Trust, Safety and Participation

Supporting children and young people affected by domestic and family violence

PRACTICE CONSIDERATIONS FOR A PANDEMIC CONTEXT

A Western Australian Practice Guide

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Local artist, Desley Taylor, taking inspiration from nature to reflect her own journey.

From the artist

Even though I'm only 20, I've experienced things in my life which no person should ever have to live through. I keep my family safe and work to ensure that my daughter and I have a strong future.

The concepts for this project are inspired by the natural growth of local plants. For me, seeds, roots and leaves, and the colours they transition through, reflect my own journey. From dark to light, trauma to safety.

I want my daughter to grow up with no violence and surrounded by love and respect. To live a happy life without fear and dread.

— Desley Taylor, mother and artist

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SECTION ONE

BACKGROUND AND CONTEXT

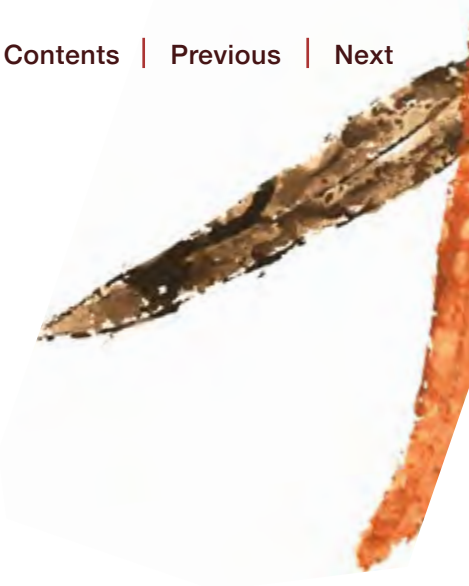
Introduction

It is increasingly being acknowledged that children and young people suffer the consequences of domestic and family violence in their own right. They are harmed by seeing and hearing violence and its effects. They are harmed by the effects of coercive control and the relational dynamics set up by perpetrators of violence. They experience the impacts of their mother's stress and distress. Children and young people are caught up in the cycle of violence. They are terrorised by it. They are confused by it. They are diminished by it. Their development is adversely affected by it. They struggle to make sense of why the violence occurs and what it means. Many children continue to experience forms of the violence even after it is described as having stopped.

Children and young people need responses that ensure they are safe in an enduring way. They need support to be able to make sense of how the violence has shaped their interactions and how it continues to influence what they know to be true about relationships. They need the people around them to offer them comfort and hope. Children and young people need to come to know that their own identity will not be determined by the violence. They need support to believe that their life will not be defined by how the violence has affected them.

The Australian Childhood Foundation has provided specialist trauma integrative family violence therapeutic services to children, young people and their families/carers for over two decades. Its pioneering work in this area has been recognised nationally and internationally. Its own **Safe and Secure Practice Framework** (Tucci, Weller & Mitchell, 2013), which has been influential in shaping the service delivery offered to children and young people. In 2017, the Foundation and the NPY Women's Council in Alice Springs also developed and published a ground-breaking approach to **preventing family and community violence** in remote communities (Tucci, Mitchell, Lindeman, Shilton, & Green, 2017). This guide draws heavily from this previous work.

This practice guide is oriented specifically toward supporting children and young people. The principles and strategies focus on children and young people as individuals with their own unique experiences, impacts, resources and needs, while acknowledging that they exist within a system and are dependent on, and affected by, the adults in their network. The content of the guide is informed b consultations with service providers and young people, and includes considerations for supporting children and young people experiencing DFV during the current global pandemic context.



> ***Most kids have a way of blocking things out but the memories are always there. I hear the echoes of screaming, visions of fighting and the fear of what will happen next stays with you.***
>
> — Words of a young person with lived experience of DFV

Domestic and Family Violence: Intersectional understanding

This practice guide is grounded in a gendered conceptualisation of the factors that underpin, perpetuate and maintain violence in relationships and society. It acknowledges the ongoing impact of colonisation on First Nations peoples. It offers an understanding of Domestic and Family Violence (DFV) which holds at its core an appreciation of a complex intersectionality, involving overlapping aspects of marginalisation and oppressive structures including gender, class and disability. Additionally, families in which DFV occurs may also be affected by substance misuse, mental health issues, grief and loss, and forms of entrenched adversity. Effective assessment, planning, engagement and intervention needs to integrate such multidimensional considerations in order for it to be respectful of the lived experiences of those who are affected by violence.

Purpose

This practice guide was commissioned by the Department of Communities, under the National Partnership Agreement on COVID-19 Domestic and Family Violence Response (Partnership Agreement), which is aligned to the State Government approach to COVID-19 pandemic and Recovery in Western Australia. The development of this practice guide was also informed by the **WA Path to Safety** document – Western Australia's strategy to reduce family and domestic violence 2020-2030, and contributes to the key outcome of increased workforce capacity.

This guide was developed between July 2021 and March 2022, during the second and third years of the global COVID-19 pandemic. The guide has been designed to ensure that services can continue providing effective, trauma-informed intervention during the pandemic context and respond to increased demand and case complexity associated with COVID-19 implications.

Who is this guide for?

This practice guide was developed as a resource to inform and drive effective, evidence-informed, trauma-responsive practice to support children and young people affected by DFV. It is intended to support the work of all professionals and services engaging with children and young people who have been forced to live with DFV, including family violence services, counsellors and therapists, schools, healthcare programs, accommodation and mental health services. It is hoped that any professional working with children and young people affected by family violence will be able to find information, principles or practice considerations relevant to their role and setting.

Note on language

It is acknowledged that terminology varies greatly between services, sectors and individuals in the area of family violence. For the purpose of this guide, Domestic and Family Violence (DFV) has been adopted as the preferred term. This terminology aligns with nominated language use by the Centre for Women's Safety and Wellbeing, as the peak body for the sector.

The term parent will include non-biological parents and carers, and children will at times refer to 'children and young people' inclusively. The preferred way to describe children and young who are the subject of support framed by this guide is through the phrases: children and young people who are forced to live with DFV and/or children and young people affected by DFV. Both phrases recognise that children are powerless to change or control their circumstances.

It is acknowledged that the majority of family violence is perpetrated by men against women, therefore the terms woman/women or mother/s will at times be used to refer to the 'parent/carer who is the subject of and affected by violence'.

How did this guide come about?

To identify principles of best practice, we adopted a multi-layered approach which consisted of researching, evaluating and integrating key messages from four pillars of wisdom described on the following page. We then adopted the **Safe and Secure Intervention Framework** and applied feedback from our consultations to contextualise this to a WA setting. Research, practice-evidence and consultation feedback from service providers and young people then informed strategies and practice considerations to support the application of this framework in the COVID-19 pandemic context.

Research evidence

A scan of the literature was completed to identify key themes in published research and practice papers from Australia and overseas, which related to the impacts of family violence on children, children's perspectives on family violence and service delivery, and young people's modality preferences for service access during COVID-19. It is noted that research focusing on specific impacts of the pandemic on children's experiences of DFV is only beginning to emerge. Findings from the research topics above were integrated into the knowledge base that forms the content of this guide.

N.B. For ease of reading, individual citations are omitted from the body of this document and a list of key references is provided at the end.

Practice knowledge

A series of consultations with service providers from multiple regional and metropolitan areas in WA as well as interstate was conducted to elicit core messages relating to effective practice in supporting children and young people affected by DFV, with particular focus on service provision during the pandemic. Services included refuges, domestic violence hubs, parenting services, frontline workers (child protection and police) and children's counselling services. A wealth of knowledge and ideas was shared during these consultations. Discussions highlighted the diversity of community contexts within Western Australia, as well as the common core themes that are inherent in family violence work across settings.

Centralising the perspectives of children and young people

Seeking wisdom from young people with lived experience was a critical component in developing this practice guide. Their perspectives were sought through a youth consultation process involving young people with lived experience of DFV completing a survey with the help of a support worker, as well as one-on-one conversations with the project's lead youth consultant.

Practitioners also shared feedback they had received from children and young people regarding their experiences and their preferences for receiving support from services.

Cultural wisdom

The principles outlined in this guide acknowledge and reflect the value of traditional healing approaches and the significance of family and community relationships embedded in the culture of First Nations Peoples. The guide attempts to uphold the importance of integrating such principles across all forms of assessment and recovery planning. The value of such approaches was repeatedly highlighted throughout consultations, and included storytelling and deep listening, recovery approaches grounded in nature, rhythm and movement, and a focus on themes of connection, place, family and belonging.

DFV and the impact of COVID-19

Police statistics and service provider reports paint a harrowing picture of the impact of the COVID-19 pandemic on the prevalence of family violence. While rates of family violence were already increasing in Australia over recent years, the impact of COVID-19 lockdowns, increased financial pressure, added levels of household stress and exacerbated mental health symptoms all compounded to create an environment where abuse dynamics accelerated.

Simultaneously, families were isolated from their extended family, neighbours, friends and support networks. The adaptive strategies women and children had relied on to keep them safe were taken away from them. Schools and other public settings were unable to keep an eye on vulnerable children and offer support. The most vulnerable children became invisible. During periods of lockdown or times when families were home together outside of their normal routine, access to services such as helplines and support workers was also difficult and risky. Rental pressures added to crisis accommodation shortages, making it impossible for many women and children to leave their home in search of a safe place to live. There was also an ongoing impact on levels of staffing in key organisations due to travel restrictions, isolation requirements and a range of other factors, with subsequent effects on service delivery and client outcomes.

While there are some indications of reductions in reporting or help-seeking during periods of restrictions such as lockdown, these trends must be cautiously interpreted, as they may be representative of other factors rather than reflecting a reduction in the occurrence of violence.

As noted by the Tasmanian Commissioner for Children and Young People (2020),

"to strengthen our understanding of the effects of family violence on children and young people during the COVID-19 pandemic and beyond, it is important that official reports and service-level data on the incidence and severity of family violence are augmented by focused efforts to understand the lived experiences and perspectives of children and young people and their protective/non-violent parent or carer."

Consultations: What did we hear?

Workers asked for a guide which:

- Summarises core knowledge and practice principles relevant for all professionals who support children and young people affected by DFV.
- Highlights the voices of children and young people.
- Speaks to the importance of cultural sensitivity, humility and competence.
- Presents DFV-related trauma impacts in relation to developmental ages and stages.
- Offers a consistent map and approach to inform practice for all professionals, regardless of their work setting or role.
- Offers practice strategies beyond telehealth to use in a pandemic.

Service providers from multiple regions also shared their experiences of supporting children and families throughout the pandemic, how they adapted service delivery, and the challenges and opportunities that arose during this time. Their insights and examples are threaded throughout this guide.

Lived experience: Young people's voices

Young people who participated in the project consultation shared that their top needs and wants from services were provision of financial support, accommodation and other safe places, and help with basic living items.

Young people told us that, during the COVID-19 pandemic, things that would make it easier for them to access supports would be to continue being able to access face-to-face services, having access to a smart phone or laptop with internet access, and more support through social media, SMS, phone calls and Facetime (preferred to Zoom or Skype). More broadly, young people told us they would like more information on the services or help that are available, and that it mattered to them that workers research their culture, and engage with understanding and respectful communication.

Conclusion

The practice guide which follows has been entitled Trust, Safety and Participation because it emphasises the three key themes that young people identified as being important to them in seeking and receiving support. It offers a reminder to all adults that the needs of children and young people affected by DFV can be met when we hold an open heart and commitment to listening to them in ways that enable the meanings they hold to shape our beliefs and actions.

SECTION TWO

IMPACTS OF DFV-RELATED TRAUMA

Neurobiological, developmental and attachment impacts

Cultural impacts

> ***Blocking out the abuse and pretending everything is okay helps me as the reality is too painful.***
>
> — Words of a young person with lived experience of DFV

Neurobiological, developmental and attachment impacts

This practice guide is underpinned by an understanding of the neurobiological and developmental impacts of family violence from in utero through to and including adolescence.

Research confirms differential impacts of exposure to violence at different developmental ages and stages, with implications across a range of dimensions (physiological, emotional, relational, psychological, cognitive).

The impacts of DFV on children and young people varies depending on their age and stage of development, the frequency and intensity of the violence and abuse, and the protective and risk factors that exist within their relationships, environment, and community. It is important to note that DFV affects unborn children and can have far reaching consequences for their development throughout their childhood. The following pages contain a summary of typical developmental trends, and how the trajectory of development and functioning can be affected for children and young people who experience DFV.

Pre-natal to two years old

When women are harmed by DFV during pregnancy, their unborn baby is at risk of being affected in a number of ways. The baby can be physically harmed if violence is directed to a mother's abdomen or if a mother falls during the violence. The unborn baby can also be affected by exposure to increased stress chemicals such as cortisol, or secondary impacts arising from poor nourishment due to low appetite or restricted access to regular healthy meals. If a mother relies on drugs or alcohol to manage the toxic stress caused by the violence, this can also affect the unborn baby. In utero, babies are undergoing rapid growth and development. Their systems are taking in information from their environment to tailor their development in preparation for the world they will be born into. A baby who is developing in a high-stress context is more likely to be born with an over-active stress system, ready to survive in a world that has been assessed as being dangerous. Statistically, pregnancy and the postnatal period are times of increased risk of violence against women, and screening and support during this time are essential in order to mitigate the risks to the mother and the infant.

Infants and toddlers are completely dependent on their caregivers, and it is the quality of their experiences within these relationships that influences their development. This is a stage of significant neural development, and the brain is extremely sensitive to stress and the presence or absence of their primary caregiver. Infants and toddlers need their caregivers to be available to them and tuned in to their emotional, relational, and basic needs. Through the meeting of these needs, infants and toddlers develop an understanding that they can rely on others to be a source of safety and comfort, they feel secure, and their world feels safe. They learn to regulate their nervous systems and their emotions, through co-regulation with their caregivers.

When their primary caregiver is threatened by DFV, the infant or toddler can be left alone in a heightened state of stress. Their primary caregiver may be unavailable to co-regulate and is themselves experiencing a heightened state of stress. Even if DFV is not directly witnessed, the unborn child, infant or toddler, can experience the toxic effect of DFV through the activation of chronic stress in their primary caregiver. DFV is experienced as a persistent threat, which the unborn child, infant or toddler has no escape from, and can be compounded by the compromised capacity of their primary caregiver to provide comfort and safety.

The persistent threat of DFV leads to a state of embedded stress which can significantly impact the parent/child bond (attachment). As a result of DFV, infants or toddles can experience high levels of anxiety, they might cry more and be more difficult to soothe. They may dissociate or stage a "mental retreat", appearing quiet and withdrawn as a way of coping with the perception of threat. The impact of DFV at this stage reverberates throughout the child's development; the biological systems responsible for managing stress and the templates that influence future relationships are formed with shaky foundations.

3-6 years old

Young children continue to be dependent on their caregiver, with an increasing sense of independence in learning new skills, taking part in activities with more autonomy and an increase in relationships outside of their immediate family. A period of rapid emotional and social development, the young child continues to need input from their caregivers through co-regulation of their nervous system and intense emotions. Young children need guidance to navigate challenges and conflict in their relationships. They begin to hold an increased understanding of their physiological and emotional responses. They start to put language to feelings and begin to read and understand the cues and feelings of others.

Children affected by DFV at this stage can exhibit more emotional and social problems, such as being overwhelmed by emotions, aggression, anxiety, difficulty playing well with other children and diminished empathy. They are also more likely to experience post-traumatic stress symptoms such as intrusive/distressing memories, hypervigilance, and nightmares. Without the cognitive processing or verbal expression skills required to communicate their experiences and states, children might express their distress through their play and interactions with others.

The trauma caused by DFV can impair the growth and activity of the connecting structures between the left and right hemispheres of the brain. As a result, young children may find it difficult to know, name and express their feelings. They might struggle to read social cues and to know how to respond in social exchanges. The unknowns of new situations, such as transitions in school or meeting new people, can feel threatening.

The extreme fear that is caused by exposure to DFV can lead to psychosomatic problems, such as headaches or body pains. Young children might regress in their development (for example with sleep, toileting or emotion-regulation), and exhibit a fight, flight, or freeze response to reminders of the DFV in their environment.

7-12 years old

Children in the middle years have a growing desire for independence while continuing to require comfort and support from their caregivers and other adults. These children begin to consider situations and ideas in more depth and from multiple perspectives. They begin to make sense of their world by thinking and reasoning in a more logical way. Children in the middle years become more oriented towards their peers and have a developing self-concept, which influences their self-esteem and a growing need for a separate identity. They may have developed some capacity to self-regulate, but still require input from adults around intense emotions and conflict that they cannot resolve themselves. They hold a solid understanding of “right” and “wrong” and a stronger ability to empathise with others.

Frequent exposure to DFV can change children’s stress response systems; their energy is perpetually directed to respond to potential threats, even when there is no threat present. These children may operate in a state or survival (flight, fight or freeze) which inhibits the thinking part of their brain and compromises the systems responsible for memory and attention. This impacts their ability to manage their behaviour and emotions, to engage in learning, to form and maintain friendships and to adhere to rules and limits – further diminishing their self-concept and stalling developmental progress.

Children in the middle years begin to develop a more advanced understanding of their experience of DFV and attempt to think of reasons for it. They tend to blame themselves, try to prevent it from happening, or they might try to rationalise the behaviour of the caregiver responsible for the DFV. If this thought pattern is not counteracted, there is a risk of children “normalising” DFV or engaging in similar behaviours themselves. Self-blame is underpinned by shame; the child’s developing self-concept and identity can be shaped by a belief that there is something wrong with them and that relationships and their world are unpredictable or unsafe.

Adolescence

Adolescence is a period where peer relationships and identity are of high importance, as well as the need for independence. Young people can experience strong and fluctuating emotions, which increases stress, and conflict with friends and family. Young people often test boundaries. They begin to partake in more high-risk behaviours and activities and to explore intimate relationships. They develop the ability to engage in abstract thinking and become more concerned with their emerging values and beliefs, body image, sexuality, and gender identity.

Adolescents exposed to DFV may try to intervene and prevent or interrupt the violence. Anger may be directed at the person using violence, or the person being targeted – for inability to leave or perceived "failure to protect". Adolescents may also attempt to take on caring roles, which can lead to significant emotional burden, and the corruption of their childhood during a critical period in their development.

Young people affected by DFV might cope with their distress by withdrawing, self-harming, alcohol and drug use or other high-risk behaviours. This is the result of the overwhelming and isolating nature of DFV, and the lack of support that can exist due to secrecy, shame, or the development of beliefs that they cannot rely on others for comfort and support. They may present with poor or reduced academic performance or disengagement from school and social groups. They may present with a range of mental health concerns such as symptoms of depression, anxiety or disordered eating.

Adolescents affected by DFV can have trouble forming and maintaining healthy and respectful relationships. This can be due to modelling of relationships within their home and issues stemming from low self-worth, normalised beliefs about DFV, elevated stress, social challenges, and low capacity to regulate emotions or manage conflict.

Young people can have difficulty trusting others due to their experience of relationships being unpredictable and unsafe. They might avoid close relationships altogether, due to their belief that relationships are a source of pain and distress, or their relational dynamics might mirror those of DFV. They may find it difficult to orient to the future, unable to make plans for their lives, develop goals, uncover passions or access motivation and planning skills required to engage in their schooling or prepare for a future that holds hope and opportunities.

Cultural impacts

DFV is sourced in the pervasive impact of violent and sustained experiences of colonisation of First Nations Peoples. This past and present context must be considered when exploring approaches that support healing for individuals, families and communities.

DFV affects a child's connection to their culture and disrupts their access to cultural strengths, identity and resources. Supporting a healing journey for Aboriginal and Torres Strait Islander families involves addressing underlying factors rather than focusing on symptoms, prioritising Aboriginal ownership and appraisal of healing initiatives, and a strengths-based orientation. These key principles are endorsed by the Aboriginal and Torres Strait Islander Healing Foundation Development Team and are consistent with stakeholder feedback received during the consultation process with service providers and young people.

Similarly, when supporting families from Culturally and Linguistically Diverse (CALD) backgrounds, it is important to understand the family's post-settlement challenges and the impact of cultural change on family functioning, particularly around gender dynamics and expectations. It is important to understand that CALD families exist at the crossroads of various forms of oppression. WA practitioners, and the relevant literature, both identified the importance of recognising diversity within refugee communities, family ties in refugee communities, expectations around family roles and the potential importance of community-involvement in DFV interventions.

SECTION THREE

PRACTICE PRINCIPLES

It is important to acknowledge that workers and services in the WA Family Violence sector are guided by existing frameworks, policies and guidelines which relate to their work with children and families. These include the **National Principles for Child Safe Organisations**, **Safe & Model™** and the **Common Risk Assessment and Risk Management Framework** (CRARMF, WA). The practice principles outlined in this guide are intended to support practitioners in their work within these parameters.

Practice principles

The practice principles presented on the following pages are drawn from a thematic analysis of key messages derived from the process of developing this guide. They are oriented to the needs of children who have been forced to live with DFV and are described with reference to impacts and how these link to intervention approaches. These principles underpin all elements of the intervention framework presented in Section 4, and inform the strategies and approaches discussed in this guide. The principles offer a checklist for intervention plans to be mapped to, and a shared set of parameters to unify multi-service efforts.

Children who have experienced DFV need responses and interventions that:

- Prioritise all elements of their safety
- Support their connection to culture
- Are coordinated and collaborative
- Are child-centred
- Build trust with and for them
- Are tailored to their unique circumstances
- Hold an understanding of trauma-based behaviour
- Privilege their voice and participation
- Are recovery focused
- Protect and repair their relationships

Children experiencing DFV during a pandemic need creative and flexible responses.

Prioritise all elements of their safety

DFV occurs in the relationships and settings where children and young people should feel the safest. It corrupts a child's emotional, psychological and relational security, and can place their physical safety at risk. It maintains their neurobiology in a constant 'alert state', unable to settle in the place they should feel the most connected and comforted. As a result, they are often unable to detect and respond to cues of danger or safety in other settings.

Therapeutic responses need to prioritise all aspects of a child's safety. Immediate physical safety must be paramount, however, their relational and emotional safety must also be considered. This includes access to calm and containing adult figures to support co-regulation, and processes that centre on familiarity, predictability and consistency.

Support their connection to culture

Children need services and practitioners who adopt a stance of cultural humility marked by informed curiosity. This includes seeking to understand diverse value systems and parenting practices and identifying cultural strengths and resources within the child's family and broader network. Connection to culture, country and family must be integrated into all levels of intervention. Cultural healing principles including storytelling, deep listening, rhythm, and nature-based therapies can be embedded into services models to support positive engagement and healing outcomes for children from all cultural backgrounds.

Are coordinated and collaborative

Family violence is an isolating and disconnecting experience for children. Their support networks are often undermined or restricted and they receive the message that they are alone and cannot trust others to help them. When services become involved, often the child or parent's needs will be itemised and allocated to multiple services or workers. Service models which provide integrated, well-coordinated and holistic approaches mitigate the impacts of isolation and prioritise the child's needs as a shared goal.

Are child-centred and needs-oriented

Children who live with DFV often have their needs overlooked or inconsistently met. Children can learn to make themselves and their needs invisible as a way of protecting themselves or others. Services and professionals often have to balance prescriptive service parameters, resources, and competing adult rights, and are at risk of echoing the system which overlooked the child's needs. Responses which maintain a focus on the needs of the child are best placed to result in positive outcomes for the child and the family system. If responses deliberately centre around the child's best interests, this will also likely have positive outcomes for the parents/family.

Build trust with and for them

Trust is a casualty of DFV for children and young people. Trust is eroded from within the family by the violence. Children do not know who to trust, what to say, how to be. They are not confident that their own judgements are real. The constant threat of violence hangs over all their interactions. As such, trust must be rebuilt slowly with them and for them. They need adults to gradually establish platforms of trust that they can practice and rehearse in order for it to be feel familiar again. Trust emerges from shared activities that are consistent and predictable. It is amplified when these activities hold joy and comfort for them. As children experience trust as more common place, they can begin to transfer it with others who are important to them. Therapeutic interventions will be even more effective if there is time offered to children and young people for them to feel trust from their networks of care around them.

Are tailored to their unique circumstances

Family violence can be understood conceptually by explanatory frameworks and common factors, however, each family and child's situation varies greatly and these individual factors must be taken into account when shaping effective responses. The child's unique context will include a varied set of resources, networks, needs, strengths, wishes and values. Children and their safe caregiver can be supported to have their story and wishes heard and honoured, to shape unique, tailored responses that promote safety and healing.

Hold an understanding of trauma-based behaviour

DFV-related trauma becomes an embodied experience. Children's nervous systems adapt to chronic threat by keeping their stress-response activated at all times, keeping them locked in a perpetual state of fight, flight or freeze. In some cases, children's systems opt to switch off or check out as a way of protecting them from the effects of violence. They develop automatic procedural tendencies and reactive protective responses to adapt as best as possible to their situation. The outward behaviours we see can be misinterpreted as defiance, opposition, laziness, not listening, demanding, difficult. Children exist in complex and dynamic systems and rely on a vast network of adults to provide for their developmental needs. This includes educators, sporting groups, community organisations and specialised support or clinical services. Each of these sectors can best support children by developing their understanding of the impacts of violence-related trauma and how these impacts manifest in various behavioural presentations. Assessment and intervention approaches which apply a trauma-lens and needs-orientation to understanding behaviour are the most effective in attaining positive and sustained change.

Privilege their voice and participation

Children who have experienced family violence need to be held at the centre of all interventions; to be seen as having their own rights, impacts and needs. From the beginning, service design, development and review should be grounded in and informed by children and young people's input and feedback. When a child comes into contact with a service, protocols should automatically steer towards seeking the child's voice in identifying goals and needs and developing intervention plans. Processes that ensure young people's active participation in decision making, planning and reviewing should be embedded in service delivery processes.

Are recovery-focused

Interventions identify and enhance resilience and strengths within child and the family system. When children grow up experiencing family violence, they receive messages about their own inadequacies, weakness and helplessness. Once a system response has been activated, risks and the damaging effects of violence on children often dominate attention. Approaches which empower children and their safe adults, recognise resilience and resource, build on strengths and elicit agency, can counter these effects and equip children for long-term recovery.

Protect and repair their important relationships

Relational disruption is a significant impact of family violence, contributed to by the effects of violence on parental capacity and confidence to provide consistent, attuned responses to their children's needs. Secure attachment to a safe parent or carer is a substantial protective factor against the negative effects of exposure to family violence, and should always be upheld as a critical intervention safety goal. Importantly, other relationships around children and young people should be the source of focus for practitioners to enable networks of care to be strengthened and provide love and attention that children need.

Children experiencing domestic and family violence during a pandemic need creative and flexible responses

Themes inherent in family violence – isolation, increased parenting stress, disconnection from supports and relationships – are all exacerbated by the pandemic context. The needs and consequences highlighted in the above practice principles are intensified. At the same time, the capacity of services to continue delivering best practice is also affected, resulting in a compounded vulnerability. The stories of difficulties caused by the pandemic also run alongside stories of creative solutions, flexible and adaptive service delivery, unprecedented collaboration and shared problem solving.

SECTION FOUR

OVERARCHING INTERVENTION FRAMEWORK

Framework overview

Foundations

Response domains and intervention strategies

Outcomes

Additional feedback from service provider consultations

Intervention framework

The intervention framework presented in this section is based on the **Safe and Secure** framework which was originally developed by Australian Childhood Foundation in 2013 for a Victorian context. For the purpose of this practice guide, the Safe and Secure framework has been contextualised for Western Australia and updated to incorporate a pandemic-focused application. The strategies and approaches described within the framework uphold the practice principles presented in section 3, and are informed by consultations with service providers, young people and relevant literature.

The development of this adaptation of the framework aligns with the WA Path to Safety First Action Plan which has "an initial focus on actions to address the significant impact of COVID-19 on family and domestic violence in Western Australia", including aims to strengthen workforce capacity and consolidate current practices in this area (Government of Western Australia, 2020).

The aim of the framework is to provide a way for practitioners to think about how to support children and young people affected by DFV within the context of their role, organisation and the professional systems they work in around the child. The framework seeks to build a shared platform of understanding from which consistent ways of responding can be developed, regardless of when and in what capacity professionals engage with the child or young person following an experience of DFV.

The framework offers a way of conceptualising the change process for children and young people and outlines actions and strategies to be considered at all points of intervention. It defines core goals that need to be met for children and young people to heal and recover from the traumatic impact of DFV on their development, relationships and identity. It can be used to develop and organise plans that progress children along a path to recovery. Though not a linear model, its sequential design does represent a phased overarching approach to intervention.

The framework assumes a risk assessment has been conducted and it has been determined that an intervention is required. Application of the framework assumes parallel continued use of relevant risk assessment protocols, such as the **CRARMF**, where organisationally relevant.

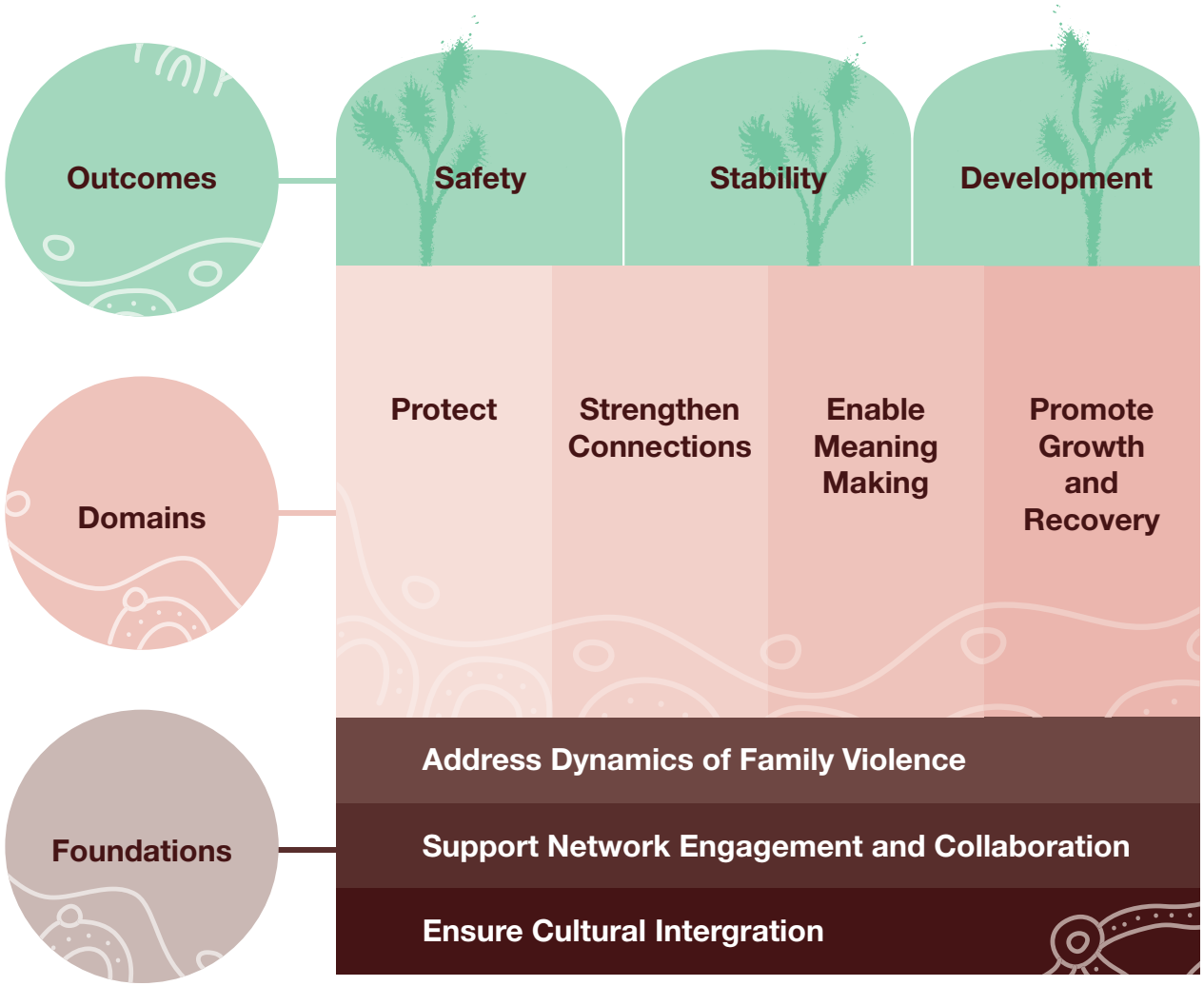
> ***Every family is different and acts out differently. Gaining trust is very important. Help them understand domestic violence is wrong. Support, care and believe in them. Show them they can change with your help and support.***
>
> — Words of a young person with lived experience of DFV

Safe and secure practice framework

(Tucci, Weller and Mitchell, 2013)

The framework comprises a component structure of Foundations and Domains.

The Foundations represent elements that underpin all interventions with children and young people. They also translate into strategies that can be applied to direct practice and contextualised to specific aspects of intervention. The Domains of intervention specifically relate to work that is undertaken directly with children, families and others in their network. Each of these elements are described below, including examples of strategies and considerations for general practice as well as the current COVID-19 pandemic context.



The foundations of intervention

The framework has three foundational elements that underpin any intervention offered to children and young people affected by DFV.

FOUNDATION 1: Cultural integration

The first foundational element is the need to ensure considerations about families' cultural background are integrated into all forms of intervention offered to children, young people and their families. Children who have the opportunity to grow up strong and connected in culture, develop confidence, positive identity, belonging and security that become protective factors as they grow through adolescence and into adulthood. Separation from family and/or country serves to deepen the tracks of trauma that are left in a child's developing brain and body. When planning interventions to support children, consideration must be given to maintaining safe and positive connections with family, community and country. For Aboriginal and Torres Strait Islander children, a strong family support system can mitigate the effects of multiple adversity, such as the impacts of colonisation, separation of families, intergenerational trauma, structural racism, and marginalisation. A trauma-informed approach to support includes engagement of family and community in determining service response. Regional practitioners spoke of the importance of developing cultural competence from a stance of curiosity and humility – building relationships with community members and Aboriginal and Torres Strait Islander colleagues and developing an understanding of the local cultural context in their region, including social norms, customs, traditional child-rearing practices and parenting values.

Similarly, for migrant and CALD families, gathering information about the family's pre-settlement experiences can help inform DFV interventions and facilitate a holistic response.

Cultural integration: Strategy examples and considerations

- Families should be provided with resources and information in their primary language wherever possible.
- Consult and collaborate with agencies that represent children's cultural background. Take the time to find out about the cultural background of the family. Identify the extent of support that may exist in the broader kinship and community structures surrounding the family.
- Explore the cultural meanings attributed to common experiences of childhood, parenting, and family.
- Determine which aspects of cultural connection or customs are affected by the pandemic context, and explore alternative opportunities to simulate these practices or meet these needs in other ways.
- Explore and incorporate cultural meanings given to concepts of safety, violence, gendered roles and authority.
- Consider interpreters and cultural brokers to facilitate conversations with children's family.
- Integrate an understanding of the impact of trauma and dislocation in the background of the parents. Implement culturally relevant healing strategies that support the broader family.

COVID-19 consideration

The isolation and physical distance implications of the COVID-19 pandemic were felt by practitioners and services in metro areas around the country, where typical connection modalities and forums were disrupted by new rules and restrictions.

But for those working in regional and remote areas, these implications were inherent in pre-COVID 'business as usual'. The necessary transition to increased reliance on technology for connecting workers within and between services has seen an increase in coordination in some areas, where online network meetings have improved access and connection for workers based in remote settings.

FOUNDATION 2: Support network engagement and collaboration

The second foundational element is based on the principle that children and young people benefit when agencies take a collaborative approach to assessment, planning and intervention. Effective coordination and cooperation can be mediated through structures such as **care teams**, where multiple agencies come together regularly to discuss needs, agree to shared goals and determine responsibilities. When implemented effectively, these collective processes align the intent and action of different parts of the system around the child and build a platform for coordinated responses.

A collaborative and partnership approach to supporting children affected by DFV enables agencies to:

- Establish clear protocols for sharing information, plans, actions, concerns, outcomes and responsibilities.
- Monitor and review the effectiveness of plans and interventions for children and young people.
- Proactively plan and respond to the changing needs of the child and family.
- Ensure consistency in approach to supporting the child across settings including home, school and therapy.
- Continually seek and incorporate the views and voice of the child and the parent/carer and professionals caring for them into all planning.

Network collaboration: strategy examples and considerations:

Within the parameters of your role and organisation, consider how you might action or participate in the following:

- Take part in care teams that support collective decision making about children.
- Establish clear processes for communication and exchange of information between parties.
- Define clear roles and responsibilities for each member of the care team.
- Establish collaborative processes to identify and respond to the risk of family violence.
- Identify immediate, medium and long-term needs for the child and develop strategies and resources to address these.
- Ensure that clear decision-making processes exist between members of the care team.
- Consider how to involve mothers and other relevant family or community members in care team meetings or decision-making processes.

- Develop and implement ways that children's views can be considered in decision making that affects them, and how outcomes will be shared and explained to the child.
- Establish processes for timely review of plans and progress.

The following section outlines two local (WA) practice models which are described by service providers as being effective in facilitating processes of network collaboration.

Domestic Violence Hub Model

Recently, the WA Government has supported the establishment and piloting of a **Hub Model**, bringing multiple services together in single sites to optimise coordination. Feedback received from both pilot Hubs (metro and regional) during our consultation process was overwhelmingly positive, with workers identifying the role of 'soft entry' in promoting engagement, relationship, trust and service uptake, as well as the increased capacity for a unified approach between programs. While in its early days, this model appears to facilitate a shift from 'collaboration' to 'partnership', expanding services' capacity to develop and deliver streamlined and comprehensive responses which recognise the multidimensional nature of DFV and its impacts.

The 'Hub Model' of service delivery aligns with a trauma-informed knowledge base around effective engagement and outcomes:

Environmental safety

Familiar and predictable settings, accessing multiple services at one site rather than many, knowing where to go, where to park, where the toilets and kitchen are, who will be behind the front desk.

Relationship-focused

Families can take time to build trust in the relationships they establish at the centre. They may see the children's counsellor around and observe how members of different programs interact before they feel confident to support their child to engage in counselling.

Meeting multiple needs

Families can attend to access food support, make a coffee or do their washing before they are ready to access parenting programs or para-legal support.

Understanding the stress response and working to simplify access

Navigating multiple services, remembering 'who is who', keeping track of different appointments and organising transport to different venues all serve to increase pressure and stress in an already overwhelming time. Consolidating services and programs in one setting works to reduce this pressure and acknowledges that families need accessing help to be as easy as possible.

Regional FDV Networks

As Australia's largest state, WA is geographically vast and comprised of great community diversity including across its regional and remote areas. Service delivery models have long had to take into account this diversity, with uniform approaches being impractical and often unfeasible. Each community has had to rely on the ability and drive of individual services or workers to establish and maintain inter-agency relationships, and continually adapt to fluctuations in funding, resources and staffing. This context is often the impetus for creative and adaptive problem solving, borne out of an increased reliance on relationships between practitioners. The coordination of family-oriented services varies across regions, though appears to work best when a lead agency holds responsibility for an active coordination role.

In regions where **FDV Networks** are established and active (for example, Pilbara Network, coordinated by WACOSS), stakeholders report feeling connected to other workers and supported in their work through the awareness of what services are available, up to date knowledge of waitlists and referral pathways, receiving information about available grants and funding, and sharing of practice wisdom.

With these relationships as a platform, when children become engaged with a service, they are benefiting from this collective knowledge and wisdom, and when a multi-service response is indicated, referral and engagement can be streamlined.

FOUNDATION 3: Address dynamics of DFV

All aspects of intervention supporting children and young people affected by DFV must be underpinned by deliberate and informed efforts to address and challenge the dynamics inherent in this form of violence, such as abuse of power, use of coercive control and underlying attitudes and beliefs aligned with gendered biases. Understanding, addressing and challenging these dynamics is a critical component in ending violence and creating enduring change.

Furthermore, at an individual level, men must be supported to make meaningful change, requiring an understanding of the causal factors that contribute to their use of violence, such as:

- Personal belief systems that legitimise the use of violence as a form or relational power
- Undiagnosed or untreated mental health problems
- Alcohol or drug addiction
- Lack of social supports
- Inability to manage personal stressors
- Unprocessed childhood trauma or unresolved grief
- Dislocation from cultural identity

Supporting change to these individual dynamics is important in addressing violence in an ongoing way. Interventions should include a focus on promoting accountability in men as well as resourcing them to undertake a change process necessary for sustainable safety.

N.B. A specific focus on 'perpetrator accountability' and men's behaviour change is beyond the scope of this practice guide, however, professionals may wish to seek further information or training from relevant organisations (for example, Stopping Family Violence; Department for Child Protection).

From CRARMF (Fact Sheet 7):

"When children are not safe due to family and domestic violence, this is often attributed to the mother for not leaving the relationship or not managing the perpetrator's behaviour or taking active steps to protect the child. This effectively holds the mother responsible for protecting the child from the perpetrator's use of violence. Holding mothers responsible for the safety of children has the effect of relieving the perpetrator of any accountability for the impacts of the violence on children."

Address dynamics: Strategy examples and considerations

- Support women's efforts (particularly though the family court system) to hold violent men accountable – including support to complete applications, paperwork, access computers, printers and email to complete and forward documents, support to access legal aid by phone or video, support to attend court via phone or video.
- Seek opportunities to challenge violence-aligned attitudes, beliefs and behaviours at a broad social and cultural level.
- Support referrals for men to relevant health, addiction, cultural and psychological support services for intervention to address underlying contributing factors.

Interrupting the cycle of violence

Long-term, sustained recovery involves supporting the child to develop healthy boundaries and safe, positive expectations of relationships, and equipping them for a strong, secure future. This includes:

- Engage women and children in a process of 'de-normalising' violence dynamics so that these are not perpetuated in future relationships.
- Facilitating the processing of grief and loss related to experiences of family violence.

Ensure intervention does not end at the point of removal from violence – engage children and their mothers in recovery plans that include processing their experiencing and equipping and empowering them for lasting change moving forward.

Domains of intervention

The domains of intervention relate to work that is undertaken directly with children, their mothers and the important people in their network.

Through shaping and reshaping a child's relationships and day to day interactions, intervention offers children and young people opportunities to heal from the impacts of DFV-related stress and trauma. To achieve these important moments of repair, the approach to therapeutic work needs to be informed and supported by a practice orientation that prioritises the needs of children and young people and gently and carefully responds to these needs.

The response domains presented in this framework are action-oriented and relate to direct work with children and the important adults in their network. The phases of intervention are presented sequentially, and should be held in mind in this way, however, a strictly linear approach is unhelpful and it should be noted that phases overlap without discreet beginnings and endings. These phases reflect the shifting primary focus and orientation of intervention in line with the child's dynamic context and needs, informed by an understanding of development, attachment and neurobiology.

Each Domain is described with reference to examples of strategies which can be adapted to a range of settings and contexts, including during the COVID-19 pandemic.

DOMAIN 1: Protect child and create safety

Protection refers to ensuring all elements of the child's safety, including physical, emotional and relational, are met. Protecting children is a community responsibility. When a service response is required to ensure protection, this includes a community response.

The intervention framework also locates an important realm of safety for a child within the mother-child relationship. Importantly, the professional system should orient itself to resourcing this relationship through legal, support and therapeutic services. An empowered and resourced mother has more capacity to provide and maintain an environment of safety for her and her children.

Children's recovery begins with them being afforded safety, and felt safety reverberating through them. When safety has been violated, the professional system around the child must be activated to establish physical safety, while also orienting its response to resourcing safe caregivers to provide and accept protection. Empowered safe parents have the best chance of maintaining an environment of safety and security, achieved through a partnership approach to the service-parent relationship.

When children have experienced DFV, the immediate removal of violence (through relocation of the violent parent or the child and their non-violent parent) does not translate to immediate felt safety. The effects of chronic, toxic stress pervade their nervous systems even after immediate threat is removed. Their fears of what will happen next, worries about the violence returning, angst for their parents' and siblings' welfare, and grief for what is lost all cumulate to maintain an alarm state. Sometimes, this state of vigilance and fear is unable to be sustained by the child's stress system, and they default to a shut down, disconnected and withdrawn state. The removal of threat is not enough to signal safety to their system. Their bodies need consistent and prolonged exposure to cues of safety in order to relax, regulate, and re-engage.

Children receive messages of safety through the words that are spoken to them and the signals they pick up in their environment. They tune into the relaxing of their mother's face and body, the calm connection offered by their teacher, the warm familiarity of their favourite toys, the predictability of routine, the availability of sensory items that calm and comfort their bodies. The stress induced by uncertainty is countered by providing answers, sharing information and allowing opportunity for the child to enact choice and agency. Only once a child has settled into a state of felt safety, can they access higher cognitive functions that allow them to engage meaningfully in verbal processing of their experiences.

Assessing and planning for safety includes determining what the child and their safe parent's views of safety are; what does 'safety' mean to them, what are they seeking from service involvement? It is important to consider differing perspectives between families and agencies or workers.

> ***"If a family are living in their car, we can either ask 'how can we get them out of their car into a house so they can be safe?' or, we can ask, 'how can we help to keep them safe while they're living in their car?'"***
>
> — Children's Counsellor, regional WA

Felt safety

While immediate physical safety often takes precedence, consideration should also be given to ensuring emotional and psychological safety for the child during any and all service interventions. Importantly, the effects of violence do not end just because parents have separated. Children can continue to feel unsafe, worrying that the violent parent may return or find them, worrying about pets or family members left behind, worrying about what will happen now. Some young people are forced to have contact with unsafe people. Some are not supported to maintain relationships that are important to them. Protection must include all elements of safety.

Protection: Strategy examples and considerations

- Involve familiar workers or family members in all aspects and stages of assessment and intervention (where possible, explore with the child who they know and feel comfortable with, who they would like to be present).
- Provide information and answers to mitigate the effects of uncertainty and worry.
- Ensure key belongings are accessible if moving from the family home.
- Take seriously any worries about siblings or pets, and address these where possible.
- Wherever possible, seek and honour input from children regarding their wishes for contact with their parent who has used violence. Consider how felt safety can be increased during these interactions. This could include the presence of a safe person, clarity around boundaries and 'rules' for the contact, resourcing the child with words and actions to enact boundaries and indicate if they are feeling unsafe. When visits are converted to video or phone, they may need to be shorter and more 'facilitated' with a focus activity or conversation prompts.

Experiences of 'felt safety' can be promoted wherever a service is provided. For example, in one regional area when pandemic restrictions limited on-site service access, children's counsellors arranged to attend their child clients' school to conduct therapy sessions in a familiar environment. This was noted to improve engagement in sessions and build a sense of competence in young clients, attributed to a sense of belonging and ownership over their setting.

Telepractice considerations

When engaging in service delivery via telepractice, extra consideration must be given to the child's safety and environment. Workers must consider who is present in the home or space, whether having an adult present promotes or inhibits engagement and safety, and how the child can communicate safety or threat to the worker.

Practice Tips from telehealth clinicians:

- Discuss and agree to 'COVID Plans' in advance where possible, to ensure smooth transition if restrictions are imposed.
- Agree to cues for child to use to indicate if they feel unsafe, or confirm that they are safe and OK to talk (for example, hand gestures, code words or using thumbs up/down signals in chat function).
- Discussing best times to conduct telepractice sessions (for example, on the way home from school, on certain days).
- Have an agreed PLAN B if unable to engage in planned session (for example, agree that worker will send text if child does not answer video call).

When face-to-face service delivery is operating, felt safety can be promoted by:

- Spending time orienting the child to the building and people when engaging with a new service, worker or location. Take time to explore any changes in the building or setting since last visit. Children will notice changes such as an absent receptionist, new paint, missing toys or artwork from the waiting room, a worker's new glasses. Taking time to share in and help them voice their observations will assist them in settling into the space.
- Ensuring mindful use of body posture, gestures and voice. These critical interpersonal elements become even more important during periods of mask-wearing. Maintain awareness of eye gaze and upper facial expression, as well as a conscious use of gestures and prosodic voice to promote neuroception of safety in all interactions.

Meeting basic needs

Children are unable to relax into felt safety and begin experiencing calm if they are unsure about their basic needs being met. The consistent provision of basic needs and essential items does more than sustain a child physically. It can provide a source of nurture and connection, communicate care and support, give messages of containment and assurance, reduce a child's cognitive stress-load, and support the development of a trusting relationship.

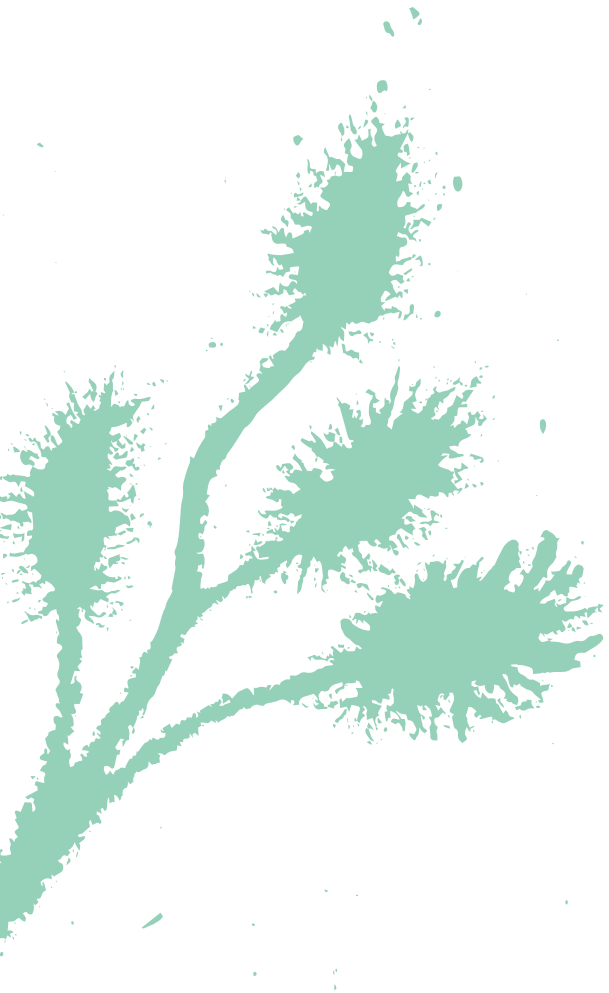
The provision of essential items can correct messages the child may have received about food and basic needs; that these have to be earned or can be taken away; that the child is responsible for securing these or should go without for other family members.

Providing essential items also reduces the stress and preoccupation of the safe parent, who will be better able to focus on their own and their child's emotional wellbeing and other tasks requiring their attention such as completing paperwork, attending meetings and actioning legal proceedings if required.

COVID-19 consideration

Young people identified that providing accommodation, safe spaces and essential items such as food, were the most helpful things they received from services or would have liked to receive, during the COVID-19 pandemic.

Some services, when unable to see clients on site for usual in-person appointments, left food and basic items outside their office for 'drive through collection'. Reported client feedback indicated this provided an important 'touch point', offering consistency and familiarity and promoting an ongoing sense of connection and being held in mind.



DOMAIN 2: Strengthen the relational connections around the child

This domain is about strengthening the relational connections around the child. It reflects the need for children to locate themselves in relationships that are committed, nurturing, acknowledging of their feelings, and reinforcing of emerging qualities that reflect a positive interpretation of their own identity.

A focus on connection involves strategies that strengthen the connection between the child and their important 'others'. This may include their mother, siblings and a range of other kinship and community relationships, promoting and enhancing the capacity of important adults to offer comfort, safety, predictability and belonging. For Indigenous children in particular, these connections enable them to experience their culture through relationships that are significant and meaningful. For all children, these strong and supported connections create the foundation and holding environment for all repair and recovery-focused interventions.

The work of re-engaging the adults around the child to recognise and respond to the child's needs can involve fathers as well, with a clear understanding that the child's safety is the most important consideration. The process of a father reconnecting with his child in a way that acknowledges the violence and gestures towards a reparative outcome, is an important part of relational work.

> ***Gain the child's trust, show them they are worthy. Every child acts out differently. Listen and feel their pain. Allow them space to talk freely. Get to know the child.***
>
> — Words of a young person with lived experience of DFV

Connection: Strategy examples and intervention considerations

Connect child/young person to other services

Implement thoughtful considerations of the most relevant and appropriate services or professionals to link the child with, depending on their current primary needs and particular intervention phase, remembering that good outcomes are linked to the quality not quantity of referrals. Take time to complete good introductions and joint handovers, with a clear outline of roles, responsibilities and expectations.

Ideally, all services involved will attend care planning meetings. Involve the young person in planning whenever and however possible; when meetings do not involve the child, agree who will discuss outcomes with them. All decisions and outcomes relevant to the child should be communicated to them as soon as possible, in language and format appropriate for their emotional stage of development.

Parent-child relationships

Protecting, restoring and enhancing the relationship between the child and their safe parent or caregiver is a top intervention priority. This can include equipping the safe parent to engage in meaningful, attuned, reparative interactions with their child, restoring play and shared curiosity.

Parent-child connection can be facilitated by:

- Creating sensory anchors that both mothers and children can access through the day when they are separated from each other. These can include bracelets, pictures, photos, items of clothing, toys, special message cards, perfume scented soft animal.
- Developing ways for parents to show children that they keep them in their thoughts even they are not together. For example, placing notes in in the child's lunch box.
- Supporting parents to know how to comfort and sooth children when they experience heightened stress levels.

When available, dyadic therapy can promote and restore play, joy and attunement between parent and infant/young child, while parenting programs such as **Bringing Up Great Kids: Parenting After Family Violence** support parents to reflect on the impacts of violence on their interactions with their child, and develop a reflective, mindful parenting approach. Several parenting programs have been adapted for online or virtual formats during the COVID-19 pandemic, with positive reports from preliminary evaluations.

Delivering parenting services through online, video and phone-based modalities

Parenting services had to adapt quickly when face-to face-delivery was not possible throughout the pandemic. Those who transitioned to providing phone-based services reported that shorter, more frequent contacts were preferred by clients and were the most effective. For group-based parenting programs, further adaptations were made and found to be successful. For example, a *Bringing Up Great Kids: Parenting After Family Violence* program in Tasmania was adapted from a weekly face-to-face session format to a multimodal delivery which included pre-recorded webinars, a weekly individual phone call to each participating parent, and a weekly group catch up via video-link. Feedback from participants indicated that the combination of all three components was well-received. This flexible approach initially created greater workload for facilitators, but enabled the delivery of the program's intended mechanisms for change: psychoeducation, reflection on content, support while trialling new strategies, and social connection. Formal and informal feedback confirmed the program was successful in increasing parenting confidence, understanding their child's needs, attunement and co-regulation skills.

Supporting the relationship between child and the parent who has used violence

Depending on organisational and professional role parameters, consider how to engage the parent who has used violence in processes that support them to work towards having a safe relationship with their child. This could include:

- Developing a list of actions that the father needs to undertake to show they accept responsibility for their behaviour.
- Organising ways for fathers to apologise to women and children for their use of violence.
- Create a set of rules with the mother and child that need to be adhered to by the father in order to commence and maintain contact with the child.

Children need support to have safe contact if and when that is important to them – and support to be protected from contact when this is unsafe emotionally, psychologically or physically. The child's safety, wellbeing and best interests should remain at the centre of all decision-making in regard to contact with the parent who has used violence.

The following practice points should be considered in this space:

- Who can support the child or young person to articulate and reconcile complex thoughts and feelings toward their parent who has used violence?
- How will we involve the child (depending on age and development) in planning and decisions about contact with their parent who has used violence?
- If a child is unable to verbalise their wishes, what observations of behavioural, physiological or emotional indicators may offer insight to inform decisions that reflect the child's needs and best interests?

If face-to-face contact (including via video) is not suitable, consider alternative forms of connection and communication that can be facilitated, including letters, drawing pictures, and sharing photos.

Sibling and social relationships

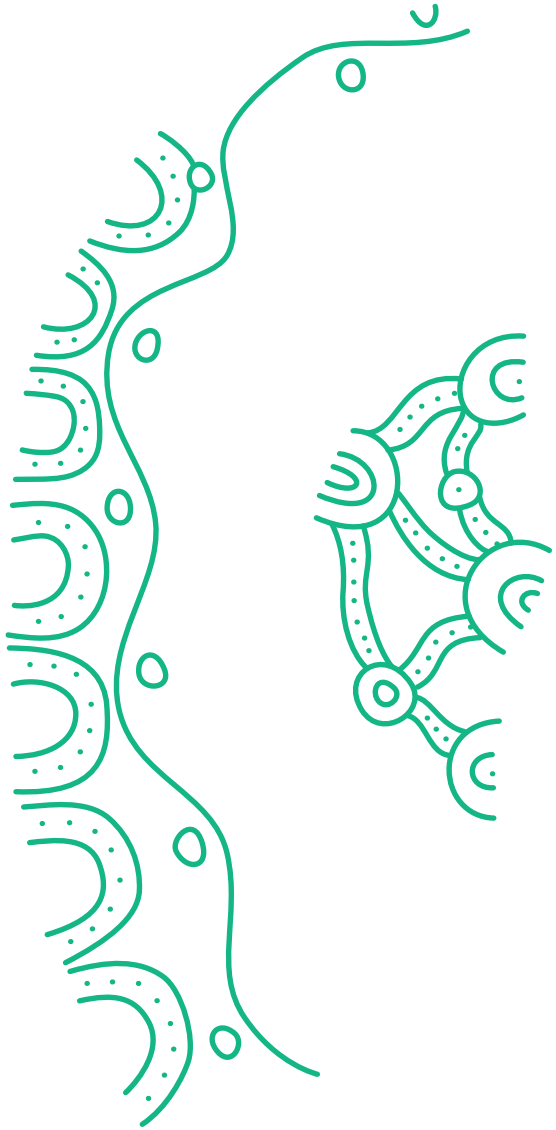
In a qualitative study completed by Children and Young People's Commissioner ACT, young people identified their sibling relationships as being critically important during and beyond their experiences of family violence. Siblings were identified as protectors, supporters, confidantes, and a source of connection and identity. Separation of siblings as part of intervention pathways was identified as damaging and experienced as a new layer of trauma.

- Interventions must include comprehensive relational mapping in order to identify and preserve the meaningful relationships in the child's world. This should be a fluid process which is reviewed and updated to reflect dynamic changes to the child's needs and network.
- Consider which important social relationships have been affected by changes in circumstances related to the DFV as well as those caused by the pandemic context. Explore opportunities to restore important social relationships and reconnect the child with positive peer experiences.

Therapeutic relationship

Alongside family relationships and service connections, a safe, trusting and reliable relationship between child and professional is also critical for creating felt safety and fostering positive engagement. While not all children will be engaged with a therapist, all relationships with professionals in their network have the opportunity to be therapeutic.

- Uphold principles of predictability and consistency throughout all interactions
- Take time for genuine rapport building, and bring a mindful use of prosody and body language into interactions, whether in person, through video or on the phone
- Offer and facilitate multimodal options for engagement (for example, phone, video, text, email).



Pandemic implications

Workers and young people both reported ‘shorter but more frequent’ contact was most effective during periods where face-to-face contact was not possible. This included several short phone calls and/or text messages per week rather than one-hour sessions once per week.

Therapists and other practitioners became quickly skilled in developing or implementing relationship-focused activities for telehealth sessions.

Continuing face-to-face contact with the addition of mask-wearing proved challenging, with a sudden collective awareness of our reliance on whole-face monitoring for social and safety cues. Clinicians adapted with increased modulation in their voice, using more hand gestures and body expression, and mindful ‘whole-face smiling’. Masks offered up a tangible metaphor for rich therapeutic work, and a unifying shared experience which promoted rapport and relationship. Services reported that some clients preferred to continue face-to-face even if masks were required, while others preferred telepractice in order to engage mask-free. Being able to tailor options to client preferences is likely to be a sustained change to service delivery beyond the pandemic.

Creating a therapeutic online space

In transitioning to telepractice, the practitioner and child have an opportunity to co-create a new therapeutic space together, and thought should be given to how this space should look, sound and feel.

- Who should be with the child or nearby?
- What room should they sit in?
- What belongings will they have with them during the session?
- What space will the practitioner share with the child?
- What will the child see in the background?

The online therapeutic space requires crafting and creating in a way which facilitates a felt sense of safety and connection, just as in face-to-face sessions.

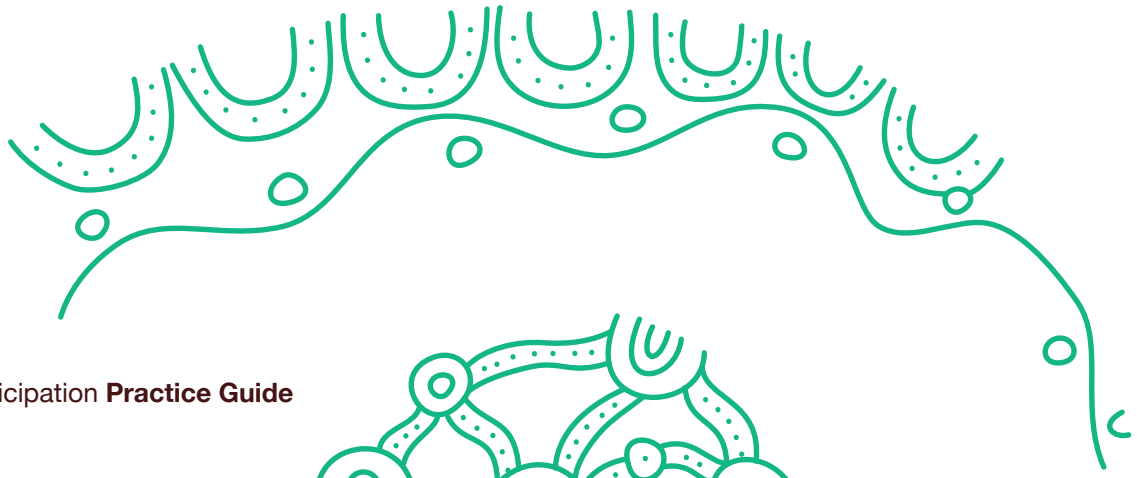
Telepractice: Establishing relationships with new clients

Early sessions should include interactive and sharing activities that promote relationship building, such as ‘show and tell’ or ‘draw and show’ activities. Workers can email an introductory letter with a picture of themselves and a few ‘get to know you’ facts. Ask the child to collect three items from around the house such as ‘something special, something fun, something old’ and tell the stories of each item.

Telepractice: Maintaining pre-existing relationships:

Sessions can include activities that promote attunement and connection, such as mirroring or following games, playing around with movements, facial expressions and body shapes. Workers can look for small opportunities to demonstrate ‘holding the child in mind’ between sessions, such as bringing an item to a session that was talked about last time, asking about something that the child showed in a previous session, and remembering the names of pets or special toys.

If office-based appointments and telepractice are not feasible, workers may also seek to maintain connection with a child client through mailing letters, pictures, resources or activities. As per usual practice, prioritising strong, connected relationships is the most effective intervention and should guide decision-making about the best safe options for contact.



> ***As an adult I feel the memories and mixed emotions of witnessing domestic violence.***
>
> — Words of a young person with lived experience of DFV

COVID-19 planning

Services are encouraged to discuss COVID-19 planning with clients at intake, so that plans are ready to implement smoothly and immediately if restrictions are imposed. Intake/assessment processes should incorporate questions about client preferences for maintaining support in the event of a lockdown/etc. and should include an audit of their technology access.

For example, if telehealth is preferred, the following considerations can be discussed:

- Does the child/parent have reliable access to a laptop/smartphone/tablet with camera/audio and Wi-Fi/data?
- Would they require support with phone credit to be able to maintain contact by SMS/phone calls?

Planning should also include considerations such as:

- Who are the important people in the child's network? Who will they continue to connect with in-person? Which relationships require adapted methods to maintain connection?
- If contact with a parent or sibling cannot happen in person, does the child wish to move this to phone or video? Who would they like to support this? Who should be present?
- How long should a phone or video contact session go for?
- How will the parent or sibling's wishes be balanced with the wishes and best interests of the child?

It was noted that some children and young people in WA were unaware that non-face-to-face service access was possible during the pandemic. It is recommended that service providers make the range of services more visible to those who may require it, for example through prominent marketing on social media, websites, and direct client communication.

DOMAIN 3: Enable meaning making

This domain is about giving children multiple opportunities, in collaboration with safe adults, to make sense of the violence and the meaning it held – and still holds – in their own lives and the lives of their family. Trauma distorts truth, knowing, responsibility and meaning. When a child is supported to construct a different narrative of their world, it is an important reparative experience.

This needs to occur within safe relationships, and includes:

- Recovery from the psychological and physiological impacts of violence-related trauma.
- The development of stories between children and safe members of their family, which integrate feelings, beliefs and reactions.
- Supporting children to access strengths within their culture or belief system.
- Helping children create and hold onto meanings that incorporate safety and hope.

This process connects them with others in their family or networks who have shared similar experiences. They can be supported to understand the experience within an empathic connection, share in the process of change, and continue to build on narratives of hope. Children can be introduced or reconnected to strengths within their cultural beliefs that are resources for them in knowing themselves and the meaning of their world.

Meaning is held throughout a child's physiology and functioning, therefore, making sense of the impacts of DFV-related trauma involves intervention across various levels of functioning. This includes:

- Sensorimotor – children are supported to learn how their bodies respond to stress and how their body holds their story.
- Limbic – children are supported to develop capacity for sitting with, expressing and making sense of emotional experiences such as sadness, anger, grief, shame and guilt.
- Cognitive – children are supported to articulate and re-author their story, addressing cognitive beliefs and attributions, and engage in identity-based work.
- Creating a stable platform for meaning-making work.

Uncertainty is interpreted by the brain as a threat, triggering a stress response which initiates a cascade of reactions throughout our nervous system. Children affected by DFV-related trauma have often existed in prolonged states of uncertainty, their brains and bodies maintained in a hyper-alert state. Often, the professional system response which is activated to attain a child's immediate safety, can inadvertently perpetuate this state of uncertainty.

An enduring period of stability is required for the child's stress-response system to recalibrate; an important component of their recovery and a necessary precursor to any deeper therapeutic work towards healing.

Creating and maintaining a stable environment for a child is reparative in itself, and also ensures the child's nervous system and their care environment are both prepared for the child to begin deeper therapeutic work towards processing and healing from trauma experiences. This includes equipping the safe parent to provide a secure base and stable relational environment for the child as they enter the therapeutic space.

When a child is ready to engage in therapy, a platform of ongoing stability will enhance their capacity to engage in and benefit from this process. At times, a child's circumstances will become rocky again, and the therapeutic journey will need to accommodate this, shifting focus to holding and containment, supporting the parent to maintain as much consistency and predictability as possible, and perhaps pressing pause on trauma processing until stability returns.

When a child feels safety within themselves, their relationships and environment, they can be supported to engage in Meaning Making processes which involve repeated, titrated opportunities to make sense of their trauma experiences and responses, at somatic, sensory, cognitive and emotional levels.

Meaning making: Strategy examples and intervention considerations

Creating a stable platform for meaning making work:

Begin with resourcing the child's important relationships, maintaining felt safety, and reducing uncertainty. This can be facilitated through:

- Providing certainty for the child about their care, living and schooling arrangements so that their minds can settle and focus on processing their experiences and developing new skills. This can include making 'plans not promises', where there are continued unknowns, for example outlining for the child what the possible scenarios or outcomes are, and what each of those might look like. It can also include giving time frames and details around when such things *will* be known, and what the 'in between' will look like.
- Orienting the safe parent/carer to the child's needs, through promoting attunement, reflective capacity and co-regulation skills, increasing parenting confidence in identifying and responding to child's needs, and increasing parents' awareness of their own needs and reactions.
- Early planning should include identifying who will be involved in coming alongside the parent to facilitate supporting and equipping, and how this will be done (for example, one-on-one, peer led, referral to group program).

Pandemic consideration: an extra layer of ongoing uncertainty

Children across Australia have been affected by the chronic uncertainty the pandemic has created over the last few years. Rates of anxiety, somatic complaints, sleep issues and depression in the general child and adolescent population have increased. For children affected by DFV, recovering from violence is not a final outcome. They are still required to endure the same ongoing stressors and anxieties as everyone else.

This context must be considered when discharging children and families from services and when supporting re-integration into their 'new normal'. Many children have struggled transitioning back to school after lock downs. For children recovering from violence, their transition may be to an entirely new school, from a new home, in a new neighbourhood.

The impacts of managing change are compounded. Effective planning to support these transition processes is essential. This may include a staggered start or reduced hours of attendance, linking the child with a safe/support person and place at the school, lots of conversation and reminders about plans and timetables, and predictable routines as much as possible.

Regulating nervous system responses

Therapeutic approaches include working to down-regulate stress-system responses of fight, flight, freeze, and up-regulate states of shut-down, collapse and withdrawal. Using creative, play and movement-based approaches, children can develop strategies to calm their brains and bodies, restoring safe connection to body, mind and self.

This is an important prerequisite for cognitive and language-based intervention. Children must be supported to develop an understanding of their brain and body's adaptive strategies that have come about in order for them to survive. Strategies that support regulation include:

- **Fight, Flight, Freeze:** Reducing sensory input, introduce breathing activities, movement and rhythm-based activities including music, dance, singing, swinging, rocking, etc.
- **Collapse, Submit, Withdrawal:** Grounding through active sensory input, orienting to the space, looking up and out, stretching, changing setting, mobilising.
- **Connecting to Space and Place:** Time spent in nature, returning to special places, connecting with elements that represent home, safety, strength and belonging.

Intervention planning should include reflections on the child's stress-response states, and targeted considerations of how the above approaches can be incorporated into their plans. As always, the child or young person and their key adult/s should be including in exploring and developing tailored plans that include elements listed above. Individualised plans that meet the child's specific needs and preferences will be the most effective.

Processing experiences

Children and young people affected by high impact and/or toxic stress can find it difficult to make meaning from their experiences. Creative and movement-based approaches which recognise the embodied nature of DFV-related trauma are well-suited for supporting children's expression of complex experiences. Art, play and nature-based therapies support children's expression and processing of complex experiences.

Children and young people can be supported to create visual representations of their experiences through art mediums or through sharing their stories in third person format.

For example:

- Writing a short story with made up characters based on their own experiences.
- Using figurines or small toys to explore themes of family, home, safety – for example, a child may not be able to describe what danger felt like or what they would have needed to feel safe, but they may be able to create a 'safe home' for a family of toy animals and tell you all about it!
- Choosing colours and textures for different feelings rather than identifying these with labels.
- Linking feeling states to particular types of music or dance.
- Externalising internal states – for example: what would your body look like if that feeling happened on the outside instead of the inside? What shape would it be? How big would it be? Would it be moving or still? Would it make any sound?

Practitioners and parents can layer onto this work by promoting emotional literacy to further support expression.

Telepractice considerations

With some consideration and planning, movement-based and expressive modalities can be adapted to online therapeutic work. Some practitioners have found it helpful to send packages of art/craft items to the child before their session or ask the child/parent to collect certain simple everyday items in advance for use in a session.

Easily adapted movement-based approaches include:

- Mirroring activities and dance movements.
- Stretching and yoga poses.
- Different seating options (such as swivel chairs and fit balls).

Resources can again be sent in advance or collected from the home, such as scarves, ribbons or elastics.

Changing narrative

Children who have experienced DFV hold messages and stories about the violence at implicit and explicit levels. Providing clear and developmentally appropriate psychoeducation regarding DFV dynamics, patterns and impacts can help to redefine these messages, challenge narratives of blame and shame, and provide a platform to begin creating new messages of strength, resilience and survival.

- Planning should include identifying who is best suited to complete this work with the child, young person or parent.
- Therapeutic interactions can then work to uncover and articulate the meanings that children have held about the violence, and facilitate the re-creation of coherent, tolerable and empowering narratives about their experiences.
- Listen for clues and themes that relate to the child's expression of the narratives and meanings they hold about the violence. Seek opportunities to gently challenge messages that maintain shame or that minimise or justify the use of violence (for example: "I've noticed you've said "it is what it is" a few times.. I'm wondering what that means for you when you say it/where you first heard that/if that's a saying your family use a lot?").
- Tune into clues that a child is beginning to question their existing narratives, and help them to define and articulate their reframing efforts.
- Develop stories with children about the events of their life that mark out a narrative of meaning around their trauma experiences.
- Support mothers and children to list the actions that the mother and other important adults took to stop the violence and protect the child.
- Support the family and network to understand the child's behaviour as a form of communication about unmet needs, and promote responses that orient to the meaning of behaviour rather than reacting to the behaviour itself.

This work can scaffold into a focus on establishing healthy parent-child dynamics and the gentle peeling away of parentified tendencies. Re-defining the roles of 'parent' and 'child' according to developmentally appropriate expectations, and equipping parents to step into these roles, supports ongoing emotional and relational safety for children.

DOMAIN 4: Promote growth and recovery

This domain is about supporting children and young people to embed an emerging positive sense of self and efficacy, along with experiences of hope. It includes a focus on supporting the child to progress through developmental milestones and re-join a developmental trajectory in line with their age and stage. This often includes referral to specialist services and a coordinated approach between multiple professionals, in collaboration with the child's parent/s and support network.

From birth, children are developing internal working models that define their perceptions of themselves, shaped daily by their relationships with those around them. When children experience family violence, their beliefs about themselves are informed by violating relational experiences and interactions. They can develop and hold onto ideas about relationships which are not helpful to them in their relationships with peers and other adults like teachers. They can find it difficult to see adults as supportive. They are cautious about being hurt and are more likely to stay closed to the development of new connections.

In the growth and recovery phase, children and young people are supported to consolidate, translate and generalise the progress they are making into different contexts, with this being facilitated by their parents, family and their network of important adults. Relationships that are now experienced safely, will continue to reshape relational templates, patters and expectations. A child's emerging sense of identity, grounded in the strengths of their family, culture and community, can continue to be supported and reinforced – remembering that recovery is not a fixed outcome to be arrived at, but rather an ongoing journey to be continuously facilitated for children affected by family violence.

Growth and recovery: Strategy examples and intervention considerations

During this phase of intervention, children and young people can be supported to develop a positive and coherent sense of self, and adaptive internal working models relationships. This work transitions the young person from their past into their future, taking their new skills, safe connections and newly-authored meanings with them. Support this transition by:

- Promoting future-oriented strategies that assist the child to project themselves into the future and expand their parameters of goal-setting.
- Supporting the development of resilience and self-efficacy through opportunities to try new things, learn new skills and develop mastery.

Many young people benefit from opportunities to give back to others who may be experiencing similar circumstances. This can include sharing their stories and the messages of survival and recovery with younger siblings or cousins, as well as being invited to produce creative pieces to be shared with children and professionals who they may never meet.

Being supported to complete artworks, short stories or other works which portray strength, hope and resilience, can act as a portal which transports a young person from 'helped' to 'helper' and solidifies a self-concept grounded in agency. This powerful act of truth-telling can counter the harms inflicted by lies and secrecy, and offer the young person a transformative corrective experience.

Additional feedback from service provider consultations

Identified gaps and barriers to effective service provision

While each community and region adapt to unique challenges in service delivery, some key themes emerged during our stakeholder consultations regarding barriers and suggestions for overcoming these. These included:

Access to technology (digital divide)

The COVID-19 pandemic ushered in new level of reliance on technology; internet access and our screens were widely embraced as a necessary and welcome tool for continuing to work, engage in education, connect, shop, distract, and cope. While this provided some mitigation for many against the far-reaching impacts of the pandemic, the opportunities afforded by technology were not available equitably across society. As highlighted by the 2020 Australian Digital Inclusion Index, the 'Digital Divide' continues to exacerbate the gap between those who *have* and those who *have not*. This divide is prominent between urban and rural areas across all measured dimensions (access, affordability, digital ability), as well as marking links between access and a range of socio-economic factors.

The impacts of the digital divide are exacerbated during times of COVID-19 restrictions, when reliance on technology for service access/delivery increases. Possible solutions included:

- Libraries, community centres, or resource hubs to be supported by local/state government to provide free access to IT/Wi-Fi/printing/phone resources.
- Resourcing of services to be able to provide Wi-Fi-enabled devices for vulnerable clients.

Client preferences must also be considered. In general, young people's feedback regarding using virtual platforms to engage with support services is mixed, with some preferring a blend of telehealth and in-person while others report a preference for face-to-face and would rather 'go without' than engage via video. Overall, research and anecdotal evidence suggest most young people prefer flexible options and a blend of modalities, such as texts, video and in-person. Attendance and engagement are likely to be optimised when flexible, blended service-delivery options are available.

Limited service locations

In regional areas, services are often located in major centres, meaning families must have access to transport in order to access them, which further disadvantages those with limited means. During COVID-19 restrictions, some communities are cut off from major centres and therefore cannot travel in to services and vice versa. Families who enter major centres may be required to quarantine or isolate before or after returning to community. This impacts on ability to tend to cultural and family obligations, which can put individuals at risk of physical and social harm. The same is true for those who must cross regional borders to access services, due to the under-resourcing in some regional areas deemed 'close enough' to Perth. Access to these metro-based services is also not feasible during COVID-19 restrictions between regions.

Possible solutions included:

Establishing satellite services in remote areas

- Introducing the 'Hub Model' in major centres within regions to ensure good access to relevant services without extensive travel, and continued access during periods of travel restriction.
- Coordinated Regional DFV Networks, with dedicated positions to manage coordination and communication.

SECTION FIVE

WORKER WELLBEING

Practitioner consultations and research evidence highlighted the importance of understanding and maintaining worker wellbeing in the child trauma sphere. Impacts of burnout, compassion fatigue and vicarious trauma can be far reaching across personal, professional and organisational domains. The compounding effects of continuing to live and work throughout the COVID-19 pandemic must also be acknowledged, with added impacts of persistent threat and uncertainty as well as new and evolving workplace requirements and pressures.

The importance of prioritising worker wellbeing extends beyond the individual worker, as impacts can affect workplace and family/peer relationships if left unchecked. Critically, burnout and vicarious trauma can both have serious consequences for the worker-client relationship and can compromise client outcomes.

Workplaces can promote a culture of wellbeing by developing targeted and embedded plans and processes. The most effective workplace wellbeing plans will include strategies across personal, professional and organisational levels, and will instil a workplace culture which prioritises staff wellbeing, as an individual and collective responsibility.

Organisations can:

- support staff to develop and implement effective, tailored self-care plans
- have structures in place for staff support, check in and debrief
- provide regular and effective reflective supervision
- identify and respond to early indicators of burnout or vicarious trauma
- ensure processes for leave entitlements professional development opportunities are well utilised and embedded as standard practice
- maintain regular connection through online or phone platforms when face-to-face team gatherings are not viable
- provide means and tools to simplify client contact and team engagement, such as tech requirements and flexible work arrangements
- ensure responding to vicarious trauma is not a stigmatising process where the worker is seen as “weak” or “not coping”.

COVID-19 practice consideration

COVID-safe, in-person service planning must include considerations for PPE requirements, social-distancing and hygiene requirements, as well as safety-considerations for check in processes.

When staff are working from home, it becomes more important than ever to define clear boundaries separating home life from their work life so that workers are best positioned to continue delivering high quality support services during their established working hours. There are real risks associated with being sedentary, being overloaded, and overworking. To reduce risks and impacts of prolonged telepractice or other computer-based work, workers are encouraged to maintain or develop a reasonable and sustainable work routine, include regular physical and mental breaks, and recognise the importance of staying socially connected.

Clear boundaries need to be communicated to clients, so that they know when to expect a response from their worker. It is also important that workers are aware of self-help, professional development and education resources, and have access to peer supervision.

In a surprising silver lining discovery, some regional and remote staff reported increased access and connection with metro-based colleagues during the pandemic when online platforms became standard modes of operating. This opened up new ideas and opportunities for receiving supervision, engaging in interagency forums, and accessing training that was previously out of reach. The WA family and social services sector have demonstrated their resilience, flexibility and creativity in continuing to meet the needs of vulnerable families during this time. It is hoped that the positive changes to 'business as usual' that have come about during this time remain long after the acute effects of the pandemic have ceased to be felt.

Conclusion

This online practice guide is centrally positioned within the Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020 – 2030 which articulates the needs of children and young people experiencing family violence and highlights the requirement to implement services that can still operate within the context of the COVID-19 pandemic.

It also aligns with other state government priorities and commitments such as the Youth Strategy, Action Plan for At-Risk Youth and implementation of the recommendations for the Royal Commission into Institutional Responses to Child Sexual Abuse.

High level outcomes for the practice guide include:

- Children and young people experiencing, or at risk of experiencing, family or domestic violence during the COVID-19 pandemic have continued access to appropriate specialist services and supports to ensure their safety
- Specialist and mainstream workforces who are employed within the DFV sector, particularly those in regional and remote locations, receive training in evidence-informed strategies in supporting children and young people during a pandemic.

Trust, safety and participation are the ingredients to children and young people experiencing their lives free from violence. They are critical in recovery.

Trust, safety and participation enable children and young people to know that it is possible for them to grow and develop without the effects of domestic and family violence in their lives.

Trust, safety and participation are the vehicles for powerful hope to be realised.

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