Hāhā-uri, hāhā-tea

Māori Involvement in State Care 1950-1999

Chapter 4: The impact of the system on Māori

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# Chapter FourThe impact of the system on Māori

Ehara i te aurukōwhao, he takerehāia.

It is not a leak at the top-strake lashing but an open rent in the bottom of the canoe.[[1]](#footnote-2)

## Summary

The State Care system has had various and interrelated impacts on Māori as individuals, and as collectives over the period (1950-1999). These impacts ‘circle out’ beyond the individual survivor to whānau, hapū, iwi Māori as well as following generations. The intersection of race, gender, class and ability resulted in differential impacts for Māori men and women, and tamariki Māori with dis/ abilities (p. 189).

The psychological, cultural, emotional and physical harms arising within and from State Care were considerable. For those children removed from their whānau, impacts included the loss of fundamental attachment relationships. For some children, removal granted them relief from abusive or harsh family environments. However, in most other cases, children experienced enduring sadness, guilt and internalised blame (p. 192).

Tamariki and rangatahi Māori also lost their access to the aspects of Māori culture that were positive and affirming. State Care survivors and Māori adoptees who grew up in the first half of the period in question (i.e. 1950 – 1970s), had the shared experience of growing up in contexts in which being Māori was openly disparaged (p. 194).

Children’s experiences of multiple placements while in State Care amplified their feelings of unwantedness. There was instability and insecurity arising from ‘failed’ and frequent placements. Children became wary of forging relationships with others, protecting themselves from the inevitable pain of displacement (p. 192).

State Care environments exposed children to neglect, physical, sexual and emotional abuse. For Māori (and Pasifika) children, abuse frequently had racist overtones. Survivors’ strategies for coping with their pain and suffering can also produce secondary impacts. Alcohol and drug use is a relatively common disconnecting/avoidance mechanism and will often develop into dependence (p. 193).

The failure of State Care to provide quality education for tamariki Māori led to widespread educational underachievement. This compromised the future employment and economic prospects of survivors (p. 195).

In conjunction with these factors, recruitment to gangs while in State Care set a number of rangatahi on a pathway to prison, with a significant subsequent effect on their life trajectories. The enduring lack of trust and resentment towards state authorities engendered by their treatment in State Care extended in life beyond, reinforced by subsequent experiences of incarceration (p. 199).

Despite these ‘pathologies’ resulting from their State Care experiences, the ‘survivorship’ of survivors must be acknowledged, their ability to endure and resist in the face of considerable and ongoing adversity (p. 203).

## Introduction

This chapter draws together document analysis and research findings that highlight the various and interrelated impacts the settler State Care system has had on Māori as individuals, and as collectives over the period 1950-1999. Placing survivors at the centre, we foreground the impacts experienced according to the life journey; the description of survivors’ experiences in State Care as tamariki or rangatahi and the subsequent events, impacts and consequences attributable to that experience across their life course (Katz, Jones, Newton, Reimer, Heintze, Pitts & Rosalky, 2017, p. 192). We also utilise Bronfenbrenner’s ecological systems theory (1976) to consider these impacts as they ‘circle out’ beyond the individual survivor to whānau, hapū, iwi Māori and following generations, and as they are embedded in broader processes and impacts.

Bronfenbrenner's (1976) theory proposes that human development is influenced by a complex system of relationships and proximal processes affected by multiple nested environments. The impacts of various environments and relationships are explained in the following figure.

Figure 4.1. The impact of Micro and Macro environment on tamariki Māori

Bronfenbrenner highlighted the interrelatedness of these nested levels from the micro-system through to the macro-system. These different levels also highlight various impacts. The micro-system includes the immediate settings of the child within a family, through to other social institutions (such as schools, residential facilities, youth justice facilities, foster homes). The macro-system encompasses society and government policies, including dominant societal values and norms, as well as broader economic conditions that influenced the way families live. For example, the degeneration of tribal networks and economic base – the very things that sustained whānau wellbeing – in the nineteenth century, followed by post-WWII economic changes, assimilationist social policy and urbanisation gave rise to conditions that saw tamariki admitted to State Care in increasing numbers. In addition, structural racism and discriminatory practices across State Care were fuelled by cultural superiority myths, perpetuating negative stereotypes of Māori as lazy, delinquent, criminal and deserving of their marginalised status (as described in the previous chapter).

Results will highlight the various harms inflicted, but this is not a deficit story of whānau. Literature review findings emphasise both variability and resistance. Māori communities are heterogeneous and individual factors mean not everyone is affected in the same way (Reid et al., 2017; McIntosh, 2019). Micro-level contexts and interactions with foster families, social workers, residential staff members and peers influenced tamariki and rangatahi behaviour, goals and expectations of success. They also produced different life journeys and trajectories. Not every child experienced abuse in State Care and for some, their recollections were positive (Stanley, 2016). Acknowledging the significance of intersectionality, we also recognise the differential impacts experienced, based on socially assigned ethnicity/race, gender, dis/ability and class among other factors. Although empirical evidence may not always be available, at the least any impacts at the macro- and micro-system levels must be conceptualised as variable according to how survivors and Māori are positioned structurally (i.e., the intersection of gender, dis/ability, race and class, producing particular effects for wāhine and tāne Māori).

As tangata whenua, Māori continue to experience marginalisation that shapes both lives and identity. Marginality can be expressed in a number of ways. Some are able to draw on the marginal experience as a site of resistance and use that location to challenge the status quo and to transform the marginal experience. This is usually a highly politicised identity where proponents are able to draw on significant cultural capital and an in-depth knowledge of both Māori and Western traditions. Others may acknowledge a marginal status but seek to redefine it under their own terms to allow them to develop a dynamic, distinctive and authentic fusion identity. For others, marginalisation creates a forced identity. This is characterised by a marked and stigmatised marginalisation where deprivation due to social, economic and political factors is entrenched and far-reaching. This last identity is particularly associated with the activities of the State and the intervention of the State into the lives of individuals and whānau. (McIntosh, 2019, p. 3)

Document analysis and research findings also demonstrate the considerable resistance of Māori collectives. The witnessing of trauma and damage arising from the failure of settler State Care, generated initiatives led by whānau, hapū and iwi. This is covered in further detail in Chapter 7.

### A note about sources

Where possible, we have drawn on Aotearoa New Zealand-specific data, although empirical evidence is limited in many respects. Bronwyn Dalley, Elizabeth Stanley and Judge Henwood (the Confidential Listening and Assistance Service) have produced important accounts, although these are only ever ‘partial tellings’. Dalley’s historical work gives more weight to official accounts of State Care, given her focus on government department archival records. Stanley’s work is more comprehensive in terms of incorporating survivors’ lived experiences/ oral accounts together with historical and other research, however her participants do not fully represent the demographic characteristics of children in institutional care. Only eight of the 105 contributors were female, and they were largely non-Māori (55/105) despite the disproportionate representation of Māori and Pasifika children in residential facilities from the 1970s onwards (Stanley, 2016, p.4). That this produces a particular version of events in State Care is recognised by Stanley, who recommends further research in order to understand ‘how institutional care is differentially experienced on the grounds of gender, ethnicity, age, sexuality and ability’ (Stanley, 2016, p. 4; Blake, 2017, p. 224). The report of the Confidential Listening and Assistance Service includes the accounts of a larger number of contributors (n = 1103), representing almost equal numbers of men and women (551 and 552 respectively), but still a minority of Māori and Pasifika survivors (432), and very limited numbers of people with intellectual disabilities (Henwood, 2015, p. 11). We have drawn on Mirfin-Veitch and Conder’s (2017) research into State Care abuse experienced by people with learning and other disabilities between 1950 and 1992. There were 17 participants, and only three identified as Māori. To learn more about the diverse experiences of Māori children in residential State Care, we have utilised a Youtube video interview Patrick Wikiriwhi Thompson (Queen Service Medal (QSM)) gave in 2004. Patrick was of Ngāti Paoa/ Ngāti Whanaunga descent and was a rangatira for Māori and Māori Deaf.[[2]](#footnote-3) He boarded at Kelston School for the Deaf in the 1970s. Patrick passed away on 29 March 2014 and his whānau have given us permission to use his interview.

**‘Āpiti hono tatai hono, te hunga o rā ki te hunga ora, tēnā koutou katoa’.**

Despite the limitations of current evidence, in culmination these sources provide the most detail of the institutional care environment in Aotearoa New Zealand and its impacts upon survivors.

As we trace the impacts out more broadly, we have had to draw on literature that is either less directly focussed on the Aotearoa New Zealand context, or less directly focussed on State Care.

 Research relating to institutional abuse and Out of Home Care (OOHC) from international contexts is largely supportive of the impacts that have been hypothesised or theorised in the Aotearoa New Zealand context. The broader historic/ intergenerational trauma/colonisation literature is useful in contextualising the societal and structural backdrop to State Care abuse of Māori children, however a reliance on this lens risks ‘glossing over’ the unique and specific colonising impacts for survivors and their descendants. In this way, the complementary blend of empirical and conceptual literature enables the respective strengths to address the respective limitations.

## Impact

The following section examines the main themes associated with impact from the perspectives of survivors, that emerged from the literature review. Psychological, cultural, emotional and physical harms arising within and from State Care were considerable (Mirfin-Veitch & Conder, 2017; Stanley, 2016). The final report (2015) from the Confidential Listening and Assistance Service identified ‘common legacies’ experienced by State Care and protection survivors:

* Distrust
* Difficulty forming relationships
* Fear of authority
* Loss of culture
* Family breakdown
* Anger and violence
* Depression
* Criminal behaviour
* Poor education and subsequent loss of potential (Henwood, 2015, p. 30).

The following section explores these impacts in more depth as a result of children being removed from their whānau.

## Effects on children removed from their whānau

### Disconnection from support systems

The State Care system impacted most directly and profoundly on those children who were placed within it. Through removal from their whānau, they lost fundamental attachment relationships. For some children, this granted them relief from abusive or harsh family environments. However, in most other cases, children experienced enduring sadness, guilt and internalised blame (Stanley, 2016, p. 44; Dalley, 1998, p. 138-9). Through admission to care, children were also separated from siblings and friends. Through the loss of these supports and sources of social identity, children became isolated. Some also experienced a profound sense of rejection, surmising that they were not wanted by anyone (Stanley, 2016, p. 45).

### Instability and insecurity arising from ‘failed’ and frequent placements

Children’s experiences of multiple placements while in State Care amplified their feelings of unwantedness. In 1988, for example, about 60% of children in state institutions had experienced at least one other placement, and approximately 30% had been in three or more. Children would often be transferred several times along the continuum of foster parents to family homes, church homes, and other community placements before arriving in institutions (Stanley, 2016, p. 46). These frequent transfers were disruptive and compromised children’s abilities to forge connections with others. This was particularly upsetting when children experienced loving, supportive home placements and foster families that were temporary (Henwood, 2015, p. 13). Children became wary of forging relationships with others, protecting themselves from the inevitable pain of displacement.

Emotional security and attachment are fundamental to infant and child development (Else, 1991; Fleming, 2018; Field & Pond, 2018). Children’s vulnerability towards adverse lifetime outcomes is linked to disordered attachment patterns, whereby the child does not form an emotionally secure attachment

 to their caregiver (Atwool, 2006). This vulnerability ‘increases exponentially with the number of placements’ and particularly for children in State Care (Atwool, 2006, p. 325). Even in a more permanent placement, such as that of closed adoption, the effects of initial relinquishment have been shown to impact adoptee relationships throughout their life course. All but one of 15 published studies reviewed by Field and Pond (2018) reported the influence of adoption on attachment style and intimacy across the adoptee’s lifespan, associated with enduring fears of abandonment: ‘The centrality of this anxiety of being rejected and abandoned, and thus afraid to trust, was reflected in both quantitative and qualitative studies, and for women and men alike’ (Field & Pond, 2018, p. 36).

### Exposure to harmful environments: neglect, physical, sexual and emotional abuse

The most confronting element of State Care is the extent of abuse that children were and have been subject to. Working under the pretence of children’s ‘best interests’, the state placed children into ‘chaotic, insecure and sometimes intensely harmful environments’ (Stanley, 2016, p. 50). However, 1959 marked the first time that child abuse was discussed in the Child Welfare Division in any depth (Dalley, 1998, p. 250). Survivors have reported suffering sexual, emotional and physical abuse at the hands of staff, peers, caregivers and their children, as well as relatives in some cases. Although a proportion of children had been admitted to State Care from abusive homes, it was later conceded by officials that the dangers from institutional or non-familial care were often greater than in the family home (Stanley, 2016, p. 50). Research into the experiences of children with learning and other disabilities confirms they experienced all types of abuse and neglect, as well as the trauma of not being believed when it was reported.

Most people had been physically abused. People who had been physically hurt often said that the physical abuse made them feel angry and powerless. Staff as well as other people living in the institutions and care homes were responsible for the physical and sexual abuse.

Sexual abuse started when the person was a child and was often kept secret until they were adults. People did not talk about it because they were ashamed and they thought they would not be believed. Those who did report that they had been sexually abused were not supported. (Mirfin-Veitch & Conder, 2017, p. ix)

Children’s bodily integrity, autonomy and dignity were compromised right from the outset of admission to State Care facilities. Survivors of institutions report being stripped naked, soaked with benzyl benzoate for treatment of lice or skin conditions, and showered roughly before being confined to secure cells without sufficient clothing or bedding for warmth. Intrusive, unnecessary and sometimes physically damaging examinations for venereal disease were experienced by female residents, for some giving rise to an enduring fear of medical practitioners (Dalley, 1998, p. 299; Stanley, 2016, p. 62). As part of daily life in institutions, verbal abuse, gruelling housework and kitchen tasks and lack of affection were commonplace (Stanley, 2016, p. 50). Furthermore, violence and humiliation administered by untrained, insufficiently experienced and poorly paid staff members could be mood-specific and therefore erratic, the unpredictability of which fuelled the almost constant fear (Stanley, 2016, p. 55).

For Māori (and Pasifika) children, abuse frequently had racist overtones. The Auckland Committee on Racism and Discrimination (ACORD) reported on the basis of a 1979 inquiry that the treatment meted out in institutions was ‘brutal, undignified, impersonal and racist’ (cited in Dalley, 1998, p. 299). This included generally being treated with contempt, being addressed in pidgin English to insinuate stupidity, as well as racial taunting (Stanley, 2016).

Significant proportions of survivors have reported sexual abuse in State Care; 57% of both men and women made such disclosures in their presentations to the Confidential Listening and Assistance Service (Henwood, 2015, p. 27). Sixteen of Stanley’s (2016,

p. 48) research participants reported being sexually assaulted within foster care, family homes or religious homes, and many more had been physically abused. Only a small number of children who had been abused appeared to become perpetrators themselves (Henwood, 2015, p. 27). However, there were exceptions.

Peer-to-peer abuse is an aspect of State Care that has only recently begun to receive attention internationally, primarily because the prevalence of sexual abuse in state institutions (specifically residential schools) was not widely acknowledged. Furthermore, it is also more complex as the perpetrators are also likely to be victims, subject to similarly abusive environments and situations (Charles & Lowry, 2017, pp. 2-3). The extreme toxicity of state institutional cultures created the ideal conditions for child-child abuse: firstly, through the de-culturation of individuals and the loss of self (dehumanisation), and secondly through the modelling by staff and other adults of harsh, unpredictable, abusive, and oppressive behaviours (see Charles & Lowry, 2017, pp. 4-5 for a detailed account of how ‘survival morality’ lays the foundation for peer-peer abuse).

One example of the use of violence to disrupt normal and potentially supportive relationships between residents was the purposeful pitting of residents against each other. Tamariki Māori in residential institutions experienced abuse ‘staged’ for staff and other adults’ entertainment:

“Pitting children against one another to entertain drinking adults, like dogs. Boys against girls and brother against brother. Your own siblings were used as leverage to keep you in the ring, especially if like me you were exceptional at getting back up again and not wanting your younger sibling to be pitted.… We were all like brothers and sisters in state care so this forcing us to fight each other added another layer of cruelty. Like some intentional means of keeping us from being close and finding comfort in one another. I usually felt no pain because of the fight or flight response. One time I did feel the pain and heard the ‘e tū’ call. With a fractured kneecap I stood up and put myself in between my brother and his adult abuser.” (Moyle, 2016, p. 4).

One of the outcomes of these institutionally mandated attacks on ‘children’s bodies and beings’ (Milloy, 1999, p. 295, cited in Charles & Lowry, 2017, p. 2), is that children internalised the belittlement and abuse, believing it to be a true indictment of their self-worth. Culminating with the stigma of being a state ward, for some survivors, this became a self-fulfilling prophecy (Stanley, 2016, pp. 49, 60).

### Cultural disconnection

As part of the removal from whānau, and the stripping away of any sense of who they were in State Care, tamariki and rangatahi Māori lost their access to the aspects of Māori culture that were positive and affirming. In the 1950s, ‘kin placements’ were paid at a lesser rate by the Child Welfare Division resulting in fewer Māori foster homes being available. Thus, young Māori were often placed with Pākehā foster parents, which proved to be a difficult ‘change of lifestyle’ (Dalley, 1998, p. 238).

Attachment from a te ao Māori worldview includes relationships and connections that are beyond immediate personal bonds. These include connections to tīpuna, maunga, whenua, awa/ moana alongside tribal networks. Such attachments emphasise wairua and the spiritual realm. Fleming (2018, p. 23) states that, ‘alongside vital interpersonal relationships, these extra personal connections are substantial to the development of an indigenous Māori self which is well and supported within a holistic framework’. The loss of these cultural attachments for tamariki and whānau Māori have created considerable harms over generations (Fleming, 2018; McIntosh, 2019), as cultural disconnection is often associated with feelings of loss, grief and shame (Fleming, 2018). Whakapapa is hugely important geographically and relationally for Māori to achieve a sense of self, community and home, so the absence of such cultural anchors is foreign to Māori society (McIntosh, 2005, p. 42).

For Māori adoptees, the ‘clean break’ from birth whānau enforced by closed adoption resulted in a complete loss of connection to and knowledge of their whakapapa. This caused profound feelings of loss which intensified if, as adults, they were unable to trace their whakapapa (Haenga-Collins & Gibbs, 2015; Pitama, 1997). Mead (1994, pp 91- 92) described some personal observations of Māori adoptees re-entering the Māori world as adults, as ‘traumatic, painful, difficult and terrible to witness’ due to their alienation from Māori culture and whānau and their upbringing by Pākehā as Pākehā. It appears that in some contexts, being-adopted was perceived as spoiling Māori identity beyond repair, akin to ‘not-being-Māori’ (Ahuriri-Driscoll, 2020, pp. 251-2). Many adoptees spend the rest of their lives working to heal their early disconnection from te ao Māori.

“I will never forget Māori Deaf who have gone to prison, who have died, who have not had what they wanted … they are like my brothers and sisters ... I can’t leave them … I can’t run away from this…. This has been part of my upbringing … I have seen Māori Deaf go to jail – I have seen the problems and abuse – the disadvantages – how they have died because they couldn’t access simple things like health care and experiencing everyday problems … so I just can’t leave it and go on my way ... my heart is there … that’s my Māori Deaf whānau … that’s who I am connected to.…”

- Patrick

Whakapapa also constitutes the elements of wairua, mana (prestige, status), mauri (life force, the vital essence of being), ihi (energy, essential force within) and wehi (energy force, awe, reverence, respect) (McClintock, Haereroa, Brown & Baker, 2018, p. 12). Loss of connection and belonging, in combination with the effects of abuse, therefore, also fundamentally impact on an individual’s wairua, mana and mauri (Bush & Niania, 2012), something keenly felt and reported by survivors (Moyle, 2020; Harawira, 2021). State Care survivors and Māori adoptees who grew up in the first half of the period in question (i.e. 1950 – 1970s), had the shared experience of growing up in contexts in which being Māori was openly disparaged. Without the protective factors of whānau and whakapapa, these children did not have a secure base from which to explore identity issues related to race and culture (Nuttgens 2013, 6). Furthermore, they were more likely to develop a marginal identity, as they were aware of not being fully accepted by the white community, whilst also being isolated from their indigenous community (Australian Human Rights and Equal Opportunity Commission 1997, p. 411; McIntosh, 2005, p. 42). The internalisation and normalisation of negative perceptions form the marginal self-concept, creating the potential for ‘alternative forms of collectivity and identity’ such as gang membership and identification, to develop (McIntosh, 2005, p. 49; McIntosh, 2019, p. 3). For some, their experiences of being in abusive State Care residences created kaupapa whānau and a lifetime of service to that whānau.

### Educational underachievement

In earlier chapters, we highlighted the failure of the state and its culpability in ensuring educational underachievement for tamariki Māori, particularly for those in State Care. Our analysis has highlighted the micro impacts of educational underachievement (within institutions) and also the macro impacts, caused by the failure of the state to deliver quality education for tamariki Māori in terms of the State Care and prison pipeline. We were unable to locate achievement and qualification records obtained by tamariki and rangatahi Māori within State Care residential schools for the period 1950-1999, however, recent educational qualifications of mokopuna Māori in care published by the Office of the Children’s Commissioner (2015) are damning:

As might be expected, the number of school leavers with at least NCEA Level 2 was lower for those from lower quintile schools, but even in the lowest quintile, more than 50 percent of school leavers achieved at least NCEA Level 2, and the national average was over 70 percent. By contrast, only around 20 percent of children in care left school with at least NCEA Level 2 in 2012. The result was even worse for mokopuna Māori: just 15 percent of Māori children in care left school with NCEA Level 2 in 2012. (Office of the Children’s Commissioner, 2015, p. 50)

Document analysis highlighted State officials’ low expectations of tamariki Māori (Henwood, 2015, p. 27) and the prominence of a ‘practical education’ in State Care institutions. The curriculum in State Care residential facilities typically focussed on ‘carefully graded work within the capacity of the individual’ (Clerk of the House of Representatives, 1949, p. 4). There were clear gendered, cultural and social class differences in the ways in which children in residential facilities were educated (Stanley, 2016). Boys were encouraged to learn skills that would enable them to become farm hands, factory hands, shop assistants and labourers whilst girls were encouraged to learn skills that would enable them to be employed as domestics, factory hands, shop assistants, clerical workers and nurses (Clerk of the House of Representatives, 1949; Stanley, 2016). Concern about Māori educational underachievement was raised by Beaglehole (1957), noting that the concentration of Māori in unskilled occupations was ‘a continuing challenge to Māori leaders’ (pp. 109-110).

The failure of residential institutions to provide children and young people with adequate education is well-established. In theory, the Department of Social Welfare expected all children to be adequately schooled, ‘unless they had serious mental health problems’ (Stanley, 2016, p. 68). However, in practice education was discouraged, as tamariki Māori and other children were expected to undertake chores and tasks as directed by residential staff. Thus, the attendance of state wards at local schools was variable (Stanley, 2016). Furthermore, most Māori children who did attend school, experienced stigmatisation, low teacher expectations, monocultural teaching practices, bullying, and a lack of quality teaching (Bishop & Glynn, 1999; Stanley, 2016).

“We always need to know where we’re from, otherwise, we’re forever lost.”

– Norm Dewes, Te Rūnanga o Ngā Maata Waka

The fact that very few adults saw potential in them invariably led to children internalising these low expectations, believing they were unintelligent and lacked ability.

Māori Deaf people experienced discrimination and marginalisation in complex and interrelated ways (Smiler & McKee, 2007). Pākehā-dominated schooling systems perpetuated negative stereotypes of Māori tamariki and rangatahi as underachievers (Shields, Bishop, & Mazawi, 2005). In addition, the medicalisation of deafness coupled with a disability label associated with medical diagnosis, created deficit/impaired identities (Obasi, 2008; Smiler & McKee, 2007). Furthermore, access to te ao Māori was severely limited for Māori Deaf tamariki and rangatahi, due to the severe shortage of trained, trilingual interpreters and teachers fluent in te reo Māori, New Zealand Sign Language and English (Hynds, Faircloth, Green & Jacob, 2014).

Patrick Thompson (2004) explains how Māori Deaf children in Deaf residential schools experienced ‘double oppression’:

 “I grew up when people looked at you from a medical perspective … I know for Mum to send me off to Kelston was a way to try and make me normal … it was a real shock … it was the first time my parents had ever said goodbye to me…. And there must have been about 90% Māori students here … most of our education was speech therapy, teaching us how to speak properly ... trying to make us become hearing … Sign language was banned…. And a whole lot of us ... were all signers … if we were ever caught, we were hit, with something like a ruler… all the teachers did … I would say all the children in the school were victimised in a way … we weren’t allowed to talk to each other … a lot of our Māori Deaf are adults now … unemployed ... very low education, very low income, probably doing very basic manual work – cleaning or road works, very simple basic jobs, most of them are isolated – they didn’t go home to their families once they left school – and so a lot of them are still not aware of what it means to be Māori, … Māori Deaf are worse off than non-Māori ... it’s that dual oppression ... we are doubly disadvantaged … Deaf education is led by Pākehā Deaf ... it’s a Pākehā education system.…” (Patrick Thompson, Māori Deaf, QSM, 2004).

As discussed in previous sections, deficit explanations for Māori educational underachievement have endured for decades, typically locating the ‘problem’ of underachievement with Māori tamariki and their whānau, rather than the racist beliefs, low expectations, monocultural, and ineffective practices, of teachers and school leaders (Bishop & Glynn, 1999; McKinley & Hoskins, 2011). Māori social and cultural factors including low socio-economic status, a deprived home, community environment, as well as cultural and language deficits were blamed (Harker, 1971, p. 3, cited in McKinley & Hoskins, 2011).

“Being Māori, female and a ‘State Care kid’, even other Māori kids at school gave you shit because you didn’t belong to anyone, bottom of the barrel. Why would you even try to be smart?”

- Moyle, P. personal communication, 27th April 2021

Many educational theorists have noted that education and schooling in Aotearoa New Zealand was underpinned by racist, assimilation policies that intentionally forced Māori to adopt Pākehā values and practices, finding no place or value for te reo me ōna tikanga (Bishop & Glynn, 1999; McKinley & Hoskins, 2011; Walker, 2016). Educational research undertaken in the 1980s and 1990s in Aotearoa, demonstrated historical and structural influences as well as unequal power relationships between Pākehā and Māori students, as explanations for disparities in educational outcomes (Jones, 1989; Bishop & Glynn, 1999; McKinley & Hoskins, 2011). The schooling system in Aotearoa New Zealand pushed Māori into unskilled work, predisposing whānau to the effects of poverty during economic recessions (Tolmie & Brookbanks, 2007). In addition, the underachievement of Māori has negatively impacted the involvement of Māori in higher education, skilled work, and executive roles in law making and procedure (McKinley & Hoskins, 2011; Tolmie & Brookbanks, 2007).

Although state educational reforms were attempted from the 1970s through to the early 2000s, they were inadequate for tackling Māori educational inequities as they failed to address the structural racism responsible for marginalising generations of tamariki Māori. The Puao-te-Ata-Tū report noted previous reports that had highlighted over- representation of Māori in educational and economic underachievement:

In 1975, the Joint Committee on Young Offenders found that the Māori were over- represented in lower socio-economic groups. Other Government and non-government reports in the last decade have demonstrated that the relative socio-economic status between Māori and non-Māori has remained unchanged for many decades. Educational and economic underachievement by Māori people has been reflected in increased crime rates, poor infant and life expectancy rates, high unemployment rates and low incomes. (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988, p. 15)

Despite the ‘crisis’ warnings of the Puao-te- Ata-Tū report, little changed between 1988 and 2000. Becroft (2009, p. 14) lamented how many serious offenders before the Youth Court were not meaningfully engaged in any form of education programme: ‘The size of this group can only be estimated, but from the perspective of the Youth Court, it ranges from 1,000 to 3,000 young people.’

### Lack of trust and resentment towards state authorities

Many survivors have highlighted how their experience in State Care has resulted in an enduring lack of trust and resentment towards state authorities. The following quotes are extracts from the ACORD, Ngā Tamatoa & Arohanui Inc 1979 report on social welfare children’s homes. Reflecting on their experience of State Care residential homes, participants attributed their defiance of the law and institutional authority to their poor treatment:

*“I am sure my progression of crimes came from the way I was treated – at first I only ran away from home … I really turned against authority – assaulting cops and things like that.” (Owairaka resident 1964-65) (1979 p. 11).*

*“The whole experience was traumatic for me – it sticks in my mind. I was perpetually in punishment, for example for swearing. The worst part was being stripped of your privacy. I felt resentment, and increased hatred of authority.” (Bollard resident 1974) (1979, p. 15).*

*“I began by being picked up for trespassing, and I wasn’t a bad kid, and nor were the ones I was in with. It taught me how to use the system, and how to fight back. It doesn’t teach you respect for society, or for adults. You see how adults treat children.” (Allendale resident 1960s) (1979, p. 17)*

*“I ran away. I hated her [the woman in charge at Welfare home] and the Welfare and the Police. After wandering around the streets, I came across a Police Station. I picked up some large stones, smashed the windows and took off.” (Resident in several Child Welfare homes) (1979, p. 17)*

*“I feel that if only the Social Welfare had listened to me, I would not have spent my years from 14 to 21 years old, in institutions.” (p. 18)*

According to these survivors, the injustice of receiving excessive and degrading punishment, as well as loss of autonomy, provoked their mistrust of and opposition to authority. This had effects beyond their time in State Care, laying the foundations for future criminal behaviour.

### Criminalisation & incarceration

There is clear evidence that once in the State Care system many Māori young people are on a pathway to prison (Boulton et al., 2018), described as the ‘hard pipeline’ (McIntosh, 2019, p. 7). This was emphasised in participant interviews.

It has been estimated that approximately 40% of prisoners grew up in State Care (Henwood, 2015,

p. 12). Children with a Child, Youth and Family notification are fifteen times more likely to have a conviction as a young adult resulting in a corrections-managed sentence than those without (Children’s Commissioner, 2015, p. 51). Offending patterns among youth with a history of out-of-home-care are more likely to be chronic and persistent into adulthood (Gluckman 2018:17). Similar outcomes have been found in other jurisdictions, including Australia, the United Kingdom and the United States (McGrath, Gerard & Colvin, 2020). Stanley’s research (2017) with 105 contributors who had been in State Care between 1950 and the 1990s showed a ‘criminalising trajectory’ associated with five key factors. First, a history of abuse and neglect; second, placement instability and disruption of education, social relationships and (mental) health; third, the criminalisation of children’s behaviour while in care; fourth, limited support given to care leavers; and lastly, differential treatment by the criminal justice system in relation to bail and sentencing.

 These factors somewhat combine two prevailing explanations for the link between care and crime; the risk factor approach, and the adverse environment approach (Staines, 2016, cited in McGrath, Gerard & Colvin, 2020). In the first explanation, offending is deemed the result of pre-existing risk factors such as a history of trauma or victimisation, whilst in the second, the care environment itself is deemed criminogenic. Research supports a complex configuration of both explanations working in tandem.

Māori are also more likely to follow a ‘soft pipeline’ to prison, which refers to the phenomenon of people who are poor, marginalised and members of racial minorities being significantly over-represented in the incarcerated population (McIntosh, 2019, p. 6). As mentioned in the previous chapter, this issue has been a long time in the making, through various historical and structural processes of dispossession (Curcic, 2019, p. 4). However, the higher rate of imprisonment for Māori (700 per 100,000) must be carefully interpreted; the rate of imprisonment does not correspond simply or directly to the rate of crime but measures instead ‘the consumption of punishment’ (Workman, 2012, p. 4). Māori are apprehended, charged and convicted at higher rates than non-Māori, seven and a half times more likely to receive a custodial sentence than Pākehā, and eleven times more likely to be remanded in custody while waiting for trial (Workman & McIntosh, 2013, p. 126). For Māori women, the rates are higher still; Māori women constitute approximately two-thirds of women prisoners (McIntosh & Workman, 2017, p. 725). These statistics reflect the phenomenon of hyper-incarceration, the politically targeted and selective incarceration of Māori within Aotearoa New Zealand society (Curcic, 2019, p. 5).

Incarceration has a significant effect on life trajectory. There is considerable stigma associated with having served time, which limits future opportunities and reinforces an already marginalised status (McIntosh & Radojkovic, 2012, p. 43). Furthermore, there may be significant impacts upon physical and mental health from the trauma of the prison experience. Beyond this, the effects upon whānau and communities are also profound. Absent fathers and mothers are unable to fulfil their roles as parents, the impact of which is particularly pronounced for mothers more likely to be actively parenting at the time of their arrest (Gordon & McGibbon, 2011). Given the disproportionate representation of Māori among the prison population, it is highly likely that the majority of the 20,000 children who have a parent in prison, are Māori (Gordon, 2009; National Health Committee, 2010). The impact on children is immediate and devastating, and in too many cases will see them put into State Care themselves (Gordon, 2009). Families go on to suffer the economic and social effects of parental absence due to imprisonment (Gordon & McGibbon, 2011).

A cycle of imprisonment has also been observed in some Māori communities, where children of imprisoned family members are 66% more likely to be imprisoned themselves (Gordon & McGibbon, 2011, p. 3). Factors such as the normalisation of imprisonment due to hyper-incarceration (Hemopo, 2015, cited in Dowden, 2019, p. 95), and limited family support may, in combination with truancy, problems with school, substance abuse, as well as limited skills and employment prospects lead rangatahi to become involved in activities that culminate in incarceration (McIntosh & Radojkovic, 2012, p. 44). At a community level, high imprisonment rates can erode stability and cohesion, and perpetuate stereotypes of Māori as inherently criminal. The fact that these are patterns are observed in other settler nations (Curcic, 2019) tells us something important about the colonial and structural processes at play.

### Recruitment to gangs

A critical factor in the criminalisation of young people in State Care is the influence of and recruitment to gangs. A gang presence was intermittent in the 1960s but became increasingly apparent in State Care institutions in the 1970s. In 1981, for example, youths with gang affiliations accounted for more than 80 percent of admissions to Auckland’s Owairaka Boys’ Home (Dalley, 1998, p. 271). More recently, foster homes have become a key site for gang recruitment (Curcic, 2019, p. 92). The appeal of gang membership lies in the promise of protection or power within a threatening environment, as well as a potential future source of support and income (Stanley, 2016, p. 104; Henwood, 2015, p. 31).

“The cohort of children that we took into care between 1970 and 1988 had very high imprisonment rates for the rest of their lives. The cohort of their children, basically born between the mid-late '70s, right through to 1990, early 1990s, had quite similar imprisonment rates. However, the cohort of Māori males born since 1990, typically the grandchildren of the cohort which experienced high rates of State Care and youth imprisonment are imprisoned as youths at rates similar to males who were teenagers during the 1950s”.

- Len Cook, public servant researcher

“It made sense to me that those gangs started in institutions, and that gang members who had come from them said 'We formed gangs for protection, for security, for love, for belonging. And it was great. Initially we felt safe. We knew we could protect ourselves against the authorities.”

– Tā Kim Workman, Māori senior public servant

“…Those places destroyed our fuckin-heads, man. [So, we said] fuck the system. If that is the way they are going to treat us, then we will treat them the same way. We are going to give them what they gave us – and [via the Mongrel Mob] they got it alright.”

- Gerbes quoted in Gilbert, 2013, p. 42; Henwood, 2015, p. 31

State Care survivors who are or have been gang members have also talked about the role of violence perpetrated by staff members in homes and institutions in teaching them that violence was acceptable (Smale, 2017). As an amplification of the resentment and mistrust of ‘the system’ and authority, gangs represent violent resistance.

Institutionalisation and confinement are enduring impacts common to both the experience of State Care and prison. The ‘cage’ that survivors exist in is one constructed by their institutionalisation, which persists, becomes embedded and manifests in ‘trapped lifestyles’ and ‘blunted’ trajectories characterised by risk, marginalisation, offending, poor health and the notion of ‘no escape’ (Durie, 2003, p. 62; Stanley, 2016; McIntosh & Coster, 2017).

Understanding how the role of State Care contributes to criminalisation, hyper-incarceration and gang membership is critical if we are to understand the true origins of ‘once were warriors’ (Stanley, 2016, p. 11). On a societal scale, the surveillance and racism that led a disproportionate number of Māori to be admitted to, and abused in, State Care, laid the foundations for generations of marginalised and traumatised tamariki and mokopuna.

### Mental distress and behavioural challenges

Social deprivation, trauma and exclusion have been very clearly linked to increasing levels of mental distress (Government Inquiry into Mental Health & Addiction, 2018, Chapter 3). As highlighted throughout this chapter, such factors are central to the experiences of State Care survivors, often occurring within and subsequent to State Care. Behavioural and mental health problems are the most common adverse impacts reported by over 80 percent of survivors of institutional child abuse and sexual abuse (Sheridan & Carr, 2020; Katz et al., 2017). Depression, anxiety and post-traumatic stress disorder are most prevalent, but survivors have also reported the internalisation of trauma, self-harm, suicidal ideation and mood disorders (Henwood, 2015, p. 31). For some, these mental health issues become entrenched, affecting functioning in many areas of their lives over an extended period of time (Blakemore, Herbert, Arney & Parkinson, 2017). Interpersonal relationships suffer considerably, affected adversely by a reduced ability to trust, profound anger and feelings of shame, guilt, self- blame and low self-worth (Blakemore et al., 2017; Katz et al., 2017; Tarren-Sweeney, 2008; Tarren- Sweeney, 2018). The distinct features of institutional abuse, including prolonged traumatisation, institutional powerlessness, and normalisation, are compounded by a significant lack of supportive family or social systems. (Sheridan & Carr, 2020).

Survivors’ strategies for coping with their pain and suffering can also produce secondary impacts. Alcohol and drug use is a relatively common disconnecting/avoidance mechanism, and will often develop into dependence (Katz et al., 2017; Henwood, 2015, p. 31). Anger and aggression represent another survival strategy, reported predominantly by males as serving a self-protective function immediately following the abuse and into early adulthood (Katz et al., 2017; Stanley, 2016; McIntosh, 2019, p. 14; Kendall-Tackett, 2003). Excessive substance intake and reckless behaviour can also lead to physical illness, injury and ongoing medical difficulties, adding to the significant and long-term physical effects of neglect and abuse (Katz et al., 2017; Henwood, 2015, p. 31). Furthermore, poor physical and mental health have significant bearing on future life prospects – for example, being able to enjoy the benefits of employment and social inclusion. Survivors have talked about some of these negative life trajectories as diminished lives, of turmoil and struggle (Katz et al., 2017).

Despite these ‘pathologies’ resulting from their State Care experiences, the ‘survivorship’ of survivors must be acknowledged, their ability to endure and resist in the face of considerable and ongoing adversity.

‘Post-traumatic growth’ (Sheridan & Carr, 2020) is possible, and so too redemptive life trajectories (Katz et al., 2017). However, the features of institutional abuse noted above make this far less likely, and survivors’ accounts are no less valuable for not being positively oriented. Instead, these accounts instruct us to maintain our focus on the pathological social power relations that underpinned and enabled such institutional violence towards children (Blake, 2017, p. 223; Stanley, 2016).

## Impacts on whānau

The impacts on whānau have been relatively under-researched in accounts of State Care abuse (Bombay, Matheson & Anisman, 2014, p. 321). The difficulties for whānau in challenging their children’s admission to State Care feature briefly in Dalley’s historical archival research: ‘Some families protested vehemently when their children were committed. At times the [Child Welfare] Branch failed to disclose the intention to admit a child to an institution so as to avoid ‘disagreeable scenes’ with parents’ (Dalley, 1998, p. 140).

Legal and institutional processes and bureaucracy constituted a key barrier for whānau in fighting to retain their tamariki, and the following quote conveys the relative powerlessness of whānau in this regard:

Māori parents and families attending courts with their children were often particularly disadvantaged. ‘What chance of making any satisfactory plea had a frightened Māori woman when confronted by a magistrate, lawyer, Child Welfare Officer, police and social workers?’ one Māori group wondered (Dalley, 1998, p. 106).

“Being involved in child welfare or the prison service is one of the biggest sources of creating poverty in New Zealand, because we leave people in a very disparate, poorly-off situation.”

- Len Cook, public servant researcher

Individual cases of grandparents seeking to adopt their mokopuna were heard in the courts, but their applications were frequently discounted based on age, socio-economic circumstances, and in the following example, not meeting the Adoption Act 1955 criteria:

As recently as 1989 the Family Court denied a paternal grandmother standing to apply for the revocation of an interim adoption order in respect of her grandchild, Inglis DCJ finding that she did not fairly come within the category of ‘any person’ in section 12 of the Act (Mikaere, 2003, p. 141).

When children were removed, whānau often experienced difficulty and sadness over the severed relationship. The Department of Child Welfare would receive correspondence from parents asking for the return of their children, for photographs and messages to be passed on to them, or queries about their wellbeing (Dalley, 1998, p. 240, see also Chapter 7). Officials could easily dismiss such requests.

The ‘uplift’ of tamariki continues today, and so too the devastating impacts on whānau. Fathers and other male whānau members have often found themselves unsupported and excluded from Oranga Tamariki processes. Mothers have described the removal of their pēpi as ‘unforgettable’ and ‘carried forever’, leading to multiple harms: severe depression, suicidal thoughts and self-medication via substance abuse, relationship problems with partners and whānau, and even homelessness. Losing babies to the State Care system is best described as a life sentence (Moyle, personal communication, 13th May, 2021). In fact, North American research found that the mental health outcomes of mothers whose children are placed in care are worse than mothers who experienced the death of an infant (Wall-Wieler, quoted in Plantinga Byle, 2019, p. 23). Whānau may have further children to replace those they have lost, and then have to deal with those children also being removed (Office of the Children’s Commissioner, 2020, pp. 33, 37, 39).

### Impacts on the capacities of whānau

Whānau are the carriers and transmitters of ira tangata, the human element or life principle, the basic biological essence of humanness (Jackson, 2010, personal communication). Whānau are also the embodiment of whakapapa, in terms of constituting the immediate relationships and genealogical connections that build out from or upon the biological base (Ahuriri-Driscoll, 2016). Thus, whānau serve several critical purposes in te ao Māori, not least that of caring for and nurturing the next generation. The removal of pēpi, tamariki and rangatahi to State Care and the severing of whakapapa connections decimates whānau, undermining their key capacities and their essential purpose.

The capacity to care, manaakitia, is a critical role for whānau. Unless a whānau can care for the young and the old, for those who are sick or disabled, and for those who are temporarily out of pocket, then a fundamental purpose of that whānau has been lost (Durie, 2003).

There is clear evidence that state custody of Māori pēpi is intergenerational: 48 percent of pregnant women whose babies were taken into state custody before birth had been in state custody themselves (Office of the Children’s Commissioner, 2020, p. 24). Furthermore, if a ‘history of state care’ was identified as a risk factor by Oranga Tamariki social workers, this gave added impetus for the removal of pēpi (p. 38). Some people coming to the attention of the state are the fourth generation of their whānau who have experienced State Care (Boulton et al., 2018, p. 4). This suggests that being in State Care fails whānau significantly and does little to empower whānau to develop their own capabilities. Thus, there are complex layers and generations of trauma, disconnection and marginalisation to address.

### Impacts on parenting

At the individual level, it has been established that a history of being in State Care can affect the capacity and capability to care for others (Stanley, 2016; Dalley, 1998, p. 253). After all, how parents were parented themselves is one of the most enduring predictors of parenting behaviour in published studies. Because survivors of State Care abuse were taught neglectful and abusive disciplinary practices through observation and direct experience, it could be expected that this would have a profound and negative impact on parenting (Chief Moon-Riley, Copeland, Metz & Currie, 2019, p. 2). Contemporary research confirms the adverse impacts of maltreatment and Out Of Home Care (OOHC) to parenting difficulties; for example, poor mental health (specifically PTSD and depression), young parental age, lack of knowledge about child development, parenting stress, fewer social supports, low social functioning, negative coping strategies, insecure attachment and likelihood of living with a violent adult (Ussher, 2021, pp. 19- 20). It is estimated that 25-33 percent of children who have been maltreated will go on to abuse their children (De Bellis, 2001, cited in Ussher, 2021, p. 27). That the majority of survivors do not perpetuate the abuse they experienced, is a positive indicator of ‘survivorship’, given that they enter the parenting role with significant disadvantages: ‘On leaving care, these young people frequently bore poor educational advancement, unemployment and underemployment, welfare dependency, inadequate housing, homelessness, mental health problems, socio-cultural disconnection and poverty’ (Stanley, 2016, p. 187).

## Intergenerational trauma

As outlined earlier in this chapter, individual outcomes of State Care feed into much larger social problems, transmitting the effects of trauma across generations. The mechanisms are biological and social. Maltreatment affects a child’s neurobiological systems, influencing developmental and regulatory structures (e.g., fronto-thalamic system and hypothalamic structures), brain systems and stress responses, as well as affecting how genes interact with life experiences. These effects may predispose an individual to mental illness, physical health problems, or particular ‘maladaptive’ behaviours, which influence their interactions with others and the world. In terms of social learning theory, exposure to abuse increases the likelihood that children will go on to model that behaviour (Ussher, 2021, p. 28).

When the effects of trauma are not resolved in one generation, or when trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. The concept of intergenerational trauma has been utilised to account not only for the consequences of State Care abuse, but also for the consequences of colonisation. Historic trauma is an accumulation of traumatic events at scale, that impact indigenous communities in colonised countries over time.

Unresolved grief can be passed from generation to generation, alongside maladaptive social and behavioural patterns (such as learned helplessness, external locus of control, interpersonal maladjustment, domestic violence, and sexual abuse). Walters, Mohammad, Evans-Campbell, Beltrain, Chae & Duran (2011) state that current indigenous health disparities reflect, in part, the embodiment of historical trauma. Wesley-Esquimaux and Smolewski (2004) describe the intergenerational process and effect:

In short, historic trauma causes deep breakdowns in social functioning that may last for many years, decades or even generations. The clusters of symptoms associated with specific disorders that manifest themselves as a result of historic trauma may be passed to next generations in a form of socially learned behavioural patterns. In a sense, symptoms that parents exhibit (family violence, sexual abuse) act as a trauma and disrupt adaptive social adjustments in their children. In turn, these children internalize these symptoms and, not to trivialize, catch a ‘trauma virus’ and fall ill to one of the social disorders. In the next generation, the process perpetuates itself. (2004, p. 71)

The biological impacts of residential school attendance on the children of survivors have been confirmed in recent research (Chief Moon-Riley et al., 2019). Maternal residential school attendance was associated with a moderate increase in allostatic load among adult children, a finding that was not explained by adverse childhood experiences. Allostatic load is a marker of ‘cumulative, multisystem strain on the body produced through the elevated activity of physiologic systems under challenge, and the changes in functioning it can predispose’ (Chief Moon-Riley et al., 2019, p. 2). This finding affirms that at the very least, trauma experienced in residential schools becomes ‘biologically embedded’ and passed to subsequent generations.

Within Aotearoa New Zealand, intergenerational harms experienced by Māori communities are referred to as whakapapa trauma (Kaiwai, Allport, Herd, Mane, Ford, Leahy, Varona & Kipa, 2020; Moyle, 2017). The settler State Care system inflicted whakapapa trauma, the destruction of mātauranga Māori, and whānau child rearing practices on whānau. It continues to impact wāhine Māori (Kaiwai et al., 2020).

## Impacts on wāhine Māori according to an intersectional lens

An intersectional lens is essential for understanding the factors and actors that caused Māori over- representation to happen and continue over time.

Intersectionality holds that the classical models of oppression within society, such as those based on race/ethnicity, gender, religion, nationality, sexual orientation, class, disability do not act independently of one another: instead, these forms of oppression interrelate creating a system of oppression that reflects the intersection of multiple forms of discrimination. (Ritzer, 2009, as cited by Grant & Zweir, 2011, p. 182)

The impacts of State Care abuse were certainly gendered, with there being different outcomes for Māori men and women. In the case of wāhine Māori, the colonial and patriarchal orientation of the settler State Care system saw them differentially affected based on their gender as well as their race. As highlighted in an earlier chapter, prior to the white settler invasion, wāhine Māori held special status and leadership roles within whānau and hapū. They experienced autonomy equal to that of males (Mikaere, 1994). Neither conception nor sexuality were viewed as sinful. However, this status of wāhine Māori quickly changed because of colonial law, whereby they were viewed as subordinate to men (Mikaere, 1994; Moyle, 2017). Colonial, patriarchal attitudes embedded within the settler state often interpreted wāhine Māori behaviour as immoral and lacking male discipline. Kōtiro and wāhine Māori behaviour could easily upset Pākehā gendered norms. The ‘moral panic’ of the 1950s discussed in a previous chapter (refer to Chapter 1) fuelled state and societal anxieties to control and contain juvenile delinquency, particularly of females. Wāhine Māori and kōtiro who were seen as troublesome, skipping school or perceived as sexually promiscuous, could ‘find themselves inspected by State Care authorities who readily legitimised institutionalisation as a means to domesticate, civilise or control them’ (Stanley, 2016, p. 38).

### Wāhine Māori survivors

For young kōtiro entering State Care institutions they often experienced compulsory vaginal inspections to test for sexually transmitted diseases, whether or not they were sexually active (Dalley, 1998; Stanley, 2016). If they refused, they faced ‘repercussions’, such as removal of privileges, being denied home leave or being placed in ‘secure’ (Stanley, 2016, p. 63). Girls labelled as difficult could find themselves being identified as mentally ill and were often given medication to calm them, leading to drug dependencies. Stanley (2016) notes that from the late 1960s ‘between 20% and 30%’ of girls at Fareham House ‘graduated’ to mental health hospitals (p. 67). Stanley highlights that just as many female Māori children were abused as male Māori, yet wāhine Māori feeling whakamā were less likely to report abuse. ACORD (1979) noted that Pākehā girls in State Care institutions were better treated than Māori girls, who were seen as troublemakers, reflecting negative stereotypes.

Kōtiro and wāhine Māori who experienced State Care, often emerged with psycho-social harms (Stanley, 2016). Many left State Care feeling whakamā, worthless, being labelled troublemakers if they spoke out or tried to escape abusive situations (Moyle, 2017). Many were told falsely that they were in State Care, because their parents had deliberately abandoned them (Stanley, 2016).

Wāhine who later partnered with gang members after leaving State Care, often did so in an attempt to re-recreate the sense of whānau and belonging that had been deliberately denied them (Wilson, Mikahere-Hall, Sherwood, Cootes & Jackson, 2019).

Wāhine faced a ‘damned if you do and damned if you don’t scenario’. ‘If you stay, you risk your children being uplifted. If you leave the violence increases and then there are increased chances that CYF will get involved. So you stay to try and keep it on the down low’ (Moyle, 2020). Thus, it was difficult for wāhine and their tamariki to leave harmful relationships characterised by domestic violence and move on (Wilson et al., 2019).

 For those wāhine with partners with gang associations, they had added layers of complexity making it difficult to leave or stop the violence – these wāhine were not just leaving their partner but their gang whānau. They had very little support from other wāhine in gangs because they were in similar positions, and because of the gang association they were often further marginalised by agencies and services (Wilson et al., 2019, p. 30).

### Wāhine Māori and whakapapa trauma

Whakapapa trauma has enduring consequences, altering the DNA of colonised, indigenous communities (Kaiwai et al., 2020; Moyle, 2017). Stripped of their revered status, their cultural identity and childhood, wāhine Māori and their pēpi are most at risk of whakapapa trauma.

Trauma happens when there is a physical injury where blood ceases to flow, such as with the severing of a limb. Papatūānuku herself experiences the trauma because we are not separate from her and the memory of it is passed on through our DNA. Trauma can be passed on through the grief of loss, of land, belief systems, language, self-determination, and stolen children; it is passed onto the babies, who are then genetically pre-disposed to the effects of colonisation. We have historical trauma responses showing up in our whakapapa (Moyle, 2017, p. 2).

Indicators of whakapapa trauma are evident, among wāhine Māori and other whānau members suffer from deteriorating health, higher rates of incarceration, domestic abuse, unemployment, homelessness, mental illness, drug and alcohol addiction and reduced educational opportunities. All of these factors impact on wāhine ability to care for whānau (Kaiwai et al., 2020). Māori concepts such as ‘patu ngākau’ (a strike or assault to the heart/source of the emotions), ‘pouri’ and ‘mamae’ (physical and/ or emotional pain) speak to the experiences of abuse and trauma (Pihama, Cameron & Te Nana, 2019; Smith, 2019).

Wāhine Māori are over-represented in the lowest socio-economic group, when compared with tāne Māori and both male and female non-Māori (New Zealand Law Commission, 1999). The following graphs demonstrate that wāhine through the 1990s had lower incomes than Māori males, and non- Māori females, were mostly likely to be unemployed, leave school with no formal school qualification and were more likely to receive a benefit; increasing dependence on a state system they didn’t trust. Each and all of these statistics highlight the failure of the colonial, patriarchal State Care system that has entrapped wāhine Māori and their children.

Figure 4.2. Proportions of the labour force unemployed in each age group (source Statistics New Zealand, Census of Population and Dwellings 1996, (New Zealand Law Commission Report 1999, p. 53)



Table 4.1. Percentage of Māori and non-Māori post-school qualifications by gender, 1996 (cited in New Zealand Law Commission Report 1999, p. 52)

* No qualification: Māori males 82.6%, females 84.2%; non-Māori males 65.5%, females 72.7%
* Basic or skilled vocational: Māori males 9.9%, females 7.3%; non-Māori males 14.1%, females 7.5%
* Intermediate or advanced vocational: Māori males 4.3%, females 5.8%; non-Māori males 8.9%, females 11.4%
* Bachelor’s degree: Māori males 2.3%, females 2.1%; non-Māori males 7.5%, females 5.7%
* Higher degree: Māori males 0.9%, females 0.7%; non-Māori males 4%, females 2.6%

Figure 4.3. Source Statistics New Zealand, Census of Population and Dwellings 1996 (New Zealand Law Commission Report 1999, p. 55)



Research in the 1990s also demonstrated that wāhine Māori had a higher risk of being victims of crime and of domestic violence than non-Māori women (National Survey of Crime Victims 1996, and National Collective of Independent Women’s Refuges, cited in New Zealand Law Commission, 1999). This remains the case today, which is of particular concern because violence in the family is a key reason for the uplift of pēpi Māori (Kaiwai et al., 2020).

Violence within families and whānau is a global problem, particularly for Indigenous wāhine (Berry, Harrison, & Ryan, 2009; Garc a-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Compared to other women living in Aotearoa, wāhine Māori bear the greatest burden of family violence as victims of assault and homicide. While partner violence is estimated to affect one in three women in Aotearoa during their lifetimes (Fanslow & Robinson, 2011), prevalence rates of 57% and 80% have been found for lifetime violence for wāhine Māori (Koziol-McLain et al., 2004; Koziol-McLain, Rameka, Giddings, Fyfe, & Gardiner, 2007). Wāhine Māori are three times and tamariki are four times more likely to be victims of family violence-related homicide (NZ Family Violence Death Review Committee, 2017). This is cause for national shame especially given the disparities between Māori and other populations groups living in Aotearoa (Wilson et al., 2019, p. 4).

The following table demonstrates that wāhine Māori and kōtiro from the ages 0-14 and up to the 45- 54 years old were significantly over-represented in hospitalisations for injuries inflicted by others, when compared with non-Maori females and Māori and non-Maori males (New Zealand Law Commission, 1999, p. 57).

Table 4.2. Wāhine Māori and kōtiro hospitalisations for injuries inflicted by others compared with non-Māori females and Māori and non-Māori males

* Aged 0-14 – Māori males 27.5% and females 32.1%; non-Māori males 23.5% and females 23.7%
* Aged 15-24 – Māori males 24.3% and females 40.0%; non-Māori males 18.1% and females 18.9%
* Aged 25-34 – Māori males 26.5% and females 52.1%; non-Māori males 14.6% and females 15.4%
* Aged 35-44 – Māori males 21% and females 46.5%; non-Māori males 11.7% and females 12.2%
* Aged 45-54 – Māori males 12.6% and females 40.5%; non-Māori males 8.8% and females 9.1%
* Aged 55-64 – Māori males 18.9% and females 7.7%; non-Māori males 8.1% and females 8.3%
* Aged 65+ – Māori males 34.3% and females 9.1%; non-Māori males 3.9% and females 3.6%
* Total – Māori males 24.1% and females 42.7%; non-Māori males 14.5% and females 14.4%

While family violence occurs in all communities in Aotearoa, it is exacerbated by certain factors that create stress. These factors include hardship, social disadvantage and cultural marginalisation as well as differential scrutiny by the system (Stanley, 2016, p. 13). Cook (2020) notes that having their first child at a young age and having a prior history in State Care means that young wāhine Māori are most likely to be screened and scrutinised by State Care departments. Moreover, where children have been exposed to family violence, the responsibility for protecting their children is aimed squarely and solely at the young mother rather than the perpetrator of the abuse. This has led to the removal of children from their mother’s care, in spite of the perpetrator having caused the harm (Moyle, 2020). The resulting mistrust in and fear of State Care institutions, coupled with prior experiences of racism, can lead wāhine Māori to avoid contact with any services, even those potentially beneficial in providing health care, security and safety from harm (Cook, 2020, p. 370; New Zealand Law Commission, 1999; Office of the Children’s Commissioner, 2020, pp. 32, 36).

Other statistics provided by the New Zealand Law Commission (1999) demonstrated that because wāhine Māori have lower incomes, than non-Māori females and Māori men, they are less likely to be able to access legal services. This is demonstrated in figure 4.4.

Healing must take place on both individual and collective levels to prevent the intergenerational transmission of trauma, however our literature review demonstrates the state’s deliberate negligence in this area. The State Care system has concentrated its focus on the perceived deficits and needs of wāhine Māori, who have lived with violence in their whānau (Wilson et al., 2019). This deficit focus has done nothing to address the systemic structural racism, sexism and deprivation that wāhine face in protecting themselves and their tamariki, and, as well as ensuring whānau wellbeing.

Figure 4.4. Proportions of Māori and non-Māori with high and low personal income by gender 1996 (Source: Statistics New Zealand, Census of Population and Dwellings 1996 (New Zealand Law Commission 1999, p. 51)

## Effects on hapū, iwi and Māori communities

### The loss of power

The effect of colonisation on Māori communities is undisputed and well established (see previous chapters). At every stage, Māori have sought to resist and persist. In the post-World War II period, Māori maintained their collectivist perspectives and tribal/sub-tribal identification in various forms, such as the tribal committee system and Māori Women’s Welfare League. Thus, Māori continued to express their rangatiratanga in relation to the state, in spite of Crown assimilation policies and mass urban migration. However, the Crown responded by attempting to control Māori organisational forms for the second half of the twentieth century (Hill, 2009).

One of the enduring impacts of colonisation was the decline of the political and economic power of hapū and whānau. Since the 1990s, iwi leadership has been favoured, which, while advantageous for some aspects of iwi development, it has limited the direct benefits to hapū and whānau (Reid et al., 2017, p. 46). In terms of State Care, there has been a lack of genuine partnership with, and appropriate funding for whānau, hapū, iwi and Māori organisations. However, following the publication of Puao-te-Ata-Tū in 1988, the Department of Social Welfare took important steps towards adopting a bicultural perspective, sometimes with guidance from the Māori community (Dalley, 1998, p. 310). Iwi representatives who had visited residences in the 1980s and were ‘very disturbed by what they saw’, responded with their intention to become more involved in the Mātua Whāngai programme. The closure of residences saw increased emphasis on community care. However, without the time or adequate resources to care for former residents, Māori communities bore the considerable burden:

One Māori who made a submission to the 1992 review stated that ‘we have some quite dangerous young people in our community, who have been placed back here by the Department, who are wandering around destroying whānau after whānau. And now the Department won’t help us with them. They say they have empowered us (Dalley, 1998, p. 318).

 Despite the establishment and proliferation of Māori health providers in and since the 1990s, it remains the case today that iwi and Māori organisations lack the necessary funding and resources to support the significant needs of whānau resulting from intergenerational disadvantage and trauma. Genuine and sustainable partnerships between Oranga Tamariki and iwi and Māori organisations are needed, but these are contingent on a ‘major power shift’ to support the necessary delegations, funding, resources and infrastructure (Office of the Children’s Commissioner, 2020, p. 41).

### The loss of children from Māori communities

The large-scale removal of tamariki from whānau and communities has had a considerable impact. Tens of thousands of Māori children were either admitted to State Care or adopted into non-kin families between 1950 and 1999. This removal of children from their cultural communities in such number constitutes a significant loss of human capital, described by some as ‘legalised cultural genocide’ (Bradley, 1997, p. 41). In the case of closed adoption, the assimilationist goals were somewhat achieved; the majority of Māori children available for adoption were adopted by Pākehā families, thus enculturated in the Pākehā world and worldview, without connections, experiences or understandings to facilitate their identification or orientation as Māori (Ahuriri- Driscoll, 2020, p. 26). As has been described at length in this chapter, the tamariki admitted to State Care, also lost to their communities, were returned as damaged and traumatised adults, ‘assimilated’ in the most abhorrent way. For a community attempting to regroup and regenerate from over a century of depopulation and destabilisation, these further losses were a substantial setback.

### The loss of cultural institutions: whāngai

The colonisation of Aotearoa was as much ideological and cultural as it was, or is, economic and political. Breaking down ‘the beastly communism of the tribe’, perceived to stand in the way of the assimilation of Māori, was deliberate and calculated (Sorrenson, 1975, p. 107). Subjugating and controlling the population could be achieved through child welfare policy (Armitage, 1995, pp. 5-6), beginning in the Native Land Court. It was here that the practice of whāngai was progressively undermined. Whāngai was a relatively common practice in which children were given to someone other than their birth parents to be raised. Such an arrangement was not necessarily permanent, and it was openly acknowledged; this meant that whāngai children remained children of their birth whānau, and they retained the right to know their whakapapa (Mikaere, 1994, p. 136). Practised in this way, whāngai served to strengthen whānau and kin connections (Bradley, 1997, p. 38). However, examples of children being brought up in conditions of disease, ignorance and poverty were used to justify the eventual prohibition of whāngai (Williams, 2001, p. 238), in favour of its imposed colonial substitutes: removal to State Care or closed adoption. Ultimately, the responsibilities and rights of whānau, hapū and iwi with respect to their children have been deliberately undermined, resulting in the ‘near-destruction of the Māori social fabric’ (Mikaere, 1994, p. 140).

## Discussion and summary

In this chapter, we presented evidence of the cascading and interrelated impacts of the settler State Care system on tamariki and rangatahi Māori, their whānau, hapū and iwi as well as other Māori communities. Using Bronfenbrenner’s ecological systems theory (1976) we examined impacts as they ‘circle out’ beyond the individual survivor to whānau, hapū, iwi Māori as well as following generations. Because there has been a dearth of research on the experiences of diverse Māori communities engaged in the settler State Care system 1950-1999, it is likely that these impacts are just ‘the tip of the iceberg’. Further research is needed that speaks to the diversity of whānau and the multiple, layered impacts of being ‘cared for’ by the settler State Care system, particularly for tamariki with disabilities in foster care (Mirfin-Veitch & Conder, 2017) and in residential schooling situations (such as Schools for the Deaf, Schools for the Blind).

Our analysis clearly demonstrates that the settler State Care system remains a key mechanism for, and an enduring part of the colonising environment. A raft of evidence shows experiencing this environment has had compounding negative impacts, resulting in intergenerational trauma and harm for Māori individuals, whānau, hapū, iwi, and other communities. In the interests of social justice, equity and human decency, tamariki, rangatahi and whānau Māori deserve more.

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1. This misfortune is not minor, but a major disaster. Mead, H., & Grove, N. (2001). Ngā Pēpehā o ngā Tīpuna. Victoria University Press: Wellington. (82, p.23). [↑](#footnote-ref-2)
2. We use uppercase ‘D’ in recognition of Patrick’s belonging to the Māori Deaf community, a distinctive linguistic and cultural group in Aotearoa. [↑](#footnote-ref-3)