STATEMENT OF Dr Charlene Rapsey

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1. Introduction

[1] I am a lecturer in the Department of Psychological Medicine, University of Otago and a registered clinical psychologist. My research interests include: mental disorder and the effects of childhood adversity. I use quantitative and mixed methods and have a particular interest in applied research. Whilst in practice, I have worked as an ACC approved clinical psychologist; at times this has included working with incarcerated men who were victims of sexual abuse as well as with children currently in foster care. This work also included working with those where the abuse occurred in state care and I bring an understanding of the issues faced by survivors of abuse in care.

[2] My current research projects include:

(a) Psychiatric epidemiology - The WHO World Mental Health Surveys project is a unique international collaboration with over 30 countries focused on epidemiology and the prevention of mental disorder.

(b) Childhood adversity - The Otago Women's Health Study, a 25-year longitudinal study investigating associations between childhood abuse and outcomes across the life course.

(c) The Foster the Whānau project - investigates the costs, benefits, and long-term outcomes for children when the mother participates in an intensive, residential intervention as an alternative to foster care.

[3] First, I am proud that our Government has chosen to commission this Royal Inquiry into abuse in care. Today, the evidence I am presenting is based on my summary of the

research field primarily addressing the question, posed by the Commission: What are the effects of abuse?[1]

[4] In this brief, I have used the word maltreatment as a term that includes physical, emotional, and sexual abuse as well as neglect.

[5] I am going to discuss evidence addressing the following four questions:

(a) What are the effects of childhood maltreatment?

(b) What are the effects of time in out-of-home care, that is, foster care or institutional care? Specifically, what are the effects for children in Aotearoa/New Zealand?

(c) What is the effect on the family and the likelihood of family reunification when a child has been removed into care?

(d) What evidence supports alternatives to out-of-home care?

2. What are the effects of childhood maltreatment?

[6] There is strong and robust evidence that all forms of child maltreatment are associated with an increased risk of deleterious outcomes across the lifespan of the individual [1-8].

[7] The magnitude of risk of poor outcomes increases with increasing exposure to maltreatment and/or increasing severity of the abuse. That is, cumulative maltreatment and/or higher levels of abuse harm are associated with increasingly greater risk of poor outcomes [8-11].

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[1] When the *effects* of abuse and foster care are discussed in this report, it is noted that it is *associations* between variables that have been measured and that cause and effect cannot be conclusively established.

[8] The effects of child maltreatment are pervasive, with disruption of multiple interacting systems – biological, psychological, relational, and social. This pervasive disruption influences development in multiple ways with long-term implications across the life-course [12, 13].

[9] Psychological effects of maltreatment include an increased risk of meeting diagnostic criteria for all types of mental disorder [14-17].

[10] For example, the WHO World Mental Health Surveys is the largest international survey of mental disorders. They conducted an analysis of the relationship between childhood adversity and adult mental disorder with almost 52,000 participants from 21 countries including Aotearoa/New Zealand. Surveys were nationally representative. They assessed diagnosis of 20 commonly occurring mental disorders including depressive disorders, bipolar I and II disorder, anxiety disorders (e.g., post-traumatic stress disorder, phobia, generalised anxiety disorder), behaviour disorders (e.g., ADHD, conduct disorder), and substance disorders (alcohol and drug) using a clinical interview. They found that childhood maltreatment increased the risk of meeting criteria for all types of mental disorder at all ages [15].

[11] The WHO World Mental Health Surveys analysed the extent to which childhood adversity contributed to the prevalence of mental disorder in a country. They reported that eradication of childhood adversity would lead to a 23% reduction in mood disorders, 31% reduction in anxiety disorders, 42% reduction in behaviour disorders, and a 28% reduction in substance disorders. Overall, eradication of childhood adversity would lead to a 30% reduction in all mental disorders.

[12] The WHO World Mental Health Surveys did not assess psychosis but other research finds that child maltreatment increases the risk of psychosis [18].

[13] Child maltreatment increases the risk of death by suicide and suicidal behaviours [19, 20].

[14] The increased risk of mental disorder persists across the life course [8, 21].

[15] In addition to an increased risk of mental disorder, child maltreatment affects physical health. Child maltreatment is associated with an increased risk of a number of chronic diseases and associated disability and loss of quality of life [1, 2, 11, 22-30]. For example, there is an increased risk of a range of physical health problems including pulmonary, cardiovascular, gastrointestinal disease; musculoskeletal problems; chronic pain; and cancer.

[16] Specifically, in the WHO World Mental Health Surveys, child maltreatment was associated with an increased risk of all six of the measured physical health conditions (heart disease, asthma, diabetes mellitus, arthritis, chronic spinal pain, and chronic headache) [25].

[17] Childhood physical and emotional abuse is associated with an increased risk of all-cause early mortality for women [7].

[18] Maltreatment in childhood also has implications for relational and social outcomes. Effects include increased risk of sexual and physical re-victimisation [31], greater likelihood of developing insecure attachment styles, which are associated with later relationship difficulties [32-34], and diminished educational and employment opportunities [5, 35-38]. Diminished social and economic capital also has implications for reduced mental and physical health.

[19] There are a number of proposed mechanisms that contribute to understanding why childhood maltreatment increases the risk of poor physical and mental health [39, 40].

[20] Research focused on biological mechanisms finds that there are neurological changes that can occur in adverse environments. In particular, there is evidence that child maltreatment can lead to altered HPA (hypothalamic-pituitary-adrenal) stress response networks [3, 41-44]. The HPA axis is involved in the fight or flight response. Fight or flight is a useful system to get us out of danger quickly. The HPA axis is a complex system that also regulates immune system functioning and inflammatory processes [27]. One theory suggests that child maltreatment alters the HPA system so that it is more sensitive to stresses (or danger in the environment) whereby subsequent stressors result in more frequent and intense responses. The physiological mechanisms involved in a stress response are valuable for short

term dangers but persistent and chronic exposure to stress is associated with a range of poor outcomes [45].

3. What outcomes are associated with time in out-of-home care, that is, foster care or institutional care?

[21] Removing children from adverse home environments and placing them in out-of-home care, should improve outcomes for children who have experienced maltreatment. However, when children are removed from parental care due to maltreatment, they remain at increased risk of experiencing a number of poor outcomes including mental and physical illness, poorer educational outcomes, and greater contact with justice and child protection services [46-52].

[22] When compared with children from similar backgrounds, (i.e., taking into account that children in care are at greater risk of poor outcomes because they come from backgrounds of adversity) studies indicate that outcomes are not improved and may even deteriorate for children in care [53-56].

[23] For example, children who go into unfamiliar foster homes experience a greater increase in mental and behavioural health problems than children who remain in maltreating homes [57]. To clarify, that children in severely maltreating homes should be removed from that harm. The point to take from this research is that foster care is not reparative for many children.

[24] One factor that contributes to poorer outcomes is placement instability. When in care, New Zealand children typically experience seven to eight placement moves by the time they are eight years of age [58].

[25] There is evidence from a number of studies that placement instability is associated with a greater risk of mental distress and symptoms of mental disorder [59, 60]. Attachment theory and research present a compelling argument for the necessity of consistent, loving, and responsive caregiving and thus the likelihood that placement disruption will have devastating consequences on a young person's development [61-64].

[26] Furthermore, in support of the argument that placement instability contributes to an increase in problems, children who go into foster care with average levels of mental and behavioural health problems are **most** likely to experience an increase in problems following placement instability [65] (i.e., it is not just that children with pre-existing difficulties are more likely to experience placement disruption).

[27] Children placed in residential care (i.e., group home, institutional care) have worse mental and behavioural health outcomes than children place in family-based foster care (family-based foster care is not taken to imply kinship care whereby the child is placed with a familiar relative) [66].

[28] When children and young people are asked their perspectives on going into care, many children reported missing their mothers and that their lives would have been better or the same if they had stayed with their families [67]. Young people report preferring family-based foster care to residential care [66].

Aotearoa/New Zealand

[29] Specifically, in Aotearoa/New Zealand children who were in the care of Child, Youth, and Family (CYF, now Oranga Tamariki) are at greater risk of experiencing a number of adverse outcomes including higher engagement with youth justice and Corrections, poorer educational achievement and poorer mental health when compared to children who have no contact with CYF [46].

[30] Women with contact with CYF as children are nearly three times more likely to be parents before age 25, and as parents are three times more likely to have their child referred to CYF [47].

[31] A set of analyses of a cohort of children born in 1990/91, found those children who were ever placed in CYF care were [46]:

(a) Twice as likely to fail NCEA level 2; 78% left school with less than NCEA Level 2 compared with 36% of children with no contact with CYF;

(b) Ten times more likely to have been in prison before age 21 (18.3% compared to 1.8% of all children);

(c) More than twice as likely to have a mental disorder. Five out of ten have identified mental health issues compared to two out of every ten who do not have contact with CYF.

[32] Māori children are particularly affected:

(a) Māori children were significantly more likely to have a hospital admission arising from assault, neglect, or maltreatment than European children (unadjusted rate ratio 2.6) [68].

(b) Six out of ten children in foster care are Māori [69].

[33] Intervention practices with a narrow focus on child removal do not address structural barriers, systemic racism, and can further perpetuate harm through a placement that does not ensure cultural continuity [70].

[34] Moreover, a focus on risk and individualistic child protection policies conflicts with ways of knowing embedded in indigenous identity and values of Māori within Aotearoa/New Zealand [70].

[35] My research most often focuses on statistics and increased probability of risk but behind these numbers are the stories of individuals. I have also worked as a clinical psychologist and heard, and read in their files, some of the stories of individuals who grew up in care.

[36] Some historic files contain accounts of boys who spent time in multiple group homes until the State relinquished responsibility for them when they turned 15, leaving them with few resources. At the time I talked with them, these men were incarcerated.

[37] It has seemed to me, that as a society we failed in our care of these men when they were children in our State mandated children's home. We placed these children in institutional care, failed to provide adequate care, and then placed them in the institutional control of prisons when they went on to commit crimes that hurt others.

4. What is the effect on the family and the likelihood of family reunification when a child has been removed into care?

[38] In addition to research finding poor outcomes for children removed into foster care, there is evidence that removal of children into care has deleterious outcomes for the mother – which, ultimately, has implications for her children [71-77].

[39] Qualitative evidence describes mother/child separation as a traumatic event that involves the devastating grief of losing a child, loss of identity as a mother, and the added assault of stigma and the societal invalidation of such a loss [77-79]. Not only does a parent experience the loss of a child but they experience guilt and marginalisation at being blamed for that loss.

[40] Internationally, quantitative evidence finds that compared with mothers in the general population, mothers whose children were taken into care had higher rates of mental disorder, housing instability, and poverty prior to having their children removed. Moreover, this inequity increased in the two years after having a child taken into care [72].

[41] When mental health and structural factors that contributed to the initial removal of a child are intensified following the removal of a child, family reunification and thus, ultimately, the child's welfare, is undermined.

5. What evidence supports alternatives to out-of-home care?

[42] In New Zealand, the recent Government commissioned review of, then, CYF (Modernising Child, Youth, and Family) concluded that the current system of foster care provision was failing to provide adequate care and protection of our most vulnerable children [58].

[43] Therefore, to improve outcomes for children and mothers in the context of child welfare concerns, effective alternatives to out-of-home placements are needed [58, 80, 81].

[44] Broadly, there is some international evidence that interventions to reduce child maltreatment can be effective [82-84]. Larger effect sizes were reported for curative interventions that provided social and/or emotional support [82].

[45] Consistent with research that focuses on the importance of attachment relationships, the Modernising Child, Youth, and Family report identified supporting families to care for their children as a key principle that should underpin interventions [58].

[46] A family preservation intervention is an intervention that aims to reduce child maltreatment and other care and protection concerns in order to avoid an out-of-home placements.

[47] In Aotearoa/NZ, at least two NGOs (the Anglican Trust for Women and Children and Merivale Whānau Development Centre) offer residential, family preservation interventions that aim to avoid parent/child separation. These two, similarly structured, services offer an intensive, 6-18-month, support programme whereby the mother and the children in her care are placed in residential care *together*. During the intervention, the mother and her children participate in a therapeutic and parenting skills focused programme aimed at changing the factors associated with care and protection concerns.

[48] A qualitative evaluation of one of these Aotearoa based family preservation services was undertaken by my team [85]. We found that service users and staff provided hopeful narratives that included the centrality and importance of relationships, the development of

practical skills and psychological resources through participation in a wrap-around, holistic programme. These reports contrasted markedly with qualitative reports of women's experiences with child welfare services [75, 77-79].

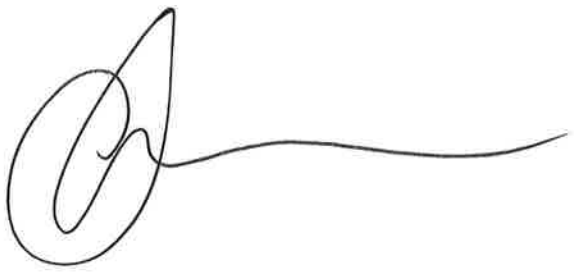
[49] The stories told in our study suggest that a relational and skills based programme within a supportive residential community environment has the potential to change the lives of women and children:

[50] Internationally, few studies have investigated longer-term, residential programmes and there is minimal robust evidence available to determine effectiveness [80, 86-88].

[51] Robust research directly assessing the effect of family preservation interventions is limited but indicates some components may reduce out-of-home placements for some children [86, 89-92].

[52] Further research, in particular, quantitative research is necessary to investigate whether participating in this Aotearoa-based family preservation programme resulted in reduced risk of future out-of-home placements and improved outcomes for children.

[53] It is time to change the focus of child welfare interventions from one that focuses only on the child to a new paradigm that understands that parent and child well-being are inter-related. The stories of service users and of staff suggests that there is value in pursuing a paradigm that supports and fosters family resilience.



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