

Stop Organised Rape and Torture of Children

**Submission to the Productivity Commission Inquiry
into the Social and Economic Benefits of
Improving Mental Health**

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Part A Introduction

A.1. Brief background on organised rape and torture of children (ORTC)

Organised rape and torture of children has a centuries long history; however, it has always been, and continues to be well hidden. If the average Australian knew that organised rape and torture of children happens in Australia, our society would not tolerate it. The ongoing cover-ups which allow it to continue are a pivotal part of the problem.

Some of us started trying to speak up about ORTC thirty years ago. The backlash orchestrated by perpetrators, and those that aid and abet them, has very effectively muted the voices of both victims and advocates.

Whilst there has always been considerable resistance from many quarters to the truth about ORTC coming out, in past decades at least some government and non-government agencies were willing to try to address the issue.

In 1993, the NSW state government's NSW Sexual Assault Committee published an information booklet: *Ritual Abuse: Information for Health and Welfare Professionals*.¹ In 2006, the organisation Advocates for Survivors of Child Abuse, (now called Blue Knot Foundation) published a 48 page document: *Ritual Abuse & Torture in Australia*.²

The introduction was written by Dr Marie O'Neill AM, (Clinical and Forensic Psychologist) and the late Freda Briggs AO, whose awards included Senior Australian of the Year (2000 for child protection work), Australian Humanitarian Award, and a national Centenary Award. They stated,

'Although there are more than six million documents on the Internet addressing the issue of ritual abuse, few take as fair and comprehensive approach as this; many of the writings **deny the existence of ritual abuse despite masses of evidence to the contrary. As a consequence, some victims are persistently re-abused psychologically by having to deal with the fact that organised abusers, their defenders and even police refute their realities and dismiss their reports as fantasy or mental illness.**'³ [emphasis added]

In recent years neither government bodies addressing child sexual abuse, nor government funded child abuse organisations are willing to address the issue. (See B.15, B.16, B.19.) ORTC victims are ignored and refused a voice in any of the conversations we are now, as a nation, starting to have about child sexual abuse. (See B.15, B.16, B.22.) The perpetrators' ongoing disinformation and discrediting campaign has been highly effective.

For many years people thought that child rape was primarily committed by strangers; it took decades of victims and advocates speaking up before it was recognised that the perpetrators are more often trusted people well known to the child, including family members. Likewise, even when some attention was drawn in past decades to the organised rape and torture of children, most people were unwilling to believe that this was happening within mainstream churches, preferring to believe it must only be happening in small little-known sects.

In fact, many institutions and groups are involved in organised rape and torture of children. By the time the Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) began,

some professionals were acknowledging some of the organised rape and torture within the catholic church (see below).

We are unable to provide a list of studies and peer-reviewed articles evidencing the fact that ORTC victims are silenced in many ways, including through diagnoses and 'treatments', as this is not a topic that any pharmaceutical company, government, or other body thus far has had any interest in funding.

Perpetrators, those that aid and abet them, and other enablers continue to discredit victims by insisting they provide proof of the crimes in order to be believed. The reality is that ORTC perpetrators protect themselves very well, making 'proof' extraordinarily difficult. However, there is some evidence available. We can provide PCI with a large amount of documentation regarding the existence of organised rape and torture of children both in Australia and internationally if requested. A few examples follow.

1. Dr Michelle Mulvihill, consultant psychologist and former member of the Professional Standards Committee of the St John of God Brothers, stated publicly in 2012 that victims had told her of being tortured by St John of God Brothers and that she would term it ritual abuse.

'Some children had complained of being tortured. We heard stories about children committing suicide. We were taken to graveyards to see their gravestones in some places.'

'And there were acts of ritual abuse, I would call it, where perpetrators would sit in a group with young boys and conduct sex with them and then sit back and watch boys conduct sex with each other.'⁴

In 2007 she spoke to media about having written to Rome asking that the Australian province of the St John of God Brothers be shut down, stating that there were allegations against more than 75 percent of the then current brothers.⁵

2. Psychiatrist Dr Helen Driscoll is a childhood trauma expert, consultant adolescent psychiatrist to juvenile justice centres in Victoria, and former senior lecturer in Child Psychiatry at the Royal Children's Hospital and University of Melbourne. She stated the following to journalist Rachel Brown,

'The royal commission has had lots put to it about children being killed,'

'and I think that happens, and it happens with organised paedophile groups...'⁶

She discussed that some of what appears to victims to be murders may be simulated in order to terrorise the victims witnessing, but makes it clear she believes some are actual murders.

'There have been murders, I've seen and worked with people who as children had pregnancies, and things were done to the babies – they were never registered or they were aborted. I have no doubt about that. Think about the Third Reich, right under people's noses. So the fact that there are sadistic human beings who think they can do something and get away with it, they will and they do.'⁷

'After the money from illicit-drug-trafficking, the biggest money-maker in the world is child-sexual abuse porn.'⁸

She also states that **the tendency of people who have been ritually abused,**

'is to minimise, not to exaggerate, because its too difficult.'⁹ [emphasis added]

She states regarding her ritually abused clients,

'Some are too ill to be giving information to the royal commission. Some have.'¹⁰

'...I've had survivors of ritual abuse who've had to have colostomy bags because their rectum is so damaged... I've had others where [medical] records have disappeared. And I think an issue for the royal commission has been that police records have disappeared, because some officers were involved in a cover up to protect the Church.'¹¹

3. In 2018, Victorian police arrested 20 men in relation to child abuse material including images of babies being tortured. A Victorian catholic school deputy principal was charged with producing child pornography: the alleged offences were committed in 2017 and 2018.¹²

The article excerpts below explain more,

'Child abuse material seized in recent raids across Victoria included images of babies being subjected to violence and torture, police say.

Twenty men were arrested in the raids targeting online child abuse material, and 13 were charged with offences including possessing child exploitation material, transmitting child exploitation material and drug offences.'

'The principal of St John's Regional College in Dandenong, Tim Hogan, said a staff member had been immediately suspended from work after police informed him of the allegations last week.'¹³

'The deputy principal of a Melbourne Catholic school is facing fresh allegations of producing child pornography following his arrest in March.

Quentin Paul Smith, 49, who resigned from St John's Regional College in Dandenong after he was charged, fronted Melbourne Magistrates Court on Friday morning.'

'He was charged with using a carriage service to access child pornography between June 1, 2017, and March 27, 2018, knowingly possessing child abuse material and possessing a drug of dependence being GHB.

The Age can now reveal Mr Smith has since been charged with using a carriage service to produce child pornography material at Richmond on March 3 this year.'¹⁴

(To be fair to Mr Smith these articles do not actually make it 100% clear whether the 'images of babies' seized were part of the child pornography he allegedly produced.)

4. Whilst one of the ways perpetrators and their enablers discredit ORTC victims who speak up, is by claiming that if babies and children were being sacrificed their disappearance would be noticed; Australian Bureau of Statistics modelling (reported in media in 2014) showed that more than 35,000 babies turn one without being registered or issued a birth certificate.¹⁵

As stated by former Victoria police detective, Max Schiavon, in answer to a question from journalist Rachel Brown about whether it was possible for past deaths to not have been investigated, '...there's always people that go missing and they may not have family – family don't bother chasing them up, they might've been runaways.' He also noted that some babies are not registered, and not knowing how good the record-keeping was many decades ago.¹⁶

Whilst he was answering a question related to many years ago, children and adults still go missing today, and runaways still are not necessarily followed up by their families. The Australian Federal Police missing persons website states,

'In Australia, more than 38,000 people are reported missing each year. While most people are found within a short period of time, there remain approximately 1,600 long term missing persons; those who have been missing for more than three months.'¹⁷

A.2. About Stop Organised Rape and Torture of Children (StopORTC)

The organised rape and torture of children will not stop whilst it remains hidden, and victims are silenced through diagnoses and 'treatments'.

The mental health of ORTC victims is impacted not only by the organised rape and torture itself, and the often abusive 'treatments'; but also by the ongoing cover-ups, including the refusal of our public institutions to even acknowledge the existence of ORTC in Australia.

Stop Organised Rape and Torture of Children (StopORTC) is victim led, non-funded, and non-affiliated.

This document has been primarily written by ORTC victim and StopORTC founder Ben Tomyris, with input and review from others including medical and mental health professionals with experience with ORTC victims.

This submission does not give an exhaustive list of the factors that impact the mental health of ORTC victims and prevent full social and economic participation, but rather provides some information which we hope will be a starting point for the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health (PCI) to further investigate.

StopORTC is currently in the process of producing a document regarding the needs of ORTC victims and practical suggestions regarding healing: we will make this available to PCI when completed as much of it will be of relevance. This document (and other information) will also be available on StopORTC.com.

We look forward to continuing to engage with PCI and can provide further documentation regarding many aspects of this submission including the following:

- additional peer-reviewed academic literature documenting many points
- case studies documenting some points
- further evidence regarding ORTC and the cover-ups of it in Australia (and internationally)

There are also some broad topics mentioned as background in this submission, which we presume you have some knowledge of, but we are happy to provide reading lists if requested.

We trust PCI will explore the issues raised in this submission with the seriousness they deserve and engage further with StopORTC.

A.3. Terminology

ORTC: Organised rape and torture of children

Over the years ORTC has been referred to by a number of terms. The terms 'ritual abuse' and 'ritual abuse and torture' have been (and continue to be) used by some people to describe some forms of ORTC. StopORTC use the term 'organised rape and torture of children' for a number of reasons including the following:

- we believe this is the most accurate definition of what we survived
- in order to focus on what the problem actually is: child rape and torture
- not all organised rape and torture of children is ritualistic in nature

Victim

We primarily use the term 'victim' rather than 'survivor' because ORTC victims, (like all victims of child sexual assault) are victims of crimes: we are victims of the criminal acts of child rape and torture.

In addition, not all ORTC victims survive into adulthood; many who do are then revictimized in the psychiatric system.

The term 'victim' does not denote identity, nor imply that we are not strong people, doing our best to live empowered lives: it is a statement of fact.

Consumer

Whilst not disputing that many people are happy with the term 'consumer' for those who use mental health services, it is important to note that this term is not accurate for those who are drugged or given electric shock against their will. People who are forced or coerced to receive mental health 'treatments' are victims not consumers.

Acronyms

PCI: Productivity Commission Inquiry into the economic impacts of mental ill-health

RCIRCSA: Royal Commission into Institutional Responses to Child Sexual Abuse

DSM: *Diagnostic and Statistical Manual of Mental Disorders*

ECT: electroconvulsive 'therapy' i.e. electric shock

CTO: community treatment order

ACE: adverse childhood experience

A.4. Disclaimer

Given that this submission will be available to the public, StopORTC would like to make clear the following:

- Nothing in this document should be construed as medical advice. If you are considering reducing or stopping psychotropic medication it is important to do so under the care of a medical doctor who understands the process.
- If your current doctor is unable or unwilling to help you with this, contact mental health advocacy groups for help with doctor referrals.
- If you need legal help regarding community treatment orders contact Legal Aid.

A.5. Safety Net

Given the nature of threats received in the past, StopORTC would like it to be known that a number of people, including high ranking officials of well-respected mainstream international human rights organisations, have copies both of all StopORTC materials, and also all documents regarding the StopORTC's founder's personal history. In the event that anything should happen to him they will be asking questions, ensuring that all this material is made publicly available, and continuing to submit these materials to appropriate government bodies.

Part B

Factors that negatively impact the mental health of organised rape and torture of children (ORTC) victims, and prevent full social and economic participation.

N.B. Some of these factors also impact victims of other forms of child sexual abuse, or other types of trauma.

We are aware of at least one submission you have already received (from psychiatrist Dr Niall McLaren) which details similar concerns to those we raise in B3-B6 and B9, in terms of how these issues affect the broader population, and we assume you will receive other submissions also re these issues. We therefore do not try to cover these points in depth. (We can provide extensive lists of the academic literature on these points if you wish.)

We are also aware that you have received information regarding how trauma affects the brain, so have not covered that, but we can provide a reading list of peer-reviewed articles, and other information on this also, if requested.

B.1. Diagnoses, pathologisation, and ‘treatment’ can silence, retraumatise, and prevent victims from healing.

As stated by Austrian neurologist, psychologist, and nazi concentration camp survivor, Dr. Viktor Frankl,

‘an abnormal reaction to an abnormal situation is normal behaviour’¹⁸

Normal and natural responses to extreme trauma, particularly in childhood, include a range of emotions, thoughts, experiences, and behaviours that clinicians tend to diagnose as abnormal.

ORTC victims who come in contact with mental health professionals, whether as children or adults, are usually diagnosed with one or multiple ‘disorders’. Whilst it is certainly true that victims’ brains and bodies are affected by rape and torture, this is not evidence of ‘disorders’. Nor is there evidence that most of what is offered or forced on ORTC victims as ‘treatment’ is of any use.

Some victims find diagnoses useful; others do not. Diagnoses frequently silence the victim and keep the truth of what has happened to them hidden. ORTC victims survive and journey towards healing in a myriad of ways, often in spite of rather than due to mental health ‘treatment’.

Diagnosing the effects of trauma as disorders can result in a form of secondary abuse. The effects of this secondary abuse can be as devastating as the now well-recognised effects of the secondary abuse caused by institutions who refuse to believe victims. In many cases these effects are worse, as in addition to their psychological effects, the physical effects of psychotropic drugs such as neuroleptics, and also of ECT, can be both devastating and permanent, and lead to drastically shortened lifespans. (See B.4, B.5, B.6.)

Mainstream psychiatry is not evidence-based medicine. Given that psychiatrist, Dr Niall McLaren has made a submission to PCI evidencing this fact, we refer you to that document.¹⁹ If you would like further evidence regarding this we are happy to provide an extensive reading list including many peer-reviewed academic articles.

Whilst it may be easier for many people to believe that mental health issues are caused by 'chemical imbalances' that can be fixed by drugs, there is no evidence to suggest that this is in fact the case.

Even if a victim does feel a short-term benefit from psychotropic medication, (which most certainly is not the case for all ORTC victims) these drugs are not a long term fix, do not lead to healing, and come with a hefty price tag in terms of ill-effects. (See B.4.)

Articles published by the organisation Blue Knot states the following,

'Trauma affects brain development. This in turn can negatively affect many systems of the body. This includes psychological AND physical health. The greater the severity and duration of childhood trauma the more severe are the psychological and physical health consequences' (Middleton W., in Blue Knot Foundation, 2012). People who have experienced complex childhood trauma often have multiple diagnoses. This can happen without workers identifying or acknowledging their underlying trauma. This can pathologise the person and their experiences. It can also traumatise them all over again (re-traumatise). It can also be ineffective (Jennings, 2004; Fallot & Harris, 2009).'²⁰

'Ninety percent of people presenting to public mental health services have experienced sexual, physical or psychological trauma (Cusack et al., 2006). Two out of three patients presenting to emergency, inpatient or outpatient mental health services have experienced childhood physical or sexual abuse (Read et al., 2005). Research has found that childhood trauma and abuse makes it more likely to have depression, anxiety disorders, addictions or personality disorders (Spila al., 2008) eating disorders, sexual disorders and suicidal behaviour (Draper et al., 2007). A recent study found that almost 76% of adults reporting child physical abuse and neglect have been diagnosed with at least one psychiatric disorder in their lifetime and nearly 50% have been diagnosed with three or more psychiatric disorders (Harper et al., 2007).'²¹

'People who have experienced trauma are at significant risk of re-traumatisation. This can occur inadvertently. It occurs when services replicate the power, control and silencing around prior traumatic experiences. Sadly **coercive practices e.g. seclusion and chemical and physical restraint are used more commonly with people with trauma histories in mental health units** (Wilson et al., 2017)' ²²[emphasis added]

'People with complex trauma can have many mental health diagnoses. These include Post Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (Spatz et al., 2007), Affective Disorders, Anxiety Disorders, psychosis (Shevlin et al., 2007) including Schizophrenia and Bipolar Disorder, Dissociative Disorders (Dorahy et al., 2016) and Somatic Symptom Disorder (Spitzer et al., 2008). Trauma puts people at risk for psychosis (Schäfer and Fisher, 2011). Many survivors have been diagnosed with multiple coexisting (comorbid) conditions such as substance misuse, Eating Disorders, self-harming behaviours, and suicidality (Cutajar et al., 2010).'²³

The more extreme the abuse, and/or the younger it started, the more likely that,

- a. the victim will suffer severe impacts
- b. the victim will not be believed

There is zero indication that this is improving for ORTC victims.

There is a long and well-documented history throughout the world, including Australia, of psychiatric diagnoses and 'treatments', including drugs, electric shock, and some psychological tools, being used as tools of oppression, including against child sexual assault victims who dare to speak up. This is especially so when the perpetrators are powerful, regardless of whether the abuse is based in institutions, families, and/or elsewhere. (We presume you have some awareness of this history, but can provide a reading list if this is useful.)

The so called disorders that ORTC victims are diagnosed with are in fact totally normal reactions to the manifestly disordered and abnormal crimes of the perpetrators.

In addition to the effects on the individual victims, the silencing of ORTC victims through pathologisation, diagnoses, and 'treatment' plays a major role in keeping ORTC hidden, thereby ensuring it will continue. Electroconvulsive 'treatment' and psychotropic medications can both dull memory, and can also make it less likely that victims will be able to clearly articulate what has happened to them.

B.2. Unwillingness of many mental health practitioners to accept that organised rape and torture of children happens in Australia, or to hear about it.

Whilst a small minority of mental health practitioners do their best to learn about ORTC and work hard to support victims, many simply do not want to know. They find it easier to believe that an ORTC victim's intense distress is caused by some form of 'disease' or 'disorder', than to believe that the extreme horror the victim has experienced happens in Australia.

There are also many mental health practitioners who whilst not denying the existence of ORTC do not want to hear about it: the fact that a person has trained to become a mental health professional does not necessarily mean they are willing to hear the truth about child rape and torture.

Although the human tendency to recoil from horror is understandable, it is unacceptable that so many people who choose to work in fields that require a willingness to deal with the range of human experience continue to choose to refuse to hear or learn about the organised rape and torture of children.

Mental health professionals silence ORTC victims in a range of ways. It is an indictment on the industry that so many adults who are paid to work in mental health are not robust enough to learn or hear about what ORTC victims spend years as children actually living. (These are sometimes the same practitioners who think they can teach resiliency skills to victims.)

Being allowed to tell the truth is an absolutely essential element to healing; being prevented from doing so is literally crazy-making. (N.B. Victims should have the choice of if, when, and how to do

this; the choice to not discuss one's victimisation should also be respected. The point that is essential to healing is being afforded that choice, rather than denied it.)

B.3. 'Schizophrenia' diagnosis given to ORTC victims

Whilst ORTC victims are given a range of diagnoses, the diagnosis of 'schizophrenia' usually has the most detrimental consequences.

The following excerpts from a *Psychiatry, Psychology and Law* article, regarding a 2013 New Zealand district court ruling, discuss some of the evidence regarding 'schizophrenia' and child sexual abuse.

'The medical concept of "schizophrenia" is a contested category within health and social care. It is a concept understood by some to be an illness of biological origin, and by others, as a stigmatising label for a sometimes troubling pattern of experiences and behaviours.'²⁴

'In recent years, however, an accumulating body of evidence has shown a strong association between personal experience of trauma and later diagnosis of schizophrenia. In a recent New Zealand case this latter body of research was accepted by the court, challenging commonly held conceptualisations of schizophrenia.'²⁵

'He [psychiatrist Dr Codyre] disagreed with the two preceding reports by Drs Willamune and Newburn, determining their assessments as "not evidence-based" (SL v ACC, 2013, para. 12) in regards to their argument that sexual abuse is not causally related to schizophrenia.

In adopting this position, Dr Codyre noted that almost 200 studies have demonstrated an association between childhood sexual abuse and the risk of psychosis. Dr Codyre provided a reference list, including a meta-analysis of 36 methodologically rigorous studies, for the judge to consider.'²⁶ [emphasis added]

The media article below gives further information on this case,

'...Judge Grant Powell in the Wellington District Court agreed with a psychiatrist who said a man's schizophrenia had been caused by trauma from sexual abuse in childhood.

Two ACC-employed psychiatrists had earlier said there was no evidence schizophrenia was anything other than a biological condition passed down through families and so the man's abuse had nothing to do with his condition.

However, the judge agreed with a growing body of research that says traumatic events can cause psychosis.

The research includes the work of clinical psychologist John Read, who has been at the forefront of research to show a relationship between childhood sexual and physical abuse and psychotic symptoms, including schizophrenia.

Read said the ramifications of the decision were "enormous".

"It is gratifying that years of research on this issue is impacting the judicial system. These rulings will also make it harder for psychiatrists to ignore disclosures of sexual abuse by severely disturbed patients, or to dismiss them as either irrelevant or imagined.

"This is a significant victory for all those patients and researchers who have been saying for many years that the experiences which biological psychiatry believes are symptoms of a brain disease called schizophrenia are best understood as responses to adverse life events.

"Very often the voices abused people hear are the actual voices of the perpetrator of the abuse."

Read said it was "alarming" that the two ACC psychiatrists "either knew nothing about the many studies documenting the relationship between child abuse and psychosis or were trying to mislead the judge".'

'... psychiatrist David Codyre provided a report that completely disagreed with the previous psychiatrists.

"With due respect to my colleagues who undertook the prior psychiatric reports . . . their opinion that sexual abuse is not causally related to schizophrenia is not evidence based."

Judge Powell said ultimately he found Codyre's analysis "a more compelling and inherently more credible cause of the appellant's schizophrenia".

Read said the finding would reduce the frequency with which psychiatrists dismissed abuse disclosures as irrelevant or imagined and increased the probability of people being offered trauma-based psychological therapy instead of anti-psychotic medication.

[New Zealand Association of Psychotherapists public issues spokesman Kyle MacDonald said]

"For a long time there has been a mindset of how schizophrenia and psychotic disorders are treated, which is that it is a biological disorder which needs to be medicated and managed.

"The reality is that actually these people are underserved in terms of therapy and psychological intervention."²⁷ [emphasis added]

A recent Australian Supreme Court ruling re ECT is also pertinent. One of the complainants in this case, 'PBU',

'does not agree that he has schizophrenia, but says he has depression, anxiety and post-traumatic stress disorder.'²⁸

Whilst the information on this case does not give details of PBU's history, the fact that he says he has post-traumatic stress disorder indicates a trauma history. The diagnosis he was given that was the justification for electric shock was 'treatment-resistant schizophrenia'.²⁹ (People with many different types of trauma histories are diagnosed 'schizophrenic'.)

'In his judgment, Supreme Court Justice Kevin Bell found that VCAT had misapplied the law in relation to whether PBU and NJE had the capacity to decide if they wanted ECT, and breached their human rights.'³⁰

Whilst some ORTC victims do have psychotic episodes (an effect of the severe trauma rather than a brain 'disorder') there are also victims who do not, but are still labelled 'schizophrenic' because clinicians refuse to believe that the extreme horror they describe could be true. Many find it easier to think that the bizarre and ritualistic elements that are part of some types of ORTC are not real. (One of the reasons that perpetrators of organised rape and torture of children often include bizarre aspects is that it makes it less likely the victims will ever be believed.)

Similarly, many ORTC victims are also labelled 'paranoid' if they attempt to describe the death threats, and other threats and harassment that can continue into adulthood.

Also, behaviour deemed 'strange' can be the result of a victim trying to avoid things or situations that cause flashbacks.

Sometimes in psychosis a victim may be confusing the past with the present. However, some victims present to support services requesting help when they are still being victimised: but then rather than being believed and given help to get away, they are instead diagnosed as schizophrenic and given

drugs. This makes it less likely they will be able to think clearly enough to be able to formulate and execute a plan to try to achieve safety from their perpetrators.

When we compare the strides that have been made with diseases such as HIV and Hepatitis C, to the ongoing downward trend of Australians' mental health, the most glaringly obvious difference is that these advances have been made through the use of evidence-based medicine.

If psychiatry was actually evidence-based medicine, then by now, after all the money governments and the pharmaceutical industry have poured into researching brain 'disorders' and 'diseases', some pertinent discoveries would have been made leading to an improvement in outcomes and life expectancy for those given psychiatric diagnoses.

B.4. Effects of psychotropic drugs and electric shock

(We acknowledge that most psychiatrists prefer the euphemistic term: 'electroconvulsive therapy', it is in fact electric shock.)

Dr McLaren's PCI submission covers these issues well. We assume you are also familiar with the 2017 Australian Commission on Safety and Quality in Health Care's report: *Medication safety in mental health*, which is a shocking indictment on the state of mental health care in Australia. We would like to draw attention to a couple of points from it,

'Side effects associated with taking psychotropic medicines can be severe and debilitating.'³¹

'We found that people with severe mental illness may have between four and eight medication-related problems per person on average, including drug interactions and adverse drug reactions. Several medication safety issues relating to the use of antipsychotics were identified, including use of more than one antipsychotic at the same time, excessive dose and increased 'off-label' use. We found that a considerable number of consumers taking antipsychotic medicines endure unpleasant medication-related side effects, whilst **a third of consumers with a psychotic illness live with moderate to severe impairment due to side effects.**'³² [emphasis added]

Dr Yolande Lucire, a pharmacogenetics author who specialises in antidepressant and antipsychotic-induced suicides and homicides, and their relationship to metabolising genes, stated the following to the 2017 Public Accounts Committee Inquiry into the management of health care delivery in NSW,

'There is a major problem in the education of psychiatrists in Australia who do not know the difference between mental illnesses, which cannot be diagnosed until every other cause of their symptoms has been eliminated, and medication-induced states. It is a systemic error of Australian psychiatry that has grown and grown since the nineties. I have been a psychiatrist for 52 years. I have a six-page curriculum vitae [CV], a multidiscipline PhD in public health, and half a dozen or more papers on the discipline of pharmacogenetics.'

'The point about mortality is that it is underpinned by morbidity, which means that for everybody who dies from psychiatric drugs and from various forms of organ failure there are probably 30 or 40 admissions, and they cost money. For everybody who commits suicide, there are 100 people who have suicidal ideation and 20 who are admitted for suicide attempts.'³³

There is a large amount of further evidence and information on her website:

<https://www.drlucire.com/>

StopORTC can also provide PCI with many peer-reviewed academic articles on these topics.

B.5. Continued use of forced and coerced ‘treatments’ in violation of the UN Convention on the Rights of Persons with Disabilities

Australia’s continued use of forced and coerced ‘treatments’ is in violation of Article 17 of the UN Convention on the Rights of Persons with Disabilities which Australia has ratified.

Whilst there are now far fewer people in psychiatric wards than there were decades ago, people are still being held in them against their will, even when there is no evidence that they are a risk to themselves or others.

Little is known about the forced drugging of patients that continues in these institutions today. The 2017 Australian Commission on Safety and Quality in Health Care’s report, *Medication safety in mental health states*,

‘We found no Australian studies which investigated the use of psychotropic medications for restraining people in mental health units.’³⁴ [emphasis added]

A 2016 article in *Australian Health Review*, titled, ‘How shortcomings in the mental health system affect the use of involuntary community treatment orders’ states the following,

‘The rates of use of involuntary treatment in Australian community settings (under CTOs) vary between state and territory jurisdictions and are **high by world standards**; however, the reasons for variation in rates of CTO use are not well understood.’ [emphasis added]

‘More than 8.7 million community mental health care service contacts are provided each year in Australia, of which **more than 1.1 million (14%) are involuntary.**’³⁵ [emphasis added]

‘Community treatment order’ (CTO) is a euphemism; a CTO is compulsory out-patient ‘treatment’: forced and/or coerced drugging.

The article excerpt below from Dr Peter Gøtzsche, author of 6 books and more than 70 papers published in the top five general medical journals explains more,

‘Forced treatment in psychiatry cannot be defended, neither on ethical, legal or scientific grounds. It has never been shown that forced treatment does more good than harm, and it is highly likely that the opposite is true. We need to abolish our laws about this, in accordance with the United Nations Convention on the Rights of Persons with Disabilities, which virtually all countries have ratified.

Forced treatment in psychiatry is not evidence-based medicine, as this builds on reliable research, clinical expertise and the patients’ values and preferences, none of which apply.

First and foremost, the patients’ values and preferences are not being respected, although the fundamental human right to equal recognition before the law applies to everyone, also to people

with mental disorders. This is clear from the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the United Nations Convention on the Rights of Persons with Disabilities.

Secondly, clinical expertise is highly misleading in psychiatry. **Doctors tend to credit the drugs for any spontaneous improvement and to put the blame for any untoward symptoms on the disease. What makes the practice of psychiatry particularly problematic is that many drugs can create the diseases they were supposed to alleviate, or worse diseases, or they have adverse effects that are similar to the symptoms used to define other psychiatric disorders.** Therefore, many patients get several psychiatric diagnoses and become in treatment with several drugs. Because of the changes in the brain caused by antipsychotics, for example, continued treatment can lead to supersensitivity psychosis, which should be treated by tapering off the drug, but which is usually treated by an increase in dose, or the addition of an additional antipsychotic, which increases the harms. When patients try to come off their drugs, they often get abstinence symptoms similar to the disease being treated, and they are therefore usually put back on full dose.

Thirdly, it has never been shown that forced treatment does more good than harm, and it is highly likely that the opposite is true'

'In 2015, the UN Committee on the Rights of Persons with Disabilities called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restrains. **The Committee found, like patients do, that these practices are not consistent with the prohibition of torture.**'³⁶ [emphasis added]

Reputable researchers have been publishing studies demonstrating that CTOs do not lead to improved outcomes compared to voluntary treatments, for a number of years. Some examples from the last few years follow.

'CTOs do not deliver clinical, social functioning or well-being benefits for patients and the evidence is now sufficiently strong that in the absence of further trials, moves should be made to restrict or stop their use.'³⁷

'CCT [CTOs] results in no significant difference in service use, social functioning or quality of life compared with standard voluntary care.'³⁸

'... there is now robust evidence the CTOs are not effective.'³⁹

The following excerpts from a December 2015 article by Piers Gooding, Postdoctoral Research Fellow at the University of Melbourne's Disability Research Initiative, explain more,

'Australia reportedly has rates of involuntary community treatment that are among the highest in the world. One study estimated that 5,675 Victorians were subject to CTOs in 2012, with figures rising significantly. Today, more than 10,000 people are likely to be subject to CTOs across Australia.

CTOs are based on the logic that forced treatment reduces the suffering of people with profound mental illness and saves lives. From this view, CTOs offer an alternative to more restrictive detention in psychiatric facilities, freeing up resources elsewhere in the system.

While this might sound attractive to some, it is not supported by robust evidence. Instead, mounting research indicates CTOs are no more effective than standard care.

A recent editorial by leading psychiatrists in the UK called for CTOs in their current form to be scrapped. Members of an executive committee of the Royal College of Psychiatrists (UK) cited three large-scale randomised control trials, which failed to show the efficacy of CTOs. According to the authors, if this standard of evidence was applied in general health care, “no clinical procedure would have any support from any regulatory institution”.

This is the most high-profile criticism of CTOs from a professional body to date, and echoes concerns raised by human rights advocates in recent years.’

‘In particular, three large-scale, randomised control trials and their meta-analyses have failed to support the view that CTOs are effective in achieving their principle aims. These are: lowering hospitalisation rates; improving service use, mental state, or quality of life, or satisfaction with care.’

‘The ease with which clinicians can compel treatment via CTOs potentially undermines therapeutic relationships based on trust.

Finally, some of those subject to forced treatment have reported the experience as being like torture. The intervention is generally agreed to be a significant curtailment of personal liberty.’⁴⁰

The United Nations Committee on the Rights of Persons with Disabilities has recommended that Australia repeal laws that authorise forced treatment.⁴¹ The UN Special Rapporteur on Torture stated that compulsory treatment is “often wrongfully justified by theories of incapacity and therapeutic necessity”⁴²

The extent of child sexual assault in Australia will remain hidden whilst victims continue to be silenced by state mandated drugging and electric shock. Whilst these practices are referred to as community treatment orders, medication, and electroconvulsive therapy; the reality for many victims is that they are being drugged and given electric shock against their will and suffering the effects (euphemistically called side-effects) of this ‘treatment’.

ORTC victims are sometimes forced to retract what they have disclosed about their histories and ‘accept’ they have a particular diagnosis in order to have any hope of getting out of an institution or ever having a CTO terminated, as refusing to do so is deemed as resisting treatment and further ‘evidence’ of the supposed ‘disorder.’

Drugs and electric shock are part of the organised rape and torture in childhood for many ORTC victims. As ruled by the UN, forced and coerced treatments are abusive to anyone; they are additionally inhumane and traumatising to ORTC victims.

Australia is a long way behind many other countries including the UK in terms of mental health practices, as noted last month by Power Threat Meaning Framework founder, clinical psychologist Lucy Johnstone,

‘Meanwhile, a current Royal Commission into Mental Health in the state of Victoria has, unbelievably from a UK perspective, no consumer representation at all, along with a failure to acknowledge the potential harms of medicalisation and a corresponding lack of emphasis on trauma and adversity in all their forms, as noted by the leading Victorian consumer organisation (Victorian Mental Illness Awareness Council, 2019). Our impression was that the whole Australian mental health system is more biomedically based than in the UK, with therapy virtually unavailable in community mental health teams or hospitals, very high prescribing rates, and liberal use of labels like ‘schizophrenia’. We were horrified to hear that ‘shackling’, or restraining people with Velcro strips and nets, is common practice.’⁴³

B.6. Twenty-five year reduction in life expectancy for those given a diagnosis of ‘schizophrenia’

University of Sydney research published in the February 2017 *Medical Journal of Australia* summary includes,

- Patients with schizophrenia die on average 25 years earlier than the general population, and this gap appears to be increasing.
- Most of the excess mortality is due to premature cardiovascular deaths rather than suicide.
- Many psychotropic agents are orexigenic and can increase weight and promote dyslipidaemia.⁴⁴

Further information from this study:

- ‘One in three illness-related deaths among people with schizophrenia is due to cardiovascular disease
- Compared to the general population, people with schizophrenia have up to a three-fold increased risk of both coronary artery disease and sudden cardiac death
- Up to 88 percent of people with schizophrenia have untreated dyslipidaemia
- Up to 62 percent of people with schizophrenia have high blood pressure⁴⁵

Whilst this study was published in 2017, much of this information has been known for years. The following ABC article was published in 2013,

‘Mental health advocates say the 200,000 Australians with schizophrenia have the worst physical health profile of any group in Australia, with a life expectancy 25 years less than the general community.’⁴⁶

B.7. Forced drugging of ORTC victims often starts in childhood

The children most at risk of being ORTC victims include those in out-of-home care and those whose families are involved. (N.B. Not all ORTC victims fit into these categories.) These children have little defence against forced psychiatric drugs.

Even children who are not in care, and whose families are not offenders, are still at risk of forced psychiatric drugs. The extreme threats given to victims prevent most from disclosing, and those that do are often not believed. Even many supportive families, when dealing with an extremely distressed child believe the psychiatrists who tells them the distress is caused by a brain disorder that needs medication.

Traumatised children, including organised rape and torture victims, naturally display the evidence of this in a range of ways, including behaviour that gets diagnosed as a range of mental ‘disorders’ such as ADHD, as explained in the following article excerpts,

‘First, it’s possible that doctors are simply mistaking the signs of trauma in children for ADHD. “What we find is that there is often an overlap in the symptoms of children who have ADHD and children who have experienced trauma, particularly small children,” said Alicia Lieberman,

professor and vice chair for academic affairs at the University of California, San Francisco, Department of Psychiatry and the director of the Child Trauma Research Program at San Francisco General Hospital, in an interview with Healthline. "The inability to concentrate, the fidgetiness, the inability to pay attention, the distractibility, the restlessness, and the irritability are often behaviors that trigger a diagnosis of ADHD. And often, the people making the diagnosis do not ask what happened to the child, what kind of experiences the child has had."

Brown agrees that this may explain her findings. "Studies have also shown that symptoms of post-traumatic stress disorder (PTSD) or acute stress disorder resulting from adverse life events closely resemble ADHD symptoms, so there is a high likelihood for clinicians to diagnose ADHD and overlook a possible trauma history," she said.⁴⁷

Lieberman also stated,

'When a child is presenting difficult behavior, the first thing to ask is 'What happened to the child?' rather than 'What is wrong with the child?'⁴⁸ [emphasis added]

'Our findings suggest that children with ADHD experience significantly higher rates of trauma than those without ADHD," said lead author Nicole M. Brown, MD, MPH, MHS, FAAP. "Providers may focus on ADHD as the primary diagnosis and overlook the possible presence of a trauma history, which may impact treatment.'⁴⁹

'Children with ADHD have higher ACE [adverse childhood experience] exposure compared with children without ADHD. There was a significant association between ACE score, ADHD, and moderate to severe ADHD. Efforts to improve ADHD assessment and management should consider routinely evaluating for ACEs.'⁵⁰

Given that the wide range of long lasting negative effects from ADHD drugs is well-known and documented we do not include quotes re this: we can provide many references if requested.

The 2017 Australian Commission on Safety and Quality in Health Care's report, *Medication safety in mental health states*,

'Concerns about off-label psychotropic use among children and adolescents also emerged during our consultations.

"And also these drugs, the antipsychotics, are being used on people under the age of 18 and, by goodness, under the age of 15 and under the age of 12. If you read the packaging, they've not been road tested on that age group; there are no control trials on that age group."

Consumer and carer representative'⁵¹

Children in Australia also continue to be given electric shock supposedly as 'treatment' despite the fact that the World Health Organisation has stated it 'should be prohibited through legislation'. (See more re this in Dr McLaren's PCI submission.⁵²) There is no way of knowing how many of these children are ORTC victims, however given the extreme impacts that ORTC can have, it is likely that some are.

Whilst presumably the intention of most professionals who give ORTC victims (and other child sexual abuse victims) psychiatric labels and 'treatment', is not to silence them, thereby enabling the rape and torture to continue; this can be the result.

We are currently creating the next generation of distressed adults, many of whom will be addicts (to both psychotropic and street drugs) through the drugging of distressed children.

B.8. Many mental health professionals treat victims in ways that replicate and reinforce perpetrators' programming

Unfortunately this includes some who consider themselves to be trauma-informed, and child sexual abuse 'experts'.

Deliberate torture-based mind control techniques are a part of the way that some ORTC perpetrators operate. Whilst there is a wide spectrum in terms of the sophistication of these techniques, the primary aims are similar across many different types of groups that rape and torture children: destruction of the child's sense of self, and ensuring the victim remains silent and compliant.

Countless victims of other forms of child sexual abuse also have their sense of self destroyed, and are intimidated and manipulated into silence and compliance. When intentional torture-based mind control techniques are used to achieve this, it can be more difficult to overcome.

It is not impossible.

However, the destructive effects of torture-based mind control cannot be undone or mitigated by the use of psychiatric or psychological techniques which rob the victim of a sense of agency.

The primary reason that so many mental health professionals' treatment of victims reinforces perpetrator programming rather than supporting liberation from it, is not the dearth of knowledge about organised rape and torture of children - even though the majority of mental health professionals who consider themselves experts in trauma or child sexual abuse have zero knowledge or understanding about ORTC. Rather it is that the 'treatment' is based in the assumption that the practitioner knows better than the victim what they need. The most well-intentioned 'treatment' can retraumatise rather than be of any assistance when it is based in this faulty assumption.

Many mental health professionals fiercely guard their right to be in control, and appear to be simply incapable of being present, listening, and bearing witness. Even some professionals (in both mental health and other fields) who have some knowledge of ORTC are very attached to their particular viewpoints regarding diagnoses which they see as helpful for victims, and their own role as 'experts'. Pathologisation is not conducive to healing and can prevent it.

Many 'experts' focus on victims' lack of trust in others, or in the case of institutional abuse victims, emphasis is placed on the fact that they do not trust institutions, or that victims of churches have 'lost their faith'. What is rarely mentioned is that child sexual abuse can (and in the case of ORTC often does) destroy the victim's trust in themselves, and in life itself. It is difficult for victims to develop the self-trust that is vital to healing, when practitioners are attached to being the 'experts' who are in charge of what is actually the victims' own healing process.

StopORTC would also like to point out that professionals, whether in mental health, criminology or other fields, who claim to be experts about organised abuse, do not necessarily have a good

understanding of all the issues involved, or the full picture; many continue to ignore the role of the catholic church in ORTC.

B.9. Psychiatrists and other mental health professionals' conflicts of interest

a. Pharmaceutical industry conflicts

The financial conflicts of interest between many psychiatrists and the pharmaceutical industry are well documented. Dr McLaren covers this in his PCI submission.⁵³

An example of this is blatantly clear in the 'Declaration of Conflicting Interests' in the RANZCP submission to the PCI, 'Guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it?'⁵⁴

As stated by Dr Lucire (see her credentials B.4) to the 2017 Public Accounts Committee Inquiry into the management of health care delivery in NSW,

'...the corruption comes from the pharmaceutical industry. Five minutes on the internet will tell you that we have approved drugs in Australia that have paid massive fines under the False Claims Act in the United States.

We have no way of dealing with these pharmaceutical problems. The drug companies are foreign donors and they give to both sides of politics. They are capable of destroying people. They have damn near destroyed me by putting in the paper that I was ordered into treatment by the medical board and the registrar of the medical board just laughed and said the journalist got it wrong. That is the sort of thing they do. They have damn near destroyed my practice.'

'The regulators are captured. The Australian Prudential Regulation Authority [APRA] and Medical Council are captured by the Royal Australian and New Zealand College of Psychiatrists, which takes the position that it does not believe the contents of prescriber information or the warnings of suicide and homicide put out by the United States Food and Drug Administration, which has the data.'⁵⁵

Should you require further evidence of the fact that many psychiatrists have clear financial incentives to collude with the pharmaceutical industry in the creation of imaginary diseases and bogus cures we are happy to supply it.

b. Involvement in and enabling of ORTC and other forms of child sexual abuse by some mental health professionals

Another conflict of interest for some mental health professionals is their involvement in or enabling of ORTC or other forms of child sexual abuse. It is unfortunate that the mental health industry thus far has not addressed this issue: presuming that all mental health professionals are 'good' people, and if a victim is uncomfortable with a clinician it must be the victim's 'trust issues', makes no more sense than presuming priests could not possibly be child-rapists.

These types of conflict of interest include the following.

1. Some ORTC victims are institutionalised or put on CTOs with forced drugging by psychiatrists who are either personally involved in ORTC, or colluding with perpetrators for a variety of reasons including financial incentives.

2. Mental health professionals have spearheaded the campaign to discredit ORTC and other child sexual abuse victims both in Australia and internationally by promoting a bogus syndrome, 'false memory syndrome', that in fact has never been recognised as a syndrome in the DSM, or by any medical or psychological body anywhere in the world.

The term was invented by people who had been accused of child sexual assault. They also established a 'false memory syndrome' foundation (FMSF) specifically to discredit victims of child sexual assault.

Much of the child sexual abuse evidence given to the Royal Commission into the NSW Police Service (Wood Commission) in the mid-1990s involved multiple offenders; some was organised rape and torture of children. But rather than properly investigate this, the Wood Commission instead went to great lengths to discredit many victims and the professionals trying to help them; primarily by using 'evidence' from FMSF members.⁵⁶

A psychiatrist, who according to his LinkedIn profile, 'served on the Advisory Board of Australian False Memory Association for many years'⁵⁷ played an instrumental role in the Wood Commission's discrediting of victims. He also tried to take a loaded gun into a court, and police found illegal weapons in his house including 800 ammunition rounds, loaded spear gun, knives, a shotgun, and an electric cattle prod.⁵⁸ The Medical Board suspended him (he was sentenced on the above) and he then faced further suspension due to 'having an inappropriate sexual relationship with a patient'.⁵⁹

StopORTC can provide additional information about how mental health professionals' promotion of the non-existent 'false memory syndrome' impacts ORTC victims' mental health. In addition to the devastating effects on the individual victims who get 'treated' by these clinicians, it is also a very significant part of the ongoing denial and cover-up of ORTC that allows it to continue, and directly contributes to severe adverse mental health effects for victims including suicides.

3. A recent example of child sexual abuse charges laid against a prominent mental health professional: in January this year, as reported in an ABC article, a former president of the Australian Psychological Society, psychologist Dr Bob Montgomery, was arrested on nine charges of indecent assault on males and two counts of buggery; the alleged victims were three 12-year-old boys.⁶⁰ (The article neglects to mention that he is a former president of the Australian Psychological Society.)

B.10. Some relevant points re above factors

a. The issues discussed in B.1 - B.9 stem from a system based on a white, middle-class view of mental health and 'disorders'

Inherent in this viewpoint is the idea that the 'experts', especially those with the most letters after their names, know better than victims themselves what they need to heal.

There are in fact many different ways to understand and support mental health.

Some cultures place more importance on listening. e.g. Deep listening is used by some Aboriginal people.

b. Other normal, natural human behaviour pathologised in the DSM until 1973 is now recognised as normal

Up until 1973 the DSM listed homosexuality as a psychiatric disorder. People were 'treated' for their homosexuality; the 'treatment' was usually abusive, although presumably some of the professionals were well-intentioned.

Some religious people still think that LGBTI people should be 'treated'. Earlier this year, Victorian Premier, Daniel Andrews included the following in a statement regarding that,

'But for far too long and for far too many Victorians, an evil practice has instead peddled in shame and stigma. These activities –commonly referred to as 'gay conversion therapy' –claim to be able to change someone's sexuality or gender identity. What they really are is a most personal form of torture, a cruel practice that perpetuates the idea that LGBTI people are in some way broken. Some survivors, seeking genuine professional support, have instead found themselves on the other end of this bigoted quackery. Others have sought it out, forced to believe that they somehow need to be 'cured'. But it's not LGBTI people who need to change. It's our laws. That's why, in an Australian first, we will introduce new legislation to ensure so-called 'conversion therapy' is against the law –once and for all. We'll drag these practices from the dark ages and into the brightest of lights. We'll put an end to the suffering and help survivors to heal'⁶¹

How many more decades will it take before our politicians and others will acknowledge that forcing victims of organised rape and torture of children (and other victims) to deny their history; declaring that they have a brain disorder; and forcibly injecting them with drugs that have severe effects and drastically shorten life span, is also a cruel practice that perpetuates the idea that these victims are 'in some way broken': that this too is torture and quackery. When will our politicians legislate to comply with UN and WHO stipulations, and drag our mental health practices out of the dark ages to 'put an end to the suffering and help survivors to heal'?

The state sanctioned forced electric shock and drugging of ORTC victims and others is no less of an atrocity than gay conversion therapy.

c. The pathologisation of child sexual abuse victims continues to be used by perpetrators as a means to discredit victims

This not only effects the specific victims who are targeted, but also causes distress for other victims seeing media coverage of this, e.g. when perpetrators' lawyers use this strategy in court cases. There does not appear to be any improvement with this issue: the catholic church continues to use victims' mental health history as a means to discredit them including as recently as the Pell case, as mentioned in media,

'The defense attorney alleged there was no supporting evidence or witnesses to back up the claims of abuse by the accusers, many of whom he claimed had been treated in psychiatric wards in the past and had allegedly also been abused by other clergy.'⁶²

B.11. Lack of training and support for the frontline of help: general practitioners

General practitioners are on the frontline for child sexual abuse intervention, and victims' physical and mental health, including suicide prevention. They are also mandatory reporters.

There is copious evidence linking child sexual abuse to ongoing adverse physical and mental health outcomes. (See B.1 re mental health outcomes. Can provide extensive list of peer-reviewed articles regarding the links to both physical and mental.)

Not only are general practitioners mandatory reporters, they are also in a position to possibly notice indicators of child sexual abuse in children, that others have missed or are ignoring. Sexually abused children are likely to have more frequent interactions with general practitioners than other children for both physical and mental health reasons.

If general practitioners were given training and support about ORTC, and other forms of child sexual abuse, they would be better able to recognise both physical and psychological indicators in current victims, as well as those who have been victimised in the past.

The research below is from the United States; therefore the statistics may not be correct in Australia, but the overall point is still relevant.

'The association between childhood abuse and adverse adult health outcomes is well established...'

'If physicians caring for adults who suffer from a condition associated with abuse in childhood are unaware of this link, [a number of physical illnesses, depression, and anorexia nervosa are mentioned prior as associated] they will neither elicit an abuse history nor make appropriate patient referrals. This is especially troubling because **conditions associated with childhood abuse are burdensome to both the patient and the health care system, relatively simple interventions may prove effective in alleviating much distress**, only 2% to 5% of patients with a history of childhood sexual abuse will themselves report it to a physician...Furthermore, while most patients say they want their physicians to screen for a history of abuse, most physicians admit that they do not do so.'⁶³ [emphasis added]

Training and support for general practitioners about ORTC, and other forms of child sexual abuse, could potentially result in big savings for our health care system.

General practitioners are on the frontline dealing not only with victims' physical health, but also mental health. Medicare only funds up to 10 counselling sessions annually: general practitioners can end up as the primary ongoing support for victims. Some victims are alive due to the sustained support efforts of their general practitioners, who effectively lose income by choosing to take the time involved to support victims, despite the lack of adequate Medicare payment. Not all doctors are willing or able to do this, as explained in the media recently.

'Doctor's surgeries are reportedly turning away mental health patients and children because stagnating Medicare rebates do not cover the cost of complex consultations.'

'Australians can see a doctor for free at bulk-billing clinics, but the president of the Royal Australian College of General Practitioners said it is common for longer appointments to be refused because they are not financially viable.'

“They are saying, ‘it’s 10 minutes and the patient goes out’. And people are being told ‘if you have a mental health condition you probably have to go elsewhere’,” Dr Bastian Seidel said.’

‘Dr Seidel said longer consultations were better for patients, as they allowed doctors to talk through health issues, making them less likely to prescribe medication.

Yet most bulk-billing centres offer standard consultation times of just 10 or 15 minutes.’

‘While there are Medicare rebates for consultations longer than 40 minutes, doctors say they make more money by charging for multiple short consultations, creating a “perverse” incentive to avoid difficult patients.

An ongoing review into the Medicare Benefits Schedule has been told that GPs who want to spend more time consulting are unfairly penalised.’

‘Australian Medical Association president Dr Tony Bartone, a Melbourne GP, said it was not a case of doctors crying poor. He said that if Medicare rates had kept up with the consumer price index, they would be more than double the current rate.’⁶⁴

The Royal Australian College of General Practitioners *Health of a Nation 2018 Report*⁶⁵ clearly shows the crucial role general practitioners play in mental health.

‘Psychological issues (e.g. depression, mood disorders, anxiety) remain the most common health issue managed by GPs.’

‘Patients talk to their GP about mental health more than any other health issue’ p2 [emphasis added]

‘In addition to being the most common reason patients visit their GP, mental health was also identified as the health issue causing GPs the most concern for the future...’ p4

‘In line with perception of current and emerging health issues, GPs also identify mental health and obesity as key areas the federal government should prioritise for action.’ p 5

Commenting on the report RACGP president-elect Dr Harry Nespolon stated,

“As access to psychologists and psychiatrists can be restrictive, to say the least, GPs must not only work as the frontline of support – but as the entire support model, something which is currently not supported by patient Medicare rebates,”⁶⁶ [emphasis added]

Other recent media also addresses this,

‘GPs are reasonably arguing for increased funding for longer consultations. There is a vital link between self-harm and mental illness. Suicide is the leading cause of death for people aged between 15 and 44, and accounts for about twice as many deaths as the road toll.’⁶⁷

‘Our Medicare system needs to better reflect the times we live in and the health problems we face. Doctors need the financial support to offer longer consultations for patients with complex psychological needs.’

‘Many people are no longer here because they couldn’t afford their mental illness. It’s a devastating indictment on a system that is fundamentally broken.’⁶⁸ [emphasis added]

B.12. Religious institutions publicly funded to provide public health and community services that victims need

Whilst victims of other forms of organised crime are not expected to return to the perpetrating organisation to get help, many victims of catholic church child sexual abuse are.

This section is not specific to ORTC victims but rather addresses issues that can potentially apply to any victim of church abuse, and also has relevance for other people whose mental health may be adversely effected by having to engage with religious institutions in order to receive necessary government funded services.

RCIRCSA's Final Report acknowledged child sexual abuse victims are more likely than the broader population to need to access these services.⁶⁹

As stated by victim of catholic church child sexual abuse, John Brown,

'If you want to keep us alive simply provide us with genuine secular pathways through government systems'⁷⁰

Whilst this is also an issue regarding funding of other churches, given the extraordinary number of children raped in catholic institutions, and the exorbitant amount of public funding given to catholic institutions, this issue is especially pertinent to the funding of catholic institutions.

Many victims of child sexual abuse in the catholic church are either unable to access needed services, or are severely re-traumatised whilst doing so, due to situations where the only option for a required, publicly funded health or community service is a catholic institution or organisation.

Clearly, victims of child sexual abuse in churches should not have to go to religious organisations to receive government funded services; but due to the large number of government funded services run by the catholic church, many catholic church victims have no choice other than to return to the institution responsible for their childhood rapes in order to receive needed services.

Whilst the examples given below are primarily NSW, victims face many similar issues throughout Australia.

Hospitals and other health services

Examples are included regarding both mental and physical health services because there can be severe mental health consequences from the inability to access needed physical health services (or to have to be retraumatised whilst doing so.)

RCIRCSA's Final Report showed that 3.2 per cent of female victims who discussed impacts in private sessions became pregnant as a result of child sexual abuse.⁷¹

Catholic institutions continue to enforce their beliefs on others, even when providing publicly funded health services, in public hospitals: a rape victim who goes to her local hospital to access the morning after pill, is out of luck if she lives in an area where her local public hospital is run by a catholic organisation, as they refuse this, even for child rape victims.

If you need to use services such as physiotherapy through NSW Health, and you are not able to travel to another area, then you are stuck with your local hospital: if that is a catholic hospital and

you cannot cope with the flashbacks from the crucifix emblems everywhere, even on the physiotherapy equipment; then you end up without the needed service.

If you end up in hospital as a result of an emergency, you have no choice: if your local public hospital is catholic then you end up hospitalised in a building full of catholic symbols and paraphernalia.

The only option for ongoing mental health help through NSW Health is through your local hospital. So, if you live in an area where your local publicly funded, public hospital is run by the catholic church you have no option other than that. (Whilst for physical health you can choose to go to a hospital that is out of your designated area, for mental health you are not allowed to.)

Many victims are hospitalised, especially victims of organised rape and torture of children. The additional traumatising for those victims of rape and torture in the catholic church who end up in catholic hospitals is extreme.

An additional issue regarding hospitalisations in NSW (and possibly some other states) is that chaplains have access in all hospitals to patient information without patient consent, because it is an opt out rather than an opt in system to give consent for this. You have to know to state ahead of time that you do not consent because the default is consent: if you arrive in hospital unconscious or in an emergency situation you do not even get the chance to refuse this. Even if it is a planned hospital visit, unless you have read the brochure about privacy, you would not know you need to opt out.

It appears that some perpetrator priests are moved from parishes to roles as hospital chaplains. Broken Rites researchers detail on their website instances where the history of convicted priests shows that after offences in parishes (which they were later convicted of) they worked as hospital chaplains.⁷²

Domestic violence services

As acknowledged in RCIRCSA's Final Report, victims of child sexual abuse are more likely than non-victims to need to use domestic violence services.

'Research suggests that victims of child sexual abuse are at increased risk of re-victimisation in adult life as well. One large-scale Australian study found that compared to people with no history of abuse, victims of child sexual abuse were more likely to be a victim of violence, more than four times as likely to experience threats of violence, and at five times greater risk of sexual assault. One large-scale prospective study found that prior victimisation, including abuse and neglect, increased the risk for future physical and sexual abuse. Evidence from other studies associates child sexual abuse involving greater force, and occurring over a long duration and with more frequency, with up to three times greater risk of re-victimisation. Female survivors, in particular, told us in private sessions about re-victimisation occurring within intimate relationships.' For example, 'Dora' told us that she had been sexually abused at the age of seven by the chaplain at her Catholic school in Sydney's north-west, and at the age of 14 by the religious studies and sex education teacher at her Catholic high school. 'Dora' told us that these incidents had significant impacts on her mental health and believes they also made her more susceptible to later emotional and sexual violence. She had a number of abusive relationships as an adult and experienced a further rape. 'It made me vulnerable to certain types of people, who would take advantage of me ... There was almost a different side to me.'⁷³

In NSW, funding for many domestic violence refuges was taken away several years ago from secular organisations which had established and run these services for decades, and instead given to St Vincent de Paul and other religious charities. Many women who have been raped by clergy as children, then revictimised through domestic violence often have no option in terms of a domestic violence refuge other than to go to one run by a religious organisation.

Other services

There are a range of other government funded services that victims need to access that are run by religious organisations. e.g. The contracts for the National Disability Insurance Scheme (NDIS) local area co-ordinators throughout nearly all of NSW were given to Saint Vincent de Paul and Uniting Church.

Some victims of catholic church child rape have been deeply disturbed when they were contacted by phone, with the caller identifying themselves as 'calling from St Vincent de Paul'. Their personal information had been given to a catholic organisation without them even being warned. [Whilst NDIS applicants consent to their information being shared as needed there is no warning that this includes religious organisations.]

The federal government had other options; other organisations also tendered for these contracts; there was no need to give them to religious organisations.

Victims' lack of trust in catholic institutions is well founded and rational: the catholic church has a long history of lying to and retraumatising victims who ask for support, and sharing information given by victims, in order to protect perpetrators.

The tragic end to Chrissie Foster's daughter's life is an example of what can happen to victims who access help through catholic institutions. (There are others whose stories never gets into the media.)

'Emma checked into a rehabilitation centre where her parents say a counsellor, a nun and other staff convinced her that she was to blame for the assault. She took her own life the day after she was discharged.

The Royal Commission into Institutional Responses to Child Sexual Abuse heard the Catholic Church was aware of allegations against O'Donnell almost 30 years before Emma started prep.⁷⁴

The continued blatant homophobia and transphobia displayed by the catholic church mean that LGBTIQI victims can face additional levels of retraumatisation if they have to access services through a catholic organisation.

We will never know how many victims suicide as a result of one of the following:

- a. being put in the no-win situation of their only option for needed services being a catholic institution and therefore feeling like they have no options
- b. the additional retraumatisation of going for help from a catholic institution pushing them over the edge
- c. being told the abuse was their fault from someone within a catholic institution that they had to go to for needed services

B.13. Lack of safe housing

Whilst not having safe housing impacts the mental health of anyone, there are some additional impacts for ORTC victims.

ORTC is organised crime. Most victims who are trying to heal understandably do not want to live in areas impacted by any form of organised crime, and are likely to experience severe exacerbation of hypervigilance and flashbacks if forced to do so. The extent of drug dealing that occurs in some public housing estates renders public housing an unviable option for many ORTC victims. Those who are on limited income currently have few if any other options.

Safety, or relative safety at least, is absolutely the first necessity for healing. Whilst it is impossible to ensure that ORTC victims are protected from reprisals from perpetrators if they identify them; it should be possible to provide victims with housing that is basically safe in other respects.

B.14. Ways that victims are often treated by government agencies such as Centrelink can prevent access to needed services

The contempt with which ORTC victims (and others) are often treated by Centrelink and other government agencies can have a very significant effect on mental health. It is unacceptable that Centrelink administrative staff can decide to reject valid medical certification, and tell people that they do not believe they are not well enough to work, i.e. that they know better than the person's doctor.

Whilst there are Centrelink employees who treat people with respect, there are also those who do not. It can be an impossible system to navigate for people who are already struggling just to stay alive.

B.15. Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) ignored institutional organised rape and torture of children

RCIRCSA was given information by victims of institutional ORTC. They also had access to other information about it:

- Information regarding the catholic church's involvement in organised child sexual assault had been well documented in the media prior to RCIRCSA.
- Dr Reina Michaelson, executive director of the Victorian Child Sexual Abuse Prevention Program bought attention (mainly in 2003-2005) to the institutional involvement in and cover-up of the organised rape and torture of children.
- Information regarding institutional organised rape and torture of children had been given to prior government inquiries
- Australian authorities were well aware, prior to RCIRCSA, that some of the child sexual assault within the catholic church and other institutions was organised crime.
- Other information regarding institutional involvement in extreme and organised child sexual assault was both publicly known, and given to RCIRCSA
- Questions had been raised in Australian parliaments regarding the refusal of public institutions to investigate organised child abuse for decades prior to RCIRCSA.

(StopORTC can provide documentation evidencing all the above)

Despite this, there are only a couple of places that even come close to possibly mentioning ORTC in RCIRCSA's Final Report:

The first, Volume 2, '2.1 How we define child sexual abuse' includes only,

'We also heard about adult perpetrators, most often men, who abused children as part of a group or network.'⁷⁵

'We heard about some institutions where networks or groups of perpetrators operated'⁷⁶

No actual information about this is given in this ten-page section or anywhere else.

The other mention; Volume 5, section 3.3.2, 'Types of sexual abuse, Exposure to sexual acts and material and sexual exploitation' states,

'A small number of survivors described being trafficked and sold for sexual purposes or being **forced to participate in group sex activities.**'⁷⁷ [emphasis added]

It is inexcusable, incomprehensible, and extremely offensive that RCIRCSA defines as 'group sex' what is actually sexual assault with multiple offenders/pack rape.

Child rape should not be called sex; sexual assault with multiple offenders is not 'group sex'.

We do not know why RCIRCSA chose to ignore us: they never gave any reason and a Freedom of Information request that included asking for:

1. *Documents that show when and why the decision was made by the Royal Commission into Institutional Responses to Child Sexual Abuse (Commission) to ignore institutional responses to the institutional organised rape and torture of children.*

received the following response:

I am writing to advise you that the documents you requested do not exist (section 24A(1)(b)(ii)) – the Department undertook searches of the Royal Commission records held in its records management system based on terms used in your request, and was unable to identify any records.

The consequences of RCIRCSA ignoring ORTC include the following:

- ORTC victims are now even less likely to be believed: in the last year a number of journalists have raised the fact that RCIRCSA did not address ORTC as a reason to justify doubting ORTC victims
- No information about ORTC for those who if they had information, could then potentially recognise and help children currently being victimised
- Organised rape and torture of children now even less likely to be researched
- None of the recommendations addressed institutional ORTC prevention
- Needs of ORTC victims were not addressed
- Organised rape and torture victims now less likely to disclose
- ORTC victims will continue to be given psychiatric labels, and silenced with forced treatments due to not being believed

- Perpetrators of organised rape and torture of children protected and enabled
- Delegitimising effect of RCIRCSA ignoring ORTC will impact any criminal and civil cases in the future
- ORTC is not being addressed by appropriate current bodies and inquiries, and will likely continue to be ignored in the future.

RCIRCSA Final Report states,

‘...where there is a power imbalance, perceptions matter a great deal.’⁷⁸

There is a huge power imbalance between perpetrators of ORTC, who usually have resources and power; and their victims, who are dealing with the impacts of their extreme victimisation, and also usually receive severe threats regarding disclosure. In addition, whilst the perpetrators are often well known and respected, the extent of the impacts suffered by victims means they often are not. People do not want to believe this level of atrocity occurs; most people would prefer to believe that the victims who do try to disclose are just ‘crazy’.

RCIRCSA’s omission of ORTC empowers the perpetrators to continue portraying their victims this way in order to keep their crimes hidden.

In addition to the overall effect of protection of perpetrators by refusing to address the issue, there are also specific ways perpetrators have been afforded protection by the omission of ORTC from the Final Report. One example of this is the fact that whilst Volume 9 looks at barriers to effective sexual assault service responses, there is no mention of perpetrator involvement in services (and other bodies and institutions). Whilst there is of course no easy solution to this, the starting point needs to be acknowledgement of the fact that just as some perpetrators position themselves to have access to children, some perpetrators of organised rape and torture of children position themselves where they can help prevent the truth being exposed.

The exclusion of ORTC from RCIRCSA’s reports also means the people involved in establishing child safety protocols have been denied the wealth of experience and knowledge provided by institutional organised rape and torture victims to RCIRCSA, and therefore ORTC is not being taken into account in the establishment of any of these protocols.

RCIRCSA’s Final Report states the following,

‘We also heard that mental health services intended to support victims of child sexual abuse can instead have profound negative effects if they respond inappropriately to the abuse. This could result in victims feeling unable to speak about their experience of abuse.’⁷⁹

‘Unsurprisingly, victims are less likely to disclose if they feel they won't be believed, expect a negative reaction or response, or believe the disclosure will have negative consequences for them, their families or communities.’⁸⁰

It is impossible to put into words the depth of despair felt by ORTC victims as a result of RCIRCSA refusing to address this issue at all.

As stated in the UN report: *How can children survive torture*,

'Torture is intentionally kept secret. As a result, the acknowledgment of torture by society, governments and perpetrators is an incredibly important part of the healing process for survivors, in particular children.'⁸¹ [emphasis added]

The devastating impact of RCIRCSA's refusal to address ORTC will be felt by victims who did not engage with the RCIRCSA, current and future victims, as well as those of us who did give information to RCIRCSA about our experience of institutional ORTC. One of the impacts of being the victim of crimes that people do not want to believe happen is having to deal with the constant, ongoing denial of reality by institutions, and the world at large; and the intense sense of isolation this causes, which has now been greatly exacerbated by RCIRCSA.

RCIRCSA's Final Report Volume 5 *Private Sessions*, states,

'Many survivors told us how important it was to them to tell their story to a Commissioner who in their eyes, represented the 'highest authority in the land'. They felt that the Australian Government and the people of Australia were finally taking them seriously and that what they had to say about their experiences of child sexual abuse was valued – that it mattered and they mattered.'⁸²

Many of us were given the exact opposite message to this: that **the 'highest authority in the land', the Australian Government and the people of Australia refused to hear us, instead making it patently clear that we do not matter, and they do not want to know. It is impossible to explain how devastating this is; it is a huge blow that has impacted victims' mental and physical health.**

We will never know how many victims have killed themselves due to the extreme distress of being ignored by RCIRCSA. It is unconscionable that we found out that we had been ignored ten days before christmas; the time of year that is most difficult for many victims, and the time of year with the highest suicide rates.

How can trauma be healed when even RCIRCSA refused to address the type of institutional victimisation you experienced?

The RCIRCSA's refusal to address institutional organised rape and torture of children is a double tragedy; not only has it sentenced ORTC victims to continue to struggle to be believed, and to live in a society that denies the horrific reality of our experiences, but even worse, this refusal ensures that ORTC perpetrators remain protected, their crimes still hidden, and children will continue to be raped and tortured.

We already have to live with the severe, ongoing consequences of years of rape and torture (too extreme for most people to want to have to believe happens), and the trauma of living in a society that views the criminals who raped and tortured us, and their enablers, as good people. For catholic church ORTC victims we also have to live with the fact that our governments continue to give them massive amounts of government funding.

In addition to the impacts listed above, the distress of knowing, that despite the fact that we were willing to go through intense retraumatisation and terror to document our histories with RCIRCSA, we achieved absolutely nothing and therefore nothing is being done to stop it, is indescribable.

There is an incredibly heavy burden of responsibility for any victim capable of speaking up about ORTC, because so many victims cannot; they are dead, sedated, institutionalised, or understandably too terrified to speak up.

We also now have to live with the fact that a Royal Commission into Institutional Responses to Child Sexual Abuse decided that what happened to us did not actually matter to them at all; that they did not care about the consequences of telling us for five years that our ‘stories mattered’, and then totally ignoring our stories; or that children are still being raped and tortured because this remains covered up.

Our lives, our victimisation, the children still being victimised in this extreme manner, did not matter enough to be addressed in any way at all. Our experiences as institutional organised rape and torture of children victims most certainly could have helped create a safer future for children but instead they were ignored.

B.16. RCIRCSA Redress scheme in no way offers justice for ORTC victims

RCIRCSA’s Letters Patent (Terms of Reference) required they ensure ‘**justice for victims** through the provision of redress by institutions’⁸³ [emphasis added]

The Redress and Civil Litigation report Recommendation 15 states,

‘The purpose of a monetary payment under redress should be to provide **a tangible recognition of the seriousness of the hurt and injury suffered by a survivor.**’⁸⁴ [emphasis added]

RCIRCSA recommended,

- ‘19. The appropriate level of monetary payments under redress should be:
- a. a minimum payment of \$10,000
 - b. a maximum payment of \$200,000 for the most severe case
 - c. an average payment of \$65,000.’⁸⁵

These figures in no way ‘ensure justice for victims’, or ‘provide a tangible recognition of the seriousness of the hurt and injury suffered by a survivor’. **The recommended maximum payment (now lowered even further to \$150,000 by government) is a gross and insulting minimisation of the impacts of child sexual abuse, especially for ORTC victims.**

Whilst the lower burden of evidence in a redress scheme means the amounts are lower than through civil litigation, there is no excuse for these pitiful figures. Even some of the catholic church’s own compensation schemes overseas have paid considerably more than this; presumably because the much larger amounts they have had to pay in civil cases in those places meant they knew that the court of public opinion would not accept the pittance recommended here.

The Final Report also states,

‘4c. All redress should be offered, assessed and provided with **appropriate regard to what is known about the nature and impact of child sexual abuse** – and institutional child sexual abuse in particular...’⁸⁶

The distress caused to ORTC victims, (and many others) by RCIRCSA placing so little value on the intense suffering caused by ORTC and other forms of child sexual abuse indicates that even after five years they had no understanding of the 'nature and impact of child sexual abuse'.

This distress has been exacerbated by the government setting up a scheme that is even worse than what RCIRCSA recommended.

B.17. Refusal of Australian parliaments to address ORTC or to properly address the overall issue of child sexual abuse

Some current federal and state MPs were contacted regarding the fact that RCIRCSA ignored ORTC: none were willing to even try to do speak up about this.

MPs who have dared to speak up about public institutions' protection of child sexual abuse perpetrators in the past have been denigrated and their careers destroyed.

Examples of this include:

- NSW state MP Deidre Grusovin was denigrated, lost her position on the front bench, and then was pushed out of parliament by her colleagues due to her efforts to expose organised child rape and torture and other forms of child sexual abuse.
- South Australian state MP and Speaker of the House, Peter Lewis was falsely defamed, forced to resign his position as House Speaker, and then lost his seat due to his efforts to expose organised child sexual assault and institutional cover-ups of it.
- Victorian Liberal MP Ken Smith's political career was negatively affected by his attempts to get his parliamentary colleagues to address the catholic church's cover-ups of child sexual assault.
- Heckling in parliament of MPs who raise issues related to institutional child sexual assault and cover-ups

StopORTC can provide further details regarding the above.

B.18. The cover-up of ORTC and other forms of child sexual abuse by Australian public institutions

The ongoing efforts of ORTC perpetrators and their enablers have led to numerous cover-ups, and cause many people to doubt the existence of ORTC and the credibility of victims. In addition, the dynamic of being viewed as above reproach which has protected religions from scrutiny continues to protect perpetrators and enablers within our government institutions.

People in government institutions cover up for child rapists for a number of reasons including:

- being involved as a perpetrator themselves
- perceptions of loyalty within the institution
- owing favours
- the perpetrator(s) having the power to negatively impact their career
- the perpetrator(s) knowing information about them which they don't want exposed

- other pressure to keep quiet/not take action
- financial or other reward
- not wanting to get involved

An obvious example of cover-up is the fact that more than a year after the end of RCIRCSA, despite all the clear evidence of this presented for five years, we are yet to see a single catholic church or other institution official charged with aiding and abetting child rape.

Why are journalists being threatened with aiding and abetting regarding coverage of the Pell case, whilst clear evidence of aiding and abetting child rape is ignored?

Another example: whilst RCIRCSA conducted seven case studies on historical out-of-home care, they conducted none on contemporary out-of-home care. (They classed contemporary as post 1990.) Surely attempting to investigate institutional responses to child sexual abuse post 1990 was as important as looking at that which happened decades ago: it certainly would have had more relevance to stopping what is happening today.

The ongoing cover-up of organised rape and torture of children: the refusal of our public institutions to address this issue, is one of the primary factors which allow ORTC in Australia to continue. It therefore is crucial to address as a factor impacting the survival and well-being, including mental health, of ORTC victims as children; i.e. current and future ORTC victims.

No amount of mental health care is likely to be of much use to a child who continues to be raped and tortured. The ongoing cover-ups of ORTC and other forms of child sexual abuse need to be urgently addressed.

As with other forms of crime, the more powerful are less likely to see justice than the 'little fish'. In addition, those involved with more organised child sexual abuse are likely to be better protected, and also to severely intimidate or kill victims who try to speak out. They therefore are rarely exposed.

A society that continues to enable and cover-up child rape and other forms of child sexual abuse can never be mentally healthy. We will not reduce suicide rates, and no amount of funding for research into brain 'chemical imbalances' will provide a solution to this.

B.19. Refusal of both government and non-government agencies dealing with child sexual abuse to address organised rape and torture of children

The refusal of appropriate bodies and organisations to address ORTC not only enables ORTC to continue, it also has devastating impacts on the mental health of ORTC victims.

It is not possible to adequately put words to the deep and abiding sense of alienation that results from the fact that people paid to work with child abuse issues, the majority of whom no doubt genuinely care about the issue of child sexual abuse, continue to ignore the organised rape and torture of children.

How can ORTC victims heal, how can we achieve good mental health, when we continue to be ignored and shut out of the very conversations we have a right and need to be part of?

Even more important is the fact that ignoring ORTC victims ensures the perpetrators remain protected and children continue to be subjected to organised rape and torture, which presumably is not what the majority of people working within these organisations and bodies actually want.

Maintaining one's sanity in the face of overwhelming denial of the horrific violence you have endured is extremely difficult. It is a normal human need to be allowed to tell the truth about one's experiences. The truth is grounding; conversely denial of the truth creates insanity.

An example of a body that claimed to be 'survivor-focused'⁸⁷ and yet ignored the needs of ORTC victims was the apology consultation reference group which followed the RCIRCSA. Their website states,

'The diverse membership of the Reference Group ensured the views of a broad range of victims and survivors, their families and Members of Parliament from across Australia were represented.'⁸⁸

A detailed and well-evidenced submission was given to the apology consultation reference group evidencing the fact that ORTC was ignored by RCIRCSA (and that written accounts were also ignored in their Final Report) and requesting the following be included in the Prime Minister's apology:

- A clear and specific apology to victims of institutional organised rape and torture of children (ORTC) for the fact that we were ignored.
- A clear and specific apology to the victims who submitted written accounts, for the fact that RCIRCSA ignored the written accounts.

In addition, this submission detailed the devastating effects to victims of being ignored by the RCIRCSA.

Amnesty International also wrote a letter to the Prime Minister requesting he do this and stating that they had looked at the evidence in the submission given to the apology consultation reference group.

(This submission and the Amnesty International letter can be provided to PCI if requested.)

The 'survivor-focused' apology consultation reference group, which included representatives who are directors of child-abuse organisations, did not recommend that the Prime Minister include these in his apology.

Repeated requests were made to the apology consultation secretariat for transparency regarding what had been recommended to the Prime Minister. When asked directly, on the day of the apology, whether these requests were part of what they recommended to government, the chair of the reference group initially responded by stating that all submissions received were passed on to the Prime Minister. After the question of what had actually been recommended that he include in his apology was repeated a couple of times, she eventually responded that no, these requests had not been recommended. She walked away refusing to answer any further questions re this. The apology consultation secretariat kept saying the information about what had been recommended would be posted on the website, but it never was. A Freedom of Information request for what they did include was refused.

RCIRCSA left in its wake many victims who are extremely retraumatised by the disgusting way they were treated. An apology from the Prime Minister would not have fixed this, but it at least would have been an acknowledgement.

B.20. The role of the Family Court

It is beyond the scope of this submission to fully address this point. However, we would like to point out that the concerns repeatedly raised by others, including child abuse organisations, regarding the very serious issues with our Family Court system (see links below) also have ramifications in terms of ORTC.

Some of the children who the Family Court force to live with perpetrator parents (sometimes even when medical evidence has been presented to the court) are likely to also be at risk of being subjected to ORTC by the perpetrator parent.

The physical and mental health of children who are forced to live, have overnight stays, or spend time with a parent who is sexually abusing them is clearly greatly endangered: this can result in suicide.

<https://www.smh.com.au/lifestyle/the-family-court-has-a-serious-attitude-problem-when-it-comes-to-domestic-violence-20160501-goj6mg.html>

<https://www.news.com.au/lifestyle/parenting/teens/abbey-committed-suicide-after-years-of-alleged-sexual-abuse/news-story/b7241b950a04cb52c4a711edcb201148>

<https://www.canberratimes.com.au/lifestyle/life-and-relationships/family-court-reform-must-be-driven-by-child-safety-20190220-p50z5m.html>

<https://www.abc.net.au/news/2018-09-04/family-report-writer-used-in-court-referred-to-medical-council/10038516>

<https://www.sunshinecoastdaily.com.au/news/mums-told-to-keep-child-abuse-allegations-from-fam/3099754/>

B.21. Undue influence of the catholic church in our public institutions including parliament

For ORTC victims (and many others) who were victimised by the catholic church, the ongoing undue influence of the catholic church in our public institutions is an unending source of distress. The special treatment and deference afforded to the catholic church by members of parliament and other public institutions plays a significant role in enabling their ongoing cover-up of child rape.

Australian parliaments and other public institutions have refused to apply the same standards to churches, in particular the catholic church, that are applied to other organisations which engage in systemic criminality. Whilst the catholic church is not the only church, or indeed the only institution to benefit from the collusion of MPs to protect child rapist officials, it is certainly a striking example of this.

It is fair to presume that when it comes to politicians collusion with the catholic church, a primary motivator is the catholic vote. Church votes equal politicians turning a blind eye to church crime. Despite their continued proven cover-ups and refusal to accept responsibility for systemic child rape, the excessive funding to catholic institutions continues unabated.

In addition, by far the vast majority of our members of parliament remained silent when the Vatican refused to hand over files to the RCIRCSA. If documentation regarding systemic child rape was sent out of Australia by any other religion, to a nation that then refused to give the Australian government the needed documents, would our politicians remain mute? Why did they not sever diplomatic ties with the Vatican when they refused to give RCIRCSA the requested files?

The outpouring of support for George Pell, both before and after his conviction, from sitting and former members of parliament, including two former prime ministers, has been yet another kick in the head for victims.

This is exactly the same response that we as victims, have always had from those who cover up child rape: those in power protect each other, and speak loudly about how much they trust each other, whilst silencing and/or blaming the victims.

In addition to the no doubt very traumatising effect on the surviving victim in this case, the devastating effects for other victims, of MPs' continued protection of Pell include:

- reducing the likelihood of victims being believed when disclosing
- increasing the hopelessness of victims
- increasing the consequences of this hopelessness including self-harm, addictions and suicides
- lessening the likelihood of victims disclosing at all
- decreasing the willingness of victims to report to police or try to take legal action

B.22. Australian media very rarely gives a voice to ORTC victims and does not appear to be interested in investigating this issue.

This is relevant to the mental health of ORTC victims not only because it is part of why ORTC stays hidden, but also because it means ORTC victims never get to see their experiences reflected, and are never given the sense of connection and hope that can come from that. The majority of ORTC victims are extremely isolated; media coverage could help.

Not a single media outlet was willing to publish anything about RCIRCSA ignoring ORTC and written statements, despite the clear evidence given them, accompanied by the Amnesty International letter to the Prime Minister regarding this. (Some media refused to even accept a media release.)

They all filmed when Scott Morrison was asked questions he had no answers for: he knew nothing about the requests nor the Amnesty International letter. No media outlet aired that footage; they all aired the footage of him hugging victims; the acceptable feel good story.

The media had their script re RCIRCSA; i.e. that they did a great job. Whilst the media have scrutinised many other royal commissions they refused to do so with RCIRCSA. Why?

In terms of the issue of child sexual abuse overall, Australian media consistently gives much more of a voice to everyone else but the victims. In the year 2019 it is thankfully no longer acceptable to have panels discussing gay people that include no gay people, or discussing aboriginal people with a panel of only white people. But we have television programs including a recent Q&A and a recent 4 Corners both, that include everyone but an actual victim to discuss child sexual abuse in the catholic church. Why?

Whilst the media (and others) now make an effort to pay attention to domestic violence, child sexual assault still remains largely covered up. The statistics on child sexual abuse are actually worse than domestic violence, and children have considerably less opportunity to escape than adult domestic violence victims. Our media are complicit.

B.23. Some points re victim suicides

1. Child sexual abuse is a known factor in many suicides. It is likely also a factor in others where the victim has never disclosed. Forensic, child and family psychiatrist, Associate Conjoint Professor Quadrio told RCIRCSA there is a,

‘very strong relationship between abuse and suicide’.⁸⁹

There is no way of knowing how many suicides are the result of ORTC or other forms of child sexual abuse, however it is unlikely we will see much of a reduction in suicide rates in Australia whilst the epidemic of child sexual abuse continues unabated.

We, as a nation, desperately need to shift the focus of our mental health conversations from ‘What is wrong with you?’ to ‘What happened to you?’ Some of us have been stating this for decades. Many professionals are now calling for this shift to happen including the UK founders of the Power Threat Meaning Framework,⁹⁰ award-winning US paediatrician and author Dr Nadine Burke Harris,⁹¹ and Professor Alicia Lieberman, vice chair University of California, San Francisco, Department of Psychiatry and director, Child Trauma Research Program, San Francisco General Hospital.⁹²

Victims need to be heard, respected, and supported rather than ‘treated’.

2. We will never know how many suicides are actually the direct result of psychotropic drug effects and/or due to the person having unbearable ‘side’ effects from these drugs, which they have been told they will have to take for the rest of their life.

3. We also will never know how many victim (and other) suicides are related to the way the victim is treated by Centrelink, e.g. being taken off benefits and having no money for food and other essentials.

4. Many ORTC victims receive torture-based mind control programming regarding suicide, including that they must kill themselves if they disclose. If this fact was better known, ORTC victims could be better supported to deal with this programming. (Information regarding simple, practical ways that anyone can support victims in dealing with this are part of the document we are working on.)

5. Whilst it is clearly beyond the scope of PCI to address this, it is important to note that some deaths of child sexual abuse victims that appear to be suicides may in fact be murders: making a

death appear to be a suicide prevents further investigation. Child sexual abuse victims, especially ORTC victims, are given a range of threats by perpetrators, including death threats. Some victims are murdered after speaking up. (We can provide documentation regarding victim deaths after disclosing to authorities, that Australian police have investigated as murders.) Murder is also part of some forms of ORTC, see A.1.2.

(N.B. The StopORTC founder will never commit suicide.)

B.24. Involvement of perpetrators and enablers in positions of authority within public institutions and child abuse bodies and organisations

It is important to recognise that one of the reasons organised rape and torture of children, and other forms of child sexual abuse, remain covered up is that some of the perpetrators hold powerful positions within institutions. Child rapists can and do work in positions where they have the opportunity to influence the national dialogue and/or silence victims and protect other perpetrators.

It is highly likely that within any body established to address child sexual abuse there will one or more people whose intent is to prevent the whole truth from coming out. Sometimes the person with the most credentials, or the one who seems the most committed to addressing the issue is actually a perpetrator and/or enabler.

We point this out not to foster an attitude of paranoia, but rather because this reality must be understood if we as a nation are ever going to properly address ORTC and other forms of child sexual abuse.

Whilst there is no quick fix for this problem, greater transparency and accountability within government bodies and government funded organisations dealing with child abuse issues would be a start. **The public have both the right and the need to know when decisions are made, regarding the use of tax-payer funds, that allow ORTC to remain hidden. Whether these decisions are due to deliberate intent to cover-up or just a refusal to address the issue, the results are the same.**

The cards are drastically stacked in favour of ORTC perpetrators and against victims. Many perpetrators are respected members of the community, and some hold positions of power; the victims are often struggling just to survive whilst dealing with the impacts of child rape and torture.

In addition, we have had decades of successful concerted efforts by ORTC perpetrators to discredit victims, resulting in a large amount of media doing exactly that.

In order to work towards building a nation where children are no longer raped and tortured, and suffer the devastating physical and mental effects, which create a huge cost both to victims and to the economy, **the ongoing cover-ups of organised rape and torture of children need to be exposed.**

Many of us we were told as children that the influence of our perpetrators meant that Australian government authorities would never do anything to help us. The effect on our mental health, of the fact that the last couple of years has shown our perpetrators were in fact correct about this, is indescribable.

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