Children Australia
Volume 37 ▌ Number 3 ▌ pp. 90–93 ▌ © The Authors 2012 ▌ doi 10.1017/cha.2012.26

Practice Commentary

Including Infants: An Inter-Agency Model for Parent–Infant Mental Health and Well-Being in Rural Regions

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There are well-recognised and articulated difficulties in the provision of health services to communities in rural and remote areas. These difficulties encompass practicalities and geography, economics and politics, as well as the personal and professional. This article describes a multi-level model developed by a group of regional services to address the mental health and well-being needs of infants and small children of rural and remote families, utilising existing resources creatively and collaboratively. The model draws on understandings from attachment theory about the nature and needs of humans as relational beings.

■ **Keywords:** rural mental health, infant mental health, collaborative service provision

Introduction

We have seen a growing number of people identified as suffering from mental illness in Australia over recent decades, with a low percentage of this population receiving appropriate intervention (Australian Bureau of Statistics, 2007). This is occurring at a time when state and federal policy shifts have resulted in mental health services being incorporated into mainstream health services and a concerted focus on the de-stigmatisation of mental illness.

Over this period, research in the fields of infant mental health and child development has yielded a radically expanded understanding of the nature and needs of children in the development of all domains of growth (physical, emotional, psychological, social, cognitive, and speech and language) (Cohen, 2001; Gerhardt, 2001; Siegel, 1999). It is now recognised that the organising mechanism for child development is a relationship, and when a relationship has the required organising characteristics it is termed 'attachment' (Siegel, 1999). Our knowledge of the developmental needs of infants and children has improved; however, adjustment and expansion of services which reflect the needs of very young children as relational beings has been slow.

Compounding this picture is the challenge of service provision in rural and regional areas (Smith, Humphreys & Wilson, 2008). While services may be available in regional areas, they are not necessarily accessible to rural families, particularly those with infants and small children. Research findings indicate that rural people have limited preparedness to travel distances for services, even for medical services to treat potentially life-threatening conditions (Humphreys & Wakerman, 2008). The sensitivity of rural people about their privacy is another important factor when thinking about service provision. Termed 'relational propinquity and geographical distance', rural people have friendships and acquaintances with each other, despite living many kilometres apart. This can contribute to the aversion they demonstrate to situations in which being seen entering a medical/welfare service has the potential to identify their reason for being there.

Providing services in regional and rural areas holds some characteristic challenges: widely scattered service demand, sustainable funding and attraction of suitably qualified staff, and the proportion of time service providers spend travelling – which they frequently do on country roads to deliver a service for which they carry the burden of major or sole responsibility – are elements of regional and rural

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employment that militate against the attraction and retention of staff (Humphreys, Wakerman & Watts, 2006). Additionally, service providers in rural areas face the complexity of maintaining a professional relationship with clients amongst whom they may have friends and acquaintances (Scopelliti et al., 2004). The purpose of this paper is to describe a model developed by a group of rural agencies in the north central region of Victoria to address issues associated with adequate service delivery to meet the mental health and well-being needs of infants, young children and their families in the catchment area of the rural agencies.

Model development

In late 2004, Bendigo Health's Child and Adolescent Mental Health Service (CAMHS) invited welfare agencies in the Greater Bendigo area to join a Parent-Infant Mental Health and Wellbeing Interest Group. This was in response to growing appreciation of the critical and potentially lifelong impact of the early years by clinical staff. The focus of the Interest Group was to articulate and address the mental health and well-being needs of young children and their families in the rural region. The benefits of the Interest Group were identified as: networking through linkages between agency staff; forums for information dissemination (for instance, educational and professional development opportunities); opportunity to raise issues pertinent to young children and their families in regional and rural areas; and developing responses to emerging situations.

The Interest Group members investigated different models for service response at the three tiers of intervention for 'universal', 'selected' and 'indicated' populations (Goldberg & Huxley, 1980). An inter-agency Network Model was developed, reflecting the perspectives of the Interest Group member agencies as rural and regional service providers. Five guiding principles were established for the operation of the Network Model. First, maintaining an 'open structure' was considered important to ensure relationships that allowed service engagement at different intervention tiers. Secondly, taking a 'regional focus' ensured that the model was applicable in remote areas as well as regional centres and towns, resulting in accessibility through local contacts. Thirdly and essentially, the structure and nature of service delivery reflected the neuro-developmental and relational needs of infants, children and adolescents, and of adults as parents/carers and as service providers. This was underpinned by the acknowledgement of humans of all ages as relational beings. Fourthly, sustainability for the model needed to reflect shared responsibility for service provision across agencies so that service delivery did not cease when staffing in one agency changed. Finally, the model needed to embed respect for rural relational patterns which require privacy and discretion.

The Network Model was named 'Including Infants: An Inter-Agency Model for Parent-Infant Mental Health and Wellbeing in Rural Regional Areas', and has three components for action:

- **Education** through forums, parent-infant mental health and well-being promotion, prevention and early intervention around potential difficulties
- **Consultation and collaborative practice** between agencies
- **Clinical assessment and treatment**

In order to implement the Network Model 'Including Infants', the Interest Group reconvened as the Parent-Infant Mental Health & Wellbeing Working Party and the development of the model included acknowledgment and respect for pre-existing model components, as well as working to fill any gaps identified in the model components.

Education

A number of elements are used to ensure the educational aspects of the model are addressed. Forums are run twice yearly on topics pertinent to parent-infant mental health and are open to any agency staff in the region who provide services to families with infants or small children.

In addition, the Parent-Child Mother Goose program was chosen by the Working Party as an attachment-based playgroup which promotes cognitive and speech and language development in young children. The program operates comfortably in both the 'universal' and 'selected' tiers of service delivery. It contributes to children's broad resilience and to both prevention of, and early intervention for, emerging relational and mental health concerns in young children. Evaluation of the original Canadian program showed increased, generalized and sustained competence and confidence in parents/carers, in addition to the children's targeted gains (Formosa & Heinz, 2003). Beyond the facilitators, very few resources are required. The key tools are age-appropriate songs, rhymes and story-telling. Local schools are also implementing Parent-Child Mother Goose to address poor school readiness in their Prep children. Training for facilitation of the Parent-Child Mother Goose playgroups has been offered on four occasions, with the two-day training workshops attended by interested professionals and community members.

Currently, however, very few Parent-Child Mother Goose playgroups are running sustainably. A major barrier appears to be the view, held by employers of trained facilitators, that Parent-Child Mother Goose is not their core business. To address this, a part time Parent-Child Mother Goose playgroup co-ordinator has been appointed for three years. This was achieved through the federally funded Communities for Children program, and the role is supported by a local non-government agency. The co-ordinator has the potential to liaise with existing facilitators, provide extra relief facilitation in playgroups, and to link trained people who are in need of an additional facilitator to run or maintain

a Parent-Child Mother Goose playgroup. The co-ordinator will also support a facilitators' network for information dissemination and sharing, and for collaborative action and further professional development.

Further, a Children's Literacy Plan has been completed by a small group, the Parent-Child Mother Goose Implementation Group, under the auspice of the Working Party and key agency personnel. The Group includes representatives from the Department of Education and Early Childhood Development (DEECD), a local non-government organization, CAMHS, the region's Aboriginal Co-operative and a community representative. Embedded in the Children's Literacy Plan is the Parent-Child Mother Goose Playgroup, which is a key component of parent education regarding the developmental needs of infants (0–12 months) and young children (12 months – 3 years), and increasing competence and confidence in parents/carers. The Children's Literacy Plan has now been presented to the Bendigo Leadership Group to be considered in addressing the needs highlighted in the State of Bendigo's Children Report, April 2011(City of Greater Bendigo, 2011).

Consultation and collaborative practice

Consultations have been established between CAMHS and Specialist Children's Services (SCS), and between CAMHS and Maternal and Child Health (M&CH) nurses in the region. These consultations are providing opportunities for clinical discussion, Parent-Infant Mental Health education and appropriate referral. Pre-existing collaboration between the Women's Mental Health worker within Bendigo Health and Bendigo Community Health Service has been providing group work opportunities for women with post-natal depression, and a local non-government agency supports women with mental health issues who are mothers of infants. Shared facilitation of Parent-Child Mother Goose playgroups has occurred with M&CH, CAMHS and community representatives.

Clinical assessment and treatment

A small group of professionals under the auspices of the Working Party has been developing a model for Parent-Infant Mental Health Assessment for rural regions. Members are drawn from DEECD including SCS, CAMHS and the Victorian Department of Human Services (DHS) Intensive Therapeutic Service 'Take Two'. The Parent-Infant Mental Health Assessment model is built on an inter-agency framework which:

- provides shared responsibility for service provision;
- provides a threshold of viability for staffing numbers, i.e. the minimum point where staffing numbers are sufficient to provide services adequately;
- provides the range of disciplines needed for a Parent-Infant Mental Health Assessment Team (PIMHAT). This can include a child psychiatrist, paediatrician, speech therapist, Infant Mental Health clinician such as a trained psychologist, M&CH nurse, occupational therapist and social worker. The participation of a child psychiatrist may also allow for the placement of a psychiatric registrar.
- draws on existing networks of each agency (SCS is home-based, M&CH is local, CAMHS and DHS Take Two are regional); and
- anticipates close relationships with M&CH, general practitioners and paediatricians and maternity services staff

In the model, clinical governance is addressed by registration of referrals with one of the treatment agencies involved (CAMHS, DHS Take Two). Information about the assessment process is provided to referring services, families and communities. In the first instance, the PIMHAT provides secondary consultations to services. Following this, and where indicated, the PIMHAT provides primary consultations to families with infants, together with the referring service. A report with recommendations by the PIMHAT is generated through the assessment process.

The next steps for the Clinical Assessment and Treatment component involve submitting the PIMHAT brief to the management groups of each of the participating agencies, and further exploration of sustainable and ongoing funding, including what role Medicare might play in the employment of Mental Health accredited professional staff. Consultation with potential referring agencies and community groups will also be required.

The Parent-Infant Mental Health & Wellbeing Working Party is now a robust inter-agency group with a seven-year history of promoting parent-infant mental health and wellbeing, which recognizes the critical roles of both mothers and fathers. The Working Party provides its members with a forum for mutual support, links services including the introduction of new staff, shares information and education (formally through its Journal Club and informally through members' reports on seminars and conferences attended) and presents and develops ideas and responses to local or regional issues and opportunities. In its structure and functioning, the Working Party reflects the principles underpinning the Network Model 'Including Infants'. Recognising humans as relational beings, its structure over the years continues to provide the focus, energy and perseverance needed in the task of developing and implementing the Network Model, to better meet the mental health and wellbeing needs of infants, young children and their families in our rural regional area.

Conclusions

There are particular challenges in rural regions for service provision to be both client friendly and also supportive of

staff. Additional consideration is needed when the focus of the service is families with infants and young children. In one rural region, an inter-agency group has developed, and is implementing a collaborative model which draws on and integrates with existing services. The underpinning principles of the model recognise people – whether service providers or recipients – as relational beings. It is anticipated that when these principles are met, agencies can strengthen their own sustainability and better ensure service accessibility to families.

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