Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF HELEN MILROY

I, Helen Milroy, care of The University of Western Australia, 35 Stirling Highway, in the State of Perth, Australia, 6009, and [redacted], do solemnly and sincerely declare that:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

2. My qualifications include a MB BS CertChildPsych W.Aust. FRANZCP.
3. I am a descendant of the Palyku people of the Pilbara region of Western Australia. I was born and educated in Perth Western Australia. I studied Medicine at the University of Western Australia, worked as a General Practitioner and Consultant in Childhood Sexual Abuse at Princess Margaret Hospital for Children for several years before completing specialist training in Child and Adolescent Psychiatry.
4. From 2013 to 2017 I was a Commissioner on the National Royal Commission into Institutional Responses to Child Sexual Abuse (**NRC**). In 2019 I was appointed as a Commissioner with the Australian Football League.
5. I have been on numerous State, National, International and College policy committees, Reference and Advisory groups and Boards including the NHMRC Human Ethics Committee; Headspace Board; Australian Indigenous Doctors Association Board; the Wharerata group for the International Initiative in Mental Health Leadership and Co-chair of the Million Minds Medical Research Advisory Group I was also a Commissioner with the National Mental Health Commission.
6. I am currently the Stan Perron Professor of Child and Adolescent Psychiatry at the Perth Children's Hospital and UWA and Honorary Research Fellow with the Telethon Kids Institute.
7. I am currently a member of the RANZCP Foundation; RANZCP Presidents advisory group; Young Lives Matter Board; inaugural board of Gayaa Dhuwi Australia; WA Mental Health Tribunal and the WA Care Plan Review Panel. I am also the Chief Investigator on a project concerned with culturally and clinically capable models of mental health care.

IMPACT OF CHILD SEXUAL ABUSE

8. There is no doubt that significant trauma adversity in childhood, including child sexual abuse, will have a significant impact on a person's mental health throughout their life.

9. That trauma or adversity is a risk factor for adverse outcomes across all developmental domains. It affects people's capacity to learn at school, to relate to others and it can affect mental health in very significant ways. It can be the underlying driver of many of the mental illnesses that we see in mental health services.

10. In this statement I have set out a number of the current key learnings around the proper response to child sexual abuse and steps to minimise its prevalence and impact.

BARRIERS TO DISCLOSURE

11. When a child is sexually abused there are a number of barriers to them disclosing that abuse. Without being exhaustive, I make the following observations:

    (a) At a societal level, child sexual abuse has always been a taboo topic and it is an extremely difficult thing to talk about. There is a lot of stigma, shame and negativity associated with child sexual abuse. There is still a level of disbelief in the general population and questions like, '*did this really happen?*' or '*is the child lying*' are still asked. While these attitudes are less prevalent than in times gone, there is still denial and disbelief that operates. In addition, being the recipient of disclosure brings ethical, moral and professional obligations which some people find emotionally challenging and would rather not be involved in.

    (b) A child may not understand what actually happened to them. It is often so beyond their normal experience that they don't know what to make of it. This confusion can be exacerbated where the abuse involves or is accompanied by grooming, lies, threats and other manipulations of the child. This confusion is itself a barrier to identifying and disclosing child sexual abuse.

(c) There are gender differences in the pattern and nature of disclosure, and some further complexities for children who are gender diverse. That is because they may fear that disclosure of abuse may require or lead to disclosure of their gender identity. Boys are less likely to disclose than girls. Stigma and questions around sexuality also prevent disclosure especially for boys as the majority of perpetrators are men. If the perpetrator is female, boys think they won't be believed or should have enjoyed the contact.

(d) Other barriers include age (very young children), disability especially if non-verbal, fear of consequences, shame, embarrassment, fear of disbelief, fear of being labelled a potential perpetrator.

12. There are additional, external barriers surrounding institutions, once again without being exhaustive, I note that:

(a) institutions may be unwilling or ill-equipped to actually think about child sexual abuse, or to recognise that it might be the cause of an individual's problems; and

(b) institutions may have a reluctance to make enquires about events of child sexual abuse because of the resource-intensive obligations to respond to that disclosure – as well as the reputational impact of the disclosure.

(c) Institutions that value reputation over child safety, belief in adults in preference to children, have poor policy, procedures, and inadequate record keeping, have a culture of intimidation or punishment.

13. Accordingly, any response to child sexual abuse needs to address these barriers to disclosure, so that individual victims are empowered to speak up and get the help and support that they need.

INSTITUTIONAL RESPONSE TO DISCLOSURE

14. For a service or an institution to properly respond to disclosure they must be equipped with the necessary resources and expertise. The period immediately following disclosure by a child can be dangerous for that child. There must be very safe systems in place to respond to any disclosure.

15. Once a disclosure is made, it is unknown what the pathway will be. If the case is dismissed, the abused child may be returned to the same risky environment and suffer the consequences. The child may also be removed from their home, family/community violence may result. Both survivors and perpetrators are at risk of suicide around the time of disclosure.

16. I am aware of some techniques whereby a child's disclosure is delayed to ensure that the appropriate supports in place. When done skilfully this can increase the prospect of a disclosure. However, it does carry a risk that if a child's disclosure is interrupted, it may not be started again, and the disclosure may be delayed for many years.

17. There is a difficult balance in trying to support a child to disclose without damaging the evidence required for an investigation. Hence using a techniques to support the child to hold the information until a safe and trusted interview can be held may be required. If however, the child is interrupted in a way that is not supported, the child may not disclose again for a very long time. It takes a lot of courage in the first place to speak up.

18. On a practical level, things like telling the child they are doing the right thing in speaking up and their story is very important and needs to be heard by the right people etc.

EARLY INTERVENTION – WHY IT IS IMPORTANT AND WHAT ARE THE BARRIERS TO IT

19. There is often a disconnect between understanding trauma as an event and understanding trauma as an impact on a child's health and wellbeing. The two are often thought of as exclusive to each other. This can lead to a lack of recognition or understanding of the pathway that can develop for an individual who has experienced significant trauma, be that physical or sexual trauma.

20. The disconnection between event and impact of trauma can mean that health practitioners and other important people in children's lives fail to recognise the little signs that a child might manifest and so therapeutic intervention does not occur soon enough. Often no one intervenes until adolescence when the young person is self-harming or suicidal, using drugs, or in the juvenile justice system.

21. Some children may show very little but some level of psychosocial support should still be offered to build resilience and to ensure development stays on track. Other signs can include anything that is different from before the trauma such as changes to sleep, eating or other routines, anxiety and worry, sadness or fear, problems with friends, problems at school with attention or learning

22. If a child suffers significant trauma in the first 10 years of life, or thereabouts, dramatic changes in the brain can occur which cause the brain's development to go off on a completely abnormal developmental trajectory. If that trajectory becomes hardwired, it can be extremely difficult for that individual to get a good level of recovery. If there can be effective intervention at the earliest point in time, even if the child is not at that time displaying significant symptoms, then the child's brain is able to be brought back onto the right developmental track.

23. Trauma can still have an impact on brain development at any time, but generally the earlier and more sustained the trauma is, the greater level of impact occurs.

24. It is not too late to intervene later, but the best chance of recovery occurs when intervention takes place at the earliest possible point in time.

25. Of course, the effects of trauma never completely leave a person. They may be dormant or in the background for periods of time but they never entirely go away.

26. As part of the normal process of ageing, people's defence mechanisms and coping strategies start to diminish in their effectiveness. This can lead to the brain throwing up earlier, traumatic memories. This is why you might see older people who lived in missions as children, many decades ago, re-experiencing and remembering the early childhood years in that environment. The memory is being re-experienced. The effects are more problematic when the trauma hasn't been addressed as early as possible.

BARRIERS TO INTERVENTION AT ALL LIFE STAGES

27. One barrier to intervention for child sexual abuse is the compartmentalisation of Mental Health Services and Specialist Treatment Services from the treatment for childhood trauma.

28. Child sexual assault is an event, not a diagnosis but access to mental health services usually requires a diagnosis. Even if mental health services are accessed by a young person, the problem remains that the patient is treated according to their

diagnosis (like depression or suicidality) with no management of the impact of the child sexual abuse event. If you looked at the way that some symptoms manifest through the trauma lens it would be apparent that they are often reactions to significant and sustained trauma – sometimes over generations.

29. Child sexual abuse is a common issue when it comes to suicide and yet when we look at most suicide prevention programs and the way suicide is managed, child sexual abuse is not even considered. There aren't many reasons why a little girl of 10 years old in a remote community is going to want to hang herself but sexual assault is one of them.

30. In addition, childhood trauma certainly underlies a lot of alcohol and substance abuse problems, particularly when this sort of behaviour starts early in childhood and what we most hear is that kids start using substances at the age of 10 to try and dampen the memories of abuse. Despite this most drug and alcohol services are separate from mental health treatment programs. This separation is nonsensical.

31. Another issue is how we choose to deal with children with harmful sexual behaviours. This is not something that Mental Health Services want to take on so we have ended up with separate specialist services to deal with that issue. Again, services like these should be allied with a mental health service approach, and not separated into silos.

32. Our current system compartmentalises childhood trauma depending on the way that it presents: mental health is treated differently to substance use, which is treated differently to harmful sexual behaviours. If a person has significant trauma in childhood, and then become depressed, then that depression is often driven by the trauma, not only by some biological mismatch in the neurotransmitters in your brain. While depression-specific treatment (such as anti-depressants) may be appropriate, but without addressing the index trauma, the depression is more likely to continue to re-occur.

33. It should not be enough for mental health services to be trauma informed. Mental health services should be trauma **competent**. In my experience, there can be a lack of trauma competence in mental health care. There needs to be an increase in investment in the sort of trauma informed and trauma-competent approaches in services provided for children.

34. Child Mental Health in Australia has been in a state of neglect for around 15 - 20 years. In many instances, mental health services have become so risk averse and only risk-responsive, that they are acting as an ambulance at the bottom of the cliff, rather than engaging with the issues before they escalate. I have recently been involved with a Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in Western Australia. The Final Report, which deals with many of these issues was released in March 2022. Attached to this statement and marked **HM-01** is a copy of that report.

35. I understand that Tasmania has a very small child mental health system that is not dissimilar to Western Australia. Workforce is a major issue in this respect. The difficulties with resourcing of infant, child and youth services are exacerbated in regional or remote areas. The breadth of expertise necessary to assist competently all categories (youth, infant, adult) is rarely held by one person. This means there is a small workforce to draw from. It is difficult to recruit or retain enough people with sufficient qualifications to carry out comparatively difficult therapeutic tasks.

36. Unfortunately, when a system is under siege, it just draws back and does as much it can with the resources it's got, and that tends to then become very exclusive. It focuses in on only the most severe, or the most at risk and so has no capacity to actually improve the mental health of the vast number of children that require assistance.

37. Part of the problem has been that we tend to have had this tiered system, where to get to a child psychiatrist you have to be really, *really* unwell or really about to kill yourself – or you don't get seen. That's wrong. Child psychiatry should be up front, informing the primary health care system and the rest of the NGO system as well, into how to understand child mental health, provide those early intervention models and that collaborative way of working. This can lead to a reduction in the number of kids that end up getting further down the spectrum in terms of severity or complexity.

RESOURCING SERVICES

38. In terms of formal training there is not a great deal of emphasis on trauma training, and little with respect to child sexual abuse across the spectrum of clinicians.

39. Psychiatrists do a six year training program after they have qualified to become a doctor and completed the intern and residency years. That is an extremely long

time. If you want to specialise in child psychiatry, it is necessary to do a further 2 years of advanced training.

40. Psychologists generally have no child training when they qualify as psychologists and the same is true for social workers. They might have had a short placement at best. There are very few post graduate training programs focusing on this area.

41. In terms of counsellors, there is no standard, no specialisation necessarily that permits a person to identify themselves as a trauma expert. Anyone who has a basic counselling qualification can counsel people who have experienced trauma - but that doesn't mean that they have the expertise that's required.

42. There is a balance between requiring some level of accreditation and creating such a high level of accreditation that everybody is excluded. This is a significant risk in somewhere like Tasmania where here is a lack of clinicians to start with.

43. It is certainly possible for work in the trauma space to be carried out by people who have less than the full suite of training for psychiatrists but it is necessary that the person has had really good trauma training, they understand the area and they've got extremely good supervision. Working in trauma also requires competent supervision, and this increases the range of professionals that are required to staff any particular area. That is because of the risk of vicarious trauma to the clinician themselves. Clinicians who are completely burned out are not able to assist anyone. That risk of burn out is heightened without proper supervision.

44. Overall, it seems to me, based on my experience, that one thing that we fail to do to is give children everything they need for good recovery after becoming aware of a trauma like child sexual abuse. They often receive the bare minimum. I once visited a trauma centre overseas, to review an absolutely amazing homeless shelter for adolescents who had been traumatised and were homeless. People criticised the facility – questioning why such a beautiful place should be built, assuming that the clients would 'just destroy it'. In fact, it was never destroyed. The kids really looked after it. The philosophy behind it was that with all that these kids have been through, they should have the very best we are able to give them. Because that's what they deserve. And I just don't think we have that attitude here in Australia.

45. We are missing that sort of level of understanding, that if you invest in a 3 year old, you're going to have a productive, healthy, happy citizen for 50, 60, 70, 80 years. The investment at that level is probably relatively small compared to what it may

cost you with unemployment, drug use, mental illness, prison. In fact if you do the socioeconomic analysis, we're way out in front if we just invested ten times as much as we currently do in children.

CONSIDERATIONS FOR FIRST NATIONS CHILDREN

46. All children are vulnerable to child sexual abuse in residential institutions but Aboriginal and Torres Strait Islander people face additional vulnerabilities to child sexual abuse relative to non-Aboriginal children.

47. The issue of transgenerational trauma is relevant in this context. Removal of children from families into institutions, starting from missions to out of home care has created a historical context of sustained trauma and helplessness, profound grief, loss, disconnection and fragmentation of familial relationships. These multiple removals have resulted in cumulative, collective and intergenerational trauma.

48. If you take, say one woman who was brought up on a mission and suffered significant trauma in that mission, she may well have had a mother and a grandmother who experienced the same trauma on the same mission. She may have a daughter and a granddaughter who were also removed either under a colonial practice or current child protection practices. In this way you can have five generations of trauma represented in one family system, sometimes six.

49. Once there is intergenerational trauma of this magnitude the capacity for recovery is difficult because you have so many generations affected by the same level of traumatic exposure.

50. It is very hard to get everyone better and we do not actually have any mechanisms whereby mental health systems know how to deal with a problem of this complexity.

51. Children from First Nations backgrounds and also some other ethnic groups are subjected to negative stereotyping and it is the case that this is reflected in a greater level of discrimination shown towards them by staff in institutional settings which increases the likelihood of all forms of discrimination, racism and abuse.

52. In terms of best practice and effective programs around treating child sexual abuse in a First Nations context involve a mixture of both culturally safe, trauma informed and healing informed practices. The Healing Foundation has developed some good resources in this respect.

53. Safe practice for child sexual abuse for First Nations children must be accompanied by the broader context of cultural safety. A good historical understanding of colonisation, the impact of genocide on families, understanding kinship systems and how family systems work is all important.

54. It is also important to be able to manage the negative stereotyping and the blaming that occurs, including the myths which say that child sexual abuse is normalised in Aboriginal communities. It was never normal in Aboriginal communities.

55. There is a large overrepresentation of Aboriginal children engaged with state institutions. In the case of out of home care for example, I do not know the data in Tasmania, although I understand that there is overrepresentation. Most of the kids have come from very, very adverse and traumatic backgrounds.

56. The Aboriginal Child Placement Principle says that removal of any Aboriginal child must be a last resort; if, after consultation with a community controlled Aboriginal welfare organisation, removal of a child from its family is unavoidable then the authorities must have regard to the direction of the Aboriginal Welfare organisation. If such a removal is necessary then the child must be placed within the extended family, or if this is not possible, the child may be placed within the Aboriginal community within close proximity to the child's natural family. If there is no Aboriginal placement available, then in consultation with Aboriginal and Islander Child Care agencies the child may be placed with a non-Aboriginal family on the assurance that the child's culture, identify and contact with the Aboriginal community are maintained.

57. There is very little training or support for carers when they take on a child and there seem to me to be some outmoded attitudes in some regions, such as kinship carers should not be paid because they are family. This ignores the reality that many kinship carers are looking after multiple kids and are not on high incomes.

58. There is very little training extended to kinship carers. Although I am not aware of the situation in Tasmania I expect it would be similar to other jurisdictions in that there is no Aboriginal parenting program that is culturally derived that show non-Indigenous carers how to parent an Indigenous child.

59. Indigenous carers are expected to do white parenting programs but no Aboriginal parenting programs are offered. Even the Aboriginal version of the Positive

Parenting Program (developed in Queensland), of which I am not critical, is an adapted program.

60. There is a need, across all services working with children in an institutional context, for really well informed cultural safety training which should happen alongside a development of an understanding of trauma and trauma informed approaches and what healing looks like from an Indigenous perspective.

61. In the case of schools for example, if Aboriginal parents never feel comfortable about coming into the school because there is nothing that makes them or their kids feel welcome, then it is really hard to create a sense of cultural safety in that environment.

BEARING WITNESS

62. The NRC was extraordinary in its depth and scope and that work speaks for itself. The NRC developed what we called Private Sessions which was a process where we could actually hear in a very safe way and in a very empowering way, the stories of people.

63. Stories build a picture for us which we cannot make sense of until we hear from the people who lived through it. Building that coherent narrative is what helps us build hope.

64. When I was a Royal Commissioner I had the privilege of bearing witness to many stories.

65. The Commissioners had the ability to allow people to give a free narrative, a description of their life events at that their control and pace. People could essentially start at the beginning and just tell their story. Sometimes it was the first time that they had ever actually done that. During that process, often, all of the dots connect for that person and the events of their life made sense to them. In that moment the person was able to see the whole story, whereas prior to that it had only ever been dealt with in fragments and often disbelieved.

SURVIVAL

66. When I listened to the stories I hear from victim-survivors, I was inspired by the courage, resilience and survival that they displayed. There were some resilience factors which emerged, including:

(a) Having a safe person to talk to. Someone who they feel that they can speak to in a way where they will be believed, where they will be validated and where they will have some sense of compassion. When you think about kids in out of home care, they often don't get that at all because they have constant turnover of placements. Kids can have 50 foster placements before they're 18 with no continuity of case workers.

(b) Mastery is a developmental stage in childhood. It starts with things like when kids learn how to tie their own shoelaces or learn how to ride a bike. The child learns a sense of mastery. That developmental process sets up the ability to have agency when you're older, which then gives you the ability to have personal responsibility in your life. This is disrupted by trauma. It makes you feel useless, hopeless, worthless, not good for anything. If a person can retain some sense of mastery – those feelings can be, at least in part, avoided.

(c) Hope is an important resilience factor. Hope is tangible and intangible at the same time. Whether people are born with hope, or whether it's instilled is open to debate but it does seem that some people just had a natural ability to think that things would get better. This is important.

67. Overall, trauma disrupts a person's ability to give and experience love, and to know what love is. To experience joy, as opposed to thrill-seeking. And to ever be at peace. Love, joy and peace are three requirements for healthy development. These are all disrupted by child sexual abuse, and our collective response to that trauma needs to focus on attempting to restore love, joy and peace for those children.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at Perth
on 28 April 2022

[redacted]

[Signature of witness]

Before me

[redacted]

[redacted]

[Full name of Justice, Commissioner for Declarations or Authorised Person]

This document was signed and witnessed in according with the Notice made by the Premier under section 17 of the *COVID-19 Disease Emergency (Miscellaneous Provisions) Act 2020* on 4 September 2021.