Statement of Ignatius Kim

RFS-TAS-011

Name	Ignatius Kim
Address	Child and Adolescent Mental Health Service
	26 Clare Street, New Town in Tasmania
Occupation	Clinical Lead

1. This statement is made by me in response to RFS-TAS-0011 (**'RFS'**), issued on 29 March 2022 by the President of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission), the Honourable Marcia Neave AO.

2. My name is Ignatius Kim and I am a Clinical Lead at the Child and Adolescent Mental Health Service ('**CAMHS**'), Tasmanian Health Service ('**THS**').

Professional Qualifications and Experience

3. I have a Graduate Certificate in Mental Health Nursing (University of Technology Sydney, 2007). In 2012, I completed a 3-year clinical traineeship in trauma-informed psychoanalytic psychotherapy (Australian & NZ Association of Psychotherapy) under a faculty established and trained by eminent psychiatrist, Emeritus Professor Russell Meares. In 2017, I completed a Certificate in Developmental Psychiatry (University of Melbourne). I also have a Bachelor of Arts (History, Sociology – Murdoch University, 1997).

4. I have been a psychotherapist and senior mental health nurse for more than 10 years. In this time, I have provided trauma-informed psychotherapy, therapeutic case management and inpatient care in a range of mental health settings in Tasmania and New South Wales. This has involved work, often in-depth and long-term, with both children and adults who have suffered child sexual abuse, including institutionally. My current role is in a mental health service specifically for children and adolescents. I have also taught undergraduate and postgraduate nursing students at the University of Technology and the University of Sydney. I have been an invited presenter at psychotherapy and nursing conferences.

5. In 2014, I was employed by the Sexual Assault Support Service (SASS) under funding from the Royal Commission into Institutional Responses to Child Sexual Abuse. SASS was contracted by the Royal Commission to provide support and counselling for survivors in southern Tasmania who were in contact with the Royal Commission. In this role, I attended and provided support to men testifying at the Royal Commission's Hobart hearing into the Hutchins School.

6. I was the lead co-author of a chapter on trauma-informed care for the 2019 book *Humanising Mental Health Care in Australia* (Routledge, London).

7. I have been the Clinical Lead of the CAMHS South Community team for nearly 6 years. I report to the Team Leader of CAMHS South. This role comprises direct, family-inclusive care to children and young people; trauma-informed clinical guidance and support to a multidisciplinary team; service development; regular consultations to external agencies; policy work; and clinical education and training. In this role, I am currently a member of the Child-Safe Event Management Working Group, a part of the Tasmanian Health Service's Child Safe Organisation Project.

8. I have undertaken the following training that is relevant to my current role:

    (a) Training in Developmental Psychiatry (University of Melbourne)

    (b) Training in trauma-informed psychoanalytic psychotherapy

    (c) Brief training with Julian Ford and Christine Courtois, internationally-renowned experts in therapeutic work with survivors of child sexual abuse

    (d) Brief training in neuroplasticity with psychoanalyst and psychiatrist Dr Norman Doidge

    (e) Long-term clinical supervision from trauma-informed child psychiatrist and psychotherapist Dr Joan Haliburn

    (f) Current, long-term clinical supervision with all-ages trauma therapist and mental health social worker Rochelle Hersch

Child-centred and trauma informed responses to allegations of child sexual abuse in an Institutional Context

9. Several crucial factors intersect to sharpen the impact of institutional sexual abuse on the child, thereby further heightening the onus on services to respond to disclosures with the utmost care and diligence:

    (a) Many institutionally abused children have predisposing social and psychological vulnerabilities;

    (b) Perpetrators in the offending institutions carry out calculated steps to systematically exploit these vulnerabilities;

    (c) Perpetrators and enabling personnel within the offending institutions bear the stated mission and community expectation of caring for children;

    (d) Institutions such as schools, sporting clubs and care homes hold some hope of providing respite, if not sanctuary, for the difficulties that pre-exist elsewhere in the children's lives.

10. Where such children are then institutionally abused, these factors combine to further aggravate the direct experience of the abuse itself. The abusive worker and their enabling colleagues, in perpetrating their wrongdoing, do so by perverting the purported role and mission of the organisation.

11. As such, the preferred term in this statement is *institutional child sexual abuse* rather than "child sexual abuse in an institutional context".

12. Disclosures by children to professionals are already comparatively rare. But against the above backdrop, they are even more salient – especially when disclosed to those working within the offending institutions. Therefore, such disclosures carry a particularly weighty responsibility and opportunity to act properly and protectively.

13. Those who work with children should be adequately trained, including continuing professional development and supervision, to understand the interaction of the above factors when receiving a disclosure of institutional sexual abuse from a child.

14. Workers should be trained and supervised to understand that disclosure is a dynamic, non-linear and complex process, rather than a discrete event. A first disclosure is a part of this emerging process. Disclosures can be complicated by their indirect, partial and non-verbal nature. Those working with children need to be trained to pick up on such potential cues, to approach them calmly, openly, curiously and supportively, and with the professional judgement to be proactive and dutiful within their scope of practice.

15. Disclosures may be hesitant, contradictory and inarticulate. They may be partially or wholly retracted, and then changed again. The child may feel responsible for, and caring towards, the perpetrator. There may even be indications that the child possibly enjoyed what happened. None of these are signs that abuse has not occurred. They are consistent with complex trauma responses in children, as well as the non-linear, processual nature of disclosures. Training staff in these complex phenomena is integral to services working with children.

16. The initial response to a disclosure is pivotal. It is vital for the worker to recognise and manage their own inner reactions, in order to maintain a believing, calm, compassionate and confident response. Being calmly attentive, believing the child and acting for their immediate safety is the priority. The child needs to be thanked and commended for their bravery in disclosing.

17. Gathering further information to establish immediate safety should be done in consultation with senior colleagues and relevant authorities. However, procedural and legal concerns must not jeopardise actions to provide safety for a child. Such concerns should never be cited to justify inaction.

18. Gathering information to establish immediate safety should be done in a safe, confidential space (preferably one that the child is already familiar and comfortable with), with calm, compassionate and confident use of open, exploratory and age-appropriate questions and dialogue. Time needs to be allowed for the child to talk at their own pace, and to use their own language, including their choice of anatomical terms. The disclosure should be documented, with as much verbatim content and as contemporaneously as possible.

19. The child must be assured that the abuse was wrong but that they did not do anything wrong or bear responsibility in any way. This assurance will need to be regularly reiterated, as will be the message that disclosing was right and courageous.

20. Further interviewing for investigative purposes is beyond the scope of my practice and, hence, this statement. I would just stress that such forensic interviewing must be done by

appropriately trained and experienced interviewers, with sensitivity and attunement. The use of child-specialist, trauma-informed intermediaries should be strongly considered.

21. A parent/carer should be informed in person as soon as possible. This should be done, at minimum, by the worker who received the disclosure and their manager. It should be clearly communicated that the organisation believes the child and that the child did no wrong. There will need to be a careful appraisal of how the parent/carer is receiving the information and the support they may need. It is possible that this sort of news could trigger the person's own traumatic memories. Any persistently adverse reaction, such as emotional unavailability, denial, disbelief or anger at the child, will need to be empathically approached, but without losing the focus on protecting the affected child from additional, secondary harm. Assistance from the child safety service may be necessary.

22. Ideally, one or a small number of human services professionals, with suitable training and experience, should be available to continually support the child and family, and to keep them informed of the steps being taken all along the way, including the need to involve other people and authorities. The child's wishes must be heard and responded to seriously, without jeopardising safety. Whenever possible, the child should be offered specific choices appropriate for their age and functioning. But all adult decisions should be authoritatively taken by the relevant adults.

23. Throughout, the child needs tangible demonstrations of being protected. This includes stand-down procedures for any person in an institutional role accused of abuse, coupled with measures to prevent their direct or indirect contact with the affected child and carers/family. This cessation of contact may necessitate further support for the child and carers to help the child manage any paradoxical/traumatic attachment they may have towards the perpetrator.

24. Any problematic outcomes need to be communicated honestly and supportively, with a carefully-planned and scaffolded communication strategy that includes the child's carers, and with appropriate adjunctive or follow-up support.

25. The organisation must take responsibility, financially and otherwise, for the provision of specialist counselling and healthcare services for the child and their parents or carers.

26. This points to the critical need for child-centred and trauma-informed responses to be more than the responsibility of individual staff. They crucially require, and rely upon, a whole-of-agency effort to be truly child-safe, to ensure collectively coordinated support to the child and family, underpinned by the National Principles for Child Safe Organisations.

27. A whole-of-agency effort requires committed, proactive managers and leaders. Institutional reporters of disclosures must be supported and protected in their own right. The agency must have time-efficient, easily accessible and transparent mechanisms for reporting, accountability, enforcement and redress. This includes:

    (a) accountability of managerial staff, to ensure reports of institutional abuse are properly managed; and

    (b) alternative reporting and appeal mechanisms, with requisite confidentiality, in cases where reports and disclosures are mishandled or otherwise unsatisfactorily actioned.

28. Any culture of silence, passive bystanding and privileging of personal loyalties must be actively and tactfully addressed, with a sensitive ear for any underlying, hidden issues within the organisation's overall culture and functioning.

29. Such culture change may be assisted by how the agency recruits, by not settling for the minimal legal checks, but recruiting to standards and criteria that test for an applicant's integrity and courage to act on child-safe values. This should especially be so for managerial positions.

Impact of failing to provide child-centric and trauma informed responses

30. Failure to adopt the above steps will lead to secondary institutional abuse. The term secondary does not imply "lesser", but, rather, that it stems from the originating abuse. This commonly aggravates, compounds and complicates the primary trauma. This is particularly so when the abusive institution bears the ostensible mission of caring for children.

31. Moreover, even though it is secondary in *form*, betrayal trauma is itself a very particular type of substantive abuse. And it is not limited to explicit disbelief or denial, but also includes passivity, silence, nonchalance, inaction, mismanagement, procedure-centred responses and assurances that are unsupported by real protective action. A parent or carer who fails to protect can induce such betrayal trauma. This is writ large when it comes to a whole organisation that is experienced as collusively failing to protect.

32. The malignancy of such a fusion of sexual and betrayal abuse, undergirded by the weight and power of an institution, cannot be overstated. The concatenating impacts are immeasurable and can lead to tragic and lethal consequences.

33. Conversely, if an organisation were to act promptly, safely and protectively, then the affected child may have an entirely contrasting experience that could, to some extent, even remediate the sense of betrayal and *institutional* abuse.

Tensions between the rights of an alleged perpetrator and child-centred and trauma informed responses to allegations of child sexual abuse

34. The starting point and focus of a child-centred, trauma-informed response to a child's disclosures is the presumption of their truthfulness and, on that basis, taking active steps to protect the affected child, including standing down the accused from their role in the organisation and associated restrictions. This is bound to be irreconcilable with natural justice for the alleged perpetrator. Considering how to manage such a conflict, as well as related matters of investigation and due process, are beyond my scope of practice.

35. I will limit myself to the general principles of a child-centred, trauma-informed approach to this tension, as the process of conducting fair investigations is beyond my scope of practice.

36. Child-safe organisations must prioritise the wellbeing of the children in their charge. This begins with believing disclosures and presuming they are true. Such services cannot be expected to work to the evidentiary requirements of a court of law. A child's safety cannot be jeopardised by a presumption of innocence of the alleged perpetrator. Nor can a child's disclosure be treated as a matter between complainant and respondent, in which the organisation strives for neutrality. Restrictions upon the accused (such as being stood down, preventing direct and indirect contact, limiting and supervising movements in the

organisation's premises if they must attend) will be unavoidable when the actual and perceived safety of the child and their family is the chief concern.

37. In working to stay faithful to its child-safe mission, an organisation may encounter internal conflicts of interest, particularly in relation to a duty of care to the accused person. This duty would most appropriately be met by an external provider who does not have a conflict of interest. Extended confidentiality will also be necessary to provide a level of procedural fairness to the alleged perpetrator while protecting the affected child.

38. An organisation's front-line managers should be supported to focus exclusively on a child's safety, free of any need to concern themselves with the legal and industrial implications of denying natural justice to an alleged perpetrator. Such concerns must be borne by separate legal and human resources offices, in a manner that does not challenge or undermine the child-centred actions of the managers.

39. Working on a presumption of guilt of a perpetrator will entail litigation and other legal risks for child-safe organisations and their staff. As my scope of practice is limited to what is child-centred and trauma-informed, I will only stress that, given the long history of institutional sexual and betrayal abuse, in my view, such legal risks are, on balance, the "lesser evil".

Challenges for CAMHS clients making allegations of child sexual abuse or harmful sexual behaviour in institutional contexts

40. CAMHS has a trauma-informed team of clinicians. Nonetheless, there are varying levels of confidence about how to approach sexual abuse, due to its particularly and acutely sensitive nature. There are also differences in skills and experience in picking up on cues. As such, it is unclear whether the relatively few disclosures or reports of institutional child sexual abuse among CAMHS clients is due to these gaps. At the same time, once a disclosure is received, the first response of CAMHS clinicians is usually believing, sensitive and protective.

41. Almost all the disclosures or reports that we receive relate to abuse in the private setting. With these, the most common difficulty we encounter is in our efforts to involve child safety services. The redesign of these services in Tasmania has resulted in a new service, the Strong Families Safe Kids Advice & Referral Line (ARL), which is not the Child Safety Service proper. From my experience working at CAMHS, the ARL operates essentially as a call centre, on a minimally voluntary basis, such that, if a family declines the caller's offer of help, there is no further action. During business hours, the ARL is the first and only point of contact for all services with concerns about a child's safety in the home; services cannot directly contact or access the actual Child Safety Service.

42. In my experience, the ARL staff are trauma-informed and sensitive in their practice, but they are structurally limited in their reach and role. This problem would, therefore, seem to fall within the scope of institutional responses to child sexual abuse, even if the abuse itself has occurred in a private context.

43. In cases of CAMHS clients who have disclosed institutional sexual abuse, the most common difficulties seem to be limited to the offending institutions. I will cite two examples I have direct experience of.

44. A young person (then 12 years old) was sexually abused in a foster home, by another young person in care. Both children were under the guardianship of the Child Safety Service. The abusive young person was not removed from that home by the Child Safety Service for

several months, despite repeated pleas by the foster carer. CAMHS discovered this in retrospect, after our help was sought due to the abused child suffering a significant deterioration in her mental health.

45. Another young person (then 15 years old) was sexually assaulted on school grounds by an older male student. Despite repeated pleas by her and her parents, the school placed no restrictions on the perpetrator. My own attempts to advocate to the school on the young person's behalf were to no avail. The client was eventually forced to change schools. Police dropped the case, citing insufficient evidence.

46. In my regular contact with a range of organisations, I have encountered a legalistic, quasi-evidentiary approach to disclosures that oversteps the scope of the organisation. This approach directly conflicts with the organisation's actual remit to care for and protect children. The need to "keep an open mind" is often raised by the organisation, interpreted as a need to treat the affected child and the alleged perpetrator impartially. This approach results in a secondary betrayal of the child in that the child's disclosure is not treated as though the child is believed. In this, there can be a ceding of responsibility for safety to other agencies, such as the police or child safety authorities. And when these do not act, the organisation accepts this as confirmatory of their non-committal response and takes no further steps.

47. In case consultations with other agencies, I have come across a well-intentioned wish to avoid further harm by closing off disclosures. Workers state that it is outside their scope and expertise, and that they do not want to open "Pandora's Box". They then refer the matter on to police and child safety authorities. But, again, if police or child safety authorities do not act, there can be general inaction.

48. Rigorous and comprehensive training in trauma-informed, child-centred handling of disclosures must be a key criterion for any child-safe organisation. This should then be able to be tangibly demonstrated in real cases, and at a whole-of-service level.

49. However, education, professional support, service development and cultural change need to be paired with external constraints to ensure greater consistency in child-safe practices. Ultimately, criminal sanctions are necessary for a wilful failure to protect and to report.