Webinar Responses from Dr Karen Gaunson, Child Psychiatrist, Mindful Centre, The University of Melbourne

- Being unable to keep eyes on the children is the biggest concern

This is a significant concern that many share – some children who normally have have network of people looking out for them have been isolated. We do not know how many of them have been getting on. We do know the risk of being exposed to abuse of their parent (often their mother), direct maltreatment & neglect of their needs is likely to have increased.

- 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?

The courts are open with family violence being fast tracked in the family court Remind people that some behaviours are unlawful & will entail consequences for them now & in the future. Using COVID19 as a justification for escalating past patterns of abusive behaviours is not seen as OK by the Family Court. It is important to seek advice from police & legal professionals. Chat rooms are available if it feels unsafe to use the phone. Excellent webinars are available on the Law week 2020 website. The Office of the e-Safety Commissioner website has useful resources.

- Not being able to get through

Think about their past pattern of engagement with you. Consider keep trying to contact them by different means – email, sms & phone. Contact the referrer/ other professionals who have been previously involved to see if they have seen them recently. Medicare now funds mental health interventions via phone and videoconferencing. This means many private practitioner can more flexibility meet people where they are as they put safety plans in place.

- Being unable to keep eyes on the children is the biggest concern

If an infant is not brought into sight through the screen, they might not be being held in mind. Some caregivers do not act on bruising by seeking medical assessment. Some infants lives have been saved when other concern adults do. It is surprising to many that infants can still move their limbs after they have been fractured. Give caregivers permission to move around attending to what the infant needs. Avoid replicating the "still face" or people feeling they are unable to move. This can lead to a dissociated state and increase the anxieties re being monitored /judged/looked at cf related to and understood. Invite caregivers to bring the baby into the session, where we can include them directly in the therapeutic conversation. Look at the camera when you are speaking not at your own image. Be aware of your hands getting bigger as they approach the screen. Move backwards in the room to create a sense of space – allow for each person's whole body to be seen so you can read

each other's non-verbal cues. This also creates more space to be playful with the young children.

- Trying to access the mother on her own to be able ask questions regarding how she is really feeling when faced with the partner who is always present during the phone consult

Respect her choice not to talk with you – she might be doing what she can to protect herself & the children. It might not be a safe time. Chat rooms are being used more often than phonecalls in higher risk situations. Some women will find it safer to access help by others means – trust in her resourcefulness & her other professional social connections which might be more acceptable/less threatening to the perpetrator. I have found people come back to me at different points of their lives when they have more significant symptoms, losses or distress. Often they want to talk through some obstacles they are facing to inform their decision making. It is fabulous to see the progress they make in between episodes of care.

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

Schedule sessions according to the infants daily rhythms & caregiving needs. Ask about their day. What do they enjoy doing? How are they soothed? Be curious and interested in their experience – be playful. Talk about what you notice especially moments of shared joy & attunement. Ask if what is happening is usual for them – if not, why not? Ask about those moments where they can't settle their child and whether they feel connected.

- 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.

Despite mental health literacy improving along with reductions in stigma & improving access to digihealth & primary & second tier service support – there can still be fundamental confusion about what might be wrong in the perinatal period. Professionals often feel stuck re what can be done to help those parents with more severe and complex difficulties. Earlier direct assessment by a mental health professional of the symptomatic family member can inform the care team's approach to supporting the family. It can also reduce unhelpful myths & speculation and bring a focus to the meeting tangible goals. There is a long way to go in many areas of Victoria before people facing multiple adversities are predictably able to access timely, evidence informed & compassionate mental health care. I am waiting to see if the Royal Commission into Mental Health prioritise this life stage & invest in very young children and their families. Over the past two decades availability of perinatal and child mental health services has reduced. Too many people are suffering.

Recommendations:

1. *Prescribe active coping – what do they enjoy doing? What has worked to calm them down in the past? E.g/ walking the dog, drawing, playing solitaire, playing music from their teenage years, sorting through their photos.*

2. *Speak about what you have noticed about them & ask about what has been happening in their lives. Overt fears of seeking help & self stigma. Validate how difficult it is. Normalise aspects of their experience (grief, uncertainty) which are shared, whilst highlighting any safety concerns or more significant symptoms that need to be addressed. Provide them with information re options & empower them to take charge with how they go about the next step in seeking help. Talk about what is likely to happen at each stage & what the goals of seeking help are – clarify roles. Highlight the central role they play in their child's life & how if they don't take care of their mental health it will be much harder for them to meet their child's needs – actually increasing the risks for their child. Bring hope & provide context by reminding them of their "angels" in the nursery, what they have overcome & how they have functioned in the past. Connecting them with memories of feeling soothes, loved and understood can bring great confort along with feelings of grief/ missing people.'*

3. *Encourage caregivers to reconnect with their trusted social network – join, back-up & strengthen their network of supports cf taking over/ competing/undermining trust. We all rely on other people to think and function at our best. No-one can go it alone. Some people need to rely more on professionals supports for a period of time whilst they rebuild a social support network.*

4. *It is essential to share information regarding inter-sectional factors which compound child safety concerns. Given legislative changes protecting a parent's privacy is no longer a valid reason to withhold safeguarding information. It is not your secret to keep and sometimes children can't wait until their parents capacity to keep them safe improves. Shifts in cultural norms are needed to overcome people's bias, obstacles to warm referrals & to build bridges between siloes.*

5. *If the infant or caregiver is symptomatic you might be able to seek an expert opinion through secondary consultation through your local CAMHS/CYMHS. The more referrals they receive the greater the pressure will for those services to be funded. There is expertise available which is underemployed.*

6. *Place based stepped care is available in some regions – primary consultation in a familiar setting, where the family already attends, conducted along with the referring practitioner is an excellent option to make sense of what is happening and what help options are available.*

7. *Consider the red flags & discrepancies in the information you have be given. What are you not being told? Has the mother re-partnered? Sometimes the new partner who they might turn to for care & is just out of view is placing them /the infant at*

risk. How does this new relationship impact on her caregiving & the child's wellbeing ? List the risk factors in this family for infanticide / severe child maltreatment & intimate partner homicide. It is important to look beyond the surface objectively so timley action can protect children. You are not doing anyone a favour by not acting on your intuition by sharing your concerns if there is a tragic outcome.

8. *Have a working knowledge of the symptoms of mental illness & how to access help through the local system (which might seem to be constantly changing & about to undergo reform). People's presentations and diagnoses can change over time – don't rely on out of date or hersay information. Risk assessment is dynamic & tailored to the individuals situation. If someone has suicidal ideation make sure they have been asked about infantical & homicidal thoughts, plans & urges. This should be done routinely. It can be very difficult for some people to even think about the possibility of child maltreatment let alone talk about how to reduce the risk. Denial is only healthy when it is adaptive.*

9. *Upskill in trauma informed practice – so anything you provide is more likely to be harm & trauma reducing than trauma inducing. There are many excellent resources available.*

10. *Check in with professionals who know them well – the GP is a key person to help determine how they are travelling & what else they might need. They are often someone who has known them overtime and is trusted by their extended network. Some people feel less at risk of escalating family violence if their partner sees them attending the GP or consulting over telehealth, than trying to contact a family violence service.*

11. *Seek professional supervision, peer to peer support or a referral for mental health care if you are finding the work challenging. I am part of a writing group #mindingCovid which is publishing a series of handouts for frontline healthcare worker wellbeing during the pandemic. Check out the Pandemic Kindness website, the Mentate referral service or the Hand-in-Hand peer to peer support group on Facebook.*