ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE

Public Hearing - Case Study 28
(Day 81)

Ballarat Magistrates' Court,
100 Grenville Street, South Ballarat
Victoria

On Monday, 25 May at 10.00am

Before	
The Presiding Member:	Justice Peter McClellan AM
Commissioner:	Justice Jennifer Ann Coate Mr Andrew Murray
Counsel Assisting:	Gail Furness

THE CHAIR: Yes, Ms Furness.

MS FURNESS: Your Honour, can I indicate first, that there has been an issue with the air conditioning.

THE CHAIR: We've noticed, Ms Furness.

MS FURNESS: I suspect that many people have noticed. Just to indicate that, I'm not sure whether it's going to be fixed, but there is an issue.

Secondly, can I indicate that Dr Quadrio is the witness for today, and indeed the only witness today, and Father McInerney will be giving evidence tomorrow. It may well be that today is shorter than usual.

So, perhaps if the witness could be sworn, Your Honour

<CAROLYN QUADRIO, sworn: [10.20am]

<EXAMINATION BY MS FURNESS:

MS FURNESS: Q. Would you tell the Royal Commission your full name and occupation?
A. Carolyn Quadrio, and I am a Conjoint Associate Professor with the School of Psychiatry with the University of New South Wales and a consultant child and family and forensic psychiatrist.

Q. Thank you, doctor. Would you tell the Royal Commission your qualifications?
A. Yes, MBBS, which is a medical qualification; DPM, which is psychological medicine, a PhD and Fellow of the Royal Australian and New Zealand College of Psychiatrists in the faculty of psychotherapy, forensic psychiatry and child and adolescent forensic psychiatry.

Q. What did you do your doctorate of philosophy in, doctor?
A. In gender issues and the influence of gender on mental health, and particularly women and mental health.

Q. Since 1985 you've worked as a teaching supervisor in major teaching hospitals in Sydney?
A. That's right.

Q. What was your role as teaching supervisor?

A. I've been supervising teams and also individual trainees in the management of trauma particularly, sexual trauma with children and with adults and a range of psychiatric disturbances as well.

Q. In relation to the trauma of sexual abuse, is your work both in institutional abuse and familial abuse?
A. Yes.

Q. Do you tend to work in one area more than the other?
A. I've seen a lot of both. I think in sheer numbers, probably I've seen more intrafamilial abuse, but I've also seen quite a few of institutional abuse as well.

Q. Where has your clinical research been primarily directed?
A. I primarily looked at sexual abuse of patients in psychiatric treatment and the abuse of patients in medical, clinical treatment relationships generally, and I've also looked at the influence of gender on mental health, and family therapy and psychotherapy.

Q. You refer to a study of more than 200 men and women who were sexually abused in childhood by members of the clergy or by teachers or other caretakers; can you tell us about that study?
A. That's not one study. I first became involved in assessing institutional abuse in the 1980s, when the Christian Brothers case in WA first became a matter of the courts and there were 250 plaintiffs in that case. I didn't assess 250, they gave me 32 to assess, which were going to be a sample, so I assessed 32 men in the late 1980s in that case.

After that, I haven't had a big group like that again, but I've had --

Q. Before you go on to another group; what were your findings?
A. The Christian Brothers, they were men who mostly come out from Britain, some from Malta, but mostly from Britain. They were called child migrants, although they were not really migrants, some of them weren't here voluntarily; some of them had just been told they were coming, so migrants is a fairly generous word.

A lot of them had been in orphanages in England.

Often they were children of single mothers who hadn't been able to care for them because there was very little social security for single mothers in the 1940s. Some of them had been left by their mothers in the institutions with the idea that they would come back and get the children later, but when they came back, the children weren't there anymore. So, the whole migration process in itself was quite an abusive thing really, because it was an understanding between the governments of Australia and Britain really about bringing these children over.

So, they were very vulnerable children and they came to WA and they were sent to - there was one particular place, Bindoon, which was quite a way out of town so it was quite isolated. It was systematic abuse in that institution, so there was a lot of abuse; there was physical abuse, there was sadistic physical abuse, there was very severe privation, very little education, the boys were working, doing hard manual labour a lot of the time, and there was a lot of sexual abuse as well, so it was a very brutal environment .

There were three institutions, but Bindoon had the largest number of boys in it. There was also Clontarf and Tardun, so that's where the 32 came from. So, those men were extremely damaged psychologically because there had been just so much trauma; there was much more than the sexual abuse. There was the loss of country and connection with their homeland and whatever family they might have had. There was a lot of physical abuse, so that was part of it as well, a lot of verbal abuse; they were denigrated by the Brothers all the time, you know "you dirty Pommie bastards", and "bastards" being used particularly because a lot of them were the children of single mothers.

They didn't get much education and then there was the sexual abuse as well. And, if they showed any signs of distress, they were punished, so it was a really abusive environment and they were very, very damaged. So, they led very difficult lives. There was a lot of depression, unemployment, alcoholism, very few of them were able to make relationships outside of the - when they left the institution they struggled to make relationships. If they did have children, they struggled to relate to their children; they were always - they seemed to live in fear and dread that they might harm their own children, so that caused them tremendous distress. There was suicidality.

A lot of them made disclosures, so it's not that it was kept secret; many of them made disclosures when they got out of the institution and they were discredited. Everywhere they turned they were told they were lying and it wasn't possible that this could - that men of the church could do this, and so, after a while they stopped complaining because they could see it was futile.

Q. And the purpose of your assessment was to provide a report for the litigation?
A. Yes, there was litigation, and so I assessed them and submitted 32 reports to the court.

Q. You were going to go on to talk about another study.
A. I also saw - interesting from the point of view of looking at different kinds of abuse, I saw an interesting contrast, because it was a group of I think seven boys who were at a private school; quite the opposite --

Q. Sorry, seven or 70?
A. Seven from a private school, and so they were boys that came from intact families, mostly they had good families, they were often from rural areas and had been sent to the boarding school because they were not close to a high school. So, these were quite the opposite, with good intact families and going to a good school, and they also were extremely damaged by their experiences, so it was useful to compare that the children will be just as badly damaged even when everything else in their life seems to be relatively sound, and even so, the sexual abuse is quite damaging. In that case there was very little in the way of physical abuse; in fact, there was no physical abuse, so it was strictly sexual abuse.

But it was a particular offender who groomed the boys, and the grooming was very prolonged and effective, and that has its own consequences in that it's a very psychologically abusive process to be groomed; quite different from the systematic abuse of the Western Australian experience.

Q. And that, again, was for the purpose of litigation?
A. Yes.

Q. Are there any other studies that you've been involved in?

A. Not groups, no. The other ones have been two or three here and there.

Q. And again, for the purposes of litigation?
A. Yes.

Q. You've presented in a number of workshops and other forum in relation to clergy abuse. Perhaps you could tell us about your more recent presentations.
A. Yes. In 2008 I helped convene a conference in Sydney on sexual abuse in religious organisations and we invited people from all the major faiths to participate. That was interesting, in that, there were some faiths that said, "We don't have a problem, it doesn't happen in our church". But the major churches, the Catholic Church, the Anglican Church, they participated.

We had a lot of survivors who came, and help organisations as well, and we gathered speakers from Europe and North America, so that was a very interesting conference. We tried to roll that into a research program afterwards but we couldn't get any funding, nobody was interested in funding it in 2008. We approached the churches for funding and they weren't interested in funding it either so we didn't get any further with it.

Q. Did any new learnings come out of that conference?
A. I think the new learning was to see that the issue is global and that it's very similar in one country and another and it's very similar in one faith group and another, much as some of the faith groups at the time said "we don't have that problem", all of those faith groups have since had problems that have been widely reported in the media. I think what we learnt is what is well-known, that it's a global problem and it occurs in every faith group.

Q. What were the parameters of the research project that you wished to come from that conference?
A. We wanted to look at what were the organisational issues. We had an ethicist and a philosopher looking at how organisations allow abuse to continue and flourish, and that was what we wanted too. We weren't going to take an individual psychological study, it was going to be about organisational issues.

Q. Has any work been done in that area since 2008 to your

knowledge?
A. Not by my group. I think there has been work though done in other organisations.

Q. In 2010 you gave the keynote address to the Survivors of Clergy Abuse Conference on Difficulties in Disclosure.
A. On difficulties?

Q. In disclosure?
A. Oh, disclosure, yes, yes.

Q. What was that topic, difficulties in disclosure, that you spoke of?
A. The difficulties in disclosure is a huge issue with children who are abused - well, with adults as well; children usually don't make disclosures at the time of the abuse, so that really allows it to continue because they usually don't make disclosures and the trouble is, when they do make disclosures they're often not believed, so disclosure is a really critical element. And not being believed itself is an extremely damaging experience so that compounds the trauma that they've already been subjected to.

A lot of the clinical work that I've done has been with adults who are now disclosing what happened when they were children, and they've often experienced years and years of not having talked about it, and part of their life is kind of cut off, part of their experience is cut off. Some of them are married and never told their spouse what happened. So there have been many years of living that kind of secrecy.

When they do disclose, they're still, even today, even at this stage of our development, there's still often very negative reactions to victims, so that it's a very traumatic process, disclosing.

Then the disclosure itself is very traumatic. It's like once something is spoken, somehow it hurts all over again, so the whole disclosure process is really very difficult.

Q. In 1998 you presented a paper at the annual conference of the Faculty of Child and Adolescent Psychiatry for the College of Psychiatrists on systematic sexual abuse of children by clergy.

A. Yes.

Q. In 1998 what was known about that?
A. By 1998 it was fairly well-known. In Australia, for example, the Christian Brothers case was widely known by then, that was litigated around 1991 I think, and there had been lots of other cases. Also, by 1998 in America there was a huge case in Boston and so there'd been a huge amount of media attention to the Boston case, so I think by then it was getting to be very well-known that systematic sexual abuse within religious organisations was a problem in the world.

But still, I don't think victims were being very well assisted in 1998. I think that was just the beginning, maybe, of being able to assist victims, but it wasn't good for victims at that stage.

Q. Prior to the Christian Brothers cases becoming known in 1991, what was known in your area of work?
A. I'm afraid that was the dark ages for psychiatry. There was very little attention - I think psychiatry was just as much in the dark as the general community, assuming that it didn't happen in religious organisations and so forth. I mean, even abuse within the family wasn't very well recognised, so I think psychiatry also in the 1980s had to make a big shift to understand the extent of child abuse. Even now; I think psychiatry hasn't really fully taken on board the extent of child abuse and how damaging it is and how prevalent it is.

Q. Did psychiatry come out of the dark ages, as it were, following convictions of perpetrators of child sexual abuse in the clergy?
A. I think it's been a very slow process. I think changing community attitudes is extremely hard, it's been a very slow process.

Q. But is convictions the main reason that there is a change or is there something else that occurs?
A. Convictions, yes, and the publicity. I think the survivor organisations have been very effective in becoming heard and in lobbying; I think the survivor organisations really have done a lot to lobby psychiatry to take their difficulties seriously and understand the effect, and there's been a lot of research that's accumulated too, so a lot of good research work's been done over the last

20 years. There's a huge body of research now that's available.

Q. When you say you don't think psychiatry is quite there yet in relation to victims or survivors, what do you mean?
A. I think psychiatry is still rather pre-occupied with the idea of diagnosis and medical treatment, whereas abuse and trauma doesn't fit neatly into a diagnosis, it's usually much more pervasive than a single diagnosis, especially if the person was a child when the abuse occurred, and so I think psychiatry has been rather focused on diagnosis and medication as treatment. So, that approach doesn't really help trauma survivors at all, they need a much more holistic approach than that. And medication can be helpful symptomatically, but there's no medicine that will cure trauma.

Q. When you say a more holistic approach, what would that involve?
A. Well, if a person's abused in childhood, it affects every aspect of their development. So, there's no kind of discrete area of their function that you can point to, whereas most psychiatric diagnoses tend to focus on more discrete areas of dysfunction; you know, like depression. Well, people who have been abused are usually depressed, but that's not all; it affects them in many ways. Children will be affected in terms of their capacity to form relationships, their ability to function at school, their ability to progress in education, then their ability to progress in employment. They're often anxious, depressed, they often turn to alcohol or drugs as a way of kind of medicating their distress, and so then substance abuse becomes a problem.

So far as psychiatry is concerned, for a long time they've been treated as substance abusers, rather than as trauma survivors who are relying on substances to treat their symptoms

THE CHAIR: Q. Professor, you use the word "abuse". Can you let us know what you mean when you use the word "abuse"?
A. You mean, child abuse?

Q. Yes.
A. Okay. Well, abuse of children can be physical, psychological and sexual and often they all go together

depending upon the environment. So, the Christian Brothers cases that I'm talking about, those children were subjected to abuse in every possible sense of the word. Then I mentioned that private school, that was a case where the abuse was very much confined to the sexual relationship, but that's psychologically abusive in itself, so it's impossible to sexually abuse a child without psychologically and spiritually abusing them as well.

Q. When you speak of sexual abuse then, what do you have in mind?
A. Sexual abuse, I have in mind that there is actual sexual contact.

Q. Meaning?
A. Well, it could be that there's some sort of physical contact, and that ranges from touching to penetrative sex.

Q. And are we to understand that you say that the symptoms that emerge, the outcome for the abused person, may be the same but there may be different levels of abuse as we would understand them?
A. Yes. And psychological abuse can be extremely damaging without any physical component to it.

Q. When the law looks at sexual abuse, we generally tend to differentiate between penetrative sexual abuse and touching. Is that rational as far as psychiatry is concerned?
A. No.

Q. Because the outcome can be the same?
A. Yes, and because there can be a lot of manipulation of a child's mind by an offender, which is psychologically damaging. And then for example, particularly with religious organisations, there's the kind of enormous sense of betrayal and loss of faith that's very damaging, and for a young child to lose faith, that, you know, the world's a bad place and good people are actually bad people and you can't trust anyone, that's extraordinarily psychologically damaging to a child.

MS FURNESS: Q. Where does grooming fit into your definition?
A. The issue with grooming is that it's very psychologically abusive because it's a manipulation of the child's mind. In religious institutions, my experience is,

there hasn't been so much grooming in those contexts because the children are already under the power and control of the abuser, so in a sense they don't need to be groomed.

But in the community, there's a lot of extensive grooming that goes on, especially like teachers, family friends who abused their friends' children, sports coaches and that sort of - there's usually very extensive grooming so that the child is gradually manipulated by the offender, and sometimes made to feel they're special, that this is very special attention. So there's a kind of a seduction that goes on that really is a serious manipulation of the child's mind.

Q. Is there any non-contact, including grooming, that you would consider fits the definition of child sexual abuse?
A. Without touching?

Q. Yes.
A. Grooming is psychologically abusive, because it distorts the child's reality.

Q. What have you learnt from your research and your experience about the prevalence of sexual abuse of children in institutional contexts, including religious or faith based?
A. It's very common, I think. When children are in care of any kind, they're subject to abuse by caretakers.

Q. They're subject to; what about, they have been abused?
A. Well, often you've got vulnerable children who are put in institutions, so that's really a double jeopardy for the child who may have come from an abusive home or an abusive environment or a neglectful environment and is put into institutional care and then is abused in institutional care.

I think, as I just pointed out, the actual sexual abuse itself is not necessarily what's most damage damaging there. What's most damaging is for the child to feel worthless, to feel betrayed, to feel they have no value, to feel that they're just there to be used or abused and that's extremely damaging to a child's psychological development.

Q. Is there any work that you consider reliable that

tells you anything about numbers?
A. There's a huge amount of studies of numbers; there have been numbers counted for a long time now. I think we can reliably say that about 25 to 30 per cent of girl children suffer some form of sexual abuse and something like 5-15 per cent of boys, and they're fairly consistent statistics, and in institutional care it's more than that; that's in the general community.

Q. So that includes familial and stranger abuse, as it were?
A. Yes.

Q. When you say it's larger in relation to institutional care, are there any figures that you can refer to?
A. Again, it's around about 30 per cent of girls and about 20 per cent of boys in institutional care.

Q. What are those figures based on, do you know?
A. There are lots and lots and lots of studies that have been done now, and so there are figures from various countries and various institutions. You have to really be more precise and think about which particular country, which particular institution, because in some institutions it's like - in the Christian Brothers one there was systematic abuse, so once it becomes a systematic issue the numbers become very high. Otherwise, if it's not a systematic issue, then it's much more random, but even in a random situation, there's still a significant number of children that are abused.

Q. In the research that you're aware of that has been done using Australian children, what institutions have caused the numbers to be greater?
A. In the Catholic Church the numbers are significant. I think they have been the most studied.

Q. And do you think it's because they're the most studied that the figures are more significant or do you think it's something about the way the institution operates?
A. No, there have been a lot of studies done of abuse in the Catholic Church in the United States, in a number of countries, in Australia, in England, in Ireland, in Austria, in the Netherlands, Mexico, so there are a lot of studies that have been done and I think the consensus is that there is a - although it happens in every faith group, it seems to be more marked in the Catholic institutions.

Q. Why is that?
A. I'm not sure myself. Some people have said that celibacy is a problem, other people say it's got nothing to do with celibacy. I think it's about the degree of control; it's a highly controlling organisation, with a strict hierarchy, and so, then you have a lot of control over people if you have a strictly hierarchical organisation, although most religious groups tend to be fairly hierarchical and rigid in their approach.

Q. Any other factors?
A. I think the issue of celibacy is important, not because - my opinion is, I don't think the celibacy drives child abuse, but I think that people who - they have men who for example have already got an orientation to be attracted exclusively to children as sex objects, they will feel more comfortable in the priesthood because it doesn't bother them - you know, the celibacy vow is not going to bother you if you're not interested in having sex with other adults, so obviously that will be a more comfortable environment. Then a lot of offenders seek situations where they can have access to children and seek situations where they have authority, so they have access, they have authority and they have the cover of a very respected profession.

Q. The emotional development of a boy or young man who goes into the priesthood at an early age, would that be a factor?
A. As I said, I don't think that celibacy is driving it; I think that what happens is that young men who are perhaps troubled in their sexual development and are not developing along the usual lines will obviously be attracted to an environment where they don't have to prove themselves as sexually adjusted in the conventional sense, so that's of great assistance. Then, those that have difficulty, an immature young man would be also attracted to an environment where there's a highly organised structure and he immediately gets some status from his profession.

Q. What about screening; what screening do you think should be put in place to screen those people out?
A. I don't think there's been any effective screening to date with the religious organisations.

Q. What would effective screening look like?

A. It's difficult to screen people as sex offenders, because obviously it's not something that someone's going to - it's not information that one's going to volunteer.

Q. It's not going to be a box that they tick on the application form?

A. So people are not going to tick that box. A lot of offenders will not show any abnormality psychologically or psychiatrically.

Q. Is there any testing that's been looked at in the research that you're aware of to move that area along so that screening can be more effective; not just in faith-based but in other institutions?

A. There's a lot of experimental designs to try and detect people who are attracted to children sexually. A particular researcher in America called Gene Abel who's done a huge amount of work, and he's tried to develop a screening for offenders, which is to have them look at photographs and they measure eye movements and look at the responses to pictures of adult males, adult females, female children, male children and measure their eye responses.

There's also measuring penile responses which is more complex, but the eye responses is reasonably reliable too. But, you know, that's not foolproof. There's no - it's not like a test you can do.

Q. What else can you do?

A. Well, general screening. So, anyone with a history, and that was a problem in the church in the past, in that, offenders were moved around to different areas and they actually did have a past history. The same with - teachers have been able to move interstate and so forth, so any past history obviously is a problem.

Any psychological difficulties need to be looked at. There's no particular psychological profile to look for. Sociopathy or psychopathic traits are a worry, but there's only a minority. Only a minority of offenders will be clinically significant in that regard.

Within the Catholic Church, because of celibacy, you can't look at measures of what we would call "normal sexual adjustment", which you can in other institutions for screening; look at the person's general sexual adjustment. But a lot of that kind of screening depends on people

voluntarily talking about things like their thinking, their fantasies, you know, what turns them on, you know and I think it's very difficult to get a full disclosure from people who are going into institutions to work.

THE CHAIR: Q. Professor, we've learnt and people often have said to us that one of the problems for churches, but particularly the Catholic Church, was the age at which young boys, adolescent men, if you like, commenced training, became part of an institution that would lead to them ultimately becoming a priest.

Is there any reason to think that, if you delayed any man from entering into training until he was into his 20s, and perhaps had done some other tertiary education, that that would be of benefit to the church insofar as addressing this issue is concerned?
A. It would, in that, obviously an adolescent male is much more easily inducted into any organisation that he becomes a part of, any adolescent is more malleable. So having a wider life experience and having already formed values and ideas in a wider context would only be of benefit.

Q. That's a general benefit, but in terms of identifying those who may have psychosexual development issues that lead to them offending if they were to become priests, is there reason to think that delayed entry into a process of training would be a good thing for the church?
A. For those who have a fundamental orientation towards sexual interest in children, it probably isn't going to make a difference, but there's no one single type of offender. Some of them are exclusively sexually attracted to children and I don't think age is going to make any difference to that group.

There are others who we describe as situational offenders who are very much responsive to the environment, and that group will be certainly less likely to become involved if they have a later age of induction, so they've got more opportunities to develop themselves psychosexually.

MS FURNESS: Q. You've said that there's a substantial literature in this area. Can we firstly turn to the short-term effects and then move to the long-term effects.
A. With children?

Q. Yes.
A. First of all, about 20 to 40 per cent of children who have been abused won't show any symptoms at all, and that's because some of them are what we describe as resilient; children who somehow survive trauma and make a reasonably good development. But some of those apparently non-symptomatic children become symptomatic later on. That's called the sleeper effect; that they look fine at the time and then some years later something else triggers it.

So, the 20-40 per cent who are asymptomatic, it's really hard to know which ones of those are just going to be resilient their entire lives or which ones will in later life under certain circumstances be triggered to decompensate.

THE CHAIR: Q. Professor, when you speak of resilience; again, is the level of abuse or the period of time over which it occurs relevant to whether or not a child shows resilience?
A. Yes. It's relevant, but it's not the only factor. There are some human beings who are just remarkably resilient and we don't necessarily know why, they just seem to survive the most dreadful experiences. But, if you pile enough trauma onto any individual, there comes a point at which they can't take any more usually.

Q. And again, touching as opposed to penetrative sexual contact, does that show up as a factor that may mean that, for that individual, there's no consequence if they're merely touched?
A. Well, penetrative sex is the most traumatic form of abuse. So, when it's penetrative and when there's coercion or violence, that's extremely damaging. It's much harder for a child to survive that.

MS FURNESS: Q. What other short-term --
A. So that's the resilient group which includes some what we call sleeper effects. Otherwise, as I've said before, there's no particular syndrome of abuse. A child is disturbed and may show the disturbance in all kinds of ways. So, being sad, scared, unable to sleep, starting to bed wet, regressing in their behaviour, maybe being angry and aggressive, not functioning so well at school, maybe starting to refuse to go to school. The symptoms are those

that could be thought of as sort of general nervousness, general unhappiness in a child.

Specific sexual acting out is one area that is of most concern, because most of those other symptoms are symptoms that can occur for a wide range of reasons and are frequently misunderstood. For example, if a child starts to show symptoms at a time when a younger sibling is born, it's really easy for a family to say, oh well, ever since the new baby arrived this child's been unhappy, whereas actually it was what was happening at pre-school or school that was the problem.

But very aggressive or sexualised acting out are more specific. So a child who's acting out in very aggressive ways is a concern. It's not - you can't say for sure, but you've got to be really concerned that there's some abuse. And a child whose behaviour becomes highly sexualised, a very high proportion of those children are being sexually abused. And, if a child shows predatory sexual behaviour, that's almost always a sign of sexual abuse in my experience.

Q. Is there any age group which is more or less likely to show the sexualised behaviours?
A. No, it depends; it'll show in pre-school children, and just as children get older they're more likely to conceal it, whereas little children are less likely, it's more easy to spot in little children, but older children obviously become aware that you can't be seen to be doing these things, so they become more likely to cover up.

Q. How does post-traumatic stress disorder play with child sexual abuse?
A. Well, children often have post-traumatic symptoms, but the classic post-traumatic stress disorder that most people are familiar with is not so prevalent in children, that they have post-traumatic symptoms, and some of them will have clear post-traumatic stress disorder. But children don't manifest PTSD in the same way that adults do, and even if they've only got a few symptoms that can be just as damaging for a child if they persist over time.

For example, hyperarousal, meaning kind of revved up in your functioning, hyperarousal is just one symptom of PTSD and it's not enough to make a diagnosis. But if a child is continually suffering hyperarousal, that can have

a very damaging impact on their entire function, because it means that they won't be concentrating so well at school because their thoughts are racing, they won't be as attentive because their attention's flickering all the time, they won't be sleeping so well, that will affect their growth, that will affect their energy levels. So, hyperarousal being one symptom and not enough to make a diagnosis can be enough to cause a huge amount of disturbance in a small child.

Q. Is it more likely that that diagnosis is made as an adult who suffered child sexual abuse than a child?
A. Adults are more likely to develop the classic PTSD symptoms but even so, even in adults, PTSD is not the commonest outcome; the commonest outcome is depression, anxiety and then secondarily resorting to substances to deal with your problems, and often post-traumatic symptoms but not necessarily the full disorder.

Q. What does a classic disorder look like?
A. The classic PTSD consists of hyperarousal and hypervigilance, so being revved up a lot; being hypervigilant, so that's really mistrustful and watching the environment the whole time; being preoccupied with memories of the trauma, and at the same time an important part of PTSD is that they're a contradictory phenomena. So, while you may be pre-occupied with the trauma and can't get it out of your mind, at the same time you often have blanking it out as well.

Similarly, there's a contradictory approach avoidance, so the contradictory phenomena, they coexist in PTSD. So on the one hand there's avoidance, so you might find a person who won't watch the news because they can't bear to hear any reports of sexual assault, or won't read anything about it or will walk away from a conversation about it. So in that way they're highly avoidant of anything that triggers them. On the other hand, they may be intensely pre-occupied with reading about abuse, so there's a combination of running away and running towards the problem.

Reacting to queues, so that something quite innocent can trigger a massive reaction in someone with PTSD. For example, if you were abused as a child, watching a child walk down the street may be enough to make you remember yourself. Driving past the institution where it happened,

seeing someone who looks like the perpetrator; they're all classic kinds of triggers. Then people will sometimes go into very elaborate ways of avoiding triggers, so that impacts on their adjustment as well.

Hyperarousal usually results in an inability to sleep, there's often traumatic dreams, there's flashbacks, people have a lot of visual imagery of what happened. And memory is affected, so there's often - there's a combination sometimes of amnesia for whole patches of their life, and at the same time there may be intense inability to not remember, you know, something that keeps coming over and over and you can't get the image out of your mind. So you have that strange combination of what's called hyperamnesia and hypoamnesia going together.

Q. Is there any classic treatment?
A. Trauma treatment really is - again, there's no specific treatment, there's not a specific medication or specific treatment. You have to look at the person's symptoms, you know, what symptoms are troubling them and treat them on that basis.

So, some people are very switched off, very dissociated and cut off; they will need different treatment from the person who's kind of in turmoil and revved up. But most of all what's important is that they need a treatment process where they can establish a sense of trust with the person who's treating them to feel that they're believed and they're not judged and they're accepted, and to be allowed slowly in their own time to be able to talk about what's happened and try to put it into perspective and re-examine their own feelings, because usually there's a lot of guilt and shame and self-doubt that has developed. So, people need a lot of opportunity to talk about those feelings and it's very difficult to get rid of shame which is a very fundamental disturbance.

Again, it's not a psychiatric diagnosis but it's extremely damaging; children have a sense of shame. They feel dirty, defiled, damaged, they blame themselves, "I'm a bad child, it wouldn't have happened to me if I wasn't bad". Even though intellectually as adults they get to understand that it's not their fault, that sense of being damaged can be very, very difficult to shift and cause a lot of distress in their adult life.

COMMISSIONER MURRAY: Q. Professor, the Royal Commissioners have had a very wide contact with victims, not just through public hearings but through written accounts and private sessions. This aspect which is almost unique in a crime against a person, of taking the guilt onto themselves, is a very large element in the impact reports to us.

Can you elucidate a little more than you just have on that phenomenon. Why is it that children who are victims end up feeling guilty?

A. Well, because a child doesn't understand why this is happening and the tendency is to think that they must have caused it in some way or deserved it in some way because they don't have any understanding of why this is happening.

Offenders often also will say things that lead the child to believe that they're culpable as well. But there is something very fundamental in little children about this sense of defilement or self-blame or shame. I think children, when they're treated badly, begin to internalise, "I'm being treated badly, I'm bad", so that's the way the child's thinking goes.

Q. Even where the adult doesn't tell them they're bad, because as you know, that's been a form of abuse by carers in institutions such as those you described in Western Australia; even where they're not told they're bad, they end up with those feelings?

A. Even when the offender has gone through a very protracted grooming process and persuaded the child that he's special and this is our special relationship, and the child becomes a kind of, if you like, willing participant because the grooming's been so effective. There comes a point where those children too begin to feel a deep sense of shame, because they become aware that they've allowed themselves to be manipulated, and that brings a sense of shame.

Q. As you probably realise, the Royal Commission is intensely interested in counselling as a form of redress, therapy, professional help.

A. Yes.

Q. Would you consider that the psychiatric and psychological professions are well acquainted with this effect and would focus on it?

A. I don't think there's enough understanding of the problem of shame; it's not - people who are working in the trauma area a lot, yes, they do understand it, but if you look at generally across the board of the psychiatric and psychology professions, I don't think it's very well understood.

MS FURNESS: Q. Is there any difference between PTSD and chronic or complex PTSD in this area?
A. Yes, the classic PTSD that people generally think about is more likely to be the result of a time limited trauma. So, if you have a car accident or something very shocking happens to you, you witness a violent death or something like that, then you're more likely to get that what's sometimes called simple PTSD which has got those classic phenomena that I just described.

That's not what's going to happen with a child, because with children, the abuse is usually ongoing, it's very rarely a one-off phenomenon, because the person who's abusing them is usually a family member or a carer, so they have access to the child over a long period of time. So, child abuse is usually ongoing, it's not a one off trauma.

And because the child is developing, they're growing and developing, it's part of - their developmental sequence is disrupted by the abuse and, if the abuse continues over a long period of time, every new phase of development is being affected by the ongoing trauma. So, it ends up being what we call developmental trauma or complex PTSD, because it affects their personality. So now you're not dealing with just symptoms, like symptoms of depression; you're dealing with characterological disturbance, and so every aspect of a child's function becomes disturbed; their feelings, their thinking, their memory, their concentration.

What's very damaging is that a child is supposed to be developing a sense of who I am and what kind of person I am and a sense of understanding the world and other people in it, and so obviously the child's self-perception is very damaged, all those feelings of shame for example are very damaging to the sense of self.

Q. Are there any neurological changes?
A. There are brain changes that are quite clear in children who have been abused. The most dramatic

illustration is, you know, the Romanian orphans some 20 years ago now I think. The orphanages in Romania were full of children who were just kind of parked in the orphanage and fed and watered and not much else, so they had no human stimulation, no cuddling or talking, or anything like that, and they were grossly retarded and grossly retarded in their physical and mental development. They were given a lot of battery of tests and their brains were shrunk, and so what we know - it's easy to see pictures of them, you can just Google them and see these very dramatic pictures of brains that are actually smaller than what they should be.

So, what we know is, in order for a brain to development, a child doesn't just need food and water and shelter; they need to be cuddled, they need to be stimulated in an affectionate way, they need a lot of complicated social and cognitive stimulation for their brains to develop. So, if you just feed and water a child and don't do much else, then their brain doesn't develop.

THE CHAIR: Q. What about, if the child is given physical and emotional support, but within the place where it's living, there is an abuser who abuses them; do we know whether there has a neurological impact.
A. Yes.

Q. How do we know that?
A. Because a lot of brain studies have been done now that show brain changes in children who have been abused. So, for example, a child in a reasonably normal family who's subjected to ongoing abuse, let's say by a family friend, and it goes on for a period of time but the rest of the family function is okay and the child's life is normal in other ways, they still have brain changes.

Q. And what sort of changes can you see in those brains?
A. The changes affect particularly the part of the brain that's concerned with memory, which is not surprising, there are a lot of memory disturbances in traumatised people, so the hippocampus is affected, and there are changes in the volume of the hippocampus, and also which hemisphere is dominant is affected. There's a middle part of the brain that connects the two hemispheres and that's affected. So, there are a lot of brain changes that are very well documented.

Q. Are these changes likely to be greater the younger the child?
A. Yes. A young child's brain is very, very malleable because it's supposed to be, it's supposed to be a sponge that just soaks up information, so it will soak up bad as well as good. And also because young children are often in the position of sustained abuse, because they don't have much option except to stay put.

Q. Do we know whether neurological change is less likely in an adolescent who's abused or not?
A. No, I don't think it's less likely.

Q. You don't think it's less likely?
A. I'm not sure, but there's plenty of studies of adolescents who have been abused that show brain changes.

Q. When adults suffer trauma and are left with PTSD or a version of it, do we know whether that has a neurological effect?
A. Yes, sustained trauma in an adult will show up in brain changes too.

Q. It will, in the same way?
A. Yes.

Q. So the brain effectively goes into retreat, does it, if that happens?
A. Well, the brain is the organ of the mind. So, if you affect a person's mind, then their brain has to be affected. The thing with PTSD is there is a state of hyperarousal which is a bit like an engine being constantly revved which is going to have to damage the engine eventually.

Q. And you can see that?
A. Yes, you can see that in brain changes, yes. Also there are other physical changes that are very serious too, which is changes to the immune system. We see a lot of real illness in children who have been abused, and there's psychosomatic kind of complaints, that means children who are kind of showing somatic symptoms which are mainly expressions of their anxiety or fear, but then there's real illness; so things like ulcerative colitis and asthma, there's a whole range of autoimmune diseases which are more common, and children who have been abused often have shorter life expectancy, up to 10-20 years shorter life

expectancy.

THE CHAIR: Q. When we're talking about these changes, again going back to the question I asked you before, can you discern whether a change is more likely in the brain in a child depending upon the level of severity of the abuse?
A. Well, the severe abuse will usually have a more severe effect, yes.

Q. But lesser abuse can have?
A. Yes.

MS FURNESS: Q. Can we come back to the shorter aspect.
A. So they're longer term effects. So the shorter effects are a whole range of psychological symptoms, the sort of thing that any upset child might show; so, being sad, withdrawn, having temper tantrums, not sleeping well, not wanting to go to school, being very emotional, so bursting into tears easily, being frightened, suddenly being afraid of the dark, suddenly being afraid of the bogeyman coming, suddenly having bad dreams, a whole range of disturbances which we call non-specific, so mostly non-specific. So those same disturbances can occur under a wide variety of difficulties.

Q. How does traumatic attachment feed into this?
A. That's where a lot of the psychological difficulty arises for children. Children who are abused by someone who's close to them, they usually have a bond of attachment to that person. So, if it's a family member or if it's someone that they're quite attached to, or that they've got a significant bond, so that puts the child in a very confusing position where someone I love and want to be with is actually hurting me so I want to run away. But because children are children, they don't have an option to run away, they're held, they're really captive in a situation of abuse, and so, they're in this situation which is a kind of push me, pull me kind of psychological situation of wanting to be with a person and then wanting to get away.

Then what is kind of perverse in the way we function under those circumstances and really positions us for more damage is that, the more distressed a child feels, the more likely it is to want to cling to someone. So, we all do that, if we're upset, we want contact, we want soothing, we want someone to take care of us. So, if you're very distressed you're actually likely to become more clingy

and, if it's the person that you're attached to who's abusing you, then you're positioned for more abuse.

It's like the well-known situation of the kicked dog that clings to its master, so it's common in animals as well as human beings that creates that paradoxical situation where people are attached to their abusers.

Q. Can we turn to the long term impacts, dealing firstly with psychiatric disorders.
A. As I said a little while ago, there's no particular psychiatric diagnosis that attaches to the long term outcome of childhood sexual abuse. There's almost any psychological or psychiatric diagnosis you care to name has the --

Q. What's the more common?
A. The commonest ones are depression, anxiety, and in our culture substance abuse which is a phenomenon of our culture really because we tend to see drugs and alcohol as a way of dealing with our upset feelings. But also heavy reliance on prescription drugs is another one because that also is a phenomenon of our culture, that we tend to go to the doctor and get a pill if we're feeling bad, so there's a lot of dependency on medication and substance abuse. But depression and anxiety are the commonest ones, which unfortunately, because they are the common psychological presentations, don't necessarily alert people who aren't familiar with dealing with this, and so, sometimes it's just saying, "Oh, the person's depressed", and maybe not enough effort's made to look into it.

But personality disorder of all kinds is common, because as I said before, a child in an ongoing situation of trauma, their entire development is affected, so the character is affected. So they show characterological or personality disturbances; usually disturbances in relationships and disturbances in sexual adjustment and sexual identity. Young boys who have been abused by a male offender over a long period of time are often very confused about their sexuality. They often assume that, because a male offender's had sex with them over a period of time, that that means that they're homosexual, where they may not be, so they become quite confused about their sexual orientation.

They can become very hypervigilant around other men,

so not comfortable in a situation where they're dealing with other men. And having difficulty establishing a functional sexual relationship, having difficulties with intimacy. Again, you've got the contrast of, some people just get switched off sex and other people become sexually hyperactive. A child who's been sexually stimulated before they're ready for it can sometimes go on to have excessive sexual activity. And, when they become adolescent, and here's where the psychological abuse feeds into the sexual trauma, feeling angry with the world and betrayed and all those terrible feelings that they have, an angry young teenager who's been abused is likely to use prostitution and be re-victimised.

Q. So use prostitution, become a prostitute?
A. Well, use prostitution often as a well to get drugs and money, and there's often a perverse kind of gratification; it's kind of like, "I've been used and now I'm going to use these people to get money". Often they're terribly exploited by pimps and people like that because they're young and can be exploited, and often they're drug using and so sex work is a way of sustaining their drug use. And of course, they're likely to - young girls are likely to get pregnant and teenagers that have sex are much more likely to get sexually transmitted diseases, so you get a whole calamity that follows because of what's happened to them.

Q. You referred to people as sleepers, that is, those who don't respond to or understand or realise that they've been abused until much later in life. Is the treatment that's given to them different from those who disclose earlier?
A. No. If I see a child who seems to be showing no symptoms and yet we know that they've been abused, after a careful evaluation, if they do seem to be functioning well, then what we do is counsel the parents to keep a watching brief over them really, and then if there difficulties that arise, then to seek further evaluation immediately. But if the child seems to be putting it behind them and getting on with their life, then there's no benefit really in trying to force the child to think about something bad.

Q. You've spoken of sexuality and the consequences that it can have on a person's sexuality. What about sexual offending?
A. Yes, there are a small - there are a proportion of abused children who will go on to become offenders

themselves. It's a source of enormous pain and anxiety because most people who have been abused kind of live in fear and dread that somehow it's contaminated them, it's taken them over, that it will come out in them so they often - and that's very sad because it often makes them unwilling to have good relationships with their own children, they kind of hold back from their children the whole time, as if they're afraid that this thing's going to come out of them in some way.

But there are a proportion that do go on to become offenders - not the majority by a long shot. Adolescents who are being sexually abused are more likely to become offenders, because they're abused at a time when all adolescents are kind of more sexually aware and have much more sexual drive developing, and so they can become - they get kind of flashbacks of the abuse and then it's very hard to know what's a flashback and what's a sexual fantasy, so they may end up enacting the very trauma that they experience themselves; whereas little children who are sexually abused are much less likely to have any genuine sexual feeling or have any sexual fantasies or sexual drive of any sort and so it's less likely to affect them that way.

Q. Is that based on your clinical experience or research that's been undertaken?
A. Both.

Q. And they're consistent, your experience with the research?
A. Yes.

Q. In terms of those who have the fear that you have described, is there anything they can do to alleviate that fear?
A. Well, I think trauma counselling will help them to understand why they're having the feelings they're having and to also understand that an impulse doesn't have to be a behaviour; that you can have a fantasy or an idea, but you can still have adequate control of yourself; it's not like something that's going to just leap out.

Q. That you can resist it?
A. Yes. Yes, that's an important part. Well, first of all to realise that a flashback is different from a fantasy; that's difficult, because people who have been

abused have flashbacks, so a picture comes into their mind of the sexual act that they experienced, but ordinary human beings have sexual imagery all the time and so it can be very confusing for the trauma survivor to know what's a flashback and what's sexual imagery.

Q. And trauma counselling is a good approach?
A. That's very important to help them understand what precocious sexual stimulation has done to them, and especially to realise that they're not in the grip of something that's just going to take control of them and push them in a direction they don't want to go.

Q. Does trauma counselling refer to a person who's got expertise and qualifications in that area?
A. Yes, trauma - we usually refer to trauma-informed services or trauma-informed counselling, which is having a thorough knowledge of trauma and the effects trauma has on people and being able to incorporate that into your treatment. And it's not a specific treatment, so there are a variety of counselling approaches and a variety of psychological techniques that are used in counselling, but if it's trauma-informed, then it takes account of what's happened to this person and what effect it's likely to have, and understands how treatment can be traumatising in itself and how to avoid that; that people who have been traumatised need to feel safe, need to feel trust, they need to be able to go at a pace that they can handle and not a pace that's imposed on them.

It's really important that they don't feel abused by the therapy, and I'm afraid psychiatry has been abusive in the past at times, especially by imposing treatments on people that they don't necessarily want so they feel abused by the treatment itself. So trauma-informed counselling means understanding all of those difficulties.

COMMISSIONER MURRAY: Q. Professor, this has been reported to us as a problem: what happens to victims and survivors of these crimes is, they're referred to counselling by an institution or by their doctor or whatever, but they themselves aren't equipped to know whether that person who's going to counsel them is trauma-informed, and many of them have reported to us that their counselling experiences have been thoroughly unsatisfactory.

I said to you earlier that the Royal Commission is very interested in the area of counselling therapy for victims and survivors. Is there anything you'd say to us about how victims and survivors could be much better directed to those who could provide them the best care? Is there some sort of process or improvement which you could indicate to us might be helpful?
A. Well, I think it's important that the person that they're seeing has had some kind of postgraduate exposure to trauma - to education about treating traumatised people.

Q. But how would they know? You see, that's the difficulty; if they're directed, how would they know that they're going to the people who can actually help?

THE CHAIR: Q. Professor, I think the suggestion has been that the professional bodies should accept the responsibility of accrediting people. Do they have any accreditation process at the moment?
A. No.

Q. Would it be difficult to organise for that to happen?
A. The professional bodies ought to be really doing much more continuing education in this area. There is some going on but not nearly enough, it should be routine.

Q. So in terms of education, and then the representation would be through accreditation?
A. Yes.

Q. Is that feasible, could we think of the profession organising itself to do that?
A. It's not difficult for the professional bodies to mandate a certain amount of trauma training in continuing education. Continuing education is specified, it's compulsory. It would be - you've got to do about 100 hours of continuing education every year. It would be very easy to make sure that 20 hours of that 100 hours is done in some sort of trauma-informed service.

Q. Would that mean that those people who undertake that level of professional training would be entitled to say to the general community, "I have this level of knowledge and experience that I can deal with this sort of trauma"?
A. Well, it's up to the professional bodies how they want to do that; whether they want to say, well, that's part of our ongoing - our continuing education program, so we

certify this person is in a continuing education program, therefore they're up-to-date, or whether they want to have some kind of certificate or recognition of some kind.

Q. Which would you suggest would be the best way to go?
A. I think probably having it as part of the continuing education, because it depends whether the training bodies are interested in doing this. It would be nice if they were. They ought to be, because it's such a pervasive problem.

Q. We might be able to move it along a little.
A. Well, if you are able to move it along, then I think that it ought to be absolutely part of the training programme.

Q. Part of the fundamental training programme?
A. Yes, it ought to be part of that.

THE CHAIR: We'll do what we can, professor.

MS FURNESS: Q. Part of the training as well as continuing education?
A. It ought to be part of the training program, yes.

Q. Including on the ongoing requirement for 100 hours a year, it would be part of that as well?
A. Well, I think, yes, because it's a growing field; it would be important to remain abreast of it.

THE CHAIR: Q. Professor, from this community and others, there are great concerns about the level of suicide in people who have been abused, and no doubt you've considered this topic. The starting point for the discussion is this question: firstly, I assume you accept that numbers of people who have been abused end up committing suicide?
A. Oh, absolutely, it's well documented, yes.

Q. Is the mechanism by which that occurs because that person may have had triggered a depressive illness by reason of the abuse and then the depressive illness is the pathway to suicide, or is there a direct relationship between abuse and suicide?
A. Well, there's a very strong relationship between abuse and suicide, a very strong relationship.

Q. Is that through the depressive illness?
A. It's through a variety of things. Severe depression is often part of the consequences of trauma, and then, as I said, often there's substance abuse as well, so it's very common that people who are chronically depressed and traumatised then turn to drugs or alcohol; and then drugs and alcohol have a depressogenic effect anyway, and also will exacerbate the person's negative thoughts, so they go on a binge and then they wake up and just think, "Well, I'm useless anyway and look at the life I'm living and I'm good for nothing", and they feel damaged and they feel ashamed, and then they feel ashamed at the way they're dealing with their problem, and so that compounds as well. Sometimes they're plagued by symptoms, that they just can't stand the symptoms any longer.

Q. The symptoms of?
A. Symptoms, say, flashbacks and intense preoccupation and feeling tormented by memories, and sometimes that will be what will drive a suicide. But there's no one kind of situation, there are lots of factors.

Q. But it's right to think that we should be concerned that one of the outcomes for people who have been abused is suicide?
A. Absolutely, and I think that that shame and self-blame thing that's so fundamental feeds into that because, if you feel like "I'm a bad person", it's easier to think about killing yourself.

THE CHAIR: I think we might take a short adjournment now and come back after a short break. We'll adjourn.

SHORT ADJOURNMENT

MS FURNESS: Q. Dr Quadrio, are there any specific effects from abuse by a clergy on a child or subsequently an adult's view of spirituality?
A. Yes. That's a very important aspect and a particular aspect of abuse within a religious context because, especially with young children, see a priest or a member of the clergy as someone's who's close to God really, and so, the sense of betrayal is particularly shattering because it's kind of like, not just one bad person, but it feels like, well, maybe God's bad. The loss of faith and shattering of the belief is really very damaging to a child.

If a child grows up feeling, well, you can't trust anybody and everybody's bad, and even God's bad, that's what I mean about the profound characterological damage that can have.

And also, it's very important because usually the child's family or their entire community may be strongly affiliated with this particular religion, and that means that when children make disclosures they very often get a bad reception and told they're lying, it can't be true. The negative response from family and community can really compound the damage enormously.

Q. What about when a child is asymptomatic and then the sleeper effect applies and they remember and disclose much later on; does that have a similar effect on their spirituality?
A. Yes. Yes, it does. The long delay doesn't make any difference, it still shatters one's belief. It's very disturbing to the sense of identity, because you may have a child that's been abused, let's say for argument's sake, maybe between the ages of 5 and 7 and then they go into a period of four or five years where they seem to be going okay, they don't even think about it anymore, and then something triggers it and it all comes out. They also have this very damaging experience of, it's as if that part of my life is just false, that whole part of my life is just a lie, the whole thing, so everything that they established as part of their identity just suddenly falls away from them because they just feel like it's not only abuse years, but all the subsequent years suddenly just seem to mean nothing anymore, and so they can profoundly - have a sense of alienation from themself, which is really damaging to be feeling alienated from yourself.

Q. Just before the break you were giving evidence about suicidality and the increased number of suicides from people who were abused as children. Leaving that to one side, what other effects are there on the longevity of those who have been sexually abused as children?
A. They don't live as long as children who have not been traumatised. So trauma has, it's not just the psychological damage, it's the real physical damage; so they have more illness, they have more real illness. On top of that, they often have unhealthy lifestyles, so they're prone to substance abuse and poverty and

unemployment, so they're factors that are on top, and all of that adds up to something like 10 to 20 years less life for a child who's been traumatised. So there's an enormous morbidity in terms of physical ill-health and psychological ill-health.

Q. You've referred to grooming throughout your evidence this morning. What are the particular and more common characteristics of grooming?
A. As I said, the children in institutions often aren't particularly groomed because they're already captive, they don't need to be groomed, sometimes they are just subject to the authority of the offenders. In the community the grooming, you can see grooming that's really quite complicated and there can be very careful grooming. Features for example, often there's very careful grooming. And the grooming is not just grooming a child. We talk about grooming in the family, grooming in the community, so an offender can establish themselves as a very, very respected and maybe much loved member of the community or the school or the organisation and they go to a lot of trouble to really establish themselves in that way.

Children abused by clergy, often the clergy befriend the family, visit the family, have dinners in the family home, all of that is part of really establishing themselves very firmly, so that, when the disclosure comes, the immediate reaction is, no, it's not true.

Q. You've indicated earlier that there's no one profile of an offender who's a sexual abuser. What characteristics are there, however, that apply to offenders of the children?
A. There's no particular profile. They are attracted to areas where they will have access to children. Obviously if a person has that kind of sexual interest they will want to work with children, so they are attracted to areas where they have access to children, and they're often quite adept at grooming the community and grooming the organisation so that they're quite well respected and often quite functional in their jobs, they're not dysfunctional in any way, they might actually be very good at their job so that they're quite respected in what they're doing.

Then looking at their sexual orientation itself, a considerable number of them will be what's sometimes called a true paedophile, in that they're exclusively attracted to

children, they're not interested in other relationships. Some will abuse children but also have adult relationships as well. That's sometimes true of ministers in the community - not so much obviously with a Catholic priest it's not so true.

Q. Sorry, true of?
A. Ministers in the community. Often they will have relationships in some of the religions where priests can marry, they marry but are still abusing children. But the majority that you see, especially in the Catholic context, tend to be people who really have fairly much an exclusive orientation towards children.

There's a reasonably higher level of substance abuse amongst offenders, so they're often using, alcohol usually; I mean a socially accepted substance abuse, if you like, rather than recreational drugs or anything like that. But yes, they don't have any particular profile, and they are not particularly psychopathic either, so they don't come to anyone's attention for breaking rules in other ways or breaking the law, and they usually are very good at establishing themselves and being accepted.

Q. You've spoken in terms of the true paedophile. Are there also opportunistic offenders?
A. Yes, there are.

Q. How do they work?
A. If people don't have access to a regular kind of usual sexual relationships. For example, in prison, men in prison have sex with each other who wouldn't be the least bit interested in sex with men when they're out of prison but that's in a situation where they don't have any option. Or sometimes, if people are having contact with children, where it hasn't been a particular predilection of theirs in the past, the fact that the children are there and there's a lot of physical contact with them, they find that the opportunity has arisen and they take advantage of it, but they may not be people who normally seek out children to have sex with.

Q. Are there any other characteristics?
A. Sometimes offenders are people who are not functioning well, but that's a minority. Ones who are not functioning well, not getting along well and sort of immature and turn to a relationship with a child because they're not feeling

able to conduct a more adequate relationship with another adult, but they do tend to be the minority.

Q. And that's a general immaturity, emotional and sexual immaturity?
A. Yes.

Q. You, I understand, have been involved in some treatment programs for offenders in the past?
A. Yes, I worked in the prisons for a number of years and we had offender programs in New South Wales, there was a number of offender programs, so I'm familiar with the offender programs that we have.

Q. The current offender programs in New South Wales?
A. Yes.

Q. How successful are there?
A. Not terribly, I have to say. The difficulty, and it's especially difficult in religious contexts, is that, in order for someone to be a good prospect for rehabilitation they need to be willing to admit what they've done and to have some genuine sense of remorse or contrition and to be motivated to do differently. And these people don't fit into that category; usually, by the time it comes to light, their usual reaction to the disclosure is to deny it, "No, it didn't happen". Then usually after that there comes vilification of the victims, so "the victim's lying, the victim's bad, the victim's manipulative, the victim's whatever". So by the time you've been protesting your innocence for a long time and then vilifying the victim, you're not really the ideal person for rehabilitation who's supposed to be willing to admit what they've done and feel some contrition for it, so it's very hard to come back from that position that you've got yourself into.

It's true of offenders outside the church, the usual reaction is denial and blame the victim, and that's not good prospects for rehabilitation, and even if you do get them into the rehabilitation program, in the case of people who really have an exclusive orientation towards sex with children, it's very hard to change people's sexual orientation, and you really need to have someone who's motivated to change, so it's not easy.

Q. What form of treatment are you talking about?
A. In the prisons in New South Wales they use an offender

program which is about, first of all, trying to move the offender into the position where they accept responsibility for it and stop blaming the victim; they accept that it was entirely their own responsibility; trying to get them to develop empathy, have some sense of the harm that they've done and what the victim must have experienced; and then to focus on ways of changing their behaviour and ways of having more adaptive relationships, but it's not easy.

Q. Do you keep success rates in relation to offending of those in prison?
A. The success rates are not good.

Q. Are they indicated by them leaving prison and whether or not they're back in the prison system for similar offending?
A. In order to get into one of these programs you already have to be totally committed to rehabilitation, so that eliminates actually a whole lot of them, and you have to be willing to admit guilt, and that eliminates quite a few. About 50 per cent of people in prison tell you that they didn't do it, whatever it is that they've been convicted of, they didn't do it, and that's certainly true of sex offenders, they didn't do it or the child lied or whatever. So you get down to only a minority who will accept responsibility and commit themselves to a treatment program.

Q. And the treatment program involves intensive counselling?
A. Yes, they have treatment - an offender program they go into and it's about four months, the program, and then, if they complete the program, then they're eligible for parole.

Q. When you indicated the success rate was low, is that because there is a percentage of those who, when released, commit similar offences and then come back in?
A. There's a significant recidivism rate, and we've already selected out the best prospects, and even with those best prospects people, there's a significant recidivism rate, yes.

Q. You left the prison system in the early 2000s?
A. 2001 I left, yes.

Q. What's changed from then till now in terms of offender

treatment?
A. Not a lot.

Q. No new learnings?
A. Look, I think the programs are fairly similar. The difficulty is, the prisons are getting fuller and fuller, so it's harder and harder to deliver good psychological services. There's an awful lot of mental health morbidity in prisons. The majority of prisoners have been sexually abused as children, so if you wanted to deal with complex trauma in a prison, you'd need an army of psychologists to move into the prisons, because the incidences of child abuse and trauma in their backgrounds is enormous; it's something like 60 to 80 per cent.

Q. That's based on both research and your experience; 60 to 80 per cent?
A. (Witness nods).

Q. And that's sexual abuse as a child?
A. Developmental trauma.

Q. Familial and institutional?
A. Both. Most of the men in prison have had traumatic childhoods, either physical, sexual, psychological abuse of some sort; it's very prevalent. It's just one of those sad things. One of the difficulties that really is a huge difficulty in our society is that, for whatever reason - and it's very complicated, I won't go into it - for whatever reason little boys seem to be predisposed to become externalisers and little girls are predisposed to be internalisers; meaning that, if a little boy's upset he's more likely to show it in an overt way, become overactive, become temper tantrums, become something, acting out, externalising. Little girls are more likely to internalise, meaning getting sad, scared, withdrawing, that sort of thing. It's not exclusive, boys can be withdrawn and girls can be angry, but it tends to be a very strong difference.

The problem with that is that, by the time a boy's 11 years old and externalising, people just see him as a bad kid and then he's set for delinquency in the prisons. And a little girl at 11 is seen as sad, fearful, anxious, whatever, and she's set for psychiatric services rather than the prison. And it's really sad because we end up with a huge amount of mental health difficulties in men

being channelled into prisons where there's not adequate rehabilitation services and not adequate treatment and 11 per cent of men in prison have got a psychotic illness, which is not a place to be treating someone with a psychosis, and most of those men with psychotic illness have got a history of childhood trauma.

So it's just one of those sad things about the way our society functions that, once you put the "bad" label on a boy, it sticks, and once he does something really bad, like hurt someone, then any sympathy or understanding of his trauma gets lost and it's just thrown - lock him up and throw away the key is the general feeling in the community.

Q. You gave evidence earlier about the effect of trauma on the development of the brain, including memory, and you also gave evidence about flashbacks. In your clinical experience, does repressed memory play any role in people seeing you who have been abused sexually as children?
A. Memory is a really important part of trauma. I think I said earlier, the strange thing about trauma is, there's this combination of remembering too much and not remembering enough. So there will be patches of memory missing and then there will be experiences that just are burned into the mind and the person can't get rid of them, and it varies. Some people are just full of imagery and are tormented by it and other people have huge blanks.

There's been a lot of controversy in the area of memory, a huge amount of controversy. So there's suppressed memory, repressed memory and recovered memory. First of all, we have to accept that part of the definition of what trauma is about is that it's a disturbance of memory, so that's fundamental, that there is some disturbance of memory in trauma.

Recovered memory is a very controversial area where people have claimed to have absolutely no memory whatsoever of the abuse and they go into treatment or counselling and suddenly it comes back, and there have been instances where it's been suggested by the therapist and so then the whole area became muddied with accusations. Of course, you're dealing with a community that's very quick to discredit the victims anyway, and some of it probably has been bad counselling, but the context of course is that the community's always willing to discredit the victim, so it easily becomes a case of, that's recovered memory so don't

count any of that.

What I see a lot of is what I think you call suppressed memory. There are a lot of people, and boys more than girls, who just decide I'm not going to think about that, I'm putting it out of my mind, I'm just going to get on with my life, I'm not going to deal with this, and some people can do that more effectively than others. So in that case it's a suppressed memory. You may then get the situation where the person said, "I forgot all about it", and then something's happened to trigger it. But if you sit down and very carefully go over it with them, you find that they never actually didn't know that it happened, they've just managed very effectively to not think about it at all, maybe for years and years and years. But if you go over it carefully, you find that actually they always did know. If you'd ever sat down with them and said, "Well listen, what happened when you were 7 years old and going to boy scouts", they would have said, "Oh, yeah, well I remember", but they just haven't given it any thought, so it's suppression.

Then repressed memory is a bit more complicated, that's supposed to be a psychological mechanism. It's a controversial area, whether your memories can actually be deliberately buried as a way of protecting yourself. There are some people who think that repression is possible and others who don't. But certainly suppression is very common. I mean, ordinary people do it every day, we all do it, we always say, "Look, I'm not thinking about that, nothing I can do about it, I'm not going to think about it anymore", and if you can do that effectively, then some people can actually put something behind them and move on

Q. That would affect significantly when, and indeed if, a person discloses what happened to them as a child?
A. Yes. It's more likely that the disclosure will come - sometimes it comes as a shock to the person because they have spent so much of their life keeping it buried and not thinking about it, and then once they start to talk about it, they sometimes feel shocked themselves of the intensity of what they're feeling, and that's when people will often say, you know, "I'd forgotten all this", but you actually hadn't forgotten it, you actually had found a very effective way of keeping it completely bottled up. Sometimes it's totally bottled up, there's no evidence that the person's troubled. Other times they say it's bottled

up but it's actually leaking out in little ways that you can see. Little ways like, they never stay in a relationship very long, or they don't relate very well to their children, or you know, it's leaking out if you like in those ways but they don't put it together in their minds. They don't stop and think, well, the reason I'm not getting very well in my life is because of all of that.

Q. In your evidence so far you've spoken of the need for trauma-informed counselling and those who have sufficient skills and qualifications at it; you've spoken of the need for more mental health resources in prisons for those who have been abused as children. What other areas of support do you think survivors need?

A. We have to be much more mindful of symptoms in children than we are as a community. It's a very common scenario that I see; I see kids who are troubled, and in my experience they tend to be about 11 years old by the time they get to see a psychiatrist, and then you sit down and go into it and you find out that this little kid was banned from pre-school for biting other children, and the family just felt embarrassed and ashamed, which compounds the child's feelings of shame, and just moved to another kindergarten. Then you get this history of all these little phenomena over the years, and people have said, look, he's just a hyper kid he's got ADHD, he's got this, he's got that, he's got dyspraxia, he's got learning disorders, the labels proliferate and the treatments proliferate and the medication proliferates, and nobody really stops and thinks, something's happened to this kid. And by the time they're 11 years old it can be really hard to turn them around.

That's what's really sad about boys because by the time they're 11 they're angry and they're big, and now people are starting to feel intimidated by them and the general approach then is, you know, put him away somewhere, and you've missed the boat because we need to deal with these kids when they're littler, when they're already symptomatic, and not say, this is just a bad kid or this is just ADHD or this is just a hyper kid or this is a reaction to cordials, or whatever theory of the day happens to be around, and there's always a theory of the day.

Q. Those children would probably see GPs as a first port of call, so it's GPs who need to be made better aware of symptoms that might indicate some underlying abuse?

A. The whole community needs to be aware that when children are symptomatic, there's a reason. Children are actually very rational creatures; they're not irrational creatures. There's a tendency to say, he or she is just a child, you know. Children are very rational creatures. If you stop and think about why is this child symptomatic and why have they got these particular symptoms, then usually there's something there.

Q. In addition to GPs, it may well be teachers who would be able to observe this behaviour in children?
A. I think the community generally, teachers, psychologists, counsellors, GPs, there needs to be just a huge amount of awareness that children who are troubled are troubled for a reason. There's so much gobbledygook going on about this disorder or that disorder or this allergy or that allergy or whatever, and sometimes it is, but an awful lot of child distress gets ignored or covered up, or gets channelled into all kinds of treatments.

Q. So, looking then at trauma-informed counselling, you were asked questions earlier about the need for some form of accreditation system so that survivors know that they're going to see somebody who's properly qualified and experienced. Are there any other forms of counselling that would provide a similar service for survivors?
A. There are a lot of survivor organisations that are very helpful. The support that people get from other survivors is really important. Finding other people who have been through the same experience is a great comfort, it makes you feel like you're not alone, and also, you have people you can talk to who really do understand what you've been going through, so survivor organisations are very helpful. And also, survivors get to be cluey about who's who in town and who you can talk to and who you can't talk to, so you get good advice from other survivors about which psychologist to see and which not to see, and which doctor to go to and which not to go to, so all that's really important for the survivors. So I think the organisations, the self-help and support groups, have been really good, and also the support groups have been wonderful in lobbying the professions to change what they're doing.

Q. In your clinical experience, do you think survivors would feel discomforted by going to see someone when that someone was paid for by the institution where they were abused?

A. Yes, that's been one of the problems of attempts at redress made by the institutions. I think you have to get the help - maybe the institutions can pay the bill, but that's all. They shouldn't be providing the treatment, no.

Q. So they provide the money and there's an independent administration as to --
A. Absolutely.

Q. -- funding of counselling and the like as well as any redress?
A. It's a bit like psychiatric research is run by drug companies and that's, straight up, you know the results are going to be skewed, and they are; the same thing. It has to be separate from the money, otherwise it gets skewed.

Q. In addition to having a clinical practice and doing the research and speaking engagements that you've spoken of, do you also do assessments of offenders for courts?
A. Yes.

Q. Who approaches you to do those generally?
A. I did most of it when I was in prison - not when I was in prison, when I was working in prison. Since I've been out of prison, I do them occasionally, but I don't do a lot. I've got a reputation for being on the side of the victims and that compromises me.

Q. I was wondering about that. So who approaches you generally now?
A. Sometimes I am approached to assess, yes, more often with familial abuse.

Q. Do you consider that an important part of your work in the profession as providing that service?
A. I always felt it was really important - I was interested in the prison situation because, seeing the amount of trauma in prisons is really important, so the sex offenders are difficult to help, but in prison the sex offenders aren't the big group; the big group of offenders in prison are other kinds of offenders, so it's been important to work in that context, to see the effect of trauma on their trajectories. As I said, I do a lot of family assessments and that brings me into contact with family members who abuse other members, and children who abuse other children and adolescents. But the institutional abuses, no, I'm not the favourite person to

assess them.

Q. Do you think that survivors might feel difficulties in being counselled by somebody who also provides assessment for offenders?
A. I think it needs to be kept very separate.

Q. And it's not necessary for your ongoing development as a psychiatrist to have that component, just using you as an example, in your work?
A. I thought it was necessary for me to have that, and I think it's necessary in one's training to have both so that you don't just see one side of this.

MS FURNESS: Thank you. Thank you, Your Honour, I have nothing further.

JUSTICE COATE: Q. Doctor, can I just take up with you a couple of issues that you've spoken about. You've talked in general terms about what we've come to understand as the various barriers to children disclosing, so you've given evidence about those feelings of shame and guilt. Can I ask you just to focus for a moment on the issue of children worrying about not being believed. We've heard a considerable amount that, as being a barrier to disclosure.

In child developmental terms, what do you think is going on for the child who is concerned that he or she won't be believed if they disclose?
A. I think children are intuitively correct, they have an awareness and they're correct because children are often not believed, and they certainly have an intuitive understanding of what their parents will and will not accept, so there's that kind of intuitive level of understanding.

The children who do disclose often will realise that they've got parents who are going to be supportive, but if a child intuitively realises that the family's not going to be willing to listen, then they won't disclose and then the shame and the guilt and the self blame is also part of that.

Q. So, is it your view that part of that is the impact of what we've been referring to this morning as the grooming process?
A. Well, for example, the child might be well aware that

their parents admire the offender - in the case of the church for example, if mum and dad are firm believers in the church and committed to the faith, then the child realises that it's very hard to destabilise that system and that mum and dad probably won't want to know about this. If there's been grooming of the family, like when the offender has actually become a visitor to the family home and that sort of thing, it becomes very difficult.

Q. Thank you. Again, with respect to the grooming process, we've heard a considerable amount of evidence about denigration, humiliation and physical abuse being perpetrated on children in conjunction with sexual abuse. Is it your opinion that those forms of abuse are part of the grooming continuum or are they part of something else that's going on?
A. When there's frank physical abuse, it's usually children who are in care, and in that case there's much less grooming that goes on because the child's under the control and the authority of the offender, so they don't have to - they can just force what they want on the child, so there's not much grooming that goes on there.

Some of the institutions, especially the ones that - --

Q. The schools.
A. Yes, and also especially looking at institutional care of children prior to the last maybe couple of decades when corporal punishment of children was much more widely accepted, and so, children would be punished physically, sometimes just for not complying with the authority of the offender. I think in the last couple of decades there's much more of a consciousness in the community that corporal punishment is not a way to go with children.

But in the days, for example of the Christian Brothers that I saw in the 40s and 50s, corporal punishment was just standard, it was standard in schools, even in good schools it was standard to punish children physically.

Q. Just a completely separate question: in the course of responding to Ms Furness's questions you've said that, I think it was the 2008 Sydney conference, you said that some of the faiths said they didn't have a problem. Are you able to tell us which ones they were that took that view?
A. Well, they've since all had media exposure for having

the same problems.

Q. Yes, but which ones in particular do you recall?
A. At the time we approached the Jewish organisation and they didn't, and the Muslim ones that we approached said that they didn't have a problem too.

Q. Can I take you now to resilience, and I think you've given evidence to us about what you've called innate resilience. I understood you to say to us generally that it was your view that resilience in a child was not particularly well understood by your profession at this stage.
A. That's right, yes.

Q. Although, what I understood was that there was work going on in that area.
A. We don't understand, not just with children, with adults too, that some people will just bounce back from some horrific experience, and others will be crushed by it, and then a whole spectrum in between. So, we don't always understand. We know some of the factors that make for resilience. So, if you're healthy and intelligent and able and had a good, strong family upbringing and environment, then you are going to be more hardy than if you've been damaged and abused and neglected and not loved and all those sorts of things. But, even so, there's still a kind of innate hardiness or lack of hardiness that sometimes is hard to account for.

Q. That work that is currently going on, is that going on in the psychiatric field?
A. Yes.

Q. In any particular area that you can draw to our attention?
A. Resilience is something that's being researched all the time, and also looking for what are the correlates. So, can we see what factors are important in determining resilience, and can we do things to make children more resilient. There are counselling programs now that actually aim at promoting resilience. But there's some sort of innate level of resilience that is hard to account for, but you can give a child an environment that will promote resilience, and you can also provide counselling that will promote resilience.

THE CHAIR: Q. Professor, you may not be able to answer this, and don't be embarrassed if you can't, but a significant part of our obligation is to make recommendations so that, so far as possible, children aren't abused in the future. Have you got any thoughts as to where we might look or suggestions as to what might be an approach that institutions might take to minimise the risk?
A. I think when children are in institutional care there's a risk of abuse.

Q. So much is plain. What should we be saying to institutions to try and minimise it?
A. First of all, they have to face up to the fact that it happens in every institution. I think religious institutions have suffered a little bit in the past from feeling that, if we just put good people in charge then nothing bad will happen. I think we need to think about - the way we think about money, for example, is quite different. I mean, we have massive security in banks, and that's not because we think all the people who work in banks are bad people, we just know that human nature being what it is, we've got to keep the money secure. We don't treat children with the same level of, you know, we've got to keep them secure. We do have the assumption that we just get all these nice, good people and put them in charge and everything will be okay. Wouldn't dream of running a bank like that. Just, let's find some good people and put them in charge and not worry about security.

So you've got to realise that, you know, children are vulnerable to abuse by caretakers, and in institutions they're far more vulnerable, so they need to think about, have an approach to screening people and keeping transparency in the way the place operates and an environment where children are free to complain, to be listened to if they have any problems, and not to have authoritarian systems where you shut up and do as you're told or don't complain. Children need to have their voices heard and have sympathetic people who will listen to them, and we just have to keep that level of reality testing, that adults are prone to abuse children in their care, so we have to have scrutiny of these institutions.

COMMISSIONER MURRAY: Q. Professor, following from the Chair's questions to you, the Royal Commission is interested, and then there's examining the prospects for a

public health model with respect to prevention really of child sexual abuse; you'd be familiar with the concept; yes?
A. Yes.

Q. In what respects, do you think, a public health model approach might facilitate much less abuse and a more secure and more safe environment for children?
A. Well, I think it's absolutely essential that we have a public health approach, because the biggest risk to children is abuse and violence, and family violence and abuse and trauma, and we have public health approaches to all kinds of illnesses, but the biggest cause of morbidity is right under our noses and we don't have a public health approach to it.

Family violence and abuse and trauma are huge morbidity factors; there's not a psychiatric diagnosis that's not correlated in some way. 50 per cent of people who are hospitalised with mental illness have a history of childhood trauma. If 50 per cent of people who were hospitalised had a history of drinking cow's milk, or whatever, we'd ban it instantly, but we don't have that public health model at all

The other problem is that, because there's not a discrete syndrome, it cuts across all areas, that's also been hard for people - people have these sort of discrete areas, you know, there's this area and that area and the other area - well, it cuts across all those areas.

And the transmission - I haven't mentioned transmission - the transmission of trauma is extremely significant. For example, 40 per cent of boys who grew up in a domestic violence household are likely to become domestic violence perpetrators themselves. Now, there are not many genes that have 40 per cent penetration, and yet, there's a massive amount of research money that goes into looking at the gene that causes depression and the gene that causes schizophrenia and the gene that causes ADHD, and we've got causes under our noses that we're not doing anything about, which is that if you brutalise children when they're little, they're going to behave in bad ways when they get bigger. But we're not doing enough.

Q. Professor, we have some ideas about what a public health model might look like, but I'd be interested to know

from you what do you think the main constituent elements of a public health model should be in the area of child sexual abuse?

A. Understanding first of all that childhood abuse and neglect and adversity is the single greatest pathogen that children are exposed to, over and above all other pathogenic influences in our community. If you put together all the problems of childhood adversity, so then you look at poverty, neglect, abuse, violence, all of that, they are the biggest components, and they cost the community a fortune. So, it's important that we deal with it as the biggest pathogen.

It's not easy to deal with a pathogen that's so widespread and that there's a huge amount of denial about, but we've been able to do it in other areas and we can do it in this area.

Q. A second area I wished to ask you about briefly: you have given evidence about impact arising from child sexual abuse. Would you explain to us what you feel are the differences in impact between abuse by an adult or abuse by an older child on the victim?

A. If there's a considerable age difference between the victim and the perpetrator, then the fact that the offender is not an adult doesn't make a great deal of difference. We generally define abuse as being when there's more than three years difference or where it's coercive or violent, because there's sexual play that goes on between children that's not abusive.

But, once a child has been abused by a child who's three or more years older, then it pretty much fits into the paradigm of abuse generally.

Q. So the impact would be similar?

A. It's similar, yes.

Q. The last area I just wanted to deal with briefly, if you wouldn't mind: your evidence has concentrated, because that's where the majority of offence lies, on men. Where the offender is a female, an adult female with a child and in an institutional context, are there differences that we should note in terms of impact or causality or anything at all?

A. Again, there's a huge amount of childhood trauma in the background of women who offend. It's really very

unusual to find a female offender who hasn't got a history of childhood trauma and abuse herself, and substance abuse is really very common too amongst women - well, amongst all offenders, but women offenders it's often substance abuse as well. Otherwise - and it is unusual - it's not that women don't abuse children, they do, but sexual abuse is not much of a modus operandi with women. Women will abuse children physically and psychologically and verbally, but sexual abuse is not so common. But, where there is sexual abuse, in my experience almost always it's a background of the woman having been sexually abused herself.

Then there's a smaller group which is notable but where they're working in conjunction with a male offender. Occasionally, some of the famous cases but they're really unusual, where they're working in conjunction with a male offender.

Q. You have said it's very unusual. We have had evidence at some public hearings, and of course we've also had discussions with thousands of victims, where it has been reported to us that women have known that offending by men was going on. Is that in your experience a more common matter?

A. Yes, I think women have been - women have sometimes colluded in that way by not taking action, sometimes because they're intimidated but sometimes because, particularly in the church, there's that false view of the good name of the church is really important and will do more harm to the community by disclosing than by covering up. So I think that women have been complicit in that, for the variety of motivations, from being complicit to being fearful, or fearful of retribution. And there have been nuns who have been very physically abusive towards children in their care. There are a lot of people I have seen who have had very sadistic experiences with nuns and occasionally sexual abuse as well by nuns.

MS FURNESS: Q. Doctor, you know that there are tens of thousands of children in out-of-home care today.

A. (Witness nods).

Q. And you'll know that there's been a trend towards most out-of-home care being provided in individual homes rather than orphanages. Is there anything you can say to help the Royal Commission understand what is a model for the delivery of out-of-home care that is more protective of

children?
A. Well, there has to be scrupulous screening. I've seen cases of children abused in out-of-home care where, with a little bit of digging around, you find out that the offender's actually had some previous problems, so I think the screening has to be really scrupulous.

The whole idea, children in out-of-home care are very vulnerable to abuse. We need to do a lot more about dealing with family problems, and I think that - you know, you have to ensure that a child's safe, you can't leave them in a home where they're being abused, but I don't think enough is done to try to repair families that are not functioning well.

Q. So there should be more early intervention, where there are problems before the child is removed?
A. Sometimes children are removed where I don't think there's been nearly enough effort made to rehabilitate the parents or the mother. Drug offenders are a real problem because treating drug offenders is very hard work. But removing the children and putting them in out-of-home care, that's not a solution either, we need to be a bit cleverer about this.

Q. In cases where it is in the interests of the child to be removed from their family, what is it about out-of-home care that can be more protective than it is now when you understand that most children in out-of-home care are living in individual families, leaving aside screening, I understand what you're saying about screening.
A. There are lots of families who have provided extraordinarily well for children placed in their care, but still, there is a very significant incidence of abuse of children in out-of-home care as well. So I think prevention, we need to do more at the beginning before - we don't have nearly enough people working in family and community services. Everybody knows that the workers have their work cut out, they can only deal with the worst. There are a number of children every year who die of abuse and neglect and trauma at home because they haven't got the services. We're not treating children like the priceless commodity that they really are.

Q. Is there a better model than having children in individual homes?
A. We don't do nearly enough mother and infant care that

we could do. For example, a woman who's not functioning well as a mother, the tendency is to remove the children, even if it's supposed to be on a temporary basis, but that's very damaging to a child anyway. We don't have nearly enough mother and child treatment units. We could put mothers into a treatment unit where they are resident with their children and are treated while they are resident. There's very little of that. There's not even a lot of mother-infant units in New South Wales. You know, infancy is a very critical time, we're not doing nearly enough to deal with mother-infant problems.

We should be trying to get people to be better parents, rather than waiting until the thing breaks down or the children are abused.

Q. You would agree that the move from the orphanage-style provision of out-of-home care to the current one is preferable?
A. Well, institutional care is not good for children, no. The sad thing is that children are abused by their own biological parents, but the further you remove a child from the biological parent, the more the incidences of abuse goes up. Until, if you have complete strangers looking after children, like in detention centres and so forth, then the rate of abuse just goes higher and higher and higher. Once that kind of bond of attachment is not there between an adult and the child, the risk of abuse becomes very significant.

Q. And if a child has been abused sexually in the familial setting and then is removed and placed in another family, as it were, what are the chances of that child being abused in this placement?
A. As I said, the further away you go from your biological parents, the more your risk of abuse increases, just as a sort of a risk factor; that's not to say that there aren't lots and lots of foster families and adoptive families that are wonderful. But just looking at raw statistics, the further you are removed, the more likely you are to be abused.

Q. So more resources should be put into early intervention in families that are struggling and more resources should be put into alternative forms of accommodation, such as, as you say, mother and infant units?

A. We have very little in the way of mother-infant services and parent-child services. We had a service in Sydney that was an admission unit for children with their families, and that's been wound down till it's - I think the program is not even running any more, and there was only one program in all of Sydney.

Q. There was a program, wasn't there, where the Department of Health people visited new parents, particularly mothers, over a period of time to see how they were getting on?
A. Yes, but that's a study that hasn't been sufficiently acted upon either; a lot of it was done by a particular person called Olds who did a 15 year study of having home visitors, usually nurses, and they just go to the home where there's - it started in pregnancy, had a visit to the mother; they picked vulnerable women, like young teen single mums, and follow them over a 15 year period with a regular home visit, and the delinquency rates dropped by something like 90 per cent in the ones that had the regular home visitor.

Q. Is that program across Australia or just in New South Wales?
A. It's not across Australia, no.

Q. But it's still operating in New South Wales?
A. No, the Olds didn't work in New South Wales, this is an American study. But there have been studies like that that show very good outcomes when you institute some fairly simple things; you know, this is having a regular adult who visits and just as a kind of a troubleshooter and a shoulder to cry on if things go wrong and that makes a huge difference.

MS FURNESS: Thank you.

THE CHAIR: Now, does anyone else have any questions? Anyone else at all? No. Very well.

<EXAMINATION BY MR MOLONEY:

MR MOLONEY: Q. I represent two men who gave evidence last week and they reported and gave evidence which was all too characteristic of the evidence given by the people who have given evidence.

One of the things that my clients have discussed is the possibility of a triage or a process at the commencement of counselling whereby they are able to essentially have an audit of their life as it is at that point. The difficulty that they are experiencing is that they are not necessarily the best advocate for their own position. The developmental and psychological and memory issues that you've very clearly identified render the individual only able to self-report a component of what they are experiencing, and there's a good much else which they are not even aware of which could be ascertained by psychometric testing, by psychiatric assessment, by physical assessment and by interview with partners and siblings and the like.

Is there merit in the proposition, particularly in Ballarat where we have a large number of people all seeking care and counselling, for a triage system of that type with high quality, highly experienced people conducting the triage, compiling reports, and then that report being used as a basis for ongoing assessment?

A. So, that kind of prioritises the problems and the needs?

Q. Yes.

A. Yes, I agree, yes. Especially when there's been - I think there's been a lot of people in the Ballarat area who have been affected.

Q. On a second and unrelated issue, you made reference to various assessments that you've conducted. My clients are very concerned about being able to identify or imagine the life that they might have had but for the abuse and, as they learn more and as people listen and educate themselves in the way - of the consequences that you're demonstrating - the notion of the harm ripples out and expands exponentially.

So, in the process of imagining or for the purposes of perhaps seeking compensation they try and imagine what else, what might have been.

Is it possible for people in their 40s or their 50s to disaggregate the normal vicissitudes of life or other adverse child events from the specific sequelae to childhood sexual abuse, or is that not something that a --

A. It's difficult, because if you're traumatised as a

child, it affects every part of your being, so every part of your being is affected by that experience. It's not like you can isolate it like, just one organ; not like you've just got kidney damage but your liver is working fine. It's like every part of your person is affected by that, so it's really difficult to separate out. It's almost impossible to know what could have been if it hadn't been for the trauma because every part of your being has been affected by it.

Q. Though it is difficult, can useful observations be made from a psychiatric perspective?
A. Observations about what? What might have been?

Q. The what if.
A. The what if? You know, that question opens up a huge amount of grief for the victim; it's really difficult to deal with, because there's a huge amount of grief that goes into just posing the question of what might have been; it's a life lost, it's an identity shattered. It's very difficult to deal with what might have been and it's unknowable, unless - if you're in a family where you've got siblings who were completely unaffected by the trauma, you can sometimes look at your siblings and think, well, roughly I should have - you know, if my brothers have all gone to university or my sisters are all happily married and have beautiful children, then maybe that's what I could have expected that I could have had if I had a different life, but it's only a rough estimate.

Q. Is there some scientific rigor in that analysis, for instance, between siblings?
A. Roughly, you can say that children - siblings in a family tend to have similar, similar trajections, not identical but similar. So, if you look at a family and one child was abused and is grossly affected and the other three all seem to be living fairly secure and stable lives and they've got employment and they've got stable relationships, then you can say, well, there's only one reason why this one's so different from the others.

Q. On a third unrelated point: amongst the Ballarat survivors group, which is an informal group which my two clients are a part of, they have discussed amongst themselves and colloquially they have never come across an instance of someone identifying as having been the subject of childhood sexual abuse and this not being the case; that

is to say that their experience is that people would never lie about such a thing.

Is there a body of literature about false reportage, and is it --

A. Yes, it's unusual.

Q. And it is unusual?

A. It's unusual. It's unusual not only for children but for adults as well; it's unusual. So, yes, false allegations - there has to be a fairly solid motivation for someone who make a false allegation, and considering the amount of trauma that a disclosure brings, and most people realise that that's not an easy path to take, you have to ask yourself, what's the motivation for making a false allegation? Children don't have much motivation at all to make false allegations; adults sometimes do, but even so false allegations of sexual assaults in adults are not common either.

MR MOLONEY: Thank you.

THE CHAIR: No one else? Ms Furness?

MS FURNESS: Nothing further, Your Honour.

THE CHAIR: Thank you, professor. Thank you for your evidence, you are excused.

<THE WITNESS WITHDREW

MS FURNESS: Your Honour, I understand my friend has something to say.

DR HANSCOMBE: If the Commission please. I represent Timothy Green. An enquiry has been made as to whether Mr Green, although he has been excused from the witness box, would be willing to be recalled by the Commission and cross-examined, and my instructions are that he would be willing to do that.

THE CHAIR: Thank you. Ms Furness?

MS FURNESS: Thank you, Your Honour. There's no further witnesses today. Father McInerney will be giving evidence in the morning.

THE CHAIR: Mr Gray, is it proposed to ask that Mr Green be available?

MR GRAY: No. I don't know what enquiry my learned friend was referring to. It wasn't an enquiry from us.

THE CHAIR: Sorry?

MR GRAY: I don't know, is the answer to Your Honour's question. I don't know what enquiry my learned friend is referring to. It was not an enquiry from us.

THE CHAIR: I'm now totally confused. It's plain to us that Mr Green is prepared to be cross-examined. I take it, you're saying you don't want to cross-examine him?

MR GRAY: I am saying that.

THE CHAIR: Very well. Yes.

DR MARICH: And the position is the same in relation to Mr David Ridsdale.

THE CHAIR: I'm sorry?

DR MARICH: The position is the same in relation to Mr David Ridsdale.

THE CHAIR: Mr Ridsdale will make himself available to be recalled to be cross-examined?

DR MARICH: If needed.

THE CHAIR: Well, Mr Gray?

MR GRAY: I hear that. I should say for the record that both of those positions are very different from what was conveyed to us on Friday, but in any event our position is the same.

THE CHAIR: You don't wish Mr Ridsdale to be recalled either?

MR GRAY: No.

THE CHAIR: Very well. Ms Furness?

MS FURNESS: Perhaps we could adjourn until 10am tomorrow morning, Your Honour, if that's convenient.

THE CHAIR: 10am in the morning.

AT 1.02PM THE COMMISSION WAS ADJOURNED
TO TUESDAY, 26 MAY 2015 AT 10AM

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