To: House of Representatives Standing Committee on Social Policy and Legal Affairs
Parliament House Canberra ACT

Inquiry into local adoption

I write to you today in reference to the inquiry into local adoption.
I myself am an adoptee. I wrote a submission the the Federal Senate Inquiry into Forced Adoption. I gave evidence in person at the Sydney hearings for the Forced Adoption Inquiry. Also I am a sitting member of the FASS NSW (Forced Adoption Support Service) Relationships Australia. A federally funded service provision resulting from the Federal Apology and the findings of the Forced Adoption Inquiry.

1. Stability and permanency for children in out-of-home care with local adoption as a viable option.

To begin to address stability and permanency of care for children in 'out-of-home-care' one must first understand the complexity of needs these children have. As someone who has lived experience, as well as who has worked with countless adoptees and mothers for over 25 years in a purely volunteer capacity.
I find the lack of comprehension, still to this day within government, mental health professionals, service providers and society in general very disturbing and feel very strongly that the continual focus on meeting the needs and perceptions of adults claiming to have the 'best interests of the child,' whilst ignoring the global growing evidence of the failures, trauma and abuses resulting directly from adoption. The creation of a for profit/sustainability adoption industry turning children into a marketable commodity and the process of assessment and placement into a business opportunity is very concerning indeed.

Adoption is an archaic process that not only dehumanises and belittles the needs of vulnerable babies and children, it is also rife with abuses of power, corruption, lies and ignorance. It makes it legal to strip a person of their legal and inherited identity, issue them with a new one and creates a legally binding for life separation from your biological family, regardless of their level of awareness of the childs existence. The only other form of government practice that has had this type of power and scope was slavery. An outlawed practice as should adoption be.
Adoption makes it legal to transport children across boarders to achieve adoption placement. It makes it legal to charge money to obtain a child or baby. It makes it legal to set up a private industry either for profit or sustainability, will for financial reasons and justifications cut corners, alter records to create a financially viable supply and demand process to acquire babies cheaply and supply children to fulfil the demand. Adoption has been used for centuries as a mechanism that enabled some of the worst atrocities in human history. With many of the same justifications used today and given to this inquiry, government both State and Federal as well as the general public. Regardless of how you word it or try and change its appearance, adoption is a outdated practice that should never be an option when addressing the needs of vulnerable babies or children in out-of-home-care or removal at birth to adopt as is common practice currently in NSW.

If you need to market children to achieve permanency of care then you will for the most part only attract those who have the wrong reasons for taking on a child or baby that has been removed from parental care.

The only permanency solution that can have the structured framework necessary to enable the appropriate level of assessment, required interventions and support and that minimises expectations and risk of abuse and/or neglect is ‘Permanent Guardianship.’

Permanent Guardianship provides the permanency structure needed for children in-out-of-home-care, enable the keeping of the childs name and by its very term provides a level of protection and acknowledgement for children and newborns who have been deemed as unable to be raised with either the mother and/or father or other biological family members. The protection lies with the fact that the child or newborn has a history, both genetically inherited (epigeneticaly inherited predispositions, perceptions, environmental and interactional interpretations as well as direct memories, inherited personality and identity) and experiential as in in-utero and post birth. This history in the majority of cases comes into direct conflict with the conscious and sub-conscious expectations of the adoptive parents the reality of this expectation both emotional and psychological is placed upon a already traumatised child or newborn to fulfil. Prospective adoptive parents by the very nature of the reasons and processes that have led them to consider adoption, creates a desperation and heightened level of hope and real expectation that the moment they first hold the child or newborn they have been assigned. They will feel a certain ‘unrealistic’ feelings of wholeness and a new level of meaning and purpose in their lives.

This expectation cannot be repressed and to a trained observer is very real and when it is unmet becomes a real threat and highly complex barrier to the stability of the relationship between the child that has been placed with them and the security of any form of bonding process.
When the expectations are not met to the level required to abate the feelings and experiences of loss (miscarriage, failure to conceive,) anxiety, depression, frustration and insecurity of purpose and identity, or in the case of ‘same sex couples’ the pressure to prove to an unaccepting society that their relationship is real and that they are a real family. When reality sets in that these expectations are unrealistic or the societal views have not changed, the child or newborn that has been placed/assigned to them becomes a constant reminder of the failure to fulfil, accept and/or resolve.

The result for many adoptees in this situation is a constant reminded that it is their fault, a belittlement of the adoptees needs and a real risk of harm, neglect and/or abuse.

Though initially in many cases the adoptive parents will do their best to hide this fact. Many are informed by organisation that are currently pushing for adoption on how to answer questions, behave in interviews as well as how to fill out forms and meet adoption approval requirements. They will attempt to work hard to create the perceived connection they require. But in the end it will not happen due to the lack of genetic and endocrinal/pheromonal exchanges and interactions required to enable an actual familial attachment/bond. The actual attachment style in the majority of adoptions is cognitive in nature rather than actual felt-sense. It is a process of assigned roles and the successful navigation of interactions to enable the creation of a script that both the adoptive parents and the adoptee will follow, enact out untill its inevitable collapse at some point in the future.

Attachment requires far more than just a stable environment 'home' to become secure and long-term. The majority of the attachment processes are physiological/biological in nature and begin from the moment of conception. With the genetic, endocrinal/pheromonal and cross placental compatibility built into the attachment processes, anything outside of a direct maternal bond alters the entire attachment processes within the child for life. When a secure attachment doesn't occur in-utero, the attachment structures within the child are reassigned to enable survival and the navigation of the environment he/she will be born into.
The common presumption that with adoption a secure attachment style can be achieved is for the majority a fallacy. It is far more realistically a cognitively created series of learned mimic and acceptance responses tied up within a trauma created survival script. The true feelings of the child are forcibly repressed and the creation of a perpetual dissociative process of enactment and repression becomes the norm for life.

Within the adult adoption community we call this process 'The Fog' and when it collapses and eventually it always does, without adequate and comprehending support adoptees tear apart their lives trying to understand what is happening and why they feel that no matter how hard they try to maintain their perceived lives, they are dismantling. To understand the creation of 'The Fog' and the trauma created survival script that enable it one must take a realistic far broader view of the actual needs of a child. Not the current held beliefs of resilience and lack of comprehension and interpretation of the world around them.

From the first point of conception, the developing child begins to interpret the world it will inevitably be born into. This process involves many different forms of assessment. He/she will draw upon the genetic database of environmental and emotional experiences, food availability, levels of safety or threat, immunal responses, memories and perceptional responses, attachment/neglect; all the experiences of the parents ancestry, recorded and contained within DNA.
Researchers are now discovering and proving the level of interactions, experiences, generational perceptions, direct memories, emotions and learned responses that are passed down from generation to generation. One of the leaders in the field of Epigenetics,

Rachel Yehuda*, PhD Professor of Psychiatry and Neuroscience, Director of the Traumatic Stress Studies Division at the Mount Sinai School of Medicin*e.

Has shown in her research how trauma experienced by previous generations is genetically passed on to the generations that follow. When the experiences are trauma , deprivation, violence and abuse, the methods used to survive (trauma scripts) will developmentally and biologically alter the framework used by the body to construct many parts of the body, neurological and immunal systems and brain.

Leading to altered developmental processes both interpretive and structural, altered stress responses HPA Axial (hypothalamic–pituitary–adrenal, Fight Flight Freeze), altered cortisol responses and the reduction in the ability to complete triggered threat response cycles from activation to safe which can lead to complex illness (immunal disorders, cardiac/respiratory disease), predispositions to PTSD (Post Traumatic Stress Disorder), CPTSD (Complex post traumatic stress disorder, also known as complex trauma

disorder), depression and attachment disorders, complex anxiety disorders and depression.

Catherine Monk, PhD, is a Professor in the Departments of Psychiatry, and Obstetrics & Gynecology, and Director for Research at the Women's Program, Columbia University Medical Center, as well as Co-Director of the Sackler Parent-Infant Project and the Domestic Violence Initiative, and a member of Columbia's Women's, Gender, and Sexuality Studies Council.

C Monk PhD and others have shown in their research how the experiences of the mother during pregnancy, what the mother experiences the developing child experiences.

Catherine Monk, PhD, Perinatal Pathways lab. 'When pregnant women experience stress, anxiety, and depression, it affects them as well as their offspring in utero. There is a 'third pathway' for the familial inheritance of risk for psychiatric illness beyond shared genes and the quality of parental care: the impact of pregnant women's distress on fetal and infant brain–behaviour development.'

Researchers at the Imperial College, London, UK, analysed blood and amniotic fluid samples from 267 pregnant women, and found a strong correlation in levels of cortisol in the two fluids in each woman.
'*The correlation between the mother's blood cortisol levels and the amount of cortisol found in her amniotic fluid could be seen from as early as 17 weeks gestation.'*

Stress in pregnancy may affect the unborn child. P. Sarkar†, K. Bergman*, N. M. Fisk*†, T. G. O'Connor‡ and V. Glover**

Toxic stress, deprivation, domestic violence, past trauma triggering, survival stress, all crosses the placenta and signals to the development of the fetus that he/she will be born into a hostile environment. The effect this has on the developing child has life long ramifications as it alters the structural framework of the developing brain and body to increase survivability with the expected stress/threat/deprivation exposure by altering neuroendocrine based responses and coping mechanisms, heightening physiological sensory assessment structures in both the brain and body, altering structures associated with bonding and attachment. As well as structures associated with memory transfer and recall. Altered digestive processes allowing for perceived mammalian based survival responses to deprivation and food shortages (feast/famine reflex). Heightened immunal response/activation due to altered HPA Axial activation and response (hypothalamic–pituitary–adrenal axis) resulting in the increased risk of threat activation to the point of moving from fight or flight into a prolonged freeze response state (Feign Death Response). All create the predispositional ecology for serious long term social, physical and mental health difficulties as well as attachment and relationship issues throughout their lifespan.

Contained within the biological mechanisms of life are rules, where there is gain there is also sacrifice. It is in this context that the increased likelihood of complex social, physical and mental health predispositions plays out. Where the brain and body has overcompensated due to epigenetics and cross-placental influences upon the developing fetus, there are areas of sacrifice. Heightened HPA Axial (hypothalamic–pituitary–adrenal) alterations due to inherited and cross-placental alterations can result in the over

development of the Amygdala due to excessive stimulation in the developmental stages (response to increased/prolonged cortisol exposure).
This can result in a reduction or reassignment/altered function in the hippocampus and cognitive aspects of the brain (reduction in grey/white matter and altered sectoral connectivity).

This can also result in the heightened sensory input and assessment processes that result in the hyperarousal of immunal responses that can physiologically increase the hyperarousal state, creating a negative feedback loop that can cycle into a complete shutdown or freeze response (feign death response). This is were cognitive brain shuts down, base and mid brain take over, digestive function stops, smaller blood vessels constrict reducing blood supply to the extremities and surface tissues, concentrating blood supply to the core, blood coagulant levels increase and respiration rate drops (autonomic mammalian predator response).
Hypoarousal states are triggered when the body assesses that there is no escape, in newborns and the very young their ability to respond to threats is very limited. Biologically this process is far more likely to happen to the very young as a result. Children especially the very young take their danger assessment triggers and responses from parents or adults in their immediate vicinity or if in-utero from the endocrinal signalling crossing the placenta. Vocal tone, adrenaline secretion, parental fear responses play a huge role in the child assessment and response to danger, as well as what and how to perceive danger. Though the exact processes associated with this response are still being researched, it is not too far a stretch that if the mother, during pregnancy, is under a high level of stress, to the point of no perceived escape. This would effect the development of threat assessment processes in the developing child.

Fear and the Defence Cascade: Clinical Implications and Management
Kasia Kozlowska, MBBS, FRANZCP, PhD, Peter Walker, BSc Psych, MPsychol, Loyola McLean, MBBS, FRANZCP, PhD, and Pascal Carrive, PhD

I have also come across in my time working with adoptees and adult survivors of child abuse, people who experience a partial or complete hypoarousal physiological response state regularly during high stress or when triggered. This has lead to complex medical conditions as this has become their primary response to triggering or stressful situations.

When considering or assessing cross placental implications of a mother’s stress levels, a therapist who is working with a client who was removed, especially at birth. The imminent threat of removal from the mother is an obvious toxic stress activation event, Add to this the process of her being assessed or pressured to relinquish as is so often the case with the ‘remove to adopt’ policy implemented as a government solution to teenage/underage or single/unsupported pregnancies.

The implication of the mothers toxic stress and its influence upon the developing child need to be taken seriously when working with removed children and or adults that were removed as children, not only in the therapeutic processes, but also in the assessment of need and policies that will attempt to address that need.

Another level to take into consideration is where the mother is fighting to keep her child during pregnancy or has given up the fight and has accepted she will loose her child to removal, or is a surrogate for adoption, is the process of fetal attachment and interactions

between the mother and the child growing within her. The bonding and attachment process between mother and child begins at the point of conception. In the case of imminent or known removal at birth or surrogacy to adopt, the level of interaction and attachment between mother and child comes into question.
Researchers are now only begging to understand the complexity and levels of developmental interactions associated with attachment that happen between both the mother and the developing child within her.

Attachment (parental bonding) is one of the most fundamental and powerful stabilising structures for any and all human beings. It is essential for the development of identity, interpretation and problem solving capacities, security and self awareness and mindfulness. The mechanisms that support and interpret attachment have evolved over millions of years. It is a process that has been investigated for many decades, but still is barely understood due to the complexity of body/brain systems involved, interactional processes involving more than one person, environmental and epigenetic influences, medical interventions pre/post birth and the difficulty faced with effective investigation and research.

Bowlby's evolutionary theory of attachment (Bowlby, 1969) and Ainsworth Attachment Theory (Ainsworth, 1973) relied primarily upon observations and assumptions based upon experiments conducted with animals. Though both theories were a breakthrough especially for their time, much more in known now in the realms of Neuroscience, biology, radiology and genetics enabling a far more detailed investigation of the fundamental processes of attachment and all the psychological, physiological, neuroendocrinal, biological, interpretive and perceptional systems involved.
Even though varying aspects of attachment and parental bonding has been investigated in more recent years, there is a real need for further research specific to the expansion of the understanding around attachment and parental bonding to enable a more accurate and complete reference process to enable greater assessment potential in regards to attachment and dissociative disorders and the developmental aspects associated with childhood ACE’s (Adverse Childhood Experiences).

In reference to attachment processes within human beings, fundamentally there are three levels involved with three different processes that need to find a homeostatic point to function cohesively together.
Biologically the process of attachment follows the base mammalian pathways of pheromonal and endocrinal interactions between the mother and her new born child, neurological connections triggered by genetic encoding, sensory touch and feel as well as the activation of physiological stabilising and regulatory processes.
Cognitively the process of attachment follows predetermined pathways associated with genetically encoded parental recognition, perception, spacial awareness, safety and security, to allow the integration and development of the higher cognitive structures of the brain and the beginning of the interpretation of language (vocal tone, Polyvagal theory Dr Stephan Porges PhD), tactile and other environmental interpretive processes.
Emotionally (endocrinal, neurochemical) the process of attachment enables the completion of the trauma activation of birth for both the mother and the new born child. Then the connection and felt sense of belonging, identity, achievement and family. To create the stable foundation necessary to promote exploration, problem solving and successful navigation of the experiences of life.

From the point of conception right through to the post birth belly crawl and successful latch on for the first feeding, a babies need for a secure safe parental bonding (secure attachment) is critical for not only the baby, but also the mother.
Research has shown how an uninterrupted process of attachment with the mother leads to far better outcomes for both the mother and her new born child.
Wherever possible it is critical to allow this process to naturally occur, where medical intervention is necessary for the survival of either the mother or her child, the recognition that the absence of successful parental bonding needs to be not only recognised but also worked with to enable a secure attachment with the biological mother and father to enable the stabilising of all the associated aspects of trauma processes and to enable the completion of the birthing process for all involved.

Many within the medical and social work areas guided by past practice, outdated information from mental health professionals, feel that a secure attachment can be initiated with any significant care giver.
The longitudinal evidence resulting from enquiries into past adoption practices and studies conducted post adoption with Romanian orphanage survivors clearly demonstrates that this assumption is untrue. Evidence from a longitudinal study of Romanian orphanage survivors placed for adoption in the UK, US and Canada has shown unhealthy attachment states ‘indiscriminate friendliness’ with a high percentage of survivors. The children now older showed researchers that they will attach to complete strangers or whom they instinctively feel is the more dominant. Though there are perceived success and a level of stabilisation in some areas , this still opens the door of interpretation that attachment is not what was previously interpreted as secure or successful, but more so the playing out of a survival trauma script. That is the instinctual process of finding security to improve survivability rather than a healthy attachment to enable the successful development for a stable and productive life.

*APA (*American Psychological Association)
The lasting impact of neglect
Psychologists are studying how early deprivation harms children and how best to help those who have suffered from neglect.
By Kirsten Weir June 2014, Vol 45, No. 6 Print version: page 36

As stated previously the process of attachment when it is not secure in-utero or immediately post birth, instinctively revolves around the best possible process of perceived survivability. This comes from the autonomic base mammalian instinctual processes inherited and refined over millions of years. When a traumatic experience or experiences are not adequately resolved to completion or remains active as in prolonged or continually reinforced or reenacted, the autonomic processes to ensure the best possible survivability take control and often are misinterpreted or misunderstood as compliance or acceptance. The continual reinforcement of this state triggers a dissociative process of coping and can develop into DID (Dissociative Identity Disorder).
As is the case with adoption the removal and placement with adoptive parents becomes the continual negative reinforcement enabling the need to dissociate from biological identity as well as past experiences to survive. There is no actual pathway to process or resolve past trauma as the raising of it requires the adoptive parents to acknowledge that they are raising someone else’s child.

The interpretation of the emotional minefield of expectation within the adoptive family enforces the continual survival state to the point of separation of self and the creation of a cognitive created personality state that best enables successful navigation of the adoptive environment (trauma survival script). Thus negating or repressing actual identity and replacing it with a learned interpretive series of responces to enable acceptance and to promote survivability.

With removal at birth for adoption, many processes to enable a secure attachment to the adoptive parents have been tried. From immediately post birth placing the newborn with the adoptive parents to the more extreme of deliberate rough handling or deliberate traumatising of the newborn to enable a fear state and reinforcement of insecurity to promote a more successful attachment to the adoptive parents.

Many abuses have occurred in the belief that it will promote a more successful attachment to the adoptive parents. Many archaic practices are still the norm and are still seen as best practice today. With the promotion of a supply and demand based for profit or sustainability adoption industry and as the push to expand adoption as the preferred pathway for permanency placement. Many of these archaic practices will and are still perceived as the best way to achieve a secure attachment to non biological parents and/or caregivers.

The success or failure of an adoption placement falls on a single moment. That first moment when an adoptive parent, first picks up and holds the baby or child they have been allocated to adopt. With children who have been in the foster care or out-of-home-care system that moment is filled with fear and mistrust, learned through the sometimes years of negative reinforcement, dehumanisation and betrayal. The right of choice as to who cares for them and where they will ultimately end up is not for them to decide, it is made for them often by people they will never meet. For at birth removals it is more primal, the hyperarrousal state of the highly traumatised newborn and the highly emotional expectation state of the adoptive parents. With the lead up experienced by the prospective adoptive parents and the reasons they have chosen to adopt a child, their emotional fulfilment expectations, fear of rejection and the expectation of finally becoming parents verses the attachment deficit, HPA axial response hyperarousal state, trauma activated new born baby. The assumption that a successful connection/attachment occurring within this type of environment is at best naive and in the majority of cases leads to a complex rejection base response in both the adoptive parents and the new born child. Expanding over the following days and weeks, with real potential to competitive rejection verses obligation psychological processes occurring with the adoptive parents and the continual crying for a mother they will never meet or be held by leading to a complete shut down HPA axial freeze/feign death response or within the child.

For children who have been in the foster care system the difference between the perceived needs and the actual needs are often vastly different. When a child has been removed for the reasons of abuse and neglect they are very often so dehumanised by the system and foster placements that they require a slow and highly considerate approach to placement permanency, for the majority this in not the case as funding limitations and placement opportunities are difficult to come by. Any trust they may have had in the ability of carers to see them and to acknowledge how they feel understand them and what they wish for, has in most cases been repressed or has been completely betrayed and buried.

The traumatic experiences that have put them in this situation and the consequences resulting from them have been repressed into the only mechanism they have left, survival.

Some have fixated on images of rescue by a parent or significant family member, some have completely shut down. Others have found the perceived power of lashing out in either internalised or externalised destructive behaviour. All have a dissociative history of repressed experiences, aspects of repressed memories and some to the point of dissociative alters that they keep hidden for fear that they will be excised from them, as they have become the only permanency figure they know has and will always be there.
The make up of children in the foster care and out of home care system is far to often overly simplified to the point of fixation on the only resolution that society can provide for them, a permanent placement.
This belief though important, very quickly becomes the only aspect considered in the resolution, welfare assessment and policy directions initiated by governments, NGO's (Non Government Organisations) and child welfare institutions. What they have experienced and have been through is put to one side and will be ultimately placed upon the adoptive parents or permanent caregivers to resolve, often left until symptomatology and/or behaviour requires strong interventions due to the perceived negative reflections upon adoptive parents or permanent care givers parenting ability.

The physiological and psychological ecology of children who have experienced child welfare, foster care and out-of-home-care placements is vastly complex and individualistic. It is dependant upon many factors all of which need to be assessed and understood by trauma therapists, government and intervention services before undertaking any intervention or resolution measures. The reason for this is based upon the perceptional and interpretation structures the child has developed to survive and has developed to navigate the many obstacles they have faced within their life so far. Repressed memories states, dissociative alters are common, some are legitimate psychological processes some are developed with full awareness of the child as a defensive or protective measure to stop adults prying into the secrets or beliefs (scripts) they hold close to enable survival.

Self harming and internalised destructive behaviour is common, creating a framework of self sabotaging reenactments to reinforce the learned process of worthlessness they believe and feel both internally as well as perceived by those around them, especially any who they feel have authority or decision making capacities. Developmental and emotional deficits are also dominant in the psyche of the child's makeup and behavioural expression, socialisation and interactional skills are often defensive or manipulative by nature. They have learned how to place instinctual minefields in front of the therapist/service provider to enable a power play game of cat and mouse as well as a interpretive process to show what level of understanding the therapist/service provider has and how interested the therapist/service provider is in them. Due to the age at which these processes have developed they are more instinctual (felt sense) rather than cognitive in nature. They require careful navigation and interpretation to enable successful therapeutic/supportive interventions and resolution based outcomes.

Observational profiling and piecing together the survival scrips and perceived defensive processes learned by these children is a simple way to begin to understand the complex nature, ecology and makeup of children who have experienced abuse and neglect, child welfare, foster care/out of home care systems. It teaches the observer the internal

language used by the child to interpret their surroundings and can give valuable insight into how to approach the therapy or service provision process.

With children removed at birth for adoption the physiological and psychological ecology is similar to that of children who are in the foster care and out of home care systems but is far more primal in nature. There is still a belief in the mental health and social welfare sectors of society that a new born is basically a blank slate that can be easily imprinted upon to enable a secure attachment to a non biological or adoptive primary caregiver. This belief prevails with adoption where in other sectors of childhood ACEs (Adverse Childhood Experiences) and trauma hold a far different view.

When a new born has been slated for removal to adopt, the whole pregnancy and birthing experience changes. The attachment process between mother and her baby is altered or completely halted. The baby is seen as an object that is either being fought over or is part of the legal process of removal and placement. The newborn is no longer seen or referred to (in the felt sense) as a new life being brought into this world, but a representation of loss and failure, as well as an object to be acquired to fulfil a need.
This significantly alters many aspects of the newborns development, attachment and bonding structures, HPA Axial (hypothalamic–pituitary–adrenal) developmental and activation responses, structural framework as well as synaptic connectivity within several sectors of the developing brain, vocal tone and vagus developmental responses (Polyvagal theory) and many other aspects of the initial critical natural developmental and attachment processes. Instead of the birthing experience following the natural birth and attachment processes, the newborns first breath is taken during a traumatic experience that will alter how he/she will develop, perceive, feel, learn, problem solve, connect and respond to life.

The process between removal for the mother and placement will be handled without comfort or consideration for the child's initial welfare. He/she will never hear their mothers heartbeat, know her smell or touch. All critical in the natural developmental, critical nurturing and attachment process.
They will be expected to successfully bond to a stranger and fulfil what is asked and perceived of them, without true recognition of where they have come from, what they have inherited or what they truly feel and who they truly are.

The process of removal at birth to adopt places the newborn in a unique and complicated situation. Normally many aspects of the higher cognitive brain, are not really active untill on average 12 months of age, but due to the developing child’s prenatal exposure to the mother’s threat activated heightened cortisol levels crossing the placenta and the resulting developing processes associated with preparing to be born into a hostile environment. The higher cognitive structures of the developing brain that are often shut down due to the overwhelming threat responses being experienced, by need of survival remain active. The normal sequences of brain developmental steps and connectivity, from base through mid to higher brain is significantly altered.

Dr Bessel van der Kolk, Dr Stephan Porges and others have shown in their research how pre/post natal stress and trauma alters the developmental activation and connectivity stages of brain developmental structures associated with early trauma. ‘Removal at birth is a significant trauma.’

These altered structures combined with the continual survival state triggered with the placement and expected outcomes of adoption placement, create in the very early stages of child development the critical need to repress and comply. This is where the natural prolonged threat coping mechanism of dissociation becomes a part of the developing process of interpretation and survival. To become compliant and perceived as accepting to what from a newborns perspective is the dominant parental caregivers requirements for attention and response. The natural mammalian survival processes of acceptance and complicity to enable greater survivability becomes the primary process of interpretation and developmental process associated with the interpretation of environment, connection, socialisation and safety.

The result is a highly active, continual process of scanning, interpretation and response development to maintain survivability, resulting in the potential reassignment or redesign of how the normal structural brain connectivity and function is formed, resulting in the capacity for higher interpretive abilities for stress and threat perception and responses, rather than secure attachment and belonging. Add to this the engagement of aspects of the ‘old factory senses (sight, smell, hearing, intuition) the developing child creates a process of perception and interpretation that over time becomes non-conscious, but remains continually active. The results of which is a continual feeling of separation rather than participation and the need for continual reaffirming of value and belonging.

Within adoptee circles you will hear the term mentioned ‘The Fog’ this refers to the survival state required to function within the adoptive family. Where many believe that the attachment experienced by many adoptees is actually secure, the experiential evidence from adoptees and the level of negative outcomes associated with adoption shows otherwise.

The Fog refers to a state that has been created to survive. The attachment style of the majority of adoptees is in fact a survival script. Continually switching between, Insecure, Anxious–preoccupied and Disorganised attachment. Resulting in the developing of a survival scrip that enables the perceived successful navigation of the requirements for survival and acceptance within the adoptive family environment.

With the heightened ability to interpret continually active, combined with the requirement to repress or dissociate what is often referred to by adoptee’s as the ‘vault of despair’ buried deep within them (cross placental and inherited emotion from their mother, combined with their own traumatic birth experience). Creates the need to have a perceived functional state that enables a level of functionality. The layers of protective and denial processes are often quite elaborate and well scripted. If pressured many adoptee’s will get aggressive in their responses and their need to have the survival script remain intact, as this script in the foundation they have built their entire life, beliefs and identity upon.
Though as important this perceived and created survival script is, the ability to have it remain intact for a persons lifetime is a challenge, if not impossible.

In my work with what are termed ‘late discovery adoptees’ that is adoptee’s who were never told they were adopted and only found out through a death bed confession, a medical event as in DNA test for transplant/blood etc, or through a family member outside of the adoptive family challenging a bequeathment in court as well as many other ways of unplanned disclosure.

Witnessing the level of neurological , physiological, psychological dismantling of a person who experiences the late discovery that they are adopted is quite overpowering and highly complex in finding avenues to begin to help stabilise, as many standard therapeutic processes prove ineffective or only short term effective and ultimately destructive.
Not only are they faced with processing the levels of deceit and betrayal, but they also experience a cascade complex physical health deterioration. That if left untreated can often result in premature death commonly within a few years.

The explanation for this is complex, but as you take into account the physiological components associated with dissociation, the alteration of memory process and recall, structural alterations and endocrinal processes associated with hyper activation during the early developmental stages, the complete repression of pre/post birth trauma state, the alteration and reassignment of cognitive and functional brain structures. The neurological , physiological, psychological cascade associated with the dismantling of all the processes that kept the adoptee functional is a reasonable assumption as to why this occurs and is so debilitating.

The resolving of ‘The Fog’ for those adoptee's who are informed of their adoption earlier in life , though perceived to be the wiser choice, still the adoptee has to come to terms with the reality as to why they were adopted and not raised by their mother and father. The process of this also creates a unique set of circumstances along with defence and coping structures that can make therapeutic interventions difficult and far more challenging.

For any therapist or service provider who is faced with working with adoptees the level of understanding necessary as to the background of adoption, not only the clients personal experience, but also the overall complex history that is adoption. The reason for this is that most adoptees are unaware of their own history, most focus on the surface perceptions of others and create a external expressed state that will be more easily acceptable to others in their chosen group, but repressed within them are many experiential memories, repressed dissociative states, epigenetic predispositions and perceptions, all are aspects of a repressed personality that will inevitably rise to the surface within a true therapeutic process. The confusing nature of this often accounts for misdiagnosis, unwarranted use of medication, therapist influenced/altered memory recall and a cascade of other potential outcomes that are not in the best interest of the client or the practitioners welfare.

Sadly there is a real deficit in research in all areas associated with the alterations and life-long consequences that child removal and adoption as well as the lifelong consequences child removal and adoption creates. Especially the aspects that don’t come to light until a significant life altering event or that presents late in adult life. The study of which would give great insight into the lives of millions of adoptees, as well as many other aspects of childhood developmental trauma and ACEs (Adverse Childhood Experiences). It will take a brave person to challenge the sociological acceptance of adoption, but it is imperative that is challenged. Today children and newborns are sold daily to adoptive parents and agencies that facilitate adoption. With same sex couple’s now being eligible to adopt the need for children and newborns for the purposes of adoption is growing every day. Children should never be turned into a marketable commodity, but we are and we live this fact every day of our lives.

Appropriate guiding principles for a national framework or code for local adoptions within Australia

As there is no need to have adoption on the table, but as this inquiry and those that are pushing to continue to have adoption as a solution to the need of permanency of placement for babies and children deemed by the courts as being unable to be returned to their parents or biological family member. The points below will give a guide to what needs to be addressed before any expansion or continuance of adoption or any other form of non biological placement option is rolled out nationally.

- The true recognition of the trauma aftermath of removal and any other trauma experienced by a baby or child before placement. This recognition and assessment needs to be addressed before placement and the appropriate support services need to be in place for as long as the child needs them.
- Service provision needs to be able to address the complex nature of and the required time frame to not only stabilise, but also have the required therapeutic processes to minimise the trauma consequences of cross placental, removal trauma, deficit and attachment disorders, dissociative disorders as well as many other common issues created as a direct result of childhood trauma and ACE's (Adverse Childhood Experiences.)
- School teachers should have a direct involvement in the continual monitoring of children that have been removed, as the child is with them for six hours a day. A quarterly observations and learning assessment can easily be used by teachers reported directly to FACS (Family and Community Services,) to better enable the recognition and far simpler interventions prior to issues developing into embedded mental illness or emotional reactive states that can effect educational outcomes, endanger the child or other students as well as better enable a more real time assessment of policy to better enable the true best possible outcome for children that through no fault of their own have experienced the life they have.
- All babies or children removed should remain in the state that they were born or where the majority of their biological family reside. Unless deemed by the Criminal Courts as the child will be a risk of harm by the biological family. This will ensure the best and simplest opportunities to have regular contact with biological family members as deemed as a requirement of 'Open Adoption' policy. As the majority of babies and children removed are born from mothers who live in the lower socioeconomic demographic sectors of society. The removal and crossing of boarders to permanently place can only be seen as a deliberate attempt to limit any and all contact with members of the babies or childs biological family.
- Amendments to inheritance laws need to be made to ensure that children who have been permanently placed have the same legal rights as biological children associated with inheritance within the placement family.
- Baby and child removals need to be moved from the Family Courts into the Criminal Courts. To remove a baby or child, the required evidence needs to enable criminal charges to be laid against the mother/father and those charges result in conviction. This will ensure true accountability on all sides as well as make child neglect and abuse a true criminal offence. Judges can be given greater latitude in sentencing as in rehab or educational requirements to be met, as well as true accountability and recognition of completion. As it currently stands now many mothers, some to the point of completing dozens of FACS (Family and Community Services) required parenting courses are still not being allowed to have their children returned to them, with no clear understanding of why. NGO's (Non Government Agencies) are costing millions of dollars in government funding to run these courses, but there is no direct process of true completion to enable the return of children.

- Any and all removed children either at birth or post birth should not have their original birth certificate altered and name changed unless requested by them when they are of legal age (18 years.)
- Interdependent monitoring and accountability including the laying of criminal charges where breaches of practice/procedure or deliberate fraudulent acts have been found involving FACS (Family and Community Services) management/staff, service providers, NGO's (Non Government Agencies) and any other organisation that has direct involvement in child removal and placement.
- The development of an in depth training and education module that is required learning for all front line medical staff (particularly maternity and mental health), caseworkers and FACS (Family and Community Services,) police, Legal and Family court, to enable more accurate assessment and respect of the aftermath of removal and placement trauma. To enable a greater depth and accuracy of assessment for adoptees who experience psychological, physiological and behavioural/attachment disease/disorders as a direct result of removal trauma. To aid in the treatment and assessment of mothers who are adoptees as many experience prolonged post natal depression and other behavioural disorders that can very easily be misdiagnosed and often results in their own children being removed. This is due to the simple fact that often their child is the first biological 'blood' family they have ever come into direct contact with and the resulting process of either complete withdrawal or over attachment. For fathers who face custody and family court issues as a result of easily misinterpreted closeness to their children due to the same reality that they are the first biological family they have come into contact with. This relationship often is a catalyst that ends relationships due to the wife feeling left out and ignored, added to by the already distance attachment disorder base separation experienced within many adoptee relationships.
- The complete banning of advertising children for either foster or permanent placement in all forms of media. As currently it is common practice to market children on social media by NGO's (Non Government Agencies) advertising for carers and adoptive parents.

I am aware of the perceived attractiveness adoption has to government. The ability to remove accountability for care, both cost and liability as well as the closing of the books on children who are deemed as unable to be returned to biological family by the courts. However this 'attractiveness' comes at a price.
The question that government needs to not only explore but truly comprehend, is the longevity of the cost of taking what can only be termed as a very narrow perspective and one sided argument for a process that has been clearly shown in the past as a dangerous and shortsighted.
With Australia having a low population density compared to other countries of similar land mass and therefore a lessened capacity to absorb societally the cost and aftermath of bad governmental sociological decisions.
With the sociological affects of the stolen generation and aboriginal displacement, WW1-WW11, Korean and Vietnam Wars, Iraq and Afghan conflicts, refugee intake, growing poverty, health and educational systems crisis, youth mental health crisis, growing addictions rates and alcohol related violence.
The questions are:
At what point does the cost of not only the sociological outcomes, but also the resolving of the mental and physical health consequences, that become generational in their aftermath, become beyond the financial capacity of the Australian economy to fund?

At what point does Australian society become sociologically nonviable?
What will be the cost to government to try and rebuild or police a society that has the social factions and problem equivalent to the United States or Britain?
If Australia is to have a future, Australia needs to learn from the past mistakes and accept the reality that the perceived ‘easy solution’ is not necessarily the right decision.

Thank you