Royal Commission
into Family Violence

WITNESS STATEMENT OF EMMA TOONE

I, Emma Toone, Child Psychotherapist, of 1 Salisbury Street, Richmond, in the State of Victoria, say as follows:

1. I am authorised by Berry Street to make this statement on its behalf.

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

Current role

3. I am currently employed as the Senior Clinician, Turtle Program, Northern Domestic and Family Violence Service, Berry Street.

4. I have made a submission to the Royal Commission which is attached to this statement and marked "**ET1**". My submission is titled "Therapeutic responses for infants and children at escalating risk of family violence" and is supplementary to the submission made by Berry Street.

Background and qualifications

5. I am a Child Psychotherapist with experience working in community, educational and private consultancy settings.

6. Since January 2014, I have worked as a lecturer in Psychoanalytic and Developmental Theories, Child Psychotherapy Stream for the Master of Mental Health Science, in the School of Clinical Sciences at Monash Health, Department of Psychiatry in the Faculty of Medicine, Nursing and Health Sciences.

7. From June 2013 to June 2014, I took a 12-month secondment role at Berry Street working as a Clinician in the Western Metropolitan Regional Team of Take Two.

8. From January 2012 to 2014, I worked as a School Facilitator in the Peaceful Schools Program as part of an organisation called CASSE, facilitating student-driven solutions to violence and bullying within schools.

9. From February 2005 and continuing to the present day, I have worked offering psychotherapy to infants, children, young people and their parents in private practice.

10. I hold a Bachelor of Health Science (Naturopathy) from the Southern School of Natural Therapies, a Graduate Diploma of Psychoanalytic Studies from Deakin University, and a Master of Child Psychoanalytic Psychotherapy from Monash University. I am a clinical member of the Victorian Child Psychotherapy Association and the Psychoanalytic Psychotherapy Association of Australasia. I am also a professional and committee member of the Victorian Branch of the Australian Association for Infant Mental Health.

11. Attached to this statement and marked "**ET2**" is a list of key references which have informed the content of this statement.

The importance of a therapeutic response

12. The quality of children's relationships with their primary caregivers is disrupted by family violence. A child's relationship with their caregiver/s is the primary resource for their development and recovery after experiencing violence. Research has shown that working therapeutically with mothers and children together can be particularly effective in promoting children's recovery from family violence. In particular, the evidence suggests that therapeutic mother-child interventions of 12 months' duration decrease children's symptoms of traumatic stress, and depressive symptoms in the child and mother.

13. These models, and their healing effects on mother and child relationships, can be replicated in shorter time periods for mothers and infants in the perinatal period. In the United States, these models have also been adapted to be used effectively with older children and young people. Therapeutic support for children and parents together after a potentially traumatic incident (such as witnessing a physical assault) has been shown to decrease the child or young person's propensity to develop post-traumatic stress disorder.

The Turtle program

14. The Berry Street Turtle program is a small therapeutic service, which focuses on mother-child attachment and supporting the mother-child relationship as an effective vehicle for children's healing. The Turtle program is embedded within

Berry Street's adult-focused women's specialist family violence service (the Northern Domestic and Family Violence Service), which is situated in the Northern metropolitan sub-region of Melbourne.

15. The Turtle program was developed to:

    15.1. support the child's wellbeing and development after family violence;

    15.2. support mothers and their children affected by family violence to recover and strengthen their relationship; and

    15.3. build the capacity of practitioners in the service system working with children and mothers affected by family violence to engage more effectively with children directly, and to more effectively support mother-child relationship recovery after family violence.

16. The target group for the Turtle program can be divided into two main subgroups:

    16.1. Infants, children and young people who are living with their mum after she has just separated from their dad and they and their mum are high risk of further violence from their dad. This group are often in acute circumstances of justice responses, changes in housing, schools, and as yet family law arrangements may not have been instigated.

    16.2. Infants, children and young people residing in post-separation families, having contact with a non-residential parent with a history of using violence and who are below the threshold for statutory intervention.

17. Both these populations would not meet criteria for statutory services or associated therapeutic services. They may not meet criteria for other clinical services because they do not meet mental health diagnoses, because of the presence of family law proceedings, or the presence of protective issues (family violence risk). However, children in these groups may still suffer significant symptoms of distress and trauma, along with their mothers.

18. The Turtle program draws together existing expertise within Berry Street Family Violence Services and Berry Street's therapeutic and systemic focus on supporting children in the statutory system. We provide brief therapeutic support to children and mothers, in addition to increasing the skills of non-therapeutic practitioners to

feel better equipped to engage directly with children and mothers who have experienced violence.

The specific unmet need addressed by the Turtle program

19. At present, there are no specific statistics as to the number of children living in post-separation families with a history of violence, or who are in contact with a parent with a history of violence, and who may still be suffering significant symptoms of distress and trauma. However, we do know that the numbers are substantial, given that the ABS 2009-10 Family Characteristics Survey tells us that there are currently 879,000 single parent families living in Australia, and that we know that family violence is common before, during and after separation.

20. As noted above, both crisis and post-crisis groups of children may not meet criteria for statutory services, associated therapeutic services, or other therapeutic service options. Consequently, their experience of family violence renders these children and their mothers ineligible for support within the current system.

21. Children and infants affected by violence depend on parents and caregivers to be their voice in the adult world. Mothers who live with the fact of violence may doubt the service system can help. They may feel the best way to protect themselves and their child is to hide. The question is how to engage women to support them as mothers and to talk about their children's needs.

22. Programs that link risk management with therapeutic mother-child support can keep women and children safe, support the child's relationship with their caregiver, and build the capacity of both adult and child-focused services to respond to the mother and child in the context of family violence. A child therapist, enlisting the mother's primary practitioner as co-therapist can deliver brief mother-child therapeutic responses within a family violence risk management framework.

Framework of the Turtle program

23. The Berry Street Northern Domestic and Family Violence Service is the lead family violence service in the northern sub-region. Based on the understanding that violence and trauma in families can have a disruptive impact on mother-child relationships, the focus of the Turtle program is to strengthen this relationship to support children's recovery from trauma.

24. There are many complex challenges facing the service system in meeting the needs of children who have experienced trauma. Embedding child therapeutic specialists in services can build team and organisational capacity to provide child-centred trauma and relationship informed responses to support child wellbeing.

25. The Turtle program's approach is informed by:

    25.1. The Child-Parent Psychotherapy model developed by Alicia Lieberman and colleagues in the United States, "which describes a way of thinking clinically that focuses on strengthening the protective quality of the parent–child relationship with the aim of ensuring the child's healthy social–emotional development".

    25.2. The approach of the Berry Street Northern Domestic & Family Violence Service which combines a multi-agency partnership approach in responding to family violence risks, and a gendered and trauma-informed approach to engaging with women subjected to violence from their partners.

    25.3. The broader approach of Berry Street and Berry Street Take Two, in providing trauma-informed therapeutic support to statutory children and working with the system of carers around the child to maximize the therapeutic process. These children require an integrated and trauma-informed system where systemic work is part of the therapeutic strategy.

Referral pathway

26. Referrals to the Turtle program come from the following avenues:

    26.1. internally, from Berry Street services, including specialist family violence and family services; and

    26.2. externally, from mothers calling in directly with concerns for their children, from maternal & child health nurses, schools, child protection practitioners, and infant, child & youth mental health services.

Key service activities

27. The key service activities or interventions of the Turtle program are as follows:

Risk assessment

28. The work in the Turtle program occurs amidst the storm of practical and safety responses that need attention after family violence. Before Turtle can engage with the needs of a child and mother in her parenting role, a family violence risk management plan is required.

29. For internal referrals from within Berry Street Family Violence Service this will be undertaken in direct conversations with women seeking a service.

30. For external referrals, the practitioner discusses family violence risk assessment and management with Berry Street's specialist family violence service.

Delivery of mother-child secondary consultation

31. The Turtle program delivers a secondary consultation to the primary practitioner working with children and mothers. The secondary consultation focuses on the child's needs, women's experiences as mothers, and the mother-child relationship.

32. As part of the consultation, a dedicated reflective space of approximately 30 minutes is provided to the practitioner to help them think about the child and the woman in her role as mother to this child. This may include workshopping ways in which the practitioner may directly engage with the child and support the woman as mother.

33. A direct clinical intervention may also be offered if the Turtle child therapist and practitioner consider this necessary and the timing right.

Delivery of mother-child clinical work

34. This work is delivered to children and mothers together. It is preferable that direct clinical work be delivered alongside the primary practitioner who has an existing relationship or engagement with the family. This intervention seeks to directly engage children and mothers to support them to make sense of the violence, and the impact of violence upon their family. We seek to help mothers understand their children's needs after violence and family separation, and help them regain confidence in their parenting role. The focus is on engaging directly with children and includes modelling ways of listening and talking to children.

35. Child-focused work with mothers focuses on listening to women's experiences of being mothers after violence. An important part of this is to hear the mother's grief, anger and shock that may be part of her experience of separation. This includes feelings of fear and damaged self-esteem that may accompany her experience of violence. Decades of infant mental health research inform us that listening to mothers in this way will support her ability to hear the distress of her child and feel more confident in her role as parent. Put simply, mothers will have more 'in the tank' to respond to their often highly distressed children.

36. The Turtle program currently works with only one of the child's parents. It is vital for the child to hold the other parent in mind. It is important to recognise that children need to have their love for both parents respected, even when their father has hurt them or their mother. In order to help children feel able to feel loved and loveable, any mother-child work strives to understand a child's experiences of their father. Further, the work supports mothers to keep father's love for their children 'alive' in their child's mind especially following assaults or reduced contact.

37. Stopping the cycle of violence is important. Our work aims to help children develop non-violent and adaptive ways of managing strong feelings. For example, we might speak to the child about the fact that 'Daddy needed help with his angry feelings from the police. Perhaps he didn't get enough practice with feelings when he was little. We and mummy can help you with your feelings however big they feel'.

Delivery of follow-up support to practitioner

38. Following the delivery of child-focused parent work, there will be a follow-up support to the primary practitioners provided by Turtle. This includes time to reflect on the child and mother's experience of clinical session and what the practitioner may feel they have learned. This may also include discussion of future recommendations for the child (for example, liaising with the child's school, ways in which primary practitioner could continue to build on engagement with mother and allow space for child's voice, referral options for the mother individually, linking the child to group-work, etc.)

Limitations and future possibilities for working with children in the post-separation period

39. In the post-separation period acute practical and safety considerations have at least in part resolved. It is in this setting that separated families with concerns about

children's experiences of two households may feel able to commit to longer-term interventions to support their children and coordinate parenting. Longer-term interventions may facilitate repeated experiences of safety to help children overcome affects of trauma and feel safe and loved. To date our mandate has been working with children and their mothers only in a women's specialist family violence service. Indeed this is an appropriate model for the many children who do not have contact with their fathers, such as those living in acute circumstances.

40. However, Berry Street believe that where children are in contact with both parents interventions that consider opportunities for parallel work with both parents will be required. Alicia Lieberman and colleagues have developed clear criteria for the inclusion or exclusion of fathers who have used violence. It appears to Berry Street that the Lieberman model offers real promise toward a future workable Australian model that safely enhances a child's relationships with both parents. Further description of this model is included in my submission to the Royal Commission which is attached to this statement and marked "**ET1**".

Illustration of the Turtle program in action: two case scenarios

41. I set out below two case scenarios typical of the kinds of cases that may be referred to the Turtle program. I also describe the programmatic response to each of the scenarios to illustrate how the Turtle program does its work.

Scenario 1

42. This scenario relates to the first sub-group targeted by the Turtle program, being infants, children and young people who are living with their mother after she has just separated from their father, and where the children and mother continue to be at high risk of further violence from the father.

43. 3-year-old Sonia,* 6-year-old Ben and their mother Heather recently moved in with their grandma after their dad Andrew hurt their mum and bruised her neck. The children have not been able to go to their child care or school and their mum is having lots of meetings with police and adults they don't know. They have been stuck in the house and are beginning to argue and fight. Sonia has not left her mum's side and both children keep being woken up with scary dreams. They are missing their dad and asking when they can see him. Their mum doesn't know how

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* Names have been changed to protect confidentiality.

to talk to them. She worries she is a bad mother for taking them away from their dad. She is also missing Andrew, but worrying about how he will hurt her and her children if she returns.

Scenario 2

44. This scenario relates to the second sub-group, being infants, children and young people residing in post-separation families. They have contact with a non-residential parent who has a history of using violence.

45. 4-year-old Billy* and 7-year-old Jess's parents separated a year ago and they have been living with their mum Kate. They visit their dad John every two weeks and stay overnight. They both love their dad but wish that their dad but feel scared when he speaks about their mum to them. When they tell their mum what their dad has said, she cries. When the children are staying with their dad John, Kate is unable to rest. She remembers what it felt like to feel powerless with him. She wants the children to see their dad but is worried he doesn't notice their fear. When they return from their dad's, Billy wets his bed and Jess doesn't want to go to school.

Step one: referral and risk assessment

46. If either of these family scenarios were presented to Turtle for referral, our first step would be identical. A preliminary mapping and management plan for risk is a precondition for any therapeutic work. Thus a risk assessment and management plan would have been completed by the specialist family violence practitioner making the referral, or for external practitioners completed in consultation with a specialist family violence practitioner.

47. In Scenario 1, where a bruised neck may indicate a recent assault involving choking, we would be immediately alerted to the woman's high risk of intimate partner homicide. Thus if not already in place, we would direct the practitioner to consult with one of Berry Street's High Risk Coordinators regarding consideration of the family for presentation at Risk Assessment Management Panel (RAMP) to keep Heather, Sonia and Ben safe.

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* Names have been changed to protect confidentiality.

Step two: delivery of mother-child secondary consultation to referring primary practitioner

48. Depending on the role of the referring practitioner, we (at the Turtle program) would listen carefully to the practitioner's concerns about the children and their mother. We would strive to support their capacity to engage with the children and woman in her parenting role, and to help the practitioner bear witness to the children and mother's acute circumstances of distress. If it appears in the discussion with the practitioner that there is a window of opportunity where mother might be open to a visit from a child therapist, we would offer a primary consultation with them together.

Step three: delivery of direct mother-child clinical work

49. In relation to Scenario 1, we may deliver a mother-child session provided to mother Heather and children Sonia and Ben, together. Prior to meeting with the family, we would direct the primary practitioner to talk with Heather in advance of the session to identify possible activities that her children may feel comfortable with. This is part of working to align with women in their authority as mothers to then allow space for children to be acknowledged as well.

50. In the session we would work alongside the primary practitioner with the same intention. In the quiet moments of a therapeutic session, a child therapist can carefully observe children and the way they communicate, and facilitate their capacity to express feelings of worry, fright or sadness - for example feelings they may have about missing their dad and their house. Women can find it helpful to observe and learn from child therapists talking with their child, in a way that privileges and supports her in her mothering role. The therapist can also highlight to both child and mother the importance of their relationship with each other which exists beyond their experiences of violence.

51. For Scenario 2, assuming the presence of family court proceedings or shared parenting arrangements, we would be reluctant to provide a mother and child session together. In these instances, it would be usual for us to offer to meet with the mother on her own for child-focused parent work. The focus would be on supporting her to understand her children's experiences and to feel more equipped in her role and confidence as their mother to respond to their needs. We would strive to support her in obtaining sufficient individual support to support her wellbeing.

Step four: delivery of follow-up support to primary practitioner

52. In both scenarios, we would be available to meet with the practitioner to continue to support them in their daily role of walking alongside the mothers and their children. We would also support the practitioner in advocating within the system for the child's needs and the woman's needs as a mother.

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Emma Toone

Dated: 9 July 2015