Royal Commission
into Family Violence

WITNESS STATEMENT OF WENDY BUNSTON

I, Wendy Bunston, Senior Social Worker, Family Therapist, Infant Mental Health Clinician and PhD Candidate of La Trobe University, Bundoora in the State of Victoria, say as follows:

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

Current role

2. I am currently a senior consultant and trainer, working at my own business, wb Training & Consultancy. I am also currently a Research PhD Candidate and associate teacher at La Trobe University.

3. I supervise children's programs at a number of agencies in Melbourne, including Women's Health West Children's Workers, Banyule Council Maternal Child Health Nurses, Brimbank Council Maternal Child Health Nurses, Cradle to Kinder (Melbourne City Mission), Melton Council Family Services, and Children's Specialist Service – Hanover Housing Support Services.

4. Currently, through the Domestic Violence Resource Centre Victoria, I am running infant training on the topics of "'How to talk to Babies in Refuge, or the Counselling Room" and "Adopting Child-Led Practice".

5. In the past 18 months, I have provided training to multiple organisations across Australia and internationlly, including the Family Referral Service in Kempsey in New South Wales; Norcott, Coffs Harbour and Taree in New South Wales; Communities for Children, in Brimbank, Victoria; Centre for Research on Families and Children, The University of Edinburgh; Scottish Women's Aid; AVA (Against Violence and Abuse) in London; AUSMED education in Melbourne; and Australian Association of Infant Mental Health in the Australian Capital Territory.

Background and qualifications

6. I am a senior clinical mental health social worker, qualified family therapist and an infant mental health specialist with 18 years' experience working in the family violence sector.

7. From 1996 to 2012, I worked at the Royal Children's Hospital in Melbourne (the **RCH**) in the Addressing Family Violence Programs (**AFVP**). During this time, I developed a number of national award winning programs, including:

   7.1. Parkas (Parents Accepting Responsibility - Kids Are Safe) – this was a group work intervention program for children (aged 8 to 12 years) and their mothers;

   7.2. The Peek-a-Boo Club – this was a program for infants and mothers affected by family violence;

   7.3. BuBs (Building Up Bonds) on Board – this was a pilot intervention program for infants and mothers in refuges; and

   7.4. Dads on Board – this was a program for men who had participated in a Men's Behaviour Change Program, and their children.

8. In 2011, the AFVP ceased to operate. However, I continued to work at the RCH in a senior clinical role until 2012 and currently provide clinical external supervision to their specialist group work clinician.

Past Employment

9. From October 1994 to June 1996, I worked as a Senior Social Worker, Class 3 (Team Leader, Adolescent Protective Team) at the Victorian Department of Health and Community Services.

10. From April 1992 to October 1994, I worked as a Professional Officer, Grade 2 (Social Worker/Mental Health Officers) at Tuggeranong Mental Health Centre (Australian Capital Teritory – Health).

11. From December 1989 to March 1992, I worked as a Social Worker, Class 2 (Youth Counsellor) at Camcare Family Counselling and Support in Camberwell, Victoria.

12. From January 1988 to November 1989, I worked as a Social Worker, Class 2 at St Augustine's Adolescent & Family Services in Geelong, Victoria.

13. From 1983 to 1987, I worked as a residential child care workers and intellectual disabilities worker.

14. I hold a Bachelor of Social Work (with Distinction) from La Trobe University, a Masters Degree in Family Therapy from La Trobe University, a Graduate Certificate in Organisational Dynamics from RMIT, and a Graduate Diploma in Infant Mental Health (equivalent) from Royal Children's Hospital (The University of Melbourne). I am currently a PhD candidate at LaTrobe University and my doctoral thesis is examining how Refuge provides 'refuge' to infants, exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence.

15. I have undertaken significant research into the effects of family violence on children, focusing on research that centres on the child's perspective and experience of family violence, based on child-led observation. I have written and contributed to a number of articles and papers which set out my research. Attached to this statement and marked **"WB1"** is a copy of my current curriculum vitae.

16. I have made two submissions to the Royal Commission which are attached to this statement and marked **"WB2"** and **"WB3"** respectively. My first submission (**"WB2"**) is entitled "Infant-led research: a key to understanding the impacts of domestic violence on a vulnerable and under-represented population."

The impacts of family violence on infants and children

17. Young children and infants are the most vulnerable victims of family violence and are frequently present during episodes of family violence.

18. A child's development will be affected by their experiences of remaining in a home where there is violence and/or leaving that home to escape violence. A child living in such an environment is frequently in survival mode. Their brain is constantly flooded with chemicals to manage heightened states of arousal or disassociation, and is not able to thrive.

19. An infant's development is dependent on their relationship with others. From a very early age, infants are highly sophisticated in their capacity to process information. Infants have astounding cross-modal sensory capacities (namely, sight, smell,

vocalisations and hearing) which enable them to absorb information, imitate what they see and anticipate outcomes from a very early stage in life. An infant can receive information through one sensory system, and translate its meaning into another. A child is highly attuned to their environment and whether they feel safe in that environment. Where a child consistently feels unsafe and frightened, and their care giving environment does not attend to this or worse, the feeling state of the infant becomes dysregulated. This adversely affects the child's developmental pathways. We need to recognise that often the mother is experiencing her own traumatic responsesas a result of family violence and is not always available to provide a safe and nurturing environment for her child.

20. In my experience, children will communicate to us that they are not feeling safe and nurtured. For example, I have observed in the children's groups I have facilitated that some children will seek out the facilitators of the group over their own mothers, because the child can sense that the facilitator is more available to them as a caregiver. The mother may not have the capacity to engage with her child as she may be dissociating from the child as her own survival mechanism. The more regularly the mother shuts off from her child (and herself), the more the child's developmental pathways are affected.

21. Although there is extensive research demonstrating that early childhood exposure to family violence negatively impacts a child's development, there is little to no research about understanding the impact of family violence from the young child's perspective. This is even more so in respect of very young children and infants. There is no research on an infant's experience or perspective to living in a home with family violence. Additionally, there is no research on their experience of fleeing a home where there is family violence and how they then experience crisis accommodation. Too much we rely on the voice of workers and mothers over what children and even infants may tell us.

22. To understand an infant's experience of family violence requires us to observe and engage emotionally with them. The programs I have developed (as outlined below) focus on the perspective of the infant and child in situations of family violence, and seek to give those young children a voice in the research on family violence. Through these programs and in my research I have attempted to understand infants and their experience, what meaning the infant and young child is making of the family violence and how this will affect them and their development.

How we should research children's experience of family violence

23. Infants demonstrate a clear capacity to respond to their environment. Research shows that they have their own subjective experience and have the capacity to participate in the construction of meaning. This research is consistent with my experience of working with infants affected by family violence.

24. There are challenges in working with children and their experiences of family violence. The research method must respect the experience of the child who has been exposed to family violence and must not risk re-traumatising them.

25. The way in which children respond to family violence is more complex than we appreciate. In my experience, children do not view their relationships with their parents and/or caregivers in a rigid manner. Working with children who have been exposed to family violence is more complex than simply excluding the father from the child's life (in circumstances where the father is the perpetrator of violence). The child has the right to determine their relationship with their parents, subject to that relationship being safe for the child. Where that relationship may be unsafe, we need to consider alternatives as to how the child can have some form of relationship or connection with their parent. Another factor that contributes to the complexity of family violence circumstances is that there are often intergenerational issues at play.

26. I consider that the scant research regarding infants and children has too often adopted mechanistic and standardised measures to assess children, and therefore fails to take into account the complexities of a child's experience of family violence. In my opinion, research using such mechanistic and standardised methods seems all too often to be used to validate predetermined hypotheses, without considering the child's perspective.

27. In my experience, infant observation has proved a successful research technique. It is a well validated qualitative method which offers insight into a child's experience of family violence, whether that be in respect of a child living in an environment with family violence or fleeing with their mother (or primary caregiver) from those circumstances. Observational research is explorative and offers a sensitive, unobtrusive, contextually and developmentally appropriate way through which we can engage with infants and children, and build a foundation of knowledge not currently available.

28. Observational research ensures that the child is at the centre of the research (rather than the female victim or the male perpetrator, as is in the majority of the research), but also recognises the significance of the mother and other caregivers for the infant. This enables us to observe interactions between children and their parents, which is very important as the child's relationship and personal interactions with their mother and other caregivers are fundamental to the child's development.

Programs working with children

29. Each of the below programs that I was involved in developing and managing endeavoured to provide mediated opportunities for children and infants to emotionally and psychologically re-connect with their mothers and/or primary caregivers around what has often been a shared experience of trauma.

30. I am not aware of any other programs in Victoria, or even Australia, that have been developed specifically for infants exposed to circumstances of family violence. Programs currently in existence, such as Pairs and Baby Makes Three, are not specific to children experiencing family violence.

31. All of the programs I developed have been evaluated, to the greatest extent possible in a context accessing a highly ambivalent and very cautious client group. It was my experience that, because the programs I developed were within a mental health service setting, we were more able to evaluate the programs we were running than other community based programs have the luxury of doing. For example, for the Parkas program, we collected data from the "Strengths and Difficulties Questionnaire" (SDQ - Goodman, 1999) from the participants. For the Peek-a-Boo program, we collected a reasonable amount of standardised data (as outlined below). Should child and adolescent mental health services work alongside community based family violence programs, more specialised as well as evidenced based work may be possible.

32. It is critical that we assist children dealing with the trauma they suffer as a result of family violence. Such severe trauma is too much for children to process and overcome on their own, and left unattended, will alter their developmental pathways. This is why the programs I have developed, and program developed by others that are infant and child inclusive, are of such significance, both psychologically and economically, for our society.

Parkas

33. Parkas was started in 1996 as a program for mothers and their children, but the focus of the group was to be child-led. At that time, I was employed by the RCH Mental Health Program. Parkas was run collaboratively by the RCH Mental Health Program and Melton Community Health Centre until early 2000, when differing service demands prevented the partnership from continuing. After this time, the RCH team continued to run Parkas but also developed four new programs under AFVP – 'just for kids', BuBs on Board, the Peek-a-Book Club, and Dads on Board, through successfully accessing philanthropy support from the Victorian Women's Trust, The Grosvenor Foundation, Sidney Myer Fund and the R.E Ross Fund.

34. When we started Parkas, the comparable programs run for mothers and children at the time were based on a model of two groups (one for the mothers, one for the children), with different workers facilitating each of groups. The two groups would then come together at different points of the program. I did not consider this to be a successful model, as there were competing dynamics between the two groups. The result was that the children's group workers often felt disempowered by the mothers' group workers, as the mothers' group would drive the program. The programs were driven from the perspective of the mother, and as a result, the voice of the child was lost.

35. Based on this experience, my colleague, Helen Crean and I set up the Parkas program according to a different model. My colleague and I worked together with both the children's group and the mothers' group, and then supervised joint sessions between the two groups. We found this to be a successful model, much more so than programs where different workers ran the separate groups. I believe that because we ran all components of the program, we accelerated some of the developmental shifts in the child/mother relationship. Because we ran both groups, we were able to hold both child and mother in mind at all times.

36. We made sure that the children were at the centre of the program, by running the mothers' group based on the activities of the children's group. For example, in the children's group, we might ask the children to draw a picture of their family. Then, in the mothers' group, we asked the mothers to draw their family picture, but from the child's perspective. With the child's consent, we then showed the mother their child's drawing. The child's perspective of their family was often very different from what their mother assumed their perspective to be. This kind of activity was very

powerful for the mothers, visually as well as semantically. By helping the mother to see the world from their child's perspective, we gave the child permission to have a perspective.

37. The work we undertook in the Parkas program taught us very quickly not to demonise the fathers, who were generally the perpetrators of the violence. In the first Parkas group we ran, we talked to the children about their parents in absolute terms, for example, mum as victim and dad as perpetrator. However, we found the children did not respond well to this rigid way of categorising their parents, and in response, the children shut down. We learnt from this experience that when working with children, it is important not to deal in the absolute stereotypes that so often pervade the family violence sector. We need to recognise that the family unit is much more complex than the typically defined roles of mother and father.

38. Part of this complexity is that family violence is often intergenerational. We learned that it is important to work with the adult to re-connect them with their own experiences as a child exposed to family violence. We worked therapeutically with the mothers to help them get back in touch with their feelings as a child so that they could relate better to the own child's experience. Often this is very difficult for the mothers, because in circumstances where the mother has been systematically traumatised for a number of years, they become very disconnected with their feelings, as this is the only way they can survive in their world.

39. I believe that one of the reasons Parkas (and the other programs I have developed or co-developed) have had positive outcomes is because it enables mothers to engage emotionally. Programs that focus only on psychoeducational elements, namely, telling people what they should and should not do, are not effective in the long term. In my experience, learned behaviour does not get put into practice. To make a meaningful change, it is necessary to engage emotionally.

40. To date, the Parkas program continues to run on an ad hoc basis at the RCH. A colleague who remains at the RCH has and does run Parkas when other agencies express interest in running the intervention collaboratively, as there are currently inadequate resources available to run the program within the RCH. I then supervise these sessions in a private capacity. The Parkas program is not currently funded, and in fact, was never properly funded. However, a leading Victorian agency has begun the process of establishing Parkas and the some of the other programs mentioned as part of their service delivery.

The Peek-a-Boo Club

41. As stated above, the Peek-a-Boo Club was an initiative of the RCH Mental Health Program. It is a therapeutic program for infants aged 0 to 36 months and their mothers who have been exposed to family violence.

42. The Peek-a-Boo Club commenced in 2005. By November 2010, a total of 26 programs of 6 to 8 weeks had been run with 172 infants and their mothers participating. Groups were usually run in developmental clusters (i.e. 0-12 months, 12-24 months, and 24-36 months).

43. We established the Peek-a-Boo Club with the aim of positively re-aligning the relationship between child and mother, and subsequently, the developmentalpathways of the child. We recognised the neurological and psychological vulnerability of infants arising from exposure to highly stressful and violent environments, and worked with the children always bearing this in mind.

44. Similar to Parkas, the Peek-a-Boo Club used an activity based and interactive format to create a therapeutic arena for the infant and mother to form and consolidate a healthy attachment. This program is directed at infants because early intervention is so critical. A child’s ability to form healthy attachments is largely determined within the first few years of life. Early intervention is critical for infants exposed to significant trauma and relationship disruption. Early intervention is also critical to disrupting intergenerational cycles of family violence. The program aims to engage women and children early in a pathway other than one disrupted and damaged by family violence.

45. During this program, we collected a lot of data about the children’s and mothers’ experiences. The data was collected over a period of 5 years, from 30 groups. However, despite the amount of data we collected, there were significant gaps. This was mainly because we had a number of mothers from different cultures and some illiterate mothers who had difficulty completing the questionnaires. We published our findings in an article in the Australian and New Zealand Journal of Criminology. The evaluation could not be considered what is defined as ‘gold standard’ as control groups were not possible to include. The use of ‘control groups’ presents ethical issues for myself and my colleagues in the context of working with infants and children ‘at high risk’, as does withholding services in the ‘name of

science'. If you believe that a program is beneficial for children, it follows that you are acting contrary to the best interests of those children in a control group.

46. The Peek-a-Boo program was not large enough to include such measures due to insufficient funding. If more funding had been available, it would be the job of ourselves as facilitators to find better, ethical and more tailored measures to capture the experience of participants and evaluate outcomes. Research into attachment and brain development conclusively demonstrates that intervening as early as possible is crucial in the first few years with vunerable infants and their caregivers.

BuBs (Building Up Bonds) on Board

47. BuBs (Building up Bonds) On Board was a pilot group work intervention program for infants and their mothers, which was trialled in five Tasmanian women's shelters in 2008. The program had a dual purpose: to rebuild the bond between mother and child where it had been affected by family violence, and to skill shelter workers in the delivery of the program, ensuring they had an appreciation of the potential mental health needs of infants.

48. Data collected from this program showed an alarming number of relationships between mothers and their children were in severe distress, with the majority of infants observed to be suffering from significant developmental delays. Myself and a colleague from Barwon Health produced a comprehensive report about this pilot intervention with an article published in the Domestic Violence Resource Centre Victoria Quarterly in 2008. This article concluded that shelters are in an ideal position to do important and urgent work with infants affected by family violence to enhance the mother/infant relationship.

49. The report also concluded that it is important for specialist children's services, in addition to child and adolescent mental health services, to support the important work able to be undertaken in the Refuge setting. The Refuge setting caters for the most vulnerable and most at risk infants and children but is the most underserviced and unrecognised part of the family violence sector.

Programs for fathers and children

Why work with men?

50. The family violence sector needs to work with men because they cannot be ignored. In my experience, children very clearly demonstrate that they want their fathers to

remain in their lives. The child often has an attachment to their father, regardless of what the father has done or whether the father is the perpetrator of violence. Regardless of the child's opinion of the father, there will always be some form of attachment between a child and their biological parent.

51. Some children might experience their mother as being hostile and violence, and their father being more available to them, even in circumstances where the father is the perpetrator of violence. Alternatively, it might be that the mother is violent or there is reciprocal violence. Situations of family violence are extremely complex, and also include intergenerational issues. The family violence sector does not currently take into account this complexity.

Dads on Board

52. Similar to the Peek-A-Boo program for mothers and their infantsen, we established Dads on Board to be an infant led group work intervention program for infants and their fathers, in circumstances where the father has been identified as a perpetrator of violence.

53. To participate in the program, we required that the fathers had first participated in a Men's Behaviour Change Program. Generally, we would not work with fathers in the program who have had a clear and untreated mental illness, who have made threats to harm or have behaved in other ways to suggest it would be unsafe for the children, for example, where there is a history of the father taking off with the children. The father needs to substantiate that they are worthy of being in the child's life and willing to commit to building a better relationship with their child. We were very careful not to put the infants in a position where they might be emotionally or psychologically at risk.

54. Initially we conducted two successful pilots of the program. The third pilot was not as successful. There were a number of challenges to running this third program that were not present in the first two groups. We established Dads on Board to be focused on what was best for the child. If the child was uncomfortable attending a program with only their father present, then we needed to find a way to make the child comfortable. The program had to be run in a way so as not to further traumatise the child.

55. For that reason, we did not initially prescribe how the program should be run. We allowed the program to evolve according to our experiences. It so happened that all

except one of the mothers wanted to attend the program, so we allowed this to happen. The mothers took a periphery role, and let the fathers take the central role in the group.

56. The program was run by a male and female facilitator with a third facilitor, an allied health student. Having a male and female facilitator was, I considered, very important to the success of the program and how the fathers related to the program.

57. The objective of the program is to enable these fathers to develop healthy, safe and developmentally appropriate relational skills when interacting with their infants. As we had done in the programs for mothers, we sought to re-engage the fathers with their own experience of family violence when they were a child, to connect them back to how they felt as a victim. We facilitated the fathers' capacity to make sense of their own experiences, to recall their own experience of feeling vulnerable, and to then translate those recollections into how they now functioned as an adult and considering how their behaviour impacted their own children.

58. Assisting the fathers to emotionally connect with their own experiences was incredibly powerful in the context of the group with their infants 'in the room'. A good example of the significance of these interactions is one group session when we were sitting on the floor and little two brothers fought over who would sit in their mother's lap. The father sat close by, but neither child wanted to sit in his lap. Given the immediacy of what was playing out in front of us, the father was encouraged to reflect on the reasons why neither child was making use of his lap. We explored with the father whether he ever sat on his own father's lap as a child, why that was so and how that had made him feel. Each of these experiences we had in the group were always linked back to the father's own experiences as a child, to engage them. It is difficult for the father to ignore the child's response in these situations, and find themselves confronted with an emotional as well as a physiological response to their children, in addition to their own past experiences at the hands of their own parents. This then is the entry point for work.

Lessons learned and how we should work with children going forward

59. In my opinion, the main issue with the current programs and systems in the family violence sector is that there is little continuity. There is not much utility in constantly implementing new pilot programs that are not funded long term. It would be more productive to learn from, develop and improve existing programs.

60. The commitment to children's work in the family violence sector is severely lacking. Despite the compelling evidence about how a child's brain develops, there has been no shift in how we deal with children experiencing family violence. The family violence sector needs to move away from focusing on fixing the problems of the adults first, with the attitude that doing so will automatically also address children's issues. This approach is incredibly flawed as it is so difficult for adults to take on board any meaningful change. We should focus on children. The earlier we intervene, the more opportunity we have to make meaningful change in the child's life and to disrupt the cycle of intergenerational family violence. Additionally, infant and children, more often than not 'hold hope' for the possibility for change in the future, for both mothers and fathers. They want to do things differently to how they were parented. Children represent that possibility and for many parents are the motivation to enact this change.

61. Rolling out universal programs is not the solution to dealing with these issues. Often, the neediest families and the families most at risk are excluded from universal programs, and/or are wary of accessing them. Instead of implementing new programs, I think we should focus on re-skilling workers already working in the family violence sector with child specific skills. For example, we should have workers who specialise in children and infants to work alongside Men's Behaviour Change programs, and vice versa – the facilitators of Men's Behaviour Change programs working with children's groups.

62. I also consider women's refuges to be ideal places to target working with infants and children. Women and children living in a refuge (often having fled extreme circumstances of family violence) are usually the most at risk, the most damaged and traumatised victims of family violence. Workers in refuges often feel very under skilled in working with children and most certainly with infants. There are enormous opportunities to not only improve this but to engage the high risk families in work early. If we do this work well, and with adequate resources, it will not need to take an average of 7 times before mothers sucessfully leave extremely violent relationships. Infants and children can not afford to wait. Nor can we wait any longer in limiting inventive responses and including men as part of the healing, both as clients and as service providers.

63. I do acknowledge that programs working with infants and children in these ways are relatively new. While we continue to learn from experience as to how best work with infants and children who have been exposed to family violence, we need to

ensure that the children are always in a safe environment that does not further exacerbate their trauma. The success of how we are approaching this work currently is proving limited. Recognising and engaging with the severity of the emotional harm done to children, and of their caregivers as children, is begnning at the point at which this damage began.

Wendy Bunston

Dated: 8 July 2015