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In this issue

Guidelines for contributors

AAIMHI aims to publish quarterly editions in March, June, September and December. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

Referenced works should follow the guidelines provided by the APA Publication Manual 4th Edition.

All submissions are sub-edited to newsletter standards.

Articles are accepted preferably as Word documents sent electronically. Send to Shelley Reid at email:

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Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

Irritable infants: How caring makes a difference

Michelle Meehan

In an intervention programme for irritable infants based in an inpatient paediatric setting in Australia (Jordan, 2006), parents were asked about the value of the admission itself. Many of the positive responses related to the attitude and assistance of the health care workers, especially nurses.

The key features of the intervention were primarily a joint nursing and psychotherapeutic interview, addressing issues of practical baby care and the baby's symptoms, as well as emotional issues. The aim of the counseling intervention was to understand and help the infant to cope with distress, with the focus on the baby, the parents and the relationship between them.

The joint consultation was a single one and a half-hour interview with a maternal and child health nurse consultant and a child psychiatry social worker both members of the infant mental health team. Observations, formulations and recommendations were then discussed with the medical and nursing staff. The joint psychiatry and nursing consultation was always well accepted by the parents, who seemed interested in talking of babies and psychiatry together.

Too often parents may receive reassurance about a lack of serious medical problems, but while accepting this, their next question is, "Well that's good, so now what do we do?" When a family is told that there is "nothing wrong", this may make the parents feel not understood or sometimes even guilty of complaining of something that does not exist.

The idea that baby will 'grow out of it' may be less than reassuring to an exhausted family. Parents feeling that they have 'drawn the lottery' of a difficult baby, or on being told of the infant's temperament, feel they are expected to just put up with it. Casual talk of stressed parents needing to relax to reassure the baby may be seen as insulting or demeaning. Nurses in the inpatient units often expressed feeling powerless in understanding what would assist the infant. Keefe (1997) talks of the process that parents move through in adapting to the needs of an irritable infant, and that nurses are in an ideal position to help parents make the transition from feeling overwhelmed, to understanding and coping with the demands of the baby. However seeking to understand the impact of the experience on the infant, rather than just parent directed advice, gives a broader scope to what nursing can do to make a difference. Parents reported that what was helpful in the admission was support, understanding, validation, advice, reassurance and time spent talking and observing the baby. In the process the infant contributes to this change as well (Jordan, 2004).

In seeking to understand how nursing makes a difference, the skill of the

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nurses themselves was recognised and acknowledged and nurses were able to be confident in accepting that parents' concerns were valid. They were able to acknowledge the impact the baby has on the family, and by looking at what the baby contributed not just what the parents must do, they were able to develop confidence in talking about the baby's capacities and behaviour.

This paper will describe how these processes allowed space for the infants' experience and emotional response to be considered and interpreted, so that the intervention was seen as contributing directly to the infant, not just changing parent's projections.

There are thirteen interventions or aspects of management of the admission that I wish to explore, and by using these to reflect on both the effect of the intervention both from the parent's point of view as well as the infant's.

1. The hospital admission

It is a big decision both for parents and doctors to decide to admit a baby to hospital. Hospitalisation has long been recognised as being a potentially stressful time for both children and parents. An acute paediatric unit with many very sick children, the atmosphere of anxiety, and worry about cross infection makes the decision to have their baby admitted no light one. (Darbyshire, 1994). For many parents the offer of an admission was accepted with relief, and in greeting the child and his parent(s), immediately imparting knowledge and experience of caring for other irritable infants, the nurse can help validate their decision. By welcoming and accepting why the baby is there, the nurse is assuring the family that their baby is a valid patient, amidst the atmosphere of severe illness.

The effect this has on the mother is that of being taken seriously. There is seen the opportunity for on the spot assessment of what she is talking about (especially, as is often the case the baby has fallen asleep in the car on the trip in!). There is the chance to rule out any serious organic problem, an underlying concern despite frequent reassurances, and also the chance to realise that they can meet or hear from other parents with similar problems.

But what of the baby?

We greet the baby as a person. We say, "Well hello there, you're having a tough time of it aren't you?" Here is a chance for the baby to be seen as a new entity, not the difficult, crying baby, but a baby who is seeing a new face, receiving expressed sympathy from one not caught up in the distress. What does the baby see? Stern (1993) emphasises the control the infant has of gaze at 3½ months of age as opening a whole new social world. Mutual gaze forms the structure for interactions between infant and others. Mutual gaze may elicit strong emotions both positive and negative, and by offering this opportunity for interaction to the infant, by talking and looking, we are saying, "Here is something you can share that's not about your distress". How does a different reaction affect his response? By experiencing a different reaction to his cries or distress he can feel that the future is not the same as the past; there is a chance to feel something new (Thomson-Salo, 2007).

2. The value of recording.

Part of the Study Protocol was the use of the Infant Behaviour Observation Record (IBOR) 'Cry Chart'. This chart, based on the Sleep Activity Record of NCAST (Barnard, 2003) is a 24-hour recording at 15 minute intervals of feeding, sleeping, crying, fussing, play and attempts to settle. This was filled in by the parent and/or the nurse. Data from this was used to measure one outcome in the study, that of reduced crying time. The chart however had unexpected benefits, as it provided a valuable 'proof' of what was happening. Previously, without this chart, medical teams would visit the baby and comment on how well he is sleeping, or how settled he looks, not seeing that this was of only five minutes duration, or that staff and parents had spent a great deal of work getting the baby where he was now.

The nurse's task was to assist the mother with the record and minutely recording the baby's day; clarifying what meaning the mother has when she is describing infant behaviour, and advocating for the mother during discussion with medical staff. This validation of the mother's day-to-day experience by assisting with detecting patterns, was also telling the mother that we were seeing some sense in the chaos of their life. It was also an opportunity to perhaps link events – and thereby breaking a cycle of fruitless interventions. The baby benefited by sharing in the close observation of the day, so that small changes or events were not lost in the day of 'distress'. His every few minutes of activity were noted and not just measured by how much crying was happening.

3. Parent counselling

Parents were willing to tell their story over and over to any of the health professionals they met in the process of seeking help, and again during the subsequent admission. Story telling was the taking of a detailed story from both mother and infant's perspective. Rather than just a measure of history, taking this detailed recounting was a therapeutic and valuable process both for the baby and baby's parents. The nurse in caring for this couple would often find herself listening again and again to the difficulties experienced as well as the trial and errors that were encountered along the way. Parents burdened with feeling they must be doing something more for the baby, often did not have the chance to tell the story in its smallest detail.

Shifting the discussion to the idea that the infant may have had a similar experience to theirs, opens the idea to a responsibility of someone other than themselves. They were doing as much

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as they could, but if the baby was not responding as expected then what more could they be expected to do? From the infant's point of view he is experiencing or hearing the emotions of his distress but not actually directed or focused on him. The distress and anxiety is there but he is protected by the mediation of the nurse as she absorbs the emotion in place of the baby. He is hearing his mother talk, with the anxiety directed away from him.

4. Containment and caring

By describing a plan of action for the next immediate hours/day the nurse is able to contain the mother's anxiety about what will happen next, by helping plan what will be done in the next hour or so rather than the future worry of "what if he doesn't stop crying". Review of the IBOR helped to see a pattern of events and gave a focus for discussion about "What did you do then, as he settled well after that" or "lets try that this time and see how we go".

Holding

The sense of holding the parent's anxiety and letting them pass this anxiety to others may feel a relief to overburdened parents (Winnicott, 1964). From the infant's perspective he was no longer the container of mother's anxiety; she could share this and leave the infant to his own concerns. The intervention of the nurse in carrying out her care provided containment during his distress. By being there for the mother she was containing her to be able to offer comfort to the infant.

Containment

Nurses perform this therapeutic function everyday. To be listened to, particularly if in detail, may be very reassuring and comforting for a new parent or a family. The story of something that happened then is 'contained' by the listener, particularly if the listener is in some role of respect or 'authority', like a health worker. To be able to contain the story that is told, its details, the emotions associated with them, and absorb those emotions, empathize or accompany the person in their situation are all aspects of therapeutic functions that may be very reassuring and comforting for the parents. Compare this with the possibility of not being able to "get something off of your chest" or not having someone to talk to. There is a sense of relief when one feels listened to and understood.

5. Describing and pointing out the infant's contribution / view of events

A valued role of the nurse was that of helping mother read her infant's cues. Too often with a long period of distress mothers report that they can no longer differentiate the cries of their infant. This may well be that after a time of mistimed responses, the infant no longer knows how to tell mother what is the matter, even that *he* no longer know what he is upset about. What started his distress may not be what is prolonging it. It is the distress itself that is distressing.

By watching the infant the nurse can help reinforce the infant's experience by suggesting what the message he might be giving is about. This looking at the infant affirms the contribution of the infant as well as the parents. It is not just what the mother does that matters, but what the infant contributes to his own distress by being hard to read. The nurse can then give voice to his experience by ascribing meaning to his signals. Telling him what is the matter "you're hungry now aren't you?" rather than asking (even sympathetically), "What's wrong?" We can voice his messages and allow his voice to be heard. This technique also helps give the mother messages about what the baby may be thinking and/or experiencing, e.g. "you're just getting tired aren't you?"

6. Advice and reassurance

Emotional support

This is a therapeutic function that perhaps is not appreciated as much by the people who provide the support. Many families are quite isolated and may not have anybody with whom to share news, good or bad. To be "right there" when a mother gets bad news, or to be part of a celebration of a new accomplishment in the baby are very important aspects of providing emotional support that may ameliorate the impact of that isolation and of multiple stressors.

By responding to an infant's communication and seeing him as an individual and talking about THIS baby, not 'babies in general', nurses can give tailored advice. By giving words to his activity we are speaking for the baby. With this assistance the mother is helped to look with fresh eyes at the baby and identify developmental gains/skills of the baby, to recognise that while he is easily distracted he can still play. By strengthening the power of his communication, by giving meaning to his communication and responding to his overtures we help the infant regain some control over his environment.

7. Chance to focus on the baby

The hospital admission may give parents the chance to just think about the baby, rather than the chaos that has been created in the family. We can provide time for the mother as she tries to determine the meaning of the current behaviour. There is space for allowing for uncertainty, a chance to talk about what is happening *now.* "If he's not sure what he wants, let's wait and see".

By trying to assist with parents' interpreting infant experience, they can 'make a fresh start', rather than be burdened by past failures. There can be seen to be an expanded meaning of the cry from just distress. The baby starts to hear, "There, there, it's OK", "I don't know what the matter is but you're OK", rather than, "What's wrong now?"

8. Establishing a plan of day

The overburdened parent may welcome the chance for someone to help with decision-making. By supporting

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parents to not feel totally alone in decision-making, we alleviate the sense of anxiety and pressure that is in turn passed on to the infant. With a plan, we can more confidently respond to infant behaviour with a message about what is planned next. "You're tired – it's time for sleep".

9. Supporting the mother's care as best for baby.

By listening to her knowledge of what the baby likes and dislikes (how he likes or dislikes being wrapped, how warm he likes his milk etc.) nurses are reinforcing the mother as the expert on her baby. By reinforcing the mother's confidence and intuitive response to the infant, she can represent the mother's skills to relatives; discuss the plan for the baby and reasons behind it.

Attachment behaviour is not an exclusive domain of the infant. Although less readily aroused we see it in adults whenever they are anxious or stressed. For a mother (and father) caring for young children there is a strong desire to be supported and cared for themselves. The nurse can mediate and convey to the extended family how best they can help mother and baby, not just relieve them of the baby.

10. Establish a daily routine incorporating feeding, sleep and play

Too often in the cycle of trying to get the baby settled, his increasing need for playful interaction is often lost. By discussing and promoting his increasing interest in the world we can allow the mother a chance to cease the endless cycle of trying to settle the baby. By supporting the mother in reading and interpreting cues and directly helping cue baby for sleep, we can help see when he may only be fussing as he seeks other stimulation. Poor regulation in babies interferes with their ability to be content. By engaging the infant in appropriate developmental play, we can encourage this interest to prolong calm behaviour, thus giving the mother an alternative interaction with her infant. By clearly moving from one activity to the other and picking up clearer cues the infant experiences a clear beginning and end to events to allow development of sense of control.

Play and visual interest in toys or movement increases the infant's repertoire to help self soothing, as well as relief from the campaign to settle. Parents are more likely to respond to the infant's interactive overtures and avoid the distress expressed by the infant when his attempts lead to frustration and attempts to resettle.

11. Exploration of mother's mental health

After the infant's needs were addressed then mothers were ready to talk about themselves and the effect the distressed infant was having on their own emotional state. Mothers appreciated the chance to talk about how they were feeling AFTER discussion of the baby. Too often mothers complained that the minute they mention how stressed or tired they feel, "they stop looking at the baby" as though if they are depressed nothing could be wrong with the baby. Many mothers admitted they felt very stressed and even depressed, but felt this was a result of the crying and lack of sleep, not the cause. If mothers felt more emotionally available then there was less likely to be projection in response to the infant.

12. Planning community support

Seeking the most supportive community service for the family was an important transition to home, so parents did not feel abandoned. Parents may have feelings of anger or disappointment about local health professionals and feel reluctant to use them again. Finding practitioners who were sympathetic to the family's struggles was important. By providing liaison with community based professionals especially those the mother knows, e.g. Maternal & Child Health Nurse Service, we were able to ensure parents felt 'held' even on discharge.

By being kept in mind by others, the mother may feel more able handle any initial anxieties. This liaison also ensured consistent advice and it was planned that there would no major changes without consultation in the first week.

Attachment figure

When the relationship is long lasting and predictable, the primary health care staff may become trusted and appreciated. Indeed, we have encountered situations in which a nurse or a social worker has participated in work with a family for several generations within a family, becoming something like a crucial attachment figure. A social worker in a Health Department service who has worked there for over 20 years may have become such an attachment figure for several families that they call her first when they have a problem or a doubt. Such predictability and availability have a profound therapeutic impact for these families.

13. Post discharge follow up phone call

The importance of this was originally underestimated by us but was considered very important to the families. A medical follow up appointment in 2-3 weeks was not enough to contain the family at this crucial point. This call was primarily a discussion of what had happened since going home. Parents were given the opportunity to discuss how they managed any setbacks, playing a role in seeing the mother as having solutions and not swamped by the problem as before. It also gives a chance to fine-tune any strategies in light of the routine of family life and for mother to feel supported. We may also be able to interpret and give meaning to any changes that may have occurred.

CONCLUSION

While admission to hospital seems an extreme intervention for a 'well' baby, the principles of our approach are the key to success. Acknowledging that

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parents are struggling and that the baby's behaviour is a contributor not a result, can only reassure the family that the stress they are under is understood. Lengthy discussion and targeted strategies, with active short-term follow up are essential. The use of short-term medication may be of use but many of the babies on discharge were no longer taking the medication they had on admission.

The other important finding was that babies who did not improve with careful assessment, parent counselling and active support, all warranted further investigation.

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NATIONAL NEWS

The WAIMH conference which was held in Yokahama in August was a great success and a number of our members from Australia were able to go. We look forward to hearing more about it from them. Some of the national committee attended the International Affiliates meeting, which is a meeting of all the infant mental health organizations affiliated with WAIMH. One of the issues discussed was the concern of our organisation that the age of infancy for WAIMH be raised from three to five years. It was decided that it should remain at three years which allows us to continue our focus on the earliest years.

Paid maternity leave

As you know AAIMHI has sent a submission to the paid parental leave in Australia inquiry, on behalf of infant needs and you can read this on the inquiry website - http://www.pc.gov.au/projects/inquiry/parentalsupport/docs/submissions.
We also made a personal appearance before the inquiry together with Early Childhood Australia (SA) and NIFTeY (SA).

You may know about the national advocacy website which supports worthwhile causes – *Getup.org*. They have undertaken support for the paid parental leave inquiry and we can support them by adding signatures through their website. I encourage you to sign the petition and to circulate information about it amongst your colleagues. They also have a draft letter on the site for people to send to friends and colleagues if they wish. At this time when the government is seriously looking into the issues around paid parental need we must keep letting them know in whatever way we can, how important it is. The website is www.getup.org.au

AAIMHI news

We are very pleased that our web-based membership data base is almost ready to go. When it is ready we will write to you explaining how you can use it, which will hopefully make things much easier for members and State membership secretaries.

We have been talking with Kim Powell the president of the newly formed NZ infant mental health association about how we can relate more closely to them and where the two associations can work together. For a start Kim will be putting NZ news in our newsletter from time to time and we will be looking to share information when overseas speakers come to NZ or Australia. I will keep you posted about this.

And most exciting, members in ACT are getting together to start a branch of AAIMHI in the ACT. There is a lot of interest in infant mental health there and we look forward to having another State (territory) with its own chapter. If you are a member (NSW) living in the ACT and would like to be part of starting up the branch, contact Anna Huber at email: Anna.Huber@marymead.org.au

AIMHI conference

The AAIMHI conference is being held in Adelaide in November and we look forward to seeing as many of you there as possible. The programme looks really exciting. You will find more information in this newsletter and on www.aaimhi.org. We hold our AGM in conjunction with the conference and members are invited to come and share in the meeting. We are recommending some small changes to the constitution at that meeting and you will receive information about the changes before the meeting. They are mostly to help us keep up with the times (e.g. using email) and responding to changes in WAIMH.

Please write to the newsletter editor or leave a message in the guest book on the website if you have any issues, ideas or concerns that you would like us to look at.

Pam Linke AM
National President

WAIMH Affiliates Meeting

In August this year, I was fortunate enough to attend the11th World Congress for Infant Mental Health in Yokohama, Japan. Amongst the myriad interesting events at this congress was the Affiliates meeting. Chaired by Tuula Tamminen, this meeting drew attendance from about 40 representatives from countries around the world (mostly Western nations from my observations). A mood of relaxed expectancy was evident as Tuula opened it to discuss the implications of the new constitution. The dominant issue was the reorganization that will be required as the executive board of WAIMH is delineated more clearly from the affiliates. Lively debate ensued around how to elect representatives of affiliates to sit on the executive board and the weighting of votes by affiliates. For example process issues such as whether Australia has one vote or five (one for each state affiliate), and the USA have one vote or 16 were thoughtfully addressed. Where does that leave the German speaking Association (Germany, Austria, Switzerland) with one vote or three votes? Marc Tomlinson the current representative received a vote of confidence as members looked to him to negotiate some of these issues. Marc will continue as affiliate representative for the next year to help with this reorganization.

Other points discussed included issues such as the expectation that affiliate representatives will be expected to attend the world congress every two years to participate in meetings such as this one. Debate centred on where that leaves representatives from countries who cannot afford to attend. For me it was also interesting to learn that WAIMH is comprised of individuals, this means all its members are the likes of you and me who make a specific effort to join WAIMH. Being a member of a State and National organization is quite separate from membership of WAIMH as many found out when they wished to qualify for members rates to the world congress. As such, it is not a wealthy organization, there are no fees flowing to it from the affiliates and they cannot afford to subsidize representatives to attend. Every member counts in this organization. We were introduced to the new executive management team who are sponsored by the University of Finland.

Finally, I was struck by the respect with which attendees at this meeting listened to the Australian point of view. Clearly, the work of the likes of Brigid Jordan and Campbell Paul and our current National President Pam Linke at the world level of administration are appreciated and respected. From a Western Australian perspective, my attendance at this meeting meant I could personally ask Hiram Fitzgerald to reassign us affiliate status, a simple administrative task that has frustrated us for months. WA is back on the map. Finally, I would urge all of you to check the WAIMH website and if you are not already a member for a very small fee join up on-line. Benefits include the journal *Signal* and discount fees to the next world congress to be held in Leipzig in Germany, which is but one hour from exhilarating Berlin.

Lynn Priddis
Chair, AAIMHI WA Branch

Congratulations

To Brigid Jordan and Campbell Paul as they were presented with the WAIMH Affiliate Award for their “leadership, devotion and diligent work” in advancing the work of Infant Mental Health throughout Australia.

2008 Conference

Australian Association for Infant Mental HealthandAboriginal and Torres Strait Islander Perinataland Infant Mental Health

5 - 8 November 2008

Adelaide Hilton Hotel

Angels in the Nursery

Supporting Parent-Child Relationships Supporting benevolent parental influences

Programme and registration now available, see: www.sapmea.asn.au/aaimh08

STATE REPORTS

Victoria

Once again the AAIMHI-Vic Branch soldiers on as the committee continues to strive to present interesting and innovative experiences to its members in the interest of promoting the community's engagement with the concept of Infant Mental Health.

With a view to improving the capacity of the organization to respond publicly and with immediacy to topical issues of the day, several members recently were involved in a highly productive media training session. This session gave members the opportunity to hone their 'being interrogated by a real journalist while being video-ed' skills as well as helping to focus our minds on the specifics of often emotive issues such as child care for very young infants, paid maternity leave and the use of controlled crying.

In August, the third in a series of Saturday morning scientific meetings for 2008 was held and featured Kathy Walmsley from Western Australia who provided an overview of the DIR (Developmental, Individual Difference, Relationship-Based)/Floortime approach, developed by Stanley Greenspan and Serena Wieder in the USA. This therapeutic model provides a comprehensive framework for understanding and treating children challenged by autism spectrum disorders. Kathy illustrated the approach with excellent vignettes and video case work and an engaging and informative discussion ensued.

Our final scientific meeting for 2008, in November, tentatively entitled "Where do babies come from?" will consider the infant's place in Assisted Reproduction Technologies (ART). The panel will include Ann Morgan, Karen Potter, and Jane Brooks - a lively discussion can be anticipated! All welcome.

The Vic Branch AGM was held in August with two new committee members, Jane Brooks and Sue Breese, stepping forward. Office bearers will be elected at the next committee meeting in September. Within the committee, planning is steadily progressing for the AAIMHI conference to be held in Melbourne in 2009. Watch this space.

Many members recently traveled to Japan for the WAIMH Congress, withseveral members involved in workshops, presentations and posters. Congratulations to Brigid Jordan and Campbell Paul as they were presented with the WAIMH Affiliate Award for their "leadership, devotion and diligent work" in advancing the work of Infant Mental Health throughout Australia.

And finally, many members are planning to attend the Adelaide conference in October this year. See you there.

T. Russo

Western Australia

President: Lynn Priddis

Vice President: Gillian Fowler

Secretary: Anne Clifford

Membership secretary: Annie Mullan

Treasurer: Lynda Chadwick

Members: Sue Coleson, Ella Scott, Jane Doyle, Elizabeth Seah, Jennifer Neubold

Reporting member: Lynn Priddis

Most recent Activities

May: Evyn Webster previously of NFGALA and now PMH spoke on father-inclusive practice to a small but enthusiastic audience. Evyn has a very engaging style and those who attended were rewarded by an informed and challenging presentation.

July: Leander Verrier presented on the activities of our State Perinatal Reference Group including a very moving DVD of aboriginal mothers who experienced depression.

September: This will include our AGM and a panel presentation from those who attended the WAIMH congress in Japan. This promises to be a very stimulating evening and we are hoping it will inspire members to think about attending future conferences, both National and International.

Membership

We are still going strong although have noticed a fall off in attendance at seminars this year. We are looking forward to the synchronised on-line membership system.

Issues

At our AGM we will have a turnover of committee members with our Treasurer of several years (Lynda Chadwick) stepping down as well as our secretary (Anne Clifford) and Vice President (Gillian Fowler).

A recurring issue is how to include rural members in our presentations and discussions.

Plans

In 2009 we plan to focus on the 2010 AAIMHI conference which is our turn to host.

Future events

Australian Childhood Foundation Seminar

The neurobiology of childhood trauma and attachment - Understanding the brain science of modern attachment theory and its relevance to practice with children, young people and families.

A seminar with Dr Allan Schore (USA) 2009

Sydney Convention and Exhibition Centre, Darling Drive, Darling Harbour, Sydney
17 March 2009 9.30am - 4.00pm

Event Cost: $260

This seminar is a unique opportunity to hear first hand from one of the world's leading authorities on early childhood trauma, neurobiology and attachment theory. The seminar will focus on understanding and interpreting up to date neuroscience research about the impact of stress and trauma on bodily-based processes, emotional regulation and early experience-dependent brain maturation. It will also examine how to apply this knowledge base about the brain systems which underlie attachment to support positive developmental outcomes for children and young people who have experienced abuse and neglect.

Dr. Allan Schore is on the clinical faculty of the Department of Psychiatry and Biobehavioral Sciences, UCLA David Geffen School of Medicine, and at the UCLA Center for Culture, Brain, and Development. He is author of three seminal volumes, Affect Regulation and the Origin of the Self, Affect Dysregulation and Disorders of the Self, and Affect Regulation and the Repair of the Self, as well as numerous articles and chapters.

This workshop will appeal to case workers, case managers, residential care workers, therapists, teachers early childhood professionals, medical professionals and others who are involved in supporting children and young people to recover from trauma. It will have direct relevance to practitioners working in the fields of Child Protection, Out-of home Care, Early Childhood Intervention, Family Support, Disability, Indigenous Services, Mental Health, Private Therapy, Sexual Assault, Drug and Alcohol, and Family Violence Services.

AASW Learning Credits Awarded

Registration Fees

Early Bird Fee 1/8/08 – 30/11/08 $260 (GST inclusive)
Standard Fee 1/12/08 – 31/1/09 $280 (GST inclusive)
Late Fee 1/2/09 and after $300 (GST inclusive)

Website: wwwchildhood.org.au
Email: info@childhood.org.au