Case Example answers to Webinar 1 questions, Restoring Childhood – Take Two – Berry Street

Further in-depth discussion around keeping the infant visible during this time. How to do that dyadic work?

In working with two mums who have a 6-months old, are pregnant and have a 1 and 2-year old. The Restoring Childhood clinician is undertaking parent child focused sessions via telephone at this stage, as its difficult for parents to sit in front of the computer while juggling toddlers (unless the kids are asleep, but often mums are doing a million other things during that time). To keep the infants and toddlers central to the work goes right from the beginning of the intervention in partnering with the parent to develop the goals that are child and relationally focussed.

When the clinician starts sessions, one of the first questions they ask is - how are the children? This is to keep the focus of sessions about the children and the SC found that mums want to speak about their infants and toddlers and what's going on for them as they feel quite anxious as to the impact of Family Violence (FV) and the extra stress of COVID-19. There are some natural points of entry to the session i.e. when the kids are calling mum or when the infant is in the arms of mum. Sometimes sessions can have limitations surrounding what is spoken about, particularly with toddlers within earshot. This is challenging when mums want to talk about the children and their concerns including the joys of seeing their growth and development, which often can strengthen the parent-child bond.

Key points of therapeutic engagement with a family (dyad) online

More time is spent priming the non-offending parent for the dyadic session:

- What does the parent anticipate could occur in the online session? How do they imagine the child will manage during the time with interacting with someone on a screen?
- Reassure the parent the session is welcome to be child led and that the timeframe of the session will be based on the needs of the child and parent.
- Set up emergency contact procedure, for anything that may occur.
- Assist the parent to explore how they will speak to their child about the purpose of the sessions i.e.:
  "We are seeing someone today who is going to help us to talk about some of the things that have happened to us, they are going to help us. They have suggested that I set up the toys so that we can all play together." "what toys would you like to set up to play with?"
- Discuss what filming mode they have – Phone, Ipad, laptop etc
- Assist the parent to focus on an activity that will contain the session is important. Being in front of a moving screen for too long is fatiguing for the therapist and for a parent moving a camera around the room attempting to capture everything. Remembering the aim of a therapeutic session is to set up a safe and comfortable space for an interaction to take place. (this will also be based on the home life families set up, chaos might be their "safe and comfortable").

The following is an example of the types of engagements we have with our clients in dyadic work:

15-20 mins is focussed on engagement. Following the child's lead for exploration (showing the therapist *their* space) and setting up the tone for the session.

15 mins is spent introducing the purpose of the clinicians engagement or recapping the last session and using that discussion as a scaffold to bring the trauma memories explored into the room i.e. "do you remember in the last session, when you told me that daddy hurt mummy? Etc" "Well today we are gonna think about how you have kept yourself safe and who has helped to keep you safe… let's make a list of all your helpers". During this exercise the online whiteboard is/can be engaged – it provides a virtual interaction to occur between the therapist, child and mother. It involves bright colours, using stamps and drawing pictures (this is an application available online with Zoom, telehealth, Microsoft teams etc).

A final 15 mins is finishing play, wrapping up, summarising and focusing with the mother on a follow up session.

Importantly it was a session very much focused on the child and parent in their own space and the therapist is an adjunct to their engagement. Working in an office the clients come to the space that the *therapist* has created, whereas working online, the writer is invited into the space the *clients* have created.

The question is not so much about family violence, but around supporting a parent living experience of a mental health condition who seem to be spiralling down, feeling very isolated. It would be good to explore the impact of deteriorating mental health of the parent on the baby during isolation when the child only has that person to rely on.

This is addressed at the time of assessment (diagnosis or not and just general emotional wellbeing) of the mother including Post Natal Depression, which is explored and includes mental health supports they have in place i.e. General Practitioner, friends, family, Maternal Child Health Nurse, self-care strategies etc. The clinician explores this with mums and normalises the experience of having infants and toddlers is challenging, let alone in the context of COVID-19 and FV. Clinicians talking about mental health for all mums is important, right from the beginning of therapy. The transparency at the start helps mums to reflect how their mental health impacts on their parenting capacity, so that together the clinician and parent can work towards ways of reducing the impact it then has on their child/children.

What can staff do to improve safety for children who are living across multiple homes (e.g. following separation) and where the PUV is using the child / children's tech devices to continue to control the family?

This is a tough question and often Restoring Childhood would refer to the Berry Street FV team or WESNET Safe Connections (www.wesnet.org.au) to see if there are any technological strategies and/or resources that can be utilised to increase safety. However, a Restoring Childhood clinician has recently worked with a young person where awful power and manipulation using tech occurred, which impacted on the young person's mental health. Firstly, the clinician used Safe and Together principals on their file notes to document the emotional and mental health impact the perpetrators pattern had on the young person (in case it went to Court). Secondly, the young person felt alone and not knowing who to trust, was confused and a forced messenger. For the clinician, the priority was how to promote emotional safety for the young person during this time e.g. strategies for when their father did this, talking about things with their mum to fact-check, and therapy provided the 'safe space' for the young person to explore these issues, rather than them carrying the burden on their own.

Additional practitioner resources discussed in the video and referred to in this document

1. *Working Together with Men to Prevent Violence Against Women*
   Created by Shelly Hewson-Munro & HealthWest Partnership
   https://wtwm-healthwest.nationbuilder.com/

2. *SAFE & TOGETHER Model COVID-19 Quick Practice Guide*
   https://safeandtogetherinstitute.com/evidence-resources/covid-19-case-planning/

3. *Infant Response Decision Tool*
   https://www.cpmanual.vic.gov.au/sites/default/files/2991%20Infant%20Response%20Decision%20Tool.pdf