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Providing therapeutic services to women and children who have experienced intimate partner violence during the COVID-19 pandemic: Challenges and learnings

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ABSTRACT

Background: In the face of the COVID-19 pandemic, many therapeutic services for children and their parents who had experienced intimate partner violence (IPV) were required to rapidly transition to telehealth.
Objective: The current study aims to explore parents' experiences of participating in a parent-child telehealth intervention during the COVID-19 pandemic. The study also aimed at exploring clinicians' experiences of delivering the service, including key strengths and challenges.
Participants and setting: Participants were five mothers who took part in Berry Street's Restoring Childhood service during the COVID-19 pandemic in Melbourne, Australia, and 14 Restoring Childhood clinicians, delivering the service across metropolitan and regional sites.
Methods: Semi-structured qualitative interviews were conducted, and data were analysed using thematic analysis to determine key themes and sub-themes within the data.
Results: Parents identified several strengths and benefits of Restoring Childhood delivered via telehealth including improvements in parenting skills and confidence, parent-child relationships, and children's emotional-behavioural functioning. Both parents and clinicians noted the creativity utilised during the online approach, and the increased accessibly it offered for families. However, challenges to the telehealth approaches were also noted. Clinicians discussed important considerations for telehealth within this context including safety and confidentiality, technology challenges, and challenges working from home.
Conclusions: The current study highlights the promise of telehealth interventions for parents and children who have experienced IPV. It also poses several important considerations for the use of telehealth within this setting and emphasises the need for rigorous evaluations of telehealth services for children exposed to IPV.

During the COVID-19 pandemic there have been serious concerns about increased risks of intimate partner violence (IPV) for

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women and children (Van Gelder et al., 2020). IPV includes any behaviour within a current or former intimate relationship which causes physical, psychological or sexual harm (Breiding et al., 2015). The public health crisis response (i.e., social distancing, stay-at-home orders) to slow the rate of infection has led to unemployment, financial insecurity, and social isolation for many families (El-Osta et al., 2021; Kawohl & Nordt, 2020). For some, this has contributed to or exacerbated mental health difficulties, frustration, aggression, and poor coping strategies such as alcohol abuse, increasing the risk of IPV (Campbell, 2020). When stay-at-home orders are in place, there are increased opportunities for violence to occur, and additional challenges for families to seek support (Bradbury-Jones & Isham, 2020; Van Gelder et al., 2020). Early reports indicate that IPV has increased during the pandemic. In two Australian studies, health care practitioners reported a considerable rise in the number of clients disclosing IPV and/or an escalation of violence (e.g., increased death threats, threats to children, and an increase in physical violence) since the pandemic started in March 2020 (McLean & McIntosh, 2021; Pfitzner et al., 2020) is consistent with past research indicating that IPV increases during crises and disasters (e.g., Australian Black Saturday bushfires, Hurricane Katrina, and the 2004 Boxing Day tsunami) (Anastario et al., 2009; Fisher, 2010; Parkinson, 2019).

Pre-pandemic research indicates that approximately 1 in 4 children are exposed to IPV between caregivers (Gartland et al., 2014; Hamby et al., 2015). Stay-at-home orders, school closures and remote learning have resulted in more time spent at home, potentially increasing the risk of IPV exposure for some children (Van Gelder et al., 2020). Exposure to IPV in any form can increase children's risk of mental health difficulties including post-traumatic stress symptoms, depression, anxiety, and behavioural difficulties (Gartland et al., 2021; Howell, 2011; Vu et al., 2016). Although not all children exposed to IPV experience difficulties (Fogarty, Giallo, Wood, Kaufman, & Brown, 2020; Martinez-Torteya et al., 2009), early psychological intervention of traumatic symptoms can prevent the onset of complex and long-lasting mental health presentations across the life course (De Young & Kenardy, 2017). Given the disruptions to family life, friendships, schooling, and extracurricular activities faced by children during the pandemic (Van Gelder et al., 2020), access to services to support healing and recovery after IPV has never been so important.

There is growing evidence for therapeutic parent-child dyadic interventions to support children's healing and recovery following IPV (Anderson & Van Ee, 2018). Such interventions provide an opportunity to repair the relational bond between mothers and their children often disrupted by IPV and have demonstrated the ability to reduce traumatic stress symptoms in young children (Hagan et al., 2017; Lieberman et al., 2005). With the aim to strengthen parent-child interactions at their centre, dyadic interventions rely heavily on age-appropriate play-based discussions to assist young children and their caregiver to strengthen their relationship and understand the child's experience of violence (Gomez, 2012; Lieberman et al., 2015). The COVID-19 pandemic and subsequent social distancing restrictions have profoundly impacted the provision of therapeutic services. To enable the continued provision of services to women and children following IPV, many services have rapidly transitioned interventions to telehealth platforms, offering this mode of delivery for the first time (McLean et al., 2021). There is a need to capture the lived experience of parents who have participated in IPV telehealth interventions to ensure the acceptability, viability, and utility of such services for families.

Telehealth platforms have the potential to reduce barriers to accessing treatment including lack of transportation, travel time, and difficulties getting childcare (Comer et al., 2015; Cunningham & Shapiro, 2018). They also have a strong evidence base in many therapies including cognitive behavioural therapy (CBT) (Sztein et al., 2018) acceptance and commitment therapy (ACT) (Herbert et al., 2017),and parenting interventions (Comer et al., 2015). However, less is known about the use of telehealth with children and their parents who have experienced traumatic events such as violence (Racine et al., 2020). Of the research available, a recent pilot study of 15 7–16-year-old children exhibiting trauma symptoms demonstrated that Trauma-Focused Cognitive Behavioural Therapy delivered via telehealth resulted in reduced post-traumatic stress symptoms (Stewart et al., 2017). This study also highlighted telehealth as an effective way of reducing barriers to treatment access for some experiencing social and economic disadvantaged populations.

Despite the promise of telehealth, there is currently little evidence about its use in the family violence sector, specifically in the provision of therapeutic support for children (Racine et al., 2020). Further, there is limited research into use of telehealth during community wide crises where it is not possible to provide consumers with alternative treatment modes. During the COVID-19 pandemic, many interventions that have rapidly transitioned to telehealth platforms were not designed to be delivered in this way (Ghosh Ippen et al., 2020). The transition of dyadic interventions to telehealth has challenges due to the play-based nature and emphasis on caregiver-child interactions during the sessions. In addition, the demands and stress associated with rapid changes to service delivery are likely to hold challenges for the family violence workforce who are already at risk of burnout (Coles et al., 2013) (McLean & McIntosh, 2021). The implementation of telehealth within family violence settings requires consideration, adequate training, and suitable processes to ensure safe therapeutic services during this time (Racine et al., 2020). Capturing the practice experience of clinicians delivering interventions via telehealth can generate important evidence to inform telehealth implementation and service improvement.

The aim of the current study was to identify key themes related to parents' experience of taking part in a telehealth delivered parent-child dyadic intervention for healing and recovery from IPV exposure during the COVID-19 pandemic in Victoria, Australia, as well as to identify key themes related to clinicians' experience of delivering the service. Specifically, the aims of the study were to explore (a) parents' perceptions of the strengths, benefits, and challenges of the telehealth intervention for them and their children, and (b) clinicians' experiences of delivering the telehealth intervention including perceived strengths and challenges. Although evaluations of telehealth therapeutic services for children exposed to IPV are needed, the current study represents an important initial stage of evaluation, generating evidence to guide the refining of this service and its processes prior to a rigorous evaluation.

1. Methods

1.1. Setting and participants

Prior to the COVID-19 pandemic, Restoring Childhood, a dyadic model of therapeutic support for children and their caregivers who have experienced violence was being provided by Take Two Berry Street in Victoria, Australia (Frederico et al., 2019). Restoring Childhood is a stepped care model of therapeutic support for children (aged 0–17 years) who have had a recent exposure of IPV. Restoring Childhood has three stages: (1) specialised triage and intake; (2) a brief relational intervention and screening; and (3) medium- longer term Child-Parent Psychotherapy (CPP; Lieberman et al., 2015) or individual and relational therapies incorporating Eye Movement Desensitization Reprocessing (EMDR; Shapiro et al., 2017). The aims of Restoring Childhood are to (1) decrease children's initial traumatic stress symptoms, (2) strengthen parent-child relationships and parenting self-efficacy, (3) provide a positive therapeutic experience for mothers, other caregivers, and children, and (4) promote an understanding of the impact of IPV on women and children.

The Restoring Childhood intervention was introduced by Berry Street in 2018 and is currently delivered across one metropolitan and two regional sites. Victorian Government lockdowns aimed at containing the virus commenced in March 2020 and resulted in face-to-face services being extremely limited to situations involving significant risk. Restoring Childhood, like many other services, rapidly transitioned to a telehealth model. The delivery of Restoring Childhood via telehealth remained consistent with the face-to-face delivery model. Telehealth adaption of CPP (Ghosh Ippen et al., 2020) was informed by participation in CPP Community of Practice and supervision networks established as part of the RECOVER project (Hooker et al., 2019). Although government restrictions differed across metropolitan and regional settings in Victoria, at the time of the interviews, all sites had completed at least 8 weeks of consecutive lockdown. The current qualitative study focused on parents' and clinicians' experience of Restoring Childhood during the pandemic and via a telehealth platform. The study was approved by the Royal Children's Hospital Human Research Ethics Committee (HREC 38037A).

Interviews were conducted with 14 Restoring Childhood clinicians and 5 parents who had participated in the Restoring Childhood intervention via telehealth. Clinicians included three team leaders (21%), two senior clinicians (14%), and nine clinicians (64%), working across metropolitan and regional settings. Twelve clinicians were female (86%), all held qualifications in social work or psychology and had on average 15 years' experience working with families. Although all of Victoria experienced periods of Government lockdown during COVID-19, Melbourne experienced a significantly higher threat of COVID-19 infection with restrictions in place for increased duration in metropolitan areas and often involving a higher level of restriction. Regional areas were able to go back to face-to-face delivery models earlier in 2020 than Metropolitan areas and as a result participant recruitment for the current study was restricted to Restoring Childhood clients who were residing in metropolitan Melbourne. All parents who took part in the interviews were female and were aged between 29 and 45 years ($M = 37$, $SD = 6.2$). Most participants were Australian born (80%), and all spoke English at home. Participants had on average 3 children (range 1–5), however in most cases just one child from the family was participating in Restoring Childhood. One mother who took part had four children taking part in the Restoring Childhood intervention. The mean age of child participants was 8 years (range 2–12 years).

1.2. Procedures

Parents participating in Restoring Childhood were told about the study by their clinician. Parents who expressed interest in the study were provided the option of contacting the research team directly or giving permission for their clinician to pass their contact details to the research team. Clinicians were informed about the study by their managers, and those who expressed interest gave permission for their contact details to be provided to the research team. A member of the research team further explained the purpose of the study to clinicians and parents and obtained informed consent. Researchers emphasised that participation was voluntary and non-participation would not impact on their employment or access to services at Berry Street in anyway. Clinicians were provided with a choice of participating in an individual interview or focus group. Seven individual interviews and two focus groups were completed with clinicians. All interviews were conducted via the phone or zoom and were audio recorded using a handheld recording device. Interviews ranged in duration from 44 to 96 min. Audio recordings of interviews were transcribed verbatim.

1.3. Analysis

Interview transcripts were analysed using thematic analysis with the assistance of NVivo Version 12 software (QSR International, 2018) by two members of the research team. Thematic analysis allows for the identification of common themes and sub-themes which emerge across participant data (Braun et al., 2014). Researchers followed the methodology outlined by Braun and Clarke (2006) whereby transcripts are first read to increase familiarity with the data, followed by the generation of initial codes. Researchers then searched the initial codes to identify themes before these were reviewed, refined, and defined. The two researchers met regularly during the analysis period to discuss and review emerging themes and sub-themes and to resolve any divergences between coding. Final themes and subthemes were discussed with the broader research team to identify any inaccuracy within the coding framework and identify any researcher bias. Analysis of parents and clinician data was conducted separately but concurrently. Integration of the analysis was completed at the theme level, with similarities and differences between the themes reviewed, allowing for the assessment of triangulation.

2. Results

2.1. Strengths and benefits of restoring childhood delivered via telehealth

Strengths and benefits of the Restoring Childhood program were described by parents and clinicians. Thematic analysis of parent interview data revealed themes related to: (a) positive intervention experience (b) therapeutic space and processes, and (c) outcomes of Restoring Childhood for families. Similarly, thematic analysis of clinician interview data revealed key themes around (a) service delivery, (b) therapeutic space and processes, and (c) benefits for clients. Although there were similarities in the key themes related to clinician and parents' perceptions of strengths and benefits of Restoring Childhood, sub-themes between the participant groups were considerably different. Parents focused on what they and their child gained from taking part in Restoring Childhood via telehealth and elements of the service that they found beneficial to their or their child's engagement. In contrast, clinicians focused on changes to therapeutic processes and service provision which they considered strengths.

Figs. 1 and 2 present key themes and subthemes for the strengths and benefits as perceived by parents and clinicians, respectively. Analysis of the parent interview data will be presented first, followed by analysis of the clinician interview data. Sub-themes and corresponding quotes for each theme are discussed below.

2.1.1. Strengths of restoring childhood as perceived by parents

2.1.1.1. Positive intervention experience. Parents expressed gratitude for the continued provision of service during the pandemic, explaining that the support they received was extremely valuable during such a difficult time.

> *There's still someone on the other end trying to help you and your family, I think if it wasn't there to support throughout this pandemic, for me that would have been hard. Even for [Daughter] with expressing her feelings regardless if it's in person or over the phone it needed to happen.*
>
> *(Parent 02)*

All parents noted that the telehealth modality *increased accessibility of the service*, particularly for parents with multiple children who may otherwise have had to arrange childcare to attend sessions.

> *…it was really good to do online. We lived a fair way from the [town] office where I would've had to bring them or [Clinician] would've come to the new school. It was probably really handy doing it that way because you don't actually have to take them anywhere. You could just do it at home.*

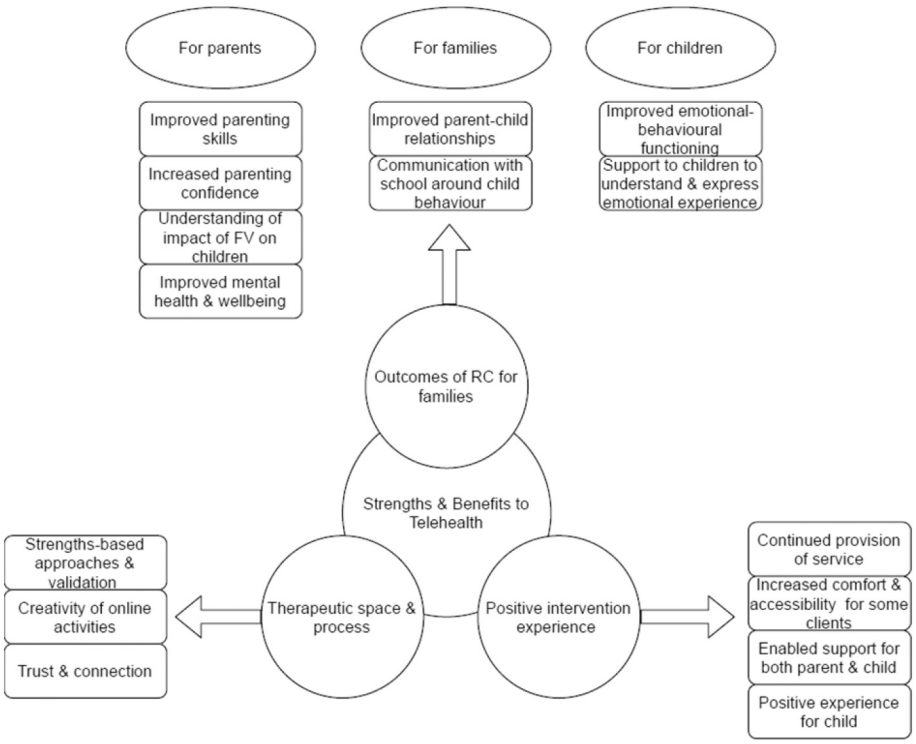

Fig. 1. Strengths and benefits to Restoring Childhood via telehealth as perceived by parents.

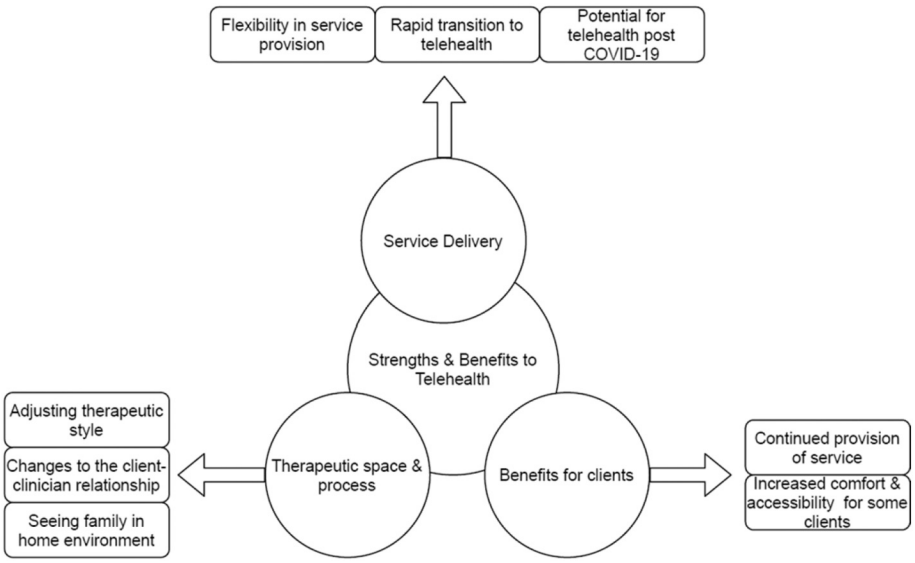

Fig. 2. Strengths and benefits to Restoring Childhood via telehealth as perceived by clinicians.

(Parent 03)

In addition, two participants with boys aged 11 and 12 years noted that engaging in Restoring Childhood online was less anxiety inducing and *more comfortable* for their sons.

> *…it was really good that it was online rather than me having to go to an actual location to take him to. I think that would've been a lot harder as well. To begin with, he would've really hated that, and the fact that we were at home I think made him a lot more comfortable too. He's gone through so much. Just anything just in terms of him having to talk to anyone else, I think there's a lot of fear involved, even though he doesn't understand his feelings. I think it's him being scared because that's why he acts out in terms of 'I don't want to do this'.*
>
> *(Parent 01)*

Parents explained that their children appeared to enjoy and/or reported that they liked their Restoring Childhood sessions, with parents expressing relief that their child had a *positive experience* of help-seeking.

> *He was seeing a psychologist beforehand and it was a real effort to get him to go. He was never keen on going, didn't want to…. after the first session with Berry Street he commented on how lovely she was and how he really liked talking to her and I said to him, "would you like to do it again in a couple of weeks", and he said, "yeah". And there was a fortnight where we had to cancel and he was disappointed. He commented a number of times about how he enjoyed the sessions.*
>
> *(Parent 05)*

Parents noted the value of the *program providing support both to their child/ren but also support to themselves.*

> *I feel like even though she was able to help me with [Son] and [Daughter] and stuff like that, she was also able to help me in the process as well. That was really good. That's why I can't really fault it because I feel like I got the help that I needed for myself and for the kids.*
>
> *(Parent 04)*

2.1.1.2. Therapeutic space and processes. Parents explained that the *strengths-based approach and validation provided* within Restoring Childhood was a strength and assisted them to build their confidence in parenting within the context of family violence and the pandemic.

> *Just how reassuring it is to hear back feedback to let me know that I am doing a good job, she's very helpful like that, she's very reassuring.*
>
> *(Parent 02)*

Parents noted that despite only meeting their clinicians via telehealth, they were able to develop a strong level of *trust and connection.*

> *I just knew from the way they spoke and they were genuine. They wanted to help, I'd dealt with counselling for myself throughout the years and I've just never clicked with any. As soon as I spoke to [Clinician] I knew that I needed to come and see someone.*
>
> *(Parent 02)*

The *creativity of online activities* was noted as a strength by parents who described how it assisted in rapport building and engagement with their child/ren.

They used the whiteboard in Zoom. They were able to draw pictures about what the session was directed at. Then they were working more on a sheet that had all the different zones you were in. We managed to put in different feelings in each zone…. [daughter] was a bit uncomfortable talking about herself. She did them about one of our dogs. It was quite interesting because even though the dog is the most placid, tolerant thing, she was still able to talk about things like, "This would make Maggie very angry". It was like [Daughter] was Maggie. She wasn't saying, 'This would make me angry'. She did it about the dog. It was just her way of putting that on paper and doing pictures and putting words around it.

(Parent 03)

2.1.1.3. Outcomes of restoring childhood for families. Parents noted key outcomes of the Restoring Childhood program for (a) parents (themselves), (b) families, and (c) children. Parents described that participating in Restoring Childhood and the support and therapy provided contributed to *an increase in parenting skills and confidence*. Specifically, they noted that they *developed new skills and confidence in managing child behaviour and talking to their children about emotions*.

My parenting behaviours really changed a lot. I've become more able to listen and I'm not just trying to control the situation completely and allow them to speak more. It's actually calmed a lot of our situations down a lot faster than what it would've. Before things would escalate really quickly with their emotions and I didn't understand why. I would just want to control it and just get them to stop crying or stop getting upset rather than trying to take five minutes to try to understand where they're coming from and do something differently.

(Parent 01)

What's going on his little mind, maybe there's things that he feels like he can't tell me, maybe he'll be able to tell somebody else. I was constantly worried about because he wasn't talking about certain things I was just constantly worried about how it was impacting him and the effect that it was having on him. Talking it through with [Clinician]- she was just able to reassure me that what I was saying was the right thing and how I was handling it was the right way. I think that constant second guessing yourself am I doing the right thing, I don't want to make things worse, and it's just that reassurance…..It's really meant that I'm a lot less anxious about where we're at and when things come up, I guess I'm not panicking, I'm not going to break him.

(Parent 05)

Parents noted that their *understanding about how exposure to family violence can impact children* and their development also increased, and this helped them understand their child's behaviour and responses within this context.

What I've gotten out of it is just understating the little triggers from domestic violence and the trauma it has on your kids. I never seen it as anything, now I realise the affects it then has on your child growing up and reading brochures and getting sent things to understand it. I never knew any of it, I would never have thought that anything that I had gone through had anything to do with [Child]. Even with my anxiety and then passing that on back down to her and even talking things out, I never would have done any of this with [Child] and that's the only way I can be thankful for her behaviours and how we are now as a mother and daughter without a dad. That's all thanks to [Clinician] and Berry Street, I suppose.

Parents also described that the support they received during a time of stress and isolation contributed to *improved mental health and wellbeing*. The isolation of the pandemic was reflected upon, emphasising the importance of having someone to speak with regularly and provide support for themselves and their parenting.

I feel like for myself it was really vital. I was in a place where I was really confused and they provided answers and resources for me and just made me feel really at ease and supported and not alone. I think that was the biggest thing for me was how lonely I was at the time because being a single parent and then having to go through this and then also I was working as I had to do home-schooling, they really grounded me. So, the fact that we could speak weekly, there were a couple of fortnightly ones, but just knowing that we'd have these conversations, for my mental health it was really important.

(Parent 01)

Just knowing that they were there too if I did have issues. I know there was one time that I did ring [Clinician] during the week. I said, "I'm okay but I don't know how much more of this I can go through before I'm not okay". Just being able to tell her that actually made me feel a lot better.

(Parent 03)

Parents noted *improvements in relationships with their child* with some parents noticing more open communication around feelings and emotions.

She's slowly learning to talk to me about it all which is good… instead of slamming doors if I sit her down now she will then say to me, "Mummy, I'm feeling like this, can we write it down?" Or she will want to talk to Frankie which is the teddy bear that [Clinician] uses for feelings. Before this, she would slam the door and if I was to ask her, she would just scream and there would be no words, there would be no communication, was just all screaming and crying. There was no understanding of each other of what we were both trying to get out of the emotion side of things.

(Parent 02)

He always was a very quiet, cautious and shy. He's definitely come out of his shell a lot. Definitely able to communicate his feelings more effectively and not just identifying his own emotions but other people around, like he's a bit more in tune with my emotions too. He'll come in and tell me, "mum you've been quiet today, are you sad" or things like that. He's also more calm.

(Parent 05)

Parents also noted that Restoring Childhood *had facilitated communication with their child's school*, assisting teachers to better understand their child's behaviour within the context of their exposure to IPV.

The teachers were getting really upset with his behaviour but they didn't understand why and so once I explained it to them, it made them a little more sympathetic to him instead of always just trying to put a label on him as being the child that will mess around or not pay attention or be rude or disrespectful. So, I think it's helped them not to see him as the bad child, which is how he sees himself. I think it definitely opened up that space for me. I think at the start I was very hesitant to talk to them about it because I didn't know what to say.

(Parent 01)

Parents also observed improvements in their child's ability to understand their emotional experiences and *regulate their emotions and behaviour*.

I feel like he's definitely not as aggressive anymore. It's not non-existent, it's still there, but he calms down a lot quicker. Because he was really cuddly before and he stopped being cuddly and now he's back to giving cuddles and things like that, which is really good.

(Parent 01)

2.1.2. Strengths of restoring childhood delivered via telehealth as perceived by clinicians

2.1.2.1. Benefits for clients. Clinicians noted benefits of the transition to telehealth for the families with whom they were working with. They commented that the rapid transition to telehealth enabled *continued service provision* to families during a vulnerable time of increased stress, isolation, and at times, increased escalation of family violence.

My clients spoke about their fear of isolation, and I think that offering Zoom was really helpful for them to feel less isolated and to have confidence that they could still connect in this time, even if it is outside of our organisation.. [it] gave them this sense that they're not completely on their own, just because we are at home.

(Focus group 2)

Clinicians also noted that for many families, telehealth was a *more accessible and/or comfortable service* compared to a face-to-face model. Specifically, telehealth enabled parents to access therapeutic services for their child without taking time off work or arranging childcare for siblings.

They don't have to leave the house, they don't have to get the kids ready to go somewhere, pack them all up, I guess it's a bit more convenient because they're in their homes, so they can be cooking while we're on the phone or doing two things at once. I've found that most have found it to be okay and to be probably more helpful.

(Clinician 04)

In addition, clinicians noted a preference for telehealth for clients who may have been reluctant to engage in a traditional face-to-face service. Specifically, they observed that adolescents were most comfortable with telehealth.

I've found the more internal or inhibited children seem to, and this is just a generalisation, but some of those children seem to be more comfortable over Zoom than they would be face-to-face, and that's something about them perhaps being in a familiar space, having familiar things with them, and being able to share those things with us through the screen, I find, seems to help them to open up a little bit more, more than if they had come to a foreign office environment.

(Focus group 2)

2.1.2.2. Therapeutic space and process. Clinicians noted several strengths in the transition to telehealth and consequential changes in the therapeutic process. They stressed the importance of adjusting therapeutic style to engage with clients online, describing key changes in how they built rapport, and creative ways of bringing play-based therapy into the telehealth space.

It has been a process of trying to adapt and translate some skills that I already had in terms of clinical skills, skills for engaging children, and trying to adapt that into this Zoom platform.

(Focus group 2)

I have become more aware of the young person and having to really rely on their tone of voice to be able to gauge how they're feeling…I'm really specific now about how I'm gauging how they're going over the session, and if there are too many long pauses and it's becoming too hard for them.

(Clinician 04)

Clinicians shared that telehealth *required parents to be more actively involved in the preparation and/or delivery of sessions*. They reflected how this could create a sense of empowerment within parents and de-emphasise the clinician as the expert.

One of the challenges that I often found when I was working in the office and having sessions that weren't online was that the dyadic sessions are a place where we want to set that dynamic up so mums and children explore together. I often found that mums would often take a bit of a back seat because the clinician is in the room, and so the clinician would do all the questioning. I guess, one of the things that I was always trying to encourage mums to do was, "I want you to start asking the questions as well, and if something comes up in the session, to explore it with your child and I'll be there to guide you or support you if you need that". I'm finding that it's happening more being online. It seems more intuitive because they're in the space and I'm a bit more distant this way.

(Clinician 03)

Telehealth also enabled greater insight into *the family home environment.* At times this assisted with the assessment of a child and their family and offered opportunities for children to practice strategies within their home environment.

You get a different insight to a child's world, …Instead of just talking about the place they feel safe at home, they can show you their safe place.

(Clinician 07)

2.1.2.3. Service delivery. Clinicians reported several strengths of the service delivery via telehealth during the pandemic. Telehealth enabled increased flexibility in the time, frequency, and duration of sessions based on the individual needs of the family. For some families this meant shorter but more frequent sessions to meet the attention and/or capacity of the child. This would not have been possible if the service were delivered face-to-face.

One of the really exciting ways is, with the younger cohort of children, using interventions such as Theraplay and thinking about the dosing of those interventions. Rather than necessarily doing a one-hour session, doing a number of shorter sessions over the course of the week with parents and their young children, and really thinking about what the goals and purposes of that interventions are.

(Clinician 07)

Clinicians also reflected on the potential for telehealth to *be integrated as a key component of the Restoring Childhood service post-COVID-19* to increase accessibility of their service for families, including those from regional, rural and remote areas.

Obviously, it was forced upon us in a way that we're in this situation, but I think that fairly opened up a lot of possibility for us for future as well. When we think that Zoom has already been there ..So, I think it's probably given us more tools to use.

(Clinician 02)

Hopefully, it's something we can keep providing when it's necessary. We'd be doing drives to [town] which is an hour there and back to see clients at times. Now maybe there's a way of minimising some of that by doing some of that online.

(Clinician 03)

2.2. Challenges of restoring childhood delivered via telehealth

The challenges of delivering the Restoring Childhood program via telehealth were described by parents and clinicians. Thematic analysis of parent interview data revealed themes relating to (a) challenges for treatment, and (b) challenges for service delivery. In contrast, thematic analysis of clinician interview data revealed key themes relating to (a) service delivery- therapeutic, (b) service delivery- processes, and (c) working from home. There were minimal similarities in sub-themes across the participant groups. Figs. 3 and 4 present the key themes and sub-themes relating to key challenges of Restoring Childhood delivered via telehealth for parents and clinicians, respectively. Themes, sub-themes, and corresponding quotes relating to parents will be discussed first, followed by the clinician data.

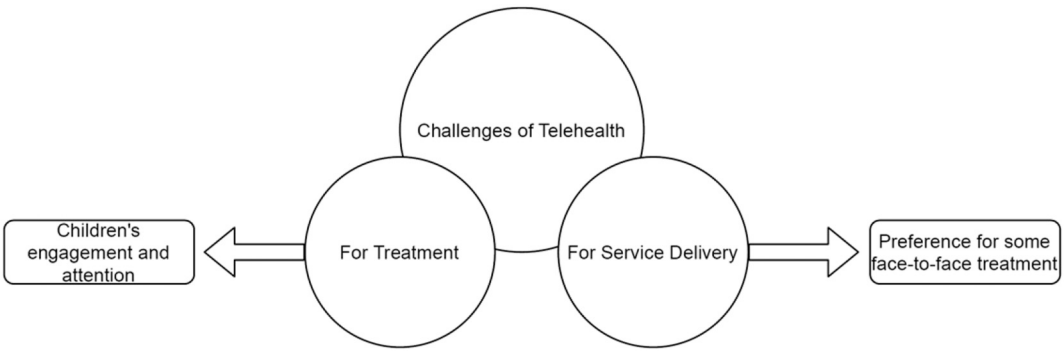

Fig. 3. Challenges of Restoring Childhood delivered via telehealth as perceived by parents.

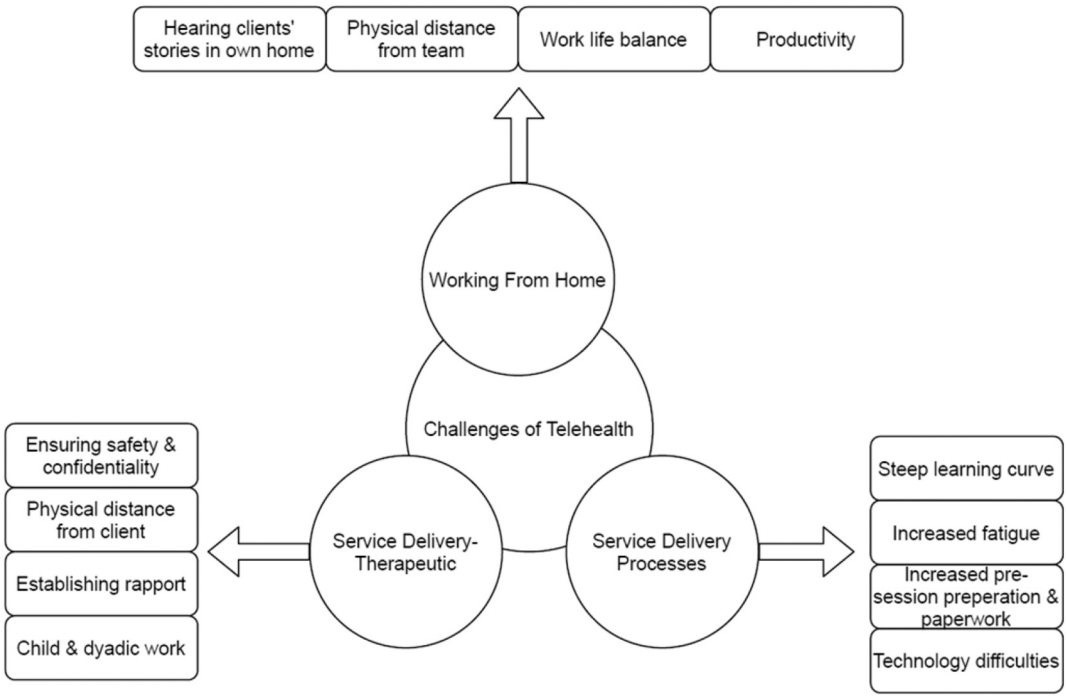

Fig. 4. Challenges of Restoring Childhood delivered via telehealth as perceived by clinicians.

2.2.1. Challenges of the restoring childhood program delivered via telehealth as perceived by parents

2.2.1.1. For treatment. Parents of younger children (children under approximately 8 years) explained that at times their child/ren had difficulty maintaining attention and engagement across the telehealth session, particularly after spending considerable amounts of time in front of a screen during the day for remote learning at school.

> *I find that it's hard with [daughter] to get her to sit at a screen with how easily she is distracted. Generally, it's pretty good it's the same thing, it's a little bit harder when it's not in the room to keep her focused on [Clinician] if [Clinician] is discussing something now through the iPad.*
>
> *(Parent 02)*

2.2.1.2. For service delivery. Although all parents endorsed aspects of the telehealth model, some parents noted a preference for some face-to-face sessions which can allow for different therapeutic techniques and may be less tiring and more engaging for children than screen time.

> *I probably would prefer a phone call if it was just a parent session, so that worked out really good. The Zoom's, they weren't bad, it was just would have been better in a room together as a different environment to watching an iPad. It was still just as effective I believe, I don't think it was any different.*
>
> *(Parent 02)*

> *When he had the first face-to-face we were there for the full hour and he didn't comment once about how tired he was, he actually said at the end, "Mum that went really quick, was that shorter than what we normally do?", I said, "mate, it's actually longer". Sort of obvious that there's definitely the benefit of doing the face-to-face.*
>
> *(Parent 05)*

2.2.2. Challenges of delivering the restoring childhood program delivered via telehealth as perceived by clinicians

2.2.2.1. Service delivery-therapeutic. Clinicians noted several aspects of therapeutic process which were more difficult via telehealth. They needed to implement additional processes to ensure safety and confidentiality within sessions. They spoke about the importance of developing clear protocols of how the clinician would know if the perpetrator of IPV was in the home at the time of the session, how the client may react (e.g., quickly end the call) and methods of checking back in to ensure safety.

If we know that the person who uses violence does come and go from the house, but they haven't been there when we've been talking, we certainly say, "If we can't get onto you, what would you like us to do? Is there someone else we could call to check on you?" Things like that. Some of the safety planning. It's thoughtful safety planning, but it's under these conditions, in terms of, "If we haven't from you, what would you like us to do? What would be most helpful?" Just to ensure that we're partnering with the survivor so that they can tell us what they think would be helpful.

(Clinician 05)

Probably the big change that's been about that, in the preparation, and having to think about safety in different ways, because we're not contained in the environment in the same way that we do when we're in the office.

(Clinician 01)

Clinicians explained that certain aspects of telehealth required them to adjust their therapeutic style. For example, they described that *not being in the same physical space* as the client created challenges.

The other week I had a session with Mum and child and they had an argument in the middle of it all and so the child took off to the bedroom. Mum followed him and I could hear the discussion in the background but I wasn't present. They then had to come back to me. So, that was certainly a concern of how is Mum coping with this and what's the child's response to Mum having a bit of a go at him? How can I bring this back together when I'm not actually physically there? That was certainly a challenge to think about that and thinking, 'Well, how would I manage that face-to-face and what do I need to do differently to be able to make this work through Zoom as well?'

(Clinician 02)

In addition, clinicians noted that *developing rapport* with families was more challenging via telehealth and that this also required changes to their usual therapeutic style.

Trying to build up that rapport and that level of engagement and trust probably takes more effort, takes a little bit more time on our part as well. It takes time for mums to feel, "This is somebody that I can work with." The priming takes more time.

(Clinician 03)

What I've done in that is that I've made a bit of an About Me page that I'll either send to them via mail or email, and it's got a picture of myself, so that at least they can see what I look like and I'll have some random facts like my favourite colour, favourite food, those kinds of things. Sometimes the mum will help them make one of those themselves or they'll just tell me what they look like. I did that, because I found that they were often quite curious about what I looked like. "What colour hair do you have?" "What colour are your eyes?" and things like that. That's where I came up with that. I guess it's been able to try and build that rapport over the phone.

(Clinician 04)

Therapeutic work with young children and dyadic work were also identified as more challenging via telehealth and clinicians noted the importance of being prepared and creative for sessions to facilitate this work.

The work with the children, but that's what I've found to be trickier, if I was to be honest, working in Zoom, is thinking about how I'm going to remain really playful. Sometimes it does just flow and sessions are really playful, but I perhaps get a little bit more concerned about what I might do it doesn't go to plan. I can't just play a game of Uno or play a game of Jenga.

(Focus group 2)

I think more preparation needs to go into that, preparing the mum for what that's like for them, what activities they are going to provide, what's it like to be in their space and thinking about providing a face-to-face for that to happen so that afterwards is that space even necessary, reminding they're talking about traumatic things? So, yeah, really helping Mum to think about some of that containment for her and the kids doing it.

(Clinician 02)

2.2.2.2. Service delivery-processes. Along with changes to the therapeutic work, clinicians discussed changes to service delivery processes which created challenges. They noted that telehealth was more tiring than face-to-face therapy, describing increased fatigue.

I find it much more tiring, and I needed to have much more available to me physically around, or via the Zoom, to try and keep them engaged.

(Clinician 01)

Clinicians also described an *increase in preparation and paperwork prior to sessions* compared to face-to-face sessions. This included contact with parents to ensure materials required for the sessions were available, and in some cases posting packs out to families. Usual paperwork (e.g., self-report measures, forms) often required multiple emails or phone calls to be returned, and this was viewed as more time consuming than asking families to complete paperwork during sessions.

I also think just in terms of the priming sessions with mums. More time is required.

(Clinician 03)

One of the biggest challenges that I've come across so far is consent and the documentation becomes incredibly difficult to do. I think that's also adding to the timeframes that we're spending with our clients because it takes so much longer to do.

(Clinician 03)

Technological difficulties including losing internet connection momentarily, or the family's lack of access to stable internet connection were common and described as a challenge by staff.

In [region] and surrounding regions, if you don't have Telstra your range is terrible. Even so, there are dead patches where you don't really get really good range. Even over the phone sometimes, I've found if I'm talking to them that I'll have to be, "You're crackling. I can't really hear you." It will drop in and out. Some houses have spots where they get really good range, so they'll have to be in a specific room in a specific corner to be able to talk to me and have that really good range. Some can't even afford internet. That's generally what we're finding as the barrier to be able to use Zoom.

(Clinician 04)

Certainly, the technology glitches, though – the stopping – I find myself feeling really anxious when it freezes for a second or two. I've noticed that about myself, that that I really don't like. It feels like it's quite jarring at times, in that you're not sure what's been heard and what's been said while that's been frozen for a couple of seconds.

(Focus group 1)

Lastly, clinicians described that the adaption of Restoring Childhood to telehealth was rapid. They explained there was a *steep learning curve* to adapting their therapeutic approaches and service delivery processes, and that this was stressful and challenging at times.

Telehealth, it wasn't something that we have even talked about in our programme, so we were in an area that I wasn't skilled in, because I've never done it before. It was certainly that sense of being thrown into a whole new world, It was a fairly steep learning curve initially.

(Clinician 01)

2.2.2.3. Working from home. Clinicians described several challenges associated with delivering Restoring Childhood via telehealth from their own home. *Hearing clients' difficult stories of FV in their own home* was emotionally challenging at times.

I don't want them [my children] to hear all the things that we talk about…I literally open my front door and I'm in my house, there's no drive home to process your day, there's no space of my own to go if you've had a difficult conversation with a client.

(Clinician 01)

I would just say that having family around, I remember when I started this work, I've got older children, so it's a little bit different, I have 2 children and when I started the work I had to have conversations with them, and my partner as well, around privacy and confidentiality around my clients, but also making it really clear why I would never ever want them to hear the conversations that I have, and I think in respect to our families that we work with and the children, but also, I don't want my family to hear those things.

(Focus group 2)

Consequently, clinicians described that maintaining *work life boundaries* became more difficult without physical work-home separation, and that they were more likely to engage in work after hours.

I found it challenging. I probably didn't realise how much I tried to keep my particular role at separate, even just unconscious things like I would change my clothes as soon as I get home, and I think that was kind of leaving work at work. It probably sounds quite neurotic. I think I found it hard in an apartment, just bringing that kind of content into the home, and just practical things like I was initially at my dining table and then thought it would be a great idea to buy a desk and keep it a bit more separate, so really just trying to create those psychological boundaries around it.

(Focus group 2)

The *physical distance* from team members was also a challenge, with clinicians describing fewer informal debriefing opportunities than might normally occur with colleagues following a difficult session or phone call.

What I'm really mindful of, when we're in the office, if one of the clinicians has a difficult conversation, I'm aware of that, I can see that it's been difficult and I'm able to check in with them afterwards, I don't know that now, so it's really having to make sure that they know they can call me any time and that they have to have a lot more self-awareness, I suppose, and it's much more on them to reach out.

(Clinician 01)

What's tricky about it for me, is not having that same kind of informal peer support when you do have some really rough information shared, a tricky session, or just a feeling that you're left with. I know you can call, and I definitely think that the organisation, and in particular my supervisor and our team leader have been really thoughtful and consistent in their messaging of, "Please just call if you need support" or thinking about different ways we check-in, but I probably haven't felt like I could use those - the check-ins aren't really a space where you might discuss a tricky session as you would to someone you're sitting next to in your pod.. The content we hear does make working from home more just kind of working remotely from your team tricky for me.

(Focus group 2)

Finally, there were contrasting discussions about clinicians' self-reported *productivity* levels. Many expressed that they felt more productive when working from home despite the increase of administrative tasks and a larger workload. A small number of clinicians had their difficulties in maintaining usual levels of *productivity,* and some felt building pressure to return to pre-pandemic productivity levels.

> *It has been a challenge to be able to keep up with the work. I feel that I'm slower in my work at home. So, having supervision has been really good to be able to think about those things.*
>
> *(Clinician 02)*

> *"Everyone work from home and do the best that you can." That was really wonderful, and I think gradually, that's become, "Actually, you still need to do the same amount of work." … We still need to get our numbers.*
>
> *(Clinician 03)*

3. Discussion

The COVID-19 pandemic has resulted in remarkable changes to the provision of therapeutic services for women and children who have experienced IPV. Many organisations have swiftly adjusted their service delivery model to provide telehealth options, enabling ongoing support to families in need during the pandemic. This study sought to capture the experiences of clinicians who rapidly transitioned to providing a dyadic intervention for parents and children who had experienced IPV. Complementing clinicians' experiences, the voices and experiences of women who accessed the intervention were also captured. Identifying the strengths, challenges, and acceptability of telehealth therapeutic interventions for IPV is an essential first step to providing therapeutic services via telehealth platforms that are accessible, engaging and responsive to the needs of families experiencing IPV during the pandemic and into the future.

Clinicians and women within our study identified many strengths and benefits to the Restoring Childhood telehealth model delivered during the COVID-19 pandemic. Specifically, women noted that the creative and strengths-based approaches used within sessions resulted in positive therapeutic experiences for themselves and their child. The establishment of a trusting therapeutic relationship was noted as a strength. This is important given that the therapeutic relationship is a strong predictor of treatment outcomes (McCabe & Priebe, 2004). These findings were complemented by clinicians who reflected on the adjustments which they made to their therapeutic style to engage with families. Our findings suggests that telehealth is an acceptable mode of delivery for family violence therapeutic services for both parents and clinicians. Importantly, clinicians and women within our study reported an increased need of support for families who have experienced IPV during a time of increased stress. The use of telehealth to enable provision of Restoring Childhood was highlighted as a considerable strength. This heightened need for support underscores the importance of established telehealth processes to enable services to be responsive during COVID-19 lockdowns, future pandemics and/or other community wide crises.

Women reported several outcomes of Restoring Childhood for themselves, their family, and their children. These outcomes included improved parent-child interaction, improved emotional-behavioural functioning in children and increased parenting confidence. Although these outcomes may not be specific to the telehealth context, they are important to highlight as they provide preliminary data around the potential therapeutic benefit of telehealth within the family violence context. Such outcomes are in-line with the intended benefits of the Restoring Childhood service and provide preliminary evidence for the transferability of Restoring Childhood to a telehealth model of service delivery. Evidence based interventions for children exposed to IPV are lacking (Rizo et al., 2011), particularly within an Australian context (State Government of Victoria, 2016). There is a desperate need for evidence-based, effective, and scalable interventions to support children and their caregivers exposed to IPV. Given the possibility of future pandemics and the promise of telehealth in reducing barriers to accessing support, there is also a need for evidence surrounding the effectiveness of telehealth interventions within this space.

Along with describing telehealth as an acceptable mode of delivery for Restoring Childhood, a small number of women described telehealth as preferable for them and their family over face-to-face services. In line with past research that telehealth may reduce barriers to treatment engagement for some families (Comer et al., 2015; Stewart et al., 2017), participants within our study noted that telehealth enabled them to overcome barriers to attendance such as difficulty getting time off work and lack of access to childcare for children not participating in the session. In addition, the two mothers of adolescent boys reflected that their children would have been reluctant to engage in face-to-face services and that telehealth provided a less anxiety-inducing experience. This increased accessibility and comfort provided by telehealth was also supported by data from clinicians within the study. Clinicians noted that telehealth enabled increased flexibility to provide shorter more frequent sessions to better meet the developmental needs of younger children. Together these findings highlight the potential of telehealth to provide family violence therapeutic support to vulnerable families who would otherwise not be able to access it, including those living in regional and rural areas where access to services is severely lacking (Campo & Tayton, 2015; Peek-Asa et al., 2011).

Despite telehealth being preferred by some families, it is important to note that telehealth may not be suitable for everyone. A small number of mothers within our study noted that they would have preferred the option of face-to-face service delivery. Moreover, the effectiveness of telehealth may vary depending on children's developmental stage with mothers of younger children reflecting that maintaining concentration was difficult for their child at times. These findings highlight the need for further rigorous research to determine the effectiveness of telehealth in providing therapeutic services to children exposed to IPV across developmental stages and different therapeutic treatments. Findings also emphasise the importance of acknowledging limitations in services to fully meet the

needs of certain families during the pandemic.

Our findings highlight the challenges that the family violence workforce and services faced/are facing during the COVID-19 pandemic. The initial rapid transition to telehealth was described as a steep learning curve, placing considerable pressure on staff at all levels of the service. Although there appeared to be a level of adjustment, increased fatigue and increases in administrative and session preparation tasks associated with telehealth delivery continued for clinicians. Clinicians discussed needing to adjust their therapeutic style to establish rapport via telehealth, as well as the need to be creative and innovative within their sessions with children and dyadic parent-child sessions. Ensuring safety and confidentiality were also key challenges, with clinicians describing the importance of clear communication of safety and confidentiality processes to clients at the outset of treatment. Importantly, this concern was not raised by mothers within our study, indicating that they felt that the use of telehealth was safe. However, it is likely that with a larger sample, this may have been raised by some participants, with safety and the reliable risk assessments identified as a key challenge of telehealth delivery within the context of violence (McLean et al., 2021; Racine et al., 2020).

The COVID-19 pandemic added an additional layer of difficulties with Restoring Childhood staff required to work from home due to State-wide government lockdowns. This created many challenges including maintaining a work life separation and hearing difficult client stories within their home, often with their own children in another room. In addition to bringing this work into their homes, clinicians discussed the impacts of the physical distance from their team, a usual source of support. Although clinicians reported good structures in place for supervision, it was the informal debriefing among colleagues that they were less likely to engage in due to this physical distance. Working therapeutically with parents and children who have experienced violence is challenging and comes with risks for both vicarious trauma and burnout (Cocker & Joss, 2016; Coles et al., 2013). For many clinicians, the pandemic has increased stress and workload and a decreased access to usual protective factors such as informal debriefing, further increasing risks. Services may need to provide additional supervision to overcome these risks and create more structured methods of allowing for peer support when staff are working offsite.

3.1. Strengths and limitations

The current study is one of the first to explore the experience of engaging in and delivering therapeutic services for families exposed to IPV via telehealth during the COVID-19 pandemic. The inclusion of clinician and parent perspectives provides insights from both a service and consumer point of view. Importantly, clinicians' voices hold important practice based knowledge to inform the implementation and delivery of family violence telehealth services and the importance of safeguarding clinician wellbeing. Moreover, the voices of parents who engaged in therapeutic family violence services during the pandemic is essential to understand the acceptability and appropriateness of telehealth for such services.

Despite these strengths, there are several limitations worth noting. Our sample of parents was small ($n = 5$) and included parents of children who varied in age from early childhood to adolescence. This is likely to have limited the depth of experiences collected. Moreover, our sample consisted of only mothers and may not represent the experiences of fathers or other caregivers who took part in Restoring Childhood.

In addition, there were significant differences between the benefits of the service noted by parents and clinicians, and this limited the triangulation observed across our data. This is likely due to clinicians having prior experience delivering Restoring Childhood within a face-to-face setting. This enabled them to compare process level observations between the two modes of delivery. In contrast, taking part in Restoring Childhood via telehealth was the first time many mothers had engaged in therapeutic services in response to IPV.

3.2. Conclusions and implications

Findings from this current preliminary study into the use of telehealth services in delivering therapeutic services to parents and children exposed to IPV hold important implications for practice and research. Parents and clinicians within our sample reported that the use of telehealth was acceptable and may even be preferred by some families. Telehealth modes of delivery may offer increased accessibility of services for families who may otherwise experience considerable barriers to engagement including geographic distance from services, access to childcare and transportation. It is important that services consider the long-term role of telehealth within their service post the COVID-19 pandemic and provide families with choices in how they would like to engage. Additionally, further research is urgently needed to determine the effectiveness of family violence therapeutic interventions for parents and children delivered via telehealth.

Despite the promise of telehealth interventions for families exposed to IPV, there are several considerations to ensure the appropriateness of telehealth for the individual family's needs. The limitations of telehealth must be considered including the children's developmental age, ability to access reliable internet, technological devices, access to confidential spaces and ensuring safety (Racine et al., 2020; Ragavan et al., 2020). Our findings highlight the need for clear and explicit guidelines on the use of telehealth with families who have experienced IPV to assess and maintain safety and confidentiality. Furthermore, clinician supervision and professional development needs are likely to increase, particularly if work from home arrangements are in place. Safeguarding the health and wellbeing of our family violence workforce is essential for the longevity of the workforce as well as ensuring the quality of service provided to families in need.

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