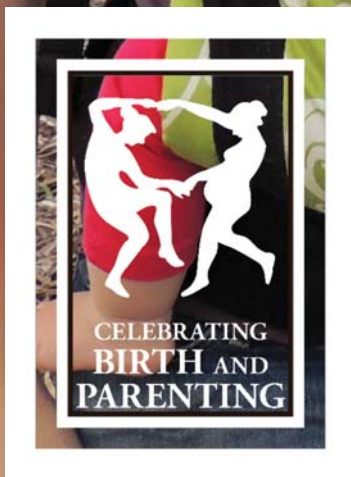


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INTERACTION

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INTERACTION



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From the Editor's Desk

Hi everyone, and welcome to the first edition of *Interaction* for 2015! Hope this year is off to a positive and productive start for all of you, and that everyone enjoyed a safe and fun Christmas / New Year. It felt too early to share the news in the December edition, but I am pregnant with my second baby at the moment, due in May! After an exhausting and hard first 20 weeks with ongoing nausea and vomiting, I am now feeling really well (although a little more tired than usual!) and getting very excited about the new addition to our family. I experienced ongoing nausea and vomiting with my first pregnancy, but have to admit that it felt a whole lot tougher this time to manage with a busy little toddler in tow!!! Very grateful to be feeling human again. The whole experience of pregnancy is such an incredible one. Our bodies truly are amazing. Yet it is also such a vulnerable time (as well as empowering) and I have once again been reminded as to the importance and influence that midwives and parent educators can have to women and their families through this time. I plan



to continue on as Editor over this year. Ambitious potentially, but manageable I hope! I feel very supported by the CAPEA team, and am still very much enjoying working in this role.

This edition has come together really nicely, and I am excited by the articles I have been able to include. Many thanks

to Nikki from Nurture Nest for her article on Babywearing and for allowing us to use such a beautiful image for our cover; Lisa for sharing with us her experience of studying Clinical Hypnotherapy through last year; Lucille from SANDS Australia for her insightful look into this very important service; and Tracey Semmler-Booth and Diane Becker for their research into Children of Parents with a Mental Illness. Thanks also to Laura from Finch Publishing for bringing us a book review of *20 Tips for Parents: The realistic parent's guide to understanding and shaping your child's behaviour* by Prof Kim Oates. As always, thanks to the NEC team and all our state reps for providing me with their reports and updates in time for me to put it all together!

Enjoy the read, and we will meet again in August (with my new baby — oh my goodness!!).

Take care,

Kassie

Web Report

We now have 100 'likes' on our CAPEA facebook page. It would be wonderful if people felt confident enough to initiate or contribute to a discussion topic relevant to our work — a challenge to you who are comfortable engaging with social media!

Thanks to those who have emailed to let us know that they like the new website. There are plans for ongoing additions, including more about the history of childbirth and parenting education in Australia, documents demonstrating good governance of our voluntary organisation, more practical teaching ideas, and great images for our home page.

The last webinar series was held in November, with 18 attendees, mostly from NSW. For several reasons, this excellent way of delivering professional education relevant to our specialty is temporarily on

hold. It is likely to return soon as single sessions, perhaps 2-3 per year. You will be notified via email, facebook and website when organized by Tracey Rayner or the new webinar coordinator.

Finally, if you did not receive an email from either myself or info@capea.org.au in late January / early February, it is because we do not have your current email address or it has gone into your junk mail folder. Please update your details with us, as emails are the primary way of CAPEA notifying you personally about local events and reminders about membership renewals (due annually on 1st July). Thanks to the member who reminded me about sending group emails only via Blind Copy (BC), ie. to undisclosed recipients, aiming to preserve your privacy.

Lisa Robertson
CAPEA Web Administrator

Dates of Publication and Deadlines for *Interaction*

Deadline 28th February
for inclusion in April edition.

Deadline 30th June
for inclusion in August edition.

Deadline 31st October
for inclusion in December edition.

CAPEA Inc website
www.capea.org.au



National President Report

Hello everyone and welcome to CAPEA 2015! Members of CAPEA are a diverse group, ranging from those who are actively involved in assisting women to birth their babies to those whose expertise is more in the preparation for this wonderful event. What binds us together is our passion for assisting prospective and new parents to have the most positive birthing and parenting experience possible, whatever the circumstances.

Those of us not on the front-line may envy those who are, but every so often, we are given the chance to experience the wonder of birth first-hand. I have just had the privilege to assist my daughter and her partner in the birth of their first baby, in a Pacific island nation where conditions were good, but basic. To see our philosophy of active birth in action, and really working, was amazing, as were the ensuing weeks of parenting their beautiful little girl. It hasn't all been smooth sailing, but they are getting

there — it has been a real eye-opener for me, as our value as educators has been reinforced over and over again. I have never been more proud of our role!

Our state branches are getting their 2015 planning underway and the National Executive Committee is not far behind, with the first teleconference for this year planned for mid-March. We hope to start working on a Strategic Plan for CAPEA, determining our aims and values as well as what we see as our key strategic directions for the next few years.

Some members of the NEC have been hard at work during the break and have come up with updated position descriptions for all of the executive positions, which we hope will also be useful for the branch executive committees. These will be circulated once they have been ratified.

The ability to communicate via our website has been aptly demonstrated over these past few months — issues have been raised and forwarded to the appropriate



members or set aside for review by the NEC. The website is a terrific asset that all of us as members can make use of and benefit from, so please access it whenever you need information or want to make contact.

I am looking forward to a very productive year!

Sue Spencer
National President
Susan.spencer@health.nsw.gov.au

Further Education Committee Report

As we celebrate the dawn of the Chinese New Year of the goat, 2015, I am reminded of some of the associated traditions, red lanterns and envelopes, paper cut pictures, fireworks and lantern festivals. An important tradition that happens days before the new year, involves families doing a total home purge, scrubbing and cleaning house in hopes of sweeping out bad luck and welcoming the future with open arms. While the Further Education Committee, (FEC) are not about to purge our “house” we are ready to get our “house” in order to support CAPEA to welcome the future with open arms.

The future of CAPEA relies on strengthening what we already have established and embracing the challenges, both real and potential challenges of our changing world. The FEC has a key role in providing a leadership role in the development of educational processes, including the recognition of educational programs, products and services. As I mentioned in our last report, these processes have become more complex with the advent of the new CAPEA website and are in need of review.

Here are some of the interesting questions the FEC will consider during 2015. If you have a short or long course related to facilitating childbirth and early parenting education, what would be the benefits of having it endorsed by CAPEA? Would it have more credibility by being endorsed by the only national organization involved in childbirth and early parenting education? Would it attract more participants by being an endorsed program on the website?

Could individuals and organisations have their program for expectant or early parents endorsed by CAPEA? What criteria would need to be developed to achieve this outcome? What would the benefits and possible pitfalls be?

What about services or products? If an individual writes a book or provides private parenting education groups for parents, can they promote it on the website for free or should there be a cost? What are the benefits (if any) for CAPEA? If they are a CAPEA member, do they pay less than someone who is not a CAPEA member or the same?

Are all of the above in accordance with CAPEA philosophy and the Competency

Standards for Childbirth and Early Parenting Educators?

Would local, state and federal governments be more inclined to consult with CAPEA representatives when developing new programs, policies or guidelines because all the above has promoted a higher profile?

There is also the issue of CAPEA certification, we need to review the 3 levels of certification and the process for applying that have been in place for some years now and is due for review. What are the strengths and weaknesses of certification, are CAPEA members taking advantage of it, if not why not, what are the obstacles?

Finally, we still need new members on the FEC. It is time for some of the younger generation of CAPEA members to join in, learn the ropes and eventually be part of leading CAPEA into the future. We invite your thoughts, opinions and ideas and would be delighted to discuss by phone or email or contact via the website.

Deb Galloway
Acting Chairperson
CAPEA Further Education Committee



State Reports



Things have been quiet for CAPEA Tasmania over the Christmas / Summer time. Finances have been finalised from the CAPEA National Conference in Tasmania, resulting in a healthy profit. The majority of this goes to National, Tasmania keeps a portion and a small seeding grant goes to South Australia to get them started for the 2016 National Bi-Annual Conference.

Plans continue for a State Meeting / Education Session in May this year. Tasmanian members keep in contact regularly via email in between study days.

Marilyn Steers



We have started 2015 with a great dinner meeting in January. It was a great catch up for all and opportunity to plan our year; it was encouraging to have a good attendance for the start of the year.

The new SA Branch team for 2015 as elected at our last meeting in November 2014 is:

President: Lisa Masters
Secretary: Deb Rossi
Treasurer: Sue Bulluss
State Rep: Mary-ann Baker

ALL Important conference convenor: Delice Sauerwald

The planning for the National conference Nurture the primal instinct 2016 is underway with great input for members but of course there is much to do. Venues are being explored that tie in with the theme and location and the development of a conference logo will be next. Remember to keep the dates 12th-14th October 2016 free and there will be more to come.

After discussion at our January meeting teaching skills was an area identified as of interest to all members new and old and was requested after our last SA workshop. It was decided that at each of our meetings throughout the year a particular aspect would be chosen and presented. We will again meet in various locations around Adelaide as this enables a wider spread of our members to attend. We are always keen to accommodate others.

Our next meeting is Monday 30th March at 5:30pm the location will be advised soon. The topic for discussion Positive language: How to connect with the class; this is a flow on from our great presentation and discussion on educating Dad's last November.

Mary-ann Baker



The Queensland State AGM was held via teleconference on Sunday

16th November 2014.

Election of Office Bearers for November 2014 to November 2015 remain unchanged:

President: Jeannie Lynch

Vice President: Jenni Price

Secretary: Alison Sell

Treasurer: Richard Hayes

Jacqui Morrison continues as the Queensland State National Representative.

Our first teleconference for the year was held on Sunday 22nd February 2015. The main purpose of this meeting was to plan for rural workshops in 2015. As Jeannie wrote in her President's Report for the branch meeting "Our vision for this year is to continue to travel to rural Qld to conduct workshops so all members can benefit from the networking opportunity to attend and further their own professional development."

At this stage Longreach is the preferred location. This workshop will be a good opportunity for existing and new members from Longreach and nearby towns. We also anticipate members from the Southeast corner, North and Far-North Queensland will visit the Queensland outback in the cool winter months.

It will also be an excellent opportunity for interstate members to participate in the workshop while gaining some rural Queensland experiences. Points of interest include the Australian Stockman's Hall of Fame (which pays tribute to the pioneers of the Australian outback) and the Qantas Founders Outback Museum. Both are well worth a visit.

Confirmation of location, and further details, will be available on the website and will be emailed to Queensland members.

At the teleconference we agreed to trial Monday evening for our next state branch meeting in May. The date and time will be emailed to all Queensland members. Hope you can join us.

Jacqui Morrison





Remember to be in attendance at our Study Days to be in the draw to win sponsorship to the next National Conference “Nurture the Primal Instinct”, which will be in lovely Adelaide in 2016.

Keep an eye on the CAPEA National website for updates.

As always we encourage each of you to invite your colleagues to join us.

We look forward to seeing you soon, and until then, best wishes.

Krystelle Tarburton

NSW Report

Greetings to you, and welcome to the new CAPEA Vic Branch year.

We look forward to bringing you some stimulating presentations including:

- ❖ Perinatal Mental Health Study Day
Saturday 14th March 2015,
0900 – 1330
Mary McKillop House, 7
Brunswick St, Fitzroy
- ❖ PND The Partner’s Perspective
- ❖ The Circle of Security – Parent /
Infant attachment program
- ❖ When Two Becomes Three.

Join us for our study day on Monday 22nd June, 1700 – 2000 Mary McKillop House, for a twilight Winter Solstice — Celebrating birth rituals and traditions from different cultures.

A Vic Branch CBE Training Course will be offered on May 22, 23, 29, and 30. Mary McKillop Centre at St Vincent’s Private Hospital.

NSW CAPEA had two meetings since my election in November. These have been attended by face to face and also via teleconference.

The items of discussion are the filling of vacant positions on the NSW branch those being; NSW Secretary and Professional Development Officer. Vigorous canvassing is to peruse amongst NSW members to try and fill these positions. At present these positions are being shared and remaining NSW executive fulfilling dual roles. Thank you NSW team.

Position description for NSW committee member position were distributed, and members whom have previously held these NSW Executive positions, have been asked to peruse these documents and make comment, and return before next NSW CAPEA meeting.

Meeting venues are being decided for 2015 for NSW, one of the main criteria being teleconferencing facilities, dates thus far as follows for 2015; 17/5/2015; 14/6/2015; 9/9/2015; 25/11/2015.

Webinar series for 2015 was decided to do 1 webinar conference per session at costing of perhaps \$30 as opposed to 3 for \$100 as trialled in 2014. This is perhaps more affordable in time and monetary wise.

Professional development for 2015; A discussion of the success of Nan Tien Temple Active workshop in August 2014, and the expression of NSW CAPEA members to repeat this format and venue for 2015. However on reflection of NSW & ACT CAPEA State branch meeting at National Conference it was decided to consult with ACT CAPEA members and run a CAPEA education /workshop in ACT with full support from NSW. Consultation with ACT CAPEA members to commence.

Kimberly-Clark Australia /Huggies Phyllis Harris, has approached NSW CAPEA branch to help a promotional event in March held by Costco at their Auburn and Casula sites. The CAPEA members are not to recommend HUGGIES product but to answer general questions from expectant parents or parents with babies or toddlers. CAPEA members will be able to refer people to the CAPEA website and members will be remunerated for their services. Meredith Haultain NSW Vice President will be manning Auburn site . It was also decide that NSW CAPEA Guideline be established for such promotional events.

Discussion for CAPEA Certified Trainers and the reduced numbers discussed. Further discussion will be on going and will be an issue raised in the Strategic Planning meeting set down for May 2015.

Jacquie Myers



CAPEA Membership Secretary's Report

We have over 250 members on our database but unfortunately not all members are financial. Late last year I sent out 70 letters to unfinancial members and to date I have received over 25 replies which is very encouraging. There have been some members who have paid but unfortunately there is no way to link the payment to the person paying — I do realise some financial institutions won’t allow names on deposit slips as reference

but may I suggest a telephone number could be a solution. The other request I have is that if paying by direct deposit or the web could all members please email me at: members@capea.org.au — this way I can keep the database updated.. If any member has paid and not received the December *Interaction* could they please let me know so I can forward one onto them? Renewals will be due again on the 1st July and emails will be sent in June.

When renewing via the web please use your member number that has been allocated to you previously. If anyone is unsure of their number please contact me at member@capea.org.au

Thanks

Jeannie Lynch
Membership Officer



Babywearing

Nikki Wilkins (BSc, Dip. Children's Services) is a **Certified Baby Carrier Consultant** and was one of 8 people invited to train in Australia through Trageschule Dresden; world-renowned babywearing school which has been practicing for over 20 years and consults with a board of medical advisers. Nikki is the founder of **Nurture Nest** which is one of Australia's largest baby carrier stores, and she proudly offers free baby carrier consultations via email to parents and medical professionals. Located in Adelaide, she also offers free fittings and advice for people looking for a carrier, as well as personal consultations and workshops for professionals and parents. Nikki has worked with families for over 10 years in a variety of settings, and very much enjoys helping parents to be the best parents they can be so their children can receive the best start in life.



What is 'babywearing'?

Babywearing is the act of carrying a child close to your body in a baby carrier. It has been practiced for thousands of years and was once considered the norm for most families. It was simply common sense for a parent to use a baby carrier to make their busy life much easier.

In recent years, there was a push from parenting 'experts' to encourage independence in children and thus prams, cots, walkers, bouncers, and other baby items became popular. Many studies since then have shown that children need touch, and in fact a responsive and nurturing parenting approach will ensure that children will independently explore their world when they are ready knowing they will have a safe person to return to if and when they need. Babywearing has since started to become more popular with many parents describing it as a necessity.

Many parents who have used a comfortable baby carrier with their children have reported that it has had an enormous positive impact on their parenting experience, and argue it's perhaps the most important baby product available.

Benefits of babywearing

Babies who are worn cry less, sleep more peacefully, breastfeed more successfully, have better digestion, and are more calm and content. It benefits parents by enhancing their attachment with their children, it facilitates breastfeeding, and it helps working parents reconnect with their children when they are home. Most of all it allows parents to meet their baby's regular need for touch while allowing parents to get things done. In a study published in the journal *'Pediatrics'*, researchers found that babywearing for three hours per day reduced infant crying by 43 percent. During the evening hours, infant crying reduced by 54 percent. Just imagine the difference this could make in the lives of many parents if it were to become more widely practiced.



Babywearing allows parents to have the freedom to continue their general daily routine by carrying their child close to them and simultaneously keeping them calm and content. It also enables parents to continue doing things they love (social events, walks along the beach, travelling) without needing to be separated from their child. If they already have other children, wearing their baby enables them to tend to them hands free, and to spend more quality time with both of their children without interruptions from a distressed baby, which helps to reduce sibling rivalry. Babywearing is incredibly practical — parents wearing their children in a carrier can go many places a pram can't go. Hiking, navigating crowded airports with your luggage in tow, climbing stairs and walks along the beach can all be done with ease with the use of a well-designed baby carrier. As a result, parents are able to feel much less isolated during the day as they can still continue with many of their favourite activities.

As well as the practical benefits, there are also several emotional benefits to babies being carried in baby carriers. Babywearing can reduce the occurrence of post natal depression and can also benefit women who are suffering from it. Some of the risk factors of postnatal depression include a baby who is unsettled, difficulty with establishing breastfeeding, feelings of isolation and a lack of practical support. Babywearing can help with these problems by reducing the incidence of crying or settling a distressed baby, promoting the establishment of breastfeeding and providing a convenient and discreet way to breastfeed (breastfeeding can be done with ease in a good quality baby carrier),



and offering parents a hands free way of caring for their baby as well as reducing their isolation from society.

There are a wide variety of baby carriers available today, however you may be surprised to hear that there are no safety regulations for baby carriers being sold within (or into) Australia. This is no reason to be alarmed, but it is important that we arm ourselves with information so we can encourage safe and comfortable babywearing in our community.

Despite there being a wide variety of different types of baby carriers available, some general safety rules apply which can be achieved with each type of recommended carrier.

Safety Considerations

The baby carrier should be tight

Any sling or carrier should be tight enough to hold the baby close to the parent's body. If the parent leans forward, the baby should still be positioned close to their body — the carrier should be able to be used completely hands free. If the carrier is too loose, it may allow the baby to slump forward so that their spine is not properly supported, it could hinder their breathing, and will move them further away from their parent which will make the carrier uncomfortable.

Baby should be in view at all times

The parent should always be able to see their baby's face by glancing down at them. There should be no fabric across the baby's face.

Close enough to kiss

The baby's head should be as close to possible to the parent's chin as is comfortable for the parent. Without having to lean forward too far, the parent should be able to kiss their baby on the head/forehead.

Keep baby's chin off their chest

A baby should never be curled up so that their chin is forced onto their chest, as this can restrict their breathing as their airways are so small. There should be enough space to fit a finger width under the baby's chin. For this reason, many baby carrier professionals do not recommend 'pouch' style slings or carrying baby's in a cradle position. It's not impossible to get a safe fit with this style of carrier, however it is

difficult even for experienced wearers. For this reason, I personally recommend teaching parents to carry their babies in an upright position in all carriers. Not only is it easier to get the baby safely positioned, but it also carries the baby closer to the parent's core, making it a more comfortable carry.

Baby's back should be supported

The baby should be held comfortably close to the wearer so their back is supported in its natural position and their tummy and chest are against the wearer. If the parent places a hand on their baby's back and presses gently, they should not move any closer to the wearer. This is a quick test to ensure the carrier isn't too loose. The carrier also shouldn't be too tight — baby's have a natural 'c' curve to their spine which curves slightly outwards, and a carrier should allow for this.

Comfort Considerations

The above recommendations have discussed safety considerations, however there are also health and comfort considerations as well.

Besides comfort and safety for the parent and baby, the difference between a reasonably good carrier and a high quality carrier will enable the person using it to gain all of the benefits of using a baby carrier for a much longer period. For example, one of the most readily available baby carrier brands will allow parents to only comfortably carry their baby for up to 3-4 months until it starts to feel uncomfortable (despite their weight recommendations). In comparison, a high quality baby carrier will allow them to carry comfortably for up to 20kg (an average 4-5 year old!). This enables them to carry their child comfortably for more than four times longer than a non-optimal carrier.

A really important consideration when choosing and/or fitting a baby carrier is to ensure the hips and spine are adequately supported.

The most optimal positioning for the developing hips and spine of the baby is to have their knees slightly higher than their bottom, in what we often call the 'M' position, or what is also referred to as the frog-position or spread-squat position. With this positioning, the baby's knees are higher up than their bottom and their legs are spread 90 degrees. This is the position babies automatically assume when they are held, and it is also ideal to mimic this when



they are being carried in a carrier. In this photo, you can see that the baby is supported right out to the back of her knees, and her hips are higher than her bottom (note the 'M' position).

This is supported by recommendations of the Hip Dysplasia Institute who encourage parents to select a baby carrier that allows healthy hip positioning.

"When babies are carried, the hips should be allowed to spread apart with the thighs supported and the hips bent. The most unhealthy position for the hips during infancy is when the legs are held in extension with the hips and knees straight and the legs brought together, which is the opposite of the foetal position".

The following baby carriers demonstrate how the above safety and comfort considerations can be followed with a variety of different baby carriers.



Mei Tai/Asian style carrier



Soft Structured Carrier/Buckle Carrier



Ring Sling



In summary, a baby carrier should follow these guidelines

- ❖ Tight (adjustable, not one size fits all)
- ❖ In view at all times
- ❖ Close enough to kiss
- ❖ Keep chin off the chest
- ❖ Supported back
- ❖ The carrier should be able to extend as close as possible to the back of the baby's knees
- ❖ Baby should be able to be carried in an 'M' position, with their knees higher than their bottom

Unfortunately many ergonomic, safe, comfortable baby carriers cannot be found in general baby stores. It's also important to be aware that many well-known baby carriers have fake versions available on ebay which haven't been properly safety tested or had their materials tested for lead or other dangerous materials (fake carriers are often produced in China and are unregulated) and there have been issues with the baby carriers coming undone which creates a falling hazard. I would strongly suggest directing parents towards a reputable store which can provide ongoing support for parents prior to, during, and after their purchase so they can receive support as needed. A reputable online store will offer this, and parents should be able to send in photos of them using the carrier if they need further advice or assistance.

If we keep the above considerations in mind, we can provide parents with a tool that could very well be their best parenting asset. A safe, comfortable carrier will help to enable a parent to be the best parent they can be. Importantly, it will help parents to continue to do more of what they love with the people they love. If we can support them in this, we are helping to provide a child with the best start in life.

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The Power of Words for Childbirth Educators

Lisa Masters Registered Nurse / Midwife, Grad Dip CBE, Dip Clinical Hypnotherapy Parent education Coordinator Children, Youth, Women's Health Service, Adelaide, South Australia

lisa.masters@health.sa.gov.au

All educators know the power of words we use in facilitating antenatal sessions and how much concentration it takes to get the words right. If you get it wrong you can change the whole tone of a session. We are always juggling language (spoken and body) and trying to gauge what is appropriate. I have just spent the last year learning a different style of communication that uses the subtlety of language to utilise the power of a person's own mind — clinical hypnotherapy. There is nothing magical about hypnosis (I wish it was) and nothing scary about it either, you can't control someone's mind and quacking like a duck is optional! Stage hypnosis gives the impression people are under control of the hypnotist; what I have learnt is that hypnosis is the ultimate in self-control. Hypnotherapy concepts can be used to help us choose the words we use day to day and to enhance what we already know as educators.

Allan Cyna, Marion Andrews, Suyin Tan and Andrew Smith wrote an excellent book in 2011 *Communication in Anaesthesia and Critical Care* and although directed at anaesthetists it is applicable to any health professional. Dr Cyna and Dr Andrews are anaesthetists and clinical hypnotherapists who work with women and children. The clinical hypnosis concepts I have included are well written about in this book and I would recommend it to all educators.

Here are a few things that I have learnt through clinical hypnosis training and how I have applied them to my work

Educators unconsciously choose particular words, those words can have an impact on a person's subconscious, and we need to be mindful of that effect. Through clinical hypnosis training you learn techniques and theories which become tools to help choose the most effective way to communicate your point whilst encouraging the person to



utilise the power of their own subconscious. As example pregnant women constantly have the size of the baby judged publically and clinically, who wants a 'big baby', the woman doubts her ability to birth her baby on a subconscious level, wouldn't you prefer a 'robust baby' where the connotation is that the baby is strong and healthy? Our job is to impart a confidence in woman not undermine it. Similarly the word 'delivery' instead of 'birth' may be appropriate in a clinical handover situation but to me it undermines the woman's role in the process and I don't use it in a session.

When talking about labour and birth I try to keep the pain description words neutral e.g. contractions become more intense over time not more painful. I emphasise positive words like comfort, safety and control. Breathing in comfort and control and breathing out tension. This is all basic and goes back to Grantley Dick-Reads fear pain and tension cycle. The concept of time distortion can also be introduced; experiential time is quite different to clock time. We have all experienced time going fast when we are having fun and very slow when we are bored. The seed can be planted for women to focus on the rest that follows a contraction so in their mind it lasts longer.

The word 'try' used in a sentence suggests anticipated failure. As a clinician it can be used both ways. Avoid it if it is intended that the person will succeed and use it if you want them too. As an example

Power of Words



a woman in the labour ward says

'I feel a bit sick'

and the reply is

"Try not to vomit. I will just go and get a bowl".

Have you ever tried not to vomit? It gives you permission to do so! Conversely you could ask someone to

'try not to relax too much' if you want them to relax.

Truisms (Cyna, 2011, Chapter 4) are very useful but take time and practice to master, a truism is something you say that is supported by the belief that the person has already realised themselves, they are felt on a subconscious level. An example is *'most people enjoy the feeling of warmth on their skin in the sun'*.

One of the most valuable tools I have learnt (not mastered) is the use of pauses and silence... We are quick to make assumptions about where a person is going in their mind and think ahead for them, we can become very efficient at shutting people down and moving on. This can be a good management tool sometimes in the class situation when you may need to move onto another subject or someone is disruptive. A few moments of silence creates thinking time that can be very valuable. Sometimes the pause will give you more information than you actually wanted or can deal with.

The last concept I would like introduce is the LAURS of communication (Cyna et al, 2011, Chapter 2) as it provides a structure when communicating with people especially in the class situation. I am sure you may have come across different communication tools but this one suits me and I find it easy to remember.

Listen reflectively

This means really listen, not just the words but the body language, the tone of their voice, the subtle signs that people give out about how they really feel about a situation. Resist the temptation to second guess what the person is thinking and allow silence or pauses. 'Check in' to clarify your understanding and their understanding e.g. 'what do you mean by that?'

Acceptance

Accept the persons reality, it is not your take on the situation they are expressing it is theirs, be open minded and non-judgmental, this is difficult if their beliefs seem counter to yours or even illogical and may be loaded with emotion. Anger may be

the demand for recognition when a person feels like they have not be listened to.

Utilisation

All educators have learnt about preferred learning styles visual, kinaesthetic and auditory but how many of us use the words we hear reflectively back to the person? 'I'm looking forward to...' 'That sounds clear to me'... 'It's like a weight off my shoulders...' When you listen you can pick up clues about their preferred learning style. Utilisation also includes recognising the person's strengths, abilities, qualities and experiences and using them to build success in the situation.

Reframing

My favourite part of this process and the one you really have to nail, turning the situation into a positive, subtly reframing the situation using the person's strengths and hopefully getting them to see the situation in a different light. It is a powerful way the subconscious mind works and rewrites the paragraphs of a person's thoughts. The person has to feel they are in control of the reframing.

Suggestion

Making a suggestion for the person to take away from the interaction, this is not advice it is an indirect positive suggestion that the subconscious uses e.g. 'Most people find it more comfortable than they thought' elicits the perception of comfort.

In the following scenario I have used the LAURS of communication concept you might use with a woman

Woman: *'This baby is keeping me awake at night kicking me inside.'*

Facilitator: (Listening and watching her push on her ribs and screw up her face) *'Mmm... I can see the kicks are making you feel uncomfortable. What are the movements like?'*

Reframe her concept of this baby which is dissociative into your baby later. You want her to connect to her baby rather than dissociate and the kicks are reframed into movements.

Woman: *'As soon as my head hits the pillow it starts to go crazy.'*

Facilitator: *'Movements can feel quite strong at this stage of pregnancy. (Accepting the woman's reality) and when everything is quiet at night things*

can seem more intense.'

This is an example of a truism; people have experienced it and know things seem worse at night. The word intense acknowledges the feeling but is not labelling it as pain.

Facilitator: *'What do you think she is doing in there?... What might she be feeling?' 'Do you think she might sense you are feeling tense when she starts to move?' 'Have you found anything that helps you get more comfortable when your baby is active?'*

Utilising any positive perception you are given.

Facilitator: *'It is good to know that your baby has lots of strong movements as it's a reminder that she/he (utilise this if the woman knows or a name if possible) is growing strong ready to be born.'*

Planting the seed in preparation for birth about strength and resilience.

Facilitator: *'Perhaps you might like to practice relaxing your mind and muscles when she starts moving at night, it's a way of practicing for labour'. just take note of how she responds to you as you take control and calm yourself.* (Suggestion)

Good luck with your communicating and keep working on it. If you are interested in learning how to become a clinical hypnotherapist check the Australian Society of Clinical Hypnotherapists for your state branch. You are required to be registered with AHPRA to apply.

asch.com.au

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sands

miscarriage, stillbirth & newborn death support

Sands Support Services

Opportunities to talk about, remember and acknowledge babies who have died:

Phone support —

Talk with a parent supporter on our national telephone support line on 1300 0 sands — 1300 072 637

Email support —

Our parent supporters are also available via email:

support@sands.org.au

or live chat at:

www.sands.org.au.

Online live chat support —

Online support from a parent support is available through live chat.

Monthly meetings and coffee mornings —

Held in metropolitan and regional areas, these local support groups are run by, and for, bereaved parents.

Memorial services —

Held annually, these non-denominational services provide an opportunity for family and friends to celebrate the lives of babies who have died.

About Sands

Sands is a national not-for-profit organisation that offers support when a baby dies before, during or soon after birth.

No one can be prepared for the level of grief that follows the death of a baby. Families' dreams for a future with their child are lost and their heartbreak can be immeasurable. Parents may wonder if their feelings are normal and how long they will last. They may also need to make some difficult decisions at a time of great distress.

Sands understands what it is like, because we have been through this experience ourselves.

Sands is available to offer immediate support and quality information whenever a baby has died — whether through miscarriage, termination due to medical reasons, stillbirth, newborn death or other pregnancy loss. We are here to comfort parents and offer hope for the future.

Our services are not just for those touched by the recent death of a baby. We also offer support prior to the death of a baby, to bereaved parents who are feeling anxious throughout a subsequent pregnancy, as well as those who were unable to express their grief when their baby died many years ago.

Numerous people may be affected by a baby's death, including family and friends, who may not know what to say or do. Sands offers ongoing support for all, in the hope that no one will ever have to say *"if only we had known help was available"*.

Sands was established by bereaved parents in the early 1980s and since then has been dedicated to improving the quality of care delivered to those affected by the death of a baby.

We work in partnership with obstetricians, midwives, nurses and other professionals, often advising on best



practice in the care of bereaved families. We supply these contacts with education packs to be given to parents at the time of their baby's death, enabling parents to instantly access information and support services.

Sands has offices in Queensland, Victoria, Tasmania, South Australia and Western Australia. We have parent supporters in every state, including some regional areas.

The Sands model of support

Providing access to specially trained parent supporters is a key Sands service. All parent supporters are volunteers who have experienced the loss of their baby and are using their understanding to help others through their journey.

Society often underestimates the profound grief that can be felt by parents whose baby has died before, during or soon after birth. Grief can involve all sorts of emotions and thoughts, many of which are not considered socially acceptable. When the reasons behind these strong reactions are not properly understood or acknowledged, parents can be left feeling isolated and confused.

Talking freely with parent supporters who have lived through the experience can help to reassure bereaved parents that they are not alone and their reactions are normal. Sands also recognises that this model of caring and non-judgemental peer support can help to minimise grief-related problems later on.

Capturing Memories

For most parents the shock that follows after receiving the news that their baby has died will be devastating. Many have found it difficult to make decisions or know how to create memories in the precious limited time they have with their baby.

Many parents have said that keepsakes provide loving memories that they can also share with family and friends.

Memory creation can be done at any time, it does not have to be before the funeral or memorial service. Bereaved parents may think of a memorial idea years after their baby died — it is never too late.

Some parents may feel that if their baby has died very early in pregnancy they will not be able to create any memories but many of the ideas can be used to create meaningful memories for an early pregnancy loss as well as for a loss in later



pregnancy when you have had a chance to see and hold your baby.

Dani's Story

Dani's son Jasper died just ten hours after he was born. This is Dani's story:

"My husband and I had only been trying for two months when we fell pregnant the first time. Everything was fantastic until I woke at 14 weeks with heavy bleeding. After an emergency run to the hospital they could not find anything wrong and sent me home. This became a regular occurrence during my pregnancy and they eventually told me I might have an irritable cervix.

Then, at 23 weeks I lost a lot of fluid and I was diagnosed with Pre-ruptured membranes. I was in and out of the hospital for weeks until the 18th of November 2009. I endured needles, magnesium drips and adrenaline shots. I was on constant medication to prevent any kind of illnesses. I had to take my temperature 5 times a day to make sure my temperature remained constant.

On November 18th, I woke up in pain. A few hours later the pains were worse than before. We headed towards the hospital once again. I was moved into a birthing suite where the pains got worse and worse. The monitor on my belly was

telling us that the baby's heart beat was breaking 200 beats a minute. I was just 26 weeks pregnant.

At about 9am the surgeon came in and told us that the only way Jasper was going to have a chance was if we deliver the baby now via emergency c-section, I was in the surgery by 9.15am and the baby was out and born at 9.31am. To our shock and amazement it was a boy, Jasper Rhys (4 separate ultra techs told us it was a girl). They got him breathing and then they rushed him to the neonatal unit. He had not made a sound. An hour later we went to see him, he was in a incubation chamber, with lots of tubes going in and out of him as a machine making him shake to help him breath. He was red in colour due to the bruising because he refused to come out into the cold.

Later that afternoon around 6pm we left my hospital room to go down and see him again. We were greeted at the door by two solemn nurses and a very serious doctor, basically they told us that he wasn't taking oxygen anymore and his oxygen stats were dropping, and that we had basically had to make a decision, he had a very slim chance at recovering his oxygen but because he had been with so little for a long period of time and that there is a very high chance he would be severely brain damaged. So basically we could let him live and see if he would pull



through or we could pull the plug and let him slip gently away surrounded by those who care for him.

We decided that it was best to just let him go. As my husband went into the waiting room to get his family, it fully dawned on me that we were losing our son. By the time my husband had gotten back I had organized for Jasper to be baptized and a priest was on his

way down. He was baptized still in his incubation chamber, then the rest of the family turned up to say their farewells.

For the first time I was allowed to hold my son. He still had not made a sound. Jasper was taken out of his incubation chamber and laid on a bed with me and my husband. Everyone said their good-byes then as his machine was turned off he went still. The doctor pronounced

him at 7.32pm on the 18th of November 2009. We said our final goodbyes a mere 10 hours after first meeting our little man. After two years we finally got what many don't get... Answers as to what happened which helped us fall pregnant again and we now have a happy and healthy 4-month-old Harrison."

North West Private Hospital Antenatal Education Classes

Maree Reedman

Antenatal Education & Early Parenting Education Classes have been delivered at North West Private Hospital in Burnie for many years. Specific sessions for the Dad's have been an important aspect & have been supported by Johnson & Johnson and for the past 10 years, Good Beginnings. During this time the sessions involved the Mum's remaining with the midwife, and the Dad's going to a separate room with a Dad's Facilitator. Organizational changes in the latter part of 2014 required us to rethink how we were conducting the education, therefore we trialed a combined session with both Mum, Dad or support person together.

Based on the feedback and a desire to assist parents during this life changing adventure, we have developed a new Mum and Dad Combined Session, which is supported by a Powerpoint presentation and 2 short video clips. The focus is on the journey of pregnancy, birth, bonding, sleep deprivation, going home, support services, perinatal mental health, settling techniques,



the importance of self care, the differences in parenting style of Mum's and Dad's and the importance of strong relationships. Within this new model we have flexibility to continue to separate into a Dad group

with the Dad's Facilitator and the Mums with the Midwife/Childbirth Educator. An opportunity is created to explore topics in more depth within a safe space.

Current research in Australia suggest that 50% of relationships will not make the first 18 months after the first baby is born. Our aim is to assist the couples / families to gain skills in active communication, and have a point of contact where support can be obtained if requiring support on their journey.

Currently 3 Dad's Facilitators are involved with the 4 midwives who conduct the Childbirth Education Classes. Federal Government changes means that Good Beginnings will cease to fund the program from the end of February. The sessions are sponsored by Rural Health Tasmania Inc & North West Counseling Service. A proposal to fund the sessions by Rural Health Tasmania Inc has recently been approved.



Children of Parents with a Mental Illness (COPMI) —

interventions in prevention, and early intervention, observations from a European study tour

Diane Becker & Tracy Semmler-Booth

Tracy has **extensive clinical experience** having worked in the field of adult, perinatal and infant mental health since 1987. Tracy was Project Manager of a major health initiative, The NPDI, which led to the introduction of new mental health screening and assessment practices for pregnant and postnatal women throughout South Australia. Tracy has been involved in staff training throughout her career; this includes running training courses, speaking at conferences and developing staff resources. Whilst working for both NPDI (2010 – 2014) and COPMI (2013 ongoing) a major focus of Tracy's work has been staff training and development. Training focus has included: mental health information, screening, assessment, strategies and interventions.

Diane Becker is a Workforce Development Officer at COPMI, and a Clinical Nurse at the Women's and Children's Health Network. Diane has **extensive clinical experience** having worked in the field of nursing since 1977 and in mental health since 1983. Diane was the Private Sector Coordinator of the NPDI and coordinated training for staff working with Aboriginal perinatal

women throughout South Australia. Diane has been involved in staff training throughout her career, this includes conducting hands on training in basic life support, running training courses, speaking at conferences and developing staff resources. Diane has also worked as a Facilitator and Tutor at the Flinders University for nursing students. Diane currently is involved in writing e-learning modules and conducting face to face training for COPMI on a national level.

Introduction

Children of parents with a mental illness have a high risk of developing a mental illness during their lifetime (Beardslee, Gladstone, Wright, & Cooper 2003) as well as higher rates of behavioural, developmental and emotional problems (Beardslee 1998). The importance of family centred principles is considered to be crucial for positive outcomes for children and families.

Beardslee et al (2003) recommend that children who are at risk of depressive disorders should be targeted for evidenced based preventative interventions. Currently in Australia, many of the international family based parenting interventions that have evidence of good outcomes are not implemented by practitioners.

Literature Review

According to The Royal Australian and New Zealand College of Psychiatrists (RANZCP) (2010), the prevention and early intervention of mental disorders in childhood is critically important, both to

improve children's mental health, and to help prevent the onset of mental disorders in adolescence and adult life. Mother-infant interaction is the key mechanism through which maternal depression affects short and long term consequences for the child, thus intervening early in the child's life is critically important. Current evidence advises that intervening early in a child's life (when parental mental illness can have the greatest impact) helps to improve child outcomes (RANZCP 2010). Infants of mothers with depression represent a population at high risk for intergenerational transfer of psychopathology (van Doesum, Hosman & Riksen-Walraven 2005), risk of depression, anxiety disorder and alcohol dependence (Weissmann, Warner, Wickramaratne, Moreau, & Olfson 1997). Symptoms of illness and the adverse effects of medications can affect quality of attachment often resulting in insecure or disorganised attachment (Cooper & Murray 1997). Many studies have reported on the adverse effects that parental mental illness has on children. Parents with psychosis can have compromised parenting caused by lack of motivation, lack of sleep, medication side effects and from symptoms of their psychosis (Kowalenko, Mares, Newman, Sved-Williams, Powrie & van Doesum 2012). In a review commissioned by RANZCP it was concluded that infants of depressed mothers show fewer emotions, the mother may exhibit intrusive parenting, be less involved, less responsive, more hostile and irritable. Evidence concludes that the best preventative interventions for preschool children include family support and parenting interventions, that have been shown to prevent the onset of emotional and behavioural issues (Sanders, Ralph, Sofronoff, Gardiner, Thompson, Dwyer, & Bidwell 2008; RANZCP 2010).

Prevention is likely to have its greatest



impact in young children due to the considerable potential to reduce long-term, as well as short-term issues (Murray & Cooper 1997). Mental disorders have been reported to have caused the highest burden of disease among children (Kowalenko, Mares, Newman, Sved Williams, Powrie & van Doesum 2012).

Background and Rationale for Study Tour

The authors undertook an international study tour meeting with staff in Finland, Belgium and the Netherlands to investigate approaches and interventions in prevention, and early intervention for children of parents with a mental illness. The study tour focussed on:

- ❖ Reviewing current interventions and treatments for children of parents with a mental illness;
- ❖ Examining treatments and interventions used in mother and baby mental health units;
- ❖ Discussing policies and processes that have enabled services to roll out their family interventions nationally; and
- ❖ Exploration of training and staff development approaches.

The Netherlands is a small densely populated country in north western Europe. Since the late 1980s there has been a large focus on preventative mental health which has led to the development of a national prevention program for children of parents with a mental illness. The Netherlands' Kinderen van Ouders met Psychische Problemen (KOPP) Programs have over twenty years of evidence of positive outcomes for supporting children of parents with a mental illness. This multi component program includes a wide set of interventions that addresses evidence based risk and protective factors. The interventions are for children of all age groups, parents and families. More recently guidelines have been introduced which state that adult mental health workers should check on the wellbeing of children in families where there is adult mental illness.

In Finland, in 2001, the countrywide Effective Child and Family (EC&F) Programme was launched. The goal was to implement preventive child mental health interventions in health services that

were treating adults/parents with mental illnesses. Research, training and programs were implemented countrywide. The Let's Talk intervention was developed as part of this program.

In Finland 97 percent of pregnant women visit community based maternity clinics. Women are routinely screened for depression and screening for paternal depression is increasing. Parents and families at risk are then supported within the community or referred to infant psychiatric units and adult psychiatric services.

In Finland both the Child Welfare Act and the Health Care Act state that the need for care and support for a child must be investigated and safeguarded when the child's parent is receiving treatment for a mental illness and where the parent's capacity to provide child care may have deteriorated (Ministry of Social Affairs and Health 2010, Finland-Child Welfare Act; Ministry of Social Affairs and Health 2010, Finland Health Care Act). The existence of this legislation has been instrumental in the 'Let's Talk about the Children' intervention being widely accepted and utilised as a prevention method. The Finnish program 'Let's Talk about the Children' developed by Tytti Solantaus is an intervention that focuses on children and offers support to children and parents in parenting with a mental illness.

In Belgium eight family organisations that provide care for families where there is parental mental illness, have formed a

collaborative partnership. This service is called the Family Mental Health Platform; it promotes family-friendly care by having a focus on the children of parents with a mental illness and brings services together with a united plan.

Finnish and Dutch Interventions

Let's Talk

'Let's Talk about Children' (Let's Talk) is a brief, evidence-based intervention that trains professionals to have two to three structured discussions with parents who experience mental illness about parenting and their children's needs. The aim is to make these conversations a routine part of the alliance between parents and professionals. The wellbeing and development of children is discussed and how the children understand the parent's mental illness and its possible effects. Evidence from families completing the program show a decrease in children's emotional symptoms, anxiety and hyperactivity and an improvement in children's prosocial behaviour (Solantaus, Paavonen, Toikka & Punamäki 2010).

Let's Talk is suitable for professionals in adult mental health settings, primary health care, non-government organisations, child mental health and child and youth services. Let's Talk supports healthy parent-child relationships and promotes protective factors for the child's wellbeing.



Vertti Groups

The Vertti multi family support group is an intervention used in communities mainly in the south of Finland and also in Sweden. The goal of the Vertti groups is to support families when the parent has a mental illness.

KOPP Programs

KOPP Programs are a range of programs established as preventative and early interventions to support children whose parents have a mental illness. There are a variety of programs running in the Netherlands including: KOPP parent baby intervention (see below), and Child Talk. There are a range of children's groups for children of various ages. Squeak Said the Mouse is a program for four to seven year olds of families with stress. Other groups exist for ages 8-12, 12-16, 16-25, and 25+. All groups support children who have a parent with a mental illness. Groups provide support, encourage the expression of feelings, teach coping skills, and help with self esteem. There are also numerous parent groups that run parallel with the children's groups that support parenting.

KOPP Parent Baby Intervention

The KOPP Parent Baby Intervention, developed in the Netherlands by Karin van Doesum and Carla Brok is an early intervention program for depressed parents and their infants. It involves eight to ten home visits where parent-infant interaction is videoed. A multi-disciplinary team analyses the video tape focusing on parental sensitivity to the infant's needs and cooperation versus interference. The home-visitor professional then chooses strategies to achieve these goals and fine tunes the intervention to the parent's needs. For example, helping parents to expand communication behaviours, encourage partner support, cognitive restructuring, baby massage and practical support. This intervention has been introduced in the Netherlands as part of a national multi-component program to reduce the risk of psychiatric and social problems in the children of parents with mental illness. An effect study undertaken by van Doesum in (2008) on the KOPP parent-baby intervention showed that children in the intervention group demonstrated significant improvement of the quality of the mother-baby interaction, increased secure attachment and social emotional competence.



Prevention Program for Pregnant Women

In the Netherlands, a prevention program for pregnant women aims for the early detection of psychiatric disorders and promotes healthy pregnancy. This intervention provides psycho-education, medication and treatment information, provides preparation for delivery, education on child development and parenthood, social support, stress management and relaxation. Women are also supported through attending the 'POP-pol' clinic. This clinic incorporates visits from a psychiatrist, obstetrician and paediatrician to support women with psychiatric disorders. Parents are also eligible for the parent baby intervention after birth.

Web-based

In the Netherlands, a number of web-based services have been established to support parents and children where there are mental health and/or addiction issues. These include online self-help courses, closed group forums, resources and lived experience stories. Examples of these web-based services include www.kopopouders.nl, www.Kopstoring.nl, www.drankjewel.nl, www.familievan.nl and www.survivalkid.nl.

Existing Australian Initiatives and Frameworks

The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) was established to help meet the needs of professionals and people with a lived experience of parental mental

illness and their children. AICAFMHA actively promotes the mental health and wellbeing of infant, children, adolescents and their families. AICAFMHA secured funding from the Australian Government in 2002 to implement the COPMI national initiative and has continued to support the initiative. COPMI has established an international reputation as a centre of excellence for promoting better mental health outcomes for children of parents with a mental illness.

COPMI is a national initiative that is funded by the Australian government. COPMI develops information for parents, families, children, and professionals. Information is developed with the goal of fostering better mental health outcomes for children of parents with a mental illness. COPMI develops training courses and resources for professionals to support families. Resources are developed with the assistance of persons who have a lived experience and in consultation with researchers and service providers in the field of mental health.

Throughout Australia there are national policies and frameworks that have been developed to guide organisations in the support of children of parents who have a mental illness. These include: A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers (2013), The National Framework for Protecting Australia's Children 2009-2020 (2009), Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health (2009-2014), and the National Practice Standards for the Mental Health Workforce (2013).



Australian National Prevention Programs

National Perinatal Depression Initiative

The National Perinatal Depression Initiative (NPDI) was created in 2008, when states, territories and the Federal Government agreed to collaborate on the initiative. The aim of the initiative is to improve the prevention and early detection of antenatal and postnatal depression and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression.

Key elements of the initiative include:

- ✧ Routine and universal screening for perinatal depression – using the Edinburgh Postnatal Depression Scale and a psychosocial screening tool;
- ✧ Providing follow-up support and care for women assessed as being at risk of or experiencing perinatal depression;
- ✧ Developing and providing workforce training and development for health professionals involved in the care of perinatal women and their babies;
- ✧ Ongoing research and data collection;
- ✧ National guidelines for screening for perinatal depression and treatment of perinatal depression have been developed by beyondblue. <http://www.beyondblue.org.au/resources/health-professionals/clinical-practice-guidelines/perinatal-clinical-practice-guidelines>; and
- ✧ Raising community awareness about perinatal depression.

COPMI National Prevention Programs

The Let's Talk intervention was launched as a new e-learning program in 2015 by

COPMI Australia. Our aim is to introduce a similar training program through our work at AICAFMHA/COPMI Australia and at our local health networks.

Study Tour Findings

There is an extensive range of public health prevention services that include a child perspective when a parent has a mental illness. In Finland, the Netherlands and Belgium these services are provided free and have good outcome data. Collaborative partnerships have been formed between mental health, drug and alcohol and numerous health, child and family organisations.

A whole of country approach to staff training around preventative intervention has been established in the Netherlands and Finland.

In Finland maternal child and family health clinics have a large focus on mental health and wellbeing. The Let's Talk intervention has wide-spread use and is used early in the treatment process. Services have been diligent to continue organisational change to include a child perspective in relation to adult mental illness.

Successful evidence exists on numerous preventative programs for children of parents with a mental illness. The use of these interventions has been supported by child care and health care legislation in Finland.

Conclusion and Recommendations

Preventative work in Australian health care settings is in its infancy. In order for uniform change to occur, policy and legislation needs to be developed on a national level. Significant evidence exists on the possible impact of parental mental illness on children. It is imperative that workers and parents start to understand how parental mental illness symptoms may impact on children and the importance of offering a whole of family service. Services need to work together to allow this organisational change and all mental health and drug and alcohol services should include a child perspective in discussion with patients.

Promotion throughout health, education

and welfare settings about the importance of supporting children when a parent has a mental illness needs to be seen as a priority. A nationwide approach that raises awareness of the impact of parental mental health on children, collaboration between all services caring for parents, children and families and training in interventions to support children and families will ensure that lessons learnt from the following overseas initiatives are implemented successfully:

- ✧ van Doesum's Parent Baby Intervention that has good evidence could be introduced as a lead on from the National Perinatal Depression Initiative using existing established services and networks.
- ✧ Establishing POP-poli clinics at major birthing hospitals to ensure quality care and referral in pregnancy and postnatally.
- ✧ Maternal child and family health services could incorporate more of a mental health and wellbeing focus for children of parents with a mental illness. The Let's Talk intervention could be implemented as part of the services provided for families.
- ✧ Training programs implemented through a national organisation, such as COPMI Australia would ensure continuity of the training.

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Childbirth And Parenting Educators of Australia Inc



CAPEA goals are to provide:

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A Realistic Guide to PARENTING

Book Review

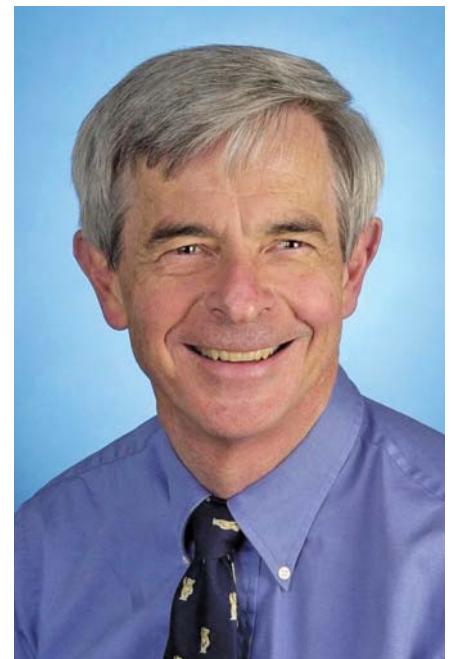
Professor Kim Oates is a **paediatrician** whose professional work has long been associated with the Royal Alexandra Hospital for Children (now The Children's Hospital at Westmead) and the University of Sydney, where he is an Emeritus Professor. He has received numerous awards including the Kempe award from the USA for 'Outstanding contributions to the community on behalf of children', the 2006 Alumni Award from the University of Sydney and The **Howard Williams Medal** from the College of Physicians for 'Outstanding contributions to Paediatrics and Child Health in Australasia'.

How does a parent know if the job they are doing is good enough? Everybody always has an opinion on parenting, and many people are not shy about sharing their opinions either. So how do parents, especially new parents, navigate their way through the minefield of bad advice and half-truths from nanna, Uncle Pete, their mother-in-law and the myriad other 'experts' out there?

Here is a list of ten pieces of parenting advice. Which do you consider true and which are false?

1. Aim for perfection when parenting
2. Love is important; don't give it away lightly
3. You can train your children to be the way you want them to be
4. You should only need to say it once
5. Television is a useful baby sitter for toddlers
6. Children are too immature to have serious opinions
7. Always give your children as much help as possible
8. Discipline stifles creativity and isn't necessary in a loving family
9. Childhood experiences are easily got over
10. Parents need to rule the roost

All ten statements above are **FALSE** and examples of the bad parenting advice that is frequently handed out to new parents says Prof Kim Oates, paediatrician, Emeritus Professor at the University of Sydney and



Professor Kim Oates

former CEO of the Children's Hospital at Westmead.

"In a career spanning (40 years), I've never met a parent who doesn't want to do a good job," says Prof Oates. "The problem that parents face today is the high expectations they and others have of doing a really good job. This makes them feel inadequate."

In his new book, **20 Tips for Parents: The realistic parent's guide to understanding and shaping your child's behaviour** (July 2014), Prof Oates explains why the advice above is wrong and goes on to give twenty practical tips that really will make a difference to your parenting skills and strategies.

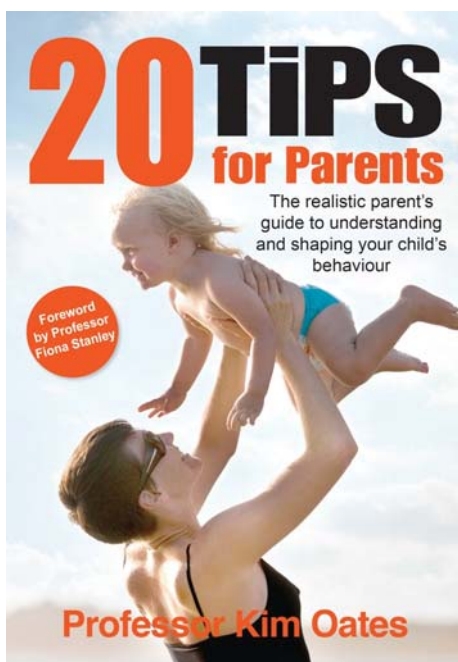


Prof Oates' 20 tips for parents

- Tip 1** You only need to be a “good enough” parent
- Tip 2** Love unconditionally
- Tip 3** Understand why you are like you are
- Tip 4** Know about normal behaviour at different ages
- Tip 5** Be authoritative, not authoritarian
- Tip 6** Understand your child’s temperament
- Tip 7** Separate the behaviour from the personality
- Tip 8** Understand attention-seeking behaviour
- Tip 9** Have realistic expectations
- Tip 10** Give praise where it is due
- Tip 11** Respect your child’s views and opinions
- Tip 12** Communicate clearly and without ambiguity
- Tip 13** Save your energy for what really matters
- Tip 14** Deal with conflict between siblings
- Tip 15** Use discipline that works
- Tip 16** Avoid the types of discipline which don’t work well
- Tip 17** Control TV and other screen time
- Tip 18** Let your child play
- Tip 19** Teach your child responsibility
- Tip 20** Set a good example

"The good news is that parents don't have to be perfect. They don't even have to be almost perfect. Rather, they just have to be a 'good enough parent'".¹

"Children need love, clear boundaries, consistent rules, positive stimulation, nurturing and respect for their feeling. They need these things as much as they can get them. But if you don't manage to supply these needs 100 percent of the time, your children



won't be psychologically scarred for life," says Prof Oates.

The 20 tips he gives in his book may not address all specific problems; however, they are very useful broad principles that do work and can be adapted to most family situations. They are not only helpful but reassuring for all parents. The book also contains features on subjects ranging from: *'The amazing brain of a child'* to *'What parents want for themselves'*, *'The effects of stress on children'* and *'When grandparents don't agree with your methods'*.

¹Child psychologist Bruno Bettelheim originally coined the term *'good enough parent'* in the 1980s, adapting it from the writings of English paediatrician Donald Winnicott on *'the good enough mother'*.

Media

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To set up an interview with Prof Oates and / or obtain a review copy of his book, contact me, Laura Boon, Finch Publishing on 02 9418 6247 laura@finch.com.au



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