THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH

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FROM THE EDITORS

This newsletter includes a range of reading from the serious to the silly. We have a report on the Sydney workshop where Professor Heidelise Als presented her work on care for newborns. We follow this with a long but important document we decided to publish in full. As you will see considerable work went in to a AAIMH submission to the NSW government's inquiry into Parenting Education and Support Programs. The excellent submission from our NSW colleagues focused on appropriate parent education from pre-conception through to birth to 2 years of age.

On the less serious side we have a review of a show at the Comedy Festival in Melbourne. We hear this is touring other capital cities in the next few months. Our National Conference is in Sydney in September. The speakers will be well known to many of you. See the Conference Update column for further info. See you at the conference too!

Any contributions, letters, reviews, or written comments on local issues are always welcome.

Paul Robertson & Sarah Jones

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Newborn Developmental Care - Professor Heidelise Als

Report on Seminar March 23rd, 1998 in Sydney

Professor Heidelise Als from the Boston Children's Hospital, and Associate Professor of Psychology (Psychiatry) at the Harvard Medical School gave a morning seminar on "Newborn Developmental Care" on Monday, March 23rd, 1998, preliminary to a training programme in the Neonatal Intensive Care Unit which ran for the rest of the week. The seminar was sponsored jointly by AAIMHI and the New Children's Hospital, Westmead, N.S.W, and was made possible by the dedicated work of Helen Hardy and Beulah Warren. It was also a tribute to Heide Als' goundbreaking work in the care of preterm infants that the seminar hall was packed to overflowing with what were clearly enthusiastic participants.

Heide Als has worked for many years now in the area of prematurity and neonatal infant care units and has, in this age of evidence-based medicine, been able to produce convincing data to show that it makes good economic sense to consider the developing nervous system of the infant, and to encourage interaction between the infant and the family.

The seminar was organised as follows:

1. To present an overview of preterm foetal brain development and the Synactive Theory of Development.
2. To identify preterm infants' neuropsychological development.
3. To describe a model for clinical implementation of developmental care in the NICU and SCN.
4. To describe research on the effectiveness of developmental care implementation.
5. To discuss steps in facilitating nursery-wide developmental care implementation.

Heidi commenced by noting that high-risk preterm infants are now surviving in greatly increased numbers, so that the current challenge facing those who work in this area lies in finding means to support the developmental progression of the infant:

> "Through assessment and documentation of an infant's

current active behavioural efforts towards developmental differentiation and thresholds to disorganization, opportunities may be gleaned for the provision of developmentally - and individually- appropriate supportive care for the preterm and high-risk newborns and their families."

Noting that prematurely born infants with immature nervous systems normally experiencing the relative environmental stability of the womb have instead to adapt to numerous interventions and constant noise and light, Heide Als stated that the observed increase in attentional disorganization and difficulties in self-regulation found in preterm infants suggested that this mismatch between brain expectancy and environmental input had led to a form of active inhibition of pathways to the prefrontal cortex due to an unexpected and overwhelming sensory load. In fact the frontal lobe of preterm infants is differentially vulnerable.

Relationship-based individualised developmental care was possible even within the constraints of an NICU and could be carried out by specially trained professionals with particular skills in reflective process work. Heide Als presented work from several impressive studies which showed that this approach reduced the number of days in the ventilator and in hospital, reduced the risk of intraventricular haemorrhage and the severity of chronic lung disease, and showed that behavioural indices for such preterm infants was significantly improved up to 36 month post-term corrected age.

Key phrases in Heidelise Als' work are:

Neurodevelopmental care
Training in reflective process work
Developmental specialist
Individualised developmental care

References:

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Trevarthen, C. & Aitken, K.J. (1994). Brain development, infant communication, and empathy disorders: Intrinsic factors in child mental health. *Development and Psychopathology*, 6, (597-633).

Als, H., Duffy, F.H., McAnulty, G.B. (1996), Effectiveness of individualised neurodevelopmental care in the newborn intensive care unit (NICU). *Acta Paediatrica Supplement 416*: 21-30.

AAIMH SUBMISSION TO THE INQUIRY INTO PARENTING EDUCATION AND SUPPORT PROGRAMS - NEW SOUTH WALES[1]

This submission was prepared by the following committee Members:

- Bryanne Barnett, Associate Professor, School of Psychiatry, University of NSW
- Julie Campbell, Consultant, Early Childhood Education
- Kerry Lockhart, Nursing Unit Manager, PND Unit, St John of God Hospital, Burwood
- David Lonie, Consultant Child Psychiatrist, New Children's Hospital, Westmead
- Isla Lonie, Consultant Psychiatrist, Royal Prince Alfred Hospital, President of AAIMHI
- Marija Radojevic, Clinical Psychologist, Hornsby Ku-ring-gai Hospital & Private Practice
- Beulah Warren, Registered Psychologist in Private Practice

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[1] This submission was made to The Standing Committee on Social Issues of The Parliament of NSW Legislative Council in February 1998 on behalf of AAIMH. It addresses parent education as appropriate from pre-conception through to parenting of children from birth to twenty-four months.

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PART A
EXECUTIVE SUMMARY OF INQUIRY INTO PARENTING EDUCATION AND SUPPORT PROGRAMS

1. INTRODUCTION & OVERVIEW OF SECTIONS 1 TO 6

The Australian Association for Infant Mental Health is a non-profit organisation which includes among its objectives the growth of professional and public recognition that infancy is a critical period in the development of social skills and a secure sense of self. Its membership consists of professionals who have an active interest in the development and well being of infants and their parents.

This submission addresses parent education as appropriate from preconception through to parenting of children from birth to 24 months. Learning begins before birth and continues throughout the lifespan, but is at its most intense during the first 5 and particularly the first 3 years of life. Learning occurs in terms of the development of physical, social, psychological and cultural skills as well as in terms of ethical, moral and aesthetic values.

The authors believe that good parenting at this time of life is of the essence in preventing much subsequent pathological functioning.

It is financially responsible for a community to spend money to preserve and enhance the mental health of young families, and the NSW State Government's initiative in asking for submissions on this subject is very welcome. Healthy individuals represent minimal financial drains on public and private health, education and welfare services compared to individuals who are overtly ill or disabled, including emotionally disabled.

Particular attention is paid to the fact that human infants are biologically hardwired to become and remain attached to the person who cares for them. There is now a large literature which shows that the result of disruptions in attachment relationships is a greatly increased risk of psychological and social difficulties. These in turn may form the basis for life-long problems such as chronic depression, and may moreover be passed along to the next generation. In a world environment of rapid social change, social competence must be considered as a developmental imperative. Being securely attached acts as a protective factor for mental health by providing a

solid foundation from which life's inevitable difficulties may be negotiated.

In addition to the need for a secure, reliable and available attachment relationship, children require protection from physical and/or sexual abuse, emotional abuse, and/or neglect, all of which have been shown to have a deleterious effect on the individual's later mental health, and moreover, show a striking intergenerational effect. Children who are not protected from these evils will grow up to become adults who perpetuate the behaviour which they themselves suffered. Those at risk in these situations should be identified and offered appropriate interventions, which will reduce the likelihood of adverse outcomes. The use of home visitor programs as an intervention and support for families at risk of child abuse and neglect was supported by the Report on Home Visitor Programs in Australia which offered useful recommendations, including emphasis on the need for further evaluation, especially of longer-term outcome, of all such programs. Review of the literature suggests that adequate support for high-risk families requires such home visitation to begin antenatally and continue for 12 to 24 months postpartum.

A mentally healthy society parents its children in the best possible way. Unfortunately those who have not themselves experienced satisfactory parenting may not have the psychological resources and/or the understanding of the developmental needs of infants and small children to enable them to respond to their infant's signals appropriately.

Even if they do, the inherent stresses of parenting mean that all parents at some time, whether at a particular stage in a child's development, or the advent of a crisis in the life of the family, such as unemployment, serious illness or divorce, require assistance with their parenting. Many parents feel depleted and often defeated by the many demands upon them, such as combining parenting with work responsibilities. Currently, appropriate assistance is often unavailable. Given the breakdown of many traditional parent support structures, such as extended family networks, parents may require more support and guidance than hitherto from community-based initiatives.

Infants and small children also learn about the world via the medium of play. This may be thought of as the 'work' of infancy and early childhood. A child cannot develop the mental skills to engage in formal modes of learning unless these have been tested and developed extensively in the medium of play.

Parents are the child's first teachers, as well as the child's first attachment figures. Because of this, they have a crucial and ongoing role in providing the child with opportunities to playfully explore the full range of learning opportunities, and to develop a security of expectation of availability and protection. They have an important role in mediating between the child's natural curiosity and propensity to explore on the one hand, and ensuring safety and that the experience is within the child's developmental capacity to master, on the other. It is important to note that parents and others should avoid stressing children by creating a 'hot- house' environment in which the child's need to play alone and with others is curtailed by an excessive emphasis on being 'productive'.

In this submission, parent education is distinguished from parent training and parent support. While education provides information on child development (physical and psychosocial), general and specific health needs of children (diet, immunisation, sleep etc), care of the self and partner, training implies the acquisition of skills, such as communication, conflict resolution, behaviour modification and so on, through role-modelling, rehearsal, practice, viewing and reading prescribed material and completing homework tasks. Supportive activities are intrinsic to any education or training program with personal contact between the helper, whether professional or not, and the parent.

Both parent education and training need to begin long before conception occurs, commencing with the child's own experience of parenting, moving on to input from other caregivers, and from teachers and school programs. There is a need for particularly intense input in the perinatal period, including attention to communication, parenting skills and the marital relationship. In addition, screening for risk factors such as maternal disability, isolation, psycho-social stressors (eg. unemployment, marital discord, relationship problems, an unhappy family background), substance abuse or psychiatric disorder should be carried out. Here active intervention is of great importance for the future well-being of the child and the family as a whole, for those with such problems are likely to be susceptible to appropriate intervention, particularly around the perinatal period. Postnatal classes in basic child care, such as bathing, sleep and settling techniques, should be universally

offered (choice is important) to both parents, whereas specific group and individual attention is required for those who are experiencing other stresses, depression or anxiety disorders.

These interventions must be available in the appropriate language and at a time of day and place accessible to the parents. In some populations, instruction and information materials (in the appropriate community language) may need to be provided free of charge, while transport and free child care may be essential. Incentives should be considered, for example for adolescent parents.

Various techniques for providing specific assistance for at-risk parents and children are detailed in the text of the submission. There is now convincing evidence of the effectiveness of intervention strategies that promote the self-esteem and efficacy of the parents and diminish the vulnerability of children to current and subsequent health problems, both mental and physical. Most such strategies involve working with the family, for example, the Positive Parenting Program (Triple P) (cf Appendix 1). The Draft Report of the NSW Children and Adolescent Mental Health Task Force (1997) suggests programs in the perinatal and infancy period (antenatal to 24 months) of prevention, early intervention and treatment. (See Appendix 2). Intervention should be targeted to factors relevant to the particular developmental stage and specific needs or vulnerabilities of the child or parents in question. In high-risk families, home visits may be the only means of establishing and maintaining contact.

Examples of programs currently offered in Sydney are detailed in Appendix III.

This submission notes that a serious barrier to the effective management of parent education lies in the current division of services to families between the three Government Departments - Health, Community Services and Education. No effective action can be taken to implement policies related to parent education until a relevant management model is devised, and several are suggested in the text. A major problem with the current system is that funding is based on annual submission which is not cost effective, and limit both the development of effective professional teams and the evaluation of programs within a realistic time-frame. It should also be remembered that professionals suffer from burn-out and become ineffective in emotionally stressful work such as that with high-risk families when they feel harassed by understaffing, time constraints and financial uncertainty.

The professional role required of parent educators is considered within the context of a particular professional training and responsibility (e.g. for confidentiality), as well as in terms of changing needs and context as the children in a family develop. The various roles of Government and Non-Government agencies and others involved in parent education are considered in detail in the text.

PART B
INQUIRY INTO PARENTING EDUCATION AND SUPPORT PROGRAMS AGE: PRE-CONCEPTION TO TWO YEARS

SECTION 1
INTRODUCTION

The Australian Association for Infant Mental Health is a non-profit organisation which includes among its objectives the growth of professional and public recognition that infancy is a critical period in psycho-social development. Association membership comprises professionals who have an active interest in the development and well being of infants and their parents.

Although the Association itself makes an indirect contribution towards education of professionals and non-professionals by conducting courses on the development of infants and young children, this submission is not about that contribution. The aim is rather to provide information about the need for parent education, a critique of programs which have been tried, or are presently in place, and some suggestions about the ways in which the effectiveness of such programs might be evaluated.

The Association sees itself as being able to offer some expertise in this area as its membership represent a wide range of professionals with particular knowledge about the development of infants and their families. Members include early childhood nurses who work with parents and their infants in community clinics, child psychologists involved in early childhood education, and child mental health specialists: psychiatrists, psychologists and paediatricians.

This submission addresses parent education as appropriate from preconception through to parenting of children from birth to 24 months.

SECTION 2
(i) DEVELOPMENTAL NEEDS OF CHILDREN

Attachment.
Arguably, the core developmental need during the first year of life is for the infant to have the opportunity to develop attachment relationships. These attachment relationships are established between infants and their principal caregivers; usually mother, father and sometimes a day-caregiver (Bowlby, 1988).

Human attachment is a particular form of relationship. The function of an attachment relationship is to promote felt security. Attachment relationships form the prototypical relationship in which an infant learns to trust (or mistrust) the availability of reliable emotional support in times of need. A corollary of this is that the infant learns to trust (or mistrust) his/her own competence in eliciting the care and assistance needed to cope with and to master necessary developmental tasks, eg. establishment of self-efficacy in interpersonal situations. Additionally, the development of attachment permits the infant to stay close to a preferred attachment figure during times of perceived or actual stress, (a protective function) and, when successfully comforted by the attachment figure, to move away and learn about the environment (an exploratory function). Both of these behavioural orientations are necessary for healthy physical and psychological development (eg. self esteem, self-efficacy, competence in peer interactions etc.).

The human infant is biologically predisposed to form attachments (Bowlby, 1971). Therefore, if the infant has regular, sustained contact with a constant attachment figure, then an attachment relationship will form.

Several types of attachment organisation are possible. The optimum model is a *secure attachment*. This results when the caregiver responds to the infant's signals in a prompt, appropriate, emotionally warm and responsive manner.

Many parents simply do not have the psychological resources and/or the understanding of the developmental needs of infants and small children to enable them to respond to their infant's signals in contingent and emotionally responsive ways. Even if they do, the inherent stresses of parenting mean that most parents feel depleted and often defeated by the many concurrent demands upon them (eg. combining parenting with work responsibilities). Given the breakdown of many traditional support structures (eg. the extended family network), parents require support and guidance for their parenting efforts via more formalised parent education programs.

Protection from physical, emotional abuse, neglect and/or sexual abuse.
The survival of the human infant and small child depends on the provision of food, shelter and love, and safety from harm. Lack of provision, or else inadequate provision of any of these essential aspects of care will endanger the life and/or psychological health of the infant. Abuse of any sort places the helpless infant at risk of physical and/or psychological disability, or even death (Cicchetti & Carlson, 1989).

Provision of a safe and stimulating play learning environment.
Learning begins before birth and continues throughout the lifespan. However, the most intense learning occurs during the first 5 and particularly the first 3 years of life. Learning occurs in the physical, psycho-social, cultural and aesthetic domains.

Children who are competent learners have the greatest capacity to respond flexibly to the demands and challenges of society. Infants and small children learn about the world via the medium of play. Play is the 'work' of infancy and early childhood (Berndt, 1992). A child cannot develop the cognitive skills to engage in formal modes of learning unless these have been tested and developed extensively in the medium of play.

(ii) THE ROLE OF PARENTS AND THE WIDER COMMUNITY IN FULFILLING THESE NEEDS.

Clearly, the parent carries the greatest responsibility for the maintenance and enhancement of the infant's physical and emotional life.

Parents are the child's first teachers. Because of this they have a crucial and ongoing role in providing the child with opportunities to explore a full range of learning opportunities. Additionally, parents have an important role in mediating between the child's natural curiosity, on one hand, while ensuring safety and that the experience is within the child's capacity to master, on the other. Teachers and the wider community share the responsibility to provide play and learning experiences. All should avoid stressing children by creating a 'hot-house' environment in

which the child's need to play alone and with others is curtailed.

The community shares the responsibility for ensuring that the human infant is protected from any and all forms of abuse. Its role in performing this function may be either direct, indirect or both. Direct forms of community protection involve the establishment and maintenance of caregiving and parent support and education systems (eg. Daycare, substitute care, parenting education programs). Indirect protection is afforded by socio-political-legal systems (eg. Departments of Health and Community Services, self-help groups etc.).

(iii) THE BENEFITS TO PARENTS AND THE WIDER COMMUNITY OF FULFILLING THIS NEED.

The benefits for both groups of stakeholders are essentially the same. That is, infant and child protection is fundamental to the development and preservation of physical life and psychological health. The benefit of the preservation of physical life clearly needs no elaboration. The benefits to the community of the development and preservation of mental health are incalculable, particularly in terms of the positive contribution which psychologically competent and healthy individuals are potentially able to make at both micro and macro levels of society. Furthermore, it is a truism that healthy individuals represent minimal financial drains on public and private health, education and welfare services compared to individuals who are overtly ill or disabled.

Children are the next generation of working citizens. The benefits of motivating young children to become competent learners will be observed in children who ultimately become skilled and enthusiastic contributors to society.

Parents (and other individuals to whom the infant is attached, eg. day-caregiver) benefit from knowing that they fulfil a unique and preferential place in the affections of the child. The feelings of being loved and needed are arguably central to maintaining psychological well being. They act as protective factors in mental health (Mrazek & Haggerty, 1994). Furthermore, competent parents are more likely to produce competent children.

Securely attached infants have been shown to be more socially competent than their insecurely attached peers (Sroufe, 1988). In a world environment of rapid social change, social competence must be considered as a developmental imperative. Being securely attached acts as a protective factor for mental health (Belsky & Nezworski, 1988).

SECTION 3
THE VALUE AND SUPPORT ACCORDED TO PARENTS AND PARENTING BY THE COMMUNITY

Federal Government initiatives to promote effective parenting clearly reflect a community recognition of the importance of the relationships which children have with their parents in providing a secure base from which life's inevitable difficulties may be negotiated. Increasing levels of unemployment and rapid social and technological change are creating a situation where a sense of self-worth and a capacity to consider the needs of others are essential both for the survival of the individual and indeed of our culture.

A mentally healthy society parents its children in the best possible way. Unfortunately, those who have not experienced satisfactory parenting may find the demands of parenthood very difficult to meet. It will be argued that this group of at-risk parents needs particular assistance in order not to inflict traumas similar to those which they themselves may have suffered, on yet another generation.

SECTION 4
THE ACCESSIBILITY, RELEVANCE AND FLEXIBILITY OF EXISTING PARENT EDUCATION AND SUPPORT PROGRAMS.
AGE - CONCEPTION TO 2 YEARS

Preamble:
Competent parenting is an acquired skill, requiring considerable psychological, social and economic resources, and much more besides. Skills can be taught. Most people would not send their children to a school where the teachers had received no formal training. Why does the same thinking not apply to parents themselves?

Most parents manage reasonably well most of the time, but all parents at some time need help with their parenting, whether at a particular stage in a child's development, or the advent of a crisis in the life of the family, such as unemployment, illness or divorce. Appropriate assistance is often unavailable. Even when they are available, parenting programs must be perceived to be relevant, and accessible.

Parent education differs from parent training or parent support. Parent education provides information on child development (physical and psychosocial), general and specific health needs of children (diet, immunisation, sleep), care of the self and partner. Parent training implies acquisition of skills, such as communication, conflict resolution and behaviour modification through role-modelling, practice, viewing and reading prescribed material, or completing homework tasks. Parent support would be intrinsic to any education or training program, with personal contact between the helper, whether professional or not, and the parent. Provision of written or electronic media material without personal contact would not usually be seen as providing support.

(i) Parent education.

Parent education needs to begin long before conception occurs.

Parenthood is only one of the many roles available to the individual for self-fulfilment. Education about these roles can begin in primary school, when the situation remains hypothetical, and be resumed at intervals during subsequent schooling. This education should be offered as part of a comprehensive program enhancing self-esteem and resilience, addressing healthy lifestyle choices, personal responsibility and appropriate self-care.

Most people will have some contact with relevant professionals, such as teachers, nurses, doctors, during the years prior to the first conception. Many opportunities are thus provided for continuing educational and supportive activities concerning parenting.

For the young adult, perinatal and infancy strategies would include attention to parental self-care, communication, parenting skills and the marital relationship, in addition to screening for risk factors such as maternal disability, isolation, substance abuse or psychiatric disorder and offering active intervention for these. For women not attending antenatal clinics or classes, home visitation should be offered. Partners should be routinely included in the process.

Postnatal classes in basic child care, such as bathing, sleep and settling techniques, should be universally offered (choice is important) to both parents, whereas specific group and individual attention is required for those who are experiencing other stresses, depression or anxiety disorders. Again, home visiting will be more appropriate for some, while socialising at the local clinic may be attractive to others.

These interventions must be available in the appropriate language and at a time of day and place accessible to the parents. In some populations, instruction and information materials (in the appropriate community language) may need to be provided free of charge, while transport and free child care may be essential. Incentives should be considered, for example for adolescent parents.

(ii) Support programs.

Problematic parenting is repeatedly reported as a major risk factor to the wellbeing of children (e.g. Silburn & Zubrick, 1997) and thus to the next generation of parents. Universal (directed at the whole community), selective (for groups considered to be at increased risk), and indicated (for those showing early manifestations of disorder) interventions are described in the literature.

There has recently been an international upsurge of interest in targeting parenting education and training. Reasons for this renewed and expanding interest include:

- the advent of managed care in the USA;
- the recognition that tertiary intervention (i.e. intervention after the illness or disorder has manifested) is extraordinarily expensive, often ineffective in the short-term and does not prevent intergenerational transmission of the problems; ease of communication through various media, and
- the publication of a few acceptably standardised and evaluated programs (cf reviews by Long, 1996, 1997).

As a result, universal programs are now becoming affordable and specialised intervention strategies are receiving increased support. Workers such as Meisels et al (1993) and Rae Grant (1991) review more complex strategies for at-risk children (eg. pre-term birth, disabled infants).

There is now convincing evidence of the effectiveness of intervention strategies that promote the self-esteem and efficacy of the parents and diminish the vulnerability of children to current and subsequent health problems, both mental and physical. Effective intervention to prevent disorder and abuse in children reduces costs to education, health, social care and criminal justice services. Most such strategies involve working with the family (cf Sanders, 1995,

1996), for example, the Positive Parenting Program (Triple P) (cf Appendix I).

Intervention should be targeted to factors relevant to the particular developmental stage and specific needs or vulnerabilities of the child or parents in question. Premature infants, children with disabilities, ATSI and NESB families, single mothers, parents affected by physical or mental illness or socio-economic disadvantage would require different types and levels of support and education from a well-resourced couple having their first baby. Known risk variables should be addressed.

The Draft Report of the NSW Children and Adolescent Mental Health Task Force (1997) suggests programs in the perinatal and infancy period (antenatal to 24 months) of prevention, early intervention and treatment (cf Appendix II).

Successful education or training does not necessarily require personal support, but it is generally accepted that more disadvantaged families are likely to require this. Perinatal home visitation schemes using professional staff may offer education, training and support, with link-up to other relevant services, aiming to raise maternal self-esteem and competence with the expectation that the mother will then take better care of herself and her child. Non-professional visitation is more likely to offer support, practical help and advice (cf Barnett, 1995). With more disadvantaged families, reports suggest the intervention needs to be lengthy and will only be acceptable if other aid is offered, ie. help is provided in addressing other difficult areas in the parent's life (eg. Hardy & Streett, 1989).

(iii) Accessibility, relevance and flexibility of existing programs.

The Shearman report (1989) noted that some 80% of primiparas and between 10% and 30% of multiparae attend one or more antenatal classes. Provision of counselling, support and education in pregnancy has been shown to reduce the risk of maternal cigarette smoking and alcohol consumption, prolonged labour, instrumental and operative intervention during delivery, and postnatal distress and depression. Interventions aimed at improving the partners' communication skills and capacity to collaborate have also proved successful in enhancing the lives of both parents and children (cf review, Barnett, 1995).

Currently, the programs offered vary widely in content and application. Most tend to be offered too late in the pregnancy (when parents are concentrating only on acquiring survival skills to cope with labor and delivery); by educators with a narrow and often idiosyncratic focus (eg. avoidance of analgesia during labor); with little or no input regarding psychological and social aspects of pregnancy and parenting; at times or places inconvenient for many partners or indeed expectant mothers themselves, and most programs cease abruptly when the practical parenting actually begins. Provision of antenatal and postnatal classes in appropriate community languages and locations is also a neglected area (McCarthy & Barnett, 1996). Thus antenatal classes are widely offered in our community, but it is rare for them to be evaluated and they frequently fail to reach those most in need, such as parents suffering significant socio-economic disadvantage or geographical isolation, recent migrants, adolescent and single mothers. Postnatal classes are less available, perhaps because the hospital-based obstetric services are no longer involved by this stage – an unfortunate hiatus in the care of families at such a crucial stage in the family's development.

As noted above, the aims and content of such perinatal programs tend to be somewhat arbitrarily determined; that is, depending on the particular interests of those offering them. Requests from women and their partners regarding education and support antenatally include the following items: to be treated with respect and dignity; to be consulted and be able to participate when decisions are made; to have continuity of care; to receive information and active, practical help rather than warnings and advice; less emphasis on physical and more on psychological and social aspects of pregnancy and childbirth; more time for discussion, and flexibility of arrangements.

Family planning decisions, pregnancy and early parenting offer many opportunities for parenting education and support and thus enhancement of resilience for the child and family (cf Barnett, 1995). These are times when all women (and often their partners) will have some contact with health professionals. Therefore an opportunity to offer pro-active assistance is provided. Having an unhappy family background or current relationship problems or other stresses increases vulnerability to depression, marital discord, parenting difficulties and thus intergenerational transmission of problems, but these aspects are susceptible to intervention, particularly around the perinatal period.

The use of home visitor programs as an intervention and support for families at risk of child abuse and neglect was supported by the Report on Home Visitor Programs in Australia (Vimpani et al, 1996). The Report offered 17 useful recommendations, including emphasis on the need for further evaluation, especially of longer-term outcome, of all such programs. Review of the literature suggests that adequate support for high-risk families requires such home visitation to begin antenatally and continue for 12 to 24 months postpartum (Barnett, 1995).

Postnatal support for families at risk is offered by other services in Sydney - eg. The Benevolent Society of NSW (Early Intervention Program, Families Together Program, Scarba); Karitane and Tresillian Family Care Centres (offering outpatient and residential services), and elsewhere, often depending precariously on the special interest of a particular local worker or agency, but all are available on a basis limited by location or funding. Rural families have limited supports available. Many programs have been inadequately evaluated, which contributes to their uncertainty regarding ongoing funding.

A review of antenatal and infancy programs for at-risk mothers in North America, Australia and England (Ministry of Community and Social Services, 1989) concluded that the most effective programs were comprehensive, included home visiting, began during pregnancy and continued for some years postnatally. Both short and long-term benefits resulted. These included: healthier infants, fewer low birth weight infants, fewer feeding difficulties, fewer accident and emergency clinic attendances and less child abuse, more confident, competent parents, improved marital and parent-infant relationships, longer intervals between pregnancies, improved social skills for the children, better education for the mothers, and higher rates of family employment (Rae Grant, 1991).

For lower risk populations also, postpartum home visiting is an economical and effective strategy (cf. Barnett & Parker, 1985). The authors found over the first three months that lay volunteers were extremely effective in offering support, guidance and practical help. This accords with the results of a study in Dublin (where there was insufficient funding to employ professionals in the role of home visitors) in which volunteers who were experienced mothers made a significant difference in the lives of the women and families visited. The Dublin program built on the experience of the Early Childhood Development Unit at the University of Bristol in England (Percy & Barker, 1986; Barker, 1990). The aim was to 'empower' parents and encourage them to solve their own parenting problems.

In Sydney, systematic application of these principles is being attempted on a wider scale by Good Beginnings; a volunteer home visiting program aiming to enhance parenting skills in families with a new baby. The Lions Club of Greater Sydney in collaboration with the Commonwealth Government sponsors this venture. Pilot programs are also being evaluated in several sites across Australia. The eventual aim is to be able to offer a trained, volunteer, home visitor to all homes with a new baby.

Home visiting of brief duration (eg. daily for one week) is commonly offered postnatally, for example to women who elect to be discharged from maternity hospitals within three days of delivery. Many women seem to fall through the large holes in this safety net and there has been a suggestion that they may be at increased risk of postnatal depression. Similarly home visits may be scheduled in the early weeks and months following the discharge of an infant from a neonatal intensive care unit. These programs also require further evaluation. Informal discussion with parents suggests that they find them very useful. Application of the scheme appears to be somewhat ad hoc and little is available which caters adequately for the needs of families of non-English speaking background (McCarthy & Barnett, 1996).

O'Meara (1992) discusses issues pertaining to childbirth and parenting education, noting continuing official (and academic) scepticism about the effectiveness of such programs despite some evidence of consumer satisfaction and the widespread commitment of maternity services to such education. She recommends systematic evaluation of these programs from the point of view of consumers and services and suggests a framework for this task. Data are still needed to resolve these and related questions.

Thorogood (1996), notes that "childbirth and parent education is big business". She offers a brief overview of the history of antenatal education and notes that we do not know whether the emphasis on the need for women especially to attend classes may actually be harmful, for example, undermining their confidence and implying that nothing can be accomplished without the aid of the 'experts'. Often much of the 'information' and 'advice' offered is actually dogma or opinion unsupported by facts.

Several State Health Departments have called for review of antenatal programs in recent years, such as the research underway at St George Hospital, Sydney (Myors et al, 1996).

Comprehensive economic evaluation of programs, measuring costs and outcomes, would assist with future decision-making, but currently, as noted by writers such as Knapp (1997) "the economic evaluation cupboard looks particularly bare". We do not know whether the pay-off in terms of outcome as well as cost would be greater if we target particular problems (anxiety, depression or conduct disorders, say) or particular families (eg. low income, parent affected by mental illness) or apply universal remedies, or some combination of these.

SECTION 5
THE ACCREDITATION, FUNDING, CO-ORDINATION, MONITORING AND EVALUATION OF PARENT EDUCATION AND SUPPORT PROGRAMS, AND THE PROFESSIONAL EDUCATION AND DEVELOPMENT OF PARENT EDUCATORS.

Parent education takes place at different times as parental roles change, in different health, welfare and education contexts, and through a variety of media and community resources. Because of the pervasive and dynamic nature of parent information needs, systems to address those needs must match the circumstances in which those needs arise.

(i) Management.

An immediate, organisational barrier to effective management of parent education lies in the current division of services to families between the three Government Departments: Health, Community Services and Education. No effective action can be taken to implement policies related to parent education until a relevant management model is devised. A system for management could be developed in one of the following ways:

- within the auspices of the NSW Children's Commission with representatives seconded from the existing departments. The Department of Ageing and Disability is currently responsible for early intervention for children aged 0-5 years with disabilities. The particular information needs of these children must also be represented;
- as a co-ordination project on a regional basis. This is done for early intervention programs for young children with disabilities. Its disadvantage as a model is a lack of specific infrastructure support and demand for time taken away from direct service. Its advantage is its regional establishment and capacity to meet local needs;
- with one department or agency as "lead agency" with a capacity to co-ordinate a unit or units with all relevant departments and agencies. The issue of central versus regional organisation must also be addressed, particularly as all departments have different regional territories. A central unit might be responsible for initial policy development with the actual implementation, monitoring and evaluation taking place at a regional level.

(ii) Funding.

The tasks of management based on one of the above models would be primarily to secure funding that could maintain continuity of services. Funding based on annual submission is neither cost effective, nor appropriate for this purpose. Families may be in crisis at any time of the year. The time which staff must take away from direct services for the preparation of funding submissions is justified for biennial or triennial planning, but is hard to justify for shorter periods. A longer planning period also allows for the development of effective professional teams and the opportunity for evaluation within a realistic time frame. This is a field in which there are both short-term effects and long-term gains. Where the type of funding limits continuity and evaluation, the quality of program development and service delivery suffers.

Programs in the fields of health, welfare and education may already include elements of parent education. If these are clearly identifiable it should be possible to fund such elements within multi-purpose programs. It is possible that those who have been undertaking the task of parent education as an extra-professional responsibility might continue to do so, but such an important function should not be left to subjective goodwill.

(iii) Training For Parent Educators.

The development of parent educators could be seen as an opening for a new para-professional category. This is because information for parents should not be provided simplistically, but based on sound theory that is the substance of professional training. Furthermore, the relationship between parent and educator must be one of trust not only in the quality of the information but in the relationship itself.

A designated role as parent educator might suggest that one person in one time and place could provide for all information needs. However, as noted above, these needs arise at different times and in different contexts; eg. pre-natally, post-natally, in relation to nutrition, toddler behaviour, pre-school education and care and school entry. The information needs of young parents are different from those of older parents (Sparling & Lewis, undated). The needs of fathers are not the same as those of mothers, and the needs of parents in one cultural group cannot be assumed to be identical to those in another. It follows, therefore, that parent education may be recognised in many professional roles in human services.

No one agency currently meets all needs for all parents at all times. Many agencies meet some needs at some times. Existing professional training may address some needs of parents, but parent education is best realised in the context of service delivery. For this reason, in-service opportunities for professionals from a variety of backgrounds would be more relevant. A transdisciplinary approach provides a model for community liaison, an important feature of work with families. Broad professional experience can contribute to understanding the many and complex needs of young families. Individuals with in-service accreditation, complementing their initial professional training, would be well placed to undertake a leadership role in provision of parent education in the community.

SECTION 6
THE APPROPRIATE ROLE OF PARENTS, GOVERNMENT, NON-GOVERNMENT ORGANISATIONS AND EDUCATION INSTITUTIONS IN THE DEVELOPMENT, DELIVERY AND PROMOTION OF PARENT EDUCATION AND SUPPORT PROGRAMS

If 'it takes a village to raise a child' then all strata of society should be involved in education for parenting, which is a life-long process. Good parenting is learnt.

The step taken by the NSW Government to integrate government departments to provide a unified parent education package across different departments is to be commended (Sanders 1995, 1996). Parent education is a shared matter between education, health and welfare. Such a commitment by the government reinforces the desirable community value that part of the ethos of parenting is continuing education in parenting.

(i) Government's role.

The Government's role is firstly, to recognise the importance of parent education as a community, rather than family, responsibility. Societal change includes increased mobility of families, smaller families, and increased awareness of the impact of early family life on later development, adult behaviour and well being. Similarly, much has changed in the manner that parents acquire the skills of parenting. Previously, this was from their own parents, but for many new parents, the model of the previous generation is either unavailable or not considered relevant.

Secondly, it is essential that government ensures that once a program is implemented, continuous funding is available. Funding needs to cover promotion of the program, audiovisual aids and material appropriate for the cultural needs of the community the program is addressing. Constant consumer input will ensure the program remains relevant to the community.

Government is also responsible for ensuring that all professionals involved with families are sensitive to their role in parent education. Informal learning of optimal ways for adults to relate to children can take place through professionals modelling behaviour and attitude to parents or a child in his /her care. This is more likely to happen if professionals in both government and non-government institutions are provided with a caring environment and valued for their contribution. They require time to provide appropriate services as well as be a listener to parents and children. Most such professionals received little or no formal exposure to parent education in their own training. This is a serious deficit which should be addressed.

Government departments must ensure that policies involving personnel have minimal impact on family networking, for example, within the Defence Services. Where such policies are potentially disruptive then personnel involved need to be informed of the risks and appropriate supports to maintain networking implemented.

(ii) Educational institutions.

Educational institutions have a responsibility to include education for parenting in their curriculums. This proposal focuses on parenting and family issues prior to and during pregnancy, through the first two years of life. Preparation for this period can begin as early as primary age, when children are interested in where they come from and caring for others. As

children and adolescents acquire communication skills and expertise in how to resolve conflict they are laying the foundation for what is required in all relationships, in particular at stressful, highly demanding times. Children can also learn what is involved in being responsible for another through visiting and participating in activities at childcare centres or visits to aged care facilities.

During the child-bearing years opportunity to further develop communication skills needs to be available in addition to acquiring knowledge of the needs of pregnant women, their partners, newborns and young infants.

(iii) Non-government organisations.
Non-government organisations with a focus on community needs may be in the best position to provide a variety of parenting education options and support programs.

Once pregnant, couples need to learn about the specifics of labour, birth, how to care for an infant post-partum, anticipated changes in both pregnant woman and her partner. When the baby arrives, issues of understanding and caring for the infant are paramount - feeding, settling to sleep etc., in addition to how to meet their own needs as well as those of infant.

The most commonly occurring issue for new parents is the adjustment to having to put the needs of another before one's own. For some this is closely allied with becoming a three-some from a two-some. This can be *known* as a requirement of parenting, but it is in the *experience* of parenting that this capacity can be developed. Well conducted groups, where parents are able to talk about such issues with peers having similar experiences, enables parents to resolve their issues.

As the child and family grows there needs to be opportunity to participate in situations where new information can be gained relevant to changing needs (Brazelton 1993).

Different parents have different needs. Where parents have relocated from their support networks, have not experienced caring, nurturing parenting themselves, or have experienced severe loss, parent education alone may not be adequate. It is recognised that, in the period of pregnancy and early parenting, such families benefit from home-visiting programs from either a supported volunteer, in particular a parent, or a professional (US Home Visiting Report, 1990; Barnett & Parker, 1985).

For the parents of new parents (ie. grandparents), education opportunities to learn about current infant care practices, how best to support new families, and how to impart family and cultural knowledge in an acceptable manner, are necessary. Grandparents and other family members often seek information on how to remain in touch with grandchildren once separation or divorce occurs.

(iv) Parents.
Parents, as consumers, need to be involved in each stage of parent education: development, delivery and promotion. Learning takes place within a relationship, whether it be as an accepted member of a group with other parents, or with a professional who is trusted. Parents in a group can share information of family customs to ensure differences are valued and not lost. Being able to discuss problems and share information with other parents can provide a measure of support through identification not obtained from a more formal teaching situation.

SECTION 7
RECOMMENDATIONS

1. Government should recognise the importance of parent education; in particular with continuous funding for programs.

2. Parent education should not be considered as a 'one off' event. Parenting is dynamic and parents' needs change over time so a variety of education packages need to be available.

3. Parent representation should occur in planning the development, delivery and promotion of parent education and training.

4. Parent education should begin before conception occurs. Information and discussion should occur at home, at school and during routine visits to the family doctor and other relevant professionals.

5. Parent education should occur as universal programs in order to avoid stigmatising those who may actually be in most need of assistance, but most reluctant to access it. Published studies indicate that these can also be effective in attracting and helping high-risk groups.

6. All programs should actively attempt to include partners rather than the mother alone.

7. Programs should be available at times and in locations convenient to parents.

8. More specialised interventions should be available to those not successfully assisted by lower level, universal solutions.

9. Programs should always be evaluated before they are widely implemented, while less rigorous evaluation of subsequent individual or group interventions is also important.

10. Methodology of program implementation and evaluation should be tailored to the culture, language and literacy level of the participants. What is appropriate and acceptable to a middle class, educated, anglo-celtic population may be offensive, aversive or incomprehensible to others.

11. Those personally offering education, training or support should only do so after attending suitable training and with ongoing monitoring and supervision to maintain standards, and receive personal support. Accreditation of parent education programs and of those offering them is recommended.

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APPENDIX I

The Positive Parenting Program (Triple P) mentioned above was devised and evaluated by the School of Psychology, University of Queensland (Parenting and Family Support Centre). It aims to provide five levels of intervention tailored to the family's needs.

Higher levels (4 and 5) require specialist mental health assistance, addressing marital and mental health problems, for example, in addition to problematic child behaviours.

Level 1 is a universal strategy, making material widely available to parents from local services at their request, eg. 'tip sheets' on tackling common problems, video material, books. The aim is to increase general access to information and resources.

Level 2 is a primary care strategy based on a model of brief consultation between the family and their general practitioner or community child health nurse which gives anticipatory guidance and advice on behaviour management.

Level 3 targets day-care, pre-school, kindergarten and school. Parents are actively taught management skills through modelling, rehearsal, feedback and homework assignment.

Level 4 provides more intensive teaching in a range of settings and may be offered on a group or individual basis.

Level 5 combines the focus on teaching parenting skills with a brief, focused intervention for specific problems in that family, such as marital conflict, parental depression and so on. Marital communication, mood management and coping with stress are addressed.

APPENDIX II

The Draft Report of the NSW Children and Adolescent Mental Health Task Force (1997) suggests programs in the perinatal and infancy period (antenatal to 24 months) of prevention, early intervention and treatment should include:

5.1.1 Prevention

5.1.1.1 Best Practice in Psychosocial Antenatal Care

Women and men, childbirth educators, obstetricians, early childhood health nurses and general practitioners will be involved in developing guidelines for psychosocial assessment and interventions. These include: universal preparation for parenting, identification of those at risk of parenting problems, support for mothers and fathers who have mental health problems, or who have suffered loss of support.

5.1.1.2 Specialist parent psychosocial support and home visiting for parents in need of support and where there may be a higher risk of parenting problems. Specialised mental health programs for families where necessary. A systematic skilled home visiting intervention program should be available, and can lessen risk of parenting problems, abuse and negative outcomes for the infant.

5.1.2 Early Intervention

5.1.2.1 Screening and preventive intervention/counselling for postnatal depression. Screening using the Edinburgh Postnatal Depression Scale (EPDS) or similar questionnaire has been shown to enhance detection. Preventive counselling and possible further treatment including medication for some may lessen negative impact on parent-infant relationships and infant development. This requires coordination and planning with primary care networks

to ensure appropriate intervention and management. Training programs are available and General Practitioners may need mental health support to achieve these aims.

5.1.3 Treatment Programs

5.1.3.1 Programs for attachment, eating, sleep, arousal and developmental problems of infancy. While specialised mental health interventions are rarely targeted towards infants themselves, specific interventions may be necessary with parents.

5.1.3.2 Emotional and behavioural disturbances and disorders. Treatments involve interventions that are family and parent-focused but with special programs for infants, including short-term psychotherapyÕs and behavioural programs."

APPENDIX III
EXAMPLES OF EXISTING PARENTING EDUCATION

1. Prenatal classes with child care component:

Most maternity hospitals,
Some community centres,
Community organisations-Childbirth Education Association,
Private - the Physiotherapy Centre for Maternal and Child Health; Glebe Physiotherapy Centre for Pregnancy and Postnatal Care.

2. Parenting education and support

Early childhood health centres,
In SESAHS Home Visiting Support Team,
Tresillian Family Care Centres - outreach, home visiting, day stay, residential,
Karitane Family Care Centres - day stay, residential,
Local councils mothers' groups - eg. Holdsworthy Street (Woollahra),
Nursing Mothers Association of Australia,
Playgroup Association,
Private,
Some general practitioners - eg. Dr Amanda Gordon's groups at Edgecliff.

3. Support for specific groups

Families First,
Home Start - for minimal risk families,
Early Intervention Program (Benevolent Society of NSW) - at-risk families,
Families Together (Benevolent Society of NSW) - parent has a psychiatric diagnosis,
Chemical Use in Pregnancy - CUPS (SESAHS),

Good Beginnings (A volunteer home visiting program aiming to enhance parenting skills in families with a new baby. The Lions Club of Greater Sydney in collaboration with the Commonwealth Government sponsors this venture. Pilot programs are currently being evaluated in several sites across Australia. The eventual aim is to offer a trained, volunteer, home visitor to all homes with a new baby.).

MUM'S THE WORD - OR IS IT?

A Theatre Review

Infants can not quite put on their own comedy about what it is like to be an infant but these mums make a very good go at letting us know what it is like being a mum . A by-line to this unmissable show, performed at the George Fairfax Studios, could well be 'Motherhood - the Secret Stories'. This play is a mixed montage, vignettes of motherhood-life. "It sucks", they seem to be saying, and they're not just talking about their new babies.

Brought to Melbourne following sell out performances from all over Canada, its focus is women who, having become parents, are coming out from behind the nursery curtains. Why, they ask, were we not prepared for this? Why is the turmoil not talked about? Where is my life? Where is my waistline? The Canadian actors wrote the show at the time they became mothers, partly as a way to sort out the "whole rather unsentimental trench work of parenting". Pregnancy, sex (or lack there of) relationships with children and partners become the play's raw material. The humour and irreverence reveal the deeply complicated and unexpected emotional life behind the curtain. Those actors passed the show on to an Australian cast, who have taken up their parts and introduced some laconic Australian humour.

As therapists, I suspect we have all heard clients tells us their secret stories. Learning about what may lie ahead is one of the spin offs of our profession. For pure professional field work this play will tell you everything you need to know, (and a lot you don't want to), about the poos and wees of parenting. What parent has not lost sleep, hair and self-esteem in

struggling to work out what on earth to do with a fractious baby, tantrumic two year old, or the disrupted deprived marriage that often ensues. This show goes beyond or below all this and reaches the underbelly of life with a baby. Some people enter this stage with public pride and positivism, their private angst hidden. Here is a play that allows one to vicariously enjoy a flagrant expose of motherhood, with out having to own up to one's own heinous sins of parenting.

Whilst couples come to grips, gripes and grief, the emerging bump can come to represent emerging and, often unwelcome, change. One of the themes these six Canadian comedians tackle with their Australian counterparts is that so much of what being a parent does to us, goes against our late twentieth century feminist culture. Isn't this the time, we keep being told, that women have choice? Haven't we gone past the 'career or family' dichotomy of the 1950's and gone straight to "Go"? (And whilst you're at it, collect £200!) Young women now are portrayed as being competent at doing everything, and if that means having a baby and being straight back to the lab/office/boardroom/newsdesk, well good luck to them. Work is almost synonymous with power and status in the world. After "the little bundle of joy" arrives it is expected to fit in with the demands of employment; anyway the laptop, briefcase and baby can all be packed the night before. One mother laments as to why all the promised milk and honey she has goes at breakfast time and doesn't come back.

Men of course should now be SNAGs; there are books, courses and groups to bring them up to speed with all those touchy-feely skills women are thought to possess just by virtue of their chromosome count. If there can be equal pay for equal work in the big world, then that should naturally carry over into the home. Should there really be anything different about the shared-labour policy, once ratified regularly in the kitchen, now that she's swapped networks for nipple shields? The sketch that sends this message home offered some light relief to this otherwise painful process. Had other couples, I thought, got into that awful stage; the competition for whose life was most miserable? Is it the stay at home mother desperate for the odd cappuccino on her own whilst drowning in washing, baby food and domestic drudgery. Or is it the exhausted father, wearily arriving back from the coal face, wanting peace and refuge. That particular competition being most fearsome at the 6.00pm "suicide hour".

I defy any parent not to see their own private peccadilloes craftily exposed on stage. Yet the saving grace for me about this show, is that the emotional roller coaster ride isn't all finally painted as all scarey and hair curling; just that intense love and self doubt inevitably comes with this moving, unspeakably personal experience. This is best seen in the sketch about "The Other Man". It shows us a new parent's love and adoration for her baby. The mother falling in love with another is made more bearable as she watches her husband do the same.

The message underneath it all is that hate as well as love needs to be factored into the equation. Victorians in need of some light relief but some black humour can indulge in both if they see this play. There is a nappy bucket full of scatological satire that will make you laugh, cry and cringe at the wonderfulness and awfulness of maternal life in the slow lane.

Sarah Jones

"Mums the Word", showed at the George Fairfax Studio, April 1st to April 19th.
Transferring to the Athenaeum Theatre commencing 2 May (Melbourne).

CONFERENCE UPDATE

AAIMH Fifth Annual Meeting, Rex Hotel, Sydney, September 3-4, 1998.

Plans for the Annual Meeting are well in hand. The guest speakers include Dr Mary Sue Moore, Dr Janet Dean and Professor Barry Nurcombe. Although the details of the program are still being finalised, it is planned that the conference will open with a full day Symposium of Trauma and Infancy which will be a joint presentation by Mary Sue Moore and Janet Dean. The material will integrate recent research findings with the implications of these findings for clinical interventions. Professor Nurcombe will be presenting work on an intervention program for Low Birth Weight Babies, research which is currently under way in Vermont and now has a 9 year follow up. In addition there are a number of clinical and research papers which include work on postnatal depression, research on the father's role. Workshops will cover the areas of intervention programs in the pre and perinatal periods; on the Parent and Infant Relationship Support group model; and the effects of

premature delivery on infant and family. The Conference Brochure, which includes more details of the program, and the registration form, should soon be posted to all members. Extra copies will be available from The Conference Organiser, PO Box 214, Brunswick East, 3057, Phone (03) 9380-1429, Fax (03) 9380-2722.

FROM THE DESK

COMMENT FROM DR CAMPBELL PAUL WAIMH REGIONAL VICE PRESIDENT

Following the success of the National Conference in Adelaidewas a very exciting and well attended meeting at the Children's Hospital in Sydney. A talk about premature babies was presented by Heidlise Als. At the next National Conference in Sydney in September invited speakers include Dr Mary, Janet Dean, Sue Moore, Dr Barry Nucombe and Dr John Byng Hall. It looks like an exciting conference with plenty of opportunities for networking and learning from local and overseas presenters.. The details about the conference will appear else in the newsletter.. Byng-Hall will also be a guest of the Victorian Branch of the association, and will be presenting a workshop there in collaboration with the Victorian Association of Family therapists. We hope this will be a catalyst for further involvement of Family Therapists in clinical work with infants and their families. Presenting with Mental Health workers from other fields means multidisciplinary collaboration is possible. It also helps us to reach an over all objective; that is to make the range of services available to infants, as wide as possible.

There is the general move to looking outwards towards other countries in our region and I believe there should be a significant role for our association in this process as well. We would be very keen to develop links with people within the association who know of potential connections internationally. These connections could be with individuals, institutions or agencies. You let me or their local executive committee know of such connections. I have had discussion with Miguel Hoffman from Argentina who's also keen for some Southern Hemisphere connections.

I think the process of "internationalisation" enriches our thinking and practice.. Of course this has to be combined with us reaching out to those who recently arrived from overseas, with our need in this country to provide the appropriate service. At the conference in Sydney I hope to have plenty of discussion I about the role of advocacy for infants and their families within the public arena and within the public health and welfare sectors.

STATE NETWORK NEWS

NEW SOUTH WALES

Kerry Lockhart

The NSW Branch of AAIMHI are presenting a series of eight weekly lectures on working with parent -infant problems. Subjects are emotional processes of pregnancy for mother, father, infant, birth and the shock of the new for infant and parents, what do we mean engagement of parents and their infants, mental health problems during pregnancy and the first months of life, latest parent-infant research, feeding, sleeping, crying, how does the professional help the parents. We intend to video this series and welcome enquires toNorma Tracey 02 - 94272028 Tel or fax and email-nortrac@ozemail.com.au.

QUEENSLAND

Susan Wilson

The second issue of our local Queensland newsletter was distributed in February. It outlined the proposed dates of both clinical and committee meetings for the year. There was significant interest generated by the first issue and we received requests for membership application forms from more than 10 prospective new members. At the first clinical meeting on 3 March, Dr Ken Armstrong (community paediatrician), Joan Mee (clinical nurse) and Jenny Fraser (project officer) presented some initial results from the Family Care Project - an intervention to promote caregiver-infant attachment in a highly vulnerable subgroup. The home-based intervention is delivered by a child health nurse and has shown promising outcomes at twelve month follow up. Longitudinal

data is to be collected. Our next two clinical meetings in May and June will again see local speakers presenting papers.

AAIMH (QLD) members presented several posters at a public forum on postnatal depression on 26 February. During the tea break we also showed the video "What About Fathers?", prepared by AAIMH(SA). We made some valuable new contacts including the organisers of the forum from Women's Health Queensland Wide. They hope to develop a consumer information kit on PND and are now interested in including an infant mental health perspective.

SOUTH AUSTRALIA

Pam Linke

We have been discussing with Foundation Studios (a department of the Women's and Children's Hospital) the next steps for our Fathers video. We are developing a booklet to go with the video with discussion ideas for uses with different groups eg fathers, expectant fathers, mothers, students, men's groups etc. We are hoping to launch the package in June.

Negotiations have begun with Dr Bob Marvin from the University of Virginia about the possibility of his visiting Australia early next year, possibly March. It seems as if he would be interested and may be willing to do some attachment training as well as some one-offs. Those of us who heard him in Sydney were very interested in his work with parents of children with disabilities would like to hear some more about that. If any other group are interested in having him they could get in touch with Pam Linke on (08) 83031566.

Elizabeth Puddy and Anne Sved Williams have been involved with a major inquiry into the future of mental health in South Australia and have been very strongly advocating for the importance of infancy. That is about all at the moment.

VICTORIA

Sarah Jones

John Byng-Hall, well known family therapist, author and clinician is coming to Australia in September. His visit is being hosted by the Victorian branch. He helped found the first Tavistock Clinic family therapy course where he is a Consultant Child and Family Psychiatrist. He is also a past Chair of the Institute of Family Therapy. Dr. Byng-Hall has had a long standing interest in helping clinicians work with children in the context of their families.

Dr. Byng-Hall speaking at the AAIMH Conference in Sydney. He will then conduct a workshop at the Royal Children's Hospital in Melbourne co-sponsored by the Victorian Association of Family Therapists. It is planned for him to be a Visiting Scholar in the RCH's Mental Health Service, attached to the Infant Mental Team. His final speaking engagement will be at the National Family Therapy Conference in Brisbane in September. Dr. Byng-Hall also wants a holiday with his wife Sue!

Jeannette Milgrom is the Scientific Programme co-ordinator for our state association. She has organised a very interesting calendar for our members. At the AGM it was proposed that the committee offer a clinical forum, so that people had opportunities for direct practice base learning. The first meeting in March a member presented a complex infant mental health referral, of two premature babies, born 10 months apart to a teenage mother. Although only a small number of people attended it was seen as a successful new professional development forum for our members.

Also in March AAIMH members were invited to hear Professor Ian Brockington from the University of Birmingham speak on motherhood and mental illness. His talk offered a very disturbing account of aspects of infanticide. He also discussed the little known documented evidence of child abuse in France during the late nineteenth century.

The comedy festival came to Melbourne in April. Amongst a large number of reviews and shows was one dedicated to mothers. "Mum's the Word", a cast of Canadian comedians were joined with Australian comedians when they performed a couple of pre-view shows in late March. Staff from women's health centres, counselling agencies, and hospitals were invited free from all over Melbourne to the previews at the Royal Women's Hospital. A sub-title to this could have been *"how infants turn the worlds of sane parents upside down"*. See fuller review in this newsletter

COMING UP!

JAMES MCKENNA is speaking in Brisbane at 'The Passage to Motherhood' conference organised by Capers on 7 - 9 August. There will be a pre-conference tour to Perth, Adelaide, Melbourne and Sydney. James MacKenna is an anthropologist from California with a special interest in Medical anthropology. He has been involved in sleep and SIDS research in particular looking at solitary versus co-sleeping environments; the benefits of parental skin contact, culture and sleep.
The contact in Brisbane is Jan Cornfoot 07 3369 9200, fax: 07 3369 9299, email: capers@gil.com.au.

EDITORS

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JOHN BYNG-HALL IS COMING

Australian dates for Dr. Byng-Hall's trip are as follows:
Sydney 3-4 September
Melbourne 10-17 September
Brisbane 23-26 September
Further details next newsletter