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2 **PROFESSOR MICHAEL TARREN-SWEENEY - AFFIRMED**
3 **DR CHARLENE RAPSEY - AFFIRMED**
4 **EXAMINED BY MR MERRICK**

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7 **MR MERRICK:** I acknowledge everyone here today and if I
8 could start by saying a little bit about how we
9 might commence with these two witnesses, Sir.
10.03 10 **CHAIR:** And then I'll ask them for their initial
11 statements.
12 **MR MERRICK:** Yes. So, the proposal is that we have both
13 Professor Tarren-Sweeney and Dr Charlene Rapsey
14 seated at the witness table, as you can see. What
15 we will start with, is Professor Tarren-Sweeney
16 will read portions of his brief of evidence. We
17 will then turn to Dr Rapsey who will read her brief
18 of evidence and we will allow for questions at the
19 end, so that we can essentially - where there's
10.04 20 overlap, there might be ability to comment one with
21 the other. That is the proposal. No difficulty
22 if, Mr Chair, you propose to deliver the
23 affirmation to both of them at the outset.
24 **CHAIR:** All right, I will do that. (Witnesses
25 affirmed). I will now leave Mr Merrick initially
26 to ask you the questions that he wishes.
27 **MR MERRICK:** Thank you, Sir.
28 Q. We will start, as I've outlined, with you, Professor
29 Tarren-Sweeney. Can I just confirm that in the open
10.05 30 volume of documents which is just in front of Dr Rapsey
31 there, behind tab 21 you have sighted a copy of your
32 brief of evidence?
33 **PROFESSOR TARREN-SWEENEY:** Yes, I have.
34 Q. And you've signed that?

1 **PROFESSOR TARREN-SWEENEY:** I have.
2 Q. And it's true and correct?
3 **PROFESSOR TARREN-SWEENEY:** Yes, it is.
4 Q. Thank you. What we propose to do is have you begin by
5 reading your brief of evidence. If you could commence
6 doing that now.
7 **PROFESSOR TARREN-SWEENEY:** Thank you. First, I'd like
8 to thank the Royal Commission for giving me the
9 opportunity to talk today on a topic that's been my
10.06 10 life's work and my curriculum vitae is annexed in
11 full, annex 1 to this brief.
12 I am a clinical child psychologist, psychiatric
13 epidemiologist and child developmental theorist and I
14 work as a Professor of Child and Family Psychology at the
15 University of Canterbury in Christchurch, where my family
16 and I have lived since 2006.
17 My earlier research focused on identifying various
18 mental difficulties experience by children in State care,
19 using epidemiological and clinical research methods,
10.07 20 including development of new psychometric measures. And
21 this was mainly based around a longitudinal study that I
22 ran in NSW called the Children in Care study between 1999
23 and 2011.
24 Since then, I have advised statutory child welfare
25 ministries and national health services on how to provide
26 services for children in care in New Zealand, in
27 Scotland, Ireland, England and Wales and South Australia
28 and NSW, bearing in mind that in Australia Child Welfare
29 is a State jurisdiction.
10.07 30 Following on from that, my work has been referred to
31 in the 2008 Special Commission of Inquiry into Child
32 Protection Services in NSW.
33 **CHAIR:** Excuse me intervening, if I could ask you to be
34 mindful of the stenotyper in front of you and

1 equally the signers who are working at high speed
2 with technical material, so if you could keep your
3 eye on both and pace the delivery of what you say,
4 that will be greatly appreciated by everyone.
5 **PROFESSOR TARREN-SWEENEY:** If I keep an eye on the
6 screen, okay.
7 **MR MERRICK:**
8 Q. I think you were at paragraph 6.
9 A. Yes. And the Royal Australian and New Zealand College of
10.08 10 Psychiatrists submission to the 2017 Australian Royal
11 Commission into Institutional Responses to Child Sexual
12 Abuse.
13 The realisation that these children's mental health
14 difficulties and their life circumstances are poorly
15 matched to generic Child and Adolescent Mental Health
16 Services led me to work on the design of specialised
17 Mental Health Services for these populations.
18 But in the latter half of my career, my focus has
19 shifted from clinical research to measuring and
10.09 20 understanding how these children develop over time in the
21 midst of what are often unnatural childhoods.
22 So today I want to provide some insights from
23 developmental science on how the State should respond to
24 the plight of children growing up in statutory care. In
25 particular, my evidence will focus on those who have
26 suffered abuse, trauma, or neglect prior to their entry
27 into State care.
28 Because my work has not been focused on the
29 New Zealand context, my evidence refers to the
10.10 30 developmental needs of children growing up in statutory
31 care generally, without addressing the specific aspects
32 of the New Zealand care system, or the specific cultural
33 context in which it exists.
34 Such children leave their parents' care with

1 neurobiological systems that are adapted to cope with
2 neglectful or abusive environments, but which are poorly
3 adapted to normative social environments.
4 This translates as heightened risk for various
5 developmental, social and mental health difficulties that
6 are often persist in adulthood, and what a colleague of
7 mine, Eamon McCrory describes as latent vulnerability.
8 If there's any good news from this story, it is
9 fortunately neurobiological development is not fixed.
10.11 10 Children can experience psychological and neurobiological
11 recovery in response to consistently sensitive, loving
12 care, as well as other experiences that foster felt
13 security.
14 In thinking then about how society should tend to
15 these children's care and wellbeing, I propose three
16 priorities.
17 The first is restoring to them the opportunity to
18 experience and enjoy what remains of their childhood in
19 much the same way as do other children.
10.12 20 The second is restoring the social and familial
21 conditions that are necessary for healthy human
22 development, and which are also the pre-conditions for
23 these children's developmental recovery.
24 And the third is ensuring that they and their
25 caregivers are provided specialised clinical and
26 developmental services, as well as intensive caregiver
27 support.
28 In this first part of my evidence, I will describe
29 the psychological development of children placed in
10.12 30 statutory care, focusing mainly on the effects of severe
31 maltreatment, and their mental health.
32 Firstly, when I use the word maltreatment, I am
33 using it as a collective term to describe child abuse and
34 neglect. It's a term that's mostly used in the
research

1 field to describe both.
2 The toxic effect of maltreatment on children's
3 psychological development and wellbeing, particularly
4 when this is done by children's parents or other primary
5 caregivers, are well established.
6 We know considerably more about these effects now
7 than we did 20 years ago, and this is largely due to
8 advances in neurodevelopmental science and other research
9 advances.
10.13 10 A range of neurobiological and psychological
11 processes in early childhood that are critical to human
12 social functioning are impaired by early and prolonged
13 exposure to traumatic maltreatment. These include
14 behavioural and emotional regulation, executive
15 functioning, intellectual abilities, language and memory.
16 Similarly, severe and chronic maltreatment
17 profoundly alters children's attachment development,
18 affecting their interpersonal relationships; how they
19 understand and value themselves and others; the meanings
10.14 20 children attribute to social relationships; and how they
21 understand the minds of others, which has implications
22 for the development of empathy.
23 The effects of maltreatment on children's
24 development vary somewhat depending on children's ages
25 and stages of development at the time they are harmed.
26 In particular, maltreatment in the first 3-5 years
27 of life has more adverse effects on children's
28 development than maltreatment at older ages. That's
29 because most of the important parts of our human
10.15 30 development occur in those first 3-5 years of life.
31 There is also evidence that, whilst children's
32 development is seriously compromised by maltreatment,
33 some of these effects can be reversed over time in
34 response to optimal care, including the development of

1 attachment security, while other effects tend to persist.
2 So, for example, inner-tension hyperactivity and
3 intellectual disability tend to persist, despite changes
4 in the quality of care.
5 In this next section, I want to talk a little about
6 the effects of pre-care maltreatment on the development
7 and mental health of children in statutory care.
8 The protection, psychological development and
9 wellbeing of a large majority of maltreated children is
10.16 10 best served through varying levels of family support
11 services, including specialised parenting interventions,
12 and parental drug and alcohol treatments. It goes
13 without saying that providing effective family supports
14 earlier, rather than later, is the key to arresting and
15 preventing further developmental harm for such children.
16 However, a relatively small proportion of children
17 who are maltreated by their parents or other guardians
18 have an ongoing need for care, and in modern times, these
19 children are mostly placed into statutory care following
10.17 20 severe and chronic maltreatment.
21 In terms of terminology, in New Zealand, Australia
22 and North America, statutory care is referred to as
23 out-of-home care. Whereas, in the UK and Ireland the
24 preferred term is "looked after children".
25 And out-of-home care includes placements with
26 families, which collectively is referred to as family
27 based care. And placement in residential facilities
28 which can range from small group homes to large
29 institutions.
10.18 30 There are, in turn, two types of family based care.
31 Namely, foster care and kinship care. In New Zealand,
32 the term for kinship care is whanau care and this refers
33 to placements with extended whanau, such as grandparents,
34 uncles and aunts, and even more distant relatives.

1 Foster care refers to placements with families who are
2 not biologically related to the child.
3 Whereas residential care was once the predominant
4 form of State care, last year in Australia only 6% of
5 children in State care were in residences, and they were
6 predominantly adolescents with more serious behavioural
7 difficulties. By comparison, in Australia 51% of
8 children are in whanau care and 39% in foster care.
9 Q. Can I pause you there, Professor, and just ask a question
10.19 10 about the use of residential care and why nowadays it's
11 less used? Are you able to comment on what the research
12 is? You've talked about the detrimental effects of
13 maltreatment on children. Is there a link between the
14 impact of residential care on children and its lesser use
15 over time, so historically it was used very frequently,
16 we've heard that over the last few days. Can you comment
17 on that?
18 **PROFESSOR TARREN-SWEENEY:** The extent to which
19 residential care is developmentally harmful, is
10.19 20 somewhat linked to the age of the child. And so,
21 the younger the child is, the more that they are in
22 need of being nurtured by parental figures. The
23 more it is that residential care is manifestly
24 harmful for their development.
25 When I first started working in Child Welfare in the
26 mid 80s, I was also working in Youth Justice at the time,
27 New South Wales still had large residential services that
28 included family groups, including infants. And over
29 time, and I imagine New Zealand had the same, but over
10.20 30 time as the harmful effects of residential care had
31 become better known, and in particular for younger
32 children, it's been increasingly reserved for those older
33 children and adolescents who are seen to be not placeable
34 with families.

1 Q. Thank you. If we can return now to your brief, I think
2 we were at paragraph 30 and moving on. Can I also check
3 in with our stenographer to check with the pace?
4 **PROFESSOR TARREN-SWEENEY:** I think it's important that
5 we differentiate between these children and a much
6 larger number of maltreated children who remain in
7 their parents' care.
8 So, these children are not a random cross-section of
9 children that are known to Oranga Tamariki. Generally
10.21 10 speaking, western jurisdictions, these are children who
11 are found by the Courts to be in need of care and are
12 involuntarily removed from their parents and have
13 experienced the highest levels of harm.
14 They are more likely than other maltreated children
15 to have experienced more severe, more chronic, more
16 pervasive and more diverse maltreatment.
17 This is important because, whereas all maltreatment
18 is developmentally harmful, research has confirmed that
19 the level of developmental harm is proportionate to the
10.22 20 severity, chronicity and pervasiveness of the
21 maltreatment they have experienced.
22 Q. So, what you are saying there is we need to acknowledge
23 at this stage there are the varying degrees we're talking
24 about?
25 **PROFESSOR TARREN-SWEENEY:** Yes.
26 Q. You are talking about the higher end of severity when it
27 comes to maltreatment?
28 **PROFESSOR TARREN-SWEENEY:** That's right. There are two
29 implications for that. One is that it is the most
10.22 30 severely maltreated children that tend to come into
31 care through the Courts.And it's those very
32 children who have had the most adverse
33 developmental experiences.So, in other words, the
34 children that are coming into care are the most

1 vulnerable.
2 Q. To be clearer still in the context of this hearing, we're
3 talking international research currently or the current
4 state, correct?
5 **PROFESSOR TARREN-SWEENEY:** Yes, that's right. This is
6 not, what I'm talking about is now, and so
7 historically children came into care for many other
8 reasons historically.
9 Q. We have heard a lot about that. We won't dwell on that
10.23 10 now. We will carry on with your brief of evidence.
11 **PROFESSOR TARREN-SWEENEY:** The most illustrative point I
12 can make about this is the strongest independent
13 predictor of the mental health of children in care
14 is the age that they are when they come into care,
15 with earlier placement in family-based care being a
16 strong protective factor. And this is in spite of
17 what I'm going to talk about in a minute, about all
18 of the harmful effects that care actually excerpts
19 on children's development. In spite of that, the
10.24 20 younger a child is when they're placed into care,
21 the better the mental health generally is
22 throughout their childhood, at least when we
23 examined this across the entire care populations.
24 I think it is important not to interpret this
25 statistic as an endorsement of statutory care as being
26 generally reparative or therapeutic for these children.
27 Later I will explain how out-of-home care also
28 compromises many children's development, limiting their
29 recovery from effects of serious maltreatment and
10.24 30 sometimes leading to further deterioration in mental
31 health.
32 But the reason why I want to emphasise this, is that
33 this statistic refutes a commonly held belief that some
34 children are better off remaining with families who

1 persistently maltreat them than being placed in statutory
2 care, at least in the modern context.
3 Q. I suppose, what you're saying there is that runs against
4 any proposition that might say we won't act for this
5 reason?
6 **PROFESSOR TARREN-SWEENEY:** Yes. Within the field
7 because people are exposed to all of the problems
8 that statutory care has and they can see the
9 various harms caused by the statutory care system,
10.25 10 a lot of people working in the field have a crisis
11 of confidence and start to believe that children
12 may be better off if they remain in severely
13 maltreating homes. And the evidence that I've just
14 given you refutes that. In spite of all the harm
15 that care does, it is a less harmful option than
16 remaining in families where they are being severely
17 and persistently maltreated.
18 Q. And you're going to come on to this later?
19 **PROFESSOR TARREN-SWEENEY:** Yes.
10.26 20 Q. One of the big questions you've pointed out is what form
21 does that care take?
22 **PROFESSOR TARREN-SWEENEY:** Yes. I am not suggesting we
23 need to choose between two bad options. I am
24 suggesting that we need to be thinking about what
25 the better option is, yes.
26 Q. Pick up again from, I think, paragraph 40 now.
27 **PROFESSOR TARREN-SWEENEY:** Yes. Let me know if I'm
28 taking too long and I need to move on.
29 In this next part of my evidence, I want to talk
10.26 30 about the mental health of children in long-term
31 statutory care.
32 Over the past 30 years, numerous population studies
33 carried out in countries with comparable care systems to
34 New Zealand have mentioned the mental health of children

1 and young people in care.
2 Most of these studies were carried out in the
3 United States, Canada, the United Kingdom, Europe and
4 Australia.
5 These include the study that I conducted that I
6 spoke about earlier.
7 What's really interesting about this research, is
8 just how consistent the estimates are. So, around the
9 world, studies are finding much the same results.
10.28 10 Whilst no comparable research has been carried out
11 to date in New Zealand, this consistency of international
12 research suggests that New Zealand children in care are
13 likely to have comparable mental health problems, at
14 least as understood and measured within western
15 epistemologies.
16 It is important to note that children experience
17 mental ill-health within the context of broader
18 developmental impairments, as well as physical health
19 problems and physical disabilities.
10.28 20 And to address that, New Zealand has introduced,
21 within the last 5 or 6 years I think, a cross-government
22 health screen procedure for children entering statutory
23 care, called the Gateway Assessment. This screening
24 assessment seeks to identify not just mental and
25 emotional difficulties, but also learning difficulties,
26 physical ill-health resulting from maltreatment, social
27 disadvantage and poverty.
28 Several population studies, including my own, have
29 estimated around a quarter of children in care have some
10.29 30 level of intellectual disability, and similar rates of
31 language difficulties.
32 However, the most important developmental
33 difficulties experienced by these children, as measured
34 by the number of affected children, their felt

1 experience, the impact on their present wellbeing and
2 social functioning, the impact on their caregivers, and
3 their future lives are their mental health difficulties.
4 Q. Before you move on, at paragraph 47 you said that across
5 these population studies the estimates, as you've
6 described, have been quite consistent but that around a
7 quarter of children in statutory care have some level of
8 learning disability or language difficulty. How did that
9 compare to the population of children at large?
10.30 10 **PROFESSOR TARREN-SWEENEY:** That compares to around 2% of
11 children at large.
12 Q. So, 25% for children in care across these studies and 2%
13 for children at large?
14 **PROFESSOR TARREN-SWEENEY:** Yes. Yeah, I skipped some of
15 the details there.
16 Q. That's fine. I think we were at paragraph 51, thank you.
17 **PROFESSOR TARREN-SWEENEY:** With regards to mental
18 health, international research consistently
19 indicates around half of children in long-term
10.31 20 statutory care have mental health difficulties that
21 require clinical intervention or support. And
22 around another quarter have difficulties
23 approaching the need for clinical support. So,
24 that means there's only a quarter of children who
25 are travelling well and otherwise we don't need to
26 be continuing to monitor them.
27 So, for a population, from a public health
28 perspective, this is one of the highest risk populations
29 for mental health difficulties that we have in our
10.31 30 society.
31 Also, in addition to the numbers of children that
32 have these problems, what's very pertinent is the types
33 and culminations of symptoms that children in care
34 experience differ somewhat from that of other children

1 that may have need for clinical services.
2 And this is also the case for severely maltreated
3 children who remain with their parents. So, in other
4 words, the mental health problems that I'm talking about
5 are not specific to children in care as such. They're
6 specific to maltreated children.
7 Firstly, the mental health difficulties that
8 children experience whilst growing up in care are mostly
9 trauma related and attachment related. And they are also
10.32 10 developmentally based, which means they develop over long
11 periods of time.
12 In particular, difficulties with social and
13 interpersonal relatedness linked to attachment
14 development are hallmark features that differentiate this
15 population from other children with clinical-level
16 difficulties.
17 I am sorry for all the big words.
18 Other characteristic difficulties include
19 relationship insecurity, inattention/hyperactivity, Post
10.33 20 Traumatic Stress Disorder symptoms, disassociation,
21 conduct problems and oppositional-defiance, self-injury,
22 food maintenance behaviours, which means hoarding,
23 gorging and storing food, abnormal responses to pain and
24 sexual behaviour problems.
25 However, the most defining feature is not the forms
26 or types of difficulties, but their complexity and
27 severity.
28 In my longitudinal study of 347 children in
29 long-term care in New South Wales, 20% had complex
10.34 30 attachment and trauma-related problems that are not
31 adequately explained or classified in either the
32 Diagnostic and Statistical Manual of Mental Disorders,
33 what they call the DSM, the Psychiatric Classification
34 Manual, or the World Health Organisation's International

1 Classifications of Diseases.
2 And this is one of the reasons why these children
3 require specialised clinical services.
4 In the context of children entering long-term care
5 with seriously compromised psychological development, it
6 is understandable that their mental health difficulties
7 persist whilst growing up in care. That's because these
8 difficulties are developmentally-based and thus tend to
9 follow a long-term developmental course.
10.35 10 So, these are not like simple problems like anxiety
11 and depression that may arise over a short period of time
12 and can be treated quickly, where the course ~~course~~ of
13 the problem can be changed fairly quickly.
14 Q. That's because the developmental problems that have taken
15 a course of time in the child's development which is what
16 we spoke about earlier?
17 **PROFESSOR TARREN-SWEENEY:** Yes. An analogy might be
18 that problems that are not developmentally based,
19 it's like steering a speedboat on the water. But
10.36 20 developmentally based problems is more like trying
21 to change the steering or the course of a big ocean
22 ship, you can't just change it very quickly, it's
23 very slow to change over time.
24 Q. And I think now you're going on to talk about the
25 conditions of a child's development which lead to a
26 child's development at paragraph 61.
27 **PROFESSOR TARREN-SWEENEY:** So, the conditions are slow
28 to change but without improvements in a child's
29 developmental conditions, these more serious
10.36 30 problems are likely to become increasingly fixed or
31 trait like, which is a psychological term, having
32 lifelong implications for social, educational and
33 occupational functioning.
34 On the other hand, even with optimal conditions

1 where the child's care, life circumstances and their care
2 changes dramatically for the better, that recovery tends
3 to be slow and this often tests their foster
4 ~~parents~~parents’ commitment and strength. Even in the
5 best of worlds when they do recover, it occurs over long
6 periods of time.
7 I will now move on to canvass what I believe are the
8 most important things that children need if they are
9 unable to remain in their parents' care.
10.38 10 At the start of my evidence, I proposed that
11 severely maltreated children can experience psychological
12 recovery in response to consistently sensitive, loving
13 care, as well as other experiences that engender felt
14 security.
15 I also expressed my belief that the State, by which
16 I mean the government at large and civil society, not
17 just the statutory Child Welfare department, that the
18 State has a duty of care to do three things for these
19 children.
10.38 20 The first was to restore to them their right to
21 experience and enjoy what remains of their childhood in
22 much the same way as do other children.
23 The second was to restore the social and familial
24 conditions that are necessary for healthy human
25 development.
26 And the third was with regard to providing
27 specialised clinical services and support.
28 Although costly, this third priority is perhaps the
29 simplest, it is the most straightforward to achieve,
10.39 30 because unlike the first two priorities, we can do this
31 without reforming the statutory care systems.
32 So, here I'm talking about Governments providing
33 specialised clinical services for children in care.
34 Q. And that's because, as you described earlier, in terms of
the complex range of factors which are present in this

1 population of young people, some of the tools which are
2 available within the mental health setting aren't
3 necessarily addressing those; is that the point?
4 **PROFESSOR TARREN-SWEENEY:** Yes. And it's not specific
5 to New Zealand, this is a problem all around the
6 world and I might just talk because there's a fair
7 bit to get through here and I think we wanted to
8 get to the other parts, make sure we get to that.
9 If I can just summarise what I say from paragraphs
10.40 10 68-81.
11 Q. Thank you.
12 **PROFESSOR TARREN-SWEENEY:** No government has managed to
13 get this right yet. The government that's done -
14 where it's been done the best is in the
15 United Kingdom and in this part of the world New
16 South Wales has shown the most progress, in terms
17 of not just the Child Welfare Department but
18 particularly the Health Department developing
19 specialised clinical services.
10.40 20 Q. We with ~~he~~ pause there? We are both conscious of the
21 time but there's a point about what's happened in New
22 South Wales which might be worth touching on very
23 briefly. That's the extent to which they have tried to
24 change the way that they look at their system in terms of
25 Care and Protection and Youth Justice; is that correct?
26 **PROFESSOR TARREN-SWEENEY:** They have done a number of
27 things. Firstly, early in the early years when I
28 was first working in the Ministry, they separated
29 out Youth Justice from Child Welfare, for the
10.41 30 reason being that the institutional approaches to
31 running Youth Justice services cross-contaminate
32 the way that they care for children in residential
33 services because the same agency is doing both.
34 It's difficult for them to care for children in

1 residential care in the manner in which a parent
2 would be thinking about a child, when at the same
3 time they are running equivalent institutions for
4 young offenders.
5 Q. So, two separate departments effectively?
6 **PROFESSOR TARREN-SWEENEY:** Yes, in different ministries,
7 yes.
8 Q. Thank you.
9 **PROFESSOR TARREN-SWEENEY:** The second thing they did,
10.42 10 was in the 90s they did a very radical move, it was
11 the Usher Inquiry led to the closure of every
12 residential service in NSW, including small group
13 homes, every single one was closed. That had some
14 negative consequences, in terms of children that
15 were difficult to place with foster families
16 sometimes winding up living in youth refuges\and
17 things but it was a revolution in terms of forcing
18 the government to confront how do we care for
19 difficult to place children with families? I think
10.42 20 it was largely successful.
21 Q. If we can return to its summary, the four points?
22 **PROFESSOR TARREN-SWEENEY:** I will go through the four
23 points very quickly. The first is, we know these
24 children actually consume a disproportionately
25 large amount of generic State run Mental Health
26 Services. In spite of that, many of them don't get
27 the services that they need. So, there is a
28 problem with capacity.And so, New Zealand, as
29 with other places in the world, doesn't have enough
10.43 30 Mental Health Services to meet the needs of this
31 population, let alone the population at large.
32 Secondly, the existing Child and Adolescent Mental
33 Health Services, partly because they're so stretched,
34 operate under an acute care model, which means that

1 they're focusing on getting clients in and out as quickly
2 as possible, using brief therapies and brief
3 interventions. And these children need long-term
4 interventions.
5 Q. And that's the point you've made around the
6 ~~cruiseliner~~cruise liner and the speedboat, developmental
7 versus other more acute
8 -
9 **PROFESSOR TARREN-SWEENEY:** Yes. The irony is they don't
10.44 10 necessarily need treatment services that are as
11 intensely provided as the acute care services.
12 Sometimes an over the horizon approach is a better
13 one where the children aren't even aware that
14 they're receiving Mental Health Services. It's
15 mainly provided through their carers. So, they
16 don't need as intensive services all the time but
17 they need a service that their caregivers can
18 access that are available. In other words, they
19 can't - presently they have to join queue and then
10.44 20 wait and then fall off and again join the queue
21 again and then wait and then fall off.
22 The other problem, as I mentioned, these children
23 have difficulties that are not well understood within
24 existing diagnostic classifications, and that points to
25 the need for, well that points to a bigger challenge or
26 problem, which is we don't have a clinical workforce that
27 is sufficiently skilled in terms of understanding -
28 speaking too fast?
29 **COMMISSIONER ALOFIVAE:** No, I'm appreciating the point.
10.45 30 **PROFESSOR TARREN-SWEENEY:** We need more specialised
31 clinicians and the best way to do that is to train
32 them and to employ them within specialised
33 services.
34 Q. And on that point, earlier you've talked about western
approaches to this and later on you talk about cultural

1 parameters, in terms of relationships. On this point
2 around specialised clinicians, would you support the
3 proposition that a diverse range of clinicians with
4 different cultural backgrounds would add to the workforce
5 in that area?
6 **PROFESSOR TARREN-SWEENEY:** I think in New Zealand
7 currently around half, or a little more than half,
8 of children in care are Maori. And so, I think
9 it's self-evident that, the work that I've done has
10.46 10 been voiced internationally, so I've not talked
11 specifically about this, but I think it's
12 self-evident that if you were to develop
13 specialised Mental Health Services for children in
14 State care in New Zealand, then there has to be,
15 not only the model of treatment models in ways of
16 delivering services, but trying to recruit more
17 clinicians from the cultural backgrounds that
18 reflect the population of children in care.
19 I think I've covered that enough. I guess the last
10.47 20 part of my evidence, I'm really wanting to talk about
21 present statutory care systems, the extent to which they
22 meet the needs of children and specifically focusing on
23 what I see as being systemic factors that compromise
24 children's lives.
25 Q. Just so we can follow along, we're now at paragraph?
26 **PROFESSOR TARREN-SWEENEY:** 82. I am seeing how far I've
27 got to go.
28 A recent review that I carried out of studies that
29 measured longitudinal changes in children's mental health
10.48 30 in family based care found no consistent evidence that
31 care excerpts a general population wide effect on
32 children's mental health. In other words, at least in
33 terms of measuring children's mental health over time,
34 there is no evidence that foster and kinship care are

1 either generally harmful or generally therapeutic.
2 Instead, several longitudinal studies have found
3 that sizeable proportions of children show meaningful
4 improvement in their mental health over time but similar
5 proportions show deterioration in their mental health
6 over time.
7 And if I can refer to my New South Wales study
8 again, around 35% of those children around 9-11 years of
9 time, had good mental health at the start and good mental
10.49 10 health at the end. A quarter of the children showed
11 meaningful improvement in their mental health. Another
12 quarter showed meaningful deterioration, things got worse
13 for them. And the final 15%, their difficulties, they
14 had difficulties at the beginning and difficulties at the
15 end, that stayed much the same.
16 And so, what this kind of draws our attention to, I
17 think, is not asking whether or not carers itself is
18 generally harmful or generally therapeutic, but what are
19 the characteristics of care that foster children's
10.50 20 healthy development and what are the aspects of care, the
21 care system, that either impede their development or
22 recovery or actually cause further harm?
23 I am just going now to paragraph 92.
24 Q. To 92, thank you.
25 **PROFESSOR TARREN-SWEENEY:** Within a family preservation
26 framework, the designated purpose of statutory care
27 shifted in the 1980s and 1990s to temporary
28 protective care with restoration, meaning restoring
29 the child to their birth family, being the ultimate
10.50 30 goal.
31 This reflects the belief that foster care should
32 serve as a support intervention in the aid of family
33 preservation, not as a means for effecting family break
34 up.

1 The problem is, however, if we look at the reality
2 of what has happened since then, today statutory care
3 increasingly serves a very different function. I don't
4 have the equivalent statistics for New Zealand but, for
5 example, in Australia there is an increasing trend for
6 children to enter statutory care at a younger age and to
7 spend the remainder of their childhood in care. And
8 based on current trends, the majority of children placed
9 into care will effectively grow up in care.
10.51 10 Children experienced statutory care through the lens
11 of their previous experiences of harmful care. Harmful,
12 insensitive and inconsistent parenting adversely affect
13 children's attachment style and how they understand and
14 interpret adult caregiving behaviour. Attachment theory
15 predicts that the developmental effects of statutory care
16 should vary according to the characteristics of a child's
17 attachment development prior to their entering into care.
18 And so, I've written some technical terms here but
19 basically, what I'm saying is that if as a young child
10.52 20 you were raised by parents where your relationships are
21 very distorted and maladaptive, then when you are
22 subsequently placed with other families you still
23 perceive those people and understand relationships
24 through that lens that developed earlier.
25 Whereas, the attachment styles of very young foster
26 children tend to match their foster mother's attachment
27 styles, children who come into care at older ages are
28 more resistant to change, despite receiving markedly
29 improved care.
10.53 30 Many such children are thus prime for insecurity
31 when they enter care, due to their compromised attachment
32 development, as well as the loss of their parents and
33 being placed with unfamiliar carers.
34 Therefore, even with optimal reparative conditions,

1 and with specialised support, children's recovery tends
2 to be slow.
3 Whilst growing up in statutory care is preferable to
4 ongoing exposure to maltreatment, there is good evidence
5 that it systemically compromises children's development
6 and wellbeing.
7 There is accumulating international evidence that
8 the quality of caregiving provided to children in
9 statutory care, caregivers' motivations for fostering
10.54 10 children, their commitment and bonding to children placed
11 with them; and of course maltreatment of children in care
12 all influence children's felt security and psychological
13 development and these factors regulate their recovery
14 from their mental health difficulties.
15 Q. At this stage, if we could move down to paragraph 112
16 because it would be good to talk about this idea of a
17 qualified commitment to care and then go on to talk about
18 the impact of familial love.
19 **PROFESSOR TARREN-SWEENEY:** Maltreatment and care, we'll
10.55 20 skip that, 105?
21 Q. I think if we can direct ourselves now to 112.
22 **PROFESSOR TARREN-SWEENEY:** Okay, yep. The accumulating
23 research challenges a myth embodied within western
24 statutory care systems, that children can be
25 adequately nurtured for the remainder of their
26 child hoods by caregivers who have a qualified
27 commitment to them, so long as those children
28 receive good or adequate day-to-day care.
29 By that, what I'm saying is that there was a belief,
10.55 30 at least within the care system that I've worked in, that
31 it didn't matter whether caregivers and children had
32 bonded to each other as if they belonged to each other.
33 All that was essential was that children were loved and
34 nurtured on a day-to-day basis. But this kind of

1 misunderstands what the concept of love is, which I will
2 talk about now.
3 While children may not initially understand or
4 respond positively to loving care, over time familial
5 love is the most important therapeutic mechanism that we
6 have for repairing these children's lives.
7 But familial love, and the close relationships that
8 underpin it, are not momentary transactions of nurturance
9 or affection. So, it's not transactional and it's not
10.56 10 something that we can provide on a time limited basis as
11 something that we do in terms of behavioural nurturing of
12 children on a day-to-day basis.
13 Q. At this point, I think it's a good point to jump now to
14 paragraph 117 where you talk about relational permanence.
15 **PROFESSOR TARREN-SWEENEY:** Put simply, children with
16 only truly feel secure when they acquire relational
17 permanence. Familial love and relationships are
18 not time limited, they are unending.
19 At this stage, I should also emphasise that
10.57 20 relational permanence and the associated felt security
21 that flows from it, is experienced and shaped within
22 cultural parameters and shared belief systems.
23 For example, for Maori, felt security does not flow
24 exclusively from close, permanent, familial
25 relationships. It also flows from having a secure
26 connection with and a sense of belonging to one's
27 whakapapa and connection to whanau, hapu and iwi.
28 Based on my understanding, the practice of Whangai
29 operates within the strengths of that cultural framework.
10.58 30 I also believe that the practice of Whangai provides
31 a vehicle for facilitating relationship permanence and
32 felt security for Tamariki who otherwise cannot or should
33 not be raised by their parents.
34 Almost all aspects of present statutory care systems

1 work against children acquiring relationship permanence
2 and associated felt security, even in cases where foster
3 parents and whanau are strongly motivated to permanently
4 care for a child.
5 Children's felt security is constrained or
6 undermined by the legal, philosophical and historical
7 bases of statutory care systems throughout western
8 jurisdictions.
9 To illustrate this, I was going to provide some
10.59 10 examples but I won't but I will just mention, I should
11 mention that, I should refer the Commission to the TVNZ1
12 documentary "I am a survivor of State care" which
13 provides an historical example in which Daryl Brougham
14 and his former foster parents recount his involuntary
15 removal from their care and the long lasting effects this
16 had on all of them.
17 My experience has been that children growing up in
18 long-term care begin to fully understand their legal and
19 care status from about age 6 or 7. In my clinical work,
10.59 20 I have observed this growing awareness is often
21 accompanied by increasing insecurity about the
22 possibility of that child losing or being taken from
23 their caregivers.
24 In my NSW longitudinal study, one of the clearest
25 predictors of children's mental health problems was
26 foster parents' perceptions of placement security.
27 Within the confines of family relationships, felt
28 insecurity of one family member impacts on the felt
29 security of others.
11.00 30 Thus, foster parents' own concerns about a child's
31 tenure with them can raise anxiety within the family
32 system. This can be quite detrimental when children are
33 already highly anxious about their placement security.
34 Statutory care systems add here to the myth that

1 caregivers can simultaneously nurture and love children
2 "as much as any child might need" but that those
3 caregivers should also be able to readily let go of those
4 children if it the agency decides they should be returned
5 to their parents or moved to another placement. In
6 practice I believe that this is rarely achieved, and that
7 there is an inevitable trade-off between the level of
8 nurturance and expressed love, and a caregiver's ability
9 to let go. I will move now to paragraph 147. Let me
11.01 10 know if I'm taking too long.
11 By and large, out-of-home care services are staffed
12 by very caring and emphatic professionals and yet,
13 complex systemic factors deny these children the
14 possibility of enjoying the same standard of care and the
15 same experience of childhood that most children enjoy.
16 The most intractable problem within our system of
17 legally impermanent statutory care is placement
18 disruptions and placement instability.
19 Q. At this stage, can I ask you to summarise some of the
11.02 20 points you've made about placement disruption and
21 placement instability, starting on page 16,
22 paragraph 149?
23 **PROFESSOR TARREN-SWEENEY:** I can skip a lot of this,
24 okay. There are two main problems. First of all,
25 placement instability is very common in statutory
26 care. Some of it occurs because children are moved
27 in a planned way. When they're moved from
28 placement to placement in a planned way, it may be
29 because a child is being moved from a supposedly
11.03 30 temporary placement to a permanent placement. But
31 not enough thought is given to how that affects
32 children. The most common reason children move is
33 because placements disrupt or breakdown. And the
34 most often stated reason for that is foster parents

1 or whanau carers not being able to cope with
2 children's behavioural difficulties or their
3 unusual or problematic interpersonal relatedness
4 difficulties, so their attachment behaviours.
5 And we haven't had enough research to definitively
6 map out and show exactly what the psychological toll is
7 on children when their placements breakdown, and the
8 reason for that is, it's technical reason. But numerous
9 qualitative studies of children growing up in care,
11.04 10 children describe the devastating effects of placement
11 moves and placement breakdowns.
12 Q. As a matter contributing to placement breakdown, would
13 you add, if the level of mental health support is
14 deficient or not adequate, that would be a factor which
15 would contribute to placement breakdown?
16 **PROFESSOR TARREN-SWEENEY:** It is. And so it works in
17 the other way as well, and that is that placement
18 breakdowns incur a toll in terms of children's
19 mental health. So, we see a spiral, what we
11.05 20 typically see is a spiralling pattern, after the
21 first placement breakdown the likelihood of another
22 one increases because the children's distorted
23 views of themselves and of others, the breakdown
24 confirms their distorted views. So, they're living
25 in a dangerous rejecting world, they see themselves
26 as being unlovable and they see the placement
27 breakdown as being inevitable.
28 And so, over time you get this reverberating cycle,
29 that we see this pattern with older children/adolescents,
11.05 30 where eventually they are placed in residential care.
31 But the biggest, I think the biggest cost of
32 placement breakdowns is that every time one happens, the
33 clock is reset for this child actually developing a
34 permanent relationship. That's actually a bigger cost

1 because whilst when a child is moving from placement to
2 placement, they are adrift and they are alone. And the
3 more chance it is that when they reach adulthood as a 17
4 or 18 year old, they are literally alone in the world.
5 And so, Mental Health Service, in terms of the
6 specialised special approach for these children, the
7 number one goal is not to bring about some improvement in
8 their mental health in the short-term. The number one
9 goal is to maintain children's placements because if you
11.06 10 can do that early on and keep placements that are at risk
11 viable, so that caregivers and children become closer to
12 each other and they develop stronger bonds to each other,
13 and foster parents and whanau carers are adequately
14 supported to deal with the problems that children have,
15 then we reduce the risk of placement breakdown. And the
16 placement breakdown is the catastrophe, more than the
17 mental health problems getting worse, if that makes
18 sense.
19 Q. Shortly we're going to take a break but before we do
11.07 20 that, I just wondered if you had any final points that
21 you wanted to make in closing, Professor Tarren-Sweeney?
22 **PROFESSOR TARREN-SWEENEY:** I have probably spoken too
23 long.
24 Q. No.
25 **PROFESSOR TARREN-SWEENEY:** I can read my conclusion?
26 Today's I've presented evidence that I believe
27 supports the case that statutory care systems are
28 not able to restore to children their right to
29 experience and enjoy what remains of their
11.08 30 childhood in much the same way as do other
31 children.
32 And that an impermanent care system cannot provide
33 children with the social and familial conditions that are
34 necessary for healthy human development and are also

1 preconditions for their developmental recovery.
2 I believe that the experience of growing up in
3 statutory care in the western world constitutes an
4 unnatural childhood, one that exposes our most vulnerable
5 children to unique developmental risks that other
6 children do not encounter.
7 Furthermore, there is good evidence to show that
8 these developmental risks are systemically
9 interconnected. It involves a complex interaction of
11.08 10 Child Welfare practices, caregiver motivation, the
11 child's experience of impermanence and felt insecurity.
12 The core problem is that this system sees many
13 children growing up without acquiring permanent
14 relationships. In other words, without enjoying
15 unconditional, lifelong commitment by a loving family.
16 My present research focuses on designing and testing
17 a developmental theory which I call a permanence theory,
18 and I should skip that because we are running out of
19 time. The theory proposes felt security is the core
11.09 20 psychological state that underpins developmental recovery
21 and that it can't be fully attained without close
22 permanent familial relationships.
23 Q. It would be interesting to hear about how some of the
24 work you've done to try and test that theory in term of
25 your research?
26 **PROFESSOR TARREN-SWEENEY:** It's still in its early
27 stages but partly what I've been doing is unusual
28 for a psychologist but I've been doing historical
29 work to test - well, humans are a social species
11.10 30 that evolved such that close and enduring familial
31 relationships are essential for their psychosocial
32 development.
33 In other words, if that part of our lives is
34 approximately non-negotiable, that all of us do this,

1 then that provides evidence for it having an evolutionary
2 basis. The in other words, what I'm looking for is any
3 evidence historically or cross-culturally where children
4 are raised in a similar way to how we raise children in
5 care would potentially provide evidence that we can, as a
6 species, cope with this.
7 And so, I've searched as far back as pre-Christian
8 Europe and the Roman Empire, as well as ethno~~oto~~graphic
9 accounts of traditional societies throughout the world,
11.11 10 and so far I have not found any such precedent.
11 What this tells us is the abs~~tin~~ence of such
12 precedents~~ce~~ infers this experience lies outside the
13 boundaries of human adaptation as determined by our DNA.
14 In other words, being raised without a semblance of
15 a permanent family is both developmental harmful and
16 contrary to human evolution.
17 Thank you.
18 Q. Thank you. First, Mr Tarren-Sweeney, a big
19 acknowledgment to you. I will just turn to the Chair now
11.11 20 to see whether that might be an appropriate time,
21 although slightly early, Sir?
22 **CHAIR:** Yes, I think I speak for all my colleagues, this
23 would be a good time to take the morning break.
24 When we resume, counsel if they wish can ask
25 Professor questions. Is that the way in which
26 you're going to do it or are we going to hear from
27 Dr Rapsey first?
28 **MR MERRICK:** We will hear from Dr Rapsey first and then
29 have questions to round off.
11.12 30 **CHAIR:** Very well. We will take the break and then we
31 will receive the evidence of Dr Rapsey.
32
33 **Hearing adjourned from 11.12 a.m. until 11.30 a.m.**
34

1 **MR MERRICK:**
2 Q. We will now turn to you, Dr Rapsey, and we will follow
3 the same process as we did with Mr Tarren-Sweeney.
4 At tab 22 of the folder in front of you, if you can
5 open to tab 22, can we see there a signed copy of your
6 brief of evidence?
7 **DR RAPSEY:** That is correct.
8 Q. Do you confirm that that is true and correct?
9 **DR RAPSEY:** I do.
11.33 10 Q. With the proviso that at paragraph 23 there is something,
11 a point you would like to clarify around the brief at
12 that point. We can do that in your oral evidence.
13 **DR RAPSEY:** Yes, correct, thank you.
14 Q. I will invite you to start by reading your brief of
15 evidence, thank you.
16 **DR RAPSEY:** Thank you. Tena koutou. I am a lecturer in
17 the Department of Psychological Medicine,
18 University of Otago, and a Registered Clinical
19 Psychologist. My research interests include mental
11.33 20 disorder and the effects of childhood adversity.
21 While in practice, I have worked as an ACC approved
22 clinical psychologist; and at times this has
23 included working with incarcerated men who were
24 victims of sexual abuse, as well as with children
25 in foster care.
26 This work also included working with those where the
27 abuse occurred in State care and so I bring an
28 understanding of the issues faced by survivors of abuse
29 in State care.
11.34 30 My current research projects include: the World
31 Health Organisation World Mental Health Surveys project.
32 This is a unique international collaboration with over 30
33 countries focused on epidemiology and the prevention of
34 mental disorder.

1 The Otago Women's Health Study, a ~~25 year~~25-year
2 longitudinal study investigating associations between
3 childhood abuse and outcomes across the life course.
4 And the Foster the Whanau project which investigate
5 the costs, benefits and long-term ~~-turn~~ out comes for
6 children when the mother participates in an intensive,
7 residential intervention as an alternative to foster
8 care.
9 First, I am proud that our government has chosen to
11.36 10 Commission this Royal Commission into abuse in care.
11 Today, the evidence I am presenting is based on my
12 summary of the research field, primarily addressing the
13 question posed by the Commission: what are the effects of
14 abuse?
15 In this brief, I have used the word "maltreatment"
16 as a term that includes physical, emotional and sexual
17 abuse as well as neglect.
18 I am going to discuss evidence addressing the
19 following four questions:
11.36 20 What are the effects of childhood maltreatment?
21 What are the effects of time in out-of-home care,
22 that is foster care or institutional care? And
23 specifically, what are the effects for children in
24 Aotearoa New Zealand?
25 What is the effect on the family and the likelihood
26 of family reunification when a child has been removed
27 into care?
28 And what evidence supports alternatives to
29 out-of-home care?
11.37 30 So, beginning with the first question, what are the
31 effects of child maltreatment?
32 There is strong and robust evidence that all forms
33 of child maltreatment are associated with an increased
34 risk of deleterious outcomes across the life span of the
individual.

1 Q. By deleterious?
2 **DR RAPSEY:** Bad, poor, reduced.
3 Q. Thank you.
4 **DR RAPSEY:** The magnitude of risk of poor outcomes
5 increases with increasing exposure to maltreatment
6 and/or the increasing severity of the abuse. So,
7 that is cumulative maltreatment and/or higher
8 levels of abuse harm are associated with
9 increasingly greater risk of poor outcomes.
11.38 10 The effects of child maltreatment are pervasive,
11 with disruption of multiple interacting systems -
12 biological, psychological, relational and social. This
13 pervasive disruption influences development in multiple
14 ways with long-term implications across the life-course.
15 Psychological effects of maltreatment includes an
16 increased risk of meeting diagnostic criteria for all
17 types of mental disorder.
18 As an example, the WHO World Mental Health Surveys,
19 which is the largest international survey of mental
11.39 20 disorders, conducted an analysis of the relationship
21 between childhood adversity and adult mental disorder
22 which included almost 52,000 participants from 21
23 countries, including Aotearoa New Zealand. They assessed
24 diagnosis of 20 commonly occurring mental disorders, so
25 that includes depressive disorders, bipolar disorder,
26 anxiety disorders, including Post Traumatic Stress
27 Disorder, phobias, generalised ~~the~~ anxiety disorder,
28 behaviour disorders, examples of behaviour disorders are
29 conduct disorder, ADHD, as well as substance abuse
11.40 30 disorders, so alcohol and drug. They did this using a
31 clinical interview. They found that childhood
32 maltreatment increased the risk of meeting criteria for
33 all types of mental disorder at all ages.
34 In this survey, in this study, they also analysed

1 the extent to which childhood adversity contributed to
2 the prevalence of mental disorder in a country. They
3 reported that eradication of childhood adversity would
4 lead to a 23% reduction in mood disorders, 31% reduction
5 in anxiety disorders, 42% reduction in behaviour
6 disorders, and a 28% reduction in substance disorders.
7 So, overall, eradication of childhood adversity would
8 lead to a 30% reduction in all mental disorders.
9 So, this study, the World Mental Health Surveys, did
11.41 10 not assess psychosis but other research has found that
11 childhood maltreatment increases the risk of psychosis.
12 Childhood maltreatment increases the risk of death
13 by suicide and suicidal behaviours.
14 This increased risk of mental disorder persists
15 across the life course of an individual.
16 In addition to an increased risk of mental disorder,
17 child maltreatment affects physical health. Child
18 maltreatment is associated with an increased risk of a
19 number of chronic diseases and the associated disability
11.42 20 and loss of quality of life. For example, there is an
21 increased risk of a range of physical health problems
22 including pulmonary, cardiovascular, gastrointestinal
23 disease, musculoskeletal problems, chronic pain and
24 cancer specifically, in the WHO surveys, child
25 maltreatment was associated with an increased risk of all
26 of the measured physical health conditions. They were
27 heart disease, asthma, diabetes mellitus, arthritis,
28 chronic spinal pain and chronic headache.
29 Childhood physical and emotional abuse is associated
11.43 30 with an increased risk of all-cause early mortality for
31 women.
32 Maltreatment in childhood also has implications for
33 relational and social outcomes. Effects include
34 increased risk of sexual and physical re-victimisation,

a

1 greater likelihood of developing insecure attachment
2 styles which are associated with later relationship
3 difficulties, and diminished educational and employment
4 opportunities.
5 This diminished social and economic capital also has
6 implications for reduced mental and physical health.
7 There are a number of proposed mechanisms that
8 contribute to understanding why child maltreatment
9 increases the risk of poor physical and mental health.
11.44 10 Research focused on biological mechanisms finds that
11 there are neurological changes that can occur in adverse
12 environments. In particular, there is evidence that
13 child maltreatment can lead to altered
14 hypothalamic-pituitary-adrenal stress response networks,
15 the HPA network.
16 The HPA axis is involved in the fight or flight
17 response. Fight or flight is a useful system to get us
18 out of danger quickly. It is a complex system that also
19 regulates immune functioning and inflammatory processes.
11.44 20 One theory suggests that child maltreatment alters
21 the HPA system so that it is more sensitive to stresses,
22 to dangers in the environment. While the physiological
23 mechanisms involved in a stress response are valuable and
24 useful for short-term dangers, persistent and chronic
25 exposure to stress is associated with a range of poor
26 outcomes.
27 So, coming to the question, what outcomes are
28 associated with time in out of home care, foster care or
29 institutional care?
11.45 30 We would expect that removing children from adverse
31 home environments and placing them in out-of-home care
32 should improve outcomes for children who have experienced
33 maltreatment. However, when children are removed from
34 parental care due to maltreatment, they remain at

1 increased risk of experiencing a number of poor outcomes,
2 including mental and physical illness, poorer educational
3 outcomes and greater contact with Justice and Child
4 Protection Services.
5 When compared with children from similar
6 backgrounds, taking into account the extent that's
7 possible, that children in care are at greater risk of
8 poor outcomes because they come from backgrounds of
9 adversity, some studies suggest that outcomes are not
11.46 10 improved and may even deteriorate for some children in
11 care.
12 So, for example, children who go into unfamiliar
13 foster homes can experience a greater increase in mental
14 and behavioural problems than children who remain in
15 maltreating homes, but maltreating homes that are not at
16 a level for the children, to the extent that the children
17 would be removed into foster care.
18 This is the point I wanted to clarify, that children
19 in severely maltreating homes should be removed from that
11.47 20 harm. The point to take from this research is that
21 foster care is not reparative for many children.
22 One factor that contributes to poorer outcomes in
23 placement instability. When in care, New Zealand
24 children typically experience 7-8 placement moves by the
25 time they are 8 years of age.
26 There is evidence from a number of studies that
27 placement instability is associated with a greater risk
28 of mental distress and symptoms of mental disorder.
29 Attachment theory and research present a compelling
11.48 30 argument for the necessity of consistent, loving, and
31 responsive caregiving, and thus the likelihood that
32 placement disruption will have devastating consequences
33 for a young person's development.
34 In support of the argument that placement

1 instability contributes to an increase in problems,
2 children who go into foster care with average levels of
3 mental and behavioural health problems are most likely to
4 experience an increase in problems following placement
5 stability. So, that is it's not just that children with
6 pre-existing difficulties are more likely to experience
7 placement disruption at first.
8 Children placed in residential care, so group homes
9 and institutional care, have worse mental and behavioural
11.49 10 outcomes than children placed in family based foster
11 care. And by family based foster care, I mean unfamiliar
12 based foster care, not kinship care.
13 When children and young people are asked their
14 perspectives ongoing into care, many children reported
15 missing their mothers and reporting that their lives
16 would have been better or the same if they had stayed
17 with their families.
18 Young people report preferring family based foster
19 care to residential care.
11.49 20 Specifically, in Aotearoa New Zealand children who
21 were in the care of Child, Youth and Family, now Oranga
22 Tamariki, are at greater risk of experiencing a number of
23 adverse outcomes, including higher engagement with Youth
24 Justice and Corrections, poorer educational achievement
25 and poorer mental health when compared to children who
26 have no contact with Child, Youth and Family.
27 Women with contact with Child, Youth and Family as
28 children are nearly three times more likely to be parents
29 before age 25, and as parents are three times more likely
11.50 30 to have their child referred to Child, Youth and Family.
31 So, a set of analyses of a cohort of children born
32 in 1990-1991, found those children who were ever placed
33 in Child, Youth and Family care were:
34 Twice as likely to fail NCEA level 2; 78% left

1 school with less than NCEA level 2 compared with 36% of
2 children with no contact with Child, Youth and Family.
3 They were ten times more likely to have been in
4 prison before age 21. So, 18% compared to 2% of all
5 children.
6 They were more than twice as likely to have a mental
7 disorder. Five out of ten had identified mental health
8 issues compared to two out of every ten who did not have
9 contact with Child, Youth and Family.
11.51 10 Maori children are particularly affected. Maori
11 children were significantly more likely to have a
12 hospital admission arising from assault, neglect or
13 maltreatment.
14 6 out of 10 children in foster care are Maori.
15 Intervention practices within a narrow focus on
16 child removal do not address structural barriers,
17 systemic racism and can further perpetuate harm through a
18 placement that does not ensure cultural continuity.
19 Moreover, a focus on risk and individualistic child
11.52 20 protection policies conflicts with ways of knowing
21 embedded in indigenous identity and values of Maori
22 within Aotearoa New Zealand.
23 My research most often focuses on statistics and the
24 increased probability of risk but mind these numbers are
25 the stories of individuals. I have also worked as a
26 clinical psychologist and heard, and read in their files,
27 some of the stories of individuals who grew up in care.
28 Some historic files contain accounts of boys who
29 spent time in multiple group homes until the State
11.53 30 relinquished responsibility for them when they turned 15,
31 leaving them with few resources. At the time that I was
32 talking with them, these men were incarcerated.
33 It has seemed to me that as a society we failed in
34 our care of these men when they were children in our

1 state mandated children's homes. We placed these
2 children in institutional care, failed to provide
3 adequate care, and then again placed them in the
4 institutional control of prisons when they went on to
5 commit crimes that hurt others.
6 My third question, what is the effect on the family
7 and the likelihood of family reunification when a child
8 has been removed into care?
9 In addition to research finding poor outcomes for
11.54 10 children removed into foster care, there is evidence that
11 removal of children into care has poor outcomes for the
12 mother, which ultimately has implications for her
13 children.
14 Qualitative evidence describes mother/child
15 separation as a traumatic event that involves the
16 devastating grief of losing a child, loss of identity as
17 a mother, and the added assault of stigma and the
18 societal invalidation of such a loss. Not only does a
19 parent experience the loss of a child but they experience
11.55 20 guilt and marginalisation at being blamed for that loss.
21 Internationally, quantitative evidence finds that
22 compared with mothers in the general population, mothers
23 whose children were taken into care had higher rates of
24 mental disorder, housing instability, and poverty prior
25 to having their children removed, which is what we would
26 expect. But this inequity increased in the two years
27 after having a child taken into care.
28 So, when mental health and structural factors that
29 contributed to the initial removal of a child are
11.56 30 intensified following the removal of a child, family
31 reunification and thus, ultimately, the child's welfare,
32 is undermined.
33 My final question, what evidence supports
34 alternatives to out of home care?

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

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

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

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

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

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

1 aimed at changing the factors associated with Care and
2 Protection concerns.
3 A qualitative evaluation of one of these Aotearoa
4 based family preservation services was undertaken by my
5 team. We found that service users and staff provided
6 hopeful stories that included the centrality and
7 importance of relationships, the development of practical
8 skills and psychological resources through participation
9 in a wrap-around, holistic programme, described by many
11.59 10 of the participants and the staff as being like a family.
11 The reports from these women and from the staff
12 contrasted markedly with qualitative reports of women's
13 experiences with Child Welfare services.
14 The stories told in our study suggest that a
15 relational and skills based programme within a supportive
16 residential community environment has the potential to
17 change the lives of women and children.
18 Internationally, few studies have investigated
19 longer term, residential programs and so we have minimal
12.00 20 robust evidence to be able to comment or determine
21 effectiveness.
22 Robust research directly assessing the effect of
23 family preservation interventions is limited but
24 indicates some components may reduce out of home
25 placements for some children.
26 Further research, in particular qualitative
27 research, is necessary to investigate whether
28 participation in this Aotearoa based family preservation
29 programme results in reduced risk of future out of home
12.00 30 placements, along with improved outcomes for children.
31 It is time to change the focus of Child Welfare
32 interventions from one that focuses only on the child and
33 the child's risk, to a new paradigm that understands that
34 parent and child wellbeing are inter-related.

1 The stories of service users and of staff suggest
2 that there is some value in pursuing a paradigm that
3 supports and fosters family resilience.
4 Q. Kia ora, thank you for that.
5 **MR MERRICK:** Mr Chair, I have had discussions with
6 counsel about possible questioning. I have a
7 couple of questions to put, I will put on behalf of
8 Ms McCartney. As I understand it, Mr Stone may or
9 may not have questions, in light of Dr Rapsey's
12.01 10 evidence but we can confirm that. I will put these
11 questions first.
12 Q. They are to you Professor Tarren-Sweeney. The first
13 question relates to briefly what happened with children
14 in New South Wales who were moved out of residential
15 homes into the community as a result of that shutting
16 down of residential homes?
17 **PROFESSOR TARREN-SWEENEY:** That occurred in the 1990s
18 following the Usher Inquiry, Usher report, Father
19 John Usher was the man who did that, led that
12.02 20 Inquiry. Every residential facility from the
21 largest residential institutions to the smallest
22 group homes were closed. There were no exceptions.
23 And so, with such a radical change, there were, of
24 course, some negative outcomes from that for
25 specific children but in the main it was a brave
26 and positive move because it forced cultural change
27 and it forced a way of thinking afresh around how
28 to care for difficult to place children.
29 New South Wales at the time had a funded, parallel
12.03 30 funded service for young people, teenagers, who had run
31 away from home or homeless, there was a youth refuge
32 system. And so, for a time, for several years, many of
33 those young people, they were mostly adolescents that
34 were very difficult to place, found themselves living in

1 the youth refuges for periods of time.
2 Over time, there was a very small number of young
3 people that could never be successfully placed with
4 families and over time the government relented and
5 gradually started to reintroduce funded residential
6 placements.
7 And so, I think it was in the 2000s that happened,
8 and so particularly organisations like Life Without
9 Barriers, who I think work here in New Zealand as well,
12.04 10 started to be allowed to provide small group homes for
11 those most difficult to place kids.
12 Q. Was that monitored by the child protection?
13 **PROFESSOR TARREN-SWEENEY:** It was oversight, they were
14 licensed by the State Child Welfare authority but
15 there was also oversight by the children's
16 guardian. But I think the important thing is that
17 even though residential care has been reintroduced
18 in New South Wales, the numbers of children in
19 residential care of young people is far, far lower
12.05 20 than it was previously. And so, on the positive
21 side, it effected positive side because it forced
22 the State to think about how could we place young
23 people, mostly young people, mostly adolescents,
24 and some children, who historically and
25 traditionally were seen as being unfosterable, how
26 can we make that happen?
27 And so, I think in the process of being forced to do
28 that because of this quite radical change, the State had
29 to learn ways of doing this, in terms of training
12.05 30 particular caregivers, foster carers, to be able to take
31 specific, very difficult to care for, young people and
32 children.And off then those were placements where there
33 was only one person, one child or one young person
34 placed. And there was definitely a financial cost to

1 this because the level of resourcing and the level of
2 support and training and ongoing assistance required to
3 support these placements is quite expensive but bearing
4 in mind that we're talking about a relatively small
5 number of children in care that this applies to.
6 Q. Thank you. I'll move on to the other bigger question
7 that I have been referred, and that's seeking some
8 clarification or reconciling your earlier evidence that
9 statutory care exposes children and young persons to
12.06 10 developmental risks, alongside this tension that you both
11 talked about, that it's against the interests of children
12 to remain in environments involving serious maltreatment.
13 And so, the question was, how do you reconcile the two?
14 It may have something to do with what you talked about,
15 being two bad choices but I will leave that to you to
16 answer.
17 **PROFESSOR TARREN-SWEENEY:** There are two solutions, and
18 they are not mutually exclusive and they shouldn't
19 run in conflict with each other or be seen as
12.07 20 opposing choices. In other words, there is a kind
21 of perception there is a false dichotomy between
22 family preservation and permanent placements, and
23 there doesn't need to be. It's not paradoxical
24 that the State could both be investing more efforts
25 into family - the State should be at the same time
26 investing more efforts into not only funding
27 family's parenting interventions but I think, more
28 importantly, funding research into finding
29 effective family parenting interventions. In other
12.08 30 words, developing interventions that work to reduce
31 maltreatment to the point where children don't need
32 to come into care.
33 At the same time, we have to recognise that even if
34 we got to that Utopian point where we were able to

1 develop interventions that dramatically reduced
2 children's exposure to harm, there would always be some
3 children that need to come into care.
4 And so, the other point is that for those children,
5 for those small number of children who cannot be raised
6 by their parents, the point that I'm trying to emphasise
7 is that they need to be raised by someone else, not by
8 the State.
9 And so, I see statutory care or State care as
12.09 10 really, it should only exist for strictly temporary, for
11 children who need temporary care. It shouldn't, no child
12 should grow up in statutory care in this situation that's
13 extremely unnatural and harmful for their development.
14 So, I don't actually see that those two endeavours
15 as being contradictory. I see them as being
16 complementary.
17 However, I think in practice, if we look around the
18 world, the bigger difficulty is social workers being able
19 to be able to simultaneously, philosophically be able to
12.10 20 be comfortable with those two positions. In practice,
21 it's very difficult. People tend to, we see for example
22 in Scandinavia which has the strongest and highest level
23 of family preservation resourcing and the strongest
24 commitment to family preservation resourcing, that
25 because the philosophy is so strong, that those social
26 workers that work in that system find it very difficult
27 then to raise their hand and say, "These children need to
28 be in care".
29 In other words, it becomes difficult for people who
12.10 30 were investing from a philosophical and from their hearts
31 into a system of supporting and improving families, so
32 that children can remain with their families, it's very
33 difficult for those people to simultaneously be the
34 person that says, "Look, these children's experience of

1 maltreatment is ongoing, it is severe" and what happens
2 sometimes in Scandinavia is social workers then become
3 complicit in children being maltreated and not being
4 responded to.
5 Q. That covers that group of questions, I think. I'll leave
6 it now to you, Mr Chair, to see if Mr Stone has some
7 questions.
8 **CHAIR:** Thank you, Mr Merrick. Now, Professor and Dr, I
9 am going to ask if any of the other counsel wish to
12.11 10 address questions to you. Mr Stone?
11 **MR STONE:** Yes, I'd like to.
12 **CHAIR:** Please come forward.
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2 **DR CHARLENE RAPSEY**
3 **PROFESSOR MICHAEL TARREN-SWEENEY**
4 **QUESTIONED BY MR STONE**
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8 Q. I act for Dr Lynn Russell, she is the main claimant for a
9 claim currently with the Waitangi Tribunal. Her WAI
12.12 10 number is 2684.
11 In her claim, she says that Maori who are entering
12 into prisons actually have mental health issues and that
13 a large number of them are going into prison because
14 they're not getting their healthcare met before they
15 enter and then once they're in prison, they're not
16 getting the care they need there either. And then when
17 they're released, again they're not receiving the mental
18 healthcare that they need and they subsequently reoffend
19 and enter back into prison again. So, they are on this
12.13 20 perpetual merry-go-round. I was interested in your
21 evidence because it reinforced a report I read regularly
22 which said that entering into State care is a gateway to
23 criminal offending.
24 Professor, you said before that a quarter of
25 children, I think you used the term travel well and don't
26 need monitoring. That means then that there's 75% of
27 them don't travel well that need help?
28 **PROFESSOR TARREN-SWEENEY:** Yes.
29 Q. And you said that the Crown has three duties, the last of
12.13 30 which was to provide specialised clinical support, and
31 that they're not really getting that. That process IS to
32 get them in and to get them out as quickly as possible?
33 **PROFESSOR TARREN-SWEENEY:** Yes, the existing Mental
34 Health Services are not designed for children in

1 care or maltreated children. They are designed for
2 the community at large. Because the demand for
3 services is so high and the waiting times are so
4 high, there's such a long wait list, the government
5 prioritises psychological treatments that are
6 relatively brief and rapid, rather than longer
7 term, so that they can get more throughput, so more
8 children can access the services. But that very
9 approach doesn't work well for these children.
12.14 10 Q. We can say then that the Crown is failing these people at
11 every level? It is failing them as children placed in
12 care? It's failing them as young adults? It's failing
13 them as adults and as inmates? And failing them once
14 they get out?
15 **PROFESSOR TARREN-SWEENEY:** This is a really good example
16 of how, if the State, if the Crown were to address
17 the core problems of these children's development
18 in lives at the earliest possible times in their
19 lives, not only would they save those children's
12.15 20 lives and save future generation's lives, but they
21 would prevent so many consequential effects that
22 affect everyone and which add to the cost for
23 society, in terms of provisions of services.
24 So, this is a really clear example of where early
25 decisive intervention, doing the right thing even if it's
26 costly, saves many things, not least of which is that we
27 don't have as many lives destroyed.
28 Q. If the Minister of Corrections were here today and he
29 said to you, "Look, I'd like to build bigger prisons",
12.16 30 what would you have to say about that?
31 **PROF TARREN-SWEENEY:** I'm not sure that that's an area
32 I'd have expertise in but I think that - I think
33 what this kind of puts a light on, is the idea that
34 this is actually something that requires a whole of

1 government approach because, you see, the Minister
2 of Corrections is only thinking about the
3 particular concern that the Corrections Department
4 has. It doesn't necessarily make sense that
5 Corrections goes into the business of children's
6 social work or Mental Health Services. But a
7 government at large can be thinking about this
8 strategically. For example, in New South Wales one
9 of the things I didn't say that actually led to
12.17 10 increased revision of Mental Health Services for
11 children in care, was that that government
12 introduced a thing called best endeavours
13 legislation or a best endeavours law. And what the
14 law said was that children in State care, by virtue
15 of the fact that not only was those children's
16 guardianship legally transferred to the State but
17 as a society when we remove children from their
18 parent's care, we as a society then have to take on
19 a duty of care and a degree of responsibility for
12.17 20 children's lives that other families don't share.
21 So, best endeavours legislation says that if a child
22 is in care, they go to the top of the queue for the
23 waiting list for any government service, whether it be
24 educational services, social work services, mental health
25 services or even services that may prevent young people
26 from offending and coming into Youth Justice.
27 And so, that was actually, that became law. And
28 because the law says you have to do that, it's like
29 submitting a freedom of information request. Social
12.18 30 workers would submit a best endeavours request to a
31 local, to their child Mental Health Service, which places
32 that child at the top of the queue.
33 **MR STONE:** Thank you.
34 **CHAIR:** Thank you, Mr Stone. Any other counsel? There

1 being none, I'll then ask my colleagues if they
2 have any questions of either Professor
3 Tarren-Sweeney or Dr Rapsey?
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DR CHARLENE RAPSEY
MICHAEL TARREN-SWEENEY
QUESTIONED BY COMMISSIONERS

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

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

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

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

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

1 New Zealand children that are known to Oranga Tamariki,
2 I'm talking about the most serious cases here. It's
3 about being able to have the means to more clearly
4 identify which of these children we need to be focusing
5 on the most.
6 The problem that you allude to around institutional
7 abuse of power, to some extent, racism, bias, that is
8 problems I don't have any expertise in or I don't have an
9 answer to, other than the fact that in identifying a
12.21 10 policy, a policy need like I have done here, it's
11 important not to believe that it's a straightforward
12 matter of achieving that.
13 And so, we can say more clearly that developmental
14 science says we need to find the children who have been
15 harmed the most as early as we can and to work out
16 whether we're providing enough support or services for
17 their family in order for those children to be able to
18 remain with their family or whether, in fact, they need
19 to come into care.
12.22 20 And one of the problems, one of the larger problems
21 that, one of the larger impacts that happens for these
22 children, is when we don't do that because children that
23 experience really severe maltreatment for long periods of
24 time, coming into care for example at age 8 or 9 or 10,
25 are in such poor shape psychologically that it's really
26 asking a lot of us to be able to work out how we can then
27 repair that within the short space of time that's left of
28 their childhood.
29 But I think what you're talking about is a really
12.22 30 important point, and that is we can have a clear idea,
31 this idea to me is crystal clear, but when you go to try
32 to kind of implement that idea, just as I've alluded to
33 all sorts of systemic problems within the care system,
34 there are potentially systemic problems within the child

1 protection system which is within the same ministries but
2 child protection remember is a different part of Oranga
3 Tamariki as distinct from out of home care.
4 So, I don't have an answer for you but I think it's
5 a valid concern.
6 **COMMISSIONER ERUETI:** Thank you. I did wonder too if
7 you could elaborate some more about the specialist
8 services that should be provided to children in
9 statutory care which you've referenced also the
12.23 10 cultural needs that they might have. To what
11 extent do we have those services available here in
12 New Zealand? Are there models or are we forced to
13 look to Australia like NSW for inspiration?
14 **PROFESSOR TARREN-SWEENEY:** There's nowhere in the world
15 that does it very well. There is a very - there
16 are some examples that I can refer to but what's
17 really interesting, is even in the United Kingdom
18 where they seem to have done the best, this never
19 came out of a central government policy change or
12.24 20 an issue. Most of these services arose from the
21 ground up because dynamic clinicians, you know,
22 visionary clinicians decided we needed this. In
23 Glasgow, for example, I believe there were five or
24 six Child and Adolescent Mental Health Services,
25 government ones within the National Health Service,
26 and a group of clinical staff that specialised
27 themselves individually in work in this area came
28 together and said, "Look, we want to do this
29 better". And so, they managed to do a restructure
12.25 30 within the Glasgow services, so that one of them
31 was setup just for children in care and maltreated
32 children. And then the clinicians that work in the
33 six services that specialise in that work all came
34 to that one service. Not only that, we're finding

1 with this service and others, they are best if they
2 are co-located with Child Welfare services. So,
3 they then move that new specialised service into a
4 building with, in one of the most impoverished
5 parts of Glasgow, so it was not fancy, and they
6 co-located with the Child Welfare service. And the
7 reason for that is, a lot of the nature of this
8 specialised work is not just about the clinical
9 work, it's about how those specialised services can
12.26 10 shape casework.
11 And so, it's realising that some of the best ways
12 that we can use this specialised knowledge is to guide
13 social workers and what they're doing, rather than
14 providing some kind of magic treatment that will fix this
15 problem. There is no magic treatment.If there is one,
16 it's just really stability and love. And so, it's
17 helping social workers work out how to do that and to
18 kind of try to ward off things like moving children from
19 one place to another.
12.26 20 **COMMISSIONER ERUETI:** Thank you, Professor, I really
21 appreciate that. Me and my colleagues have spent a
22 lot of time in private sessions hearing about in
23 foster care our children being moved from dozens of
24 homes to the next.And hearing about the long-term
25 effects that has had on the survivors.
26 One last question for Professor Rapsey, it's about
27 the comment you were describing as family preservation
28 intervention, I was really fascinated by that. It seems
29 there's very little research to that, quantitative
12.27 30 research you said?
31 **DR RAPSEY:** That's right, yes. So, we can theorise that
32 family stability is optimal and if you can
33 intervene sufficiently with that family of origin
34 to ameliorate those Care and Protection concerns

1 that would have otherwise led to those children
2 going into foster care. And you can prevent that
3 additional harm that goes from the initial
4 separation, then that will have better outcomes for
5 children and for their families. But we don't have
6 any actual evidence to support that.
7 **COMMISSIONER ERUETI:** Is that research that you're
8 undertaking?
9 **DR RAPSEY:** I am, yes. I'm not sure if you are familiar
12.28 10 with the IBI integrated data, yes? So, I'm
11 waiting, I'm on the list to use that data to
12 investigate - the children whose mothers have gone
13 through these services, what were their "outcomes"
14 in terms of this really big imprecise measurement.
15 We can't measure their developmental outcomes but
16 we can measure their outcomes in terms of did they
17 go on and end up in foster care anyway? Did this
18 intervention just stall the process or did those
19 children, and potentially additional children that
12.28 20 that mother might go on to have, were they then
21 protected from going into a system that might then
22 have involved multiple placements? So, that's the
23 first step in terms of the effectiveness of this
24 programme and looking at the health, other outcomes
25 as well, as much as we can with this clunky data
26 that we have.
27 **COMMISSIONER ERUETI:** Kia ora, thank you.
28 **COMMISSIONER SHAW:** Thank you both for your evidence.
29 I've got two questions that arise from what my
12.29 30 colleague has just referred to, and that's the
31 private sessions which the Commissioners have been
32 undertaking, speaking with individual survivors.
33 We've heard from currently up to this stage from
34 about 200 individuals and we have over the last

1 days of this hearing heard from individual
2 survivors. One of the horrifying things that many
3 of these say, is that they did not feel as though
4 they were treated as humans, they were not being
5 treated as human beings, and they say that in many
6 ways but I think that just summarises what they
7 felt.
8 Listening to your evidence today seems to me to
9 suggest maybe why they felt that. For you, Professor
12.30 10 Tarren-Sweeney, you spoke of loss of attachment of love,
11 loss of a permanent family. Could this be why they felt
12 as though they were not being treated as human?
13 **PROFESSOR TARREN-SWEENEY:** Perhaps many of the people
14 that you've been speaking to privately were in
15 residential settings but perhaps also with families
16 as well. Sometimes we can over think this but for
17 me, I often just try to imagine myself, you know,
18 or the thing that I keep saying to try and shift
19 people's thinking, is what is it that you would
12.31 20 want for your own child or for your own
21 grandchildren? Does it meet that standard?
22 And the first thing is, no-one would ever want their
23 own child or grandchild to be raised in an institution,
24 not because an institution has a bad reputation or bad
25 name but because institutions, as good as they can be in
26 terms of the absolute best types of institutions that
27 ever existed, the childhood or the experience a child has
28 in growing up in an institution, as I said right at the
29 end of my evidence, I think goes beyond the limits of
12.31 30 human adaptation, goes beyond the limits to which we've
31 e~~in~~volved as a species, which is at its very core we are
32 a social species and at the very core of that social
33 aspect is family.
34 If you read between the lines, my way of thinking

1 about family is quite fluid. You know, it's not
2 necessarily tied to blood but it's certainly about how we
3 feel and the strength of relationships.
4 And so, that really is - that's why institutional
5 care, there are almost no chances, there are very rare
6 cases where children may have bonded very closely to a
7 residential care worker but if they're working shifts,
8 you know - and then for foster care, I think the
9 experiences of growing up in foster care are much more
12.32 10 varied than what I have explained today. There's a risk
11 in reading my evidence that you would go away thinking
12 that all foster care is bad. In fact, I've worked for
13 many years of my life working with foster carers and some
14 of the foster carers I have worked with are amongst the
15 best people I have ever met in my life and quite
16 inspirational and their capacity for love and for giving
17 love to children and their commitment to them is
18 phenomenal. But by and large most foster carers'
19 commitment to the children that they raise is conditional
12.33 20 and it's conditional by virtue of this contract. So, we
21 can have a situation where foster parents can be as good
22 as any parents that exist, and yet the nature of the
23 relationship and the longer term commitment is qualified.
24 **COMMISSIONER SHAW:** So, when survivors say, was it my
25 fault that I wasn't treated as a human being; what
26 would you say to them?
27 **PROFESSOR TARREN-SWEENEY:** Well, first of all, I would
28 say I can understand why they believe that, even
29 though it's not true.
12.34 30 **COMMISSIONER SHAW:** Yes. And that's the important
31 thing, it's not true, is it?
32 **PROFESSOR TARREN-SWEENEY:** It's not true. There but for
33 the grace of God go us.Every one of us is born
34 the same and equally. I believe that the vast

1 majority of negative feelings that people have for
2 themselves are acquired after birth, not because of
3 genetics or other things like that. And so, in
4 that respect, children in care are as a result of
5 two things; one, the experiences that they had
6 before they came into care; and secondly, the
7 experiences they have in care, they often have
8 very, very negative self-image. They see
9 themselves sometimes as being essentially
12.35 10 unlovable. And then they also have similar
11 distortion this is how they recognise and perceive
12 the people that are trying to care for them.
13 And so, on the one hand, sometimes the care that
14 they're getting is not good enough or it's qualified but
15 also, how they perceive that and understand it and
16 reconstruct it is often distorted. And so, it's
17 definitely not their fault.
18 **COMMISSIONER SHAW:** I think it's important that you say
19 it is definitely not their fault.
12.35 20 **PROFESSOR TARREN-SWEENEY:** Yes. And one of the reasons,
21 the problem with placement breakdowns and placement
22 instability, is that it's typically constructed in
23 terms of the placement breakdown because this
24 child's behaviour was too difficult. Now, at the
25 face value that may be the case, that the foster
26 parent says, "I can't care for this child because
27 their behaviour is so difficult". But the way the
28 child then reflects on that and perceives that, is
29 this is confirmation of my own belief of myself as
12.36 30 being unlovable and bad, and they don't have the
31 ability, and neither do the foster parents, of
32 actually understanding and making sense of how it
33 came to this.
34 **COMMISSIONER SHAW:** Thank you for that and that leads me

1 directly into Dr Rapsey's evidence because you
2 listed in paragraph 10 all of the commonly
3 occurring mental disorders that were suffered by
4 children. Again, just bringing it back to a
5 survivor perspective for a moment, so many say I
6 was a naughty kid, I was being naughty, they
7 punished me because I was being naughty. And it
8 just struck me that what they felt was in a blaming
9 way their own fault, in fact could well be
12.37 10 explained by the matters in your paragraph 10 and
11 probably other things as well?
12 **DR RAPSEY:** Yes, absolutely. And I think we all try to
13 make sense of our world and one of the ways that
14 children in care can do that, is to make it, how do
15 I understand why I'm in this situation? It must be
16 something that I have done. Children will do that,
17 even if that's not told to them explicitly. But
18 certainly in the historical files that I have
19 reviewed, there is that impression - well, that
12.37 20 explicit message that comes through from workers at
21 the time, that it is naughty behaviour which is be
22 a abhorrent sort of interpretation to us now or to
23 myself because whatever that outcome is, whether it
24 is a greater likelihood of experiencing depression
25 or anxiety, whether it's a greater likelihood of
26 becoming incarcerated, those things are a result of
27 a person adapting to the best of their ability to
28 the situation that they are in, in a way that any
29 of us would adapt if we were in that situation.
12.38 30 It's quite clear what the drivers of - what it is
31 that leads a person to that end outcome and it's
32 certainly not because of any fault or inherent
33 capacity of that individual.
34 So, yes, both that experience of mental disorder is

1 likely a normal and a person doing the best that they can
2 do to survive in an impossible situation, as well as
3 contributing to their impression, it's something that's
4 also going on at the time, if they're experiencing a
5 mental disorder then that's going to contribute to their
6 behaviour.
7 **COMMISSIONER SHAW:** Thank you for that answer. I have a
8 quick question of detail for you from your
9 paragraph 32, where you're talking about the
12.39 10 Aotearoa New Zealand experience and particularly
11 Maori children.
12 There you say that Maori children were significantly
13 more likely to have a hospital admission arising from
14 maltreatment than European children. You say that in the
15 context of - you start by talking about New Zealand
16 children who were in the care of Child, Youth and Family.
17 Is your statement there in paragraph 32, does that relate
18 to all Maori children or only those who have had contact
19 with or were in the care of Child, Youth and Family or
12.40 20 Oranga Tamariki?
21 A. I understand that that applies to all children but that
22 isn't - that's part of why they come into contact with
23 Oranga Tamariki.
24 **COMMISSIONER SHAW:** New Zealand children in the care of
25 Child, Youth and Family were at greater risks of
26 experiencing more adverse outcomes. That's you
27 saying children in contact with the authorities
28 basically. Then when you go on and talk about
29 Maori children, does that refer to Maori children
12.40 30 who were in contact with the authorities?
31 **DR RAPSEY:** No, I don't think, I think it's the general
32 population. That's my remembering of that
33 research.
34 **COMMISSIONER SHAW:** Okay, all right, thank you. And

1 then I have one more question of a sort of higher
2 order, and it came through the evidence of both of
3 you. And that was the cost of providing care,
4 particularly you, Professor Tarren-Sweeney, in New
5 South Wales, the intervention at that very early
6 stage, the very high cost of that, and the cost to
7 our society of mental disorders. I know that
8 either of you is an economist and I think we will
9 be looking for economic evidence in the course of
12.41 10 our Inquiry over the negotiation few years but do
11 either or both of you want to comment on what you
12 perceive as the best spend for New Zealand in this
13 area, beginning with the start of the early
14 intervention or the outcome end?
15 **PROFESSOR TARREN-SWEENEY:** Colleagues of mine at Oxford
16 University have developed a tool actually that can
17 be used for this. It's a cost calculator that can
18 be used in Child Welfare services and you can
19 actually pop in different numbers into this
12.42 20 calculator and it can actually show you how much
21 money interventions cost, for example for a child
22 with high levels of mental health needs in care at
23 a certain age, and what you actually gain in terms
24 of economic benefits to the State through that
25 person's lifetime.
26 So, their research has shown using real examples and
27 using this calculator, has actually provided practical
28 proof, I guess, that intervening early with effective, I
29 think the emphasis is on effective, effective
12.43 30 interventions, effective services, not only does it save
31 lots of money for the State but, you know, there is an
32 incalculable savings in terms of the human side.
33 **COMMISSIONER SHAW:** Did you want to add anything to
34 that, Dr Rapsey?

1 **DR RAPSEY:** My understanding is that there is, Treasury
2 has already calculated the cost of care, so I can
3 provide you, I can't remember what the numbers are
4 but you can, of course, draw conclusions from what
5 we have presented, that the cost of later
6 incarceration, the cost of later involvement with
7 Child Protective Services, that there is a
8 substantive cost associated with care. So the
9 former Governments focused on a social investment
12.44 10 model done at that time, which did generate an
11 estimate of what being in care cost compared to
12 not. And part of the work that we're planning in
13 terms of looking at these intensive family
14 preservation interventions, which are costly
15 interventions, do they work out cheaper in the
16 long-term?
17 And the other piece of evidence that I could direct
18 you to, is to that 2015 investigation into Child, Youth
19 and Family. I am fairly sure they have a table that
12.44 20 details the cost benefit of particular interventions
21 early on to prevent child maltreatment. And certainly
22 significant savings can be achieved by intervening early
23 and intensively.
24 **COMMISSIONER SHAW:** Thank you both very much. I am
25 sorry to have ended on that rather, on the economic
26 note which I hope doesn't take away from the fact
27 that your evidence has been very powerful in terms
28 of showing us the dramatic and negative effects of
29 children in care, of the treatment that they have
12.45 30 received. Thank you both very much.
31 **COMMISSIONER ALOFIVAE:** Thank you for that. That might
32 be a nice segway into the question I would like to
33 ask you both, if I may.
34 I think, Professor Tarren-Sweeney, there would be

1 many NGOs and clinicians who would be feeling very
2 victoronic at your comments that actually, often the
3 answers lie, it comes about through the practice that can
4 then inform how they should be restructuring their
5 programs but it doesn't always fit the contract that they
6 might have actually landed in terms of delivering a
7 particular resource.
8 My question really is around, in paragraph 35,
9 Professor Tarren-Sweeney, you refer to the strongest
12.46 10 independent predictor of mental health is the age that
11 the young person enters into care. And I know you
12 referred to this too, Professor Rapsey.
13 Regrettably for us, one of the things that we've
14 come to know very well through the Inquiry, is that a lot
15 of kids come in as infants and age out in care. And so,
16 the issue of placement then becomes very critical because
17 in terms of looking at the systemic barriers, so we have
18 lots of language in our different bits of legislation and
19 health legislation, MOE, social services, around the
12.46 20 child focus, doing things in the childhood of a child.
21 Do you have any comments around actually where the nubs
22 are that actually in that pipeline, that actually need
23 particular attention?
24 **PROFESSOR TARREN-SWEENEY:** When you were talking about
25 nubs, do you mean with the -
26 **COMMISSIONER ALOFIVAE:** There are some critical points.
27 When you talked about your nature versus nurture
28 theory and talked about attachment, the timeframes
29 around actually when babies need to really be
12.47 30 placed either back with whanau or into a kinship or
31 a permanent caregiver?
32 **PROFESSOR TARREN-SWEENEY:** First of all, what I'm
33 illustrating with this point about age of entry
34 into care, it's not particularly pertinent to the

1 idea that children are in care, children who come
2 into care at an earlier age are in better shape.
3 It's more illustrative of the harm that happens
4 cumulatively for children severely maltreated over
5 time. So, all this, this is not an endorsement of
6 out of home care. It's really shining a light on
7 the fact that Child Protection Services are
8 increasingly focused on identifying severely
9 maltreated as early as possible. And despite all
12.48 10 of the current controversies, I believe that's the
11 right approach.
12 So, that doesn't mean, however, that those children
13 should come into care as infants and then grow up in
14 care. I think pretty much everything that I'm saying
15 suggests that either they need to be quickly returned to
16 their families, if they can safely care for them, or they
17 should be raised by another family or by extended family,
18 by whanau, or by unrelated family. But they shouldn't be
19 spending their entire childhood as a case. Right?
12.48 20 So, in terms of what your question is around what
21 we're talking about, the developmentally sensitive
22 timeframes and such. I mean, there's a different, a
23 range of different opinions on this. All I can say is
24 that the research tends to suggest that the incremental
25 effects of maltreatment are linear. In other words, it's
26 not like a particular - and that the first 3-5 years of
27 life is when most of it happens. So, if children are
28 severely maltreated for more than 5 years and they're
29 going into school, then often, even if they come into
12.49 30 care, it's very difficult for those children to come back
31 onto a normal life path.
32 In terms of at what age should be returned to their
33 families, I think that's partly what you're referring to
34 as well.

1 **COMMISSIONER ALOFIVAE:** Yes.
2 **PROFESSOR TARREN-SWEENEY:** I think this is where we need
3 to be guided mainly from attachment theory and very
4 good assessment, individual assessments, rather
5 than rules of thumb. So, I don't know if you saw
6 "I am a survivor of state care" documentary of
7 Daryl Brougham but there was a particular placement
8 that he had with a family and he was moved from
9 them and he was still fairly young and he had
12.50 10 endured some terrible, dreadful maltreatment in
11 care prior to that. But for whatever reason, he
12 had bonded to that family. So, I think the
13 important thing is not so much time but it's the
14 significance of the relationships.
15 And so, I think it's fundamentally wrong for us to
16 be dragging children away from caregivers where they have
17 bonded together very closely.
18 That said, the younger children are, attachment
19 theory tells us, the more malleable they are, the more
12.51 20 capable they are of forming new attachments and it's also
21 driven partly by the amount of contact that they've had.
22 So, if they've been returned to their mother, then if
23 they'd been seeing their mother a lot, so an existing
24 relationship has been preserved, then they're not
25 returning home to a stranger. And in turn, that's partly
26 determined by memory. So, the younger a child is, the
27 shorter their long-term memory is. And so,
28 relationships, ultimately relationships are held in
29 memories. So, if you don't know who someone is, right,
12.51 30 then you can't really have had a continuing relationship.
31 As you get older in your mind you can kind of construct
32 what appears to be a relationship but in terms of a real
33 relationship, carrying someone in your mind in memory is
34 important. That's why older children retain much, much

1 longer memories of relationships then. I am not sure if
2 I've answered that.
3 **COMMISSIONER ALOFIVAE:** You have. The systems issue
4 that I'm referring to that our survivors have been
5 referring to throughout the stories that we've
6 heard and what we've heard in our private sessions,
7 is exactly what you're describing. It's the
8 inconsistent, there's just no attention paid
9 actually to how they feel, to the removal, they say
12.52 10 they like a caregiver but they're removed anyway.
11 This is the policy work that's going on behind the
12 scenes that is incongruent to I think -
13 **PROFESSOR TARREN-SWEENEY:** If you can imagine for a
14 moment that your child or grandchild had to live
15 with someone else but you were still concerned who
16 they were going to live with, you can imagine all
17 the things you would be thinking about. But the
18 State is a poor corporate parent, right? This is
19 notwithstanding the fact that we have so many
12.53 20 wonderful social workers. The people that work in
21 this field are so wonderful and yet, they're
22 working within a system that shapes their thinking
23 in ways where they intervene and make decisions
24 that don't reflect what they would do if this was
25 their own child or grandchild.
26 In terms of funded services and funded agencies, I
27 think if you read between the lines or maybe it's even
28 more explicit than that, I'm not advocating for services
29 necessarily to be funded with more money, I'm advocating
12.53 30 for the whole system to be basically closed down. And I
31 know that privatisation of foster care services has
32 actually led to an increasing powerful industry. And so,
33 what I'm proposing actually would be opposed by that
34 privatised fostering services. What they would rather do

1 is approach this from the point of view that it can be
2 remedied.
3 What I'm trying to argue, is that the system, this
4 system can't be remedied, it needs to be replaced.
5 So, people, there are funded services that, again,
6 they're doing all of this for the right reasons. Their
7 motivations are pure. But they will argue against what
8 I'm arguing for because the ultimate end point of this
9 would be that we would eventually replace care, the care
12.54 10 system with something else.
11 **COMMISSIONER ALOFIVAE:** Thank you, that's what I was
12 after.
13 And, Professor Rapsey, just your comment around the
14 RDI, and really the big dots that we look at but
15 obviously the qualitative data you were referring to, the
16 small dots, the colour, the journey that tells us.
17 Is it about scale? Is that what you're referring
18 to, in terms of being able to explain the stories of the
19 different cohorts, the different groups of families
12.55 20 you're working with?
21 **DR RAPSEY:** Is the question, why do we need that
22 additional evidence?
23 **COMMISSIONER ALOFIVAE:** I know why we need it. It's
24 about to tell the picture more clearly but is it
25 about scaling services? I just want you to unpack
26 it a bit more, if you are able to, please?
27 **DR RAPSEY:** I don't think I understand the question yet,
28 sorry.
29 **COMMISSIONER ALOFIVAE:** You have talked about your ADI
12.55 30 and you're waiting for that data but you've got
31 some qualitative work you're wanting to match it up
32 with or tell a story in those big dots. Can you
33 explain what you two would like to see come out of
34 that, is what I'm asking?

1 **DR RAPSEY:** We have qualitative data, we've analysed
2 that, done that part of the study but that's only a
3 small, a certain type of evidence and only a small
4 part, only the people who are in the service right
5 now. And so, ideally, we want to know what the
6 outcomes are of all of the children who have
7 participated over time. But actually, what's
8 really required is a bigger study which actually
9 assesses the outcomes of the children going into
12.56 10 the future, yeah. So, assesses their mental
11 health, assesses their behaviour, assesses their
12 attachment, and measures accurately how things are
13 when they go in and how things are when they go out
14 and over time.
15 **COMMISSIONER ALOFIVAE:** Thank you, no further questions.
16 **COMMISSIONER GIBSON:** Thank you both for your evidence.
17 I will start with a question to Professor
18 Tarren-Sweeney. The first part of it, you talked
19 about 25% of those going into State care were
12.57 20 people, children with intellectual disabilities and
21 language disabilities, and that's 2% of the general
22 population, so it's not just an over
23 representation, it's in the order of 12 times what
24 you'd be expecting.
25 I suppose, first I imagine it's complex what's going
26 on but what's your sense of what's going on for that
27 scale of these people who will be coming into State care?
28 And second to both of you, is there any difference in the
29 evidence of the journey to recovery wellbeing for this
12.57 30 group of people that have gone through care?
31 **PROFESSOR TARREN-SWEENEY:** There hasn't been, to my
32 knowledge, good research in trying to drill down
33 and identify the reasons for this. We know that
34 the type of intellectual difficulties is much more

1 likely to be verbal difficulties and language based
2 difficulties. And there's a fairly simple causal
3 mechanism that accounts for that for maltreatment
4 children and that is social neglect and
5 under-stimulation in infancy. So, children acquire
6 verbal intelligence and acquire language, learn to
7 speak, because they're spoken to and it's through
8 our social discourse and social interactions that
9 we acquire language.
12.58 10 And so, you see for example, extreme examples of
11 this if we look at research on children, infants that are
12 raised in orphanages in eastern European countries, the
13 very famous study of the English Romanian adoption study,
14 study of children that were experiencing very profound
15 neglect in orphanages where they were left in their
16 accounts for most of~~ever~~ the time.Almost all of those
17 children had some level of intellectual disability and
18 yet, there was no kind of underlying genetic or
19 biological reason for that. In other words, the evidence
12.59 20 suggests it was almost entirely due to their social
21 developmental experiences.
22 The other reason that I suspect again there's not a
23 lot of research done on this but I suspect the other
24 main, a contributing factor to this is pre-natal exposure
25 to alcohol and other substances. Particularly foetal
26 alcohol effects, we know there are quite well-known
27 effects on children's intellectual development.
28 That's the only two main ideas that I have.
29 **COMMISSIONER GIBSON:** Is there any difference in the
13.00 30 journey to recovery, the evidence around that for
31 this group?
32 **PROFESSOR TARREN-SWEENEY:** In my study, intellectual
33 disability was one of the independent predictors of
34 children's mental health. So, in other words, we

1 know that children in care with intellectual and
2 language difficulties are more likely to have
3 mental health problems than other children in care.
4 But we don't know how to explain that relationship.
5 It may just be that children that experience the
6 most severe maltreatment manage to get doubly
7 disadvantaged in terms of more likely having mental
8 health problems and having language problems.
9 **DR RAPSEY:** And I don't know whether to add to that with
13.01 10 a story. It's not research based. I assessed a
11 young person or seeing them, spending time with
12 their foster parent, they'd been in foster care for
13 the first 2-3 years of their lives and they were
14 developing typically and doing well and then they
15 were returned to their maltreating environment and
16 I got to see them again when they were 7 or 8. At
17 that time, they had lost all of the language they
18 were developing. They are almost not able to
19 communicate and had developed a number of
13.01 20 behavioural and extensive difficulties that were
21 now irreparable.
22 So, there are, yeah, crucial periods where remaining
23 in a maltreating environment, that sets the course for
24 the rest of the life of that young person.
25 **COMMISSIONER GIBSON:** Would it be right to assume that
26 there's, I suppose, strong evidence, fertile
27 ground, that there should be a lot more early
28 support pre-State intervention, whether it's
29 clinical or social or other, for this group of
13.02 30 people in particular who so many to be
31 over-represented in coming into the system?
32 **DR RAPSEY:** Yes, I would certainly argue for that. I
33 think keeping in mind what Professor Tarren-Sweeney
34 said about the need for intervention - sitting

1 there alongside the need for intervening and
2 keeping families together there is the need for
3 both of those but certainly to intervene with
4 families to address Care and Protection concerns
5 would be invaluable.
6 **PROFESSOR TARREN-SWEENEY:** I think it's pretty clear if
7 we look at Scandinavia, for example, if you apply a
8 population-wide family support and family
9 preservation approach, in other words across the
13.03 10 larger number of families where children are known
11 to Child Protection Services, that that has
12 effects, positive effects, in terms of not just
13 family preservation but children's wellbeing and
14 development.
15 So, that's kind of like a public health approach,
16 you know, where basically across the board we up the ante
17 in terms of providing support and interventions that can
18 improve family functioning and reduce the need for Child
19 Protection Services.
13.04 20 But I think with this particular population of
21 children in care, as I said before, these are the kids
22 the most, at the top of the pyramid. In this situation,
23 generic family support services and generic interventions
24 are not going to work. We are not even, at this stage we
25 don't really have good confidence yet that we have
26 interventions that do work for those families. My
27 colleague at Canterbury University, Sarah Whitcombe-Dobbs
28 is finishing a doctoral study on this topic and one of
29 the things she has done is quite a detailed review of the
13.04 30 effectiveness of parenting interventions for the highest
31 risk families and measuring effectiveness in terms of
32 reduced child protection notifications after the
33 intervention.
34 And the review doesn't really provide or yield many

1 promising studies yet. So, that's not to say we should
2 be giving up on this. I think if society has - if there
3 is a big goal for governments, rather than shooting for
4 the moon and trying to land a man on the moon, if we
5 could solve this problem of how to repair families, the
6 highest risk families so children don't come into care,
7 then that should be something the Noble Prize is given
8 to.
9 So, this is, you know, the problem, the human
13.05 10 condition we're trying to deal with, this problem.
11 So, we have a situation there, I think, of
12 simultaneously trying to - I think one of the problems
13 that Governments have got is just referring every family
14 to whatever the service is that's available. And we know
15 that for our highest risk families that's not going to
16 work. They actually need very, very targeted, very
17 specific services. And even in that situation, there's
18 no guarantee that it will work but at least if we try it,
19 we can - for the ones where it works, then it works. And
13.06 20 for the ones where it doesn't work, we know what we have
21 to do in terms of protect~~t be~~ing the children.
22 **COMMISSIONER GIBSON:** Thank you both.
23 **CHAIR:** Thank, you Professor Tarren-Sweeney and
24 Dr Rapsey. This is bleak territory but if I may
25 say so, your written briefs, which have been well
26 integrated by Mr Merrick, and the generous and
27 frank way in which you answered the many questions
28 we've put, have put considerable clarity to what we
29 have in front of us. That doesn't diminish in any
13.07 30 way the bleak picture that we look at regarding our
31 family. The Commission is very grateful for the
32 evidence that both of you have given. Thank you.
33 Madam Registrar, could you please adjourn the
34 sitting?

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