

University of South Australia | Australian Centre for Child Protection

Professionals Protecting Children

Nurturing and Protecting Children: A Public Health Approach

UNIVERSITY OF TECHNOLOGY SYDNEY

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THE IAN POTTER FOUNDATION

Improving the lives of vulnerable children

Nurturing and Protecting Children: A Public Health Approach

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FOREWORD

Nurturing and protecting children is a fundamental moral obligation which all humans share. The recognition of this moral obligation, as well as a growing understanding that children are holders of human rights, is leading professions to accept their duty of care to children. Nurses and midwives are especially well placed to enhance the wellbeing of children and families given the range of acute and primary care settings in which they work, and their trusted and respected role in the community.

The resources in this manual and the accompanying DVD have been designed to support nursing and midwifery students and practitioners to develop the values, knowledge and skills necessary to prevent child abuse and neglect and enhance the ability of families to nurture their children. Based on both research and the practice experience of nurses and midwives, we hope the resources will stimulate and inspire those who use them.

As governments in many jurisdictions strive to go beyond responding to the problem of child abuse and neglect with policies based only on 'identify and notify' measures, and to build the capacity of all service providers in prevention and early intervention, these resources are very timely.

Child maltreatment covers a broad range of problems, which often co-exist. While child physical and sexual abuse tend to have a high public profile, child neglect and emotional abuse are the most common reasons for children entering statutory child protection systems. All forms of child maltreatment can lead to serious long-term consequences for children, and this is especially so when children are exposed to multiple and cumulative sources of harm. While we now know a great deal about the risk and protective factors relating to child maltreatment, the knowledge base which can inform our response once it has occurred, is still in its infancy. This is why prevention is critical.

The resources are based on a public health approach to enhancing child wellbeing and reducing child abuse and neglect. Such an approach seeks to intervene early in the causal pathways of problems by reducing the underlying risk factors and strengthening key protective factors, whether that is at the level of services to individual families or broader population-based measures. For example, from a public health perspective, the risk factor of parental alcohol abuse and the protective factor of social support, need to be tackled at both individual and community levels if we are to make real progress.

Ultimately, if we are to fulfill our moral obligation to nurture and protect children we must all work together to place children at the core of our culture. Let us do this.

Emeritus Professor Dorothy Scott
Australian Centre for Child Protection, University of South Australia

INTRODUCTION

This teaching and learning resource has been developed to support the *Nurturing and Protecting Children: Nursing and Midwifery Curriculum Standards.* The modules can be implemented as stand-alone sessions to form a subject within your curriculum or the resources and activities can be integrated with other appropriate education sessions.

The following from the *Nurturing and Protecting Children: Nursing and Midwifery Curriculum Standards* are the recommended teaching and learning outcomes for pre- and post-registration nursing and midwifery curricula. These outcomes provided the foundation for the development of this resource.

The Teaching and Learning Outcomes in this resource are mapped against the ANMC National Competency Standards for the Registered Nurse (4th edition) and for the Midwife (1st edition). Educators are strongly encouraged to review current course components against the *Nurturing and Protecting Children: Nursing and Midwifery Curriculum Standards*.

Prevention/Professional Preparation

In respect to nurturing and protecting children, the nurse or midwife graduate will be able to:

- Articulate, support and advocate for the rights of children
- Demonstrate an understanding of the need to support and promote the family unit and its importance to the child's wellbeing through trusting relationships and strengths-based approaches
- Articulate the importance of having a primary health care approach to child nurturing and wellbeing
- Respect and work within understandings of cultural safety and cultural and family diversity
- Articulate and respect the history and culture of Aboriginal and Torres Strait Islander Peoples
- Articulate and respect the political, social, cultural and historical issues of family separation and displacement for relevant groups and communities
- Demonstrate engagement in critical reflection on child wellbeing and a commitment to lifelong learning in this area.

Early Intervention

In respect to nurturing and protecting children, the nurse or midwife graduate will be able to:

- Demonstrate an understanding of risk and protective factors for child abuse and neglect
- Identify strategies and opportunities to strengthen protective factors and reduce risk factors for child abuse and neglect at individual family and community levels
- Demonstrate an understanding of the legal context for nursing or midwifery practice in child protection in Australia and the legal and ethical responsibilities of nurses and midwives in relation to child protection, including the relevant legal reporting responsibilities of nurses and midwives
- Demonstrate communication skills to build rapport with children and families to: enable sharing of information; enable disclosure; and to challenge inappropriate behaviour
- Demonstrate the ability to work in partnership with families and provide timely and appropriate information to children and families in a respectful and confidential manner
- Explain and demonstrate awareness of the importance of providing continuity of care to children and families.

Response

In respect to nurturing and protecting children, the nurse or midwife graduate will be able to:

- Integrate an assessment of child and family wellbeing into a nursing or midwifery assessment
- Plan and provide nursing or midwifery care that takes account of child and family health and wellbeing
- Collaborate effectively with multi-agency/interdisciplinary teams of health, education and social service sectors and organisations in the provision of nursing or midwifery care related to child and family health and wellbeing
- Recognise and act appropriately when children and their families are at significant risk of child abuse and neglect
- Demonstrate knowledge of the processes of identifying and responding to risk of or actual child abuse or neglect
- Demonstrate knowledge of legal and professional responsibilities in relation to responding to and reporting of child abuse and neglect.

Structure of the resource

This resource package consists of 10 modules:

Module 1:	Nurturing and Protecting Children: Identifying Risk and Protective Factors
Module 2:	Reflecting on Practice, Learning Together and Supporting Each Other
Module 3:	Supporting parents and families to nurture and protect their children
Module 4:	Supporting fathers to nurture and protect their children
Module 5:	Support groups: building social capital and reducing social isolation
Module 6:	Supporting Parents and Families in Aboriginal and Torres Strait Islander Communities
Module 7:	Supporting young mothers (and parents) to nurture and protect their children
Module 8:	Supporting families where a child or parent has a disability
Module 9:	Support for women and families experiencing mental illness
Module 10:	Families on the edge: working with complexity

Each module is linked to video segments (provided on the included DVD or via the internet), trigger questions and activities that have been developed to support the achievement of the *Nurturing and Protecting Children: Nursing and Midwifery Curriculum Standards*. To assist with session planning and student discussion the transcript for each section of the DVD is provided at the completion of the module. This enables educators to read the text and decide whether this would be useful for the teaching and learning outcomes they have planned.

suggested resources and websites have been provided in each module. These offer a range of additional information and resources. It is anticipated that educators will continue to update and/or develop additional resources to support the inclusion of the curriculum standards within their teaching activities to ensure they remain contemporary and relevant.

Caring for students and educators

The focus of the activities in this resource encourages students, with the support of educators, to explore numerous confronting and emotive issues. Unfortunately, for some students and educators this may raise issues from their past and/or current family situation.

It is strongly recommended that the educator, prior to implementing these modules, identifies support systems within their organisation to manage student or educator distress or concern.

As part of the introduction to the session the educator may choose to identify that the content of the session may raise issues or concerns for the student due to their own experiences of being parented or as a result of a personal relationship.

MODULE 1:

Nurturing and Protecting Children: Identifying Risk and Protective Factors

Nurturing and protection of children are the most important parenting responsibilities. Midwives and nurses play a significant role in supporting parents and modeling appropriate behaviours.

Unfortunately, many families experience extreme stress that can result in some children experiencing neglect and/or abuse. This module aims to raise awareness for nurses and midwives regarding many of the issues that place children at risk.

Learning outcomes

On successful implementation of this module, students should be able to:

- Discuss what is meant by a 'public health approach to nurturing and protecting children'
- Identify family protective factors that enable parents to provide a nurturing environment for children
- Identify family risk factors that place children at risk
- Discuss the notion of resilience
- Explore the role of midwives and nurses in facilitating the nurturing and protection of children
- Identify their duty of care to the child
- Discuss sensitive measures that can be put in place to respond to parents' grief when a baby or child is placed in care
- Identify local statutory processes related to child protection.

Important note to educators:
Unfortunately, it is common for some students in every course to have experienced trauma due to child abuse and/or neglect, domestic violence. They may have a family history of mental illness or have experienced other types of traumatic event (death of a child or parent). Acknowledging this at the beginning of the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students.

DVD section 1.1: Nurturing and protecting children: a public health approach

In this introduction to these resources, Emeritus Professor Dorothy Scott from the Australian Centre for Child Protection provides an overview of the issues related to nurturing and protecting children. Professor Scott has worked in this field for more than 30 years and has considerable expertise in helping others to develop skills and capacity to identify risk and protective factors.

A hard copy of the slides used in Professor Scott's presentation is included in this Module Guide.

Trigger questions

One teaching and learning strategy would be to break the class into groups of 6-8 students and work through the following trigger questions and activities.

After viewing this first section in this section of the DVD discuss with the students:

- What is a public health approach to nurturing and protecting children?
- What reforms are needed to our current health services and systems?
- During Professor Scott's presentation she compares a picture of smiling Aboriginal children with a picture of other children. When showing the picture of the smiling Aboriginal children she refers to the disadvantage of Aboriginal children and their families, consider: what this might mean and how we as nurses and midwives can work to address these inequities at a local level?

Activity/assessment: 'A stitch in time saves nine'

The following activity can be used in several ways as: a focus for a tutorial, an online student discussion or as an assessment.

Direct students [individually, in pairs or in small groups] to the website of the National Child Protection Clearinghouse (Australian Institute of Family Studies, Australian Government) http://www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html

Ask students to read the article *A stitch in time saves nine: preventing and responding to the abuse and neglect of infants* (written by Brigid Jordan and Robyn Sketchley).

The activity or assessment task is to identify and discuss:

- reasons why a public health model is important in nurturing and protecting children
- how a public health model approach might apply in your individual working situation.

To conclude this activity, provide an opportunity for students to present their ideas/findings to the larger group or online.

DVD section 1.2: Understanding risk and protective factors: the potential role of midwives and nurses

Midwives and nurses have a key role in supporting parents to care for their children. An awareness of protective and risk factors that impact on families with children is crucial. In this section, some of the main issues will be explored. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing this second section in the DVD, provide time for the students to address the following questions:

- What are the protective and risk factors for children and their families?
- What is resilience – how would you define the term?
- Does resilience look different to different people?
- How can they as nurses and midwives support children and families to develop resilience?

To conclude the activity, discuss with the students their findings in the larger group or online.

Activity/assessment: What constitutes 'neglect'?

The following activity can be used in several ways as: a focus for a tutorial, an online student discussion or as an assessment.

Direct students to the following websites in order for them to identify what constitutes 'neglect':

National Child Protection Clearinghouse, Australian Institute of Family Studies, Australian Government http://www.aifs.gov.au/nch/
NAPCAN – The National Association for the Prevention of Child Abuse and Neglect http://www.napcan.org.au/

The activity or assessment task is to identify and discuss:

- scenarios that highlight situations involving neglect
- potential responses by health professionals when managing situations of child neglect
- challenges involved when identifying child neglect and supporting parents to ensure appropriate interventions are implemented.

To conclude the activity, provide an opportunity for students to present their ideas/findings to the larger group or online.

DVD section 1.3: Duty of care to the child

Frequently midwives and nurses experience challenging situations in the care of families. They want to support the parents but may also identify that the child may be at risk of emotional and/or physical harm. Midwives and nurses must be confident about how they will address situations where parents and others make disclosures about potential or actual harm to children. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing this second section discuss the following questions with the students, either in small groups or in the larger class:

- What is meant by the term 'duty of care'?
- What is your duty of care to the families you care for?
- What is the action to be taken when potential or actual harm to a child is identified?
- What are the relevant child protection legislation, policy and/or guidelines in your state and territory? How do these influence you when you work with families?

Activity: Vulnerable children – health professionals working together to keep children safe

This activity requires the students to access an interactive website developed for the Department of Health in Victoria: http://www.vfpms.org.au/childrenatrisk/vuln.htm

The website is an easily accessible and easy-to-use learning resource with a series of interactive, hypothetical case studies. It assists health professionals to develop their skills in identifying vulnerable children and appropriate courses of action. The theme of the learning resource is 'Ask, Listen, Record, Share.'

The Modules are:

- Who are the Vulnerable Children?
- How do we recognize Vulnerable Children?
- What is My Role?

Although this website is designed for individual health professionals, it would be possible to use it in a classroom situation where there is access to projecting online resources. This might involve working through the hypothetical case studies and directing students to discuss responses in small group activities.

To conclude the activity, facilitate a general discussion about each scenario and the issues that have been identified.

It is important to ensure the students are aware that statutory obligations differ in each state and territory. An essential part of this activity is identifying those obligations and making sure that the most up-to-date documents are sourced.

If individual students work their way through this learning resource in private, on conclusion they are able to download a certificate for their Continuing Professional Development Record.

Activity: The Convention on the Rights of the Child

The Convention on the Rights of the Child is an essential document to guide midwifery and nursing practice. Discuss this convention with the students.

To support your discussion a summary of the *Convention on the Rights of the Child and Myths & Facts Concerning the Convention on the Rights of the Child in Australia* are available on the following site:
http://www.earlychildhoodaustralia.org.au/childrens_rights/un_convention_croc/un_convention_croc.html

Case studies to promote discussion

In facilitating a discussion about these case stories, as an educator it is important to recognise the diversity of views and experiences that the students will bring to their responses. Some will be shocked by the second case story, while for others it could be a familiar scenario. Some students may come from challenging family situations themselves and will react in a more personal way. Later modules in this Package address issues of support for oneself. In particular, see Module 2 Reflecting on Practice, Learning Together and Supporting Each Other. We recommend that you use Module 2 to ensure that the students are also supported in addressing these challenging issues.

Case study 1

Josie is a second time mother. She has been coming to see you on a regular basis for several months. Her baby and toddler are always beautifully dressed and clean. You have noticed that the snacks she brings for the toddler are appropriate for his age and healthy. Josie is still breastfeeding her infant.

When the baby is about 12 weeks old you start to notice that Josie seems very tired and does not smile as readily as she used to a couple of weeks ago. The toddler's behaviour is a bit erratic during visits and he has become demanding. You find out Josie has stopped her regular attendance at a playgroup for children with multiple vulnerabilities.

How would you approach this situation?

What strategies would you use to encourage Josie to talk with you?

What protective factors can you identify for the children?

What potential risk factors can you identify?

What supports in your local community could you suggest this mother might find useful?

Would you make a child protection report on this family? If so, on what grounds would you make the report [given the limited information you have about the family]?

Case study 2

Peta has just left the maternity unit after giving birth to twin girls. When you visit her at home 2 days later you find that she is living in one room in a boarding house. She only had a mattress on the floor and the twins were sleeping with her. The room was very cold and there did not seem to be very much food in the fridge when you made a cup of tea. She tells you her mother lives close by and she will visit regularly to help.

How would you approach this situation?

What protective factors can you identify for the twins?

What risk factors can you identify?

What supports in your local community could you use to improve the situation for this mother and her twins

What strategies might have been in place to recognise this situation earlier?

The immediate concern would be to find more appropriate housing for this family – what strategies would you use to address this housing need?

Would you make a child protection report on this family? If so, on what grounds would you make the report [given the limited information you have about the family]?

Note to Educator: nurses and midwives may not think that assisting with housing needs and food security are part of their remit. However if we are using a public health approach, acting as a facilitator to enable the fulfillment of basic needs is an essential component of our role.

DVD section 1.4: When a baby or child is placed in care

Midwives and nurses are sometimes present when a child is removed from the custody of their parents and placed in care. This can be a distressing time for all involved in the process and nurses and midwives are often left supporting the family after the event has occurred. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing this section ask the students to reflect on:

- The parents' experience of having a child taken from their custody.
- How they may feel when they are involved in this removal process as a nurse or a midwife?

Activity/assessment: Review of a protocol

This activity requires students to review a protocol or guideline for 'The care of a family following stillbirth or neonatal death' from a local maternity unit.

After listening to Margaret Spencer on the DVD, what changes would you make to this document if it were to be used to address the care of a woman and her family when a newborn baby is placed in care?

Activity/assessment: Legal aspects related to child protection

Ask students to form 3 or 4 groups. Each group is to examine the state legal aspects related to child protection. The four areas to concentrate on:

- Mandatory reporting
- The process of placing a child in care – including the legal process around this action
- The placement of children in foster care – the legal rights of: biological parents; their families; and foster families
- The process of return of children to their biological parents.

Each group is to take one of these four aspects and prepare a presentation and handout for the rest of the class.

Resources

Arney, F. & Scott, D. (2010), *Working with Vulnerable Families - A Partnership Approach.* Melbourne: Cambridge University Press.

Donnell M., Scott D.A., & Stanley, F., (2008) "Child Abuse and Neglect – is it time for a public health approach?" *Australian and NZ Journal of Public Health*, 32(4): 325-330.

Scott D. (2010) Working together to support families of vulnerable children *Social Work Now* 45: 20-25. http://www.cyf.govt.nz/documents/about-us/publications/social-work-now/final-social-work-now-april-2010.pdf

Scott D.A. (2006) "Towards a Public Health Model of Child Protection in Australia" (pdf 1.7Mb) *Communities, Families and Children Australia*, 1(1): 9-16.

A Picture of Australia's Children http://www.aihw.gov.au/publications/phe/phe-112-10704/phe-112-10704.pdf
This is a useful document to assist in developing a profile of children living in Australia.

Australian Centre for Child Protection http://www.unisa.edu.au/childprotection/default.asp
The Australian Centre for Child Protection is located at the University of South Australia. There is access to some excellent child protection resources through this site.

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides a starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources is available on this site that relate to the Australian context.

State Child Protection Agencies
Each state has a Government department devoted to the protection of children. These sites provide information about policy and processes. These include:

Child Protection, Family and Early Parenting Services Vic http://www.cyf.vic.gov.au/child-protection-family-services/home

NSW Community Services http://www.community.nsw.gov.au/

NSW Health Keeping them Safe http://www.health.nsw.gov.au/initiatives/kts/index.asp

Families SA http://www.dfc.sa.gov.au/pub/Default.aspx?tabid=257

Department for Child Protection WA http://www.community.wa.gov.au/DCP/

Department of Health and Families NT
http://www.health.nt.gov.au/Children_Youth_and_Families/Child_Protection/Child_Protection_System_Reform/index.aspx

Department of Health and Human Services Tas
http://www.dhhs.tas.gov.au/service_information/services_files/child_protection_services

Child Safety Services Qld http://www.childsafety.qld.gov.au/

National Association for Prevention of Child Abuse and Neglect (NAPCAN) http://www.napcan.org.au/
NAPCAN is a national organisation that advocates on behalf of children and young people and to promote positive change in attitudes, behaviour, policies, practices and the law to prevent abuse and neglect and ensure the safety and wellbeing of Australian children. The site provides access to parenting pamphlets, research findings and links to other like organisations.

Australian Childhood Foundation http://www.childhood.org.au/home/
This Australian organisation provides child protection information and resources. The organisation is actively involved in research and the development of resources.

Communities and Families Clearinghouse Australia http://www.aifs.gov.au/cafca/
The Communities and Families Clearinghouse Australia provides access to evidence about planning and the delivery of services to children and families for disadvantaged Australian communities. Of particular interest are sections on how to engage hard-to-reach families and fathers.

UNICEF http://www.unicef.org/
The UNICEF site provides a global perspective on the needs and rights of children. Information available on the site includes: the state of the world's children and country specific information, and access to the Convention on the Rights of Children.

The Convention on the Rights of the Child was 20 years old on the 20 November 2009, UNICEF dedicated a special edition of its publication *The State of the World's Children* to child rights. In the report the Convention's impact on children's well-being and human development during the past two decades is broadly examined, the critical challenges for the next 20 years are identified and an agenda for action is outlined to ensure the Convention's promise becomes a reality for every child. UNICEF publication The State of the World's Children Special Edition: Celebrating 20 Years of the Convention on the Rights of the Child. The document link is:
www.unicef.org/publications/index_51772.html

Understanding Risk And Protective Factors

DVD transcripts for discussion: section 1.2

Dorothy Scott
Emeritus Professor Australian Centre for Child Protection, University of South Australia

If we think of risk and protective factors as part of a public health way of thinking then we realise that each one of us has risk factors and protective factors in relation to a whole range of physical conditions and in relation to emotional wellbeing. And that any one risk factor should not be given too much weight and be seen as loading dice toward pathology or dysfunction.

So for example, the risk factor of poverty. Families where there are warm and enduring bonds, where there is high morale, where there is a deep commitment to their children, may be embedded in strong extended family networks which are much richer and much more supportive than the social networks of a family which is far more affluent in the material sense but is actually devoid of extended family structure and where those qualities within the family may be absent.

So in relation to any one risk factor, whether it's poverty, whether it's social isolation, whether it's a parent's history of mental illness, we need to be very careful that we don't slip into thinking about deficits. We also need to understand that we all carry risk factors but these don't always get expressed as problems because the protective factors are buffers. And so it's on building the protective factors impact that we can often have the greatest impact. Because sometimes we can't do a lot about the risk factor if someone brings to parenting a childhood experience of their own of poor nurturing. We can't undo the history but can build on the protective factor of attachment, through a very nurturing and sensitive relationship, say by a midwife and this pregnant woman and a continuity of care, that can help create a level of parent/infant attachment in this family which is stronger than in the family of origin of this mother. So understanding the protective factors: that's the foundation on which we build to prevent child abuse and neglect.

Resilience: 'the capacity to bounce back'

Resilience is something that these days people have spoken and written about. Fundamentally it's the capacity to bounce back or respond to adversity. We all face adversity. Often if we look at what enables someone to respond positively to adversity, we find that they bring with them from their own family backgrounds experiences, which help them to form healthy relationships, to seek and be able to use help from others. And some families where there is greater vulnerability have had experiences in childhood where it's harder to trust, where people have left you, have abandoned you so for a midwife or nurse to form an effective partnership with a vulnerable family, them may need to persist in engaging. They may need to reach out with greater warmth and with a greater commitment and not be put off by behaviour that might say, 'Go away… I don't need you'. If that 's the message that you're getting it may be that you're needed more than ever. And that by offering that relationship based on trust, on empathy, the respect and honesty, that you can actually create resilience and nurture resilience in families that have not yet been able to acquire that. That's an extraordinary gift!

'Insatiable curiosity': making judgments and avoiding assumptions

Cathrine Fowler
Professor of Child and Family Health

Midwives and nurses have been often told to be non-judgmental. It's written in every textbook. But I get very concerned about that because I think it's our role to make judgments, particularly in the area of child abuse and child protection. We really need to…rather than not be judgmental, we need to put a brake on our judgments, and before we go in to see a parent or a family, to make sure that we leave our assumptions at the door and not take those stereotypes and assumptions with us to inform our practice. I think that that's really important. And I was reading the other day a really interesting quote and it said that nurses need to have an 'insatiable curiosity' about the people that they're working with.

And I think that that's a really important thing; because then we can find out about the histories of the families. And often these histories are quite painful and quite painful for us as nurses and midwives to have to deal with.

Insatiable curiosity helps you to uncover some of the hidden histories that we really need to know about as CFH nurses and midwives. It's not that we want to be 'sticky beaks' or get pleasure out of knowing those difficult histories. But we need to have a context from which we work with parents. We need to know if a mother has been abused herself because that's going to really impact on the way that she parents her child. Or if a father has been physically abused as young boy – maybe his anger control mechanisms are not well refined and he's going to need some support and help with that when he becomes a parent. And often when parents do abuse their children – and this is not to forgive them for doing that - but we need to understand often it's out of fear because that's their default and that's what happened to them. It can be really difficult and they often feel very guilty, and particularly if they disclose to you as a nurse or a midwife, you need to be able to take that in the spirit that it was offered to you. And that certainly is – you have to constantly keep in mind the protection of the child.

Duty of Care to the Child

DVD transcripts for discussion: section 1.3

Cathrine Fowler
Professor of Child and Family Health

We have a duty of care to the child, and they must be foremost in our mind. That can be often difficult when you're dealing with a parent and you're hearing a very difficult story about what's happening in their lives. But the constant script that's got to be running in your head, 'Is this child safe?' 'Is this mother or father safe' 'Is this family safe'. If there are other children,' what's happening for them?' So we really need to be 'with' the parent and the child constantly.

When we're not sure a child is safe

Often we're in situations around duty of care where a mother discloses something to us that worries us because it does sound like it could be a Child Protection issue but it's not quite there. And you're left in this sort of limbo as to whether you should report this child or this parent or whether you should just file it away for the moment, but be aware of that - check out that the child is safe and continue on. It's not always clean cut. In those situations, I would certainly be checking out how safe the child is and the mother or the father are and other children but I would also be going off and talking to my manager or my supervisor, and making sure that my judgments are right, and that I'm picking up what I need to be picking up.

Making a report: honesty and sensitivity

I think for many of us the dilemma when you work with really vulnerable families is that they've already been reported, they've come to you and they're wanting support, and you worry that if you do report them again you're going to loose them, and they're not going to come back. Really, you're the one who's the professional, you must fulfil your legal responsibility but you must do that in a way that is with an awareness of the feelings of the parent. And certainly, unless you're at risk, physically, you really need to be talking to the parents, and tell them what your actions are going to be.

If you're going to make a report about a child you have to be really open with the parents. And often the parents are quite accepting of it. They've told you because they want some help; they're reaching out for you.

Trudy Allende
Aboriginal Health Education Officer

I guess somehow we deal with any disclosure issues. We have a really open and honest relationship with our clients. And we let clients know if Community Services are contacting us and want information and vice versa. We try to keep that really open. So we can work with Community Services and work with the families to get to the underlying issues and how we get around that so really important thing to be open and let the families know what's happening when they're happening. Let them know if Community Services are wanting to talk to us and that we have to talk to them. 'This is what their issues are and what are your thoughts on that?' And we make sure that they're involved rather than leaving them out of the loop, making sure they understand what's happening. So we can try to fix the problem before it becomes an issue.

Sometimes the issues that Community Services see aren't what is really going on in the family so that's really important to get to the root of that. And then I guess we're advocates for our women. When we believe that there's people worth fighting for and they can be helped and there's issues, then we help our women. It's all about trying to keep the family structure together. And putting in as many support structures as we can to help that, make that happen I guess.

The role of mandatory reporters

Leona McGrath
Midwife

When we're concerned about children or the woman while she's pregnant, the unborn child, like Trudy said, we are always open and honest with our women; as mandatory reporters. We tell them that we are mandatory reporters. If we do have to contact Community Services, we will let them know. But we won't keep anything from the women. We're always honest with them and we're saying we will try anything if we can and if we see a woman has a chance of keeping her baby then we will fight to [Trudy interjects] put things in place to really help her. We aim for the best outcome.

Trudy Allende

We always put something in place so we're not just saying to them, 'People are concerned' so that it's a whole big worry, we actually try to address those concerns so they've actually got something they can fall back on. And then seek help in, as opposed to saying that's the way it is – you know we offer them help. And find that help if it's not immediate and straight to us, we look to see where we can get that expertise. Because we think that it's really important that those issues are addressed. And that we try and work it out to keep our families together if that's what's best for our families.

Julie Corkin
Child and Family Health Nurse

My parents know that I'm a mandatory reporter at the beginning because I tell them that that's part of my role, that it's confidential the information that they share with me, that we sign a confidentiality form, and it states there that if for any reason that I have to notify thing, I'm a mandatory reporter. So most of clients would know that from word go if they share the information with me then they know that legally I'm required to report.

When a Baby or Child is Placed in Care

DVD transcripts for discussion: section 1.4

Trudy Allende
Aboriginal Health Education Officer

Leona McGrath
Midwife

Trudy: With the removal from families it's a really, really tough one in communities – in any situation whether you're Aboriginal or not, it's a really, really hard thing to deal with, and as I said, having kids myself, I feel what parents are going through. And I guess a lot of things that we look at, because we deal in that caseload midwifery, and because we do have all those people that are helping out, I think it's really important to use their expertise as well. So it's a matter of that collaborative approach. And also I think it's important – I know my role is talking to the families and basically working out how it got to that position in the first place and how do we – we try not to let it get to that position because of the team we've got and how we do work closely – that's one of the things we try really, really hard with. But if it does happen we try really hard to work out why, getting to the bottom of it and helping the parents and the families understand and things like that.

Leona: We had a young girl lose her 3 children last year which… it' really hard, yeah, really hard to deal with yeah, on a daily basis. But we put programs in place for her because DOCS required – or Community Services required all these – they put down that she had to do parenting classes. So we organised cooking classes for her and all these other things where we could help her to try and get her children back. We still kept in contact with her as much as we possibly can. And that's where… Trudy does a lot of that work; for the midwives that's sort of outside our scope. So Trudy does most of the work in that area. But yes, it's really difficult. And there's not one clear answer to it. Every situation's different. It's hard.

Dealing with our own feelings of distress when a child is placed in care

Margaret Spencer
Social Worker, Nurse, Academic

Being in a situation where a child is removed is one that – from my own experience of being on maternity wards when that has happened – is one of … there's a lot of stress for the staff. Staff often don't know how to react to this. They've often been the ones that have made the notifications so that there's a sense of concern that the parent might find out that they're the one that had made these allegations about them so that there's a sense of fear about how the parent might react to them. There can be a sense of guilt that, 'I've bought this upon this person, even though, you know, professionally I've had to, morally I've had to.' But still feeling, 'Could there have been another way?' And so often for staff it's, 'What do we do?' And I suppose one way of handling it is to avoid it and let the social workers deal with it but often the parent has had the relationship with the nurses because they're the ones that are there 24 hours a day.

I think what we do know is that where grief of a patient is handled well then for nursing staff particularly they have a sense that they've achieved something. If we look at palliative care, you know, a good death is a good death for the staff too if they've been able to provide the care that they wanted to provide. That they could actually be present to extended family. If they could do those things that showed compassion to the person that was dying, the staff member can have a sense of, 'Yes that was worthwhile, I did my job.' And I think the same with these parents. Instead of treating it like, 'This is an OHS issue, let's just get Security up and we'll all just avoid it', you know, it's about being able to understand, being able to deal with your own feelings in it. So I think for staff when a child is removed by child protection, particularly after birth, that staff need to talk about how they feel about that.

Acknowledging parents' grief when their child is placed in care

Also, I think for the parents to be able to acknowledge their grief. My experience is that what parents find hardest is where people are not understanding that they're hurting. And so for someone just to acknowledge and to be empathetic that this is really tough and that this is really painful is all the parent needs to hear.

I think that as I was saying, around the loss of a child, you know we've become so much more sensitive to issues say around mothers who have a miscarriage, a stillborn child, a child who dies after birth; and in terms of putting protocols in place, to be sensitive to the grief that those parents are experiencing. You know, we've become much better at that but there's a group of parents that come through our system who have their children removed and their grief is just not even acknowledged. It's as if, because they're a bad parent or a neglectful parent, that their grief is not as legitimate as the grief of a parent who lose their child in some other way. And what we see particularly in this group of parents is there's the unresolved grief and the ongoing grief that sits with these women and has an effect on their mental health.

Sensitivity to Loss When a New Baby is Placed in Care

So it's those things we need to acknowledge in this group. But particularly I think around the grief that they experience, that when their child is removed, that they hurt just as much as a parent whose child has died in utero, or has been born stillborn or who has died afterwards. And for these parents they need to have their grief issues looked at in that context, just as sensitively as we would with other parents.

So I think for staff to be able to do what they would do with another parent who's had a loss. To be able to do things like be part of offering perhaps to, you know, get the hospital camera and take some photos of them and their baby before the child is removed. Some nice things like, when CP is coming to remove the baby from the hosp, to have it planned so that it doesn't become a situation where it has to be an OHS issue around safety and we have to have Security guards around. But to do things like have the time, discharge the mother before the baby's discharged, allow the parents and their extended family to be able to say goodbye, to allow the mother to be able to dress the baby in whatever she wants the baby to be dressed in to leave the hosp, to offer things such as, the nightie that the baby has been in so that the mother can take that with her from the hospital.

To do things like make sure that the cards from the top of the crib are given to the parent, make sure that they do have photos, remember many of these parents are very poor, they don't have resources. So things like to get photos taken, and to have those photos taken. They're just, some of those things that can, for staff can be a way of not [pauses] of not denying what's happening but entering in to what's happening and do that in an empathetic way.

Entering Into the Relationship With a Mother Whose Baby is Being Placed in Care

What we're asking of nurses and midwives when a child is being removed is all of those things that they know how to do with, say a parent who, that they've been taught how to do with a parent who loses a child. This is a loss. It's a different kind of loss but it's a loss. So it's all of those things that they've learnt about respecting the loss, about acknowledging the loss, about ritualising the loss, which are very important. And I think that at the heart of being midwives and nurses, we're good at doing that. So it's really about rather than avoiding that confrontation is to actually enter into that relationship, to enter into that grief as we would with any other mother. And to do all of those rituals that are really important.

Reflecting on Practice, Learning Together and Supporting Each Other

Midwives and nurses require a range of formal and informal self-care strategies to ensure their continuing mental health and to support and maintain both their professional competence and their ability to work effectively with families. Midwifery and nursing work can be extremely complex, challenging and stressful and is influenced by personal experiences and one's own history. The ability to critically reflect on practice is a necessary skill to support an increase in knowledge and skills and to ensure that clinicians are also nurtured and protected.

One strategy that has been implemented to support clinicians is known as clinical supervision. In some health services in Australia, clinical supervision initiatives include midwives and nurses.

Clinical supervision is an ongoing, regular process that allows clinicians to have time to explore a practice experience, learn from the experience and prepare for future similar situations. The process supports the capacity of the midwife or nurse to reflect on practice in a supported and confidential way.

A safe space should be provided so that clinicians can explore issues and concerns related to practice. It enables critical thinking and problem-solving ability. In group clinical supervision, the midwives and nurses are able to share their experience, learn from each other and develop practice insights.

Activities in this session will provide opportunities to discuss potential distress related to the midwife's or nurse's own professional and personal experiences. Importantly, it will enable a discussion about the need to seek professional assistance to manage personal experiences of abuse or trauma that may be raised where a clinician relates closely to the parent's story or experience.

In the video clips for this module, issues are discussed relating to the importance of accessing support and providing peer support. The importance of reflecting on practice and clinical supervision are also highlighted. As described by the clinicians, support and reflection can occur in numerous ways through formal and non-formal activities.

Learning outcomes

On successful implementation of this module, students should be able to:

- Describe the role of critical reflection to enhance clinical practice
- Identify and discuss the importance of clinical supervision
- Discuss the development of a supportive network to maintain their physical and emotional health as midwives and nurses.

Important note to educators:
Unfortunately it is common for some students in every course to have experienced trauma due to child abuse and/or neglect, and/or domestic violence. They may have a family history of mental illness or have experienced other types of traumatic event (death of a child or parent). Acknowledging this at the beginning of the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students.

DVD section 2.1: Support for each other and reflecting on practice

In this first section two crucial midwifery and nursing issues are discussed, that is, supporting each other and reflecting on practice. The impact on midwives and nurses of the often highly charged situations they experience can have a profound effect on their long term ability to care for families and their children. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing the video clips discuss with the students:

- What activities were identified to assist midwives and nurses when they are working in challenging situations?
- What systems are in place in your health service for support and reflection on practice?
- What is clinical supervision?
- Who should provide and facilitate clinical supervision?
- How would you advocate for reflective systems like clinical supervision to enable reflection to occur in your health setting?

Activity: Developing a support network

Introduction

The development of a professional and community support network is crucial to enable ongoing emotional and physical availability as a midwife or nurse.

Activity

Direct the students to work in groups of three. Ask them to identify who is 'A', 'B' and 'C'. When they have done this, explain the process that will take place:

1. In the first round A will act as a midwife/nurse who needs to identify a support network [the student can base this on their own situation], B will act as the midwife or nurse facilitating the supervision session, C will act as an observer. [Reassure them that they will each have an opportunity to play all of these roles as the process will be repeated].
2. B [the student acting as the facilitator] will work with A [the midwife/nurse] to facilitate the development of a support plan using the support network questionnaire and C will observe the process.
3. A and B will position their chairs so that they sit opposite each other to facilitate good communication and C will sit at a distance between the two so that they can observe the interaction between A and B.
4. You will call time at the end of 5 minutes so that there will probably only be time to identify a few support people in this activity.
5. The students will then have 5 minutes to talk in their group of three about how the session went, starting with A, then moving to B and finally C will give positive feedback about what they observed, identifying:
   - Language used to facilitate the support plan development (questioning, wondering, directive)
   - Body language used by both the facilitator and the midwife/nurse
   - Aspects of the process that seemed to 'work well' or 'not so well'.

The steps 1- 5 will be repeated twice, rotating the roles so that everyone has a chance to experience all three roles.

Finishing the activity

Bring the students back into the larger group. Debrief by discussing the experience of participating in the activity and what they learnt from it. [Students should be encouraged to talk about their own experiences and learning and avoid identifying how their colleagues performed.]

- How did it feel?
- What worked?
- What felt uncomfortable?
- What else could have been done to improve the interaction?

A similar process can be used with parents to assist them identify support networks.

Note to Educator: to ensure students provide appropriate and respectful feedback during this session it is useful to provide feedback guidelines prior to commencing the session.

Activity: Reflecting on practice

Educators may like to give a formal presentation about reflection as part of this module. The book by Taylor (described below) is a useful resource that could assist the development of a presentation that meets the needs of your particular students and setting.

After a talk on reflection, you could ask the students to come together in pairs and identify both formal and informal situations in which you have engaged in reflection on your practice and/or support for each other.

Resources

Arney F. & Scott D. (2010), *Working with Vulnerable Families - A Partnership Approach.* Melbourne: Cambridge University Press.

Davis H., Day C. & Bidmead C. (2002) *Working in partnership with parents: the parent adviser model*. London: The Psychological Corporation.

This communication approach for working with parents is now being extensively advocated within Australia and New Zealand for working in Midwifery and Child and Family Health Services.

Taylor B. (2006) *Reflective Practice A Guide for Nurses and Midwives* (2nd Edition) Open University, Buckingham, UK.

NSW Child and Family Health Nurses Association
The NSW Child and Family Health Nurses Association *Guidelines for Clinical Supervision for Child & Family Health Nurses (2003)* are available via the following link: http://www.cafhna.org.au/cfh-n-practice-development
This document is widely used as the basis for development of clinical supervision policies. It is available free of charge from the CFHNA website.

Australian Nursing and Midwifery Associations
The following sites are nursing and midwifery associations that provide professional support and networking for midwives and nurses working with infants, children and families.
Australian College of Midwives http://www.midwives.org.au/
Australian Association of Maternal Child and Family Health Nurses http://www.aamcfhn.org.au/
Child and Family Health Nurses Association (NSW) Inc http://www.cafhna.org.au/
Victorian Association of Maternal and Child Health Nurses http://www.vamchn.org.au/

Community Health Nurses Western Australia http://www.chnwa.org.au/
Australian College of Children and Young People's Nurses http://www.accypn.org.au/

The Centre for Parent and Child Support http://www.cpcs.org.uk/index.php
The Centre for Parent and Child Support staff developed the Family Partnership Model (FPM) of working with parents and families. The FPM has been introduced in all Australian states and territories for use by child and family health nurses and midwives. This site provides the supporting FPM research and resources.

Family Partnership Training Australia http://www.fpta.org.au/
Family Partnership Training Australia (FPTA Inc) is an interagency, multi disciplinary group that works collaboratively to make the Family Partnership Training Program available to anyone who has a role in providing help and support to parents. Most states in Australia support and promote the use of the Family Partnership Model for working with families and their children.

Support for Each Other and Reflecting on Practice

DVD transcripts for discussion: section 2.1

Supporting each other

Julie Corkin
Child and Family Health Nurse

We were talking about supporting the mother so she can support her child… but in actual fact as a clinician we need lots of support also, I can't say strongly enough what a wonderful support it is as a clinician to have key people that you can go to that you trust that will give you valuable advice and support.

Jeannie Minnis
Midwife and Drug Health Clinical Nurse Consultant

I really do love my job. I think I have the best job. But it's a job with some uncertainty on a day-to-day basis. And with considerable stress at times. So I don't keep things to myself. And I work with a fantastic multi-disciplinary team. And I can easily voice concerns with them. I have no shame about going to the Employee Assistance Program, using that. I have used that when, for example, children have been removed. It can be quite emotionally draining. And I've found that very useful. I look after myself.

Sheryl Sidery
Midwife and Perinatal Mental Health Coordinator

When we have a new midwife starting I think it's quite overwhelming. It often brings up stuff around her own past. The questions that women are asked can be quite confronting. So I usually try and spend time with her and we have a bit of a practice run so I'll be the woman and I'll try and be a woman with some complex needs.

The other thing that I do in my workplace is that I meet with the midwives every month. We have a Tuesday morning breakfast where we meet in the antenatal clinic and we talk about what's been coming up for them whilst doing psychosocial assessments. And they love that and they tell their stories and, 'I had a woman…' and you know [big smile]. Sometimes they're funny stories and often they're very sad stories and it's just to try and unburden them with the information that they're taking in.

Amanda Davies
Executive Officer, Mother and Child Drug & Alcohol Abstinence Program

When children get taken away and driven away by Child Protection workers it's extremely distressing - for the client obviously and all the staff, and myself. We just have to support each other through that. You just need lots of good support, lots of de-briefing. And look for the small wins.

Reflecting on practice

Julie Corkin

With the early intervention home visiting program that we work in, my colleague and I, part of the process is to improve our practice, is to do reflective practice, reflective writing, about our feelings about how we felt in a certain situation, about what we did, and what we could have done better.

Cathrine Fowler
Professor of Child and Family Health

For many of us Supervision is quite an alien concept; it really only come into nursing and midwifery in the last 10-15 yrs. For some nurses and midwives who have never experienced Clinical Supervision, just the name is off putting. In nursing, there's a connotation of management, a disciplinary approach; certainly clinical supervision is not meant to be like that.

It needs to be offered by someone who is not your line manager, in a very safe place for you where you can talk about your concerns about clinical situations and how you're managing them; with an aim to improving your practice and making sure what you're doing is safe.

Group Supervision is the usual form of supervision. You come together with a group of your peers, with similar connections. The supervisor doesn't need to be an expert in nursing or midwifery, or child and family health. Their expertise is in area of S. Does help if they have knowledge of your area. Their role is to be good at asking questions, asking the right questions. So that these trigger your thoughts and reflections on what has occurred.

Jeannie Minnis

To work with substance using parents you really need to have a good support network; to work within a team; to have clinical supervision and to be a reflective practitioner. And above all you need to be consultative. And that means consulting with your peers – we don't have to know it all - and also consulting with the women. And that's something I've learnt over the years that the women are wonderful teachers. I've learnt so much through listening to their stories and asking them: 'What do you think would help you the most?'

Clinical Supervision is really paramount in any clinical field, but particularly so in this area. And I find that very valuable. And being a reflective practitioner. And I write – not for publication. I write little scripts and I get things off my chest. And I sometimes take the 'micky out' of difficult people in these little scripts. And they just stay there and that's one of the ways I ventilate things. I guess use of humour helps too.

Support Network														Activity Template 1
First name	How long known?	Type of help person will provide	How helpful has this person been?			What concern(s) did this person help with?	Have you been able to help this person?		How much trouble is it for you to use this person to help?					
			Not at all	Somewhat	Great deal		yes	no	none……..lots					Explain
									0	1	2	3	4	

Adapted from NCAST Network Survey

Supporting Parents and Families to Nurture and Protect their Children

Supporting parents and families to nurture and protect their children is the best possible child abuse and neglect prevention strategy. Responsive, sensitive and appropriate parenting is crucial for the development of a secure attachment by babies to their primary caregivers.

Midwives and nurses are in a privileged position when working with families with young children. This position is due to our ability to combine both physical tasks and psychosocial support and interventions. A powerful tool is the modeling of behaviours or the use of a parallel process. This means caring for the parents as we encourage and support parents to care for their infants and children.

Learning outcomes

On successful implementation of this module, students should be able to:

- Discuss the realities of new motherhood
- Identify the behaviours and strategies that midwives and nurses can use to support mothers with a new baby
- Describe communication styles appropriate when working with parents (families)
- Refine their parent-child observation skills.

DVD section 3.1: The realities of new motherhood

It is extremely difficult to prepare expectant parents for the realities of parenthood. For many new parents their expectations out-weigh the realities of exhaustion, sleep deprivation and often overwhelming feelings of responsibility for parenting an infant. In this section, several mothers discuss their expectations and the reality of parenting young children. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

One teaching and learning strategy would be to break the class into groups of 6-8 students and work through the following trigger questions and activities.

After viewing this section ask the students to discuss in pairs:

- The reality that these women experienced as parents
- What strategies could be used to better prepare women and men for parenthood?
- In the larger group ask the students to share their findings.

Activity: Myths and expectations of parenting

Introduction

Being a new parent can be really difficult at times, unfortunately being a new parent is often made more difficult due to the unrealistic expectations they have about what being a mum or dad really is about. These unrealistic expectations often come from the many myths that are perpetuated about parenting in the media, by family and friends. Many parents also struggle with cultural expectations especially as families migrate to Australia.

Activity

Explain what you are going to get the participants to do:

- Break into two groups
- Ask one group to develop a list of the myths and unrealistic expectations that you have heard about women and mothers
- Ask the other group to develop a list of myths and expectations you have heard about men and fathers
- Record the myths and expectations on a piece of paper
- Allow 5 minutes for the small group discussion
- During this time, divide the whiteboard in half and on the top of the first column write mothers, on the other, write fathers
- Ask the groups to tell you their findings, fill in the two columns and encourage group discussion about:
  - similarities and differences between the 2 groups
  - the potential effect of these myths and unrealistic expectations on parents and families?

Conclude activity

Discuss what we need to do to help us expose these myths and unrealistic expectations.

DVD section 3.2: Women's experiences of support from professionals

Midwives and nurses play a crucial role in supporting women and men as they become parents. In this section the mothers highlight the support they received from health professionals that was helpful, as well as the support they would have found useful. To assist with educator planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing this section ask the students to discuss in pairs:

- What were the strategies the women found useful?
- What strategies did the women in the clips use to develop and foster resilience (you might want to refer back to Module 1, section 1.1 when you do this question)
- What other supports, information or activities would the women have liked health professionals to provide?

Activity: Listening to the words women use

Before showing the *DVD Section 3.2: Women's Experiences of Support from Professionals* ensure that students place any possessions in a safe place where they can leave them during the activity. Explain that they will be moving around and all they will need is a pen and a sheet of A4 paper that you will provide. The instructions are:

- After watching the video clip, students will be asked to spend a couple of minutes in which they will write down in large letters on their piece of A4 paper three single words that will stay in their minds as a result of having viewed the video [Encourage them not to do this while watching the video as this is a listening exercise]
- They will then be asked to move around the room showing each other which words they have on their paper for not more than 5 minutes
- They will then find one other person with similar words to theirs and sit down with them to discuss why they chose those words and what they will remember as a result of watching the video – for 5 minutes.

After watching the video

Repeat instructions above so that students are clear about the activity.

Facilitate a feedback session in the whole group where students are invited to share with the whole group anything they learnt or any questions they are left with as a result of engaging in this activity. This activity can also be used to allocate students into pairs for further activities. Also, by asking the students to join up with other pairs you can form groups of four, six or eight for further activities involving small group work.

DVD section 3.3: Engaging with new parents – communication and observation

Two important issues are discussed in this section: 1) communication with parents and 2) developing an ability to be observant. These are extremely important midwifery and nursing skills. Communication and observation are closely aligned when working with parents and children. Midwives and nurses regularly assist parents develop insight into their infant or child's behaviour and how the infant or child experiences specific situations. Many midwives and nurses are finding the most effective way to work with parents is to use a partnership approach. This type of approach is grounded on building strengths and a relationship. It draws extensively on parents' existing experience, knowledge and skills. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

After viewing this section ask the students to discuss in pairs:

- What communication skills were identified?
- Observation of the parent and infant discussed in this section:
  - What was being observed?
  - Why was this significant?
  - What strategies were suggested to support parents?

Activity/assessment: Contact with a mother and her new baby

Ask students to make contact with a mother or father with a new baby and gain permission from that mother to spend an hour observing her interaction with her new baby and document the findings of the observation and interview. This activity needs to be undertaken over a number of weeks giving students time to go into practice.

Interview

- What were the mother's/father's expectation of parenthood prior to the birth of their baby?
- Were those expectations met after the birth of their baby?
- What aspects of parenthood would they like to have been informed about prior to the birth of their baby?

Observation

- What was happening during the hour?
- How much time did the mother/father focus on the baby?
- Did the mother/father talk to the baby? What type of language did the mother/father use? (e.g. descriptive, questioning, statements); How did the mother's/father's voice change when they spoke to their baby?
- What type of activities did the mother/father do with their baby?

Activity: Parent-infant relationship DVDs

There are numerous DVDs available that focus on the parent/child relationship. Watching these DVDs will assist develop the midwives and nurses skills in parent-infant observation and to understand the powerful language of infant cues or signals.

The suggested DVDs are:

Getting to Know You DVD available from the NSW Institute of Psychiatry http://www.nswiop.nsw.edu.au/index.php?option=com_content&view=article&id=262&Itemid=121

Baby Cues: A Child's First Language DVD available from NCAST University of Washington http://www.ncast.org/index.html

Activity/assessment: Understanding the theories of early attachment

Direct the students to the following chapter, which provides a comprehensive overview of theory related to early attachment.

Redshaw, M. (2006). First relationships and the growth of love and commitment. Chapter 2. In L. A. Page & R. Campbell (Eds.), *The New Midwifery: Science and Sensitivity in Practice. Second Edition.* (pp. 21-47). Edinburgh: Churchill Livingstone/Elsevier.

In small groups, direct the students to develop a poster summarising the content of this chapter.

Alternatively, you might like to suggest they develop a performance - a skit or a dance – that symbolises the theory identified in this chapter. The students can be asked to provide a handout summarising the main points covered in the performance to share with the class.

Resources

Davis H., Day C. & Bidmead C. (2002) *Working in partnership with parents: the parent adviser model*. London: The Psychological Corporation.

This communication approach for working with parents is now being extensively advocated within Australia and New Zealand for working in Child and Family Health Services.

Feeley N. and Gottlieb L. (2000) Nursing approach for working with family strengths and resources. *Journal of Family Nursing*, 6(9): 9-24.

Gottlieb L. & Feeley N. (2005) The collaborative partnership approach to care: a delicate balance. Toronto: Elsevier Mosby.

Mares, S., Newman, L., & Warren, B. (2005) *Clinical skills in infant mental health.* Melbourne: ACER Press.

This Australian text provides a beginner's guide to the specialist field of infant mental health and attachment.

Slade A. (2005) Parental reflective functioning: an introduction. *Attachment & Human Development 7*(3): 269-281.

Wright L.M. and Leahey M. (2009) Nurses and families: a guide to family assessment and intervention (5th edn). Philadelphia: F.A. Davis Company.

Raising Children Network http://raisingchildren.net.au/
The Raising Children Network is supported through Australian Commonwealth Funding. Whenever possible it provides evidence based/informed parenting advice. The resources include parenting information for birth to the teenage years. Resources for use with parents who experience learning problems or have a child with a disability are a particularly valuable resource for nurses and midwives. To increase access to community supports and networking there is a facility to find out what is available in each Australian suburb.

Family Partnership Training Australia http://www.fpta.org.au/
Family Partnership Training Australia (FPTA Inc) is an interagency, multi disciplinary group that works collaboratively to make the Family Partnership Training Program available to anyone who has a role in providing help and support to parents. Most states in Australia support and promote the use of the Family Partnership Model for working with families and their children.

Circle of Security http://www.circleofsecurity.org/
The Circle of Security is a well regarded intervention program that aims to alter the developmental pathway for children by improving the way parents relate and interact with their young children. The Circle of Security program is uses a foundation of attachment theory to work to develop a secure relationship between children and their parents.

Nurse Family Partnership http://www.nursefamilypartnership.org/index.cfm?fuseaction=home
The Nurse Family Partnership program was developed by a US team lead by Prof David Olds. This home visiting program has been adapted for use in several countries including Australia. The Australian program is funded by the Commonwealth Government and is being implemented within Aboriginal communities. This site provides the research evidence that demonstrates the program outcomes, and provides an overview of the program.

The Centre for Parent and Child Support http://www.cpcs.org.uk/index.php
The Centre for Parent and Child Support staff developed the Family Partnership Model (FPM) of working with parents and families. The FPM has been introduced in all Australian states and territories for use by child and family health nurses and midwives. This site provides the supporting FPM research and resources.

Family & Parenting Institute http://www.familyandparenting.org/
This United Kingdom website provides some interesting and useful resources including a free download document on: Knowing What You Do Works. This document aims to assist professionals understand what, when and how to measure the impact of their work with families, parents and children.

NCAST http://www.ncast.org/index.html
NCAST (originally known as Nurse Child Assessment Satellite Training) was established in the late 1970s within the University of Washington. The programs offered by NCAST have a strong research base and are widely used within many well-known programs such as the Nurse Family Partnership program. Two main programs are the Keys to Caregiving and the Parent Child Interaction Assessment. The Keys to Caregiving aims to enhance nurses and midwives ability to observe and interpret infant cues (signals) to support parents develop their ability to intervene at an early stage before their child becomes overly distressed. The Parent Child Interaction Assessment provides nurses with the skills to objectively observe and rate the interaction between a child and their parent, design an intervention and then reassess the interaction after the implementation of the intervention. This assessment is accepted within the US child protection legal system. Two organizations within Australia have accredited instructors Tresillian Family Care Centres (Sydney) and Queen Elizabeth Centre (Melbourne).

Zero to Three http://www.zerotothree.org/site/PageServer
Zero to Three is a well-respected US organisation that provides child development and infant mental health information. There are resources for parents, professionals and policy makers. Publications are available for purchase and/or download.

Centre of Excellence for Children's Wellbeing: Early Childhood Development
http://www.excellence-earlychildhood.ca/home.asp
The Centre of Excellence for Children's Wellbeing is part of the University of Montreal. A key resource available on this site is an *Encyclopedia on Early Childhood Development*.

The Realities of New Motherhood

DVD transcripts for discussion: section 3.1

Manal Kassab
Mother

Actually parenting is something wonderful and having kids it's something like you can't expect how much it's... wonderful for you to be a parent and for taking care of other human but at the same time I found it like difficult and stressful especially because I have to do everything myself without having a support system. And for me in my culture, family support system is very important… to help you and raising the kids and to enrich them with the values and the cultural beliefs – you know what I mean – so yeah, it was hard and stressful at some stages which make me feel guilty at some stages, that I can't afford everything to them.

In my own country usually we ask for our Mum's help and sometimes our grandparents, but usually it's the Mum who can share a lot with their like daughters to take care of their new babies. In some stages they like sit with them for a couple of months, they make sure that everything is all right with them and usually they don't make us move or do anything because we have like 40 days to relax and not to do anything, to not get our self hurt and to focus on taking care of our bubs, yeah. So, yeah, I missed this role here.

Jackie Roche
Mother

So – the time we had the most sleep deprivation was truly an awful time. It's like torture being… It's obviously – physically you feel like a wreck but emotionally you feel like you're not happy – and you're meant to be happy because you have a little baby. It's a very stressful time. It doesn't feel like it's a happy time. Umm. Your relationship with your partner is often under a lot of stress. Ours was definitely. It was nothing to do with us as a partnership anymore. It was nothing to do with us as a couple of people who loved each other in a relationship, it was all about an unsettled baby and a toddler and a whole lot of hard work.

I guess – one of my children reminds me of tantrums more than the other one. I guess the hardest thing for me is to let go, to not take on the anger, not take on the frustration, let go of my stuff, and concentrate on the fact that I am the adult and he is the child and I need to de-escalate the situation. Because I find that instantly if I escalate, everything escalates. If I feel anger, if I get involved in the emotion of the tantrum, it just goes nowhere. Actually it goes up. Yeah. So that's one of the hardest things to not take on the feeling of anger.

Anna Murray
Mother

It never occurred to me that I would suddenly be responsible for somebody… I remember driving home when she was a few weeks old and every time I crossed the bridge from visiting my mother and grandmother I burst into tears. Suddenly there was this small person I was responsible for. I was overwhelmed with exhaustion and just the responsibility of her.

Tess Lloyd
Mother and Designer

I think one of the biggest adjustments for me was never being alone. I was used to independence, be able to physically and mentally getting a lot done, running a business, renovating a house while pregnant, travelling overseas. I was used to getting a lot of things done. It was a big shock suddenly not being able to get anything done, that lack of independence. My husband goes to work, he can go training, go for beers after work, have a lot of independent time, whereas I'm generally the one holding the baby. It's wonderful and very special but it's a big adjustment from being independent.

I think lack of sleep is probably the hardest thing that I faced. Lack of independence was hard but I think lack of sleep is harder. I keep telling myself it is a torture method. Natural childbirth is nothing – it lasts a few hours – but lack of sleep for me has lasted 6 months.

I think for me my self-esteem is on a roller coaster since being a mother. I have real highs and lows, a real sense of pride, but when I'm tired and strung out, I really question myself, and my ability and my choices. It's a challenging thing and one area where midwives have helped me, encouraged me that I'm doing a good job. It's not like a job in the paid workforce where your work's measured and you get feedback or a report. You get feedback from your baby if she's happy or not, if she's growing, feeding and healthy, but it's sometimes hard to measure that and you need someone to – some external support – to help you to feel confident about what you're doing. It's such a new role, one you're not prepared for, not able to be prepared for, motherhood the first time round.

Priya Nair
Mother

My sister when she came to Australia she was already three months pregnant. And she was young. And it was the first time she was travelling overseas. She had a very hard time. Actually. And as soon as she had the baby, a baby girl, she developed with arthritis and then suddenly she had a second baby. So she had a big trouble but somehow they coped well because her husband was supportive, and they were both together…I think also they had great help from the nurses after the baby was born actually to give her information. And I think she coped well. She didn't have any parent support. She wished she had. When she looked back now. She wished she had a family support. That's the whole reason that I came here because she didn't have any family here.

Women's Experiences of Support from Professionals

DVD transcripts for discussion: section 3.2

Jackie Roche
Mother

Really, physically and emotionally or spiritually, you've been through such an incredible thing with the birth, that to have a positive outlook for those first couple of months is just so valuable, it really is. It really stands you in good stead. You feel like you can do it. So I was fortunate to have that. I was fortunate to have that every time. A good birth experience and really positive midwifery care. I always felt like they had absolute belief in my ability to have a happy experience and to have a good birth experience. Also the emotional support: that if something came up that wasn't an absolutely straightforward birth experience, that I would be cared for and supported in a really positive way through that and not dropped and handed over to the next department. So that was a really useful thing.

So it was a residential facility. I was there all week with my son, I was there for sleep related issues because my son really didn't sleep longer than two hours at a time for six months for the first six months of his life. And my husband was working full time all the way through. It was a very, very hard time. It was probably the hardest time of my life really. So – they gave me skills and tools of how to settle him, the method that they recommended. I'd do it if he woke up to get him back to sleep - to promote a healthy thing for him and for me. And it worked really, really well and – you know, I became a much happier and more rested mother and I think he became a much more rested baby as well.

Anna Murray
Mother

I called a parenting help line centre – they obviously need more funding, there were only three of them doing the massive job of dealing with all these mothers - but after being on hold for an hour (I distracted myself with the washing) I finally spoke to a wonderful nurse who was warm and reassuring and made me feel like I was the first person she'd spoken to all day. She reassured me I was doing a great job and gave me some suggestions and told me the steps I needed to take.

Manal Kassab
Mother

Actually this part is very important for me because it made a big difference in my life and especially during, having my first kid. I struggled for that first six months of his age and the only person who provided me with the care and advice and who like lifted me up at some stages is a midwife.

The message would be that – keep supporting these women, and because from my own experience, without the support I think at some stages I would like lost my energy, my faith in being a mum, especially being a new mum. I won't make it without that nurse. She stayed there to notice everything that I'm doing with my baby. To see - even she asked me to let him go and sleep and to watch what kind of time he take to go to sleep and then to see what's wrong with him and why he's crying. So every time she came to my home I feel very safe. I can't tell you how much I felt at that time but it's a great feeling. And then she directed me to ask for… she started to tell me where to go, she started to tell me what kind of support in the community I have.

Tess Lloyd
Mother and Designer

I was entitled to the hospital system where because we went home on the same day, we were visited by a hospital midwife for five days for an hour each day. It was really wonderful but on a personal level, having midwives as part of our extended family meant a personal approach, people I could call on. I don't know if it's part of the profession but they always have a very calming voice on the phone or in person. In the early days having someone come round and reassure me I was doing the right thing and telling me that my baby was beautiful and healthy was exactly what I wanted to hear and what I needed.

As a mother I think the most valuable thing that my midwife gave me was confidence that I was doing the right thing. It's that sort of gentle reassurance that I was capable and I suppose giving me the confidence to make my own decisions as a mother and as a pregnant woman. Rather than having to go back to someone every time I had a question I felt empowered to make those decisions myself and that was a really special thing so I felt I had made the right decisions for our birth and had a wonderful birth and the right decisions for the way we're raising Indie and caring for her and feeding her. And that's pretty special to feel like you can make those decisions.

Engaging with New Parents: Communication and Observation

DVD transcripts for discussion: section 3.3

Asking Appropriate Questions

Cathrine Fowler
Professor of Child and Family Health

When I'm trying to find out the what the parents' needs are, it can be really difficult because if they're sleep deprived or they're depressed they can be really immobilised by it, and they can't think about what they need or what they should be doing. And you ask them a question like, 'What do you think would work for you?' And it doesn't really get you where you want to get; you don't get the information you need from them. So one of the questions I ask parents is, 'If tomorrow you woke up and the world was perfect with your baby, what would it look like?' And they often can then start telling you about this fantasy world they have. And it can frequently provide these little hooks that you can grab onto to work with them. And you can say to them, 'Look that sounds like a really wonderful world you've got there, how about we look at some of the things that you said would work for you? You said you'd like to have some time on your own, so how about we look at how you can get some time on your own?'

That's something that I – as a nurse or a midwife – can achieve with this parent. I can find out what's available in this woman's community, who's in her social network, who if called on would do half an hour's babysitting while she went for a walk; those sorts of things. We often try and solve the big things in life, yet if we start with the little things, and get some achievement going for this mum or this father, then the world can look a whole lot better for them.

Observing parents interacting with their baby: 'looking beyond the niceness of things

Being able to observe a mother and her baby or a father and their baby is really, really important. What we need to do is to look beyond the niceness of things, and we need to focus very clearly on what's happening - that space between the parent and child. Things like, if the mother smiles, does the baby smile? Does the baby smile, does the mother reach out and touch the baby? Those sorts of contingent reciprocating behaviours are what our social world is made up of and it reassures child, it teaches the child that it's important. But also the child - you know, we often talk about the mother having lots of responsibilities for this baby but the child has responsibilities to provide some feedback to the mother. But we might have to interpret for the baby.

We might have to say to the mum, 'Look at your baby, it's smiling at you. And it's only got eyes for you. Look, you move around the room and keep an eye on your baby. It will follow you'; those sorts of things. We can also talk to the mum about, 'Look at Johnny there. He's got a smile on his face, if he could talk what would he say to you? And when you looked like that just a minute ago, you had a funny look on your face, it was sort of a half smile, what were you thinking then?' So we start to tap into their feelings, and also help the mother work with the baby, and understand that the baby may have feelings. We can also, with some mums who really are, haven't quite got adequate levels of sensitivity towards their babies, we might start to talk through the baby, not in a patronising way, but saying, 'Oh Mum. I'm getting really tired now, it's time for a cuddle.' And just soften voice a little bit. And that helps the Mum to cue into the baby. It's a bit nicer than saying, 'Oh I think you should stop now, the baby's getting tired.'

Understanding the importance of early attachment

Attachment's really important and we need to be very aware of how, in the early days of life, a baby can attach to its mother and its father. We need to set the parents up to be responsive, and appropriate in their behaviours

Modelling responsive behaviour

I think from observing lots of parents and infants, the most important thing I can do as a nurse is to model that behaviour that I want the mother or the father to model to the baby. I have to be responsive, I have to be with the mother, and not let my mind wander somewhere else, I have to be constantly aware of what's happening between the mother and the baby and sometimes act as an interpreter, but often I need to model that behaviour. The way I speak to the baby, the way I speak to the mother. I need to use language that is appropriate; I need to allow adequate silences. Silences are really important between interactions. If a 4-month old starts to talk to me I need to respond and give the right amount of timing and space to get the child really communicating with me. And it's great fun! That's really the joy of working in this area – it can be great fun!

Listening to the woman's story of her birth experience

The birth experience is really important. What we might interpret as being good or a fabulous birth experience, or a terrible birth experience may be not how the mother experienced it. It's really important that we sit and listen to the mother's opinion of what her experience was. She's the one that knows intimately how it felt, whether it met her expectations, went way beyond her expectations or was just a really traumatic event for her. Particularly a traumatic birth experience can have a profound effect on a woman, the way that she actually bonds with the baby, which then influences the attachment of the infant to the mother. It can influence her breastfeeding.

The potential effects of child sexual abuse on women's experiences of pregnancy, birth, breastfeeding and parenting

I think, on the subject of breastfeeding, we need to be very careful about how we promote breastfeeding with new mums. That's why need to actually ask some of the tough questions about previous child abuse and sexual abuse. Because if a woman has been abused, then she is likely to have a lot of difficulty around birth and around breastfeeding because this can cause bodily sensations that remind her of the abuse. But unless you ask the questions, you often don't know. The mother's behaviour can seem extraordinarily strange and you're not able to deal in the way we should be dealing with it.

And the same really applies to examinations during pregnancy. We need to understand that every woman has a history, and that history can be quite a devastating and traumatic history and it will influence the way that she parents and reacts to birth.

Supporting fathers to nurture and protect their children

Fathers are being encouraged to become involved in all aspects of their children's lives and care. Most men are excited about becoming fathers and have strong views about how they will behave with their children; they expect to be fully involved in most aspects of their lives. These feelings are often tempered with an overwhelming sense of responsibility to provide financially for their family and to be the best possible father for their children. For some men, fatherhood can be a difficult experience due to the lack of positive modeling of fathering behaviours provided during their own childhood.

Cultural expectations about the role of men and fathers can frequently restrict their involvement with their children. The way fatherhood is talked about can perpetuate these cultural practices. For example, fathers are often congratulated when they care for their children for short periods of time. Their role is often talked of as a secondary carer rather than one of sharing parenting responsibilities.

Fathers can often be actively discouraged from participating in the early parenting of their children. This can be as an outcome of the language we use and the lack of inclusion in decision making when fathers are present.

Fathers who do share the care of their children or become the primary caregiver often identify that there are not the same social support networks available to them as for mothers.

Important note to educators:

Unfortunately, it is common for some students in every course to have experienced trauma due to child abuse and/or neglect or domestic violence. They may have a family history of mental illness or have experienced other types of traumatic event (death of a child or parent). Acknowledging this at the beginning of the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students.

Learning outcomes

On successful implementation of this module, students should be able to:

- Identify the issues and challenges for fathers
- Discuss and critique community attitudes to fathers and fathers as primary caregivers
- Explore some of the different cultural views of fatherhood
- Identify relevant community and professional resources and support services for fathers
- Explore strategies to manage feelings of frustration and anger when caring for young children that fathers may experience.

Activities

It is suggested that you watch the following clips related to fathers then discuss with the students the contents of the clips. This can be done in several ways. For example, by watching all the clips first then having a discussion using the trigger questions as an overall guide or having a discussion between sections or clips using the trigger questions.

There are three sections in this module; each section aims to encourage discussion about the experiences of fathers and ways in which midwives and nurses can engage fathers in antenatal care, support groups, and services for babies and young children. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Section 4.1: Engaging fathers in services for parents

In this 7-minute video clip, nurses and midwives discuss the ways in which they encourage fathers to participate in services in order to foster their confidence about nurturing and protecting their children.

Section 4.2: 'Good Beginnings' videos about fatherhood

These clips are available on YouTube and produced by Good Beginnings (Google: YouTube fathers Good Beginnings). They provide a rich source of information about fatherhood:

Several men talking about the positive aspects of the child and family health services they visited
http://www.youtube.com/watch?v=KoGktbtdeKE&feature=channel

Men provide critical feedback about their experiences of child and family health services
http://www.youtube.com/watch?v=CfEF2AsYdco&feature=channel

The benefits for fathers of interacting at a fathers only play group are discussed in this video
http://www.youtube.com/watch?v=sMYx2LkMQ7Y&feature=related

This Youtube series has 5 more videos you may find these useful for the students. Youtube provides a rich resource that is forever changing. There are many videos that may provide the information you require or be an improvement on the suggested videos. Unfortunately some videos are replaced so no guarantee can be provided that these videos will remain available.

Activity/assessment: Expectations and perspectives

Facilitate a discussion about:

- Societal expectations of mothers and fathers
- Similarities and differences between these expectations
- Cultural perspectives of fatherhood.

This activity could be adapted as a written assessment task.

Activity/assessment: Using media and photographs

Collect a range of photographs from newspapers, magazines and other sources showing fathers interacting with their young children. Ask the students to form groups of 3 or 4. Distribute the photographs.

Ask the students to identify:

- What is their initial reaction to the photographs?
- How are the fathers portrayed?
- Do these photos match societal expectations/stereotypes?

This activity could be adapted as an assessment task, with the students being directed to find the media images themselves and providing a critique.

Activity: Case study

Case Study

Garry is a father of two children (Tom: 3 yrs and Ella: 18 months). His partner Susie is a nurse and works night duty shifts on Friday and Saturday at the local hospital. This works well because they don't have to pay for childcare while she works.

Unfortunately, Ella has always been a 'poor sleeper' and wakes during the night. When Garry is looking after them while Susie is working, Ella wakes even more frequently. All day Saturday and Sunday Ella is cranky and Garry has to try and keep her quiet so Susie can sleep. Three-year-old Tom tries to help his Daddy but it often ends with Tom getting angry with Ella. Garry sometimes worries he might get really angry with Ella and hit her. Susie tells you this story while having a shift break at work.

Ask the students to talk about this situation by dividing them into four small groups. Provide each group with a question to discuss.

How might Garry, Tom and Ella be feeling?

What impact may Tom and Ella's behaviour have on Garry and Susie's relationship?

What strategies might they suggest to Garry?

What are the risks for Tom and Ella?

Conclude activity

Facilitate a large group discussion about their responses to these questions. Focus the large group discussion on:

1) How might this situation be improved?

2) The issues related to a colleague disclosing a potential child at risk family incident:

Would you put in a child 'at risk' report? If yes, on what grounds would you write this report?

Resources

Family Action Centre http://www.newcastle.edu.au/research-centre/fac/
This Centre is located at the University of Newcastle. The Centre focuses on a numerous areas of interest to child and family health – resilience, inclusion of fathers and community development.

There are many useful resources available from this site.

- Australian Fatherhood Research Network
- Indigenous Programs

- Communities for Children (Raymond Terrace & Karuah)
- The Boys in Schools Program
- Involving Fathers in Early Childhood Services
- Aboriginal and Torres Strait Islander fathers, father-figures, pops and uncles
- Father Inclusive Practice
- Home-Start
- SNUG: Special Needs Unlimited Group
- The Caravan Project

Brighter Futures: NSW Department of Community Services
http://www.community.nsw.gov.au/for_agencies_that_work_with_us/early_intervention_services/brighter_futures_resources.html
A guide and activity sheets to assist practitioners working with vulnerable families to include fathers has been launched by the NSW Department of Community Services. The Brighter Futures *including fathers in work with vulnerable families* was produced in partnership with The Family Action Centre, The University of Newcastle.

The guide sets out a rationale and provides suggested approaches to including fathers in the support offered to vulnerable families. Topics include: Family conflict and violence; Fathers and depression; Fathers and nurturing; The importance of play and Gender of workers. A strengths approach to fathers is outlined and research on the importance of father–infant and father–child relationships for child development is summarised. A set of evidence based practice principles and evidence based practice strategies are provided.

Dads Make a Difference information sheets for 0-6 months, 6-12 months, 1-3 years, 3-5 years and 5-8 years to be used in engaging with fathers can also be downloaded.

Good Beginnings http://www.goodbeginnings.net.au/support/volunteers.shtml
Good Beginnings provides a volunteer home visiting parenting support and community development services. The service is active in most Australian states and territories.

Fatherhood Institute http://www.fatherhoodinstitute.org/
The UK Fatherhood Institute aims to collate fatherhood research, contribute to government's family policy, influence public debate about fathers and provide education for organisation to become father-inclusive.

State Child Protection Agencies
Each state has a Government department devoted to the protection of children. These sites provide information about policy and processes.

Child Protection, Family and Early Parenting Services Vic http://www.cyf.vic.gov.au/child-protection-family-services/home

NSW Community Services http://www.community.nsw.gov.au/

NSW Health Keeping them Safe http://www.health.nsw.gov.au/initiatives/kts/index.asp

Families SA http://www.dfc.sa.gov.au/pub/Default.aspx?tabid=257

Department for Child Protection WA http://www.community.wa.gov.au/DCP/

Department of Health and Families NT
http://www.health.nt.gov.au/Children_Youth_and_Families/Child_Protection/Child_Protection_System_Reform/index.aspx

Department of Health and Human Services Tas
http://www.dhhs.tas.gov.au/service_information/services_files/child_protection_services

Child Safety Services Qld http://www.childsafety.qld.gov.au/

Relationship Australia http://www.relationships.com.au/
Relationships Australia is a leading community-based provider of relationship support services. They provide support to achieve positive and respectful relationships. The site provides access to relationship counseling and related resources.

National Association for Prevention of Child Abuse and Neglect (NAPCAN) http://www.napcan.org.au/
NAPCAN is a national organisation that advocates on behalf of children and young people and to promote positive change in attitudes, behaviour, policies, practices and the law to prevent abuse and neglect and ensure the safety and wellbeing of Australian children. The site provides access to parenting pamphlets, research findings and links to other like organisations.

Engaging Fathers in Services for Parents

DVD transcripts for discussion: section 4.1

Leona McGrath
Midwife

The way that we engage fathers in our service is, the antenatal educator at the hospital, she's happy to provide our women with one-to-one classes. That's one way that we can get the fathers involved. When we do antenatal checks we'll get them to – you know - listen in to the baby. We'll do a palp [palpation] and we'll get them to put their hands on also and they can feel. Yes and just… with a lot of Aboriginal people they're quite shy and just to get the men to come to the visits or speak, that's a huge thing and if they do show, we really try to engage with them, to have them more involved.

Trudy Allende
Aboriginal Health Education Officer

Yeah that's really important: to engage the fathers. So we make them feel welcome and that they're valued and respected in what they're talking about as well, it's just as much their journey as that supported journey of their partner with the baby, so I think just being open and friendly. And letting them know that they're valued in this as well and making them a part of everything. And also respecting if they don't want to be a part of everything as well.

Kate McNamara
Peer Support Facilitator: 'Mytime' Groups For Parents Who Have A Child With A Disability

Fathers are also an important part of MyTime groups; we often get fathers attending. We are very careful to include fathers in the literature to say it's a group 'for Mums and Dads', not just for mothers and nothing to do with fathers. We try to include them in photos and literature. When they come along, I try not to point them out as, 'You're the father with the father's experience' or separate them. I'm very careful to include them. Often fathers don't see groups as for them; they see it as the mother's business so sometime we have to modify them. It might be coming together for a barbeque – the secondary part is that they're all sitting around chatting. Or fathers are more likely to get involved if they think it's a playgroup for their children. There's a play helper there and while they're there, they're catching up with other parents and sharing experiences.

Kim Brickwood
Midwife, Child and Family Health Nurse and Early Parenting Project Officer

In the role that I'm working in at the moment we've been involved in setting up several different types of groups. One of those was the 'Baby Share' groups, which are groups for Dads after they've had the baby. What happened with those groups was that Mum and Dad and the baby came to the group. There was a male facilitator, a Child and Family Health nurse, and the project manager who was also a male.

And they would come to the groups, introduce themselves, have a very brief session, then Mum would go. And in actual fact they thought she'd go shopping but they actually gathered together, the women. And they had a little session on their own, just a chat. And Dad and the baby stayed. So those groups were about getting Dads to have more confidence, also introducing them to infant cues and how to read infant cues and trying to improve that connection between Dad and baby.

The main issues I think that Dads face is – well, the project officer for the 'Babyshare' [project] believes that it's on that psychological level that they are not allowed to talk about things, as easily, or it doesn't come as easily to them as it does to women, for a group of men to all sit around and talk about what's happening. Once they do it they love it! But it's not something that comes as second nature to a man I think, like it does to a woman. I think for the men it's often more about sport and work maybe and perhaps what they're doing in their recreation time, where they went for their holidays. Not how emotionally connected they feel to their partner or having been at the birth or to this new little person and how wonderful that is. Unless of course they get to talk to another Dad, which is where men in groups is very good.

The issues for men too are around their size. And often they worry about handling the baby because they've got big hands and they see the baby as fragile.

I think another issue for fathers is a difficult one. There's so much talk about abuse and that link to touching. I think Dads are very often reluctant to touch their little babies; particularly if they're girls. And I think having someone show them the benefits of massage, and the way to do that and that it's all right to touch your baby, I think that's a good thing. There's so much in the media about – you know, about men and children and I think that's a big issue for dads. They're worried I think to be seen to be touching their children when they're out and about in case they're judged.

Support groups: building social capital and reducing social isolation

Social support is essential for enhancing and maintaining the mental health of parents and families, and the ability to overcome a difficult and challenging parenting situation. Group programs during the antenatal period and into the early years of parenting have been found to provide more than just pregnancy, childbirth and parenting education; importantly, groups provide an inherent component of social support. Parents are able to develop informal support networks, share knowledge and skills and explore the impact on their lives of their pregnancy, childbirth and parenting experiences. Many new friendships are formed during their participation in pregnancy and parenting groups; these friendships can last a lifetime.

New parents will often be reluctant to join groups especially if they have not experienced these types of organised events before. Nurses and midwives are in critical positions to enable and encourage parents to attend groups and also to ensure that the groups are effective and meet their needs in relation to information sharing and support.

Learning outcomes

On successful implementation of this module, students should be able to:

- Discuss the potential role of nurses and midwives in building 'social capital' and how this relates to nurturing and protecting children
- Discuss the importance of group programs in terms of reducing social isolation
- Discuss ways in which information is shared in groups and the roles of nurses and midwives as facilitators
- Discuss strategies to manage disclosure (e.g. domestic violence) in antenatal and parenting groups
- Identify local support groups for pregnant women and new parents and other sources of family, community and professional social support.

DVD section 5.1: Social support and the concept of building social capital

In Section 1, Emeritus Professor Dorothy Scott from the Australian Centre for Child Protection at the University of South Australia explained the concept of social capital in terms of the webs of relationships that facilitate the nurturing and protection of children. She describes the special role that midwives and nurses have in building social capital through the facilitation of antenatal groups and new parent groups in the community, giving the example of a group she studied called, 'Parenting in a New Land'.

Professor Scott draws on the work of Robert Putnam in explaining the difference between 'bonding capital' - which occurs when we socialise with people who are like us - and 'bridging capital' - friendships with people who are not like us. Putnam argues that these forms of social capital strengthen each other and contribute to the formation of healthy societies. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

The following questions can be used to facilitate discussions with students after watching the video clip:

- What does the term 'social capital' mean for you?
- In your own family and culture are there examples of both 'bonding social capital' and 'bridging social capital'?
- How do you think both these forms of social capital contribute to strengthening families and helping them to nurture and protect their children?
- What are the potential roles of midwives and nurses in the development of social capital?

DVD section 5.2: Experiences of facilitating antenatal and parenting groups

In this Section, practitioners share their experiences of facilitating support groups. They discuss their understandings of the value of support groups and the dynamics of group facilitation. Some suggestions are offered for how to deal with disclosures related to child protection issues if they arise in a group setting. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

The following questions can be used to facilitate discussions with students after watching the video clips in Section 5.2:

- What are the features of a successful antenatal or parenting group?
- How would you manage a situation if a parent disclosed within the group that they were:
  - concerned about getting angry at their baby
  - upset because they often had violent rows with their partner
  - living in fear of their current or ex-partner.

Section 5.3: Child and family health nurses model group facilitation skills – 'Early Bird' group DVD

We have drawn on a DVD entitled 'The Early Bird Program Facilitators Training DVD'. A number of copies of the DVD were kindly donated by the Women's Health and Community Partnerships Unit, South East Sydney Illawarra Area Health Service for use in this project. The 'Facilitators Manual for Early Bird Groups' is available from: http://www.sesiahs.health.nsw.gov.au/Health_Promotion_Service/Publications/Healthy_weight_resources/EarlybirdProgramManual.pdf

The Early Bird DVD and Manual can be used to identify group facilitation skills and discuss how the facilitators responded to issues that arose during the groups. The DVD is organised in the following sections:

- Early Bird Program group facilitator
- Getting started – Welcome and introductions
- The role of the co-facilitator
- Cycle of problem solving
- Dispelling myths
- Dealing with incorrect information
- Weaving in relevant issues
- How to deal with disclosures
- Ending the session
- Debriefing and follow up.

Each section of the DVD can be played separately to promote discussion about what the students observed in terms of:

- Words and phrases used by both the facilitators and the parents in the group
- Body language and facilitation style
- Key messages about group facilitation and the organisation of groups.

Activity: Practising group activities

Students can role play being pregnant women or new parents and practise some activities that may be carried out in groups. These activities can be facilitated by the educator or they can take turns to facilitate the activities in pairs. This is followed by a discussion about what it felt like carrying out the activity and what the potential value might be for pregnant women, their partners/new parents. Some examples of group activities:

A selection of photos - these images can be related to birth/parenting or not - are placed in the middle of the circle. Each participant chooses a photo and then talks in the group about the photo, what it means to them as a pregnant woman/partner/new parent.

Buttons in cups – each pregnant woman/partner is given a cup full of buttons and places the buttons on a sheet of paper or large plate – 'myself in the middle and buttons representing people in my life who will be there for me - or not - when I've had my baby'. Arrange according to importance and distance. They then talk about the buttons/ arrangement with one other person

Body changes in pregnancy – using a template drawing of the outline of a woman's body, participants identify changes that are affecting their life by drawing on the template. They then share their drawing and discuss it in the group.

Activity: Fears expressed by group facilitators

Introduction

Some midwives and nurses are anxious about facilitating groups. In many instances it is due to a lack of confidence in their knowledge or ability to handle difficult group situations and/or parent disclosure. Often by talking about their concerns and assisting them to develop strategies can reduce their anxiety. Students are often surprised that they are not the only ones who feel this way.

Equipment

Small container
Slips of paper – one for each student

Activity

After introducing the activity ask students to write one of their concerns, issues or fears on the slip of paper then place into the container. The instructions are:

- Draw out the slips of paper one at a time and discuss
- Draw on the experiences of the group first before answering the concern/fear
- When responding to the concerns/fears take care not to minimise the students concerns or dismiss them. You will find that many of the students put down the same concern/fear, point this out to them. Some possible fears/concerns to be prepared to answer are:
  - What if the parents know more than I do?
  - I'm not a parent. What do I say if a parent asks me if I have children?
  - What if a parent challenges me?

- How do I manage:
  - quiet parents
  - an angry parent
  - disclosure of harm to a child
  - disclosure of domestic violence
  - the 'know it all' parent (dominates group responses)
  - the 'I've tried that already' parent
  - a distressed parent
  - a parent with unrealistic expectations.

Concluding Activity

Reassure students that group facilitation can be very rewarding. Most facilitators feel anxious when they first start but with mentoring, preparation and experience most start to look forward to this important midwifery and nursing role.

Resources

Teate, A., Leap, N., Rising, S., & Homer, C. (2009). Women's experiences of group antenatal care in Australia: the Centering Pregnancy Pilot Study. *Midwifery*, doi:10.1016/j.midw.2009.1003.1001.

Ickovics J., Kershaw T., Westdahl C. & et al. (2007). Group prenatal care and perinatal outcomes: a randomized controlled trial. *Obsterics and Gynecology,* 110(2): 330-339.

Kennedy H.P., Farrell T., Paden R., Hill S., Jolivet R., Willetts J., et al. (2009). "I Wasn't Alone"—A Study of Group Prenatal Care in the Military. *Journal of Midwifery and Women's Health, 54*(3): 176-183.

Leap N. (1991). Helping You to Make Your Own Decisions - antenatal and postnatal groups in Deptford SE London. VHS Video. Available from Birth International. www.birthinternational.com.au

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources is available on this site that relate to the Australian context.

My Time http://www.mytime.net.au/index.php/home
My Time provides support for parents of children with disabilities through facilitated peer support groups. Mothers, fathers, grandparents and anyone caring for a child with a disability, developmental delay or chronic medical condition can participate in the groups. The groups allow carers to socialise, share ideas and information with others who have some understanding of the rewards and intensity of caring for a child with special needs. Groups are available in all Australian states and territories.

Healthy Start http://www.healthystart.net.au/
Healthy Start is a national initiative to provide support for parents who have learning difficulties and to assist them promote a healthy start to life for their children. Research-informed practice is promoted and there are a range of excellent parenting resources. This initiative is funded by the Australian Government and is a partnership between Australian Family and Disability Studies Research Collaboration at Sydney University and Parenting Research Centre.

Family Action Centre http://www.newcastle.edu.au/research-centre/fac/
This Centre is located at the University of Newcastle. The Centre focuses on numerous areas of interest to child and family health – resilience, inclusion of fathers and community development. There are many useful resources available from this site.

- Australian Fatherhood Research Network
- Indigenous Programs
- Communities for Children (Raymond Terrace & Karuah)
- The Boys in Schools Program
- Involving Fathers in Early Childhood Services
- Aboriginal and Torres Strait Islander fathers, father-figures, pops and uncles
- Father Inclusive Practice?
- Home-Start
- SNUG: Special Needs Unlimited Group
- The Caravan Project

Family Partnership Training Australia http://www.fpta.org.au/
Family Partnership Training Australia (FPTA Inc) is an interagency, multi disciplinary group that works collaboratively to make the Family Partnership Training Program available to anyone who has a role in providing help and support to parents. Most states in Australia support and promote the use of the Family Partnership Model for working with families and their children.

Australian Breastfeeding Association http://www.breastfeeding.asn.au/
The Australian Breastfeeding Association has a significant history of providing support for Australian parents who wish to breastfeed their infants. This website provides access to resources and research findings.

Playgroup Australia http://www.playgroupaustralia.com.au/
Playgroup Australia has been long established in Australia providing a much needed social networking service for mothers and fathers with young children. Importantly it provides opportunities for young children to play together and enhance their development. This site provides information about how to find a playgroup and resources for playgroups.

Circle of Security http://www.circleofsecurity.org/
The Circle of Security is a well regarded intervention program aims to alter the developmental pathway for children by improving the way parents relate and interact with their young children. The Circle of Security program is uses a foundation of attachment theory to work to develop a secure relationship between children and their parents.

NCAST http://www.ncast.org/index.html
NCAST (originally known as Nurse Child Assessment Satellite Training) was established in the late 1970s within the University of Washington. The programs offered by NCAST have a strong research base and are widely used within many well-known programs such as the Nurse Family Partnership program. Two main programs are the *Keys to Caregiving* and the *Parent Child Interaction Assessment*. The *Keys to Caregiving* aims to enhance nurses and midwives ability to observe and interpret infant cues (signals) to support parents develop their ability to intervene at an early stage before their child becomes overly distressed. The *Parent Child Interaction Assessment* provides nurses with the skills to objectively observe and rate the interaction between a child and their parent, design an intervention and then reassess the interaction after the implementation of the intervention. This assessment is accepted within the US child protection legal system. Two organizations within Australia have accredited instructors Tresillian Family Care Centres (Sydney) and Queen Elizabeth Centre (Melbourne).

Zero to Three http://www.zerotothree.org/site/PageServer
Zero to Three is a well-respected US organisation that provides child development and infant mental health information. There are resources for parents, professionals and policy makers. Publications are available for purchase and/or download.

Centre of Excellence for Children's Wellbeing: Early Childhood Development
http://www.excellence-earlychildhood.ca/home.asp
The Centre of Excellence for Children's Wellbeing is part of the University of Montreal. A key resource available on this site is an *Encyclopedia on Early Childhood Development*.

DVD Transcripts for Discussion: Section 5.1

Support Groups: Building Social Capital and Reducing Social Isolation

Social capital – what does it mean?

Emeritus Professor Dorothy Scott
Australian Centre for Child Protection

Social capital can sound like a bit of a 'buzz-word'; it was a word that Robert Putnam used to describe the webs of relationship, that we all have, which are based on trust and reciprocity, on trust and 'give and take'. We are all born with a certain amount of 'social capital'. The family into which we're born exists in a web of kith and kin, or family and friendship networks. Some of those are strong, and some of those are weak. Death, migration, breakdown in family relationships, geographical distance, can all weaken that web of relationships. So that for a family with new baby some families bring enormous strengths in the social capital, in the social support that is there for them immediately. And others need to nurture their children in a context of far less social capital, far less social support. Midwives and nurses have a special role in building the social capital.

The potential role of nurses and midwives in building social capital

For example, in antenatal groups and in new parent groups, which many nurses would run, we can see the potential for families, not just to learn about the skills associated with being a parent, but building relationships with one another so that you're engaging in this transition to parenthood or the birth of a subsequent child, strengthening those relationships with other families, which then means that the mother or the father walking down the street may actually recognise another family, may invite them home.

Building healthy societies through social capital

In a study I did on first time mother groups run by Child and Family Health nurses, one nurse ran a group called 'Parenting in a New Land'. She started with mothers who were all immigrants but the group grew to being on the weekends all of those families coming together, with the fathers, sharing their different cuisine and actually creating what Robert Putnam calls 'bridging social capital'. He talks about 'bonding social capital', which is the trust and cohesion that exists within groups based on ethnicity or religion or social class or your own clan. But what really makes for a healthy society is the 'bridging social capital' that builds the bridges between social classes, between age groups, between cultural groups. And that's something that midwives and nurses can do in the community-based practice of their professions.

Experiences of Facilitating Antenatal and Parenting Groups

DVD transcripts for discussion: section 5.2

Value of Groups: Building Friendships and Support Networks

Ali Teate
A midwife with experience in facilitating antenatal groups

Pregnancy and childbirth – particularly for a first time mother, can be quite daunting. And it's a time where she can also be quite vulnerable. So bringing women together during their pregnancy, can engage them in discussion about how to deal with problems in pregnancy, or how to deal with fear of childbirth. Quite often by learning from other women's experiences, they gain a sense of self-belief, of self-esteem and that 'can do' attitude. They don't enter into this childbirth experience or this parenting experience with so much fear since they develop strength about their own skills and a sense of empowerment.

Common issues that parents and new mothers experience are: a sense of inadequacy; a sense of vulnerability; it's a new role for them so quite often they don't understand the changes in role, the changes in their own persona; so they're in a time of transition and quite often in a large need of actually being able to share those role changes and also new experiences, with others who are going through the same things at the same time.

Karen Lamour
Midwife with experience of facilitating groups

I think one of the main issues that women face, having a new baby, is isolation. Some of these women don't have partners, so they've not got partners to lean back on. And coming to the groups they learn that they do have support out there, even if it's from people that they don't know terribly well, there's always someone there who can help. I think it's a positive thing for their mothering, it reinforces that they can do it, and that if they have problems, there's always lots of support out there, whether it's within that group that they've joined or community support as far as early childhood and other facilities that are out there.

Judy Massey
Midwife with experience of facilitating groups

For a lot of women that we see, they have no family in the area at all and these women become their friends over the course of the pregnancy, and they become their family. And they will meet up again at the end of their pregnancy and keep in contact; it's great for them. It gives them someone to refer to if something happens, a phone, call: someone's just very close by, a friend who can just give them some advice.

Sheryl Sidery
Midwife, Perinatal Mental Health Coordinator

I guess my personal opinion on mothers groups in the postnatal period is that they're vital. I don't know that in our culture we really prepare women very much for motherhood. There's so much focus on the pregnancy and the birth but not a great deal on the protective measures around caring for her in the postnatal period. We have a postnatal group in the hospital that I work in that goes for four months postnatally and certainly there's a need because we get about 40 women a week so there's obviously a huge need for women to just network with other women. But again most of the Early Childhood centres in most areas offer a postnatal group.

Kim Brickwood
Early Parenting Project Officer

The main thing I liked about the Early Bird groups was that it got young people – well people with babies – out into the groups to meet others. I think often when the babies are born, in those first few weeks, those tumultuous first few weeks, it's very difficult to get out with a baby and I think unless there's something to go to, often they will stay at home because it's much easier.

Group processes – information sharing and knowledge facilitation

Karen Lamour

When you're facing motherhood for the first time it can be quite a scary, daunting thing, and just the positive reinforcement that they get from other women that already had children to know that it's not quite as frightening as they imagine and that everything that they're feeling - which is scared and worried about what's going to happen - is all quite normal. It's not abnormal to feel like that.

Ali Teate

The facilitator role for groups is a very important role. It's one about balancing out the discussions that the women have; it's about providing information and knowledge if the women don't have that for themselves; it's also about drawing people out in the group so that they actually can gain a voice within the group. So, those skills often are used sitting and waiting for the conversations to happen.

Some of the unexpected outcomes for women when they have their care in a group – whether it be during pregnancy or a new parenting group – are that they gain friendships that they did not realise they were going to gain from the group. They also gain other women's experiences and other women's knowledge about parenting and childbirth. The other thing that they might gain is a sense of self-knowledge, of self-awareness, that they actually do have those skills already. Because when they discuss issues or experiences with other women, they realise that they all have that knowledge, that innate self-knowledge to parent or to give birth.

So it actually improves their capacity to parent, because it allows them to realise that they have those experiences or they have that knowledge from other women that they can draw on. So it provides them with strength and confidence as they move through the next phase of their life.

Judy Massey

As a facilitator in our groups, we don't actually stand in front of them and teach them, we sit in a circle, we're all part of the group and we promote the discussion, we really try and encourage the women to bring up ideas that are relevant to the topic that we might be talking about that particular week. And we'll just fill in some of the gaps. But it's much better for each of the women if they hear it from their peers rather than the two midwives running the session.

Kate McNamara
'MyTime' Peer Support Facilitator

Some parents may feel comfortable talking about themselves, in some cultures, that may be something that they're not comfortable about that, in which case we might have MyTime groups that are more structured, that may have more guest speakers, more of an information focus than a, "Tell us about yourself and your personal journey…" Again it just depends on the group and what they want. It's the parents' group, they lead it and tell us what they want. Some parents do just

want to sit around and have a cup of tea and share stories and then others do want something a bit more structured and less personal I suppose.

Dealing with disclosure about potential child protection issues in groups

Ali Teate

On occasions, women might bring up issues of domestic violence or history of abuse during the groups. And facilitators need to have preparation for those issues that might be brought up. They need to be aware of processes or facilitation skills that they can use when women bring up these issues.

It's important to discuss our role as mandatory reporters and discuss avenues or ways in which we can deal with women's issues when they bring them up. Sometimes the group will deal with it for you, and they will support that woman and they will also explain the reason why mandatory reporting is so necessary.

Judy Massey

We do – at the beginning of the sessions – encourage the women to keep anything that's discussed as private. So they do become quite comfortable in disclosing things. There have been very personal things disclosed and kept private within the group.

If someone in the group disclosed any personal issues about domestic violence issues and we were concerned that there was a real situation there, we would address it in the group as to where anyone may seek help and the resources available locally. We would certainly speak in private to that person after the session and make sure that they had the follow-ups.

Kim Brickwood

So I think really for any disclosure, whether it be a Mental Health disclosure, whether it be a Child Protection issue, a Domestic Violence issue, whatever the disclosure, I think letting the group know that you are there, you've got the trust built up. I think they will probably come and speak to you afterwards.

Supporting Parents and Families in Aboriginal and Torres Strait Islander Communities

Australian Aboriginal and Torres Strait Islander families show remarkable strength and resilience. Australian Aboriginal culture is the world's oldest living culture, with knowledge systems evolving over many thousands of years and in adaption to the changing Australian environment (Gostin and Chong, 1998). Knowledge about cultural practices including childrearing, spirituality, relationships to the land and nature, kinship networks, laws and rites have been passed down, within and between different cultural groups through ceremony, art, storytelling, dance and song for millennia. We do not need to be experts on each culture we work with, but we do need to be aware of those cultural differences and how this may impact on parenting methods. For example Aboriginal people are more likely to live in a family household then are non-Aboriginal people (81% compared with 68%); with the household more likely to have multiple families living in them and to be headed by a sole parent (Australian Bureau of Statistics 2008). Overcrowding in a home may be seen as neglectful if there is insufficient bedding, minimal supervision etc but this may be a cultural difference and with openness and respect with families, the cultural differences and safety of the child can be explored without the family feeling judged. Aboriginal and Torres Strait Islanders have a long history in Australia and it is important for clinicians working with Aboriginal communities and families to gain knowledge on cultural awareness to understand this history and the impact that the Stolen Generation and removal of children has had on Aboriginal communities. It is difficult for Aboriginal families to trust services after the history in Australia which has led to over-representation in the child protection system.

Australia-wide, Aboriginal and Torres Strait Islander children are more likely than non-Aboriginal children to be the subject of a non-substantiated notification of abuse and almost nine times more likely to be placed in care (Australian Institute of Health and Welfare, 2009). Aboriginal children, when compared with non-Aboriginal peers, have also been shown to be more likely to have poor health outcomes such as preterm birth, low birth weight, hospitalisations, higher mortality rates, more recurring infections, chronic ear infections and poor nutrition. These poor outcomes for children speak to the need for a public health approach to support and promote Aboriginal child health, safety and wellbeing (Scott and Arney, 2010).

Midwives and nurses are in a very privileged position. Our work enables us to enter into other people's lives in times of absolute joy, as well as during periods of deep despair. Listening, not having assumptions about families, parents and children, and having a respectful curiosity about culture and parenting practices will foster rich and positive relationships with families from Aboriginal and Torres Strait Islander communities.

A constant question we need to explore to enable tolerance of parenting difference is to ask – is it safe for the child? This is an essential question when working with families from cultures that are different from our own. For example, there are many safe ways to bath a baby beyond the way we may have been taught as a midwife or nurse or that we may have used as a parent– the important thing is that the baby is safe and that the parents feel confident in the method they are using. We need to remember to be tolerant of the many ways there are to do things while keeping in mind the basic principles of safety.

Important note to educators:

Unfortunately it is common for some students in every course to have experienced trauma due to child abuse and/or neglect, and/or domestic violence. Some may have a family history of mental illness or have experienced other types of traumatic events, such as the death of a child or parent. Acknowledging this at the beginning of

the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students. In particular with this module, we encourage you to be aware of the culture, history and experiences of students who are part of Aboriginal and Torres Strait Islander communities.

Learning outcomes

On successful implementation of this module, students should be able to:

- Examine their attitudes and beliefs about parents and families from Aboriginal and Torres Strait Islander communities
- Understand the importance of cultural safety and sensitivity in working with families from Aboriginal and Torres Strait Islander communities
- Explore effective ways of working with parents and children from Aboriginal and Torres Strait Islander communities
- Discuss the major health challenges impacting on families and children from Aboriginal and Torres Strait Islander communities
- Discuss the importance of family in Aboriginal and Torres Strait Islander culture.

Each of the three sections in this module use video resources to stimulate discussion and interaction. In each section, we have suggested activities and potential assessments that can be supported by the individual video clips.

DVD section 6.1: Supporting parents and families in Aboriginal and Torres Islander communities

In this section, Trudy Allende (Aboriginal Education Officer) and Leona McGrath (Aboriginal Midwife) discuss their work and issues that arise in a Community Midwifery Project. They talk about:

- Common issues that Aboriginal and Torres Strait Islander women face, such as access to services and the need for flexibility
- Building trusting relationships and a welcoming hospital environment
- The importance of extended family in Aboriginal and Torres Strait Islander communities
- Cultural awareness training to increase understanding and awareness
- The qualities people need to work with Aboriginal and Torres Strait Islander communities.

Trigger questions

The following questions can be adapted to facilitate discussion, using either a large group or small group approach:

- What are some of the issues Aboriginal and Torres Strait Islander families with young children experience that impact on their current and future health status?
- What might be the additional pressure on midwives and nurses who live and work within their own, often small, communities?
- Why is it important to work in a collaborative way with the community and other health professionals?
- When working with families from Aboriginal and Torres Strait Islander communities, who might you try to enlist to assist you to facilitate cultural safety for the families you work with?
- What strengths do you have that will be appropriate for working with parents from Aboriginal or Torres Strait Islander communities?

Assessment/Activity: Cultural Awareness training

Identify how to access Cultural Awareness training in your workplace (if you have no access to Cultural Awareness training - what you can access via the web)

- Who facilitates and who accesses it, how often?
- How long is the program and how is it provided?
- What are the key features of Cultural Awareness training?

Section 6.2: Closing the Gap

The Closing the Gap YouTube video provides an insight into the health challenges faced by people from Aboriginal and Torres Strait Islander communities. The video provides examples of successful, community controlled health services and interventions. This video is available via: http://www.oxfam.org.au/act/events/close-the-gap-day

Activity: Closing the Gap

Before showing the video, ensure that students place any possessions in a safe place where they can leave them during the activity. Explain that they will be moving around and all they will need is a pen and a sheet of A4 paper that you will provide.

Explain that after watching the 'Closing the Gap' video they will be asked to write down in large letters on their piece of A4 paper three single words that will stay in their minds as a result of having viewed the video. They will then be asked to move around the room showing each other which words they have on their paper for not more than 5 minutes. They will then find one other person with similar words to theirs and sit down with them to discuss why they chose those words and what they will remember as a result of watching the video.

Activity/assessment: Identifying community-controlled services

Ask students to identify the Aboriginal/Torres Strait Islander community-controlled services in their local area.

- The activity or assessment could include asking students to identify the features of one of these services. The students can either report back verbally to the larger group or an assessment piece could also include writing a report or developing a poster about the services.

Section 6.3: 'It takes a Village': community-building project in Kalumburu, an indigenous community in Western Australia

Go to the website of the Rural Health Education Foundation and register/log on if already a member: http://www.rhef.com.au/

Enter 'It Takes a Village' in 'Search Programs' and go to the third segment.

It Takes a Village' has three sections, each introduced by Julie McCrossin:

- A program for young mothers in Mildura, Victoria (this section will be useful to show students when working with the module on support groups);
- A workshop on fathering in Nowra, on the south coast of NSW (this section will be useful to show students when implementing the module on engaging fathers);
- A community-building project in Kalumburu, an Indigenous community in Western Australia.

Section 6.3 provides an overview of an intervention to address community trauma. It demonstrates how a community has the capacity to heal itself and become strong, with appropriate support.

Trigger questions

After watching the clips facilitate a discussion using either a large group or small group approach to discuss the positive messages from this section of 'It Takes a Village'?

Activity: It takes a village

Case Study

Donna travelled to the city to visit her uncle, who was in hospital. She was 39 weeks pregnant with her 12th child when she arrived at the local maternity unit in labour. She gave birth to her baby son after 2 hours in the birthing facility. Many of the maternity unit staff made very critical and derogatory comments about Donna and her 'tribe of kids'. Some remarks were racist about her Aboriginality. It was obvious they had not heard the full story before making judgments.

Donna had come to Sydney because she was extremely close to her uncle who cared for her as a child. Her uncle had become very ill and was thought to be close to death when Donna's sister contacted her about her uncle's condition. Donna was desperately sad and needed to see him even though she was pregnant and close to full term. Donna's extended family were caring for the children until Donna could return home.

Ask the students to talk about this situation in pairs then come back to discuss their responses:

How might you have felt in Donna's situation?

Would you have taken the same action as Donna if it was your parent or childhood carer who was near death?

How might you have felt and behaved if you had been working in that birthing unit when Donna came in with her children; in particular, how might you have responded to racist comments made by colleagues?

How else might the situation have been handled?

Activity: Learning more about cultural influences and childrearing beliefs

Ask students to form groups of two and practise asking each other these questions. Suggest they work with someone they know little about.

- Did you grow-up here? (If not, where did you grow-up?)
- What is it like living where you live?
- What do you think it is like being a parent, raising children in your community?
- What do you think children need most from their parents?
- What do you think parents from your community are trying or hope to provide for (dreams/desires) their children?

- How can you help parents in your community be the kind of parent they want to be?
- What characteristics are essential for midwives and nurses to work with Aboriginal and Torres Islander communities?

Activity: Understanding identity

Introduction

How we construct our identity is complex, with a great many features that impact on the final outcome.

Activity

Invite students to take a piece of paper and for 5 minutes work quietly on their own to make a list of features that describe their identity. Reassure them that they will share what they write with one other person only.

Give them a made up example such as this one:
I am a 45 year old, white Australian woman, mother of two children, wife of John, daughter of Mary and Bob, a community nurse, a Christian, an artist, from a family of Irish origin, a red head, etc.

When they have written their statement, ask them to re-order the features in terms of which ones are most important to them. They will then discuss with one other person why they chose that particular order and what they learnt from carrying out this activity.

Conclusion

Encourage the students to reflect on which features are obvious to the general public on first acquaintance and which features they have a choice about sharing. How might their public and personal identities form the opinions of them that are made by others?

Resources

A Picture of Australia's Children http://www.aihw.gov.au/publications/phe/phe-112-10704/phe-112-10704.pdf
This is a useful document to assist in developing a profile of children living in Australia.

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources are available on this site that relate to the Australian context.

The resource sheet: *Child Protection and Aboriginal and Torres Strait Islander Children* by Claire Berlyn and Leah Bromfield (2009) can be downloaded from this website as a pdf. It presents and discusses a snapshot of data describing the rates of involvement of Aboriginal and Torres Strait Islander children in child protection and out of home care and contains useful statistics and references.

Closing the Gap Clearinghouse http://www.aihw.gov.au/closingthegap/
The Closing the Gap Clearinghouse is a Council of Australian Governments initiative jointly funded by all Australian governments. Resources are provided to assist in improving the health and wellbeing of Australia's indigenous peoples.

The Australian Indigenous Health*InfoNet* www.healthinfonet.ecu.edu.au/
This free Internet resource aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible. In this way, the Health*InfoNet* aims to contribute to 'closing the gap' in health between Indigenous and other Australians.

Language use when working with NSW Aboriginal communities
This research brief provides general guidance as to the appropriate language to use with Aboriginal communities.
http://www.community.nsw.gov.au/docswr/_assets/main/documents/researchnotes_aboriginal_language.pdf

Health Care and Indigenous Australians: Cultural safety in practice.
Authors: Kerry Taylor and Pauline Guerin. Published by Palgrave Macmillan. January 2010.
This book focuses on the health care professional and what they can do to contribute to improving the health outcomes of Indigenous Australians. The book uses a cultural safety approach for health students or professionals wanting to improve their practice. It has14 Chapters that include activities, critical thinking questions, poems, 'making it local' activities, and case scenarios to encourage readers to think in new ways about Indigenous health and about their practice more generally.

Birth Rites VHS video 58 mins.
Jag Films Pty Ltd, PO Box 53, Margaret River WA 6285, ph: 08 9758 7404, fax: 08 9757 3180, email: jagadmin@westnet.com.au
This video draws powerful comparisons between birth in outback Australia and the icy regions of Canada. These two Indigenous cultures have a shared history of dispossession as well as social and health problems. Both countries have routinely evacuated women from their hometowns to birth alone in far away hospitals. The Inuit midwives have made a breakthrough with the first Inuit controlled Birth Centre in remote Puvirnituq (Canada). In Australia, the women's stories expose the devastating personal and cultural repercussions of this 'separation policy'.

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Australian Institute of Health and Welfare (2009) *A picture of Australia's children,* Canberra: Commonwealth of Australia.

Arney, F. & Scott, D. (2010), *Working with Vulnerable Families - A Partnership Approach.* Melbourne: Cambridge University Press.

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Supporting Parents and Families in Aboriginal and Torres Islander Communities

DVD transcripts for discussion: section 6.1

Trudy Allende
Aboriginal Health Education Officer

I think the common issues that a lot of our women face on their journey to motherhood: I guess accessibility's a big thing for us. Where our local community it takes two buses to get to hospital, and things like that and if you're carrying a couple of kids with you and it's a rainy day… hospital systems can sometimes be unforgiving so if you rock up there late and, you know, go to the front desk and you're late, you're really flustered and the person at the front desk is a bit stroppy with you because you missed your appointment time or you're setting everyone else back. Once they have a bad experience the women aren't going to go back to the hospital. So I guess that accessibility, being able to come out to the clinic, being flexible, at the clinic we don't have an appointment system, we have a drop in time – women can come anytime between 10 and 12 to drop in and see us.

We do also take appointments as well. So that's a huge issue, accessibility, actually getting them. And also the trust in the hospital system. Once we build that relationship with our women, we have that trust and then we can refer them on to other services.

Leona McGrath
Midwife

Issues that some Aboriginal women would have accessing maternity care – I think like Trudy was saying earlier, it's that trust. It's huge history - you know – with Aboriginal people, that they don't feel like they can trust, go to the hospital. That's why our statistics are so appalling. Our babies are dying and our people are dying 17 years younger than, you know, 17 years before White Australia.

Other issues – we don't want to sort of put Aboriginal people into this sort of little box and tick – say, 'They're Aboriginal and so they have that'. You know, it's the same with everybody. You know – transport, like Trudy was saying, transport and trust, [Trudy interjects 'Money'] Leona: Money yes.

Trudy Allende

And also not feeling comfortable in a hospital setting. Um as I said, a lot of the women say, 'We walk in there and we feel uncomfortable and we feel like people are looking at us.' You know, whilst we hope that that doesn't happen any more, it still does sometimes. And I guess from years and years of that, it's just that feeling when you walk in and you feel you don't belong. And that's a big thing and that's a huge thing that will stop our people walking into a hospital.

Leona McGrath

Extended family is very important in the Aboriginal community. We'll just grab a hold of it because if we have a young lady come in and have her visit and she'll say, well her Auntie's here and then her Grandma will come next visit and then her Great Aunt will be there next visit and she'll say she wants everyone at the birth. And we say, 'That's fine'. That's quite common. It's quite common that we have… especially the young women – they will have Aunties, sisters, you know, cousins…

Trudy Allende

Yeah family plays a really big important role and that extended family as well, as Leona was saying, in the birth it's not unrealistic to have a whole heap of family members in there and that's what the woman's comfortable with. And even the appointments, as Leona was saying, about a woman turning up with little brothers and sisters in tow, you know, Mum… and it's lovely and that's the way we open our doors and say, 'You guys are all welcome, come on in'. And let them be involved and things like that because it's all about family and that's what we're all about so…

Leona McGrath

We really encourage it. But if the women don't want that, that's fine. We're happy for that. It's what the women want ultimately.

Trudy Allende

Having that cultural awareness, that's really, really important and even myself as an Aboriginal person, I need that awareness that I can't just go into a community and big note that I'm here because yes.

Leona McGrath

That's what a lot of hospital staff may not have had that training, that cultural awareness training. We feel that's really, really important that all staff do, you know, get that training because – so they can be a little more open minded when Aboriginal women do come in.

We see Aboriginal women from anywhere and we had a woman present at 39 weeks having her 12th baby – she'd just come down to visit her uncle – and she just came in one night and had her baby and people were going – people say stuff about, you know, anybody with a tribe of kids around. Like all the kids were in the room when she had her baby. If they would have had that training they would have been a bit more sensitive, because she was quite upset by some of the things what was said to her – which is really unfortunate.

Trudy Allende

There are a lot of qualities people need to work with Aboriginal communities. I think being open and honest is a huge thing. Confidentiality as well is really huge in the Aboriginal community. Yeah, not disclosing things to other people. Not being judgmental. Things like that. Everyone's individual and has got their own story. And I guess that's really important. And also I think it's really, really important for people to undergo Cultural Awareness Training. It cannot be underrated. I know at the moment it's not mandatory, but it's something that really should be. And specific to that community you're going to be working with. Because we still get it wrong. You know, we still get it wrong. And you can never stop learning. But that's a really important thing. People have to be culturally appropriate.

Leona McGrath

And being open minded – you said that – and non-judgemental. The way the media has portrayed Indigenous people as though … We're not all alcoholics! [laughs] We're good parents and we have jobs!

Supporting young mothers (and parents) to nurture and protect their children

The shift in Australia over the past decades has been towards women and men being older when they become parents for the first time. Importantly this is a relatively new phenomenon as 30 or 40 years ago, being under 20 years and having your first baby was not abnormal due to the nonexistence of oral contraception and the different expectations of women in Australian society.

This module defines young mothers as under 20, although this arbitrary age cut-off may vary depending on your setting and the cultural background and norms in the community. Feel free to vary the age cut-off depending on the circumstances.

Supporting young women and men during pregnancy, childbirth and early parenthood can be complex and challenging for all concerned. These challenges are often related to community attitudes, the developmental stage and tasks of the young people, and a sense of loss and isolation from their peer groups.

Learning Outcomes

On successful implementation of this module, students should be able to:

- Identify the issues and challenges for young parents
- Identify relevant community and professional resources and support services for young parents
- Explore strategies to manage parental sleep deprivation and feelings of frustration and anger
- Identify relevant child protection reporting requirements.

DVD section 7.1: The Young Parents Project - Young mothers provide feedback to health professionals about their experiences of care

Kim Brickwood, a midwife and nurse describes a project that she was involved in developing in her role as Early Parenting Project Officer in an area health service. Her comments provide background information to inform the 'Young Parents – An Insight' activity. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

DVD section 7.2: Pregnancy and parenting for under 20: young parents – an insight

This suggested online resources is the project discussed by Kim Brickwood in section 7.1. To access this online resource: *Pregnancy and Parenting for under 24: Young Parents – an insight* go to the following website: http://www.sesiahs.health.nsw.gov.au/Young_Parents/Videos/yp_dvd.asp

This video features 4 young mothers talking about their experience of pregnancy, childbirth and the early days of being a parent. There is a focus on the attitude of health professionals and key messages for working with young parents during this period of their lives.

Once the students have viewed the video ask them to discuss the following questions, either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group.

Trigger questions

These questions may promote discussion in this activity:

- What are the strengths of these young mothers?
- What were the positive aspects of being a young parent?
- What were the positive characteristics/attitudes of midwives and nurses that were appreciated by the young mothers?
- What were the characteristics/attitudes of midwives and nurses that resulted in a negative experience in childbirth and early parenting for these young women?
- What lessons have you gained as a midwife or nurse from hearing about these positive and negative experiences?
- The young women provided several key messages for health professionals, what were these?

Additional questions/activity

- What were the challenges and/or frustrations a young parent may experience when parenting an infant and/or toddler?
- Being a parent of an infant can be frustrating and sometimes parents become exhausted and angry. Identify strategies you can talk to young parents about to ensure they are able to maintain the safety of their infants and/or young child
- Within your local community, what are the services/ activities available to young parents? This question could form the basis of a mapping activity to investigate the type of services within the student's local community.

Activity: Role play

Introduction

This activity can be used in several ways as a role play, as a case study for discussion in class or online, or as an assignment. If using as a role play it is important to reinforce how to provide feedback in terms of looking at strengths but also by respectfully challenging statements or actions and providing alternative ways of dealing with issues that are raised.

Activity

Ask the students to form groups of 3 to role play this case study. Each student is to take a role (Sally, midwife/nurse and observer). The observer will provide feedback to Sally and the midwife/nurse.

> During an appointment with Sally (who is 18 years old) and her 2 week old son she tells you how tired she is and talks about her feelings of anger when her son continually cries. Sally doesn't like feeling this way and is asking for help due to her concern she may hurt her son. How would you handle this situation?

Concluding activity

To conclude the activity in the large group - ask students to discuss their feelings of playing each part.

The following question can be used to extend the learning from the role play or if using the scenario as a case study:

- What are the possible causes of Sally's frustration other than feeling tired?
- What strategies would you explore with Sally to reduce her tiredness?
- What strategies would you explore with Sally to manage her feelings of anger?
- What are the community supports and services you could offer to Sally?
- What are the child protection reporting requirements in your state? Would you report Sally? Justify your response
- How would you document this interaction with Sally in your midwifery/nursing notes?

Before closing the activity, ensure everyone leaves their role behind.

Resources

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources are available on this site that relate to the Australian context.

Live Smart http://www.livesmart.net.au/
Live Smart is where young people can find information in 6 languages to get by in the real world. From budgeting to public transport, health, mobile phones, Live Smart aims to provide young people with the information they need.

Parenting as a teenager – Raising Children http://raisingchildren.net.au/articles/parenting_as_a_teenager.html
This is a section of the Australian Raising Children website. Using a case study it highlights the challenges, links to some government agencies and some statistics about teenage pregnancy. Also see the recommended website handout.

Good Beginnings http://www.goodbeginnings.net.au/support/volunteers.shtml
Good Beginnings provides a volunteer home visiting parenting support and community development services. The service is active in most Australian states and territories.

Commission for Children and Young People
These Australian Commissions provide a range of resources for parents, and people/organisations providing services for children and young people.

NSW Commission for Children and Young People http://kids.nsw.gov.au/

Qld Commission for Children and Young People and Child Guardian http://www.ccypcg.qld.gov.au/index.html

Tas Commissioner for Children and Young People www.childcomm.tas.gov.au/

WA Commission for Children and Young People http://www.ccyp.wa.gov.au/index.aspx

Vic Child Safety Commission http://www.ocsc.vic.gov.au/

ACT Guardian for Children and Young People http://www.gcyp.sa.gov.au/cgi-bin/wf.pl

NT Office of the Children's Commissioner www.childrenscommissioner.nt.gov.au

Headroom www.headroom.net.au
Headroom is a site that promotes positive mental health for children.

Kidsafe: Child Accident Prevention http://www.kidsafe.com.au/
Kidsafe is a national organization with state branches. It aims to prevent unintentional childhood injuries and reduce the resulting deaths and disabilities associated with childhood accidents in children under the age of 15 years.

Early Words http://www.earlywords.info/aboriginal/index.html
A Western Sydney Aboriginal Early Literacy Project for Families. This website provides resources for Aboriginal parents.

The Young Parents Project

DVD transcripts for discussion: section 7.1

Kim Brickwood
Midwife, Child and Family Health Nurse, Early Parenting Project Officer

The other project I was involved in was the Young Parents project. And for that project we recruited young women. They had to be under age 24, currently under age 24, and needed to have been under 20 when they had their babies. And they were trained in order to give in-service sessions to health staff about engaging with young people and having friendly services. They did sessions with GPs, midwives, child and family health nurses, and social workers.

What the idea behind it was, we were going to get them to come and tell their stories about when they had their babies and their experiences. So what we decided to do was film it, and then at the in-services we showed the film and then we would have 2 or 3 of the young people from the film in a panel with the Youth Coordinator facilitating the discussion. And they would then answer questions.

So the DVD itself goes through positive experiences and not so positive experiences – as you can imagine there were more of those [smiles] and messages that they would like health staff to take away from the in-service.

And that's the DVD that was used in the in-service and also the website. So the website has actually been accessed from overseas which is very exciting. And the DVD's in a wmv – Windows Media Video file. Accessible via the internet. It's only 14 mins long and it's quite good [laughs].

The main issues that the young women identified

For young Mums the main issues were what they perceived as a lack of respect. And an attitude that they picked up from the staff who might talk over them as though they weren't there. Another issue is the assumption that because they're young, they haven't thought about it. Because some of them have thought about it, they've made a conscious choice and because they're young doesn't mean that they can't be a good parent.

I think they feel judged. Their issues are different. Often their housing is an issue. They may not have housing or they might be still living with their parents. Sometimes the relationships they are in are stable; sometimes they are not stable and they are abusive so they have other issues. Sometimes there's substance abuse linked to all this as well.

And these are issues that they need to overcome and then they need assistance and non-judgmental care.

They feel … I think they often feel out of place in a group with older mothers for that reason. But I think that depends on the young person really.

Resources for young people: identifying local services

We also developed several resources so there's a resource card for young people – it's about credit card size – double sided, phone numbers on one side and websites on the other. And a fridge magnet.

MODULE 8:

Supporting families where a child or parent has a disability

Giving birth to a baby is a time of profound joy for most parents – dreams and expectations for a healthy child are met. For other parents their lives are sent into turmoil as their child is recognised as having a disability. Feelings of guilt, anger and disappointment are mixed with love and joy for their child. The immediate response of health professionals, the support provided and access provided to accurate information are of crucial importance in the days following their child's diagnosis.

The first two sections in this module address the experience of parents who have a child with a disability. In Section 8.1, Kate McNamara talks about the support that 'MyTime groups' across Australia can offer these parents; in Section 8.2 Karen Gomez shares the experience of finding out that her second baby, Mark, had a serious disability related to a chromosomal abnormality and the impact it had on her and her family in the first year of his life.

People with disabilities also may become parents. This raises other issues in relation to their need for additional support in their parenting but also in the response from others, including health professionals. Parents with disabilities often manage really well – they may however require additional assistance and consideration.

Parents who have a disability may come to the attention of child protection and other government agencies during pregnancy or during the early months of parenting. This can be due to not conforming to the idealised image of what parents should look like or act. It is important to remember that having a disability, whether physical or learning, does not negate a person's ability to be a loving, responsive and appropriate parent. Dr Margaret Spencer explores these issues in the third section of this module.

Learning Outcomes

On successful implementation of this module, students should be able to:

- Identify the range of feelings that parents who have a child with a disability may experience in the initial stages and then later on
- Discuss the importance of enabling parents to talk about their infant or young child who has a disability
- Identify the strengths of parents with a disability
- Be aware of some of the challenges facing these parents
- Discuss the importance of providing parents who have a disability with appropriately targeted parenting information and support or directed assistance
- Discuss the challenges for parents with a disability
- Discuss and critique community attitudes to parents and/or children with a disability
- Assist parents identify and use their support network of family, friends and community
- Identify services available for parents with a disability or who have a child with a disability.

Important note to educators:

You may have students in this session who have the experience of growing up with a parent who has a disability or have a child or sibling with a disability. These students will be able to provide valuable insight, they may be able to demystify and normalize the experience of living with a family member who has a disability. These students may also

have experienced loss, grief and trauma from their experiences. Acknowledging this at the beginning of the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students.

DVD section 8.1: Supporting parents and families where a child has a disability

Kate McNamara describes the MyTime program she works in as a peer support facilitator. In this DVD section she also provides insights into the emotions and distress experienced by parents who have a child with a disability. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

- What are the challenges and frustrations experienced by parents who have a child with a disability?
- Why are support groups such as MyTime are a valuable resource for parents?
- Identify where parents with children with disabilities can access MyTime groups in your local area. What does the MyTime promotional material say?
- Identify other local professional and community services and agencies that can provide support for families where a parent has a child with a disability
- When working with parents who have a child with a disability, what strategies can you use to:
  - ensure you are providing the most appropriate care?
  - maintain your own mental health?

DVD section 8.2: A personal experience of having a child with a disability

In this section Karen Gomaz tells an inspirational story of her experience of having a child with a severe intellectual and physical disability. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Activity: Reflective Activity

After viewing section 8.2 ask students to take a couple of minutes and reflect on the story Karen has shared. In groups of 3 ask the students to identify the:

- challenges that may be experienced by midwives or nurse when they are working with parents who have a child with a disability
- personal qualities that are essential as a nurse or midwife to provide support to these parents.

In the larger group, record on the whiteboard/butchers paper their findings.

DVD section 8.3: When a parent has an intellectual/learning disability

Margaret Spencer as a social worker, nurse and academic has spent much of her working life advocating for parents with a learning disability and providing practical support and interventions. Her insights are further enhanced due to

her experience as a foster parent for children with a learning disability.

In this DVD section Margaret may challenge some of your pre-existing beliefs about parents with a learning disability and their capacity to parent. To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger Questions

- The presenter in the video clips identified the strengths of parents with a disability. Are you able to identify any additional strengths?
- What are the challenges and frustrations experienced by parents who have a learning disability?
- Identify some of the challenges faced by midwives, nurses and others working with parents who have a learning disability
- What do you think are the attitudes/characteristics you need to work in these areas of practice?
- What are the potential risks for young children living with a parent who has an intellectual/learning disability?
- Identify local professional and community services and agencies that can provide support for families where a parent has a disability
- When working with parents who have a disability, what strategies can you use to:
  - ensure you are providing the most appropriate care?
  - maintain your own mental health?

Additional questions

Parents with a physical disability encounter challenges and frustration as well as prejudice. Explore the following questions with the students:

- What might be the challenges and frustrations experienced by parents who have a physical disability? (include a range of physical disabilities)
- Identify some of the challenges faced by midwives, nurses and others working with parents who have a physical disability.

What are the potential risks for young children living with a parent who has a physical disability?

Activity: Insight building

The following story provides an insight in the disappointment and the lost dreams of parents who have a child with a disability. It does not matter how severe the disability, parents still mourn the perfect baby.

Read the students the following story – ask them:

- to reflect on the feelings of the mother and the message the mother is trying to convey
- if they can relate it to an experience they had anticipated but it did not turn out as planned – what happened, how did it feel and what was the outcome?

Discuss their reflections in either small or large groups. Before completing the discussion it is essential the educator:

- checks personal issues have not been raised for the students
- reinforces that there are support services available if students would like to talk with someone about feelings that may have been triggered.

WELCOME TO HOLLAND

I am often asked to describe the experience of raising a child with a disability - to try to help people who have not shared that unique experience to understand it, to imagine how it would feel. It's like this.....

When you're going to have a baby, it's like planning a fabulous vacation trip - to Italy. You buy a bunch of guide books and make your wonderful plans. The Coliseum. The Michelangelo David. The gondolas in Venice. You may learn some handy phrases in Italian. It's all very exciting.

After months of eager anticipation, the day finally arrives. You pack your bags and off you go. Several hours later, the plane lands. The stewardess comes in and says, "Welcome to Holland."

'Holland'?!? you say. 'What do you mean Holland?? I signed up for Italy! I'm supposed to be in Italy. All my life I've dreamed of going to Italy'.

But there's been a change in the flight plan. They've landed in Holland and there you must stay.

The important thing is that they haven't taken you to a horrible, disgusting, filthy place, full of pestilence, famine and disease. It's just a different place.

So you must go out and buy new guide books. And you must learn a whole new language. And you will meet a whole new group of people you would never have met.

It's just a different place. It's slower-paced than Italy, less flashy than Italy. But after you've been there for a while and you catch your breath, you look around.... and you begin to notice that Holland has windmills.... and Holland has tulips. Holland even has Rembrandts.

But everyone you know is busy coming and going from Italy... and they're all bragging about what a wonderful time they had there. And for the rest of your life, you will say 'Yes, that's where I was supposed to go. That's what I had planned'.

And the pain of that will never, ever, ever, ever go away... because the loss of that dream is a very significant loss.

But... if you spend your life mourning the fact that you didn't get to Italy, you may never be free to enjoy the very special, the very lovely things ... about Holland.

Emily Perl Kingsley 1987 http://www.our-kids.org/Archives/Holland.html

Activity/assessment: Child protection reporting

Making a child protection report is a major step and once the process has commenced there may be significant harm to the relationship you have developed with the parents of a child with a disability or to a parent with a disability and their family. There may also be significant parental and family distress. It is therefore crucial that appropriate assessments are completed to objectively justify a decision to report a child at risk. As part of this activity you may wish to review the state mandatory reporting requirements and processes.

Ask the students either in the large group or in small groups to:

- identify the steps they would take to confirm and justify the need for a child to be reported at risk
- identify areas we may have failed to adequately support parents (e.g. assuming they understand what we have suggested they do to improve their care of their child)
- discuss the possible implication of reporting a child at risk (both positive and negative)
- discuss how they could support a parent through the reporting process.

In the larger group discuss these steps and the rationale for inclusion in their decision making process. The aim of this activity is to raise the awareness of the students to the:

- complexity of reporting a child at risk
- consequences of reporting a child at risk
- need for a comprehensive assessment
- consider their own prejudice towards parenting practices that do not align with their own experience of parenting or being parented
- importance of gaining support from management and others such as clinical supervisors.

At the completion of this activity ensure a debriefing session is included to ensure students are emotionally ready to leave the activity.

Resources

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources are available on this site that relate to the Australian context.

Healthy Start http://www.healthystart.net.au/
Health Start is a national strategy for children of parents with learning difficulties. It is a collaborative activity of the University of Sydney and the Parenting Research Centre. This excellent site provides resources for professionals, parents and carers. The resources focus on the strengths of parents and providing support for parenting through understanding, support and education.

My Time http://www.mytime.net.au/index.php/home
My Time provides support for parents of children with disabilities through facilitated peer support groups. Mothers, fathers, grandparents and anyone caring for a child with a disability, developmental delay or chronic medical condition can participate in the groups. The groups allow carers to socialise, share ideas and information with others who have some understanding of the rewards and intensity of caring for a child with special needs. Groups are available in all Australian states and territories.

Raising Children Network http://raisingchildren.net.au/
The Raising Children Network is supported through Australian Commonwealth Funding. Whenever possible it provides evidence based/informed parenting advice. The resources include parenting information for birth to the teenage years. Resources for use with parents who experience learning problems or have a child with a disability are a particularly valuable resource for nurses and midwives. To increase access to community supports and networking there is a facility to find out what is available in each Australian suburb. The following links are of particular interest for this module.

Children with a Disability http://raisingchildren.net.au/children_with_disabilities/raising_children_with_disabilities.html

Parents with physical disability http://raisingchildren.net.au/articles/parents_with_physical_disability.html

Parenting with an intellectual disability http://raisingchildren.net.au/articles/parenting_with_an_intellectual_disability.html

Supporting Parents And Families Where A Child Has A Disability

DVD transcripts for discussion: section 8.1

Kate McNamara
MyTime Peer Support Facilitator

The MyTime program is a national program and it's a peer support program and it's for parents – mothers and fathers – grandparents and carers of young people who have a disability or chronic medical condition.

The MyTime model is about bringing parents together in a network combined with resources that then reduces the parents' social isolation and encourages and strengthens them with information and resources and again I think it gives them that sense that they are in control – from probably starting off in a situation that they had no control over.

The reason why I'm a facilitator for MyTime groups is predominantly that I have a child with a disability myself. I suppose I came to it because I had a passion for it and I had a commitment to the program because I saw how valuable the groups were and I wanted them to work. So I suppose the point I'm making is to recognise parents as a valuable resource – for practitioners when they're dealing in this sort of situation to realise that parents can also give back and they have valuable information and resources that they can, that you can tap into.

Finding Out that Your Child Has a Disability

When you find out that your child has a disability you start on a path that's totally different to where other people are. You go through stages of feelings that including: denial; not accepting your child's diagnosis; to being fearful about what's going to happen to your child and your child's life; of changed expectations for your child; to feeling guilty that maybe you've done something that's caused this; you want someone to blame; or something to blame; so there's a whole range of emotions that you have. And I suppose one of the main things is that feeling of isolation, that generally it's not a path that you planned; it's not um, often you don't know anyone else who has ever had a disability; it's totally unknown to you. So these groups are an opportunity for parents to realise they're not alone; that there are other people who have similar experiences; and they can come together and find out what resources are available and what information is there to help them and their siblings and their children

Babies and Children who Have a Disability

I think the impact often on babies and children in that situation of having a disability or a medical condition is they often can become a 'medical condition'; or they can become 'a disability'; or they can be...generalisations are made about them. Suddenly, they are no longer a cute little baby, they're 'a Downs' where generalisations are made like 'they're lovable' or 'they're stubborn' or whatever. So I think it's important to always remember that they are children and they belong to a family, and they're still loved even though they're not what their parents necessarily thought they were going to be. And er… they are individuals with the opportunity for a full life ahead of them still.

Encouraging resilience and control

You often have parents come in initially who are totally shell shocked from a recent diagnosis. They haven't accessed any other services. And to see over the course of time that parent build a network with other parents and gain information and maybe six months down the track, they're the ones that are sharing information with the new mothers, that's very rewarding.

Sometimes the stories can be really distressing. We saw a woman last week who said that her in-laws had told her and her husband that they were no longer able to look after their two disabled children for them because they were too challenging for them. And that was very difficult for them. So in those sorts of situations, I try to work through that but also turn the problem into a solution. And get the group to work out what in this situation the woman could do. We talked a lot about respite but she's never accessed respite before and said she'd had problems with it so afterwards we rang up and got her respite. And I think it just … she just sort of skipped out of there and was so happy that she'd organised that respite, that suddenly it went from a very distressing story of being basically rejected by her in-laws to one of feeling in control. That's one of the things in the MyTime groups to try and encourage resilience and that sense of taking control and being in charge of your life.

Working with Parents who have a Child with a Disability

I think I'd say to nurses or midwives who are in that situation when they're dealing with a parent who has a new child with a disability – is to recognise that the life of a child with a disability has changed significantly in the last 20 years; that there are many interventions that are available; there are medical interventions; there are early childhood interventions; there's therapies that are available; that the life's expectations for a child with a disability should be celebrated; that there are things that they can do.

The expectations for a child now are that they would live independently; that they would hold down a job; and be educated in a mainstream school with their siblings. And I think to keep that in mind. And I think that's what parents probably need to think about, be made aware of rather than just, "This is a dire situation".

I suppose it would be the mother who with a recent diagnosis of a son with autism who came to the group. She was on a waiting list for services, she had no idea about autism, she had never met anyone with autism, and worst of all, she hadn't told a soul of the diagnosis. So she was totally raw and there was that shame and stigma and not wanting to be exposed I suppose. And she hadn't told family and that's not an unusual situation.

In MyTime groups some parents are very open to say, 'This is my child and this is his disability' and then you have the same number again who wouldn't let on who couldn't share that. To see her, I suppose, in the course of a MyTime group starting to understand that she's not alone and that she, eventually, was able to share her stories and her experiences. She realised that during the course of it that the friends and family who had supported her in the past may not necessarily be the friends and the family members who would support her in the future, and that she had to perhaps change her support networks. And I think she started to look beyond the negatives of her child and start to think about what her child's achievements were and where her child's life could be.

'Life Long Grief that Trips You Up'

I think when you're on that journey of having a child with a disability there are lots of things that present themselves that are triggers, that can cause grief that is ongoing often and life long. It can be a careless word, a turn of phrase, it can be being in a situation where it's very apparent that your child isn't meeting the same milestones as other children.

Grief is not something that parents just get over and they move onto the next stage. It is often something that trips them up through their entire lives with things that are just unexpected.

So I suppose in the MyTime group, what we…by talking about those sorts of issues and looking at situations, and looking at ways of dealing with situations, it helps parents to deal with them the next time they come around.

A Personal Experience of having a Child with a Disability

DVD transcripts for discussion: section 8.2

Introduction

Karen Gomez
Mother and part-time Administrator

I'm originally from Malaysia, I came out to Australia in 1990, and I've lived here … I came here to study, then I graduated, went back, got married to my Australian husband, came back for good in '98. And then had my first baby in 2003. His name is Adam. And he was born, yeah, with no problems.

The Birth of a second child, named Mark

And then I had my second child. He was born in 2006, sorry 2005, in November. And when he was born, he had some problems at birth, they saw some red marks, some spots on his body, and they took him straight to the Special Care Nursery.

At that time a Paediatric Registrar came to see me and said probably it was a chromosome disorder. And yeah – so that's when I found out that he had the 5P Deletion Syndrome also known as 'Crie de Chat' – the 'Cry of the Cat' Syndrome. So that came as a total shock to me, yeah. And just finding out that it was a very rare disorder, it was about 1 in 60,000. And that totally, yeah, just shocked me. It didn't register then that, when the geneticist told us that it was a chromosome disorder, I didn't think that… I thought medicine could fix it [laughs] at that time. I didn't know that it was part of his blueprint that it was going to affect him in various ways. And they couldn't tell us much either because they didn't know themselves because it was a very rare disorder.

So just finding out came as a shock. So we went to a – what do you call it – to an internet café and just did some quick research and what we found out was staggering, especially when we found out that some kids with Crie de Chat they could still do lots of things. All of that depended on the severity of the deletion. And then we found out that his deletion was very significant, so that was another blow to us as well, not knowing what he was capable of achieving, what he could do, what he couldn't do obviously.

We were also told that the mortality, it was quite high, so probably he would only live until about two and then, you know… be gone. So that was… there were so much uncertainty; we didn't know what to expect; no one could tell us anything….

'I felt like a zombie…'

I felt very… um… I wasn't depressed, I just felt all sorts of different things going through me. Uncertainty. I felt like a zombie. Because we would come home and I would sit on one corner of the sofa and Russell would sit on the other corner of the sofa and all we would do was just sit and cry. And then we would take turns and cry because… and we still had Adam. He was two and a half years old.

It was very, very difficult because then I would have to get up and think, 'God I've got to look after him as well, I've got to get up and do things for him.' And I suppose that gave me a bit of strength to know that I had this other normal child. And he'd come up to me and he'd wipe my tears and say, 'Why are you crying?'

It was very hard but interestingly, depression was not one of the things I went through at all. But it was just very hard because I didn't know what to expect, just that uncertainty that I felt.

'One day at a time…'

There wasn't anyone for support. Because I didn't have any extended family here. So that was hard and what we decided to do was sort of like deal with it ourselves. So once we got him back it was just us. And just trying to deal with it one day at a time.

It would have been good if someone had been able to advise us on what are the sort of things to expect, like with a child with special needs, just like with schooling and things. It didn't register at all that he was … like I didn't know that there was a special needs school out there.

A lot of positive things

I think there are a lot of positive things. It has brought Russell and I closer. Because I've come to hear from lots of other people that when you have a child with a disability it breaks the marriage. In our case, we've been lucky; it's brought us closer.

It's made me realise that I am very thankful for what I have. I've got Adam and now I'm pregnant with my third baby so I'm really happy about that. But just the fact that Mark… we are really lucky we're really blessed in the sense that Mark is a very happy child. He's always, he always has a smile on his face regardless of how sick he is he always has a smile on his face and the thing is to know that I didn't give up on him. That makes me really happy because it was very hard.

The day I knew I could deal with it was when I felt… the day I felt the burden lift off my shoulder was when… the day when I told myself, 'I accept this.' And that helped me to move on.

The first year and a half of his life was very hard and painful. I would cry all the time. But I haven't done so since and now that he's at school he's doing so well. He is learning to swim, he's able to rotate in the pool himself. I've been told by his teacher that he will be able to walk - even unassisted because he's got strong leg muscles [laughs]. So that in itself is an achievement and is rewarding to know. So yeah but the smile that he gives me is fantastic!

When a Parent has an Intellectual Disability

DVD transcripts for discussion: section 8.3

A Personal Journey

Dr Margaret Spencer
Social Worker, Nurse, Academic

My background originally is as a nurse and my area of interest is in parents with intellectual disabilities so women – and men – but particularly mums with intellectual disability – who are taking on the job of parenting.

In one particular instance of a family that I was working with the mother … the children needed to come into care quickly and though the story is very long and convoluted, but it ended up happening at midnight that I was asked could I take these three children home for the night. Seventeen months later those children then went into long term foster care so I became the carer of children of a mother with intellectual disabilities where the children had been removed.

I then started the journey of walking with the children of parents with intellectual disabilities. So I've had the privilege of journeying with them, seeing what's happened for the children as they've grown up in families and also where they've grown up without their parents.

In terms of the children that were with me, the two older ones went into their long term foster care placement and there was abuse in the foster care placement and after two and a half years they actually asked to come back to me and so I then inherited the girls again at nine and ten. And they are both young women with intellectual disabilities and now they're both parents so I've sort of been… now onto the next generation and been journeying with them.

So for me this has been… my interest in this area started from being a community health worker in the inner city of Sydney and then it has become quite personal in terms of the questions I've asked, both as a carer of children of parents with intellectual disability and as an advocate for parents with intellectual disability.

Parents with Intellectual Disabilities and Child Protection Care Proceedings

What we know is that parents with intellectual disabilities represent about 0.25% of the parenting population but when it comes to care and protection when it comes to care proceedings they're over represented. One in ten cases that come before the children's court both in New South Wales, Victoria and the statistics are the same internationally, so I suspect for other states in Australia, that it's one in ten families that come before the children's court around care matters are parents with intellectual disabilities.

We know that then once they enter into that system the chances of their children being restored to them is very poor. By just merely having your case taken to the court you've got less than a 50% chance of having your child restored to you. About one in six kids in foster care has a parent with a learning difficulty or intellectual disability. So it's a big cost to society us not getting this right.

For most parents, the idea of losing a child is the worst thing. It's the biggest fear. For most parents the only way that they're going to loose a child is by some accident or by illness – and that's how they'll lose their child. For these parents it's that fear that the State will take their child and that's just so strong and so they live with that fear. And we all know how debilitating fear is.

Children of Parents with Intellectual Disabilities

If we treat their parents as… if we make it difficult for their parents to access services, if we make the parents reluctant to ask for help, well then, the children miss out because of that.

There's a young man that err.. I've done some co-education with. He comes from a family where both his Mum and Dad have intellectual disability, and his brother has with intellectual disability. This young man is just completing an economics law degree. And he's been very, he's been quite a high achiever, quite, you know, involved in his community. And what he would say is, when he talks about growing up with his mum and dad, which wasn't an easy situation, was that, for him the last thing he wanted to do was to be removed from them. He knew things were difficult, he said, but the difficulty was that you couldn't tell people that things were difficult because of how they would react. So we've also got to be careful that we don't create a situation where kids can't actually get the help they need, where families can't get the help they need because of fear of what we're going to do.

So I think, how do we get around that? I think the most important thing is that we have to be very honest with these parents, we need to be very honest about what is expected, about why we're expecting it and that starts right from the beginning, that starts right from the first antenatal appointment, the first moment when this person becomes aware that they're pregnant. You know, 'Why are we suggesting things around your own health? – Because this is for the health of the baby'. But we need to explain it in a way that the parent actually understands why we're expecting this of them, why we're expecting them to turn up for antenatal appointments, why when, after the birth of the baby, why we're asking them to do the things on the ward that we're asking them to do.

Involving Fathers

I think that when we look at this group, that, like the general population, you'll have, we have mothers with intellectual disabilities who are going to be in all sorts of relationships. It's often thought that the relationships that these women are in are exploitative but that's not proven by research, they're quite a heterogeneous group. And I think sometimes you'll have fathers that will be involved, fathers that are, you know, less than helpful in the situation, in terms of there could be domestic violence, but I think the most important thing is that where there is a father involved, that we work with them, that we don't exclude them, that we make them aware of what responsibilities they've got in terms of being instrumental in the rearing and caring of their child.

So what we do know is where, particularly around parent education with this group, when we've looked at what leads to, particularly in this group, who actually completes parent education programs and who actually benefit from them, the ones that actually have supportive partners, the ones who actually get involved in the programs, are the ones that actually are more likely to complete programs that we set up for them. So it's really important, particularly if we want parents to, mums to complete programs, that we actually should be involving the fathers.

I think also often the father will also have learning difficulties, so often the father's own history is one where people have not been, haven't realised that the aspiration of being a father is something that he should have taken on or that was realistic. So often fathers feel very much that they're doing this against the odds. And against public opinion. And so their desire to be a good Dad is just as great as anyone else. But often they can be looked upon as that they, that like the mother, that they shouldn't have taken on this role, that it was beyond them. So they feel that same feeling of being under the gaze and scrutiny.

Challenging Assumptions About Parents with Learning Disabilities

There's a lot of assumptions that are made about parents with intellectual disabilities and many of those come from an entrenched belief that people with intellectual disabilities can't and shouldn't be parents. It comes from a long history of why we institutionalised people with intellectual disabilities so they couldn't procreate, so they couldn't have more children like themselves. It was about trying to eradicate intellectual disabilities from the population

What we've now got is over six decades of international research that consistently shows that intellectual disability per se does not preclude a person from being able to parent. So we also have in that wealth of research that we've done, we've also worked out what are the best ways of putting in support for parents with intellectual disabilities.

So we know a lot about how we can make this work. But I think the biggest issue that we find is overcoming the attitudes in the community, overcoming the attitudes that are there within health and welfare professionals within the Child Protection system, which is one that sees these parents as incapable.

So there's often a presumption, particularly when a person presents at antenatal or turns up in a maternity ward and they get identified as having a learning difficulty, having an intellectual disability, that they're not going to be able to do this job. So there's a presumption of incompetence. And when we have strong assumptions, we start to see things through that lens.

And some of the assumptions that people hold are that this parent will – well the one that led to their institutionalisation – that this parent will, if they don't produce a child that has an intellectual disability they'll cause the child to be developmentally delayed. We know that that does not hold up. What we do know is, yes there is a higher prevalence of developmental disability in children of parents with intellectual disability, however, we also know that many children do just fine. And that often it's about us not recognising the need for early intervention for this particular group of children. And getting that in early.

The other assumption is that they can't learn and so people will often say, 'Well, there's no point teaching them.' Or if they've gone to show them for example, after the birth of the baby perhaps how to do some mothercraft skill, and they don't do it the way that they should, or that they fumble doing it, then, instead of seeing it as, this person needs more

practice, or we need to break this down into steps so that they can understand what has to happen, it's just assumed they can't learn. It's not that parents with intellectual disability can't learn: we're not good teachers of people with intellectual disability.

It is often said that these parents, because of their intellectual disability, you know, they're more likely to abuse their children. We find that there's very little abuse by parents with intellectual disabilities of their children. It's the issue of neglect and that neglect is often by omission rather than commission, not being aware of what's expected, being afraid – sometimes we create problems, child protection problems, for this group because they're so fearful to seek out help that they don't go to perhaps a doctor or they don't consult with the Early Childhood nurse as quickly as what they might because they're worried that they'll get blamed for something. So while we create a situation of fear and have people under the radar, it's more likely that children are neglected or that things are going to happen.

Working with Mothers Who Have an Intellectual Disability

So often it can be – and you know I read affidavits that have been prepared after a baby has been removed from a parent after birth – and it will be, you know, 'We suggested to the mother that she change the nappy and the mother didn't change the nappy' or. 'The mother had the baby on the bed and that was dangerous.' You know, we need to actually understand that we need to say why that is dangerous, why we don't want you to do it, what would be the outcome if you continue to do that. So it needs to be made very clear to the parent how we're observing it so that they can stop that behaviour.

People with intellectual disability don't pick up on the subtle cues that we give. You have to be very clear about what it is that you're wanting from them and why you're wanting it from them.

An example of this and it's er…one of… a mum that I was working with, who, her son had a muscular dystrophy condition and Mum had an intellectual disability and the concern was about this little boy turning up at day care with a dirty T-shirt. And he used to drool – he had a drooling problem. Now it was assumed that this mother was not putting clean clothes on him. But the T-shirts were stained. And – but – the mother was saying, 'But I'm washing the T-shirts and they are clean.' So in her mind they were clean. But to the Day Care they weren't clean. And she was able to explain to me that, 'Yes I do put on a clean T-shirt, but by the time that I get to Day Care it's dirty. And just by being able to say to her, 'When Child Care see the dirty T-shirt, when they see that, they're not seeing just dirty T-shirt, they're seeing, 'Is this child being looked after? Are these things being done for this child?' And they're actually seeing, 'Is this parenting good enough for this child?' Now when I was actually able to say how the Day Care were seeing it, then it changed the mother's response to Day Care's complaint. For her it was, 'Oh, it that's how they're seeing it, well then I need to change it.'

Questioning our attitudes

So I think, whilst we have a pessimistic attitude about the outcomes for these families, I think that it becomes a self-fulfilling prophecy. In terms of their children, you know, I think often the difficulty is that you see a parent and they're pretty disenfranchised, they're on the margins, they're not, you know, maybe not the prettiest or most handsome parent around, you wonder how they're going to sort of manage, and it's very easy for us, particularly when we see a very cute little baby, a very cute little child, to think, 'Oh, what's the future going to be for that child?' And to fall into a child rescue mentality.

I think that what we've always got to remember – and it's something that I've had to learn over the years – is that our job is not to find better parents for children, our job is to protect them from unsafe practices and unsafe parents. And we need to be very careful that we're not falling into that sense of um… falling into that mentality of rescuing this child, of seeing this child's life as a tragedy because they're with this person.

MODULE 9:

Support for women and families experiencing mental illness

National and international research literature has raised our understanding of the importance of parental mental health and the positive impact this has on the development and future health of the infant and young child. We now know that if a parent has a mental illness the child's physical, social and emotional development is placed at considerable risk.

In many instances, the parent with a mental illness experiences an inability to respond in a timely, appropriate and sensitive manner to the infant or young child. Unfortunately it is not uncommon if the mother has a mental illness that her partner may also be unwell. This further compromises the care and interaction with the infant.

Women with an existing mental illness require specialist care and additional support when they become pregnant. There is a need to review existing medication, identify additional needs requiring management and support and ensure plans are in place for their children's care. It is crucial that the woman and her family (if she agrees) are involved in any management meetings and decisions. The overall aim is to put interventions in place that will stabilise the situation and ensure the mental and physical health of the woman during her pregnancy and the early years of motherhood.

Learning Outcomes

On successful implementation of this module, students should be able to:

- Discuss the issues experienced by parents with a mental illness
- Discuss the importance of early identification and intervention when a mother is identified with a diagnosed mental illness during pregnancy
- Identify strategies to support the mother's partner to care for the family
- Identify strategies to support and promote the infant or young child's development and mental health
- Discuss child protection issues that may arise when a parent has a mental illness
- Discuss antenatal assessment and follow up processes involving interdisciplinary working
- Discuss the importance of promoting early attachment.

DVD section 9.1: A personal story of postnatal depression

In this section Cathy tells her story about becoming a new mother and her experience of postnatal depression. Included in the story is her struggle to acknowledge her illness and the lack of professional support offered in the early stages of her illness.

Cathy's partner, Vijay, then discusses his experience of Cathy's postnatal depression and provides insights into the needs of fathers who have a partner with a mental illness. Vijay is also an obstetrician. As a health professional as well as drawing on his experience as a father, he is able to provide advice about supporting fathers when a new mother has postnatal depression and the raising of awareness about this illness in the community.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module

Trigger Questions

Once the students have viewed the video ask them to discuss the following questions either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group.

Cathy's story

- Identify Cathy's strengths
- What were the challenges she faced?
- What were her main concerns?
- How did her mental illness impact on her ability to parent?
- Were her children at potential risk due to her mental illness?
- What actions could you take as a midwife or nurse to ensure early intervention occurred for a mother with a similar story as Cathy's story?
- What interventions would you instigate to ensure the safety of the infant and any other children?
- When working with parents who have a mental illness, what strategies can you use to:
  - ensure you are providing the most appropriate care?
  - maintain your own mental health?

Vijay's story

- What were Vijay's strengths as a father?
- What were the main issues highlighted by Vijay?
- What type of support and interventions would you provide for partners?
- What interventions would you suggest to fathers to ensure the infant's and young children's mental health and development is not compromised?

Activity: Perinatal mood disturbances

The BeyondBlue website lists a number of factors that can make perinatal mood disturbances more likely as well as a list of symptoms that women with perinatal mood disturbances may experience.

Always exhausted or hyperactive
Not being able to sleep even when you have the chance
Crying uncontrollably or feeling teary
Finding that your moods change dramatically
Feeling very irritable or sensitive to noise or touch
Constantly thinking in a negative way
Unrealistic feeling that you are inadequate
Anxiety or panic attacks
Not being able to concentrate
Becoming more forgetful
Confusion and guilt.

Factors in these lists can be placed individually on cards and used to devise interactive activities in small groups or pairs. For example, students can pick a card and discuss what is on it in terms of how they might engage with pregnant women or new mothers who raise such an issue.

DVD section 9.2: The role of nurses and midwives in identifying women with mental health problems

In this section, Cathy and Vijay are joined by Trudy Allende and Leona McGrath who work in a community based project with Aboriginal women. This section finishes with Sheryl Sidery, a Perinatal Mental Health Coordinator in a large Australian city maternity unit. They reflect on their experiences and discuss the important role that midwives and nurses can play in identifying women with mental health difficulties or mental illness.

The video clips in Section 9.2 can be used to promote discussion with students about the processes that are used in their local services for psychosocial assessment and the identification of women with mental health difficulties.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger Questions

Once the students have viewed the video ask them to discuss the following questions either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group.

Ask the students to respond to the following questions:

- What are the strategies provided by Cathy, Vijay and Sheryl to improve support and assistance they provide for mothers and fathers?
- What was the major barrier to asking psychosocial questions highlighted by Trudy?
- What are the strategies used by Trudy and Leona to complete a psychosocial assessment in their work with Aboriginal women?

Activity: Role play

Scenarios described in this section can be used to devise role-plays where midwives and nurses can practise a range of communication skills:

- A mother with a new baby tells you she is struggling with sleep deprivation
- Making the case for a formal psychosocial assessment process in a meeting at a private maternity unit
- Entering information on the computer about the psychosocial assessment in the antenatal clinic
- Explaining to women the rationale for asking questions about Domestic Violence or filling in questionnaires such as the Edinburgh Depression Scale.

Highly refined communication skills are essential for working with parents and young children. In all states of Australia and New Zealand many midwives and maternal, child and family health nurses have found the Family Partnership Model useful for supporting their clinical practice. More information about this model is available from: http://www.cpcs.org.uk/index.php

It is important to include the approach used in your state to psychosocial assessment as a key resource for students. Additional resources to support this activity are also available from the following sites:

Beyondblue – The National Depression Initiative http://www.beyondblue.org.au/index.aspx

NSW Health/Families NSW 2009 *Supporting Families Early Package*, NSW Department of Health, North Sydney: http://www.health.nsw.gov.au/pubs/main_index.asp

DVD section 9.3: Following up when women are identified as having mental health problems or concerns

In Section 9.3 Sheryl Sidery explains the processes in her maternity unit for following up situations where pregnant women are identified as having mental health difficulties.

The video clip in Section 9.3 can be used to trigger the simulation of an 'intake meeting'. The following activity can be adapted by educators.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Activity: Intake meeting scenario

Aim of activity

- Recognise the value of interdisciplinary and intersectoral approaches
- Experience how practitioners from other disciplines might approach planning decisions in an intake meeting
- Identify appropriate support structures for the family
- Recognise the need to intervene when there are potential risks of neglect.

Students are divided into groups of six and provided with a slip of paper identifying the role they will play in the intake meeting.

Scenario

There are a number of women to discuss who have been highlighted at antenatal booking as being in need of additional support and/or where concerns have been raised in relation to potential child protection issues.

Sets of notes can be simulated representing women with a variety of backgrounds and situations.

Below are the roles of the people at the intake meeting. We recommend that you encourage the students to embellish their roles in terms of their levels of concern for the baby, based on their past experiences, to make the activity more engaging, while avoiding stereotypes.

– Alex the midwife
– Chris the child and family health nurse
– Robin the community mental health nurse
– Billie the sustained home visiting nurse
– Sam the social worker
– Pat the psychiatrist

Alex the midwife
Alex is responsible for coordinating the notes that have been flagged in the antenatal clinic as needing to go to the intake meeting. S/he has experience in mental health before becoming a midwife and it is her/his role to liaise back with the midwives and doctors caring for the women. S/he has not met the women whose notes s/he brings to the meeting but meets regularly with the midwives and will feed back to the manager of the antenatal clinic and/or the woman's midwife if she has continuity of care.

Chris the CFH nurse

Chris is the manager of Child and Family Health (CFH) Services. Her/his role is to be aware of women who may be in need of additional support and coordinate appropriate responses from CFH services. Try to combine appointments so that the woman does not have to run from 1 clinic to another because this requires excellent coping skills. Family is given priority in regard to home visiting and EDS should be done as early as possible.

Robin the community mental health nurse

Robin is responsible for liaison between the maternity unit and community mental health services. Some of the women identified at the intake meeting are already known to Robin in her/his role in the community. S/he also works with the emergency mental health team, who can respond in times of crisis. A key feature of her role is to gather key information including from private therapist to ensure that what needs to be known is known and appointments are made including a visit by liaison psychiatrist registrar prior to discharge from maternity.

Someone needs to look at medications and parenting (best time to prevent sedation of infant etc)

Billie the sustained home visiting nurse

Billie does extended home visiting for families identified as requiring additional support.

Sam the social worker

Sam is employed by the maternity unit to provide social work support. S/he links women with support services in the community. Sam is also usually the link between the Community Services department [or local equivalent] and the maternity unit.

Pat the psychiatrist

Pat specialises in the perinatal period and is a well-known expert on early attachment. S/he has a lot of experience of supporting women with mental health and issues involving alcohol and other drugs. S/he has a long history of collaborating well with nurses and midwives. Pat ensures psychiatric management is clearly documented in the medical record. As Pat is employed in the public system liaison occurs with his/her private sector counter part.

Activity

Alex presents the story of each woman based on her history using the simulated notes. The group will have a discussion about the woman's situation and identify concerns. They will be asked to address the following issues:

- Based on the resources that you know of in your local area, suggest possible ways of supporting the woman.
- Consider the strategies and steps you would use if there were serious concerns that might necessitate the removal of the baby, including mandatory reporting.

Extension activity

Imagine that it is some months later and concerns about the baby have continued to be raised in spite of efforts to address the situation. The same group of people [with the exception of Alex the midwife] meet at a case management meeting with a representative of the local Department of Community Services [or the equivalent in your jurisdiction].

Through the pregnancy, events have unfolded that mean a decision has been made that the baby will be placed into the care of the DCS soon after birth.

Discuss the processes that will need to be put in place to enable this to occur in a safe and supportive way. [You make like to review Section 3 Module 1 before doing this extension activity].

Section 9.4: Parenting with an existing mental illness

Caring for a woman with a mental illness during pregnancy and after the baby is born can be challenging for midwives and nurses. However a sensitive approach and appropriate planning can make a significant difference to the outcome for the women, the infant and her family. In particular, it may stop the onset of a psychotic episode that can be triggered by such things as sleep deprivation. The multi task expectations of being a new parent are difficult for most parents. A useful strategy is home visiting as it saves time and it allows for the midwife or nurse to assess effectively if the mother is coping or chaos is happening; as well as ensuring that the mother does not have an appointment every second day. This population group has grave problems being organised and problem solving so a competent midwife or nurse will look at reducing or breaking down the tasks and decisions to be made.

Remember that people with a mental illness are frequently disadvantaged: do they have enough money to buy what the child needs but also pay for their medication, the bus etc. Midwives and nurses are the most trusted group by those parents so they can ask the question about daily concerns.

Being able to separate antenatal and postnatal activities is essential. The antenatal period is usually about putting in place prevention or early intervention activities and the gathering of the right information. For example:

- who should be part of the team?
- what information should be collected?
- what past treatment worked?
- does the person know how to recognise early signs of illness?
- what has increased the woman's resilience in the past?
- who could be enrolled to assist the woman e.g. family and friends:
- to help with minimising sleep deprivation
- to provide parenting support
- to assist with managing multiple demands
- who is a trusted confidante to allow the woman to discuss her concerns
- to assist with identifying and putting in place stress management techniques.

Postnatal activities rely on:

- continuity of care
- ensuring that there is information cross over
- avoiding early discharge from maternity
- using extra days in hospital to plan well
- introducing early in the antenatal period the nurse who will care for the woman in the postnatal period
- gathering a baseline understanding of the woman so that any changes to the mental status of the woman are identified early
- ensuring an appointment with psychiatric service is organised in antenatal period to avoid delay in getting an appointment.

A multidisciplinary approach is required to ensure appropriate interventions are made available to the woman and her family. It is essential that the characteristics of a true multidisciplinary approach are understood. To have four different professionals addressing various separate issues does not work. The parent must know who does what (this must be totally transparent and clear this is why a last antenatal meeting is crucial with each clinician stating what they are responsible for). The intersection between the disciplines/teams must be understood, including how you bring everyone together (maybe by teleconference, letters…) with the family involved (including all members). Importantly the focus of intervention should ensure that not only the needs of the newborn infant are considered, but also the older children's needs are assessed and included on the management plan.

It is absolutely essential that the woman and, if she agrees, her family are involved in the development of the management plan.

Activity: Case study

The following case study is in two parts. It can be used in a class setting or as the basis for an online discussion. If used to form the basis of a small group discussion it may be more time effective and interesting if each group is given 2 or 3 different questions to respond to in the feedback session.

Kim is a 30 yr old woman; her pregnancy is in its 18th week. Her partner and family are very supportive and excited by the prospect of a new baby. Peter her partner has a 10 year old daughter from a previous relationship. The daughter has lived with Kim and Peter for the past 3 years.

Kim was diagnosed with a severe mental illness when she was 19 years old. Kim has been stabilised on medication for the past 5 years and is in reasonable health most of the time. As the pregnancy was planned Kim was able to have her medication adjusted prior to conceiving to reduce the impact on her baby's development. Kim's main problem is that she becomes very tired and vague.

The following actions have occurred:
A series of planning and monitoring meetings occurs with Kim's: psychiatrist, midwife, obstetrician, social worker, community mental health nurse, general practitioner and home visiting child and family health (CFH) nurse. Importantly, Kim, her partner and mother also participated. A care plan was agreed and documented to ensure Kim had the appropriate support and any potential risk was managed and minimised. This meeting enables the monitoring of the identified management strategies and helps to ensure Kim is receiving the best possible care and that the suggested strategies meet Kim's health and parenting needs.

Kim has had a review of her medication by her psychiatrist.

Home visits have commenced by the 24th week by the CFH nurse. With the nurse's help Kim and her partner complete the *Baby Care Plan* available on the COPMI website: http://www.copmi.net.au/files/bcp_final.PDF

Ask the students to respond to the following questions:

- During the pregnancy, what would be the concerns of:
  - Kim
  - Her partner and mother
- How would you assist Kim and her family manage these concerns?
- What possible activities can the midwife implement during the antenatal period?
- What possible activities can the home visiting nurse implement during the antenatal period?

Additional activity: ask the students to form groups of 3 (nurse/midwife, Kim and an observer to provide feedback) and role play the introduction and completion of a *Baby Care Plan.* At the completion of the activity ensure a debriefing component is included.

Kim gave birth to a healthy son after an 18 hour labour. As soon as Kim arrived in the postnatal ward the midwives reviewed her management plan. A crucial strategy was to enable Kim to sleep as much as possible to minimise the risk of a psychotic episode occurring. Kim is still undecided whether she should breast feed. Kim will have her stay in hospital extended to make sure her condition is stable before taking her baby home. During her stay in hospital the midwives have noticed that Kim becomes very drowsy at times and falls asleep while cuddling her baby.

Ask the students to respond to the following questions:

- What strategies can you suggest to enable Kim to have adequate rest while in the postnatal ward?
- What strategies can you suggest to Kim's partner and family to provide her with additional support?
- What strategies can you suggest to Kim's partner and family to enhance the relationship between Kim and her son?
- Why might Kim be undecided about breastfeeding her baby?
- What information would you need to assist Kim make an informed decision about breastfeeding her son?
- What changes in Kim's behaviour would you be alert to during her stay in the postnatal ward?
- What strategies can be identified to ensure the child's safety?
- As a midwife or nurse what is the role you should play in Kim's care when there are also social workers and a psychiatrist involved in her management?
- What attributes and skills are necessary for the midwife and home visiting nurse to have when working with Kim and her family?
- Would you make a child protection report about Kim and her baby? Justify your decision to report or not to report.

NB: it is important students understand their role is not diminished due to other professionals being involved. Midwives and nurses need to clearly understand the importance of their role and the specialist knowledge and skills each brings to the situation. The midwife's or nurse's role will be closely linked to their scope of practice.

Note to educators: it will be important to understand requirements and processes used in your state. Each state will have resources that are appropriate to use within this activity. The following are useful resources for this activity

The Best for Me and My Baby booklet: http://www.copmi.net.au/common/files/BestforMeandMyBaby.pdf

NSW Health/Families NSW 2009 *Supporting Families Early Package*, NSW Department of Health, North Sydney: http://www.health.nsw.gov.au/pubs/main_index.asp

Resources

Göpfert, M, Webster, J & Seeman, M (eds) 2004, *Parental Psychiatric Disorder: Distressed parents and their Families,* Cambridge University Press, New York.

NSW Health/Families NSW 2009 *Supporting Families Early Package*, NSW Department of Health, North Sydney.

This package consists of 3 companion documents:

- Maternal and Child Health Care Policy
- Supporting Families early SAFE START Strategic Policy
- Improving Mental Health Outcomes for Parents and Infants SAFE START guidelines

The documents are available from: http://www.health.nsw.gov.au/pubs/main_index.asp

Solchany, J 2001, Promoting Maternal Mental Health during Pregnancy: Theory, Practice & Intervention, NCAST-AVENUW Publications, Seattle.
This book provides an outline for working with pregnant women to ensure their continued mental health. It provides suggested activities and ways of working with women. Even though it is 10 years old it remains available and useful for practice. http://www.ncast.org/

Sved Williams, A & Cowling V (eds) 2008, *Infants of parents with mental illness,* Australian Academic Press, Brisbane.

DVD Resource: Working with High Risk Families: Skills to Stay Afloat – DVD
This DVD addresses key issues such as the early recognition of risk factors in infancy and early childhood and how to work with families reluctant to engage with professionals. This includes what the infant, the family and the service each bring that can potentially complicate therapeutic relationships and interventions. The DVD is available from Tresillian Family Care Centres. See for further information:
http://www.tresillian.net/shop/health-professionals/symposium-2008-dvd.html

Websites

Children of Parents with a Mental Illness (COPMI) http://www.copmi.net.au/
Children of Parents with a Mental Illness website provides excellent resource for Australian health professional. On this site health professionals can complete an eLearning program to assist them understand the issues and how to increase their effectiveness for working with these children and families. There are resources for parents, children and young people. Of particular interest are the COPMI GEMS (Gateways to Evidence that Matters).

Parental Mental Health and Child Welfare Network http://www.pmhcwn.org.uk/index.asp
This English site provides some excellent resources for understanding parental mental illness and the impact on children.

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources are available on this site that relate to the Australian context.

Beyondblue – The National Depression Initiative http://www.beyondblue.org.au/index.aspx
This site provides a major resource for increasing knowledge, skills and understanding about mental health and illness. Of interest is the section on postnatal depression.

Black Dog Institute http://www.blackdoginstitute.org.au/
The Black dog Institute provides a range of depression and bipolar information resources.

Gidget Foundation http://www.gidgetfoundation.com.au/information.html
The Gidget Foundation aims to promote awareness of Perinatal Anxiety and Depression amongst women and their families, their health providers and the wider community to ensure that women in need receive timely, appropriate and supportive care. There are several very useful resources on this website

PANDA http://www.panda.org.au/
PANDA Postnatal and Antenatal Depression Association is located in Victoria. PANDA provides a range of resources and a national telephone helpline.

Parenting with a mental illness http://raisingchildren.net.au/articles/parenting_with_a_mental_illness.html
Resources are available for parents with a mental illness are available from the Raising Children website

Postpartum Support International http://postpartum.net/
Women who have experienced postpartum depression established this long established international organization. It aims to increase public awareness through education, research and engagement with the media. There are resources available on the site for women and health professionals.

A Personal Story of Postnatal Depression

DVD transcripts for discussion: section 9.1

Cathy's story

Cathy Knox
mother

We had never talked about having children and all of a sudden I discovered that I was 10 weeks pregnant, which of course was a shock, but we were in fact quite excited about it and thought, 'This is… aren't we clever'.

And the pregnancy progressed reasonably OK until I was in my, oh about 32 weeks and I developed Pre-eclampsia. And I guess my feeling for the pregnancy was that I would be the herbal birth mother and everything would be beautiful and I was going to the birth centre, seeing the midwives. And in the end, with the Pre-eclampsia, I ended up having a very interventionalist birth and quite a lot of what happened during that period was, in my mind, quite shocking.

The end result was a beautiful, big, fat, lovely boy and we were delighted by him. I just thought, 'Oh, this is a gorgeous baby!' But in the back of my mind, I kept having these rather repetitive, intrusive thoughts, which I'd never experienced anything like this before. And I thought, 'Oh it's just because this is what happens after you've had a baby.' And I also had this niggling feeling of, 'I just want to go back to work now' and, 'I've had the baby, here it is, and I want my, you know, I'll get back into my old life.'

And it was something, I mentioned it once to my mother, who was quite … I guess her reaction was very, 'But you're a mother now dear.' So… and I felt, 'Oh well, I'm a mother, so this is what I have to do.' I was on maternity leave so I knew that I would, in fact, be going back to work.

I went to my 6-week visit with the obstetrician and mentioned that I felt… just not quite right, but I don't think he actually 'heard' what I was saying. My husband in fact, who also happens to be an obstetrician, decided that it would be a good idea just to make sure that we could 'do it' again before I went to my 6-week visit, because that was very important and so we did and I didn't realise at the time but in fact, I had become pregnant, again! [laughs]

So I went back to work when my first baby was four months old. I was already pregnant and knew I was pregnant with the second baby and I was very, very distressed. And this is in fact when my whole life started to unravel and I suspect had I not become pregnant again so quickly that what then sort of happened in my life would never have occurred.

So the following few months I was in fact very distressed and didn't tell anybody I was pregnant. And my husband in fact, he was very excited. He thought it was a wonderful, you know, 'How exciting, we're going to have two babies in 11 months or something!' And I felt like I had lost total control of my life. Up until that point I was one of those people who was pretty anal, pretty focussed, pretty goal-driven and things just fell into place because I made them and then all of a sudden, things were not falling into place at all.

A lot of these thought processes were very personal and I didn't even share them with my husband, but I'd have a lot of nights just lying in bed feeling like an alien had invaded my body. I thought, 'I'm not me any more, I'm not the person, I'm sort of like this pregnant woman.'

The pregnancy physically was really straightforward but emotionally I was in a really, really bad place. My other little boy was a very, very easy, straightforward, happy, content baby. So I never had any sort of concerns about him. And he wasn't causing me stress as such; it was more the pregnancy and this loss of control.

So I was too scared to tell anybody because I thought, 'You're supposed to be happy when you're pregnant'. I was 32 years old, done a lot of things in my life and I had never experienced these sorts of emotions and I guess I had no insight into exactly it was that I was experiencing… at all.

The pregnancy was straightforward; the baby was born; this time it was at the Birth Centre; it was this very beautiful experience; it was very quick; and in fact I was on – people talk about endorphin highs in labour and that's the sort of labour I experienced – I was on an amazing high. Everything was fantastic. The baby came out; the placenta came out and my endorphin high just dropped [gesticulates] like that. And so Vijay was phoning all the relatives and appropriate friends as you do and I just refused to talk to them. I didn't want to talk to anybody. So this extreme emotional experience began right at the birth. So unfortunately I guess that's where it all started unravelling.

I didn't realise that I was unwell. My behaviour was extraordinary; I was very angry; I was still having these repetitive, intrusive thoughts, which had stayed with me for all of those 11 months, which eventually as it was diagnosed is a post-traumatic stress disorder, so that was one aspect of it. But the other one was I was having very disordered thoughts; I felt terribly black. I mean I have a lot of family and friends around and yet I felt quite isolated, from them and it was a very personal thing.

On the other hand, I was also very high functioning. So I could still manage to get my children sorted out, myself sorted out, get out to playgroup or have coffee with friends and nobody actually knew in fact how I was really feeling But I was incredibly emotionally labile, fragile – brittle, I guess. So we'd have this beautiful, white picket-fence persona thing happening on the outside and then I'd get home and I would completely de-compensate.

I think one of the biggest issues was the transition to being a mother. I think I had some significant adjustment issues. Again, I had no self-awareness, which in hindsight's a very beautiful thing. I can look back and look at myself a bit dispassionately and think, no self-awareness. And I had two unplanned pregnancies in 11 months; that was not part of the plan for my life. So suddenly I was a career driven woman, who, all of a sudden, I felt like I was plonked in suburbia and I didn't think that was in the plan for my life [laughs] – it was not there, at that point. I really couldn't get my head around the fact that I was now responsible for these two little babies. That was one issue. I didn't realise that I needed to adjust my life to sort of encompass what that involved, what looking after children involved. Looking back I think part of being the Type A person I am involves anxiety and I think I am an anxious person; I think I still am. But I've learnt how to manage that. At that time I had no understanding of that and so, instead of relaxing I would be on the go the whole time. And when the babies were sleeping, I would be tidying the house and making sure everything looked beautiful.

The second baby also was very unsettled. He was born a little bit early, he was very skinny. I guess the other aspect of this was I was also going to be the 'Breastfeeding Goddess' and in fact it ended up being the S26 Poster Girl, because I had terrible breastfeeding problems with both babies. I had the Lactation Team on my case [laughs] who eventually told me I had to stop breastfeeding or attempting to breastfeed because it was such a disaster. But I was expressing a lot of milk for that baby, you know, it would take an hour to express; he would then feed, over a period of half an hour or something, because he was very refluxy, and then about 10 minutes later, he would then vomit it all up again anyway. And so all of that was rather soul destroying apart from anything else that was going on, and he cried and he cried. And so in my head I was just thinking, 'I've got no head space, I can't think clearly. And of course, the obvious things like lack of sleep, which all mothers experience but all compounded.

When I was feeling very unwell, I actually had real difficulty relating to my children and I also felt that if my children were not there then all of my problems would go away. Now, I never actually considered actually harming them, but I did do some risk taking activities I think, which I thought, 'Well if we all go away, then the problem is solved'. And it was very, very, distressing. So that was in my very, very darkest times. I just kept thinking, 'If we're not here everything's solved'. But I was always including myself in that I guess. The other thing I did on a really practical level was I often left them crying in their cots. And I would put them in their cots because I thought, 'I can't deal with you anymore.' And I would close the door and I would walk away, outside, down to the bottom of the garden generally and because then I couldn't hear them crying anymore. And I would usually just sit and curl up and cry myself. But I guess looking back on that, at least, they may have been very distressed and crying and it was all very awful but at least I had removed myself from the situation and because I just felt I needed to do that.

So I think as a mother, I just thought, 'I'm not enjoying this at all!' [laughs] you know, 'Where's all this 'the beautiful motherhood' thing? It's not happening in this house!' I look back now and with such sadness because I think that it could have been different but unfortunately that's the way it was.

I was very angry. In my distress I guess I took it completely out on Vijay. 'It was his fault. He got me pregnant – twice! [laughs] Without me wanting it! And he should have known better. He was an obstetrician! And our relationship was right on the edge and his response to my anger was more anger. He thought very much that it was my problem and that I had to sort it out. Yeah and so it was a very dysfunctional relationship at that stage and a lot of angst and I mean, a lot of weeping and wailing and gnashing of teeth and all that stuff. It was incredibly intense emotionally.

And there was a lot of rocking on the kitchen floor and self-harm, and all sorts of things, which were never, I mean, so foreign to me. And yet, I had no idea that I actually had a problem, as bizarre as that would seem now. And neither did my husband. And he finally spoke to a colleague around about six or seven weeks after that second baby was born and said, sort of explaining, just generally, that things weren't exactly as we thought they should be and he wasn't sure what he should do, and he didn't know how he could help and he was getting angry because of my apparent inability to, you know, be a mother. And the colleague was the one who said, who planted the seed about, 'Perhaps Cathy is suffering from postnatal depression' which, of course, was diagnosed and was very much what I was suffering from.

I often wonder myself how my own children really experienced the early years of their lives because of the fact that I was so unwell. And I was very unwell. I was in a psych unit for four weeks.

And yeah so, it was a very, very difficult period and it took me a long time and quite a lot of professional help until I got my head around the fact that, you know, these are the things that you can do as a mother and also have your own life. You can still have your own identity. And it's a multi-factorial and very rich experience. But at that time I couldn't see that.

When I eventually had the following three babies, I suspect, well I know, the depression came back but I was forewarned so I was able to deal with it. And we put things in place and so they were very different, even though I did feel those, that same sort of emotional distress to a certain extent, it didn't impact on my life.

Motherhood is really important and it's really hard work. And it's really fulfilling. And having now had five children and lived through various different stages in their lives, I'm just so glad that I have the five children that I do and that we managed to get through that very difficult time at the beginning because it's just been such a worthwhile experience

Vijay's story

Vijay Roach
father and obstetrician

I never saw it as an illness and I think that was where the problem lay. I saw it in her personality or our marriage or in her inability to cope. I saw it in myself, possibly as a 'poor husband' or not being around enough or being insufficiently supportive. And it took two years until it was a chance conversation with a friend of mine, who said, 'Could she have postnatal depression?' which all those years ago was not an entity that was recognised in the way that it is today. And so having recognised that, we then agreed that we would go and see a psychiatrist and the psychiatrist made that diagnosis. But up until that point, we simply thought that we had a problem. And we also we were quite isolated, despite having a big family and lots of friends and the fact that I was a doctor. It didn't mean that we knew more about the condition at all. We were thinking that we were just a hopeless couple and all these arguments were occurring within four walls, we never revealed it to the outside world. And – even when the diagnosis was made, we were very careful about whom we revealed it to because mental illness at that time had such a stigma. My perspective was that I didn't want anyone making judgmental comments about my wife because I didn't see her as someone who was bad or who was wrong. Once we realised it, we recognised that she was someone who was unwell.

One of the hardest experiences that both Cathy and I have had in our journey towards, in talking about our story and reflecting back on it, is being brutally honest, in which we recognise our failures. And I think very often about my failures as a father when we were in circumstances of stress, whether it was Cathy crying or being unable to cope, or ringing me at work every five minutes or the children being difficult to manage. And I forgive myself but I still feel regret my anger. And my outbursts and the yelling or the smacking that went on at that time. And I don't think that that is something that

one needs to condemn another person for but I think we need to help those people in that situation to avoid that because at the very least, even if no particular physical harm is done, there is the potential for psychological harm to the child, or maybe even more importantly, psychological harm to the person who is angry or who does act out those feelings, because then there's that enormous regret and sense of guilt that happens afterwards.

I think that parents who find themselves in that situation, fathers who find themselves in that situation, have to talk and they have to find someone whom they trust, and whom they can talk to and I think that if there was more honesty of, if while you're down at the pub and the other bloke says, 'Oh yeah, I had that argument in my house as well', then there's a sense that you're not alone. So that would be one step. The other is the very important thing of encouraging men – or women – to move themselves from the situation, to place the child in a safe place, whether that might mean closing the door and walking away, calling a parent or a friend to ask them to look after the child while you went for a walk, but it's important that you separate yourself at the time. And then there are more complex behavioural, psychological advice such as counselling, whether it's as simple as counting to ten or going through other thought processes to limit the risk of getting to a point of no return or damaging yourself or the child.

There's a lot of controversy about the impact on the baby of perinatal anxiety and depression. And the line that I take in pregnancy in particular and then for women or families after a baby is born, is that love does not need to come from one individual. That if a child is in a safe and secure environment, whoever provides that, that the child will be OK. And that if the parent is in some way unable to provide that environment, then there are others who can. And that they need not feel that they are failing in some way. Even in friendships or professional relationships we can't be everything to everyone and it might be that you can't be everything at that time to your child. So if the only environment that the child experiences is that of dysfunctional parents or parents who are suffering, then it's not unreasonable to assume that that baby or that infant may be affected in some way - although quantifying that's difficult. But if there are other people involved, be they family or friends or professional people, then the child can receive the care and attention and love that it requires. And the child should be OK.

If we could move towards making motherhood matter, if we could move towards recognising that early parenthood is difficult, and if we could move towards a community supporting and caring for those people, then I think we can change the world. Because what happened to Cathy and me affected us, it affected our children and it affected our wider community. And if we had been cared for that might have made a difference that would have made a difference. And we stay away from early parents, er from young parents, new parents and I think that's the thing that needs to change. It has to be wider. It can't just be a government led, program led approach. It has to be a change in the way that the community relates to each other.

I am chairman of the Gidget Foundation which is an organisation which was established when a girl whose nickname was 'Gidget' took her own life after she had a baby. And she had many friends and many close connections. She was in a happy situation when she'd just had her daughter and despite all of these people being around her, she took her own life.

I can tell you what I do say to fathers which is that the Gidget Foundation once a year is asked by one of the world's biggest alcohol companies to come along to a pub and I stand up and we have 400 guys who come along, thinking that they're going to talk about rugby and I have Wallabies standing on either side of me and I say, 'G'day, I'm here to talk to you about postnatal depression.' And there's dead silence! Nobody moves! And we have to lock the door so they don't all run away. And then I tell them about my experience as a husband and a father. And I tell them about the times when I lost my temper. I tell them about the times when I was unkind or ungenerous. I tell them about the times when I failed. So that those men realise that they are not alone. And I think that that's the most important message, that 'You are not alone', that 'You are not abnormal', 'You are not a bad person', that 'All of those experiences that you are going through, all the feelings that you have, the things that you say, are common with many other people who are adjusting to parenthood'.

The Role of Nurses and Midwives in Identifying Women with Mental Health Problems

DVD transcripts for discussion: section 9.2

Validating concerns and taking time to listen

Cathy Knox
Mother

I think as a midwife and nurse you're seeing women at their most vulnerable all the time and often when they come to see you, they're coming because they're feeling vulnerable. And it's really important to be mindful of where the mother is coming from and not be dismissive of her concerns, to validate, I guess, what she's feeling and at the same time, to be able to say, 'Look, what you're feeling is also very normal and a lot of women feel like that.

And I think the other issue is that it is very difficult because women often will be presenting with, 'I can't sleep' or you know, things like that and it needs time to delve down underneath that sort of superficial reason why somebody's come to you. Because often I think that there are more things going on and sometimes having those conversations, it does take a long time but they're really worthwhile conversations to have.

By helping them, yes practically, that's really important, but being mindful of their emotional state is also really important and it's really difficult to do that and it takes a lot of time. And often you don't, as professionals, have that time but it's really worthwhile if you can make the time to spend with women because it makes a huge impact on the life of that woman.

Asking questions about feelings

It is very difficult I think for health professionals to help women such as myself I did not want anyone to know that I was a 'failure' that I thought I was. And I mean I was visiting the Early Childhood Centre with both of my first two babies and I think had they… had I been asked the question, I actually would have answered. I think I was actually so distressed that I wanted somebody to know. But, everyone was focussing on 'the baby'. And the physical situation. There was no discussion… no one ever asked me how I was feeling. No one said, 'And how are you feeling now that you've got two babies under 11 months old; and that you wanted to breastfeed and the breastfeeding's all turned into a big disaster; and that this baby's very unsettled? No one… They were all focussing on the practical issues and no one spoke of, 'How would that make you feel?'

Revealing mental illness requires trust

Vijay Roach
Father and obstetrician

If a nurse sits down and asks you how you are, that's very different from any other lay person, that it means something, and to engage with those people and to give them the sense of security where they can tell us about the way that they're feeling because to reveal anxiety or to reveal mental illness requires enormous trust and that's the important message that midwives and nursing staff need to realise is that they are worthy of that trust; and that they have that power; and that society values them; and that they can use that to help these women.

Formal assessment of antenatal anxiety and depression

In a formal way, it is recognised that we should have mandatory screening available for all women who are pregnant to screen them for antenatal anxiety and depression or perinatal anxiety and depression and that should be followed up after they've had the baby. And there's a very robust scheme in the public hospital system but a very weak one in the private

hospital system and that's been one of the roles and goals of the Gidget Foundation to introduce that to the public.. er to the private hospital system. So I think that it's important that midwives and nursing staff and medical staff are aware that that sort of program either does exist or should exist and they should engage with that and encourage that to be promoted.

Sensitive use of screening tools

One of the problems with the way that screening is conducted and the way in which we try to find out whether people have any form of mental illness is to use check-lists, and/or screening tools. The most common one in the area of anxiety and depression is the Edinburgh Depression Scale and it has limitations. The biggest limitation that we hear from the women themselves is that they lie. And therefore we need to be aware that women lie, that they do not want to reveal themselves, – women are afraid of being judged. Women-police-women and women's greatest enemy is particularly young mothers, are other women, and sometimes health professionals and it's not unreasonable to say, often midwives, who make women feel that they are incompetent or failing in some way. And I think the conversation therefore needs to go well beyond giving someone a sheet of paper.

The other feedback that we've had is that the sheet of paper is handed over and the woman perceives that when it's handed back, that it simply is put into a tray. And so therefore we need to be very conscious of the fact that women, if they're going to reveal that, would like their personal feelings to be taken seriously.

Trudy Allende
Aboriginal Health Education Officer

In the AHS we have to do the psychosocial screening and all the tons of paperwork. I know that was a huge thing when we first started up our service, like 'Huh! Don't do it on the first visit!' because it can put a lot of women off and Aboriginal women that come in sometimes they think, 'These questions are just for me.' So that's one huge thing that our girls do, we let them know that this is a generic form, basically everyone has to do it. And we let them do it at their pace. So if they're not comfortable doing it first time round, filling it all in, we say, 'Look if you don't want to answer a question or as soon as you feel uncomfortable, let us know. We'll stop. We'll move on to something else or we can come back to it, we can do it next week. Because those forms can be really daunting for anyone.

Leona McGrath
Midwife

Well with the psychosocial assessments, I've done quite a few bookings where it's the first time I've met this woman and especially young Indigenous girls, I'm more than happy to put it to the side until I feel like I've built up some sort of rapport with them. You can gauge it you know, with women, you sort of feel that you can ask some women questions and I start it with – yeah – 'This is a generic form, this is a question that all women in NSW are asked… 'So I go along those lines. But yes – you don't want to push it with some women.

Trudy Allende

And you normally get the prompts and you know when someone doesn't want to answer something. So if you're feeling that tension or you're just not getting anything back, 'OK, we'll leave this for another time.'

Leona McGrath

I'll finish the booking appointment with: 'There's a few more things that we have to ask, but we can do that next time. That's fine.'

Trudy Allende

So I guess all of those questions that are you know that are around those – what's the word? [Leona: personal] – personal things, yeah.

Leona McGrath

I understand how relevant they are. For us to get that information. But – yeah – that's the wonderful thing about caseload. You get to know your woman and you can … Pregnant women are so honest. Most pregnant women are brutally honest.

Trudy Allende

Because they want the best care for their baby.

Leona McGrath

And they will disclose. They will disclose that information. If you don't get to ask that question at the first booking, they will eventually disclose it. But yeah – it's quite hard having to ask women those questions.

Involving the woman in entering information on the computer

Sheryl Sidery
Midwife and Perinatal Mental Health Coordinator

I think it's important when midwives are using the screening tool to have the woman sit with her, and face the computer and get the woman to decide what information she wants put on there. And sometimes, I mean this has happened to me many times, the woman will go right off top deck and start telling you a story that's meaningful and important to them and I'll say, you know, 'How does this sound if we word it like this?' So always involve her in putting the data in there. So that it's their story and that they own that information, so that the midwife helps her to interpret it. So that it's not a great big long story but it's definitely not a tick box.

The importance of identifying domestic violence

Domestic violence screening is part of the psychosocial assessment. And of course we have no idea whether women are telling the truth at that time or not. But if it comes up throughout the pregnancy the midwife will usually ring either myself or the social work department. And I guess when we're working with women in situations like that they're often unaware of the impact it has on their child. Or, if she's pregnant for the first time, the potential harm for the unborn baby – they do need a lot of support around that. And often it's a shock for them to actually realise that children who are exposed to violence in the home, that you know the potential harm that that can do. I guess that we're very fortunate again that we do have social workers that are very skilled at counselling women around domestic violence. And we have to tell women that it's mandatory reporting. We must involve Community Services. That the woman and her children are the centre of that care. *[Mandatory reporting requirements may vary between states]*

The baby's needs are paramount

With the current Child Protection laws that are mandatory, you know the baby's needs are paramount really. And when we say, 'woman-centred care' that does include the family, it does include the baby. She's not a woman on her own, just as there's not a baby on her own. We're always inclusive of the families. So I think, when we're talking about 'woman-centred

care' we're talking about the opposite of putting the needs of the organisation first. We just try and put the family in the centre of everything. And so I guess when I'm working with midwives, I try to get them to understand that the relationship that the baby has with their primary caregiver forms the basis of all their future relationships so we – you know, we have to be mindful of that. So we have to be sure when we're sending that baby home that they're going to, you know, be provided with the best possible start.

I guess there has been times – fortunately not often – where um I've just not been sure about the information that the parents have been disclosing or I have had genuine fears for the baby. So in that instance we would make sure that we've built in some sort of support network to guarantee that someone does follow that family up.

Following up when Women are Identified as having Mental Health Problems or Concerns

DVD transcripts for discussion: section 9.3

Interdisciplinary working

Sheryl Sidery
Midwife and Perinatal Mental Health Coordinator

When women have completed the questionnaire, the computer actually prompts the midwife to initiate a referral pathway. So in the hospital where I work we have a pink basket and so anyone that's identified that needs follow up, their notes are put into the pink basket. And then we're very fortunate where I work, we have a multidisciplinary team - which I understand other areas don't have - but somebody can take responsibility for looking into the basket. So in our hospital that job's mine.

Once a week I empty the pink basket and we have myself and perhaps two social workers, look through all those notes and triage which notes need to go to a weekly multidisciplinary – we call it the mental health intake meeting for want of a better word - been shortened to MIM! [laughs]

So we meet. We sort of cull the notes because invariably there's about 30 sets of notes in there. The basket's not actually big enough. But by the time we've triaged those notes we usually present about 10 – 15 cases to the multidisciplinary meeting and that meeting's attended by a perinatal psychiatrist, usually her registrar, two social workers, myself, a midwife from the Outpatients Dept, usually there's a psychologist from the early intervention program and a representative from the Chemical Use in Pregnancy Service.

So then we discuss each case and we work out a plan for care and women who are identified as being very high risk we re-present those notes and that case a couple of times throughout the pregnancy and then formulate a plan that everyone that's involved in the care is involved in making the plan and primarily the woman.

Continuity of care across the interface of hospital and community settings

We're very fortunate where I work that midwives now work in a continuity model so they're able to take a caseload and there's quite a few midwives in those groups who are happy to take on women who have those very high risk needs and they follow them up through the pregnancy and then after the birth. Which is kind of an ideal model really. If all women could have that is would be fabulous [big smile].

Part of the reason I guess, the purpose behind working out a complex management plan is around discharge planning and continuing care from the hospital setting to the community setting. And we work very closely with early childhood nurses

in our area and they have a social worker that's attached to them, so the plan, particularly if we have a complex needs woman and we have a 32 week multidisciplinary meeting to discuss her, her plan for after the birth, we invite the Early Childhood nurses to come to that meeting. In an ideal world, I would like the woman to meet them then too and that's something I'm working towards – it's met a little bit of resistance but I think that would be perfect for women to have a relationship with the community nurses prior to being discharged. We do it with the Aboriginal group practice but we haven't been able to set that up yet with you know the normal Early Childhood setting. Something for the future! [raises finger and big grin]

Working with families from multicultural backgrounds

Working with multicultural families is an enormous challenge. I guess mainly because their expectations, particularly in the early postnatal period, is that they'll have their mother there. And in their culture, they would be surrounded by women. For example in the Indian culture, the woman doesn't step foot over the threshold to the kitchen for 4 weeks. And it's meant to be very superstitious. But really it's to protect her. It's very, you know, it's lovely that the women will be there to cook for her. I remember home visiting once and the woman got up with her plate and went to go to the kitchen and the family all went, 'Ah no! Stop!' [laughs] So she wasn't to step over the threshold.

So there are expectations when the family doesn't come that are just not met. These women often feel abandoned. And often have difficulty attaching to their baby. And of course, because they're, sometimes, they may be from the same country but maybe have very different or conflicting religious views so their husbands may forbid them from joining groups. So it's a real challenge. We've actually set up in our hospital like a working party to address one particular culture that's really struggling. They've had like a seven-fold increase in autism being diagnosed in children under the age of five in this particular cultural group. And we believe it's from isolation and severe depression and poor attachment in those first few years. So whilst we're aware of it we're struggling to meet those women's needs. We really are.

What we try and do is work closely with Social Work to try and bring the family out, to help them with application of need to try and get his mother or her mother to come out and be with her.

Promoting attachment

When I think about attachment and think about primary caregiver - and for this it's we'll say it's the mother but it doesn't necessarily have to be – I can't help but think that certainly infant mental health, the study of infant mental health is a fairly recent branch of science like maybe the last 25-30 years. And if you think about in our country, women only started birthing in hospital like 50 years ago or maybe 60 years ago. So prior to that I guess we really had no idea what happened. Women birthed at home. They were most commonly cared for by their family. And their children were raised in probably a more holistic way in that there was certainly a lot more family involved in raising that child. And so I personally think that we're still really suffering from that shift from birthing at home and birthing in an institution where, if you think about it, only as recently as 20 years ago mothers and babies were separated from birth.

And even today we still, after the baby's born, teach the mother to care for the baby in a plastic box, that wheelie cot that babies are put into after birth. And I'm not, obviously I'm not just talking about physical attachment, I'm talking about emotional attachment. You know, I'd like to see women being given slings in the postnatal period, because I think it's easier to respond to the cues of your baby if the baby is with you all the time.

I just wonder whether a lot of the struggles that we're having seeing family breakdowns and women struggling with attachment is because they're still I think, listening to the voices of their mothers' generation and her mother's generation and you know, 'babies are to be in a routine, they're to be fed on a schedule' and so if their baby doesn't fit into that schedule, you know they can feel quite, almost intimidated by the baby or just feel like the baby hasn't met their expectations and that can really interfere with attachment.

And having run a postnatal group for many years it's probably the most common thing that women talk about is, you know, the baby isn't as they thought it would be. And that somehow the baby was going to meet needs for them and not the other way round. And from my personal professional experience I see it all interlinked.

And so I think we're getting there and certainly by having, providing women with the opportunity to have continuity through the antenatal period, postnatal period and the birth, is certainly a good step in the right direction to provide an environment where the woman has an optimum time to attach well to her baby.

Avoiding assumptions of disaster

I've had stories where everything looks like it's going to be a disaster and it's actually worked out amazingly well with the right amount of support. So I guess that's what keeps me doing this work is those pleasant surprises.

I had a woman last year who was actually scheduled with a mental health disorder in a psych unit and became pregnant. She 'took her pleasure' with the gardener! [laughs]. 'I wasn't intending to get pregnant'! She was from another country and you know, the plan that was in place was that this woman would come from the psych hospital, have her baby, go straight back to the psych hospital, but each time she came for her antenatal visit I just got to know her a little bit more and heard more about her story. And you know after many months of living in a supported accommodation, she's now living with her baby. You know, which is such a, you know a joy to see her become well and I guess her focus for her recovery was around the needs for her baby. Yeah it was a lovely story. [big smile]

MODULE 10:

Families on the edge: working with marginalised families

This module addresses working with families who are marginalised by society and whose children may be at significant risk of child abuse and neglect due to a range of complex factors. These frequently include family violence and the use of alcohol, illegal drugs and other substances or children who have been placed in the care of kin or the state.

Frequently, parents in extremely vulnerable situations have experienced abuse as children and have very limited experience of sensitive and nurturing parenting. Their tolerance to external stressors is usually extremely low, causing normal childhood behaviour to be a significant irritant. When working with these families it is crucial to understand the mother's (family) history and the intergenerational nature of parenting and the transfer of parenting behaviours. The women have often experienced incarceration and forced separation from their children and in many cases, the children are known to child protection agencies.

Midwives and nurses have a significant role to play when working with families who have multiple and complex vulnerabilities. This often includes an advocacy role when addressing the prejudice and misunderstanding that compound marginalisation. Facilitating access to appropriate family and community supports and services requires effective interdisciplinary working and a clear understanding of primary health care principles.

In this module we have focussed on working with women who have a history of alcohol and drug dependency and women who are in prison but you may wish to engage the students in identifying other marginalised groups in your local area.

Learning Outcomes

On successful implementation of this module, students should be able to:

- Identify and discuss the challenges faced by midwives, nurses and others working in these complex areas of practice
- Describe the attitudes/characteristics practitioners need to work with women who have a history of alcohol and drug dependency and/or incarceration
- Discuss potential risks for children living in situations involving complex vulnerabilities
- Identify strategies to ensure the most appropriate care is provided to marginalised families addressing primary health care principles
- Discuss strategies the midwife/nurse can use to maintain their mental health
- Identify local professional and community services and agencies that can provide support to marginalised families.

Important note to educators:

Unfortunately, it is common for some students in every course to have experienced trauma due to child abuse and/or neglect, domestic violence. They may have a family history of parental incarceration or have experienced other types of traumatic event (e.g. victim of crime). Acknowledging this at the beginning of the session and letting students know there are supports available and that you would encourage them to seek assistance is essential to enable the safety of the students.

DVD section 10.1: Working with women who have a history of alcohol and drug dependency

In the first DVD section 10.1 Jeannie Minnis and Amanda Davies talk about their work with women who have a history of alcohol and drug dependency.

Jeannie Minnis is a clinical midwife/nurse consultant who works in the Perinatal and Family Drug Health project of a large city hospital. Jeannie and colleagues in a multidisciplinary team provide continuity of care to women with substance use issues through pregnancy and childbirth and the early years of the child's life.

Amanda Davies is the manager of Kathleen York House, a residential abstinence treatment program for women with drug and alcohol dependency issues and their young children. This is a 12-month residential program followed by a 12-month aftercare program and the option of community housing. Amanda is a sociologist and has extensive experience of working in community development.

Further information is available from: http://www.adfnsw.org.au/kathleen-york-house/index.html

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

The following trigger questions can be used either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group.

After viewing this section ask the students to reflect on:

- What are the extra burdens women with a history of drug and alcohol dependency encounter?
- List the characteristics needed to work in this specialist area of health and community work?
- What strategies can you use to address and/or raise some of the challenges encountered by these mothers and families?

DVD section 10.2: Working with women in prison

Cathrine Fowler is a child and family health nurse and has had experience of working with incarcerated mothers and their young children and managing a home visiting program for mothers experiencing depression. She describes some of the issues faced by incarcerated women and how engaging with these women changed her nursing practice.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger questions

The following trigger questions can be used either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group. After viewing this section ask the students to reflect on:

- What might be the special needs of women/men trying to parent from prison?
- What might be the special needs of children with a parent in prison?
- What are the challenges faced by midwives, nurses and others working in these complex areas of practice?
- What are the attitudes/characteristics you need to work in these areas of practice?

DVD section 10.3: Midwives and child and family health nurses working together

Ali Teate has extensive experience in a number of Australian states working across the interface of hospital and community services, providing midwifery continuity of care. She describes the importance of effective collaboration between midwives and child and family health nurses, particularly in situations where women have complex needs and need to access a range of services.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Trigger Questions

The following trigger questions can be used either in small groups or as a large group discussion. If using online teaching these questions could form the basis for an online discussion group. After viewing this section ask the students to reflect on:

- What are the challenges faced by midwives, nurses and others working in these complex areas of practice?
- What are the attitudes/characteristics you need to work in these areas of practice?
- What are the potential risks for children living in the situations described in the video clips?
- Identify local professional and community services and agencies that can provide support for families living in high risk situations
- When working with parents who have complex vulnerabilities and requirements, what strategies can you use to:
  - ensure you are providing the most appropriate care?
  - maintain your own mental health?

Activity: Working with our own prejudices

Introduction

Prejudices are usually developed over a lifetime. They are preconceived opinions and bias that are likely to impinge on a midwife's or nurse's ability to make well informed and balanced judgements about a person or situation. Prejudices often result in misjudgements about people and situations, and development of fear, mistrust and discrimination.

Awareness of our prejudices is crucial to ensure they do not impact on the way we work with or care for families. In the DVD sections for this module there were many statements that referred to prejudices and the impact they have on families.

Equipment

A range of magazines and newspaper articles plus photocopies of the articles. Each person in a small group will need a copy of the article they will work on to read.

Activity: Using media

Request students to form small groups of 3 or 4 people. Provide each group with a magazine or newspaper article. Ask students to address these questions:

- Identify the prejudicial statements about individuals, families or communities in the article
- How would you address prejudice about marginalised families in your own workplace?

Concluding activity

In the larger group ask students to discuss their findings to the 2 questions. Challenge the students to consider their own prejudices and how these may impact on their work with families.

This activity can be expanded as an assessment by asking the students to complete a scan of the popular media to identify prejudicial reporting and the impact this may have on families and communities.

DVD section10.4: 'Real life' situations

Three stories drawn from 'real life' situations are presented here by Jeanie Minnis and Amanda Davis. These stories will provide a stimulus for discussion.

To assist with session planning and student discussion the transcript for this section of the DVD is available at the completion of the module.

Activity/Assessment: Community agencies

For each story students can be asked to carry out the following activities:

- Identify the practitioners, services and agencies in their local area that might be involved in supporting the woman and her family
- Discuss how their own attitudes and values are challenged by the stories
- Identify how the principles of primary health care have been addressed.

The scenarios could also be adapted for use in the 'Intake Meeting' role play described in Module 9.

Resources

State Child Protection Agencies
Each state has a Government department devoted to the protection of children. These sites provide information about policy and processes.

Child Protection, Family and Early Parenting Services Vic http://www.cyf.vic.gov.au/child-protection-family-services/home

NSW Community Services http://www.community.nsw.gov.au/

NSW Health Keeping them Safe http://www.health.nsw.gov.au/initiatives/kts/index.asp

Families SA http://www.dfc.sa.gov.au/pub/Default.aspx?tabid=257

Department for Child Protection WA http://www.community.wa.gov.au/DCP/

Department of Health and Families NT
http://www.health.nt.gov.au/Children_Youth_and_Families/Child_Protection/Child_Protection_System_Reform/index.aspx

Department of Health and Human Services Tas
http://www.dhhs.tas.gov.au/service_information/services_files/child_protection_services

Child Safety Services Qld http://www.childsafety.qld.gov.au/

National Child Protection Clearinghouse http://www.aifs.gov.au/nch/
This Australian Government website provides an excellent starting point for finding Australian information about Child Protection and related topics. The links provide access to all Australian states Child Protection government agencies. A comprehensive range of trustworthy resources are available on this site that relate to the Australian context.

National Drug & Alcohol Research Centre (NDARC) http://ndarc.med.unsw.edu.au/
NDARC is funded by the Australian Government as part of the National Drug Strategy (formerly, the National Campaign Against Drug Abuse). The overall mission of NDARC is to conduct high quality research and related activities that increases the effectiveness of Australian and International treatment and other intervention responses to alcohol and other drug related harm.

ChildTrauma Academy http://www.childtrauma.org/
The ChildTrauma Academy is a collaboration of individuals and organisations with an aim of improving the lives of children at high risk of trauma. This site provides access to free online education and downloadable resources.

Centre on the Developing Child http://developingchild.harvard.edu/topics/science_of_early_childhood/
The Centre on the Developing Child is funded by Harvard University. This Centre provides a large number of excellent resources. Of particular interest are the early brain development publication developed as part of the National Scientific Council on the Developing Child initiative.

SHINE for Kids http://www.shineforkids.org.au/
SHINE for Kids is a non-profit organisation that provides services and support for children with a parent in prison. There are numerous resources on this site.

Communities and Families Clearinghouse Australia (CAFCA) http://www.aifs.gov.au/cafca/
CAFCA provides assistance with accessing evidence regarding the planning and delivery of services to children and families in disadvantaged Australian communities.

Australian Centre for the Study of Sexual Assault http://www.aifs.gov.au/acssa/
This Centre provides a clearinghouse for resources about sexual assault, under the auspices of the Australian Institute of Family Studies. There is information about the impact of sexual assault and best practice approaches to care for victims/survivors of sexual assault.

Good Beginnings http://www.goodbeginnings.net.au/support/volunteers.shtml
Good Beginnings provides volunteer home visiting parenting support and community development services. The service is active in most Australian states and territories.

Australian Domestic & Family Violence Clearinghouse http://www.austdvclearinghouse.unsw.edu.au/
This clearinghouse is located at the University of NSW. It provides a range of research outcomes, policy and legislation information and notification of conferences.

Working with Women who have a History of Alcohol and Drug Dependency

DVD transcripts for discussion: section 10.1

Complex issues and vulnerabilities

Amanda Davies
Executive Officer, Mother and Child Drug and Alcohol Abstinence Program

The profile of the women who come to our service: generally they have a very long history of drug and alcohol dependence; numerous attempts of detoxification and rehabilitation, of some experiences of being on methadone, or buprenorphine or other pharmaco-therapies; they have sometimes been using up to ten, fifteen or twenty years; they have children, both in their care and that have been removed from their care; they often have a long history of domestic violence, childhood abuse, socio-economic disadvantage, being very marginalised, multi-generational disadvantage and are often isolated from their families. So there's a range of really complex and very serious issues around their parenting

Jeannie Minnis
Clinical Midwife/Nurse Consultant Perinatal and Family Drug Health project

Pregnant women and mothers who use our service, substance using mothers, really their main issue is stigma and feeling judged, and because of that, they're often very reluctant to engage in services. So that in itself brings about its problems. And then of course, the other major concern for them is having children removed and placed into foster care and most of them come with a story of knowing someone or even having experienced it themselves. And that again makes them very fearful and reluctant to engage in services and to disclose really important information. Many of them come from backgrounds where they had very inadequate parenting themselves and poor attachment, parenting attachment. So they haven't got that to draw on. They're socially isolated. And so they don't have the supports that a lot of people enjoy.

The other really difficult thing for the women who I see is – particularly if they're on say a methadone program – they have a lot of things that they have to do that other people don't. Can you imagine what it would be like every day, being pregnant, maybe feeling very nauseous, and sometimes with other children, having to attend a methadone clinic or a pharmacy, lining up in a queue, most of the women are quite poor and can't afford a car and so they have to walk and catch public transport – they do this, day in, day out. And so with all the other issue that they face – some times poor housing, and having to go to Centrelink, it doesn't leave very much space for the woman and for developing an attachment with her baby – her unborn baby - and her child.

The main issues for children

Amanda Davies

The main issue for the children is that often people have moved around a lot so they haven't had a lot of stability in their housing. A lot of our clients are often homeless by the time they come to us so: instability in the housing, instability in their families. Schooling is often disjointed and not routinised. Sometimes there are nutritional issues as well. Often they don't have much to do with one of the parents, usually the father. I mean, there's just a range of really complex issues. It's often not just the drugs and alcohol or even the drugs and alcohol that are the main issue but often violence is one of the key issues for children at risk with women on our waiting list.

Jeannie Minnis

A lot of the babies, particularly mothers on opioid treatment and those using benzodiazepines, go through Neonatal Abstinence Syndrome. So there's the separation of mother and baby with the baby in the nursery.

With the children we do see delay in speech and language development. And that's often environmental. Some of the women have very low levels of literacy and so things that many people do, like reading to their children, it's very difficult if you've got a low level of literacy. And we often find too that the babies don't get out of the pram very much. You know, because they're walking everywhere, they've got no transport. So they're not stimulated. And sometimes the problems aren't really noticed until the child's at school. Again, due to stigma, the mothers are reluctant to go to Child and Family Health services. They drop off very quickly and so the developmental checks are missed out and it's often not until the child's at school that they pick up the deficits.

The children are more likely to experience neglect than other members of the community, other children in the community. But I must say that many of the women I see make absolutely wonderful mothers. They're very protective and nurturing. So there are women who are just brilliant with their mothering.

Addressing situations where children may be at risk

Jeannie Minnis

If I think a child is at risk, either an unborn or existing children, I will talk to the woman about it. And one of the things that I do with the women I see when they're pregnant is I get them to draw up a list. I get them to write two columns. On one side what they see as the positive strengths they bring to this pregnancy in relation to parenting, and on the other side, the risk factors. I get them to fill that out. And then I bring out my list and we go through it and share notes and then I get them to work out with me a strategy for addressing the risk factors. And that often involves referral to other services.

It's well known that substance use is a chronic relapsing condition. And it's not a moral issue. Many women who have abstained from using substances or gone on a treatment program in pregnancy say, 'Oh when I have this baby I will never use again.' So during pregnancy, as a preparation I say, 'Yeah, well, that's wonderful, however, sometimes people do have lapses and there needs to be a plan in place for a lapse'. So we talk about having a plan, just in case it ever happened. So that, if they were breastfeeding their baby, that they discard their breast milk for 24 hours. And that if they have a lapse, that they use the substance, particularly if it's a sedating one, with someone around who's not intoxicated; that if they use heroin, they smoke it rather than inject it – all those safety issues. But having someone who's not affected by substances care for the baby while they're intoxicated. I also say to the women that a lapse is a lapse, and it's unfortunate but it's not the end of the world. And I encourage them, if they have a lapse, to come and speak to me or someone else on our team. Because it's often a sign that extra support needs to be in place. And I get them to identify the triggers that in the past have led to lapse or relapse.

If of course their actions are putting their baby at risk I would make a notification. And I talk to them about that. I say in pregnancy, I say, 'I have a mandate to report children at risk of neglect or abuse or harm…' I'm quite upfront about that.

Personal attributes needed

Amanda Davies

There cannot be a whiff of judgement in the work that we do because, for our clients, they're so highly attuned to any sense of judgement that it will have an absolutely detrimental effect on any rapport that you need to build, that we need to build, that's essential for the rehabilitation process**.** All of the parenting behaviour needs to be interpreted in the context of these women's lives and so we really need to be not black and white in our thinking but very grey in our understanding of people's behaviour and interpreting issues of parenting.

You need to be really, really open minded, not have any sense of self righteousness, be open to admitting when you're not coping very well and that you need some additional support yeah, and a good team of people around you. I have incredibly realistic expectations. I expect that we'll have small wins with people and if we have big wins then that's an absolute bonus. I get encouraged by people's courage to even show up in rehab after so many attempts and so many issues and so many children removed from their care – and they're still having a go.

So it's just I find inspiration from a whole range of things. And it's not just about people graduating and being abstinent. That's not all, I mean that's ultimately a success but there's lots of other successes along the way. And some people are just not ready and they're just not going to make it. And that's the reality of it. And I get lots of support when I get distressed and disappointed about that.

Addressing prejudice – the role of advocacy

Jeannie Minnis

I sometimes encounter people who are prejudiced in my work regarding people who use substances and alcohol and other drugs in pregnancy and when they're parents. I remind myself that prejudice is often the result of ignorance and fear. And sometimes through past experience perhaps; I have come across professionals who have had a family member with an alcohol problem, and that feeds their prejudice When people display prejudice, I don't argue with them. I find that is just counter-productive. And I will say something like 'You sound as though you're feeling uncomfortable about this woman and her substance use. Tell me about it.' And that often brings out the issues.

Amanda Davies

In terms of managing other peoples' prejudice about drug and alcohol dependent women who have children, it's a very pervasive issue and I know that our clients feel the heavy weight of society's judgement on them.

I think the major thing that we do is try and educate people on understanding that these women didn't just wake up one day and decide to neglect their children because they could. That there are a whole lot of things that led up to this point in time. We try and educate people about the potency of the compulsion to use drugs and alcohol. Some of the issues around that are really important to understand: that people aren't necessarily 'choosing' just to neglect their children or 'choosing' to use drugs because they can. And I think just really showing that people can do well and really that rehab is something that does work for some women. And that they can go on to re-parent themselves and their children in a really productive and healthy way.

Interdisciplinary working

Jeannie Minnis

Continuity of care is really important for the women and their families. And having an identified person who's really their primary carer. I work with a fantastic multidisciplinary team and without them, my job would be so much harder. I think it's an area where you could easily burn out if you didn't have that wonderful team support. It's very effective working with the families I care for to work within a multidisciplinary team because we all bring different insights and skills.

We have our multidisciplinary meetings once a week. Once women reach 30 weeks, we have case planning meetings, where we discuss the woman's care as a team. And we have a care plan that goes in the woman's notes and the women actually sign their care plan. I go through with them in their pregnancy, all their strengths; their housing issues; their need for antenatal and parenting education - which they often miss out on because they feel different; their contraceptive needs; all of those things are documented in their care plan. And the woman signs it so that postnatally, we can address things like contraception and it's already been flagged. And they'll know how long they will stay in hospital or they'll know what sorts of supports will be put in place afterwards.

Building on women's strengths in difficult circumstances

Amanda Davies

In terms of protecting the children against relapse, I don't personally have the belief that just because someone's using drugs and alcohol that they're a bad parent. A lot of people do believe that, because someone drinks or takes drugs that immediately transfers into their parenting. I'm not a proponent of that belief system. But I understand the pressures of abstinence versus relapse in terms of parenting and what we try and do is keep people from not going down too far in their lapsing and affecting things like their relationships and their parenting.

Jeannie Minnis

It is important in addressing the needs of women who use substances to acknowledge that – even thought they often come from quite impoverished backgrounds and they might have very chaotic lives – that they are women with incredible strengths and resources. And it's important to acknowledge that and to build on what they've got. It might be 10 steps forward and 4 steps back but we need to acknowledge the very good work that the women do under very difficult circumstances.

Working with Women in Prison

DVD transcripts for discussion: section 10.2

Cathrine Fowler
Professor of Child and Family Health

Several years ago I started to work with the Department of Corrective Services. They'd asked me to come in and provide some parenting programs. And rather than going in and providing some of the normal things that Child and Family Health Nurses provide, like feeding and bathing infants, I asked that we use those things but also went in and provided a lot of work around relationships. We developed and implemented a program called 'Mothering at a Distance. This program was a 10-session program and we went in on a twice-weekly basis to work with the women.

Women in prison are quite a challenging group to work with. They've got lots of issues. Their lives have not been easy. The majority of the women have been abused as children, both physically and sexually; they have very low tolerance to stress; many are coming off drugs and alcohol; it is not an easy place to be in. But when they tell their stories and they sit around in a group of mothers, that's all they look like: they look like a group of mothers. They all love their children, they all want to do the best for their children, but they don't have the skills or the experience to do that and that's our role in there, to provide those skills and those experiences for them.

They really want to know how to relate to their children. Many of the children don't realise their mothers are in jail. And even though my focus is on 0 - 5 years of age, often these women have had multiple pregnancies, they've had their children taken away from them or their children are in kinship care. So it's really about relationship that they want to learn.

A lot of the work that we do with them is not providing them with lots of information. It's about sitting down and doing craft work and being beside them, not face-to-face. We sit around as if we're a group of women and we make picture frames and jigsaw puzzles and things that they can send to their children and keep that connection. We write letters to the children from their mothers. And some of the women who have literacy problems then they draw pictures and we help write the letters and their feelings. And we try to get the mums to change their language to become much more descriptive

about the way they talk to their children in the letters. So rather than saying, you know, 'I really love you', we get them to tell the children why they really love them. And how important they are to the women in their lives.

We really have not had any problem going into the prison, we've changed the attitudes I think of many of the prison officers, who now, rather than thinking that we were just doing something rather 'warm and fuzzy', appreciate the depth of the work that we do because they can see the results. The women have often become much more - they're able to relate more easily to the prison officers than they had before; they're less aggressive with them.

I think for me it's changed the way I practise because I no longer assume that everything's right with every woman. I've got a strong sense that women have hidden histories. And that, these women, even thought they're in jail now, will be out in the community, they'll have more children out in the community. Some will be able to keep their children. But I know that they're going to turn up at the Child and Family Health Nurse's office, or they're going to turn up in the labour ward or the postnatal ward. And that it's really important that we ask questions. And that we don't make assumptions that life has been easy for everybody. These women are not silly; they're not unintelligent. They're often very intelligent women. But they just haven't had the right start. They haven't had the nurturing parents that have been able to model and 'hold' them as children.

I think it's really important when you work with these vulnerable groups that you don't think that you're going to go in and change the world. I've no illusions that that's what we've done. We've started the water dripping on to the rock. And hopefully we've shown them an insight into what nurturing is about.

Midwives and Child and Family Health Nurses Working Together

DVD transcripts for discussion: section 10.3

Ali Teate
Midwife

It's very important that there's a good relationship between midwives and child and family health nurses because it aids the transfer of care from the childbirth experience to the parenting experience. So it's very important to have good relationships with these people and to develop a trust about where the strengths lie within their individual professional roles to care for that woman and her family.

You can assist that woman in having a seamless service so that she is able to access the most important health services that she needs at that time. So it's very important to discuss with the woman in her pregnancy about the benefits of child and family health services, and other health professionals, such as GPs and paediatricians so that they're aware of what services are available once they've given birth.

There's many experiences of working with child and family health nurses and engaging that transfer for care from me as the midwife to the child and family health nurse. It's difficult to draw on just one experience to explain that but I think the importance is that when you refer a woman, sometimes that woman may carry complexities that need to be referred to child and family health. For example, a couple of weeks ago, I cared for a woman who had a Downs Syndrome baby and I was able to support that woman as she accessed paediatric care initially – because they weren't aware that they were having a baby with Down's Syndrome. But then I was able to refer them appropriately to child and family health. So then they could assist that woman in accessing the appropriate services for this child that would have extra needs as it's growing up. It was very beneficial for the woman to see the supportive professional relationship that the midwives and child and family health had.

It's always important if you're developing relationships with other peers that you have a good sound basis that's built on trust and respect. That quite often takes a while to build up so it's always important to engage people in conversations, whether it's by email or actually just picking up the phone at the local child and family health centre and just talking to someone if you're worried about a woman that you're caring for. Because quite often you can work in these little silos and not actually understand what other people's roles are, exactly what services are available. So you need to actually communicate with these other health agencies to ensure that women get their individual needs met.

Jill's Story

DVD transcripts for discussion: section 10.4

Jeannie Minnis
Clinical Midwife/Nurse Consultant Perinatal and Family Drug Health project

There are some scenarios, which look quite grim on the outside when you look at the issues, but with careful negotiation and consultation with the woman and engagement of services, a difference can be made. I will give a couple of examples:

Let's say, 'Jack and Jill' – now that's not their real names but I'll call them Jack and Jill for de-identification purposes. Jill came to see me and she was 20 weeks gestation with her second baby. She smoked $50 – $100 worth of heroin a day and she financed that through sex work. She had a partner, Jack, and that was a relatively new relationship and she had an ex-partner, Bill, who was a very violent man but her five-year old son lived with Bill. And Bill would not let her see her son. She was very frightened of him. Jill thought that Jack was the father of the baby but there was a little bit of uncertainty because Bill had been her dealer and she sometimes had to pay him for heroin with sex.

Jill lived in stable housing – unlike a lot of our clients. She had a one-bedroom flat, however Jack had moved in with her. Jack had a 14-year old son and a 17-year old daughter and they left their mother and were living in the lounge room. Now Jack was a lovely man and he had a significant heroin problem – very long term. He was 40 and had been using since he was 15. He also used psycho-stimulants. So overcrowding was a huge problem with this family. Jill's mother, who she was very fond of and who had been a great support in the past, had had a stroke and was in a nursing home. She had a sister who was very critical of her but who had offered support.

On the face of it there were huge concerns. However, she entered a treatment program, engaged well in antenatal care and never missed an appointment. She continued to smoke heroin for a little while, once she started a methadone program but then subsided and she has been abstinent ever since. We got the perinatal social worker working with her and she identified that her substance use was really linked to her anxiety and depression; she had post-traumatic stress disorder related to the beatings she's received from Bill. So she saw a psychologist and with the help of the psychologist and the social worker, she gained access to her five-year old and the baby is now one year old and she is doing extremely well. And they have suitable accommodation now. So on the face of it, it looked pretty grim to start with but it was a good outcome – but she is still a very vulnerable woman.

Sherry's Story

DVD transcripts for discussion: section 10.4

Jeannie Minnis
Clinical Midwife/Nurse Consultant Perinatal and Family Drug Health project

I'll call her 'Sherry' – and again that's not her name. And Sherry was an older woman, single and a clubber; she very much lived in the club scene and she was an entertainer. Sherry was referred to the antenatal clinic by her GP. She had gone to the GP to have an ultrasound to determine the cause of a large abdominal mass and discovered, to her horror that she was around about 26 weeks gestation. She had never envisaged having a baby. The father not really on the scene – he was a friend but certainly there wasn't a stable relationship. She had housing concerns. She lived in a crowded little room, a very cluttered little room, upstairs, and she was in arrears with her rent. Even though she worked as an entertainer, she was on a disability pension because she had a significant skeletal problem and she was in a lot of pain. The main concerns were her alcohol use; being a party girl – party woman – she drank usually about six standard drinks a day binge and at the weekend she would have a binge – at the club. She also had binges of Methamphetamine and had used quite a lot at one stage, including when she didn't know she was pregnant. She was absolutely horrified to think of the impact that this might have on her unborn baby. She also used a lot of Neurofen Plus and Panadeine Forte to control the pain and mobility was a problem for her. She had few social supports; all her friends were clubbers and she didn't know anyone who was a parent. Her mother was not particularly close to her – she wasn't close to her mother. She also had an anxiety disorder due to the result of a rape and for that she was taking benzodiazepine in fairly large doses. So it looked pretty grim. It was a very challenging situation for her and us as a team.

However we got her involved with the perinatal outreach social worker. Sadly, her baby had the facial features of Fetal Alcohol Syndrome and the baby has been involved very much in an early intervention program. During her pregnancy – what was left of her pregnancy - she got absolutely everything ready for the baby. She found out about the early childhood services that could come to her. We've now got a play person coming to her home to help her play with the baby. She's doing exceptionally well – even though life is a struggle for her.

A Journey to Independent Mothering

DVD transcripts for discussion: section 10.4

Amanda Davies
Executive Officer, Mother and Child Drug and Alcohol Abstinence Program

I'm thinking of one particular case where a woman who was about 35, she came into the service about seven months pregnant. She had been using amphetamines for a very long time. She had two other children in foster care, one with the maternal grandparents, one with paternal grandparents. And there was a lot of hostility in those relationships. There was a long history of a high level of domestic violence.

And so she came to us, she was de-toxed but she hadn't had a lot of rehabilitation, and she hadn't had any successful experiences of living in the community as a non-using woman or as a woman with a child. So obviously the main focus was getting through the birth of the baby and supporting her through that process. So that was the first thing on the agenda. And that all went amazingly well. She was incredibly courageous and her family came to the birth. And that was a very joyful experience. The father of the child is also alcohol dependent and he was in a rehabilitation unit at the same time, so he was able to come to the birth as well. So that was complicated in terms of the dynamics.

So here she was with one baby and the threat obviously when you have had children removed before is that the next child automatically gets removed. So we were able to work with her and DOCS [community services] to support her to be able to keep the baby while she was in rehab – and promote the rehabilitation aspect of her process with DOCS and so they allowed her to keep that baby initially, instead of removing it automatically, which is their general policy.

She went through a honeymoon period after the birth in terms of having this beautiful new baby. She was drug free, and everything was quite rosy for her. As time went on obviously the reality of her situation started to dawn on her in terms of the other two children being in foster care and now she was negotiating three children and needed to start to re-establish herself as a mother for the absent children. So this was an incredibly difficult dynamic for her to negotiate – and for us to kind of negotiate with her – all the mean time trying to work with her, trying to up-skill her parenting with the current baby and all the aspects of grief and guilt that she was feeling about not having done that with the other two children. The oldest of the three is on anti-psychotic medication and displaying all sorts of behavioural problems, so there are some real issues there for her in terms of guilt about what had gone on previously.

We also had to focus a lot with her about how there was another person in the picture, who was the partner; it was a really violent situation. It wasn't just about 'your drug use'; there were a whole lot of complicating factors going on so she didn't own all of the guilt. And trying to keep her focussed on the successes that she was having now in terms of re-engaging with those children, looking after her baby. And I guess that's been our focus for the whole time, but all the mean time, not losing track of the rehabilitation aspect of the work, not just the parenting. So this is the challenge for us, is that often people want to just focus on the parenting, and get restoration and do all of that, and loose focus on dealing with their trauma, the DV, which is all related to the drug and alcohol dependence. So our job is to just maintain a balance – around the children and the children out of care and the visits and all that sort of stuff, and the baby whilst doing the therapy, and the support and the skills development and the relapse prevention. So it's just about balancing all of those roles.

She was from regional NSW and she was unwilling at first and reluctant to think about going into transitional after-care but by the time she came to graduating, she was very willing – but also really scared because she had never lived independently in the community away from her family with a child, with a small baby. So she was really terrified and for the couple of weeks leading up to departure, she became almost immobilised by fear. She became overly invested in the child's wellbeing to the point where she thought he was getting sick all the time. So we had to do a lot of work with her about building her confidence around her capacity, and the fact that we were still going to be there down the road, that we're staffed 24/7, that she would be coming back every day for as long as needed to, and that we would be working with her for another year. So we weren't abandoning her and sending her off into the community, so that she was able to be an independent woman with her baby and that she would be OK. She got a lot of support from the other women and eventually she was able to leave the rehab and she's currently living independently – probably 10 minutes walk from us – but she's doing extremely well. And the baby's doing really well.

She's moved out of the rehab and she's living 10 minutes away from us. She's thriving in the community. She's had her ups and downs; the baby got diagnosed with chicken pox but it was actually infected mosquito bites – but she did really well in terms of getting herself and baby through that, which was quite contrasting with how she'd coped with him being sick in the house.

She's really starting to blossom in her independence, and for us that's incredibly encouraging because she was so scared of her capacity to live independently. And she's travelling up to see her other two boys and developing a relationship with those other children. That's really complicated for her, and it's often fraught with emotional distress but she comes back and she debriefs with us when she comes back. She's currently struggling with knowing that she needs to start detaching a little bit from the current child and start to put him onto some formula, but she's finding that quite a difficult process and she has quite a lot of emotional distress around that. She was only able to breastfeed the other children for a very short time. And of course, this child has thrived after a number of months of breastfeeding. And so there's a lot of guilt associated with that. But we're able to take each challenge as it comes, so far, she's been able to step up to the mark each time and do really, really well.