental Health Act. Many submitters across the country emphasised the need for New Zealand legislation - and the practices enabled under it - to comply with international and domestic human rights instruments".

Q. To try and shine some light into the doom, have there been any changes that have any impact to stop abuse since 1999? 16.06

A. There have been changes and there have been some developments but I think they really have yet to reach fruition, and that's both at the international and national level. You know, 20 years on, abuse in Mental

Health Services continues, despite the closure of the long stay institutions, rhetoric about recovery and the development of human rights protection.

Q. And there have been the United Nations Convention on the Rights of Persons With Disabilities and the rights of Indigenous Peoples; is there anything you'd like to say about those developments?

A. Yes. The UN Convention on the Rights of Persons with Disabilities states that persons with disabilities, and 16.07 that includes people with mental distress, are equal before the law and should not be deprived of their liberty because of their disability. As a result, much of the commentary coming from the United Nations is critical of mental health legislation. For instance, the Special Rapporteur for the Disabilities Convention has made it clear that mental health legislation that permits discrimination, forced treatment, substituted decision-making, and the "best interest" standard must be repealed.

16.08 Member states, including New Zealand, appear to be in denial about the full implications of the Convention, and they respond to the Convention by seeking reformed legislation, rather than repeal.

Q. And do we know, one of the recommendations from the Mental Health Addiction Inquiry was replace and repeal the Mental Health (Compulsory Assessment and Treatment) Act, do you have any sense about whether that will resolve the concerns that you've expressed in your evidence completely?

16.09 A. So, I don't have a lot of confidence that replacing the Act, as is the plan, is going to resolve the issues in a thorough way and there is good evidence and anecdotal evidence from Victoria and Australia, that changing the Act does not make any difference to what actually happens. And that's because the people who administer the Act, they may be chastised for not using it enough, they're never chastised for using it too much.

Q. In terms of the rights of Indigenous Peoples, how would you characterise the involvement of the Treaty of Waitangi in Mental Health Service design and delivery?

A. Well, the UN Declaration on the Rights of Indigenous Peoples specifically recognises the rights to enforcement of Treaty and that includes the Treaty of Waitangi. I'm 16.10 going to be talking a bit more later on about the implications of this for Maori service development going forward.

Q. And very briefly, there have been inquiries and compensations and apologies. So, from paragraph 106 you talk about the Lake Alice settlement and the Crown Health Financing Agency. Can you just summarise your thoughts on those points?

A. Yes. So, the Confidential Forum for former in-patients of psychiatric hospitals was established in 2004 but its 16.11 Terms of Reference was kept narrow, I believe to avoid Crown liability. It was set up to provide a confidential environment for people to talk about their experiences, to support them to find counselling and other assistance services, and to report on the numbers of participants, the services they were referred to and the usefulness of the process to participants. While the report stretched the boundaries of the Terms of Reference by giving a thematic summary of people's experiences, there was no substantive response from the government towards a formal 16.12 apology for compensation for survivors and this is something that is very keenly felt by some survivors. And I want to acknowledge Anne Helm who was on the Panel of the Confidential Forum, who is herself a survivor, and the valiant effort she took after the forum reported to organise an apology but to no avail.

So, we really believe that the Royal Commission is our next opportunity for this to happen.

The Residual Health Management Unit, which was later named the Crown Health Financing Agency was formed in 93 to manage the residual public health system assets and liabilities that could not be transferred to the new Crown Health Enterprises. Among them were claims associated with historical abuse and neglect in 16.13 psychiatric hospitals. By 2011 the Crown health funding agency had received 336 psychiatric patient claims. CHFA developed a settlement strategy in consultation with the plaintiffs' lawyers and in 2012 made offers to the plaintiffs that included a modest wellness payment, payment of legal costs related to the complaint and a letter of apology. All but seven of the plaintiffs accepted.

Q. Turning then to complaints and resolution mechanisms. You've talked about three mechanisms but can I just point 16.14 you to paragraph 110 where you talk about people under the Mental Health Act and the Review Tribunal. You had specific thoughts about that?

A. People subject to the Mental Health Act can since 1992 seek review through the Family Court or the Mental Health Review Tribunal. There is strong evidence that these processes put in place to protect human rights and prevent Mental Health System abuse do not work well. For instance, in 2017, the mental health Review Tribunal heard 62 applications for release from the Act. Of those 16.15 applications, only six people were released.

Q. And in terms of the programme to achieve zero seclusion by 2020, what are your thoughts on that, and in particular in relation to Maori and the use of seclusion and restraint?

A. There have been some successes but the mental Health Commissioner has recently highlighted a high rate of seclusion for Maori and noted that although the overall seclusion rate has decreased 30% since 2007, the seclusion rate for Maori has only decreased by 9%. In 2016, 102 young people aged 19 or less were secluded. There remained wide variation in the use of seclusion and restraint across District Health Boards. Seclusion rooms continue to be built in new mental health facilities in 16.16 2019.

Q. Mary, under the Terms of Reference, the Royal Commission has a forward looking mandate and you've spoken about the e Kore Ano campaign that led to the Royal Commission. I would like to invite you to read from paragraph 115 because you have set out what your thoughts are about areas the Royal Commission could think of so it doesn't happen again.

A. Yes. Abuse in Mental Health Services will continue until most if not all institutions are replaced by community 16.17 based responses, there is an end to special mental health legislation for people diagnosed with "mental illness" and psychiatry is replaced at the hub of the system by communities who control the narrative and resources, including Maori, Pasifika and people with lived experience of distress. At the same time, we need to continue to work to reduce stigma and discrimination in the wider community.

I'm now going to talk about redress and rehabilitation. The process of redress and 16.18 rehabilitation for people abused in Mental Health Services has not got off to a good start in Aotearoa New Zealand. The report of the Confidential Forum did not lead to redress and rehabilitation, there has been little public acknowledgment and the settlement process with affected individuals has not been completed.

And these statements were echoed by Judge Henwood in her report of the Confidential Listening and Assistance Service.

The Royal Commission provides an opportunity to establish a more deliberate and comprehensive redress and rehabilitation process. And I think the survivor perception of the process so far, is that it has been piecemeal and half hearted, and I think the Royal 16.19 Commission needs to show that this country has a commitment to redress and rehabilitation. And of course, survivors need to lead decision-making about this process.

I want to talk a little bit about a good process and for this I thank Dr Heather Barnett. The aim must be to fully recognise and enable healing across all spheres of survivors' lives.

Claims need to be assessed against national and international human rights frameworks.

16.19 The State must ensure that the process and people leading it are independent from government and organisations that have perpetrated abuse.

The process needs to be administered by people who have a sophisticated understanding of human rights, abuse and trauma.

The system needs to be straightforward and prompt.

I now want to go on to the issue of apology. Survivors of psychiatric abuse have called for two public apologies. One from the State and one from the Royal 16.20 Australian and New Zealand College of Psychiatrists. Survivors need a "complete apology", as Marist elucidated. This includes an acknowledgment of a wrong committed, including the harm it caused.

An acceptance of responsibility for having committed the wrong.

An expression of regret or remorse both for the harm and for having committed the wrong.

A commitment, explicit or implicit, to reparation.

A commitment to non-repetition of the wrong.

We haven't achieved this in New Zealand and felt in the paper quoted in her statement, felt that the government apology on the Lake Alice abuse did not reach the threshold in Marist's definition.

16.21 The process leading to apology, especially for survivors of abuse in Mental Health Services, needs to affirm the reality of their experiences, which have often been routinely denied. The apology also needs to acknowledge survivors who have died and to extend the apology to their families and whanau.

Survivors have called for a belated public acknowledgment of the report of the Confidential Forum published in 2007. They are seeking acknowledgment of the report that started the Royal Commission of Inquiry's 16.22 report and identification of how the voices of people who participated in a Confidential Forum have been included in the Royal Commission's processes and recommends. They also want the report to be more widely disseminated throughout New Zealand.

I want to talk about monetary redress. Monetary redress needs to involve consideration of five key factors. Is it in the survivors' interests? Are realistic costs given by the State? Is the process transparent?Does it include ongoing support for 16.23 survivors?And is justice being served to survivors?

If you haven't already, I would ask you to read Winter 2018 cited in this report. Winter compares the processes for people who are State wards in New Zealand and Ireland. New Zealand does not come out very well in that comparison. He said the costs awarded by the State were very low in New Zealand compared to Ireland, probably about, I think about 1/5th. And I think also there may be consistency between the Lake Alice pay out and pay outs that have been subsequently given for instance through the Crown Health Funding Authority and I think probably needs further examination. Has there been consistency to date? But certainly to ensure that we have a realistic and generous pay out and not a little 16.24 wellness payment.

Winter said that transparency of process is very low in New Zealand. And he was saying that the process was widely advertised in Ireland but in New Zealand very few people know about the process that's going on in health, the monetary redress in health, social development and education. And they don't advertise them because they feel flooded but that does not justify not letting people know that these processes are available.

Q. Mary, I just want to, I am conscious of the time. We are 16.25 at 4.30 and we need to finish by 5.00 and there will be some other questions for you.

Could I ask you to quickly summarise funding for healing and your thoughts on the clean slate policy and other remedies. Thank you.

A. Yeah. Funding for healing need to be part of a broader package, should be available for as long as the individual needs it and the nature of the approach needs to be broadly defined. This may include access to Kaupapa Maori, re connection to whanau, hapu and iwi, 16.26 alcohol and drug counselling, sexual abuse counselling, peer support services and so on.

And I would also like to talk about the clean slate policy that survivors have spoken about the link between abuse in Mental Health Services and entering the Criminal

Justice System. The legacy of a life in institutions, mental health and penal, is one of stigma and discrimination. A qualified clean slate policy would be a powerful mechanism to assist survivors' healing and opportunities for the future.

And there are some examples of clean slate systems around the world.

There are some other remedies which I think are interesting because they are a bit more lateral than the 16.27 traditional remedies. I have cited some examples in my paper. A national memorial to publically acknowledge people who were abused in State care.

A national approach to remembering the people who died in psychiatric hospitals and were buried in unmarked graves.

Compulsory education about state abuse as part of the national school curriculum at primary and secondary levels.

Guaranteed access to university or tertiary 16.27 education, placement in a programme of choice, and payment of fees, costs and living expenses for this purpose.

Free access to survivors to numeracy and literacy education.

Free access for survivors to primary health services. And these are all excellent examples that occur somewhere in the world.

To conclude, the road to the Royal Commission is lined all the way back to the 1840s with the casualties 16.28 of abuse in Mental Health Services. Governments, communities and Mental Health Services have yet to fully reckon with this abuse. They must acknowledge the harm done, to provide redress and rehabilitation and make systemic reforms that end institutionalisation, the dominance of psychiatry and compulsory interventions as well as resolve the impacts of colonisation. The Royal Commission is our overview opportunity for New Zealand to draw a line in the sand and to say e kore ano - never again.

Q. Thank you, Mary. I just have a few supplementary questions that hopefully we can quickly go through.

Just returning to the Mental Health and Addiction Inquiry, do you have any views about whether more work is 16.29 required to mental health systems for Maori and to incorporate Kaupapa Maori alternatives to psychiatry?

A. Look, Maori expressed disappointment in the Inquiry. And one of the issues was the lack of recommendations specific to Maori, including the lack of a recommendation for the establishment of a Maori health authority. The report referred this on to the Health and Disability review and I don't see hopeful signs that the Health and Disability review will result in a Maori health authority. After 170 years of systems failing Maori, 16.30 they are calling for control over planning, funding and delivery of their own services and support. And I support this and I do hope that the Health and Disability review supports this as well.

Q. And turning to another topic. Your evidence didn't give a ringing endorsement of Mental Health Services, particularly Psychiatric Services. What alternatives would you see to that clinical model in terms of psychiatric models, drug treatment, compulsory orders and the like?

16.31 A. People with lived experience outline an alternative in the wellbeing that exists for Aotearoa New Zealand which was a major submission to the Mental Health and Addiction Inquiry. With your permission, I could append that to my evidence statement.

The Wellbeing Manifesto calls for an end to a health-led system and talks about the need to move from big psychiatry to big community. And it describes what big psychiatry and big community are.

In big psychiatry, we have deficits based, we have a view about mental disorder, which is deficits based. In big community, we talk about the stress that we can recover from.

In big psychiatry, entry to the system is done by 16.32 health. But in big communities, we need multiple entry.

Most of the dollars, as I said before, in big psychiatry still go into what I call pills and pillow services. And we need far more resources to go into the broad menu of services and supports for people.

You find in big psychiatry that most of the people who are paid to be there, are medical and allied professionals. In big community, we are proposing we have an equal mix of peer, cultural and professional workers.

16.32 Big psychiatry has a legacy of abuse and neglect. And big community has a commitment to human rights partnership.

There is a dynamic in big psychiatry arrange risk management. They are very focused on managing immediate risk. But in big community, the focus is on access, seeing people's strengths and actually being accountable for long-term life outcomes.

Big psychiatry is a major tool of the Mental Health Act with hospitals, big tools for people who are 16.33 struggling, crisis and big psychiatry, compassion, insensitive support and a community based crisis benefit.

And, as I said, big psychiatry is an agent of colonisation that promotes one world view. Big community needs to include multiple world views.

Q. Thank you, and with the permission of the Commissioners, we will actually enter that too and it will be Exhibit 10.

Report produced as Exhibit 10

CHAIR: Thank you.

MS JANES:

Q. Slightly different topic, you talked about Lake Alice and Porirua and experimental and punitive treatments. Were they more widespread than those two organisations or institutions at the time, and what about now? 16.34

A. Look, I think the type of abuse that I described are less widespread today because, simply because there are less people in long stay institutions. But let's be clear, it still happens. And abuse doesn't just happen in the name of experimental or punitive treatment. It can be a part of industry and, as I said, put someone on a community treatment order, on drugs that can shorten their life, to me is an abuse. And this happens thousands of times every year in New Zealand.

16.35 Q. From your perspective, what are the general attitudes that allow or sustain abuse to continue? And particular with reference to the concepts of mentalism and ableism and discrimination of disabilities?

A. As I said earlier in my statement, stigma prejudice and discrimination allow a sustained ableism and mentalism and that's why programs such as like minds like minds programme that hold the mana and human rights of people with mental distress are so important and need continued and generous resources.

16.36 Q. And you set out a fairly comprehensive recommendation of what you thought would be helpful in the way forward. But if you were saying to the Royal Commission that at the end of this process, from your perspective are we looking at a tweak or a fundamental transformation?

A. I think a tweak will lead to the same disaster. We need a fundamental transformation. And I gave you a hint of what that might look like in my answer to question three and in the Wellbeing Manifesto.

The first thing, in order to achieve the fundamental transformation, our laws need to comply with the United Nations Convention on the Rights of Persons With Disabilities which can only mean the end of the Mental Health Act and a move to supportive decision-making. 16.37 There is no other interpretation from 95% of the commentary that is coming out of the United Nations.

The other thing is, we keep building more hospital beds. Every time I hear an announcement of a new ward or a facility, I want to weep because despite people's best efforts, these wards are on the whole unsafe, unhealing and a coercive environment. We need to drastically down size hospital beds and create home life and humane crisis services in the community.

As I said, psychiatry is the dominant, singer 16.37 dominant force, and it needs to move from the hub of our system and become one of the spokes. We need people with lived experience in multiple sectors of the hub, developing policy, jointly funding and delivering a broad range of services and support.

I'm not anti-psychiatry. I'm anti-dominant psychiatry.

Finally, we need to wholeheartedly, and I mean wholeheartedly, address the impacts of colonisation by giving back control to Maori, fund and provide services 16.38 and supports to Maori.

And in order to lay the ground for these changes, we have to fully reckon, acknowledge the harm done, provide redress and rehabilitation, in a very comprehensive planned and whole hearted way.

Q. Thank you, I have no further questions but stay on the line and I'll check with the Commissioners do before we disband.

CHAIR: Thank you. I'll first of all ask counsel if any have a wish to address cross-examination to Mary O'Hagan? There's none.

Can I then ask my colleagues if there are any questions and shall I start with Mr Gibson?

***

MARY O'HAGAN
QUESTIONED BY COMMISSIONERS

COMMISSIONER GIBSON: All my questions have been answered, thank you.

CHAIR: Thank you.

COMMISSIONER ALOFIVAE: Nothing further from me, thank you. 16.39

CHAIR: Judge Shaw?

COMMISSIONER SHAW: Mary, thank you very much for your evidence. I just have a short question on your paragraph 108 of your brief of evidence, in which you refer to the fact that the CHFA developed a settlement strategy because it had received 336 psychiatric patient claims. Are you with me there?

A. Yes, I am.

COMMISSIONER SHAW: Thank you. I have two questions about that. 16.40

Do you have any idea what the period over which those claims were received was?

A. I don't. I think they went back, you mean the period of the abuse or the period the claims were made?

COMMISSIONER SHAW: The period the claims were made.

A. I don't know but I am sure that information could be sought from Graeme Bell who is the former CEO of CHFA or someone who is currently working in this area, in health.

COMMISSIONER SHAW: I have a motive for asking the question. 16.41 I just wonder whether you think that the number of 336 claims is a true reflection of the numbers of people in psychiatric care who suffered abuse and neglect?

A. No, I think it's a drastic - I think it's a very small number. And, as I said, you know, I remember finding out about this and I was active in the movement and I didn't even know this process existed until someone pointed it out to me. So, they're very much under the radar and I don't think that is a good way of running such a process.

COMMISSIONER SHAW: Thank you, Mary. No other questions.

COMMISSIONER ERUETI: Dr O'Hagan, I just want to thank you for your thoughtful and comprehensive brief of 16.42 evidence. I really enjoyed reading that and hearing from you.

I want to thank you in particular for the emphasis and the attention that you have directed towards Kaupapa Maori subjects. Of course, it will be critical for this Royal Commission to hear directly from Maori themselves and Maori pukenga on this kaupapa, both mental health and learning disabilities but I want to acknowledge the mahi that you have done and I found it have valuable, kia ora.

CHAIR: Mary, I have the final word which is to thank 16.43 you sincerely on behalf of the Royal Commission for your evidence and the way in which you've been able to give it, notwithstanding the technological difficulties that we have encountered this afternoon. Thank you very much.

A. Thank you.

MS JANES: Thank you, Mary, and I really appreciate your forbearance and patience and everyone else's in the room as we've gone through this afternoon, thank you.

16.43 **CHAIR:** Thank you. Madam Registrar, can you invite Ngati Whatua to come forward and to conclude our proceeding for today.

(Closing waiata and karakia)

Hearing adjourned at 4.45 p.m.