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The impact of using an infant and child-led therapeutic approach in providing in situ consultations and transferable learnings to key workers working with families identified as at risk: A retrospective Australian study

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Abstract

This paper reports on a retrospective, qualitative evaluation of an 'infant and child-led' therapeutic family practice approach undertaken by an infant-mental-health-trained family therapist between 2013 and 2023 with early years service providers working with families deemed to be 'at risk' within the Western suburbs of Melbourne, Australia. Direct, targeted, therapeutic consultations were delivered to families in situ (in the moment) alongside their key worker, with whom they had already built trust, and who could continue to build on the infant and child-led therapeutic approach undertaken during these sessions. This collaboration between the therapist and the key worker enabled the provision of time-limited, therapeutic consultations to families in their own home or in spaces that were familiar and felt safe. Data collection included an anonymous survey completed by key workers, and reflections from two program managers who supervised the key workers. The key workers who completed the surveys identified they had been impacted by the experience of actively involving and inviting in the voice and perspective of infants and children into the very space that constitutes why, as early years workers, they were involved with these families in the first instance. Workers reported that the quality of services delivered to these families was enhanced through their improved ability to adopt an infant and child-led approach in their practice.

Keywords:

infant and child-led practice, infant and child mental health, 'in situ' key worker consultations, intergenerational family therapy, family violence.

Knowledge translation and impact

Infants and children considered to be at risk are the very reason for child protective services and specialist early years workers to become involved in working with families; however, infant's and children's voices are often the least likely to be heard or taken seriously. Accessible, specialised, therapeutic approaches that actively include the voices of infants and very young children honour, not only their agency, but their right to have their voices and their interests both heard and considered in interventions that directly impact them. Furthermore, families, and parents in particular, benefit from an approach that harvests the hopefulness infants and children bring to their lives and their desire to do for their children what they may have wished their parents could have done for them. Such approaches can provide opportunities for parents to revisit their own childhood traumas, to explore their own parents' lives and choices and, from a position of curiosity, to play with how they might make choices now that their children will value as they grow up and become parents themselves.

Families considered at high risk do not always have access to specialist therapeutic services. Developing inroads with families who are wary of accessing therapy but who have built trust with their key family workers makes this approach more powerful. The strength of this in-situ consultative approach is that the work already untaken by the key workers accelerates the impacts of the therapeutic sessions, not only on the families, but enhances the key workers' ability to bring a more therapeutic lens to how they do the work themselves.

Introduction

This paper describes the journey and retrospective evaluation of an infant and child-led family therapeutic approach delivered to families deemed to be 'at risk' by child protection, family support services, family violence services and women's refuges, and early years' professionals with whom they were already involved. The infant-mental-health-informed family therapeutic consultations were provided when requested by the families and key workers, and where trust had already been established with these existing services. Building on and consolidating the work already undertaken by their key workers, this intervention provided a unique, 'in the situation' intervention for the families and a training opportunity for key workers engaged with the family by being present 'in' and a 'part of' direct infant and child-led family therapeutic consultations.

An infant and child-led therapeutic family approach

While difficulties with parenting is a major reason for seeking therapeutic support from human services, counsellors and family therapists have been slow to invite infants and very young children into the therapy space (Johnson & Thomas, 1999; Lund et al., 2002; Rober, 1998; Vossler, 2004). Specialist family therapy approaches have evolved to address this issue in part, but many remain committed to using the parents or older, verbal children as their entry points for change (Carr, 2019). Where there is an infant, this top down, adult-centric approach ignores the most accessible, ready-to-engage little person, and the one who is likely to have the shortest trauma history, as the entry point for familial change (Paul & Thomson-Salo, 2013). Furthermore, curiosity about the infant or child's experience invites exploration of a 'whole of family discourse', where multiple perspectives may open a richer landscape for discovery.

While filial therapy and other play-based approaches involve children, the emphasis is on teaching parents how to use play to enhance their attachment to, and ability to be attuned with, their child (Daley et al., 2018; Griffin & Parson, 2023; Topham & VanFleet, 2011). The impetus remains adult down. Reciprocity is important in the wider system because the use of play to 'grow change' is powerfully acknowledged; however, these approaches stop short of seeing infants or young children as subjects who possess their own separate agency (Paul & Thomson-Salo, 2013).

Within Australia, there is still much work to be done in 'positioning children as rights-holders ' rather than passive dependents and providing children 'with a universal framework for advancing their wellbeing, dignity and agency' (Marwitz et al., 2024: p. 1). The capacity to comprehend infants and very young children as possessing their own agency, and demonstrating through their own actions and behaviours who they do/do not feel safe with, is far from recognised by many practitioners. Neither is how much infants and very young children can tell us about their world through their bodies, their actions, vocalisations and how they engage with their world.

What sets an infant or child-led family approach apart from existing familial approaches is the purposeful elevation of the voice of the youngest, most vulnerable members of families to a level that allows their subjective experience to be thought about, their presence in the therapeutic space to be welcomed, and the powerful therapeutic contribution the infant and/or child offers to be recognised (Bunston, 2008, 2015, 2017). The intention is to recognise that infants and young children have every right to be equally considered in all matters that directly impact them.

Family members are invited to observe, be curious about and consider what the very young infant may tell us about their experiences were they able to speak. Equally, family members are invited to wonder about the powerful non-verbal cues infants constantly provide as they engage with their family members and caregivers (Cohen, 2006; Cohen et al., 2002). The therapist directly talks to and engages with the infant as they would any other. Infants communicate volumes about their world through how they track with their eyes, how they hold their body – either when in the arms of others or laying on a cushion on the floor – and by babbling or crying. Simply being conscious of what feelings are aroused in us when we observe the infant gives us valuable information (Reddy & Trevarthen, 2004). Workers being curious about what they see and wondering aloud with other family members about what the infant might be disclosing is key to this approach (Cohen, 2006). They do this by asking family members to

imagine what the very young child/infant could tell us about their experiences thus far, whom they may feel safest with, what they like most or what may frighten them. Other, older, verbal children can be startlingly profound in their observations when they are safely invited into such conversations.

The verbal, mobile young child discloses much by whom they go to in the room and for what. When workers slow down, allow space to really see, engage and delight in children, they may offer parents a distinct perspective of their child and of themselves as parent/s.

Play is one of the first tools with which to explore the world and understand ourselves and others (Meares, 2005). Sitting down on the floor and playing with infants and children and inviting the adults to join in can shift the atmosphere in the room dramatically (Thomson-Salo et al., 1999). The depressed infant may need more time and gentle engagement to feel safe enough to become more alive in the space. The anxious infant may need help modulating (or managing) their emotional states. It is invaluable to observe the infant or young child's interactions with their parent/s, siblings or grandparents, and how they interact with the worker (Beebe, 2006; Rustin, 2009). This approach essentially asks workers to watch with their eyes, mind and body (Bunston & Jones, 2023). Humans' earliest grasp on navigating the world occurs non-verbally, and workers benefit from holding in mind that foundational physiological template within.

Living in an adult-centric society, workers can, without thinking, automatically defer all things to the adults in the room (including asking a parent how a child is when the child is sitting right there with you). Being trapped in one's own trauma history and anticipating danger in forming relationships with others can hinder shifts in thinking and behaviour (Fraiberg et al., 1975). Many parents hope to give their infants/children a better life than they have had. This desire to grow something different, something better, is a powerful motivator for change.

The client group

Some families identified by these early years key workers agreed to seeking therapeutic support because they admitted they were struggling, feared child protection involvement, or were already involved with child protection, and feared having their children removed. An accessible therapeutic response was provided to the families in places where they felt safe. This was not the family coming to the therapist, but the therapist coming to the family, and with the family agreeing to these sessions because of their existing trust in their key worker. Having their key worker be present and involved in these therapeutic sessions reassured these families, enabling encounters that reached a client population who seldom actively or reliability make it into traditional therapeutic or child mental health spaces.

The key workers

The key workers/services were the secure base, working alongside the family and as something akin to the 'good enough' parent (Winnicott, 1960). The worker steps into a role that offers parents with infants and young children a level of support previously not available to them. Often the family's involvement with certain services will be mandated by the state. However, the services involved in these consultations operate on an empowerment model and will not commence work until 'good enough' engagement with families is achieved.

Where there has been intergenerational trauma, in particular family violence and other significant risk factors, these workers provided 'extraordinary support'. This is support that requires a level of time, compassion, expertise and resilience that ordinarily is not required or available in generalist services. These in situ consultations support the worker through enhancing the family's capacity to see, think about and engage with the subjectivity of the pre-verbal infant and/or young child. The family therapy consultant comes to the family, rather than the family coming to them. This enhanced the engagement because the space is familiar. Crucially, so too does having the key worker present. These workers have had to 'earn their stripes' with families who have often had lengthy, and not always positive, contact with the service system.

The in situ family consultations

During the consultation, the consultant, an infant mental health social worker and family therapist, already known to and trusted by the key worker, worked in situ with the worker and visited families in their own homes, residential units, or services' offices. Involving their key worker in these therapeutic family sessions provided a powerful platform for an accelerated intimacy with these families who were already actively involved with child protection and/or other affiliated services, enhanced maternal child health or other early years' service providers.

Important to these consultations was appreciating the intergenerational threads woven through time. This involved appreciating how the infant and/or child in the 'here and now' might be making sense of their experiences in their families, reflecting on how these parents in the 'here and now' made sense of their parents' choices (Fraiberg et al., 1975; Lieberman, 2007) and being curious about what pressures their own parents may have experienced as they were growing up. In opening the capacity to wonder about the past, there is also a capacity to wonder about the future. This included: being curious about what their children may think; experiencing the choices they as parents are making; and, when they are older, and their children are perhaps parents themselves, how the children might look back on and make sense of the choices their parents made back then (Bunston, 2015; Bunston & Jones, 2023).

Consultations were most often time limited, determined by the family, and intended not to take over but deepen the appreciation for what the infant and/or child offers this family (as well as the key worker), subjectively, and representationally. This was in recognition that the youngest family members were not only the very reason for families seeking or being directed to receive help, but that they were often the most responsive to engagement, the quickest to thrive and the very reason families were involved in receiving support services. Retaining, or receiving support to care for their children proved a powerful motivator for making changes and having backing to create a different, more hopeful and robust future.

‘Building up’ not ‘tearing down’

Also imperative to this time-limited approach was an emphasis on strengths such as used in Single Session Therapy (SST) (Hoyt et al., 2021), or brief therapy approaches (De Shazer et al., 2021). These consultations were designed to build on, capture and enhance existing capacities, many already set in motion and supported by their key workers, with a focus on the infant/young child in the present, reflecting on the past childhood of the parent/s (Bunston & Jones, 2023; Campbell, 2012; Fraiberg et al., 1975; Lieberman, 2007; Malone et al., 2010), and looking towards the future (imagined and hoped for).

These families were already connected into intensive support systems. An ethos adopted in ‘Single Session Therapy (SST) thinking is a practical and ethical response to the abundant research that shows that whether we like it or not, a significant number of therapy clients seeking help will only attend one session and will find that one session sufficient ‘ (Hoyt et al., 2021: p. 36). This time-limited approach rested with what families and the workers chose, and only on very few occasions did the number of sessions exceed two or three sessions because the key workers themselves continued with the infant and child-led approach that commenced within these consultations.

The impacts of taking on an infant and child-led approach for the key workers themselves

Workers across multiple family-focused support services who participated in these infant and child-led family therapy consultations were invited to complete an online anonymous survey, providing their insights into how this intervention impacted the families and their own ways of working. In addition, feedback forms from service users and reflections from two program managers where the consultations had been conducted over many years were sourced and analysed.

In situ time-limited therapeutic consultations with families and their key worker

These direct family therapy consultations occurred with the therapist providing in situ (in the moment) training for the key support worker/s who have the day-to-day responsibility for these families. The number of consults was limited. The ‘hard yards’ had already been undertaken by the key workers and agencies. These consults enhanced the position and power of the infant/young child to be seen, heard and fully considered, to inspire hope for what is already changing the threads of the past, and to amplify the existing work taken to build a different future.

This approach was modelled for the family and the key worker by the family therapy practitioner sitting on the floor, and purposefully, gently but directly engaging with the infant and/or child, purposefully wondering aloud about their experience, and noticing what was occurring in the room in the ‘here and now’, as well as being curious about what was happening right in front of us, and ‘wondering’ just what these little ones might be telling us about their experiences. This way of working and engaging with the youngest family member/s was revelatory for some families. This brings attention to who the little one turns to, who they track with their eyes, how they use the space, what might their play disclose, and what might their cooing, crying, smiling and laughter tell us?

Through moving back and forward through time, the parent is invited to be curious about what their life was like when they were small, often exploring the history of the family through using a genogram (DeMaria et al., 2017), exploring who they went to to feel safe, what memories they want their child to have of them when their child becomes a parent, what sort of relationship do they imagine they will have with their grandchildren? In the ‘here and now’, delighting in the infants and young children, being curious about what they could tell us, and perhaps are already telling us, is a very powerful way of helping the adults in the space consider their infant and or child’s perspective, as well as opening a door to being curious about who delighted in them, or who they wished had delighted in them when they were small.

The key worker is the continuous presence in this vital work, whereas the infant/child-led family therapy consultant offers a therapeutic role that is singular through to intermittent. The consultation offers a powerful reflective space to unpack the past, enhance and celebrate achievements, capture the voice of all family members and garner hope for their future. The family therapy consultant, by virtue of inviting space to uncover the intergenerational storyline of these families, may also discover things about the family previously not known, understood, nor appreciated. In their day-to-day relationship with the family, the key worker uses the messages and stories uncovered in the family consultation to further enhance hope and growth in their work with families.

The in situ experience for the key worker

The intention of involving the key worker in these family therapy consultations is to have them bear witness to the family pausing, unpacking and processing the relational stories and unacknowledged strengths of each unique person and unique familial story. As the continuous intensive support worker, they actively participated in this holding process, increasing their understanding of the underlying intergenerational dynamics that may thwart such families’ attempts to recover from past traumas. This allows the worker to identify the shift in perceptions and understandings that take place in these therapeutic consultations, and to create and strengthen the bond and power their role has in supporting familial growth. As the key worker finds moments of clarity in the consultations, something in them also changes. These key workers report experiencing revelations that shift how they see, hold and appreciate the family’s intergenerational storylines. Involvement in these consultations also unlocks different understandings of the families of themselves and others, allowing something new to emerge.

The key worker is an imperative, reparative member of their family support system. While their involvement may be time limited, it is intensive, and they will stay in the family’s lived experience as an important healing presence. Their involvement in these sessions changes the way they think and enhances the way they work; not just with this family but all the families they work with. This approach, in situ, offers a unique training opportunity in how to work with complex families.

Methods

The purpose of the study was to investigate how the infant and child-led family therapy approach impacted how key workers worked with vulnerable families. The research sought to determine if workers' participation in direct infant and child-led family therapy consultations positively impacted the way they worked and what they subsequently incorporated into their practice with families. Data collection included an anonymous survey completed by key workers, reflections from two program managers who supervised the key workers, and a small sample of feedback forms from service users.

The study obtained ethics approval from La Trobe University Human Research Ethics Committee (HEC22394) before commencing.

Research questions

Three research questions underpinned the study:

1. How do workers incorporate an infant and child-led approach into their practice with at risk families following their participation in direct infant and child-led family therapy consultations?
2. In what way does this experience enhance or change the way they practice?
3. What effects for the infant and their family do workers observe when families have been involved in direct infant-led family therapy consultations?

Recruitment of participants

An email was sent to senior staff at each of the agencies where consultations had been conducted introducing the research project with an attached invitation asking each agency to advertise the study via their internal communication channels, such as team newsletters and notice boards. Also attached was a detailed participant information consent form and the link to the online, anonymous survey, which could then be sent out directly to staff. The research team was not directly involved in advertising the study.

Study population

The study population was clinicians, maternal child health nurses, social workers and family support workers who attended the sessions facilitated over the past decade. The organisational contexts of the respondents included: maternal and child health centres (a universal service provided by specialist nurses to which all mothers and babies are referred) and who are often the first contact for mothers and infants experiencing family violence because these nurses are tasked with undertaking family violence screening (https://www.health.vic.gov.au/primary-and-community-health/maternal-and-child-health-service); women's refuges that provide 'specialist crisis accommodation and support services for people escaping family violence' (https://refugevictoria.org.au/about-us/); community service organisations that provide a range of family support services, including family preservation services (https://services.dffh.vic.gov.au/family-preservation-and-reunification-response); and statutory child protection (https://services.dffh.vic.gov.au/child-protection) that is delivered by the Victorian Government. It was unclear what the sample size would be because not all practitioners who attended the sessions were contactable. Over fifty workers have participated in these consultations over the past 10 years.

Data collection

Data collection involved an online, anonymous survey that was accessible for 5 months. The survey took participants an average of 36 mins to complete, longer than the anticipated 15–20 mins. Though the survey was viewed more than one hundred times, fourteen respondents completed it. Time demands and difficulties accessing the survey were reported by some services. The fourteen respondents who did successfully complete the survey had participated in over sixty consultation sessions.

The survey was divided into three areas:. (1) demographics: the age of respondents, their professional background and how long they had worked in the family violence sector; (2) How many consultations the respondents had undertaken and in which years these had occurred; and (3) open-ended questions asking respondents to consider what they had learnt from participating in the consultations, how their practice had been impacted and feedback (if any) they had received from the families who participated. Finally, workers were asked how they would rate the success of these consultations (from one to ten) on their ongoing practice after their involvement in these sessions as well as how they rate any improvements for the families. The survey was hosted by QuestionPro (https://www.questionpro.com/au).

Results

The respondents' demographics are outlined in Table 1. Social work was the highest represented professions with maternal and child health nurses following (Table 2). Respondents indicated lengthy careers in the sector with almost 75% having practised for more than 10 years (Table 3). There was a diversity of attendance by respondents, with some having participated in up to ten consultations while three had attended three or fewer (Table 4).

Table 1. The ages participants who completed the survey

Age	Number of respondents
20–29 years	0
30–39 years	3
40–49 years	1
50–59 years	4
60–69 years	6
Total	14

Table 2. The professional backgrounds of those who completed the survey

Professional background	Number of respondents
Maternal and child health	3
Social work	6
Psychology	2
Refuge work (support staff in women's refuge)	1
Family violence (specific family violence services)	2
Total	14

Table 3. The length of time the respondents had worked in the child and family welfare field

Length of time in the field	Number of respondents
Less than 2 years	1
2–5 years	1
6–10 years	2
10+ years	10
Total respondents	14

Table 4. Number of consultations in which respondents had participated

Number of consultations	Number of respondents
Five or less	9
6–10	2
Multiple (more than 10)	3
Total respondents	14

Analysis

A thematic analysis of the qualitative data was undertaken. 'Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun & Clarke, 2006: p. 6). Thematic analysis involved each researcher reading the survey qualitative responses and individually categorising them into themes. The researchers then came together to discuss their identified themes and each theme was reviewed and discussed. This inductive process resulted in the researchers identifying three dominant themes from the surveys:

1. Infant and child-focus;
2. Changes in workers' approach; and
3. Increased skills/knowledge of workers.

Theme 1: Being child focused

Though aware that infants and children are likely to be present within the family violence space (Kertesz et al., 2022), it was evident from several respondents that prior to participating in the consultations, they did not have the confidence to know how to elevate infant and children's needs.

Respondents commented:

> [I] *feel much more confident in how to engage with the children in the families I work with during therapy sessions.* (Respondent 1)
>
> *… having the child in mind and the child-version of the adult in mind – unpacking patterns that occur within families.* (Respondent 12)
>
> *… to actively ensure that the child is always the focal point and is always in the room, even if they may not physically be in the room.* (Respondent 6)
>
> *… exploration of relationships going back to how parents are parented, and how trauma has an impact on children and how it feeds through whole family units.* (Respondent 7)

The sessions allowed workers to deeply consider the infant and child to

> *… wonder with the infant if they are feeling such and such or that it's hard to express feelings when you are non-verbal but that as a clinician you can observe the physical behaviour, posturing, movements … be curious about what might be happening for the infant.* (Respondent 4)

Theme 2: Changes in workers' approach

One of the aims of the infant and child-led consultations was to influence practice in the family violence sector by drawing workers' attention to the impacts of family violence on infants and children. There has been a 'tendency to minimise the potential impact of domestic/family violence on children, through the use of language that framed recorded incidents as an issue between parents only ' by sector workers and child protection practitioners (ANROWS, 2018: p. 3).

Respondents noted that participating in the consultations had influenced their approach to working with children and families:

> [Participation] *changed my approach to be child-led rather than mother or father led … children are a reflection of things they are a window into what is going on enabling me to reflect and ask questions that explore relationships and where they have started which has given me insight into dynamics and trauma in families.* (Respondent 7)

One worker considered that they had a child-focused lens in their practice but having the expert consultant

> *… reiterate this with* [their] *practice, is reassuring for me in my work with family challenges.* (Respondent 9)

Supporting parents to adopt a child-focused lens was also a key aim with workers focused on strengthening the parent–child relationship as noted in this quote:

> *I spend more time in gathering an in depth understanding of a parent's childhood, exploring what they believe is a good parent and helping the parent understand that their parenting can be reflective or a response to their own childhood experiences.* (Respondent 11)

Theme 3: Increased skills and knowledge

Workers' identification of their developing skills and knowledge due to participating in the consultations was noted by many survey respondents with comments such as:

> *Change in my practice, leading to better support for the infants and children in my practice.* (Respondent 10)
>
> *Listening to* [expert consultant] *tease out the family dynamics individually with the parents and then making their baby the focus was very inspiring.* (Respondent 9)
>
> *I found it extremely helpful to observe* [expert consultant] *in action! There is no better way of learning I believe than watching everything unfold in front of you and having the opportunity to discuss what you saw afterwards.* (Respondent 4)
>
> *It was a great learning process to be present in the room to observe firsthand how* [expert consultant] *uses herself to facilitate each family member to contribute to the (family) story – even the reluctant/tentative family member/s.* [Expert consultant] *regulated authentic presence transfers to those around her allowing space to challenge and be curious within and out of client's window of tolerance.* (Respondent 12)

The opportunity to observe the expert consultant was valued by respondents – it enabled them to not only build their knowledge about the approach but also to participate in the consultation and directly build their skills.

Two organisational management responses

Though workers sought the infant and child-led family therapy consultations, it was agency managers who recommended the consultations and ensured the funding of the consultations. Two managers from the organisations that were most engaged in this work were asked to give their direct feedback on the decade of their service's involvement in these consultations.

One manager who oversaw their staff's engagement in the consultations commented that they supported their staff to attend the consultations to

> … *shift* [workers'] *focus onto children and help mothers/carers to see the impact on FV on infants and see things from the infant perspective (some mothers believe that infants have not been affected as they have not seen or witnessed violence).*

This manager had co-facilitated groups with the expert consultant for children and families exposed to family violence and noted over time how their way of 'seeing children was shifting '. The children had often experienced profoundly serious family violence, family breakdown, homelessness and/or intergenerational trauma and often their parents or care givers had alcohol and drug issues, which impacted their children's rights to a safe and happy childhood.

The consultations produced good outcomes, with managers citing the importance of the in situ availability of the expert consultant to conduct the sessions, including in refuges. With respect to what managers wanted from the consultations, a clear message was to enhance their workers' skills

> … *to work therapeutically with families without being* [a] *therapist. It is understanding that relationship building is sometimes the key to unpacking trauma and empowering a family to seek help.*

Noting too that the families with whom they were working had intergenerational trauma, managers wanted families to be given the:

> … *best opportunity to get the help and support they need and, not just another service that does not meet the family's needs and just ticks a box until the next time; and they find themselves in a vicious cycle of needing to be engaged or involved in the service system once again.*

Enhancing staff empathy for the families with whom they worked was seen as an outcome of the sessions, with workers developing increased empathy.

> *The key to this model I think is empathy and the power of empathy, I feel that by being privileged to be in that space and sit in that space with the families and for the families to be held and heard it creates empathy and I think creates a shift in the way the key worker works moving forward with the family. It is not just getting them housing and making sure they have appropriate material aid, it is supporting them through this journey by linking them into things that help them heal. Sometimes some of these families are so complex and so challenging to work with, but if you don't have that empathy and the best interest of them, the families aren't getting the best services that they deserve and for me as a manager that's what I feel we need to continue to grow in this sector.* (Manager)

One manager advised that an unintended (but positive) outcome was that some workers subsequently enrolled in 'child focused [courses] such as play therapy and family therapy ' as a result of the consultations. Ensuring that workers across all areas of the practice prioritised children was an intended organisational outcome of the infant-child-led consultations by placing children at the forefront.

Discussion

This infant and child-led family therapy consultation approach was delivered in situ with workers from specialist services and provided consultations to families and their key workers on an as needed basis across multiple services. The aim of the approach was to situate infants and young children into the practice space on an equal footing with other family members. The key workers in this retrospective evaluation specialise in working in the early years space, where there is a high prevalence of family violence, child protection involvement, early intervention and intergenerational relational trauma. Supporting their work with a high-risk client group who do not necessarily access nor trust mainstream therapeutic family services was a major benefit of this collaboration.

An 'all of family', therapeutic family approach is not commonly afforded to infants and children where high levels of risk are identified, including exposure to family violence. However, Australia is not the only country where infants and children exposed to high risk are excluded from easy access to therapeutic family responses. Even in countries such as Norway, where family protective services are mandated to provide specialist, therapeutic responses to children living with issues including family violence, it does not necessarily translate into practice. In an evaluation of Norway's provision of family therapy services to child protective clients, Flåm & Handegård (2015) found that:

> *Out of a total of 106 cases, only 39 families include children and only in 15% of the total sessions in these families. Only 4 of them include children below 4 years. Given the substantial clinical research and documentations of the consequences of domestic violence for children, this sums up as a major neglect of the child. The living, partaking child is to a large degree excluded and the psychological child position not adequately taken care of.* (p. 81)

It would be entirely possible to imagine that such outcomes could be replicated should such an evaluation be undertaken in Australia to assess which family therapeutic responses are provided to children involved with child protection services, or who are referred into early intervention programs.

The evaluation of this in situ training of key workers in infant and child-led therapeutic consultations with families was not to garnish the numbers of how many children were present in the intervention. Infants and children were the very point of the

consultations and present both in person and in mind in all the consultations. Every therapeutic session was intended as a purposeful engagement with the youngest family members. Each consultation sought to foster curiosity in the parent/s and workers about infants and young children: interacting with the infant and child directly; asking them questions; wondering with them what they might be trying to tell the adult in the room; and, with the key worker, developing positive differences in how parents understood their children and their behaviours. This provided parents with a new appreciation of their own behaviours as parents. Further, the approach seeks to walk alongside parents as they look anew at their own childhood experiences to make sense of how they were impacted by trauma and how what they now do as parents impacts their own children.

Furthermore, as practitioners working in the early years space, where infants and children are unable to be physically present in sessions, they can be readily kept in mind, should the workers truly commit to an infant/child-led approach. This simply involves workers actively inviting parents or older family members to imagine or consider what the viewpoint or experience of the infant or child might be should we simply ask them. Imagining what the perspective of the infant or child could be invites adults to keep them present in their minds and in their decision making. In child protection case conferences, for example, having the infant or young child present, and/or having a photo of the infant or child in the room, and/or having a coolamon or cradle in the middle of the room, may invite the adults around the table to keep the infant or child at the centre of all discussions and decisions. It may even assist the adults in the room to modulate their discussions and behaviours, such that the best interests and wishes of the infant/child are given equal weight.

Despite family therapy and therapeutic family approaches emphasising families with infants, children and adolescents rather than families with older parents and their adult children, the former remains heavily reliant on interventions that are adult or parent centric. This involves interventions that emphasise their entry point for change as directed at parent training or guidance (Carr, 2019) or are over reliant on manualised responses (Berry et al., 2019; Economidis et al., 2023) over inviting infants and children as powerful participants in the change process, in and of themselves.

The feedback obtained from the fourteen completed worker surveys, and program manager feedback, provided evidence that these aims were achieved. Understanding the familial threads of trauma and violence over the generations was an immensely powerful learning for workers, helping them feel more confident to thicken out the rich and complex landscapes that shaped the past, present and potentially the future of the families with whom they worked. This emboldened workers' capacities to move beyond the current stressors families identified and make sense of the complexities that filled in the 'backdrop'; helping to understand how these families came to be where they were now.

Workers reported feeling confident to ask sensitive questions, inviting the voice of children gently and respectfully into the space and immobilising the shame and guilt families so often feel when directed or 'encouraged' to seek help by statutory bodies. Already well versed in building empathic engagement with vulnerable and often disempowered families, these workers relished the opportunities to deepen their understanding of, and capacities to support, the families in ways that expanded the families' understanding and appreciation of their own, and their children's journeys. Most consistently, workers noted the shift within themselves. They developed the ability to observe, be curious about and invite the infant and child more powerfully into the working space, enriching their practice and celebrating the wonderment infants and children brought with them.

The two agency managers who provided their feedback echoed the sentiments of their staff. Both have a long-term commitment to this consultative process. It is their belief that the opportunity to bring an infant-mental-health-informed family therapy consultant into this specialised space was beneficial to the empowerment of their families and the growth of their workers' capacities to place infants and children at the centre of all that they do. Further, they noticed the aspirations some staff had to commit to further studies themselves, and the deepening of the empathetic response their staff had to the families and the benefits of the outcomes to staff learnings.

Limitations

The key limitation of this study is the small number of survey respondents. Although 52 workers participated in the infant and child-led family therapy consultations over the past decade, only fourteen participants completed the survey, approximately 28% of the population. The unexpected difficulties with the online survey and the length of time it took to fill in the survey itself possibly impacted this low result. Further still, numbers were affected by the inability to reach some staff who had moved on to other organisations over the decade. The opportunity to hear directly from the families themselves at the time or soon after the consultations would have provided a more robust evaluation.

Conclusion

For effective work with at-risk families with infants and children, we argue that infants and children are entitled to be involved in matters that directly affect them and are, in fact, the most powerful motivators and participants in therapeutic work that is about them. Infants and children bring enormous riches into the therapeutic space simply by including them, noticing their responses and being curious about their experiences. An infant mental health and family therapy approach that invites infants and children to be considered equal participants in the room gives them the best chance to been seen, heard, thought about and actively engaged with.

There is no work in the child protection, family support and maternal child health sectors if there are no infants and children. Women's Refuges often have more infants and children in residence than they do women. Infants and children are often the very reason mothers leave violent relationships, or why mothers and fathers agree to be involved with early intervention services. Gently and respectfully seeing, engaging with, being curious about and including infants and young children in our work will bring opportunities to heal the past by embracing the hopefulness infants and children bring. This offers parents in the 'here and now' chances to create a different future.

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