AAIMHI

Australian Association for Infant Mental Health Inc.

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Affiliated with the

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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Welcome to the Ann Morgan Prize and National Training Courses Special Edition of the AAIMHI Newsletter 2015.

Incorporating membership feedback, the newsletter committee decided this year to dedicate the October edition of the newsletter to publishing the Ann Morgan Prize essay and the Winnicott lecture. Due to timing the latter could not be included. Information on 2016 National Training Courses has been moved forward to the current edition to maximize time for prospective students to consider training.

The Ann Morgan prize first awarded in 2010 has become an important feature on the AAIMHI calendar. This year in August a gathering in Victoria of over 50 members enjoyed Heather Warne from South Australia reading her winning entry entitled Moments from inside an Infant Therapeutic Reunification Service. Ben was at this event and said he found it difficult to discern if the reading was richer from a clinical or a literary perspective – both through Heather's presentation and the lively discussion it prompted. The event was filmed and will soon be uploaded to the AAIMHI website for members to enjoy at their leisure.

The newsletter committee draws your attention also to a range of training courses offered for 2016 many of which have their application periods closing soon. Regarding upcoming conference events, members not already registered are encouraged to consider attending the upcoming national AAIMHI conference, organized by the AAIMHI NSW branch. Please be advised also that the WAIMHI 2016 organizing committee have extended their submission deadline and invite members to submit proposals for abstracts (no matter how small).

As always, the newsletter committee welcomes diverse written contributions for the final newsletter for the year, submissions due 8 November 2015. Pieces may include, for example: commentary, letters, clinical notes, reviews, reflections, arts.

We wish the AAIMHI conference organizing committee all the best for a fascinating and successful conference in Sydney, and encourage members to submit reviews of conference events or discussions in the next newsletter.

Ben Goodfellow and Emma Toone

Guidelines for contributors

AAIMHI aims to publish three editions per year in March, July and November. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

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

All submissions are sub-edited to newsletter standards.

Articles are accepted preferably as Word documents sent electronically to the AAIMHI Newsletter Committee.

AAIMHI Newsletter Committee

Inquiries on submitting items to the newsletter may be made to:
Ben Goodfellow at newsletter@aaimhi.org
Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

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AAIMHI Vic Branch

It is my pleasure to welcome you to the presentation of the 6th annual Ann Morgan Prize.

My name is Nichola Coombs and it has been my privilege and honour to administer the Ann Morgan prize for the first time this year. I would first like to acknowledge and thank the previous winners – Fiona McGlade, Sophie Constantanides, Judy Corum, Joanne McDoland, Margaret Dugdale and Michele Meehan for their on-going support of the prize and to thank Dr Julie Stone who has been a wonderful prize administrator and custodian since its inception.

The Ann Morgan Prize was inaugurated in 2010 as a way of honouring Dr Ann Morgan when she retired from her official role on the AAIMHI (Vic) executive committee as Vice-President. Ann's clear, compassionate and courageous thinking about the infant and her experience within the family and the world has inspired and enriched the clinical work of many. She has touched the lives of infants, parents and colleagues who have been fortunate enough to meet her face to face. Additionally, through her teaching, mentoring, supervising and contribution to countless clinical discussions over the years, Ann's understanding, her wisdom and her knowledge have travelled widely and enriched the clinical work of infant mental health clinicians practicing in many places around the world. So this prize was created on their behalf and on behalf of the infants and families they work with, as our way to say thank you Ann. The prize brings together two of Ann's many passions: first is the infant and her experience, and second is literature. Ann delights in good writing.

The Ann Morgan prize was created to invite contributions that would illuminate something about the infant's experience and also to be a forum for creative writing not bound by the rules and restrictions defining many professional publications. The prize has attracted very good interest over the past six years with diverse styles of writing submitted from a wide field of writers including submissions from most states around Australia. We are always open to suggestions of how we can further nurture and shape the prize and if you have ideas about ways to better to define the task or shape the prize, we would love to hear from you.

For the last four years, an annual writers' workshop has been offered to our AAIMHI (Vic) members to encourage and support them to write about their experience and, hopefully, to give them the confidence to enter the prize. This year's writers' workshop was facilitated by Lee Kofman for the second year in a row and was titled "Finding your writing voice".

Lee Kofman is an author of books, short works and a prize-winning publication and she has been mentoring writers for over ten years. Participants of the workshop again spoke very enthusiastically about Lee's mentoring and the workshop in general and we plan to continue to offer this workshop annually in support of the Ann Morgan Prize.

Before I tell you about the judging and get to the announcement of the winner and the reading of the prize winning contribution, I would like to tell you about my role as administrator and what happens to the Ann Morgan Prize entries.

The invitation to submit is extended to all members of the Australian Association for Infant Mental Health. Entries are sent electronically to the administrator at a special Ann Morgan Prize email address. I read each submission to ensure there is no identifying information. When there is, I attend to it and our judges receive a hard copy of each submission. The identity of the writers is not revealed to judges or others at any point, except of course to announce the winner. Each year all of the submissions have been reviewed blind.

Ann was a judge in the first three years but wanted to be free from the restriction of having to choose which one was best. She has been relieved of being a judge, however still receives a copy of the blinded entries and joins the judges' meeting. The jury for 2015 has remained the same as for 2014 and includes Campbell Paul, Joanna Murray Smith, Christine Hill and Jennifer Harrison. We are very fortunate to have had Campbell Paul and Joanna Murray Smith as judges for all of the six prizes to date. Joanna's ongoing support of the prize has been fantastic. She continues to find the time and says it is a pleasure to be able to honour Ann. Last year we were delighted that Christine Hill, who has organised and facilitated the writers' workshops agreed to be part of the panel and along with Jenny Harrison, child psychiatrist and published and celebrated poet. The judges take their role seriously. They are all exceptionally busy professionals and I cannot thank them enough for their generosity in thoughtfully reading, critiquing and discussing each entry with the care and attention they bring to the task. It was a great privilege being in the room with such esteemed individuals thoughtfully discussing each entry.

Although there was a healthy number and diverse field of entries, with every contribution having its merits, the judges arrived at their decision for a winner with ease. There was some interesting discussion about the challenges writing about work in a creative way and how hard it can be to write creatively as a therapist. It was this capacity in the winning writer that impressed our judges. The writer managed to create an interesting story with impressive sensitivity, painting a compelling picture of the clinical work in a very human way.

Nichola Coombs

Ann Morgan Prize-winning essay

Moments from inside an infant therapeutic reunification service…

He turns up regularly, weekly, though sometimes late. Today he's on time, and sits awkwardly in the waiting room. He's thick-set, 24 years old, pumps weights and drinks Red Bull. He never wears a jumper. His baby, a girl, soon to be a toddler, sits in her pusher, face slightly dirty, big blue eyes alert, wispy hair awry and poking out from under a red and white knitted hat with red pom poms dangling from the ear flaps. Her feet are bare. Today she grins at me, a wide toothy smile – she has a big gap between those two front teeth, and she looks just like her dad. Although her paternity is obvious, in the beginning it was contentious and required scientific verification.

He is less effusive in his greeting, doesn't directly say hello. He's a bit shy, and socially awkward. The greeting is important. Sometimes our parents can't share, not even with their infant, and it can be a mistake to greet the infant first; if the parent flickers, and turns away just slightly with dry displeasure, we're off to a bad start. This dad is not like that, but he is on the edge of his comfort zone, here under duress. Mostly he warms up as we trundle down the corridor, through the grey security door then right, left, left and into the playroom. He reminds me of a friendly but slightly inept bear with a dolly in a flimsy toy pusher.

Usually he connects with me, on his own terms, by way of cars. He relates his latest mechanical exploits – the new shockers he's just installed on the V6, the deal he's wrangled for good second-hand tyres, and after this (meaning the session), he's off to the wreckers with his dad because the timing belt is on its way out. I will ask him again, a little later, about where the baby will be and I'll say something like, 'Wow that's a long time for her to sit in the car …' And he will say, 'Oh she's used to it,' and I will grapple with how much of a problem it is in the general scheme of things.

But today it's a bit different – he sucks on his can of Red Bull and fiddles with his phone as he pushes her along. He's not looking at me. Just as we get to the room his phone rings, and he says can he answer it? Perhaps he's remembering last time, when, sitting on the floor with the baby, I relayed what I felt, what the baby might feel, as he texted back and forth, one of the candidates he was vetting for a relationship. Perhaps he's remembering something of that conversation, carefully delivered with humour and empathy, so as not to shame him. I said how I felt alone and forgotten right then and there, while he held his phone, in his hands and his mind, and it was probably like that for his baby too. He scrabbled about, keen to tell me that the 'chick' on the receiving end of his attentions was only free now, since it was lunchtime … How would he manage, I wondered out loud, the romance and compulsion of a new relationship, while caring for a baby? Easy he said, we'd only do stuff where she could come too. He has criteria, has learned from his mistakes, he says. Good with kids is on top of his list, and he can provide details.

But maybe he did feel criticised, or there's something else on his mind. Whatever it is, the baby is here, however he feels, and how does he manage that? She's off by herself, busy with the toys, but she looks at him more than when they first came; she was eight months old. Now she's almost walking and he's keen for her to be properly mobile. Small babies are not really his thing.

There's no doubt she's in his heart, I can feel it in the room. He no longer goes out drinking; he doesn't tangle with the law. He's solid and reliable and committed. He's recently been shopping for her, for new clothes, and, apart from the hat, she's decked out in pink. Sometimes she arrives buttoned at the front when I'm pretty sure the buttons belong at the back. Her bottles are clean, and he tells me she gobbles up the vegies he cooks for her. She's healthy, growing well, and meeting her developmental milestones – a far cry from the emaciated, silent, dull-eyed infant who arrived, aged four months, precipitously into his care.

Our service, small, committed, and meagrely resourced, works with infants and parents at risk. All of our clients are involved with the child protection system. Our job is to put the infant first; we grapple with the complexities of parenting capacity assessment, out-of-home care, early decision-making in the best interests of the infant and within their developmental timeframe, and where possible, intensive therapeutic support with the infant and their parent/s or carer/s. Most of our therapeutic work is with mothers and their infants, most of the fathers are violent and don't have what it takes.

This father, however, is not violent, and took on his daughter's care when the mother couldn't do it. Within the hour he'd said yes, and had rallied his network and the basic necessities – cot, nappies, bottles and formula, singlets and grow suits and blankets. Fatherhood was huge for him, and he took it on. She arrived from her mother via a child protection worker, a haunted shell. Her mother was homeless and mostly drugged. This infant, like many we see, had witnessed violence, ugly and terrifying. She was left alone, to scream and despair, her bottles filthy and unfilled. She spent days at a time with mere acquaintances when her mother failed to return. She'd been seriously ill and was way too thin, admitted to hospital for 'failure to thrive'. Her body told the story. Her mother, repeating her own history, did not know how to do it differently.

He had fallen into a relationship of sorts when the mother was 'up'. They met through a friend, and for a few good weeks, she was fun loving and affectionate; then she moved in. She needed somewhere to stay. They talked about children, but she didn't stay faithful. He found the evidence on her phone. By then she was pregnant, and stealing his money, and leaving her other child in his care. He left, or threw her out, it's not clear which. He never went back. She alleged that he threatened their unborn child and took up again with a man who beat her. The father, our client, wasn't at the birth, and she disputed paternity. Hence the test.

He's not good at relationships, he says. As a boy he was angry, difficult to manage, and struggled at school. He received a dual diagnosis that has stuck. Asperger's Syndrome and ADHD. Heavily medicated to keep him compliant, he gained huge amounts of weight, and thus dulled and conspicuous, struggled more at school. He started drinking and thieving, and 'got in with the wrong crowd'. It seems no one heeded that he lived in fear; his father drank and abused his mother. When his parents separated, home was a toxic soup of blame and acrimony. When we talk about it now, he glides over the pain,

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Ann Morgan essay cont.

says his father has given up the drink, goes fishing instead, and that he, the grandfather, has Asperger's as well. The idea that something else was going on is very difficult to face and he doesn't appear to have taken in the recent psychiatric opinion that he was labelled wrongly…

He says he doesn't think his baby has Asperger's, and I agree. We edge about it some more. Trauma can look like Asperger's, I say, and again we talk about her brain, what all those stress hormones do to a small baby, how she learned not to rely on anyone and what she needs now. He says he's getting better at that, and I agree. At some point, he gathers her in, a bit rough, but he holds her close and for a moment she snuggles in. She goes to him more. There's an authentic quality in what he says, and I trust it. He says he's not good at the feeling stuff, and finding a way to say things.

And so it goes. We talk about the past, and what happens in the moment. I try to give to him what I want him to give to her. I wonder what he's thinking and feeling, what does he imagine she's thinking and feeling, tell him what I see him doing, let him know that I like him and know him to be a good person, understand that parenting is hard. Especially when you weren't expecting it and are going it alone when you really want a family, different from when you were little. Back and forth we go, between the baby and him, including both. What do you think that's like for her? Did you see what she did when you sat on the floor? What do you think it's like for her to see her mother? Is she any different when she gets home? This sounds like an interrogation, but I hope it's not. It's to and fro, joining them up, making links that weren't obvious before.

And I talk about how weird it is to come in here and talk to someone as old as me in ways that he's not used to and not comfortable with and is anything we're doing here helpful because sometimes it's hard to tell … and at regular intervals he talks about cars. He's not deterred by my ignorance.

Although awkward and at times repetitive, these sessions are not that difficult. Despite some worries about the time this baby spends in the car and wrecking yards, and sitting in her playpen next to the latest being worked on vehicle, this dad is good enough. He knows his baby, thinks about her, plans for her. He accepts help. And she relies on him. She makes a beeline for him when she's hurt or frightened, looks for him and cries when he's not there. Though she's too self-sufficient, and cruises the furniture on tiptoes, and parts of her are hidden, she is safe, and held in his arms and mind.

Not so, for others that we see. Young infants, for example, with unexplained bruising or broken bones, the ones who hold themselves rigid and stare with hopeless eyes into the distance, the ones who look down, with flat lifeless faces and their hair worn away in telling patches from too much lying down or rocking back and forth. The ones who spit up their milk and scream without warning, or the ones who are eager and overbright and latch on to strangers with desperate eyes. These are the ones who are not safe and not seen, and exist in helpless desperation.

As I recall the many such infants who come in through that grey security door, part of my brain disengages, and something else, akin to instinct, takes over, as it does in the room. The language of young infants is powerful and primitive. It is as if they speak through the feeling states that they evoke, how they hold themselves, and where they look. Infants cannot lie. They cannot help but tell the truth of their experience, the truth of their connection with the adult who holds them. Feeling states that are difficult to bear invade the room. Helpful theories and models simply evaporate, and, just as the infant cannot escape, I feel as if I am living on wits alone, with nowhere to hide. Trapped in their bodies, exquisitely sensitive, and helplessly vulnerable, the infant has no choice in the matter … the best they can do is to not look, hold themselves rigid, go still and silent and sometimes floppy, or overly bright and wide eyed, whichever serves them best. There's such rawness in the room, so much excruciating need. And there is always more than one baby, though only one is visible. The mother's infant self, as well as mine, are also present.

The mothers we work with are always wounded, horribly wounded, and champions of survival. They say the things that, logically, we would want to hear, and they trust no one.

'Good mother, no drugs, no violence, reformed, unfairly treated, love my baby, baby perfect, a few past hiccups but all good now. No one will listen, it's so unfair, I've done nothing wrong, I really am a good mother, had a few issues keeping things tidy, I'm not seeing the father, the baby is perfect, my world, my life, I'll do anything for him. I will get him back, I know it. It's just a matter of time and showing up here. I've done everything they've asked of me.'

How can she believe, though we've made it clear, that her best chance is to tell the truth? In her mind the truth, some version of this, would surely seal her fate: her childhood, or what little she remembers of it, was awful. She didn't feel safe, wasn't safe. From early on, she knew violence, abuse, neglect, terror, abandonment, and utter aloneness. She learned to numb herself. At some point, often very young, she fell pregnant. The promise of a baby, as if by magic, would fill the void. Here at last was someone who would love her, and not leave her.

It was not as she'd hoped. The infant screamed, was helpless, needed her. There was no one to help, she trusted no one to help. The partner, jealous, became more violent. She did her best, but sooner or later, she spiralled down, and reports were made. Or even worse, she'd been through it all before, once, twice, three times or more, and they took the baby early, straight from hospital …

We search for the signs that show she recognises her part. She has, though she did not mean to, hurt her baby. Either directly, or indirectly, either way the baby was not safe, as she was not safe. She has to see that she has done to her baby what was done to her, and to face the shame of that. She needs to face and to feel what that was like for her baby. Then we can work with her, that little chink in her armour.

The process will be long, imperfect and blundering, with moments of triumph and no guarantee of success. We will sit through session after session of rage and blame, anguish and grief. It will be the infant who leads the way; he will turn in circles, or back away, he will spill his jumbled world onto the floor. We will sit with chaos, sit in chaos, amongst a sea of plastic coins, pots and pans and teacups, dinosaurs and crocodiles, wild animals and items from a doctor's set. It will be a long time before the train tracks join up and the train doesn't crash. We will wait for the crocodiles to move out of the doll's house. We will try to make sense of it all, and see through the infant's eyes.

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My part will be to show up regularly and willingly. The process will challenge me to the core, to sit with what is not contained, to hold a boundary, to stay thinking and connected, with myself and them. At best we will build enough safety for a real relationship to emerge, one in which vulnerability can be shown, pain can be held, and soothing experienced. It will be difficult to get there. The work requires a team, regular supervision, and a shared belief that change is possible; intergenerational trauma does not have to go on and on.

They're back, the dad and his baby. They're fifty minutes late. I go to the waiting room, pleased to see them; I thought they weren't coming. She's straining to get out of her pusher, and missing a sock. He's dishevelled but upbeat. They have been on holiday to see his mum and celebrate the baby's first birthday. They've been on the road since early morning, have just arrived in town. I take a breath and imagine them, flying down the highway in the V6 with the spoiler on the boot and her strapped into the baby seat, staring out the window with eyes glazing over, or asleep. I'm glad they're safe. It's not that he's keen to see me; he's in trouble with his social worker for missing access, and he didn't dare not show up. Nevertheless, he bubbles with news. His mum is proud of him, she even said so, and they went camping, all together, and cooked lamb on a spit. The baby had a great time too, he said, and his best mate has just become a father. He wants to move back to the town he grew up in. It's as if in claiming his baby he has also been claimed, back into his family.

A while ago I asked if I could write about them, and told him why. He laughed, a bit bemused and said 'yeah, sure', as long as he didn't have to write anything.

The next thing, he says, will be to take her fishing, out in the boat. I feel instantly queasy, and I say so. He's been thinking about that, the way he got his sea legs was to get started early, when he was five. She's only one, I say. We'll just do little trips, he says, and if she's not okay, we'll turn around and go back in. He's saving up for a very small life jacket.

Heather Warne originally trained as an occupational therapist and has spent most of her 35-year career working with children and families in community settings. Her engagement in reflective practice around the limited effectiveness of working with children within a developmental framework lead, around 15 years ago, to her discovery of attachment theory and the field of infant mental health.

Since then Heather has undertaken extensive training in infant mental health, parent-child therapy and adult psychotherapy, and now combines these skills with her training as a paediatric occupational therapist. Heather works as an infant mental health specialist with the Infant Therapeutic Reunification Service which is a joint Child Protection and Health initiative based at the Women's and Children's Hospital in Adelaide. She also maintains a small private practice and is a committee member of the SA branch of AAIMHI.

Heather sustains herself by delighting in her grandchildren, writing, and occasionally getting to dig holes and plant things in her garden.

Association for Infant Mental Health Inc. Vic Branch Seminar

Saturday 21 November 2015

Baby, I'm Your Man: Words and Music of Dads Who Can

Presented by dads, about dads, for everyone!

Featuring

Levi McGrath, Singer-Songwriter and Father, **Timothy O'Leary,** Therapist, Author and Educator and **Dr Matthew Roberts,** Perinatal Psychiatrist

Tim has written a book for new dads (*Dads Who Can*) and will talk about his approach to engaging dads around intersubjectivity and psycho-biological attunement (without using those terms) with his Two-Windows and Five Gauges Approach. He will also include a couple of case vignettes- one with a father's trauma and one around a dad and PND. Tim is also keen to hear from how women find it working with dads and to address the thoughts/questions that people bring.

A Melbourne perinatal psychiatrist and father of 3, Matthew Roberts specialises in family-wide practice involving fathers and their new families. As a recovering professional musician, Matthew will present 'Dads Rock: Songs for a Paternal and Child Health Centre', in which he plays some recordings which help articulate his evolving understanding of fatherhood. He will then invite discussion about Paternal and Child Health as connected to but distinct from Maternal and Child Health, especially with respect to the experiences of infants.

We hope you can join us.

Time: 9.30am-12.30pm on 21 Nov.

Venue: 'Glen Nevis'
18 Erin St, Richmond

There is metered parking in Erin St.

Public transport options include:
-train to West Richmond
-Punt Road bus to Bridge Road
-tram along Bridge Road to Epworth Hospital.

Cost: Free to AAIMHI members; $45 for guests (cash or cheque only - please pay on the day)

RSVP to this email: Lisa Bolger aaimh.vic@gmail.com

MASTERS of MENTAL HEALTH SCIENCE (INFANT STREAM) – The University of Melbourne

The University of Melbourne **Master of Mental Health Science** programs are recognised professional development for a wide variety of mental health and associated vocations and provide a solid grounding in selected areas of mental health practice. A Graduate Certificate, Graduate Diploma or Master degree in Mental Health Science will be viewed positively by employers and may lead to advancement within a mental health related career. The research year at Masters level provides graduates with the experience for those who may wish to pursue a PhD course.

The focus of the **Infant Stream** is primarily on the baby and the infant/parent relationship. We provide an interdisciplinary training in skilled assessment and intervention with families, which can greatly assist the capacity of parents to facilitate their child's development. ***The teaching is based on the theoretical and practical foundations of clinical work with infants and families in a number of settings and contexts.***

The **Infant Stream of the Master of Mental Health Science** builds upon the former University of Melbourne *Graduate Diploma and Masters courses in Infant and Parent Mental Health* (est 1996) and was developed out of the clinical, teaching and research work of the Infant Mental Health Group at the Royal Children's Hospital Melbourne and other infant mental health programs in Australia and world-wide. The course draws broadly on the disciplines of psychiatry, developmental psychology, attachment theory and psychoanalysis for the theoretical basis to provide sound theoretical, practical and observational foundations for working with infant and families experiencing mental health problems.

This course is available both to students on campus and students remotely by distance education. Distance students join live the online teaching week by week, and like all students have access through the University of Melbourne student portal to online readings, and other teaching resources.

The Student Experience: What can you expect in this stream?

Students are drawn from a wide range of health and welfare professionals, and a strength of the course is a rich interdisciplinary experience.

The Infant Stream is taught at the Health Education Learning Precinct located at the Royal Children's Hospital Academic Centre. It is delivered as a part-time course with **on-campus** teaching one afternoon per week over two twelve-week semesters each year. **Distance students** attend using video conferencing facilities and obtain reading material supported by the University ePortal.

The Infant Stream is coordinated by Associate Prof Campbell Paul and subject coordinators are Associate Professors Brigid Jordan and Frances Thomson Salo. Additional teaching faculty are drawn from the staff of the Infant Mental Health Group, Royal Children's Hospital, and other clinical infant and parent mental health programs.

Infant Course Stream Structure

Designed to develop professional practice in infant mental health, the Infant Stream offers a Graduate Certificate, Graduate Diploma or Master Degree in infant mental health. This course aims to develop understanding and clinical skills necessary for working with expectant parents, babies, toddlers, infant–parent dyads and families.

Infant Course Stream Structure

YEAR 1 Graduate Certificate: 1 YEAR PART-TIME- 50 Credit Points

2 Infancy theoretical units

1 clinical and 1 observation units

YEAR 2 Graduate Diploma: 2 YEARS PART-TIME - 100 CP

2 Infant observation seminar units

1 clinical infant mental health theory unit

1 Research prep (if continuing to masters level) or 1 Selective subject

YEAR 3 Master: 3 YEARS PART-TIME - 150 CP

2 Research Units (completion of a research thesis)

Applicants must meet all relevant entry requirements to complete any part of this course. A current working with Children check is a requirement.

Now accepting applications for 2016 entry

Contact Information: Melbourne Medical School:

http://go.unimelb.edu.au/49in

The Masters of Mental Health Science is now open for applications through this website: http://medicine.unimelb.edu.au/study-here/postgraduate_coursework_programs/master_of_mental_health_science

MDHS Student Centre t: +61 3 8344 5890 e: mdhs-sc@unimelb.edu.au ; www.sc.mdhs.unimelb.edu.au ;

http://medicine.unimelb.edu.au/MC-MHSC

The Academic Programs Administrator: Ms Victoria Kingsley

Department of Psychiatry, University Of Melbourne

Phone: 9035 5739 (Office) Fax: 03 9035 8842 E-mail: victoria.kingsley@unimelb.edu.au

Other course enquiries: Infant Stream Coordinator

Assoc. Prof Campbell Paul

Phone: 03 9345 5502; Fax: 03 9345 6002 E-mail: cwp@unimelb.edu.au

Perinatal and Infant Mental Health (PIMH) Program of Study

The NSW Institute of Psychiatry (NSWIOP)

The perinatal, infancy and early childhood periods are a time of enormous developmental and relational change for all family members. Early development occurs in the context of relationships, past and present, which act as risk and protective factors during this period. Knowledge of early development, skills and confidence in infant and relational assessment and intervention are central to competent perinatal and infant mental health practice. Professionals with these skills are therefore essential to comprehensive service delivery. Programs are offered in distance education mode with web conference supervision.

Graduate Diploma of Mental Health (Perinatal and Infant) (48 Units)

A 4 semester course providing theoretical and practical knowledge and skills for therapeutic work using a relationship based approach with infants, care-givers and families in a variety of settings, and for roles in service and policy development and delivery.

Year 1

Semester 1: Core Infancy Studies I (6 Units), Infant Observation I (6 Units)
Semester 2: Core Infancy Studies II (6 Units), Infant Observation II (6Units)

Year 2

Semester 1: Clinical Infancy Studies I (6 Units), Clinical Supervision (6 Units)
Semester 2: Clinical Infancy Studies II (6 Units), Clinical Supervision (6 Units)

Master of Mental Health (Perinatal and Infant) (Clinical/Research) (24 Units)

The 2 semester Coursework stream program is designed to equip professionals working in the area of perinatal infant mental health with appropriate, comprehensive, skills for providing leadership within the discipline. There is an emphasis on developing students' critical thinking, analysis and awareness of current debates within the area.

Completion of Graduate Diploma of Mental Health (Perinatal and Infant)

Semester 1: Advanced Clinical Practice I (6 Units), Current Debates in PIMH/Elective Unit (6 Units)
Semester 2: Advanced Clinical Practice II (6 Units), Current Debates in PIMH/Elective Unit (6 Units)
A Research stream (by application) is also available on achievement of a satisfactory pass in the Graduate Diploma and Research Methods. (12 Units)

Infant Observation

A 2 or 4 Unit Infant Observation, with entry in Semester I or II, provides 12 units toward the Graduate Diploma or can be undertaken as a Stand Alone Unit of Study. Infant Observation augments psychotherapy training and clinical knowledge by observation and discussion of the emotional development of an infant, within the context of the family. Small group supervision is provided by web conference.

Prospective students can download the **Course Handbook** from our website. This contains enrolment information and an **enrolment form** to complete online.

NSWIOP Locked Bag 7118, Parramatta BC NSW 2124 Australia 02 9840 3833 **www.nswiop.nsw.edu.au**
Course Director: Dr Nick Kowalenko
Enquiries: Kerry-Ann.Grant@nswiop.nsw.edu.au
ESO: Luisa.Mulholland@nswiop.nsw.edu.au

Postgraduate online courses on *Father-infant Attachment* and *Working with Vulnerable Fathers*

How does father-infant bonding take place and how do couples co-parent? How do we engage with fathers when partner violence or abuse may be present? How do we achieve a balance between enthusiasm for fathers' involvement and mothers' need for support? These two online courses provide answers.

Father-Infant Attachment and Co-Parenting: Theory and Intervention
http://www.newcastle.edu.au/course/HLSC6112.html

Students in this course develop a thorough understanding of the formation of father-infant relationships. Fathers' interactions with their infants are now the subject of increasing interest to researchers and their patterns of play, nurturing and care are now being linked to long term child outcomes. At the same time, a father's relationship with the mother is also identified as an independent factor in plotting children's development. How couples negotiate and develop a sense of comfort with their roles as 'mother of new baby' and 'father of new baby' is an emerging area of research. Both the role of fathers in co-parenting with mothers and the development of the father-infant bond have important implications for therapy and support of fathers and their families. Examples of effective practice with new fathers and their families will be described and discussed in order to develop the skills to engage with fathers while delivering effective programs and services for families with infants.

Working with Fathers in Vulnerable Families
http://www.newcastle.edu.au/course/HLSC6126.html

This course will provide an evidence-based, practical understanding of how to include men (fathers, uncles, boyfriends) in the services and programs aiming to support vulnerable families. The course uses motivational interviewing and Alan Jenkins' restorative approach to assist fathers to find an ethical basis and the means to develop new ways of relating. The video and written materials identify and clarify the competencies needed to promote reclamation of a sense of integrity for fathers who have been distant, controlling, violent or abusive. Successful (and promising) interventions with fathers will be examined and practical exercises including specific, brief research projects connected to students' work environment ensure that the course is relevant to practice.

These online courses will be available in 2015 as stand-alone courses or through enrolment in the postgraduate programs in Family Studies at The University of Newcastle.

Website: http://www.gradschool.com.au/ Phone 1800 88 21 21

Introductory certificate courses in Perinatal and Infant Mental Health, South Australia

Two Introductory Certificate courses are run annually from the Women's and Children's Network (WCHN) in South Australia, mainly by staff of the Perinatal and Infant Mental Health Services and Department of Psychological Medicine. Students receive an introductory certificate from the WCHN for each module satisfactorily completed. The intent of each course is to provide basic knowledge and some skills in the relevant area, with one course focusing on infant mental health (IMH) and the other on perinatal mental health (PMH). There is a mixture of didactic input with one or two lectures per week providing relevant information which will supplement students' reading. In addition, there is a significant focus on self-reflection and the impactful nature of the work, with the Certificate of Infant mental health using infant observation which is supervised in small groups and the perinatal mental health course using reflective case supervision. Each course usually takes up to 35 students from a wide range of disciplines and agencies including social work, psychology, general practice and psychiatry, mental health nursing, midwifery, childcare, NGOs, private practice, child protection services, education and more. During each run, several remote sites can be accommodated via tele health, with at least 6 people required to ensure viability of small group work at that site. Many South Australian country towns have used this facility and several remote sites from other States of Australia. The courses each run for 10 consecutive weeks on Wednesday afternoons from 3-6 pm and are run face to face at Glenside Hospital in Adelaide. The Introductory Certificate in IMH (CIMH) will run from February 3, 2016 to April 6, 2016. The Introductory Certificate in PIMH will run from May 4 to July 6, 2016. The CIMH often runs a second time in the third school term if there is enough demand, so through August and September.

The cost is $500 per student. Enquiries from Rochelle Brown at Rochelle.brown@sa.gov.au or

Anne.SvedWilliams@sa.gov.au

Master of Mental Health Science – Child Psychotherapy Stream

Department of Psychiatry, School of Clinical Sciences at Monash Health, Monash University

The Master of Mental Health Science (MMHSci) is a three-year, part-time course which will provide you with advanced training and knowledge up-skilling in the disciplines dealing with mental health issues. It will also prepare you for senior clinical management and policy and planning positions in mental health.

This course allows you to select from community mental health, child psychotherapy or generic pathways suited to your workplace training or individual need. Delivered off-campus, the course provides teaching through internet-based mediums and a weekend workshop held each semester. The MMHSci is available by coursework, research project or minor thesis and provides the opportunity to exit the course at a Graduate certificate or Graduate Diploma level as long as requirements for that alternative exit have been met. Standard duration of study is 3 years, part-time study only.

The child psychotherapy pathway gives you a deep understanding of psychoanalytic and developmental theory and how it can help children and adolescents with emotional and behavioural problems.

Professional recognition

Students seeking to be considered eligible for professional recognition (at Graduate Diploma level) in the Child Psychotherapy pathway/stream need to complete all 8 CPS units. Successful completion fulfils one of the criteria for professionals to be employed under the Child Psychotherapists Award and to be eligible for membership of the Victorian Child Psychotherapy Association.

Core units

CPS5001 Psychoanalytic and developmental theories I
CPS5002 Normal developmental observation
CPS5003 Psychoanalytic and developmental theories II
CPS5004 Psychodynamic assessment of children and adolescents

Electives

CPS5005 Principles of child psychotherapy
CPS5006 Principles of adolescent psychotherapy
CPS5007 Principles of short-term therapy and crisis work and
CPS5008 Principles of working with parents.

Further information:

http://www.monash.edu.au/pubs/handbooks/courses/4508.html
http://www.monash.edu/study/coursefinder/course/4508

Contact details:

Course coordinator: Prof David Kissane
Course Administrator: Heather Thiessens
Telephone +61 39594 1355; Email: mmhs.psych@monash.edu
Child Psychotherapy stream co-ordinator: Dr Jennifer Re Email: Jennifer.re@monash.edu

15th World Congress of the World Association for Infant Mental Health

May 29 – June 2, 2016
Clarion Congress Hotel | Prague פראג براغ | Czech Republic

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

Call for Papers & Registration

Abstract Submission Deadline: Tuesday, September 15, 2015
Early Registration Deadline: Sunday, March 1, 2016

www.waimh2016.org