Lessons learnt from opening a mother-baby unit: Qualitative evaluation of staff experiences

Gold Coast Health
Building a healthier community

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Gold Coast Health | Lavender Mother-Baby Unit

Queensland Government

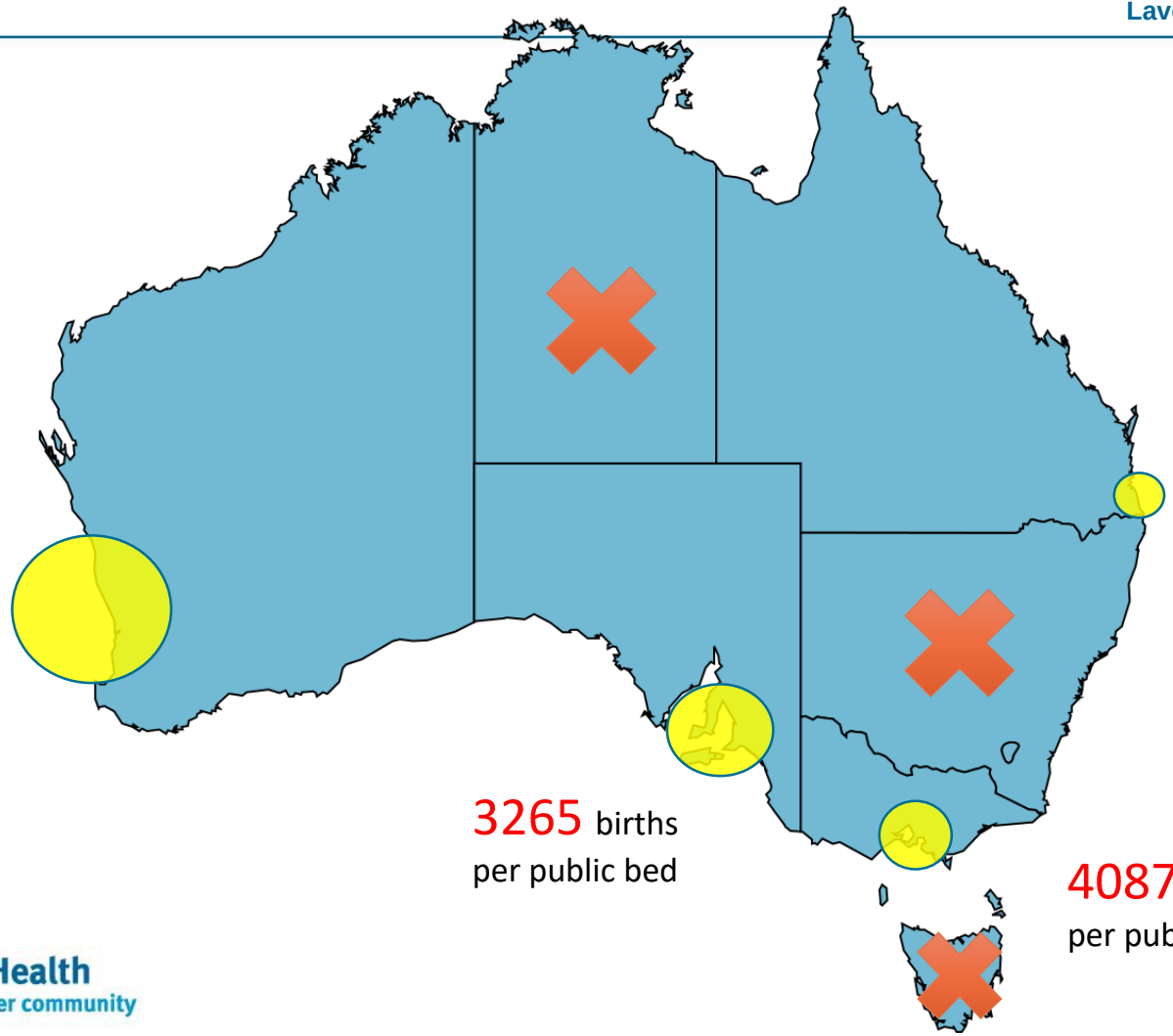
Overview

- Background of MBUs
- Research question and methodology
- Results of major themes and subthemes
- Conclusion

Background

Mother-Baby Units (MBU)

- Centre of Perinatal Excellence Guidelines – consensus-based recommendation for mothers with severe mental illness to be admitted to a mother-baby unit with their infant
- MBUs worldwide:
  - UK → 17 MBUs
  - France → 17 MBUs
  - Belgium → 3 MBUs
  - USA → 1 MBU
- Australia → 7 MBUs



15 436 births per public bed

2196 births per public bed

3265 births per public bed

4087 births per public bed

Methodology

Research question

- To understand the staff experiences of implementing and developing a mother-baby unit
- Lessons learnt to inform new mother-baby units around Australia and worldwide

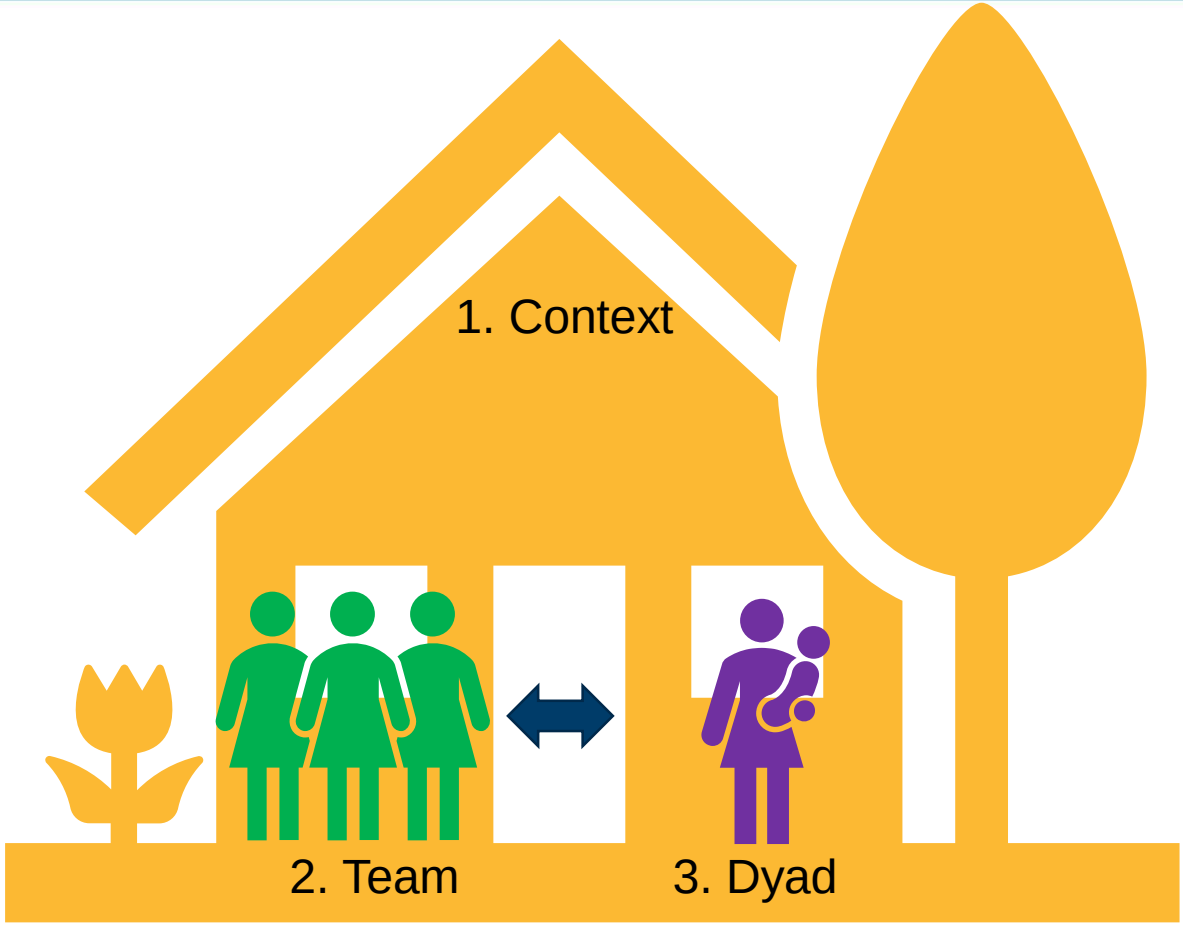
Qualitative methodology

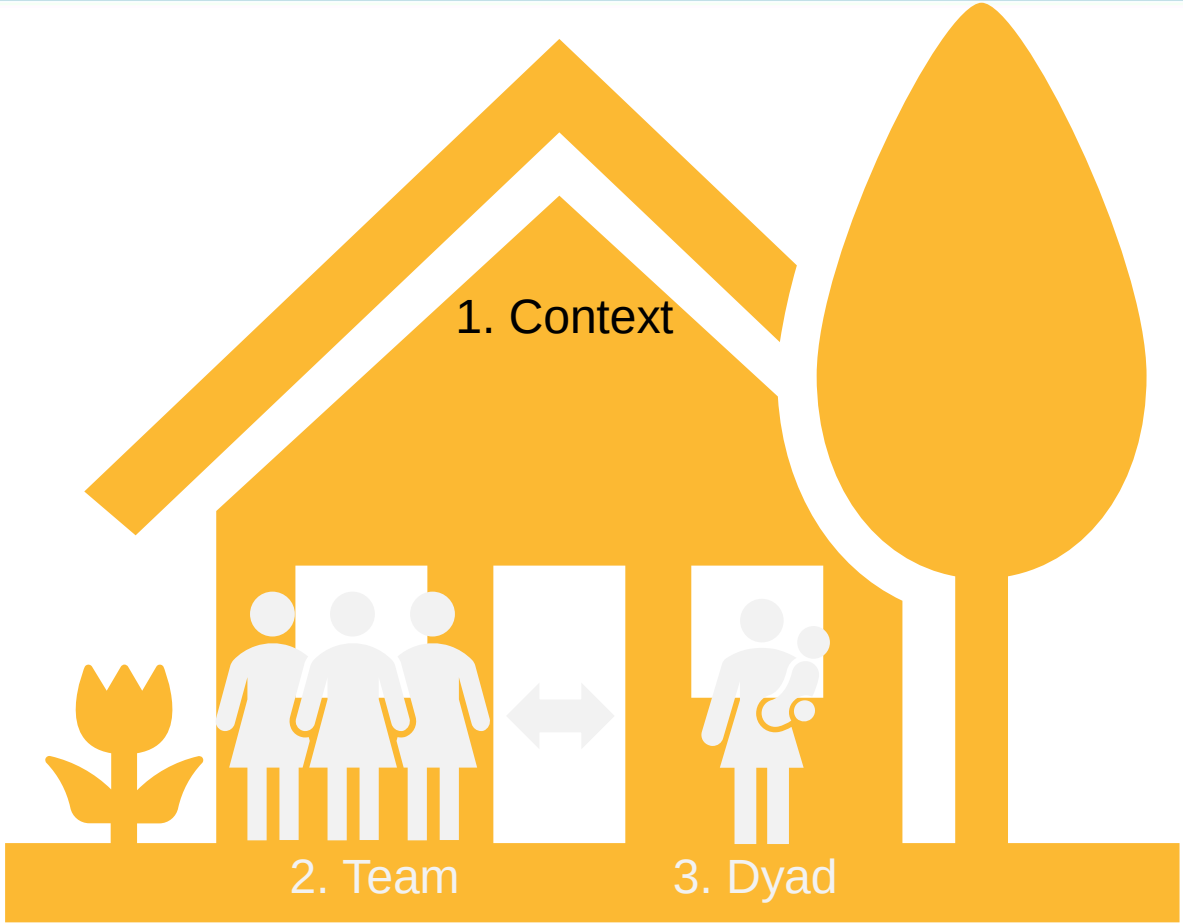
- Semi-structured interviews
- Medical, allied health and nursing staff
- 30-60 minute interviews
- Confidential and anonymous
- Individual and focus groups
- N = 10 participants

Interview guide

- Tell me about your role
- What are some of the rewarding and challenging aspects of the role?
- What do you think are the core knowledge, skills and attitudes required for the role?
- How are you finding working with mothers with complex issues and their babies?
- What different assessments and interventions do you provide?
- How have you seen the service develop over time?
- What would be your vision for the Lavender Unit?

Results


1. Context
2. Team
3. Dyad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Physical context

- Importance of a purpose-built space for:
  - Mothers to be with their families
  - Separate spaces when mothers and infants are distressed
  - Staff to have ‘safe space’ to debrief
- Building of a new sensory garden and additional room for therapeutic groups, family visitation and individual reviews

..it is a challenge that we are such a small ward that the energy does bounce off the walls and there is not much room

New sensory garden has definitely made the ward feel like there are more inviting places to take the baby or for the nurse to sit down and talk to the mum

State context: Taking charge as a beacon of perinatal excellence

- Jointly organised a perinatal mental health symposium with non-governmental, private and QLD Health teams
- Developed new resources (handouts, workbooks, recovery journal)
- Awareness-raising activities to promote perinatal mental health (trade-stalls, video-conference in-services, roadshow)
- Developing a systematic approach to quantitative and qualitative evaluation with a service development and research coordinator

…Like the recovery journal, we started out with paper with, with printout, now we have beautiful folders, we have resources to go into it…

We had the opportunity to do the Symposium which was amazing, and we had really good feedback from that, and we will continue to do that

1. Context

2. Team

3. Dyad

Upskilling the team in specialised knowledge/skills

- Knowledge base of adult mental health
- Learning curve in areas of infant mental health, child health, and perinatal physical and mental health and prescribing for breastfeeding mothers and baby medications
- 3-week initial orientation training and ongoing training for new starters, casual staff and experienced staff – online portal (Yammer), journal clubs, in-services

I learnt a lot about the mother and baby relationship… and ripple effects of mental health issues through the family unit.

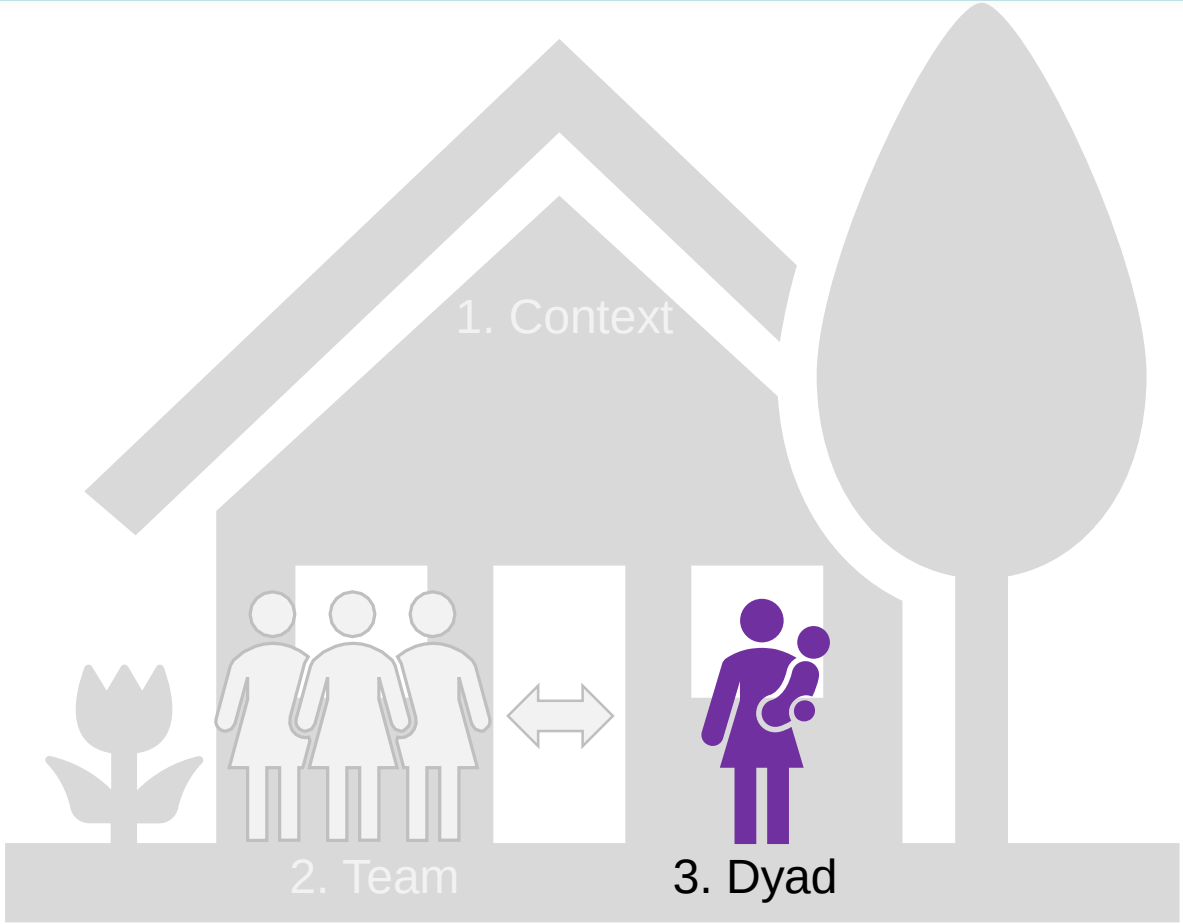
A lot of the mums that come in are sleep deprived…babies have had reflux / colic. There is a reason that the baby is being so unsettled and that's contributed to the mother's mental health decline. So, there are a lot of questions as [mental health] nurses...should we be doing this, or should we be doing that?

Transference and countertransference

- Confronting seeing how the mothers treat their babies
- Counteracting judgemental attitudes
- Importance of reflective practice with monthly external practitioner and weekly session with consultant psychiatrist

It's sometimes hard not to be judgemental. Like once we had a mother who clapped and swore at her baby to wake her baby so that she could go smoke outside as we didn't allow her out without her baby.

Having reflective practice is a big one…having a safe place to talk about challenging experiences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Risk issues

- Child safety
- Deescalating mothers while keeping baby safe
- Negative influence of other mothers

…one of the challenges we have found is deescalating the mother when she is holding the baby or in the same room as the baby…we have had a few babies that have been like 4-5 weeks old and mum's no longer safe with that baby and you need to kind of figure out how you are going to get that baby out of her room…It is just a completely different kettle of fish

Yeah, like we had one mum that was holding her baby, she wouldn't hand the baby over to us and she was holding the baby really unsafely. Yeah so you feel quite vulnerable for the baby's sake, like how do you approach this…

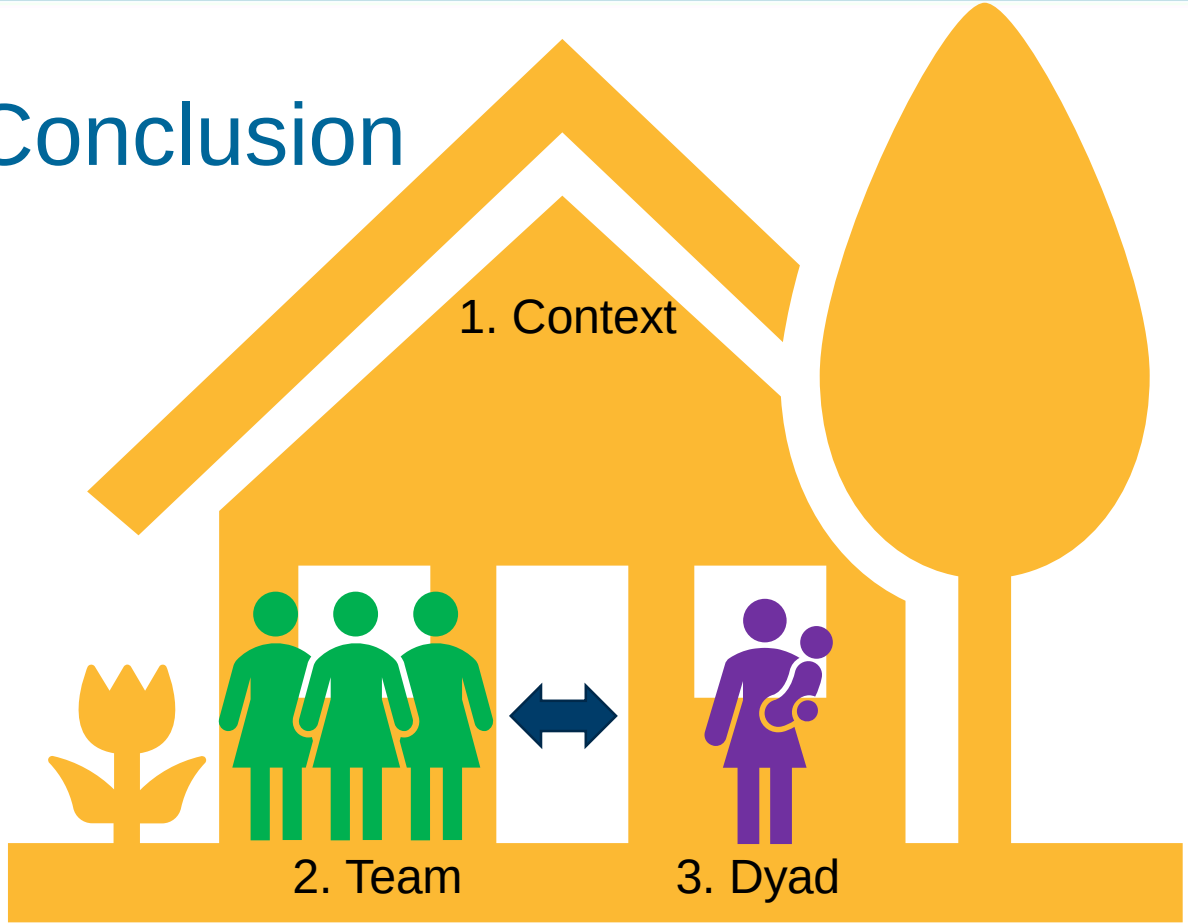
Statewide service

- Logistics of transporting/accommodating mothers, babies and family members in taxi, driving, flight, chartered bus
- Understanding the unique nature of perinatal mental health services across the state
- Multidisciplinary case reviews with numerous stakeholders around the state using tele-/video-conferencing services

Each of the perinatal mental health teams operate so differently, so it's about asking them about what they do and not assuming

At some case reviews we can at least 6 people dialling into the videoconference, like Child Health, case manager, Benevolent Society, private psychologist, NDIS representative and GP

Conclusion



- Importance of a purpose-built environment
- Having a systematic approach to training and reflective practice
- Building relationships across the state

Any questions?