Little Children, Big Outcomes

Using creative therapies to assist children under five with trauma recovery from family violence in rural communities.

Van Go Children's Creative Therapies:
a program of WRISC Family Violence Support Inc.

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This report is the outcome of the Little Children, Big Outcomes project, conceived by Sally Goldstraw and funded by UFS Dispensaries & Helen Macpherson Smith Trust.

Written by Cath Mackie MCAT - Little Children, Big Outcomes Project Officer - with generous support from:

Project Steering Group members:

Libby Jewson - WRISC Family Violence Support – Executive Officer

Ash Milne – WRISC Van Go Children's Creative Therapies Program (CCTP) – Team Leader

Project Reference Group members:

Ash Milne – WRISC Van Go CCTP – Team Leader

Chloe Gyorosi – WRISC Van Go CCTP Little Children Big Outcomes Project Administration Support

Karen Bendelle – Moorabool Shire Council – Family Support Officer

Kathryn Bell – Darley Kindergarten - Nominated Supervisor

Skye Petrie – Berry Street - Restoring Childhood Program Clinical Team Leader

Cheree Cosgriff – Ballarat Health Services - Grampians Families where a Parent has a Mental Illness (FAPMI) Co-ordinator

Mikala & Funbi – WRISC Family Violence Outreach Program – Moorabool Outreach Case Managers

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Contents

Introduction

WRISC

WRISC Family Violence Support Inc. (formerly Women's Referral Information and Support Collective) was established as a feminist collective in 1989 in Ballarat. Over time the agency has grown and developed a governance structure of an Incorporated Association with a Board of Management. The agency currently has forty-one staff: employing twenty-six part-time staff, three full-time staff, and three casual staff, with five students and four volunteers. The central office is located in Ballarat while a second office opened in Darley in 2017. The agency has four teams - Aboriginal Family Violence; Van Go Children's Creative Therapies; Family Violence Outreach and Corporate teams. WRISC supports the recovery of women and children after experiencing family violence in the Central Highlands region of the Department of Families, Fairness and Housing (DFFH).

Van Go Children's Creative Therapies Program

The Van Go Children's Creative Therapies Program (Van Go) emerged from the Van Go Project. The Van Go Project was a WRISC children's counselling initiative that operated in Moorabool Shire for two years from 2017 as one of twenty-six demonstration pilot projects funded by Family Safety Victoria. In 2019, WRISC, Berry Street Restoring Childhood Program and Ballarat Community Health (BCH) formed the Central Highlands Family Violence – Creative and Therapeutic Services (FV-CaTS) consortium partnership, which subsequently received ongoing Family Violence Therapeutic Intervention funding through Family Safety Victoria.

The Van Go model has eight key design principles (SVA Consulting, 2018):

1. Van Go is a child-led service with children's voices at the centre of everything we do.
2. Van Go provides a client-centred service and tailors each service to individual clients and families based on needs.
3. Van Go uses trauma informed creative therapies to work with children and their families who have experienced family violence. Play, art and music are the natural languages of children and allow them to express themselves and work at a pace that is suitable for them.
4. Van Go is flexible, creative and adapts services to the needs of the local community through taking time to understand a community's needs and adapting service offered. Creativity, problem solving and adaptation are highly valued.
5. Van Go staff are highly trained with master's degree qualifications. The expertise of the therapists ensures that clients are receiving the best possible therapy.
6. Van Go partners with local councils to deliver its service. By partnering with local council, Van Go staff can work collaboratively with other universal services to access local knowledge and resources to provide more accessible and appropriate support.
7. Van Go seeks to influence the system for the benefit of children – we collaborate with other services to ensure children and families access the best possible support. Van Go also seeks to educate other services about the impact of family violence on children and trauma-informed child-led approaches to therapy.
8. Van Go removes barriers to accessing services by using their mobile therapy van and online services to improve access to support for the most vulnerable and disadvantaged families. Van Go also provides services in non-stigmatising local venues and at local schools so that clients can access services in their local community.

The Challenge

The Central Highlands Family Violence – Creative and Therapeutic Services (FV-CaTS) partnership provides women's and children's therapeutic interventions to families with lived experience of family violence throughout the Central Highlands region. Van Go currently provides children's therapeutic interventions in Moorabool, Hepburn, Golden Plains and Ballarat Local Government Areas (LGAs), while Berry Street covers Ararat, Pyrenees and Ballarat LGAs and BCH provides women's counselling across the whole of the Central Highlands region. FV-CaTS hopes to secure further funding in order to expand service offerings in response to need across the region. Van Go has been fortunate to receive ongoing funding, celebrates working with its consortium partners and continues to provide high quality services to children impacted by family violence.

Under the previous pilot funding Van Go offered the following services in the Moorabool LGA alone: therapeutic case management; single session therapy; child centred play therapy; music therapy; creative arts therapy; women's counselling; filial therapy; various group programs to children of all ages and parenting psychoeducation. Ongoing funding is at lower levels than pilot funding. Van Go has adapted to provide children's individual creative therapy and single session therapy over a much a larger geographical area (an additional three LGAs). Many group programs, women's counselling, filial therapy and therapeutic case management are no longer offered. Van Go is pleased to offer a specialist creative therapist for Aboriginal children, however this one part-time position covers four LGAs. There has been a reduction in the therapeutic services available to children and their caregivers who have experienced family violence in the Moorabool LGA.

The most notably affected by these service changes are children under the age of five years old in the Moorabool LGA. Van Go is no longer able to offer this age group specialist programs such as filial therapy (educating carers on how to use play therapy techniques at home to support their children) or Circle of Security (a psychoeducational group for caregivers focussing on parenting and attachment) or individual caregiver support or therapeutic case management. Children under the age of five are limited in their ability to participate in the service as it is currently funded as they are too young to attend individual creative therapies and require a specialist response to their needs. Coupled with this challenge is a tripling of referrals received by Van Go, which coincides with two important factors. Firstly, The Orange Door has opened in the region (a central point of access that assists with referrals to a range of family violence services) and is equipped to identify the therapeutic needs of child clients. Secondly, the COVID 19 pandemic has placed families experiencing or recovering from family violence under exceptional strain and has seen a nearly 20% increase in the rate of family violence in Moorabool LGA (Crime Statistics Agency, 2021).

Moorabool children under five and their caregivers who require specialist support in their recovery from family violence, have no option but to access mainstream counselling services. While the Moorabool community can offer many rich and varied supportive experiences to families, many of which have therapeutic benefits, it is hard to deny that a specialist family violence response to infants, young children and their carers has been lost to this community. There is now a gap in services offered to very young children which provide a co-ordinated, consistent and relational care and supports their transition towards robust health after family violence (SVA Consulting, 2018)

The Response: The Little Children, Big Outcomes Project

Van Go is flexible and creative. Van Go adapts to the needs of the local community and seeks to influence the system for the benefit of children. Van Go is not shy of a challenge and sees this problem as an opportunity. Van Go knows that there is still a high demand for child-led services

counteracting the adverse childhood effects of family violence for children under five in the Moorabool LGA. Van Go is grateful for the support of the Moorabool community, especially their partners Moorabool Shire Council and seeks to create an opportunity to give back.

What if we took the time to look at the evidence base for therapeutic interventions with children under five who have experienced family violence?

What if we took the time to understand the needs of the Moorabool community and describe an approach to service delivery that addresses their needs?

Thanks to the support of UFS Dispensaries and Helen Macpherson Smith Trust the Little Children, Big Outcomes project has become a reality. This report is the outcome of a project whose aim has been to develop a sustainable creative therapies model for children under five years old in their recovery from family violence, specifically for rural communities. Creative therapy programs support caregivers to improve connection with their child through art, music, play, dance and movement. This restores trust and the capacity for healthy emotional development, physical and intellectual growth and school readiness.

Trauma from family violence jeopardises the healthy social, emotional and cognitive development of infants and toddlers. The lack of specialised therapeutic programs which target recovery for pre-school infants and toddlers creates further disadvantage in rural communities. This project utilises a strengths based framework and invites rural communities to co-design local solutions to ensure greater access to therapeutic services for very young children and their carers recovering from the impacts of family violence.

The reflection and planning phases of the Little Children, Big Outcomes project have researched best practice therapeutic interventions for children under five to assist in their trauma recovery from family violence. The project has explored collaborative service responses to benefit young children in the Moorabool Shire and has developed an accessible 0-5 creative therapies model for the Moorabool community that can also be expanded to other under-resourced rural communities. It has also developed a pathway for families and services to navigate in seeking support for very young children who are recovering from the trauma of family violence.

The original proposal for the Little Children, Big Outcomes project included children aged 0-4, which can be stated alternatively as children who are not yet five years old and children who are not yet in primary school. In the beginning stages of the project the target age group was updated to include children aged 0-5 in acknowledgement of the significant numbers of children who are five years old but are not yet in primary school (Hanley, et al., 2019).

Family Violence

Understanding family violence

Family violence can be described as:

> A pattern of abusive behaviour through which a person seeks to control and dominate another person… [Family violence] is ongoing behaviour that gradually undermines a victim's confidence and ability to leave the violent person. The severity and frequency of violence often escalate over time. Family violence includes…physical violence…sexual, emotional, social, spiritual and economic abuse…in heterosexual relationships research shows that men are most likely to be perpetrators and women the victims…. Children and young people also experience violence when they live with and/or witness violence between other family members. (Domestic Violence Resource Centre Victoria, 2021)

It is important to note that this definition is not inclusive of same sex relationships, where family violence does occur and children are also present (Laing, et al., 2013). Nor does the mainstream understanding of family violence as gender based violence adequately address the needs of Aboriginal and Torres Strait Islander women (Blagg, et al., 2018) (see Intersectionality section below).

Impacts of family violence on women

Family violence is the leading cause of death, illness and disability for Australian women under forty-five years old (New South Wales Government: Communities and Justice, 2019). 80% of family violence homicides are perpetrated by men with a history of family violence against female partners, and of the small number of women who kill their male partners, the vast majority are victims of family violence who have killed their abuser (Australia's National Research Organisation for Women's Safety, 2019). There is a strong correlation between relationship separation and family violence escalation and lethality (National Domestic and Family Violence Bench Book, 2021).

Family violence is the main cause of homelessness for women and children (Australian Institute of Health and Welfare, 2020) and has a range of significant impacts on women's health. Family violence perpetration creates significant mental health issues such as depression and post-traumatic stress disorder (Laing, et al., 2013). Victim/survivors can experience physical injury, increased long term health concerns, anxiety, sleeping and eating disorders, increases in substance use, suicidality and social difficulties (Anderson & van eE, 2018). The physical and mental health impacts of family violence create a vulnerability to further abuse, where a perpetrators behaviour compounds the effects of depression with financial vulnerability, social isolation and the manipulation of medical intervention (Laing, et al., 2013).

Impacts of family violence on the mother-child (dyadic) relationship

The term dyad simply means something with two parts. Here we are referring to the relationship between a victim/survivor and their child as the dyadic relationship. The perpetration of family violence impacts women as mothers by undermining family functioning and targeting the mother-child relationship directly (Laing, et al., 2013). Children require safe, secure and healthy attachment relationships with their primary caregiver for healthy social, physical and psychological growth and development (Leiberman & Van Horn, 2011). McLaren refers to the dyadic experience of family violence as physical, social, emotional and financial abuse that intentionally divides a mother from their child through breaking "…the maternal bond and trust between the mother and the child…"

(2013, p. 442). Women "may be less available to their children and attachment relationships may be compromised, particularly with infants and toddlers" (Laing, et al., 2013, p. 81).

Family violence can impact parenting behaviours. For example, violence can go unacknowledged and not discussed in the home, even after it ends. Harsh or punitive parenting can occur as a result of keeping children well-behaved in order to avoid aggravating the perpetrator. Some studies have observed poorer quality parenting and a lack of warmth and affection towards children in the context of family violence (Anderson & van eE, 2018). A mother's mental health has usually been undermined by abuse (Katz, 2015). Women can experience family violence related posttraumatic stress disorder which impinges on her ability to read the cues of her infant (Bunston, et al., 2020). A woman who has secured safety for her child is expected to behave as the refuge for her child, regardless of her capacity to do so. There is an expectation that traumatised women will be the sole source of physical and emotional safety for their children and a commensurate under-estimation of infant's active experience of their physical and emotional environment (Bunston, et al., 2020).

It is worth noting here that the dyadic relationship is also the source of motivation for change. Women often attribute the reason for leaving family violence to their infants and children (Bunston, et al., 2020). Many strengths are observed in mothers experiencing family violence, including acting as 'emotional anchors' for their children, demonstrating adaptive coping mechanisms to ensure child wellbeing, and mediating distress in chaotic family situations (Anderson & van eE, 2018). Infants and young children have agency and are capable of manoeuvring the dyadic relationship towards joint recovery (Anderson & van eE, 2018) (Katz, 2015).

Impacts of family violence on children under five

Family Violence can begin with pregnancy and women who are pregnant or caring for newborns are significantly more likely to experience family violence than women who are not (National Domestic and Family Violence Bench Book, 2021). Perpetrator behaviours include preventing access to antenatal care, threatening the involvement of child protective services, and physical assaults that are more likely to target a woman's breasts, genitals and abdomen. An unborn baby can be physically harmed by assault, have lower growth rates, lower birth weights, higher risk of miscarriage or early labour. Lower breastfeeding rates and difficulties with attachment relationships can emerge in mothers of newborns experiencing family violence (Centre of Perinatal Excellence, 2021). Infants have their own feeling states, trauma experiences and physiological memories of trauma (Bunston, et al., 2020).

> Infants… have a mind, which is developing and which is highly attuned to his surroundings. Babies are born with complex sensory capabilities and are highly sensitive to the harm that chaotic, unreliable and volatile relational environments can inflict, both psychologically and physically (Bunston & Sketchley, 2012, p. 12).

Recent Victorian crime statistics indicate that most family violence incidents witnessed by children and recorded by police involve intimate partners, with male aggressors and female victims. The majority of child witnesses were young, with 35% of child witnesses aged under five and 66.1% aged under nine. Regional Victoria experienced a higher incidence of family violence than metropolitan Melbourne. In addition, in relationships with children, assault and repeat incidents were more likely to occur over a longer period of time and involve Intervention Orders and Safety Notices (Crime Statistics Agency, 2021). Young children's dependence on and physical proximity to caregivers renders them more likely to be present during family violence incidents (Bunston, et al., 2020) (Anderson & van eE, 2018).

Child abuse and family violence are linked (Laing, et al., 2013) - where family violence against a woman is severe and chronic, there is a drastically increased likelihood that the family violence perpetrator is also physically or sexually abusive towards her children (Laing, et al., 2013). Children can be left under supervised or neglected amongst severe family violence perpetration, for which mothers are frequently held accountable. This co-occurrence of abuse and neglect and family violence is referred to as poly-victimisation and leads to adverse outcomes in children (Laing, et al., 2013).

The trauma of living with family violence perpetration can be understood as relational, in that it occurs within the interpersonal environment. Such trauma is also seen as complex trauma, that is, trauma that is repeated, interpersonal and occurs during crucial developmental periods. Infancy and early childhood are periods of significant brain development. Complex relational trauma, such as that caused by family violence, negatively impacts the developing brain and therefore social and emotional development (Schore, 2013).

Children who have been exposed to family violence display heightened distress, trauma symptoms, behavioural problems, poor emotion regulation, low self-esteem, attention difficulties, poor adaptive functioning and maladaptive blaming of their mother or themselves for their experience of violence (Anderson & van eE, 2018). Relationships with both parents are impacted, with young children in particular having a developmentally appropriate wish to please both parents, which can be taken advantage of through "..coercive control [that] could severely harm their emotional/psychological, social and physical wellbeing and their educational achievement" (Katz, et al., 2020, p. 322). Changes in relationships with parents are important to young children and the way loss and grief is made sense of by young children impacts their emotional development and future relationships (Bunston, et al., 2020).

Risks to children beyond separation

There are further risks to child safety, wellbeing and development from family violence during and after relationship separation. Separation is a period of high risk of family violence and is sometimes when family violence begins (Federal Circuit Court of Australia, 2013). Risk from ongoing abuse is especially high where children are involved, as shared parenting access and child care arrangements increase a mother's risk of exposure to a perpetrator's behaviours. Some perpetrators weaponise children, using them as tools for surveillance and intimidation of their mother (Laing, et al., 2013). Some fathers perpetrate coercive control over their children during access, alternating between dangerous fathering (threatening), 'admirable' fathering (making the children feel responsible for his well-being) and omnipresent fathering (creating continual fear in children) thereby trapping children in a constant and harmful state of distress (Katz, et al., 2020).

Systemic problems have been identified where statutory services expect maternal protective action while taking little interest in post-separation fathering, whilst Family Law presumes that shared parenting is in the best interests of the child. Where there is family violence this enables ongoing abuse of women and children (Fitzroy Legal Service, 2021). A mother's experience of systemic barriers to wellbeing and safety are dependent on her capacity to prove allegations of family violence (Fitzroy Legal Service, 2021). Family Violence is a factor in a high proportion of filicides, including post-separation murder suicides. The risk of child fatality from abuse co-occurring with family violence is real (Laing, et al., 2013) and is highest among 0-4 year olds, with hospitalisations from assault injuries higher in infants under 1 (Bunston & Sketchley, 2012).

Perpetrator accountability

Mandel talks about the way children experience family violence in terms of the perpetrator's actions to undermine family functioning, including the choice to expose their children to their violent behaviour and target their children in order to control their partner (2016). He argues that using the term 'witnessing' obscures the 'dynamics of the abuse and the responsibility of the person creating the harm', making it harder to respond effectively to the needs of children and families and skewing professional concern towards mothering deficits. Mandel proposes alternative statements such as a 'father who continues to put his children at risk of violence and abuse' as a means by which to ensure children's needs are identified adequately by professionals.

Anderson and Van Ee acknowledge an absence of useful terminology in their international systematic review of literature about therapeutic interventions with children exposed to family violence (2018). They suggest a change to 'violence by men' in order to shift the focus away from women's 'problematic' parenting and towards the root cause of the problem, that is, violence perpetrated within relationships, usually by men. Allen (2004) notes that therapeutic interventions are vulnerable to 'mother blaming'. She points to an increase in social concern about child wellbeing and vulnerability and a fascination with the idealised mother as having increased the focus on mothering as the source of children's problems. She argues that "an individual's mothering practices [are] scrutinised and found wanting when measured by the idealised mother image… and is covertly practiced on the least powerful mothers in our society. Responsible and ethical therapeutic practice should re-evaluate its approach to gender, power and parents" (Allen, 2004, p. 69).

Intersectionality

It is important that our understanding of family violence encompasses the 'diverse experiences and vulnerabilities' of children, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, people in same sex relationships and women with disabilities (Laing, et al., 2013). Intersectionality requires us to understand that different aspects of people's identity can lead to overlapping discrimination and marginalisation, increasing the risk of family violence and placing systemic barriers in the way of accessing support (State Government of Victoria, 2021). For illustrative purposes, we will discuss Aboriginal and Torres Strait Islander families~~,~~ but acknowledge that heightened vulnerability to family violence and challenges to accessing support exist for many Australian families.

For Aboriginal and Torres Strait Islander women and children, family violence occurs within a context of 'colonisation, systemic racism and class inequality' with gendered violence sitting among multiple threats to safety and wellbeing (Blagg, et al., 2018). For professionals working with Aboriginal and Torres Strait Islander families it is important to not only understand that 'family' includes the "…complexity of Indigenous kinship relationships" (Laing, et al., 2013, p. 5) but also, that violence is not limited to violence within the home. Further to this, we can embrace the well documented strengths and diversity of Aboriginal and Torres Strait Islander child rearing practices, such as a collective community focus on child rearing, supporting children to have responsibilities and freedom to explore the world, and the importance of elders and spirituality to family functioning (Lohoar, et al., 2014).

Child removal

Women who have been subject to family violence perpetration are also at risk of being treated poorly in the child protection system where there is evidence of harmful entrenched cultural practices (Humphreys, et al., 2018). Women are assessed for their failure to protect their children

and there is a commensurate demonstrated lack of intervening with fathers as perpetrators who put their children at risk of harm. Such practices are destructive, increase risk to women and children and 'strengthen the power of the perpetrator over the family' (Humphreys, et al., 2018). This is compounded by a perpetrators threats to remove a victim's children using systems such as Child Protection and the Family Court (Queensland Government: Department of Child Safety, Youth and Women, 2018). Government responses to Aboriginal and Torres Strait Island peoples' experience of family violence have been ineffective and in the "Indigenous welfare system children and families are receiving different, and more interventionist treatment" (Tilbury, 2009, p. 62). Women, especially Aboriginal and Torres Strait Islander women, are rightly afraid of losing care of their children as a result of engaging with services.

Grandparent carers

Grandparent carers form a significant proportion of out-of-home care referrals to Van Go. We have observed that grandparent carers face challenges in their caregiving role as they contend with: social isolation; an inability to access supports that are available to carers in the foster care system; juggling sudden full-time care of young children with their employer's expectations; increased risks to their own safety; relationship breakdown with their grandchildren's parents; and supporting children with challenging behaviours resulting from trauma from family violence. The Van Go demonstration project offered grandparent carers in Moorabool a successful grandparent specific filial therapy group program. The Little Children, Big Outcomes therapeutic intervention model will endeavour to respond to grandparent carer's unique support needs by ensuring they are included in program offerings.

Embedding safety, respect and recovery in program design

Professional responsibility in this service delivery environment necessitates an understanding that trust is not automatic. Many women and children have experienced poor service responses or systemic failures as well as perpetrator's actions to deliberately undermine their trust in services. Recovering from relational trauma whilst simultaneously supporting very young children to do the same is an enormous task and sits within a social environment that has unreasonable expectations of mothering. An appreciation of this context supports practitioners to avoid mother-blaming when encountering maternal ambivalence and inconsistent engagement. Relational trauma brings with it intense feelings of shame and guilt for women and children. Adopting a strengths based service delivery approach supports workers to recognise existing capacities in women, children and the dyadic relationship and supports the development of trust in self and relationship.

Safety is not a given in the post-separation environment. Shared parenting access and care arrangements cannot be assumed to be static and need to be discussed regularly in order to adequately assess and respond to associated family violence risks. Young children have agency and are frequently women's motivation for change. A child-led approach to therapeutic practice embraces children's agency and dyadic recovery as well as necessitating a strong position on child safety. Open and honest discussions with families around limitations to confidentiality regarding child safety are required and support the development of trusting relationships (Bunston, et al., 2016). If a notification to child protection is necessary, it is important to involve women at all stages of the process where it is safe enough to do so.

Collaborative practice

There are multiple lenses through which to view family violence (for example: gender, mental health, public health, child safety…) illustrated by the range of services within the sector working to

support family violence victims and perpetrators. It is inevitable that different perspectives bring both challenges and benefits to collaborative practice. The purpose of collaborative practice is to enhance victim/survivor safety and autonomy and to increase perpetrator accountability. Effective collaboration between agencies is made possible through fair and inclusive leadership, tackling differences in power between agencies and establishing a shared purpose (Laing, et al., 2013). One intended outcome of the Little Children, Big Outcomes project is an increase in collaborative practice in the Moorabool LGA in support of increasing the wellbeing of children under five who have experienced family violence.

Responding to trauma

Healthy childhood social and emotional development and the role of attachment

Before birth, prenatal sensory experiences help shape the brain and nervous system and prepare the infant for attachment (Commonwealth of Australia, 2019). Children from birth to five years in age are in a period of rapid brain growth and development, their stress response systems are developing, they are developing strategies with which to manage their feelings and they are forming the ways they think about relationships (Ippen, et al., 2011).

A baby thrives in a "…confluence of beneficial biological, emotional, social, and cultural processes" (Leiberman & Van Horn, 2011, p. 4). Infant mental health can be described as "… the optimal social, emotional and cognitive well-being of children … developed by secure and stable relationships with nurturing caregivers" (Australian Association for Infant Mental Health, n.d.). Good mental health in infants and young children includes "…being able to play, learn and be social with others; having healthy relationships and close bonds with family and friends; managing feelings and responses in a range of situations; being able to cope with challenges; having a positive outlook and developing and having good self-esteem" (Royal Children's Hospital Melbourne, n.d.).

Children grow and develop physically, socially and emotionally within relationships that feature sensitive and consistent caregiving. Sensitive caregiving refers to the "…caregiver's ability to notice and respond to a child's signals in a way that fits with the child's needs" (Mesman, 2018, p. 2), and forms part of the process that builds up the development of attachment.

> Attachment is the biologically based need by infants to maintain proximity, particularly at times of distress, to their caregivers. This proximity helps them to regain emotional and psychological balance which provides them with the confidence to return to exploring the world. The research evidence is increasingly showing that early life experiences and close relationships have a large impact on later mental health and wellbeing (Isobel, et al., 2019).

The attachment process is made up of the hundreds of thousands of daily social interactions between a child and their caregiver. These are known as attunement interactions and are the process by which the infant learns to understand emotional responses in others and to develop their own responses. Healthy attunement refers to interactions that communicate interest through touch, facial expressions, vocalisation, eye contact and gesture. The baby and caregiver read each other's cues and respond accordingly (Cain, 2006). Schore (2000) describes how attunement experiences inform the development of neural pathways that support regulatory function such as respiration, heart rate and emotional regulation. It is by first experiencing regulation through the caregiver that a person develops the neurophysiological structures to regulate themselves (Schore, 2000).

Young children manifest their agency, their learning and their development in play and non-verbal communication. Children are keen explorers who make sense of their world through play. From birth, children respond to and explore their environment – it's sounds, smells, textures, tastes and sights. In doing so their brains develop quickly and lay foundations for later learning. Their exploration occurs in relationship - children thrive when adults are able to support them to take time to explore, repeat, look and ponder. Adults can learn much about children in watching them play,

observing children's attention, their sounds and their facial expressions. This observant stance allows children of all ages to initiate communication - smiles, glances and vocalisations and to develop as social beings (Kolbe, 2009). A parent who recognises their child as a person with "wishes, desires and intentions" is able to "provide opportunities for growth, curiosity, play or stimulation" (Byrne, et al., 2019, p. 681).

Trauma recovery in children

A child's brain develops rapidly in the first five years of life. Long lasting and excessive stress, such as that caused by family violence, is known as toxic stress. Toxic stress "… can have a negative impact on brain development… Ongoing stress factors that are not buffered by caring and positive relationships disrupt brain architecture leading to a lower threshold of activation of the stress management system, which in turn can lead to life long problems in learning, behaviour, and both physical and mental health" (Commonwealth of Australia, 2019). Early intervention is recommended to ensure good outcomes for children exposed to toxic stress (Commonwealth of Australia, 2019).

Resolution of trauma in children is unlikely to be a verbal process. Early memories such as those formed in early childhood are felt implicitly in the senses. When traumatic memories are triggered in young children they are not experienced as a conscious memory of the past but as immediate and felt experiences in the present. Ongoing distress makes it difficult for older children to form explicit memories that make sense of their experiences and place memories more safely in the past (Siegal, 2006).

Recovery occurs with attuned caregiving that responds to a child's signals (Siegal, 2006). Just as young children thrive and develop within relationships they also heal from trauma within relationships. "Loving parental care has unmatched transformational powers in restoring the child's developmental momentum in risk situations" (Leiberman & Van Horn, 2011, p. 5). Developmental neuroplasticity means that while relational trauma might impact the structure and functioning of a young child's brain, children's brains can also repair from relational trauma in a stable and nurturing caregiving relationship (Isobel, et al., 2019).

Attachment focussed early intervention

Children under five who are exposed to family violence perpetration are at increased risk of adverse health, developmental, social and psychological outcomes (Laing, et al., 2013). Early intervention provides early support to children at risk of poor outcomes by reducing risk factors, increasing protective factors and preventing the progression of problems into long term conditions (Early Intervention Foundation, 2021). Early intervention responds to signals of risk and is not required for all children who have experienced family violence (Katz, 2015).

Early intervention programs that aim to address the quality of parent-child interactions tend to focus predominantly on one of three areas: behaviour; attachment; or cognitive development (Asmussen, et al., 2016). Attachment focussed relational repair interventions are preferred over other dyadic interventions for their ability to respond to the specific relationship needs of young children who have experienced family violence (Laing, et al., 2013). Attachment interventions have been shown to substantially reduce risks for vulnerable children (Asmussen, et al., 2016). Attachment focussed interventions have been found to be evidence based, high cost and high impact (Asmussen, et al., 2016). There are multiple attachment intervention approaches with no one intervention standing

out as the best, as interventions are best when individualised to a family's needs (Isobel, et al., 2019).

Cultural competence

The principals and patterns of attachment are widely accepted to be universal across cultures (Gregory, et al., 2020). There are, however, very important cultural differences in the ways in which caregivers from different cultures are sensitive and responsive to infants (Yeo, 2003). Attachment theory when applied to Aboriginal and Torres Strait Islander people must be based in Aboriginal and Torres Strait Islander cultural values if we are to avoid continued removal of Aboriginal and Torres Strait Islander children from their families (Yeo, 2003). A child, for example, who seeks out multiple caregivers may be misconstrued as having indiscriminate attachment when in Aboriginal Australia multiple mothering can be common practice and provide children with a secure base (Ryan, 2011). When working with Aboriginal and Torres Strait Islander families it is important to look beyond the dyad to multiple attachment relationships including "…land, extended family and spirituality" (Gregory, et al., 2020, p. 116).

Trauma recovery in adults

Laing (2013) warns that family violence creates a unique and complex form of trauma, where abuse is housed within a relationship that also features love and care and is therefore confusing for victims. It is crucial that the effects of trauma are understood to be the effects of victimisation rather than a woman's internal psychology. It is also important that therapeutic interventions occur within a service environment that seeks social change and actively works against secondary victimisation, such as victim-blaming, by adopting practices such as critical reflection and clinical supervision (Laing, et al., 2013).

Recovery from relational trauma can be understood to require three stages of intervention – firstly, the establishment of safety (managing and stabilising symptoms and establishing self-care); secondly, the exploration and processing of traumatic memories; and thirdly, rebuilding life and reconnecting with community. The first stage can take some time and requires a focus on the body, the environment and safe interpersonal relationships (Herman & Kallivayalil, 2019).

The Little Children, Big Outcomes project is interested in how best to meet the needs of women at varying stages of trauma recovery. Mothers and female caregivers in the early stages of trauma recovery are in the process of managing their own trauma symptoms and establishing self-care, whilst at the same time caring for traumatised young children. This a difficult task within a dyadic-relationship that has been undermined by violence. For some dyads full recovery requires women to engage in deeper therapeutic work that attends to trauma exploration and processing. Relational safety is required in order to begin processing trauma, including intergenerational trauma (Isobel, et al., 2019). After early stage trauma work is complete and safety and basic trust in relationships has been re-established , deeper trauma work can occur (Herman & Kallivayalil, 2019).

Intergenerational trauma and challenges with attachment

Dyadic work with caregivers and children has two important roles: to improve parental responses to child signals and to support parents to reflect on their own experiences and reactions (Isobel, et al., 2019). Complications can occur in parental responses to children and parental self-reflection when the parent has experienced trauma in their own childhood. In many circumstances the removal of risk factors can enable parents to become more sensitive to their infants and therefore promote

secure attachment (Isobel, et al., 2019). In other families, intergenerational trauma complicates and challenges attachment relationships.

Intergenerational trauma can be described as the transmission of relational trauma from one generation to another; that is, where an adult has experienced relational trauma in their own childhood and transmits this trauma to their child through their resultant attachment and interaction styles (Isobel, et al., 2019). It is important that services provide safe and sensitive support to women who are in a caregiving role and are dealing with: the impacts of relational trauma from their own childhood; recovering from trauma from family violence in adulthood; and supporting their children in their recovery from relational trauma. Bunston (2020) reflects on the importance of services holding the mother in mind so that she in turn might hold her baby in mind, so that they may thrive in safe and sensitive caregiving.

Three types of attachment focussed parent-child interventions have been found to be effective in improving attachment where intergenerational trauma exists: parent-infant psychotherapeutic interventions, video-feedback models and mentalisation-based treatment (MBT) (Gregory, et al., 2020). The Little Children, Big Outcomes project chooses not to adopt video based interventions in preference for 'live' dyadic work, where intergenerational issues are more likely to be present in the here and now and children are engaged as an active contributing participants in relational growth and recovery (Bunston, et al., 2016) (Isobel, et al., 2019) (Anderson & van eE, 2018).

Important concepts in psychotherapeutic and MBT approaches include:

- Ghosts and Angels in the Nursery (Bunston & Sketchley, 2012) – 'Ghosts in the Nursery' refers to Fraiberg, Adelson and Shapiro's concept that a parent's past relationships as a child have taken up residence in their current relationships with their own child. Psychotherapeutic approaches that support parents to explore their childhood suffering and affirm their rights as a child to safe caregiving can help parents to develop empathy towards themselves as a child and consequently develop empathic responses to their own children. 'Angels in the Nursery' is Lieberman, Padron, Van Horn and Harris' acknowledgment that a parent's positive childhood experiences of safety, love and care can be drawn upon in promoting sensitivity, strength and capacity in caregiving (Bunston & Sketchley, 2012).
- Mentalisation - refers to the skill of being able to "imagine and to be attuned to mental states in self and others" (Byrne, et al., 2019). It is an important skill in adults and children. Parents who model mentalisation (through holding their infants distress in their mind as separate from their own, that is, they hold their child's mind in mind) support their child to develop mentalisation skills and therefore a sense of self, and demonstrate sensitive caregiving and healthy attachment relationships (Isobel, et al., 2019) (Byrne, et al., 2020). Poor mentalisation skills are understood to be connected to a parents' experiences of maltreatment in childhood and result in their baby being 'lost to view' (Byrne, et al., 2019). Mentalisation-based treatment (MBT) interventions with parents and dyads have been shown to be effective with supporting attachment relationships (Byrne, et al., 2020).

Child-led dyadic interventions

Dyadic therapy offers a significant treatment opportunity for intergenerational trauma. The caregiver's early trauma experiences are explored in the here and now, as evoked by the dyadic relationship (Isobel, et al., 2019). In dyadic therapy the client is not mother, nor baby "…but the dynamic dyad of both" (Coulter & Loughlin, 1999). Mother and child attend the therapy together

and the therapist "…approach[es] the infant as an equal therapeutic partner" (Thomson Salo, 2007, p. 974). "Infant-led work sees the infant to be as critical to the recovery of families traumatised by violence as the adult carers are" (Bunston & Sketchley, 2012, p. 10). Children are active, engaged participants in the therapeutic process. Therapeutic attuning to the child's feeling states supports dyads to feel hopeful and contributes to children's agency (Thomson Salo, 2007).

An infant-led dyadic therapist offers attunement to the child through curiosity and wonder about the child's internal world (Bunston, et al., 2016). An infant led therapist will model attuned interactions with infants, but teaching is not the purpose of the therapeutic work (Thomson Salo, 2007). For caregivers, witnessing a child's interactions with the therapist can bring the infant into view. They may begin to see child as valuable and "…less damaged than they feared" (Thomson Salo, 2007, p. 967). For parents of children who display challenging behaviours, the experience of their child being seen in a positive light by others might be a novel one, and can support shifts in the dyadic relationship (Mackie & Hopkins, 2017). Shifts in infants encourage shifts in caregivers. Therapists support parents by holding their painful feelings and interacting with the infant as subject rather than object, while helping parents to make sense of their experience of their infant (Thomson Salo, 2007).

Creative therapies

Children "…often use art and play as if they were a primary language" (Urquhart, et al., 2020, p. 94). Creative therapies adopt an experiential approach to psychotherapeutic practice, using creative modalities within a therapeutic relationship to achieve emotional wellbeing (The Australian, New Zealand and Asian Creative Arts Therapies Association, 2021). Dyadic child-led creative therapies mediate the barriers between the adult verbal world, the sensory/pre-verbal world of infancy and early childhood, and the non-verbal embodied experience of trauma. Creative therapies do this by offering dyads rich opportunities for attuned communication, supporting the growth of a shared non-verbal language between adult and child (Mackie & Hopkins, 2017).

Practice experience tells us that creative processes in a therapeutic environment are able to offer a sense of safety to the dyadic relationship, where mother and child can begin to explore interactions that they find difficult. Eye contact can be made safer when it forms part of a game with music and movement. Eye contact can also be explored through open ended child-led looking games through a stained glass window which the dyad has made together out of cellophane and contact. Mess, which has become frightening whilst living with the perpetrator, can be tentatively explored in the therapeutic environment. Making playdough together from scratch can offer a messy experience that comes together in the end and reveals a child's sensory preferences in play as they explore the dry and wet ingredients. In the therapeutic environment the dyad can be supported in relational safety to discover shared delight within challenging experiences.

Mutual enjoyment supports mothers to see themselves in a positive light, building confidence for further play (Coulter & Loughlin, 1999). When adults engage in play that communicates with infants, the infant understands that the other person enjoys them and their sense of self is extended (Thomson Salo, 2007). It is crucial that arts and play processes are used therapeutically with an attuned spaciousness that allows participants to see what children offer up (Coulter & Loughlin, 1999). An environment where children can express and show themselves offers an environment in which they can be seen "…perhaps for the first time, as himself rather than as a confirmation of [his mother's] own poor self-esteem or extension of her past abuse" (Coulter & Loughlin, 1999, p. 71).

> "Trauma resolution in adults may best include a combination of verbal and nonverbal psychotherapeutic approaches aimed at developing safety, affect regulation and control…constructing a narrative that acknowledges trauma and its effects but also establishes a self and a life outside of trauma" (Isobel, et al., 2019, p. 11).

Creative therapies have much to offer adults in trauma recovery because they are sensory and body based interventions that do not rely on the use of language for processing (Malchiodi, 2020). The body is a source of trauma memory and the active nature of creative processes can bring relief from trauma reactions (Malchiodi, 2020). Creative therapies can support trauma survivors to reconnect with their bodies in a safe way, in the present moment, by exploring the physicality of art materials or the sensory experience of movement (Sigal & Rob, 2021). Therapeutic arts processes can be used to support the transformation of trauma-laden stories into the creation of a meaningful narrative that supports identity and builds a life beyond trauma (Malchiodi, 2020).

Group work

The purpose of group work is in offering a rich therapeutic environment which can support dyads to make rapid positive shifts in their relationship, rather than to reduce waiting lists or provide cost effective interventions (Bunston, et al., 2016). Group work with women who are recovering from family violence provides a powerful antidote to the isolation imposed by perpetrators. Group work has the potential to counteract perpetrator messaging that women are to blame for their abuse, provide a platform for activism, and support women as the strongest form of assistance their children have had in surviving family violence (Laing, et al., 2013). Group work offers women a 'plane of equality' to combat shame and rebuild capacities for relationship that have been undermined by violence (Herman & Kallivayalil, 2019, p. 2). Very young children in creative therapeutic groups with peers have been shown to develop in their fine and gross motor skills, social engagement, creative play and emotional awareness (Van Lith, et al., 2018). In dyadic groups, women are offered the opportunity to experience that other mothers have difficulties, and they can begin to feel supported by their sharing and understanding. Women are witnessed in successful attempts at positive interactions with their child and can therefore start to see themselves in a different light (Coulter & Loughlin, 1999). There are times where individual work is clinically indicated over group work, for example, where a woman or a child is so thoroughly overwhelmed by relationships that a group setting might be distressing for themselves or other group members (Herman & Kallivayalil, 2019).

Supervision

Clinical supervision provides a reflective space where professionals are supported to think through the work they are doing. Clinical supervision improves family violence practice through helping professionals to: respond appropriately to risk; be aware of themselves in their practice; and avoid impatient rescuing through imposing solutions on clients (Laing, et al., 2013). Reflective practice can support professionals to be aware of the social context of clinical practice (Healy, 2000), supporting practitioners to avoid harmful practices such as victim-blaming (Laing, et al., 2013). Therapeutic group work with dyads who have been affected by family violence is complex, chaotic work and practitioners require frequent supervision to ensure they are meeting each family's needs. Bunston argues for weekly supervision to support group dyadic work, noting that supervision increases facilitators emotional regulation, in turn supporting facilitators to offer this to the group (2008). A skilled supervisor can support therapists to use the reflective space to offer a rich depth to therapeutic group work (Bunston, et al., 2016). Frequent supervision improves dyadic practice

through supporting therapists to hold the baby and the mother-child relationship in mind (Bunston, et al., 2020).

Evidence based approaches

What is evidence?

The intention of the Little Children, Big Outcomes project is to develop an evidence based approach to responding to children under five who have experienced family violence. Evidence based practice relies on the hierarchy of evidence, indicating that the best quality evidence comes from systematic reviews and meta-analyses of randomised control trials (University of Canberra Library, 2021). This type of evidence is drawn on in the Little Children, Big Outcomes model development and offers us a clear understanding of effective treatment strategies. In weighing up research evidence on parent-child interventions it is important to compare like with like - behaviourally focussed interventions can appear more successful than attachment focussed interventions, however they are evaluated differently, which renders them difficult to compare (Asmussen, et al., 2016).

It is important to note that the hierarchy of evidence can obscure existing biases in scientific research (Goldenberg, 2006). For example, criticisms of research conducted in the field of treatment interventions for children affected by family violence include the absence of children's voices and a focus on mothering deficits (Anderson & van eE, 2018). Research that corrects this bias shows us that women act protectively, support their children emotionally and resist abuse while children employ numerous coping strategies (Katz, 2015). Evidence based practice requires practitioners to consider the best available evidence *and* clinical expertise *and* a client's characteristics, culture and preferences (American Psychological Association, 2021). Rich clinical expertise can be gleaned from Van Go practice experience as well as the academic writing of clinicians, such as Wendy Bunston and Cathy Humphreys, who have included children's and women's voices in their work.

What does the evidence tell us?

Anderson and van eE (2018) conducted a systematic review of randomised control trials, investigating how existing psychosocial interventions with mothers and children impacted by family violence adapt to meet client needs in individual and dyadic sessions, and the mechanisms by which change occurs. Their review led them to investigate outcomes of separate (interventions that occurred simultaneously but separate from each other), joint (dyadic interventions with no individual support), or combined interventions (separate interventions for mother and child with dyadic sessions attended together).

Separate interventions address the unique needs of the individuals in the mother-child dyad and can result in positive impacts on the dyadic relationship, and therefore positive outcomes for the untreated member of the dyad. Anderson and Van eE found that children under five are more receptive to their mother's treatment than older children (i.e. showing improved outcomes without treatment themselves) (2018). Separate interventions for mothers addressed a range of topics such as communication skills, safety planning, making community connections, problem solving, developing parenting skills, decreasing parenting stress, enhancing self–esteem and mental wellbeing. Separate interventions for children addressed mastery of behaviour, managing feelings, dealing with conflict between peers, recognizing violent behaviour in others, keeping safe and taking responsibility for their own behaviour. Positive results in children's wellbeing and parenting capacity/skills were observed in separate interventions (Anderson & van eE, 2018).

Dyadic interventions attend to the relationship needs of mothers and children impacted by family violence. Anderson and Van eE found that dyadic work increased maternal empathy and acceptance of the child, improved parental sensitivity and limit setting, decreased maternal distress, reduced

harsh parenting, improved mother-child interactions, improved children's play functioning, and improved conduct in children (2018).

Combined interventions offer attention to both the therapeutic needs of the dyad and the individuals within the dyad. Anderson and Van eE found very positive outcomes in both women and children in combined interventions, so much so that this is the treatment style they recommend (2018). There were a range of treatment approaches in both the separate and dyadic elements of combined treatment interventions studied, including both individual and group therapy.

Anderson and van eE's (2018) research reaches the clear conclusion that combining individual and dyadic interventions provides the greatest overall benefit to women and children in their recovery from family violence. Individual work in combination with dyadic work enables women to attend to their own needs for safety and trauma recovery whilst developing and practicing attachment focussed parenting skills. Further to this, play based responses were found to support young children's agency in the recovery process and support women to enhance their interactions with their children (Anderson & van eE, 2018). Children's contributions to the dyadic relationship are understood to be a key mechanism for important shifts in family violence related trauma recovery, both for mothers and for the dyadic relationship (Isobel, et al., 2019).

Key elements of recovery – existing strengths, safety, therapeutic intervention and community

Anderson and Van eE acknowledge that participating in a combination of individual and dyadic therapies might prove challenging for families with young children recovering from family violence, as they are likely to be contending with instability in a number of areas of their life (2018). It is important that interventions are provided in ways that are respectful of this challenging context, attending first and foremost to family safety and stability (Holt, et al., 2008). Recovery for women, children and the dyadic relationship is hampered by inadequate housing and ongoing violence post-separation and during access visits. Case management support is valuable in overcoming barriers to recovery (Katz, 2015).

Once the basic conditions for recovery are established, therapeutic interventions become an important response to the guilt, shame and undermining of mental health and dyadic relationships that family violence related trauma brings about for women and children victim/survivors. Therapeutic interventions support women and children to find the physical and emotional space to benefit from each other's strengths as 'recovery promotors' (Katz, 2015). Therapeutic interventions should occur promptly and intensively in response to identified need (Bunston & Sketchley, 2012) (Holt, et al., 2008). It is important to adopt a strengths based approach that empowers women and children to identify their own skills and to support each other's confidence as the dyadic relationship grows and individual recoveries become established (Katz, 2015). Attachment focussed interventions should expect a manageable commitment from families, with interventions of between five and sixteen sessions having been found to be the most effective (Gregory, et al., 2020). There is no one best response to attachment focussed trauma recovery (Isobel, et al., 2019). It is to be expected that each individual and dyad will differ in their suitability and preference for particular treatment interventions.

Family and extended community supports are highly valuable and often underestimated in the long term support of 'strong and supportive mother-child relationships' (Katz, 2015). They are particularly sustaining for families who have established a wide range of coping skills such as positive

emotional regulation skills and must be included in the continuum of intervention (Holt, et al., 2008). Communities can offer preventative and protective supports for vulnerable families and have an important role to play in promoting awareness of the impacts of family violence on women and children (Isobel, et al., 2019).

Existing Models

Separate Interventions

Lighthouse Parenting Program – GROUP (adult) and INDIVIDUAL (adult) intervention

The Lighthouse MBT Parenting Programme is a mentalisation-based treatment that is aimed at parents of children aged 0-2 identified as at risk of disorganised attachment. The program fosters in parents: active curiosity about their child's inner world; reflections on their own thoughts, feelings and reactions; making sense of misunderstandings as related to their own attachment history; inhibiting harmful responses; and repairing relationship ruptures (Byrne, et al., 2019).

Strengths:

- Currently being implemented in Perth with UK program developers supervising. UK developers accessible and open to contact.
- Eligibility criteria includes history of family violence.
- Use of visual metaphors to guide the development of mentalising skills, for example: parent as 'lighthouse'; curiosity as their 'illuminating beam'; certainty about child as parent's 'projecting beam' (Byrne, et al., 2019).
- Explicit focus on the attachment relationship.
- Trauma aware, working directly with issues of trust.
- Both group and individual support for caregiver.
- Pilot data indicates: the program is highly acceptable in hard to reach families; positive outcomes worthy of further program development and research.

Limitations:

- Intensive and lengthy program - delivered over twenty weeks, with weekly group sessions and fortnightly individual sessions.
- Parenting program without dyadic element.
- Not specifically a family violence intervention.
- Does not currently support parents of children aged 3-5.
- Not offered in the Central Highlands region.
- Not a creative therapy model.

Options for Little Children, Big Outcomes project:

- Good fit for: families experiencing intergenerational trauma as well as current trauma recovery; families where trust of services is a challenge.
- Good option for stage two trauma intervention.
- The Moorabool community/Central Highlands Region could explore the Lighthouse Parenting Program as an intervention option.
- Van Go could explore the applicability of the Lighthouse Parenting Programme to dyadic therapy and creative therapies - are there aspects of the model that are transferrable to creative dyadic therapeutic interventions and would this be beneficial for clients?

Circle of Security (COS) – GROUP (adult) intervention

Circle of Security conveys essential concepts of attachment theory in a visual framework that can be understood and used by parents of young children in their interactions with their children. COS aims to enhance attachment relationships and caregiving capacity (Victorian State Goverment, 2019).

Strengths:

- Flexible delivery – Depending on the training level of the facilitator there are options to deliver Circle of Security Parenting (COSP^{tm}) which is an eight week program or COS-Intensive which is a longer and more individualised intervention.
- The evidence base for the longer COS-Intensive shows good improvements in parent-child attachment relationships. COSP^{tm} has also been found effective in improving the emotional availability of parents (Gregory, et al., 2020).
- There is an existing Memorandum of Understanding (MOU) between Ballarat Health Services, CatholicCare, Child and Family Services (CAFS) and WRISC to support the ongoing provision of Circle of Security in Central Highlands, including Moorabool Shire.
- Strengths based intervention.
- COSP^{tm} can be delivered online.
- Suitable for parents of children aged 0-5 years.
- Attachment focussed.
- Accessible in community.
- Available to male and female caregivers.

Limitations:

- Not specifically a family violence intervention.
- No groups have run in Moorabool in 2021.
- Parenting program without dyadic element.
- Local practitioners report retention difficulties, and are seeking mid-week contact from referring services to support families to embed program learnings.
- Not a creative therapy model.

Options for Little Children, Big Outcomes project:

- Circle of Security is an attachment focussed program that is evidence based and available to families at no/low cost in the Central Highlands region.
- COSP^{tm} is a good fit for: parents requiring an understanding of attachment theory and its benefits to children; parents requiring attachment focussed strategies and skills.
- Van Go can actively support improved accessibility of COSP^{tm} in Moorabool through the MOU, supporting lead delivery agencies in group provision and supporting families to participate.
- Van Go could further investigate the availability of the COS Intensive model in the region, as a service response for parents seeking attachment focussed psychotherapy.

Trauma Information Group (TIG) – GROUP (adult) intervention

TIG is a ten week group program that supports women in early recovery from relational trauma with a contained opportunity to begin to address the impacts of relational trauma in their lives. Each session runs for one hour. The group aims to: increase understanding of the impacts of trauma; decrease isolation and shame; increase self-compassion and emotional regulation; enhance coping

skills and relational safety; and increase a sense of mastery and empowerment (Herman & Kallivayalil, 2019).

Strengths:

- Brief Intervention.
- Model is available – detailed program description available.
- Model has proven adaptability to the creative therapies.
- Family violence focussed intervention.
- Supports attachment in that it attends to emotional safety and trust in relationships. Attends to forming a coherent narrative of past trauma experiences which is known to support attachment (Siegal, 2006).

Limitations:

- Does not specifically focus on the parent-child attachment relationship.

Options for the Little Children, Big Outcomes project:

- TIG offers a promising intervention model. The guide book is worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

Dyadic Interventions

Peek-a-Boo Club [tm] – GROUP (dyadic) intervention

Peek-a-Boo Club [tm] is a dyadic group program that "…provide[s] a therapeutic space within which infants and mothers can safely play with alternative ways of experiencing and communicating with one another" (Bunston, 2008, p. 338). Peek-a-Boo Club [tm] is a family violence focussed infant mental health intervention whose structure incorporates weekly two hour sessions, a predictable physical environment with routine, infant-led curiosity, wondering and discussion, a weekly newsletter and weekly supervision (Bunston, 2008).

Strengths:

- Infant led dyadic group program for children aged 0-4.
- Brief intervention – eight weeks.
- There is scope to incorporate infant led creative therapies in program delivery.
- Program delivered in Ballarat through consortium partner Berry Street Restoring Childhood Program – Van Go currently supporting this delivery.
- Family violence specific intervention.
- Translates successfully to online delivery.
- Trademark fidelity ensures integrity of program across providers.
- Academic literature available.

Limitations:

- Trademark fidelity constrains flexibility in model adoption.

Options for Little Children, Big Outcomes project:

- Peek-a-Boo Club [tm] is a valuable program and is an option for model adoption for the Little Children, Big Outcomes project. At this stage insufficient resourcing to achieve model fidelity prevents adoption of Peek-a-Boo Club [tm].

Play Connect Program – GROUP (dyadic) intervention with option of INDIVIDUAL (dyadic/adult) sessions

Play Connect is a group dyadic creative arts therapy program for women and children under five who have experienced homelessness and family violence, offered in Central Victoria from 2005 to 2013. Groups run for one school term (eight to twelve weeks) and consist of dyadic group creative play, separate dyadic play (individual family groupings at separate tables), group morning tea and relaxation play. Groups located at neighbourhood hubs to create opportunities for families to connect to the broader community.

Strengths:

- Creative therapy model with a focus on non-verbal attunement through arts and play based interventions, planned weekly in response to dyadic presentation.
- Brief therapeutic intervention.
- Available to multi-aged family groupings.
- Program design includes maximising opportunities for community linkages.
- Family violence specific intervention.
- Little Children, Big Outcomes project officer is co-creator of Play Connect model.
- Successful external evaluation – report available.
- Families were offered a small number of individual sessions for dyad or mother as required.

Limitations:

- Program not currently available in community.

Options for Little Children, Big Outcomes project:

- Play Connect is a promising intervention model. The action research report and other publications are worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

Child Parent Psychotherapy (CPP) – INDIVIDUAL (dyadic) intervention

Child Parent Psychotherapy is a dyadic form of psychotherapy that also involves developmental psychoeducation and play. It is designed for children who have experienced complex traumas, sees the parent/caregiver as central to recovery and understands that dyadic relationships have been impacted by trauma. The model helps children and families make sense of their experiences, create a sense of safety and manage challenging emotions (Child Parent Psychotherapy, 2018). CPP "enhance[s] the capacity of the child and primary caregiver(s) to create and maintain a growth promoting partnership" (Leiberman & Van Horn, 2011, p. 8).

Strengths:

- Strong evidence base supporting CPP with stronger effects being seen in higher risk children (Anderson & van eE, 2018) (Gregory, et al., 2020).

- Spans the entire 0-5 age range - antenatal (emerging), infant, toddler and child models available.
- Attachment, trauma and family violence specific program.
- Offers additional individual sessions for caregivers where required.
- Uses play and verbal therapy.
- Literature on model and training available.
- Model used by consortium partners at Berry Street Restoring Childhood program.

Limitations:

- At twelve months this is a long treatment intervention (Anderson & van eE, 2018) (Asmussen, et al., 2016).

Options for inclusion in practice:

- CPP publications are worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

Combined Interventions

Children and Mothers in Mind (CMIM) – GROUP (dyadic and separate adult and child) intervention

CMIM was an Australian program bringing together two Canadian interventions – Connections and Mothers in Mind - into a program for 0-4 year olds that features: assessment; eight week family violence psychoeducation group for mothers with a concurrent separate play group for children; ten week mother-infant play based group; and individual case management support (weekly contact).

Strengths:

- Family violence specific intervention.
- A combination of: group dyadic intervention; group separate interventions for mums and children; and individual support which included therapeutic contact between sessions, case management and brokerage assistance.
- Evaluation report available.
- Play based dyadic intervention.
- MIM component is manualised and accessible in Australia.

Limitations:

- At twenty-two weeks this program requires a lengthy investment of time for families.
- Training does not appear to be easily accessible in Australia (pilot partnered with Canadian agency).
- CMIM ran for two years as a pilot program and does not appear to be currently on offer despite successful evaluation.
- Not a creative therapies intervention.

Options for Little Children, Big Outcomes project:

- CMIM offers a promising intervention model. The evaluation report is worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

ACORN Parent-Infant Attachment Group – GROUP (dyadic and separate adult and child) intervention

ACORN is a group program developed and facilitated by Anglicare South Australia. Essential components of ACORN are: a group session that includes dyadic dance play and a separate journaling time for mothers and separate play time for children; a weekly therapeutic letter (noting facilitators wondering and child's perspectives). The program has been developed as a mental health intervention through participatory action research and aims to: enhance parent-child interactions, strengthen attachment relationships, improve parenting confidence, competence and enjoyment, enhance parental coping skills and strengthen social connectedness. Each group session goes for two hours per week for twelve weeks (online option) - fifteen weeks (in person).

Strengths:

- Dance Movement Therapy based dyadic intervention. Arts and play based separate interventions. Uses the child's language of play, movement, music, song, voice.
- Supports children up to three years of age.
- Strengths based.
- Have developed a group specifically for Aboriginal families - Sacred Little Ones.
- Evaluation report available.
- Attachment relationship led (neither specifically child-led or adult focussed).
- Option for online delivery.
- Manageable program length.

Limitations:

- It is a mental health intervention rather than a family violence intervention, though women who have experienced family violence are able to join the program.
- Does not cater for children aged 4-5.
- Training does not appear to be available.

Options for Little Children, Big Outcomes project:

- ACORN is a promising intervention model. The action research report and other publications are worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

Beyond The Violence (BTV) – Group (dyadic and separate adult and child) intervention

BTV is an Anglicare Victoria program that supports non-violent caregivers and their children with a focus on safety, coping skills, behavioural management and relationship repair. Parents and children attend separate co-occurring groups and come together at the end for sharing time.

Strengths:

- Family violence specific intervention.
- Combines separate intervention and dyadic interventions.
- Brief intervention – eight weeks.
- Facilitator training may be accessible.

Limitations:

- Children's intervention is not specifically targeted to 0-5 year olds (though modifiable to include these ages).

- Does not appear to have a therapeutic focus or require trained therapists to facilitate.
- Does not appear to be particularly attachment focussed.
- Not a creative therapies intervention.

Options for Little Children, Big Outcomes project:

- The BTV adult focussed intervention aspect may be useful to Little Children, Big Outcomes model planning and evaluation.

Filial Therapy – INDIVIDUAL (dyadic and adult) intervention with GROUP delivery options

Filial therapy teaches a modified version of child-centred play therapy to caregivers and offers supervision sessions with parents to consolidate their learning and make sense of the dyadic play experience.

Strengths:

- Strongly supported in the evidence literature (Anderson & van eE, 2018).
- Child-led.
- Strengths based.
- Suitable from age 2-3 through to 10+ years old (VanFleet, 2012).
- Skills can be taught to caregivers in group or individual setting.
- Is considered both a type of play therapy and family therapy (VanFleet, 2012). The evidence supports family therapy, however this is usually targeted to children older than four (Anderson & van eE, 2018).
- Supports the therapeutic qualities of caregiver's relationship with child. Supports the caregiver to be able to see the child's perspective (VanFleet, 2012).
- Skills are transferrable to interactions with whole family. Once a parent gains the required skills they have them for the ongoing benefit of the whole family.
- Combines dyadic and separate treatment interventions. Supervision sessions with Filial therapist support the caregiver to consolidate skills and reflect on what emerges for them from the dyadic play.
- Suitable for online delivery.
- Can be a brief or longer intervention.

Limitations:

- Universal program, not specifically adapted to family violence practice.
- There are limited professionals available who are also skilled family violence practitioners - requires trained child-centred play therapist who is also a trained Filial therapist, and who also has a strong understanding of family violence practice and a good capacity to work therapeutically with caregivers during supervision sessions.
- Infants not included in model.

Options for Little Children, Big Outcomes project:

- Include known private filial therapy practitioners with family violence skills amongst therapeutic intervention options for families (supported by Flexible Support Package application).

- Van Go could consider supporting student placements from accredited training institutions to improve the family violence skill set of field.
- Consider filial therapy position as part of Little Children, Big Outcomes model.

The Garden – GROUP (dyadic and separate adult and child) intervention with individual family option

The Garden group program, by Relationship Australia South Australia, is a group intervention that uses creative play, sensory activities, relaxation, and reflection with the intent of supporting parent-child attachment. The garden hopes to also support children to overcome trauma, regulate emotions, manage transitions and build resilience. Group play occurs within the holding metaphor of the garden. Values: play, curiosity, sensory integration, adult reflection (Relationships Australia (SA), 2013).

Strengths

- Targets families with children aged 0-4.
- Brief intervention – weekly group programs run for eight weeks for 1.5 hours.
- Aims to strengthen and repair dyadic relationships, attachment focussed.
- Targets families experiencing housing stress including family violence.
- Some Van Go CCTP staff are trained facilitators.
- Offers separate journaling time for parents within the group in order to develop parental self-reflection (Relationships Australia (SA), 2013) and can therefore be considered a combined intervention.

Limitations

- The Garden is a structured and prescribed intervention that is highly manualised – it is unclear where there would be scope to respond to the unique therapeutic needs of individual group members and dyads.
- Facilitators do not need to be trained therapists.
- Not a creative therapies intervention.

Options for Little Children, Big Outcomes project:

- The Garden Dyad Program individual dyadic intervention may be useful to Little Children, Big Outcomes individual dyadic therapy model planning and evaluation.

Parent and Infant Relationship Support (PAIRS) - Group (dyadic and separate adult and child) intervention

PAIRS is an Australian group therapy program which "… promotes maternal health, secure attachment, and enhanced infant development" (Smith, 2010). Groups meet for two hours per week for ten weeks where they spend forty-five minutes of dyadic play, after which they form separate concurrent groups for forty-five minutes, and then return to the dyadic group for discussion for thirty minutes.

Strengths:

- Brief Intervention.
- Attachment focussed.
- Infant (0-2) group therapy model.

- Recognises family violence as a risk factor for attachment difficulties.
- Has a clear therapeutic logic for offering concurrent separate interventions and strategies for this process to be infant-led.
- Program manual appears to be available.

Limitations:

- Mental health intervention rather than a specific family violence model.
- Does not cater for 3-5 year olds.
- Not a creative therapies intervention.

Options for Little Children, Big Outcomes project:

- PAIRS is a promising intervention model worth reviewing to contribute to the Little Children, Big Outcomes model planning and evaluation.

Moorabool

About Moorabool

Moorabool Shire sits within the Central Highlands region. Moorabool is a geographically large shire – at 2,111 square kilometres it is larger than the nearby shires of Wyndham, Ballarat and Melton combined. Moorabool Shire has sixty-four localities and towns and is 74% forests and waterways. The traditional owners of these lands, waterways and culture are the Wadawurrung, Dja Dja Warrung and Warundjeri people (Wadawurrung Traditional Owners Aboriginal Corporation, 2019) (Moorabool Shire Council, 2021). The estimated population of Moorabool Shire in 2021 is 36,344 (Moorabool Shire Council, 2021), which is significantly smaller than the population of Ballarat at 113,725 (Informed Decisions, 2021) and Melton at 185,471 (Informed Decisions, 2021). Moorabool's population is tipped to double over the next twenty years, it is one of the fastest growing regions in Victoria (Moorabool Shire Council, 2021). 65% of the Moorabool Shire population reside within Bacchus Marsh, the area of the shire that is closest to Melbourne (Moorabool Shire Council, 2021).

Physical accessibility

Accessing services can be a challenge for Moorabool residents. It is not uncommon in regional areas to find key services located in central locations, either within or outside of the local government area. Central does not mean accessible. Support services provided for families within Moorabool or in neighbouring Ballarat can be as much as sixty kilometres away by car. This makes the service system inaccessible for many families on the basis of travel time, expense and limited transport options. For women and children living with family violence, this physical isolation can be further compounded by a perpetrator's abusive tactics, such as financial abuse and forced isolation from support networks (Laing, et al., 2013). Moorabool Shire is making a commitment to accessibility through the planned construction of the West Maddingley Early Years and Community Hub in response to its fast growing population (Moorabool Shire Council, 2021). However, the Little Children, Big Outcomes Project Reference Group identified that throughout the more isolated areas of the shire there remains a widespread lack of facilities from which to provide safe and appropriate service delivery for victims of family violence.

Success of the Van Go demonstration project in Moorabool

Accessibility and collaborating with local government in order to improve accessibility are key Van Go design principles. The Van Go pilot project enabled WRISC to set up an office in Moorabool, co-located with Moorabool Shire and the Darley Early Years Hub. WRISC has been able to maintain this office beyond pilot funding with the generous assistance of Moorabool Shire. WRISC's Darley office also houses the Van Go mobile therapy van which improves accessibility for children who, through geographic location or poverty and social exclusion, have found accessing office based services a significant barrier. Department of Families, Fairness and Housing data reveals that WRISC received thirty-two referrals for children's counselling for Moorabool families in the fifteen months prior to the establishment of the Van Go pilot project. In stark contrast, the Van Go project received 302 referrals in its first fifteen months of operation (SVA Consulting, 2018). The indigenous population of Moorabool stood at 1.2% (Australian Bureau of Statistics, 2020) whereas 6% of Van Go clients identified as Aboriginal and Torres Strait Islander (SVA Consulting, 2018) It is clear that improvements to accessibility had a meaningful impact on the Moorabool community and revealed hidden demand.

Unmet demand in Moorabool

Children under five years old form a larger percentage of the Moorabool population than the Victorian average (Moorabool Shire Council, 2021). The rate of family violence incidents is higher in Moorabool than the Victorian average and are increasing at a faster rate than the Victorian average (SVA Consulting, 2018). For the first six months of 2021 Van Go received sufficient referrals to run one 0-5 therapeutic group per term, without any such group on offer. There is good reason to believe that the provision of an accessible service specific to children under five who have experienced family violence will be well utilised.

Online service delivery

The COVID-19 pandemic has seen many therapeutic services pivot to online service delivery and Van Go is no exception. While not without its challenges, we have found that online sessions can be a powerful tool for sustaining children's emotional wellbeing during lockdown and maintaining therapeutic connections with families. Van Go staff have noticed that children can be particularly empowered by the small screen, introducing new forms of play and creativity and relishing in the opportunity to share their pets and their special toys with their therapist in a way that would not be possible in an office setting. Local primary schools have supported online service delivery during periods of limited professionals access to schools. Much like with the Van Go mobile therapy van, with online services we have discovered an ability to reach children and families who might have otherwise found services inaccessible. In addition, an increase in private practitioners offering online therapy has improved the options for Moorabool families accessing support through Flexible Support Packages (FSPs) with Van Go support.

Van Go's current consortium partners at Berry Street Restoring Childhood Program have shown us that online therapeutic group work with children under three and their primary caregivers is both possible and effective. They have offered a number of successful Peekaboo Club™ programmes online, as have other attachment focused therapeutic group programs such as Acorn in South Australia (Anglicare SA, 2021). Lockdowns have been a significant feature of the Australian response to COVID-19 outbreaks (Prime Minister of Australia, 2021). Capacity to offer therapeutic services online is now an essential element of program design.

Other barriers to accessibility

Constraints exists for families in accessing both physical and online services. Van Go is not funded to reduce barriers to access such as the provision of taxi vouchers, fuel cards, child care where required to support service participation, computers, internet access, data or play kits for families to use during online sessions. These types of resources are crucial, as are human resources. Van Go, CatholicCare, Child and Family Services (CAFS) and Ballarat Health Services (BHS) work together to ensure Circle of Security (COS) attachment focussed parenting education groups can run in Moorabool. This working group has found that families require the referring worker support to attend sessions and to contact families between sessions in order to consolidate learning and that without this retention is poor. This presents an opportunity for collaboration across the shire to assist therapeutic and educational programs to work along-side family support and outreach interventions in order to improve access and participation.

The Little Children, Big Outcomes Project Reference Group identified that living in Moorabool, with its' small communities, smaller number of services and lower population overall, brings challenges to service access, such as needing to interact with a service where the client might have had previous negative experiences. Therapeutic groups in regional settings pose the problem of lack of anonymity

and, therefore, challenges to confidentiality. Other barriers to participation include: a lack of consistency with group facilitators in some generalist groups which can alienate more vulnerable families; firm service boundaries meaning that women and children are not eligible for a service that they could travel to; and lengthy wait times for services. Van Go itself was closed to the majority of Moorabool referrals for most of this year (with the exception of Aboriginal children and families that presented with other exceptional circumstances such as geographical isolation) due to demand that far exceeded capacity. Moorabool Shire addresses some of the challenges families are facing by offering safe zones for women and children who have experienced family violence in some of their generalist supports, such as offering a wellbeing group and a playgroup for women only.

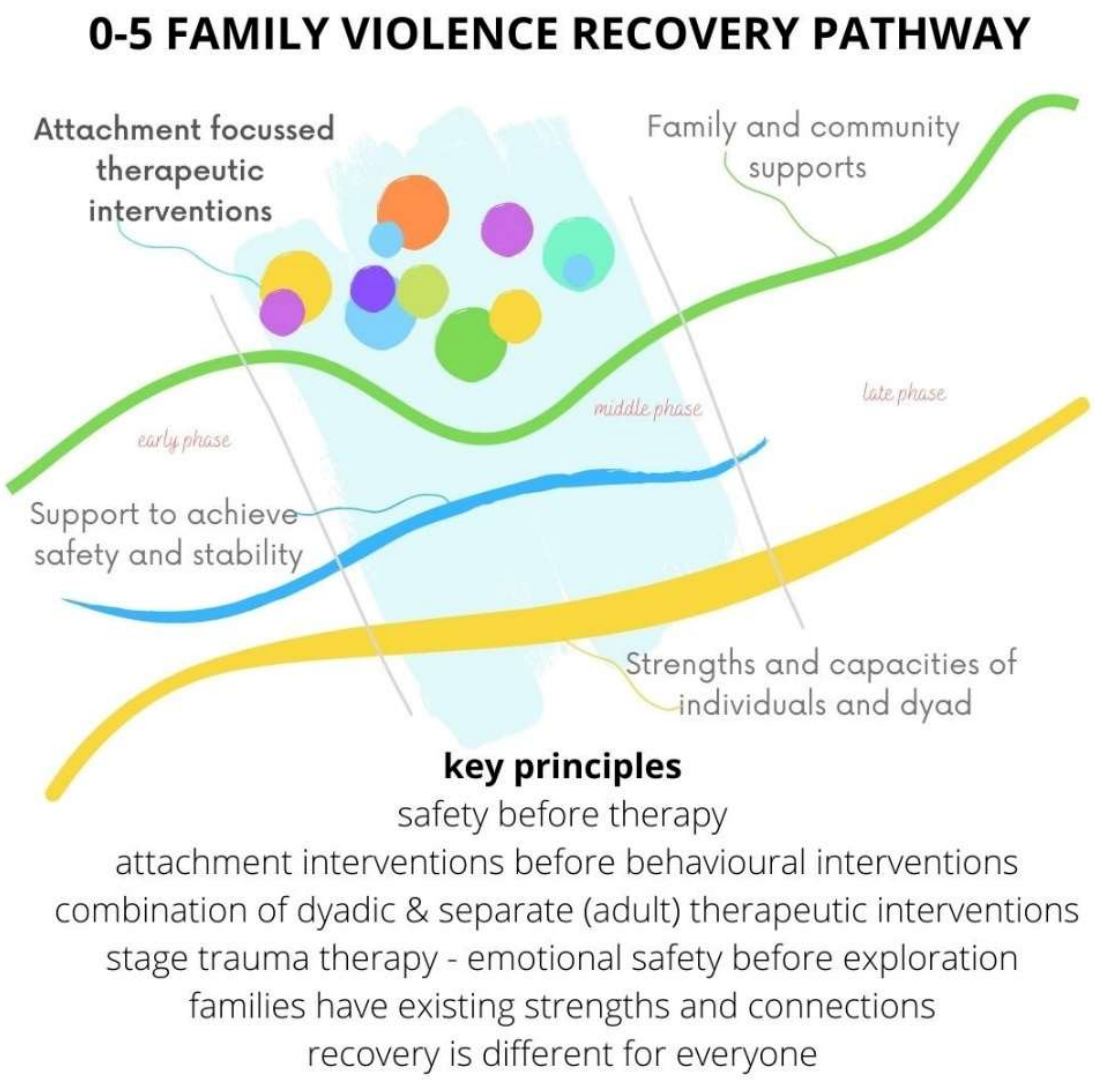
A key observation of the Little Children, Big Outcomes Project Reference Group is that the service system itself poses challenges for service access. Many families have complex needs, family violence being one of the multiple challenges they are facing. Women might approach a universal service and are then required to share their story multiple times as they navigate the various agencies in the service system. A lack of awareness generally about the therapeutic needs of children under five who have experienced family violence means that it is not clear for Moorabool families where to start in seeking assistance for their children. Neither is it clear to services which is the best evidence-based pathway to follow in accessing the most appropriate support. It is for this reason that the Little Children, Big Outcomes project has developed an evidence-based '0-5 family violence recovery pathway' and a 'Moorabool pathway services map' in order to support service planning and co-ordination in response to the needs of children under five who are recovering from family violence related trauma.

0-5 family violence recovery pathway

Early Phase – Support to achieve safety and stability

Middle Phase – Attachment focussed therapeutic interventions: A combination of mother and infant/child dyadic therapy and separate interventions for female caregivers

Late Phase – Community Support: Trauma recovery has progressed to where women and children can exit 0-5 therapeutic response into supported community options



<u>0-5 family violence recovery pathway - Moorabool services map - January 2021 - July 2021</u>

Safety, support, referral	Therapeutic Intervention	Community Support
The Orange Door		
WRISC: • Family Violence Outreach Program • Aboriginal Case Management Team • Van Go ○ Single Session Therapy	WRISC Van Go for under 5s: • FSP[1] funded referral to private Filial therapy practitioner	

[1] FSP – Flexible Support Package – brokerage funding intended to support women or children victim/survivor's safety, wellbeing and independence

○ Women's Group (parents)		
CAFS[2]: • A range of services currently offered on outreach from Ballarat to Moorabool residents including Family Services, Financial counselling, Kinship care support, Step Up, Housing services • Child First		CAFS: Early Childhood Support
CatholicCare Integrated Family Services		
MSC[3] – Maternal and Child Health and family support		MSC – Supported Play Group, Wellbeing circle, Library Time, Rhyme Time, Pram and Family Walks
BADAC[4] – Outreach from Ballarat -Family Support Program including Family Services, Family Violence and Justice Program including The Orange Door		BADAC – a range of services offered in Ballarat including Early Years Services and Social and Emotional Wellbeing Support
		Playgroups Victoria Playgroups
		Darley Neighbourhood House
NDIS[5] – Local Area Coordinator and Early Childhood Early Intervention		Health general - Ballan District Health Care, Djerriwarrh Health Services, NDIS providers, GPs, Dentists, Psychologists
DHS[6] - Healthy Mothers Healthy Babies Program	DHS - Family Violence Prevention Program - counselling (Moorabool residents travel to Melton)	
	BHS[7] - Infant Child Mental Health Services, Perinatal Community Mental Health,	

[2] CAFS – Child and Family Services Ballarat
[3] Moorabool Shire Council
[4] Ballarat and District Aboriginal Cooperative
[5] National Disability Insurance Scheme
[6] Djerriwarrh Health Services
[7] Ballarat Health Services

	Mother and Family Unit (Ballarat)	
Kindergartens – access to School Readiness Assessments		Child Care/education (multiple options): Occasional Care, Family Day Care, Long Day Care, Kindergarten
		Recreation (multiple options): Sports Buzz, KinderGym, Swimming, Karate, Dance, Mini Maestros, Self Defense for women
	Berry Street Take Two – Child Protection clients (outreach to Moorabool)	

0-5 family violence recovery pathway - Moorabool services map - capacity to provide services to Moorabool children under five but did not provide during January 2021 - July 2021

Safety, support, referral	**Therapeutic Intervention**	**Community Support**
WRISC FVOP – • Women's Group • Walking Group	WRISC Van Go for under 5s: • Creative Therapies for Aboriginal Children • Creative Dyadic Therapies	
	Circle of Security (shared delivery by CAFS and CatholicCare, supported by BHS and WRISC)	
		MSC - Imagination Magic, 123 Magic

Strengths identified

Moorabool residents have access to early and late stage pathway options.

Gaps Identified

There are no family violence specific dyadic therapeutic interventions currently being provided to children aged 0-5 within the Moorabool Shire. There are no active Circle of Security groups in the area. There are limited options for women's family violence therapeutic interventions in Moorabool.

Pathway principles

The pathway is evidence based:

- Trauma recovery involves three important steps – safety, therapeutic intervention and community connections.
- The pathway includes important 0-5 trauma recovery guidelines:
    - Safety before therapy

- Attachment interventions before behavioural interventions
- Combination of dyadic and separate (adult) therapeutic interventions
- Stage trauma therapy - emotional safety before exploration
- Families have existing strengths and connections
- Recovery is different for everyone

The pathway is child-led:

- Young children grow and develop in healthy caregiving relationships
- Family violence undermines the strengths of the caregiving dyad
- Young children have an urgent need for therapeutic interventions that support the capacity of the mother-child dyad to meet their trauma recovery needs
- The needs of very young children in trauma recovery are frequently underestimated
- The younger the child the higher the priority for therapeutic intervention in an effort to prevent the progression of trauma symptoms

The pathway is attachment focussed:

- Young children benefit from family violence therapeutic interventions that support and enhance attachment relationships

The pathway is strengths based:

- Dyads and individuals have existing strengths and capacities

The pathway is intersectional:

- The Moorabool community understands that some families face significantly higher barriers to participation and work together to make supports more accessible

The pathway is not linear:

- Families will engage in the aspect of the pathway that meets their current needs (for example, a family attending therapy might become unsafe when the perpetrator is released from jail, at which point they would engage with The Orange Door and therapeutic intervention might be put on hold)
- Referrals are likely to come from community support and these families are likely to remain engaged with their community support connections whilst navigating the therapeutic pathway
- Families will engage at their own pace and their own level of readiness. Families may choose not to engage in therapeutic interventions.
- Multiple therapeutic interventions may be required as trauma recovery progresses and a longer service period is to be expected
- The pathway is expected to help sector workers make sense of a family's experience of recovery e.g. highlight that recovery is hampered by lack of safety.

The pathway success relies on agencies working together to achieve the best outcomes for their clients:

- Collaborative work supports women and children's safety
- Collaborative work supports accessibility

- Collaborative work respects that families recovering from trauma from family violence can be ambivalent about interventions and face significant challenges to engagement and participation

The pathway makes service gaps visible:

- Interventions to support the middle phase of this pathway are significantly absent in the Moorabool community and require intentional development.
- The pathway supports the Moorabool community to make evidence based community development responses.

The pathway supports expansion to other regional areas:

- The pathway supports other regions to map their services, identify gaps and plan for improved service provision.
- The pathway can support services to work together for service navigation and accessibility.

Little Children, Big Outcomes therapeutic intervention - model design

The 'Little Children, Big Outcomes' group – the pilot in brief

Van Go will run a pilot group therapeutic intervention in Victorian School Term four 2021. The 'Little Children, Big Outcomes' group will run weekly for eight weeks and will be located in Darley. Sessions will be two hours long and can pivot to online delivery where required.

Eligibility – Moorabool residents: children aged 0-5 and their female primary caregivers. Families with the youngest children will be prioritised (where demand exceeds capacity).

Size – Minimum group size is six, maximum group size is twelve (children are included in these numbers).

Structure – Each group session will begin with fifty minutes of dyadic creative play. The session will then move into thirty minutes of child and adult separate group time (adults: early stage trauma recovery and support, children: child-led play) and will finish with twenty minutes of dyadic relaxation play. Morning tea will be included and settling in and closing time has been accounted for. In addition to the group families will be offered individualised therapeutic contact between sessions.

Staffing – two therapists and two community/student support staff

The 'Little Children, Big Outcomes' group - pilot model explained

What does the group aim to do?

The overarching challenges experienced by both adult and child members of this client group can be described as relational trauma stemming from the perpetration of family violence. Young children heal from trauma through a healthy attachment relationship with their primary caregiver. This pilot group aims to:

- Provide an environment where children can begin to recover from relational trauma through the dyadic relationship;
- Provide an environment where women can increase their capacity to understand and respond to their own needs and their children's needs as separate and unique through providing early stage trauma recovery and support to women - building relational safety, self-care and reflective capacity.
- Provide an opportunity for the community to come together to support young children who have experienced family violence.

Is the group strengths based?

This therapeutic intervention invests in the existing strengths and capacities of the mother-child dyadic relationship. The model approaches children as having agency and the capacity to stimulate growth in the mother-child relationship. It understands women's parenting in the context of their experiences of family violence and the constraints this places on parenting, engagement and participation in the service system.

Will it be an open or closed group?

The 'Little Children, Big Outcomes' pilot group will be a closed group. This will help to create maximum emotional safety for therapeutic benefit. Referred families will undergo a screening and

intake process to determine suitability for the group. The group will go ahead if the minimum numbers have been accepted into the program. If a family has not attended by week three they will no longer be eligible to join the group. The group will continue regardless of retention (if very low numbers are retained staffing numbers will be reconsidered).

Where did the model come from?

The evidence presented in this report shows us that children under five benefit most significantly from a combination of both attachment-focussed dyadic interventions and separate interventions with their caregivers. Evidence also shows us that women with very young children recovering from trauma from family violence have a constrained capacity to engage in therapeutic interventions. Young children's needs for therapeutic interventions are urgent and beneficial as they can prevent long term developmental impacts of trauma. We cannot assume that women who engage in dyadic therapy will also engage in separate interventions. In an effort to maximise potential benefit to children under five we are interested in piloting a model that combines both separate and dyadic interventions in the one group.

The success of the ACORN: Parent-Infant Attachment Program and Parent and Infant Relationship Support (PAIRS) models shows that it is possible to provide an attachment focussed creative therapy group that includes both dyadic and separate interventions in group settings for very young children and their female caregivers. However, both models are a mental health interventions and we are instead responding to women and children who have experienced the traumatic impacts of relational violence. While there is significant intersection between mental health and family violence, they are also not one and the same thing and deserve unique responses.

The Trauma Information Group (TIG) model offers clear guidance in offering a separate intervention that directly addresses the impacts of relational trauma and has the potential to support dyadic group therapy. It is a model with significant resource material available and is highly modifiable to different group environments, including arts based delivery. The TIG group structure includes printed information and worksheets that are intended to sustain engagement between group sessions and scaffold trauma recovery.

How will you measure the success of the pilot?

Existing Van Go clinical evaluation tools will be used to assess clinical outcomes – namely PIRGAS (0-3yo), CGAS (4-5yo) and SDQ (2-4yo and 4-5yo)[8]. It is expected that as the program develops Van Go will give further consideration to clinical tools, with a view to contribute an additional 0-2 evaluation tool and evaluate targeted areas of 0-5 therapeutic practice pre and post program. An action evaluation strategy will be adopted for gathering participant and agency feedback on the successes and weaknesses of the pilot group. This will inform model development and future program planning.

What makes the group trauma informed?

The focus of the group is on establishing emotional and interpersonal safety, and it is targeted to women and children who are in the early stages of recovery from trauma. The group helps to make sense of the impact of family violence perpetration on the dyadic relationship, on children and on

[8] PIRGAS (Parent Infant Relationship Global Assessment Scale, c. ZERO TO THREE 2005), CGAS (Children's Global Assessment Scale, Shaffer 1983), SDQ (Strengths and Difficulties Questionnaire, c. Goodman 2005)

victim/survivors. For young children, recovery from relational trauma is achieved through the caregiving relationship. The group offers attachment-focussed dyadic interventions and also separate interventions that support women to hear and see their children and respond to their children's expressed needs. An anticipated benefit of the group is to reduce the impacts of trauma related isolation, stigma, shame and self-blame on children and their mothers.

The group supports women to recover through understanding the impacts of relational trauma, building safety and self-care into their lives and increasing capacity to tune in to the mind of the child. The content of any group conversations where children are present will be child safe, simple, with no more detail than children can manage. There is a focus on the impacts of trauma in the here and now rather than detailed retelling of trauma experiences in the group environment, so as to avoid triggering group members into dissociative states that render them unavailable for dyadic play.

Will the group meet the needs of children whose mothers face challenges with intergenerational trauma?

The Little Children, Big Outcomes pilot group is an early stage trauma recovery model that makes strong connections between childhood experiences and present day feelings. It is anticipated that this model will support women to identify and make distinctions between the past and the present in their parent-child interactions. The child-led dyadic play is intended to support parental curiosity about the child's inner world and therefore improve mentalisation. The action research evaluation will help Van Go to understand whether intergenerational trauma is addressed sufficiently for child wellbeing in this model. We hope to learn whether further model/community development, such as a second group model that supports women to explore intergenerational trauma more deeply, is required to meet this need.

Why does the group go for eight weeks?

Brief interventions have been shown to be the most beneficial to this client group. The Victorian school term four runs for eleven weeks. An eight week group allows for unanticipated delays to the group start date and prevents the group from running up until Christmas, which can be a time of very high stress for families with young children.

How will you address accessibility?

The following strategies will be implemented to establish group accessibility:

- The group is a brief intervention.
- It is a group that combines dyadic and separate interventions – for some families this group alone may be sufficient to meet their therapeutic needs in recovery from family violence.
- While pilot group delivery is planned for Darley, Van Go adopts a common sense response to accessibility and is happy to consider alternative locations throughout the shire if referrals indicate a need for this. Future group planning would incorporate offering groups in other locations throughout the shire.
- Collaboration with local service providers is a key element to making the 'Little Children, Big Outcomes' pilot group a success. This pilot group will start from an assumption that there will be multiple barriers to access as a result of Moorabool's social and physical geography and the impacts of family violence on participation. Barriers to access will be addressed at

referral, screening and intake stages and efforts to minimise barriers and support retention will be made collaboratively between services.

- A social work student on placement will be available to support the therapist in collaborating for accessibility. Possible strategies include support workers assisting with transport to and from group or brokerage assistance being sought for access to technology.
- While face to face delivery is preferred, the capacity to pivot to online delivery during the group will be a strength of this pilot. Intake processes will ensure that adequate safety assessment is conducted and consent is obtained for online delivery, and technological barriers to access are addressed.
- Therapeutic contact between sessions will support engagement and retention, offering therapeutic holding to families during their participation in the group.

What would online delivery look like?

It is highly likely that some amount of online delivery will be required for the pilot group due to the current Victorian COVID-19 outbreak. In this case modifications will be made to group delivery such as: weekly one hour dyadic group sessions online; weekly one hour separate women's group sessions online at different time (possibly in the evening); staffing levels will be reconsidered; consideration to be given to play kits being delivered to family homes.

Why are the staffing levels so high?

Staffing levels are particularly high in this group model to allow for sufficient therapeutic support to: all individuals and dyads; all members of both groups during separate group time; all members of both groups during transitions in and out of separate time. Therapists will be required for a total of one day per week each. Support staff will each be required to commit to four hours per week. Therapists will provide support staff with debriefing each week and informal professional development over the course of a group, therefore making a contribution to community understanding of family violence practice with 0-5 year olds.

How is this a Moorabool response? Can it be delivered in other areas?

This is a response suited to a region, such as Moorabool, with poor access to therapeutic service provision to children aged 0-5 who are recovering from trauma from family violence perpetration. Delivery in other areas requires a thorough investigation into gaps in the service pathway and offering the most appropriate therapeutic response for that community. Collaborative practice will enrich the Moorabool feel of this project, with multiple agencies involved in referrals, delivery and action research evaluation processes. Van Go looks forward to seeking funding to expand into the regional areas of Golden Plains and Hepburn Shires.

Will the group be child-led?

When children are in the room the group will be child-led with a focus on supporting the child's attachment relationship with their primary caregiver. Transitions between separate and dyadic time will be rich opportunities to explore dyadic connection and disconnection and to support 'seeing' the child in this interaction. If separation is traumatic for the child it will not be pursued and the group will be modified to accommodate this. Separate adult group time will focus on child, dyadic and maternal trauma responses, safety and wellbeing, with the aim of increasing maternal availability to the dyadic relationship and mentalisation capacity.

Why prioritise the youngest children? How will you support families with multiple children under five?

Younger children in the 0-5 age group are the least acknowledged in the service system as having specific therapeutic needs and have the least therapeutic services available to them. Younger children also have the most to gain as interventions can support a dyad on the course of healthy childhood development. This preventative capacity of the group dyadic intervention leads us to prioritise access for the youngest children. This does not mean that older children in the 0-5 age bracket will be ignored, simply that may be supported to access the additional dyadic services available to them, such as filial therapy.

In order to meet the developmental needs of participants, dyadic groups are frequently grouped by age, for example e.g. 0-6 months, 0-12 months, 0-3 years, 3-5 years. This pilot group requires flexibility in group make up to ensure accessibility. While younger children will be prioritised, multi-aged groupings will be accommodated where clinically/culturally/demand indicated.

How will you meet cultural needs?

The pilot group is aimed at any children 0-5 in the Moorabool area who are recovering from family violence trauma without targeting specific cultural backgrounds. Culturally safe practices will occur in response to referrals and include inviting key culturally appropriate support staff to take part in intake processes, accessibility arrangements and group delivery. Therapists will consider the participation of multiple female attachment figures and support group diversity in child rearing practices, including resourcing participants to contribute to creative play opportunities that support a strong cultural identity for mother and child. Therapists will maintain an attitude of curiosity and an open acknowledgment of current and historical power imbalances. Culturally diverse agencies will be consulted in the action evaluation process with the aim to improve the cultural safety of the model over time.

How does intake and assessment work? Who will be excluded after intake and assessment?

Families will be pre-screened by telephone in order to provide information about the group and gauge interest. Families will then attend an intake interview where an assessment will be made about suitability for the group, based on current safety and trauma symptoms. Women and children who are unsafe will be excluded. Women and children whose trauma symptoms are such that a group environment will be distressing rather than therapeutic will be prioritised for individual dyadic work instead of group. Families who have not attended by week three of the group will be excluded from the group. Families excluded from the group will be referred to The Orange Door or offered Van Go Single Session Therapy depending on their presenting needs.

Tell me more about a group session?

Sessions are sufficiently structured to offer predictability, routine, rhythm and safety, while being flexible enough to respond to group process. A group session will involve therapists and support staff setting up the room with therapists briefing support staff in preparation for the session. Group time will begin with a group check in, group floor play (e.g. singing and looking games) and an introduction of the separate group theme for the session. Play will then move to age appropriate dyadic therapeutic creative play using a therapist guided process, where women are supported to be child-led in their dyadic play. A story and morning tea will come about midway through the group followed by a transition into separate spaces. Women will engage in a therapeutic arts process and

discussion around the theme of the week (TIG guided) with one therapist and one support staff member; children will engage in child led play with the second therapist and support staff member and will be supported to explore a theme if the child leads this. The group will then reunify with some dyadic relaxation play, for example, blanket rides or a massage, leading into a goodbye ritual. Families are provided with a modified TIG information and worksheet.

How will you manage transitions in and out of the whole group and separate groups?

A children's play space will be set up during morning tea and one therapist and one support staff will assist the children to move into this space. The other therapist and support staff will support women to acknowledge the separation with their children and move into their space. If dyads cannot separate the group will be modified to create an emotionally and physically safe joint space where the adults are focussed on themselves for a period of time and children are supported to engage in child-led play with a therapist.

At the end of this separate time the therapist will facilitate a closing check in and a strengths based guided mediation (e.g. one strength I have, one strength my child has) and support the women to re-enter the child focussed space. In the children's session, the therapist and support staff pack up toys and ready the children for relaxation play with their caregivers (for example, children are ready and waiting for blanket rides). Women re-enter the room and are supported to play at discovering their children through, for example, playing hide and seek or playing saying hello without words.

What therapeutic modalities will you use?

The Little Children Big Outcomes pilot group will be facilitated by a qualified creative arts therapist and play therapist. The model is intended to be a creative therapies model, whereby dyadic play and separate women's interventions are planned within the scope of the modality of the facilitators' training, in response to the needs of the group. For example, group processes of forming, norming, storming, performing and mourning are supported by the Expressive Therapies Continuum (Van Lith, et al., 2018). which indicates the use of safe and contained creative processes such as contact collage in the forming stage, messy play during the performing stage and a return to contained processes during the mourning stage. A dance movement therapist would move between functional and expressive movements in support of individual, dyadic and group process. Using the creative therapies supports non-verbal processing of trauma, creating a safer shared adult-child space.

What themes are covered in the separate adult sessions? Can you give an example?

The child-led aspects of the pilot group are emergent rather than manualised and will be planned weekly in response to observed dyadic presentations in group.

The separate adult portion of the group will follow a modified creative therapies version of the TIG weekly themes, which adopt the following structure: Week 1. The impacts of relational trauma; Week 2. Safety and self-care; Week 3. Trust; Week 4. Remembering; Week 5. Shame and self-blame; Week 6. Compassion; Week 7. Anger; Week 8. Self-image/body image; Week 9. Relationships with and connections to others; Week 10. Making meaning of the past and the process of recovery (Herman & Kallivayalil, 2019).

For example: Week two – Safety and self-care: ways that children help themselves to feel safe (understanding children's behaviours) and how we can support them to feel safe (regulating activities), our own coping strategies (how they come to exist) and establishing self-care. Example of therapeutic arts processes:

- Dyadic: free play with coloured masking tape. Observe and support dyads through tolerances.
- Women: body maps – explore cues to feeling unsafe, explore things that bring feelings of safety, how can we use them in our play with our children, how can we tell if our children are feeling unsafe, window of tolerance.
- Children: Free play with blocks, boxes and masking tape. Build on play opportunities from observations of children's play in previous week.

What is difference between therapist and support staff roles?

Therapists are responsible for the therapeutic group planning, preparation and delivery as well as briefing and debriefing support staff. Therapists attend to client and support staff emotional safety. Therapists will receive three sessions of joint external supervision over the course of the group. Therapists commit 7.6 hours per week to the group. Support staff commit to up to four hours per week and actively participate in group set up and pack up, learning, group process as indicated by therapists and weekly debriefing post group.

Action Research Evaluation Strategy

Action research engages in a cyclic process of *reflection*, *planning*, *action* and *evaluation*. It is known to be effective in improving interventions for client benefit and to improve collaboration between agencies for better outcomes in family violence practice (Laing, et al., 2013).

Phase One

The Little Children, Big Outcomes project considers this report and model design and the actions of the Project Reference Group to date as the phase one *reflection* and *planning*. Phase one *action* will be the provision of the term four pilot group. The first *evaluation* phase will collect the following data during term four:

- Usefulness of and updates to pathway model and service mapping
- Accessibility of pathway elements
- What works and doesn't work about the pilot group model
- What improvements can be made.

From the following people:

- Group facilitators
- Group support staff
- Referring agencies and potential referring agencies where barriers to access are likely to be higher (for example, for Aboriginal families)
- Participants – adults and children
- Secondary consultations

By means of:

- Individual interviews
- Children's voices/observations

When:

- Group beginning
- Group middle
- Group end

Phase Two

Early in 2022 Van Go will *reflect* on the data collected in the first evaluation phase by way of compiling a report addendum. Van Go will then engage in a *planning* process whereby they disseminate the outcomes of phase one to evaluation participants and seek further feedback. Van Go will then begin *planning* for phase two *action* which is likely to include consolidating collaborative relationships and seeking funding that supports phase one evaluation outcomes.

Filling the Gap - Little Children, Big Outcomes

The Little Children, Big Outcomes project will provide:

- A service map with an evidence based pathway for Moorabool services to consult in attempting to support women to access therapeutic interventions for their young children.
- An evidence based therapeutic group intervention model for children under five with a practice guide that supports model delivery.
- An action research evaluation strategy in order to support service collaboration and participant input into future program development and design.

Van Go will offer the following in Moorabool in the Victorian School Term four 2021:

- A pilot Little Children, Big Outcomes therapeutic group including collaborating with referring agencies to ensure adequate support for group accessibility, and offering student therapeutic case management to improve accessibility and retention where there is capacity.
- Develop a practice guide to support model delivery.
- Individual dyadic 0-5 therapeutic interventions in line with Little Children, Big Outcomes group model where indicated (i.e. dyad not group ready) if Van Go program has capacity.
- The 'Moorabool pathway service map' and '0-5 family violence recovery pathway' will be shared with key service providers in the Moorabool region including The Orange Door.
- 0-5 pathway specific secondary consultation to Moorabool services, including Van Go Single Session.
- Make external referrals as indicated by pathway (e.g. to COS and Filial therapy) and support FSP applications where required to achieve this.
- Support the provision of Circle of Security in the Moorabool region through the COS working group, referrals, and supporting referred families to remain engaged.
- Implement an action research evaluation strategy in order to collaboratively review and develop Little Children, Big Outcomes project outcomes (Moorabool pathway service map, 0-5 family violence recovery pathway, therapeutic group pilot model, secondary consultations and external referrals).

Beyond 2021 Van Go has the capacity to:

- Support the development of 0-5 therapeutic family violence practitioners through providing student placement opportunities (with an expansion into students wishing to practice filial therapy).
- Further develop group and individual dyadic response through professional development for existing staff.
- Compile evaluation data, revise model and pathway strategy and create addendum document to this report early in 2022.
- Seek ongoing funding for Moorabool 0-5 response and expansion to similar LGAs in catchment area.

Financial investment required to support sustainability:

- The provision of one group per term in Moorabool.
- Creating a three year 0-5 therapeutic capacity building role that: supports ongoing collaboration between services to support service provision, navigation and accessibility; provides 0-5 secondary consultation and local sector education; provides pathway

navigation supports for Moorabool services including to Van Go Single Session Therapy; supports 0-5 group therapists with weekly clinical supervision; conducts infant/child observations of 0-5 year old children in single session; develops 0-5 practice guide; conducts action research to develop model; leads expansion into other LGAs; maintains service pathway relationships, develops stronger intersectional response; individual dyadic therapy response articulation and development; embeds sustainability into program.

- Therapeutic case management for three families per term in Moorabool to assist families with significant barriers to pathway navigation e.g. parents with disabilities, language barriers, cultural barriers, large families, complex needs. Identifies and supports movement back and forth along recovery pathway, links mother in with individual and dyadic supports, FSP applications where required, consults with Van Go Single Session Therapist.
- Individual dyadic therapy for two families with children under 5 per term in Moorabool who are not yet group ready (for example, trauma response precludes group participation).
- The cost of physical resources such as taxi vouchers, fuel cards, child care where required to support service participation, computers, internet access, data & play kits for families to use during online sessions, sundries for group (morning tea, room hire, materials).
- Expansion resources to extend a 0-5 response to Golden Plains and Hepburn Shires through:
    - Mapping services in LGA, creating an LGA specific evidence based pathway and identifying family violence specific service gaps in the area;
    - Facilitating a collaborative network of services, working towards addressing gaps and providing an evidence based service response;
    - Identifying an appropriate location for therapeutic group/individual interventions;
    - Delivering and evaluating therapeutic interventions in LGA;
    - Pathway expansion not being considered for the Ballarat area currently given as it is a more urbanised LGA – further research required.

Costings

We have prepared the projected costings for our ideal service response to regional 0-5 year olds. Further adjustments are likely to be made when preparing applications for funding:

Positions Moorabool:

- Group delivery – 2 x 0.2
- Capacity Building – 1 x 0.6
- Therapeutic Case management – 1 x 0.2
- Individual Dyadic Therapy – 1 x 0.2

Positions expansion:

- Group delivery – 2 x 0.2
- Therapeutic Case Management – 1 x 0.2
- Individual Dyadic Therapy – 1 x 0.2

Total positions Van Go 0-5 response:

- 3 x 0.6 + 1 x 0.4 @ $72,000 per full time position = $264,000 per year
- TOTAL 3 years = $792,000

Annual Additional Expenses:

- Technology support for families – hardware, data – $10,000
- Play materials - group and home for online sessions – $8,000
- Group Venue Hire and morning tea – $8,000
- Transport support – fuel cards/taxi vouchers – $8,000

Total Additional Expenses:

- $34,000 per year
- TOTAL 3 years = $102,00

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