TRANSCRIPTS OF EVIDENCE

WEDNESDAY, 2 SEPTEMBER 1998

JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT:

- The Hon Jan Burnswoods, MLC (Chair)
- The Hon. Dr. Arthur Chesterfield-Evans, MLC
- The Hon. Peter Primrose, MLC
- The Hon. Carmel Tebbutt, MLC

WITNESSES BEFORE THE COMMITTEE:

SARAH BERRYMAN, Senior Manager, Benevolent Society of New South Wales, Post Adoption Resource Centre, and

PETRINA SLAYTOR, Social Worker, Benevolent Society of New South Wales, Post Adoption Resource Centre, and

LYNNE PERL, Social Worker, Benevolent Society of New South Wales, Post Adoption Resource Centre, sworn and examined:

CHAIRMAN: Did you each receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?

Ms BERRYMAN: Yes, I did.

Ms SLAYTOR: Yes.

Ms PERL: Yes.

CHAIRMAN: Do you have a written submission?

Ms BERRYMAN: Yes, I do.

CHAIRMAN: Do you wish to add to the submission, to make a statement or just answer questions?

Ms BERRYMAN: I do have a general statement on the submission of the Post Adoption Resource Centre.

CHAIRMAN: Ms Slaytor, will you be commenting on the submission or answering questions?

Ms SLAYTOR: Sarah has been appointed as the spokesperson.

CHAIRMAN: You will answer questions if appropriate?

Ms SLAYTOR: Yes.

CHAIRMAN: And Ms Perl, you will also answer questions if appropriate?

Ms PERL: Yes, certainly.

Ms BERRYMAN: I will be responding to the Committee's questions as Senior Manager of the Post Adoption Resource Centre—PARC—which is a service of the Benevolent Society of New South Wales, and as the representative and spokesperson of that service. PARC's submission was written in consultation with the staff of PARC: myself Sarah Berryman, Thea Ormerod, Lynne Perl, Petrina Slaytor and Claire Storr. PARC was established in 1991. It did not exist as a service during much of the key period being examined by this inquiry. PARC's submission, the comments and questions that we will be responding to are not a first-hand

account, nor do we presume to define the varied experiences of the women whose children were adopted. PARC has, however, spoken to 32,000 people over the past seven years. Approximately 25 per cent of the people using our service are birth parents, most of which are birth mothers.

We estimate that we have perhaps spoken with up to 8,000 birth mothers. We have therefore had the privilege of hearing the accounts of many women and of assisting them through their search and reunion. Most of our submission deals with the experience of women but we do not wish to discount the experience of birth fathers, who have also been deeply affected by adoption. It is the case, however, that the terms of reference of this inquiry largely refer to the experience of the mothers. What PARC feels able to do, therefore, is to reflect on what women have told us of their experiences and to make some statement about the nature and impact of these experiences.

Each woman who has lost a child through adoption has had a unique journey of loss and has experienced that loss in different ways. In the statements that we will be making we do not want to imply that every woman experienced the same thing in the same way. Throughout our submission and in the response to the Committee's questions here today we will be using both the term "birth mother" and the term "mother". We are aware of the different opinions on the title that should be given to women who have lost children through adoption and we mean no disrespect by our use of either term. I add also that the matter on which we will be answering questions will be PARC's practice and existence over the past seven years only and not prior to that period.

CHAIRMAN: Could you briefly describe the role and history of the Post Adoption Resource Centre?

Ms BERRYMAN: As I said, PARC was established in 1991 to coincide with the implementation of the Adoption Information Act. PARC is a service of the Benevolent Society of New South Wales, which is Australia's oldest charity and until 1992 ran the Royal Hospital for Women at Paddington and which also from 1983 ran a post-adoption service at that same hospital. PARC is a statewide service and provides the following services across the State. We provide information on the Act, on searching and on post-adoption issues for anybody affected by adoption. We have a telephone and face-to-face counselling service. We have an intermediary service, groups and information meetings, training for professionals, referrals to support groups and other counselling services, consultation for regional support groups, resource material and library, and a support group for Sydney Network for Adoption Support, known as SNAS, which is open to all parties affected by adoption, as well as conducting research into post-adoption issues.

PARC employs myself as senior manager, four counselling staff, three of which are social workers, one of which is a psychologist, only one of whom is more than full time, and two part-time administrative staff. We have a register of more than 60 volunteers who are current or past clients of the service and who provide a number of services for PARC and for people who use the service. Therefore, people are able to have a choice of whether to have professional counselling or whether to get more informal support from someone who perhaps has had the same experience as themselves.

CHAIRMAN: In your submission you explore the cultural context of adoption services,

particularly prior to the early 1980s. You say that "adoption has, until perhaps the last decade, been seen by society as a means of 'solving' two problems—that of 'unwanted' children and fertility". Can you summarise the social context for adoptions from 1950 to 1998 with particular reference to the period before 1980?

Ms BERRYMAN: Certainly. Throughout our submission we sought to reflect broadly on what women have told us about the cultural context at the time of the adoption of their children and how society's attitude has impacted upon them at that time and in the intervening years. Our use of the term "unwanted" reflects some of the social language which was evident during the period in question. The period being considered for this inquiry, 1950 to 1988, saw many changes in culture and in what was felt by society to be acceptable behaviour. Attitude towards premarital sex and children born outside of marriage have changed substantially throughout those years. There have been many developments in the availability of financial and family support for single parents and in broad attitudes to single-parent families. Developments in family planning, in the availability of legal abortions and in fertility treatment have impacted on the number of children being adopted and on the number of families who needed to seek out alternative ways of becoming parents.

Before the 1980s there was much less understanding of many concepts which informed current thinking on parenthood and on child development. Much less was known about modern concepts such as grief, trauma, the bond between mother and child during pregnancy or even about bonding and attachment. Little was known of the long-term effects we now know were experienced by birth mothers and arguably by the adopted person and the adoptive parents. There was a powerful belief recalled by many of the birth mothers with whom we speak that adoption was "the best thing for all parties". Women were told they would get over it and would go on to have other children. The adoptive family would have the joy of parenthood and the child would not know the difference.

In some cases all or some of these things were true but in many situations the adoption of the child has had a profound impact upon all parties. Birth mothers did not forget. Some adoptees speak of the difficulties they have experienced, the sense of being different and never quite fitting in, their fears of rejection and of love being withdrawn. We now, as practitioners in the late 1990s, know that right or wrong adoption had, and continues to have, a profound impact. Women whose children were adopted as late as the 1970s speak of tremendous pressure from a variety of sources, including their family, the medical profession, the church and society in general. They speak of being judged morally and being made to feel ashamed. Those whose families did not support their keeping the baby or for whom marriage was not an option had little choice but to have the child adopted. That is a difficult concept for us to take on with the benefit of hindsight and the greater freedom to make life choices now available to young women.

The period from 1950 to the early 1970s was a time of intense government conservatism with intolerant attitudes towards not only unmarried mothers but also defacto couples, homosexuals and those wanting to divorce. The women who have spoken to us about their experiences pre-1980 give many examples of the way that widely accepted language and ways of thinking made their decision more difficult. Blaming language such as unwanted children, fallen women, illegitimate, was part of the cultural context that caused pain and distress to those whom it labelled.

The Hon. Dr A. CHESTERFIELD-EVANS: Your submission states:

> Some women entered hospital with no intention of having their baby adopted, but say that the pressure to consent to adoption and their isolated and powerless position left them no space to make another decision.

You say that these women were caught up in the system that pressured them to consent to adoption. What factors contributed to the isolation and powerlessness of these women? Can you explain how this pressure was applied?

Ms BERRYMAN: Women using PARC services have told us that pregnant and single they felt caught up in an almost automatic system that saw adoption as the obvious solution to their problem. Young women who were without the staunch support of their family and could not support themselves and their coming child could perhaps see that they had no choice other than adoption. Because of the social stigma attached to illegitimate pregnancy many young women had to disguise their situation; many of them were sent from their families in the country to the city or interstate, perhaps even to New Zealand—we speak to many mothers who were in that situation; some had to stay with family members; some had to act as domestic help until the baby came; others went to mother and baby homes; many were not visited by their families during the pregnancy and this increased their sense of isolation; other young mothers had to stay within the confines of the family home only being allowed to reappear once the baby had been born.

The common factor linking the experiences of the vast majority of these women was their being told not to speak of what was happening to them. This often meant that they were ignorant of what to expect from pregnancy or from childbirth and also that they were strongly discouraged from talking about their feelings. Many women tell us that they had to go back to their family homes as if nothing had happened. Therefore, their grief was not acknowledged and the general expectation was that from this point they would get on with their lives and put the whole thing behind them. All of these factors contributed to their powerlessness and isolation. Women have reported to us that societal attitudes at the time dictated that a child was better off with two parents. Therefore, the birth mother was placed in an untenable position: by the very act of keeping her own baby she was deemed to be doing it harm.

The fact that there were so few options for single women could certainly have been experienced as pressure to relinquish the child, particularly for those women who had no family support or who were actively discouraged from keeping their babies. Single pregnant women were frequently reminded by society's attitudes to their pregnancy, by their families and by some health and welfare professionals of the benefit of a two-parent family, of their own ability to provide the kind of care a mother might want her child to have, of the benefit for the child of material stability, of the damage that might be done to their child by the stigma of illegitimacy. Pressure could also be said to be applied by religious institutions because the stigma and negative attitudes towards illegitimacy and premarital sex was very harsh in some religious groups. Many young women vulnerable and without support would be unable to present an alternative to this message, particularly if their family reinforced the view that stated adoption to be the best course of action. The isolation, the shame and the secrecy around adoption possibly contributed to the sense of pressure that many mothers felt at that time.

The Hon. Dr A. CHESTERFIELD-EVANS: You spoke about the social forces and the norms. Who actually applied the pressure? How was this pressure applied in practice? My

understanding is that obstetricians had much to do with it. Were they the main people or were there other people? Who actually got the forms signed?

Ms BERRYMAN: The women who speak to us obviously give us a range of experiences and I do not want to say any one case is the only case. However, those women say that they felt the pressure began almost from the time their pregnancy was noted; that family members, if they were not supportive of the mother keeping the child, would look at adoption as the next choice. Obviously that started the pressure. People within the hospital system, to a degree within the medical system about which women have talked, at that time felt these messages, "If you want the best for your child you should have him or her adopted", "Your child needs a two-parent family", "You wouldn't want anything other than the best for your child, would you", "If you keep your child you will not be giving him or her the best chance in life", no matter by whom they were given, built up pressure to consent to that one act.

The Hon. Dr A. CHESTERFIELD-EVANS: Your view is that it was not an individual group. Presumably the social worker was the person who brought the form. Was that the social worker's role or did obstetricians do that as part of their consultations?

Ms BERRYMAN: Do you mean in regard to signing the consent?

The Hon. Dr A. CHESTERFIELD-EVANS: Yes.

Ms BERRYMAN: The consent was taken in various ways. Our submission certainly covers that later. Obviously there were responsibilities from medical staff, from the way the hospital was run, as we heard in evidence from Dr Tim Smyth last week. The person taking the consent may have been a social worker or a member of the hospital professional staff.

The Hon P. T. PRIMROSE: In its submission the Department of Community Services states that when the Adoption of Children Act, 1965, came into effect in 1967 a mother could revoke consent to the adoption within 30 days of giving consent or before the day on which an order for the adoption of the child was made, whichever was earlier. Three questions flow from that comment. First, are you aware of any cases when the baby was placed with an adoptive family before the expiration of the revocation period? Second, in your view was the past practice of placing a child with the adoptive parents before the expiration of the revocation period an example of unethical or unlawful practice? Finally, your submission states that cases of illegal practice must be examined and the facts exposed. Can you suggest how this can be done and by whom?

Ms BERRYMAN: I am not able to site specific cases of when the baby was placed with an adoptive family, but some birth mothers have told PARC that they returned to the hospital or the adoption society within the 30 days and were told that the baby had been placed. Other mothers remember asking for their baby to be placed straight away to avoid the child spending time in a nursery. I do not have specific cases to bring before the Committee. It was not the placing of the child during the revocation period that was unethical or illegal. Rather it was the circumstances where the mother was not clearly informed of the revocation period or where she returned to revoke her consent within the 30 days and was told that she was too late or that the child had been placed.

In situations where the child was placed with the adoptive family during the 30 days, all parties should have been thoroughly briefed on the revocation rights of the birth mother. PARC believes that the inquiry today and on subsequent dates will provide an opportunity to publicly examine cases and to hear accounts of women who went through these experiences—cases where the rights of the birth mother were not honoured. It will be a chance for as many birth mothers as feel able to come forward to tell of their experiences and to have those experiences validated. It also will give a venue for agencies to be open and transparent about their practices and protocols. Perhaps it would be of interest, for example, to discover how many revocations did occur during the period in question. The submissions and all evidence given throughout the inquiry will form a body of evidence that should help to build a picture of adoption practices during the period in question and the recommendations from the inquiry will, we hope, provide guidelines for any future examination of these issues.

The Hon P. T. PRIMROSE: In your view, what is the long-term impact on women who have experienced unresolved grief and loss through adoption?

Ms BERRYMAN: The nature of the losses experienced by birth mothers at the time of and subsequent to the adoption of their children is complex and may vary depending upon a number of factors. However, the experience of grief and loss is the defining experience that links all birth mothers with whom we speak. Evelyn Robinson, a birth mother who spoke at the 1997 Brisbane Adoption Conference, talked about the mourning of children lost through adoption as being a form of disenfranchised grief. When grief is disenfranchised it is not openly acknowledged or socially supported, and without the opportunities to express and resolve feelings of loss, bereavement reactions tend to become complicated.

As we have stated already, historically there has been a pervasive silence around birth mother grief. There were no rituals to honour the birth or loss of the child and quite often friends and family avoided any mention of the pregnancy or child. The communal silence may have been interpreted by birth mothers as disapproval and may have reinforced their sense of shame. There was also disenfranchisement within the women themselves, within the shame and secrecy surrounding the pregnancy, and birth mothers had little choice but to conceal their grief also or to deny it altogether. So, rather than feelings of grief diminishing over time, the result can be depression and a deepening of these feelings.

Many birth mothers have feelings of guilt and self-blame. Even if they are able to retain a clear sense of their lack of choice and their love for the child they carried they still come up against the beliefs of others. They signed the consent and, therefore, they chose to give away their child. That can be the public perception. Many women whose children were adopted during the period under examination did not see their child at the time of the birth or at any time afterwards. Some remember this as their own choice, whilst others were clearly denied their wish to see the child, yet others returned to the hospital at a later date to see the baby. Mothers who did not see their child were denied any concrete focus for mourning and may have experienced a whole series of anxieties about the child's health and appearance which may have impacted upon reunion with their now adult child. After the loss of a child through adoption the child is lost to the mother, but still lives. The loss, the experience of the pregnancy and the reality of the child not named or publicly acknowledged impairs the grieving process. Do you want me to go on to the second part of the question?

The Hon P. T. PRIMROSE: Yes.

Ms BERRYMAN: This looks at the long-term impact of grief and loss for women. Because the adoption loss remains unresolved, birth mothers often have difficulty dealing with subsequent losses. A new loss or a traumatic situation can trigger the old losses associated with adoption, making the current situation unmanageable. Other birth mothers appear to be and find themselves to be deadened to other losses, seeming to have a dulled reaction to new losses or feeling that their emotions are somehow locked away. Women who experience this sense of emotional separateness speak of their difficulty in trusting others or in sharing intimate relationships. Some also speak of their relationship with subsequent children being damaged by their lack of resolution over the loss of their, usually, first child.

They may speak of being overly anxious or undemonstrative. Other women have spoken of their inability to conceive or to carry subsequent children and link this with the unresolved feelings caused by their first pregnancy, resulting in, for them, no baby. As PARC counsellors we listen with sadness to the grief of women, and some men, who are trying to come to terms with their massive grief and its profound impact on their lives. A significant number of birth mothers speak of their battle with mental illness, alcoholism, drug abuse, relationship breakdowns, health and fertility problems. The only factor these women have in common with each other is the adoption.

CHAIRMAN: Given what you have just said about the long-term impact, can you tell us how PARC designs its services and how you feel it addresses those problems?

Ms BERRYMAN: The main thing is that we try to provide a flexible service, and we listen to what women tell us about what they feel about our services, what they feel would best suit their needs. I am talking specifically about birth mothers, but the same applies to our other clients as well. We do not, for example, put restrictions on how long someone can see us for counselling sessions. Quite often people will see us for a few months, then go away for perhaps six months, a year or two years, then, if they have had a reunion or other issues come up they will revisit our service or use it in a different way. They may come back for counselling for a period. Then they may want to be put in touch with another mother or someone who has a different story, to try to find out about another person's experience. They may come for counselling for a period, then later they may want to come to a group. We try to be flexible and listen to what people want. We try to give people time to claim the services they want.

The Hon P. T. PRIMROSE: The Committee has received details of the non-adoption options available to birth mothers between 1950 and 1998. Although the Committee realises the availability of non-adoption options were very limited, in your opinion were the mothers given adequate information about the options?

Ms BERRYMAN: Once again, it is difficult to generalise about what information women were given without the women themselves being directly consulted, but the anecdotal information given to PARC in the past seven years suggests that birth mothers were very aware of the limited choices available to them, and they were generally without detailed knowledge of financial assistance to which they might be entitled. Prior to 1973, when adoptions were at their highest and when the Federal Government introduced a benefit for single parents, it was difficult for single mothers to get any kind of financial benefit.

If the mother was prepared to commence affiliation and maintenance proceedings against the father, if she had knowledge that this was possible, with the assistance of the Department of Community Services she might have been able to qualify for the section 27 allowance, which provided very basic assistance for the child only. She would then have to be on the allowance for six months before she qualified for the widows pension. The accounts of most birth mothers suggest they did not know they could take these steps. It would be very interesting for the inquiry to discover how many single mothers were actually able to access benefits. The other ways by which a women was able to keep the child were generally marriage or the support of the family. For many women these two options were not on offer.

The Hon P. T. PRIMROSE: Who would social workers have regarded as their client in those days?

Ms BERRYMAN: That is not a question I can answer. As I said earlier, the ambit of PARC really does not go back to that time, nor was it represented in that period.

The Hon P. T. PRIMROSE: If social workers had regarded the birth mother as their client, do you believe they were acting unethically?

Ms BERRYMAN: It is a very difficult question. You are talking specifically about the financial benefits?

The Hon P. T. PRIMROSE: Not explaining options sufficiently, as you outlined earlier in your evidence?

Ms BERRYMAN: Women should have been given full information about opportunities available to them at that time. If that information was not given to women—and that applies to revocation rights, financial benefits and other non-adoption options—then certainly it was unethical for women not to be given that information in a way and at a time when they could take it in.

The Hon P. T. PRIMROSE: So the profession essentially breached its key underlying focus of client self-determination?

Ms BERRYMAN: I am not talking about one profession, I am not talking about any particular individual. If women were not given that information when it should have been made available and made clear to them then that was unethical, certainly. However, I am not blaming a specific profession or set of individuals for that.

The Hon P. T. PRIMROSE: So the unethical behaviour was across a range of professions and it appears to have been systemic?

Ms BERRYMAN: It may have been.

CHAIRMAN: The Committee has received several submissions from women who were upset that the name of the birth father was not recorded on the birth certificate, despite recording his name on the form of information. The Committee has been informed that the father's name would appear on the birth certificate only if the mother filled out a separate form. Your submission says that the absence of the father’s name from the birth certificate caused

grief and regret for many fathers, and created additional stigma for the mothers and adoptees. Could you comment on this and the suggestion that this limited information had financial implications?

Ms BERRYMAN: Once again, although I am unable to speak for individual women whose children were adopted, PARC staff have been informed by significant numbers of women that they believed by recording the birth father's name on the form of information that his name would appear on the certificate. When, perhaps at a much later date, those mothers eventually saw the original birth certificate they were, therefore, very surprised and, quite often, distressed to find a blank space where they thought the father's name would be. Many birth fathers have contacted PARC to get information about their child, particularly since 1996 when new regulations were brought in to allow birth fathers greater access to information.

They also expected to find their name recorded on the birth certificate because they knew the birth mother had given their name and, of course, they may have been involved during the pregnancy and at the time of birth. It is distressing for those men to discover that they were not named on the birth certificate or to learn of the sometimes complicated steps they have to go through, including contacting the birth mother after an absence of perhaps 20, 30 or 40 years, to have their name added to the certificate. For many adopted people the absence of the father's name can be troubling. Without adequate information adoptees, when seeing their original birth certificate, might assume the father was unknown and it may make their thinking about their conception and subsequent adoption more difficult. PARC has no evidence about the financial implications of this.

CHAIRMAN: Can you comment on the extent to which women who have negative experiences of past adoption practices use your service?

Ms BERRYMAN: I am assuming by "negative" the Committee means both the beliefs about the unethical or illegal practices and also the negative set of experiences surrounding grief and loss?

CHAIRMAN: Yes.

Ms BERRYMAN: PARC is contacted on a daily basis by women who have been through either one or both of these kinds of negative experiences and who are seeking information or support. An average of 70 birth parents use our telephone counselling service each month. Many others attend our focus groups to explore aspects of their experience with other mothers, or they come to information meetings to listen to other stories of reunion or to gain knowledge on the perspective of adopted people or adoptive parents. Some birth mothers make contact only to be given information about their rights under the Adoption Information Act and require no further services. PARC involves and consults with many birth parents in its planning and in making sure its services are accessible and meaningful for clients approaching the service.

Out of our 61 volunteers, 16 are birth parents. Several birth parents are on the Sydney network for adoption support management Committee. PARC also has an advisory Committee chaired by a mother whose child was adopted. Recently PARC released the video "The Path Ahead" produced by a birth mother. Other women contribute to the running of PARC by being interviewed by the media, speaking at meetings or writing for our newsletter "Branching

Out". All of these birth parents speak openly about their experiences and are not restricted or scripted by PARC. Their involvement continually informs and enriches our practice and ensures that the service we provide is accessible and meaningful.

CHAIRMAN: Would either Ms Slaytor or Ms Perl, from their points of view as counsellors, like to comment on their experience with mothers who have had such negative experiences?

Ms SLAYTOR: I can really only repeat what Sarah has said. We see an enormous range of women with an enormous range of experiences. We present to them a range of services from which they can choose. I do not really have anything to add to what Sarah has said. We were all involved in putting the answers together.

CHAIRMAN: Can you tell us about the sort of contact you have with support groups?

Ms SLAYTOR: Five of us are involved with the support groups. A birth mother's weekend group is the last involvement I had. We find that an immensely sad, but valuable, experience for the mothers and also for us because we learn from every mother who ever comes to one of our groups. My involvement is on that level. A greater number of my clients are birth parents rather than adoptive people, probably because I am more of an age with them or perhaps it has just happened that way.

CHAIRMAN: The Committee is trying to get a feel for how the centre operates. Would Ms Perl like to comment on her role at the centre?

Ms PERL: One thing that strikes me fairly often in my work with birth mothers is the number of women who might have accessed other services. By that I mean community health, private health counselling, psychiatrists, a whole range of services. They have reached a point in their lives where they want to address the issues relating to the adoption, but they have not been heard. I would say that a large proportion of mothers I work with come to the centre saying, "I saw another counsellor. I tried to talk about the loss of my baby. The counsellor was more interested in hearing about other issues." In a way that always saddens me, because it is a continuation of isolation and silencing. I hope our centre would be regarded as a place where women can feel heard and can feel that their experiences are validated by us.

Ms BERRYMAN: Women who use our services are also reassured by the fact that everything they tell us is confidential. They can come to a place where they will not be judged or asked to account for themselves. They can tell us what they like and they can miss out what they like and it will go no further. That is certainly something that gives support and reassurance to many people who come our way. Even if it is through our telephone counselling service and they do not wish to give their name, that is fine. Some people choose to do that for a period and that is okay.

CHAIRMAN: What measures might assist people who experience distress as a result of past adoption practices?

Ms BERRYMAN: As part of our submission we considered what women have told us has been helpful to them and we created a list of those things. The matters are not listed in order

of importance. They were within various groupings within our submission. Anyone who wants to see the submission is welcome. These are the things that women say have been helpful: talking or writing about their experience; being heard and believed and having their grief acknowledged; acceptance by their family, by society and by the adopted child; counselling by a therapist who is experienced is post-adoption issues; breaking secrecy with the family; advocating for other birth mothers and having a public voice; reunion; telling their story to the adopted child; getting information on their child from the adoption file or from medical records; meeting with other birth parents; being part of a support group; taking part in therapeutic groups; choosing which services to access, for example, not having to go back to the agency which arranged the adoption if they do not wish; developing ways of honouring the birth of the child and finding ways of managing the stress created by significant dates, such as the child's birthday or the anniversary of the adoption; and women being able to define their own experiences and, I should add, take part in an inquiry such as this.

Some further things that PARC feels would be helpful are trained and experienced counsellors being available throughout New South Wales and ongoing strategies for making sure that birth parents are informed of their rights to seek information and contact. We would also like to see the findings of this inquiry being made available to other States to inform their own examination of these issues. PARC would also like a publication of a collection of Australian birth mothers' accounts of their own experiences. PARC would also like funding to be provided to support groups.

As women who lost children through adoption give voice to their experiences, and if these experiences can be heard and acknowledged, we will be better informed and will be able to more constructively move forward. Perhaps we might need to find ways of saying sorry to those birth parents and adopted people who have borne the burden of those practices of the past. It is not a sorry that admits direct or personal responsibility but rather, in the words of Sir Ronald Wilson speaking in the context of the stolen generation of indigenous people:

> This sort of apology is about identifying with another's sorrow with the desire to lessen this sorrow by sharing it, by taking it on a little bit oneself. It is an offering to play a part in healing. It relieves suffering to know that others have a desire to share what you are feeling.

In this spirit the staff of the Post Adoption Resource Centre would like to say that they are sorry that people have been damaged and hurt by their experience of adoption.

CHAIRMAN: Do you think a formal apology by the relevant government agencies who in the past have dealt with affected women would assist?

Ms BERRYMAN: It is very difficult for one agency to make a recommendation like that. We have clearly made our statement to women who have used our services who are here at the inquiry today, and it is heartfelt and sincere from the staff at the Post Adoption Resource Centre. I would not like to make recommendations about how other agencies should act. I would hope that some clear recommendations about that perhaps will come out of this inquiry and we would be very happy to have any further involvement as those recommendations come together.

CHAIRMAN: Some mothers have told the Committee that it is distressing for them to seek counselling in venues and with professionals with past association with adoption. What is PARC's position on that matter?

Ms BERRYMAN: PARC's premises at Scarba House at Bondi is in a building owned by the Benevolent Society. We moved there two years ago at the time that I became the manager of PARC. That decision was made because the building was owned by the Benevolent Society, we pay a lower than market rent and it is what we can afford within our budget. PARC is aware and very sensitive to the fact that some birth mothers do not want to come to Scarba House because of its past history. Because of that situation we offer alternative venues for counselling interviews at other Benevolent Society sites across Sydney which have no previous association for those women or if a client wishes they can seek a neutral venue.

Some people who are nervous about accessing our services sometimes want to meet us in a coffee bar or somewhere neutral, in a park perhaps, to talk. Some home visits are also available for clients with mobility difficulties. For those who wish we are very happy and ready to make referrals to alternative counselling or support organisations and groups that are available. The move from Paddington to Bondi, as I have said, occurred in August 1996 and there has been no decrease in our client numbers since that time. PARC employs professional staff with a range of professional and personal experiences, myself, as manager, being an adopted person.

Each staff member is committed to the ethos of PARC which is to provide support and information to any person affected by adoption and to promote each person's right to seek information and, importantly, to be treated with respect. PARC believes in being open and transparent about our practice. We are open to receiving feedback and we have a very clear complaints procedure. A person approaching the service will be given a choice of counsellors, each of whom is open about her qualifications and her experience. Referrals to alternative counsellors or support services is available.

As PARC's manager I conduct regular client confidential surveys of counselling clients to determine whether they are satisfied with the service that they receive. Each person attending one of groups or information meetings is asked to complete an evaluation form which does inform and does change practice.

CHAIRMAN: The Committee is concerned about the availability of appropriate counselling services and support groups across the State, particularly rural and regional New South Wales. Can PARC comment on the counselling needs of both parents and the adequacies of the services that are available?

Ms BERRYMAN: As I have said it is part of PARC's brief to provide services to regional New South Wales. We facilitate that by providing a New South Wales toll-free number, by visiting regional areas and by consultation with regional support groups. In the past few years members of PARC staff have visited many regional locations, a few of which are Lismore, Coffs Harbour, Moruya, Bourke, Wagga Wagga and Dubbo. We have actually got visits to Brewarrina, Broken Hill and Kiama planned for the remainder of this year and we try as much as possible to get out into those regions and give on-the-spot services to people there.

When visiting those areas we always find a huge demand for information and for support. Our information meetings are always very well attended. Part of our brief on those visits is to try to help local people affected by adoption to form themselves into support networks. In preparing the questions I added up how many of those such support groups with which we are

in current contact across the State and that number is 32 groups. That gives an indication of the level of need in those areas.

We also run professional development workshops in those areas based on the requirements of local health and welfare professionals. Birth parents have over the years given us information about what is helpful to them about counselling and what becomes clear is that birth parents want to be able to have a choice of services to access. They want the counsellor to be experienced in post-adoption counselling. They want resources and supports available and affordable locally and they want the counsellor to be non-judgmental and not to push one point of view. There are some counsellors in regional areas who provide those requirements but there are many birth parents in rural and regional New South Wales who have no access to any kind of counselling support in their region and we certainly support a need for counselling support to be increased in regional New South Wales.

CHAIRMAN: Are all the 32 support groups birth parents support groups?

Ms BERRYMAN: They vary. We have a list of contact people to whom we can refer people. If someone rings me from Bourke I can give them a contact name in that area of someone to contact. Some of the groups meet regularly, others meet for coffee on a less regular basis. Some are headed up by birth mothers, others by adopted people. It really varies from area to area but we have a list of those to whom we are happy to refer people if they wish.

CHAIRMAN: What contact do you have with Aboriginal people who have been affected by adoption?

Ms BERRYMAN: Quite considerable. We have a very good relationship with Link Up. PARC staff have, in the past, gone on tour with Link Up, if you like, to visit some of the areas where they are providing outreach and running programs. We offer Aboriginal clients who come forward to use our service the choice of staying with our service or of being referred to Link Up in the Blue Mountains and people can make their choice dependent on preference or on geography. We certainly have regular contact with that service and refer people there regularly.

The Hon. Dr A. CHESTERFIELD-EVANS: I presume the practice of adopting the children out and not informing the mothers is quite different now. If so, when did it change? Is that change completed?

Ms BERRYMAN: That is not an area in which PARC works in terms of current or past adoptions. My understanding, however, is that the practice certainly has changed. I am sure the Department of Community Services and adoption agencies, who will hopefully be coming forward to give evidence to the inquiry, will be able to answer that much better than I can.

The Hon. Dr A. CHESTERFIELD-EVANS: But you would have a consumer's eye view which they may lack.

Ms BERRYMAN: Yes I would. I certainly think that practices have changed. It may be more appropriate to get more detailed information from those other sources. In my role as chairperson for the New South Wales Committee on Adoption and Permanent Care I have put

in another submission which represents people currently practising in the adoption and permanent care which may be able to answer that question more fully.

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably people have recently adopted and have come to you and there must be a change in the stories. Can you comment on that?

Ms BERRYMAN: People who are using our services tend to be talking about adoptions that happened 18 years ago or more. We get relatively few calls from people who have adopted in more recent years, perhaps because they are getting support from other organisations or parenting groups that exist, I do not know. But the issues that people ring us about tend to be for what we are funded, that is, to provide information for adults seeking information under the Adoption Information Act so it is really outside our area.

The Hon. Dr A. CHESTERFIELD-EVANS: Is information now freely available? Can people easily trace their children or their parents?

Ms BERRYMAN: Yes, the Adoption Information Act gives equal rights to birth parents and to adopted people to seek information or to seek contact with the person from whom they have been separated. We get lots of calls from birth parents and from adopted people who want to seek contact and want to find out information about each other.

The Hon. Dr A. CHESTERFIELD-EVANS: Do they always manage to find the people and make contact? Is the information entirely available? Can they get to the relatives?

Ms BERRYMAN: In the vast majority of cases the search is relatively straightforward. It becomes slightly more difficult if people have moved interstate or internationally or if there has been some discrepancy in names given, for example, which makes it slightly more difficult but the vast majority cases are relatively straightforward. The Act allows people to conduct the search themselves by accessing marriage searches through the Registry of Births, Deaths and Marriages and then doing searches on electoral rolls.

The Hon. Dr A. CHESTERFIELD-EVANS: Do you have any clients who are adoptive parents or adopted children?

Ms BERRYMAN: We have many, yes, certainly. The majority of our clients are adopted people, probably about one-third more than birth parents. Adoptive parents are a smaller group of our clients that certainly do come forward. We also have a lot of clients who are siblings, who are grandparents, either birth or adoptive, who are other family members and spouses. A lot of people phone on behalf of their spouse or to talk about how adoption or reunion is affecting their family.

The Hon. Dr A. CHESTERFIELD-EVANS: Do the adoptive parents also have difficulty?

Ms BERRYMAN: Certainly they do, yes. There are many difficulties for all people facing reunion and facing the great impact that adoption has had on all family members.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has heard evidence that people think that adoption should be illegal. Do you think there is such a thing as an unwanted child?

Ms BERRYMAN: I do not think there is such a thing as an unwanted child, no. Again, this is something that is outside our ambit. I am not sure that I should be answering this question from the Committee on adoptions point of view. However, I think that if we looked at the numbers of adoptions occurring at this point in time we would see that most of the adoptions now occurring are cases where there have been child protection issues involved. As the Department of Community Services gave evidence, the number of adoptions now occurring is 200 to 400, compared to something like 4,000 in 1973. I think we are seeing very different reasons for adoption now occurring, and the adoptions that do occur now are mainly because of some kind of child protection issue, some kind of step-parent or intra-family adoption, children with disabilities being adopted, or inter-country adoption; those are the main areas.

I would like to add also, as Petrina pointed out to me, that I forgot to say that in terms of offering services to people who are under 18, we are currently offering a group for birth mothers whose children are not yet 18 and may want to do some work in preparing for contact, so we are starting to look at that issue.

(The witnesses withdrew)

GEOFFREY ARNOLD RICKARBY, Consultant Psychiatrist, affirmed and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Dr RICKARBY: As a psychiatrist who has seen a great number of people from all aspects of adoptions over 35 years.

CHAIRMAN: Did you receive a summons issued under my hand?

Dr RICKARBY: I did.

CHAIRMAN: Are you conversant with the terms of reference of this inquiry?

Dr RICKARBY: I have looked at them carefully.

CHAIRMAN: Have you made a submission to the Committee?

Dr RICKARBY: Yes, I have made a submission in writing and have provided a written answer to the questions.

CHAIRMAN: Do you wish to commence by making a brief statement?

Dr RICKARBY: I do wish to make a brief statement, if I may. When I first heard of the distress and illness in the lives of women who had lost a child to adoption, I thought the problems were unusual. Throughout the decades following, I found that I continually underestimated the severity of their distress and the widespread gravity of their disrupted and blighted lives. There are tens of thousands so damaged, and I consider the cruel and unnatural treatment of these women by their fellows to be of such extent and seriousness that it has only been surpassed by the treatment received by our indigenous people.

I would also say that while practices associated with drugging, threats of police and physical separation catch the attention and imagination, the great bulk of damage was due to the mind-bending techniques by those in power that shaped the mother's view of herself, her entitlements, and ability to fight for her rights and her child's obvious rights.

CHAIRMAN: Would you explain your professional experience with counselling mothers who have experienced distress as a result of past adoption practices?

Dr RICKARBY: Back in the 1960s I was to see a few people in my general practice in Melbourne, particularly one couple who were spending all their money on a private detective to find their first child that they lost to adoption. Then, as a trainee psychiatrist and a community child psychiatrist covering a large area, I was to see quite a lot of women who were very distressed, and I think I missed out on finding out that they may have been original mothers because they did not readily supply that information. However, I found that their loss was basically to do with a lot of their problems; their reaction to worrying about their children. And these mothers had children. Most of them had post-traumatic stress phenomena; that is the way that group of women present.

At that stage I was highly distressed about the failure of procedures for selecting adoptive

parents. I was striking a large number of adopted children coming forward to take up the health department's time and energies where they had been adopted by people with mental illness or very frail families, due to one parent being the adopter and the other one being the one who went along with it, and having trouble staying with very difficult identity problems in children and adolescents. I was working extensively in the other side of adoption. Indeed, my experience in the other side of adoption is still more extensive than my experience with original mothers.

A lot of original mothers then began to know about me, and ARMS—the Association of Relinquishing Mothers—contacted me during the 1970s. I had been writing in the journals, and DOCS secured my help in seeing people that they wanted to knock back as adoptive parents, because, when they had been previously faced with anybody who was going to take them to court or make a noise about them knocking them back, they had not been able to stop them. I was seeing them for DOCS on the understanding that I would go to court to support DOCS in refusing these people as adoptive parents.

I gradually started seeing more and more original mothers, and I was hearing a lot about them because, as a Child Psychiatrist, I was going from Dubbo to the Inner-Western Suburbs of Sydney and to the Hunter Region; I had a very wide area. I would hear about a lot of people in distress, and I would in fact do more supervision of other professionals looking after mothers than I would see myself. But as I have come into private practice in the last ten years, I have seen quite a large number. Over 35 years I have seen some hundreds of original mothers with a wide variety of psychopathology and a wide variety of distress. Where I have known people who were original mothers in social situations, I have also been very interested in hearing about their situations too, which has given me another point of view.

CHAIRMAN: You said earlier that you would have seen more children than mothers; hundreds of mothers and hundreds more children?

Dr RICKARBY: Particularly in the 1970s and the early 1980s we would go into an intake meeting at Child Psychiatry and we would have one adoptive family after another. They were the more healthy ones who would come forward, because the ones who had a fair idea that they wanted help, and, that they were going to get help, were the ones who were turning up to Child Psychiatry. We were more worried about the ones who would not come forward. Mind you, though, there were others in the other direction—the well-functioning, secure adoptive family—who did not need to come to us.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has received many submissions from women who experienced a high level of distress at the time of signing the consent for adoption. While the Committee realises that women's experience of adoption is wide and varied, are you able to comment on the psychological state of a women considering the option of adoption, particularly in the period 0-7 days after giving birth?

Dr RICKARBY: Yes, they were pressing them as early as they possibly could, on the fifth day after giving birth. Largely they were drugged in one form or another. A lot of them had a steady heterosexual relationship and the guy was kept right out. He was not their husband: he was kept away. They were marked for adoption; they were given, in particular, the drug pentobarbitone in its soluble, injectable form. They would have been in no state to have any idea or to work out what the possible futures were for themselves while in that state of mind.

At that stage many of them thought that they were keeping the baby.

There was the crisis of birth and the crisis of all the other things going wrong. They were given Stilboestrol by injection, usually in the labour ward before they left it, to dry up their milk. The consent form that they signed for the usual things to do with birth, certainly was not about them being given a drug such as stilboestrol to dry up their milk—or pentobarbitone sodium, which is very much what was used for deep sleep. It is an obsolete drug, a dangerous drug. Only a select group of people in the drug scene would use it in the 1990s.

The Hon. Dr A. CHESTERFIELD-EVANS: Were some of the consents signed before the child was born?

Dr RICKARBY: The consent to adoption is not to be mixed up with the broad consent that you sign when you go into hospital. As you are admitted, if you are to have an operation, you give consent to the operation. The doctor may have to do something different, depending on what he finds. You give consent to the birth and so on, but there is no way that that consent could be construed to cover stilboestrol or pentobarbitone sodium—which is really a knock-out type of heavy sedative that would last for days in the system. I would say that anyone who had it in the 48 hours beforehand would be 'off their heads' at the time of signing the consent.

The pressure was on them to sign the consent: they had been marked to sign the consent. Particularly in some places such as Crown Street hospital between 1965 and the middle- to early-1970s as soon as the women looked like saying "no" there was the threat of bringing on the Child Welfare Act, and being 'an unfit mother' and these things were put to them. That was irrespective of whether they were in the 20-21-year-old age group with a guy out there waiting for them, or in the younger age group. Part of the awful thing was that they were separated, the young women. They were in an incredibly powerless position dealing with a linked series of people who had marked them out in what was, frankly, conspiratorial activity to abduct their babies.

The Hon. Dr A. CHESTERFIELD-EVANS: You have almost answered my next question. Are you aware of any situation where a birth mother was given an inappropriate drug, or inappropriate dose of drug, at any time prior to, during or after the birth of the child? If so, are you able to advise the Committee about the impact of any of those drugs on a person's capacity to make decisions regarding consent?

Dr RICKARBY: Yes, yes, and it would compromise their capacity totally.

The Hon. Dr A. CHESTERFIELD-EVANS: Which group in the hospital was responsible for that? There has been considerable stress on social workers as the people who got the form signed.

Dr RICKARBY: Doctors must write up drugs. Social workers have no connection with the administration of drugs.

The Hon. Dr A. CHESTERFIELD-EVANS: Were the obstetricians also involved in obtaining the consents?

Dr RICKARBY: The actual consent-taking was often by a person who came into the place

merely to take the consent and was often someone from the Department of Community Services.

The Hon. Dr A. CHESTERFIELD-EVANS: The antecedents were done—

Dr RICKARBY: The antecedents were done by the people in the antenatal home; the nursing staff in the labour ward; the doctors in their prescribing of drugs; and the other professionals, in changing their attitude to the brainwashing procedures that went on for months beforehand. That is why I used the word "conspiratorial". I do not use it in a sort of Bulgarian-with-black-beard sense, I use it in the notion of a number of different people working together to one end, to take the baby.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee asked the next question in almost identical form of representatives of the Department of Health. Did mothers who were going to proceed to adoption have different regimes to those who were normal labours and childbirths and was there any evidence of different drug use. The answer was that there was no evidence of different drug use.

Dr RICKARBY: So? What? They are claiming they gave them all a big shot of Stilboestrol in the labour ward, were they?

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably that was after the consent was signed.

Dr RICKARBY: This was immediately after the birth. This had nothing to do with the consent. They could not take that until the fifth day. This is prima facie evidence of conspiratorial action, surely!

The Hon. Dr A. CHESTERFIELD-EVANS: Are you aware of any documentation a broad level, within the records of the Department of Health or within the published literature, that suggests that is the case?

Dr RICKARBY: From the Crown Street records that I have been supplied with, I have prepared thoroughly three legal issues from the psychiatric damages side, and I have studied those three in very fine detail, I have also studied another eight or nine and I have about five or six of those in my possession at home. For instance, if they had given an ordinary patient pentobarbitone to knock them off their heads, so that they did not remember anything much for days, the ordinary private patient would have complained no end. I would be astounded that they would do that to a mother that they were teaching to manage her first baby. I cannot believe that the drug regime would be the same. I would find it unbelievable and implausible if anyone said that was so.

The Hon. Dr A. CHESTERFIELD-EVANS: You used the word "conspiratorial" in regard to the events surrounding the birth, do you think that the drugs were given and then the person to sign the consent was wheeled in, with the timing of those two things being arranged by people within the system?

Dr RICKARBY: All of the things—the separation from their families, the baby being taken, their face covered, the power difference—was built up over months so that the young woman

was put into a powerless, shamed position and then the drugs were added on top of that. Then they came in asking for consent on the earliest possible day. You will find that nearly all of them are dated on the fifth day. I know of one that is dated on the second day and a few who lasted until the seventh day, but it was all done in a situation where the power difference was built up to an incredible pitch, as was the sort of mind-set of the young women and what she believed she could do. In particular she believed the kinder, powerful people were doing lawful things and that anything she would object to would be unlawful. She thought that they were right.

The Hon. Dr A. CHESTERFIELD-EVANS: With regard to the involvement of the Department of Health—obviously the Department of Community Services and the Department of Health were involved—and the point when the drug was administered, was the social worker timed to come as that drug was acting? In other words, was there a conspiracy—a word you used—between the person who had ordered and then administered the drug, and the person who came to sign the consent form?

Dr RICKARBY: No, I do not think they rang one another up on the phone, but they were coming along on the fifth day where the usual routine—for instance at Crown Street in the late 1960s—was to have the person well and truly drugged with barbiturates. They were coming along to a person who was usually drugged. Other places used valium, particularly on the morning of the signing.

The Hon. Dr A. CHESTERFIELD-EVANS: It was only when the DOCS person would come and the drug regime was arranged accordingly by other people within the system?

Dr RICKARBY: It was just the routine. One did their part of the thing, the other person did their part of the thing. Crown Street at least had the notion that the person had to go through the various steps and be what they called "cleared", which means that they had gone through and signed the form on the fifth day, therefore they did not have to pull in any threats of the Child Welfare Act.

The Hon. Dr A. CHESTERFIELD-EVANS: You do not believe there was communication between them, but you believe there was a regime, is that so?

Dr RICKARBY: There may have been. I do not know and cannot say whether there was communication, but they did not need communication: it was a well-oiled machine.

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably it would be known that the social worker was coming on a certain date.

Dr RICKARBY: Everybody knew that they would try hard on the fifth day.

The Hon. Dr A. CHESTERFIELD-EVANS: Were the drugs written up as a statutory dose for that day only?

Dr RICKARBY: No, with a lot of women they kept the drugs running from birth through until after the fifth day.

The Hon. Dr A. CHESTERFIELD-EVANS: So that the social worker could come at any time during that what you might call drugged period?

Dr RICKARBY: Well, yes. They were not allowed by law to come until the fifth day. The Act required them to. This is at a stage when the adoption Act did not come into play until they had actually signed the consent. All this was done to the guardian of the baby, before the adoption Act could start when the consent was signed.

The Hon. Dr A. CHESTERFIELD-EVANS: The stilboestrol was given long before the woman had signed anything so that she had no milk, which proved she was not a fit mother. It was just another piece of evidence, as it were.

Dr RICKARBY: I do not think they used it that way. It was just that it was part of the routine to stop them from lactating. It did not work sometimes. I know that some people had a reverse reaction and had an incredible amount of milk and were around, crying for help, despite the stilboestrol.

The Hon. CARMEL TEBBUTT: In your submission you state that birth mothers were often given the advice to "start life afresh" and that "they would soon get over" the experience of adoption. What do you understand to be the psychological impact on those women on that advice?

Dr RICKARBY: It was just so patently untrue and some of them thought that it was true, because they were so isolated. What we are dealing with here is a situation where each one went away on her own, with no other original mother, and some of them thought that that is what they ought to do; that that is what they were supposed to do, whereas the opposite was true. They did not get on with their lives. Some of them were refused school. They tried to go back to school and were pushed out of it. Their preoccupation and their grief were so profound that they could not concentrate on any form of study or any personal development for years.

Many of them thought they were different from the others, but in fact my experience is that the grief and the pathological grief goes on for years in fairly extreme cases—and sometimes gets worse in their later life as they come up to some crisis, their child's birthday or some stage of their own or the child's development. So the grief went on in a very bad way. The grief really then decompensates at any time into this psychiatric disorder. The notion that they would get over it was part of the doublespeak that they were given. There were a lot of other issues of doublespeak that they were given that were contrary to the truth. Because they were isolated from each other and had no person to support them, there was no-one to test out. They were so shamed by the process and so humiliated that it was very difficult for them to recover to communicate with anyone about that experience. Many of them after 25 years find it extremely difficult to put any of this into words. They almost have to go for weeks before they can even talk about it in a manner that is comprehensible to themselves, let alone to others.

The Hon. CARMEL TEBBUTT: The Committee is aware that many women experienced post-traumatic stress syndrome after giving up a child for adoption. I have a series of questions which relate to this matter. First, could you explain to the Committee the nature of post-traumatic stress syndrome and the impact it has had on the lives of these women?

Dr RICKARBY: Post-traumatic stress syndrome usually went along with pathological grief.

Pathological grief was much more common than post-traumatic stress syndrome. Post-traumatic stress syndrome is when there is a major trauma which imprints itself on their minds. They are preoccupied with the trauma and, in many ways, the grief occurs when they are preoccupied with the loss. So you have the trauma *and* the loss. Many of them had quite traumatic experiences and crises in their hospitals. This then sets up a super alertness to never have anything like that happen again. For some of them it was a deep-seated fear of pregnancy or sexual relations and for others it was a terrible fear that something would happen to their child; that they would lose another child.

There was a lot of anxiety, sometimes feelings of panic, that would come back on them again when various stimulae came up, for example, listening to the news and hearing about somebody else losing a baby or something happening to a baby, or going to hospital. I have known some who could not go near a hospital, which was a very dangerous situation to be in. The major depression came along in both post-traumatic stress disorder and pathological grief which can break down into major depression very easily. Major depression was often one of the most common reactions, although severe dissociative disorder, where they would block out great blocks of experience or part of their lives, is another serious psychiatric sequel of their experience.

The Hon. CARMEL TEBBUTT: You have probably answered this question, but have you come across any other psychological disorders resulting from past adoption practices?

Dr RICKARBY: Yes, I have listed those carefully and explained each of them in my written submission because it is a long list. The relation of those to the experience of losing a child to adoption is a complex subject. If I answered that question verbally now it could take the rest of our time.

The Hon. CARMEL TEBBUTT: At least it is covered in your submission. You have referred to it now so it will be on the record. How common are post-traumatic stress syndrome and other disorders as a result of past adoption practices?

Dr RICKARBY: I found post-traumatic stress disorder to be most common in the ones who would come to child psychiatry. Those who joined peer group organisations tended to have a lot of pathological grief. Major depression was very common and sometimes dissociative disorder. Those who often reject or become very anxious about reunion have the personality damage that I described under the secrecy, shame and guilt type personality. The other group of people that do not come forward readily are the ones who build heavy defences against their loss; so much so that they tend to lose their real self and become thick-skinned, anxious, but not readily acknowledging the origin of this. Some form of psychopathology is almost universal in my experience. I think that some of the more severe ones do not come forward. It takes quite a lot of emotional strength to go along to your peer group or to a doctor and tell about it. I think there are a lot more people out there who have not done this, who are more severely affected and who cannot make use of peer support. I am hoping that some of those people will get the support of their peers because their peers are the people who really understand what is happening.

The Hon. CARMEL TEBBUTT: You said earlier that women who went through past adoption practices would almost universally suffer some sort of disorder.

Dr RICKARBY: Some sort of damage.

CHAIRMAN: When measuring post-traumatic stress syndrome in a broad sense can you distinguish between the effect of the experience of having a baby adopted—the loss you talked about—and the other traumatic experiences associated with being typically very young, very isolated, being treated with shame and so on? Can you comment on how adoption compared with all the other terrible experiences that vulnerable young women went through?

Dr RICKARBY: The pathological grief goes on and gets worse. There is a lot that the people you were describing can do to grow out of that. When you have a baby somewhere else and you have lost your interaction with the baby that was inside your body, the grief, if anything, grows and comes up in waves in certain situations and arises as a crisis in a person's life. There is no comparison with that long-term loss. I see the same process occur in people who have had a severely handicapped baby. As the baby grows their grief recrudesces. But I do not see the two situations as comparable at all. There is no doubt that the loss of the baby is the pivotal issue.

CHAIRMAN: And that is quite different from, for instance, a stillborn child?

Dr RICKARBY: Yes.

CHAIRMAN: Last week when Dr Smyth was talking to us—this leads to another question that I will come back to—he referred to the issue Dr Chesterfield-Evans was questioning you about, that is, drug regimes. He suggested at one stage that the dosages given to mothers whose babies were to be adopted was comparable to the dosages given to mothers who were expecting stillbirths. I have mixed up the two questions there. My first question relates to the loss of a baby and my second question relates to the issue of drugs.

Dr RICKARBY: I think that is almost in the preposterous range. For instance, one mother was given a series of pentobarbitone doses in a prenatal hospital—the sort of dose of pentobarbitone that would make the foetus subject to hypothermia and gross distress at birth. I cannot see that they would have been doing anything like that to anybody else. Certainly in general medicine to drug people on that level with barbiturates by injection, you can't believe that doctors would do that generally in the 1960s or 1970s. It was known then to be a dangerous practice. We are talking about drugs that are looked on with horror in retrospect. They are obsolete because of their dangerousness.

CHAIRMAN: As a Committee we are trying to achieve the greatest clarity possible when someone like you, for instance, is saying that we are dealing with deliberate, planned, unethical, unlawful practices as a regime for women expecting to have their babies adopted—quite deliberate and quite different in character from the treatment of other women giving birth.

Dr RICKARBY: That is exactly what I am saying. I have seen numerous cases. I have seen only a dozen or so in the records that I have gone through closely, but I know of over 100 people that it has happened to. There is no doubt in my mind at all that there has been a concerted plan to take a woman's baby and that she has gone through the mill in the process to have that baby taken. There has not been any doubt in my mind for a long time. It took me a long time to realise that though.

The Hon. P. T. PRIMROSE: Do you believe that any systematic, illegal or unethical behaviour took place in relation to adoption practices?

Dr RICKARBY: I think that with each of the women, and considering the tens of thousands of them, you would find over a million illegal acts on women in New South Wales.

The Hon. P. T. PRIMROSE: I know that you have touched on this matter, but was adoption always in the best interests of the child? What information is available on the varieties and experiences of children who have been adopted?

Dr RICKARBY: This is a fairly contentious issue. Twenty-five years ago I was the person who was standing up and saying that adoption was not in the best interests of the child for a number of reasons. My reasons were the gross identity disorders and the difficulty experienced by adoptive families in coping with identity disorders, mainly because the poor adoptive family was really not given a lot of help. They were told that it was the same as bringing up a normal child. They were not instructed in all the difficulties, the hard, testing behaviours and the difference in temperament and thinking style. They often got children who were incredibly different to them, just in their way of thinking. We were seeing very few people who kept their babies. One issue was that there tended to be more staying power in the biological family when grandma was involved and had a strong bond with the baby. The children, no matter what fate befell their biological mothers, belonged to that family. They usually knew their father. There was some interest. They were more likely to have problems with their father wanting too much access to them rather than anything else. So I have always had a strong contention that adoption is really a last resort and the best interests of a baby was to stay with his or her biological family.

The Hon. Dr A. CHESTERFIELD-EVANS: You said earlier that you had rejected potential adoptive parents and that DOCS had been reluctant to do that in case it faced legal action from those who were rejected. I have done some work in the screening of people and I know that it becomes very difficult. Did DOCS have great difficulty in screening people and, because of potential litigation, gave children to inappropriate parents?

Dr RICKARBY: Yes. To qualify that statement, the criteria were often largely about their income, the house they had, whether they were married and made religious promises, whether they looked squeaky clean and whether they had a stack of references from Reverend so and so or Father so and so. In the 1970s I wrote a fairly extensive article, with the support of the Social Work Journal, on family psychiatry and the selection of adoptive parents trying to get realistic selection and looking out for the traps. Take, for example, the couple where mum wanted to adopt and dad did not, or a case where there was a fairly severe mental illness in the family, or where there was some obsessive wish to have a child of a certain type and that child had to fulfill certain needs of the adoptive couple. There were quite a few of those criteria. I was trying to teach people to look for those who had grown up in a good family, who had had fairly good relationships within their own family of origin and that type of thing.

This is making a very long subject short, but the adoptions certainly needed a great deal of improving. When they came to send people to me that they thought they might have to refuse through a court case, there were not any marginal cases. There were really gross issues of mental illness or personality disorder. They were not the sort that almost anybody

would have had any difficulty in the vetting thereof. They wanted me to stand up in court for them if they were challenged over this.

Dr CHESTERFIELD-EVANS: So presumably there would have been a lot of marginal ones that would have required your real expertise? I mean you were only getting the really overt ones—?

Dr RICKARBY: I was.

Dr CHESTERFIELD-EVANS: —and not the marginal groups.

Dr RICKARBY: That is correct.

Dr CHESTERFIELD-EVANS: Would you say—I do not know if this relates to the terms of reference of the Committee—that there is a danger, given that adoption is being used for fertility problems, that the vetting system is still in danger?

Dr RICKARBY: I do not know enough to say that, but I hope that their experiences made those people older and wiser. I do know that a lot of the people selecting them have been using my article that I wrote in the 70s, so I must concede that they are at least doing that. It probably needs to be revised a bit now too.

CHAIRMAN: Dr Rickarby, I return to what you said earlier, I think in answer to Miss Tebbutt's question about women being given advice that they would soon get over it, start life afresh and so on. You used the phrase "doublespeak".

Dr RICKARBY: That is a bit Orwellian. Yes, that is the origin of it.

CHAIRMAN: Could you give us your view on whether you mean that the professionals involved were really saying what they did not mean—in other words, that they were deliberately, systematically saying to women what they did not mean—or that, as other witnesses have suggested, they were following the psychological pattern of the time?

Dr RICKARBY: Well, it is pretty awful if that was so. I think there was a group of people in the antenatal homes, in the agencies, who had a belief that the married couples who were infertile for various reasons—the high dose pills, the chlamydia, and various other things that were causing quite a large amount of sterility at the time—deserved the babies. I think there was a belief system that these married couples deserved the babies. They believed, wrongly, that this was in the babies' interests and I think that their rationalisations, some maybe conscious, some maybe unconscious, went towards keeping the supply of babies up to the people who were demanding them. Of course, in-vitro fertilisation—Australia leads the world in this—has changed this. The Health Department, I think it was in 1982, gave a very clear message about what was legal and what was not. That was a bit late. Evidently, that stopped things, but they were already down to below 10 percent of their adoptions, the level they were at around about 1970.

Some of it was the universities who trained people in offering, you know, the younger social workers trained in offering the options and really offered the options, which you will find very little evidence I think from the mothers who come before, of options of any sort being offered

to them, and, the 30 days rescinding being treated with contempt. And the presence of the allowance that women could get whose husbands were in gaol; their being eligible for that was not canvassed to them at all.

CHAIRMAN: So when you say that for some it was unconscious, for others it was conscious, you are saying that at least some people involved in telling young women they would soon get over it, et cetera, were deliberately, systematically giving advice they knew to be wrong?

Dr RICKARBY: One of the things that struck me with some of the professionals—I know that people with a social work degree are not trained in psychopathology at all—was that their knowledge of grief was so thin that they not only did not understand grief, but they did not understand the relationship between grief and breakdown and psychiatric illness. I can accept that there is that sort of ignorance because that sort of thing was not in their course, but for them to be that abysmally blind to what the general public knew about—that a person losing her baby is in a stressful situation—and to be that blind to the degree of grief that that person would suffer, I find totally implausible. I cannot think that anybody of that intelligence to get themselves a social work degree or another comparable degree could be that blind.

CHAIRMAN: What measures can you suggest might assist people experiencing distress as a result of past adoption practices?

Dr RICKARBY: I think the detailed findings of this Committee will help very much. The answers coming out and being published I think will have a very therapeutic effect generally. I think it is still very important to identify some of the people who were in a leadership position who would have known better, and I think there are a few. It would appear, although I do not know of any instances, that certainly the mothers believe that there are some people who took a leadership role in illegal actions to take babies who finished up with some of the babies themselves. I think that if there is that belief, the Committee might well determine if that is in fact true.

CHAIRMAN: Do you think that an apology made by the relevant government agencies would assist the women?

Dr RICKARBY: I think it would be seen as tokenism. I would think that many of the mothers might be even insulted by it. I think some of the large religious organisations who ran their antenatal homes and who had practices that were very harsh; I think an apology that is sincere and comprehensive from them might do a great deal of help towards the mothers, but I think today's government agencies putting out an apology for what was not done back then is not helpful.

CHAIRMAN: Thank you very much, Dr Rickarby, for your evidence.

(The witness withdrew)

MARGARET McDONALD, Retired social worker, and

AUDREY MARSHALL, Retired social worker, sworn and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Ms McDONALD: I am appearing before the Committee as a former practitioner, as the director of an adoption service, a former director of an adoption service and as someone who is currently researching a book on adoption history.

CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act?

Ms McDONALD: I did.

CHAIRMAN: And you are conversant with the terms of reference of this inquiry?

Ms McDONALD: Yes, I am.

CHAIRMAN: And you have made a submission?

Ms McDONALD: I have made a submission.

CHAIRMAN: And you wish it to be included as part of your sworn evidence?

Ms McDONALD: Yes, I do.

CHAIRMAN: Do you want to make a brief statement on your submission or do you want to just do our questions?

Ms McDONALD: I would like to make a brief statement to start with.

CHAIRMAN: In what capacity are you appearing before this Committee?

Ms MARSHALL: I am here as I worked in an adoption agency, a private agency between 1972 and 1975. In 1984 I was appointed by the Minister of Community Services to do an independent review of adoption policy and practice in New South Wales, and currently with Margaret I am researching a book on the history of adoption in Australia.

CHAIRMAN: You received a summons issued under my hand?

Ms MARSHALL: I did.

CHAIRMAN: You are conversant with the terms of reference?

Ms MARSHALL: Yes

CHAIRMAN: Did you make a submission?

Ms MARSHALL: We made a joint submission.

CHAIRMAN: You are going to make a statement and then the two of you will then address our questions?

Ms McDONALD: Yes. Because of the length of time that I have worked in adoption, which is almost thirty years or more than thirty years, and the fact that I have lived through the changes that have occurred, the radical changes that have occurred in the knowledge and understanding of adoption and its current reputation and standing, because of this experience I am acutely aware of the difficulty facing a Committee in 1998 of understanding and setting in its social context practice which took place in circumstances so different from the circumstances and social attitudes of today that it might easily be another world that you are being asked to think about.

This struck me very strongly in the evidence given last week by the birth mother, when she said, "To think they knew what a terrible thing I was going to do". The assumptions underlying that statement appear to be that the knowledge available today about the possible long-term effects of relinquishment was known then, that to give up a baby for adoption was then recognised as a terrible thing and that they or, in effect, we had the power to prevent it happening. I think these are all assumptions that need to be carefully examined.

While in the light of my present knowledge I am only too well aware of what I did not know and could not do in the 1960s and early 70s, I have no doubt that over all this period my own conduct and to my knowledge that of my colleagues was based on these four pillars: our respect for the law, that is, our understanding of the Adoption of Children Act and our obligations under that Act; our commitment to the interests and welfare of the child as a paramount consideration as directed by the Act; our respect for the right of the birth mother to make a decision which she saw as being in her child's and her own interests; and our commitment to dealing fairly and professionally with the applicants for adoption.

In some cases this meant standing by a recommendation that an application should be refused. While the focus of this inquiry is on the treatment of birth parents, the Committee must be aware that, both in law and in practice, in adoption the challenge has always been the balancing of these competing interests. In the balancing of these interests the question of resources was certainly a central issue. It is hard now to realise the mere volume of work that was dealt with by very small numbers of people in those days. For example, the Catholic Adoption Agency had one full-time and some part-time staff, adding up to a total staff of three professional workers and some support staff.

We were counselling mothers, taking consents, assessing families and placing 200 or more babies in a year. When I took over as the principal officer in 1973 there were 400 outstanding adoption applications that I had to get to court. A social worker working at Crown Street in 1970 who had been a social worker student there in the previous year told me that in joining the staff in 1970 as a new graduate, her caseload was 400 single mothers. So the quality of the work and availability of services was greatly affected by those sorts of resource issues.

I should at this stage respond to the conspiracy idea that Dr Rickarby has put forward. To me the whole idea is totally foreign and bizarre. I cannot see that there was any way in those

circumstances that people could have been conspiring together to remove children from their mothers. I cannot see how this Committee can reach a balanced view of the events that have been unfolded to us, the tragic stories that we are hearing—which I do not in any way dispute—without taking into account that larger picture, including the social circumstances that were so well outlined by Sarah Berryman in her submission. All of that is totally familiar to me and they were the circumstances in which we were operating. Within that framework we are very happy to be here to answer your questions and to provide information if we can.

CHAIRMAN: Ms Marshall, do you wish to make an opening statement?

Ms MARSHALL: No.

CHAIRMAN: Can you explain the role of social workers before and after the introduction of the Adoption of Children Act 1965 and, in particular, could you comment on the role of social workers in taking consent?

Ms McDONALD: The role of a social worker depended to a large extent on the setting in which she was working. I say "she" because it was almost exclusively women who were the social workers in adoption. The hospital social workers in most cases provided initial counselling and assistance to single pregnant women, sometimes arranging accommodation and employment during her pregnancy, helping her to consider her options and to work out these plans for herself and her baby. Social workers in hospital were seeing women who presented uncertain of their plans, women who presented stating that their plan was to have the baby adopted and great numbers of women went to Crown Street for the very reason that that was known as a place from which adoptions were arranged. She would also be seeing women who were planning to keep their babies and then the various options available would be explored.

On the whole social workers in hospitals did not take consents either before the 1965 Act or afterwards, although in some cases in country areas a hospital social worker would take a consent on behalf of an agency by arrangement. The situation was different prior to the 1965 Act in that private adoptions could be arranged by individuals and at one stage up to one-half of the consents would have been taken by solicitors, possibly social workers, doctors, ministers, the people qualified under the Supreme Court rules to take consents. The rest of the consents would be taken by departmental officers, most of whom were not social workers.

I do not want to make a distinction in terms of the social worker did this and departmental officers did that. I am not trying to excuse social workers, but overall a majority of consents were not taken by social workers either before the 1965 Act or afterwards because it just happened that the bulk of adoptions were arranged by the department and not many of those district officers were social workers. It might be helpful for me to outline the experience of one social worker to give the distinction between the two periods. We have written something about this for our book and I would be happy to make that text available to the Committee. However, since we are seeking publication of the book we would ask that it be made available at this stage only for the information of the Committee and that it not go on the official record. Is that okay?

CHAIRMAN: Yes.

Ms McDONALD: This social worker worked as a departmental allotment officer. In the department consents were taken by district officers—and they were specifically designated women officers in the city who took consents—but for large hospitals such as Crown Street, the Royal Hospital for Women and probably other large city hospitals like King George and St Margaret's, the departmental person would be an allotment officer. They first existed from the mid-50s. This social worker worked as a departmental allotment officer in 1959. She described her duties as specific and circumscribed, limited to taking consents, looking at the baby in the nursery, seeing that the baby was passed medically fit and choosing the parents for the child. In relation to consent taking, the emphasis was on making certain that the consent was being freely given and that it was properly signed and initialled. If when she went to the hospital she found that the mother was not ready to sign the consent, she simply went away.

[*Interruption from the gallery*]

CHAIRMAN: Ms McDonald has come to give her evidence. The Committee eventually has to take a balanced approach and make an evaluation. We need to give her the courtesy of listening to what she is saying. She is quoting what someone has told her.

Ms McDONALD: If when she went to the hospital she found the mother was not ready to sign the consent, she simply went away, leaving it to the hospital social worker to canvass with the mother her options, which were to take the baby home or to some sort of live-in job or some days later to sign the consent. I refer to the reported judgment on the famous *Mace v Murray* case in which a mother withdrew consent after the child had been placed. This then led to a very long court case in which the different sides were funded by newspapers. The case was first heard in the Supreme Court, was appealed to the Full Bench of the Supreme Court and eventually it went to the High Court. This happened between 1952 and 1955 and the reported judgment is available and I can give you that reference.

The reported judgment in the *Mace v Murray* case confirms this description, clearly describing a process where the departmental officer took the consent, went the first time and the mother said, "No, I do not think I am going to sign." On her second visit she took the consent and then she went back a week or some days later to confirm the decision of the mother. Prior to the 1965 Act there was no period for revocation of consent, although the mother had the right to withdraw the consent right up until the time of the making of the order of adoption. However, because there was no process and because the application could have been taken immediately to court, it seemed as if the assumption was that the consent once given was irrevocable so the practice was to say, "If you are not certain, do not sign." The judgment is well worth reading because it so clearly outlines what happened.

After 1965 there were more social workers involved since it was required that private agencies employ social workers. The common process was that a mother would be referred to the agency by the hospital social worker when she indicated that she planned to have her baby adopted. In the early years of the Catholic Adoption Agency it was likely that there would be only one contact with the mother prior to the birth of her child. The focus in this interview would be on hearing the mother's story, discussing her reasons for the adoption decision, outlining the adoption process—including the taking of the consent and the right of revocation—and her hopes and wishes about the family to be chosen for her baby.

The other important task in this interview was to record the social and medical history so that on this one occasion prior to the birth of the child the agency would have contact with the mother, there was a great deal to be done in that interview. After the birth of the baby the hospital would inform us and then, mostly on the fifth day, the social workers would go to the hospital with the prepared documents to take the consent.

I thought that I would describe for you my own process in taking consents. I think I did not take any consents until probably 1970. The actual taking of a consent would be to read the documents with the mother, starting with form 9, which is the request to make arrangements about the document, and then go through that form explaining the terms. For example, it said the child could be placed with parents approved as fit and proper and selected as suitable for this particular child, so you would discuss that distinction. I would then talk about the section about the religious wish and how it may not be possible to place the child with parents of that religion but if that were to happen, permission had to be given for that wish not to be honoured. I would then talk about the clause relating to the process of revocation and calculate the 30-day period.

My practice was mostly to read that document aloud with the mother, but if I did not read the whole document I would read the last three clauses. I do not ever remember taking a consent in which I did not feel the impact of making those statements and what they must mean to the mother to hear me speak those words, which were, "Upon the adoption of my child I have lost all rights as a parent in respect of the child, I have no right to see or get in touch with the child. I have no legal redress under any Act of Parliament." They were terrible words to have to speak. In that sense, one realised the enormity of the decision that was being made. But it was important that the person taking the consent was aware that the mother had heard those words because following the taking of the consent the person taking the consent would have to sign a certificate saying that the mother had been given the chance to read the instrument of consent and that the consequences of it had been explained to her.

Following the reading of form 9 the consent would be signed and the various alterations initialled. The alterations would mostly relate to the mother's wish about the religious upbringing of the child. In the early 1970s up until 1973 when many mothers were cared for in mother and baby homes sometimes the consent taking would be the first and perhaps the only time at which the agency social worker would see the mother, but at that time it was important to have the mother explain her reasons for signing the consent. The common reasons were, "I'm too young", "I haven't the funds", "I do not have the capacity to provide for this child", "I want the child to have two parents", "I want my child to have things that I know I can't give it."

I certainly accept that so soon after the birth that if the mother was affected by the sort of medication that Dr Rickarby describes, her ability to take in that information could have been limited, no matter how clearly it was presented. But I never would, nor would any member of my staff or any colleague with whom I associated, take a consent where there was any suggestion that the mother was affected by drugs or not able to understand what she was doing. On some occasions the mother would be very distressed and you would have to say, "Do you want to sign the consent or should I come back on another occasion?" One would never take consent when the mother was in such a state that you did not feel that she could in her right mind sign the consent.

It was my common practice also and that of other workers on my staff and other people to whom I have talked to use a similar form of words, that you would recognise that for the mother this was an extremely painful decision and probably the most difficult decision she would ever make in her life; that there would be times when it was going to be a cause of sorrow for her and times when she would regret and question that decision. One would say, "When those times come, you can only feel that this was the decision you made regarding it as the best decision for your child in your circumstances at the time."

[*Interruption from public gallery*]

CHAIRMAN: It is very difficult for Ms McDonald to present her evidence when so many women present at this hearing do not agree with it. She has been summonsed to appear before the Committee to give her evidence and she must be given respect when giving that evidence.

Ms McDONALD: That is probably sufficient on the consent aspect, unless the Committee has questions about that.

CHAIRMAN: Questions about revocation and other issues will come later.

The Hon P. T. PRIMROSE: Your submission states, "It is important that inadequacies of practice resulting from the limitations of knowledge be acknowledged." What were those inadequacies of practice and could they be considered to be unlawful or unethical?

Ms MARSHALL: The meaning of the terms "unethical" and "unlawful" imply moral turpitude, that is, knowing that what you were doing was wrong and doing it anyway either acting contrary to the law or in defiance of professional ethics. I cannot speak for the whole field, but in the context of a private agency in which I worked and in the social context in which we worked at that time I do not believe there were any illegal or unethical practices. Inadequacies of practice which affected all parties to adoption arose from the underdeveloped state of knowledge, not from any ill will or power play. From what we now understand, it is the lack of support services for women who surrendered children for adoption that may be the most serious lack.

The traditional role of adoption agencies historically was to focus on the placement of children surrendered for adoption. That was our principal purpose. A secondary focus was on developing assessment methods so that the best adoptive parents could be selected. Private adoption agencies had much more flexibility than did State departments. Resources were stretched to the limit and little was done for the mothers once the consent was signed. We worked within the widely held presumption of the time that for an unmarried mother who did not have family support or partner support a decision to have the child adopted was almost inevitable. Social censure for mothers of illegitimate children was strong and there were few avenues of support.

In the agency where I worked the follow-up interview was routinely offered but it was seldom availed of. Many young women had to return to country centres or interstate and in many cases did not want a letter from the agency because the whole affair had been conducted in secrecy and they did not want it generally known. So, the sad consequences, and they have been clearly revealed to us at this stage, were that the women suffered

dreadfully and were offered no help. That must be acknowledged. While acknowledging all the different services and systems involved—medical, welfare and adoption agencies—with the lack of services for mothers and the lack of understanding about the long-term emotional consequences of surrendering a child and thinking back to actually working in that time and the limitations of what was available, it is hard to know what we could have done.

Thinking back, if we had known what we know now, what could we have done? There were no places to refer women who wanted help, unless they had resources. What could we have done? I am still not sure about that question. I have asked myself that a lot since I have learned about the suffering of relinquishing mothers. Around the early 1970s some relinquishing mothers took the initiative of asking the agency to get some information about what had happened to their child. So, the agency made tentative moves approaching adoptive parents and asking for some information and early photographs. Sometimes the adoptive parents responded sensitively and generously, and others less so, but it was the beginning of our recognition that something could be done to help and comfort women who, it was later shown, had suffered one of the most terrible consequences of adoption: not knowing anything about what happened to the child.

I remember a submission I received when I was preparing the 1984 review of adoption policy and practice. One relinquishing mother wrote, "My God, aren't I even to know whether he's alive or dead?" That really brought up sharply the injustice of them not knowing. Of course, the Adoption Information Act to a large extent has redressed that problem. However, as I said, thinking back I really do not know what we could have done, but it is quite clear that services failed those women. But I reject in the context of the time and in the agency in which I worked that there was anything illegal or unethical.

The Hon P. T. PRIMROSE: You have mentioned that under no circumstances would a practitioner with whom you were associated seek to take a consent if they believed a mother was under the adverse influence of medication. How was that assessed?

Ms MARSHALL: It would be obvious, would it not? If a woman was half asleep or dopey or crying, it would be obvious. Despite what the perception might be, we took this consent taking very seriously. If a woman was obviously or apparently not capable, we did as Margaret said and arranged to come back. But many women did not feel they had an alternative and pressed ahead regardless as it were.

Ms McDONALD: Often the taking of the consent on the fifth day was really a response to the mother's wish to be able to leave the hospital and return to her family.

Ms MARSHALL: If the women were in hospital, some regional hospitals were different but large hospitals offered no choice. The women either had to take their babies or surrender them for adoption. There were no intermediary services of any great significance on which they could call.

The Hon P. T. PRIMROSE: I appreciate that you have answered the elements of this next question, but I formally ask you, do you believe there were or may have been any instances of systematic illegal or unethical behaviour with past adoption practices? If so, could you provide details?

Ms McDONALD: I can only speak from my personal experience, and that is that I am not aware of systematic illegal or unethical behaviour, although clearly in the nature of things there were, and certainly the evidence presented to this Committee demonstrates clearly, individual instances when such behaviour took place. I am certainly aware from my experience at the Post Adoption Resource Centre and from accounts given to me by birth mothers that there were many instances in which women were treated harshly and judgmentally in a way that failed to respond to their needs or to protect their dignity. It would seem to me that such behaviour was unethical; certainly highly undesirable and possibly unethical. If the purpose of that behaviour was to force the mother to consent to adoption, in that sense it was illegal just as it would have been and is under the Act illegal to persuade a woman not to consent to adoption if that is what she wants to do.

Not necessarily professional social workers, but people who were specialised adoption workers, such as the departmental allotment officers, were aware of the importance of ensuring that the mother was acting of her own free will and not under pressure. Another question might be whether the social system was coercive, and clearly it was. That system included community attitudes, including the views of the churches, politicians, media, families and the shame they felt about the pregnant daughter, illegitimacy, social structures, the lack of adequate financial provision for unmarried mothers and some professional practices, and I include practices of social workers. I acknowledge that when one looks at the system overall, workers working at that time were part of a coercive system, but I make the distinction between the fact that these influences were being brought to bear on the mother—and we were part of that system—and the contention that the system was set up to separate women from their children.

CHAIRMAN: To what degree, in taking a consent, would a social worker check with or consult with other professionals as to the state of the mother, for instance, or the impact of drugs? Can either of you shed any light on that?

Ms MARSHALL: My experience is more limited than Ms McDonald's. I can remember not consulting but going away and saying, "I will come back in a couple of days," but I do not remember consulting with medical people. It was obvious it was not the time to do it.

CHAIRMAN: More broadly, was there any consultation between social workers and health professionals, such as team meetings, to discuss the process?

Ms MARSHALL: Not in my experience, but Ms McDonald's experience is broader than mine.

Ms McDONALD: Could you repeat that?

CHAIRMAN: Was there any process of consultation or checking between social workers and health professionals as to the process to be gone through, the timing, whether the mother was in a fit state from the medication or whatever?

Ms McDONALD: The whole question of medication is something we were unaware of, although I have recently had access to my medical record of six confinements between 1958 and 1969. My first child was a full-term stillborn, and I was interested to see that I was given pentobarb. In a number of subsequent pregnancies I was also given pentobarb. No-one asked

me, nor did I give informed consent to be given pentobarb. I was also given stilboestrol on occasions. Informed consent in relation to medical procedures and the administration of drugs, and knowledge about their severity, was very primitive.

It was a surprise to me when the first allegations were made of mothers being systematically drugged because we would have been unaware of it. We would not have raised the question of whether the mother was being given medication. We would consult if a mother wanted to leave hospital prior to the fifth day and wanted to sign a consent. There had to be a medical certificate saying she was in a fit state to sign. We would also consult if there were a question of mental illness, retardation or something of that sort which would call into question the capacity of the mother to give informed consent. In those situations we would seek specialist advice.

CHAIRMAN: What if a mother were undecided?

Ms McDONALD: If the mother were undecided, if she were really undecided and did not want to sign, we would not have taken the consent. But some women would sign a consent in the expectation that they would possibly revoke it.

CHAIRMAN: Would you consult with anyone if a mother was undecided?

Ms McDONALD: Consult with another colleague, or—?

CHAIRMAN: Someone at the hospital?

Ms McDONALD: Not generally.

CHAIRMAN: Social workers had a relationship with the mother?

Ms McDONALD: Yes.

CHAIRMAN: And the people at the hospital had a relationship with the mother?

Ms McDONALD: Yes.

CHAIRMAN: And they basically had no communication?

Ms McDONALD: You have to see it as very much a compartmentalised system. This is also one of the deficiencies of practice. We each did our bit. There would be consultation with the hospital social worker if there were particular concerns about the mother, mostly her health or her state of uncertainty.

CHAIRMAN: But basically it was compartmentalised?

Ms McDONALD: Yes, it was.

The Hon. Dr A. CHESTERFIELD-EVANS: The social worker agency—?

Ms McDONALD: The adoption agency?

The Hon. Dr A. CHESTERFIELD-EVANS: No, in evidence last session the social worker agency basically said the job as a social worker with the department was not sought after because the social workers felt it was a job in which they had little power and that they were very much constrained by departmental guidelines. I gather that social workers were bonded to the department for some time in that they were paid to go through university and they then had to serve out time with the department?

Ms McDONALD: Yes, for a relatively short period. That was mostly in the 50s and early 60s. I do not know. It was really prior to my experience. The allotment officers, who were the specialist adoption officers, had either social worker or psychology qualifications. They were graduates who had perhaps a social work background. At that time the department was regarded as somewhat unsympathetic to professional values, so people tended to move on. But a number of remarkable and talented social workers worked within the department, particularly in the allotment section in the mid-70s when Renata Tankard became the senior allotment officer. There was a great deal of contact between adoption agencies and the department, and advances in practice that came about were largely through that relationship.

The Hon. Dr A. CHESTERFIELD-EVANS: What you are saying does not seem inconsistent with that comment. You are saying they were graduates. If they came straight from university without experience, their first experience was of the department putting pressure on them. By definition the job was the business end of the system and the system was designed to either take your baby home to no income, no job, an unsupportive family and perhaps a boyfriend who could not support or sign the piece of paper. The pressure to sign the piece of paper must have been overwhelming, shall we say. Perhaps the social worker was as depowered as the mother because this thing had to be done one way or another before the mother went home, which was imminent, and taking the baby home within the social support that existed was difficult?

Ms McDONALD: That is a fair statement. It was worse before the 1965 Act. At least the 30-day revocation period gave the mother a period in which she could reconsider her decision if she were able to revoke the consent. Prior to that time the child would have been made a State ward if the mother wanted the baby fostered during that time. The revocation period gave the mother a clearer time to reconsider her decision.

The Hon. Dr A. CHESTERFIELD-EVANS: The allotment officers had up to 400 clients?

Ms McDONALD: No, it was a hospital social worker who may have had 400 clients.

The Hon. Dr A. CHESTERFIELD-EVANS: The allotment officers did not have 400 clients?

Ms McDONALD: No. One of the frustrating things in the department was that the allotment section of the adoption branch was a professional island within a bureaucratic structure, particularly in relation to the assessment of parents and the placement of children. The system was very inflexible. The assessment of adoptive parents was done at district officer level, at local level. Decisions about approval of applications was a clerical function, although the professional assessment section would have been consulted in difficult cases. Those were some of the difficulties of working in that system.

The Hon. Dr A. CHESTERFIELD-EVANS: You said the allotment officer saw that the baby was fit, chose the parents and made sure the consent was properly taken?

Ms McDONALD: Yes, and she placed the baby. But she would have to place the baby not through direct knowledge of the parents with whom she was placing the baby, but often a somewhat limited or uninformative report from a district centre. This changed later, particularly from the mid-70s. That was a problem in the system.

Ms MARSHALL: It was very compartmentalised. It was not one person who saw the mother through the whole system. It was something done here and something done there.

The Hon. Dr A. CHESTERFIELD-EVANS: So that the allotment officer really had very little room to move? In a sense the mother had to sign the paper because she either had to take the baby home or sign the paper. The allotment officer really had nothing to offer, she was guiding the mother through the distress of signing. Would that be too strong a statement?

Ms McDONALD: The department offered other sorts of services to women planning to keep their children. For example, it undertook affiliation proceedings on behalf of the mother. Prior to the supporting parent benefit this very limited amount of money would be available. Those were the available options.

The Hon. CARMEL TEBBUTT: You have probably answered this question, but you may wish to add to it. In your submission you say that prior to the implementation of the supporting mothers benefit in 1973 it was extraordinarily difficult for single unsupported women to take responsibility for a child. Although the availability of non-adoption options were very limited before the 1970s, drawing on your experience, was information about the options given freely and fairly to birth mothers?

Ms MARSHALL: Perhaps I can add a little more. No, in our agency as a matter of routine they were not. The question appears to assume that alternatives were as available then as they are now but that was not the case. The young woman who came to our private agency had been referred, in the great majority of cases, by a hospital or by a mother and baby home where the preliminary discussion about adoption had already taken place. The first step was taken when they came to the adoption agency and we presumed they were going ahead with it. The options were not routinely offered, discussed or brought up. However, when they brought it up it was a different matter and we offered them whatever information we had. When they stopped in track and said that maybe they would not go ahead, what could they do, there was not a great deal they could but we gave them whatever information we had. Of course, the agency records can verify that some women withdrew.

There were some women who went as far as completing the background information and then for some reason they were able to find a solution and they withdrew. The answer is, no we routinely did not do it for those reasons but if they brought it up and asked for help we helped. I do not know whether that fits in there or not. When a consent was signed but the mother revoked her consent within 30 days the agency would willingly give her assistance—I am only referring to the agency in which I worked. These events were stressful for everyone, I remember them well. The workers were torn between joy for the young mother that she had found a solution and sorrow for the adoptive parents. I remember going to a remote country town and reclaiming a baby for a mother who had changed her mind.

In those days if the young mother said she was sure she would not change her mind we told the adoptive parents that it was not legal until the 30 days and they could take that risk on the basis that it might be better for the child and the adoptive parents to start settling down together. We did that only when the mother said she was sure she would not change her mind. Of course, sometimes she found a solution and changed her mind. When that happened we did everything we could to facilitate getting the baby back. That is our experience in that agency and I cannot speak for others.

The Hon. CARMEL TEBBUTT: The Committee has received many submissions from women who claim they were not informed of their right to revoke consent or were obstructed in their attempts to revoke consent. Could you comment on that? In the research for your book on the history of adoption have you come across any statistical data on the number of revocations that occurred?

Ms McDONALD: Yes, speaking from my own experience at the Catholic adoption agency and from the five years when I worked in the adoption branch, I can say without any hesitation that it would have been unthinkable for me, or any worker associated with me, to fail to inform a mother of the right of revocation or to impede in any way her right to revoke, if that was the decision she finally made. However, while I was at the Post Adoption Resource Centre we prepared a submission for the Law Reform Commission on the review of the Child Welfare Act.

We did a small survey of a group of birth mothers about their understanding of the consent process and whether they understood the right of revocation. There were two mothers who said that they had not been informed of their right to revoke and in each of those cases the social worker concerned was known to me and it would have been totally uncharacteristic of that worker not to have informed the birth mother. The other characteristic of the responses that people gave about the right to revocation was that even people who said that they had been told and that they understood it they gave a very garbled account.

In the light of what we now know about the stress surrounding giving a consent to an adoption at that early stage after the birth of the child the conclusion we came to from looking at that evidence was that for many women there was not a recollection of having been told or that their memory of it was flawed because of the stress that they were undergoing and possibly the denial since.

The Hon. CARMEL TEBBUTT: Do you have any statistical data?

Ms McDONALD: Yes I have some statistics but I would also like to say that I had said earlier that after 1973 at the Catholic adoption agency we routinely gave a mother a copy of the documents which she had signed, including the form 9 with the date of revocation worked out on it. I can date that because we had a contested adoption in which a mother who had consented to the adoption revoked her consent, had taken her child home for six weeks and then reconsented and the child was placed. The mother subsequently contested the adoption on the basis that she did not understand the process of revocation.

Although the adoption went through we were alerted at that time to the fact that there needed to be some reinforcement of the decision that had been taken and that the mother needed evidence that that had happened. I was interested in the questions last week about

placement within the 30 days and whether that was unethical. It was common practice, having consulted the mother and assessed the situation, to place within the 30 days. If the mother said, "No, hold the baby" we would hold it for 30 days. It surprised me from reading that case about which there is also available a reported judgment that we would have placed the baby and we placed that baby again within the 30 days even though the mother had revoked her first consent.

Our reason for doing that was that I was the person who took the second consent and she was ringing me and saying, "I can't bear to think the baby is waiting there at St. Anthony's, have you placed it?" What, in fact, triggered her contesting the adoption was the letter that I wrote to her saying the baby had been placed and giving her some information about the parents. When I look at the evidence that came from that small PARC survey, and look back at that case, it seems to me, although I do not remember when we stopped placing during the revocation period but I think it was some time in the early 1970s and the child would go into foster care—

Ms MARSHALL: That was after a run of revocations.

Ms McDONALD: I think it was. We felt it was not in any way wise to do that.

The Hon. CARMEL TEBBUTT: Have you statistical data?

Ms McDONALD: David Handley, professor of law at the Australian National University in a paper he gave at the first adoption conference quoted these figures. In 1973 and 1974 the rate of revocation of the four New South Wales agencies was 10 per cent. This was contrasted with South Australia where the rate was 5 per cent. I am not aware of any time earlier than that, although that information must be available in the files to be collated. Some surveys have been made for the years 1981 and 1991. In 1981 the rate of revocation was 16 per cent and in 1991 it was 21 per cent.

The Hon. CARMEL TEBBUTT: What is the long term effects on women who have experienced unresolved grief as a result of the loss of a child through adoption? You may have covered that in your initial statement and in your evidence but if you wish to add anything now is the time.

Ms MARSHALL: One of the most influential studies which helped us all to understand the extent of the grief was a Western Australian report in 1983 by Winkler and Van Keppel called, "Relinquishing Mothers in Adoption: their long-term adjustment". That report was very influential and has affected practice, of course. I will give a few of the major points from that report.

The Hon. CARMEL TEBBUTT: Perhaps we can get that information from you after the hearing.

Ms MARSHALL: Certainly. To sum it up, the report reaffirms all that has been said and defines two major factors: the inability to discuss feelings and the inadequacy or absence of any support following the consent. They were two very major factors on the psychological and emotional effects long term. The report also notes that it was not the same for everybody so not everybody experienced a negative adjustment.

CHAIRMAN: Can you comment on post adoption support and counselling?

Ms MARSHALL: I addressed that earlier when I said that they were left to their own devices. There were no support services, and that was one of the major inadequacies of the practice.

CHAIRMAN: What measures might assist people experiencing distress as a result of past adoption practices?

Ms McDONALD: I would agree with Dr Rickarby that the report of the Committee is going to be a major way to address the distress mothers have suffered as a result of past adoption practices. The Committee's report could perhaps serve the same purpose for some birth mothers as the English book *Half a Million Women: mothers who lose their children by adoption*. I had a client at PARC who, having read that book, carried it around with her for a time. She said to me, "Now that it is written down I don't have to feel that I have to keep it all in my head".

The recording and acknowledgement of the coercive social circumstances at the time, the deficiencies in knowledge and practice, the recognition that the surrender of a child is a traumatic and life-changing experience from which some women have never recovered and validation of their experience should provide assistance to those women. I would also support all the measures outlined in the PARC submission, particularly the wish of birth mothers that the circumstances of the surrender should be understood by their adult children. It should be recognised by the publication of a book of stories like the book produced by Carmel Bird from the "Bringing them home" report.

The decisions of women who surrendered their children in the sincere belief that it was in the child's best interest and who adhere to that belief should equally be honoured. There should be an extension of post adoptive services which include the funding of self-help groups and, if possible, some provision, where needed for assistance in the waiver of registry or other fees, similar to the fees assistance fund that operated at PARC that enabled people to access certificates when they were in dire financial circumstances.

The Hon. Dr A. CHESTERFIELD-EVANS: Did birth fathers have any rights in terms of the decisions made with regard to adoption, were they taken into account, and how were they informed and involved?

Ms McDONALD: Birth fathers had no legal rights until the 1980 amendment to the Adoption of Children Act, which gave a father who had been identified on the birth certificate, or who had by some other means been identified as the father of the child, the right to be informed of the signing of the consent and to put forward within 14 days an alternative plan for the child. The recommendations of the current Law Reform Commission report are that birth fathers should also have to consent to the adoption.

The Hon. Dr A. CHESTERFIELD-EVANS: That happened after 1980, is that right?

Ms MARSHALL: No, it has not happened yet.

Ms McDONALD: After 1980 the birth fathers had those limited rights. They still do not have the right to consent. There is not the requirement that the birth father consent to the adoption. Although, I understand that many agencies would now involve the birth father if possible. In relation to your question to an earlier witness about when the changes started to occur, I think very marked changes in practice started to occur probably from about the mid-1970s.

(The witnesses withdrew)

CHRISTINE ANNE COLE, sworn and examined, and

DIANE PATRICE WELLFARE, affirmed and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Ms COLE: As the chairperson of Origins and as a mother.

Ms WELLFARE: As a mother and as the secretary of Origins.

CHAIRMAN: Did you each receive a summons issued under my hand?

Ms COLE: Yes, I did.

Ms WELLFARE: Yes. I did.

CHAIRMAN: Are you conversant with the terms of reference of this inquiry?

Ms COLE: Yes.

Ms WELLFARE: Yes.

CHAIRMAN: Do you wish your submission to be included as part of your sworn evidence?

Ms COLE: Yes.

Ms WELLFARE: Yes.

CHAIRMAN: Do you wish to elaborate on the submission, to make a short statement, or to simply answer Committee member's questions?

Ms COLE: I will defer to Di Wellfare, who has done the main work of the Origins submission.

CHAIRMAN: Would you explain to the Committee the background to the establishment of your support group Origins, including details of the numbers of group members across New South Wales and the nature of the support that you provide?

Ms WELLFARE: Origins was founded in April 1995 by a small group of women who saw the need to provide an alternative support service which focused on two issues that we felt were pertinent to our healing but were not being addressed, in fact, they were being ignored and dismissed. One was our need to address our past adoption experiences and to stop post-adoption counsellors and health professionals from minimising and invalidating the severity of damage created by adoption separation. At the time we recognised that almost all post-adoption workers set up to counsel mothers were the very same social workers who had been involved in taking our babies. We saw that as a continuation of our abuse through professional control. I suppose the bottom line is that we felt it was time in 1998 to bring a bit

of reality and honesty into adoption and to dispel this adoption myth.

As an organisation with a New South Wales membership of 620 mothers already, not including our interstate membership, we have a combination of 28 support groups and phone support services Australia-wide, with 14 service providers in New South Wales. We are affiliated with groups in the United Kingdom and New Zealand. We are entirely self-funded and offer confidential support and assistance through regular and out-of-hours emergency telephone services seven days a week. We hold monthly support group meetings and provide information and support in the search and reunion process, including redirection to alternative search services when the need arises.

We provide mediation where required and offer our members an informative quarterly newsletter, as well as access to a comprehensive reference and research library of historical documents, literature, books, videos and audio cassettes. We also provide information kits to health professionals who seek a wider understanding of adoption trauma to accommodate their patients' needs as required, and have recently sought funding to mass-produce and distribute a booklet on this issue to all health and referral services in New South Wales.

CHAIRMAN: Has the Origins group collected any statistical data on the number of women affected by past adoption practices and the nature of those practices?

Ms WELLFARE: The Registry of Births, Deaths and Marriages asserts that from 1950 to 1997, 76,453 adoptions took place in New South Wales. The registry was unable to provide us with the actual breakdown of step-parent adoptions and of older children placed for adoption. Non-traditional adoption statistics are believed to be relatively small and in the low hundreds per annum as during this period, and especially from the late 1950s, this was where the emphasis changed in adoption from being a service for children in need to providing a service for infertile couples, the emphasis concentrated almost entirely on infant placements, with infertile couples generally refusing to adopt any child other than a newborn, with the promotion of traditional adoption having been based on the premise of alleviating the emotional distress caused by infertility by providing an infant young enough to be "as if born to the adopting couple", rather than to its own mother.

While we have conducted no empirical research data as such, we have provided questionnaires to our members through our newsletters and have tabled those questionnaires pertaining to their adoption experience as part of our submission to the inquiry. We have gathered an enormous amount of literature dating back to the early 1940s—in fact, one going back to 1926—including psychiatric case studies clearly outlining the overrepresentation of adopted children in mental health facilities and the emotional harm and confusion created by adoption separation. I refer to Origins submissions 3, 3a and 3b presented to this inquiry, which were researched by Wendy Jacobs with assistance from Lilly Arthur.

We have observed the high incidence of suicide in adopted males and attempted suicide in mothers. Although no research has yet been conducted into this issue, it has not gone unnoticed that the peak suicide rate in Australian women coincided directly with the peak adoption period. During the last three years I have spoken to more than 2,000 callers—some being one-off calls and others becoming full members—and have observed that, in general, and almost without exception, the mother's interview and confinement process have followed

a routine pattern. The treatment I have referred to was systematic Australia-wide, with only a few slight variables depending on the hospital concerned.

The Hon. Dr A. CHESTERFIELD-EVANS: With regard to past adoption practices, what are your members telling you about the practice of not allowing the mother to view the child after delivery and the use of a pillow or sheet to ensure that the mother did not see the child?

Ms WELLFARE: Probably the best way to begin to answer this question is to quote from Pamela Thorne nee Roberts, who was the head social worker in charge at the Women's Hospital, Crown Street, between 1964 and 1976, policy maker for New South Wales adoption regulations and chairperson of the Standing Committee for Adoption in the early 1970s. As witness for the State in the recent case of *W v The State of New South Wales*, Mrs Thorne explained under oath that the routine adoption practice was to "forbid eye contact between mother and child to prevent bonding". Mrs Thorne went on to explain how the unmarried mother's medical chart would be marked with the codes “UB-”, that is “UB minus”, and “BFA", meaning "baby for adoption". Unbeknown to the mother, this code was used as a routine guide for the labour ward staff. Mrs Thorne explained that this code had three functions.

The first was to ensure that the mother did not see her child. My inclusion there is that policy dictated that eye contact between mother and child was forbidden to prevent bonding. Mrs Thorne went on to say that the second function was regarding the location of mother and child postnatally, where the mother would be separated from her child by being transported by ambulance, heavily sedated, to another hospital without her baby. The third point, according to Mrs Thorne, pertained to the type of medication to be administered to the unmarried mother. According to our medical records, she was inferring that specifically 200 milligrams of sodium pentobarbitone was routinely administered almost immediately upon birth and stilboestrol was administered at the same time to begin suppressing lactation; this is while the mother was still in the labour ward.

Mrs Thorne's explanations coincide directly with the experiences routinely conducted on every unmarried mother in Crown Street and almost every other hospital in this State. We are not aware of any mother who was advised of the medication or treatment that she was to endure and was therefore denied her legal right as a patient to refuse such treatment. It was routine adoption practice to interfere in the birthing process between the mother and child by snatching the newborn from its mother's womb while she was entering the third stage of labour and whisked away and hidden while the mother was still bound by stirrups, heavily sedated, some being shackled by the wrists to the bed, as per the video that we have offered this inquiry, whilst awaiting the expulsion of the placenta.

To prevent the mother from having eye contact with her newborn, measures used to prevent bonding included placing a sheet on the mother's chest or at her face, holding a sheet up to obstruct her view, turning lights down or off, using blind folds, turning the mother's head away, standing in her way of vision, rushing the baby out of the labour room immediately upon birth, using heavy sedation during labour, holding the mother's shoulders down to prevent her from lifting herself up, pushing the mother back down if she sat up, and shackling the mother to the bedhead, as per the 1971 video included in the submission. The baby would then be hidden from its mother within the confines of the hospital. In smaller hospitals, it would be in staff rooms, linen closets, or locked or hidden nurseries, denying mothers free access to their

babies. In Crown Street, for example, the mother would be transported by ambulance to another location, at a time when she was still the sole legal guardian of her child and she could not legally be denied access to the child.

During this post-confinement period methods of keeping the mother at bay varied. Directives came from a collusive agreement between the adoption agency and the hospital to which the unmarried mother's home was affiliated. During the 1960s the mother was usually forbidden to see her baby at all. Some were permitted to see their babies once—but only after they had signed the consent to adopt—although they were not allowed to touch or feed their babies. We have that evidence in the Carramar video that is presented to this inquiry, which is a 1966 video that we uncovered from the Carramar girls experience; that was the Anglican Adoption Agency.

By the 1970s the adoption industry decided that the mother could cuddle her baby once to say goodbye, but only under strict supervision and guarded by hospital staff, in case she got a grand idea to run off with her child. Mothers would be pushed out of the nurseries. In fact, one told me that she was dragged back to her bed by the hair. One young mother managed to grab her own baby, only to have it wrenched from her breast with the nurse running down the corridor while the mother was injected with a sedative; that was the Salvation Army in 1973.

If a mother was found loitering around the nursery window she would be chastised and sent back to bed. Upon obtaining their prescribed information, many mothers have come to realise that they had been shown the wrong baby after signing the consent to prevent bonding. As their records indicate, the baby they saw was not at that location at all. Others were told their baby had died at birth. We believe this was part of the rapid adoption process that was widely accepted by the obstetricians. They preferred that, because the mother of a stillborn child could immediately breastfeed the alien child. These women were told their babies had died at birth only to have the dead baby turn up decades later after being adopted.

Mothers recall being told their dead baby was buried in the rose garden of the hospital grounds. One asked to see her dead baby a day after birth, to be told the baby was too decomposed to view it, and on it goes. These last claims, by the way, come from the Newcastle area. That is where most of those are coming from. Ironically, it is interesting to note that although women were treated as animals without human instincts, at a Sydney staff hospital meeting in the late 1960s a psychiatrist had to remind the staff that unmarried mothers were not a lower order of human beings or animals who lived by our instincts, that we were just human beings like themselves.

The Hon. Dr A. CHESTERFIELD-EVANS: You have touched on the subject of the use of drugs before, during and after birth.

Ms WELLFARE: Yes, I have that coming up. Many women claim they do not recall too much about their hospital confinement period, and it is not until they obtain their medical records that they realise their lack of memory is caused not only by the mind blocking of the trauma and of the separation from their baby, but also by the heavy level of sedation they had received. Mothers were usually heavily sedated during labour with what was known as lytic cocktails, used medically to obliterate feelings. These consisted of a combination of pethedine, codeine and psychotropic hypnotic barbiturates, such as pentobarbitone, sparine, largactyl,

phenobarb, sodium amytil, morphine, heroin, chlorylhydrate and bomadom, which would be administered during the post-confinement period until consent was taken.

The letters "PRN" stamped on the patient's medical drug sheet indicated that the list of drugs had been authorised by the doctor and could be used for sedation as required. Drugging the mother, as it turns out, causes pharmaceutical depression of the mother or baby, or both, causing respiratory depression, and interferes with the bonding and the initiation of breastfeeding. These drugs had a dual purpose, I dare say. Lactation was suppressed directly after birth, by using the synthetic hormone DES stilboestrol—administered usually in three-times the legal dosage and known since 1971 to be carcinogenic—and/or by the method of breast binding. Some women needed both.

The process of suppressing lactation routinely commenced without asking the mother if she was keeping her baby, indicating a pre-conceived presumption and plan to remove her baby from her. All hospital treatment was carried out without written authority or consent from the mother. Most mothers would still not know they had been administered this hormone, nor would they be aware of the now-known and potential life-threatening life risk to themselves or to their subsequent children in having been administered Stilboestrol. I might say here that any woman who has come in contact with Stilboestrol is at this stage in her life not to use hormone replacement therapy because she is now at risk of cancer. This comes from an American drug institution in the recent few years.

The Hon. Dr A. CHESTERFIELD-EVANS: Would you now refer to the process involved in taking consent for adoption?

Ms WELLFARE: In 1952 the World Health Organisation recommended that a mother should be assisted to keep her child in the child's best interests, and the New South Wales Government took on those recommendations and endorsed the provision of financial assistance and other facilities to enable the mother to keep her child. We are talking about 1953. The book *Children in Need*, written by Donald McLean, was endorsed by the then Deputy Premier, Mr Heffron. That book claimed that as part of the regulations in relation to the Child Welfare Act to make sure there was no misunderstanding on the part of the mother, prior to taking consent the mother was to be advised of all facilities to enable her to keep her child.

This included financial assistance under section 27A (aid) of the Child Welfare Act, foster care, various child minding facilities, State wardship until she was better placed to care for her child; and, as a result of the Mace-Murray case, because of the debacle that split the nation, the mother was also to be advised of the risk of dire future regret and the risk of psychological harm if she was to decide upon adoption. I will now go into the actual process that was supposed to happen. According to their own manuals on adoption practices—which I believe nobody has bothered to read for over 40 years—it was and still is the responsibility of both the social worker, who was called the almoner and counsels the mother prior to delivery, and the allotment officer, who takes the consent after delivery, to counsel her wisely on her options and alternatives to adoption.

According to a report presented to the former Attorney General, Mr Frank Walker, by the former Minister for Community Services, Mr Rex Jackson, this included warning the mother of the risk of dire future regret if she was considering adoption. In 1965 *Hansard* reports how

the unmarried mother is to be warned of the psychological consequences inherent in adoption separation. That was back in 1965, yet the adoption industry continues to systematically disregard its duty of care today, in 1998. Possibly the most damning of our discoveries is that the adoption industry has never been ignorant but has been fully aware of this psychological harm that the industry has inflicted upon its clients, with Pamela Roberts declaring in my court case under oath in her written statement that health authorities had been fully aware of the potential for harm in forcing the mother to surrender her child for adoption in 1968.

The child welfare regulations, by the way, clearly emphasise that only if a mother insists upon adoption after all available alternatives and options have been made clear to her, was the adoption procedure to commence. Her consent was not to be taken unless she was firm in her decision. These regulations have never been repealed and yet none of the abovementioned regulations have ever been followed.

The Hon. Dr A. CHESTERFIELD-EVANS: Will you talk about the invasion of the birth mother's privacy before, during and after delivery?

Ms WELLFARE: I have not actually finished my answer. Instead, mothers were systematically denied all knowledge of their legal rights and options, with adoption being promoted as the only course of action available to her, which denied her the right to make any choice at all. Although the baby had already been taken at birth and hidden from its mother, routine consent-taking procedures dictated that some time after the birth, although she had been forbidden by regulations from seeing her child, a mother would be visited by a social worker while she remained conveniently traumatised and sedated. A district officer would then be called upon to take the mother's consent, to make the process look legal, whereas the baby had already been stolen five days earlier than the consent.

Put simply, what occurred as far as the history of practices is concerned is that you cannot deny a mother her legal right to make any choice, forbid her to see her own baby as per hospital practice, hide her baby from her within the confines of the hospital, keep her sedated until the consent is taken and not call it abduction. That is the bottom line with all of this. I would like to go one step further. In the Women's Hospital, Crown Street, the mother's medical chart would be marked with the term "socially cleared" upon having taken the consent, or "awaiting social clearance" prior to taking the consent. The term was an indication that consent had been signed, the mother had been socially cleared and was then free to leave the hospital and resume her place in society. She would be forbidden access to her street clothes until that consent was signed.

If she attempted to discharge herself from hospital prior to being socially cleared she would be threatened with police arrest for abandoning her baby, although by law she could not be charged with abandonment unless she had had no contact with the child for a period of 12 months. We have quite a number of medical records which state "Do not call police. Mother will return" on such and such a date. As far as the men went in this regard, the police would be called to remove a persistent mother who tried to get her baby back from the agency within the legal time. One such example was a 17-year-old mother who in 1967 explained how she had been thrown into the back of a paddy wagon and threatened with gaol if she bothered the adoption agency again. The agency was the Catholic Adoption Agency.

Police were also used to extract a young father from the hospital, although he had the same legal right to see his child as any other father. Many were warned to keep away and others were bashed up by police for good measure. If the mother refused to sign, as many did, unless she had parental support her baby would be taken to an institution such as Scarba House where it would be kept until the mother could be harassed into signing or until the 12 months were up and her consent dispensed with anyway. If the unsupported mother could not be controlled and managed to leave the hospital with her baby, the department's own literature explains that if they provide such a girl with support she will come to see how difficult raising her baby will be and it should then be possible to eventually get the baby off her later. These words are from the department's own literature: they are not my words.

Regarding the invasion of the mother's privacy before, during and after delivery, one way was marking the unmarried mother's records with a code to announce her marital status and that her baby was to be adopted. The second was that although the Secrecy Act in 1967 dictated that no party to an adoption was to have knowledge of other parties to the adoption, the adopting parents have always been entitled to know the mother's name, whereas the mother was not given reciprocal rights. Adopting parents sometimes kept a watchful eye on the mother's progress through life and could have made contact whenever they wished. Mothers were also used as specimens for teaching purposes and could be called up from waiting patients at any time if an intern needed to clock up an induction as part of his training schedule, even if the mother's labour had not begun. Mothers were usually forbidden visitors in hospital and, most importantly, mothers who did manage to see and hold their babies after signing the consent, were never permitted to do so without being heavily guarded by hospital staff.

The Hon. Dr A. CHESTERFIELD-EVANS: Does Origins believe that mothers received adequate counselling or information regarding alternatives to adoption, before signing consent to adoption?

Ms WELLFARE: We have never come across any mother who had any idea that alternatives to adoption had been available prior to 1973 until they heard it from us. Nor have we come across any mother who has been warned of the psychological harm inherent in adoption separation. To the contrary, because quotas had to be filled, all counselling centred around giving the baby up in its best interests. If a mother was audacious enough to ask to keep her baby, she would be swiftly reprimanded for her cruelty and reminded not to be selfish. Although it has been generally assumed that financial assistance for unmarried mothers first became available when Mr Whitlam introduced the sole parent's benefit in 1973, that was not historically true. All Whitlam did was to advertise the already available benefit, give it its own name and bring it into line with the consumer price index.

So contemptuous is the industry of the mother's rights, even the New South Wales President of the AASW, Miss Jill Davidson, disputed one month ago in the *Newcastle Herald* that any benefit was available until the early 1970s. Even with this inquiry they could not be bothered to do their homework! Origins discovered the availability of financial assistance in that group's own literature. The availability of financial assistance, although it varied depending on the circumstances, was always apparently $1 less than the widow's pension.

Not only did we discover our rights to such assistance in the child welfare regulations of 1956—which clearly no-one has bothered to read for more than 40 years—but in the social

work and district officers training manual of 1958, the *Daily Telegraph* of 1965, the social service statistics for 1968, the 1969 social services eleventh national conference presented by Pamela Roberts, but also in their own social work journals. They outline the financial assistance, available day care facilities which gave the unmarried mother priority to enable her to have her child cared for while she worked, temporary accommodation and the right to apply for a Housing Commission accommodation—although there was at that time a three-year waiting list in 1968.

Also outlined are: assistance with obtaining maintenance from a child's father, a layette, special foods and formula where required and State wardship or foster care until the mother was better placed to care for her child. As we managed to discover this in the department's literature, it was obviously known to the department. But none of this information was ever made known to the unsupported mother prior to 1973. Although the apologists will defend themselves by declaring that either 60 per cent or 40 per cent of unmarried mothers kept their babies—depending on who is telling the story—of those who kept their babies, the majority were older mothers in stable de facto relationships, the very young who came from child welfare institutions and possibly knew their way around the child welfare system, and those who were supported by their parents. These provisions were implemented specifically to provide for the unmarried mother and her child who had no family support, yet those were the very mothers who were being denied these options.

The Hon. P. T. PRIMROSE: Clearly, you have already indicated your belief in relation to this matter, but I will ask you directly. Do you believe that any systematic, illegal or unethical behaviour took place in relation to adoption practices? If so, what practices do you consider were, first, unethical and, second, unlawful, and could you give examples?

Ms WELLFARE: I have a whole list here. I would like to start off with what I believe was the first big mistake the adoption industry made. It has entirely misinterpreted its own regulations and the law for all most 50 years. Firstly, under the Child Welfare Act, it was in the child's best interests to remain within its family. Provisions were introduced in the early 1950s to enable the unmarried mother to care for her own child. Therefore, in having promoted adoption over assisting the mother to keep her baby and not warning the mother of the potential harm that such a course of action may cause her, the Department of Child Welfare and its adoption agents have committed an offence which not only breaches their regulations and adoption legislation but also constitutes a breach of duty, unconscionable behaviour and a breach of statutory law.

The next point needs to be fully understood. It is: the reason very little is mentioned about the natural mother in either the Child Welfare Act or the Adoption of Children Act other than the protection clauses which explain how the mother's consent cannot be obtained by coercion, duress or undue influence is because in law, the Adoption of Children Act does not come into play until a mother has signed a consent to adoption. This means that the period prior to signing a consent, that is, the process surrounding a mother's pregnancy, birth experience or post-confinement period, does not come under the jurisdiction of the meaning of any adoption Act. The natural mother, by law, whatever her age or marital status, is the sole legal guardian of her child, has the same legal rights to her child as any other mother giving birth and “could” not be legally separated from or be denied access to her newborn child at any time. Therefore, under administrative law, any hospital which introduced practices that

discriminated against unmarried mothers has gone beyond its powers, constituting not only malpractice but also a breach of ultra vires law.

In relation to unethical practices and the question of what is unethical and unlawful in this instance, it is difficult to differentiate. We understand that, while it is unethical to deprive a mother of her alternatives and options to adoption, it creates an unlawful situation which denies the mother her legal right to make a fully-informed decision based on her legally available options, as regulations and law dictate. With regard to the Department of Community Services, these are a few of the points I have made. To systematically deny mothers all knowledge of their legal rights and options contravenes ultra vires law, breach of duty of care, unconscionable behaviour, breach of statutory law and elements of conspiracy to defraud. Using both overt and covert methods of coercion to obtain consent by acts of misrepresentation, that is, using the term that adoption is in the child's best interest, constitutes undue influence, coercion, duress and unconscionable behaviour and are criminal offences.

Not informing mothers of the 30-day revocation period constitutes unconscionable behaviour, fraud, breach of duty of care and breach of statutory standards. Expecting unskilled mothers, that is, minors, to sign legal documents without an adult advocate present and without the mothers understanding the meaning or interpretation of the documents they are signing constitutes a breach of statutory law. Preventing mothers from their legal right to revoke their consent within the legally permitted time by advising them that the baby had already been placed, constitutes an element of conspiracy to defraud, unconscionable behaviour and is an ultra vires act. Promising that which can never in effect be guaranteed, that is, an ideal life for the child being adopted into a two-parent family, constitutes misrepresentation and unconscionable behaviour.

In regard to hospital practice, introducing the inhumane practice of forbidding eye contact between mother and child to prevent bonding constitutes a violation of human rights, is ultra vires and is a breach of duty of care. Interfering in the primal act of giving birth between a mother and child by removing the child prior to the completion of the birthing process and hiding babies from their mothers even though they were the sole legal guardians of their children constitutes unconscionable behaviour, an ultra vires act, an element of conspiracy to defraud, a violation of human rights, a criminal offence under section 91, taking child with intent to steal, violation of statutory law, violation of natural law, breach of duty and, under section 90A, is kidnapping under the Crimes Act. Forbidding mothers to see or touch their babies until their consent is taken constitutes an ultra vires act, coercion, violation of human rights, violation of statutory rights, duress and an element of conspiracy to defraud.

Sedating mothers during labour and the post-confinement period with mind-altering psychotropic barbiturates constitutes a criminal offence under section 38 of the Crimes Act, unconscionable behaviour and conspiracy to defraud. Preventing lactation by the use of the synthetic hormone stilboestrol or breast-binding without prior consent from the mother constitutes common assault, trespass to the person, violation of natural law and violation of human rights. Transporting mothers by ambulance whilst heavily sedated to different hospitals without their babies and without their permission constitutes false imprisonment under common law and an element of conspiracy to defraud. Informing a mother that her baby had died when it in fact had been adopted constitutes fraudulent misrepresentation, unconscionable behaviour, an element of conspiracy to defraud, section 91 taking child with intent to steal, section 91A kidnapping under the Crimes Act, violation of human rights and

intent to deprive the owner permanently.

A social worker failing to inform a mother of a conflict of interest in her dual role of serving the mother and the prospective adopters simultaneously is a breach of professional ethics where no statute of limitations in the court of equity applies. No statute of limitations applies under the Crimes Act as well. The bottom line is failing to have any proper regard for natural law and prevailing domestic and international principles concerning the advancement and protection of human rights.

CHAIRMAN: We have been told that mothers were not encouraged to speak about the loss of their children through adoption and they were advised to get on with their lives. You heard some talk about that earlier this morning. While it has since been acknowledged that this advice was inappropriate, can you tell us what you understand was the long-term impact of the advice?

Ms WELLFARE: Yes. It is understood that when a person is subjected to an unnatural trauma the sound mind protects itself by manifesting a false self, essentially in order to remain sane. Although it is correct that we were encouraged to get on with our lives and to forget what had been done to us, our silence has not necessarily been a voluntary response, but an involuntary reaction, where it becomes impossible to speak about it because it has become unspeakable and it is an unspeakable act. The loss of a living part of oneself creates in the mother a level of trauma and anxiety so great that the mother must manifest a false self in order to survive. The experience essentially becomes "Something that happened to someone I used to be." The mother blocks the experience. The mother dissociates as soon as the baby is taken at birth. She remains suspended and, therefore, silent unless a trigger event occurs and forces her mind to face her loss.

This is why it is known that, as with every other reaction to trauma, the mother regresses back emotionally to the age she was when she lost her baby. In many instances her hormones and body react in the same way as they were meant to had her birthing experience not been interfered with. The found child connecting to his or her reality does exactly the same upon reunion. It regresses back to a childlike state. We believe that this is because of the interruption of the birthing process. During this period of dissociation the mother is trapped into a pathological way of coping with affects and remains distracted and distant from her emotions. She exists on a level of anxiety created by the loss of her child and out of her unconscious terror and fear of annihilation she will suffer if she is forced to face her loss. Her ability to remain sane relies on her mind's ability to keep the secret of her experience from herself.

Mothers are being diagnosed today with severe dissociative disorders, pathogenic grief, learned helplessness disfunctions, psychogenic amnesia, severe post-traumatic stress disorders, chronic depression and anxiety disorders. Many use alcohol and antidepresssants as a coping mechanism and have done so for decades. Many attempt suicide, as with the response to trauma. A mother loses her fear of death. That is apparently an understanding of anyone who has gone through a post-traumatic experience. People lose their fear of dying. Because mothers were told to go away and forget their experience they do not attribute their emotional problems to the loss of their babies and their condition leads to being continually misdiagnosed by the health profession. The same applies to adopted children.

CHAIRMAN: You would have heard Ms McDonald refer earlier to the statistical data which is available on the percentage of revocations that have occurred. She said that for New South Wales the figure was 10 per cent for 1973-74. She gave some other figures as well. Can either of you comment on that data? What do you think it might mean in relation to the psychological handling of women?

Ms COLE: I have spoken to many women but I have never spoken to a woman who has tried to revoke within the 30-day period who has got her baby back. I can only assume that Margaret McDonald was referring to situations where the mother had strong family support and the parents or grandparents went back with the mother and assisted her in getting the baby back. The women that I have spoken to have all said that they tried to get the baby back within the 30-day period, only to be told, "Sorry, the baby has already been adopted."

Ms WELLFARE: Whereas what they were interpreting as placement ... for instance, the form 9 (request to make arrangements), actually states clearly in legislation, that the mother has to understand that she has 30 days, or before an adoption order is made through the Supreme Court, to revoke her consent. What seems to have been conveniently omitted is the word *Order* (from the document), which gives the document a different meaning that could be misunderstood by hospital staff. An order can only be made through the Supreme Court. By reading that, hospital staff could imply that the placement of a child meant the adoption had occurred, whereas that placement was only an interim foster placement that was not legally binding.

We were advised by Wendy Williamson, who was second in charge at DOCS a few years ago, that if the mother revoked the baby had to be returned to her within 48 hours. We understand that the reasons mothers did not get their babies back upon revoking were: first, that the whole process was designed to bond the baby with the infertile couple to create an "as if born to you" situation. One of the reasons why we believe rapid adoption was so favoured and why there is potential for major illegalities is that the mother could not have been advised of her legal rights if her baby had been placed with a woman whose child was stillborn. They would not dare risk taking the child off a woman whose natural child had recently died.

Ms COLE: When I was 16 I had my baby stolen. I went back to the social worker three months later. I was extremely distressed and I asked about my baby, only to be told that I should have got on with my life as everybody else had. Now, my understanding is that in that period of time I was still a minor until the age of 21, so how legal and binding was my signature? I mean, even though I was drugged and bullied, besides that there was just the fact that I was 16 and I had gone back three months later, to be told there is nothing you can do.

CHAIRMAN: Certainly the Committee will be seeking legal advice on that issue and many others. Still on that revocation issue, does that 10 percent figure strike you as high or low?

Ms WELLFARE: It does not strike me as anything because, I mean, the mothers just were not being given their legal rights, so it means little, that percentage. The vast majority of women I know did not know there was a revocation. I found out there was a revocation period in 1992. The vast majority did not know. Prior to the 1960s and 1970s the vast majority that I have come across did not know there was that period. Even in Chris's case, for instance, when she went back she wouldn't have necessarily known that the revocation period

would have been 30 days because she went back a few months later.

Ms COLE: And not only that, we were not given any instruction, for instance, on how to go about it. Who do you go and see? I mean, a 30-day period—so what! What does that mean? Who do you actually go to revoke your consent?

Ms WELLFARE: That is absolutely right. That just raised another point, that we were supposed to be advised that we could revoke by applying in writing to the Equity Division of the Supreme Court and yet we—not me—women were told to ring the agency up and so they would ring the agency up only to be thwarted in what they actually wanted to do. As soon as they rang the agency the agency would say, “I am sorry dear, you're too late. It's too late, and too bad, the baby has already gone.”

Ms COLE: Yes.

CHAIRMAN: We have heard a lot of evidence to that effect.

Ms WELLFARE: Yes. The interesting fact is even if they placed the baby, that law was put into place as protection for the mother. Essentially, we believe that that revocation period was used as a ploy to get the mother's signature, and that effectively it did not exist.

Ms COLE: Yes.

Ms WELLFARE: Effectively the revocation period did not exist; unless the mother had support from her parents, and then it was easy to get the baby back.

CHAIRMAN: Ms Cole, your initial response was to stress that you thought that where revocations occurred it was where the young woman had support from parents and so on?

Ms COLE: Absolutely.

CHAIRMAN: What about the fathers?

Ms COLE: I believe the fathers were denied their legal rights because--

CHAIRMAN: Would you think that revocations occurred because the father was willing to provide?

Ms COLE: No. The fathers were actively discouraged from visiting the mothers. They were hounded out of the hospitals. Mothers were forbidden to see their partners. Fathers were often threatened with carnal knowledge if they tried to help the mothers. The fathers, even though they would have had the same legal rights as any other father before the consent was signed, were not allowed usually even in the hospital; and, if they were, they certainly were not allowed to see, hold or touch their own baby.

Ms WELLFARE: That is right. And there's been a lot about fathers already in these questions and what seems to be indicated is that if the mother did not put the father's name on the birth certificate it wouldn't remain there. That is not the case. The father had to apparently sign a stat dec claiming paternity before his name could be placed on the birth

certificate, but once his name was placed on it then they had to have his signature as well—and they actively discouraged the boys. In fact, in 1976 in the first National Adoption Conference the Director of the Catholic Welfare Commission, Father Davoren, explained that the father had the same legal right as any other father had to see his child, but the hospitals and the adoption process was making sure the mother had no support because if the father was permitted to come and see the mother and see his baby he would be less likely to allow the separation and he would be more likely to possibly even marry the girl, but they were being forbidden to see the child.

CHAIRMAN: Just to return to our last two formal questions. What measures might assist people experiencing distress as a result of past adoption practices?

Ms WELLFARE: I am afraid I have a list.

CHAIRMAN: Do you want to table your list?

Ms WELLFARE: No. I think people need to hear it.

CHAIRMAN: I want to run through it, but for the sake of Hansard would you table some of your earlier material, names of drugs, and so on?

Ms WELLFARE: All of this is in the Origin's submission, more or less. While we believe that no mother has been provided with her legal and human rights in relation to her adoption experience, we do not profess to speak on behalf of every mother with regard to their requirement for justice and for personal healing. There will be some for whom a sincere apology and acknowledgement of past practices will be sufficient. Others will find some relief to know their children are made aware of the separation practices from their mothers. There will be others for whom that will not suffice and they may wish to take action through the Supreme Court, while others may wish to take up their right to lay charges under the Crimes Act, bypassing the Statute of Limitations; and others may wish to overturn the child's adoption based on improper consent.

This is a very serious legal issue that has potentially very serious consequences for many. So for the sake of the mothers contributing to this inquiry, and their displaced children, for the mothers waiting for the outcome of this inquiry in other States and who seek their own justice, and for future, for those mothers who remain too traumatised yet to speak, it is an issue we cannot and have no intention of taking lightly. We, therefore, request that avenues be made available for discussion with the Origins Committee and other appropriate parties for discussion into implementation of our following requirements:

We require an arrangement for provision to provide regular seminars and workshops accredited by the Department of Community Services and Health Department to educate and inform all mental health workers and other health workers of the nature of emotional implications resulting from the mother's and child's experience; and provision of weekend, week long and monthly deprogramming trauma recovery research and respite centres to be made available for those in need of in-depth recovery, where required, the same as the trauma centres set up for Vietnam vets. Our trauma is similar from a woman's point of view.

We require provision of State-wide financial and material support to enable the development of self-help organisations in city, regional and outlying areas around the State; a review into and improvement of all counselling procedures; a State-wide and national campaign to remove the stigma put on mothers who surrendered children for adoption in the past, including the removal of the stigma inflicted upon our children in having been classified as unwanted children; and a full national judicial inquiry into past adoption practices and/or a State-wide criminal investigation under the New South Wales Crimes Act, 1900; and an overturning of the Statute of Limitations. We require a full and sincere apology to all mothers and children who have been separated by adoption from the Australian Association of Social Workers, charitable organisations, licensed adoption agencies, the medical profession, the Nursing Association, the Department of Community Services and the New South Wales Health Department.

We seek reparation, and the reinstatement of all original birth certificates.There should be full disclosure of the truth regarding the past adoption practices as an Act of Parliament to begin the official rewriting of adoption history. We require to have the separation of mother and child at birth officially recognised as a severe and damaging trauma to both. There should be full research and disclosure into adoption consequences including the suicide rates of adopted children and mothers and also the mental health implications to both mothers and children. We want disclaimer stickers posted on all past historical adoption literature and case work studies found in state libraries which depict improper adoption facts based on the promotion of adoption myth to ensure that such inhumanity is never allowed to be repeated.

We require the deregistration of all adoption agency and agent licences for non-compliance with the terms and conditions of their professional licence issued by the Department of Community Services for their failure to comply with the terms of the Adoption of Children Act, the Child Welfare Act, failing to comply with their own regulations, failing to apply a professional standard of duty of care as a professional adoption service to the community. We want accountability in the failure of the relevant director-generals of the child welfare departments and its alternative and subsequent names to police the goings-on of its own department and licensed private adoption agencies as licensing regulations dictated. We also require accountability on the part of the Health Department and/or other responsible persons in its failure to police negligent and criminal hospital administration regulations and practices carried out by licensed hospital staff. Thank you.

Ms COLE: Yes.

CHAIRMAN: In many ways you have answered the last question. Do you think an apology made by the relevant government agencies would assist these women? You have gone beyond government agencies.

Ms COLE: I would like to add to that because I have some documents to table regarding that as well and I wanted to address some of the issues that were raised last Thursday. May I proceed?

CHAIRMAN: Yes.

Ms COLE: An apology from the government agencies and the religious organisations who participated in the inhumane and barbaric practice of systematically separating mothers

and their babies is a first step in assisting the healing process for the women and children affected. An apology would not only acknowledge and validate the intense feelings of pain and injustice experienced by women who have been victims of past atrocities, it would begin to alleviate the feelings of isolation they have been condemned to for decades.

For a woman to go through the experience of having her baby stolen because she was judged unworthy has a devastating and lifelong impact on every aspect of her being. Reducing the barbaric act of stealing a child from its mother, and giving it to strangers or institutionalising it, to statements like “It was the societal mores of the time” or “It was done out of kindness”only prolongs our anguish and mental torment, invalidates our experience and continues our feelings of isolation. How can we feel part of a society that sanctions such an evil with compassionless cliches and buck-passing? I am sure that future generations will judge this shameful and cruel part of our history as not only criminal, but a form of insanity. I believe it is insane to steal a mother's baby and expect her to go home, get on with her life and forget she ever gave birth.

Those that have condemned us to reside in this living hell have a responsibility to alleviate some of the distress by apologising at least for the role they played. If Germany had won the war the Holocaust may also have been reduced to the statement that it was the societal mores of that time.What happened to us mothers was not done out of any kindness. No mother I have spoken to was treated with even human dignity, let alone kindness. Common sense would dictate there was no kindness in denying us the right to see, hold or touch our babies, then giving them to strangers and denying us knowledge of whether they were dead or alive. This is akin to kidnap.

Common sense would dictate that there was no kindness in drugging or in verbally and physically abusing us. Common sense would dictate that using coercion, duress and brainwashing for the sole purpose of procuring our children when we were absolutely vulnerable could in no way, shape or form be interpreted as kindness. Forbidding even the human dignity of eye contact with our babies whilst we were still the sole legal guardians—because our files were coded "Baby for adoption" while we were pregnant—not only presumed consent and was illegal, but it defied the argument that denying us access to our children was for our benefit.

To understand the malicious intent on which the fledgling social work profession in this country was based one has only to read its literature. Single mothers were seen as less than human, moral deviates or mentally impaired. Those involved in the adoption industry saw themselves above the law and morally above us, the victims, and therefore entitled to steal our babies. Recently I participated in the submission to this inquiry by the Committee on Adoption and Permanent Care. I asked the Committee to support a recommendation for an apology to mothers. The Committee initially was reluctant, but Mr Harvey Milson, Director of Adoptions for the Department of Community Services stated, "How hard is it to say I am sorry."

His support resulted in the requested recommendation being approved. I would like to table the minutes of the Committee's last two meetings. I have been deeply saddened to hear Mr Milson now publicly stating there is no need for an apology. I must ask: why has he changed his position? Last Thursday in this House the President of the Australian Association of Social Workers, Ms Jill Davidson, stated that she did not feel it was appropriate for her to apologise. This view is not shared by all social workers. I would like to table two letters urging

a strong and clear apology to all the women the organisation has irrevocably harmed because of its past practices. Maybe the reasons Davidson has declined the opportunity to apologise is because of this comment:

> I am very aware that much defensiveness and denial still exists within government departments, and among some members of the profession who may fear that legal action could be taken against them if they admit to some of their past practices in adoption.

The letter also reveals that the author was aware that her client was "offered no assistance during that time with information to enable an informed choice about her options and had no knowledge of the pension which was available". Ms Davidson spoke at length about the part social work played assisting young mothers in realising autonomy yet the contents of this letter paint a very different picture. It stated:

> AASW needs to take an ethical position on this issue which clearly accepts and validates the disempowerment and loss of self-determination experienced by natural mothers, and the role which social work has played in helping this to occur.

She also asks that:

> The AASW formally offer an apology to natural mothers for the part social workers have played in causing hurts and injustices which have denied them self-determination . . .

She requests that apologies be written. This second letter written to Ms Jill Davidson also pleads for an apology to be given as follows:

> . . . for the profession that obviously had failed so many women and their children both by acts of commission and omission. For example, by too often failing to tell individual women what their full entitlements were and for too long collecting a salary by participating in and failing to challenge a system that inflicted so much pain.

She goes on to talk about others involved in the systematic abuses of mothers as follows:

> The district officers who seemed not to care if the adoption consent taken was informed or otherwise, the nurses who held pillows over the mother's faces, the matrons who wrote in the medical records "under no circumstances is this woman to see her child" . . . the social worker's contribution to people's misery was significant, even if in the end it did act, after its conscience was pricked or educated by the many brave people who had been the victim of such a system, spoke out—

not as was alluded to last Thursday that it was only after research dictated was change implemented. Last Thursday I sat in this House while the representative for the Department of Health decided its past abusive actions towards mothers did not warrant an apology even though its own circular sent to all hospitals across New South Wales warned medical staff that they were contravening the Adoption of Children Act on both legal and mental health grounds and, additionally, as stated above professionals, such as social workers, were well aware of the abuses taking place in the hospitals.

I would also like to make the comment that one of the main excuses from the representatives of all these departments was they acted out of ignorance. I would dispute this in this strongest possible terms. It has been well known by the professionals since the 1940s of the psychological harm occasioned to a child removed from its mother and from the 1950s of the psychological damage inflicted on mothers. They have always been aware of the intensive pain, grief and loss the mother suffers. To conclude, I agree with a member of the social worker profession who stated:

> . . . an apology as official acknowledgment of what has been done, as for many, without this, healing or reconciliation are still just not possible.

Personally as a mother who was treated like a leper, systematically drugged, used as a guinea pig for trainee doctors, had my baby kidnapped at birth and then hidden, moved miles away from my child where I was kept chemically incarcerated before being bullied into signing a consent and then having "socially cleared" written on my medical records, condemned to live a tormented anguish that only a mother who is left in the hell of never knowing where the baby she birthed has gone followed by the endless grieving of all the years stolen from my daughter and me, I do not believe an apology is asking too much.

It is a cowardly and despicable act that those bodies who appeared before the Committee last week, who were entrenched in a system that advertised our children as unwanted while at the same time denying us our legal rights or any alternatives to adoption, and who are given the opportunity to come clean and participate in a process of reconciliation and healing instead decide to cruelly wash their hands of us, like Herod, and have neither the decency nor compassion to apologise.

We must not forget that Australia is a signatory to the United Nations charter and as such has a legal duty to own up to the barbaric treatment inflicted on young mothers and the babies that were ripped from our wombs. The treatment parallels that of Argentina. Natural and civil laws have been violated. There is an obligation on the relevant bodies not only to apologise for these monstrous acts but to carry out the appropriate investigation to make those responsible accountable.

The Hon P. T. PRIMROSE: In asking this question I make it clear that I am not suggesting this is your responsibility. You have raised a number of matters in relation to criminality. Can you provide any information? Have any attempts been made to have the matters prosecuted and, if so, what has been the outcome? Have attempts been frustrated?

Ms WELLFARE: I took action three times with the Supreme Court to try to overturn the statute of limitations through the Public Interest Advocacy Centre and we did not get an opportunity to present our evidence because the judge, in all three accounts, misrepresented the evidence. He avoided presenting stuff, misinterpreted the days and I pretty well got shafted by the courts.

The Hon P. T. PRIMROSE: As opposed to a private prosecution, if these matters have been raised with statutory officers, what has been the response from officers such as the Director of Public Prosecutions?

Ms WELLFARE: Of people we have got the advice from?

Ms COLE: The big difficulty has been overturning the statute of limitations.

Ms WELLFARE: We have stepped past that because we realised five years ago when I started my case that we were in the civil courts and they could stop me that way. We could take it through the criminal courts, which we do not necessarily want to if we do not have to. We know there is no statute of limitations on the Crimes Act nor in the court of equity, but this is just further advice. We have learned more as we have gone along on where we stand on this. No mother takes too kindly to having her child taken from her and to find out almost 25

years later that it was illegal, that they were not allowed to do it—

Ms COLE: We have spent the last four years researching quite extensively a lot of the stuff we are bringing up. When you are 16, 17 or 18 you go to a public hospital and do not expect the so-called professionals to be acting illegally. When I spoke to a lawyer at the Law Reform Commission and said, "How could this have possibly gone on for decades? I cannot understand why it was not stopped", her response was simply that it had never been challenged in the way that we are challenging it.

The Hon. Dr A. CHESTERFIELD-EVANS: You were very disparaging of adoption agencies in the past. Do you think they are acting ethically now? Have adoption practices now improved both with regard to Australian practices and overseas adoption?

Ms WELLFARE: In relation to Australian adoptions, although back in 1982 they stopped the dreadful hospital practices that we were a party to or involved with, at the same time, and even though they are aware of the serious psychological harm not only caused to the mothers but to the children—very severe psychological problems adopted children have—they are not warning the mothers that the child may suffer this psychological harm.

This is a shocking breach of duty of care. People should be warned of the dire consequences to allow them to make that choice and to take that risk, if it is up to them. Once the consent is signed and the 30 days are over, the mother has no recourse. It is only after you have lost your baby that you realise what it is you have lost. Your baby has gone forever and the grief compounds itself from then on in. It is a total breach of duty of care not to warn the mother of the psychological harm. Look at breast implants.

The Hon. Dr A. CHESTERFIELD-EVANS: You are saying it is not happening now though?

Ms WELLFARE: No, they are still not warning the mothers. There is nothing in their literature to warn the mothers. They sit there and talk about self-determination. That is all very well and fine but the mother must be warned of the damage that this may cause not only to herself but to her child, not to mention the fact that the success of an adoption placement is based on having the child learn to hate its mother. The child must learn to hate its natural mother in order for the adoption placement to be seen as successful.

We hear this all the time. For instance, when one of our members lost her baby and three years later her sister adopted two, the adoptive parents were goading the seven- and nine-year-old children to make disparaging remarks around the dinner table like "I only want to see that woman once so I can spit in her face". He was talking about his own mother. This is common. We see it from our own children, the rage the adopted child has towards their natural mother irrespective of whether she was 12 or 14. They have a complete rage, saying "You gave me up, therefore I am angry with you and I hate you." The children are so full of pain and this just has to be stopped. A bit of reality must come into play and the myth has to go.

Ms COLE: Because adoption has been based on so many lies and myths that society generally has the view that adoption is a service; that there are unwanted children and loving couples save them. That is still the myth adoption is based on and, therefore, adoption is still

seen by general society as being something that is a service. The dark side is not seen; the mother's pain, suffering and the mental health damage has not been exposed and we are hoping from this inquiry that this is going to be exposed. You were also asking about intercountry adoption.

CHAIRMAN: The Committee is bound by the terms and reference and therefore we cannot inquire into that.

Ms COLE: If you are basing a system on myths and lies, as adoption has been based, that system will extend overseas.

(The witnesses withdrew)

(The Committee adjourned at 2.45 p.m.)