T R A N S C R I P T

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Responses to Historical Forced Adoptions in Victoria

Wodonga—Tuesday, 18 May 2021

MEMBERS

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Mr Meng Heang Tak

WITNESS

Dr Rosemary Saxton.

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The CHAIR: I might just start the official proceedings. My name is Natalie Suleyman, and I am the Member for St Albans. To my right is Christine Couzens, MP, the Member for Geelong, and to my left is Meng Heang Tak, the MP for Clarinda. We are really delighted to be here and to hear evidence today.

Before I begin I would like to acknowledge the traditional owners of the land on which we are meeting. I pay my respects to their elders both past and present and any Aboriginal elders of other communities who may be here today.

I now declare open the public hearings for the Legal and Social Issues Committee's Inquiry into Responses to Historical Forced Adoptions in Victoria. Thank you again, Dr Rosemary Saxton, for being here today.

All evidence taken by this committee is protected by parliamentary privilege, which means that you can say anything you want here as you are protected by the privilege, but if you say the same things on social media—for example, Facebook—some of those comments may not be protected.

All evidence given today is being recorded by Hansard, and you will be provided with a proof version of the transcript for you to check as soon as it is available. Any transcripts, PowerPoint presentations or handouts will be placed on the committee's website unless confidentiality has been requested.

For the record, we also have Debbie here with us, who is a counsellor and is available to assist during the hearing and also after the hearing.

As you know, the committee is very much interested in hearing your experiences of forced adoption, in particular the services, and also more importantly what outcomes you would like to see from this inquiry. I now invite you to proceed with a brief opening statement to the committee. Thank you so much.

Dr SAXTON: Thank you very much. I have actually got a copy of that here for you in case of spelling and weird things like that. Thank you very much for inviting me to appear.

I also wish to pay my respect to the traditional owners of this land and to the elders past, present and emerging.

I am a GP of 30 years experience with increased focus on counselling work, especially over the last 10 years, and now working entirely in that area of interest. I undertook VANISH's specific two-day counsellor training presented by Dr Sue Green in 2014, which I found to be excellent, and while I had quite a number of adoptees as patients and in my personal circle, my professional knowledge of the psychological effects of adoption practices was virtually non-existent at that time.

Since writing the original submission I have for the last year been facilitating VANISH's Albury-Wodonga support group, which has now been running for six years. Groups currently alternate between adoptee-only groups and mixed groups. These groups provide a safe place for people to discuss the complexities they are facing with peers whose lived experience gives them an understanding that is often not appreciated by their friends or family. While every story and experience is different, as I am sure you are discovering, there are shared themes that enable group members to feel validated and connected. I feel honoured to witness the journeys of participants as they negotiate searches, reunions or otherwise. For some group attendees it is the only venue in which they feel able to share their experiences.

I recently facilitated a group consisting of half adoptees and half mothers, which enabled both groups to hear the other's perspectives. The level of compassion by all group members for the others in spite of their individual sense of wounding was deeply moving and healing.

A new member became very emotional, acknowledging that it was the first time she had been able to talk so openly about her experiences, and I believe, as I remember, that was a mother. Another attendee has regularly affirmed that the group is somewhere she can feel heard and understood as never before. And such sentiments are not unusual.

My professional development over the last few years has focused on emotional trauma, including complex PTSD, and gathering therapeutic tools to manage such wounding effectively. I would like to draw the committee's attention to the summary of *Primal Wound*, of which I have a copy for you all, a seminal text in the understanding of the psychological effects of adoption practices. The author, Nancy Verrier, a US-based therapist, describes more eloquently than I can the dire consequences of separation trauma. And I am sure that you have actually heard a lot of that and experienced that yourselves.

Unfortunately in my experience I have found that the majority of my colleagues both in medicine and in the mental health field are ignorant of adoption as a trauma. As mentioned in my submission, I belong to an international online group of expert clinicians working in the emotional trauma field, and even in that forum I encountered some opposition to the comments that I made about adoption trauma. In my experience both the general public and many clinicians assume that trauma implies deficiency and therefore criticism of the adoptive caregivers, which it does not.

Adoption trauma is the result of the separation of the mother and baby unit, regardless of the quality of the care thereafter. The bond between mother and baby develops long before birth. For example, the baby responds to the mother's voice. The baby's in utero experience prepares it for the world into which it is coming. For example, the baby experiences the mother's cortisol levels in her responses to stressors. I am sure you have heard of the horror to which many mothers were subject, such as being denied painkillers in labour or anaesthetic for suturing when they had perineal tears, not to mention the terror of having their baby taken. Imagine then the extreme levels of cortisol to which their babies were exposed and then their being removed from the one person with whom they had a biological bond.

The emotional wounds of adoption for the baby occur long before the acquisition of language, so the memories of separation and loss are stored in the body, a phenomenon that Nancy Verrier describes. Such somatic, embodied, implicit memories are described at length by such pioneers in trauma therapy as psychiatrist Bessel van der Kolk and addictions and trauma expert Gabor Maté. Dr van der Kolk's work on adverse childhood experiences and their strong link to both mental and physical health issues has high relevance to the trauma of forced adoption. Extensive work on attachment theory and attunement, including Allan Schore's work, underpins the importance of the mother-baby bond. Levels of addictive behaviours as a self-soothing survival mechanism are high in this population, and suicide levels have been shown to be up to four times that of the general population. There are no figures available in Australia as questions regarding adoption status are apparently not routinely asked. The long-term effects of loss and separation lead to significant issues of trust and difficulties with relationships. The diagnosis of complex PTSD included in the latest ICD manual, which is the international classification of diseases, recognise the long-term effects of cumulative trauma, including developmental trauma.

The mothers' trauma, beyond the physical horrors to which they were often subjected, is usually compounded with the deep shame inflicted upon them by society—often by their families and by religious institutions. I am not surprised that I have had fewer mothers disclose to me than adoptive persons. As a doctor, I am an authority figure, and for many of these women, doctors were involved in the removal of their babies. I saw a woman several years ago who said she had been told her baby died, but she never saw it. I have since realised that her baby may well have been taken for adoption instead, and unfortunately I cannot remember who she was. Carrying shame has a damaging effect on self-worth and therefore on relationships and, in my opinion, on general health as well. Identifying women who were subjected to forced adoption practices and giving them the access to appropriate psychological care has implications broader than the women themselves. Intergenerational trauma is another area of burgeoning research, and the intergenerational effects of severe attachment wounding are increasingly being recognised. Forced adoption, as is being recognised in the stolen generation, has significant long-term intergenerational sequelae.

The most commonly used and promoted treatment in mental health settings is cognitive behavioural therapy. While it has a place in some settings, it is completely ineffective for experiences that occurred prenatally or perinatally. Similarly, for mothers who were drugged or extremely traumatised by the experience, their memories are likely stored more somatically—that is, in the body—than cognitively. A simple example of implicit body-based memory is when we catch a whiff of the smell of something from our childhood and we are transported back to a much earlier time. The most effective therapeutic modalities I have discovered involve body-centred somatic therapies combined with psycho-education and talk therapies. This so-called bottom-up, top-down approach requires more training than is undertaken by the majority of mental health professionals. A

very simple explanation of basic neuroscience helps my patients and my colleagues to understand why experiences that have overwhelmed their nervous system require more than one approach. Our brain's survival mechanism—which is the fastest and bottom part of the brain, and that which we share with all animals—has the right of veto over the rest of the brain. The fancy-thinking top human brain is too slow and indecisive when we are under threat. Whether real or perceived, a survival threat takes precedence and the nervous system responds reflexly. We have little to no control over this unless we have been trained to override it, such as people in elite troops or emergency personnel. Top-down therapy involves the fancy part of the human brain, which has reasoning, language and creativity. Bottom-up therapy involves accessing the survival-based reptilian and mammalian brains via the brain and body sensations or via the senses. This is an exciting area of research and development in which Australia currently lags behind the US and Europe, in my opinion. I have kept my suggestions for a moment.

The CHAIR: Lovely. Okay. We will move on to questions then, Dr Rosemary.

Ms COUZENS: Thanks, Rosemary. We really appreciate your time today, and your experience and expertise that you bring to this inquiry is very much welcomed. We have seen the trauma time and time again from those women and often children giving evidence, so thank you for your time. We really appreciate it. How many people referred to you do you promote your medical and psychological forced adoption services within the community?

Dr SAXTON: Sorry, repeat that again?

Ms COUZENS: Do you promote your medical and psychological forced adoption services within the community?

Dr SAXTON: I actually have not actively advertised that, partly because my case load is fairly full, but people seem to find me. I sometimes wonder whether I have an adoptee magnet, actually.

Ms COUZENS: Word of mouth.

Dr SAXTON: Well, I have had people launch into their adoption story on the train, and in fact just in the last two days I have had people completely randomly, when I mentioned that I was doing this, talk to me about their experiences. So yes, it just seems to come my way.

Ms COUZENS: And numbers? Are they predominantly Wodonga people, or do you have contact—

Dr SAXTON: I do not think I could say, to be quite honest. I am sorry. It is probably fairly even, but the group has had people come from up to a couple of hours drive away at times, and obviously during COVID when we had the option when we were doing everything on Zoom that gave the opportunity for people who were a bit further afield to come to the group.

Ms COUZENS: Okay. And given the work that you are doing, what would be your view in terms of what recommendations we make in relation to a redress scheme in particular?

Dr SAXTON: Yes, certainly. Obviously for ongoing funding, not just a one-off funding option, firstly to enable general education of health professionals and the population in general in regard to the effects of adoption practices, obviously particularly forced adoption, and dispelling the myths of adoption so that the right questions are asked sensitively and with the knowledge of how to refer to specialised services.

Secondly, to provide free, specialised training of the quality of that provided by VANISH to mental health professionals and for that training to be delivered face to face with input from persons with lived experience, and that was one of the really important things about VANISH's training. Online didactic training is not in my opinion adequate, as the complexities of this field require extreme sensitivity, with competence being far more important than paper qualifications.

Next, to provide long-term access to appropriate, free, trauma-sensitive and adoption-specific counselling for all parties affected by forced adoption. Therapy is expected to be long term but may be intermittent, as the sequelae of an adoption can be triggered by various life circumstances and events, so people may come in and out of therapy as new events occur in their life.

Ms COUZENS: And we have heard evidence from a number of women that have not sought counselling at all.

Dr SAXTON: Yes, certainly that has been my experience too. To utilise effectively those with specialised experience in this field so that they can provide a secondary consultation service to those less experienced and thereby grow the number of suitable therapists. Deb Garratt and I were just speaking outside about the fact that there are actually very, very few people in this area who are registered with VANISH and who do have specific training in this area. There are people who are highly trained whose service is not really being fully utilised at the moment, and if they are doing one-on-one work, that is possibly missing the opportunity for them to be training other people who could be giving far more service to a wider number of people.

Funding for support groups, especially in regional areas—my experience as a facilitator has enabled me to witness the value of peer support and the healing benefit in mixed groups where members can learn from each other's varied experiences, and that has been such an honour for me to be involved in that—also for therapeutic groups, which again can be a very cost-effective way of providing psychoeducation, and the group dynamic in that situation has its own benefit for individual members as they experience support of their peers. For example, art therapy groups have been successfully used to work with these cohorts.

Ms COUZENS: We have heard that.

Dr SAXTON: Yes. Also for provision of regional hubs where counsellors, provisions for searches and other support services could be provided on a regular or an as-needed basis. While DNA testing is becoming more common as a means of searching, simpler forms of searching need to be explored first. When DNA testing is done, the implications need to be handled very sensitively for all parties and approaches to potential matches made with very careful preparation, and sometimes that is not done quite, as you have probably also heard, as sensitively as it could be. So those are my suggestions, a wish list.

Ms COUZENS: Great. Thanks, Rosemary. I appreciate that, thank you.

The CHAIR: I just had a question about the forced adoption support services. Clearly that is essentialised through Relationships Australia Victoria. We have heard that the model is not necessarily effective and there are some challenges in providing a range of services. What is your experience working with or referring people to RAV?

Dr SAXTON: I have not had anything to do with them in this space. My concern with them is that obviously they work with all relationships and they are not adoption specific. My experience has been with VANISH, who are adoption specific, and I realise there are other organisations that are.

The CHAIR: Do you believe that there is enough choice in terms of support regionally?

Dr SAXTON: No. The very fact that Deb and I were unable to really think of very many specialist services available—that there really just are not the number of professionals who are experienced or even aware enough of these issues—is just woefully inadequate.

The CHAIR: Heang, do you have a question?

Mr TAK: I thought part of the question you already asked. I was about to ask whether in the medical community there was enough awareness about forced adoptions.

Dr SAXTON: Is Hansard able to record an eye roll on that one? No. My colleagues are very, very unaware. I mean, I do have one colleague who has a relative. Ones who have relatives who have been involved with an adoption history clearly do, but otherwise no. And in fact certainly one of my clients has seen two psychiatrists in the last six months, both of whom actually told her that an adoption was not a trauma, and I really rather wish that they had heard some of the testimonies that you have heard—I think they might change their minds. And I hope very much they are reading this.

Mr TAK: Thank you. Thank you, Chair.

The CHAIR: Thank you, Heang. The last question is: what should be done to expand the research base on the effects of forced adoption and adoption in Australia, including separation trauma?

Dr SAXTON: Goodness me, that is a big question. A lot more research.

The CHAIR: A lot more research?

Dr SAXTON: Yes, a great deal. But obviously looking at what has already been done overseas and maybe just tailoring that to Australia. I mean, the very fact that, as I said earlier, the questions are not asked in terms of coronial things as far as death certificates and things like and adoption status is not questioned on there at all—but of course the issue of mothers being recorded on that I think would be even more difficult.

The CHAIR: Yes, okay. All right. I think that that concludes the questions. Thank you so much for taking the time to put us down in your busy schedule to present and provide a submission to us. We really do appreciate the time that you have taken to contribute to our inquiry. Now, the next steps will be: clearly we are going to be deliberating on all the evidence and preparing a strong report back to Parliament in August. We will be keeping you up to date with the progress, and you can get more information online as well on our website. But again, thank you so much for being here today. Your evidence will take part in our deliberations.

Dr SAXTON: Thank you very much indeed for allowing me to appear. It is an incredibly important issue.

The CHAIR: Absolutely. And I hope we do justice in our final report. Thank you.

Dr SAXTON: Well, thank you.

Witness withdrew.