PRISM Maternal and Child Health Training
March - June 1999

Report on the program issues, themes and future ideas across the eight participating MCH teams

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P R I S M

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Introduction

Between March and June 1999, eighty-one maternal and child health nurses from eight municipalities participated in two full days of training as part of the PRISM project.

Training for primary health care professionals (maternal and child health nurses and general practitioners) is one of the key elements of the intervention program within PRISM. Training for general practitioners is being undertaken separately, and is taking place from mid 1999 in the associated project GAPP (Guidelines for the Assessment of Postnatal Problems).

The aims of the maternal and child health training days were:

1. To strengthen the capacity of the maternal and child health services in each of the intervention communities to support mothers in relation to physical and emotional health issues in the first year after childbirth, in particular by:
   - enhancing recognition and treatment of emotional and physical health problems
   - promoting listening skills and offers of time to talk

2. To assist the PRISM research team to build an understanding of the local context and issues currently affecting maternal and child health services in each of the intervention communities.

The training program incorporated:

- an overview of the research literature regarding the prevalence and natural history of emotional and physical health problems in the first postpartum year
- discussion of strategies that may assist women in dealing with physical and emotional health issues in the postpartum period, with particular attention to research evidence regarding the effectiveness of a range of approaches
- discussion of research documenting women's views and experiences of the first year after childbirth
- review of the skills involved in active listening, with opportunities to practise these skills
- discussion of strategies for fostering intersectoral collaboration within local communities, in particular linkages between maternal and child health and local general practitioners
- consideration of ways that PRISM can support maternal and child health activities in each locality.

Purpose of this report

In compiling this report we have attempted - as we promised - to summarise the main issues from the many lively and engaged discussions during different sessions of the program across the eight participating maternal and child health teams. This is contained in Part B of the Report.

Part A focuses in on some of the key themes which arose, under the heading “promoting the ‘maternal’ in maternal and child health”. We hope this provides some directions for continued active involvement in PRISM and we will endeavour to provide what ongoing support we can in achieving this, to each of the eight maternal and child health teams.

A separate brief report summarising your evaluations of the training program will be prepared and distributed shortly.

Feedback on this report is also very welcome. Please feel free to contact us with comments.

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1. Professional development: support for maternal and child health nurses

Several MCHN teams identified a need for more regular opportunities and time within their work program to undertake further professional development.

Most MCHN teams have very limited time each month where they come together for professional development activities. Regular meetings in most municipalities tend to be fully taken up with business and administrative matters. Professional development opportunities appear in most municipalities to be limited to attendance at conferences and workshops, with very little scheduled time for keeping up with the relevant research literature, or discussion with fellow team members (or other primary care professionals) regarding more complex 'cases'.

The main types of professional development activities discussed by MCHNs in the training workshops were:

- setting aside time each month to access and discuss research literature on maternal health issues, including systematic reviews of randomised trials assessing the effectiveness of treatment strategies (e.g. *Cochrane Library*)

- regular review/audit of recent 'cases' where maternal health problems have been identified, in order to discuss local strategies and resources for support

- scheduling opportunities for 'debriefing' and 'peer support'.

In order to undertake the sort of professional development activities outlined above, additional time for meeting together with other team members is needed in most PRISM municipalities.

The amount of time spent together as a team varies considerably across the 8 municipalities. All teams met at least once a month. In one municipality it is only possible (within the current roster) to schedule a one hour meeting once a month, while other teams were able to meet fortnightly or weekly. Rostering of part-time staff, particularly in municipalities with fewer nurses, is often a barrier to more frequent meetings.

Most teams had informal strategies in place for 'debriefing' and 'peer support'. There was general agreement that more structured opportunities would be useful. The City of Yarra have implemented a strategy for debriefing. Further information about this project is contained in the Appendix.

The PRISM research team have offered to resource MCHN teams

participating in PRISM with reference materials from the *Cochrane Library of Systematic Reviews* for the period of the project (1999-2000), and to provide other advice and support in relation to accessing relevant research literature on individual maternal health issues.

A number of teams expressed interest in the possibility of organising joint professional development activities with local general practitioners. A range of possible formats for this were discussed including: joint workshops with a speaker and discussion focusing on maternal health issues, local strategies and resources; a monthly or bimonthly 'journal club' for discussion of recent research papers/evidence regarding treatment strategies.

2. PRISM information kits: a vehicle for informing mothers

There was considerable discussion in the training program across all eight maternal and child health teams about the MCH service still being seen by many mothers as being “for the baby”, and agreement that this hinders the valuable work nurses could be doing around maternal health problems.

This was noted both in relation to maternal emotional health and physical health issues and prompted the suggestion of a range of ideas and strategies to address the problem, including:

- emphasising the importance of how the service is presented to mothers at the first home visit
- from the very first contact with a mother discussing with her how important her own health is, the common nature of maternal health problems and conveying MCH interest and concern in monitoring maternal health and providing ongoing support
- encouraging mothers to talk about their own health concerns
- having better information to give mothers concerning both physical and emotional health issues
- focusing in on maternal health issues to a greater extent in new mothers’ groups (discussing common problems; highlighting how important it is for mothers to look after their own health and make time to do things they enjoy)
- emphasising the important role fathers have to play in supporting their partners and strategies for informing them about the realities of motherhood and recovery after birth, and of involving them.

In discussion during the training program, the distribution by MCH nurses of the PRISM information kit to all mothers at the first home visit was seen by most teams as a vehicle for ongoing promotion of the ‘maternal’ in maternal and child health by:

- alerting women to MCH interest in *their* health, as well as their baby’s, at the very first contact
- providing women with information about the common nature of postnatal health problems with encouragement to discuss problems with their nurse when they experience them - the leaflets may also be a valuable discussion tool for new mothers’ groups
- giving women information about their local community and the services it provides and about local activities which they might enjoy undertaking (with or without their babies) in order to look after their own health and

well-being now that they have a baby - information which MCH nurses can also draw on and discuss with mothers

- providing a booklet of vouchers for local services and activities to give mothers an incentive for taking time-out for themselves - thus also giving MCH nurses a vehicle for discussing and promoting time-out with mothers

- providing a brief information leaflet for fathers acknowledging their important role with the new baby.

The PRISM information kits will be available for distribution to mothers from the date of each local PRISM launch and prior to this, the PRISM Research Team will be providing each MCH team with further information about kit distribution, including some questions and answers around a range of logisitical issues, raised in some areas during the training program.

3. The physical environment of maternal and child health **c**entres: what messages are conveyed to mothers?

There was some very interesting discussion around this topic across the eight maternal and child health teams taking part in the training sessions:

- lack of privacy for mothers, particularly in centres with small waiting rooms and/or office windows permitting other mothers to hear or see what is happening during consultations was a common problem

- providing a suitable environment for toddlers is difficult in centres with very small offices and/or waiting rooms - sometimes this leads to nurses leaving the office door open so that toddlers can play in the waiting room, but this compromises mothers' privacy

- frequent interruptions in consultations to answer telephone calls tends to give mothers the message that nurses are busy, and may discourage mothers from talking about their own health or issues that are worrying them

- note-taking during consultations, particularly computer-based systems, can tend to be an obstacle to effective listening

- a focus on the baby is often reinforced by the posters and information displayed on notice boards.

Different teams had tried a range of strategies for addressing these issues. Some 'new' ideas came up as well during the discussion sessions. Here are some of the ideas and strategies different teams discussed:

- ALWAYS closing the door for privacy, then if mothers' open it so that toddlers can play it's OK

- covering office windows with posters, and having a radio on in the waiting room to increase privacy

- trying to avoid placing waiting room seats close to the office door

- using answering machines or a central appointment booking service to minimise interruptions

- using PRISM as an opportunity to focus notice board display materials on maternal health issues, e.g. choosing a maternal health issue such as incontinence or back pain as the topic for the month, and reinforcing the information in the PRISM information kit via a poster or other display material

♦ developing a folder of information about maternal health issues for mothers to read in the waiting room with blank pages for mothers to add their own experiences of what strategies they have tried and what helped or didn't help.

4. Promoting 'befriending' opportunities for mothers: a key role for MCH nurses

Universally, maternal and child health teams raised and discussed the isolation many mothers feel when they have a new baby and the importance of practical and emotional support at this time. The valuable role of new mothers' groups in assisting women to get to know other local mothers was frequently acknowledged. Nurses also commented thought, that precisely the mothers likely benefit from meeting other mothers, were often the ones who did not attend the groups.

A number of teams had strategies in place - or were discussing implementing new strategies - for increasing the ways in which they could facilitate mothers meeting other mothers and for developing opportunities for mothers to make supportive friendships at a time in their lives when they may otherwise feel isolated and cut-off. Some of the strategies included:

- advertising a time each week or fortnight when mothers are welcome to drop in to the MCH centre and make themselves a cup of coffee and chat with whoever else is there

- starting up a walking group at a particular time each week: mothers can meet at the MCH centre and then go off for a walk in twos or threes; go to the park for a picnic; etc.

- promoting local playgroups as a good way for women to meet other mothers with young children (even before their baby is old enough to 'play'); also encouraging women to explore activities at their local neighbourhood house, or recreation and leisure centres ('back into shape' classes; aquababies sessions, postnatal yoga).

PRISM's emphasis on increasing befriending opportunities for mothers fits very well with these ideas and may provide some other ways for MCH nurses to promote befriending opportuniites for mothers too, such as:

- encouraging mothers - individually or in groups - to make use of the vouchers from their voucher books, eg the offers from local cafés of free or discounted coffee at regular coffee mornings for mothers

- discussing with mothers some of the suggestions in the PRISM locality guide, which includes ideas for mothers to be out and about in their community and enjoying local activities with other mothers (eg going to a cry-baby or nursery-time session at the local cinema and meeting other mothers for coffee afterwards)

- offering to put mothers in contact with other women who may have similar interests eg swimming, reading, playing netball, walking, going to films.

5. PRISM Steering Committees: a new 'voice' for MCH nurses?

The training program commenced at about the same time that local PRISM Steering Committees were having their first or second meetings and over the time of the training we began to hear examples of ways in which MCH teams were utilising their positions on the Steering Committee to have the voice of maternal and child health heard in a forum comprising local government, community and health agencies and general practice.

- In one area, a long-held view of the MCH team that there should be an MCH centre in the local shopping centre, gained new prominence and currency when raised at a PRISM Steering Committee meeting - and is now being explored further by senior council management

- PRISM Steering Committees have been suggested as the appropriate auspice for arranging meetings/dinners between MCH nurses and GPs to improve primary care collaboration around maternal health issues

- As a result of MCH advocacy on the need for better access to home help for mothers, at least two PRISM Steering Committees are pursuing discussions with local government managers on this issue.

We would encourage MCH teams to continue to use the PRISM Steering Committees as an appropriate local forum to advocate for the needs of mothers and to raise issues about local support for mothers - and for maternal and child health nurses!

6. Intersectoral collaboration on maternal health

The opportunities afforded by PRISM to promote intersectoral collaboration, particularly with general practitioners, were generally viewed as a very welcome and positive aspect of the project.

Most maternal and child health teams had made efforts to foster linkages with local general practitioners. All had stories to tell about how difficult it is for local primary care professionals to get together across professional groups. There was therefore some hesitancy about how feasible it will be for local collaboration between general practitioners and maternal and child health services to be strengthened. On the other hand, all teams were interested in fostering linkages if suitable strategies and processes could be agreed upon with local general practitioners.

There are a number of aspects of PRISM that we hope will assist in this process, including:

- the training being offered to general practitioners via GAPP, and appointment of a local GP as GAPP advisor
- involvement of maternal and child health nurses and local general practitioner/s on PRISM Steering Committees
- circulation of evidence based “Guidelines for Assessment of Postnatal Problems” to local GPs and MCH teams in September/October 1999.

Other strategies discussed during the training sessions include:

- the development of a PRISM MCH contact card for mothers to give to GPs as a way of notifying GPs which nurses/MCH centres mothers attend, and encouraging GPs to contact nurses
- regular distribution of contact details for MCH nurses to local general practices, perhaps annually or when details change
- holding joint workshops to discuss case studies and/or journal articles focusing on maternal health issues, possibly hosted by the PRISM Steering Committee and/or jointly organised by the GAPP advisor and MCH team leader
- holding a more informal joint dinner or lunch, possibly in association with a joint workshop or more formal meeting.

1. Local issues and challenges in meeting the needs of mothers

Issues for mothers

- ♦ Many women are still unaware that the MCH Service is for mothers too!
- ♦ Social expectations placed on mothers to cope: difficulties in asking for support when needed
- ♦ Isolation is very common - geographic and social
- ♦ Women often don't realise how common the problems they experience really are and therefore don't raise them

- Mothers have unrealistic expectations of themselves, fuelled by media and society, particularly first time mothers. "Supermum syndrome".
- Mothers who need support are often reluctant to take the first step.
- Women feel a stigma associated with being depressed and are often reluctant to speak about their emotional well-being.
- Women often experience embarrassment in relation to physical health problems.
- Women who are most in need of social contact are the least likely to come to group meetings, eg. women who are depressed, teenage mothers.
- Women experience information overload; with lots of conflicting advice; need to empower women to make their own decisions.
- The increase in IVF has meant a "precious baby" syndrome; impact of this on mothers' coping.
- Limited public transport contributes to isolation. Of the few bus services that do operate, drivers are not always helpful to mothers.

- Early discharge/ handover to MCHN - many women are under-prepared for discharge.

- Mothers often view MCHNs as 'baby weighers' and therefore don't raise issues to do with their own health.

- Many (most?) mothers are very aware of how busy nurses are and don't want to be a burden.

- The social expectation of the 'nuclear family' seems to be that women should be able to cope on their own - hence some mother's reluctance to seek or accept help from friends and family.

- Some women are hesitant about breastfeeding in public places, which can contribute increased feelings of being trapped or isolated.

- Relationship changes - partner's expectations of women can add to their difficulties in adjusting to life with a new baby.

- Women often aren't aware of:
  - what sort of problems may occur in the first months with a baby
  - that other women experience them too, or
  - what services are available to assist them.

- Pressure on women to return to work for financial reasons can make it very stressful for some mothers.

- Gambling problems are having a major impact on some families and mothers.

Particular rural issues

- Women and families often isolated from extended family supports; as a consequence, increased importance of the role played by MCH. In contrast, sometimes having families close by in a small community leads to their being over-supportive or interfering.

- In a small community, women often don't want to attend support groups - they can be too "public."

- Large geographic distances create isolation, and public transport can be more limited than in urban areas. Also means women can be isolated from MCH service.

- Diversity in rural populations, but small numbers often in any one 'group' - eg both 'older' mothers, and 'young' mothers who are often transient, small numbers of NESB families can pose a special challenge for new mothers' groups.

- Rural recession and associated issues: unemployment, social problems.

- High proportion of fathers on low incomes, often disadvantaged by having a low level of education.

- High proportion of families are unemployed - have their own needs for support, and can be an additional 'burden' for the mother.

- Increased pressure for women to return to work quickly due to financial hardships.

- Recent increase in teenage pregnancies?

- Consequences of significant local events, eg the Longford explosion.

- Few GPs with an interest in women's health.

- Little in the way of self-help groups; and lack of places to go and things to do - women need to be more innovative in rural communities.

- Many families are relocated to a particular area for 'public housing' - they don't come by choice.

MCH service issues

- ♦ Workload issues: time management, professional development, mutual support
- ♦ Continuity issues with many part-time staff
- ♦ Challenges of balancing 'mother focus' versus 'child focus'
- ♦ Nature of MCH role - autonomy, isolation and referral issues
- ♦ Importance of promoting the *maternal* in the Maternal and Child Health Service

- MCH overload: "you've only got so much to give." Overload can be a combination of a) number of clients, b) complex nature of the problems presented by women, and c) isolation of the job, providing little opportunity to 'debrief'.
- Continual demands of MCH role - emotional and spiritual.
- Need to be on top; it's not OK for MCH nurse to appear to be vulnerable herself; you feel under siege, but you have to put on a brave face.
- Trust needs to be developed from the first MCH visit - it is important for mothers to see the service for them as well as the baby, right from the first visit.
- Open sessions have advantages (gives women the chance to chat and get to know one another) and disadvantages (waiting times for mothers and the pressure for quick visits).
- MCH nurses need to look after themselves in order to give mothers the messages that they need to care for themselves.
- Need for professional debriefing: opportunities to 'unload': MCH role is one of always giving out - very draining. Example of City of Yarra employing psychologist within their contract for just this purpose.
- Visibility of MCH offices: the "fishbowl" with windows into the waiting room: issues for nurses and for mothers.
- In relation to part-time centres and staff; confidentiality; continuity of care, handover and follow-up issues ("who's responsible for a particular mother?").

- Burn-out and working in your own time: looking after yourself needs to be valued as important in being a good MCH nurse - hard to do.

- Time for follow-up phone calls; appointment slots to fit women in who need to be seen quickly; admin etc: not really built into current ways of working.

- Strategies for coping with crisis situations, given that the service is not an acute service: need to develop protocols for dealing with crisis situations with mothers (recent example discussed).

- Balancing the needs of the 'normal' mother with acute situations.

- Challenges of meeting needs of particular groups, eg adolescent mothers sometimes fearful of MCHN links to DHS and protective services; language and cultural barriers working with women of non-English speaking backgrounds.

- Trust develops from the first visit and it's also important for ensuring that mothers see the service as being for them, as well as the baby, right from that first visit.

- As nurses we are not always confident of our skills in supporting mothers; don't value what we have to offer enough ; limited time for keeping up with current knowledge in maternal and child health; very limited time spent as a team on professional development, and mostly need to travel to Melbourne for continuing education.

- Should we be providing more information antenatally?

- An internal review of local MCH Service gives us an opportunity for people to learn about what we do, but also a drain in terms of time involved in preparing documentation.

- Our municipality supports MCHN visits in addition to DHS scheduled visits; mothers generally encouraged to have around 14 visits in the first 12 months - not always the case in other areas.

- Historically Council has not supported issues raised by MCHNs, eg. proposal for new centre in the local shopping centre, need for improved public transport - potential to take these issues up via PRISM Steering Committee.

- Pressures of child health checks vs needs of mothers.

- Varying levels of experience in the team.

- How broad should our focus be?

- Strategies needed for involving/educating fathers, eg. encouraging attendance at first clinic visit.

Particular rural issues

- Challenges for nurses include:
  - getting around the area: distances and time issues
  - small team: everyone has to get on, not always easy, but necessary
  - sometimes mothers reluctant to raise issues because it's a small community; on the other hand mothers also "consult in Safeway"- nurses can feel as though they're never off-duty, always "unofficially" on call.
  - meeting extra support needs of often transient populations (eg RAAF families; families coming to area for public housing, who often don't stay long).

- If a nurse and mother don't agree/get on, often no options for changing to another nurse.

- Lack of local resources, places to refer women to, eg family support.

- Referral issues for rural areas: eg to Mother-baby units/early parenting centres in Melbourne: waiting lists, distance; but also the consequences for the mother of severing local supports if she has to go to Melbourne.

- Confidentiality issues, where various members of the one family may be using the MCH service.

- In a small community women respond to peer and family pressure; complicated at times by low levels of education ("women can be hard to influence; they do what other mothers do").

- Continuity of care antenatally, intrapartum and postnatally in small communities is a plus for services to mothers - good links with maternal and child health.

Broader local issues

- Lack of government funded, affordable and accessible health and community services - eg psychiatric services, community health.

- Not much in the way of other supports for mothers, eg few neighbourhood houses.

- Not very good collaboration between services; further exacerbated by the tendering processes of recent years.

- Poor links between MCHNs and GPs - difficulties experienced in establishing processes for exchange of information, a collaborative approach to care of mothers, etc.

- Difficult to find sympathetic GPs; frequently few women GPs who are often preferred by mothers. 'Older' GPs tend to emphasise medication as a 'solution' for depression; other strategies not covered in medical training.

- Very little access to home help services for mothers anymore - would be very helpful for some mothers.

- Long waiting times for referrals to other services when needed, eg Early Parenting Centres.

2. Women's emotional and physical health issues after childbirth

Emotional health problems

Much of the discussion focused on strategies for encouraging women to talk about emotional health issues and for ways to support them when they do.

Key messages:

- ♦ Importance of establishing trust with mothers.
- ♦ Need to encourage and support women to disclose how they are feeling.
- ♦ Importance of listening to women - before offering advice.
- ♦ Value of acknowledgement and reassurance in assisting women to work out what's best for them.

- Developing trust is important. This may be especially difficult for relievers, although sometimes women will disclose to a "new" nurse just because she is new.

- The home visit after birth is critical - you're on a woman's own territory and it's very important to be accepting and non-judgemental, (important to ring women to offer the option of Centre or home visit).

- The use of direct and open-ended questions to encourage women to talk:

- The baby's fine, *how about you?*
- 'What sort of week have you had?' can be more effective than 'How are you?' which tends to get a routine response
- How are you coping with the lack of sleep?
- How are you finding motherhood?
- It's common for women to be depressed when they have a new baby, how are you going?

- Monitor women's non-verbal cues.

- Make women feel important, and that you do have time to talk. Reinforce this message, eg. new mothers group discussion on common problems, scheduling *maternal* health visits.

- Silence is important to allow a mother to answer and continue talking.

- Timing of questions is important.

- Let the mother lead the consultation/identify issues, eg let the mother talk for 5 minutes *without* offering her any advice, simply encouraging her to talk.

- Does the woman want you to be a friend/professional?

- Normalise feelings of depression - the problem is common.

- Reinforce the importance of doing things women enjoy - every day.

- Recognise women's own efforts and skills to find light at the end of the tunnel.

- A follow-up phone call to check on how the mother is feeling is often really appreciated by mothers.

- Think about involving partners - sometimes a practical suggestion (eg the partner looking after the baby while the mother has a relaxing bath) can be helpful.

- Women are often 'drowning' in conflicting advice - need to be careful not to add to it, and build mothers own self-esteem and confidence to decide what works best for her and her baby.

- Consider using PRISM kit leaflet on emotional health as basis for discussing women's emotional health at first home visit.

- Importance of being someone non-judgemental to talk to/share experiences with. Mothers may not be searching for answers - there often are no easy solutions - but rather just need someone to listen to them.

- It is important not to make assumptions about which mothers are vulnerable to depression, but also to recognise clues that women may be depressed (eg change in usual appearance, less/more talkative than usual, being anxious/stressed, tired).

- BUT, important to ask all women how they are

- check on how the mother is at every visit, at the beginning of the consultation.
- listen to the answer/eye contact
- try not to write notes in the consultation
- reflect back to women - you look tired today?

- Offer a home visit over a cup of coffee as a choice/discuss visiting when family not around (for confidentiality).

- Weighing baby as reason for visit - do we weigh too often?? Should we suggest that we talk rather than weigh at some visits??

- Women who make frequent visits, talk about baby (minor problems) not themselves, also visit GP a lot, but underlying depression - helping mothers to switch to talking about how they are.

- Importance of reassuring women that they are 'good mothers'; that they are doing a great job; that they are not the only mother feeling down; that motherhood is an extremely demanding job; and that things do get better!

- Recognise that there are a variety of ways to cope/present strategies as options so that women don't experience us as yet another person telling them what to do:

- time out
- encourage women to work out what *they enjoy* doing, and to do whatever it is regularly
- accept offers of help
- ask family members to put the kettle on, hang out the washing
- get out of the house everyday.

- MCH centres as a venue for befriending opportunities at specific times - a time at each Centre every week advertised as "drop-in for coffee" - informal and low key opportunity to meet with other mothers.

- Supportive role of playgroups.

- Aim for women to meet other women using occasional childcare.

- Idea : walking group for women while babies in childcare.

- Role of midwives at local hospital in promoting PRISM to mothers.

- Maternity Enhancement Program: parenting groups, lactation clinics.

- Physical space considerations:
  - ALWAYS close the door for privacy
  - avoid having seats near the door if possible
  - have a radio on in the waiting room to increase women's privacy
  - recognise that women have different needs for space: some may like to sit behind the desk, others may be more relaxed in less formal setting.

Challenges for MCH in dealing with emotional health issues

- The perception of MCH services as infant welfare discourages women from talking about themselves.

- Nursing training is sometimes a hindrance - it is important to allow women to do the talking; and not necessarily be offering 'solutions':
  - as nurses we're trained to be "doers" and to give an answer
  - need to recognise that there isn't always a way out
  - not all women want a 'solution'; they may just want to talk.

- Recognise that providing emotional support all day is the most draining part of the job - work out ways to feel supported ourselves.

- Important to recognise that women's issues are theirs - not take them on ourselves; this makes it much less frustrating when women don't take our advice!

- Long waiting times for GPs are frustrating, but perhaps encourages women to talk to MCH nurses?

- Time issues
  - listening is difficult when the waiting room is full
  - insufficient time in 15 minutes/half an hour
  - DHS allocation for depression = an extra two 15 minute appointments, not sufficient for providing adequate support
  - depression is often raised in the last 5 minutes of the consultations, or as the mother is walking out the door.
  - need to devise strategies for support within time constraints, eg. encourage women to come back for another appointment
  - working out with mothers 'the next step' at the end of the consultation.

- MCHN overload
  - it needs to be clear where MCH responsibility ends
  - we need far more opportunities to debrief, especially re distressing or difficult situations
  - we need to be aware of our own needs to avoid burnout.

- Women can be very distressed at a visit - you worry about them all week - and then they come back the next week and they're fine!

- Concern re high proportion of teenage mothers in the area who are on anti-depressants: shift in community attitudes to medication. Less medication and more listening needed: role for MCH here.

- Child health vs maternal health - how do we fit everything in?: prioritise on the day, work it out with the mother.

Physical health problems

- ♦ Addressing maternal physical health issues means overcoming image of MCH service as *for the baby*
- ♦ Genuine interest in mothers' physical health needs to be shown - early and often. Mothers need to know that we know that very few women are 'back to normal' at six weeks postpartum
- ♦ Let women know how common maternal physical health problems really are
- ♦ Continued gentle persistence in asking women about their physical health may be what is needed to help them talk about issues
- ♦ Sometimes simple strategies may be helpful. Sometimes physical recovery after childbirth just takes a long time! Talking with women about strategies they might try, and encouraging them to talk about their experiences will be helpful

Encouraging disclosure of problems and providing support

- Importance of opening questions:

- use specific questions eg. have you got any aches and pains?
- always ask about tiredness
- be genuine about wanting to know - eye contact, body language
- strategies for not being intrusive
- timing - may be better to ask *how are you?* some way into consultation rather than as they come in the door when it seems like a social greeting.

- An initial focus on the method of birth and it's impact on women's recovery can be helpful.

- Use of directed questions, eg. x% of women experience incontinence, have you had a problem with leaking urine when you laugh or sneeze, or do physical exercise?

- Reassurance that physical health problems are very common after childbirth, and that women are not alone in their experiences.

- Possibly tie maternal health discussions to specific visits - 4/12 and 8/12 are baby health checks, so could schedule 3/12 and 6/12 as maternal health visits. And offer mothers a carer to look after the baby during that visit.

- Important to check relevant obstetric factors (eg forceps delivery, epidural, big baby) as potentially relevant in individual discussions of health problems (eg incontinence, sexual problems, backache).

- The PRISM kits can be an opener for discussion of physical health problems.

- Need to think further about our strategies for dealing with sensitive topics, eg faecal incontinence - importance of communication skills training in this context.

- Incorporating maternal health issues in child health record in some way.

- Use similar strategies around physical health problems as for emotional health issues - listening, acknowledgment, eye contact, support, reassurance that they are not alone in dealing with the problem.

- Sometimes with sensitive physical health topics, it's best to be blunt: "How's your sex life? Or use humour (eg recent "Mad About You" program on sex after childbirth).

- Ways to discuss research evidence with mothers, especially regarding treatment strategies when research suggest possible side effects of treatment; or research findings not conclusive.

- Information in waiting rooms on physical health issues, eg posters to reinforce that the MCH service is there for mothers and interested in physical health and recovery after birth.

- Important for fathers to have information about how common problems like perineal pain are after childbirth - fathers' leaflet in PRISM kit should be useful tool.

- "Maternal Health Bible" - a folder with current information about physical health problems in the waiting room, that also contains blank pages for women to write down their own experiences of what strategies they've tried and what helped or didn't help.

- Revise current MCH brochure to include greater focus on maternal health.

- Use of PRISM information kit leaflets on emotional and physical health in new mothers' groups, with individual follow-up with each mother at appointments.

- Be aware of our own tendency to feel we need to offer solutions - let

women work out for themselves their own next steps.

- Important to keep detailed history in the MCH record so that maternal health issues can be followed up at subsequent visits; especially important for part-time MCHNs and relievers**.**

- GP receptionists in the area might also be approached to offer to care for babies when mothers visit the doctor.

- Potential for opening the 'floodgates' - too much to deal with in one visit
  - put off weighing the baby
  - schedule another appointment or home visit
  - ask women what it's most important to deal with today.

- Pros and cons of scheduling specific visits for maternal health versus being opportunistic and dealing with health issues when women raise them.

- Underrating of physical health problems because so common - true for nurses and mothers.

Referral issues

- When to refer: a) when problems persist, b) when women want it.

- Good GPs have long waiting lists - some happy for MCHNs to ring on behalf of women to make an urgent appointment, some not happy to do this - could be taken up with GPs in the context of GAPP/PRISM.

- "GPs don't know what MCHNs do"; "MCHNs/GPs don't know how to work together", cf. UK system: foster links with selected practices?.

- Need to break down professional rivalries between MCHNs and GPs; build a better understanding of how we can work together.

- Develop letter of introduction for MCHNs to let GP know woman's MCHN and contact details.

- Encourage GP feedback to MCHNs when they make a referral.

- Referral letters - format setting out what MCHN has suggested, asking for feedback from GP regarding their opinion on management.

- Discuss with women the sorts of questions they might ask their GP.

- Follow-up is important if women are referred to GPs - so that women get the message that we still care .

- Knowing what local services are available to refer mothers to: eg low cost postnatal exercise classes with physios available at the hospital; local family planning service; women's health; incontinence clinic, etc.

- Referral to 'alternative therapies' may be another option, but needs to be presented as an option for women to consider, rather than as a recommendation given limited evidence of effectiveness.

3. Intersectoral strategies in the context of PRISM

The importance of better links with general practitioners was frequently discussed in the context of improving care for women around maternal health issues. A range of ideas and strategies was discussed:

- PRISM MCH contact card for mothers to give GPs, as a way of notifying their GP about which nurse they see:
    - to include contact details for nurse, hours available, phone number(s) etc.
    - could be clipped to a page in child health record for six week check with GP
    - for GP practices with computerised histories, details could be typed in from card
    - mothers who see more than one doctor may need several cards, or they may have a preference for a GP they see for their own health issues
    - in addition all GP practices could be sent relevant contact details for the MCH service as a whole.

- Consider organising a joint meeting/dinner with local GPs, hospital staff, MCHN to discuss case studies focusing on maternal health after GAPP training for GPs. Offer food and wine to create a social, informal atmosphere. Something for the PRISM Steering Committee to organise later this year?

- A PRISM referral letter with maternal health issues noted/listed might be useful when referring women to GPs.

- Feedback from GPs should be encouraged - how??

- Consider having a page in Child Health Records for communication between GPs and MCHNs regarding maternal health issues.

- Working with other health professionals, eg. physios, around maternal health issues
    - example of local physio with an interest in incontinence
    - discussion of research evidence locally could include involvement of other health professionals

- Strengthening contacts and networking between midwives, GPs and MCHNs - (though not necessarily to increase referrals to GPs around emotional health issues, as “not a lot of GPs do much apart from hand out pills” - at least currently)

- Distribution of evidence based guidelines for the Assessment of Postnatal Problems not only to GPs, but also to MCH nurses later this year.

4. Sharing resources, ideas and experiences relating to maternal health issues in the context of PRISM

The challenges for maternal and child health services in better meeting maternal health needs require some creative strategies for mutual support and sharing ideas and experiences. A number of ideas were discussed:

- Strategies for mutual support and debriefing
    - ringing one another (perhaps more formally)
    - setting a regular time to meet with other members of the team to off-load, possibly a Friday afternoon debriefing/unloading time
    - finding a mentor and building in the time to talk over difficult cases.

- During team meetings a regular spot could be allocated to discuss PRISM issues
    - what's happening on the Steering Committee
    - put forward ideas for the Steering Committee
    - discussion of maternal health issues, share experiences and strategies
    - perhaps half hour discussions of particular topics, eg. tiredness, sexual problems.

- Also set aside a regular time for professional development activities, eg. discussion of recent research, systematic reviews published in the Cochrane Library, discussion review of cases
    - lack of library access was discussed, PRISM will provide copies of Cochrane Reviews during the project

5. Effective communication skills

Wide-ranging discussion of the issues in effective communication with mothers in the context of MCH service delivery occurred throughout the theoretical and practical sessions facilitated by psychologist Heather McCormack as part of the PRISM training program.

What follows is but a summary listing of the many common themes in these discussions.

General ideas raised about effective communication with mothers:

- Be sensitive to cues mothers give - float ideas to see if they fit the mother's own framework/perspective.
- Be prepared to accept you might be 'wrong' - that what you think a mother needs to know/do might not be right for her at this time.
- Listen - *before* you give advice.
- Think about how 'solutions' are presented to mothers: is it really a solution she is looking for??
- Avoid blame: women feel they are to blame so easily - avoiding blame is harder than it seems. Tell women often about all the things they're doing well - probably no-one else is doing this.
- Don't set women up for failure - there are lots of issues that don't have solutions - "There are some things you might like to try.." is way better than "You really need to do X".
- Suspend your own beliefs and try to help mothers work out what's best for them.
- When you have something important to say, maximise *your* chance of being listened toby thinking about
    - when you say it - timing; always let the mother have her say first..
    - your way of presenting the advice/suggestion that takes into account what the mother has told you about what she feels/how she sees the situation.
- Be prepared to acknowledge you don't have all the answers.
- Before giving advice, work out with the mother whether she sees the issue as a problem that has a solution, or whether, with support, she's prepared to live with it (eg constantly waking baby).

- It is nearly always true that no-one knows the baby better than its mother - remember to let mothers know that we understand that.

Issues that can make good communication with mothers difficult and where creative strategies are needed:

- Encouraging women to 'open up' and then managing the Pandora's box of issues when they do, especially given MCHtime constraints - need for good 'closure' strategies

- Common 'distractions' in the consultation that can take the focus off communicating well with mothers:
  - need to record information on the computer
  - phone interruptions
  - toddlers!
  - partners (sometimes make communicating with a mother difficult).

- Nature of the MCHN role - always giving out, always listening, not having own means of off-loading - and the risk of burnout: need to develop strategies to avoid.

- Dealing with particular groups of mothers who require special expertise in communicating well, including:
  - women who say: "I've tried that, I've tried that…"
  - teenage mothers, non-English speaking mothers
  - women who are always "demanding", come late and want most time..
  - women who are aggressive
  - women who are very quiet or apologetic all the time.

Dealing with the Pandora's box, when women do disclose problems:

- The avalanche of issues pouring out - just listen: don't try to solve everything at once, don't try to 'solve' at all.

- Give women the option to come back - not possible to deal with lots of issues at one visit.

- Prioritise things with the mother: ask her what she'd like to address today, next time, etc.

- Sometimes just making a list of the issues/problems: can help to visualise them and then prioritising is easier.

- Let women know you are concerned about their well-being and not just the baby's: that you're there to support them as mothers (rather than for surveillance..).

- Let women know they are not alone with problems - depression is common; as are many of the physical health problems.

- Remember, allowing women the chance to talk, will often mean they work out themselves what is best - having someone who listens - even for five minutes and without interrupting to give advice, can be better than going through a range of options or things to do.

- Listening, reassurance and understanding are very therapeutic in their own right. There may *not* be solutions - but listening is likely to be helpful.

- "I can see how distressed you're feeling and we need to talk when there's a bit more time.." : make an appointment to continue; or agree to ring later same day or in the next few days.

- Offer regular contact for a while if you think there are things a mother needs to talk about - you don't have to 'fix' everything at one visit - you can't anyway, even if you had two hour consultations - taking things in stages and working on what is most important for the woman herself is important.

- Make sure women know they can ring if they need to - and what the arrangements are for contacting you or another nurse.

- Check if there are other people women feel able to talk with about how they are feeling - family, friends, GP.

- Remember, most of the time, it's not an emergency or an acute crisis - being a support over time is most likely to be what mothers need.

Examples of questions that help to elicit the mother's perspective on an issue or problem and encourage reticent mothers to speak:

- How are you managing with… (eg lack of sleep) ?

- What's that like for you?

- How do you feel about the support you're getting?

- It seems like you're feeling ….. Is that right? (Checking with a mother that we've understood correctly).

- Is that hard for you to deal with?

- Is that something you'd like to talk more about?

Strategies for women who present extra challenges:

Dealing with overly dependent mothers:

- Set parameters for time and nature of support you can provide.
- Don't reward dependency, whilst being supportive.
- Progressively cut down on the time spent with them.
- Be efficient with pleasantries.

Dealing with women who won't stop talking..:

- Set the parameters for the consultation at the beginning: "We've got 15 minutes today, what would you like to talk about?"
- Be prepared to interrupt sometimes.
- Remind them: "We've got five more minutes.."
- Be firm, but pleasant about needing to finish.
- Stand up, help with getting her things together.

Dealing with women who always run late:

- Acknowledge the difficulties for mothers about getting places on time, but say what time is now available for the consultation; offer a further appointment if necessary.
- Assume their understanding: "I know you wouldn't want someone else kept waiting.."

Dealing with women who present aggressively:

- Acknowledge the feeling: "You seem quite angry about.."
- Listen and give an empathic response, which is often disarming and helps to diffuse the situation.

Dealing with women who say "Yes, but.." or "I've already tried that.."

- Get the woman to do the talking, encourage her to tell you how she sees the issue.

- Acknowledge/accept that there may not necessarily be solutions (for her at this time, or for this issue).

- Give lots of reassurance.

Maximising good supportive communication with mothers means not being stressed ourselves - strategies raised for avoiding MCH burnout:

- Telephone consultations are most commonly not factored into the workload, nor is the management of admin and other tasks: need to structure work timetables and scheduling of appointments more realistically to allow for these aspects of the work to be done without their getting done in our lunch hours, or after hours.

- Define the tasks that need to be done and organise time as best as possible to reflect all aspects of the MCH role, not just allowing the face-to-face contact with women to expand to fill all the available time.

- Share ideas for doing this with other nurses - everyone is different and different strategies may work better for some than others.

- Dealing with computer recording may require a different sort of history taking that doesn't interfere with the consultation - developing a team approach to dealing with this might be helpful.

- Don't take on responsibility for mothers' lives - we support them better if we allow them space to deal with their issues themselves.

- We don't have to fix every problem.

- Find someone else on the team to share 'difficult cases' with.

- Feel OK about:
  - scheduling time in the day to make follow up phone calls
  - having some extra appointment times kept free for the crisis-appointments women sometimes need
  - having a lunchbreak!

- Talk with colleagues about ways to support each other to do our jobs well.

- Share time management strategies - between us, we probably know it all.

- As we encourage mothers to have some ‘time out’, make sure we get some ourselves!