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The UNSW led project *No child should grow up like this* focused on 20th century out-of-home care leavers and their long-term life experiences. Within the study, a cohort of Aboriginal and Torres Strait Islander people were interviewed individually; some Aboriginal and Torres Strait Islander survivors of care participated in focus groups and many completed surveys. A number of Aboriginal and Torres Strait Islander participants generously engaged in more than one form of data collection. The research team is indebted to these participants. Their courage and generosity of spirit is manifest throughout this report, both in the re-visiting of painful and traumatic childhood experiences and in the sharing of current life challenges arising from a childhood spent in out-of-home care. Their depth of knowledge and their perseverance in bringing their issues of concern into the public arena have enriched this research. We express our thanks and hope this research and its recommendations play some small part in their continuing efforts to achieve justice and redress.

Aboriginal and Torres Strait Islander readers are advised that this report contains references to people who are no longer living. The report also presents direct narratives of trauma, neglect and abuse which will almost certainly prove distressing to many readers.

Approximately 25% of Critical Reference Group (CRG) membership comprised Aboriginal and Torres Strait Islander representatives of key Aboriginal Community Controlled organisations and Aboriginal scholars. Aboriginal representatives were brought into the CRG by invitation. A designated Aboriginal subgroup of the CRG made significant contributions in developing some of the research instruments and reviewing the draft research report, including development of recommendations from the findings. We are immensely grateful for their active and invaluable contribution.

As members of the subcommittee of the Critical Reference Group Dr Tiffany McComsey (Kinchela Boys Home Corporation) and Dr Paul Gray (AbSec) provided advisory input at strategic points in the research. We are especially grateful to them for their valuable time, feedback and expertise at all stages of the preparation of this report.

The wider research study *'No Child Should Grow up Like This'* was accomplished in close collaboration with research partners: Association of Children's

Welfare Agencies; Alliance for Forgotten Australians; Berry Street; Relationships Australia; Catholic Care Broken Bay and Micah Projects. We are indebted to our partners for their extraordinary leadership and unwavering commitment in supporting this research. We would like to acknowledge research partners and all members of the CRG for extending their expertise and providing critical commentary through all phases of the larger project.

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FOREWORD

It is hard to believe that it has been more than 20 years since the Human Rights and Equal Opportunity Commission, as we were then, delivered the foremost work to document the experiences of Australia's Stolen Generations, the Bringing them Home Report.

For the first time in the history of this nation, the voices and human rights abuses of Aboriginal and Torres Strait Islander peoples were laid bare for all to see. In a moment of national truth-telling, our country was forced to turn a mirror upon itself, to glean the horror of our forebears.

Whilst we know that First Peoples were not alone in the experience of historical removals, unique to the Stolen Generations, is the extent to which their experience represented part of a broader policy agenda that sought to expunge us from history. This is the ugly truth.

The testimony of members of the Stolen Generations as heard through the pages of Bringing them Home and now this report, are yet further evidence of survival in the face of enormous adversity. Every entry represents the experience of a parent or grandparent, a sibling and a child, whose innocence was lost to the annals of time but whose experiences live on in the lives of current and future generations of Australians.

I wish to sincerely thank UNSW for their efforts in putting together this report, which offers an important addendum to the existing catalogue of voices presented through Bringing them Home, The Healing Foundation and the work of Stolen Generations organisations across the country.

It is vital that our country continue to hear these stories and to grow our awareness of the life trajectories of Aboriginal and Torres Strait Islander peoples as a result of historical policies of removal. We know all too well that these policies have had an enduring effect on the lives of our people.

Whilst it is encouraging that our nation has seen fit to deliver a series of compensation schemes and a National Apology, we must continue to rise to meet the needs of an ageing and diverse Stolen Generations population.

I pay tribute to those members of the Stolen Generations who contributed to this report and who continue to advocate for a better future for themselves and Aboriginal and Torres Strait Islander children across the country.

It is through this truth telling that our people and our nation might begin to heal.

June Oscar,

Aboriginal and Torres Strait Islander Social Justice Commissioner

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This report details a component of the UNSW national *Long-term Outcomes of Forgotten Australians Study* reported in *No child should grow up like this* which explored the in-care and after-care experiences of adults who spent their childhoods in institutions and foster care during the period 1930 to 1989. The research adopts an inclusive approach eliciting the experiences and perceptions of all individuals, who as children, were separated from parents and taken into alternative care. In this report, the focus is on Stolen Generations survivors and other Aboriginal and Torres Strait Islander individuals who participated in the research. Stolen Generations survivors are Aboriginal and Torres Strait Islander peoples who were removed from family under policies that drove the forcible removal of Aboriginal and Torres Strait Islander children from the late 1800s to the 1970s (Human Rights and Equal Opportunity Commission [HREOC] 1997). While we adopt the term ‘care leavers’ throughout the report, we acknowledge that the term ‘care’ is problematic and has the potential to negate the painful and traumatic experiences of these communities. This is due to the neglectful and negative experiences that most people had while living in institutions and foster care during this time. We use the terms ‘care’ and ‘care leavers’ to refer to their situations, that is, raised away from their parents in institutions and foster care, and not the quality of that care.

This research, led by the University of New South Wales Faculty of Arts and Social Sciences, is funded by the Australian Research Council. It was conducted in partnership with the University of Chicago, University of York, and six community partners: the Alliance for Forgotten Australians, the Association of Child Welfare Agencies, Berry Street, Relationships Australia, Catholic Care Diocese of Broken Bay and Micah Projects.

BACKGROUND

State intervention targeting families and assuming control over children can be traced to the early period of colonisation with the establishment of orphanages, industrial schools and boarding out systems. There were significant child welfare concerns in the early period of colonisation when major economic, housing,

physical and mental health and social control issues dominated (van Krieken, 1991). Distinct protectionist and assimilationist policies specifically targeting Aboriginal children and their families developed from the earliest days of colonisation (HREOC, 1997).

The mid nineteenth century saw the establishment and continuing development of a range of institutions to respond to child welfare needs of this period arising from high rates of illegitimacy, death or incarceration of parents, parental mental illness and disability, and poverty.

The conditions experienced by children in these institutions were harsh. The level of care provided was inadequate and substandard. Some children were tragically accommodated in adult jails due to lack of space (Dickey, 1987). The record of *Bringing Them Home* (BTH) (HREOC, 1997) documents this act of cultural genocide detailing the trauma, abuse, and exploitation that they experienced and the lack of oversight and accountability in relation to the quality of care they received.

Care in the twentieth century

During the twentieth century, increasing numbers of children were placed in a range of institutions that were run by the States, religious groups and other organisations. Although earlier in the twentieth century there was a preference for foster care (‘or boarding out’ children with families as it was called then), “the drift of State children back to institutions increased in the 1930s and 1940s because of a lack of foster families. By the 1940s, most young children needing residential care were placed in institutions” (Senate Community Affairs References Committee, 2004, p. 19). In addition to Stolen Generations survivors, non-Aboriginal Australian-born children (referred to as the Forgotten Australians) and former Child Migrants were separated from parents and placed in the care of State or non-government organisations at alarming rates.

The Stolen Generations

A highly interventionist approach was adopted in the state’s treatment of Aboriginal and Torres Strait Islander children and families¹. From the 1880s there

¹ The research acknowledges the different uses of the terms Indigenous, Aboriginal etc. and that for the purposes of this report Aboriginal will be used throughout to identify those participants who identified as Stolen Generations survivors and/or Indigenous.

were deliberate attempts to intervene in the rearing of Aboriginal children. The major focus was on removing children from their Aboriginal communities. The forced removal of Aboriginal children from their families and placement in white families and institutions (Aboriginal specific, state, non-government and religious) is widely documented (Haebich, 2000; HREOC, 1997; O'Connor, 1993; Read, 1981; van Krieken, 1991). The history of intervention into the lives of Aboriginal people manifests a pervasive and intentional strategy of colonisation the tragic and enduring impacts of which on Aboriginal people have been held to account in previous reports (Community Services Commission, 2000; HREOC, 1997; RCIADIC, 1990). More recently adverse outcomes with respect to physical and mental health, employment and housing are documented (AIHW, 2018a).

It is estimated that during the period 1910-1970, between one in three and one in ten Aboriginal and Torres Strait Islander children were forcibly removed from their families and communities, equating to 25,000 children forcibly removed from their family and culture (HREOC, 1997). The practice of state removal of Aboriginal children was embedded in the context of racist, segregationist and assimilationist policies of that era. Children were separated from parents using compulsion (court orders), and duress through threats of charges of neglect if the removal was not agreed to (HREOC, 1997).

State removal of Aboriginal children and placement into institutions started from as early as 1814, when the first Native Institution at Parramatta was opened by Governor Macquarie in 1814 (Brook & Kohen, 1991; HREOC, 1997). Throughout the 1800s Aboriginal people were forced off their lands and onto missions. By 1890, a policy of removing 'mixed race' children was pursued, in order to assimilate them into the non-Indigenous population (HREOC, 1997). Aboriginal people increasingly came under the control of the various State-based groups. As Chisholm notes:

The establishment of the Aboriginal Protection Board 1883 in NSW which ensued from recognition of the impact of European occupation on Aboriginal people and the unquestioning sense of the superiority of the British culture and Christian religion led to the establishment of a separate system of Aboriginal Child Welfare (Chisholm, 1985, p.13).

In 1909, legislation was enacted in NSW that empowered the Aborigines Protection Board to apprehend and remove children without the endorsement of a magistrate. This was in contrast to decisions about white children. This racist legal

exceptionalism was only applied to Aboriginal children and did not appear in general child welfare laws of the same time (although in effect child welfare officers had extended powers to remove children from poor families found in a variety of circumstances because 'neglect' was so broadly defined). Between 1916 and 1940 one thousand six hundred children were subject to removal decisions by the Aboriginal Child Protection Board in NSW alone (van Krieken, 1991). Other States and Territories had similar Acts. In Queensland, a strong segregationist policy prevailed whereby the two races were to be kept separate physically, to protect 'the Aborigine' "from hopeless contamination and eventual extinction, as well as safeguard the purity of our own blood" (Chief Protector Report, 1919, p. 7 cited in Long, 1970, p. 97). There was also a dormitory system operating in Queensland missions where children were placed in separate dormitories away from their mothers (HREOC, 1997). In the Northern Territory, not only children but all Aboriginal women as well were placed under the control of the Chief Protector unless married and living with a husband 'who is substantially of European origin'. Furthermore, Aboriginal women had no right of guardianship over their own children (HREOC, 1997).

Specific legislation relating to the removal of Aboriginal children and their control and care determined by Aborigines Protection/Welfare Boards and other similar authorities existed in the states and territories until the 1960s when these legislative regimes started to be rescinded. While they existed there were, in effect two sets of laws in operation – one for Aboriginal children and another for all other children. Aboriginal children were impacted by both. Aboriginal children were removed by both Aboriginal specific welfare authorities (e.g. Aborigines Welfare Board of NSW) and child welfare authorities (e.g. Child Welfare Department NSW). These placements were at the discretion of the relevant authorities and illustrate the assimilationist and racist beliefs of the time. Aboriginal children were placed in Aboriginal specific institutions, and less frequently with Aboriginal foster carers and were also placed in non-Aboriginal specific care placements – government, non-government and religious institutions and also adopted and fostered by non-Indigenous families. Aboriginal children were determined to be in situations of 'neglect' more often given the conditions of poverty that affected many Aboriginal communities than by 'neglect' of their parents and extended family. Traditional Aboriginal systems of care involving community, kith and kinship networks were ignored by the authorities of the day, and frequently continue to be overlooked today in

the removal of Aboriginal children and their placement in non-Indigenous care, notwithstanding the Aboriginal Child Placement Principle (ACPP) in each state and territory's child protection legislation and the current focus on kinship care placement. Children were seemingly often removed on the basis of their Aboriginality alone and placed according to their perceived degree of Aboriginality. In NSW for example, while darker-skinned children were more likely to be placed in institutions such as Bomaderry Aboriginal Children's Home, Cootamundra Aboriginal Girls Training Home or Kinchela Aboriginal Boys Training Home, lighter-skinned children were more likely to be placed in mainstream institutions or in foster and adoptive situations (HREOC, 1997).

Under these policies and legislative regimes, Aboriginal children were determined to be in situations of 'neglect' however this 'neglect' was due to the conditions of poverty and extreme disadvantage that affected many Aboriginal communities (those on missions and reserves as well as those on the fringes of towns and cities and in some inner city areas) than by 'neglect' of their parents and extended family.

The policies with regard to coercive intervention with Aboriginal children and families involved the imposition of alien norms and values in 'questionable attempts at assimilation' (van Krieken, 1991, p.109). The Senate Standing Committee on Social Welfare echoed its concerns about the continuing traffic in Aboriginal children and placement in non-Aboriginal care:

A major problem has been the reluctance of welfare authorities to accept the basic differences between Aboriginal and non-Aboriginal societies in terms of family concepts and child care practices, particularly the concept of the extended Aboriginal family and the complex system of kinship relationships and obligations that are of fundamental importance in the Aboriginal child rearing process (Senate Standing Committee on Social Welfare, 1985, p.17).

Haebich elaborates:

...Aboriginal families have been viewed as sites of physical and moral danger and neglect and the rights of parents and children to remain together denied. Official interventions into these families have taken the form of direct action through the forced removal of children from their homes and official campaigns to carve family networks into isolated nuclear family units, as well as officially condoned practices of discrimination and neglect which threatened the very survival of many families and communities (Haebich, 2000, pp.13–14).

From the mid-1950s specific laws for controlling Aboriginal people began to be repealed. The formal cessation of the policy accompanied by the dismantling of the Aborigines Welfare Board in NSW in 1969 signified the end of official policies of 'assimilation', the guise under which the forced removal of Aboriginal children was practiced.

Aboriginal opposition to these practices of forced child removal and other assimilationist interventions by the state in the lives of Aboriginal families has not always been acknowledged (Haebich, 2000; Maynard, 2007). During the 1970s this activism led to the development of the first Aboriginal children's service (starting with the Victorian Aboriginal Children's Care Association and the Aboriginal Children's Service in Redfern). These Aboriginal community-controlled organisations sought to re-direct the flow of Aboriginal children who were removed from their families back into the care of Aboriginal communities (HREOC, 1997; McComsey, 2010). These initiatives aligned with greater global recognition in the mid-1970s of the significance of children's connection to culture and community, which in Australia led to Aboriginal and non-Indigenous activism in lobbying for the establishment of the Aboriginal Child Placement Principle, now enshrined in all state and territory child protection legislation (Chisholm, 1985; Lock, 1997; Milne, 1982). While access to better education or removal from a situation of poverty may have been advanced as a justification at the time (or even today) the profound effects of cultural loss were ignored. Aboriginal communities today continue to advocate for proper compliance with the ACPP which is understood as more than a placement hierarchy (Arney et al, 2015). Profound impacts of cultural loss are still frequently ignored. For example in the current debate about the viability of adoption, Aboriginal advocates have needed to argue yet again that adoptive placement of Aboriginal children with non-Aboriginal families will not be in the best interests of these children (BTH20, 2018)

The trauma associated with the severance of parental and family relationships, the added alienation from culture and the attempted erasure of Aboriginality, has had a severe and lasting impact on the Stolen Generations survivors and their descendants. The legacies of the policies that created the Stolen Generations continue to be felt by Aboriginal communities across Australia. Currently Aboriginal and Torres Strait Islander children continue to be disproportionately represented in the care system nationally, being "10 times as likely as non-Indigenous

children to be admitted to out-of-home care during 2016-2017” (Australian Institute of Health and Welfare [AIHW], 2018b, p. 44). Contemporary over-representation is, in part, resultant from past policies of forced removal of children and disruption of families and communities (BTH, 2004). It also appears that statutory child protection systems disproportionately intervene in Aboriginal and Torres Strait Islander families (BTH20). In 2016–17, Aboriginal and Torres Strait Islander children were 7 times as likely as non-Indigenous children to be the subject of child protection interventions (AIHW, 2018).

There were a number of Inquiries into institutional care in the earlier twentieth century. The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (HREOC, 1997) investigated the removal of Aboriginal children from families during the assimilationist period 1910–1975, made many recommendations including provision of compensation, a formal apology, and measures for guarantees against repetition in the *Bringing Them Home* report.

Apologies and redress have also been part of Inquiry outcomes. The Stolen Generations were given a belated formal Apology on February 13, 2008 (just over a decade after the HREOC *Bringing Them Home* report had recommended this be done by Commonwealth and State and Territory Governments). That delay has understandably proved a source of pain to Aboriginal Communities. The ongoing failure of State and Federal Governments to implement a range of recommendations from the *Bringing Them Home* report released 20 years ago is an ongoing source of distress.

Healing Foundation's Bringing Them Home 20 (BTH20) Report (<https://healingfoundation.org.au/bth20/>) creates a fresh opportunity to make a difference. BTH20 makes three overarching recommendations:

1. A comprehensive assessment of the contemporary and emerging needs of Stolen Generations survivors, including needs based funding and financial redress scheme
2. A national study into intergenerational trauma to ensure that there is real change for young Aboriginal and Torres Strait Islander peoples in the future
3. An appropriate policy response that is based on the principles underlying the 1997 Bringing Them Home report

A current needs analysis aligned with the Healing Foundation's recommendations is clearly required, as a matter of urgency, to address current challenges faced by survivors. Sustainable support has the potential to, at least in part, reduce the impacts of trauma.

AIMS

This research aimed to explore life experiences of 'care' leavers who have lived in institutions (such as children's Homes and orphanages) or other forms of out-of-home care as children. Participants in this study were drawn from the larger cohort of those who were in care between 1930 and 1989 and includes three sub-cohorts: Forgotten Australians, Stolen Generations survivors, and former Child Migrants. The specific aims of this research were to: 1) Explore patterns of older care leavers' experiences and life trajectories in care and post care; 2) Identify their current unmet needs and ways to support them; 3) Identify factors in their past or present experiences that tend to be protective or accentuate risks; 4) Assess ways in which support from professionals, families and friends help them to achieve positive outcomes; 5) Apply learnings to contemporary out-of-home care and after care to enhance favourable life outcomes and transition services. This monograph reports on experiences of Stolen Generations survivors and other Aboriginal and Torres Islander participants. An account of the full study is available in Fernandez et al. (2016).

STUDY DESIGN

The research employed a mixture of quantitative and qualitative methods. It included three components: surveys, interviews, and focus groups. Quantitative surveys were conducted to collect information from a broad sample and qualitative semi-structured interviews and focus groups were conducted to gather in-depth and contextualised information. Both quantitative and qualitative methods were used to triangulate findings and to bring together strengths of both methods (Bryman, 2016). The mixed methods design was chosen as the most appropriate to develop a more comprehensive understanding of the complexity of human lives (Doyle, Brady, & Byrne, 2009). This study used a convergent parallel design (Creswell & Clark, 2011) in that quantitative and qualitative research components were run simultaneously with equal priority. Quantitative and qualitative data were analysed separately and then results were merged and compared to validate findings from quantitative and qualitative

data and to gain broader and deeper understanding of lived experiences of care leavers in this study. The study was launched at a public event in February 2015 by Justice McClellan, Chair of the Royal Commission into Institutional Responses to Child Sexual Abuse and formally commenced soon thereafter. From the development of the project to reporting of findings, this research benefited from the active involvement of partner organisations and a Critical Reference Group (CRG). Partner organisations had extensive experience of working with adult care leavers. Some of the research partners were care leavers themselves. Regular meetings were held with the research partners. The research partners were involved in promoting the study, refinement of research instruments, the recruitment and data collection process, reviewing the draft research report, and development of recommendations from the findings. To complement the expertise and input of the researchers and partners, the project also included a CRG with representation from researchers, policy makers, and representatives of care leaver organisations. The CRG made significant contributions in developing some of the research instruments and reviewing the draft research report, including development of recommendations from the findings. Approximately 25% of the membership of CRG was Aboriginal and Torres Strait Islander representatives from key Aboriginal community-controlled organisations and Aboriginal scholars. Aboriginal representatives joined CRG by invitation. The designated Aboriginal CRG members contributed to various elements of the research that related to Aboriginal and Torres Strait Islander peoples and communities (e.g., refinement of qualitative interview schedule, recruitment, interpretation of findings and development of the final report). Finally, a number of study participants were consulted during the report writing phase. These participants had expressed interest in larger policy issues and indicated that they wished to have closer involvement in the research. This involvement of study participants enhances the credibility of research findings (Bryman, 2016) and, in addition, is intended to facilitate a participatory approach model of engagement whereby those involved in the study could contribute to report writing and recommendations in particular and participate in the policy agenda that would potentially affect them.

PARTICIPANTS

Surveys

Individuals involved in this study participated in surveys through an invitation posted on the project webpage or volunteered by contacting researchers or partner organisations, having seen promotional material in service settings.

The total number of survey participants was 669. In terms of the cohort, 75.9% identified as Forgotten Australians, 10.0% identified as Child Migrants, 6.0% identified as Stolen Generations survivors, and 8.1% did not report their group identification.

Table 1: Group identification (surveys)

	Frequency	%
Forgotten Australians	508	75.9
Child Migrants	67	10.0
Stolen Generations	40	6.0
Did not identify	54	8.1

Note. *n* = 669.

In terms of Aboriginal/Torres Strait Islander status, 86% were non-Indigenous, 7.8% were Indigenous, and 6.3% did not know their Indigenous status. The sample of this report (*n* = 70) includes research participants who have identified as Aboriginal and/or Torres Strait Islander and/or as Stolen Generations survivors. It was noted that 54% of Stolen Generations survivors identified as Aboriginal persons. Also 41% of Aboriginal and Torres Strait Islander participants identified as Stolen Generations survivors. There could be various reasons for this discrepancy. The forced removal of Aboriginal children from their families under this policy continued until 1970 and some Aboriginal participants entered care after those official legal mandates for removal had ceased. Disconnection and dislocation from family and community has meant that some participants in this study may not actually be aware of their own heritage or identify as Aboriginal and/or Torres Strait Islander or Stolen Generations survivors. It is also possible that participants did not understand or share the meanings of these terms in completing surveys. Herein after participants who identified as Aboriginal and/or Torres Strait Islander and/or as Stolen Generations survivors will be referred to in this report as Aboriginal participants.

The mean age of Aboriginal survey participants was 59.8 where the youngest participant was 36 years old and the oldest participant was 91 years old (see Table 2 for age distribution). More than half (58.8%) were female. Just above 40% of respondents were married (35.7%) or in a de facto relationship (5.7%) at the time of the study. Aboriginal participants were from all Australian States and Territories although the majority were from the most populous states, New South Wales (47.8%) and Queensland (30.4%). This reflects the fact that the majority (73%) of Stolen Generations survivors are in New South Wales, Queensland, and Western Australia (AIHW, 2018a) although survivors in Western Australia are under-represented in this study. Table 2 provides the demographic details mentioned above.

Table 2: Demographics (surveys)

	<i>n</i>	Frequency	%
Age group	66		
Under 49		9	13.6
50–59		29	44.0
60–69		14	21.2
70 or older		14	21.2
Gender	68		
Female		40	58.8
Male		28	41.2
Relationship status	70		
Married		25	35.7
de facto		4	5.7
Never married single		16	22.9
Separated		4	5.7
Widowed		6	8.6
Divorced		15	21.4
State or territory	69		
ACT		1	1.4
NSW		33	47.8
NT		1	1.4
QLD		21	30.4
SA		0	0.0
TAS		1	1.4
VIC		7	10.1
WA		5	7.2

Interviews and focus groups

Research participants

The survey included an invitation to participate in focus groups or interviews in addition to doing the survey. Half of the survey respondents (58.6%) indicated they would be willing to undertake an interview, 22.9% indicated a focus group. Others contacted the researchers directly, or were introduced to the researchers by a specialist service during a field visit, without having completed the survey first (some completed a survey subsequently).

Purposive sampling was used to select who would be contacted for interviews or focus groups. Participants were chosen to reflect the diversity of care leavers and to capture a range of experiences. The selection criteria included gender, age, Indigenous status, education, region, and experiences during and after care (both negative and positive). Given the small number of Aboriginal and Torres Strait Islander participants who participated in the survey, those participants who indicated their willingness to undertake an interview or focus group were all invited to make sure their experiences are well represented in the study. Some logistical considerations such as location within a capital city were used to maximise efficiency in conducting focus groups and interviews; however, persons in remote and rural areas or in overseas locations were also interviewed through telephone or a video link up. Some persons encountered during fieldwork were also interviewed without having completed the survey previously.

Fifteen Aboriginal participants were involved in an interview or focus groups. Six participants were interviewed and 9 participated in focus groups. Seven focus groups have had at least one Aboriginal participant (1 focus group only included Aboriginal participants). 11 were female and 4 male. More than half (60%) were from NSW, while 1 or 2 participated from NT, QLD, SA and WA (Table 3).

Table 3: Demographics (interviews and focus groups)

	Frequency	%
Method		
Interview	6	40
Focus group	9	60
Gender		
Female	11	73
Male	4	27
State or territory		
NSW	9	60
NT	2	13
QLD	2	13
SA	1	7
WA	1	7

Note. n = 15.

Specialist informants

A number of interviews with specialist informants were conducted. These specialist informants included officials and employees of professional service delivery organisations, peak bodies, the Royal Commission into Institutional Responses into Child Sexual Abuse, Aboriginal community-controlled organisations, and office bearers of care leaver organisations. A total of 15 interviews were conducted in NSW, Victoria and Western Australia. Four out of 15 expert interviews were conducted with Aboriginal advocates.

INSTRUMENTS

Surveys

The survey questionnaire was developed drawing on Australian and international research literature and modified based on feedback from partner investigators and members of the CRG which included Aboriginal people. The questionnaire focused on the individual's circumstances at their entry into care, experience in care (including placements, contact with parents and siblings, maltreatment in care, education, work), experience of leaving care and transitioning into independent living, and outcomes in later life in the domains of further education, employment, health and wellbeing, relationships, parenting, social connectedness, support, engagement and experience with services. Participants were also asked about contemporary policy issues such as their views on

the Royal Commission into Institutional Responses to Child Sexual Abuse and on current out-of-home care arrangements. Survey questionnaires were designed for both Aboriginal and non-Aboriginal populations and did not include questions specifically addressed to Aboriginal and Torres Strait Islander peoples.

The questionnaire included two standardised scales: the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) and the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988). The K10 scale measures nonspecific psychological distress and was developed for the US National Health Interview Survey. It has 10 items on a 5-point scale. It is increasingly used for clinical and epidemiological purposes and provides normative data, and is widely used in Australia (Andrews & Slade, 2001), such as the National Survey of Mental Health and Wellbeing (NSMHW) (Australian Bureau of Statistics [ABS], 2007) and Household Income and Labour Dynamics in Australia (HILDA) (Melbourne Institute of Applied Economics and Social Research, 2010). MSPSS is a measure of subjectively assessed social support on a 7-point scale (12 items). It has three domains of significant other, family, and friends. These standardised measures offered an opportunity for national and international comparison with general population normative data.

The survey questionnaire was designed to include the short form and the long form. The short form had 19 questions about demographics and key information whereas the long form had additional 110 questions on the themes outlined earlier.

Interviews and focus groups

The interview guide for care leavers broadly focused on the same issues explored in surveys – experience of placement, contact with siblings and family, maltreatment in care, transition into the community, adult life outcomes and perceptions of needed services. In addition, participants were asked about their coping strategies and resilience, significant events post care to the present, and their views on formal Apologies. While the surveys were primarily quantitative in nature, the interviews afforded individuals opportunity to present their stories and allowed for greater exploration of how experiences in care and post care affected them, and their coping strategies.

The interview guide for specialist informants focused on the nature of services provided to the study population, types of services utilised, gaps in services, and their perceptions of clients' level of disadvantage, and impact of trauma on clients. They were also asked about the most valued aspects of the service offered, and the adequacy of resourcing. Some broader policy issues were also canvassed, around current child protection and out-of-home care practices, and expectations around the Royal Commission into Institutional Responses to Child Sexual Abuse.

The focus group guide had a similar structure as interviews and covered the same themes. Less emphasis, however, was given to questions about individual experiences, due to focus groups being collective in nature and to ensure individuals did not feel obliged to disclose personal experiences should they choose not to. In actual experience, however, individuals did choose to recount personal experiences and shared these with the group.

The guides used for interviews and focus groups with Aboriginal and Torres Strait Islander peoples were designed to capture unique experiences of Aboriginal and Torres Strait Islander peoples in out-of-home care (e.g., cultural deprivation) and were developed in consultation with Aboriginal members of the CRG.

DATA COLLECTION

Ethics approvals were obtained from the Human Research Ethics Committees at the University of New South Wales, Relationships Australia (NSW), and Aboriginal Health and Medical Research Council of NSW. The purposes and procedures of the study were clearly explained to all participants and informed consent was obtained prior to their participation. Participants were also informed that they were able to withdraw from the study at any time. Great care was taken to protect privacy and confidentiality. Surveys were completed anonymously and participants in interviews and focus groups were assigned pseudonyms. In case of reporting sensitive information, some minor details were modified to protect identities. No identifiable information was included in any reports or manuscripts emanating from this study. Given the small number of participants in some states and territories, all analyses were conducted at the national level to protect confidentiality. All participants in focus groups and interviews were offered a small payment to cover their travel expenses and to acknowledge their

time and effort. Participants were given the contact details of researchers and support services in case of experiencing psychological distress derived from the participation in this study. There was no such incident reported to the research team.

Surveys

Surveys were conducted from December 11, 2014 to March 31, 2016. The survey was delivered in three ways:

- **Online:** Participants visited the project website and clicked on a button to access the survey.
- **On paper:** The survey was made available through mail out, and included a postage paid return envelope.
- **Over the telephone:** The survey could be completed over the phone, by a research staff member administering the survey verbally with a participant.

When participants directly contacted researchers for paper or telephone surveys, they received both short and long forms of the survey. In the case of telephone surveys, a researcher made a telephone call at the time agreed by participants.

When participants completed online surveys, at the end of the short form, they were asked whether they would like to continue the long form online or complete it on paper or over the telephone. When participants opted for the completion on paper or over the telephone, they received the long form by mail and, for the telephone completion, a researcher made a telephone call at the time agreed by participants.

Sixty-three percent of Aboriginal participants ($n = 44$) completed online surveys and 37% ($n = 26$) completed paper or telephone surveys. Among them, 71.4% ($n = 50$) completed both short and long forms and 28.6% ($n = 20$) completed the short form only.

Interviews and focus groups

Interviews usually ran for 45 minutes to 1 hour 15 minutes; however, some went for longer (up to three hours). With the permission of participants, interviews were audio recorded and transcribed.

Focus groups usually involved 4 – 8 people with the optimum number being 5 persons and typically ran for 1.5 hours. Focus groups were mainly mixed groups involving different cohorts of care leavers. Some focus groups

included Aboriginal and non-Aboriginal participants and some focus groups involved Aboriginal participants only (where these were organised through an Aboriginal-specific service). Typically, a UNSW researcher facilitated the focus groups alone. On a few occasions, focus groups were co-facilitated by a partner organisation case worker or other staff member (in particular, Find and Connect service staff were involved in co-facilitation). For groups of Aboriginal care leavers, an Aboriginal co-facilitator attended and co-facilitated. The option was also given to outsource facilitation where culturally appropriate and requested. In total, 20 focus groups were conducted, and seven focus groups had at least one Aboriginal participant. Focus groups were audio recorded and transcribed with the permission of participants.

Careful thought was given to the location and timing of interviews and focus groups. In conducting focus groups, 'ground rules' were set such as allowing each other to speak and trying to give each person an opportunity to contribute. Where it was found that participants in interviews or focus groups were not in touch with a specialist service, efforts were made to refer persons to services (with their consent).

DATA ANALYSIS

Surveys

The current study is exploratory in nature and so mainly descriptive statistics were examined. Various statistical analyses were also conducted to explore how individuals with particular demographics, care related and service related characteristics varied in their likelihood of achieving different outcomes. Where available, results were compared to outcomes of community samples using, for example, NSMHW and HILDA. The quantitative survey data was analysed using IBM SPSS Statistics 23 (IBM Corp., 2015).

Interviews and focus groups

Qualitative data from interviews, focus groups and surveys were analysed using NVivo software. The material coded was the transcripts of interviews and focus groups as well as written comments drawn from the open-ended questions of the survey. The coding broadly followed the thematic structure of the interview schedule that is, focusing on experiences in care, transition from care, life outcomes, and views on specific policy issues. In addition, new themes emerged specifically in relation to coping and emotions.

In reporting qualitative data all study participants have been assigned a pseudonym. These were chosen completely at random. Specialist informants (SI) working in Government, non-Government organisations and peak care leaver organisations are referred to as SI1, SI2, etc. rather than by a pseudonym.

Findings from quantitative data and qualitative data were integrated within broad themes. Points of convergence were identified to confirm and validate key findings of this study. Points of divergence were also identified and interpreted. These provided the basis for considering implications and suggestions for practice, policy, and future research to promote wellbeing of adult care leavers and to improve the current care system.

LIMITATIONS

Because there is no comprehensive list of care leavers in Australia, it was not possible to use probability sampling strategies. Care leavers self-identified and self-selected to participate in this study. Therefore, the study sample may not be representative of all care leavers who lived in child welfare institutions or other forms of institutional care during this period. For example, participants in populous states (New South Wales, Victoria, Queensland) were overrepresented in this study. Also, compared to Stolen Generations survivors in the *Bringing Them Home* report written a decade ago (HREOC, 1997), Aboriginal participants in this study reported higher educational attainment, higher income, and higher levels of abuse in care. Self-selection implies that care leavers who had more to tell would have participated in this study and their experiences might have been more negative. However, it is also possible that care leavers in better circumstances were able to survive to tell their stories in that the average age of participants was almost 62 years and high proportions of care leavers had physical illnesses, mental illnesses, and suicidal ideations. Particularly, with the gender difference in life expectancy, it is likely that older male care leavers in this study were people in better life circumstances. Therefore, it is recommended that findings of this study are interpreted with caution.

Despite extensive efforts made to recruit participants in this study (e.g., media campaign), the number of participants in some states and territories were relatively small. However, demographics of this study indicate that this study captured views of care leavers

with diverse backgrounds in terms of gender, age, Aboriginal status, education, region, experiences during and after care (both negative and positive), and involvement with care leaver organisations.

Historically however it had been estimated that between one in three and one in ten Aboriginal children were forcibly removed from families and communities between 1910 and 1970 (Senate Community Affairs References Committee, 2004). In 2016–2017, Aboriginal and Torres Strait Islander children were 10 times as likely (35.4 per 1000) as likely as non-Indigenous children (3.1 per 1000) to be placed in out-of-home care (AIHW, 2018). In the light of this figure, Aboriginal people seem to be under-represented in this study.

Survey questionnaires did not include questions to specifically explore the experiences of Aboriginal and Torres Strait Islander peoples. However, the guides used for interviews and focus groups with Aboriginal and Torres Strait Islander peoples were designed to capture their unique experiences in out-of-home care (e.g., cultural deprivation).

Another limitation is that this study is based on self-report and it may reflect participants' perceptions and recollections. However, self-report measures are widely used in the social sciences and deemed to be best to capture perceptions, feelings, and interpretations that are core interests of social science research.

Relatedly, participants self-identified as Stolen Generations survivors and/or Aboriginal and Torres Strait Islander persons. Their self-identification may not be congruent with official categories or may be based on the misinterpretation of the terms. However, with no access to reliable information, self-identification was deemed best.

Although K10 has been widely used worldwide with diverse populations (Andrews & Slade, 2001) and some efforts have been made to test the validity of this measure for Indigenous peoples (e.g., Bougie, Arim, Kohen, & Findlay, 2016), the validity of this measure for Aboriginal and Torres Strait Islander peoples has not been established. Therefore, we suggest interpreting the results of K10 with caution.

We acknowledge the absence of Aboriginal researchers in this project as another limitation. However, this project was guided by Aboriginal CRG members and we are immensely grateful for their invaluable contribution.

CIRCUMSTANCES AND REASONS

At the time of entry into care, Aboriginal survey participants were on average 5.5 years old (ranging from at birth to 14.9 years). Table 4 illustrates that 64.1% of respondents were wards of the State, 10.3% were placed voluntarily, and the remainder did not know their status or indicated 'other' status. At the time of entry, police were involved in 33.3% of placements, 35.9% of placements had no police involvement, and 30.8% did not know about police involvement. Respondents entered care from different parts of Australia and the majority of them spent their childhood in New South Wales (41%), Queensland (35.9%), and Victoria (10.3%).

Table 4: Entry into care

	<i>n</i>	Frequency	%
Age at entry into care	66		
Under age 1	11	16.7	
1 – 2	8	12.1	
3 – 5	19	28.8	
6 – 10	18	27.3	
11 – 15	10	15.2	
Status at entry	39		
Voluntary placement	4	10.3	
State wardship	25	64.1	
Don't know	6	15.4	
Other	4	10.3	
Police involvement at entry	39		
Yes	13	33.3	
No	14	35.9	
Don't know	12	30.8	
State or territory in childhood	39		
ACT	0	0	
NSW	16	41.0	
NT	0	0.0	
QLD	14	35.9	
SA	1	2.6	
TAS	1	2.6	
VIC	4	10.3	
WA	1	2.6	
Multiple	2	1.7	

Survey results indicated that there were various reasons given for entry into care. The most cited reasons were parents' inability to cope (40%), neglect (33.3%), marital problems between parents (28.9%), parental drug and alcohol problems (28.9%), housing and financial difficulties (26.7%), abandonment (24.4%), domestic violence (24.4%), and parental illness (24.4%). Less frequently mentioned reasons included parental death, the effect of war, or maltreatment (Figure 1). Some of respondents provided additional comments about the reason for placement in care and this included Aboriginality (13.3%). The reasons reported in this study may not necessarily reflect the true circumstances that participants faced during their entry into care. It is possible that participants believed these to be the reasons because these were narrated to them by staff members at institutions, their adoptive families or foster carers, by parents or other family members at later time, or found such information identified in their case files (see HREOC, 1997). The survey questionnaire developed for both Aboriginal and non-Aboriginal participants did not include Aboriginal-specific reasons for placement (e.g., Racism). Therefore, as a data collection instrument, it would have lacked the capacity to capture Aboriginal-specific reasons. Interviews and focus groups were able to complement this.

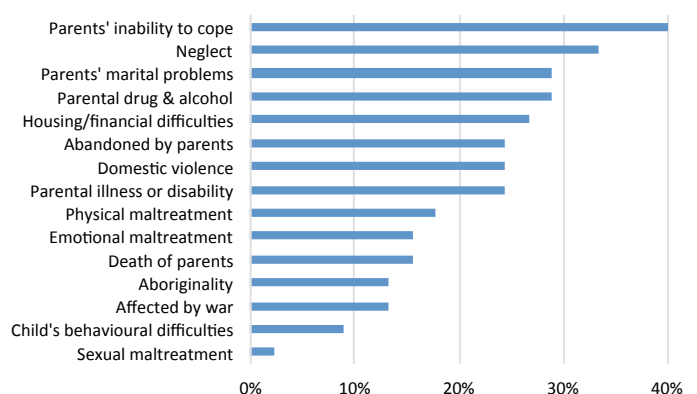


Figure 1: Reasons for placement in care (n = 45)

Data from focus group discussions and individual interviews with Aboriginal participants reflect the perception that their removal as children from family and country, largely arose from culturally embedded racism and prejudice. This was expressed in the child and family welfare policies of the day driven by the misguided belief that white man's ways were superior, and that eradication of traditional culture was justified. Participants recalled their unique caretaking environments before being removed to care.

In our culture, I can remember as a child, before I was taken, I can remember camping, you know, we were self-sufficient. We didn't want any white man, you know, we could have our language. My grandmother used to, dig a fire...the hot ashes, put it under the campers and over it, and then it would be like a hot water bottle... 'Aunty Eleanor'

Participants believed that racist and assimilationist attitudes were behind their placement in care.

Yeah it started (as) true genocide, I guess for trying to breed the black out of a child...But unfortunately, it's easier said than done. 'Charlotte'

You know.... it's a bit like the Aboriginal race. Like they hoped and dreamed we would just (be) all off, and the colour of your skin would become lighter and then, you know, there'd be no more Aboriginal. I think that's what they're trying to do with the people they've already hurt. They're just hoping that we're going to die off and go away. 'Eva'

These views appear to be well supported by historical record, including Aboriginal Protectors' Reports and other documentation from this period (HREOC, 1997). Poverty and lack of social support for Aboriginal families in desperate need led to removal of many children and their placement in care:

I was put into [institution] which was a home for children with sick mothers. My mother collapsed and was put in hospital. My dad had no support or extended family because he was a [institution] boy that came out at age nine (as a Child Migrant from the UK). There was nobody to help him to mind us and he had to work to pay Mum's medical bills. 'Ivy'

Aboriginal children were sometimes removed from home in response to abuse and maltreatment within the family of origin which came to the attention of the authorities. Addressing parental issues such as mental health problems, drug and alcohol misuse and domestic violence may have preserved the family unit; there is little evidence of such interventions being employed, however (Scott & O'Neil, 1996). For Aboriginal participants, removal from home and family almost always came without warning. In remote communities, police, sometimes bearing weapons, suddenly bore down on missions and encampments when the men were away working, hunting or on other business:

I was forcibly removed. There was a gun held at my mother. It was when daddy and the men, the uncles, were away from the mission working. It was a planned raid between the police and the hospitals and the welfare. That was back in 1960. 'Charlotte'

In towns and cities, removals were similarly brutal. Babies and children were torn from the arms of parents and grandparents, creating separations that often proved lifelong:

We were just shoved into this car and taken from our parents. Mum ran with my brother; he was a baby. She ran up to a lady and stayed there and hid there with him. He wasn't in the home, just me and my other siblings. So, we were taken to a [reception centre] and then we were split up from there. 'Von'

Disrupted family relationships were often impossible to repair in contexts of pre-existing trauma and loss for parents and children. Removal of children generally constituted cumulative trauma for families already struggling with enormous pressures:

My father had been a returned soldier after being a prisoner at war with the Japanese for four and a half years in Burma. So, there was already a lot of trauma in my family. My mother was completely traumatized after my father died. She'd also had TB during her pregnancy with me.... When I was nine months of age she was taken to Sydney to be cured...She was gone for three years. So, to save welfare, to prevent welfare from getting me, this woman – my aunt who was no blood relation, but we had extended family. We still always have extended family. She worked to keep me there. She worked during the day and my father would take me during the night and during weekends. Of course, once the father was killed (at work) – that was the absolute family breakdown. My mother couldn't cope. Aunty called in [Agency] took my brother and I off our mother and out of our town, away from everybody we knew. 'Survey respondent'

Not only were Aboriginal parents and children torn apart, often forever; children lost their extended kin network and an identity grounded in country, ethnicity, culture, subculture and language (Edwards & Read, 1989; HREOC, 1997; Walsh, 1998). Where reunification was attempted later, it often proved enormously difficult. Children removed as babies and toddlers often had no idea where their people were or where their traditional lands were located. It could take many years (and was often impossible) to piece together a lost identity which had its foundation far from home. Only very rarely was culture and language reclaimed; this is clearly identified by one of the specialist informants:

There is a huge other dimension, because it wasn't only identity. It was culture, where we systemically dismantled their identity and their culture and made them European. 'S11'

GENERAL REGIME

Most of Aboriginal survey participants (86.8%) had been in a children's Home or orphanage. Many participants also had experienced various types of care: foster care (35.3%), juvenile detention or youth correction facility (35.3%), hostel or boarding house (20.6%), family group home (11.8%), or other (e.g., residential care, psychiatric hospital, or training institution). Participants were asked about the initial and final placement. When they entered care, 70% were placed in a children's Home or orphanage, 7.5% in a juvenile correctional facility, and in foster care (2.5%). Just before they left care, 32.4% of participants were placed in a children's Home or orphanage, 14.7% in a family group home, 5.9% in foster care, and 2.9% in a juvenile correctional facility. There were some differences between the first and last placements – notably, the percentage of participants in children's Home or orphanage decreased whereas the percentages of participants in foster care and other types increased, as shown in Figure 2.

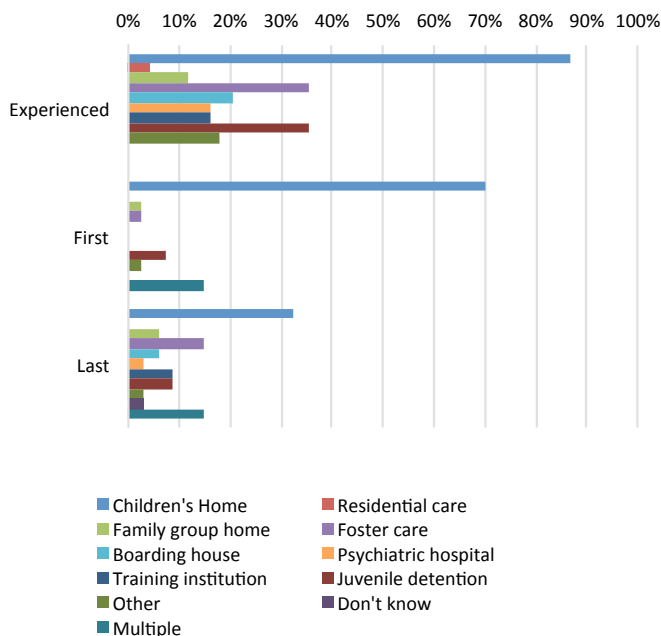


Figure 2: Types of facility (n = 34 to 68)²

Placements were managed by various organisations and service providers. Given the fact that most participants experienced multiple placements, they

were asked about the care organisation for their most recent placement. Aboriginal survey participants reported that the most recent placement was under the auspice of government (49%), church (38%), charity (5%), and other (see Figure 3).

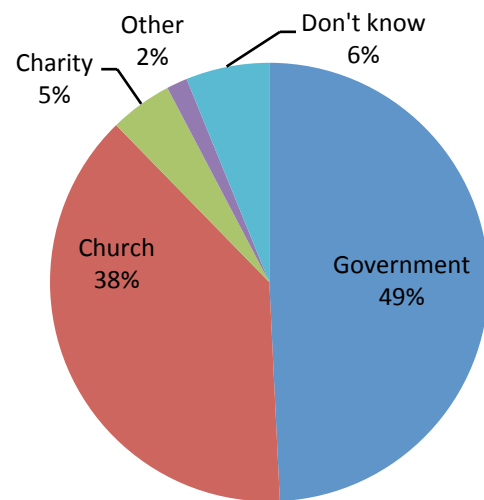


Figure 3: Organisational auspice of the last placement in care (n = 65)

With very rare exceptions the care environment was characterised by extreme neglect and abuse (sexual, physical and emotional) (Fernandez et al., 2016). This was evident in large institutions, cottage homes and foster care placements. It presents as the dominant narrative across the study period.

Within almost every care setting described, Indigenous culture was not respected or celebrated. It was denied and denigrated. For most Aboriginal children growing up in care their link to culture was lost and generally proved very difficult to reclaim later:

They did lack the cultural side. I didn't see any Aboriginality and culture or anything in there. It was always the white man's way and that was it, which made a big impact on me later. 'Robbie'

Espousal of 'integration' thinly masked racism for much of the study period, with severe punishments in situ for speaking Aboriginal languages or identifying with culture or community in any way:

2 For placement experienced, the total exceeds 100 percent because participants were able to choose more than one option. For the first and last placement, participants were asked to choose only one option for first and last placements; however, a few participants who completed paper surveys chose more than one option.

Well you had many different languages. It's not just one Aboriginal language, like not just one Aboriginal country, so because we were taken away from it and it was bashed out of us...they called it 'bashing the black out of you' and they literally did that. 'Thelma'

For some (far too few) children there were experiences of good quality, culturally appropriate care:

My foster family was nice. They were Aboriginal themselves...My foster brothers that I grew up with – the black brothers, they were protective of me because I was the only girl. 'Charlotte'

PLACEMENT TRAJECTORIES

On average, Aboriginal survey respondents experienced 4.9 placements while in care (ranging from 1 to 23 placements). As shown in Table 5, 21.6% of survey participants had only one placement during their time in care whereas most participants experienced multiple placements.

Table 5: Number of placements

	<i>n</i>	Frequency	%
Number of placements	37		
1	8	21.6	
2 – 3	13	35.1	
4 – 5	5	13.5	
6 – 10	8	21.6	
11 or more	3	8.1	

CONTACT WITH FAMILY MEMBERS

Ninety-five percent of Aboriginal survey respondents had siblings (either alive or deceased) and the average number of siblings was 6.1 (ranging from 0 to 23 siblings). Among people with siblings, 78.4% had siblings who were also in care (Table 6).

Table 6: Siblings

	<i>n</i>	Frequency	%
Have siblings	41		
Yes	39	95.1	
No	2	4.9	
Siblings in care	37		
Yes	29	78.4	
No	8	21.6	

Forty percent of survey respondents did not have any contact with their family while in care. While 45.2% had some level of contact with their mother, the percentages dropped to 27.6% for siblings, 28.6% for father, and 28% for other relatives. Overall, participants had most frequent contact with their mother as indicated in Figure 4 below; yet, the median of contact with mother is 1 which is equivalent to 'never'. (1 = Never, 2 = Less than yearly, 3 = 2-3 times a year, 4 = Monthly, 5 = Fortnightly or more).

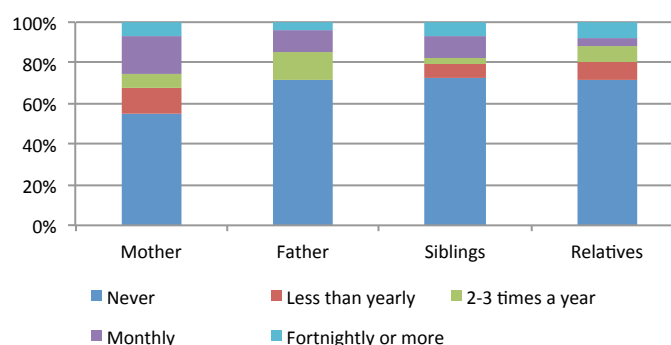


Figure 4: Contact with family while in care (n = 25 to 31)

During their time in care, half of Aboriginal survey participants (50%) returned to their family at some point regardless of duration (Table 7). Survey participants were also asked about the number of times they returned to family for the duration longer than a month. On average, they returned to their family about 0.9 times while in care (ranging from 0 to 6). It is possible that the "0" responses may reflect participants' experience of very brief returns home (e.g. for less than one month).

Table 7: Return to family while in care

	<i>n</i>	Frequency	%
Ever returned to family while in care	40		
Yes	20	50.0	
No	18	45.0	
Don't know	2	5.0	
Number of times returned to family (> 1 month)	35		
0	21	60.0	
1	8	22.9	
2	2	5.7	
3	1	2.9	
4	1	2.9	
5 or more	2	5.7	

For parents with few resources, travel to visit children placed in distant locations was extremely difficult; it often proved impossible. This resulted in serious family disruption. Some parents however, overcame extraordinary barriers to maintain precious relationships with their children. A participant whose own children was placed in care made such efforts:

I knew I was never going to win (custody) from the time I entered the court room. I gave it to the Judge on my own and said “Look the history of it is I was abused from a young age through to my mid 20’s your Honour; I know I am not going to win here today but what I would like you to do is don’t take away my kids from me; I still want to see them”. He said, “Would you travel?” So, I travelled (200 kilometres on public transport) every second weekend to see them for an hour; but with the Department office it is so damaging. A lot of men I have spoken to say, “When they get older they will come and see me”. But I wanted to see the kids. ‘Daniel’

Sibling separation often proved especially distressing. Even when siblings or cousins were placed in the same institution they were often cruelly separated within that setting or not made aware of family connections with peers (Find and Connect, n.d.; Horrocks & Goddard, 2006):

Well the overwhelming memory I’ve got is of neglect and abuse. I was spilt from my baby brother who I love dearly. They used to put me in a yard at the back of the Home that had a small cyclone fence around it. He’d be stuck out there all day with the other babies and toddlers. If you went near the fence to try and see him or say hello to him, you’d get your knuckles cracked by one of the staff that tell you to piss off. You’re not allowed near the babies. ‘Ivy’

SCHOOLING

Most of the Aboriginal survey participants (77.5%) attended school while in care: 60% attended school regularly and 17.5% attended school sometimes. Nearly seventy percent of respondents attended government schools and 60.6% attended schools attached to the children’s Home or orphanage. Smaller proportions attended Catholic schools or other non-government schools. On average, respondents attended 2.1 schools (0 – 8 schools) and they left school at age 14.5 (11 – 17 years old). Prior to 1962 and the introduction of the Wyndham system and extension of high school courses to six years, this was not unusual. Most Aboriginal respondents (90.6%) said their schooling was affected

by their experience of being in care. Table 8 indicates whether school was attended at all, and if so, what type of school it was.

Table 8: Schooling

	<i>n</i>	Frequency	%
Attending school while in care	40		
Yes		24	60.0
Sometimes		7	17.5
No		9	22.5
Types of schools[‡]	37		
School in institution		20	60.6
Government school		23	69.7
Catholic school		4	12.1
Other non-government school		4	12.1
Number of schools	35		
0		9	25.7
1		4	11.4
2		10	28.6
3		7	20.0
4		2	5.7
5		0	0
6		2	5.7
7 or more		1	2.9
Age at leaving school	32		
Under the age 15		17	53.1
15		7	21.9
16		4	12.5
17		4	12.5
Schooling affected by care	38		
Yes		29	90.6
No		0	0
Don’t know		3	9.4

Note. [‡] The total exceeds 100 percent because participants were able to choose more than one option.

Only 15.9% of Aboriginal survey participants obtained a Higher School Certificate (or Leaving Certificate, Matriculation, Senior Certificate, Year 11 or Year 12), 15.9% obtained an Intermediate Certificate (or School Certificate, Junior Certificate, Achievement Certificate, Year 10), and 68% did not obtain any school certificate although most of them attended primary and secondary schools, as detailed in Figure 5.

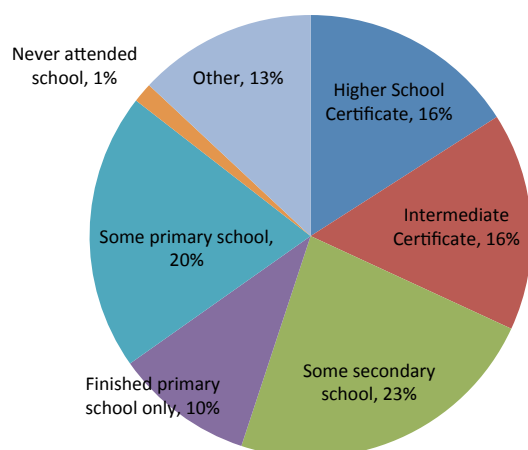


Figure 5: Level of schooling (n = 69)

Survey participants were asked about the reasons for not finishing a Higher School Certificate (or equivalent). More than half of Aboriginal respondents reported that institution did not offer the opportunity (57.1%). Participants also reported that there was a lack of encouragement from institutions (51.4%) and teachers (45.7%), they had to work (45.7%), and they could not pay attention at school (40.0%). Figure 6 displays the reasons for non-completion of the Higher School Certificate (or equivalent).

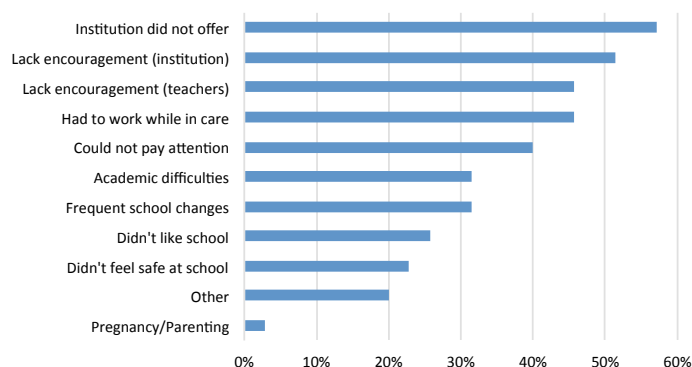


Figure 6: Reason for not finishing Higher School Certificate/Leaving Certificate or equivalent (n = 35)

Some Aboriginal participants described school as a safe refuge from maltreatment experienced in care; an environment that could help to heal trauma:

When I started school I still couldn't talk and be understood. This was because I was being severely abused by both my foster parents and the emotional and psychological effects of that abuse. I was considered really dumb. Fortunately, I was left in school. In 1st class I had a wonderful teacher. I found school to be a safe place. By the end of 1st class I had excelled. Some of the other teachers were very surprised. 'Survey response'

For many however, school proved deeply demoralising, a setting where racism was permitted to flourish unchallenged:

You didn't know what being black was. Happened to me very early in school. The few years I was there I was doing alright, sitting at the front of the class and the teacher said, 'You can go and sit down the back now. Sit down next to Mary'. ... Went to sit down and she said, 'He can't sit down next to me. He's black'. I thought, 'shit!'. 'Basil'

School was also too often the context for some of the worst abuse experienced by Aboriginal participants:

I was told I was no good and I was sexually abused by teachers. Physically, sexual abuse and beatings. I was diagnosed as borderline retarded, but I was not educated ever properly in care. I never learnt writing, reading, spelling, maths, science, etc just religion and servicing paedophiles. 'Survey respondent'

CHILD LABOUR

Among Aboriginal survey participants ($n = 19$) who reported on work while in care, 78.9% indicated that they did some type of work under the age of 13. While working hours varied greatly, the average was 21.84 hours per week (0 – 112 hours³), and the median was 15 hours. Among those who reported working under the age of 13, 73.7% did unpaid work whereas only 5.3% did paid work. For their time in care at the age of 13 and above, 88.2% reported that they did some type of work while in care. On average, they worked for 25.1 hours per week (0 – 112 hours) and the median was 20 hours. Among those who reported working at the age of 13 and above, 70.6% did unpaid work whereas 17.6% did paid work while in care. Figure 7 details the specifics of child labour such as the hours of work per week and whether the work was paid or unpaid.

Unpaid work included housework (cleaning, dusting, polishing, scrubbing, cleaning shoes); farm work (feeding animals, milking cows, bakery, grape picking,

³ Three participants reported working hours above 100. This may not necessarily reflect actual working hours. Given the extreme values, medians are also reported.

killing sheep); kitchen hand (food preparation, peeling potatoes, cooking), laundry (washing, ironing); gardening (mowing, bailing hay, digging); looking after children (nursery babies and 3-4 years old); nursing elderly at the home; painting; polishing the Church; paper boy.

Paid work included cleaning the floor and choir singing at weddings for 3 shillings a time (before the age of 13); and office work, labourer and working at aged care (after the age of 13).

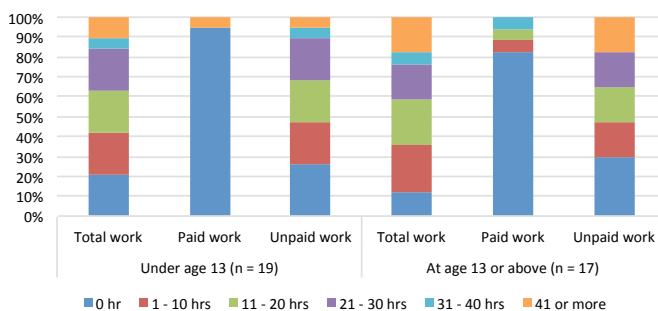


Figure 7: Hours of work while in care

Whether children were placed in large institutions, cottage homes or foster care they were often forced to undertake extremely hard physical labour. This routinely occurred from a very young age; child labour clearly remained central to the ‘business model’ of the welfare system for many years. Aboriginal children were often placed as servants with families; they received little or no payment and had no chance to develop socially, emotionally or intellectually. They were also often abused. This was a gross abuse of human rights (United Nations, 1989). This description of farm work is typical:

I was forced to work strenuously without being allowed to play with friends. I was very scared of the cows as I had never had any contact with farm animals before. I ended up milking 4 cows night and morning and feeding them with oats and husks of which I had to carry large loads. I helped with the cleaning of all the milk containers and large milk cans and all the cow stalls in the shed. I used to milk the cows in the yard and I would get belted when they sometimes kicked over the milk bucket. I helped the farmer to load the truck for delivery to the cheese factory. I used to look after the chooks by feeding them collecting the eggs and cleaning and raking out the chook houses every week. I also used to pick and pack all the fruit, apples, oranges, pears, quinces and all the stone fruit, the vegetables also and packed them some of which was sent to market and the rest was sold on a stall at the house. I wasn’t allowed to eat the fruit. ‘Survey respondent’

I mean we were made to cut grass with a razorblade all day. We had to dig three metre deep trenches in forty degree heat. We were also scraping the yellow stains off the toilets and off the shower blocks. We were also flogged with a belt thing. It was a rubber – called it the black snake because this priest used to get off on it. Turned red like a tomato while he was doing that. Whacking our butts. A lot of the labour (required) we did, you know? And if we didn’t do it we were punished into a jail cell. We were put into the bad boy’s room. It was very damaging. ‘Robbie’

Within the institutions even the smallest children routinely laboured from before dawn till late into the evening and were harshly punished for perceived resistance or incompetence:

At 4 years old, scrubbed floors, jobs that we could do for our age, cleaning, looking after nursery babies. ‘Survey respondent’

EXPERIENCE OF MALTREATMENT

The study explored experiences of abuse and maltreatment in care. Survey results revealed that maltreatment was vastly prevalent in care. All Aboriginal participants who responded to the questions ($n = 40$) reported to have experienced some type of maltreatment while in care; and 47.5% of them reported to have experienced all forms of maltreatment in care. The most prevalent type of abuse by adults was verbal abuse (95%), followed by emotional abuse (90%). The most prevalent abuse by peers was bullying (89.2%), followed by physical abuse (83.8%). Sexual abuse was widespread and 75% experienced this form of abuse from someone: 72.5% by adults and 64.9% by peers. In Figure 8, the experience of maltreatment is differentiated by abuse perpetrated by anyone, by adults and by peers.

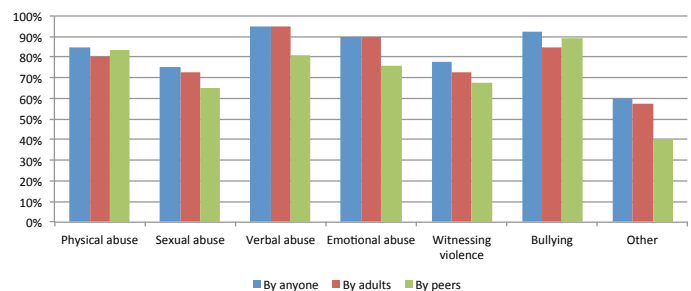


Figure 8: Experience of maltreatment (n = 34 to 40)

Survey participants provided their own assessment of the impact of maltreatment in care. While in care, the most negatively affected areas were education ($Mdn = 5$) and mental health ($Mdn = 5$), followed by

relationships with friends ($Mdn = 4.5$) and physical health ($Mdn = 4.5$). In their present life, the most negatively affected areas were mental health ($Mdn = 5$). Figure 9 illustrates this using a 5-point scale.

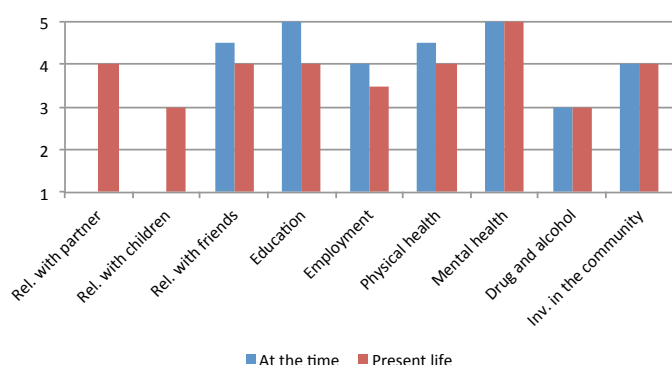


Figure 9: Impact of maltreatment in care (n = 15 to 37)

Note. 1 = not at all, 2 = slightly, 3 = moderately, 4 = considerably, and 5 = enormously.

For most Aboriginal participants, who were raised in loving and caring families and communities prior to removal from family, the immediate onset of abuse as they entered care was a terrifying portent of what was to come. In most instances, abuse escalated, and often more vicious perpetrators were involved. Cumulative trauma resulted:

We used to line up, line up, with our sheets in our hands, and if we wet our bed she used to get (us) up by the hair and rub our nose in our urine. And if you were sick in your dinnershe used to make us sit there and eat the vomit. 'Tanya'

You (would) get your hair shaved off for back-chatting...my experience is I had my top teeth pulled out 3 at a time.... Yeah, not a good experience. Every time you look in the mirror you see your own sunken mouth as you're getting older, and your new false teeth have to go in your mouth. Yeah, it wasn't a good experience. 'Eva'

For some children, abuse was life threatening:

(There was) cruelty at every point, she [worker] drowned me...I touched a tomato that some kid had put me up to doing, and they put me in the bag and stitched up the top of the sack bag, took me down to the river, and threw me in on a rope... I could feel water... and I held my breath as long as I could and till there was no more movement or anything ... I could hear water coming and a little frog kept me alive in there. 'Rosemary'

In a context of serious abuse and maltreatment it was unsurprising that children frequently ran away. Such bids for freedom were savagely punished:

Apparently with my record of running away there was nowhere else to put me so they put me in a place where they thought I could not get out but I eventually did get out; they had barbed wire on top of the fence but I got out from the inside of the place through a window just chipped away till I knew I could get it open and then just got out into the yard and over the fence and took 2 other girls with me. We only lasted being out about 2 hours or so then back in isolation, then you were put on a canvas mattress with a piece of canvas for a blanket, no clothes whatsoever, injected with god knows what, still don't know, but I slept hell of a lot and you had to urinate and defecate into just a pot and you had 2 guards who would walk you down to empty it and clean it and bring you back and put you in your dark room again and then if you don't do anything which of course occasionally you would go off your head because you are just in a locked room and then you would go out after about maybe 4 or 5 weeks. 'Victoria'

Emotional abuse was especially powerful. It seriously undermined trust and self-esteem; it also reinforced profound abandonment and alienation.

You (were repeatedly told) "You are never going to amount to anything. No one wants you and no one knows you're here. No one cares that you're here". So, you just sort of grew up with that self-esteem; I didn't like adults even when I became one myself. I used to hate them, you know? That's why I used to always have jobs where I could always be away by myself. Always. I still to this day don't like having male doctors and male dentists or physiotherapists. I always ask for a female. It's affected me that badly. 'Basil'

OVERALL EXPERIENCE WHILE IN CARE

On average, Aboriginal survey participants stayed in care for 9.7 years (ranging from 3 weeks to 18 years). See Table 9.

Table 9: Duration in care

	n	Frequency	%
Duration in care	66		
Under 1 year		3	4.5
1 – 2 years		5	7.6
3 – 5 years		12	18.2
6 – 10 years		16	24.2
11 – 15 years		17	25.8
16 years or longer		13	19.7

Although smaller in percentage, some Aboriginal participants mentioned positive experiences while in care. Twelve per cent were satisfied with their experience to some degree but none were very satisfied. Nonetheless, the overwhelming message from the clear majority participants was that their experiences were almost uniformly negative (88% were dissatisfied to varying degrees and 71% were very dissatisfied). See Figure 10.

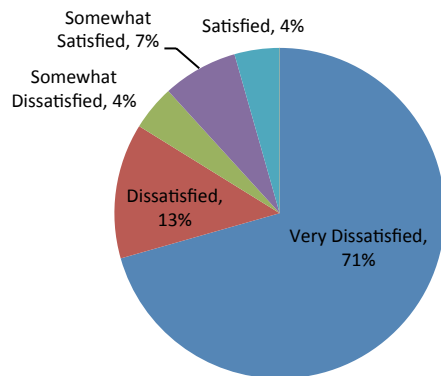


Figure 10: Overall rating of care experience (n = 68)

When they were asked about specific aspects of care experience, the level of their dissatisfaction was still high. While they were more dissatisfied (*Mdn* = 1 equivalent to 'very dissatisfied') with contact with family, emotional care, relationship with care givers/staff, and vocational training, and schooling; they were moderately dissatisfied (*Mdn* = 2, equivalent to 'dissatisfied') with food and lodging, health care, and supervision. See Figure 11.

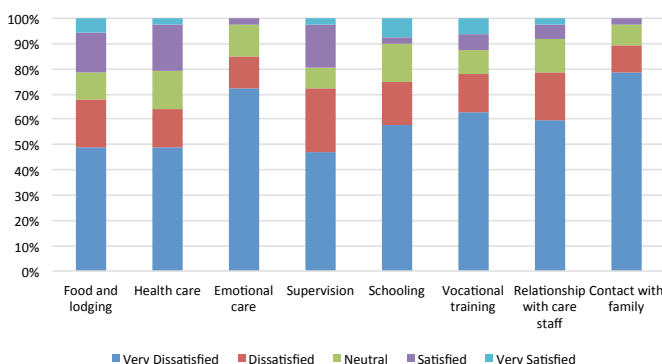


Figure 11: Satisfaction with different aspects of care experience (n = 32 to 40)

Survey participants were asked whether there was anyone helpful to them while in care. About 48.6% of Aboriginal survey respondents reported that they did not have anyone helpful while in care. Nonetheless, the most helpful people were reported to be friends in care (*Mdn* = 3), friends not in care (*Mdn* = 3), and teachers (*Mdn* = 1.5). This can be seen in Figure 12.

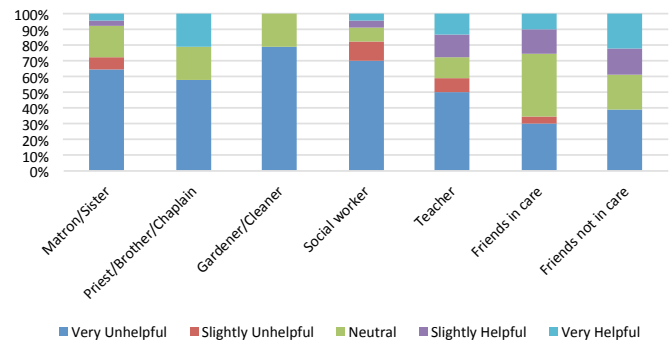


Figure 12: Helpfulness of people in care (n = 14 to 35)

These responses paint a bleak picture of the care system of the study period. Most Aboriginal survey participants (88%) were not satisfied with their care experience and there was a generally low level of satisfaction with all elements of care, as well as the level of helpfulness of people in the care environment. In short, it appears not much 'care' was experienced by most respondents, either physically or psychologically.

LEAVING CARE

The data in Table 10 indicates that at the time of leaving care, Aboriginal survey participants were 15.4 years old on average. Fifty percent of respondents said that they were worried about leaving care and about two thirds (68.4%) reported that they were not given adequate warning about leaving care. At the time of leaving care, about 65% of respondents did not have a job and 60.5% said that they were not prepared at all for living independently. The average score of preparedness was 2.7 on a 10-point scale (1 = not at all and 10 = very well prepared).

Table 10: Preparedness for transitioning out of care

	<i>n</i>	Frequency	%
Age at leaving care	36		
Under age 12		2	5.6
12		1	2.8
13		5	13.9
14		4	11.1
15		3	8.3
16		6	16.7
17		4	11.1
18 or older		11	30.6
Worried about leaving care	40		
Yes		20	50.0
No		17	42.5
Don't know		3	7.5
Given warning about leaving care	38		
Yes		10	26.3
No		26	68.4
Don't know		2	5.3
Having a job when leaving care	40		
Yes		14	35.0
No		26	65.0

After leaving care, respondents spent their first night at various places. The most frequently mentioned places were the family home (30.8%), relative's home (12.8%), or own place (10.3%). About 2.6% of those leaving care had no place to live. Figure 13 indicates their destination on the first night after leaving care.

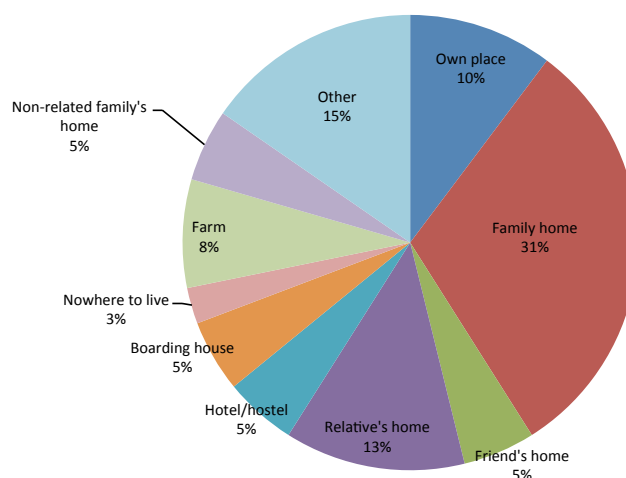


Figure 13: First night after leaving care (n = 39)

Many Aboriginal survey participants experienced difficulties in all areas during the transition from care to independent living arrangements. Figure 14 details the level of difficulty using a 5-point scale, and shows a high level of difficulty reported in general. The median score of difficulty was equivalent to 'very difficult' (*Mdn* = 5) in all domains, except for cooking/shopping and finding a place to live (*Mdn* = 4.5).

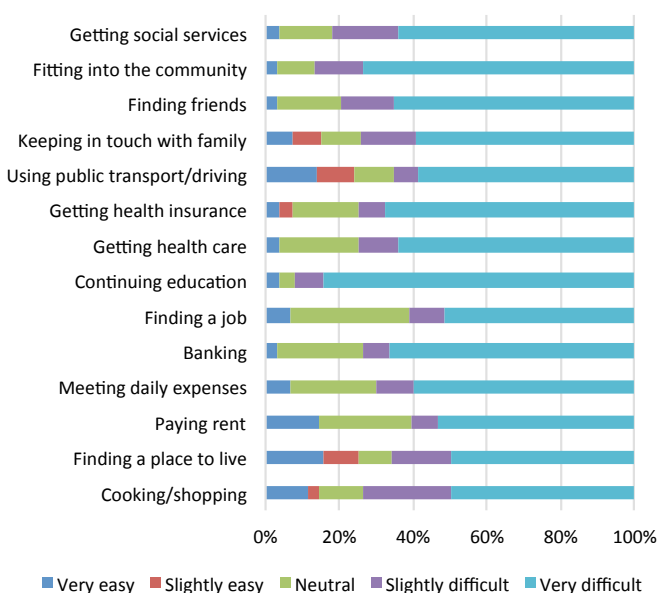


Figure 14: Difficulties during transition (n = 26 to 36)

Aboriginal survey participants reported having had limited support during the transition time (Figure 15). During this time, 37.1% did not receive any help from the institution. The most supported areas were employment (20%), housing (17.1%), and re-connection with their family (11.4%). Less than 10% of participants

received support related to education, health care, finance, or social services. Figure 14 indicates the areas where help was given – overall a low percentage (20% or under) reported receiving help in these areas. Twenty-seven percent reported they had received help in regards to ‘other’ areas. Most participants who chose ‘other’ category indicated that they did not receive any help. One participant received help in the form of ‘a railway ticket’.

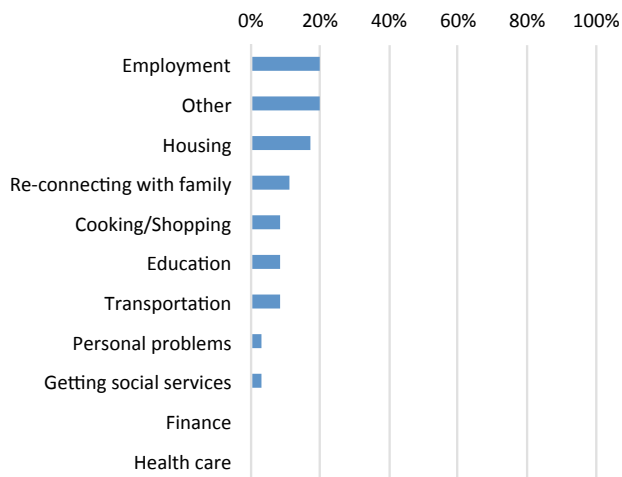


Figure 15: Help received during transition (n = 35)

Lack of support during the transition time was also apparent in their responses about sources of support. Almost half of Aboriginal survey participants (52.6%) reported having had no one to call during the transition. One in five participants (21.1%) were able to get help from their siblings and 7.9% were able to call parents. One in ten participants (10.5%) said that they were able to call other people for help. Figure 16 indicates the person(s) that participants felt they could ask for help during this time.

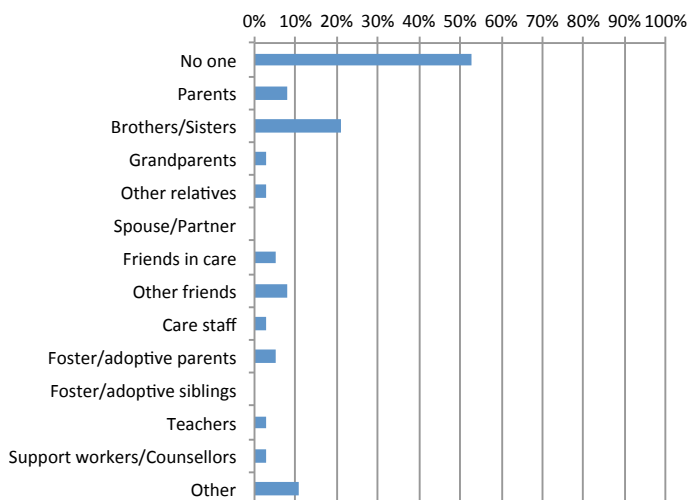


Figure 16: Someone to call during transition (n = 38)

The stage of development when young people left out-of-home care during the last century varied greatly. Some participants left care as children, whilst others were adolescents or young adults. Children frequently re-entered care on multiple occasions. For many Aboriginal children, placement away from family was long-term, often continuing till the young person ‘aged out of care’. That transition might occur as young as 14 or 15 years of age or as late as 18 or 19 years. Sometimes it appeared that placements were maintained as a convenient source of unpaid or very poorly paid labour. This seems to have especially been the case in regional and rural locations. Upon being released from care, young people were essentially abandoned to make their own way in the world – unsupported socially, emotionally and financially. As they entered care, their relationships with their birth family, community, and culture were severed. This is further compounded by the loss of peer relationships and the support these provided when they left care. Most Aboriginal participants recalled the process of leaving out-of-home care with horror. Cast adrift in a dangerous world with no social protection, little education, limited employability and virtually no funds, participants described this as one of the most terrifying periods of their lives. This is particularly significant when one considers that most were, at this point, being released from settings where they were experiencing appalling levels of neglect and abuse. Nonetheless, to confront the world outside the institution, virtually alone, ill equipped and un-resourced for independent living remained a frightening prospect. Participants almost always found themselves alone in the world with no social connections or relationships and no sense of belonging. The removal and institutionalisation had deliberately severed these connections regarded as being significant for lifelong wellbeing; this was starkly apparent at the point of leaving care.

The lived reality confirmed Aboriginal participants’ anticipation of abject abandonment at this critical moment of transition. Lack of support on leaving care has been demonstrated to have serious immediate and long-term consequences (Mendes & Snow, 2016). Within a short period of leaving care participants often found themselves homeless, struggling with mental health issues, unemployment, drug and alcohol issues, unplanned pregnancies, removal of children and other traumatic experiences.

They contacted welfare and told them I got married... and then when I had my son they had a record there, 'Clara was pregnant with an unknown man and we had to take the baby off her.' So, they did that to me. They didn't give me a choice if I wanted to keep the baby or not. They took the baby. 'Clara'

Leaving care with few life and work skills and minimal educational competencies meant that participants in this study overall faced many barriers in seeking employment. For Aboriginal participants, racism and discrimination created extra barriers in care and post care. This has meant that problems in securing stable employment have often proved even greater, especially in rural and remote parts of the country.

Well there's a disadvantage in (being) Aboriginal. It's just general disadvantage. 'Charlotte'

In the face of such challenges, the level of resilience demonstrated by many Aboriginal participants has been extraordinary.

I went through a time where there were drugs and alcohol. Angry at the world. Then there comes a time when you say to yourself especially when you have your first child – you can't bring a child into a world when I'm angry and I don't want – for them to have that trans-generational. Even though they live it every day with you. 'Katy'

For Aboriginal participants in this study, and many Aboriginal young people who leave care today, re-connecting with kin, kith and country is their key priority. Sometimes the reunification process for Aboriginal participants has proved a powerful source of healing. For others, it has proved difficult, and sometimes even impossible, to overcome the impacts of major trauma and long-term separation from family and community, country, culture and language. Even when reunification is achieved, the impact of trauma experienced in care often endures. One service provider reiterates this:

So, I would say that everyone presents with their own issues, but there seems to be a common theme with all of our clients - that their relationships with their children and their families, if they do reconnect or find their families again, are very short-lived. 'SI2'

The adult lives of participants in this study overall have been marked by serious hardship in multiple forms. For Aboriginal participants specifically, financial difficulties, mental health impacts of attachment disruption and trauma, drug and alcohol issues, relationship problems, including family violence, imprisonment, housing difficulties and homelessness along with long-term unemployment and other psycho-social issues are common experience. These issues are exacerbated by and, in part, resultant from loss of culture, people and country.

Aboriginal survey participants reported on their current wellbeing as shown in Figure 17. The highest rated domains (*Mdn* = 4 equivalent to 'somewhat good') were personal safety and receiving services. The median of remaining domains was 3, equivalent to 'somewhat poor'.

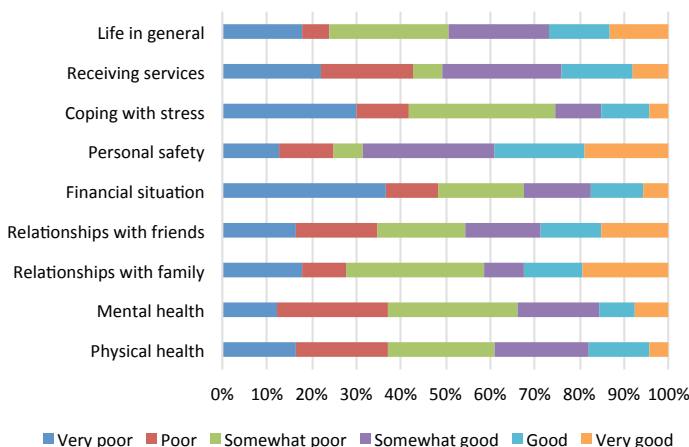


Figure 17: Current wellbeing (n = 63 to 68)

EDUCATION IN ADULthood

Although over two thirds of Aboriginal survey participants (68%) did not obtain any educational qualifications during their time in care, many participants achieved educational qualifications later in life. Regarding the highest educational attainment, about 20.3% obtained various trade or vocational certificates and 13% achieved Year 11 or 12 (equivalent to a Higher School Certificate). Furthermore, 19% were able to obtain at least one post-secondary qualification. Figure 18 shows the proportions of highest educational attainment.

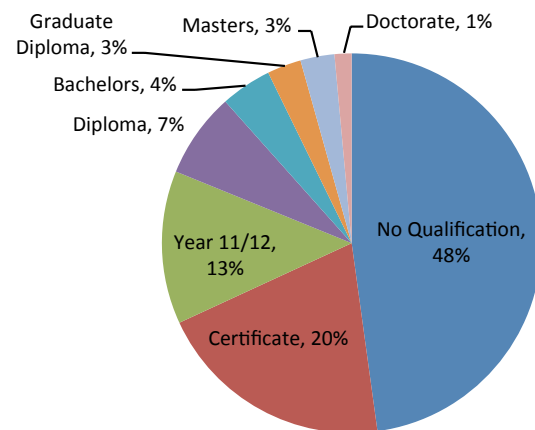


Figure 18: Highest educational qualification (n = 69.)

When their schooling status was compared with their highest educational qualification, it was clear that some participants were able to overcome the lack of schooling and achieved higher educational qualifications. As expected, higher proportion of people with a Higher School Certificate (27.3%) obtained a Bachelor's or higher degree. Despite the challenges of lacking formal schooling, 6.4% of individuals without any school certificate were able to obtain a Bachelor's or higher degree, as depicted in Figure 19. This shows the resilience of some participants who were deprived of opportunities for education while in care.

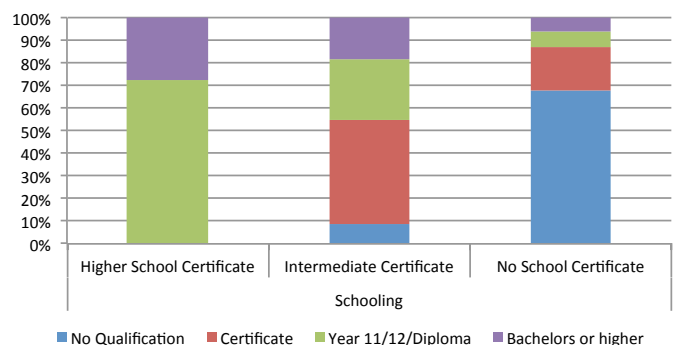


Figure 19: Highest qualification by schooling (n = 69)

Note. A Higher School Certificate is equivalent to Leaving Certificate, Matriculation, Senior Certificate; Year 11 or Year 12, an Intermediate Certificate is equivalent to School Certificate, Junior Certificate, Achievement Certificate, Year 10; and no school certificate means Year 9 or below

Achievement of educational milestones in adulthood has meant overcoming gross deficits in primary and secondary education experienced whilst in care was notable in this regard (Gilligan, 2007; Harvey, McNamara, & Andrewartha, 2016).

I did up to year 7 in boys' homes. Raised on the streets. I did do a course in prison similar to year 10. Didn't really pass but educated myself. 'Survey respondent'

From 5...but 30 years later went to [name] Uni. 'Survey respondent'

For most participants however, educational disadvantage experienced in childhood continued through adult life. Sheer survival for themselves and their families has proved an all-consuming priority throughout the adult years:

I tried but with work and school, work took priority. I ended up where my children grew up. Then I did nursing but because of lack of (adequate) diet (in childhood), I only worked for five years and then I contracted osteoarthritis so I'm out of the workforce now. By forty-five, yeah. 'April'

EMPLOYMENT

Survey participants were asked about their current employment status. Figure 20 shows that 61% of survey participants were not in the labour force (neither working nor looking for a job), 8% were unemployed (not working but looking for a job), and about 31.6% were either in full time (26%) or part time (5%) employment.

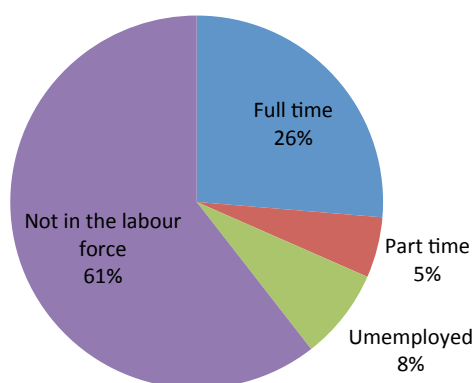


Figure 20: Employment status (n = 38)

Participants who were not in employment were asked about the reason for this. As Figure 21 below shows, the main reasons stated were inability to work (53.6%) and retirement (39.3%).

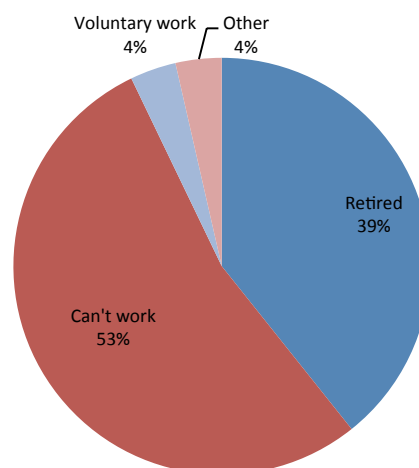


Figure 21: Reasons for not being employed (n = 42)

Participants were asked about the last job that they had. Occupations mentioned as the most recent job held were carer, manager, civil engineer, cleaner, community welfare worker, council employee, farm worker, labourer, motel manager, office worker, real estate agent, retail assistant, shop owner or truck driver.

Marginalisation from job opportunities upon leaving care was often the precursor to lifelong unemployment or to insecure, poorly paid and unfulfilling work:

First job I got was being a domestic servant looking on property...[institution] arranged that and then I wanted to find my brother ...in Sydney. They found me a job in Sydney and I was taken down there on the plane. I ended up ...working and living with the (wealthy white) people - I was the servant. I was the live-in maid. 'Charlotte'

FINANCIAL STRESS

Income

Overall, Aboriginal participants had relatively low incomes and this could be due to the fact many participants were not employed at the time of survey. As shown in Figure 22, over half (54%) had annual income below \$20,000, 22% had between \$20,000 and \$39,999, and 8% had between \$40,000 and \$59,999. In other words, most of Aboriginal survey participants (83.8%) had annual incomes below \$60,000. Nevertheless, about 2.7% of them were able to earn high incomes of \$100,000 or more per year. The median income in all jobs in 2015 was \$1000 per week (\$52,000 per annum) (ABS, 2016) and the average equivalised disposable household income in 2015-2016 was \$1,009 per week (\$52,612 per annum) (ABS, 2017a). Although these figures are not directly comparable to incomes of participants, they provide a point of reference.

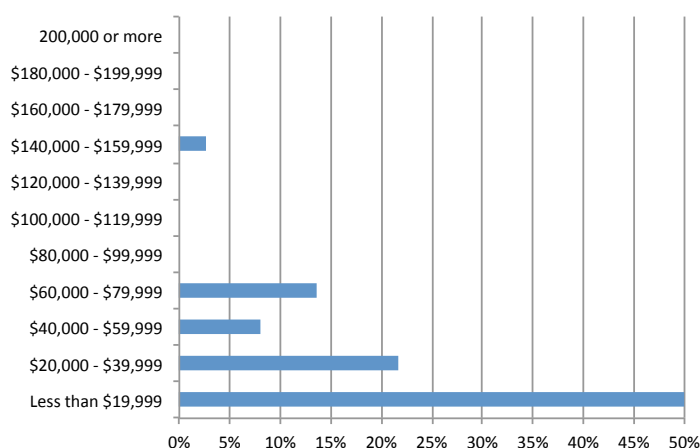


Figure 22: Current annual income (n = 37)

As illustrated in Figure 23, only 24% of Aboriginal survey participants had employment as their primary source of income and over two thirds of participants (69%) had statutory government payments as their primary source of income.

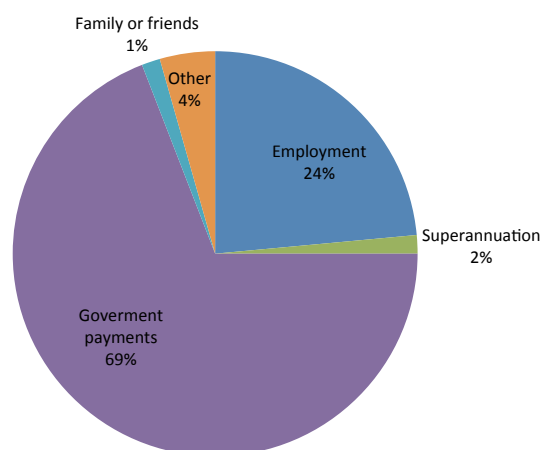


Figure 23: Primary source of income (n = 68)

The research explored participants' experience of financial stress in the past year. Given the low levels of income, a substantial proportion of Aboriginal participants experienced material hardships. Within 12 months prior to the survey, 36% experienced some forms of material hardship due to a shortage of money and about 4.7% experienced all forms of material hardship posed. Because of a shortage of money, 26.6% asked help from welfare/community organisations, 25% were unable to pay bills on time, 23.4% missed meals, 18.8% could not afford heating or cooling in their home, 15.6% asked help from friends or family, 15.6% pawned or sold something, and 15.6% were not able to pay the rent or mortgage on time. These numbers are much higher than percentages found in studies with community samples. For example,

regarding the general Australian population, Bray (2001) reported 16.1% experienced hardship in bill paying, 4.2% pawned or sold off items, 2.7% missed meals, 2.2% were unable to afford heating or cooling in the home, 9.9% asked help from friends or family, and 3.5% sought financial assistance from welfare/community organisations. See Figure 24 for comparison.

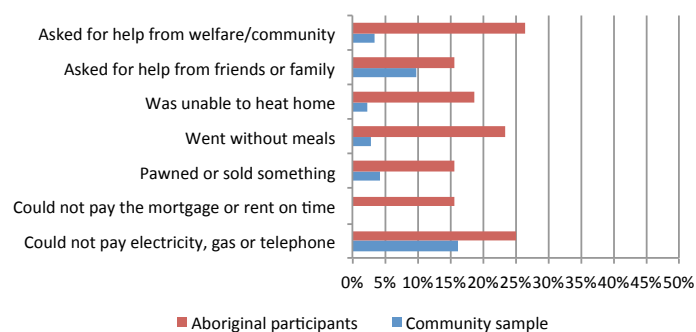


Figure 24: Material hardships (n = 64)

Note. Community sample is from Bray (2001). Bray (2001) did not include an item on paying mortgage or rent.)

Housing

As Figure 25 indicates, 32% of Aboriginal survey participants owned or were buying the dwelling they were living in, 25% were renting privately (15% with public assistance and 10% without public assistance), 29% were in public housing, and the rest were in other forms of housing (e.g., hotel, nursing home, prison). Aboriginal participants were more likely to rent in social housing and less likely to be in home ownership compared to the general community. In 2016 Census, 38% of Aboriginal and Torres Strait Islander households owned their house outright or with a mortgage whereas 66% of non-Indigenous households did (ABS, 2017b). The percentage of homeownership among Aboriginal participants in this study was slightly lower than the percentage among general Indigenous households and much lower than the percentage among non-Indigenous households, including those represented by participants in the larger study (Fernandez et al., 2016). In the large study which included the three cohorts of Forgotten Australians, former Child Migrants and Stolen Generation survivors, over half of survey participants (51%) owned, 22% were renting privately, 19% were in public housing, and the rest were in other forms of housing.

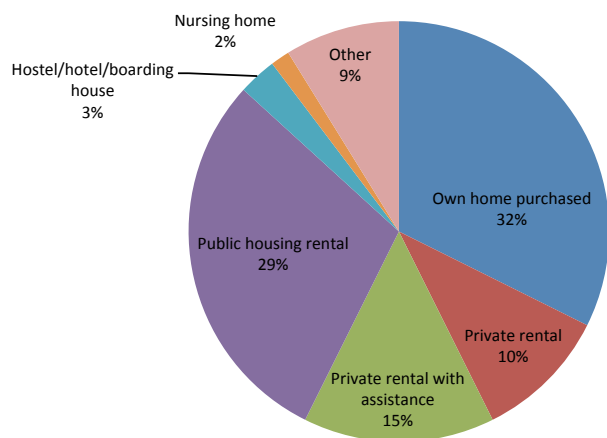


Figure 25: Current accommodation (n = 68)

High proportions of Aboriginal respondents had experienced housing difficulties. Figure 26 indicates that at some point in their lives, 53% had experienced homelessness, 53% lived in public housing, and 61% had temporary housing. Nonetheless, 48% had an experience of being a homeowner at some point in their lives.

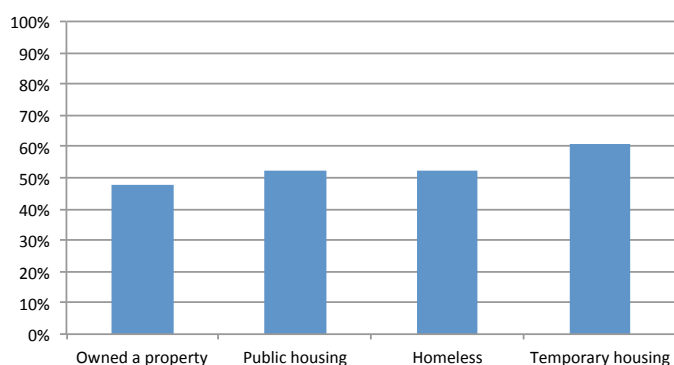


Figure 26: Housing history (n = 30 to 40)

However, many Aboriginal study participants described a relentless battle to secure adequate housing for themselves and their families. This is often ongoing and is made more complex by family breakdown and the need to accommodate kinship care of children and elders in larger dwellings. This is currently a challenge for many participants and their children and grandchildren.

You have to pay an expensive grant for a crappy house, but I've got security. I can honestly say I've never lived at one address longer than what I've lived in that house up there (now) because I've always had to move. 'Sharon'

INVOLVEMENT WITH THE JUSTICE SYSTEM

The research explored whether participants had involvement with the justice system as adults. Survey participants were asked whether they had been to gaol or had been convicted (without going to gaol). As Figure 27 below indicates, 54% of Aboriginal participants did not have any involvement with the justice system and 46% had criminal records (18% with convictions only and 28% with imprisonment).

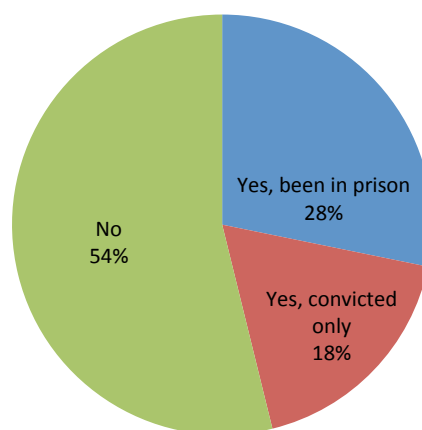


Figure 27: Conviction and imprisonment (n = 39)

Incarceration often had catastrophic impacts on individual wellbeing and on family relationships as children, parents and siblings experienced separations that too often resulted in long-term disruption:

I still to this day don't know where my brother is. I'd love to find him. I know he became a biker. He went to jail a lot of times.I had to watch him as a grown man break down and cry, hit the ground and say why? Why? Why? Why? I still can't answer that question. Just because it was. People do cruelty because they can. 'Charlotte'

RELATIONSHIPS AND SOCIAL OUTCOMES

This section explores the nature of relationships formed with others in the adult lives of participants – with partners, family members and friends, as well as their involvement in community and a sense of belonging.

Bio-psycho-social impacts of early trauma and attachment disruption often proved major impediments to adult relationship fulfilment and stability. Impaired neuro physiological development creates serious challenges in this domain (B. D. Perry & Szalavitz,

2017; Van der Kolk, McFarlane, & Weisaeth, 1996). The struggle to achieve a secure cultural and family identity, little exposure to modelling of positive relationships in childhood and alienation from community support also contribute to a tragic pattern of relationship breakdown for many Aboriginal participants. Too often that endures throughout adult life and can include friendships, intimate relationships and links with nuclear and extended family.

About one third of Aboriginal survey respondents (35%) lived on their own and 40% lived with a partner. The levels of social support that they had were measured by MSPSS (Multidimensional Scale of Perceived Social Support). As shown in Table 11, the average of perceived social support was 4.24 for significant other, 3.44 for family, and 3.53 for friends domain on a 7-point scale. The average score on the total support scale was 3.70. Although characteristics of samples vary, compared to participants in the following studies involving community samples, Aboriginal participants had lower levels of perceived social support. For example, an Australian study with university students had an average score of 5.21 for men and 5.65 for women (Anderson & Kidd, 2014) and a US study with pregnant women, adolescents, and medical residents reported average scores of 6.01, 5.60, and 5.85 respectively (Zimet et al., 1988).

Table 11: Social support

	<i>n</i>	<i>Freq</i>	<i>%</i>	<i>Mean</i>	<i>SD</i>	<i>Range</i>
Whom you live with[‡]	40					
No one	14	35.0				
Partner	16	40.0				
Children	10	25.0				
Grandchildren	1	2.5				
Parents	1	2.5				
Other	0	0.0				
MSPSS[†]						
Significant other	36			4.24	2.19	(1 – 7)
Family	37			3.44	2.19	(1 – 7)
Friends	35			3.53	2.15	(1 – 7)
Total	35			3.70	1.92	(1 – 7)

Note. [‡] The total exceeds 100 percent because participants were able to choose more than one option. [†] Multidimensional Scale of Perceived Social Support. *SD* refers to standard deviation.

Survey participants reported having frequent contact (*Mdn* = 5, equivalent to 'fortnightly or more') with their partner, children, and friends (Figure 28). Their contact with other family members such as siblings, parents, and aunts and uncles, seemed to be less frequent. This might be explained by the fact that older relatives may have passed away or that they could not be located having been estranged from them in the process of forced removal.

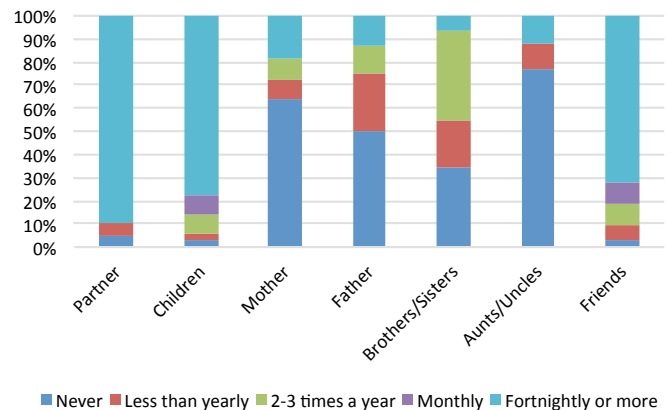


Figure 28: Frequency of contact (*n* = 8 to 37)

On average, survey participants reported feeling close to their partner (*Mdn* = 5), children (*Mdn* = 4), and friends (*Mdn* = 3) in that order (Figure 29). On average, they felt less close to other family members (mother, father, siblings, aunts, and uncles).

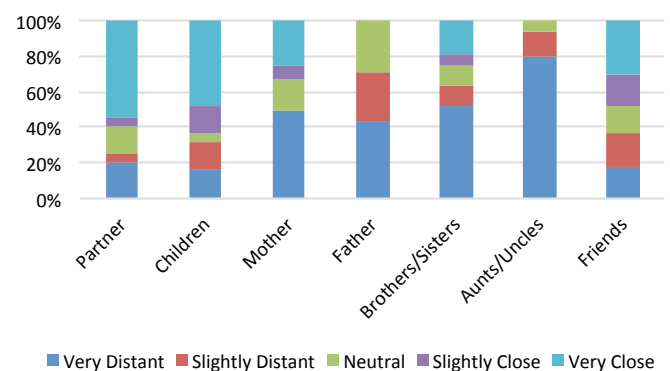


Figure 29: Closeness to others (*n* = 7 to 39)

Relationship with partners

Among Aboriginal survey participants, 41.4% had a partner either in a married (35.7%) or de facto (5.7%) relationship. They reported that the average duration of their first relationship was 19.9 years (ranging from 6 months to 61 years) whereas the average duration of their longest relationship was 21.3 years (ranging from 3

years to 61 years). Most of survey participants (87.5%) believed that their experiences in care affected their relationships with partners in some way. As indicated in Figure 30, positive effects included strong attachment to a relationship (23.5%) and strong commitment to a relationship (23.5%). They also reported that their care experiences negatively influenced their relationships with partners by creating difficulty in trusting (85.3%), difficulty in dealing with conflict and solving problems (67.6%), difficulty in communicating (73.5%), and difficulty in making a commitment (50%).

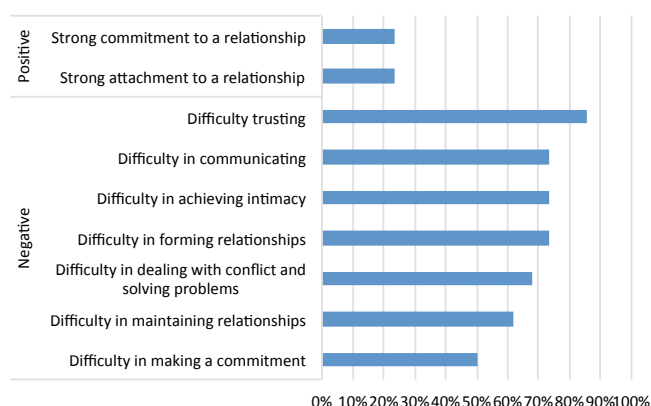


Figure 30: Effects of care experience on relationships (n = 34)

Social isolation and lack of resources for Aboriginal participants, who have struggled to locate and re-connect with their families and communities, has often been extreme (HREOC, 1997). It has driven many participants into dysfunctional and dangerous relationships from an early age:

I had nowhere to go, no family, no finance. I married young, I feel for security reasons mainly. It was an abusive relationship. I was 18 when I married, separated at 21, one child from the relationship. 'Katy'

Relationship with children

Parenthood

Table 12 indicates most of Aboriginal survey participants (85%) had children. The average number of children was 3.3 (0 – 10 children). On average, Aboriginal survey participants in this study were 23.7 years old (16 – 34 years old) when they had the first child. 37.1% of respondents said that they were worried about having their children taken into care and 8.6% of them actually had their children taken into care. More than two thirds of Aboriginal participants (69.7%) reported that their experiences of being in care affected their children in some way.

Table 12: Children and parenting

	n	Frequency	%
Have children	40		
Yes		34	85.0
No		6	15.0
Age at having 1st child	33		
Under 18		3	9.1
18 – 19		5	15.2
20 – 24		10	30.3
25 – 29		10	30.3
30 – 34		5	15.2
Worrying about children taken into care	35		
Yes		13	37.1
No		22	62.9
Any children taken into care	35		
Yes		3	8.6
No		32	91.4
Own care experience affected children	33		
Yes		23	69.7
No		7	21.2
Don't know		3	9.1

Figure 31 shows the perceived effects of care experiences on their parenting. Positive effects included strong commitment to keeping the family together (66.7%), strong desire to be a good parent (66.7%), and strong attachment to their children (55.6%). Negative effects included difficulties in providing emotional care to their children (70.4%), difficulties in relationships with extended family (66.7%), challenges in parenting children generally (55.6%), providing financially (51.9%), and educating children (40.7%).

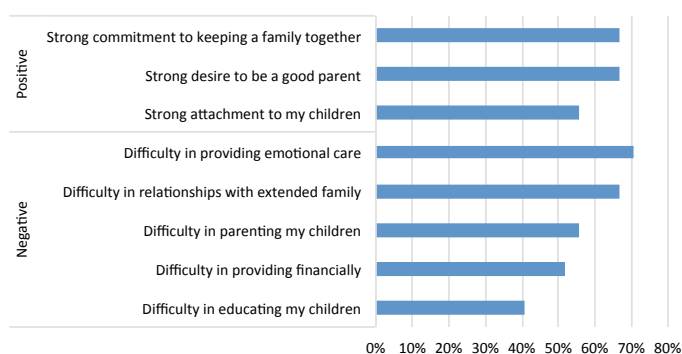


Figure 31: Effects of care on parenting own children (n = 27)

Social contact and community involvement

Figure 32 details patterns of contact with other people in care. After leaving care two thirds of Aboriginal survey participants (67%) maintained contact with friends who were in care with them. A smaller percentage of people maintained contact with other people: support workers (24%), foster or adoptive parents (14%), foster or adoptive siblings (14%), care staff (14%), teachers (5%) and others (10%).

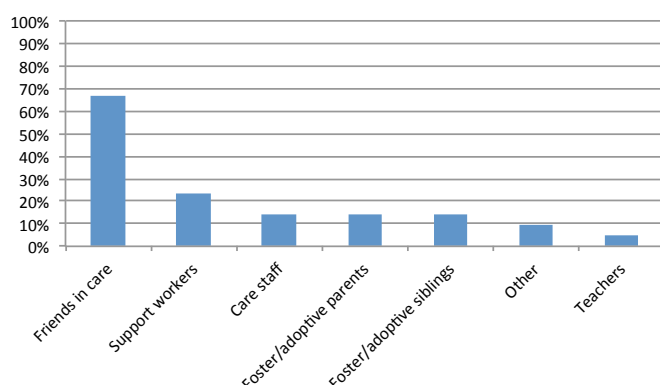


Figure 32: Contact with people in care (n = 21)

Community engagement for Aboriginal people who participated in this study, and for Aboriginal people in the broader community, would not appear to be focused on formal religion. Rather, a number of Aboriginal participants mentioned their participation in Aboriginal organisations.

I started turning things around in the Department. I said, 'You need more family consultation. You need to sit down with that family and talk about what's going on before you remove the child.' (When) the Aboriginal childcare agencies started up here in Alice Springs we started...I was on the Committee there. We had the option of consulting with the childcare agency and the families about where these children should be going. I said, 'If the parents are drinking, place them with an Aunty or grandmother.' 'Clara'

Engagement in activism on behalf of their communities manifests courage, resilience and generosity of spirit on the part of Aboriginal and Torres Strait Islander survivors. These are people whose lives have been heavily impacted by neglect and abuse and the trauma and attachment disruption associated with this. For many survivors, taking care of themselves and their immediate families is a huge undertaking in the light of health and mental health problems, educational disadvantage, housing issues and other adult impacts of removal from family in childhood. Advocating for the wellbeing of other Aboriginal and Torres Strait Islander people, including young people in the child protection system today, often means adding a heavy load to existing burdens.

Participants also mentioned the importance of connecting with peers who shared a common experience, especially the all too common experience of losing children through untimely death.

Yeah, so we sit down and support each other...we're there. We don't just walk away after...you know, 'sorry business is finished.' We still connect, and we see each other. We still hug each other and think about things. 'Clara'

Overall, the importance of religion was reported to be 2.5 on a 10-point scale (1= not important at all, 10 = extremely important). As illustrated in Figure 33, about 32% of survey participants did not have any religion and 55% had Christian faiths (35% Catholic, 15% Protestant, and 5% other Christian). A further 13% had different religions or spirituality.

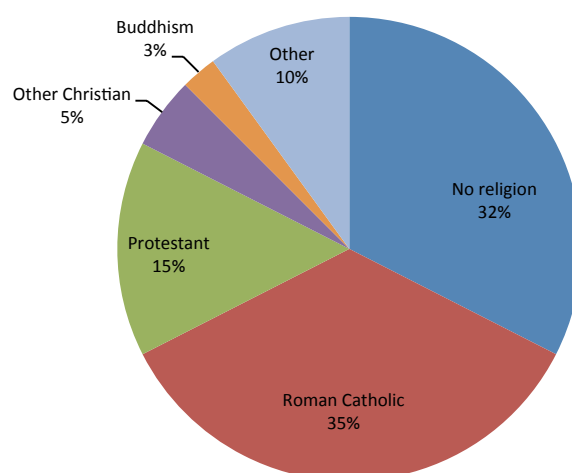


Figure 33: Religion (n = 40)

PHYSICAL AND MENTAL HEALTH

Figure 34 illustrates overall physical and mental health outcomes. Although it is sometimes artificial to totally separate physical and mental health symptoms we will attempt to delineate these in the following sections.

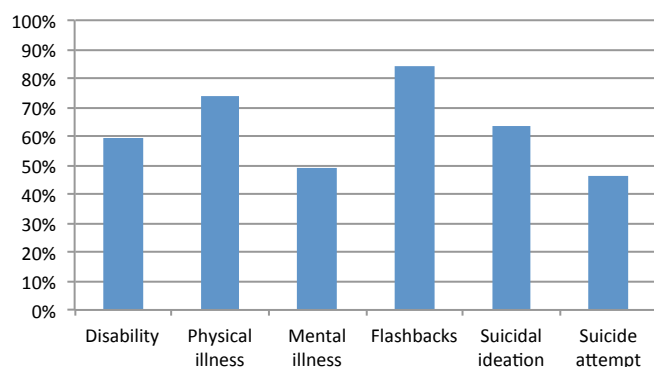


Figure 34: Physical and mental health outcomes (n = 33 to 39)

Physical health

61.5% of Aboriginal survey respondents reported having a disability (Table 13). Among people with a disability, 70.8% had a permanent disability, 58.3% needed ongoing support, and 16.7% had an intellectual or neurological impairment. Almost 87% of respondents reported having physical illnesses requiring on-going treatment at some time (73.7% had current physical illnesses) and they rated the level of its interference with daily activities as 5.7 on a 10-point scale. More than half (53.6%) considered their physical illnesses were related to their experiences in care. Those experiences of abuse and neglect have clearly had serious impacts on lifelong wellbeing.

Table 13: Physical health

	n	Frequency	%
Disability	39		
Yes	24		61.5
No	15		38.5
Type of disability[‡]	24		
Requires ongoing support	14		58.3
Permanent	17		70.8
Reduced mobility and self-care management	4		16.7
Intellectual/neurological impairment	4		16.7
Other	1		4.2
Physical illnesses	38		
Yes	28		73.7
No longer have	5		13.2
Never had	5		13.2
Physical illnesses related to care	28		
Yes	15		53.6
No	8		28.6
Don't know	5		17.9

Note. ‡ The total exceeds 100 percent because participants were able to choose more than one option.

For Aboriginal participants serious (often co-existing) health problems have been lifelong companions which continue to undermine wellbeing (Kendall-Tackett, 2002). Some injuries and issues are a direct legacy of abuse and neglect in care. Enduring impacts of back and other orthopaedic injuries appear to be especially common for participants who undertook cruel labour as children. Damage resultant from blows to the head have also had long-term neurological consequences for many. Dental problems are almost ubiquitous. Other health issues overrepresented in Aboriginal and Torres Strait Islander communities such as diabetes and trachoma are also experienced at high rates in Aboriginal and Torres Strait Islander participants (AIHW, 2011; Diabetes Australia, n.d.).

Mental health

Exposure to traumatic stressors are viewed as contributing factors to a variety of mental health problems (Rice, 1999). A high proportion of Aboriginal survey participants experienced psychological distress and mental illnesses as shown in Table 14. In total 69.2% reported having mental illnesses requiring

on-going treatment at some time (48.7% had current mental illnesses). Among participants with mental illnesses, the vast majority (81.8%) perceived their mental illnesses to be related to their experiences in care. In the past, 45.2% of respondents were hospitalised for mental illnesses (22.6% of them in the past 5 years) and they rated the level of its interference with daily activities as 6.21 on a 10-point scale. 84.2% of participants reported experiencing flashbacks with varying frequencies.

Table 14: Mental health

	<i>n</i>	Frequency	%
Mental illnesses	39		
Yes		19	48.7
No longer have		8	20.5
Never had		12	30.8
Mental illnesses related to care	22		
Yes		18	81.8
No		4	18.2
Hospitalisation for mental illness	22		
Yes, in the past 5 years		7	22.6
Yes, but not in 5 years		7	22.6
No		17	54.8
Flashbacks	38		
Yes		32	84.2
No		5	13.2
Not sure		1	2.6
Frequency of flashbacks	33		
Several times a day		4	12.1
Daily		10	30.3
Weekly		5	15.2
Monthly		7	21.2
Less than monthly		7	21.2

While in care, all Aboriginal participants experienced some form of maltreatment and almost half of them experienced all forms of maltreatment. Such experiences of cruel treatment left lasting impacts on many Aboriginal survivors. 'Aunty June' recalls serious damages done to her brother who was also in care:

When (my brother) turned eighteen he came back to the family and he's never been the same. I could remember him having nightmares and screaming and crying. My dad would run into the room and put his head on his lap. And dad would cry with him. This man was eighteen. He said, "It's what they did to me Dad. It's what they did to me". I always wondered why and one day he started talking to me about it. He was crying. He said, "I really can't talk about it because it hurts so much." He said how the boys were treated, what they did to him, how cruel they were. He went on to explain a couple of things. He broke down and he couldn't continue. And this happened a couple of times. I would cry with him. That experience in the home – he's never been the same. 'Aunty June'

A standardised measure of K10 psychological distress allowed the comparison between participants in this study and community samples. The average K10 score for Aboriginal participants was 27.41 ($SD = 12.72$). Figure 35 compares the Aboriginal participants in this study with community samples (2007 HILDA and 2007 NSMHWB). Much higher percentages of Aboriginal participants in this study reported 'very high' (43%) or 'high' (17%) levels of distress. The percentage of people in a 'low' distress category was much smaller (20%) and the percentage in a 'moderate' category was similar (20%)⁴. The percentage of Aboriginal participants in the 'very high' distress category was 9.7 times greater than the percentage found in a community sample of HILDA (2007) and 16.5 times greater than the percentage found in a community sample of NSMHWB (2007).

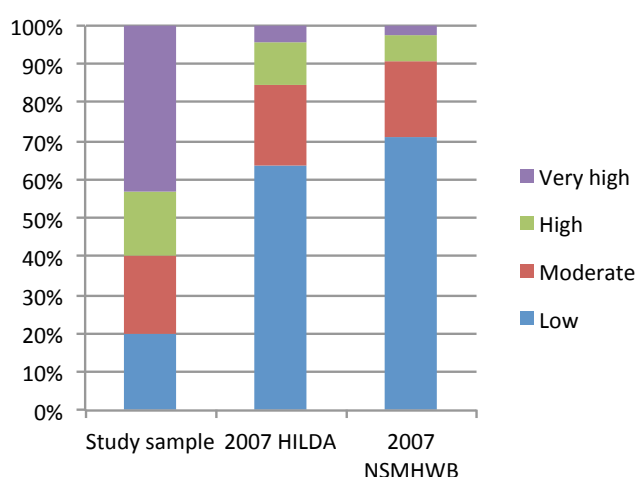


Figure 35: Comparison of K10 psychological distress categories with community samples (n = 35).

Note. HILDA refers to Household Income and Labour Dynamics Australia and NSMHWB refers to National Survey of Mental Health and Wellbeing. Source: Wooden (2009).

⁴ Following the ABS (2012), K10 scores are grouped into four categories: Low (10 – 15), Moderate (16 – 21), High (22 – 29), and Very High (30 – 50). See details from <http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08>

Flashbacks

Most participants (84%) have experienced flashbacks regularly or occasionally. The most mentioned trigger was the media, including news, the Royal Commission into Institutional Responses to Child Sexual Abuse, TV shows and movies. Family gatherings, celebrations (such as Christmas) and meetings with peers in care were also often mentioned. Situations of everyday life can be triggers as well such as, different buildings and objects (e.g. red brick buildings, yellow tiles, multi-coloured carpets, latex gloves); everyday activities (e.g. having a shower, sexual intimacy, dreams, forming a queue like lining up in a supermarket); authority figures (doctor, lawyer); food (pasta, sandwiches, lumps in porridge); a smell (beer, aftershave); noises; dark room (unable to sleep without a light), crowd or peoples' behaviours (yelling, comments, confrontation):

When out driving in new areas surprise sightings of large bright red brick buildings make me feel sick inside. Stale sandwiches, pasta meals. Finding a lump in porridge in my mouth could make me vomit. Being told to or made to form a queue (like lining up in a supermarket.) 'Survey respondent'

Suicidal ideation and attempt

When asked about suicidal ideation and attempt, 38 persons responded to this question. Sixty-three percent of them ($n = 24$) reported experiencing suicidal ideations at some point in their lives. Among respondents with suicidal ideation, 70.8% have attempted suicide, which was equivalent to 45.9% of people who answered the questions related to suicide.

Trauma arising from attachment disruption, maltreatment and neglect has been a key contributor to high rates of mental illness and ongoing mental health disabilities among care leavers generally (J. C. Perry, Sigal, Boucher, & Paré, 2006; Van der Kolk et al., 1996). For Aboriginal participants in this study and those whose lives are described in earlier Aboriginal and Torres Strait Islander specific research (HREOC, 1997; Senate Community Affairs References Committee, 2004) mental illness has often proved severe, a lifelong burden. Diagnoses of serious conditions including schizophrenia, bipolar disorder, complex post-traumatic stress disorder are reported by participants in this study. Almost all Aboriginal participants would appear to have experienced some degree of mental health difficulty in adult life. This is consistent with expert informant observation.

There would be not any of them that didn't have some element of mental health issue. 'SI1'

Every person that I've seen walk through the door has significant issues around anxiety, depression. 'SI3'

Ongoing anxiety, depression, flashbacks, dissociation, phobias, mistrust and paranoia, instability of mood and hypervigilance are some of the disturbed mental health phenomena described by participants to the researchers. Many Aboriginal participants mention episodes of suicidality and have actively self-harmed, often on multiple occasions. Repeated admissions to psychiatric facilities are commonly reported; full recovery seems rare. The latter is unsurprising given the serious contemporary and historical stressors predisposing this cohort to psychiatric ill health and long-term disability:

Being locked in dark rooms (can't sleep without light) locked in dark room for 3 months by [...] and constantly locked up in [...] mental hospital and injected with antipsychotic drugs and put in strait jackets and x shock treatments and raped repeatedly. 'Survey respondent'

Drug and alcohol misuse are frequently reported as 'self-medication' in the face of unbearable psychological pain.

Drug and alcohol use

Regarding alcohol, 23.1% of Aboriginal participants had never consumed alcohol, 20.5% had consumed alcohol in the past, 20.5% were daily drinkers, 7.7% were weekly drinkers and a further 28.2% were less than weekly or occasional drinkers. 37.5% were current tobacco users (32.5% of daily smokers) and 40% were previous smokers. A very small proportion of respondents (8.6%) were current illicit drug users although 56.5% of participants were past users, as illustrated in Figure 36.

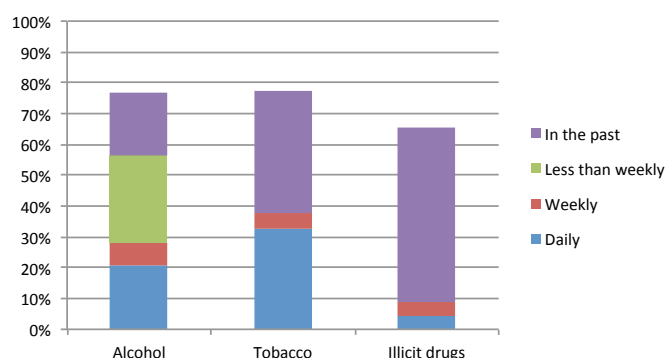


Figure 36: Drug and alcohol use ($n = 23$ to 40)

A total 23 Aboriginal participants responded to the question about the negative effects of drug and alcohol (Figure 37). Of these, some reported that drug and alcohol negatively influenced their relationships (43.5%), health (56.5%), and work (17.4%).

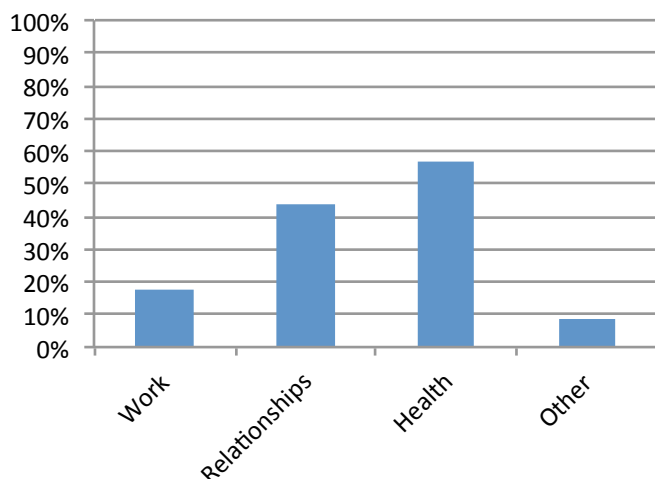


Figure 37: Negative effects of drug and alcohol use (n = 23)

Seeking help and support services

The extent and nature of assistance sought by participants and the sources of support available to them were explored in the study. In difficult times for various reasons, Aboriginal participants indicated that they intended to seek help mostly from their partners although this differed by the reason for seeking help: illness (54.5%), financial emergency (52%), emotional upset (40%), advice (31%), other crises (38%), and needing accommodation (29%). Support workers and friends were the second most frequently mentioned sources of help in times of difficulties. Participants intended to seek help from support workers for advice (28%), emotional upset (24%), and other crises (33%). They intended to seek help from friends for advice (38%), emotional upset (24%), and other crises (24%). Although smaller in proportions, some participants indicated they would seek help from their children, other family members, neighbours, and emergency services for various difficulties. See Figure 38 for details.

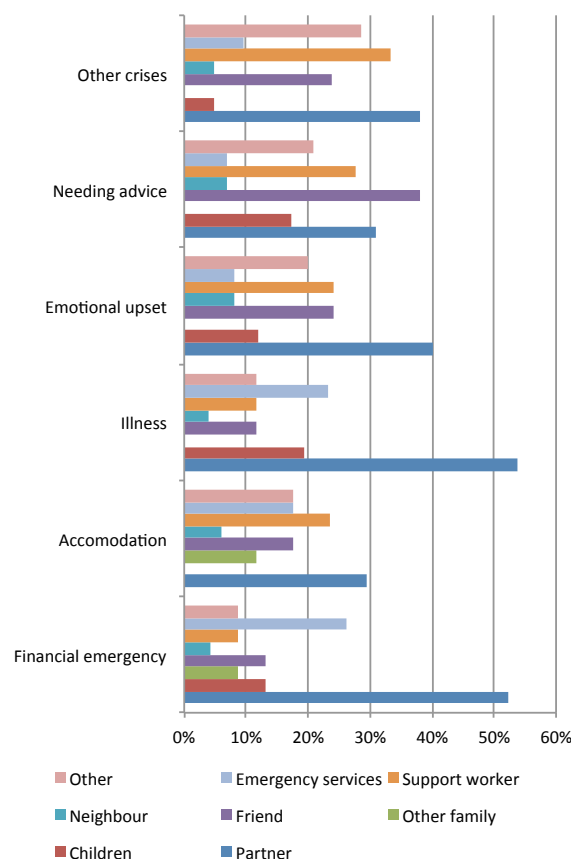


Figure 38: Seeking help in difficult times (n = 17 to 31)

About 62.2% of Aboriginal participants received help from various sources in managing difficulties related to their experiences in care (Figure 39). The most frequently mentioned source of help was organisations for care leavers (49%). This was followed by counselling/therapy (24%), children (22%), friends (22%), and partner (19%).

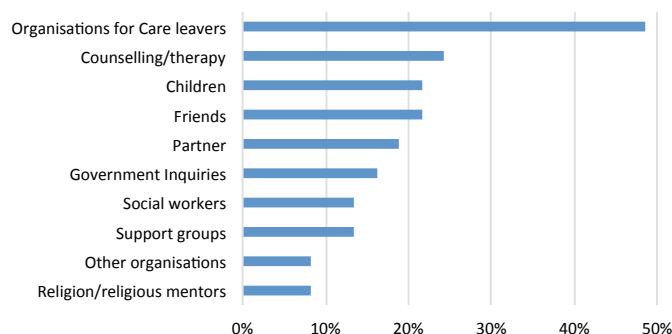


Figure 39: Help in dealing with care effects (n = 37)

More than half of Aboriginal survey respondents (59%) reported being active in organisations that promote wellbeing of care leavers. Participants reported having been active in Lotus Place (n = 11), Linkup (n = 7), Alliance for Forgotten Australians (n = 7), Care Leavers Australia Network (n = 7), Find and Connect (n = 5), Adults Surviving Child Abuse (n = 5), Stolen Generations Alliance (n = 3) as well as other organisations.

Culture

Many participants grieve the loss of connection to culture, especially loss of opportunity to pass on precious heritage to children and grandchildren:

That's completely lost, completely lost, and I'm at elder status now. And yet, who am I? Who am I actually to be able to give any guidance in regard to that? All I can do is hand on the information that I have in the hope that they might, and there's members of my family like a first cousin of mine, her, one of her boys has gone dancing...grabbed hold of it and went with it, and they're respected elders down in [...], they're respected elders and it just gives me goosebumps thinking about them because I'm not. 'Rick'

Not only were Aboriginal parents and children torn apart, often forever; children lost their extended kin network and an identity grounded in country, ethnicity, culture, subculture and language (Edwards and Read, 1989; HREOC, 1997; Walsh, 1998). Where reunification was attempted later, it often proved enormously difficult. Children removed as babies and toddlers often had no idea where their people were or where their traditional lands were located. It could take many years (and was often impossible) to piece together a lost identity which had its foundation far from home. Only very rarely was culture and language reclaimed; this is clearly identified by service providers in this domain:

There is a huge other dimension, because it wasn't only identity. It was actually culture, where we systemically dismantled their identity and their culture and made them European. 'Expert Informant'

Discrimination was clearly rife within the institutions and other forms of out-of-home care. Some participants described these as deliberate attempts to erase their Aboriginality:

We didn't know we was Aborigine. They used to call us 'negroes' and 'thick lips'. We don't know nothing. We're not Aborigines; we are white people. Yes, we feel like we wasn't Aborigine people at all. We think like we were white people! We didn't know nothing about it cos we wasn't allowed to talk about it. I feel like our culture was stripped away from us. 'Myrtle'

They tried to turn us into white... My mother was clean, you know, we knew how to be clean.... They said, 'sit down, we're gonna wash you up straight away!' You know, but that's...because in the home they made us scrub and things like that.... you know what I mean, but they got this all wrong... 'Von'

Resilience and healing

The tragic residue of a childhood spent in care has predictably proved overwhelming for many Aboriginal participants. This has made it especially moving to learn not only of survival, but of extraordinary levels of resilience and determined progress toward healing achieved by many. Traditional approaches to reflectivity, creativity and spirituality have clearly been applied to positive effect by some Aboriginal participants on their recovery journey.

You've got to come out of that fierce anger. For me I had to come into my righteous anger. That there is an anger but it's a righteous anger because there was a wrong committed originally. So just changing all the way you think about it, the way you relate to it when you're coming back at it. That's what you have to change...My Dad's from the bush. My Mum's from the beach. And I went through a lot in my life. I had a couple of breakdowns. And I had to find my place and both place had two different healings. The bush has a unique healing and when I get to that point when I'm just about to go snap, I go to the bush. But the beach has another healing. It flows through and the bush brings it out. I was taught that and that's how I got through. My granddaughter – she knew I was going to suicide one day. She's seen it. And she talked me through it. She said, "What happened? What happened to us?" ...I'm making my backyard my healing space. I'm claiming it. 'Charlotte'

Commitment to advocacy and social action are powerful manifestations of the resilience and courage of Aboriginal participants.

I think we've got to reach the grass roots people. People in our community are really shy and they're frightened of authority. We've got to go into those communities and reach them and find a way or ways of saying, "Okay. This is what's happening. I need to help you". And someone who knows that, all about the law, but be able to bring it down to our level when we understand it. 'Auntie June'

Participants want their survival and their narratives to make a difference. They exhort the child and family welfare sector to learn from their horrific history of abuse and neglect and apply those learnings to the care of children removed from their birth families today.

I would like children to be believed even when what they are saying is unthinkable. I would like all children to be safe. I would like children who have been abused to be embraced by the community and given every support and understanding that is possible. 'Survey respondent'

There is also evidence of an astonishing capacity for Aboriginal participants to locate humour in narratives where many would find only despair:

I think it's always been there. It's just something that grows in you. I call it like a protective – you know like in an egg? You've got the shell and then you've got that little membrane over the white and the yolk between that softens and the shell? There's a membrane and you don't see it when it's raw but when you cook it and you got a shell egg, you'll get to that membrane before you get to the egg. I feel that's what happened to us. We grew this membrane to protect our really soft core and that's our funky humour. 'Charlotte'

ACCESS TO SERVICES

Figure 40 presents Aboriginal survey participants' ability to access services at the time of need. When participants needed services from general practitioners, they were able to access services easily ($Mdn = 5$, equivalent to 'always'). When needed, they received specialist services and physiotherapy 'most of the time' ($Mdn = 4$) and counselling, psychiatry, dentist and disability services 'sometimes' ($Mdn = 3$). Income support was also relatively accessible ($Mdn = 3.5$). Although smaller proportions of participants expressed their need for services, respondents reported more difficulties in accessing services such as drug and alcohol services, geriatric services, food services, and veterans' affairs.

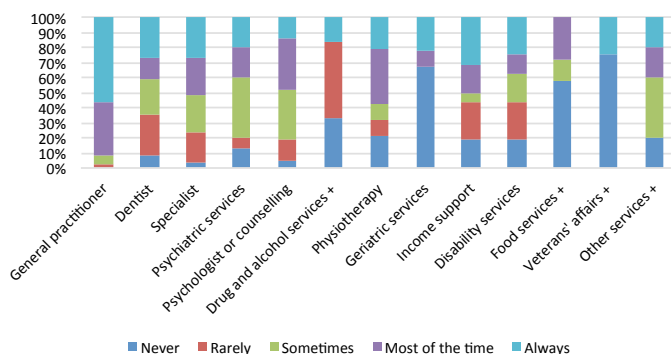


Figure 40: Access to services when needed (n = 4 to 37)

Note. +: Fewer than 10 participants responded to the question.

Barriers

The biggest barrier to accessing services was reported to be participants' inability to afford the costs involved (70%). About one third of survey participants also reported that lack of information about services (36%). Other barriers included lack of transport (24%), stigmas (18%), little or no availability of services (15%), and work commitments (15%). Figure 41 illustrates the barriers.

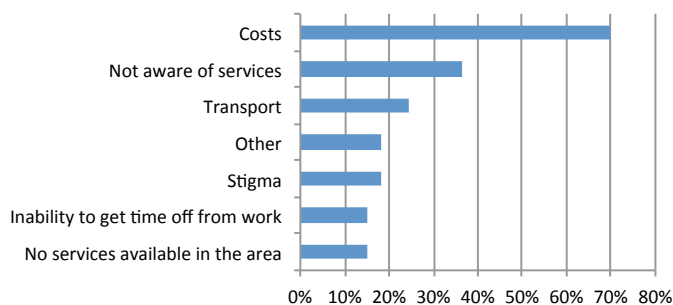


Figure 41: Reasons for not obtaining services (n = 33)

Dealing with authority figures

Aboriginal survey participants reported that their care experiences caused them to worry in relation to their contact with government organisations and authority figures (Figure 42). About 77% of them expressed their worries in relation to their contact with government organisations, this was followed by police/law enforcement (70%), welfare services (67%), or GP/health professionals (60%). Although smaller in percentages, they reported that their experience in care caused them to worry about their contact with their child's school teachers (53%), others in authority (40%), hospitals (40%), justice institutions (40%), rehabilitation centres (3%), and nursing homes (3%).

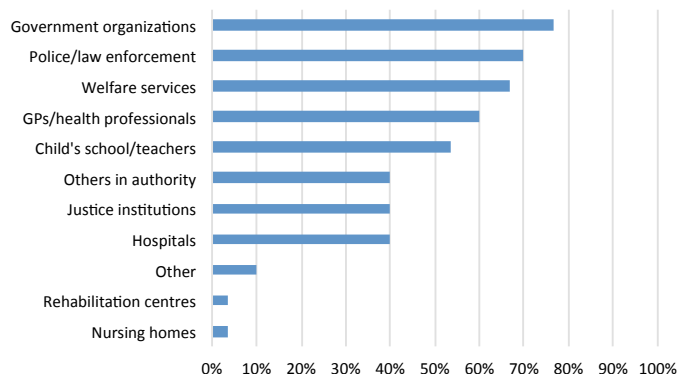


Figure 42: Perceived impact of care experiences on interactions with systems (n = 30)

The research further explored with participants their current and future concerns about engaging with potential services they might need. Figure 43 portrays some of the worries expressed by participants in the survey. In relation to their contacts with authority figures, Aboriginal participants were worried about various issues. The majority (91%) were worried about their own inability to trust people in authority and about two thirds of them were worried about being able to be taken seriously by people in authority (65%). Just around half of them were worried about abuse (53%), ability to make own decisions (53%), and lack of privacy (50%). Although smaller in percentage, respondents were also worried about care quality (44%), and relationships with staff (41%).

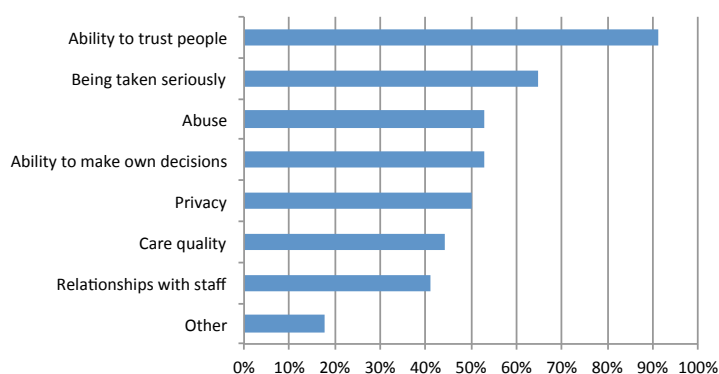


Figure 43: Worries experienced today (n = 34)

Access to care records

Most Aboriginal respondents (74.4%) had tried to access their records. As depicted in Figure 44, the most searched for items were care records and files (83%). Other items searched for were birth certificates (77%), records about their parents (73%), court documents (73%), photos (73%), siblings (67%), health records (67%), school records (60%). Most participants were not able to obtain the items they searched for. Only half of them were able to obtain birth certificates. Other obtained items included care records (23%), health records (17%), records about siblings (17%), records about parents (13%), court documents (13%), photos (13%) and school records (13%).

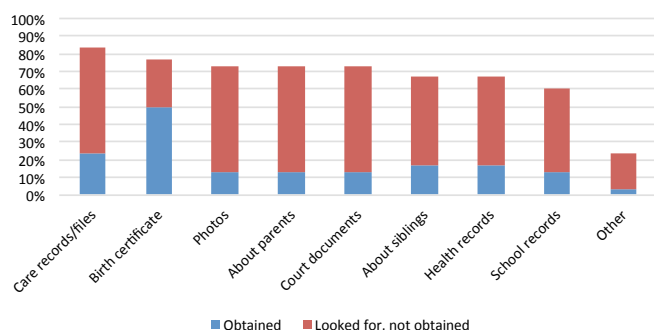


Figure 44: Accessing records (n=30)

Among Aboriginal participants who tried to access their records, about 82.8% received help from various sources (Figure 45). The most frequently mentioned source of help was organisations for care leavers (51.7%). This was followed by support workers (34.5%), other non-profit organisations (10.3%), child welfare departments (6.9%), and other sources (specialised record finding services, legal professionals, biological family, care staff, and institutions).

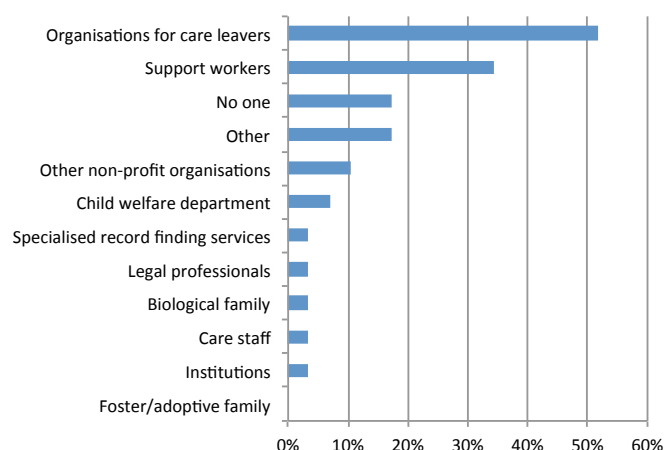


Figure 45: Help with accessing records (n=29)

Unmet service needs

The enormity of challenges faced by Aboriginal participants every day of their lives cannot be overstated. Support is urgently required in multiple domains. Lack of appropriate housing and finance combine with inadequate access to health and mental health resources. The following participants reflected deeply on the contemporary needs of Aboriginal survivors of out-of-home care, elaborating on their views:

I would like to see plenty of support for victims and their families; also, plenty of medical services for victims. There is no specialist psychiatric unit for people with complex post-traumatic stress disorder (which I have) due to years of sexual abuse and other abuse while growing up. I would like to see such a unit in both the public and private system. I would like to see compensation though no amount of money can truly compensate for the pain and suffering is too great. I would like to see privacy for the victims. ...I would like more understanding of complex post-traumatic stress disorder by health professionals and the public. I would like to see victims to be seen as strong and fortunate to have lived to tell the story. I would like victims not to be seen as mad or bad or druggies or lost causes. 'Victoria'

We need education in things like computers, literacy, numeracy and all the basic skills we did not get as children. We need programs that take into account our special needs as abused children. 'Survey respondent'

Aboriginal participants in this study are an ageing cohort. Unsurprisingly they, and those caring for them, express an urgent need for increased Aboriginal specific aged care facilities responsive to the needs of those who spent time in care as children.

Aged care is certainly something where people are going to be quite resistant. I know in our community they're all, "I ain't going into an aged care centre because it's going to feel too much like being in care". So, we're very fortunate again in [...], that we have Aboriginal aged care programs that run out of cooperatives, which encourage people to stay at home until such time that they do need to go into care. And when they do, we've actually got one (Aboriginal specific) aged care centre in [...]. It's a brand new service. 'SI3'

Aboriginal participants are often undertaking kinship care of grandchildren and other community members. This means they require different forms of housing from that which might be anticipated in the later stages of life (Martin, Pawson, & van den Nouwelant, 2016). It should also be noted that Aboriginal and Torres Strait Islander care leavers are often experiencing extreme financial disadvantage. This means that many cannot meet their living expenses on Commonwealth Government aged care packages and require special assistance (McComsey, 2010).

Those who were part of the Stolen Generations have less – suffer more than the rest of the Aboriginal population in all of the social and economic standards. So, something needs to be put in place to support them. 'SI4'

Audiology, pathology, optometry, dentistry, physiotherapy, occupational therapy, prosthetics and orthotics are just some of the ancillary health services which participants need on an ongoing basis. These are in addition to their primary health care needs for ongoing assessment, review and management of chronic health issues, disabilities and illnesses. Most also require multiple medications and surgeries. For Aboriginal participants the risk of Type 2 Diabetes and renal failure is elevated along with hearing loss and vision impairment (AIHW, 2011; Diabetes Australia, n.d.; Shaw & Tanamas, 2012).

Another pressing need identified by Aboriginal participants and those who care for them lies in the domain of child protection. Aboriginal and Torres Strait Islander children are currently removed from home on protective grounds at around 10 times the rate of non-Aboriginal children nationally. Notwithstanding the Aboriginal Child Placement Principle, only 50.6% of Aboriginal children currently in care are placed with Aboriginal carers (35.3% with relatives/kin and 15.3% with non-relative carers) (AIHW, 2018b). These are issues of grave concern to both participants, especially those who are kinship carers, and expert informants in the study. The right to maintenance of culture, language

and customs while a child is placed in out-of-home care is enshrined in Articles 20 and 30 of the Convention of the Rights of the Child (United Nations, 1989). For example, Article 30 explicitly references need for Aboriginal children and young people to enjoy culture/ language in community with other Aboriginal people.

The need for a policy and programmatic shift to a stronger therapeutic and culturally embedded focus was identified:

If you look at...some of the Scandinavian countries – it's much more about (how) a family might have a problem and let's work with the family around that problem. And it doesn't create dependency so what is it about the system that we're still repeating some of the same problems of the past? ...and strengthen and fund the rehabs because a lot of this is about alcohol and drug issues, you know? Where are the therapeutic supports? And you can't expect someone with long-term substance abuse issues to get sober in six weeks or six months. 'SI4'

We really need to help survivors live in the world today. In their families, in society and the anger and the hurt that they carry – we can never wipe it out. We do have to reduce it from being a twelve out of ten to a two out of ten, so they can live as normal as possible a life. So that's number one. Trauma informed counseling and access to that at any point. Number two – look it just depends on the survivor on what they actually want... all of this has got to be driven by what the survivor actually wants. Then again Number three I would have thought would be just to have access to... legal advice. 'SI5'

The Royal Commission into Institutional Responses to Child Sexual Abuse

Thirty-four percent of Aboriginal survey respondents ($n = 13$) participated in the Royal Commission into Institutional Responses to Child Sexual Abuse. In the main, their perceptions were slightly positive. The rating about the *'feeling that they had the opportunity to express their concerns'* was 6.5 on a 10-point scale (1 = not at all and 10 = very much). The rating about the *'feeling that there was acknowledgement of their concerns'* was 5.9 on a 10-point scale (1 = not at all and 10 = very much).

The Royal Commission into Institutional Responses to Sexual Abuse created the opportunity for some Aboriginal participants to tell their story and for it to be believed.

Finally, my story can be told without shame and not being called a liar. To have someone listen and hopefully and another child never has to go through anything like I did. Children need to be nurtured not neglected, abused, physically, sexually. 'Survey respondent'

Others saw little value in the Commission and identified compensation as the only way to address abuse and maltreatment that has occurred.

This Commission will not help in any way... the harm has been done and cannot be undone...no amount of talk will take away the pain of sexual abuse...I believe that compensation from the government for all children who were harmed whilst in their care... is perhaps one way to alleviate the harm and its daily flashbacks....'Survey respondent'

Limitations arising from the Commission's terms of reference and powers to make a difference were also raised by some participants.

Commission should be enlarged to pick up the torture & physical abuse of these children. Recompense should occur - like as in Victims of Crime. 'Survey respondent'

[The Commission] should be going deeper into non-Catholic homes and should be able to punish the organizations and remove their right to trade. 'Survey respondent'

This report presents Aboriginal specific findings from the UNSW led study *No child should grow up like this* (Fernandez et al., 2016). The study's primary purpose was to give voice to Australians who experienced out-of-home care between 1930 and 1989. It aimed to identify key features of their lived experience within out-of-home care and since leaving care. The study also aimed to profile participants' current service needs with a view to advocating for improvements in policy and programmatic development. In addition, it has attempted to elicit learnings from the study's findings that may be applied to today's out-of-home care.

Overall, this report presents an extremely grim picture of Aboriginal children's 'care' in the twentieth century. Very few Aboriginal participants recalled even a single positive experience from the moment of placement; instead, most described relentless abuse and maltreatment of the most horrendous order. Neglect of Aboriginal children on all levels was also extreme.

While these experiences described by participants can only be described as horrific, almost without exception it is humbling in the extreme to witness the courage, activism and self-healing abundantly manifest in the narratives recorded for this research. The multiple losses related to child removal and pervasive neglect and abuse associated with placement in out-of-home care, have resulted in untold damage. Loss of family relationships, language, culture, connection with family, community and country have had tragic impacts on Aboriginal participants in this study and those close to them (Coyd & Walter, 2016).

Aboriginal children placed in care during the study period clearly carried an additional burden of marginalisation, disadvantage, and cultural deprivation. This was born of the prejudice, racism and discrimination manifest in policy and practice at every level. The cruel policies that gave rise to the Stolen Generations play out in lived experiences presented in this report. Even when those policies had expired, toward the end of the study period, little appeared to change for Aboriginal families and their children. Indeed, Aboriginal marginalisation from health, welfare and educational services remains a source of national shame to this day.

Impacts of their removal and 'care' experiences, have left many within this cohort living in situations of marginalisation and extreme disadvantage, with poor education, health (especially mental health), housing and employment outcomes as lifelong burdens. Participants in this study, as is the case for Aboriginal Australians in general, have been over-represented in service systems related to justice, mental health, drug and alcohol, and homelessness. In some instances, this engagement was ongoing at the time of data collection. Formation of stable and supportive adult relationships, effective parenting and active community participation are all likely to be negatively impacted by the trauma and attachment disruption experienced in childhood (Rutter, 1985). These impacts are evident in the outcomes experienced by Aboriginal participants in this study.

However, notwithstanding traumatic separation from family and community, loss of connection to culture and the enduring impacts of abuse and neglect, Aboriginal participants in this study reflected remarkable resilience. Overall, the cohort manifests commitment to Aboriginal children and families today. Many advocate tirelessly for better supports. They defend the rights of their communities and argue for better social inclusion of marginalised Aboriginal children and families. Most participants clearly draw enormous strength from community, culture and importantly, from each other in their quest for healing, and for the best quality of life outcomes for themselves, their families and their communities.

Nonetheless, trauma inflicted on Aboriginal survivors of 20th century out-of-home care is clearly beyond measure. The lifelong and transgenerational burden of that trauma in terms of health (especially mental health) and wellbeing is also non-quantifiable. It will clearly endure long beyond the lifetime of this report's readership. As a just society Australia must urgently respond to the profound individual, family and community needs of Aboriginal out-of-home care survivors. The impact of racism, attachment disruption and major trauma currently experienced by this ageing and vulnerable cohort and their descendants was inflicted by the State. It behoves the State to respond with improvements to policy and practice and redress and reparation.

An important feature of this project is that the tragic Stolen Generations era overlaps with much of this study period (Atkinson, 2002; HREOC, 1997; Parry, 2007). For members of the Stolen Generations and many Aboriginal and Torres Strait Islander peoples placed in care since that time, their removal as children from kin and country derives in large part from, at best, misguided and at worst, determinedly inhumane social policies (Fogarty, 2008; Haebich, 2000; Milne, 1982; O'Connor, 1993; Read, 1981; Scott & Swain, 2002; Senate Community Affairs References Committee, 2004). Those policies arose from deeply embedded racism and prejudice within Australian society, elements of which clearly endure to the present day. *No child should grow up like this* (Fernandez et al., 2016) and earlier research have established that whilst Aboriginal experience of child removal and placement in care has features in common with non-Aboriginal placements in the same timeframe, there are important elements of difference (HREOC, 1997; Minister Council of Aboriginal and Torres Strait Islander Affairs, 2003). This report attempts to capture those unique experiences through the voices of Aboriginal people who experienced out-of-home care in the 20th century.

Courage, activism and self-healing are abundantly manifest in the narratives recorded here and in previous accounts (Maynard, 2007). Manifestations of resilience accompanied accounts of adverse experiences in care (Masten, 2006; Rutter, 1985). However, multiple losses related to child removal and the almost ubiquitous neglect and abuse associated with placement in out-of-home care, have resulted in unfathomable damage that can never be fully repaired (HREOC, 1997; Kendall-Tackett, 2002; J. C. Perry et al., 2006). Loss of family relationships, language, culture, connection with community and country have had tragic impacts on the wellbeing of Aboriginal participants and those close to them in this research (Coyd & Walter, 2016; Haebich, 2000). This study gives voice to the long-term lived experiences of policies that severed Aboriginal children from their families, community and culture, echoing narratives of BTH. Yet, such interventions are still being promoted, despite the courageous advocacy of survivors. The clear implication is that government is not listening and is not learning from the experiences of survivors. In the wake of apologies that guaranteed against repetition, there is a concern that current policy

directions reflect a return to the coercive interventions associated with the Stolen Generations era.

State and non-government child welfare and child protection services theoretically have improved levels of cultural competency and Aboriginal Controlled Organisations (ACCOs) are gradually being mandated to assume responsibility for the care of Aboriginal children. However, the fundamental colonial position that Aboriginal families and communities are incapable of caring for their children well enough, or as well as white people can, is clearly manifest in contemporary practice. Whilst impacts of early intervention strategies such as Cradle to Kinder (AIHW, 2017) are promising, far greater resourcing of Aboriginal specific services is required. Rates of removal of Aboriginal children remain tragically high, with investment in culturally competent family preservation and community strengthening strategies clearly inadequate (AIHW, 2018b).

The impacts of serious trauma and multiple losses not only left a lifelong legacy for Aboriginal and Torres Strait Islander survivors, but those impacts also have profound transgenerational implications (Atkinson, 2002; Burns, Burns, & Menzies, 2009). Transgenerational inherited trauma associated with separation and loss can seriously undermine lifelong wellbeing. It leads to mental and physical health problems that impact the capacity to develop a clear identity, form stable adult relationships and to parent effectively (Cowling, 1999; Horrocks & Goddard, 2006; Jamrozik & Sweeney, 1996; McComsey, 2010). Such inherited trauma is a major contributor to Aboriginal and Torres Strait Islander children continuing to be removed from home today at rates far higher than children within the general population and experience reunification at slower rates than the rest of the care population (Fernandez et al., 2017). This trend reflects government inaction to address the systemic and practice issues highlighted in BTH. This creates cumulative trauma for many Aboriginal and Torres Strait Islander participants in this study who, having courageously survived their own removal from family and community, have since had children and grandchildren removed by contemporary care systems. They have also witnessed children and grandchildren confront serious mental health issues, sometimes culminating in suicide; younger family members are also often struggling with social issues such as homelessness and

marginalisation from educational opportunity (Harvey et al., 2016). Over-intervention by government in the lives of Aboriginal people across their life course is testament to the enduring colonialism which remains embedded in Australian society.

Stolen Generations and more recent Aboriginal and Torres Strait Islander experiences of removal clearly add an extra layer to the heavy burden of contemporary racism and prejudice, socio-economic and educational disadvantage and general marginalisation carried by many Aboriginal and Torres Strait Islander peoples in today's Australian society. The attribution of pathological and problematic characteristics overlooks the historical legacy of colonisation and Stolen Generations and endemic oppression and disadvantage experienced.

For those removed from family as children, needs can be especially complex and specific (Kendall-Tackett, 2002; Masten, 2006). Affirmation and redress predictably still seem remote for many, notwithstanding pledges from the Royal Commission into Institutional Responses to Sexual Abuse. There are 17,150 Stolen Generations survivors in 2018 and almost two-thirds of them would be eligible for aged care by 2023 (AIHW, 2018a; Healing Foundation, 2018). Purposely developed and effective services are urgently needed; existing programs cannot meet current and future needs of this vulnerable and ageing cohort.

Aboriginal communities continue to be perceived and responded to through negative and pathologizing lenses overlooking their endemic poverty and social and health inequalities, ignoring the legacy of colonialism and the Stolen Generations that have entrenched their structural disadvantage and oppression. There are longer term issues which relate to human rights, respect for cultural differences, and elimination of marginalisation and disadvantage that need to be addressed. Responses need to be sensitive to the Aboriginal culture and oriented to justice and partnership with Aboriginal communities. As noted by previous commentators (Altman & Hinkson, 2007), the lack of genuine partnership in crafting solutions has exacerbated the problems the community has experienced rather than addressing them.

The need for participative, inclusive and community-controlled strategies to work with Aboriginal and Torres Strait Islander peoples towards community driven solutions cannot be overemphasised. Indigenous decision making should include implementation and resourcing of Aboriginal policies and programs. Service responses which foster trust, build on the strengths within Aboriginal communities, and respond to infrastructure needs are urgently needed. Indigenous knowledges and perspectives must be seen as integral to informing child protection systems in order to ensure the holistic wellbeing of Aboriginal children.

Needs of survivors

- That the Stolen Generations are recognised as a special needs group, to facilitate free or low-cost access to health, education and the aged care services in recognition of the significant trauma they experienced. That comprehensive and ongoing support be tailored to the needs and circumstances of these distinctive populations.
- That Stolen Generations are able to access legal advice and referral to affordable legal representation where required. This may be through a specialist community legal service similar to other specialist services such as the Women's Legal Services and the Intellectual Disability Rights service that has the specific brief and intimate knowledge of the needs of the Stolen Generations. That such service could advise on legal claims related to harm experienced, as well as other legal matters of a general nature, in recognition of the difficulty this group has in accessing (and affording) mainstream legal services.
- That the recommendations from the Human Rights and Equal Opportunity report, 'Bringing Them Home' (1997) pertaining to the Stolen Generations and contemporary child protection systems be revisited and contemporised, with a view to addressing to the fullest extent the recommendations of these Inquiries. That close attention is paid to the ongoing funding support needed to continue to implement recommended services and policies to respond to the needs of the Stolen Generations for care, support and acknowledgement.
- That a current needs analysis aligned with the Healing Foundation's *Bringing Them Home* 20 (2017) recommendations be undertaken, as a matter of urgency, to address current challenges faced by survivors and underpin sustainable support mechanisms to reduce the impact of trauma resulting from maltreatment experienced in care.
- That the Stolen Generations Survivor organisations, Link Up, Social and Emotional Wellbeing Services, and other services providing support to adult care leavers, assist them to access individual and tailored assistance plans in relation to health, housing, finding records and ongoing access to trauma-informed counselling services with a view to enhancing their emotional and social wellbeing.
- That State and Territory Governments, in consultation with the members of the Stolen Generations, undertake a comprehensive review of how records relating to care leavers are managed and accessed, with a view to allocating additional funding to the relevant government Aboriginal Family Records Units so they can provide increased assistance to those accessing records and better promote their services.
- That truly integrated services for Aboriginal and Torres Strait Islander peoples be developed, that are culturally embedded and delivered through Aboriginal Community-Controlled Organisations.
- That there be representation of the Stolen Generations in the development of Australian Government and State and Territory Government social policies relating to, or affecting them.
- That training for medical and allied health professionals, community services workers, social workers, lawyers and others working with care leavers place emphasis on awareness about the needs of adult care leavers, and specialised trauma-informed knowledge on the particular psychological effects of institutional abuse on their life course. This training needs to focus on culturally safe practices when working with Stolen Generations survivors and other Aboriginal and Torres Strait Islander care leavers. Where practicable, suitably trained people with a lived experience of childhood institutionalisation be engaged to conduct training and awareness raising in the human services sector. That attention be paid to the role of professional supervision in supporting and resourcing practitioners in managing the demands of working with traumatised care leavers.
- That as a matter of priority, a review of federally funded home care packages be undertaken to identify the number of Stolen Generations who are accessing these and whether their Aged Care Assessment Teams' (ACAT) assessment has adequately determined their level of need. The problems specific to them, and the experiences of the services they are receiving through their home care packages must be thoroughly assessed.

- That non-institutional forms of aged care be explored to support ageing needs of this cohort to minimise disruption to living arrangements of the members of the Stolen Generations. Where a high level of care is necessary, prompting a move to residential care settings, it must be assured that these settings do not replicate oppressive aspects they were exposed as children. Further, that the expertise of Aboriginal and Torres Strait Islander care leavers' organisations be used in developing appropriate models of aged care provision which respond to the specific needs of Aboriginal and Torres Strait Islander care leavers.
- That professionals delivering aged care services and assessors involved in My Aged Care, ACAT, Regional Assessment Services (RAS) and other assessment and service delivery providers, undertake mandatory training in working with care leavers to enhance holistic assessment and care planning, and case management. This training needs to include specific cultural awareness and cultural safety training for those working with Stolen Generations survivors and other Aboriginal and Torres Strait Islander care leavers and their families and carers.
- That specialist Aboriginal specific services such as healing centres and child sexual assault units be supported. In addition ongoing support should be extended to existing services such as Link-Up and the Bringing Them Home Social and Emotional Wellbeing specialist staff to enable their continuation and expansion. That resources be allocated to collective healing initiatives developed by Stolen Generations survivors and other Aboriginal and Torres Strait Islander care leavers to support their healing journeys.
- That governments and tertiary institutions create options for alternative entry pathways to higher education courses for the members of the Stolen Generations to enable them to gain higher educational credentials which translate to enhanced employment outcomes.

Contemporary child welfare

- That Government should commit to working with Aboriginal peoples through ACCOs, SGOs and peaks to establish a self-determined Child Protection system that has adequate and effective safeguards for children and young people, with greater focus on healing, family support, early intervention and prevention.
- That lessons from Bringing them Home (2004) and BTH20 (2017) as well as recommendations of the recent Royal Commission into Institutional Responses to Sexual Abuse (2017) be implemented to enhance safeguards to protect children removed by the state; these must include special provision for the cultural protection of Aboriginal children, their families and communities
- That State and Territory governments guarantee full implementation of the Aboriginal and Torres Strait Islander Child Placement Principle, in partnership with Community-Controlled Organisations and peak bodies.
- That State and Territory Governments ensure that statutory out-of-home care legal frameworks include adequate safeguards and oversight to ensure that all Aboriginal and Torres Strait Islander children are safe, cared for and experience full exercise of their rights, including cultural rights as guaranteed by the Convention of the Rights of the Child (United Nations, 1989).
- That more resources be allocated to addressing the complex needs of Aboriginal and Torres Strait Islander young people leaving care and post care as a matter of urgency. Previous research on leaving care outcomes (Mendes & Snow, 2016)) as well as data from the present study, demonstrate that under-resourcing this domain can seriously undermine lifelong wellbeing. That culturally appropriate support be made available to Aboriginal and Torres Strait Islander adult care leavers to enhance their educational, vocational, economic and social outcomes.

- That adult care leavers are recognised as a special needs group with respect to access to equity-based scholarships, and waivers of HELP/HECS. That care leavers be included in the disadvantaged groups identified in Australian Governments plan for equity in higher education.
- That Governments create options for Aboriginal and Torres Strait Islander care leavers to enter VET pathways to gaining formal qualifications applicable to their current employment positions and that fees are waived.
- That more work be done to understand and intervene from the intergenerational perspective. Contemporary government emphasis on permanency in child protection policy (for example DHHS -VIC, 2017 <http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/permanency-for-children>) is counter to the understanding of the devastating effects of Stolen Generations experiences (*Bringing Them Home*, 1997; *BTH20*, 2017) have had on survivors and their families. That instead of removing children or separating family, models of care be developed for children and families within the community. That State and Federal governments commit to working with Aboriginal and Torres Strait Islander child and family peak bodies and Aboriginal Community-Controlled Organisations to address the continuing over-representation of Aboriginal and Torres Islander children within the statutory child protection system through investment in holistic child and family services
- That research be undertaken to understand the experience and needs of descendants of Stolen Generations and their elevated risk of exposure to the contemporary child protection system and consequent ongoing disconnection from their family and community.
- That State and Territory governments appoint Aboriginal and Torres Strait Islander Children's Commissioners, in partnership with Community-Controlled Organisations and peak bodies, to oversee contemporary child protection systems and their impact on Aboriginal and Torres Strait Islander children and families.

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