



18 October 2024

Dr Claire Achmad  
Chief Children's Commissioner  
Mana Mokopuna | Children and Young People's Commission  
Sent via email: [REDACTED]

Tēnā koe Dr Achmad

### **Draft OPCAT Report – Te Au rere a te Tonga Youth Justice Residence**

In June 2024, your monitoring team visited the Te Au rere a te Tonga Youth Justice Residence (Te Au rere) to monitor the safety and wellbeing of tamariki and rangatahi. This monitoring visit was completed as part of your role as a National Preventive Mechanism under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

On 20 September 2024, you provided your draft OPCAT report for Te Au rere to Oranga Tamariki—Ministry for Children (Oranga Tamariki) for review and comment. Our response to the factual accuracy was shared with your office on 4 October 2024.

The report makes eight recommendations; of those, Oranga Tamariki accepts six, confirms one is under consideration as part of the residence future state design, and does not accept one of the recommendations as it is stated.

The recommendation that is not accepted in its current form relates to the concerns raised regarding gaps in rangatahi accessing forensic mental health services in a timely manner whilst they are in Te Au rere. I acknowledge your recommendation but note that the provision of mental health services, and any gaps within forensic services, is the responsibility of Health New Zealand—Te Whatu Ora and not Oranga Tamariki. Our response therefore notes we will continue to raise the issue of ongoing gaps in the provision of forensic and mental health services and what is being done to address them with Te Whatu Ora, including whether there are further opportunities to collaborate in ensuring all mokopuna health and mental health needs are met in a timely manner.

It was pleasing to note your findings that Te Au rere kaimahi apply a consistent approach to their model of care, with clear structures, routines, boundaries and communication to ensure both rangatahi and kaimahi know what is expected of them to ensure a high standard of care. The monitoring team observed that this clear

expectation and culture setting from the leadership team has contributed to a culture of safety and tikanga that were largely followed by kaimahi and rangatahi at Te Au rere.

A highlight of the report is the observation that rangatahi at Te Au rere take ownership of looking after the whare during their stay. The monitoring team saw minimal tagging around the facility, linking back to the afore mentioned high expectations that leadership have of rangatahi behaviour. The environment was observed as clean and welcoming, with art and murals on unit walls, and the bedrooms having personal items and photographs from home. This 'ownership' is not just of their units, but also behaviour, and it was great to hear the monitors were told of an incidence where a rangatahi said "we don't do that here" when a new admission was preparing to threaten kaimahi. The role-modelling of positive behaviour by rangatahi for one another provides peer accountability, and is a real positive of the report.

Another positive observation is that the use of secure care and mokopuna admissions into secure care has decreased at Te Au rere, which can largely be attributed to a culture of safety and structure. The behaviour management system is used as a way of bringing out the best in behaviour, and this in turn has minimised the need for secure care at Te Au rere. This again relates to the consistent practice that is being deployed by kaimahi who acknowledge that clear communication and application of facility rules and expectations has seen rangatahi more likely to remain calm and settled.

I trust you find this information useful. If you have any questions or would like further information, please contact me on [REDACTED]

Nāku noa, nā



Julie Miller  
**General Manager**  
**External Monitoring and Reviews**