Royal Commission of Inquiry into Abuse in Care

Witness Statement of Associate Professor Dr Teuila Percival, QSO, MBCHB, FRACP

Dated 6 June 2022

Introduction

Can I first acknowledge the survivors of abuse in care, both those who have given evidence and those who have not, and also those who have passed and are no longer with us. Your bravery , stories and wisdom will guide us. I am honoured to add my voice to yours in the hope that we make things better for all children and young people who face the prospect of being taken into care. I hope also that in sharing my experience, I can help with your healing and reparation. Can I also acknowledge the Commissioners who listen and embrace the stories and experiences we share.

Background and experience

1. My full name is Teuila Mary Percival.

2. I am a New Zealand born Samoan with ancestral links to the Villages of Ofu in Manu'a and Pu'apu'a in Savaii.
    I grew up and went to school in Thames on the Coromandel Peninsula, Te Tara O Te lka A Maui.

3. I attended the University of Auckland where I studied medicine and am a registered medical practitioner with MBCHB (Bachelor of medicine and surgery) gained in 1983.
    I am also a Consultant Paediatrician with FRACP, Fellow of the Royal Australasian College of Physicians (Paediatrics) gained in 1993.
    I am an Honorary Associate Professor of Paediatrics at the Faculty of Medicine, University of Auckland.

4. I have worked as a Paediatrician in New Zealand, Samoa, Vanuatu, Tokelau, Niue and Tuvalu for 27 years. This includes working as a Consultant Paediatrician at KidzFirst Childrens Hospital, in South Auckland.

5. My work and experience includes the clinical care and management of acute and long term conditions in children and young people in the Emergency department, Inpatient wards and outpatient settings.

6.   I have subspecialty interest and expertise in the clinical assessment and management of children and young people where there are concerns of maltreatment.
I have worked in this area for 27 years.

I regularly see children and young people with concerns of physical, emotional or sexual abuse and neglect in a weekly Child Protection outpatient clinic. In this clinic children or young people have usually been assessed by Oranga Tamariki and/or they have attended for an Evidential Video Unit interview. My role is to clinically assess children and young people, discuss concerns with family and ensure the child's medical needs are addressed and that there is appropriate ongoing support .

7.   I also medically assess children who are in the Oranga Tamariki Care system in a weekly Gateway Clinic. This is a clinic where children and young people in-care are seen for a holistic Paediatric assessment. This addresses issues of physical health, learning and education, behaviour and mental wellbeing. Children are assessed in collaboration with family and/or carers and their Oranga Tamariki social worker with input from other community professionals or support groups involved such as their school principle or counsellor. A plan to support the child's on-going health and development is then developed for the Family/carers and Oranga Tamariki social worker.
Gateway clinics were initially piloted in four District Health Boards in 2008 with subsequent roll-out across New Zealand in 2011.
Children are referred by Oranga Tamariki for a Gateway Assessment[1]:

-   When a referral for a care and protection Family Group conference is made, or following it as appropriate
-   Within 10 days of entering Organa Tamariki care
-   For Tamariki already in Oranga Tamariki care if it would be beneficial

Gateway Clinic assessments are carried out by both Paediatricians and Nurse Specialists with additional subspeciality input as needed. Not all children and young people in the care of Oranga Tamariki are seen. Both Paediatrician and Nurse Specialists can carry out assessments with consideration given to matching the particular skill set of individual clinicians with child or young person need. For example, Nurse Specialists with Adolescent expertise may be better suited to seeing young people and Paediatricians better suited to younger children or where there are medical issues of concern. Either way, it is normal Paediatric best practice for clinicians to work in a collegial team, able to support one another with peer review and advice. Barriers to not being seen and assessed include waiting times due to clinic scheduling and staff, lack of parental consent, difficulty in arranging attendance for whanau and caregivers and of late cancellations due to the Covid-19 pandemic.

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In this setting children and young people up to 17 years are seen, who are either in Non-kin or kin foster care placements. Children may also be living with their parent(s) supported by wrap-around extended family and community support services.

In this Gateway Clinic it is not uncommon to see children who have had multiple foster care (kin and non-kin) placements. Children of all ethnic groups are seen with proportions reflective of the cohort in the care of or having been referred to Organa Tamariki.

Purpose:

8. I have been asked to provide an opinion firstly on:

   The impact/trauma on children who have been/are in the care system (and in foster care but extending into other forms of placement such as residences) and with their being in that system as a consequence of abuse /neglect suffered when in the care of their parents (or other persons having their care)

   Having identified the nature and extent of such trauma, the opinion will then identify how that trauma can be (or should have been) remedied/addressed by the State having assumed legal authority over that child.

9. In addition, I have also been asked to discuss:

   The needs of children and young people with traumatic brain injury and how these needs can be met in residential care /institutional environment, with recommendations specifically for their care/support in care

10. In addition, I have been asked to discuss:

    The impacts on Pacific people of children being taken into care at an individual, family and community level

    And

    Whether Pacific children, survivors and families less likely to make a complaint …

11. The basis of my opinion is:

An understanding of the relevant scientific Literature

And

27 years of Clinical work in Paediatrics and in the area of child maltreatment.

Part 1: Impact, risk and outcomes for Children in out-of-home care

Introduction:

12. In Aotearoa New Zealand, almost 24% of children have had at least one notification to Statutory Child protection (Oranga Tamariki, previously CYFS), 9.7% of children have been the victim of substantiated abuse or neglect and 3.1% have experienced out-of-home placements by the age of 17 years[2]. There is a notable ethnic and socioeconomic gradient with Maori and Children living in areas of high deprivation more likely to be referred to Statutory Child Protection and to be placed in foster care[3].

13. In the decades of my clinical practice (1990's to date) Children and Young people find themselves placed in out-of-home care (foster care, kin care or residential care) following significant adversity for them and their families.

14. By in large most will have been placed in out-of-home care following substantiated safety or child protection concerns with backgrounds that might include physical abuse, neglect, sexual abuse, emotional trauma and exposure to drug use and family violence.

15. Some children can also be placed into care because of concerns with parenting capacity unable to be addressed adequately through community support.

16. Even if a child is taken out of their home for other reasons—a parent is sent to prison, both parents have died, a parent is battling a substance use disorder—they are still dealing with a traumatic event that can have serious physical and mental health implications for them.

Health, mental health, learning and wellbeing of Children in out-of-home care

17. Children in foster care face a challenging journey through childhood. In addition to the troubling family circumstances that bring them into state care, they face additional difficulties within the child welfare system that may further compromise their healthy development.

18. Exposure to poverty, maltreatment and the foster care experience itself can present multiple threats to children's healthy development including physical health, attachment disorders, compromised brain functioning, social skills development and mental health difficulties[4].

19. Children entering out-of-home care may have experienced a range of challenges which make them particularly vulnerable and at-risk. They are likely to have poorer physical and mental health, developmental and learning needs than their peers.[5]

20. In addition, the families of children taken into care will have often experienced high levels of long-term unmet need and disadvantage, including low income, unemployment and unaddressed parent physical and mental health needs, drug addiction disorders and family violence.[6]

21. Children and young people entering foster care have a high prevalence of unrecognised and unmet health needs and neurodevelopmental or learning disabilities[7],[8]

22. While living in care, these children are also unlikely to access recommended child health promotion services such as a regular General Practitioner, Dentist, or hearing and vision screening.[9]

23. There is limited information at a national population level on the specific physical, mental health, behavioural and educational needs and the maltreatment histories of the children in out-of-home care. A recent survey of young people aged 12 – 18 years in New Zealand CYF residences found that 26% of girls and 56% of boys had been hit three of more times in the past year. Only 56% of the young people had a consistent General practitioner and only 44% had seen a dentist in the previous year (compared with 79% of young people in the Youth '07 Secondary school survey). The complexity and vulnerability of preceding home life was also notable with 67% of young people having parents with an alcohol or drug issues and 54% of girls having a parent with a mental health condition.[10]

24. In New Zealand, since 2011, Gateway assessments have been provided to some children and young people entering care or already in care.

25. Past Child Youth and Families Service (CYFS) Gateway performance measures have shown that for every ten children completing a Gateway assessment: three had a mental health need, five had emotional needs, three had developmental needs, six had additional learning needs and four had needs as a result of parent or caregiver alcohol or drug addiction[11]. The initial Gateway pilot (2008 – 2010) showed that of the children and young people assessed, 88% had unmet health conditions and 65% had an emotional or behavioural condition(eg anxiety) , and 41% had a mental health disorder. Mental disorders identified in this group included depression, anxiety disorder, conduct disorder and ADHD. Other identified needs were 41% of children needing dental treatment, 37% having some hearing loss and 13% having general child developmental issues (eg slow with speech). [12]

26. Understanding and recognising the health, emotional and learning needs of children in out-of-home care is important to ensure each child receives the appropriate healthcare, emotional and learning support and services that they need to thrive and develop to their full potential. In my experience there has been more effort from Oranga Tamariki and the Health and Education sectors with systems and professional practice to identify and address these needs in the past decade. However children in care, as one of the most vulnerable groups in New Zealand should receive more priority for health and education services including more tailoring and flexibility in models of service delivery in consideration of their complex and changing social circumstances and needs.

27. Recognising the needs of children in out-of-home care is critical but equally there needs to a commitment to the sustained provision of support and services that they need. For example current specialist Paediatric or mental health services for children and young people tend to be transactional and of short duration with a reliance on family /caregiver and community monitoring and referral back if further issues arise. This type of health service design requires some advocacy on the part of caregivers , stability of residence and an understanding or how to navigate health systems.

28. It is well described both internationally and in New Zealand that children and young people living in foster or residential care face significant barriers to accessing appropriate and continuous healthcare, mental health and educational support that can worsen their prognosis or lifetime wellbeing outcomes.[13]

Impact of relationships on Children in out-of-home care

29. Children's relationships are essential to their health, socio-emotional development and wellbeing. Removed from the care of parents and placement in out-of-home care precipitates a number of significant changes for children's lives and relationships: a new home, loss of daily interactions with their siblings, often a change in school, and neighbourhood.

30. Children and young people must develop relationships with the new people they are living with, and other people in their community such as peers and teachers. This adds to the complexity of dealing with their sense of loss, of missing their parents and siblings, and in some cases, understanding who is in their family[14]

31. Understanding and navigating their relationships with members of their foster or relative/kinship family and household as well as their family of origin, may be difficult and stressful so it may take a considerable time for them to settle into their new living arrangements[15]

32. Children's relationships and interactions with the people who are significant in their lives are very important and closely associated with their well-being and long-term outcomes, both in and after care. The children who fare best are those who have a 'lasting and significant relationship with at least one parental figure' in their family of origin or the family they are living with.[16] [17] By this I mean, it is very important for children to be able to have an "attachment" figure in their lives and for our out-of-home care system to enable and facilitate this. Attachment is a continuous responsive relationship a child has with another person which provides safety and security, offers a secure base with which to explore the world and enables development and learning. Attachment is best thought of as a mutually reinforcing pattern of behaviour between a caregiver and a child. Babies and children typically have such a relationship with a parent, however attachment may be disrupted through parental mental illness and emotional trauma or through multiple changing child placements. Children can form attachments with other significant caregivers in their lives such as in foster care. It is the stability of placement along with a consistent sensitive, responsive caregiver that is important.

Impact of Trauma

33. Most children and Young people in out of home care have been exposed to and experience emotional trauma[18] . This may be associated with neglect, abuse, exposure to violence or parent drug use. Not uncommonly children will exhibit trauma symptoms such as anxiety, poor

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sleep, irritability, anger or emotional withdrawal. The removal from home itself is associated with emotional trauma for children and young people. Sifting through and ascribing negative child effects to prior abuse or parental/family separation is difficult and the literature is limited. Studies which have interviewed children removed from their parents describe feelings of fear, confusion, abandonment and absence of trustworthy information.[19]

Children report catastrophic separation days with limited preparation, uncertainty and multiple losses which increase in number as they are separated from remaining supports such as siblings or school. [20] There is also some relevant literature on the effects of child and parent separation for migrant and refugee children which describes similar emotional trauma and long term harm that children suffer when removed from parents.[21]

34. Childhood trauma is linked to mental and physical health problems extending into adult life. It negatively impacts brain development, learning, social-emotional development, the ability to develop secure attachments to others, and physical health. It is also associated with a shortened lifespan.[22] , [23]   How the effects of trauma are manifest depends on which of the critical developmental periods in childhood are affected. In the first three years of life brain cells and their connections are still forming and needing a responsive secure attachment relationship to maximize growth. Trauma experiences in this infancy period may result in poor brain growth, developmental and cognitive delays and emotional dysregulation. In older children the brain's neural pathways are being "pruned" and there is increased myelination (protein covering of nerves) which coincides with increased cognitive ability and mastery of complex co-ordination and skills seen in school aged children. Trauma during this period causes prioritization of nerve pathways for trauma adaptive behavior. This might result in children with emotional lability or heightened anxiety and poor cognitive ability and learning. [24]

35. Repeated exposure to trauma in childhood can also affect the ability to establish relationships and attachments with caregivers and family[25] putting children at risk of secondary re-traumatisation.

36. Children in out-of-home care also experience further trauma due to abuse in care, multiple placement breakdowns alongside frequent school, family and peer-group transitions, further negatively impacting relationship stability and loss.[26], [27]

37. "Trauma informed "care is a holistic approach to support and care services which is grounded in the understanding and recognition of trauma and its impact on children. Central to this is building safety and control for trauma survivors and preventing secondary trauma. A New Zealand study on trauma responsive care in residential care describes important themes to

guide practice with children who have experienced trauma - :the importance of a foundation of attachment relationships, children needing to feel safe in relationships and staff implementing the "5R "strategies of "recognise, responsive, regulate, relate and reason" when working with children. This means firstly recognising and being aware, then being responsive to each child's needs, followed by interventions helping with regulation, relational and reason. [28]

38. In New Zealand, trauma informed practice and care needs to also consider the systems-induced intergenerational trauma inflicted on Maori. It is beyond my expertise to discuss this but merely to note consideration of the trauma effects of colonisation, institutional and systemic racism on generations of Maori needs to be a consideration.

Children with Neuro-disability in out-of-home care

39. Children who have Neuro-disabilities are a particular concern. These are long-term disabilities affecting brain function, movement, speech and learning. Some of these childhood conditions such as Autism or FASD (Fetal Alcohol spectrum disorder) can be unrecognised or misdiagnosed. Without correct diagnosis their symptoms might be misinterpreted as for example an aggressive misbehaving child rather than one experiencing anxiety and distress due to language and socialisation difficulties associated with Autism.

40. It would be fair to say that health professional awareness and recognition of conditions such as autism has improved particularly over the past two decades.

41. FASD however, despite being one of the most common preventable forms of neuro-disability is still not commonly identified, in part due to continuing lack of awareness of the condition by health professionals[29] , difficulty in diagnosis and also the shortage of skilled FASD diagnosticians. New Zealand FASD prevalence is hard to determine and there is as yet no large prevalence study in our country. International estimates are that FASD prevalence is probably 10 to 40 times higher in "at-risk" populations such as children in-care and those in the correctional facilities[30]. An Australian study with comprehensive FASD assessments of 10- 18 yr. olds in a Western Australian youth detention centre found that 36 of the 99 young people had FASD , a prevalence of 36% – all undetected before the research study.[31]

42. Even with adequate diagnosis and motivated caregivers, negotiating the system and services support needs for children with neuro-disability can be challenging. Children with neurodisabilities need ongoing care and support. Typically this would consist of regular Paediatrician team visits where monitoring and treatment options are considered , therapy

team support which might include speech therapy, physiotherapy and occupational therapy for functional living and equipment such as wheelchairs. Needs Assessment and Care Co-ordination service assessments would occur every few years to determine and arrange funding for disability services such as respite care, alternative carer support, home help, house modifications. Disabled children should also access additional support through the Ministry of Social Development with the CDA (Child Disability Allowance) and Ministry of Education which might include teacher aide support and/or individualised child funding. For children with disabilities in out-of-home care, the ongoing needs and care would be the same. Navigating the Health, Disability and Education systems can be time consuming and challenging. Often there are multiple professionals and therapists involved and multiple appointments. Certain conditions such as ADHD may fall between services such as mental health and paediatrics with the result being delayed and inadequate care. What would be useful to a foster carer or youth residence placement would be a disability advocate or mentor to assist in navigating the system. This role might be taken on by a Paediatric Disability Nurse specialist, a General Practitioner or disability support organisation such as Vaka Tautua.

43. Foster and kinship caregivers report difficulties with long waiting lists, out-of-pocket expenses and barriers to navigating consent and authorization processes when trying to access health services for children in their care.[32] As an example, signed consent from a parent or guardian is needed for any surgical procedure or to immunize a child. Enrolling children in school also usually requires birth certificates, proof of residence and parental consent. Outpatient clinic appointments can be delayed/deferred or declined due to changing addresses and caregiver contact information.

Traumatic Brain Injury and Abusive Head Trauma

44. Injury both accidental and non-accidental is common in childhood. Of all types of injury, Traumatic brain injury(TBI) is the leading cause of disability in children worldwide and in New Zealand[33] . Because of this, it is a condition to be considered carefully in children and young people in out-of-home care.

45. Accidental Traumatic brain injury in children is most commonly as a result of falls or transport accidents. In Young people TBI secondary to assaults with closed head injury blunt trauma alongside traffic accidents and falls, become increasingly important.[34]

46. Babies may sustain TBI from Abusive Head Trauma (AHT) where an infant is violently shaken and/or thrown sufficient to cause rupture of brain blood vessels and shearing damage to brain cells. Abusive head trauma usually results from a violent response to infant crying, is most common in young children under the age of two years, peaking at the age of 6 months. It is particularly devastating with two thirds of children either dying or sustaining severe neurological disability[35]. The cardinal features of this type of traumatic brain injury are that it is associated with brain swelling, brain bleeding and shearing or rupture of brain cells. Additionally babies not uncommonly have bleeding in the back of their eyes and fractures of rib bones and limb bones as a result of the violent forceful gripping of torso and shaking not just of the head, but also the limbs.

47. Older children and young people can also sustain a spectrum of TBI typically from blunt head trauma secondary to assaults, traffic crashes and falls. This may leave them with skull fractures, concussion and/or permanent brain damage.

48. The immediate and acute care of children and young people with obvious traumatic brain injuries will usually be managed by hospital or Emergency department teams addressing issues such as brain swelling, seizures and pain relief.

49. The subsequent medium and long term care of children and young people with TBI occurs in the home and community and can be challenging and is often suboptimal.

50. With severe neurological sequalae such as cerebral palsy or paralysis there will be needs such as seizure control, functional supports such as wheelchairs, physiotherapy and support with everyday bodily functions such as eating and hygiene. These children are likely to have regular hospital team outpatient follow-up and ACC (Accident Compensation Corporation) funded therapy and support.

51. Less severe or mild TBI can occur without medical or indeed patient awareness of the symptoms or ongoing health problems. Mild concussion or TBI may be undiagnosed or unrecognised and still cause problems such as headaches, concentration or cognitive difficulties, emotional lability, memory loss, fatigue and impulsivity.

52. The Brain Injury Outcomes New Zealand in the Community Study (BIONIC) was carried out to understand the causes and consequences of brain injury. They found that assault was the most common cause of mild TBI in 16 – 35 year olds. Other causes included falls, sports injuries and

traffic crashes. Importantly 30% of TBI cases were never seen in hospital.[36] Of concern, also, is that around 20% of people with mild TBI continued to experience symptoms with complex attention and memory 12 months after the injury and four years on, cognitive problems significantly persisted including forgetfulness and poor concentration.

53. TBI compromises important neurological functions for self-regulation and increases the risk of behavioural disorders and mental health morbidity.

54. Traumatic brain injury, particularly mild to moderate traumatic brain injury and its ongoing consequences is often underestimated, unrecognised and untreated[37] ,[38]

55. Children and young people with TBI may struggle for years with symptoms which impact health, everyday function, learning and social relationships.

56. There is international evidence that the prevalence of TBI in young people in custody is substantially higher than young people in general [39]. In New Zealand there are reports that TBI rates are four times higher in justice-involved men compared with non-offending peers and that more than a third had multiple severe TBI's before the age of 15 years (40% by assault and 20% in road traffic crashes). [40] There is no specific study on the prevalence of child and youth TBI in New Zealand's foster care or youth residential system, however it would seem given the prevalence in the general New Zealand population, international evidence of increased prevalence in youth offenders and New Zealand's evidence of increased TBI in adults in the justice system , that TBI should be a major consideration for young people in the out-of-home care system. This means an out-of-home care system that ensures an awareness and ability to recognise, diagnose and provide care and rehabilitation for TBI.

57. Appropriate therapy for mild to moderate TBI is individualised but typically would include assessment and a rehabilitation programme of rest, occupational therapy, physiotherapy, psychological and psychiatric care, speech and language therapy , cognitive behavioural therapy and social supports including learning support in educational settings. Therapy can be complex and involve years of rehabilitation with multidisciplinary teams and rehabilitation organisations such as ABI Rehabilitation Specialists Nga Kaituku Matutu. A starting point in New Zealand is diagnosis by medical practitioner or neuropsychologist which then enables ACC case management and funding for injury specific services and support. [41] Caregivers of children with TBI are likely to need training in the needs of TBI which might include being able to support physical therapy, speech therapy and management and strategies for concentration, emotional and learning difficulties. Depending on need caregivers may also need additional support in

the home such as individualised behaviour management and occupational therapy programmes which they would co-deliver with therapists.

58. It should be noted that unrecognised TBI symptoms and subsequent failure to understand the needs of the young person or to design therapy and adapt educational and home settings to their needs will impact on a child's learning, development, education and social success with peer relationships.

59. Unrecognised Traumatic brain injury has also be associated with violence[42] and adverse social behaviours risking further injury and potentially producing a cycle of recurrent injury where cognitive and social sequalae of TBI pre-dispose young people to future high risk behaviours and further injury. [43]

Lifelong impact of maltreatment and out-of-home care

60. The simple act of leaving one's home is a traumatic experience, but this is just the beginning for children entering the out-of-home care system.

61. As noted already, many have been removed from their home due to abuse or neglect, and this along with the foster or residential care experience means children face multiple threats to their healthy development including physical health, attachment disorders, compromised brain functioning, social skills development and mental health difficulties.[44]

62. Many are forced to adapt to constantly changing environments, as they are moved from care home to care home. Some are returned to their biological family after a short-term placement, only to be reentered back into the system. The lack of stability, a sense of belonging and the ability to build connections is detrimental to the health and wellbeing of children in-care.

63. Children in foster care often struggle with issues of trust, attachment, and anxiety. They can face significant emotional difficulties such as a lack of self-worth and sense of control of their lives, which can make it hard to establish healthy, loving relationships.

64. Experiences in childhood before going into care and continuing while living in out-of-home can have a life-long impact on children with more chronic disease, disability and poor mental health seen in adult life [45]

65. This is largely due to the adverse effects of neglect, abuse and trauma on neurodevelopmental[46], physiological, epigenetic[47] and metabolic[48] pathways of individual children but also because of the effects of disruption to attachment and family structures and

ongoing neglect of needs or abuse in out-of-home care. What this means is sustained stress and emotional trauma in the child as a result of abuse and neglect can physically affect brain cell development and growth, as well as change the way the body's biochemistry and hormones operate and work in a child. If sustained this can cause long-term conditions such as learning problems in young people and heart disease and diabetes in adults. We now know that prolonged stress and adversity can affect the way our genes work. Trauma and stress in children can produce this "epigenetic" change where genes work differently increasing risk of conditions such as cancer in adults. [49]

66. What this means is abuse and neglect can cause direct biological harm to children's bodies, affecting chemical processes which impact on organs in the body producing long term chronic health conditions and disability.

67. Disruption of attachment is where the critical important long term bond between a child and their parent is damaged or interrupted producing emotional difficulties, and impacting on children's' mental health and ability to successfully form relationships. Disruption of attachment might occur when a child is removed from their parent or where a parent is emotionally disconnected due to drugs or mental health issues.

68. There is widely published evidence showing that investment in the early years of children's health, development and well-being is the most cost-effective means of tackling long term health conditions. Early interventions aimed at children, their families, carers and health services and education providers can reduce poor outcomes particularly for vulnerable children, shifting negative life trajectories and disrupting the intergenerational cycles of disadvantage.[50] [51]. Equally for children in out-of-home care, commitment and attention to early intervention can shift children and young people to positive wellbeing and health trajectories.

The importance of Culture, Identity and belonging

69. **"Ko wai au ?"** (Who am I?). The response to this question for tangata whenua and tangata o le moana is never as an individual. The answer begins with connections to land, water, ancestral gathering place(Marae), ancestors, descendants, family, parents and lastly will come the individual's name. Identity is inextricably tied to one's family, ancestral home and lands is no different for children.

70. Whakapapa can be the rock which keeps children and young people grounded and resilient when facing stress and trauma.

71. Strong cultural identity, among other benefits contributes to mental health resilience, higher levels of social well-being, and improved coping skills.[52], [53]

72. Children need to grow up in an environment where they can value and learn about their culture and "heart language". One's heart language is the traditional language of family and ancestral origins, one's first childhood language and the language with which we feel resonance. [54]

73. When children in foster care are placed with ethnically dissimilar caregivers there is increased risk of depression, feelings of loneliness and behaviour problems.[55]

74. Children having a sense of belonging and connection is also associated with positive health and social outcomes [56].

75. Conversely there are negative health and behavioural outcomes for children and young people where identity, belonging and connections are not maintained or strong.

76. Keeping foster children and young people I residential care connected to their biological parents, through visiting and other forms of contact, is essential for identity, future reunification and to re-establish and maintain family ties during out-of-home placement[57].

77. Continued contact for children in foster care and residential care with their biological siblings is also important for their sense of both identity and belonging.[58]

78. Children, no matter their situation, including those who have suffered maltreatment still identify with and care about their parents and family.[59] This should not be discounted when considering children in care and their need to not only maintain contact but to also know and understand what is happening with their parents and families.

79. Identity, culture and connections are part of normal healthy child development and the importance of these connections, and harm that occurs when they are severed or at the very least not maintained, valued or healed cannot be overemphasised[60]. This harm is life changing – and lifelong.

The effect of out-of-home placement and type of Foster care on children

80. The Child welfare system aims to protect children and when deemed necessary for maltreatment and safety reasons, removes children from parents and places them in out-of-home care.

81. The impact and negative outcomes associated with this process have been noted already. What is worth considering, is the effect of the foster care experience itself and what types of out-of-home care might be associated with less negative sequalae and more positive outcomes for children.

82. The literature is mixed when examining this question. Some studies show little difference in long term outcomes for maltreated children in either biological or foster care homes. Others have shown that older children on the margin of placement do better if they remain in their homes with biological parents.[61]

83. When comparing non-kin with kin foster care placements it seems that kin placements are more likely to address the important needs of culture and identity. However research has consistently shown that kin foster parents typically have other risk factors of higher rates of poverty, more likely to be single parents, and are typically offered less resources, training and support services from Child welfare agencies compared to non-kin caregivers.[62] In my experience with Maori and Pacific kin carers in particular, there is a sense of responsibility to care for children in their whanau, often when they (the kin carers) have very limited resources such as inadequate housing and household income. It is not uncommon for there to be a lag in support or inadequate support from other sectors such as MSD and Kainga Ora. Similarly, the preparation and support with skills such as parenting traumatised children tends to lag behind the needs of kin carers.

84. Importantly when considering stability and a sense of belonging for children, Kin placements are more likely to be of longer duration than non-kin. As well, kin- foster parents are more likely to persist in caring for children with difficult and challenging behaviours. [63]

85. Maintenance of family connections seems to be important to the wellbeing of children in care. Managed well, there are a number of benefits including the increased likelihood of family reunification, the enhancement of children's emotional and behavioural development and providing children with a greater sense of identity and belonging[64], [65]

86. Poorly managed biological parent contact, particularly with circumstances of child maltreatment, can be harmful[66]. In my experience all parties – children, biological family and caregivers (non-kin or kin) need support and planning for parent contact. Too often biological parents who are themselves stressed, traumatized and disempowered by the care and protection process see their children with little preparation or counselling around what would be most supportive for the child. Similarly, the foster carers may have returning children who are temporarily distressed, angry or acting out – all of which requires some caregiver preparation and counselling to be able to support the child.

87. Placing children in foster care with siblings is associated with more positive outcomes including more successful family reunification[67].

88. Reducing sources of stress for families promotes child and family wellbeing[68] . This is important for non-kin and Kin Foster care families where practical assistance to reduce Family stress (such as ensuring low cost appropriate quality housing) will help to optimize wellbeing for children and young people in care.

89. There are well described qualities in foster care placements and carers associated with better outcomes in children.[69]

90. These include stability of placement, caregivers with flexible expectations and tolerance, self-efficacy and an ability to communicate effectively, with an understanding of trauma and children. Caregivers should also have sufficient economic resources and access to support systems and they should value connections with the child's biological family.[70]

91. Children need to feel that they are loved and cared for whether this be in a kin or non-kin placement or residential care. Their culture and identity and sense of belonging needs to be nourished and maintained.

Hearing the voices of children and young people

92. The 2015 Expert Panel: Interim Report - Modernising Child Youth and Family conducted in depth interviews with a group of young people about their experience of being in care[71]. What the young people talked about resonates with my clinical experience and what young people and children have told me.

93. In the interviews the young people said[72]:

a. We need more nurturing and love - Not just shelter and food but environments where they can learn, grow and heal.

b. We want a say in what happens to us – they should have a voice in important decisions about them

c. We have experienced trauma and need help to make sense of what has happened – they need support and help with transitions and empowered to make sense of what they have been through

d. We crave belonging and being part of a family who bring out the best in us – finding a sense of family is critical. If others know they are in care then they would know that they do not belong to anyone. May reported the life-changing impact of finding "the one" adult who understood and supported them

e. We want to strengthen our cultural identity and connection – the value of cultural connections, especially in relation to their sense of identity and well-being.

f. We do not stop needing help, support and nurturing just because we turn 17

Part 2: Addressing and minimizing the impact, vulnerabilities and poor outcomes for children and young people in out-of-home care

If children and young people must be placed in out-of-home care, how can the care experience minimise harm and maximise wellbeing?

With the vulnerabilities of unmet needs in health, education, socio-emotional development, trauma experience and disability that children and young people commonly enter out-of-home care with, how might the State ensure recognition and that needs are met?

How can the out-of-home care experience minimise harm and maximise child well-being?

RECOMMENDATION : The Aotearoa New Zealand out-of-home care system should centre on being Te Tiriti dynamic

94. Te Tiriti o Waitangi should be at the forefront of all thinking and planning with opportunities to enact Te Tiriti articles in practice.

95. When out-of-home care becomes necessary, the system should function to address racism and bias, introducing Te Tiriti and Kaupapa Maori principles.

96. A Te Tiriti dynamic out-of-home care system requires shared power and governance with Iwi.

97. Reconnecting and building cultural connections, belonging and identity should be prioritized and a sustained resourced intervention for children and young people.

98. Colonization and intergenerational trauma may have caused disconnection from culture and languages for not just the children but also their parents and family. [73]

99. If this is the case then resourcing and supporting the family with cultural journeys, reclaiming whakapapa, and reconnecting with iwi, whenua and taonga should occur.

RECOMMENDATION : Maintaining Family and sibling connections while in care with an additional focus on family/parent wellbeing

100. Whilst Child Protection systems are concerned with removal of children and young people from their families in the interests of safety , the system must have focus and commitment (when safe), to maintaining family connections and ultimately to family reunification.

101. This requires sustained resourcing ensuring that the separated parents and families have support and intervention enabling them to heal and re-build their lives.

102. All individuals involved in biological parent and child contact – parents, children and foster caregivers - require support not only organisationally but emotionally to manage feelings and optimize best outcomes[74]

103. As noted already, the parents and families of children taken into care will have experienced high levels of long-term disadvantage and unmet need. This should be addressed and adequately resourced to minimize on-going stressors for families enabling more successful family reunification and child wellbeing.

RECOMMENDATION : Out-of-home placement qualities to optimize positive child/young people experiences

104.   The Harvard Centre for the Developing Child summarises the science behind core principles to promote positive child and family outcomes. [75] These three principles should be a guide to any Care situation in which children and young people are placed:

- A focus on supporting responsive relationships for children and adults
- Strengthening Core skills for planning, adapting and achieving goals for children, young people and adults.
- Reducing sources of stress in the lives of children and families

105.   All (core principles) are important with policy and practice implications that are consistent with other recommendations discussed including attachment, stability, and promoting identity and connections.

106.   Reducing stress for Kin and Non-Kin Foster families is critical and underpins and supports all other interventions. This needs to be resourced enabling practical support for families such as assistance with affordable quality housing, income support, financial assistance with child development activities such as sports clubs fees and music. The facilitation of this needs to be streamlined for families removing the added stress of negotiating unnecessary bureaucracy.

107. Out-of-home placements should be with kin-caregivers if possible.
Kin-foster caregivers can provide an important sense of connection and identity for children. Placements are likely to be longer with more commitment to the child long term.

108. There should be State funding of resources and support for Kin and non-kin foster parents that includes culturally appropriate parenting courses, trauma informed parenting, raising children with special needs. As noted already, Kin-foster caregivers commonly receive less supports, training and resources than non-kin foster parents.

109. If placed with non-kin caregivers consider the cultural and ethnic match of child and foster family and where this cannot be matched, support child and non-kin parents with a cultural mentor.

110. Out-of-home placements whether kin or non-kin foster parents or residential care should support and develop qualities known to be associated with better children in- care experiences and child wellbeing, namely:

- Stability of placement
- Caregivers with flexible expectations, empathy and tolerance
- Caregivers with self-efficacy and ability to communicate effectively
- Caregivers with an understanding of trauma informed care
- Caregivers having sufficient economic resources and access to support systems
- Caregivers having an understanding of the effects of trauma
- Caregivers valuing connection with the child's biological family[76]

RECOMMENDATION : Trauma informed practice in Foster care and residential care with staff, Foster parents and biological parents trained in Trauma informed approaches to caring for children

111. Trauma informed care has developed in response to the overwhelming evidence that children in residential and foster care have high adversity, trauma experiences and poor health outcomes.[77] , [78]

112. Trauma informed care recognizes the impact of trauma on a child/young person's everyday living and the need for trauma-aware foster caregivers or residential staff who can provide support and reduce the likelihood of re-traumatization while providing environments which promote secure caring relationships [79]

113. Competent and trustworthy carers are essential for a care experience that feels positive and safe for children and young people [80].

114. Foster caregivers, including Kin-caregivers and residential care staff should be trained in Trauma-informed care[81] and additionally have support and self-care for themselves to prevent and mitigate effects of secondary traumatic stress.

115. A Trauma-informed care model for children's residential care, would have key workers able to provide one-to-one mentorship and a caring sustained relationship

116. A focus and commitment to placement stability will reduce re-traumatization and promote relationships, attachment and resiliency

117. Trauma protective factors that promote resiliency should be a focus of out-of-home care, including a sense of safety at home and school, self-efficacy, cultural beliefs, child/young person goals and dreams for the future[82]

RECOMMENDATION: Children and Young people's Voices should be heard, and they should be active participants in decision making about themselves and their lives

118. Children and young people in out-of-home care should be involved in decision making about their lives. This empowers them and builds confidence and trust and models the importance of respectful two-way communication and problem solving, which are necessary skills for adult life.[83] [84]

119. Even very young children and young people with disabilities and learning difficulties can be empowered to be active partners in simple living choices and decisions if a child-centred, developmentally appropriate approach is used by caregivers, residential staff and social workers.

120. Children should be part of and kept informed about decisions for out-of-home care duration and family reunification.

121. Considered planning and support for children should occur with transitions into and out of care.

State and system addressing the special needs of children and young people in out-of-home care

RECOMMENDATION: **Ensure appropriate health, psychological, learning needs assessment and effective planning and delivery of services and therapy to meet the individual needs of   children and young people in out-of-home care**.

122. The State should be responsible for ensuring the identification and provision of services for health, disability and special needs of children and young people in out-of-home care, including Kin-Foster care, non-kin foster care and residential homes.

123. All children and young people in care should have comprehensive assessments that include health, mental health, learning needs, culture and identity. There should be opportunity for this to be strengths based involving important people in the child or young person's life.

124. Needs assessment should be holistic and include developing an understanding of the cultural needs and identity for children and young people.

RECOMMENDATION 2:   **Ensure the particular needs of children and young people with disabilities including Traumatic Brain injury are recognised and addressed**

125. Children and young people in out-of-home care who also neuro- disabilities such as autism or intellectual disability are particularly vulnerable. They require not just diagnosis of needs and facilitation of services but ongoing services management and advocacy.

126. Children with disabilities in out-of-home care are additionally vulnerable and as already discussed foster caregivers report significant barriers to accessing health and other care.

127. There should be active monitoring and advocacy to ensure the health, education and learning, emotional and mental health needs of children are met and sustained.

128. Barriers to access should be minimized and if necessary individualized funding for children should be available to ensure service and support needs are met.

129. Young people in residential care with Traumatic Brain injury (TBI) are especially vulnerable to unmet needs and poor health and disability care. They should receive a comprehensive assessment with Rehabilitation teams skilled in TBI and youth health. This team would include Neuropsychologist, Youth Health Physician, Nurse Specialist, Occupational therapist, Physiotherapist.

130. Identification and Assessment of TBI need is insufficient without planning for therapy, education, functional living strategies, environmental changes and medical care.

131. It is likely that young people with TBI in-care will struggle to negotiate health, mental health, education and disability systems.

132. There should be a long-term advocate and mentor to support young people with navigating and ensuring that services, therapists and home environments are responsive to their needs.

Part 3: The impacts on Pacific people of children being taken in to care at the individual, family and community level in Aotearoa, New Zealand.

133. Pacific peoples encompass communities from the Islands of Samoa, Tonga, Cook Islands, Niue, Fiji, Tuvalu, Tokelau, Kiribati, Vanuatu, Solomon Islands who have settled in New Zealand in waves of migration beginning in the 1950's.

134. We are increasingly heterogeneous with mixed ethnicity and 2nd and 3rd generation New Zealand born children.

135. There are some changes in social structures such as more single parent Pacific families and some young people less inclined to attend our traditional Churches, but our communities by in large maintain the cultural values and traditions of our homelands.

136. Collectivism and being part of large multigenerational families with unquestioning service to ones Aiga or family is highly valued and part of everyday life.

137. Samoan babies and toddlers are affectionately indulged and never left alone. Older children are traditionally disciplined and brought up to be well behaved, polite, to care for their younger siblings and to serve their elders with humility.

138. Each of our diverse Pacific communities has sayings that speak to the special place and value of children in our families:

    Ko te tama te tumu o te akara'anga" (Cook Islands Māori)

    "Sa idivi ni loma ni mata na gone" (Fijian)

    "Ko e tama ko e alito he mata" (Niue)

    "O le mea uliuli o mata o matua o fanau" (Samoan)

    "Ko e fanau ko e pele tu'u kanoimata" (Tongan)

    The child is the centre of one's eye (Papa'alagi)[85]

139. As communities, we look to provide environments where children grow and develop, each with a role and place within loving families.

140. Traditional Protocols, etiquette and respect for authority figures are core values. So too is the importance of the collective good of the Family or Aiga coming before that of the individual.

141.   A person's sense of identity, value and belonging is totally dependent on their family.

142.   Tui Atua Tupua Tamasese Efi, former Samoan Prime Minister and Head of State describes the collectivism of Samoans

> "I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because I share a tofi (inheritance) with my family, my village and my nation. I belong to my family and my family belongs to me. I belong to my village and my village belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my sense of belonging."

143.   The history of Pacific people in New Zealand includes decades of racism including structural racism in Government departments, systems and services.

144.   The economic challenges in New Zealand's 1970's provoked widespread backlash against Pacific people - blamed for the deterioration of inner city suburbs, taking jobs off Pakeha and for law and order problems.

145.   The Dawn Raids of the 1970's saw police and immigration targeting Pacific and deporting overstayers. This has left generations of Pacific people traumatized.

146.   Pacific people by in large valuing humility and respect for authority are less likely to complain or protest. This is within a context too of generations of Pacific experiencing racism and unfair treatment in New Zealand.

147.   With any unfair treatment in the Care and Protection system it is not unexpected then for Pacific to be less likely to speak up and complain.

148.   Removal of children from Pacific families, even with valid safety concerns, will cause trauma and harm to the family. There is loss of "face" and mana because of statutory involvement.

149.   Traditionally, Samoans would address an injustice or harm to individuals , including children through the wider extended family, turning to our leaders, our Matai and potentially using Ifoga – traditional ritual apology and reparation. The wider family takes responsibility for addressing the harm.

150.   Taking the power of collective responsibility, ownership and redress away from Aiga/Family is a hurt which will be remembered and felt by that family long term and in subsequent generations.

Statement of Truth

This statement is true to the best of my knowledge and belief and was made by me knowing that it may be used as evidence by the Royal Commission of Inquiry into Abuse in Care.

GRO-C

Dr Teuila Percival

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