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Brief of Evidence – Royal Commission of Inquiry into Abuse in Care

Contextual Hearing 29 October – 8 November 2019

Introduction

1. I would like to thank the Royal Commission for giving me the opportunity to talk today on a topic that has been my life's work. My curriculum vitae (CV) is annexed in full at annex 1 to this brief.

2. I am a clinical child psychologist, psychiatric epidemiologist and child developmental theorist, and I am employed as a Professor of Child and Family Psychology at the University of Canterbury in Christchurch, where I have lived since 2006.

3. My life's work has been to increase our understanding of the psychological development and well-being of children in care, those adopted from care, and other children who have ongoing need for care, with a view to improving lives.

4. My earlier research focussed on identifying and demystifying various mental health difficulties experienced by this population, using epidemiological and clinical research methods, including the development of new psychometric measures. This centred on the longitudinal NSW Children in Care study that ran from 1999 to 2011. [1]

5. I have advised statutory child welfare ministries and national health services on the provision of services for children in care in New Zealand, Scotland, Ireland, England & Wales, South Australia, and New South Wales.

6. My work is referred to in the 2008 Special Commission of Inquiry into Child Protection Services in New South Wales; and in the Royal Australian and New Zealand College of Psychiatrists submission to the 2017 Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

7. The realisation that these children's mental health difficulties and living circumstances were poorly matched to generic child and adolescent mental health services, led me to work on the design of specialised mental health services for these populations.

8. In the latter half of my career, my focus is shifting from clinical research to measuring and understanding how these children develop over time in the midst of what are often unnatural childhoods.

9. I am presently planning large-scale epidemiological (a cross-national cohort study) and theoretical (Impermanence Theory) work – hoping to advance developmental child welfare as a research field, and to guide further reform of child welfare legislation, policy and practice.

10. Today I want to provide some insights from developmental science on how the state should respond to the plight of children growing up in statutory care. In particular, my evidence will focus on those who have suffered abuse, trauma, or neglect prior to their entry into state care.

11. Because my work has not been focussed on the New Zealand context, my evidence refers to the developmental needs of children growing up in statutory care generally, without addressing specific aspects of the New Zealand care system, or the specific cultural context in which it exists.

12. Such children leave their parents' care with neurobiological systems that are adapted to cope with neglectful or abusive environments – but which are poorly adapted to normative social environments.

13. This translates as heightened risk for an array of developmental, social and mental health difficulties that often persist into adulthood – what Eamon McCrory describes as '*latent vulnerability*'. [2]

14. Fortunately, neurobiological development is not fixed. Children can experience psychological and neurobiological recovery in response to consistently sensitive, loving care, as well as other experiences and realities that engender 'felt security'. [3]

15. In thinking then about how society should tend to these children's care and well-being, I propose three priorities:

    a. The first is restoring to them the opportunity to experience and enjoy what remains of their childhood in much the same way as do other children.
    b. The second is restoring the social and familial conditions that are necessary for healthy human development, and which are also the pre-conditions for these children's development recovery.
    c. And the third is ensuring that they and their caregivers are provided specialized clinical and developmental services, as well as intensive caregiver support.

In the first part of my evidence I will describe the psychological development of children placed in statutory care, focussing mainly on the effects of severe maltreatment, and their mental health.

16. First, I should explain that I use the term 'maltreatment' to refer collectively to child abuse and neglect, regardless of the setting in which it occurs, or the child's relationship to the perpetrators.

17. The toxic effects of maltreatment on children's psychological development and well-being, particularly when children are maltreated by their parents or other primary caregivers, are well established.

18. We know considerably more about these effects now than we did 20 years ago, due to advances in neuro-developmental science, the employment of large-scale epidemiological studies, and more focussed clinical research on the effects of severe psychological trauma and disturbances to children's attachment systems.

19. A range of neuro-biological and psychological processes in early childhood that are critical to human social functioning are impaired by early and prolonged exposure to traumatic abuse and the absence of nurturing, sensitive care. These include behavioural and emotional regulation, executive functioning, intellectual abilities, language and memory. [4, 5]

20. Similarly, severe and chronic maltreatment profoundly alters children's attachment development, affecting:

    a. their interpersonal relationships;
    b. how they understand and value themselves and others;
    c. the meanings children attribute to social relationships;
    d. and how they understand the minds of others, which has implications for the development of empathy. [6]

21. The effects of maltreatment on children's development vary somewhat depending on children's ages and stages of development at the time they are harmed.

22. In particular, maltreatment during the first three to five years of life has more adverse effects on children's developmental pathways, because the most critical components of our psychological development occur in those years, notably development of our attachment systems and other aspects of social functioning, language, and emotional and behavioural regulation. [5, 6]

23. However, within those early years, maltreatment over time has a generally incremental impact on human development, consistent with cumulative trauma exposure models, neuroscience, and attachment theory. [4, 7]

24. There is also evidence that, whilst children's development is seriously compromised by maltreatment, and especially by more severe and long-lasting maltreatment, some of these effects can be reversed over time in response to optimal care, including attachment security, [8] while other effects tend to persist. [9]

What then are the effects of pre-care maltreatment on the development and mental health of children in statutory care?

25. The protection, psychological development and well-being of a large majority of maltreated children is best served through varying levels and types of family support services, including specialised parenting interventions, and parental drug and alcohol treatment. [10] It goes without saying that providing effective family supports earlier, rather than later, is the key to arresting and preventing further developmental harm for such children.

26. A relatively small proportion of children who are maltreated by their parents or other guardians have an ongoing need for care, and in modern times, children are mostly placed into statutory care following severe and chronic maltreatment.

27. In New Zealand, Australia and North America, statutory care is referred to as out-of-home care, whereas in the UK and Ireland the preferred term is 'looked after children'. Out-of-home care includes placements with families (family-based care) and placement in residential facilities, ranging from small group homes to large institutions.

28. There are in turn two types of family-based care, namely foster care and kinship care. In New Zealand, the term for kinship care is whanau or family care, and this refers to placements with extended family or whanau, such as grandparents, aunts and uncles. Foster care refers to placements with families who are not biologically related to the child.

29. Whereas residential care was once the predominant form of state care, last year in Australia only 6% of children in state care were in residential care, and they were predominantly adolescents with more serious behavioural difficulties. This compares with 51% in kinship care and 39% in foster care. [11]

30. It is important that we differentiate between these children, and the much larger number of maltreated children who remain in their parents' care.

31. Generally speaking, in western jurisdictions, children who are found by the courts to be in need of care and are involuntarily removed from their parents, have experienced the highest levels of harm.

32. They are more likely than other maltreated children to have experienced more severe, more chronic, more pervasive, and more diverse maltreatment. [10]

33. This is important because, whereas all maltreatment is developmentally harmful, research has confirmed that the level of developmental harm caused to children is proportionate to the severity, chronicity and pervasiveness of maltreatment that they experienced. [4]

34. Therefore, children placed into long-term statutory care not only tend to have experienced the most serious maltreatment, but at the time they enter care their psychological development is more severely compromised than that of children exposed to less severe maltreatment.

35. The most illustrative point I can make about this, is that the strongest, independent predictor of the mental health of children in care is <u>their age when they entered care</u>, with earlier placement in family-based care being a strong protective factor. In other words, the younger a child is when they are placed in long-term statutory care, the better their mental health generally is throughout childhood, at least when we examine this across entire care populations. [7, 12, 13]

36. As demonstrated in my NSW longitudinal study, the relationship between children's age at entry into care and their subsequent mental health is linear, and is not confounded by genetic or pre-natal risk exposures. [7]

37. In fact, it is likely that children placed into care at a young age had higher pre-natal risk exposures than later-placed children. Yet they have better mental health than later-placed children. This is because, among very high risk children who endured constant, high-level maltreatment, their age when they entered care approximates the length of exposure to maltreatment. [7]

38. It is important not to interpret this statistic as an endorsement of statutory care as being generally reparative or therapeutic for these children. Later, I will explain how out-of-home care also compromises many children's development, limiting their recovery from the effects of serious maltreatment, and sometimes leading to further deterioration in their mental health.

39. However, this statistic refutes a commonly held belief that some children are better off remaining with families who persistently maltreat them, than being placed in statutory care. As I will outlined below, the pivotal issue is what form the statutory care takes, and whether it is supported well enough to be effective for the needs of that child.

In this next part of my evidence I summarize what we know about the mental health of children in long-term statutory care.

40. In my view, children and young people in care constitute the most identifiably disadvantaged child population in the developed world. Over the past 30 years, numerous population studies carried out in countries with comparable state care systems to New Zealand, have measured the mental health of children and young people in statutory care.

41. The most important of these studies were carried out in the United States, Canada, the United Kingdom, several European countries, and Australia. [14-16]

42. One was my longitudinal "Children in Care Study", that I carried out in New South Wales between 1999 and 2011.

43. These studies have reported remarkably consistent estimates of the mental health of children in various types of out-of-home care, suggesting that children placed into care in North America, Europe and Australia endured similar levels of adversity and compromised development.

44. While no comparable epidemiological research has been carried out in New Zealand, the consistency of international research findings suggests that New Zealand children in care are likely to have a comparable distribution of mental health difficulties as conceived and measured within western epistemologies.

45. It is important to note that children often experience mental ill-health within the context of broader developmental impairment, as well as physical health problems and physical disability.

46. New Zealand has a cross-government health screening procedure for children entering statutory care, called the Gateway Assessment. This screening assessment seeks to identify not just mental and emotional difficulties, but also learning difficulties and physical ill-health resulting from maltreatment, social disadvantage and poverty.

47. Several population studies (including my NSW study) have estimated that around a quarter of children in statutory care have some level of intellectual disability, and similar rates of language difficulties. [15]

48. This compares with around 2% of children at large.

49. Higher prenatal risk exposures (particularly alcohol), and the impact of profound neglect in the first 3 to 5 years of life on children's cognitive and language development, contribute to these high rates of intellectual and language disability. These children also present with high rates of sensory disorders and specific learning difficulties relative to children at large.

50. However, the most important developmental difficulties experienced by these children, as measured by:

    a. The number of affected children;
    b. Their felt experience;
    c. The impact on their present well-being and social functioning;
    d. The impact on their caregivers;
    e. And their future lives ….

    Are mental health difficulties!

51. International research consistently indicates that around half of children residing in long-term statutory care have clinical-level mental health difficulties, and up to another quarter have difficulties approaching clinical significance. [15, 16]

52. The types and combinations of symptoms experienced by children in care differs somewhat from that of clinic-referred children at large. This is also the case for severely maltreated children who remain with their parents, and children who exit care to permanence guardianship or adoption.

53. Firstly, the mental health difficulties that children experience whilst growing up in care are mostly trauma- and attachment-related and are developmentally based.

54. In particular, difficulties with social and interpersonal relatedness linked to attachment development are hallmark features that differentiate this population from other children with clinical-level difficulties. [17]

55. Their other characteristic mental health difficulties include relationship insecurity, inattention / hyperactivity, Post-traumatic stress disorder symptoms, dissociation, conduct problems and oppositional-defiance, self-injury, food maintenance behaviours, abnormal responses to pain, and sexual behaviour problems.

56. However, the most defining feature is not the forms or types of psychopathology, but its complexity and severity.

57. In my longitudinal study of 347 children in long-term care (the NSW Study) , 20% had complex attachment- and trauma-related symptomatology that is not adequately explained or classified in either the Diagnostic and Statistical Manual of Mental Disorders – the DSM – or the World Health Organization's International Classification of Diseases. [18]

58. This is one of the reasons why these children require specialized clinical services.

59. While this describes children's mental health patterns at any given point in time, perhaps the most important questions concern how children's development changes over time.

60. In the context of children entering long-term care with seriously compromised psychological development, it is understandable that their mental health difficulties persist whilst growing up in care. That is because these difficulties are developmentally-based, and thus tend to follow a long-term developmental course.

61. Without improvements in a child's developmental conditions, these more serious attachment- and trauma-related difficulties are likely to become increasingly fixed, or trait-like, having lifelong implications for social, educational and occupational functioning.

62. Even with optimal reparative conditions, namely where children receive consistently sensitive and loving care, unconditional commitment from their caregivers, and specialised clinical support, children's recovery tends to be slow, testing their foster parents' commitment and strength.

I will now move on to canvas what I believe are the most important things that children need if they are unable to remain in their parents' care.

63. At the start of my evidence, I proposed that severely maltreated children can experience psychological and neurobiological recovery in response to consistently sensitive, loving care, as well as other experiences and realities that engender 'felt security'.

64. I also expressed my belief that the State – by which I mean the government at large and civil society, not just statutory child welfare departments – that the State has a duty of care to do three things for these children, which I will repeat.

65. The first is to restore to them their right to experience and enjoy what remains of their childhood in much the same way as do other children.

66. The second is to restore to them the social and familial conditions that are necessary for healthy human development, and which are also the pre-conditions for their developmental recovery.

67. And the third is to provide these children and their caregivers specialized clinical, developmental and educational services, as well as intensive caregiver support.

68. Although costly, this third priority is perhaps the simplest and most straightforward to achieve, because unlike the other two priorities, it can be done without reforming statutory care systems.

69. And so before I talk about reforming care systems, I will spend a little time presenting the case for why governments should develop specialized mental health services for seriously maltreated children, including those who subsequently enter statutory care, and those who exit the care system to permanent caregivers.

70. There are some real challenges to providing effective treatments and clinical support to children in care and their caregivers, which limit our capacity to assist children's recovery from the effects of traumatic maltreatment. [19]

71. First, despite this population's disproportionately high access to generic treatment services, few western governments have enough capacity within their existing public health services to respond to every child in care who requires clinical support. [20]

72. In this part of the world, New South Wales has done the most to expand its mental health service capacity for this population, including setting up specialized services. But most Australian states, as well as New Zealand fall well short.

73. Second, generic Child and Adolescent Mental Health Services mostly operate under an acute care model, in which there is an emphasis on achieving quick client turnaround, using time-limited interventions. This acute care model is poorly matched to the service needs of children with complex attachment- and trauma-related psychopathology, for whom recovery occurs over long, developmental timeframes. [21]

74. Third, as I mentioned earlier, roughly 20% of children in statutory care manifest complex psychopathology that can't be understood or described using standard psychiatric diagnoses.

75. A fourth challenge, is that standard psychological interventions, such as Cognitive Behaviour Therapy, are less effective for children that have complex attachment- and trauma-related difficulties, while more targeted treatments, especially some that have only recently been developed, haven't been sufficiently evaluated. [22]

76. The final challenge that I wanted to draw attention to, is the lack of clinicians with specialized knowledge and training – specifically expertise in the assessment, formulation and treatment of complex attachment- and trauma-related mental health disorders – as well as an understanding of the psychosocial-developmental context of growing up in statutory care.

77. The primary therapeutic mechanism for these children is the expression of unconditional love and unqualified commitment – not psychotherapy. To that end, the clinical intervention needs to be directed towards maintaining placement stability in the first instance, and facilitating relational permanence over long timeframes. [21]

78. The broad solution to these challenges is to expand treatment capacity by designing specialized mental health services for maltreated children and children in care, within which clinicians are able to acquire more specialized knowledge and skill, and with a service model that accommodates children's slow developmental recovery. The service model needs to accommodate both preventative, long-term engagement and monitoring, as well as the ability to respond to acute mental health crises. [21]

79. My proposal for increased mental health services for children in care, with an emphasis on the development of specialized services, was endorsed by the Royal Australian and New Zealand College of Psychiatrists in their 2013 submission to the Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

80. Oranga Tamariki has a small specialist psychology service in Auckland that fits some of this profile. In Australia, there are several specialized CAMHS services that have been set up by NSW Health, that are co-located with child welfare services, and the NSW child welfare Ministry has a very large in-house Psychology Service.

81. However, we see the largest concentration of specialized treatment services for children in statutory care in the United Kingdom. These specialized CAMHS services in the National Health Service, specialized assessment and treatment services operated by local authorities, as well as others funded by government but run by charitable agencies and private clinics.

The fourth part of my evidence addresses the extent to which present statutory care systems meet the needs of children, with a specific focus on systemic factors that compromise children's lives.

82. A recent review that I carried out of studies that measured longitudinal changes in children's mental health in family-based (i.e. foster and kinship) statutory care found no consistent evidence that family-based care exerts a general, population-wide effect on children's mental health. In other words, foster and kinship care is neither generally harmful nor generally therapeutic for children's mental health. [14]

83. Instead, several longitudinal studies have found that sizeable proportions of children in care manifest meaningful *improvement* in their mental health over both short- and long-term time frames, but that similarly sizable proportions experience meaningful *deterioration* in their mental health.

84. For example, in my NSW longitudinal study, around 35% of children maintained adequate mental health over a 7-9 year period, a quarter showed meaningful improvement over that time, another quarter showed meaningful deterioration, and the remaining 15% had clinical difficulties that neither improved nor worsened. [1]

85. And so, rather than asking whether long-term family-based care is generally reparative or generally harmful for the development of previously maltreated children, we need to identify the systemic and interpersonal characteristics of care that promote and sustain children's psychological development throughout childhood – and those characteristics that are developmentally harmful.

What then do we know about the effects that growing up in statutory care has on the mental health of previously-maltreated children?

86. To answer this, I first need to provide some historical context on how the stated purpose of statutory care has changed over the last half century.

87. In the 1970's scholars and children's advocates first identified the plight of large numbers of children who were effectively 'drifting' in long-term foster care. As with now, too many children were observed to grow into adulthood without having close, permanent relationships with either their birth families or their foster families.

88. And, as remains the case today, too many children exited care at 16 or 18 years old, alone in the world, vulnerable in a multitude of ways and with little more support than an 'independent living programme' and a social worker they might call on.

89. Jane Rowe and Lydia Lambert's 'Children Who Wait' report to the Association of British Fostering Agencies had the greatest impact in the UK, while at the same time the permanency planning movement began in the United States. [23, 24]

90. The goal of permanency planning was to reduce the length of time that children spent in care, diverting them as early as possible to a permanent family. Because permanency planning is meant to prioritise the permanent restoration of children to their birth parents ahead of 'impermanent' foster care, it was initially viewed as being compatible with family preservation principles.

91. In practice, however, permanency principles have sat uncomfortably alongside the predominant child welfare goal of family preservation, and social workers struggle to reconcile the two.

92. Within a family preservation framework then, the designated purpose of statutory care shifted in the 1980's and 1990's to temporary protective care, with restoration being the ultimate goal. This reflects the belief that foster care should serve as a support intervention in the aid of family preservation, not as a means for effecting family break-up.

93. Changes in terminology at that time, which remain in place today, reflected this policy – foster parents became foster carers. If children are temporarily unable to reside at home with their parents, then in North America and Australasia we say they reside in out-of-home care, and in the United Kingdom we say they are looked-after children. These terms may be appropriate for children who spend short times in foster care, but not for children who effectively grow up in care.

94. Today, statutory care increasingly serves a very different function to its original purpose. I don't have equivalent statistics for New Zealand, but by way of example, in Australia there is an increasing trend for children to enter statutory care at a younger age, and to spend the remainder of their childhood in care. Based on current trends, a majority of Australian children placed into care this year will effectively *grow up in care!* [25, 26]

95. I previously stated that the strongest, independent predictor of the mental health of children in care is their age when they entered care, with earlier placement in care being protective. The younger a child is when they are placed in long-term statutory care, the better their mental health is whilst they grow up in care.

96. Conversely, the older a child is when they are placed into statutory care, the more likely it is that they arrive with pre-existing attachment- and trauma-related mental health difficulties.

97. An implication of this is that children experience statutory care through the lens of their previous experiences of harmful care. Harmful, insensitive, and inconsistent parenting adversely affect children's attachment style, and how they understand and interpret adult caregiving behaviour.

98. Attachment theory predicts that the developmental effects of statutory care should vary according to the characteristics of a child's attachment development prior to their entry into care, notably their internal working model of attachment; and to caregiver sensitivity and their ability to provide a 'secure base'. [27-29]

99. Whereas the attachment styles of very young foster children tend to match their foster mothers' attachment styles, the attachment difficulties of children who enter care at older ages are more resistant to change in response to markedly improved care. [30, 31]

100. Thus, research has shown that the severity of maltreatment that older children experience in their mothers' care predicts how they construct or represent their relationships with their mothers, as well as how they subsequently relate to their foster mothers. [30]

101. Many such children are thus primed for insecurity when they enter care, due to their compromised attachment development and distorted representations of caregivers and caregiving; as well as the loss of their parents and being placed with unfamiliar carers. [8]

102. Therefore, even with optimal reparative conditions (namely, consistently sensitive and loving care, and unconditional commitment), and with specialised clinical support, children's recovery tends to be slow, testing their foster parents' commitment and strength.

103. While growing up in statutory care is preferable to ongoing exposure to maltreatment and other severe social adversity, there is good evidence that it systemically compromises children's development and well-being.

104. There is accumulating international evidence that:

    a. the quality of caregiving provided to children in statutory care;
    b. caregivers' motivations for fostering children;
    c. their commitment and bonding to children placed with them;
    d. and of course maltreatment of children in care;

    all influence children's felt security and psychological development and regulate their recovery from attachment- and trauma-related mental health difficulties. [7, 28, 32-36]

105. With respect to maltreatment of children in care, in my NSW study, two thirds of children in the study had no reports of maltreatment in foster or kinship care, 13% had one or more unconfirmed reports, and 19% had at least one confirmed report. These rates refer to all placements the children had been in, not rates of abuse within individual placements. [7]

106. In my study, the narrative investigation reports suggest that maltreatment in care falls into two broad categories.

107. The majority of events related to carers coping poorly with children's behavioural and relationship difficulties. Maltreatment in this context typically consisted of inappropriate discipline or scapegoating, ranging from smacking to serious emotional or physical harm. These carers tended to respond positively to the provision of supports such as counselling, respite or more effective casework.

108. A much smaller group of children endured neglectful, abusive, or predatory care, which was not attributed to poor coping by distressed carers. Descriptions of their carers' motivations and engagement with others, suggest that they had emotional, personality, or relationship difficulties that are incompatible with fostering.

109. With respect to the influence of caregiver motivation, commitment and bonding, and quality of caregiving, these positive and negative caregiving characteristics are linked. [32, 37, 38]

110. Thus, children who enjoy optimal caregiving that engenders their felt security have foster parents or whānau who meet these needs, namely they are sensitive, caring and loving, and are simultaneously bonded and committed to the child.

111. At an emotional level, these foster parents and whānau carers do not differentiate their feelings or commitment to the child who is placed in their long-term care, from that of their own biological children or grandchildren.

112. This accumulating research challenges a myth embodied within western statutory care systems, that children can be adequately nurtured for the remainder of their childhoods by caregivers who have a qualified commitment to them, so long as those children receive good or adequate day-to-day care.

113. While children may not initially understand or respond positively to loving care, over time familial love is the most important therapeutic mechanism that we have for repairing these children’s lives.

114. But familial love – and the close relationships that underpin it – are not momentary transactions of nurturance or affection.

115. I believe the majority of foster parents and whānau carers are sensitive, affectionate and nurturing in their day-to-day interactions with the children who are placed with them.

116. But unless over time this translates into a strong emotional bond to the child, and un-conditional commitment, then a child does not experience the kind of unconditional familial love that they need to grow into an emotionally secure adult.

117. Put simply, children can only feel truly secure when they acquire *relational permanence*. Familial love and relationships are not time-limited – they are un-ending.

118. At this stage I should also emphasise that *relational permanence*, and the associated felt security that flows from it, is experienced and shaped within cultural parameters and shared belief systems.

119. For example, for Māori, felt security does not flow exclusively from close, permanent, familial relationships. It also flows from having a secure connection with, and sense of belonging to one's whakapapa, and connection to whānau, hapū, and iwi.

120. Based on my understanding, the practice of whāngai operates within the strength of that cultural framework.

121. I also believe that the practice of Whāngai provides a vehicle for facilitating relational permanence and felt security for tamariki who otherwise cannot or should not be raised by their parents.

122. Almost all aspects of present statutory care systems work against children acquiring relational permanence and associated felt security, even in cases where foster parents and whanau are strongly motivated to permanently care for a child.

123. Children's felt security is constrained or undermined by the legal, philosophical and historical bases of statutory care systems throughout western jurisdictions.

124. To illustrate this, I will provide some examples of how our present care systems undermine children's felt security. I should also refer the commission to the TVNZ1 documentary '*I am a survivor of state care*' which provides an historical example in which Daryl Brougham and his former foster parents recount his involuntary removal from their care, and the long-lasting effects this had on all of them.

125. My experience has been that children who are growing up in long-term care begin to fully understand their legal and care status from about age 6 or 7. In my clinical work I have observed that this growing awareness is often accompanied by increasing insecurity about the possibility of them losing (or being taken from) their caregivers.

126. Keep in mind that when these children entered care they were primed for insecurity. In other words, these children are uniquely vulnerable to the effects of our legally impermanent care systems, in which caregivers are agents of state care, and guardianship rests with the state or the child's birth parents, but not their 'so-called' permanent caregivers. [8, 30]

127. In my NSW longitudinal study, one of the clearest predictors of children's mental health problems was foster parents' perceptions of placement security. Within the confines

of family relationships, felt insecurity of one family member impacts on the felt security of others. [7]

128. Thus, foster parents' own concerns about a child's tenure with them can raise anxiety within the family system. This can be quite detrimental when children are already highly anxious about their placement security.

129. Statutory care systems adhere to the myth that caregivers can simultaneously nurture and love children 'as much as any child might need', but that those caregivers should also be able to readily let go of those children if the agency decides they should be returned to their parents or moved to another placement. In practice I believe that this is rarely achieved, and that there is an inevitable trade-off between the level of nurturance and expressed love, and a caregiver's ability to 'let go'.

130. When I first worked as a Psychologist in this field in NSW, the social workers who recruited and assessed potential foster parents employed a pejorative term to describe applicants who were motivated to foster for the 'wrong reasons' – and that term was 'adoptive parents in disguise'.

131. Those applicants were screened out because there was a concern that they would bond 'too closely' to the children who were placed with them. This was seen as problematic because these carers would be 'unprofessional' and difficult to work with if the agency wanted to move the children to other carers, or to return them home to their parents.

132. At that time, few people considered the possibility that children in long-term – i.e. those who would grow up in care – would benefit most from being raised by foster parents who, for whatever reason, wanted to commit themselves to raising a child as if that child were their own.

133. This alludes to the original purpose that state care systems were designed for, namely providing time-limited care for children with a view to restoration.

134. Another illustration of the harmful effects that an impermanent care system exerts on children's development, is when circumstances cause foster parents to consciously contain or restrict their feelings for a child, so as to protect themselves from future grief.

135. In my previous career, many foster parents described to me variations of this phenomenon. Whilst it hasn't been well researched, at least one study has documented accounts of it. [39]

136. Typically, foster parents had a young child placed with them, ostensibly as a long-term placement. In some instances, social workers reassured them that there was little chance that the child would be moved elsewhere. These foster parents described how they subsequently bonded to the child as if that child had been borne to them, which despite the objections of out-of-home care services, is not an unnatural occurrence.

137. When the child was subsequently removed from their care, usually because they were restored to their parents, these foster parents experienced intense grief and loss.

138. Many foster parents who go through this experience stop fostering at that point. This is one factor that accounts for our inability to recruit and retain good foster parents.

139. However, those who elect to continue fostering have revealed to me that with subsequent children, they consciously contain or restrict their feelings towards those children, so as to protect themselves from future grief. Unfortunately, this emotional self-preservation strategy denies children the very thing that they most need.

140. Once again, we can easily make sense of this cost if we reflect on how our own children might be affected if we placed limits on our love and commitment to them.

141. Similarly, children's services around the world have struggled to manage the risk of children being maltreated in care, as well as managing the risk of false allegations – particularly the risk of sexual abuse of children in care by foster fathers and foster siblings.

142. Consequently, many agencies in different countries have established guidelines – and some have even mandated restrictions – on foster fathers having close physical proximity to foster children, on them being left alone with foster children, and on them cuddling foster children.

143. In very high-risk cases where children have pronounced and specific effects of previous sexual trauma, there may be good reasons for doing this. But in these cases this need is usually self-evident to foster parents.

144. Otherwise, placing blanket restrictions on physical affection and proximity incurs a tremendous cost to children's development and well-being. Think for a moment about how the child is expected to make sense of this.

145. And once again, imagine for a moment what your own child or grandchild's life would be like if physical affection by dads and grandads was banned, or they could not spend time alone with their dad or grandad.

146. My reason for providing these examples isn't to highlight specific practices that need to be changed or reformed. The reason I provide these examples is to illustrate the intractable problems that come from the State exercising its role as *corporate parent* of very large numbers of children in this country and elsewhere in the western world.

147. By-and-large, out-of-home care services are staffed by very caring and empathic professionals. And yet, complex systemic factors deny these children the possibility of enjoying the same standard of care, and the same experience of childhood, that most children enjoy.

148. The most intractable problem within our system of legally impermanent statutory care is placement disruptions and placement instability. Again, I would refer the Commission to the TVNZ1 documentary '*I am a survivor of state care*', which provides a chilling account of one child's journey through multiple placements.

149. Placement disruption has particularly harmful consequences for children growing up in statutory care and is all too common.

150. The most common reason that caregivers give for ending placements is children's disruptive behaviours and lack of a close relationship. [40, 41]

151. Placement instability is also accounted for by planned, administrative placement changes, such as planned transfers of children from 'temporary' to 'permanent' placements [7].

152. Hundreds of studies have measured strong associations between children's behaviour and disruptions, while a few studies have shown that behaviour problems independently predict disruptions, but without establishing the direction of the effect, or investigating whether psychological and systemic factors transact in complex ways. [42-44]

153. However, children and young people consistently report harmful effects of placement disruptions in qualitative studies.

154. Qualitative studies of children and young people in care, as well as adults who had grown up in care, consistently affirm that placement instability is psychologically harmful.

155. Children and young people experience placement moves as a series of losses and rejections that generate negative emotions and beliefs about themselves and their caregivers, degrading their trust in others and their capacity to form close relationships – the effects of which persist into adulthood [45-49].

156. There is also some evidence that the mental health and relationship security of children and young people in care are related to both self- and carer-perceptions of permanence and placement security [7, 50].

157. Placements typically disrupt when carers are confronted by severe behavioural difficulties, or they are not able to cope with (or misinterpret) children's maladaptive attachment behaviours.

158. This often occurs within a context of limited therapeutic support, and caregivers feeling simultaneously disempowered and unsupported by the children's agency [51, 52].

159. Placement disruptions in turn cause further deterioration in children's mental health. These bi-directional effects increase the chance of a further disruption. Placement disruptions reinforce the child's distorted and maladaptive representations of themselves as being essentially unlovable and of parents and other caregivers as being essentially rejecting of them.

160. This then manifests as further deterioration in their mental health and social behaviours, such that they become even more difficult to care for in subsequent placements. It accounts for a pattern of serial placement disruptions, commonly seen among children in care (especially those who come in to care at older ages).

161. I have proposed that with each successive disruption, the bi-directional effects are amplified, causing a spiralling decline in children's social functioning and making further placement breakdowns ever more predictable and frequent.

162. The developmental conditions necessary for recovery from attachment-related difficulties thus diminish, as do their prospects for being raised by a family. Instead these children and young people mostly transition to residential care. This is why protecting long-term and permanent placements from disruption is so critical.

163. Placement stability varies considerably by the type of care order, by the extent to which those orders infer that the placement is truly permanent (i.e. 'for life') and by the associated caregiver commitment.

164. This is borne out when we compare placement stability rates for various care orders.

165. Research carried out in England and Wales provides the best available comparative data. Looking firstly at children restored to their birth parents, a recent English study of neglected children restored from care found that 2 years after restoration, 59% had experienced further maltreatment and 50% had been returned to care, while 5 years post-restoration, 65% had returned to care. [53]

166. A second English study examined census data for around 4,000 children in care found similar instability among those children who were restored to their birth parents. One-third had returned to care within 6 months, and two-thirds had returned to care one or more times within 4 years of the initial restoration. The disruption rate for children restored to drug or alcohol abusing parents rose to 81%. [54]

167. Now if we look at the stability of foster care, a large longitudinal study found that seven or more years after entering their first foster placement, 45% of children had either been adopted, restored to their birth parents or were being cared for under a residence order – this includes adoptions and residence orders with the former foster carers – another 32% remained with the same foster carers – and 23% had one or more foster placement changes. [55]

168. Now if we look at children who exit statutory care on permanent orders, a recent landmark English study examined the complete national dataset for three types of permanent orders. Over a five-year period, 15% of Residence orders disrupted; 6% of Special Guardianship orders disrupted, and a little less than 1% of adoptions from care disrupted. [56]

169. The cumulative disruption rate for adoptions increased to 3% after 12 years. The small number of adoption disruptions mostly occurred when the children were teenagers. Conversely, around two-thirds of disruptions to special guardianship and residence placements occurred before children turned 11.

170. The lower disruption rates of permanent orders is not accounted for by those children having less behavioural or attachment-related difficulties than children who remain in statutory care. Recent research has confirmed that English children adopted from care have similar mental health profiles to children residing in statutory care.

Conclusion

171. And so today I have presented evidence that I believe supports the case that statutory care systems are not able to restore to children their right to experience and enjoy what remains of their childhood in much the same way as do other children;

172. And that an impermanent care system cannot provide children with the social and familial conditions that are necessary for healthy human development, and that are also pre-conditions for their developmental recovery.

173. I believe that the experience of growing up in statutory care systems in the western world constitutes an 'unnatural childhood' – one that exposes our most vulnerable children to unique developmental risks that other children do not encounter.

174. Furthermore, there is good evidence to show that these developmental risks are systemically interconnected. It involves a complex interaction of child welfare practices, caregiver motivation, the child's experience of impermanence, and felt insecurity.

175. The core problem is that this system sees many children growing up without acquiring relational permanence – in other words, without enjoying unconditional, life-long commitment by a loving family.

176. My present research focusses on designing and testing a developmental-transactional theory of the psychosocial effects of children growing up in statutory care without legally permanent caregivers, and the personal and inter-personal consequences of failing to acquire relational permanence – which I call *Impermanence Theory*.

177. Impermanence Theory attempts to explain and predict complex developmental, interpersonal and organisational-systemic mechanisms, drawing on evolutionary psychology, attachment theory, and general systems theory.

178. It proposes that 'felt security' is the core psychological state that underpins developmental recovery, and that it can't be fully attained without close, permanent, familial relationships.

179. This is because humans are a social species that evolved such that close and enduring familial relationships are essential for their psychosocial development.

180. To test this aspect of the theory, I have been searching for historical or ethnographic precedents for children raised in a state of relational impermanence, searching as far back as pre-Christian Europe and the early Roman Empire, as well as ethnographic accounts of traditional societies throughout the world. So far, I have found no such precedents. [57]

181. The absence of such precedents infers this experience lies outside the boundaries of human adaptation as determined by our DNA – in other words, that being raised without a semblance of a permanent family is both developmentally harmful, and contrary to human evolution.

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