Focus on Peer Support

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How volunteers can improve early childhood outcomes

Pregnancy Sickness Support

Australian Breastfeeding Association

Learning from the Empowering Parents, Empowering Communities programme

A support group for kinship carers

Maximising social capital through volunteers: Lessons from New Zealand
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Let parents talk to parents

Mary Nolan, Editor-in-Chief, ponders the failure of breastfeeding promotion across the world and recommends new ways of conveying key parenting messages to mothers and fathers.

Last week, I re-read the first of two excellent articles that appeared in 'The Lancet' at the beginning of the year addressing, 'Breastfeeding in the 21st century: Epidemiology, mechanisms and lifelong effect' (Victora et al., 2016). As always happens when I read scholarly articles about breastfeeding, I was overwhelmed by the depth of robust research underpinning its benefits:

‘Children who are breastfed for longer periods have lower infectious morbidity and mortality, fewer dental malocclusions, and higher intelligence than do those who are breastfed for shorter periods, or not breastfed. Growing evidence also suggests that breastfeeding might protect against overweight and diabetes later in life.’ (p476)

And in case I or any other reader was tempted to believe that such a statement might only apply to low-income or lower-middle income countries, the authors quote the following figures later in the article:

‘Breastfeeding might also protect against deaths in high-income countries. A meta-analysis of six high-quality studies showed that ever breastfeeding was associated with a 36% reduction in sudden infant deaths. Another meta-analysis of four randomised controlled trials showed a 58% decrease in necrotising enterocolitis, a disorder with high case-fatality in all settings.’ (p429)

Most deaths amongst not-breastfed babies are, however, still to be found in poorer countries that lack a consistently clean water supply. A midwife from India told me that in India now, well-off women bottle feed while poorer women continue to prefer breastfeeding, although not in the numbers that they used to. It would appear that the situation which existed in affluent countries 40 years ago when bottle feeding was chosen by well-off women has now been transferred to poorer countries, a salutary reminder if ever we needed one of the fact that Western practices may be seen as worthy of emulation in other parts of the world when they are, in fact, harmful.

The conundrum of how to convey vital health messages effectively was brought into sharp focus for me recently while pursuing research into the evolution of parent education over the last 60 years by examining its place in the various editions of ‘Myles Textbook for Midwives’. Having reached the 1980s, I was startled to read that a midwife-led antenatal class should include advice on babies’ clothes, presented in the following words:

‘One of the joys of the lady-in-waiting is planning her baby’s wardrobe. Nothing gives the mother-to-be greater pleasure than sewing and knitting for the coming baby. Who would think that fashions would change in the tiny garments babies wear?! Let me show you some of the latest models (p717).

I had my first baby in 1984. I think I was a pretty ‘ordinary’ young woman, not especially interested in feminism or even in politics more generally, but I definitely wasn’t a woman who saw herself as a ‘lady-in-waiting’ or one who was seeking advice from my midwife on ‘the latest models’ in baby clothes!

I am tempted to conclude from reading ‘The Lancet’ article, from my talk with the Indian midwife and my research in Myles that health messages have a) not been at all successful down the years in enabling equal access to health by ensuring that all the world’s babies are breastfed, and b) that parenting advice has often been notably out of sync with the realities of the women to whom it has been delivered (let alone the men).

Therefore, it certainly seems justifiable to look at new ways of getting health promotion messages across to families, and one of these is through peer-support. This issue of the IJBPE presents a series of articles examining the evidence underpinning the effectiveness of parental peer-support, the training of peer-supporters, organisation of parental-led care and support in family hubs, and the work of a third sector peer support organisations dedicated to boosting breastfeeding rates.

If we accept that key health messages have NOT been successfully conveyed to the mothers and fathers for whom they have been intended, then the time has surely come to embrace a different way of getting those messages across, by letting ‘the people’ talk to the people in their own language from a position of real empathy because of the shared circumstances in which they are bringing up their children.

Finally, I want to urge you to read carefully our Guest Editorial (Prowle & Harvell) on the challenges facing parents and children in refugee camps. As increasing numbers of very young children reach our shores, they and their parents need tailored support and education. This is very much a case where a ‘one size fits all’ approach to parent education and the early years’ curriculum will definitely not work. It is vital that those who have worked in the camps and with refugee families share their insights and skills so that we can put together appropriate, sensitive and effective programmes of support that will stand some chance of ameliorating the damage that has been done to these families’ life-course.
Tug of war: Could polarized parenting advice cause harm?

Kathleen Hodkinson, Assistant Professor of Psychology, Tara Acevedo, Researcher, and Katrin Kristjansdottir, Director of the Counseling Center at Webster Vienna Private University debate the guidance being given to parents.

Parents today are inundated with an overwhelming mass of highly polarized advice about the ‘best way’ to parent. The narrative, particularly in popular parenting literature, often centers around ‘right’ and ‘wrong’ strategies. Such polarization risks confusing and disempowering parents and may lead to inconsistent parenting practices, which are linked to poorer child outcomes. Both behaviorism and attachment parenting, which are often presented as polar opposites, may share certain common features. Not least, both approaches usually fall broadly within the framework of authoritative parenting, which is the style of parenting that has been empirically shown to lead to best outcomes for parents and children. It is of concern that excessive debate about specific details of parenting techniques may lead to the key components of evidence-based parenting nurturing and limit setting getting lost, leaving parents confused and children worse off.

Should you co-sleep with your child or is this bad for their health? Should you use controlled crying techniques or will this damage your child’s emotional development? When your child misbehaves, should you connect with them emotionally and involve them in the discipline or send them to their room? Parents today are inundated with an overwhelming mass of conflicting emotive information about how to parent (Sanders & Calam, 2016; Eisenberg et al., 2015; Strahan, Dixon, & Banks, 2009). This comes from internet parenting forums (Porter & Ispa, 2013; Cornelius et al., 2008), parenting books, (e.g. Green, 2014; Siegel & Bryson, 2014; Druckerman, 2012; Hogg & Blau, 2002), and even from healthcare professionals. Some of this advice is lacking in empirical support, and some is actually contrary to scientific evidence (Mchenes et al., 2015). So how do parents know what to believe? Knowing which advice is sound and which is little more than opinion can be a challenge, even for professionals.

The reality is that there has never been, nor is there currently, a consensus on parenting advice, even within the scientific community (e.g. Strahan et al., 2009; Finn et al., 2003). Currently, two very different theoretical approaches are prominent both within scientific discourse and the wider media: behaviorism and attachment parenting (Troutman, 2015). These approaches can seem to generate opposite recommendations about how best to parent. Simply put, behaviorism focuses mainly on strengthening certain behaviors through reinforcements (rewards) and reducing others through extinction (ignoring) (e.g. Skinner, 1974; 1953). Over the last fifty years, behaviorism has led the field of parenting research and currently forms the basis of the majority of evidence-based parenting intervention programs (Troutman, 2015). By contrast, attachment parenting (Sears, 1982; Sears & Sears, 2001) is a somewhat more recent parenting philosophy that has become increasingly popular. The focus of attachment parenting approaches is usually on the development of a secure parent-child relationship and emotion regulation skills in children. This is achieved through the presence of sensitive responsiveness on the part of the parent and respecting children’s choices (Troutman, 2015; Miller & Commons, 2010). Such is the extent of the media debate on this issue, that it has surpassed that in the scientific community. In actual fact, there is very little research evaluating the relative benefits of specific parenting techniques on parent and child outcomes. Most scientific research examines overall parenting programs and not the specific components within each program or the mechanism leading to improvement (Troutman, 2015). Despite this, the differences between these two approaches have become even more polarized in popular parenting books and on the internet. To make matters even more confusing, parenting advice given by individual scientists can actually be misleading. Scientists who present parenting advice in the form of popular literature may misrepresent their credentials as being relevant to childrearing, and those scientists whose credentials are legitimate may publish work that reflects a greater amount of opinion than scientific evidence (Strahan et al., 2009).

What effect does this conflicting information have on parents? If parents are frequently exposed to inconsistent information about how to parent, they may adopt inconsistent parenting strategies – trying one technique and then another when the original one seems to fail. Research has repeatedly shown that inconsistent parenting practices have been associated with negative behavioral outcomes in children (Taylor et al., 2008; Stormshak et al., 2000; Campbell, 1995). There is, as yet, no concrete evidence that exposure to inconsistent parenting information leads to inconsistent parent practices. However, research from other fields supports such a conjecture. Exposure to conflicting medical information, for example, is linked to lower medication compliance (Carpenter et al., 2014). Receiving mixed messages about cancer prevention leads people to feel less confident in their ability to prevent cancer (Marshall, 2013).
Inconsistent information given by doctors to parents of young children with acute illness leaves parents feeling helpless and less empowered (Kai, 1996).

In our work, we have begun to examine the effects of mixed messages on parental confidence and wellbeing. We have conducted an initial pilot study where parents were allocated to a parenting seminar in which they received either conflicting parenting information or consistent information. We are interested in examining the interactions between parenting styles and consistency of information on parents’ confidence and wellbeing, as well as consistency of parenting behaviour.

Behavioural and attachment approaches are often presented in the media as polar opposites, with the message that parents must choose one or the other (Troutman, 2015). Of course, factors such as parent and child temperament have demonstrated that a one parenting style fits all approach is far from optimal (O’Connor & Scott, 2007). In fact, behavioural and attachment parenting approaches share a number of similar principles, many of which fall within the construct of authoritative parenting. This term, coined by Diane Baumrind in 1966, refers to an emphasis on warmth and responsiveness, in the context of clear limits and helping children to understand the reasons behind rules and the consequences of behaviour (Baumrind, 1966). There is overwhelming evidence that the authoritative parenting style is a consistent predictor of both parental wellbeing and child outcomes (e.g. Hoskins, 2014; Darling, 1999; Steinberg et al., 1992). When analysed more closely, many parenting books from ostensibly very different theoretical perspectives actually place a primary emphasis on authoritative parenting. This is encouraging, given that the main ingredients of authoritative parenting – warmth and responsiveness combined with consistent limit setting – appear to be the most evidence-based approach towards parenting today. When these factors are present in a consistent way, the precise parenting tools used are not so important. In an age of increasingly polarised debate and judgement about ‘correct’ parenting practices, much of which is based on opinion rather than science, this is a key message to convey to parents.

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Challenges of parenting in a refugee camp

Alison Prowle and Janet Harvell from the Centre for Early Childhood, University of Worcester, UK, draw on their own experience of working at the Dunkirk refugee camp to describe the challenges parents face.

The last 18 months have seen the largest number, in living memory, of people forcibly displaced from their homes and/or countries. The scale of the crisis is unprecedented, with the United Nations High Commission for refugees (UNHCR, 2016) estimating that 65.3 million people around the world have been forced to leave their homes. On a global scale, this now means that 1 in every 122 people is either a refugee, internally displaced or seeking asylum; almost half of these are children, and the crisis shows no sign of abating.

At some point in their journey, the majority of refugees will spend time in a refugee camp. Indeed, the UNHCR (2006) suggests that the average time spent in a refugee camp is 17 years. This means that babies born in camps are spending most of their childhoods in basic, and often hostile, environments. Whilst life in a refugee camp may be infinitely better than conditions in the countries from which families have fled, the long-term impact on children’s well-being is cause for concern. Moreover, being a parent in such adverse conditions is extremely challenging and fraught with daily difficulties (Ghate & Hazel, 2002).

Many parents are themselves suffering from bereavement, loss and trauma. Médecins Sans Frontières has identified high levels of depression, anxiety and emotional trauma experienced by adults and children within the camps. This, together with uncertainty about the future, and a lack of autonomy, results in feelings of hopelessness and despair. Living in the cramped and basic conditions associated with the camps adds to the families’ stress.

Indeed, undertaking the most basic care for babies and small children is a major challenge for parents. With limited support for breastfeeding (UNHCR, 2016), coupled with difficulties in finding private and comfortable places to feed, organisations working on the ground have suggested that in some camps, up to half of all babies are formula-fed. In addition to missing vital opportunities for bonding, the supply of formula can be unstable. This means that when supplies are scarce, mothers are diluting the formula, with a resultant loss of nutrients. Sterilising feeding equipment is also problematic; only basic heating is available, whilst water has to be transported from communal areas. Changing nappies and washing clothes are equally difficult. Even in the best-equipped camps, overcrowding creates a breeding ground for respiratory infections, and scabies proliferate.

Taking care of a sick child in a refugee camp (or indeed being sick yourself) is exceptionally hard. Additionally, opportunities for children’s early explorations, such as crawling and toddling, are greatly curtailed with accompanying impacts on development. Medical professionals share stories of 18-month-old children who have no experience of crawling, resulting in being unable to sit unaided. For many parents, their aspirations for providing their infants with positive experiences for play, discovery and learning, are unattainable.

There is also the challenge of keeping children safe. There are many hazards within refugee camps, from unsafe structures to child trafficking. The need to keep their children safe means that many parents accompany their children, including teenagers, at all times. Consequently, opportunities for developing independence and autonomy are restricted. Conversely, some very young children are allowed unlimited freedom, resulting in challenging behaviour, as well as exposure to serious risks. The implications for children’s development resulting from each of these forced parenting styles are profound.

With older children, there is also the vexed issue of education. Many refugee parents state that a key reason for embarking on the hazardous journey from their own country to a perceived place of safety was to give their children the chance of a better future. However, the UNHCR (2016) estimates that only half of all refugee children of school age are in any form of education provision. Many have been out of education for months or years, whilst those able to attend school in the camps can only do so on a part-time basis, and such provision as there is is both under-resourced and narrow in terms of curriculum. The consequences for children’s longer term outcomes are therefore extremely concerning.

In light of global issues which affect so many children, it is easy to feel helpless. However, there are positive contributions that parent-educators can make. Firstly, we can raise awareness of the issues in our communities. There may be parents living locally, who have experienced life in warzones, in transit and in refugee camps, who will benefit from supportive and culturally sensitive parent programmes. We can also consider providing support (both of money and time) to agencies supporting parents in refugee camps. A number of parent-support organisations have already taken up these challenges, providing timely interventions to support refugee parents both within the UK and in camps abroad.

REFERENCES
Dear Editor,

It is fantastic to have a focus on peer support in this issue of IJBPE, given the difference peer support can make to the lives of women and families. NCT has for many years delivered breastfeeding peer support, and community-based antenatal and postnatal services. Building on our experience of volunteer training, delivery of peer support and expertise in the perinatal period, we have recently been working on two models of peer support that show great promise in helping us to increase the reach of our support for new parents. The Department of Health funded NCT to pilot a Birth and Beyond Community Peer Supporter programme (National Institute for Health & Care Excellence (NICE) 2016), developing a model of volunteer training and community-based peer support for expectant and new parents. The volunteer training has since been rolled out to other areas, and we have reported on the success of a cohort of Maternity Champions delivering peer support in the Queens Park and Old Oak areas of London. Funded by Westminster Triborough Group and in partnership with the Paddington Development Trust, the programme has been highly valued by the women supported, building confidence, reducing feelings of loneliness or isolation, and helping them to access local services (Bhavnani & McMullen, 2016).

In 2016, the Department of Health funded NCT to develop a safe, effective and sustainable model of perinatal mental health peer support. The ‘Parents in Mind’ model builds upon our birth and beyond training to develop volunteers’ awareness and knowledge of perinatal mental health, and skills to facilitate group-based peer support. The project is a partnership with the Institute of Health Visiting, building on their established Perinatal Mental Health Champion training. Peer support will be delivered across three pilot sites: Coventry and Central Warwickshire (where training is underway), Runcorn and Widnes, and Tower Hamlets and Newham. Following training, volunteers will go on to deliver one-to-one and group-based support in the community, working closely with local community and specialist services. We’re delighted to have Jenny McLeish (Institute for Voluntary Action Research), Professor Susan Ayers (City, University of London) and Dr Abigail Easter (Kings College, London) working with us to evaluate the pilot. We hope that the shared learning will help women to access the support they need, and improve experiences and outcomes for women experiencing perinatal mental health illness.

Sarah McMullen
Head of Research, NCT, London

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Information about Parents in Mind can be found at: https://www.nct.org.uk/professional/parents-in-mind

RISE IN ‘FREEBIRTHING’

Dear Editor,

In response to issues raised in Sally’s Column in October’s IJBPE, I would like to draw readers’ attention to freebirthing as one strategy that women are increasingly using to assert their right to make their own choices about maternity care.

The growing popularity of freebirthing, where women choose to give birth without medical assistance from midwives or doctors, suggests that when it comes to childbirth, there is a widening gap between what women want and what they are offered. Ethically and legally, a woman’s right to autonomy regarding her own body includes the right to decline medical advice or treatment she should wish it, whether or not that runs counter to the recommendations of midwives or doctors. In Britain, this is at the heart of respectful maternity care and is enshrined in law.

There is now a growing body of research from Sweden, Holland, Australia, Canada, the US and UK that explores the freebirthing phenomenon, including mothers’ motivations for choosing this way to birth and their subsequent experiences. The most obvious recurring theme drawn from mothers’ comments to researchers is that they chose freebirthing as a means of resisting the biomedical model of birth. The decision to freebirth stemmed primarily from their own risk assessment that the harms of excessive interventions often carried out in hospitals were riskier than having a freebirth. The researchers’ findings across all studies agreed that women sought to retain full control and autonomy throughout their experience of giving birth, a need they felt maternity services were unable to meet. One study from the UK that explored freebirthing revealed a ‘pervading mood of fear’. Mothers experienced midwives’ risk-averse approach to maternity care as manipulative in order to encourage conformity to guidelines, regardless of the mothers’ wishes. They felt that their midwives prioritised institutional requirements over their expressed needs. This led women to avoid maternity care altogether. A second study found that some women found access to homebirth services obstructed, leading them to choose to freebirth instead. It’s important to note that this obstruction occurred despite legislation in the UK that assures a woman’s right to bodly autonomy and that it runs contrary to the rhetoric of ‘individualised’, woman-centric care that is supposed to underpin maternity care. For some women, the decision to freebirth stems from a philosophical belief that an unassisted birth is safer, and is their right to carry out. For others it reveals a ‘broken system’ that is failing them, and points to the need for a collective response to find a fix.

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How volunteers can work with parents to improve early childhood outcomes: A review of the evidence

Jenny McLeish, Research Associate, Institute for Voluntary Action Research
Leila Baker, Head of Research, Institute for Voluntary Action Research
Celia Suppiah, CEO, Parents 1st

A 2015 review carried out in the UK explored whether and how volunteering and peer support can contribute to improving key child development outcomes for children aged 0-3: social and emotional development, communication and language development, and diet and nutrition. It found evidence that volunteers can have a positive impact on all three outcomes, both directly and indirectly. This article summarises the strengths and weaknesses of different models of volunteering, how volunteers can engage with families who are ‘hard to reach’ for professionals, the key features of successful volunteer programmes, and the importance of volunteers working alongside professionals.

Keywords: volunteer, peer support, evidence review, parents, children

Better Start (ABS) is a ‘test and learn’ programme in England, funded by the Big Lottery Fund which gives grants to organisations in the UK to help improve their communities.

It aims to facilitate system change locally and to improve outcomes in pregnancy and for children aged 0-3. It brings together public services, the voluntary and community sector, and communities, to co-produce and deliver more joined-up services for all families living in the area. The programme is running in five partnership areas (Bradford and Blackpool in the north of England; Lambeth in London; Nottingham in the east of England and Southend-on-Sea, east of London), each of which will receive an investment of £36-£49 million during 2015-25. ABS is particularly aiming to improve outcomes in three key developmental areas:

1. Social and emotional development: preventing harm before it happens as well as promoting good attachment.
2. Communication and language development: developing skills in parents to talk, sing, read to, and particularly to praise their babies and toddlers and to ensure local childcare services emphasise language development.
3. Diet and nutrition: encouraging breastfeeding and promoting good nutritional practices, giving practical advice on healthier meals for young children and portion sizes.

To support the development of ABS services, in 2015 an evidence review was commissioned to explore whether and how volunteering and peer support could contribute to improving these child development outcomes. The ABS partnerships had asked for evidence of ‘what works, when, for whom and in what circumstances’. The review was led by social enterprise, Parents 1st, and carried out by researchers from the Institute for Voluntary Action Research.

METHODS
The evidence review had two components: a rapid review of peer reviewed literature, and a call for additional evidence that was put out to professional and practitioner networks. For the rapid review, we searched bibliographic databases (ASSIA, CINAHL, Cochrane Library, International Bibliography of the Social Sciences, MEDLINE, PSYCHINFO, PUBMED, Social Services Abstracts and SCOPUS) for research published in English since 1990, carried out in the UK or countries with some cultural, social or health service similarities to the UK. Studies were included if they described a volunteering or peer support intervention that directly affected one of the three chosen outcomes, or affected another outcome where there was a plausible causal pathway to improving one of the chosen outcomes (we describe these as ‘indirect’ impacts). We included studies using both quantitative and qualitative methodologies, and
studies where the target age group included 0-3, even if older children were also included.

The call for evidence was sent out electronically via email to over 120 practitioner and professional organisations, requesting that they send us any published or unpublished material that was relevant to our research questions.

Because this was a rapid evidence review with a very broad scope and limited resources, we worked pragmatically with abbreviated filters and processes for quality appraisal, built around the relevance and transparency of the evidence, its methodological robustness and data confidence.

RESULTS

After screening over 25,000 documents, our search strategy returned a total of 267 papers that were relevant to the review, including 34 reports received through the call for evidence. Authors used a broad range of terminology to describe the activities of those helping parents, including ‘buddies’, ‘befrienders’, ‘mentors’, ‘parent champions’, ‘community champions’, ‘community parents’, ‘supporters’ and ‘peer supporters’. We therefore developed a simple typology to group similar interventions together, dividing them into ‘one-to-one support’ where an individual volunteer is paired with an individual parent; ‘group support’ where one or more volunteers lead a regular group for parents, and ‘community champions’ who spread health or parenting messages within their community. The identified strengths and weaknesses of these different models are shown in Table 1. We use the term ‘volunteer’ to refer to those helping parents (although in a small number of studies they received some payment), ‘parent’ to include pregnant women, and ‘professional’ to describe individuals who have completed specific qualifications and are registered with a professional body.

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<td>Community champions</td>
<td>• Large numbers of volunteers&lt;br&gt;• Suitable for volunteers with little time</td>
<td>Limited evidence of impact beyond that on volunteers themselves (except information about services)</td>
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<td>Volunteers leading groups</td>
<td>• Parents value social support&lt;br&gt;• May be less ‘socially risky’ than one-to-one support&lt;br&gt;• Good evidence of impact</td>
<td>Vulnerable parents often lack the confidence to attend groups</td>
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<td>One-to-one support</td>
<td>• Can engage most vulnerable parents&lt;br&gt;• Development of long term support relationships&lt;br&gt;• Good evidence of impact</td>
<td>Reaches limited numbers of parents&lt;br&gt;Significant time commitment required of volunteers</td>
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EVIDENCE OF DIRECT IMPACT ON THE THREE OUTCOMES

Outcome 1: Social and emotional development

A randomised controlled trial of the Empowering Parents, Empowering Communities parenting programme, delivered to groups of parents by highly trained peer facilitators, found significantly greater improvements in positive parenting practices and reduction in child problems for parents (almost all mothers) who attended the group, compared with parents on the waiting list (Day, 2012). The evidence of direct impact on social and emotional development from one-to-one support is mixed. Much of the evidence comes from Home Start, one of the leading family support charities in the UK, which offers unstructured one-to-one trained volunteer social support to families with young children. Parents who receive Home Start in the UK consistently report that it helps them parent better, manage their children’s behaviour better, and be more involved in child development (Kenkre, 2011; McAuley, 2004). A cluster randomised study and a quasi-experimental study in the UK (Barnes, 2006a; McAuley, 2004) did not find any impact on child outcomes, but a randomised controlled trial of the same model in the Netherlands found that Home Start families had more responsive parenting and fewer child behaviour problems (Hermanns, 2013) and these improvements were sustained to age 10 (van Aar, 2015). This suggests that measuring impact may be partially dependent on the precise outcome indicators that are chosen and how they are assessed.

Outcome 2: Communication and language

There is evidence that volunteers delivering the Early Words Together language and literacy intervention with parents in small groups can improve children’s understanding of spoken language (measured using a standardised
vocabulary test). Parents reported that it also improved their children’s enjoyment of sharing books and joining in with songs and rhymes, increased the amount of parent-child talk, and increased the parents’ awareness of the importance of talking and sharing books with their children (Wood, 2015). In a randomised controlled trial of one-to-one home visiting by volunteers, mothers who received the intervention were more likely to report that their children were read to daily and were exposed to more nursery rhymes (Johnson, 1993). In a comparison study, preschool children (aged 2-5) who received one-to-one support from a teenage volunteer had significantly increased communication and language skills (Humphrey, 2014).

Outcome 3: Diet and nutrition
The evidence for the impact of breastfeeding peer supporters is contested. Systematic review evidence has found that although peer support can increase the length of exclusive breastfeeding in high income countries, there is no randomised controlled trial evidence of impact in the UK (where all mothers have access to some breastfeeding support from midwives and health visitors) (Jolly, 2012; Ingram, 2010). On the other hand, some individual projects report that peer support does have an impact on breastfeeding rates in their local area (including in very deprived communities), particularly when delivered in combination with effective health professional support (e.g. Brown, 2011; Alexander, 2003). Moreover, breastfeeding mothers who receive peer support often say that it was the peer support that enabled them to continue breastfeeding, either through moral support and encouragement, having breastfeeding role models, or through specific help to overcome problems; and additional benefits such as improved family diet and maternal mental health and parenting skills have been reported by mothers attending breastfeeding peer support groups (Fox, 2015; Glass, 2015; Thomson, 2015; Whitmore, 2015; Ingram, 2013; Brown, 2011; Hoddinott, 2011; Muller, 2009; Wade, 2009; Briant, 2005; Ingram, 2005; Alexander, 2003; Raine, 2003; Scott, 2003; Batterby, 2002; McNenes, 2001).

One challenge with this evidence is that there are many different models of breastfeeding peer support and it appears that there is no ‘one size fits all’ for all communities or individuals. For example, some mothers value the social support and ‘normalisation’ provided by breastfeeding groups over the potential ‘intrusion’ of one-to-one support at home; but other mothers value individual support (e.g. Thomson, 2015; Ingram, 2013; Alexander, 2003; McNenes, 2001).

Looking beyond projects focused on breastfeeding peer support, there is evidence that one-to-one support from trained volunteer doulas (who give mothers one-to-one support during pregnancy, at birth and postnatally for six to twelve weeks) can significantly affect both the number of women who start breastfeeding and the number who continue for at least six to eight weeks (Spiby, 2015). Monthly one-to-one home visiting was found to improve the diets of children in a randomised controlled trial in Ireland (Johnson, 1993), and a UK randomised controlled trial of volunteer support focused on healthy diet found some limited aspects of children’s diets improved in the intervention group, but with no significant impact on vitamin C intake or (when followed up four years later) on Body Mass Index (Scheiwe, 2010; Watt, 2009).

EVIDENCE OF INDIRECT IMPACT
We described a programme as having an indirect impact when it had an effect from which there was a plausible causal pathway to one of the three chosen outcomes. In this way the volunteers could be seen as having an impact on an intermediary step in the process of change. For example, early years education is likely to promote children’s language and social development, and there is evidence that community champions can be effective in promoting uptake of the free childcare available to two year olds in disadvantaged families (Family and Childcare Trust, 2016). Parents’ attendance at a healthy lifestyle group course is likely to improve their ability to offer a healthy family diet, and community champions have been successful at recruiting parents of young children to such a course (Ives, 2015).

An important factor disrupting children’s social and emotional development is the mother’s poor mental health in pregnancy and after birth (National Institute for Health and Care Excellence (NICE), 2014). It is therefore likely that interventions supporting the mother’s emotional wellbeing will have an indirect impact on her parenting and on her children’s social and emotional development. There are a number of models of one-to-one volunteer support that offer needs-led social and emotional support, often combined with mentoring activities, information about parenting, and support to access services such as children’s centres. Although the limited randomised controlled trial evidence demonstrated that receiving unstructured volunteer home visits did not affect the onset of diagnosable maternal depression, mothers consistently report that one-to-one volunteer and peer support (structured and unstructured) reduces their stress and increases their self-esteem, parenting confidence and emotional wellbeing, including reducing feelings of anxiety and depression (Spiby, 2015; Bhavnani, 2014b; Barlow, 2012; Granville, 2012; Akister, 2011; Kenkre, 2011; Barnes, 2009; Suppiah, 2008; McAuley, 2004).

It has been suggested that in some communities there may be social factors inhibiting breastfeeding that need to be addressed at a community rather than individual level, and it has been argued that breastfeeding peer supporters may contribute to longer-term change in the local infant feeding culture by championing and normalising breastfeeding as a feeding choice (Fox, 2015; Glass, 2015; Thomson, 2015a; Whitmore, 2015;
REACHING FAMILIES WHO ARE ‘HARD TO REACH’ FOR SERVICES

It has been theorised that volunteers from a specific community may be trusted over outsiders and are therefore able to reach those who are ‘hard-to-reach’ for services (e.g. McInnes, 2001), and the core rationale of peer support is the trust and empathetic understanding engendered by common experiences (e.g. Harris, 2015; Jones, 2014; Briant, 2005). The evidence shows that offering peer support from people with ‘lived experience’ of the parents’ own issues gave vulnerable parents the assurance they would be understood and not judged, enabled them to talk honestly in a way they could not do with professionals, and gave information from the volunteers more credibility (Fox, 2015; McLeish, 2015; Marden, 2014; Turner, 2012; Murphy, 2008; McInnes, 2001). Disadvantaged parents were less likely to engage with volunteers than more advantaged parents but, once engaged, disadvantaged parents were least likely to disengage (Suppiah, 2008; Barnes, 2006b; Cox 1991). Both group support (e.g. Day, 2012) and one-to-one support (e.g. McLeish, 2015; Bhanvani, 2014a; Lederer, 2009) have been found to be acceptable and effective for parents from Black, Asian and minority ethnic (BME) communities, although the evidence does not distinguish between different BME groups. Although some parents from BME communities accessed support more readily when it was offered by someone from their own cultural and language background, support was more acceptable to others if the volunteer was not from the same minority community because this was felt to reduce the risk of gossip and stigma (McLeish, 2015; Prosman, 2014; Summerbell, 2014; South, 2012; Lederer, 2009; Muller, 2009). One-to-one support has also been shown to be acceptable to and to benefit very vulnerable families such as asylum seekers and refugees (Bhavani, 2014b; James, 2013). Travellers (Fitzpatrick, 1997), families without recourse to public funds (Lederer, 2009), mothers experiencing domestic abuse and families whose children were at risk of neglect or abuse (Prosman, 2014; Tunstill, 2012; Akister, 2011; Taggart, 2000). It is important to note that figures for take-up by parents were not always reported, and where they were, projects had variable degrees of success at engagement. For example, home visiting projects reported take up by 64−80% of parents referred (Barlow, 2012; Cupples, 2011; Lederer, 2009), but in a cluster randomised trial of Home Start home visiting, only 41% of parents referred for support received it, largely due to administrative and capacity issues (Barnes 2006b). Reported barriers to initial engagement included parents being uninterested in, or not understanding, the support offered; feeling that they already had enough support from friends and family; being concerned at taking on a stressful social obligation; feeling suspicious about the motivation and purpose of the volunteer; or experiencing opposition from family members (McLeish, 2015; Spiby, 2015; MacPherson, 2010; Murphy, 2008; Barnes, 2006b).

Although there were occasional contacts with fathers reported and sometimes particular efforts to reach fathers (e.g. Thomson, 2015; Day, 2012; Lederer, 2009), in almost all cases the volunteers were working overwhelmingly with mothers. There was no UK evidence of any volunteer projects set up specifically to work with fathers towards the three outcomes.

TABLE 2: WHEN VOLUNTEERS ARE EFFECTIVE

<table>
<thead>
<tr>
<th>Volunteers are effective when...</th>
<th>Volunteers are not effective when...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their distinctive non-professional contribution is understood and valued</td>
<td>They are seen as a cheap replacement for health professionals</td>
</tr>
<tr>
<td>Their role is to empower the parent with information and support</td>
<td>They are positioned as expert teachers</td>
</tr>
<tr>
<td>There are realistic expectations about what they can achieve and the likely timescales</td>
<td>They are seen as ‘the answer’ and have rigid, short-term targets which require intensive monitoring and data collection</td>
</tr>
<tr>
<td>They are supported by local health and social care professionals</td>
<td>Professionals ignore or obstruct their activities</td>
</tr>
</tbody>
</table>

KEY FEATURES OF SUCCESSFUL VOLUNTEER PROJECTS

The models of volunteer support in this evidence review were very diverse and not always well described, so it was not possible to draw conclusions about whether any particular model was ‘better’ than another. Looking at the evidence as a whole we were, however, able to draw some key conclusions about the circumstances in which volunteers may have an impact on the three chosen outcomes in the UK (see Table 2). We were also able to draw some conclusions about the key features that successful volunteer projects have in common (see Box 1).
WORKING WITH PROFESSIONALS

Good relationships with local professionals were key to the success and sustainability of volunteer projects. Many volunteer projects experienced tension with professionals, leading to restrictive ‘gatekeeping’, poor communication and a lack of referrals (e.g. Thomson, 2015; Aiken, 2013; Ingram, 2013; Suppiah, 2008; Curtis, 2007; Dykes, 2005). Other professionals were reported to see volunteers as a key resource, complementing and enhancing their professional support for families, and reaching families who were ‘hard-to-reach’ (e.g. Spiby, 2015; Thomson, 2015; Ingram, 2013; Tunstill, 2012; Curtis, 2007). Many projects found it challenging to publicise their work effectively to the wide range of professionals whose support they needed, and this required ongoing networking from project coordinators (e.g. Spiby, 2015; Bhavnani, 2014a; Barlow, 2012).

Successful strategies for promoting co-operation between volunteer projects and professionals have been described (Spiby, 2015; Thomson, 2015; Bhavnani, 2014a; Barlow, 2012; Tunstill, 2012; Lederer, 2009; Curtis, 2007; Raine 2003):

- Professionals were involved at the earliest stage of the development of the project.
- Projects demonstrated how the volunteers complemented professional support by contributing to the shared endeavour of improved outcomes for children.
- Projects articulated their clear boundaries, training and supervision.
- Professionals were involved in volunteer training and sometimes volunteers became involved in professionals’ training.
- Volunteers used training that was also used and/or understood by professionals (for example on breastfeeding).
- There were clear referral guidelines and a simple referral process into the project.

CONCLUSION

This evidence review has found that volunteers can make a distinctive contribution to achieving the three chosen outcomes for children, but only when they are accepted by local professionals. Volunteers can initiate a different kind of relationship with parents based on trust and equality, and can reach and be accepted by parents who do not engage with professional services. We recommend that volunteer support should be commissioned as part of a ‘whole system’ approach to improving outcomes for children. The full evidence review, and an accompanying implementation framework, which includes evidence on running successful volunteer projects, can be found at http://abetterstart.org.uk/content/resources.

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Fox, R., McMullen, S., Newburn, M. (2015) UK women’s
experiences of breastfeeding and additional breastfeeding support: A qualitative study of Baby Café services. BMC Pregnancy & Childbirth, 15, 147.


Peer-to-peer support is an increasingly common feature of healthcare provision during pregnancy and early childhood. Breastfeeding support is one of the most frequent approaches with fewer examples focussed on early communication and language, childhood social and emotional development and wider aspects of family support (Woods, 2015; Bevan & Brown, 2014; Hermanns, 2013; Day et al., 2012a, b). Peer support approaches range from the provision of informal volunteer social support through ‘befriending’ to more intensive individual and group-based structured support focussed on specific parent and child outcomes provided by trained, paid, parents.

Most peer approaches are based on broadly similar assumptions (Cupples et al., 2011; Stolzenberg et al., 2011; Webel, et al., 2010; Solomon, 2004):

• Peers who share characteristics and common experiences with parents may have greater credibility and influence than some professionals.
• The mutual identification and engendered trust that are a common feature of peer approaches may boost engagement and accelerate behavioural change.
• Peer support may be more cost-effective and improve the scope and scale of help available to parents and families, improving health behaviours and outcomes at relatively low cost.
• Peer supporters may also benefit from their improved health-related knowledge, interpersonal skills, self-confidence, community status, employment opportunities and social support.
• Peer support provides a vehicle for personal altruism and community connectedness.

Research evidence for peer support effectiveness varies greatly in quality. Peer support can engender high levels of family satisfaction but outcomes vary widely, from little evidence of effect to a positive impact that is at least the equivalent of that achieved by trained professionals (Jolly, 2012; Hoagwood et al., 2010; Suppiah, 2008).

WHAT IS EMPOWERING PARENTS EMPOWERING COMMUNITIES?

Parenting interventions, particularly those delivered in a group format, are an effective approach for many social, emotional and behavioural difficulties of early childhood. An impressive range of well-evidenced profession-led parenting programmes is available (Asmussen et al., 2016). However, research and practice evidence indicates significant barriers to their likely success including:

• Families experiencing social disadvantage, exclusion and higher levels of need are less likely to use and benefit from these approaches.
INTO PRACTICE

• The scale of need in socially disadvantaged areas far outweighs service capacity.
• Profession-led parenting services can be complex to access and stigmatising for families to use.

In order to address these barriers to effective parent support, EPEC combines parent-led parenting groups with training, organisational support and supervision provided by specialists in child mental health and parenting based at the South London and Maudsley NHS Foundation Trust. The intention is that EPEC improves the scale, access and effectiveness of parenting support available to local families, particularly those in socially disadvantaged neighbourhoods. In doing so, EPEC can improve parenting and child outcomes, parents’ wellbeing, build families’ social and community connectedness, and encourage engagement with other local services and wider community resources.

For over ten years, parents, practitioners and researchers have worked together in collaborative and reciprocal ways to develop, test and review the EPEC approach. EPEC has developed three types of group-based parenting courses:

• ‘My Baby and Us’ is designed for parents of babies aged up to one year.
• ‘Being A Parent’ is suitable for parents with children, aged 2-11.
• ‘Living with Teenagers’ is designed for parents of children aged 11-16 years.

These courses typically consist of eight 2-hour sessions, supported by on-site créche facilities, co-facilitated by two EPEC accredited parent group leaders for between 8-12 parents. The courses are mainly provided on a universal basis so that all families in a local neighbourhood can attend. We have developed a range of variations to these core courses for families experiencing specific life stresses such as homelessness, and who have children with more complex mental health and developmental needs.

The manualised content of each of these courses is based on known, effective parenting strategies and methods, and child needs from infancy to adolescence, (see Box 1 for course theory and curriculum content, and Boxes 2 and 3 for example curriculum outlines).

BOX 1: EPEC COURSE THEORY AND CONTENT; EPEC GROUP LEADER SKILLS AND QUALITIES

<table>
<thead>
<tr>
<th>EPEC course theories and methods</th>
<th>EPEC course content</th>
<th>Peer group leader qualities</th>
<th>Peer group leader skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment theory</td>
<td>Parenting role beliefs</td>
<td>Being respectful</td>
<td>Active listening and close attentiveness</td>
</tr>
<tr>
<td>Social learning theory</td>
<td>Parenting and culture</td>
<td>Being genuine</td>
<td>Communicating clearly</td>
</tr>
<tr>
<td>Relational and family systems theory</td>
<td>Understanding infant/child needs</td>
<td>Having humility</td>
<td>Showing empathy</td>
</tr>
<tr>
<td>Cognitive-behavioural theory</td>
<td>Family stress</td>
<td>Being empathic</td>
<td>Actively negotiating</td>
</tr>
<tr>
<td>Parenting and infant/child development</td>
<td>Parent and child feelings and emotional regulation</td>
<td>Being warm and quietly enthusiastic</td>
<td>Giving encouragement</td>
</tr>
<tr>
<td>Ecological theory</td>
<td>Listening, play and interaction skills</td>
<td>Having personal integrity</td>
<td>Focusing and prioritising</td>
</tr>
<tr>
<td></td>
<td>Positive behavioural management and discipline strategies</td>
<td>Using parenting and child development knowledge, experience &amp; technical expertise</td>
<td>Helping parents to change their ideas, feelings and behaviour</td>
</tr>
</tbody>
</table>

Sessions are highly interactive involving information sharing, group discussion, demonstration, role play and reflection. Practice and parents’ use of skills in everyday life are key features, with participants working on specific goals throughout the course. The courses integrate behaviour change with adult learning so that parents can gain a Level 2 Open College Network accreditation.

Each group ends with a celebration event which promotes the social aspect of the courses.

DOES EPEC MAKE A DIFFERENCE?

Over 3000 parents have now taken part in EPEC groups in the UK and Australia, with around 250 parents trained as EPEC group leaders. Research studies and ongoing practice evaluation show that the EPEC approach achieves strong parent engagement and participation. For example, in groups delivered across south and east London, around 75% of parents attending EPEC courses are from Black and Minority Ethnic (BME) backgrounds. Typically, at least two-thirds of them come from the lowest 20% of the population based on disposable

Open College Network: a regulated awarding organisation offering vocational credit-based qualifications
income, with only approximately one in 10 being owner occupiers; 75% of participants are unwaged, 40% lone parents, and half of participant parents have English as a second language. EPEC facilitators have similar socio-demographic characteristics.

Research and practice evaluation shows that EPEC achieves substantial improvements in key parent, parenting and child outcomes (Michelson et al., 2014; Day et al., 2012a,b). As a result, EPEC has been endorsed by independent assessments of quality and effectiveness conducted in the UK and Australia (Asmussen et al., 2016; Australian Institute of Family Studies, 2016).

**BOX 2: EMPOWERING PARENTS, EMPOWERING COMMUNITIES: ‘MY BABY AND US’ COURSE OUTLINE**

<table>
<thead>
<tr>
<th>Session 1: Welcome to the world</th>
<th>Session 5: My Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Birth experiences, recovery &amp; discoveries</td>
<td>o Getting to know my baby – self and personality</td>
</tr>
<tr>
<td>o Culture and your baby</td>
<td>o Hopes, dreams &amp; expectations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 2: Being ‘good enough’</th>
<th>Session 6: Connecting, relating and responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Parental expectations, good enough vs perfect parenting</td>
<td>o Parent and infant communication and interaction</td>
</tr>
<tr>
<td>o Family circumstance and looking after yourselves</td>
<td>o Play</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 3: Parents’ feelings and baby’s feelings</th>
<th>Session 7: Safety, care and nurture</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Acknowledging, accepting and expressing feelings</td>
<td>o Parent challenges &amp; managing difficulties – crying</td>
</tr>
<tr>
<td>o Managing stressful parenting</td>
<td>o Keeping babies safe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 4: Baby, parent and family needs and routines</th>
<th>Session 8: Support, next steps and celebrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Managing feeding, crying &amp; sleeping</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 5: Understanding children’s behaviour</th>
<th>Session 6: Discipline strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Understanding children’s behaviour in response to needs</td>
<td>o Understanding boundaries</td>
</tr>
<tr>
<td>o Rewards and consequences</td>
<td>o Rewards</td>
</tr>
<tr>
<td>o Assertive versus aggressive behaviour</td>
<td>o Assertive versus aggressive behaviour</td>
</tr>
<tr>
<td>o Time out, challenging, and saying no</td>
<td>o Time out, challenging, and saying no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 7: Listening</th>
<th>Session 8: Review and coping with parent stress</th>
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<tbody>
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</tr>
</tbody>
</table>

**HOW ARE PEER GROUP LEADERS INTEGRAL TO EPEC’S SUCCESS?**

Parent experience and satisfaction data from routine evaluation of over 80 EPEC groups (see Table 1) reflect the research outcomes described above and shows the substantial impact that EPEC course participation has on parents’ understanding of positive parenting, their confidence and skills, and their commitment to making everyday use of their learning and behaviour change.
TABLE 1: PARENT PARTICIPANTS’ FEEDBACK ON EPEC COURSE IMPACT

<table>
<thead>
<tr>
<th>Parent rating of EPEC course impact</th>
<th>[n=793(%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A Little</td>
</tr>
<tr>
<td>Improves parents’ understanding of positive parenting</td>
<td>5 (0.6)</td>
</tr>
<tr>
<td>Helps to develop parents’ positive parenting skills</td>
<td>10 (1.3)</td>
</tr>
<tr>
<td>Improves parents’ confidence in being an effective parent</td>
<td>8 (1.0)</td>
</tr>
<tr>
<td>Will use learning from EPEC as a parent</td>
<td>5 (0.6)</td>
</tr>
</tbody>
</table>

The evaluation data also shows that course participants strongly endorse the role of parent group leaders (see Table 2). Three quarters of participants give the highest feedback ratings for parent group leader motivational skills, relationship qualities and competence. These findings reflect the vital contribution that parents make to EPEC. Their contribution runs through EPEC outreach activities, courses, supervision and celebrations.

TABLE 2: PARENT PARTICIPANTS’ FEEDBACK ON EPEC GROUP LEADERS’ SKILLS

<table>
<thead>
<tr>
<th>Parent rating of EPEC parent group leaders</th>
<th>[n=793(%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A Little</td>
</tr>
<tr>
<td>Satisfied with competence of EPEC parent group leaders</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Satisfied with EPEC programme and group leaders</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Appropriate programme content covered by EPEC group leaders</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>EPEC group leaders related effectively to parent participants</td>
<td>2 (0.2)</td>
</tr>
<tr>
<td>EPEC group leaders motivated participant parents</td>
<td>1 (0.1)</td>
</tr>
</tbody>
</table>

Research and practice experience shows that parent group leaders’ enthusiasm, openness and mutual identification with families are critical to EPEC’s effectiveness and sustainability (Thomson et al., 2014). EPEC courses are run from the heart of local neighbourhoods in familiar community settings such as schools and children’s centres that are easy to find and less stigmatising. In each course location, parent group leaders offer information sessions, coffee mornings and one-to-one conversations with local parents. Group leader qualities and skills (see Box 1), their cultural and ethnic backgrounds, social class and status as parents play a key role in EPEC’s proactive and welcoming approach to outreach. Group leaders seek to build the relationships and trust that enable parents to feel encouraged, optimistic and well informed about EPEC so that each parent can make an active choice about participation, particularly those with higher levels of need. Group leaders continue to use these skills and qualities to shape the manualised EPEC course content and methods to reflect the individual and collective needs of parents and their children, and as they do so, help parents to develop individual plans and goals for themselves, their child and family.

The national EPEC team is composed of child mental health and parenting specialists who work with a large group of parent group leaders. Half of the team began their involvement with EPEC through originally attending an EPEC course as a parent, then becoming experienced group leaders before joining the national team. The national team maintains the integrity, organisation and quality of the EPEC approach. Core functions in maintaining group leader skills, expertise and supportive, inclusive relationships include:

- **Parent group leader recruitment and selection**
  The vast majority of EPEC group leaders have previously been course participants; equivalent experience is required for those who have not. This provides understanding of and commitment to course content and lived experience of its value and impact. EPEC’s standardised selection process includes a brief application form and interview to assess prospective parent group leaders’ capacity to self-reflect, understand and empathise with others, and aptitude for EPEC course facilitation. EPEC supports and has developed alternative roles for parents who are not successful.

- **Introductory EPEC group leader training**
  This consists of a minimum of six training days plus home study, written portfolio and workbook, and supervised trainee practice. The training is supported by a crèche. Successful
parents receive Level 3 OCN accredited qualifications. The training covers facilitation skills, group dynamics, safeguarding, local resources and services, EPEC course knowledge and skills to support positive parenting, child development, and family resilience. The training uses a combination of information sharing, group discussion, role-play, skills practice and written assignments. It gives parents a deeper immersion into EPEC's approach with the opportunity to gain further knowledge, receive warm, constructive feedback, and engage in personal reflection. National team trainers give additional support and encouragement to participants who have a good understanding of and commitment to EPEC ethos but may struggle with completing required OCN units. Research evaluation demonstrates good retention and significant improvements in intended training outcomes (Day et al., 2012b).

- **Ongoing EPEC course quality and fidelity**
  EPEC's value as a peer-led approach rests on its ability to achieve the very best outcomes for children and their parents. Appropriate group leader pairing ensures suitable matching of skills and expertise for each EPEC course. The national team provides ongoing face-to-face fortnightly supervision for parent group leaders, a minimum of five hours per course, to maintain quality, review safeguarding issues, and ensure that the group leaders are well supported and working effectively together. All EPEC courses are routinely observed by the national team members to maintain quality and fidelity. The intention is to maintain warm, supportive and purposeful supervisory relationships that over time help group leaders to reflect on participant parents' lived experiences and group contributions, their own facilitation skills and the constructive management of more challenging group participants.

- **Routine activity monitoring and outcome evaluation**
  Participant attendance and demographic information is collected for all EPEC courses. A standard battery of outcome measures is used at the beginning and end of each course. These provide ongoing information about the parent populations and feedback to the national team, group leaders, parents and commissioners.

- **Continuing EPEC group leader development**
  EPEC parent group leaders meet regularly with the national team for development sessions to exchange skills, reflect on practice, revisit and review course structures and organisation, and contribute to new EPEC developments. Through these and other routes, parents have made fundamental contributions to developing the contents and methods of each of the three types of EPEC course available. Parent group leaders advise on cultural adaptation and have led on the translation of materials to meet the cultural and language needs of specific communities.

- **Supporting employment status**
  EPEC is effective because it combines specialist and parent expertise in ways that successfully engage parents, bringing the course content alive and making a difference to families. The unique knowledge and expertise of the parent group leaders complement that of the national team and require payment and distinct recognition. All EPEC facilitators are paid for their work on a self-employed basis. Employment arrangements ensure that EPEC accredited group leaders have appropriate liability insurance, payment provision and DBS (Disclosure & Barring) checks.

  Working as a parent group leader and acquiring Open College Network accreditation offers parents a valuable source of income and of supportive, structured and flexible employment that generates motivation and confidence to explore further employment, education, training and career opportunities beyond EPEC.

  One of the challenges for the national EPEC team is nurturing a wider appreciation that EPEC group leaders make a unique contribution that complements and extends specialist health and other expertise but does not replace it. It is important that health and social care professionals understand that EPEC group leaders achieve parent engagement and family outcomes that are beyond those that can be achieved by health professionals alone. Host NHS and other similar organisations need encouraging to support the employment status of the group leaders.

**LEARNING FROM THE EPEC EXPERIENCE**

Attending peer-led EPEC courses as a local parent can be transformative. Many parents acquire new parenting knowledge and skills, see themselves and their children differently, become safe, effective and caring parents, and develop friendships and social ties based on shared values and beliefs that provide mutual support well beyond the life of an EPEC course. The EPEC approach provides parent group leaders with robust opportunities to make positive contributions to their communities, offers personal growth and skills development, career development and enhanced employability, financial reward and a sense of connectedness to a cohesive ‘family’ identity among EPEC practitioners and parent facilitators (Thomson et al., 2014). Established EPEC group leaders become an important resource for parenting knowledge, expertise and support through their family, social and community ties and a conduit to professional services for parents who are struggling. For over ten years, parents, practitioners and researchers have worked together in collaborative and reciprocal ways to plan, develop, test and review the EPEC approach and its successes, challenges and innovations. Parents’ presence, contribution and influence are fundamental to everything that EPEC does.
INTO PRACTICE

Summary: Strengths of the EPEC approach

EPEC parent leaders have a well-defined and respected role supported by:
• Written manualised materials based on sound methods, evidence and effectiveness
• Effective recruitment, selection and accredited training that build on eligible parents’ existing skills, qualities and experience and set out clear role expectations
• Ongoing skilled supervision, support and continuing development that facilitate reflection and reinforce group leader role quality, purpose and fidelity
• An inclusive, complementary partnership between group leaders and specialist professionals
• Valued connectedness to local families, communities and resources
• Ongoing monitoring and evaluation
• Employment that ensures payment and full cost recovery.

REFERENCES


PARENTING IN DIFFICULT CIRCUMSTANCES: CALL FOR LETTERS

Each of the next three issues of the IJBPE will feature an Editorial by Alison Prowle and Janet Harvell, exploring both the challenges facing refugee parents and ways in which health and social care professionals and charities can support them.
Please send us letters about your own experiences of working with mothers, fathers and young children fleeing from war zones.

Further information about supporting these families is available from the following organisations:
NCT have developed bespoke resources to support parent educator working with refugee parents. Available at https://www.nct.org.uk/professional/diversity-and-access/general-supporting-parents-who-are-refugees-and-asylum-seekers
La Leche GB have developed projects to promote breastfeeding in camps in Greece. Information at: https://www.laleche.org.uk/supportingrefuemother/ Nurture Project International is providing reproductive healthcare solutions, nutrition infant feeding support to parents and children affected by the global refugee crisis. Information at: http://nurtureprojectinternational.org/
Maximising social capital through volunteers: Lessons from New Zealand

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I have been managing Children’s Centres within Devon since 2009. In 2013, my role altered to encompass the management of Centre volunteers which fuelled my interest in how our Centres could best harness their experiences and knowledge. I looked at various models for providing support and early intervention to young children and their families. In particular, I began to explore Child and Parent Centres in Western Australia and Early Years Services Hubs in New Zealand. The Winston Churchill Memorial Trust enabled me to visit these services and gave me the opportunity to reflect on our current Children’s Centre model in the UK.

This article is part of a much longer report of my travels and focuses in particular on a model of parents as volunteers who pass on guidance and information to new parents to create a sustainable community model for parent support.

Keywords: community, children, families, outcomes, Children’s Centres

SOCIAL WORLD AROUND THE BABY

SOCIAL CAPITAL AND GREAT START TAITA, NEW ZEALAND

The central premise of social capital is that social networks have value. Great Start Taita in New Zealand is a place-based, community-led initiative, providing services for the whole community in Taita and the surrounding area.

The area has a socio-economic rating of 1-2 (where 10 is a high income decile) and consists of a transient population. Great Start Taita began life with an ethos of connecting with and valuing its community members. When door-knocking within the community commenced in 2007, people's response was overwhelmingly that they ‘did not want more services, or more money for more services’. What they said, in many different ways, was that they wanted opportunities to get to know their neighbours, to feel more connected with their community and to have a sense of belonging and pride in the place where they lived (Blagdon, 2011:12). This led to the Great Start team shifting its focus from ‘people being recipients of services towards them being actors in their own lives and in the life of their community. This didn’t have to mean doing away with services. It was not an either/or situation. Rather it was about ensuring that service providers built relationships that were enabling for residents at the same time as offering them a service’ (Blagdon, 2011:13). Early projects included bringing midwives into the Centre to meet the needs of local parents,
organising a volunteer handyman role for out-of-work community members to help them develop skills, and connecting children and their stories of childhood in primary schools.

When I visited in July 2015, I found a Centre that felt like a home, with community members actively leading groups and services within the hub. The manager was keen to show me around and talk about the initiatives at the Centre, including a toy library run by volunteers and a community park that had been developed through collaboration with other organisations. The walls of the building are adorned with photos and the work of children created at community fun days and events, and are testimony to Great Start’s journey. Team members were keen to tell me how the services they offer at the Centre change according to the needs of the community. As residents within the community change, it is important to continue to listen to them. This is similar to the Centre I manage in East Devon in the south west of England; services have come and gone and then been re-invigorated according to the needs of the families and community at that time. The work at Great Start is overseen by a group of trustees who all have a passion to develop the local community and improve the lives of those who live there. The small team of five part-time workers see themselves as co-ordinating and empowering families and community members to own their own services.

Maybe there is something to learn from Great Start about going back to the community and door knocking? Have we become so confident that we know what communities want and need that we have forgotten to ask the families themselves? Would this not give them a true sense of ownership and empower them to provide community groups? I posed these questions to myself as I discussed with the Centre manager how effective door knocking had been for them historically, and is currently. A model of appreciative inquiry is employed in their questions to residents, for example asking, ‘What would a good day look like for you?’ rather than a negatively orientated question such as, ‘What would you change in your community?’

Team members and volunteers take gifts to residents and always work in twos for safety, but no-one could recall a difficult or unsafe experience. The majority of community members were welcoming and keen to share their views and experiences. Rather than focusing solely on people who have children under five, it is acknowledged that there is lots of be learnt from older members of the community and those who have experienced what it is like to raise children in the area. Learning from residents enables the Centre to see the gaps in services and identify what would make the lives of families and community members better. It also allows them to identify the resources and services already within the community, and signpost families and residents to them, thus growing the social capital of Taita.

SUPPORTING PARENTS ALONGSIDE CHILDREN’S EDUCATION (SPACE NZ)

Supporting Parents Alongside Children’s Education (SPACE NZ) is a weekly term-time programme from birth to one year traditionally run within Play Centres in New Zealand. Great Start Taita also offers the course at its Centre. The programme is structured and offers parents an opportunity to learn together with their baby, identify the baby’s developmental stages and grow peer support networks. The programme is offered to a group of 15 families on average, with the majority joining in the first months of their baby’s life. Other families may join throughout the year if there is a vacancy and they have a baby of a similar age to that of the core group.

The group facilitators attend specific training to deliver the programme and are provided with a comprehensive manual with session plans and ideas for activities. The programme is based on the RIE philosophy (Gerber & Johnson, 1998) which advocates time for uninterrupted play with babies and promotes the importance of parents observing their child carefully in order to provide sensitive and appropriate interactions.

The basis of Gerber’s RIE philosophy is Respect for and trust in the baby to be an Initiator, an Explorer, and a self learner.

I was able to observe a SPACE group running at Korokoro near Wellington, New Zealand, and could see how the structure of the group enabled parent-child activities, as well as peer support and discussion around the learning stage of the babies. There was also singing and time allocated for the creation of individual workbooks for each baby. Parents were encouraged to reflect on their observations of their baby and to write a few sentences on what learning they felt had taken place, with guidance from the facilitators and support from other group members. The group is low cost for families and provides them with tools to support their baby’s development throughout the first year and beyond.

SPACE workbooks

The workbooks include photos, observation notes and links to the early years’ curriculum. They are an important record of the development and learning of the baby and also offer ideas for extending learning activities in the home environment. Parents are able to take these books home at the end of each term to treasure the memories of their baby’s first year. Facilitators also create a workbook for the whole group as a record of their time together and as evidence of the development of the cohort of babies.
KAWERAU COMMUNITY PLAYGROUP

Another example of a service that came out of community consultation is the community playgroup in Kawerau which I visited as part of my time at Eastbay Rural Education Activities Programme (REAP), Whakatane, a town in the North Island of New Zealand.

The service co-ordinator for the area noted the low take-up of Early Childhood Education (ECE) and wanted to find out more. A consultation process with local families revealed that parents did not want the traditional ECE set up. They themselves wanted to play a role in developing activities to support their children’s learning and to be able to attend a Centre with them. In response, the community playgroup was founded which runs in the mornings five days a week with families free to attend any sessions they wish. The building acts as a hub for community members who might not otherwise have connected.

PHYSICAL SPACE AS A BASIS FOR COMMUNITY DEVELOPMENT

Hubs are all about supporting families to ensure that children get the best start in life. They do this by creating a ‘door’ that is easy for families to enter. I visited Eastbay REAP hubs in Opotiki, Kawerau and Murupara as well as the main building in Whakatane. All of these buildings are used to house different services for their community members. The Eastbay REAP hub building acts as an information centre for the community. I observed an administrator offering school holiday activity ideas to children visiting with their mother, supporting a trainee to develop their CV, and offering admin support to a volunteer who wanted to create a leaflet to raise awareness about local issues facing families. Rooms within the building are also hired out to local organisations bringing in valuable revenue, but also ensuring continuous footfall through the hub, allowing visitors to share information with the centre and signpost to further opportunities.

The ECE Co-ordinator supports over 90 providers throughout the area, offering professional development opportunities and advice and guidance on activities to meet children’s learning needs. There is a budget for tutors who are able to offer specific skills to settings; for example, an outdoor area tutor supports families at Kawerau community playgroup to develop their garden to grow vegetables. Their Early Years Services Hub (EYSH) is based in Murupara and also houses adult learning and the Home Instruction for Parents and Preschool Youngsters (HIPPY) project. The Opotiki and Kawerau buildings are home to Heartlands Services which provide an opportunity for community members to access government services and local information, particularly in rural areas. Both of these buildings also offer space for adult learning courses and the voluntary Justice of the Peace service, and in Kawerau the Safer Kawerau Kids Injury Prevention Project (SKIP).

Seventy Core Services of Early Years Services Hubs (EYSH)

1. Antenatal services
2. Well Child – Tamariki Ora programme
3. Early Childhood Education Programme
4. Parenting information, education and support
5. Home visiting including access to programmes where appropriate
6. Supported referrals to off-site services
7. Outreach to engage with and retain the target group

In Murupara, the co-ordinator has developed an Early Years Reference Group to bring together all partners working with young children to aid information sharing, planning and peer support. At the EYSH in Levin, midwives and Hono Wahine (who provide pregnancy and breastfeeding information) are co-located at the hub and the hub steering group includes members of other organisations from the community such as Levin Childbirth Education. Families are supported throughout the early years of childhood in the one physical space where they can access antenatal care from midwives through to breastfeeding and parenting support.

Servicing the needs of a vulnerable child requires a multi-disciplinary approach with holistic case management..... Co-locating and integrating existing services at one site leads to more effective service delivery and reduces the risk of a child ‘slipping through the crack’. (Minderoo, 2014: 16)

QUALITY AND CONSISTENCY OF PRACTICE WHEN WORKING WITH VOLUNTEERS

At Great Start Taita, volunteers play a key role in the delivery of services, offering a toy library, a $1 car ride scheme, Koha café, admin support, handyman services, a food co-op, and photography services. A team member has recently been appointed to the role of Volunteers’ Co-ordinator in recognition of the importance of recruiting, training and supporting volunteers to take ownership of services. The success of this nurturing relationship is seen in Great Start’s breastfeeding support service which has now developed and moved out of the hub to become a charitable trust in its own right. The service continues to have a reciprocal relationship with Great Start which offers a space to hold regular breastfeeding network meetings.

My Fellowship travels have helped me to see the importance of early years’ professionals working to enhance the social capital present in communities and empower families to deliver their own universal services. However, for this to work effectively, community members must be supported with a physical base, training, resources and ongoing support.
Recommendations for the development of Family Centres:

a. Communities must retain access to universal services within a central Children’s Centre building to ensure there is no stigma attached to Children’s Centre support and so that early difficulties can be identified and appropriate interventions offered to families.

b. Transition universal services into community delivery models

c. Develop a clear training and support programme for volunteers and community members covering group delivery models as well as ensuring consistent advice and guidance for families

d. Develop the potential of Children’s Centre buildings as community hubs for delivery of services, a one-stop shop for information and advice, and as a space for training and meetings to integrate all services for families

e. Improve community consultation, focusing on ascertaining the views and experiences of all residents.

For more information about the Winston Churchill Memorial Trust Fellowships, please go to: http://www.wcmt.org.uk/

REFERENCES


In England, kinship care is defined as: ‘relatives, friends and other people with a prior connection with somebody else’s child who are caring for him or her full-time’ (Department for Education (DfE) 2011:4). However, this one-dimensional statement implies that entering into kinship care is something to be taken in one’s stride; it gives no hint of the frequently complex and traumatic events culminating in a family crisis, which does not end when kinship care begins. Nor does it cover all eventualities; for example, we found grandparents attending a support group for kinship carers in Worcestershire, UK, who had become kinship carers to two grandchildren, the existence of whom they had previously been unaware.

It was with this Worcestershire group of kinship carers that we became involved, responding to a request from the chairperson of the support group to discover what the parenting needs of kinship carers are. The group meets for two hours every month in a community centre; there are about 20 regular attendees and others attending intermittently depending on their need and commitments. Owing to the fact that many kinship arrangements are informal, the exact number of kinship families is difficult to estimate. The Family Rights Group (Richards & Tapsfield, 2003) suggests that there are probably between 200,000 and 300,000 children living in kinship care in the UK (Nandy, 2011). By far the majority of cases begin as a result of a family crisis (Broad, 2004), including family breakdown (DFSF, 2010), parental substance abuse (Aldgate, 2009), incarceration (Department for Children, Schools and Families (DCSF) and Ministry of Justice, 2007) and the death of one or both parents.

A definition of the term ‘kinship carer’ is not easy to pin down. In Western countries, the word ‘kin’ is generally associated with biogenetic inheritance: shared blood. In other parts of the world, ‘kin’ is interpreted more flexibly and concerns ‘clanship’, where children may be brought up by godparents, friends and neighbours as well as family (Nandy et al., 2011). It is a term which is becoming increasingly recognised as the needs of this group of people come to the attention of politicians, multi-professionals and the general public.

Keywords: kinship carer, parenting, complex needs, multiple adversities

(All names used in this article have been changed to protect the identity of the people concerned.)

### Diane’s and Mike’s Story
Diane had recently returned to work after retraining as a secondary school teacher. She and her husband, Mike, were beginning to enjoy expensive holidays with their three teenage children as well as growing independence as a couple again. This all changed when their 16-year-old daughter, Georgia, became pregnant. When the baby was born, Georgia found it difficult to cope and Diane and Mike found themselves caring for him for longer and longer periods. Initially this was on an informal basis; however, Georgia began a relationship with a new boyfriend and became pregnant for a second time. Unfortunately, her new partner introduced her to drugs. The police became involved and Georgia was charged with drugs related offences. It seemed likely that the baby would be taken into care so Diane and Mike began the process of applying for a Special Guardianship Order (SGO) to enable the children to live with them permanently. Although they were eventually successful, going through the long assessment process proved very stressful; old wounds, such as bereavement and divorce, were re-visited with no support, leaving Diane and Mike feeling vulnerable and powerless. Parenting for a second time round was a very different experience from the first time, not least because their grandchildren had both been born with Foetal Alcohol Disorder, Attention Deficit Hyperactivity Disorder and had also developed Attachment Disorder. The combination of teenagers, and a young baby and toddler with these conditions, all living together, placed strain on the whole family.
Looking back, Diane and Mike would not hesitate to take the same decision again, and are quick to outline the rewards they receive from being kinship carers. In line with other kinship carers who talk of the positives of kinship care, they mention the relief in knowing that the children are safe and cared for by family. They feel tremendous pride when the children do well and achieve significant milestones and goals (Langosch, 2012; Wellard, 2011); however, they also acknowledge that these benefits come at a high cost.

**Mental Health of Kinship Carers**

Society traditionally associates the role of grandparent with one of indulgence, so grandparents who are also kinship carers often feel that their role is ambiguous, neither parent nor grandparent, necessarily taking on the role of disciplinarian rather than lenient grandparent. Adjusting long-held assumptions of an anticipated future to a new, frequently bleak reality can provoke feelings of grief and despair. A combination of all these issues commonly leads to depression (Dunne & Kettler, 2008; Minkler, 1999) and puts strain on relationships (Selwyn et al., 2013; Wellard, 2011; Farmer, 2009).

In addition to the depression caused by financial issues, isolation and caring for a child with additional needs, kinship carers also frequently suffer from illness and conditions attributed to increased stress brought about by their situation (Purcel et al., 2014; Mukherjee et al., 2013; Harnett et al., 2012; Leticq, 2008). As well as caring for the children, kinship carers are also often caring for other relatives and/or trying to negotiate equitable relationships with their other children and grandchildren, contributing further to a sense of loss of self and exhaustion. However, their own emotional and physical health needs are rarely able to take priority (Wellard, 2011).

It is clear that kinship carers face multiple adversities and have complex needs, defined as presenting both breadth and depth in terms of scale and difficulty (Rankin & Regan, 2004). A protective factor, commonly described as a ‘lifeline’ by many individual kinship carers whom we spoke to, was attending the support group meetings. Whilst there, they experienced relief as they found acceptance and understanding. Being with others who share their situation and can truly empathise may well make the difference as to whether kinship carers cope or not (Langosch, 2012). Such groups could provide one strategy for enabling the success of a kinship care placement.

**Financial Pressures**

Issues facing the kinship carers in the support group we visited are similar to those reported in the literature. Financial difficulties caused by high legal bills, as well as additional incidental expenses, such as buying toys and clothes for the children, put financial pressure on families (Gautier & Wellard, 2014). Unlike foster carers, kinship carers are not entitled to any payments or additional state benefits such as adoption leave or the Pupil Premium (Gautier & Wellard, 2014). These financial difficulties are frequently exacerbated by the need for at least one of the carers to leave their job in order to care for the children, resulting not only in a short term loss of income, but also loss of employer pension contributions and the depletion of personal savings in the longer term (Farmer, 2009). This often leads to personal debt, and in the case of grandparent kinship carers, debt occurs at a life stage where there is little opportunity to replenish funds, which can lead to poverty, isolation and other adversities (Wellard, 2011). Less tangibly, the kinship carer may also lose social support and esteem when they leave employment.

**Isolation**

A lack of disposable income to pay suitable baby-sitters can intensify feelings of isolation (Farmer, 2009) as kinship carers single-handedly face the challenge of caring for children who are still suffering the after-effects of neglect, abuse and addiction. Gautier and Wellard (2014) report that 59% of kinship carers are caring for a child with a special need or disability, whilst 48% are caring for children with emotional and behaviour difficulties, significantly increasing stress levels, particularly in older kinship carers (Mukherjee et al., 2013). This is compounded by the fact that their contemporaries ‘have time, money and grown-up kids’, whereas kinship carers have ‘no time, no money and loads of kids’ (Gautier & Wellard, 2014:19). Kinship carer isolation is often intensified as they find they have little in common with first time parents seeking friendship at the school gate.

**Kinship Carers Face Severe Financial Pressures and Are Unsupported by the State**

Kinship carers often have neglected physical and emotional needs

Due to the unexpectedness of becoming a kinship carer, many feel resentment that they have found themselves in a position that they neither wanted nor anticipated (Harnett et al., 2012, Langosch, 2012). In psychological terms, when individuals compare the justice of their own situation with the perceived justice of others’, perceived lack of parity produces feelings of anger and resentment (Stets, 2003, cited in Backhouse & Graham, 2012). Combined with the other
stresses experienced by kinship carers, there is a danger that they could succumb to a mind-set of learned helplessness (Dweck, 2000). This not only adversely impacts on the kinship carers’ mental and physical health, but also on the child’s (Farmer, 2009). Poelmann et al. (2008) found that depressed kinship grandparents were more likely to have grandchildren with challenging behaviour. The opposite was also true; that is, kinship grandparents who were not depressed and were able to be warm and affectionate did not report significant behaviour concerns.

MEETING THE NEEDS OF KINSHIP CARERS
Fostering a culture of empowerment, maximising the social capital benefits of the kinship carer group and working within a community strengths model were our aims in supporting the group to put together a programme of events for their monthly meetings designed to meet the specific educational and support needs of kinship carers. We identified three areas as critical: practical needs, emotional needs, and support with parenting issues.

PRACTICAL NEEDS
There is a clear need for input at the kinship carer group on how to access legal guidance and other practical advice. The group has already enlisted the expertise of a fuel and energy advisor to help members secure the best gas and electricity tariffs and have established a good relationship with solicitors who have expertise in kinship cases.

EMOTIONAL WELL-BEING
Supporting the emotional well-being of kinship carers and decreasing their susceptibility to self-neglect have been addressed by running sessions on such things as the importance of finding time to eat well and take regular exercise. To prevent isolation and loneliness, trips for kinship families have taken place to the seaside and Harry Potter World. The camaraderie during these visits extends beyond the day itself, providing both eager anticipation of a shared positive experience with others who understand, and happy memories contributing to the feeling of belonging, so important for well-being.

PARENTING
Attachment-based behaviour management techniques have been shared in a session run by a specialist consultant and have proved very effective. Other sessions have focused on how to support children with Foetal Alcohol Syndrome, Attention Deficit Hyperactivity Disorder, Asperger’s Syndrome and other chronic health conditions. When kinship carers experience success in dealing with the children, the benefits are bi-directional and a positive cycle begins.

FUTURE DIRECTIONS
More targeted emotional support needs to be given, particularly in the early days of new placements where stress levels are at their peak (Leticq, 2008; Leder et al., 2007). In future, experienced members of the kinship care group could be trained as mentors to support new carers; this would help alleviate the perceived lack of visibility and support from multi-agency professionals and society as a whole (Hughes et al. 2007), as well as prevent burn-out for the leaders in the organisation.

The further development of sessions for kinship carers will go a long way in enabling them to cope on many levels. This is important because, if all goes well with kinship placements, studies show that children have better long-term outcomes than those in foster care (Montserrat, 2014; Harnett, 2012; Wellard, 2011; Farmer, 2009; Backhouse & Graham, 2006) particularly when instigated at a young age (Palacios & Jimenez, 2009). However, in the short-term, nearly half of kinship carers report having difficulty coping with the children they are looking after, compared to one third of foster carers (Farmer, 2009). This suggests that support for kinship carers is not given the same priority as for foster carers as is borne out by UK national findings which reveal that, at best, support for kinship carers is inconsistent (Hunt, 2008).

Kinship carers seek legal advice, help with family budgeting and parenting guidance.

Some members of the group have been trained by the Citizens’ Advice Bureau to enable them to answer commonly occurring queries. This ensures that the community strengths model is sustainable. A local kinship carer web page now has details of items for sale that enable new kinship carers to purchase items such as car seats quickly and at a low cost, whilst also benefitting the seller with some additional funds.

Timely support for kinship carers may prevent placement breakdown and further trauma to the children

There is a limit to how much can be achieved even with a very strong network of support and many kinship carers report being close to breaking point, particularly in the short-term (Farmer, 2009). Given that 61% of service providers contacted by kinship carers are those in health or education (Selwyn et al., 2013), it is important
that these professionals should be trained in the needs of kinship carers and in the issues associated with kinship care, as well as learning how to recognise when a placement is at risk of deterioration. Better education and understanding would enable timely intervention and multi-agency support on the family’s behalf to prevent further trauma for both the kinship carer and the child.

REFERENCES


Focus on Peer Support Organisations

Australian Breastfeeding Association counsellors: Providing mother-to-mother peer support for more than 50 years

Susan Tawia
Manager, Breastfeeding Information and Research, Australian Breastfeeding Association

More than 50 years ago, on 13 February 1964, Mary Paton hosted a meeting with five other women committed to breastfeeding. These women were the founding mothers of the Nursing Mothers’ Association, now known as the Australian Breastfeeding Association (ABA).

From its beginnings in suburban Melbourne, the Australian Breastfeeding Association has grown into a national organisation dedicated to the support of breastfeeding mothers and babies. The Association’s strong practical support and advocacy for mothers wanting to breastfeed their babies has been credited with increasing breastfeeding rates in Australia substantially since the 1960s and 1970s (Gruszin et al., 2012).

Today, ABA is one of the largest volunteer organisations in the country, with more than 1,000 volunteers (counsellors and community educators) providing valuable mother-to-mother peer support, information and assistance to breastfeeding mothers around Australia. Our volunteers are our greatest resource.

Breastfeeding is important
Breastmilk contains all the requirements for a baby’s development for the first six months and remains the most important part of a baby’s diet, with the addition of family foods, until around 12 months. It continues to be a valuable source of nutrition and immunological protection for two years and beyond. Breastfeeding forms an important part of a mother’s and her child’s physical and emotional wellbeing for as long as the child breastfeeds (Australian Breastfeeding Association, 2013).

In 2016, powerful evidence was published by ‘The Lancet’, which stressed the importance of breastfeeding, to both mothers and babies, including those in high-income countries like Australia (Vitoria et al., 2016). Key messages around child and mother health included:

‘Children who are breastfed for longer periods have lower infectious morbidity and mortality, fewer dental malocclusions, and higher intelligence than do those who are breastfed for shorter periods, or not breastfed. This inequality persists until later in life. Growing evidence also suggests that breastfeeding might protect against overweight and diabetes later in life.

Breastfeeding benefits mothers. It can prevent breast cancer, improve birth spacing, and might reduce a woman’s risk of diabetes and ovarian cancer (p476).

History of Breastfeeding in Victoria, Australia
Victoria is a state of Australia with a current population of almost 6 million people (see Figure 1). It occupies the south east corner of the continent and covers 227,600 km² – about the same area as England, Wales and Scotland.

Figure 1. Australia with the state of Victoria highlighted

Mary Paton played a pivotal role in the founding of the Nursing Mothers’ Association (now the Australian Breastfeeding Association) from 1964 to 1975. She established a network of discussion groups that provided ‘mother-to-mother’ breastfeeding support to thousands of women.

The Australian Breastfeeding Association’s vision is that breastfeeding should be recognised as important by all Australians and become the cultural norm. Its mission is to be Australia’s leading authority on breastfeeding and to support, educate and advocate for a breastfeeding inclusive society. This article explores the history of the Association, how its peer supporters are trained and the work in which it is currently engaged.

Keywords: peer support, mother-to-mother support, counselling, breastfeeding, Australia
Victoria is unique because breastfeeding statistics have been routinely collected here every year for 65 years by the Victorian Maternal and Child Health Service since 1950, and additional breastfeeding statistics are available since 1944 (Figure 2). Such comprehensive statistics are not available for the whole of Australia, but it is reasonable to assume that the Victorian results are indicative of breastfeeding rates Australia-wide.

It can be clearly seen that after the post-war period, breastfeeding rates were high and plunged to very low levels in the 1960s and early 1970s. Rates then climbed steadily through the 1970s, reaching their highest levels since the post-war period in the late 1980s and early 1990s.

ABA IS IMPORTANT

The work of ABA is vital as it provides a dependable and accessible source of accurate breastfeeding information and offers a support network for breastfeeding mothers and their families. ABA informs and supports them in their decision to feed their babies naturally, giving them the knowledge and confidence to do so successfully. In addition, ABA acts as a lobby group, to ensure that government policies reflect the needs of families.

ABA counsellors help thousands of mothers every year. They know that breastfeeding is not always easy. Their knowledge and experience can reassure mothers and help them to understand how breastfeeding works. Counsellors continually update their breastfeeding knowledge and counselling skills. However, they are not medically trained and cannot give medical advice. Their areas of expertise are breastfeeding management and mother-to-mother support.

ABA’s National Breastfeeding Helpline operates 24 hours a day, seven days per week and the number of calls received each year now exceeds 80,000. It is staffed by ABA’s volunteer counsellors who take calls on a roster system. Calls are routed via the 1800 telephone number to counsellors volunteering from their home: a virtual call centre. The National Breastfeeding Helpline is supported by funding from the Australian Government.

Behind the scenes, ABA counsellors and other volunteers run local groups around Australia, run breastfeeding education classes for parents and seminars for health professionals, give talks about breastfeeding at hospitals and schools and provide an email counselling service for members. They host baby-change tents at community events and assist at pregnancy, newborn and toddler expos and shows, and hire out electric breast pumps. They produce ABA’s printed and electronic publications, maintain ABA’s website, moderate ABA’s forum and ensure ABA is financially secure. They work with governments at all levels to advocate for breastfeeding women and their families (Barnard & Twigg, 2014).

Figure 2. Victorian breastfeeding rates from 1944 to 2015. Data presented are the percentage of fully-breastfed infants at 3 months and 6 months, according to the definition used by the Victorian Maternal and Child Health Service. Prior to 1995, breastfeeding indicators were not clearly defined by the Victorian Maternal and Child Health Service, but from 1995 a fully-breastfed infant was defined as an infant who does not regularly (at least once a day) receive any milk other than breastmilk, but may receive some solids. Source: Victorian Maternal and Child Health Service. http://www.education.vic.gov.au/childhood/providers/support/Pages/mchannualreportarchive.aspx
FOCUS ON PEER SUPPORT ORGANISATIONS

HISTORY OF THE AUSTRALIAN BREASTFEEDING ASSOCIATION [NURSING MOTHERS’ ASSOCIATION OF AUSTRALIA, (NMAA) AND NURSING MOTHERS’ ASSOCIATION (NMA)]

MILESTONES

1960s
- First meeting at Mary Paton’s home in Melbourne, Victoria (1964)
- Talks given to Victorian Medical Women’s Society and women’s groups
- Constitution adopted
- Code of ethics adopted
- Counsellor training system introduced
- Talks given to Victorian Infant Health Sisters’ seminar and mothers in baby health centres (Infant Health Sisters is an old term from the 1960s - now called Maternal Child Health Nurses)
- Research department began collecting breastfeeding information from Australia and overseas
- First group leaders/counsellors qualify
- Increase in breastfeeding rates in North Melbourne attributed to NMA in Melbourne City Council Medical Report
- First information booklets published

1970s
- First press photograph of white Australian woman (NMAA member) breastfeeding
- British actor, Derek Nimmo, wears NMAA skivvy, pictured in a Melbourne newspaper
- Two percent increase in Victorian breastfeeding rates – NMAA credited
- Participation in Home Economics schools program commenced
- ‘Successful Breastfeeding’ by member, Virginia Phillips, published – the first book on breastfeeding written by an Australian
- Commonwealth Hospitals and Health Services Commission grant to support training
- Telephone counselling roster begins
- Founder, Mary Paton, awarded the medal of the Order of Australia
- First National Mothering Week held
- ‘The Breast Atlas’, a world first, published
- NMAA’s first film made: ‘Breastfeeding – What a beautiful thing to do’

1980s
- NMAA assisted with Australian submission to WHO’s International Code of Marketing of Breast-milk Substitutes
- UNICEF asks NMAA to act as Code ‘watchdog’
- NMAA’s professional journal, ‘Breastfeeding Review’, first published
- ‘Supply line’ developed and produced
- 18,000 current members
- Annual ‘Mary Paton Research Award’ instigated to stimulate research into lactation
- ‘Baby Care Room’ awards launched
- Community Educator position developed
- Lactation Resource Centre set up
- NMAA counsellors throughout Australia received 17,500 calls in one month
- 1,625 counsellors, 560 groups

1990s
- ‘Breastfeeding Management in Australia: A reference and study guide’ published
- NMAA joins ‘Baby Friendly Hospital’ Initiative
- 1,500 counsellors handle 276,000 phone calls per year
- NMAA ‘Mother-Friendly Workplace’ Initiative begins
- NMAA ‘Breastfeeding…naturally’ published
- NMAA Breastfeeding Consultancy Services created to provide expertise to government and business
- Telephone roster renamed Breastfeeding Helpline
- Each counsellor spends an average of nine hours per week on NMAA activities
- Email counselling offered to mothers

2000s
- Launch of ‘Breastfeeding Mothers Welcome Here’ stickers
- Name change to Australian Breastfeeding Association
- Commonwealth funding for training, continuing education for counsellors and ‘Breastfeeding Confidence’ booklet, targeting parents of infants aged 0-3 months, published
- ABA online forum begins
- Flexible online training meetings available to all trainers and counsellors
- Mary Paton named a Living National Treasure
- ABA awarded Registered Training Organisation (RTO) status
- Breastfeeding-Friendly Workplace Accreditation (BFWA) established
- Additional RTO course – Certificate IV Training and Assessment
- Vision and mission statements revised to include ‘breastfeeding for two years and beyond’
- More than 40 organisations BFWA accredited
- First two RTO courses accredited – Certificate IV in Breastfeeding Education (Counselling) and Certificate IV in Breastfeeding Education (Community)
- Federal government provides $2.5 million to fund National Helpline
- National Breastfeeding Helpline: 1800 mum 2 mum (1800 686 2 686) begins for Australian mothers

2010s
- ‘Baby’s Day Out’ introduced as a breastfeeding in public annual event
- More than 3,500 venues accredited for ‘Breastfeeding Welcome Here’
- Diploma of Breastfeeding Management introduced for health professionals
- Over 7,000 National Breastfeeding Helpline calls a month answered by counsellors
ABA VOLUNTEER COUNSELLOR TRAINING: CERTIFICATE IV IN BREASTFEEDING EDUCATION (COUNSELLING)

To become an ABA counsellor, women must have breastfed at least one baby for six months. They have to hold a Certificate IV in Breastfeeding Education (Counselling), complete ongoing training to update their breastfeeding knowledge and counselling skills and complete a supported practicum on the National Breastfeeding Helpline with an allocated volunteer mentor.

Since the beginning, ABA has trained counsellors, but in 2005, ABA became a Registered Training Organisation meaning it could offer formal training and nationally-accredited courses. It developed the Certificate IV in Breastfeeding Education (Counselling) specifically to ensure that ABA counsellors have the skills and knowledge to undertake the full range of ABA work, including peer-to-peer support.

The Certificate IV in Breastfeeding Education (Counselling) is free except for a small, one-off administration fee and the cost of the Learner Guides (some of which are available electronically). This is because ABA counsellors agree to volunteer for two years with ABA after they have qualified. Much of their volunteer time will be taken up on the National Breastfeeding Helpline, although there are face-to-face counselling opportunities at local ABA group meetings, ABA breastfeeding education classes and at pregnancy and baby expos and shows.

The Certificate IV in Breastfeeding Education (Counselling) provides the skills an ABA counsellor needs to provide breastfeeding information, to educate groups about breastfeeding, to advocate for breastfeeding mothers and to run local ABA groups as well as counsel individual mothers. It requires a substantial investment of time, with most women completing it in around 18 months to two years.

The skills and knowledge identified in the three units of the Certificate are typically required by ABA counsellors for competent workplace performance of breastfeeding counselling. The units also support the skills of counsellors who prepare and deliver breastfeeding education and information sessions, facilitate group discussions, counsel breastfeeding parents and manage the hire of breast pumps within ABA.

The ABA trainers who deliver and assess the units in the Certificate IV in Breastfeeding Education (Counselling) are all volunteers who hold a Certificate IV in Training and Assessment (TAE) and a Certificate IV in Breastfeeding Education.

ABA trainees are situated all around Australia, so training is flexible and can be undertaken in several ways, including self-paced learning using learner guides, face to face or online (chats, Skype, Zoom).

FOCUS ON PEER SUPPORT ORGANISATIONS

THE COUNSELLING UNITS OF THE CERTIFICATE IN BREASTFEEDING EDUCATION (COUNSELLING)

ABA BREASTFEEDING COUNSELLING IS BASED ON THE ROGERIAN MODEL OF COUNSELLING

Work within the breastfeeding counselling process

- theories underpinning the counselling model
- stages in the counselling process
- applying the duty of care in the counselling process
- limitations of the breastfeeding counselling model
- developing the attitudes and attributes appropriate for breastfeeding counsellors such as unconditional positive regard
- seeking feedback on communication and recognising barriers
- reviewing your counselling skills and practice.

Facilitate breastfeeding counselling

- creating rapport with mothers through active listening and empathic communication
- explaining the principles of lactation and the normal behaviours of the breastfed infant to mothers
- using questioning, suggestions and positive reinforcement
- enabling mothers to make confident and informed choices
- referring mothers to other sources of help when required
- providing information, explanations, suggestions and resources.

Empower mothers through breastfeeding counselling

- assisting mothers to develop their own strategies
- offering suggestions using mother-to-mother language
- providing support for mothers in their decision-making
- reviewing the situation to assist in clarifying and deciding on strategies
- referring mothers when required
- offering ABA’s resources and services
- reassuring and encouraging mothers to trust their own ability to manage the breastfeeding situation
- summarising and closing the session.
VOLUNTEERING ON THE NATIONAL BREASTFEEDING HELPLINE

A large part of the work of an ABA counsellor is staffing the National Breastfeeding Helpline which receives an average of 7,000 calls a month, about 84,000 a year.

Who is calling?
- mothers (98%)
- aged between 30 and 34 who live in a metropolitan area (78.8%)
- with one child (67.6%)

How often are they calling?
- 85% of callers called on more than one occasion in a three-month period

Satisfaction
- 89.5% agreed that the counsellor empathised with their situation

Why are they calling?
- See Table 1 for results of the 2013 National Breastfeeding Helpline survey.

TABLE 1: RESULTS OF THE ABA 2013 NATIONAL BREASTFEEDING HELPLINE CALLER SURVEY (YATES, 2014)

<table>
<thead>
<tr>
<th>Reason for calling</th>
<th>%</th>
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<tbody>
<tr>
<td>Sore breasts or nipples</td>
<td>30.8</td>
</tr>
<tr>
<td>Concern with low milk supply</td>
<td>16.5</td>
</tr>
<tr>
<td>Baby refusing the breast</td>
<td>16.5</td>
</tr>
<tr>
<td>Expressing and/or storing expressed breastmilk</td>
<td>16.5</td>
</tr>
<tr>
<td>Positioning and attachment</td>
<td>11.5</td>
</tr>
</tbody>
</table>

In 2013, the total number of hours given by volunteer counsellors on the National Breastfeeding Helpline was 32,000. The average number of hours that each counsellor gave was 48. And the volunteer contribution required to provide and maintain the National Breastfeeding Helpline in 2013 was equivalent to just over AUD $1 million (Yates, 2014).

Volunteers’ Feedback

‘ABA and breastfeeding in general need all the publicity, support and promotion we can provide. Bearing in mind that ABA is a not-for-profit association and that all our breastfeeding counsellors are volunteers, giving my personal time to such an organisation just makes sense. Volunteering with ABA is a very rewarding experience. Breastfeeding is a passion for most of the people involved with ABA. It’s great to spend time with like-minded people and I feel as though I’m doing something important. Volunteering for ABA has given me a purpose (other than mothering) during my leave from paid work and as I feel so passionately about breastfeeding, it gives me a sense of satisfaction to know I’m doing my part to promote, support and encourage breastfeeding as the most normal and beneficial way to feed your baby.’ (Belinda, Melbourne)

‘I am a midwife and I am passionate about breastfeeding. As a breastfeeding mother, I would like to share my breastfeeding experiences with other mothers on their breastfeeding journey. Also, I am happy about volunteering as it is a way to contribute to the community. When I am involved with ABA, I am comfortable and feel supported. Being involved with ABA has helped me to understand that sometimes things do not go according to plans (i.e. breastfeeding). The life experience has made me more knowledgeable to contribute to my work. I have learnt a lot of things, and get pleasure from helping the group and friendships.’ (Louise, Sydney)

Growing the Next Generation of Volunteers

The 2010 Australian Bureau of Statistics General Social Survey found that whether a person does any voluntary work may be influenced by their parents’ volunteering behaviour. National Breastfeeding Helpline counsellors volunteer in front of their children, in their own homes, every day. They are the model of volunteering... combining mothering and volunteering. They are looked upon by their children as generous, kind and supportive people, there to give to others. ABA counsellors are nurturing our next generation of volunteers, every day, in their own homes.

Further Information

For more information about the Australian Breastfeeding Association, please visit: www.breastfeeding.asn.au

References


EARLY PLANNED BIRTH AND POOR CHILD DEVELOPMENT

Q. How can we discuss the benefits of ‘waiting’ for labour to start?

In recent years, there have been significant changes in obstetric practice resulting in an increase in planned births before the ideal time of birth at 39-40 weeks’ gestation. This is mostly attributable to the increased use of elective caesarean section and induction of labour. In a study of 153,000 Australian children, infants born following planned birth before 39 weeks were more likely to show poor development. Children in the study were assessed in five domains: physical health and wellbeing, language and cognition, social competence, emotional maturity, and general knowledge and communication. Compared to children born vaginally following spontaneous labour, the combined adjusted relative risk of a child being ‘developmentally high risk’ was 26% higher for a planned birth at 37 weeks and 13% higher at 38 weeks. This is after taking account of other important factors associated with poor child development such as socioeconomic disadvantage, lower maternal age, maternal smoking in pregnancy and fetal growth restriction. The researchers advise that the benefits of waiting for labour to start spontaneously should be communicated to clinicians, mothers and families.


VACCINATING BABIES WITHOUT VACCINATING BABIES

Q. How do we explain the immunological benefits of breastfeeding?

Scientists have long understood that mother’s milk provides immune protection against some infectious agents through the transfer of antibodies, a process called ‘passive immunity’. A research team at the University of California has now shown that mother’s milk also contributes to the development of the baby’s own immune system. Specific maternal immune cells in the milk cross the wall of the baby’s intestine to enter the thymus. Once there, they ‘educate’ developing cells to attack the same infectious organisms to which the mother has been exposed. The research, using mice, has important implications for vaccinating newborn babies. The researchers show that you can vaccinate the mother and this results in vaccination of the baby at the same time, if the mother is breastfeeding. Some vaccines are not safe to give a newborn baby and others don’t work very well so if the mother can be vaccinated or have her vaccinations boosted shortly before she becomes pregnant, immune cells transferred during breastfeeding will ensure that the baby is protected early on. The team’s work with mice has shown that immunity against TB is far more effective if acquired through breastmilk than through direct vaccination of the baby. Clinical trials now need to be conducted to test whether this is the case in humans.

Read more: https://ucrtoday.ucr.edu/40174

WINTER CONCEPTION RAISES DIABETES RISK

Q. How can we increase understanding of gestational diabetes?

Australian research has found that women whose babies are conceived in winter are more likely to develop gestational diabetes during pregnancy. The study which investigated more than 60,000 births in South Australia over a five-year period is the first population-based study of its kind to confirm a seasonal variation in gestational diabetes. Gestational diabetes mellitus is a serious pregnancy complication characterised by inadequate blood sugar control. Complications include excessive birth weight, pre-term birth, low blood sugar (which, in extreme cases, can lead to seizures in the baby), and developing Type 2 diabetes later in life. The study found that in the five years from 2007-2011, the incidence of pregnancies affected by gestational diabetes increased, with 4.9% of pregnancies affected in 2007 and 7.2% in 2011. Women who conceived in winter were more likely to develop gestational diabetes during their pregnancy, with 6.6% of pregnancies from winter conceptions affected. Only 5.4% of summer conceptions were affected. Previous studies have suggested that meteorological factors, physical activity, diet and vitamin D are risk factors for gestational diabetes, all of which are impacted by the winter season.


Pregnancy Sickness Support

Caitlin Dean, Chairperson of Pregnancy Sickness Support (three times survivor of hyperemesis gravidarum and author of two books on the subject)

Pregnancy Sickness Support is the only UK charity providing information and support to women affected by nausea and vomiting in pregnancy (NVP) and hyperemesis gravidarum (HG). The charity runs a nationwide peer support network, annual conferences and education for healthcare professionals. Referring women affected by NVP and HG to the charity for support can reduce social isolation and improve pregnancy outcomes.

Keywords: hyperemesis gravidarum, nausea and vomiting in pregnancy, pregnancy sickness, peer support

Pregnancy Sickness Support (PSS) was established in 2002 by Dr Barnie-Adshead, his daughter Caroline Adshead and his colleague Dr Gadsby, in response to their recognition that women with pregnancy sickness need support. As a young GP in the 1960s, Barnie-Adshead met a patient with severe nausea and vomiting in pregnancy (NVP) whom he felt powerless to treat with the current range of anti-emetics. During a post-partum appointment, she told him that she could not face another pregnancy and while it broke her heart never to have more children, she would have to accept it. This sparked in Barnie-Adshead, a father himself to two daughters, a passion to figure out why women suffer with pregnancy sickness and what could help. He recruited his trainee GP at the time, Dr Gadsby, to assist on his mission and decades of under-funded, small scale research followed. Between them, they have now published multiple papers on the aetiology and physiology of pregnancy sickness, and have provided the most detailed clinical descriptions of the condition to date (Gadsby & Barnie-Adshead, 2011; Gadsby et al., 2000; Gadsby et al., 1997; Gadsby et al., 1993). Barnie-Adshead’s daughter, Caroline, benefitted from her father’s knowledge and experience when she suffered the severe form of NVP, hyperemesis gravidarum (HG), in the late 1990s. Shortly after this, the three founded the fledgling charity, Pregnancy Sickness Support, to provide information and support to women experiencing any level of pregnancy sickness.

In 2011, the Peer Support Network (PSN) was launched, along with the new website. A woman could email via the website or leave a message on the helpline and later be matched with a peer supporter in her area. Thanks to the immense power of social media, demand for the PSN grew rapidly. By the start of 2013, it

Table 1. Pregnancy Sickness Support: Aims

- To develop a help line to give information and support.
- To produce leaflets to explain about pregnancy sickness with helpful information for sufferers and carers.
- To offer information about treatments available for pregnancy sickness and hyperemesis gravidarum.
- To inform and educate doctors and health care professionals.
- To raise awareness of pregnancy sickness and hyperemesis gravidarum amongst the general public through articles and information.
- To encourage further research into the condition, its impact and treatments.

In December 2011, the Peer Support Network (PSN) was launched, along with the new website. A woman could email via the website or leave a message on the helpline and later be matched with a peer supporter in her area. Thanks to the immense power of social media, demand for the PSN grew rapidly. By the start of 2013, it
was necessary to employ a part-time member of staff to run the helpline and match women with peer-supporters, and in 2014, a database was developed, guidelines and policies established and management of the PSN was formalised. There is now a full-time employee working on the helpline which is answered during office hours (with an answerphone facility for out of hours), managing a network of over 230 volunteers across the UK.

In 2016, we received over 800 calls to the helpline. Around 50% of those who phone wish to be matched for peer support and feedback is overwhelmingly positive.

WHY IS PEER SUPPORT NEEDED?
HG and indeed NVP beyond the normal level of ‘morning sickness’ (an infuriating term belittling the experience of pregnancy sickness, which is rarely confined to the mornings), are debilitating conditions (Poursharif et al., 2008; Meighan & Wood, 2005; O’Brien et al., 2002). Despite high quality literature describing the significant impacts on quality of life dating back to O’Brien and Naber (1992) the condition is still under-acknowledged and heavily stigmatised (Dean, 2016). Women with HG, and indeed those who experience severe NVP without ever receiving diagnosis and treatment, experience a host of biopsychosocial impacts from the condition. Table 2 lists some of the impacts women can experience, and the risks they run, during and after an HG pregnancy.

The UK Royal College of Obstetricians and Gynecologists (RCOG) has now published ‘Green Top’ Guidelines for NVP and HG (Royal College of Obstetricians and Gynaecologists, 2016) with the aim of improving the care and treatment of HG in hospitals. However, none of the treatments currently available, which include drugs such as cyclizine, ondansetron and steroids, provides a cure for the condition for all women. At best, they provide intermittent relief and a reduction in the severity of symptoms; at worst, they provide no relief and add to the woman’s suffering with side effects such as constipation, headaches and drowsiness. Furthermore it remains the case that many women are denied access to treatment, are unaware of their rights and encouraged to terminate their otherwise wanted pregnancies (Dean & Murphy, 2015; Sykes et al., 2013).

HOW PSS HELPS WOMEN
Women or their partners, mothers, friends or other advocates, can call the helpline during office hours to receive evidence-based information about the treatments available, local services such as HG day units, and self-help techniques. The support co-ordinator goes through an holistic assessment of each woman’s biopsychosocial needs and risks and tailors information accordingly. An online chat function was recently piloted on the website for women who feel unable to talk on the phone. The pilot was successful and feedback positive so this is now available for all website users. Additionally, women can make contact via the charity’s social media platforms where they will be directed to phone or email contact. Healthcare professionals are welcome to contact the helpline for information about treatments and we have helped a number of midwives and GPs with ‘tricky cases’ to develop care plans.

For many women, the information provided is enough to enable them to continue their pregnancy, reassured that they are receiving the appropriate treatment, or with a plan for further treatment. Women for whom one-to-one peer support does not appeal, or is not required, can access online peer support via the PSS forum 24 hours a day, seven days a week. The forum is administered by a trustee and moderated by

<table>
<thead>
<tr>
<th>Impacts</th>
<th>Life threatening:</th>
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<tbody>
<tr>
<td></td>
<td>• Deep vein thrombosis</td>
</tr>
<tr>
<td></td>
<td>• Re-feeding syndrome</td>
</tr>
<tr>
<td></td>
<td>• Wernicke’s encephalopathy</td>
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<tr>
<td></td>
<td>• Thyroid toxicosis</td>
</tr>
<tr>
<td>Non-life threatening:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Burst blood vessels</td>
</tr>
<tr>
<td></td>
<td>• Torn stomach muscles</td>
</tr>
<tr>
<td></td>
<td>• Muscle wastage</td>
</tr>
<tr>
<td></td>
<td>• Torn oesophagus</td>
</tr>
<tr>
<td></td>
<td>• Constipation</td>
</tr>
<tr>
<td></td>
<td>• Urinary incontinence</td>
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Fetal impacts:
• Death or termination
• Inter-uterine growth restriction
• Small for gestational dates
• Placental abruption
• Cardio-metabolic disruption in adulthood

(Grooten et al., 2015; MacGibbon et al., 2015; Anaforoglu et al., 2012)

Psychological Impacts and risks
• Post-traumatic stress disorder
• Peri-natal depression
• Anxiety (peri-natal and post-natal)
• Post-natal fear of pregnancy and/or sex
• Post-natal emetophobia

(Christodoulou-Smith et al., 2011; McCormack et al., 2011; Poursharif et al., 2008)

Social Impacts and risks
• Profound social isolation
• Financial hardship
• Employment problems and discrimination
• Relationship problems and breakdown
• Family limitation

(Dean, 2014; Poursharif et al., 2008; O’Brien et al., 2002)
experienced volunteers who have had specific training on forum moderation, thereby ensuring a safe and supportive online environment.

Around 50% of women who call the helpline want to be matched for peer support with PSS volunteers. Peer support volunteers are all women who have experienced severe NVP or HG themselves. Additionally, some volunteers who have not suffered first hand fundraise and undertake other work, and we have a small pool of partners and mothers who have supported a loved one through HG who can provide support to partners and carers. All volunteers are registered and go through a rigorous interview, reference checking and training to ensure the quality and safety of the charity’s peer support. Once a volunteer is matched with a caller, support continues throughout the pregnancy or until the symptoms have resolved. Support can be provided via phone, email or, most commonly, via text message. However, if geography allows and the sufferer requests it, many volunteers will visit women in hospital or at home to provide support. For severe cases in which social isolation is particularly profound, or further mental health complications require additional support, more volunteers are ‘added-in’ to support the woman. Many volunteers are now hugely experienced having supported dozens of women over the years and there are also volunteers with specific skills in bereavement counselling. In the near future, volunteers will be offered additional external training to gain recognised qualifications in a range of volunteering and charity activities such as peer support and counselling, fundraising, public speaking, social media and event management.

Feedback from PSS clients

‘She has been amazing! My peer supporter texts me regularly to see how I’m doing and has given me brilliant advice . . . I know I can always have a vent to her about how I’m feeling without being judged. I will be forever thankful to her.’ – Sufferer 2015

‘My peer supporter has texted many times throughout my pregnancy, mainly to see how I’m feeling. She doesn’t expect a reply or put me under pressure to get back to her. Her advice is second to none, her texts are informative, reassuring and positive. . . . She makes me feel like I’m not alone. She has been through it and takes the horrendous guilt that I have away, especially in relation to having time off work, and having to take medication. This is a lonely illness that very few understand but knowing someone is there that does is support like no other.’ – Sufferer 2016

‘Guiding women through the horrific journey of HG can be so tough. The despair and torture they go through brings it back to me every time. It can be raw and emotional, but to be able to share their journey and have a mutual understanding of their experience is quite special. I’ve found volunteering for the charity quite healing.’ – Volunteer 2016

The feedback received has been overwhelmingly positive. Women are emailed eight weeks after their first contact to request feedback. Many women also write to us after the birth of their baby to thank us for their support. All feedback is audited on a continuous basis and action taken in areas that could be improved, where resources allow. Quarterly feedback is collected from volunteers.

WHAT ELSE DOES PSS DO?

The PSS helpline and PSN are very much at the heart of the organisation but are by no means the only work undertaken by the charity. Trustees are actively involved in numerous internal and external research projects from providing Patient, Public Involvement (PPI) on large randomised control trials such as the Hyperemesis Gravidarum Definition and Core Outcomes research in the Netherlands (Grooten & Painter, 2016), to internal surveys to document the breadth and depth of issues affecting sufferers. PPS has teamed up with Plymouth University and the British Pregnancy Advisory Service (BPAS) to host the second International Colloquium on Hyperemesis Gravidarum in 2017 (details below).

The charity provides training and education for healthcare professionals and can assist maternity and early pregnancy units to establish HG day units and guidelines. The website provides a wealth of information for healthcare professionals with resources for managing HG, research papers and links to guidelines.

Since the condition hit the headlines in 2013 when the Duchess of Cambridge was famously admitted to hospital with HG, the media has taken a greater interest and the charity has been proactive in its response. A powerful media strategy has enabled us to raise awareness among the general public and slowly, the stigma of the condition is being broken down.

The charity’s impressive growth over the last five years has seen it receive a number of awards including the Third Sector Awards Small Charity, Big Achiever; Charity Partnership Award for work with the British Pregnancy Advisory Service (BPAS) and Charity Chair of the Year.

It is sadly unlikely that any significant breakthroughs in curative anti-emetic treatment for HG will occur in the foreseeable future. However, through effective peer support, education, raising awareness, research and collaborative efforts, the trauma and misery of women affected by HG can be significantly reduced and the condition managed more effectively.

Contact details for Pregnancy Sickness Support:

UK Helpline: 024 7638 2020
UK Office number: 01208 872801
Website: www.pregnancy sicknesssupport.org.uk
Email: support@pregnancy sicknesssupport.org.uk
The PSS 2017 International Conference is on the 5-6th October, 2017. For more information and booking please go to: WWW.ICHG2017.ORG
REFERENCES


ENCOURAGING PARENTAL SELF-REGULATION

In the second of our series of teaching activities from ‘Welcome to the World’, the Family Links 8-week Antenatal Nurturing Programme for parents, we look at the importance of parental self-regulation as a first step to encouraging healthy parent-child communication.

In this activity, we’ll be looking at recognising Difficult Feelings and cultivating self-awareness, to encourage self-regulation.

In subsequent issues of IJBPE, we’ll look at the effect of increasing self-awareness on parental relationships, before moving on to look at the long-term effect on the child.

Aims of the What We Do with Difficult Feelings activity

• To raise self-awareness, especially of our feelings or emotions
• To start to recognise how we communicate our feelings in our body language, our tone of voice and our touch
• To identify situations that may trigger strong feelings in us
• To identify helpful – and less helpful – ways to handle uncomfortable feelings
• To model helpful ways to handle feelings to the parent or group – especially when working with parents who have not had a relevant role model

Rationale and Research

• Maternal stress in pregnancy has been shown to have an impact on the developing baby, as well as on perinatal mental health (www.beginbeforebirth.org)
• The Handling Difficult Feelings activity in Family Links ‘Welcome to the World’ programme helps mums and dads recognise that difficult feelings are normal, and that there are ways to manage these feelings that are supportive of their perinatal mental health
• Modelling within the group context supplies a role model that may be absent from some parents’ lives


Continued overleaf
What We Do with Difficult Feelings

Emotions we find difficult or painful can be hard to manage. Here are some ways we deal with them. Which are your preferred ones?

The swirl image in each illustration represents our feelings.

Suppressing
Locking our feelings away, burying them, removing them from our conscious awareness

Bottling up
Holding the feelings inside us; we may become so pressurised we eventually explode

Withdrawing
Hiding away; we may become depressed, or feel paralysed or helpless

Dumping
Blaming others for the way we feel; handing over responsibility for our feelings to others

Acting out
Being taken over by the feelings, often losing control altogether; yelling, being violent

Reflecting
Accepting our feelings without being overwhelmed by them, thinking about them, reframing and resolving them

Expressing
Letting the feelings out; acknowledging them to ourselves (e.g. crying or talking to someone)

Letting go
When we have taken notice of the messages our feelings bring, we can release them

All of these ways of dealing with painful feelings may seem to help at the time but they don’t actually solve the problem, either for us as individuals or in our relationships with other people. They all tend to be destructive. Here are some more constructive alternatives.

It’s a good idea to find as many ways as we can to help us recover from difficult feelings. If we have no way of letting them go, they can pile up until they’re like a big heavy sack we have to carry around with us. This not only feels awful, but is bad for our health, too.
Worrying about worrying:
The importance of compassionate communication

Sally Hogg, Consultant working in Children’s Services and Strategic Lead for the ‘Mums and Babies in Mind’ project

Keywords: mental health, pregnancy stress, information, parent education

In the last edition of this journal, Mary argued that we cannot ignore the knowledge we have about the critical nature of babies’ experiences from conception to two, ‘nor censor it, when sharing it with the people to whom it is most relevant’ (Nolan, 2016). This statement stood out to me as it relates to an issue that has been playing on my mind a lot recently.

My background is in children’s policy and services, and I got involved in work to improve maternal mental health because of the compelling evidence that a mother’s mental state in pregnancy and during the early life of her child can affect her child’s experiences in a way that might have an important and lifelong impact on his or her social, emotional and cognitive development.

I agree with Mary that it is important to raise awareness of this issue: policy makers for example, need to know that the current shortfall in perinatal mental health services is costing £8.1bn for every one year cohort of babies born in the UK. And 75% of this cost is due to the long term effects of untreated maternal mental illness on children (Bauer et al., 2014). Professionals, too, need to realise the importance of supporting the mother-child relationship if a mother is ill, particularly as evidence tells us that reducing mothers’ depressive symptoms alone does not necessarily lead to improvements in the parent-child relationship and children’s outcomes (Center on the Developing Child, 2009).

But whether and how we share this information with parents – and particularly those parents who have lived experience of perinatal mental illness themselves – is a more difficult question.

I was recently at an event where a speaker spoke in strong, uncompromising language about the impact of perinatal mental illness on the mother-infant relationship and subsequent infant development. Her audience included professionals, campaigners and many women with experience of illness themselves. When she used the term ‘failure to bond’, the response in the room was palpable. In a later discussion about the event online, one mother described how the phrase ‘hit me like a ton of bricks’, and another described how the language used could ‘pile on the guilt to already fragile souls’.

So, while we cannot ignore the knowledge we have, we must share it sensitively. It is clearly important that we educate parents, and parents-to-be about the risks, prevalence, and symptoms of perinatal mental illness, and emphasise the importance of seeking help quickly if they get ill. However, our messages about the risks and impacts of this illness on children must be delivered with considerable care. Perinatal mental illness is already an issue surrounded by guilt and stigma. The last thing we want to do is to make vulnerable parents feel bad about feeling bad.

WHEN THE PROFESSIONAL AND THE PERSONAL COLLIDE

When studying the last edition of this Journal – late in the third trimester of my pregnancy - I found myself reading articles in a professional capacity which prompted me to reflect on my personal experiences.

As I read Punamaki-Gitai’s (2016) editorial, for example, on the impact of stress and trauma on women in pregnancy and their infants, I couldn’t help but reflect on how I was managing my own stress (recognising that this could never be even a fraction as serious as anything experienced by the women described in this article.)

There is a lot of research about the impact of stress in pregnancy, much of which has been powerfully communicated by Dr Vivette Glover and her ‘Begin before Birth’ project (www.beginbeforebirth.org). One study, for example, showed that if a mother was in the 15% of the population with the worst anxiety and depression during pregnancy, this doubled the risk of her child having a mental disorder at 13 years of age (O’Donnell et al., 2014). Fifteen per cent is a significant proportion of the population; this isn’t just mums with clinically diagnosed mental health problems.

As a mother-to-be, it is hard to read research like this and not to worry about being worried. But knowledge is also power, and understanding the importance of reducing stress in pregnancy can be an important driver of healthy behaviours. Obviously it’s not always possible for women to reduce their own stress in pregnancy – indeed, often the worse kinds of stress and trauma result from factors outside women’s control - but many women can take some steps to reduce stress in the antenatal period.
In this pregnancy, I’ve been careful to try and keep my stress levels low, particularly at work. Before my last maternity leave, two years ago, I was working very long hours and travelling a lot. My maternity cover was recruited late in my pregnancy and couldn’t start until weeks after my due date, which meant I didn’t have the opportunity to hand over work or wind down. Instead, I ended up working particularly hard in the last few weeks of my pregnancy to ensure everything would be ok in the gap before she started. Learning from this experience, in this pregnancy I took control of the situation. I ensured the recruitment of my maternity cover happened early, and engineered a longer period of handover so that I could start to wind down and be confident that the work would be picked up easily when I left. I still experienced some issues in my last few weeks of work (a toddler illness, the childminder being unexpectedly unavailable and a rail strike), but I felt substantially more relaxed entering my maternity leave, and with more ‘head space’ to think about the arrival of my new baby.

I felt empowered as a result of having taken active decisions to manage my own environment and the pressures on me during my pregnancy, rather than waiting for others to do this for me. This is a stance we should encourage many pregnant women to take. In a trivial, but very common example: I often see pregnant women standing on public transport, and feeling (rightly) aggrieved that no one has given them a seat. I so wish these women could feel confident enough to go and request that someone stands up for them. Birth and parent educators can help to empower women with the knowledge and confidence to look after their wellbeing in pregnancy, and to request other people’s help in this, whether that be employers, family members or strangers on the tube!

**REFERENCES**


Barlow, J. (2016) The persisting effect of maternal mood during the first 1000 days of life, speaking with a united voice about the importance of this life stage, and challenging cuts. Centre on the Developing Child at Harvard University (2009) Maternal depression can undermine the critical nature of the baby’s experiences during the first 1000 days of life…we can neither ignore it, nor…fail to act’ (Nolan, 2016).

Jane’s article described the potential of the 28-week promotional interview – which is specified in the UK Healthy Child Programme – to provide practitioners with an opportunity to explore women’s feelings about the unborn baby. Sadly, very few women receive this antenatal promotional interview. My own ‘28 week’ visit is scheduled for when I am 37 weeks pregnant – leaving a high chance that it might not happen before baby comes, and little opportunity for intervention afterwards if any were needed. Yet I know I am one of the lucky ones; recent research by the UK Institute for Health Visiting (2016) found that only 30% of families receive an antenatal visit from their health visitor. And there are further threats to health visiting: the ring-fence around public health funding in Local Authorities ends in 2018.

I believe that we cannot sit quietly and ignore the current threats to services for families resulting from ongoing cuts to health visiting, children’s centres and the voluntary sector. As I see it, the sector should respond in three ways:

- We must continue to advocate for interventions in the first 1000 days of life, speaking with a united voice about the importance of this life stage, and challenging cuts.
- We must use the evidence to help us to target our limited resources to where we can make most difference, and
- We must use the information we have in a sensitive and compassionate way to empower women and their families to take steps to improve their own lives and those of their children.

As Mary wrote in her editorial, when we consider the knowledge we have regarding the critical nature of the baby’s experiences during the first 1000 days of life…we can neither ignore it, nor…fail to act’ (Nolan, 2016).
DISORGANISED MOMENTS

Even a willing woman, strong in her own birth power, will be challenged at predictable points during the labour. At moments of surging hormones and intensifying contractions, women can become momentarily disorganised. What they’ve been doing in the labour so far is no longer enough to match the ramp-up in intensity. She might fall momentarily into thinking, ‘I don’t think I can’ or ‘I don’t want to’ or ‘I shouldn’t have to’ or ‘I bloody well won’t’. If the birthing woman can’t match, or isn’t supported to match, this increased intensity - this necessary, building functional pain - then this momentary disorganisation can deteriorate into a full-blown crisis of confidence. Especially if she feels she is already at the end of her tether and struggling to cope: then her fears and self-doubts, amplified by the pain-relief birth culture, spread like wildfire in her psyche. Most birthing women, especially in a first labour, irrespective of their intentions beforehand and even if they have diligently prepared, still come up against these crises.

MEDICAL CRISIS VERSUS CRISIS OF CONFIDENCE

When I use the term ‘crisis of confidence’ I am not speaking about a medical, ‘things going wrong’ crisis. I am speaking about a distress response to the intensity of the functional pain of normal birth - hitting a pain barrier, in which the mother’s usual coping strategies and even her well-practised birth skills seem no match for what she is facing. This crisis is not a sign that anything is going wrong. If this is understood and women are well supported, then these crises usually don’t last long. However, these crisis moments are critical, pivotal moments, because the way they are resolved will affect the further course of the labour.

PREDICTABLE CRISIS OF CONFIDENCE POINTS IN LABOUR

I’ve found that there are some predictable times in labour where these crises of confidence usually occur, activated (in the main) by the intensifying hormonal surges that create the potent, deeper, longer, stronger and closer-together contractions that drive the birth process.

CRISIS OF ‘CULTURE CALLING’

Increasingly, more women are experiencing their first crisis of confidence - what I call the crisis of ‘culture calling’ - before they’re even in labour. This is an ‘anticipatory’ crisis. Acculturated fears about pain and danger coupled with socially conditioned ‘pain relief’ attitudes toward controlling or eliminating labour pain, lead to this crisis.

CRISIS OF ‘MIND CALLING’

The next crisis may be experienced at about 1-2cm dilation - the crisis of ‘mind calling’. This is the ‘anxiety’ crisis. The mother’s thinking, worrying brain is still active and may be filled with anxieties and fears about the birth, baby, or the coming life changes. Resistant energy is now in the mix, increasing physical pain through the ‘fear-tension-pain’ response.

CRISIS OF ‘THE BODY CALLING’

The next shift in intensity, which marks the progression from early labour to established labour at around 4-6cm dilation, provides the next likely crisis - the crisis of ‘the body calling’. This is the woman’s challenge of committing to the embodiment of labour. The challenge of committing to feeling her body working. Does she want to engage with the functional pain?

CRISIS OF ‘EVOLUTION CALLING’

Another shift in hormones, experienced around 7cm dilation, drives another major crisis - the crisis of ‘evolution calling’. This is an ‘overwhelm’ crisis. At this stage, the shift in consciousness orchestrated by the endorphins is really driving the evolutionary regression outlined in chapter three. Everything is driven by an urgency and intensity that is becoming impossible to control. Does the labouring woman trust the birthing process with its evolutionary script enough to surrender to it? Can she surrender ego-control and allow this shift in consciousness, this evolutionary regression, to release primal birthing woman?

TRANSITION

Then, of course, the more familiar ‘transition’ occurs (8-10cm dilation), when the completion of the opening of the woman’s cervix and the transitioning energy in her body occur creating confusion and distress.

CRISIS OF ‘BABY CALLING’

For some women, there may also be the crisis of ‘baby calling’ in second stage when the stretch receptors, activated on the perineum, create the outrageous intensity commonly referred to as the ‘ring of fire’.

Understanding that when a crisis of confidence is on, with emotional distress running high, support can make the difference.
AIMH UK Conference 2017
‘Working Effectively with Fathers in the Perinatal Period’

Friday 29TH SEPTEMBER 2017, 10am – 4.30pm

Venue: Hallam Conference Centre, London

SAVE THE DATE - more details will be made available soon.

Expressions of interest to info@aimh.org.uk

The UK Association for Infant Mental Health exists to promote infant mental health through education, research, early intervention and treatment. AIMH(UK) invites you to become a member to assist us in our work and to help improve the mental health provision for babies across the UK.