WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Australian Association for Infant Mental Health

NEWSLETTER

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FROM THE EDITOR:

Carpe diem, quam minimum credula postero

With all the recent publicity relating to the Children in Immigration Detention issue and the obvious concern over the stance of our current government and their actions dating back to last November we must seize the day and become a national voice.

This special edition of the Newsletter arrives just in time for your consideration of our submission to HREOC relating to the concerns over children in immigration detention centres. With the due date for submissions, May 3rd, rapidly approaching, the AAIMHI National Executive would be delighted to receive any comments or suggestions relating to the submission. The AAIMHI National Executive committee is confident that, as an organisation, the submission, prepared by Dr. Rosalind Powrie with assistance from Dr. Sarah Mares and Dr. Louise Newman, is what needs to be said. The National Executive committee would also be delighted if you could pass on the submission to any individual, group or organisation that you feel would care to endorse it.

Also in this issue is an interesting look into Parenting Assessment and Skills Development Services (PASDS) by Pauline Sampson from Victoria. Don't forget to get your details to Frances Gibson if you are interested in attending the Emotional Availability Scales workshop in early June. See feature.

I trust the year is progressing well for you all.

Pax vobiscum,
Victor Evatt

Post Script.
ACER Press was very pleased with the review of Lynne Murray's book, "Your Social Baby", in the December Newsletter. I would just like to point out that the price quoted should be $39.95.

2002 CALENDAR OF EVENTS

MAY - JUNE 2002 (NSW)

Emotional Availability Workshop
(AAIMH is seeking expressions of interest)

More Detail in the next issue, or contact:

Dr Frances Gibson at frgibson@laurel.ocs.mq.edu.au

NOVEMBER 2002 (NSW)

14 - 16 November:

AAIMH NSW & NIFTeY
Joint Conference (See eclosed flyer.)

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- Human Rights and Equal Opportunity Commission

Submission to the Inquiry into Children in Immigration Detention

On behalf of the Australian Association for Infant Mental Health (AAIMH)

Prepared by Dr Rosalind Powrie, BMBS, FRANZCP.

Aims of AAIMH

The Australian Association for Infant Mental Health (AAIMH) is the Australian Affiliate of the World Association for Infant Mental Health. It aims to improve professional and public recognition that infancy is a critical period in psychosocial development for infants and the family and to provide a focus for multidisciplinary interaction and co-operation for those who are involved and interested in working with infants and caregivers.

In carrying out its aims the Association prepares reports and submissions to governments, other authorities, organizations and individuals on matters relating to infant and family health and welfare. The Association is pleased to take the opportunity to present such a report to the Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention particularly in relation to infants and very young children.

Focus of this Submission

In keeping with the submission guidelines and the specific experience and expertise of AAIMH the following areas relating to immigration detention and children will be addressed:

- The psychological and social well being and development of infants and young children and their families in immigration detention.
- Specific services required for young children and pregnant women in detention and on their release into the community.
- Culture and its influence on the psychosocial well being of infants and their parents.
- The impact of detention on the well being of young children.
- The UN Convention on the Rights of the Child in relation to child asylum seekers.
- Recommendations

1. The psychological and social well being and development of infants and young children in immigration detention.

The following factors provide a context for understanding the impact of detention on young refugee children and their families as they are well recognized as critical for the healthy emotional and social development of young children.

- During the first three years of life the brain develops to 90% of adult size and is extremely sensitive to environmental influences. The human brain is therefore most vulnerable to disruptive and traumatising experiences during this time (Perry 1996).
- Fundamental to the child's earliest experiences is the attachment relationship with his or her primary

caregiver(s). In most cases this will be the mother initially but may equally involve the father and other close family members.

- A healthy and secure attachment during infancy is built by repetitive and finely tuned interactions between caregiver and child and there is a critical period for its development during the first year of life.

- Infants are biologically programmed to elicit these attachment behaviours from their carers in order for them to survive and thrive. Factors crucial in this process are the emotional availability of the caregiver to "tune" into the infant's signals and cues and respond accordingly. Examples include holding and comforting, making eye contact, face to face interactions, positive touch, the use of smell, touch and sound, playing, smiling, talking with babies.

- Through these sensory interactions with the caregiver the infant learns how to regulate his or her emotional state and control distress which is important in the development of emotional stability and socialisation.

- Parental mental ill health, overwhelming stress, social disadvantage, and poor education or knowledge about child rearing, can all lead to disruption in the development of secure attachment relationships, which in turn has an effect on the infant's developing brain, sometimes with irreversible consequences for the infant's capacity to think, feel and form meaningful stable relationships. These consequences can continue on through childhood and into adult life.

- The longer term consequences of this disruption or dysfunction in the parent-infant relationship can be prevented through targeted early intervention (Kowalenko,Barnett,Fowler,Matthey 2000).

- Parents from differing cultures rear their children in ways which will best ensure their survival and socialisation according to their culture's norms and values. This means that healthy child rearing can be accomplished in diverse ways and generally occurs when parents themselves are healthy, well informed have had adequate parenting themselves and are not harassed by poverty or other overwhelming stressors (Wolff 1994).

With this general understanding of the importance of early care giving on the mental health and development of children, specific factors for young refugee children in detention need to be understood.

Mental health of refugee parents- impacts on young children

In general, refugees experience very high rates of mental ill health and psychological distress (RANZCP College Statement #46).

Refugee parents may have experienced torture, imprisonment, persecution and institutional violence by the political regimes of their country of origin, or have witnessed a spouse or close family members undergoing such experiences.

Many families prior to detention in Australia have experienced long and perilous journeys and been in transit for months or years in refugee camps or in countries where they have had no citizenship rights, lived in very poor and overcrowded housing and where basic needs have been barely met. Children are conceived and born in such situations of deprivation, uncertainty and with minimal or no health care.

Psychological distress and poor mental health is often chronic and continues after re-settlement and acquisition of relative safety. This stems from a myriad of complex factors including the consequences of traumatic stress, enormous grief and loss, social and cultural dislocation, language barriers, ongoing fears for family and friends left behind, physical health problems, loss of status and acculturation stressors.

Refugees in detention experience, in addition, ongoing uncertainty regarding their immigration status. This, of course, impacts on their mental health more acutely.

The effects of these factors and forces will compromise many refugee parents' capacity to care for their children.

More specifically both parental depression and post-traumatic stress disorder (common in adult refugees) have direct effects on the development of infants and young children.

Parents experiencing post-traumatic symptoms are often extremely irritable, have unstable moods and poorer impulse control. Infants experience these moods and behaviours as frightening and in turn are unintentionally traumatised by the parents' symptoms. This sets in train a series of difficult interactions, which if not alleviated, can lead to an insecure attachment and poorer social, cognitive and emotional outcomes for the child.

It is well known that depressed mothers in turn are less sensitive to their infants and are less likely to talk and look at their infants. In extreme cases this can result in emotional and physical neglect resulting in the infant's failure to thrive.

In disadvantaged populations, depression in mothers (and mothers in immigration detention are profoundly disadvantaged) has been shown to produce severe disturbances in the mother-infant interaction (Murray et al 1996).

Parents who are emotionally unavailable and irritable will experience difficulty managing the normal oppositional behaviour of toddlers leading to an increased risk of coercive and abusive discipline. Boys are particularly at risk of later anti-social behaviour and cognitive impairment in this context (Sharp 1995).

The following anecdotes illustrate the difficulties in recognition and prompt treatment of mental health problems of families in detention and the adverse consequences for their children

"One mother I saw had a generalized anxiety disorder. Her two and a half year old was accidentally burnt by her when she spilt a cup of tea on his leg. The burn was minor but to reassure the mother they were both admitted to the local hospital. The mother then became even more anxious. The child refused to walk and would only lie curled up in the foetal position in the mother's lap. This situation went on for some weeks until eventually the mother was given counselling and things improved."
(Dr Simon Lockwood, G.P., Woomera Detention Centre)

"A mother with a 5 month old baby presented with concerns about harming her child. The baby was removed from her care by child protection services and placed with another family in detention. The mother was severely depressed and possibly psychotic. She was finally admitted to the local hospital with her baby and treated with medication. It was reported she recovered and is back in detention with her baby."
(Dr Fiona Hawker
Psychiatrist, Rural & Remote Mental Health Service)

In this case adult mental health services had recommended an admission to a specialised mother infant unit which did not occur.
It is not known what, if any, after-care this mother and her infant were offered. Post-partum depression with intent to harm oneself or the infant is a medical emergency.

It usually requires immediate hospitalisation preferably in a specialised mother infant facility to ensure safety of both, treatment of the mother's illness and also to prevent separation of mother and child which can be detrimental to the attachment relationship. In addition, specific treatment for the mother-infant relationship is usually required, or at least needs to be monitored.

The Effect of Detention on Parenting

The effects of institutional living on parents in detention undermines and significantly limits their already compromised capacity to nurture and protect their children. There is little privacy for families, individuals are identified by numbers not name, parents lose their roles and responsibilities, there is regimentation, constant surveillance and in at least some detention centres, sparse recreation facilities for families.

"In detention parents of young children become completely disempowered.... They cannot cook for their children or do anything for their kids. They lose their self-esteem... they stop caring. Most of the parents I see have mental health problems, many of the mothers are depressed. Mothers of toddlers often don't care if they turn up for meals or if they wander off....mothers and children housed outside detention in the community housing project in Woomera do better. These children are better fed, and clothed, mothers are able to look after them better."
(Dr Simon Lockwood, G.P., Woomera Detention Centre)

Parents feel helpless, despairing and enormously guilty because they are unable to help improve their children's situation. Pregnant women in isolated centres such as Woomera experience further trauma and loss through the accepted practice of transferring women at 36 weeks gestation to regional hospitals for delivery. This vignette describes one such experience for a mother and her family with young children

A couple with a 2 year old and a baby aged 5 months repeatedly begged, "Please take our children, find a place for them away from here. He will change to a savage not a human. Please do something for a family to adopt him until we can care for him again. He doesn't trust in us anymore. He can't play, he won't eat, he can't sleep well".

This family had spent 9 months in detention and had recently had their application for refugee status refused. Mrs Z had her first child in the Middle East, in a normal, uncomplicated delivery and had breastfed him for 12 months. She was too distressed to tell me about the second child's birth so the story came from her husband. During the interview she was expressionless and almost mute, occasionally tears coursing down her face. She cared for her infant in a mechanically adequate way with no animation. She appeared helpless in the face of her older son's behaviour.

Her second child was born in a hospital 200 kms away by caesarian section that she says she did not understand or consent to. This occurred after a period of 4 weeks enforced bed rest, away from her husband and son, under guard in the hospital. She did not see her baby for some days and could not breast feed when she was returned to her. She was returned to the centre one week after delivery and given no follow up, apart from occasional visits to the detention centre nurse, who gave her panadol and wound dressings but did not help Mrs Z dress or clean her wound. The wound continued to weep for 6 weeks and remains painful. She feels violated and disenfranchised. The 2 year olds behaviour deteriorated during and after his separation from her. The parent's relationship was also clearly under stress, "He says I should be getting better everyday, instead I am getting worse".

The toddler was indeed angry and disruptive. He threw any offered toys away and spat at people, he attempted to eat bits of foam that lay on the floor. He repeatedly tried to leave the room and when he succeeded, wandered quite far until returned by a guard. His father said " You see his behaviour ? It is because we are sad and weeping all the time. He has lost his trust in us.....

His wife had an air of despair. She attempted to limit her son's behaviour but soon gave up. She asked to leave

the interview to take him back to the compound. She remained quiet and withdrawn occasionally weeping throughout the interview, initially placing the baby in his pram in the corner of the room, facing the wall. She fed her without eye contact... The infant (at a developmental stage when most babies interact socially at every opportunity), made no attempt at eye contact and looked profoundly sad. She made little sound or complaint, but later became more animated when direct attempts were made by the interviewer to smile at and talk with her.

Mr Z feels unable to protect his children, impotent and trapped, reduced to less than human himself and unable to fulfill his role as father and husband. I asked whether his desire to have the children placed with another family came out of fear that he might hurt his child, and he said, partly this was true, relating an attempt to cut his own and his son's throat when their refugee application was rejected after 8 months of waiting. He says he was only stopped from hurting himself and his child by other detainees."

(This vignette submitted by Dr Sarah Mares,
Child and Adolescent Psychiatrist)

Safety of infants and young children in detention

Clearly parents who are disempowered and depressed are less able to protect their children. In addition, events in the Woomera Detention Centre and to a lesser extent other centres have demonstrated without any doubt that detention is a dangerous place for children. Children of all ages have been exposed directly to adult violence, riots, hunger strikes, self mutilation and attempted suicide by other detainees. As there is no separate accommodation for families children are exposed to the extreme acting out and despair of adult detainees including in some cases their own parents.

"Three schools have been burnt down in 18 months, there is no pre-school- any equipment supplied to younger children is destroyed by the adolescent or adult male detainees...women and children need to be moved out....they cannot be protected in detention.
(Dr Simon Lockwood, G.P., Woomera Detention Centre)

Toddlers and pre-schoolers are exhibiting phobias and other forms of traumatic anxiety when exposed to reminders of violence in Woomera such as fire trucks and tractors. These anxieties continue on release into the community and cause disability. For instance, a three year old has, since his family's release to Adelaide, continued to exhibit phobias from his detention experience - even cyclone fencing causes him distress. (personal communication, Steve Thompson, Psychologist, STTARS – Survivors of Torture, Trauma and Rehabilitation Service).

While symptoms of trauma and distress may be more obvious in older children, infants only present with global problems in physical functioning- settling, feeding or sleeping difficulties, listlessness, apathy or irritability (Schwartz et al 1994) which is likely to go unrecognised by staff in detention centres.

2. How is trauma and developmental harm detected and what services are required to treat infants and young children

Assessing young children for trauma related developmental harm and attachment difficulties requires specialised skills. Prompt access to child mental health services which can assist and support primary health workers or provide a direct service to refugee families is essential for such assessment.

Assessments of the parent's capacity to provide consistent protection, nurturing and stimulation appropriate to the developmental level of the child need to occur through direct observation of carer and infant and by assessing the mental health problems of parents. Parents require prompt access to mental health services to identify and treat these problems, and support in parenting their children whilst this occurs.

The child's family is central to the child's recovery from developmental harm. Refugee families will require continuing and high level support to assist with the many and ongoing environmental stressors they experience during detention and on release to enable the child's safety to be ensured over time.

Interventions targeting refugee parents and their infants should follow best practice guidelines in infant mental health this means high quality ante-natal and peri-natal care including screening for ante-natal and post-natal depression, parenting education, appropriate language and cognitive stimulation for children, regular visitation in their place of residence, family support, and the gamut of well baby care offered in the community.

All of these interventions must be delivered by services and persons who are culturally sensitive and inclusive of the values and beliefs of refugee families. Specialist refugee services, bilingual and bicultural workers should be utilised and work in collaboration with mainstream health services.

However a fundamental condition which must be met in order for any intervention to work is the child's safety. Detention poses, by its very nature ongoing threats to the physical and emotional health of children and therefore will undermine any therapeutic interventions and efforts.

3. Culture and its influence on the mental health of families

Infants begin learning about their culture from birth through the daily caregiving they receive. Cultural beliefs and practices give meaning to everyday life. Refugee families experience enormous cultural loss and bereavement on arrival in Australia and invariably experience "culture shock", the disorientation and confusion associated with attempts to understand new lifestyles, social structures, the geography, and the educational, health, welfare, legal and government systems which they must negotiate in order to re-settle.

A strong sense of cultural identity and maintaining access to one's cultural and religious community (religious figures, schools, education and other resources) can enhance resilience and coping in the face of these tumultuous changes.

Detention, by its institutional nature must severely reduce the opportunities for families to practise their culture and religion because they simply do not have access to like communities, places of worship, rituals and activities of cultural significance.

4. Impact of Immigration Detention on the well being of children

The evidence previously cited and the vignettes discussed show that the policy of mandatory detention of families who seek asylum in Australia has direct and harmful consequences for families of all children- infants and young children being especially vulnerable. In summary

- Infants and young children are placed in a physically harsh and restricted environment with inadequate space and facilities for safe play and development.

- The detention environment is dehumanizing. For example, children witness their parents and themselves being introduced and identified by number not name, and subjected to the daily humiliations that detention involves.

- Children witness their parents' powerlessness in the face of the institutional environment.

- They are exposed to adults who are depressed angry and suicidal.

- Their parents are unable to protect them from witnessing the violence and despair of adults living with them.

- The parents themselves inevitably feel hopeless and guilty, in part with the recognition that they are exposing their children to their own despair and unable to make their circumstances better.

- The extent of untreated trauma and depression in some of these parents puts their children at risk of emotional neglect and physical and emotional abuse.

5. The United Nations Convention on the Rights of the Child and children in Immigration Detention

The rights of child detainees in Australia are far from being met under the Convention for reasons already outlined in this submission. These include the right to:

- family life and to be with parents unless separation is in their best interests
- highest attainable standard of health
- protection from all forms of physical or mental violence and the right to recover and be rehabilitated from neglect and abuse
- practise their culture, language and religion
- rest and play
- primary education and secondary education
- appropriate protection and humanitarian assistance
- not be deprived of their liberty unlawfully or arbitrarily with detention only in conformity with the law, and as a measure of last resort and for the shortest possible period of time.
- be treated with humanity and respect for their inherent dignity and in a manner which takes into account their age
- access to legal assistance and the right to challenge their detention
- not be subjected to torture or other cruel, inhuman or degrading treatment or punishment

Recommendations

Continued long term detention of young children and their families is unjustifiable on developmental, medical and mental health grounds. Provision must be made immediately for child asylum seekers and their parents to be housed in the community and not held in detention centres. Immigration detention is directly and indirectly traumatizing for infants, children and their families. The impact of living in this environment compounds existing problems experienced by parents already compromised by past trauma, loss and continuing uncertainty about their future. Mental health interventions and services will be ineffectual in this context of ongoing trauma.

Children and their parents must have access to the full range of health services available in the community including adult and child and adolescent mental health, early childhood and disability services and bicultural workers. These are most likely to be available in urban or large regional centres.

Pregnant refugee women must have access to high quality antenatal care which ensures they are fully informed and consent to the type of child birth options available to them. All efforts must be made to prevent prolonged separations from pregnant mothers who have other young children. After delivery mothers must have access to perinatal mental health services and mother-infant services.

State and Federal governments must make clear and immediate agreements to ensure that the best interests of child asylum seekers are upheld in delivering health and welfare services to them.

REFERENCES:

Kowalenko, N., Barnett, B., Fowler, C., Matthey, S., (2000) The Perinatal Period Early Interventions for Mental Health. Vol 4 in R Kosky,A Hanlon, G Martin& C Davis (Series Eds.), Clinical Approaches to early intervention in child and adolescent mental health. Adelaide: Australian Early Intervention Network for Mental Health in Young People

Murray, L.,Hipwell, A., Hooper, R., Stein, A, and Cooper, P., (1996) The cognitive development of 5-year-old children of post-natally depressed mothers. Journal of Child Psychology & Psychiatry & Related Disciplines, 37(8).927-935

Perry, B., Pollard, R., Blakley, T., Baker, W., Vigilante, D. (1995) Childhood Trauma, the Neurobiology of Adaptation and Use-dependant Development of the Brain:How states become Traits, Infant Mental Health Journal 16 (4) 271 – 291.

RANZCP (2000) Position Statement #46 Principles on the provision of mental health services to asylum seekers

Sharp, D., Hay, D., Pawlby, S., Schmucker, G., Allen, H.& Kumar, R.(1995) The impact of post-natal depression on boy's intellectual development. Journal of Child Psychology and Psychiatry, 36, 1315-1336

Schwarz, E., Perry, B.,(1994) The Post-traumatic response in children and adolescents. Psychiatric Clinics of North America, 17(2): 311-326

Wolff, S., (1994) The Scope of Infant Mental Health: Pointers to helpful interventions Newsletter of the Australian Association of Infant Mental Health, Vol 6,4, December 1994.

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On behalf of AAIMH I would like to thank Dr. Sarah Mares and Dr. Louise Newman for their helpful comments and contributions in the preparation of this submission.

The PASDS Program:

A Framework for Understanding and Practice

By Pauline Sampson (Vic)

Parenting Assessment and Skills Development Services (PASDS) operate in Victoria as part of the Department of Human Services High Risk Infancy Project. These services are aimed at assessing parenting capacity and providing skills development, education and support to families who have come under the jurisdiction of Child Protection Services, with children believed to be at significant risk from maltreatment or neglect. PASDS programs take place on a home-based, day stay or residential basis. The residential services are provided by early parenting centres.

Clients enter a residential PASDS program from diverse and complex backgrounds, which may include substance abuse, intellectual disability, mental illness, isolation or domestic violence. An integrated model of systems and attachment theories is useful in our attempts to understand, and assist, these clients in the difficulties they experience during their admission. Such difficulties may result in non-completion of the program, and diminish chances of family re-integration.

In their family (or familiar) system, members behave in predictable, scripted ways. These scripts are based in memories of their own childhood (and can result in transgenerational continuance of inadequate parenting practices) and by observing others. To improvise and try new scripts, such as new and improved ways of parenting, the client needs to feel secure. Security is obtained from an attachment figure (Byng Hall, 1995).

PASDS clients leave their family, or familiar, system for admission for a number of days to the 'establishment' system of one of our early parenting centres. Here, they find themselves under constant observation in their parenting practices – an unenviable position, which would make the majority of us feel insecure and cautious. Within this environment, the clients are expected to try out - and maintain - new scripts of parenting.

The following example, based on a past client of PASDS, shows what can happen.

Brion was admitted to a PASDS residential program with her twelve week old baby, Charlie.

She was twenty-one years old, with long brown hair, dark eyes, and a pleasant smile. Her clothes were "tailored", though the short skirt of her suit accentuated some excess in weight. Brion had been "on the streets" since age fourteen, and her polydrug use began then. Nevertheless, she had a dignified manner and spoke quietly and well. She described herself as a "good" mother.

Charlie exhibited marked gaze avoidance. He would do everything he could to avoid meeting his mother's eyes, despite her cajoling behaviour of endearing verbalisation with her smiling face close and tracking his as he desperately turned from side to avoid eye contact. At times, such as during bathing, his behaviour would change, and he would gaze intently at his mother as she spoke and smiled at him, though his smiles to her were almost non-existent. On other occasions, Charlie was seen to gaze at his mother for minutes at a time, but Brion was oblivious, requiring prompting by staff to notice and respond to her baby. Charlie was also, at times, gaze avoidant to staff.

Charlie's inconsistency in gaze and prominent gaze aversion seemed indicative of infant pathological defence (Fraiberg, 1982). It suggested that he had learnt to edit people out as a means of avoiding emotional pain, but the fact that he responded to them sometimes was a positive sign that the damage was not yet complete, and could perhaps be reversed with skilled assistance to the family.

Brion's familiar system was of fellow drug users, with daily functioning revolving around the demands created by her drug dependency. This reduced her capacity to be emotionally available for Charlie, and respond to his needs. She had developed effective strategies within her system to achieve her personal goals. These strategies involved manipulation of her environment, and she employed some of them whilst she was resident on the PASDS program. The escalating nature is interesting.

The first stage: when Brion first arrived at the early parenting centre for commencement of her program, her behaviour appeared co-operative, and she assured staff that she understood and would work towards achieving the parenting goals required by PASDS. Over the next few days, she smiled pleasantly as she emphatically lied about different things. Two examples follow:

Brion was on a large dose of Methadone as well as Serepax. Due to the potential danger to her baby of large doses of these drugs in her breast milk, she had been advised by DHS to discontinue breastfeeding, to which she had agreed. However, on a number of occasions, her baby was seen cuddled to her bare breast and sucking sounds were heard by different staff members. Each time, Brion denied that she was breastfeeding. Staff were concerned, as Charlie seemed particularly irritable and unsettled at times. It was thought that this might be caused by drugs in his system from his mother's milk.

Brion denied bringing any drugs into the unit. On the evening of her admission, she was seen by a staff member to be swallowing a white tablet. When asked about this,

she said that it was a Neurofen, which she had taken for headache, and that she had nothing else. Over the next few days, she was seen on a number of occasions by her co-clients to be taking oral tablets and capsules, though this was not reported until the end of her admission.

The second stage in manipulative strategies tried by Brion was her attempts to obtain justification for her behaviour by attributing responsibility to others, eg. she was found to increasingly leave the care of her baby to staff. When it was pointed out to her that it was her role to care for her baby, she said that staff had told her to walk away from the baby if she felt stressed, and she was only doing what she had been told her to do.

The third stage was of intimidating behaviour. This began with aggressive verbal and non-verbal behaviour, eg. face thrust close to staff and unblinking staring; going into a co-clients room in the middle of the night and standing over her; threatening staff and co-clients with a "hitman". This third level of behaviour, combined with clear signs of drug abuse (unsteady gait, confusion, slurred speech, dilated pupils), finally resulted in Brion's discharge from the program.

I suspect that this was Brion's goal from day one. She found the program too stressful, and wished to leave. She tried some relatively benign behaviours which did not bring about her desired goal, so escalated to the point where staff had no alternative but to discharge her. This provided, to her, an acceptable reason for her non-completion of the program: the early parenting centre discharged her rather than she could not cope with its demands.

Many clients complete PASDS programs successfully. With others, variations of Brion's creativity may be seen. Some may be less creative. They say that they are homesick, depressed, have had enough ... or just leave.

All cases of incompletion of the program are, of course, of concern and make the overall goal of assisting parents and their children to remain safely together difficult.

What can we do to assist these clients to feel more comfortable, able to successfully complete the program, and so increase their parenting capabilities?

A feeling of security is needed if clients are to try, and maintain, new scripts of parenting. Security is normally obtained from an attachment figure, who acts as a safe haven or base. This figure might be a partner, parent, sibling, friend, drug dealer, prostitution pimp, support worker or other figure. The difficulty is that our client is now part of a residential program and her attachment figure may still be "outside". Who, then, does she turn to when she is feeling under duress, when everybody she meets on the program is part of a different system to her own? Not only is the system different, but it is one of judgement. What does she do to protect herself from the helplessness she is feeling?

The answer is that she returns to strategies that have always worked for her in her familiar system. In this way, she regains some sense of control. These strategies, however, may be quite unsuitable for the new system of which she is temporarily a part.

The challenge for programs such as residential PASDS is to find ways of reducing clients' feelings of helplessness and help them to find a sense of security within the program, and so be willing to try new and more appropriate ways of parenting.

A temporary attachment figure, with whom clients can feel safe and secure, is needed. This may require a new and independent position within PASDS residential programs. Regular staff working on PASDS, despite their attempts to help clients feel valued, are also their assessors, and so engender feelings of caution, rather than security.

The structure of PASDS residential programs should include regular psychotherapy sessions with each client. Interaction Guidance seems custom-made for the problems with which clients present.

Interaction Guidance was created as a non-intrusive method of family intervention for parent-child relationship disturbances in families resistant to other forms of treatment. The approach highlights individual family strengths using video technology, and nurtures the development of adult family members in their roles of parents or caregivers, enhancing the likelihood of positive therapeutic change within the family. It has been found to be particularly effective for young, inexperienced, and cognitively limited parents, and for infants with failure to thrive, regulation disorders, and organic problems (McDonough, 1993; Benoit, 2001-2002).

A modification to the approach has recently been proposed to focus not only on positives and strengths, but also on areas of difficulty, such as frightening caregiver behaviours associated with disorganized attachment. Sessions take place at weekly intervals, rather than the more spread-out structure of the original model. Each session is of 60-90 minutes duration and includes approximately 10 mins of videoed interaction between parent(s) and child, followed by discussion and feedback (Benoit, 2001-2002).

For residential PASDS programs, I propose the further modification of sessions taking place on every second day of the program. This would be a positive way of engaging difficult clients, helping them to resolve conflicts from their own childhoods, and assisting the interaction between parents and child. It would maximise the educational and skills development component of residential stay and assist the therapeutic goals of improved parenting practices.

DHS Referral

Consideration should also be given to the referral structure to PASDS. The constant observation and assessment necessary in residential programs makes participation in them stringent, and clients need to be ready to undergo

their demands. Parents who are still coming to terms with major changes in their lives may not be ready for admission. Premature admission may result in premature discharge, eg. clients who have just completed, or are still completing, drug detoxification; clients admitted directly from hospital with birth trauma.

What, then, does DHS do with these clients until they are suitable to enter the program? Perhaps a "half-way" program needs to be considered. This could be a short admission to a facility where clients are counselled about the issues/stressors in their lives and in this way, prepared to attend the PASDS program.

These additions to PASDS would provide positive steps toward combating the problems of families who come to the attention of Child Protection Services. In these ways, parents may find PASDS less threatening and be able, with the help of the staff, to change to new scripts of parenting which they find enjoyable, are safe, and which contribute positively to their children's healthy development. And babies such as Charlie might be saved.

References:

Akister, J (1998). Attachment theory and systemic practice: research update. *Journal of Family Therapy,* 20, 353-366.

Benoit, D (2001-2002). Modified interaction guidance. *IMPrint: Newsletter of the Infant Mental Health Promotion Project*, Ontario, 32, 6-10.

Byng-Hall, J. (1995). *Rewriting family scripts: Improvisation and systems change.*

Fraiberg, S. (1982). Pathological defenses in infancy. *The Psychoanalytic Quarterly*, L1 (4), 612-635.

Marvin R.S. (1992). Attachment and family systems based intervention in developmental psychopathology. *Development and Psychopathology*, 4, 697-711.

McDonough, S. (1993). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In Zeanah, C.H. (ed.), *Handbook of infant mental health, 414-426. New York: Guilford Press.*

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Emotional Availability Scales UPDATE

Frances Gibson

Strong interest has been shown in the Emotional Availability Scales (EAS) by Assistant Professor Zeynep Biringen PhD, of Human Development and Family Studies, Colorado State University and planning is underway for both a seminar and workshop on the construct of emotional availability and the EAS. The Workshop will be held in early June.

The EAS is an observational measure designed to evaluate mother-child interaction across the dimensions of parental sensitivity, structuring, intrusiveness and hostility in addition to child responsiveness and child involvement of the parent.

The EAS Seminar (1 day) will be of great value to a broad range of professionals working with infants, young children and families. It will provide an overview of emotional availability and it will include relevant background on attachment and observational methodology. The research use of the EAS and the scales' application to clinical practice will also be covered. Videotaped vignettes of mother-child interaction will be shown to develop the practitioners observational skills across the various dimensions of emotional availability and to illustrate the use of the EAS.

The EAS Workshop will be conducted over three and a half days (inclusive of the EAS Seminar). It is designed for professionals who want to achieve reliability in the use and scoring of the EAS for evaluation in research or intervention projects (workshop numbers will be limited).

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VICTORIA NETWORK NEWS

VICTORIAN COMMITTEE MEMBERS

The AAIMH committee has begun its work for the year. We have our World Conference 2004 as a standing item for the committee. This event will take up planning for the next two years, and it is certain to be a meeting not to miss! Six scientific meetings, on a slightly less grand scale, are planned for our members. (Should there be interstate visitors in Melbourne please feel free to contact us if you wish to attend one). These activities, not only bring us together, but continue to put the infant's mind on the map. We attempt to find speakers who can speak from the infants' point of view. This is not always possible, but we try. Lately the importance of cultural understandings of infants and families have had a theme. Perhaps in the aftermath of September 11th, we are trying in our own way to make sense of different cultures to equip ourselves when we work with families from cultures other than our own. Over the last six months we have had speakers who have brought us opportunities to learn more about Indian traditions, Vietnamese culture and our first for 2002, the Horn of Africa.

Ms. Niggisti Mulholland, an Eritrean nurse, lecturer and researcher, spoke on the countries that make up the Horn of Africa, namely Somalia, Ethiopia, Eritrea and Djibouti. The Sudan is often considered in conjunction with the countries in The Horn. Ms. Mulholland provided the audience with information sheets, a most helpful orientation. We learnt that "these countries emerged from colonisation in the 1950's with artificial boundaries, fragile national identities and distorted economies. Disastrous consequences developed because Africa's colonisers created many boundaries without consideration of ethnic, economic or social realities. For example, the Ethiopian border with Djibouti and Eritrea splits the Afar tribe; and on the border with Somalia and in the north there are Tigringa populations on both sides of the border with Eritrea. Of the world's 20 million refugees today, over 6 million are Africans. In addition, there are some 15 million internally displaced people in the continent."

Ms. Mulholland showed us a video of women from thi region, now living in Melbourne, speaking about the antenatal care, their experiences of having babies (often the one woman might have had three of four children in as many different countries). Some spoke on the custom of 40 days of care and rest provided by women friends and relatives, for the new mother and her babe. Others spoke of the rushed pace in Australian for mothers, and the loss of the traditional caring. Ms. Mulholland spoke most eloquently about her own experience and those who attended were given a very stimulating opportunity to learn from her.

By: Sarah Jones

ACER Workshops with Lorraine Rose

During the first half of the year the **A**ustralian **C**ouncil for **E**ducational **R**esearch with Lorraine Rose will be holding several workshops in Sydney and Melbourne

- **Early Emotional Development 0-5 Yrs With Lorraine Rose.**

The presenter: Lorraine Rose is a very experienced psychologist and psychotherapist with a special interest in early emotional development and the significance of attachment in later development. Lorraine is the author of "Learning to Love: the developing relationships between the mother, father and baby during the first year". The session: This session will focus on the emotional development taking place in the child in the first five years. The session will support us as teachers and parents to better understand this complex area of development so that we can more easily enter the child's world and help them to grapple with the tasks confronting them.

Dates:
19 April (Melbourne East) 9.30am - 12.00 noon
Cost: $55 (includes GST)

- **Emotional Development & Learning P-3 With Lorraine Rose**

The session: The emotional development of the young child has a significant impact on their readiness and capacity to learn. Understanding the stages and complexity of emotional development during these years helps us to adapt the teaching environment to allow optimal learning opportunities for individual children and optimal enjoyment in the classroom for everyone.

Dates:
20 March (Melbourne South.) 2.00pm - 5.00pm
15 May (Sydney) 2.00pm - 5.00pm
Cost: $66 (includes GST)

For registrations and further information on venues please contact:Margaret Taylor taylor@acer.edu.au or free call 18000 66 616