

Mothers with Mental Illness: Public Health Nurses' Perspectives

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Abstract

Mothers with mental illness are in need of support as they struggle to cope with competing demands of their illness and those of parenting. Health professionals' attitudes and experiences have been shown to affect how clients with mental illness are assessed and what resources are provided. The purpose of this research was to explore and describe experiences of Public Health Nurses (PHNs) in Manitoba who visited families in the postpartum period. Qualitative data were collected via focus groups consisting of PHNs within the city of Winnipeg. Emerging themes, "Dealing with where they're at"; "Treasure hunting"; "I kept wanting more"; "You can only do so much" together aimed at a common theme, "Helping Moms succeed". Results suggested that PHNs wanted to provide the best resources for mothers to succeed at parenting. PHNs provided recommendations for the needs of families and changes in practice to help improve service to families.

Chapter One: Introduction

As the largest professional group within the Public Health system, Public Health Nurses (PHNs) have great potential to have a positive influence on community health (Diaz Swearingen, 2009). PHNs working with women in the community during their childbearing years are presented with opportunities to have a positive effect on family health through health promotion activities, such as parenting education. Mothers with mental illness have unique parenting challenges for which PHNs are able to provide support and assistance in terms of accessing community resources. PHNs' perspectives and attitudes can influence how mothers are assessed and how they provide assistance to them in the community. Their perspectives regarding mothers with mental illness are therefore important to explore particularly in view of the active role they have in supporting families within the home environment.

Within the general public health program in Winnipeg, PHNs offer a wide range of services in efforts to promote the health of women and their children. Their services are offered to every mother who has given birth whether in hospital or at home. Among these services are telephone and in-home assessments, and short and long-term follow-up with home visiting. Mothers receive information regarding both infant care and self-care, including signs of postpartum mental health issues. PHNs are in a prime position to detect postpartum mental health concerns and provide appropriate support (Davies & Allen, 2007). Whether the onset of mental illness is postpartum or not, mothers with mental illness are in need of additional support and resources to cope with their illness and the added stress of parenting.

In order to support PHN practice with families where perinatal mental illness is an actual or potential concern, the Winnipeg Regional Health Authority (WRHA) recently developed a toolkit and provided workshops regarding perinatal mental health for PHNs. The aim of the project was to assist PHNs with early identification; to encourage access to treatment and follow-up; to promote awareness and education with families (WRHA, *Perinatal Mental Health Toolkit*, 2009). Although this toolkit focuses mainly on perinatal mood disorders, the interventions suggested such as education, support and resources are appropriate for more serious forms of mental illness as well.

Baby First, a family-visiting support program introduced in 1999 by Healthy Child Manitoba, is a provincial government initiative to promote healthy families. The criteria for healthy children are based on the following: physical and emotional health, safety and security, success at learning, social engagement and responsibility to the child's fullest potential (Healthy Child Manitoba, Programs and Services). In 2004, the Baby First program integrated with *Early Start Program* from Manitoba Child Care and is currently referred to as *Families First* (as per telephone contact with Marion Ross, Provincial Coordinator, Families First, 2010). The program involves an initial screen of all postpartum families within Manitoba by the PHN via a questionnaire; based on this score, the PHN does a further "in-depth" assessment and depending on this score, families are offered the Families First home visitor resource. The presence of maternal mental illness and other risk factors which are noted from the postpartum referral and upon the initial interaction with the family could potentially provide the family with access to this home-visiting program. The home visitor, under the PHN's guidance, provides resources and support to individual families regarding infant/child development,

positive parenting and activities to promote healthy development (Healthy Child Manitoba, Families First).

Whether or not mothers with mental illness are primary caregivers, parenting constitutes a major life role and developmental task in adulthood. As Bornstein and Cheah (2006) state, “In the minds of many observers, mothers are unique, the role of mother universal, and motherhood is unequivocally principal to development” (p. 16). Women with mental illness are as likely to become mothers as other women (Nicholson & Biebel, 2002) and these women are more likely to be actively parenting than their male counterparts (Mowbray, Nicholson, & Bellamy, 2003). Much of the focus of the research on motherhood for these women however is placed on the negative effects of their illness on children rather than on their experience, abilities and challenges of parenting. In order to further address this gap, more recent studies have looked at the experience of women who are parenting with serious mental illness (Dipple, Smith, Andrews, & Evans, 2002) as well as with postpartum mental disorders (e.g., Beck, 1995, 1998; Logsdon, Wisner, & Pinto-Foltz, 2006). Although postpartum mental disorders may not be long-term like serious mental illness (SMI), childbirth itself may trigger first time depressive, bipolar-depressive or psychotic episodes which can become long-term illnesses. Giving birth may also exacerbate symptoms for women with schizophrenia (Solari, Dickinson, & Miller, 2009) and may provoke a relapse for women with bipolar affective disorder (Foreman, 1998) hence the reason for considering all forms of mental illness as viewed by PHNs for this study.

A general lack of awareness of existing mental health services and how to access them is a concern for the public as well as for many health professionals. Some issues of

access revolve around what Corrigan (2004) refers to as “self-stigma”, where mothers internalize a stereotype of being incompetent, for example, and these mothers will often refuse to seek help for fear of being labelled unfit to care for their children (Dennis & Chung-Lee, 2006; Edwards & Timmons, 2005; Nicholson & Beibel, 2002). For Winnipeg’s PHNs, the health authority has reported a “lack of a coordinated response” with regards to postpartum mental health issues despite one of their core functions being to provide resources and support to all families in the region (WRHA, 2006). The Mental Health Toolkit (2009) and associated workshops were developed in response to this issue; however the perspectives of PHNs regarding mothers with perinatal mental health issues or mental illness have not been explored as part of the process. These could potentially affect how services are provided by PHNs.

Mental health professionals as a group have been shown to focus treatment and care mainly on individual women and their illness and have neglected the parenting aspects of women’s lives (Dipple et al., 2002; Joseph, Joshi, Lewin & Abrams, 1999; Montgomery, 2005; Nicholson & Biebel, 2002; Slack & Webber, 2007). Unlike mental health professionals, parenting is a main focus for PHNs; however, because physical aspects in the postpartum period remain a priority (and justifiably so), mental health issues can be missed or may not even surface during initial contacts with families. In cases such as postpartum depression (PPD) for example, symptoms often appear several weeks after birth.

Attitudes of mental health nurses regarding clients with mental illness have been recently studied with differing results as to whether nurses had positive attitudes towards mental health consumers in general (Caldwell & Jorm, 2000, 2001; Hugo, 2001; Munro

& Baker, 2007; Nordt, Rössler, & Lauber, 2006). It is possible that for PHNs, similar attitudes exist and that consequently, mental health issues may not be detected or addressed appropriately in the postpartum period, although these have not been researched. A study which looked at mental health nurses' ability to assess parenting, recommended that joint training between nurses and child protection workers would provide a more effective multidisciplinary approach (Rutherford & Keeley, 2009). As part of the PHN role in assessing families, consultation with Child and Family Services (CFS) is necessary for certain challenging family situations. The relationship between these two professional groups has also not been explored as to its effectiveness in dealing with "at-risk" families.

Attitudes of mental health nurses with regards to perinatal mental illness have also recently received some attention with one study revealing that nurses were not "comfortable" dealing with mothers with perinatal disorders (McConachie, & Whitford, 2009). "Comfort" levels for PHNs dealing with mothers with mental illness remain unknown.

Ross and Goldner (2009) in their literature review found that despite professional beliefs regarding holistic nursing care, many nurses working in general medical settings have negative attitudes towards persons with mental illness, primarily fear and blame/hostility. In view of these general negative attitudes among general practice nurses, it is not known how a mother with a mental illness is assessed and cared for on a maternity unit. It is not known whether similar attitudes exist among PHNs and how these affect the care they provide to these mothers.

Purpose of the Study

The purpose of this study was to explore and describe experiences of PHNs working with mothers with mental illness and how these affect how service is provided. PHNs often constitute a primary link between the hospital and the community for mothers with mental illness, particularly in the childbearing stage. Exploring their experiences will help to: 1) identify attitudes and perceptions regarding mothers with mental illness, 2) clarify their role in the provision of services, 3) identify challenges and barriers to providing services. The intent of the discussions will be to provide insight into the role of the PHNs working with this client population as well as the challenges they face from their perspective. These insights will lead to future recommendations for improvement in their practice and the delivery of service which in turn, can lead to better support services for these families. The ultimate goal is to promote healthy families by supporting mothers with mental illness and help reduce subsequent negative effects on children.

Healthy Child Development (Healthy Families)

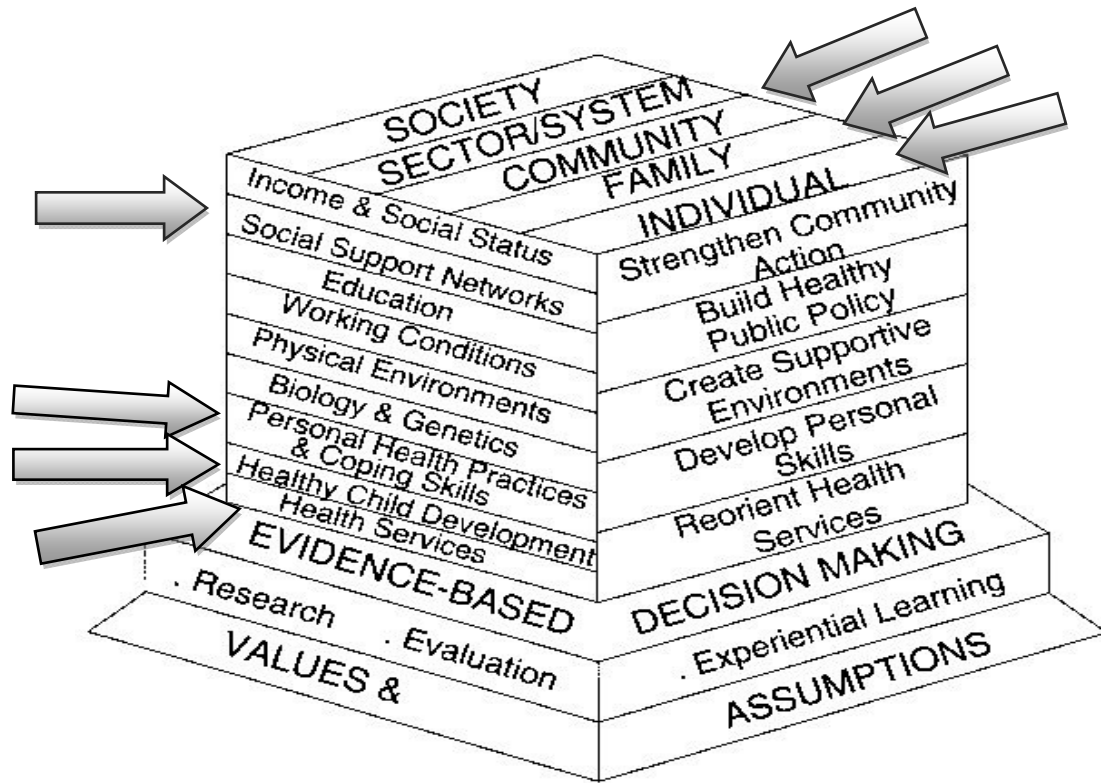
Health promotion, illness prevention and health protection constitute core functions of the PHN within the Regional Health Authorities of Manitoba (Manitoba Health, 1998). Prevention of illness specifically involves strategies to avoid the development of health issues in “at-risk” or potentially “at-risk” populations. Preventative goals related to the PHN role are: “...healthy pregnancies and healthy children” and “...having personal supports and coping skills to function effectively in everyday life” (p. 14), under the PHN core services of Reproductive and Family Health and Mental Health (Manitoba Health, 1998). It is therefore an integral part of the PHN

role to provide parenting education, support and appropriate resources to mothers who present with mental illness to prevent negative effects on families as a whole.

Conceptual Framework

In keeping with the role of the PHN in promoting healthy child development, the conceptual framework for this study is based on the *Population Health Promotion Model*, created in 1996 by Hamilton and Bhatti (see figure 1., p. 16). This model integrates two government documents, one which summarizes the determinants of health, *Strategies for Population Health: Investing in the Health of Canadians* (1994) and the other which describes action strategies for change, the *Ottawa Charter on Health Promotion* (World Health Organization, 1986). The role of the PHN within this model is working with families and communities to promote health and affect the determinants of health in a positive manner. In the case of mothers with mental illness, the PHN affects the following determinants of health: 1) social support networks, 2) personal health practices and coping skills, 3) healthy child development, 4) health services (by promoting the use and access of appropriate resources). By becoming more aware of PHNs' perspectives of their role and their experiences with these families, policy makers will be in a better position to address the challenges for PHNs in their professional role as well as any potential barriers to the provision of quality care for mothers with mental illness.

Figure 1: Population Health Promotion: An Integrated Model of Population Health and Health Promotion (Hamilton & Bhatti, 1996)



Research Questions

The research questions identified for this study are as follows:

1. How do PHNs understand the needs of mothers with mental illness?
2. How do PHNs perceive their role in meeting the needs of mothers with mental illness?
3. What do PHNs perceive as the challenges or barriers to supporting these families?

Significance of the Study

An understanding of PHNs' experiences working with mothers with mental illness is important to ascertain for several reasons: 1) to clarify their role in supporting mothers with mental illness within the intersectoral and multidisciplinary environments of the health care system, 2) to identify potential learning needs of PHNs in view of supporting them in their role with families, 3) to provide recommendations for educational opportunities to meet PHNs' needs and thereby promote quality care to families affected by mental illness, 4) to identify potential gaps and barriers for services to families.

Barriers to service for families will be highlighted and may potentially lead to future research and changes to improve services and resources to families. The information provided by PHNs can give insight into their education and support needs which can promote positive change in their role with mothers who have mental illness and potentially improve outcomes for families.

Chapter Two: Literature Review

Motherhood is generally viewed as both a rewarding and challenging experience. When a mother has a mental illness, the challenges of parenting are much greater as she is trying to balance competing demands from her illness, those of her children, and family life. Support for mothers has been shown to increase positive parenting among the general population. For mothers with mental illness, the support need is much greater due to the competing demands for managing illness symptoms and providing safe care to children. A core function of the PHN is to support families and promote positive family functioning. They would thus play a critical role for mothers with mental illness, yet their perspectives in this area have not been explored. Through this study, practical recommendations will attempt to facilitate some changes in public health nursing practice with families.

This chapter will present a review and synthesis of the literature relating to the study. The majority of studies were found in the disciplines of Nursing, Medicine and Social Sciences. This review includes literature on mothers with serious mental illness (SMI), mothers with postpartum mental health issues, the role of the PHN, and attitudes of health care professionals. These topics are reviewed according to the Population Health Promotion Model, focusing particularly on the determinants of health and the role of the PHN within this system.

Biology and Genetics

Mental illnesses such as major depression, bipolar disorder, schizophrenia and schizo-affective disorders are categorized as serious mental illness or SMI. Statistics for mothers with mental illness indicate that more than half of women with SMI have

children (Joseph et al., 1999) and that 20% of these mothers are primary caregivers of dependant children (Blanch, Nicholson, & Purcell, 1994). Fertility rates appear to be the same for women with mental illness as for those in the general population therefore mothers with mental illness are as likely as any other woman to have children (Nicholson & Biebel, 2002).

Postpartum depression (PPD) is a mood disorder which meets similar criteria to major depression with the exception of its occurrence in the postpartum period, anywhere between four to six weeks, even up to one year (Beeghly, Weinberg, & Olson, 2002). Although depressive symptoms are much the same as with major depression, the thought content for mothers with PPD, is generally focused on the baby. PPD is considered a major public health problem (Wisner, Chambers, & Sit, 2006), at a prevalence rate between five and 20% of women within six months postpartum (Solnek & Seiter, 2002). Puerperal psychosis, the most severe form of perinatal mental illness is rare at an incidence rate of 0.1- 0.2% (Miller, 2002) however its consequences can be lethal, such as infanticide.

Historically, women who suffered from SMI were segregated from society by institutionalization and were prevented from becoming pregnant by sterilization or if they did become pregnant, were prevented from parenting by removing children at birth. Sterilization was done in relation to the idea of eugenics where reproduction was discouraged for persons with genetic “defects” such as SMI, thereby preventing transmission of these illnesses to future generations and supposedly improving the quality of the human species (Krumm & Becker, 2006). The removal of children at birth was related to the belief that mothers with SMI were incompetent to parent. With more

community-based care and increased awareness of individual's rights with SMI, the focus has changed to one of rehabilitation and assisting persons to lead more productive lives (Mowbray, Oyserman, & Ross, 1995). Still today however, a high percentage of these mothers lose custody of their children. It is estimated that 30 to 70% of mothers with schizophrenia for example, experience custody loss (Nicholson & Miller, 2008). Consequently, many mothers with SMI who are parenting do not seek support from existing resources for fear of losing custody of their children and stigma.

Creating Supportive Environments

The PHN's role in creating supportive environments involves a socio-ecological basis for health, viewing individuals and families within their social and physical environments (Manitoba Health, 1998). As with holistic care in nursing, PHNs view mothers with mental illness within their social and environmental contexts and provide care accordingly. This includes the determinants of health such as poverty and lack of social support networks which negatively affect health as a whole. The stigma of mental illness can also be seen as a contextual factor as it can affect delivery of health services on both the part of the client and health professionals.

Stigma of Mental Illness

Although the days of sterilization are long since over, this history tends to continue to cloud perceptions regarding mothers with mental illness by the general public and health professionals alike. These mothers often face the risk of losing custody of their children in relation to their illness. Park, Solomon, and Mandell (2006) found that mothers with SMI were three times more likely to have had involvement in the child welfare system or to have children who had an out-of-home placement. Despite

significant progress that has been made over the years, these mothers continue to face challenges with stigma in relation to their ability to parent and the lack of support for parenting.

The stigma that mothers with mental illness are not competent to parent can have a negative impact on how parenting ability is evaluated by health professionals as well as on whether families seek assistance or not. Mothers with SMI report having to work harder than other mothers to prove themselves as capable to parent due to the fear of custody loss (Nicholson et al., 1998a). For mothers with acute and shorter-term mental health issues such as postpartum depression (PPD), an estimated 25% of mothers report not seeking help due to stigma (Lintner & Gray, 2006). Health professionals who are in contact with such families thus need to ensure they are assessing mothers appropriately and providing adequate support while ensuring safety.

An important role for PHNs working with mothers in the community is to encourage these mothers to seek help, yet seeking help means admitting she is mentally ill which can be perceived as equivalent to incompetence. This perception constitutes a critical barrier. Help seeking behaviours realistically should demonstrate strength and have the potential to reduce the need for out-of-home placements if adequate support is provided. Unfortunately, many people in the general public and health professionals still hold these views and need to be more aware and educated as to the needs of this client population. It is not known if PHNs hold these same attitudes. Also, their knowledge and experience in dealing with these mothers and how they assess and support them is not known. Changes in their perception of mothers with mental illness could help increase confidence for mothers to seek proper support.

Montgomery (2005) in her literature review found several studies demonstrating that mothers with SMI were managing the mothering role adequately. She noted however that many studies on mothers with SMI tended to focus on children who were found to be in need of protection. In such studies, mothers were framed as unfit to parent due to the label of mental illness that overshadowed other life circumstances for these women. She suggested that the focus on the children's need for protection and the negative effects on children of mothers with mental illness, contribute to the marginalization of this population.

In Fox's (1999) personal experience of mothering with bipolar disorder, the lack of support for parenting is demonstrated:

No one made an effort to support me in caring for my children. Either I had the children and was totally responsible for their care, or I didn't have them. There was no in-between and no effort to develop an alternative plan that would help me negotiate the demands of my mental illness and motherhood (p. 193).

In addition to the lack of support for mothers, the lack of attention on the part of health professionals is also evident (Bassett, Lampe, & Lloyd, 1999; Joseph et al., 1999; Krumm & Becker, 2006). Efforts should be made to support them in their parenting role as well as with their need to maintain contact with children (Dipple et al., 2002). Contextual factors such as poverty are also important considerations in the assessment of these mothers and how these contribute to parenting competence (Montgomery, Tompkins, Forchuk, & French, 2006).

The media's portrayal of mothers with mental illness revolves mainly around extreme cases of puerperal psychosis. Although rare, this severe form of perinatal mental illness is most often sensationalized in the media particularly with cases of infanticide. Mothers are labelled as "killer mummy"; claims are made that the public is tired of the "hormonal defence" and that mothers affected by psychosis "get off lightly" (Picard, 2001). Such highly publicized incidents create further stigma and prevent mothers from getting much needed support. Stigma can also lead to the development of negative attitudes towards these mothers whether as a member of the general public or amongst health care providers.

Attitudes of Health Care Professionals

Attitudes of health care providers towards consumers of mental health services affect care and recovery (Munroe & Baker, 2007). Negative and stigmatizing attitudes have a negative effect on the care that is provided and can thus impact the recovery process. Corrigan, Backs Edwards, Green, Diwan Lickey, and Penn (2001) maintain that negative attitudes lead to social distancing which reduces one's ability to provide quality care. Attitudes of professionals also affect collaborative relationships with families (Kim & Salyers, 2008). With regards to PHNs, attitudes can affect their interactions with mothers with mental illness and how they are assessed, hence the importance of exploring their perspectives.

Few studies look at nursing attitudes towards mental illness. Munroe and Baker (2007) studied attitudes of mental health staff regarding mental health patients and discovered overall positive attitudes amongst professional nursing staff and more negative attitudes for nursing assistants. In addition, they found that nurses who were

knowledgeable regarding the aetiology and risk factors for relapse of mental illness had more positive attitudes. This reinforces that awareness and education play an important role in attitude development. Kim and Salyers (2008) found professionals who had received more training on working with families, provided more services to families and had more positive attitudes toward families. In their US state-wide survey of over four hundred community clinicians working with clients with SMI, they evaluated mental health professionals' perceptions of the barriers to the development of services as many did not provide services to these families. Those who had no specific training to deal with families provided fewer services and expressed barriers such as heavy workload and family's lack of interest. Recommendations were made that professionals need more training in order to increase and improve services to families with SMI. Interestingly, these professionals did not see variables related to their own competencies and attitudes, nor lack of support from their agency as major barriers leading one to suspect that negative attitudes played a role in service provision.

In Ross and Goldner's (2009) review on nurses' attitudes towards mental illness, they concluded that considerable additional education regarding mental illness and mental health care was required for both entry-level and practicing nurses to upgrade their knowledge base. In many of their reviewed studies, nurses from general medical settings expressed their lack of skills to confidently and competently manage clients with mental illness. They linked this gap to fear of clients. Fear was in relation to the stereotypical beliefs that those with mental illness were dangerous, violent and unpredictable. Nurses in some of these reviewed studies believed they could "say the wrong thing" and "set them [clients with mental illness] off". Such attitudes among

nurses affect how care is provided; nurses would thus distance themselves in response to their fear and hence not be providing quality care. Many nurses in their review did not see the mental health component of their clients as part of their job and this despite the professional nursing belief in holistic care. It is not known whether similar attitudes exist among PHNs and how these affect delivery of care and supports.

A sociological perspective of motherhood and mental illness recently studied by Krumm and Becker (2006) has shown that despite the shift from problem-focused to resource-focused care regarding motherhood and mental illness, issues such as partnership, desire for children, unplanned pregnancy, birth control, family planning and childbearing are often neglected by mental health professionals. In addition, they found that family planning for these women generally focused on the consequences of maternal mental health problems on child development. For PHNs, these issues are critical to their role yet it is not known how these are addressed specifically with this client population.

As an influential aspect of human life, motherhood needs to be supported by PHNs particularly in view of their role in promoting healthy families. Krumm and Becker (2006) maintain that professionals need to improve their understanding of the needs of women with mental health problems with respect to reproductive health and motherhood in order to support the entire family.

Mental health professionals have been found to overlook issues of motherhood for women. Dipple et al. (2002) found little information in women's charts regarding their roles as mothers. Conversely, professionals from the general programs have been found to neglect issues of mental health as a whole. Nicholson and Biebel (2002) found many general health care providers overlooked or did not ask the appropriate questions with

regards to mental health. In Fox's (1999) personal experience she states, "Rather than having to help me find ways to cope with my daughters, they (health professionals) chose to deal only with me" (p. 194). It is thus important for all health care professionals to assess women in a holistic manner, including aspects of motherhood and mental health.

As shown, issues of parenting are often ignored by many health professionals whether on a general medical unit or in mental health. For mental health professionals, mental illness symptoms were deemed more important and the additional stresses for women such as motherhood were often ignored (Joseph et al., 1999). For many health care professionals outside of mental health, physical health and rehabilitation is the primary focus. In Ross and Goldner's review (2009), general medical nurses did not treat mental health clients' needs as priority, giving clear messages that they had "better" things to do. In order to uphold the professional value of holistic care, nurses working in mental health and other areas need to ensure issues related to parenting for mothers are included in their assessments and care plans, and that they provide additional support as needed.

Stigma, illness symptoms and stress affect parenting for mothers with mental illness (Nicholson et al., 1998a). Due to stigma, these mothers are often stereotyped by society and health professionals alike as being "at-risk" for being incompetent parents. As in Fox's personal account, "I feel I was pressured by my treatment providers to give up the care of my children" (1999, p. 193). Such negative attitudes by health professionals can increase feelings of inadequacy for mothers, affecting parenting. More importantly, such attitudes can have a serious impact on the potential for custody loss. A

supportive environment is most conducive to positive parenting with or without mental illness.

Slack and Webber (2007) in Australia found community mental health professionals had a more positive attitude than those on an in-patient unit. Although attitude was studied in relation to identifying the needs of children whose parents had mental illness, this demonstrates the potential for differences between hospital nurses and PHNs. Community professionals were more likely to say they would address issues with children in the case studies presented. If PHNs are found to have positive attitudes towards mothers with mental illness, the “lack of coordinated response” may be related more to a lack of resources to address parenting issues versus how mothers are assessed. This study will help clarify this issue.

Experience of Mothering with a Mental Illness

Past research has mainly focused on the negative effects of maternal mental illness on children. In order to address issues relating to parenting, more recent studies have focused on the experience of mothers with SMI (e.g., Bassett et al., 1999; Diaz-Caneja & Johnson, 2004; Dipple et al., 2002; Joseph et al., 1999; Montgomery, 2005; Montgomery et al., 2006; Mowbray, Oyserman, Bybee, & MacFarlane, 2002; Nicholson et al., 1998a,b). Nicholson et al. (1998a,b) studied the experiences of mothers with SMI by means of focus groups. Major themes from this American study involved: the stigma of mental illness, day-to-day parenting, managing mental illness, and custody of and contact with children. Mothers who were primary caregivers spoke of difficulty deciphering what was “normal” for parenting stress and what was related to mental illness symptoms.

Managing mental illness was viewed as a risk for conflict between the mothers' own mental health needs and the needs of their children. As these mothers try to balance the needs of the children with their own mental illness needs, they may have difficulty prioritizing, which can potentially result in neglect of children. Nicholson et al. (1998a) showed stigma played a role in parenting where mothers felt additional pressure to have to "prove themselves" as able parents. Stereotyped ideas from society that their mental illness is responsible for their children's problems and that mothers with mental illness abuse their children, add to parenting stress. The additional stigma and pressure from society and health care professionals add to the stress of parenting, which could potentially increase illness symptoms and affect parenting ability. Although many of these mothers do experience a high rate of custody loss, it is not known to what degree contextual factors such as poverty play a role in the determination of incompetence.

In the Canadian Incidence Study (2003) caregiver functioning and family stressors were evaluated in over 77,000 cases of substantiated child maltreatment for female caregivers across Canada (excluding Québec). Factors included were: substance abuse, criminal activity, cognitive impairment, mental health issues, physical health issues, few social supports, maltreatment as a child, and victim of domestic violence. These were "confirmed" or "suspected" by the investigating workers. In a sample of just over 4000 cases, mental health issues came in third at 27%. Concern for domestic violence was first at 51%, followed by lack of social supports at 40% and maltreatment as a child was fourth at 25%. Maternal mental illness itself thus represented only a small part of at-risk family situations. Although many mothers with mental health issues such as SMI also

have few supports, and possibly some other of these factors, this report does demonstrate the multiple contextual factors that interplay in parenting and parental competence.

Mowbray et al. (1995) found that some mothers with SMI showed positive parenting. They looked at parenting and the significance of children for women using interviews of 24 mothers. Women in the study completed structured measures on parenting behaviours and attitudes and responded to open-ended questions about problems and joys of having children. Results demonstrated that child behaviour and parenting responses were within appropriate ranges. Women in this study reported lack of emotional, material and financial resources. Parenting difficulties were reported in the domains of discipline and separation. Discipline is a common challenge for many parents with or without a mental illness. This would be important to clarify as a “normal” parenting concern and not related to mental illness. Through public stigma and self-stigma, mothers view themselves as inadequate to parent yet despite their many challenges mothers with mental illness demonstrate competence in parenting children (Montgomery, 2005). The need for support remains critical to raising their children (Chernomas, Clarke, & Chisholm, 2000).

Singleton (2007) discussed the needs of children whose parents had mental illness. Some of the needs expressed included peer support groups, a child-friendly hospital environment for when parents are admitted, a personal/family care plan in situations of a parent’s hospitalization, and more information sharing regarding their parent’s mental health problems. Family-focused interventions in relation to these needs were recommended. Mowbray et al. (1995) also maintain that “supports and resources available to bolster and reinforce the parent are clearly critical to the process and

outcomes of parenting both for parents and for the children they seek to nurture” (p. 189). As all family members are affected when one has a mental illness, any support provided will affect the entire family.

Important moderating factors that affect parenting are also mentioned by Singleton (2007) such as the severity of the illness, how it affects “normal” family life, the presence of another caregiver, individual resilience of the child, and the child’s understanding and acceptance of their parent’s mental health problems. Contextual factors such as poverty, homelessness, single parenting, substance abuse, domestic violence, and lack of supportive parenting services influence parenting (Montgomery, 2005). In view of these, Montgomery (2005) recommends a shift in thinking for clinicians from looking at illness and symptoms to the mother’s total life situation. These factors are important to consider when developing programs and resources for this client population.

Develop Personal Skills

The PHN role in developing personal skills of individuals and families, relates to health promotion activities such as health education, parenting skills, and self-care skills which support their personal and social development (Manitoba Health, 1998). The objective of such activities is to have a positive effect on parenting and child development. For mothers with mental illness, such activities are particularly important in view of the added stress of illness symptoms. Without support, these mothers may experience isolation which in turn can affect their parenting abilities. When parenting is compromised, children are potentially at risk.

Healthy Child Development

Mothers constitute the primary caregivers of infants; they make up the main source of social stimulation and interaction for their infant's first year (Logsdon et al., 2006). When mothers experience symptoms of mental illness, their caregiving skills can be impaired. It is well known that infant attachment in the early stages of life is an essential component of healthy development (Ainsworth, 1972, 1982, 1989 & Bowlby, 1969, 1973, 1980, 1988a & 1988b, as cited in Bee & Boyd, 2008). This process is no different in families where the mother has a mental illness with the exception that their need for support is crucial during this phase. Infants and children can be affected by negative parental behaviours and they are sensitive to the emotions of their caregivers (Currie & Rademacher, 2004). Parenting behaviours are affected particularly when mothers are experiencing mental illness symptoms; the focus of her attention will tend to be more on her own needs versus those of her child.

Numerous child development studies have demonstrated long-term negative effects of PPD including impaired attachment, antisocial behaviour, poor cognition, and intellectual deficits (Beck, 1998; Hay, Pawlby, Sharp, Asten, Mills, & Kumar, 2001; Murray, Sinclair, Cooper, Ducourneau, & Turner, 1999). According to attachment theory, a secure versus insecure attachment can predict social competence and behavioural disturbances in children (Foreman, 1998). As symptoms of mental illness can negatively affect the security of the mother-infant bonding and attachment in the early stages of infancy, there is a risk of long-term impact on children. Support networks, treatment and follow-up care for the family can moderate these effects. Whether as an initial contact postpartum or as a longer-term follow-up such as with Families First, the PHN acts as a

liaison between families and resources, including those for mental health, to promote positive family functioning.

Several studies have found that depressed mothers perceived their infants as more difficult to care for and more bothersome than non-depressed mothers (Field, Morrow, & Adlestein, 1993; McGrath, Records, & Rice, 2008; Whiffen & Gottlieb, 1989).

According to the National Institute of Child Health and Human Development (1999), depressed mothers demonstrated more irritability and were less responsive to their infants' needs. Mothers with depression were found to have fewer affectionate contact behaviours toward their infants and were less likely to respond to infant vocalizations by vocalizing themselves (Fleming, Flett, Ruble, & Shaul, 1988), and also had fewer positive and animated faces and voices (Raag, Malphurs, Field, Pelaez-Nogueras, Pickens, Martinez and others, 1997). These parenting behaviours could be reflective of a mother's withdrawal from the infant subsequent to ineffective coping, as she is trying to balance her own self-care needs with the care needs of her infant. Interventions exist to promote positive interaction such as coaching on attachment strategies which can support mothers and reduce negative effects on infants and children.

Studies have also looked at negative effects on children of mothers with severe mental illness (SMI). Snellen, Mack, and Trauer (1999) found that mothers with schizophrenia and their infants were at risk for displaying disturbed interactions. A literature review on parenting with SMI by Oyserman, Mowbray, Meares, and Firminger (2000) revealed that mothers with schizophrenia were less involved, more uncertain, and less able to create a positive climate for their infant while their school-aged children were more likely to have cognitive deficits. When Riordan, Appleby, and Faragher (1999)

compared mother-infant interactions of mothers with schizophrenia and mothers with affective disorders, they found that those with schizophrenia were significantly more insensitive and intrusive. Foreman (1998) adds that acute onset of schizophrenia in the postnatal period likely results in breakdown of parenting leading to removal of children from their mother. Mothers with bipolar disorder expressed problems in disciplining children (Venkataraman & Ackerson, 2008). Children of mothers with SMI have been found to be at increased risk for neurodevelopmental disorders (Jablensky, Morgan, Zubrick, Bower, & Yellachich, 2005).

Mowbray et al. (2002), in a quantitative study on mothers with SMI, looked at both clinical and parenting variables on over 300 mothers with diagnoses of schizophrenia, major affective disorder, or bipolar disorder. Clinical variables including diagnosis, symptomatology and community functioning were compared with parenting variables namely discipline, nurturance, parent-child relations and parenting stress. They found that for parenting variables, women with schizo-affective disorder and non-African American women with schizophrenia or schizo-affective disorder had more parenting problems than women with other affective disorders. The severity of mothers' symptoms and the degree of community functioning were key factors. The chronicity of their illness had minimal effects as they found that individuals tended to "plateau" in functioning after five years of mental illness. They found that mothers with SMI were not necessarily at higher risk of problematic parenting than mothers with less serious or more acute mental illness if symptoms were under control and community functioning was positive. Community functioning was a self-report item in this study so it would be important to look at what was considered to be "functional" in the community for these women and

what specific supports would be needed at this level. Interventions needed to focus on alleviating symptoms and providing more opportunities for community involvement. In light of these results, they concluded that current knowledge about how mental illness affects parenting which was based primarily on contrasts between mothers with mental illness and those without, inflated negative effects on parenting.

A stronger focus on demographics, differential diagnoses, symptoms and community functioning for this client population would be more representative. Illness symptoms that interfere with parenting abilities can contribute to custody loss for some families; this in turn has an impact on family functioning.

Impact of Custody Loss

In relation to negative effects of mothers' SMI, children are often viewed as at risk, resulting in potential loss of custody (Busch & Redlich, 2007; Howard, Shah, Salmon, & Appleby, 2003; Park et al., 2006; Risley-Curtiss, Stromwall, Truett Hunt, & Teska, 2003). Studies on the negative impact of maternal mental illness on children view children as in need of protection versus the mothers being seen as in need of support. Although security of children is the priority, children in care are also at risk: "What is known is that all Canadian children who receive child protection services have been deemed at significant risk of or actual victims of child abuse, neglect and maltreatment" (Child Welfare League of Canada, 2003, p. 3). Limited resources in the child welfare system also limit availability of appropriate out-of-home placements. It is therefore most beneficial to help families by providing supports within the home and prevent separation of families.

Unfortunately, loss is a recurring theme for women living with SMI (Chernomas et al., 2000; Dipple et al., 2002; Nicholson et al., 1998a). Many mothers lose their partners, children, financial and family supports due to stigma and illness symptoms. Dipple et al. (2002), through semi-structured interviews of mothers affected by SMI, looked at the extent of contact between these mothers and their children, when and why they lost custody and how this had occurred. Up to 50% of children were permanently separated from their mothers during childhood and 37% had no further contact with their mothers. When custody loss does occur, these women often struggle to meet the cognitive, emotional, and financial demands of drawn-out custody proceedings (Logan, Knights, Barton, & Boyce, 2009). They may not understand procedures and more importantly, the requirements they need to fulfill to gain access to their children or regain custody. Such stressors can also exacerbate illness symptoms for mothers. Fox's (1999) personal experience reveals:

The focus of my early treatment was to eliminate what was going wrong in my life and eliminate it. My children were viewed as major stresses. Instead of getting recommendations for parenting classes and family treatment, I was urged to simplify my life. I was encouraged to believe that I couldn't cope with my children. Although this idea left me feeling guilty and inadequate, the people caring for me seemed to believe it, so I thought it must be true (p. 193).

This highlights the need for more comprehensive supports at all levels of service delivery.

Despite these issues, mothering remains an important aspect in women's lives. In a survey of hospitalized mothers suffering from SMI, Joseph et al. (1999) found that 12% of respondents described themselves as the primary caregivers for their children. None of them, however, felt that continuing to mother their children was unimportant. Major themes identified in their study centered on coping with loss of their children i.e., coping with sadness related to losing their children, getting children back, learning mothering skills, and learning how to discipline their children appropriately. Their study emphasizes the importance of addressing issues of mothering for women who suffer from SMI whether they are primary caregivers or have lost custody of their children. Findings by Nicholson et al. (1998a) are similar to those found by Joseph et al. (1999) and Chernomas et al. (2000) where mothers talked about lifelong effects of having lost custody of their children.

Mothers that are separated from their children need support not only in dealing with the loss but also how to maintain contact with their children. Their children also need to know that their mother has not abandoned them and still cares about them even if they are not with her. Most importantly, health professionals need to help these mothers keep their children by providing appropriate support.

Perinatal Mental Illness

Perinatal mental illness, such as PPD, has been studied extensively in the past decade as a significant risk factor for mothers and infants in terms of maternal-child interaction (Beck, 1995; Cohn, Campbell, Matias, & Hopkins, 1990; Field et al., 1993; Riordan et al., 1999; Stein, Gath, Bucher, Bond, Day, & Cooper, 1991), infant and child growth and development (Beck, 1998; Murray & Cooper, 1996, 1997) and neglect/abuse

(Attia, Downey, & Oberman, 1999). If left untreated, PPD can have adverse long-term effects for the mother, as a possible precursor of chronic recurrent depression. Horowitz and Cousins (2006) found few women received treatment despite screening and referral for postpartum depression (PPD). For children, PPD can contribute to emotional, behavioural, cognitive and interpersonal problems in later life (Jacobsen, 1999). In Ontario and Manitoba, an increased focus on perinatal mood disorders by Public Health has prompted discussions on the PHN role in assessment and support (Leitch, 2002; WRHA, 2006). PHNs' involvement with mothers suffering from perinatal mental illness has received attention; however their perspectives on mothers with mental illness have yet to be explored.

Parenting Programs

Service needs for this client population have also been advanced in relation to mothers' experiences (Cook & Steigman, 2000; Nicholson & Blanch, 1994). These originate from a mental health perspective and offer recommendations for mental health professionals and mental health services either in hospital (Mayberry & Reupert, 2009) or in the community (Brunette & Dean, 2002; Oyserman, Mowbray, & Zemencuk, 1994). Most often, programs fall under the umbrella of either Mental Health or Public Health, with little integration of existing programs. Mothers with mental illness have issues with parenting and illness symptoms, therefore would benefit from a comprehensive approach by health professionals from both mental health and public health.

Mowbray et al. (2003) looked at the needs of women with mental illness for psychosocial rehabilitation services. The concerns expressed by women in their study revolved around child welfare. They recommended a psychosocial rehabilitation program

to benefit these women including: 1) parenting skills at all children's developmental stages; 2) basic survival (self-care) skills including home maintenance skills; 3) stress management; 4) self-help group skills; 5) vocational/educational skill development; 6) peer support/counselling. In Winnipeg, the WRHA Mental Health Program is responsible for programs and ideally should collaborate with Public Health to provide the most comprehensive service to parents. The Perinatal Mental Health Toolkit/Pilot Project (2007) and workshops are examples of a collaboration between Mental Health and Public Health programs. PHNs provide important services to mothers at risk for mental health issues and to those with existing mental illness yet research on the collaboration between these professional groups is scarce in the literature.

Parenting programs should be geared specifically at supporting mothers with mental illness to help reduce their possible isolation as they are at risk of isolation in relation to symptoms and stigma. At the former Clarke Institute of Psychiatry in Toronto, (now the Centre for Addictions and Mental Health) a program for women with schizophrenia was established to meet their support needs (Seeman & Cohen, 1998). It involved specialized services such as comprehensive individual and family assessments, medication and psychosocial rehabilitation therapies, and management during pregnancy and early parenthood. For mothers, there were parenting groups. Many referrals to the program were from Child and Family Services (CFS) relating to parenting abilities and custody disputes. The general philosophy was that it is best for children to be with or spend as much time with their mothers and, so as long as mothers' symptoms are not dangerous to them and the extra supports are provided, this should occur. In-home support in the postpartum period was also provided through a case manager assigned to

each patient and through workers from CFS. Helping women stay connected to a social network is an important focus which as we know, helps promote positive parenting.

Love, Suarez, and Love (2008) describe a successful program in the USA directed at young mothers with mental illness (under 24 years of age) which includes home-visiting support for parenting, addictions and relationship counselling. These mothers typically are or have been in the child welfare system. Such programs offer a multidisciplinary approach to care addressing the multiple needs of mothers with mental illness.

Mowbray, Oyserman, Zemencuk, and Ross (1995) through their literature review (1983-1992) regarding motherhood and SMI (specifically the parenting difficulties experienced by mothers) recommended that awareness-building and education need to be put in place so that treatment programs address childcare and parenting problems faced by mothers with SMI. Their review found little information on the availability of specialized programs for women and children. Of those reviewed, many were in specialized in-patient settings with non-representative samples or part of out-patient programs with very high drop-out rates. Given the high drop-out rates for the programs mentioned in their review, it would be important to do a needs and feasibility assessment in order to implement a successful program.

Issues such as transportation could be a barrier to providing group programs at a clinic for example. In-home parenting support, although beneficial, may lack the group-support that clients could experience from attending a session, as well as the need for a “break” from parenting. Therefore, although Families First is an important resource for

these mothers, support groups are beneficial particularly to prevent isolation. PHNs would constitute an initial contact for such programs.

Although the need to support mothers with mental illness can be demonstrated by the negative effects on parenting, the focus on negative effects can add to the feelings of guilt and pressure that these mothers already experience. Research on how these women experience motherhood is more relevant in view of developing appropriate resources to assist them in becoming better parents and prevent adverse effects on children. Such parenting programs can help to alleviate some of this pressure while providing much needed support.

Nurses' Role in Caring for Mothers and Families

The family is considered the most important context in nursing, where health evolves for the individual; it determines beliefs, attitudes and behaviours related to health and how illness is managed (Duhamel, 2007). It is thus essential that nursing interventions are aimed at families rather than individuals in order to influence health in a positive manner. As PHNs work with families in their homes, they have a special opportunity to establish and maintain therapeutic relationships with families thus increasing the potential for successful interventions. PHNs help to create supportive environments in the homes of families by providing health education and resources that promote family health.

The relationship of trust between the PHN and families becomes an opportunity to assess and address mental health needs. As Gaul and Farkas (2007) state, "Contact with public health, a trusted entity that tends to be viewed as helpful, caring, and nonjudgmental, becomes an opportunity for mental health needs to be assessed and

addressed”. PHNs that see families in the postpartum period are in a position of trust when assessing and intervening within the context of the family, the home and the community in which families live. Opportunities can include assessment of parenting and mental health concerns that may impact parenting.

Recent studies have focused on the role of nurses with regards to PPD in terms of early recognition and increased support to mothers in view of preventing negative effects on families as a whole (Beck, 2002, 2005; Beeber, 2002; Horowitz, & Goodman, 2004; Lintner & Gray, 2006; Logsdon et al., 2006). Few studies have focused on their role in working with mothers with SMI. In order to address the needs of these mothers, nurses need to feel comfortable and confident in their practice. Nurses from many different areas of nursing are not assessing parenting. Mental health nurses do not feel comfortable assessing parenting abilities and it is not known if PHNs feel the same way regarding assessing mothers with mental illness. Kim and Salyers (2008) found that professionals with more training to work with families provided more services to families and had more positive attitudes toward families. There is a need for providers to increase and improve services to families with SMI and more training is recommended to enhance their skills.

Nurses need to view the woman as both a mother and as a person with a mental illness to help them with the dual task (social roles) through their interactions and disciplinary power (Davies & Allen, 2007). According to Davies and Allen (2007), Western societies do not consider mental illness as part of the “ideal” of motherhood. There is a tension between societal ideals of a “good mother” and social norms of mental illness which makes women with mental illness feel like failures as mothers by not

reaching this “ideal”. Supporting the parenting role is part of the care provided by the PHN; it is important to study their perspectives of mothers with mental illness in order to best serve this client population. Their perspectives can help to identify needs of these families as well as their own professional needs to better support parenting.

Home Visiting

Home visiting has been shown to have positive effects on family health (Boris, Larrieu, Zeanah, Nagle, Steier, & McNeill, 2006; Ciliska, Mastrilli, Ploeg, Hayward, Brunton, & Underwood, 2001; Davies, & Allen, 2007; McIntosh, & Shute, 2006; Risley-Curtiss et al., 2004; Shaw, Levitt, Wong, & Kaczorowski, 2006). The home environment offers a realistic context for the development of a therapeutic relationship between the PHN and families. This position of interacting with families in the home also lends itself to witnessing both positive and negative parenting styles, where nurses can intervene in several ways depending on the situation: 1) positive modeling; 2) providing support and offering resources for improvement; 3) consulting and/or reporting to CFS if safety is a concern. These interventions all constitute part of the PHN role in promoting family health (Crisp & Lister-Green, 2004).

Reorient Health Services

As the responsibility for the determinants of health is shared among communities, government and all sectors, the role of the PHN is to promote responsible and effective use of the health care system and community resources. The PHN refers families to appropriate services and engages other sectors in addressing the determinants of health (Manitoba Health, 1998). Engaging other sectors includes collaboration amongst various disciplines to address the determinants of health and promote healthy families.

Interprofessional Focus

Professionals from community mental health and family services who work with clients and families affected by mental illness have supportive roles with mothers with mental illness. Community Mental Health Workers (CMHWs) provide support mainly for managing mental illness, while family services provide resources to support families. These however are not necessarily specific to the perinatal period. PHNs have a major role in the perinatal period. Collaboration between PHNs and these other professionals would be helpful to families yet once again, research on the collaboration between these professional groups is limited. Since Community Mental Health Workers (CMHW), in many instances, share physical space with PHNs in the public health offices of the WRHA, it would be important to investigate what, if any, collaboration exists between them.

The extent of the collaboration between PHNs and CFS would also be important to explore. This sharing of knowledge between professionals could lead to more partnerships and improved programming for this client population. There is a need to coordinate services between CFS, mental health and Public Health as PHNs are in a position to provide mental health care in the childbearing years and beyond. Lewin and Abdrbo (2009), in their study of mothers with SMI and child protection issues, concluded that there was a need for coordination of services to address parenting and the support of children.

In a cross-sectional survey of mental health professionals in the United Kingdom, Slack and Webber (2007) found that the needs of children whose parents had mental illness were largely unrecognized and unmet. They concluded that adult mental health

professionals lacked experience to deal with children; children's professionals may feel they do so in mental health rendering them both reluctant to deal with this group of children. These families therefore "fell between the cracks". This demonstrates the lack of integrated and comprehensive focus on families.

A public health - mental health model in the USA has proven success in having a psychiatric nurse clinician as part of the public health team to act not only as a consultant for the PHNs but also for client assessments and interventions (Gaul & Farkas, 2007).

Blanch, Nicholson, and Purcell (1994) have also shown support for increased collaboration between these groups in order to best meet the needs of this particular client population. Their findings are based on a public hearing held by a state wide interagency taskforce in the USA where persons with mental illness who were raising families, families of persons with mental illness, and service providers all voiced needs and concerns with regards to services, public policies and procedures and coordination between systems. Authors emphasized that a services integration approach to families with mental illness would reduce out-of-home placements, reduce need for mental health interventions for children, improve parenting skills and increase satisfaction for all involved.

The program described by Seeman and Cohen (1998), addressing the multiple needs of women with SMI, was a comprehensive program involving various disciplines at the clinic and integrated services with other agencies for community support. Case managers constituted an important link for clients in terms of coordinating and accessing resources. Although this program has since been discontinued, this was an example of an

interprofessional approach to the complexities of mothers' situations and emphasized the importance of a case manager.

In Australia, authors Hauck, Rock, Jackiewicz and Jablensky (2008) have developed a framework for mothers with SMI with the potential for ongoing development of intervention resources aimed at the child-bearing continuum i.e., from preconception planning to postpartum support through to early childhood years. Such a program would integrate mental health and public health programs. PHNs in Manitoba have a role in the child-bearing continuum, providing prenatal and postpartum care. This is considered primary prevention level of care with the ultimate goal of mitigating problems early on, a core function of the PHN.

A Canadian study by Shaw et al. (2006) consists of a systematic literature review on the effectiveness of postpartum support strategies on maternal knowledge, attitudes, and skills related to parenting, maternal mental health, maternal quality of life and physical health. They looked at randomized controlled trials (RCTs) of interventions initiated at birth up to one year postpartum. Studies were categorized according to outcomes for these factors. Although no RCT evidence was found to endorse universal postpartum care for improving parenting, maternal mental health, quality of life or physical health for low-risk women, some evidence supported postpartum support for high-risk populations particularly when a detailed needs assessment was performed and intervention was intense such as in frequent home visiting. They recommended more qualitative and non-randomized controlled trials for further research targeting specific high-risk populations for postpartum care as RCTs focus on predetermined measurable outcomes that are not always reliable or relevant.

At present, programs specific to parenting issues for mothers with mental illness such as these, do not exist within the WRHA. A literature search of published articles has also detected a gap in interagency collaboration among public health and mental health professionals as a whole. A coordinated effort with public health, mental health and family services is essential to provide parents with the needed supports including comprehensive parenting programs, as well as to advocate for families living with the stigma of mental illness and in situations of poverty.

Mowbray et al. (1995) suggest that the public mental health and child welfare systems need to collaborate and provide assistance to these women in terms of financial, personal, interpersonal and economic supports in addition to parent skill training, parenting support groups, and money-management skills. Results in this study showed that child behaviour and parenting responses were within normal range which indicates that other factors such as poverty and lack of support could be the mediating factors for poor parenting skills and negative outcomes for children. Thus a diagnosis of mental illness itself should not be what determines parental competency. Poverty being a determinant of health is likely a factor in parenting ability for these mothers. Mowbray et al. (1995) also emphasize such contextual factors, looking at the mothers' life situations rather than their illness. Once again, the importance of a comprehensive and interprofessional approach to helping mothers within their contexts.

Social Support Networks

Recent studies have shown positive effects of social support in childbearing and childrearing (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; Balaji, Claussen, Smith, Visser, Johnson Morales, & Perou, 2007; McCue Horwitz, Briggs-Gowan, Storfer-Isser,

& Carter, 2007; Raikes, Thompson, 2005; Surkan, Peterson, Hughes, & Gottlieb, 2006). For mothers with SMI, Mowbray et al. (1995) found a gap regarding the extent to which social support functions to mediate the relationship between SMI and problems during pregnancy and postpartum. Exploring this relationship would help to uncover personal strategies and provide information to health care providers on how to better support these women. In contrast, Nicholson et al. (1998b) looked at family relationships and social support for mothers with severe mental illness. Although some women described their families as supportive, many spoke of conflicts and unsupportive family members who stigmatized them. As Fox (1999) stated, "No one, professionals or family members, thought it was possible for me to maintain my family while coping with bipolar disorder. The message was that I was a hopeless case" (p. 193). Poor supports can have a negative impact on recovery for these women and lead to feelings of inadequacy as a parent. Stigma of mental illness can lead to conflict and resentment amongst family members and it is often the client and her children that pay the price by not receiving adequate and appropriate support. Health care professionals need to listen to mothers and acknowledge their needs and concerns. They should not assume that family support is always positive and provide support and education to families where possible. This demonstrates the influence of contextual factors in assessment of parenting for which the PHN is in a key position.

Education

Nicholson and Biebel (2002) suggested that professionals examine their own assumptions about mental illness and child bearing, asking questions related to being a parent and parenting skills, acknowledging parents' strengths, facilitating access to

treatment and education about illness, family planning, and child development. They asserted that parents with mental illness are like any other parent with similar goals and challenges; providers can help make a positive difference by providing support. This commentary stressed the need for health care providers working with families to feel comfortable asking questions. All nurses working with families could benefit from these suggestions. Nurses working in areas outside mental health may not feel confident discussing mental health concerns for mothers with mental illness, and nurses in mental health may not feel comfortable discussing parenting issues for mothers with mental illness. PHNs comfort level with mental health issues is not known. PHNs in particular need to understand their own attitudes about mothers with mental illness to care for them appropriately.

Summary

Mothers with mental illness can experience serious challenges in their parenting as they struggle to cope with their illness symptoms as well as the care needs of their children. In view of the added stress of mental illness, they are in need of support for parenting. Health professionals' attitudes and experiences can affect how these mothers are assessed and consequently what they are offered in terms of support and resources. PHNs visit mothers in the postpartum period and are in a unique position to assess mental health and parenting needs of families within the home environment. Although perinatal mental illness has been recently addressed by Public Health within the WRHA, it is not known how PHNs view these mothers or mothers with SMI. Through sharing their experiences with these families, PHNs can clarify their role with these mothers and identify challenges and barriers to providing service. How PHNs view the

needs of mothers with mental illness will potentially provide insight into attitudes they hold and their need for more education. Understanding these needs will help in the development of appropriate resources for both the PHNs and mothers with mental illness and promote healthy families.

Chapter Three: Methodology

This chapter presents the methods used for this study including, general aims, research design, sampling strategy, and inclusion criteria. Rationale for the qualitative paradigm is also included along with data collection procedures and ethical considerations. Lastly, an explanation for the methods used for data analysis and a brief summary are provided.

Aims

The overall aim of this study was to explore experiences of PHNs (within the Winnipeg region) working with mothers with mental illness to identify potential barriers to meeting their support needs. As highlighted in the literature review, the discussion revolved around professional barriers for nurses such as education, interdisciplinary collaboration and the availability of resources for families. The goal of these discussions was to provide recommendations for PHN practice and ultimately improve outcomes for families. The research questions were as follows:

- 1) How do PHNs understand the needs of mothers with mental illness?
- 2) How do PHNs perceive their role in meeting the needs of mothers with mental illness?
- 3) What do PHNs perceive as the challenges or barriers to supporting these families?

Research Design

Given the exploratory nature of the study questions and the researcher's interest in the subjective views of PHNs perspectives, opinions and experiences, a qualitative approach was most appropriate for this study (Hesse-Biber & Leavy, 2004). Qualitative methods are chosen when the researcher wants to explore a topic about which little is

known resulting in a description and a greater understanding of the topic. The design was both exploratory and descriptive. The intent was to explore PHNs' experiences in working with mothers with mental illness for which little is known, and describe their role with mothers who were parenting in this situation, the phenomenon of interest. This relates to Marshall and Rossman (1999) who maintain, an exploratory study is "to investigate little-understood phenomena" and a descriptive study is "to document and describe a phenomenon of interest" (p. 33). Qualitative approaches are not rigid in structure and can incorporate characteristics of other forms of qualitative inquiry. Sandelowski (2000, p. 337)) states, "...qualitative work is produced not from any 'pure' use of a method, but from the use of methods that are variously textured, toned, and hued" (from other qualitative approaches). The views of PHNs regarding mothers with mental illness will also contribute to informing WRHA decision makers of any issues raised regarding the PHN role as well as those of the client population. This is what Sandelowski (2004) refers to as transformative knowledge, considered characteristic of qualitative design.

Interpretive Paradigm

The qualitative approach, chosen for this study, maintains the interpretive paradigm where one "...acknowledges multiple meanings and that knowledge can be derived from sources other than the senses" (Monti & Tingen, 1999, p. 71). Important epistemological characteristics are: 1) knowledge is derived from experience, art, ethics; 2) observations are value-laden; 3) cognition, perception and experience affect what is seen or conceptualized (Monti & Tingen, 1999, p. 67). These characteristics qualify the chosen method of study for exploring perspectives of PHNs where data collected is

derived from their experiences of dealing with mothers who have mental illness and meanings are shared within interactive focus groups. This approach is useful when little is known about a topic in order to identify patterns of experiences and the relationships between them (Monti & Tingen, 1999).

Participants

Public Health Nurses (PHNs) were chosen for their specific knowledge and experience vis-à-vis the research topic. Speziale and Carpenter (2007) state, “individuals are selected to participate in qualitative research based on their first-hand experience with a culture, social process, or phenomenon of interest” (p. 29). Participating PHNs were recruited via the Team Managers (TMs) and Community Area Directors (CADs) of each selected community area (CAs) within the Winnipeg Regional Health Authority (WRHA). Following overall approval by the Acting Population and Public Health Director, CADs gave permission to make initial contacts with the TMs from each CA who then provided information about the study to the PHNs in their respective offices. TMs thus acted as “gatekeepers” by assisting with recruitment and providing group members with the letter of invitation to participate in the study. Polit and Beck (2004) affirm that “gatekeepers” can provide or deny access to important sources of data, and can make arrangements for gaining entry. Contact with the TMs was be done by the researcher to initiate the implementation of the study.

Inclusion Criteria

For the purpose of this study, Public Health Nurses (PHNs) were those who worked in the four chosen community areas (CAs) of the general program of Public Health within the WRHA. These CAs were located in the southeast, northeast, west and

central regions of the city of Winnipeg (Appendix A). PHNs in these communities worked either full-time, part-time (half-time) or casual and had varying levels of nursing experience. Their varied experience and backgrounds brought differing perspectives on the topic. The PHNs working out of each CA all did postpartum home-visiting as part of the Healthy Beginnings program of the WRHA. PHNs that were excluded were those working in the other CAs and those in specialized programs such as Travel Health, where family home visiting was not part of their role.

Population Health Profiles

Population Health Profiles from the WRHA Executive Summary Report (2004) provide health information according to specific CAs in the city. These were used as a sampling strategy. Indicators that were assessed for the profiles included: chronic health conditions (cancer, cardiovascular disease, and diabetes), infant and maternal health, injury, mental health, obesity, respiratory illness, and sexually transmitted infections. In order to summarize the overall health status of the population, the WRHA categorized each community as **average**, **below** or **above average** based on the comparison between the CAs and the national or provincial values and the categorization of these six indicators for individual CAs (Community Health Assessment Report, 2004). The Community Areas Overview (WRHA, 2004) also included an assessment of health determinants for each CA. These determinants correspond to those illustrated in the Population Health Promotion Model (see Figure 1, p. 13) namely, income and social status, social support networks, social environments, education and literacy. According to this report, the 12 CAs demonstrate varying levels of health.

Sampling Strategies

The Population Health Profiles as described above guided the sampling for the study. A purposive sample of four CAs was chosen according to geographical location and “health status” as assessed by the WRHA. According to Sandelowski (2000), the “ultimate goal of purposive sampling is to obtain cases deemed information-rich for the purposes of study” (p. 338). The WRHA consists of 12 CA offices (see Appendix A). All PHNs in each of these offices were invited to participate in a focus group within their respective offices. The St-Boniface CA was excluded to prevent certain bias from the researcher’s former PHN position at this office as well as the River East CA where one PHN was a personal friend of the researcher. The sample of PHNs was chosen based on their current positions as PHNs within the general public health program of the WRHA. Their main role was that of family visiting in the postpartum period. These nurses interacted in some form with all new mothers in their assigned CA and therefore were likely to have contact with mothers who had mental health issues in the postpartum period. They were considered to be the experts with respect to the proposed research questions.

In order to have representation from PHNs from these different communities, one centrally-located CA was chosen as well as a CA from each geographic area in the city (Appendix A). Individual names of the chosen CAs were concealed by assigning numbers to each individual CA. Although there are two centrally-located CAs both considered **below average** for health status and health determinants, CA 3 was chosen for this study based on its higher proportion of children and youth compared to the other. CA 3 also showed lower levels of socio-economic status than the other centrally-located CA.

Both CAs fared poorly for social support and social environments compared to the rest of the CAs. Both CAs also had more single parent families, low education and the highest proportions of Aboriginal people. In the southeast, CA 4 was **above average** for health indicators and health determinants particularly a high socio-economic status, social support and environments and high education level of attainment. In the Northeast, CA 3's health status was viewed as **average** for health indicators and health determinants with good socio-economic status, social environments and average social support. In the west part of the city, CA 1 was **above average** for most health indicators however **slightly below average** for health determinants. They had a higher proportion of seniors and smaller proportions of Aboriginal people and visible minorities compared to other CAs. The CA 1, CA 2, CA 3 and CA 4 comprised the four CAs for the focus groups in this study based on the criteria described above. CA 4 was excluded from the sample once the study was underway due to lack of participation. The three participating CAs provided the researcher with data from PHNs with experience and views from these diverse communities.

Data Collection

The research questions reflected a new area of inquiry therefore focus groups were the preferred method of data collection (Brown, in Crabtree & Miller, 1999). A focus group is appropriate if the purpose is to explore the views, feelings, and experiences of a homogenous group (Curtis & Redmond, 2007). Focus groups allowed the researcher to collect subjective data from participants through group discussions, and permitted the interviewer to direct the interaction and inquiry in a structured manner (Denzin & Lincoln, 2005). Through interaction in a homogenous group such as in this

study with colleagues, focus groups had the potential to provide rich data on the selected topic. Morgan (1988) maintains “The hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group” (p. 12). Group interviews were most appropriate to explore perspectives of a specific group of nurses regarding a broad topic such as mothers with mental illness. As the groups of PHNs chosen for the study all worked with families in the community, they had a common role with regards to the topic of discussion. Through interactions amongst colleagues in small groups, PHNs were allowed to openly discuss their views.

Focus groups have also been shown to produce rich data from a number of viewpoints, because the participants are questioning and explaining themselves to each other, as well as to the researcher (Barbour, 2005; Morgan & Krueger, 1993). A key characteristic of focus groups is the quality in which spontaneity and candor is encouraged (Nyamathi & Shuler, 1990). Group “synergy” also adds to data. Nyamathi and Shuler (1990) concur and describe this as a dynamic group interaction atmosphere where researchers can obtain insights, perceptions and attitudes of people. Attitudes and perceptions can also be influenced through these interactions (Lewis, 2000).

Focus groups are useful for data collection in several ways and contribute to nursing knowledge. Stewart, Shamdasani, and Rook (2007, p. 41-42) have summarized some common uses for focus groups, their application to the current study are described concurrently: 1) “Obtain background information about the topic”- The researcher was interested in PHNs’ views and experiences in dealing with mothers with mental health issues in their communities. As little is known about PHNs experiences regarding

mothers with mental illness, this background information was important to begin exploration on the topic.

2) “Generate hypotheses that can be submitted to further research and testing using more quantitative approaches” - Group discussions amongst PHNs generated issues (hypotheses) that could be further researched and add to existing knowledge.

3) “Stimulating new ideas and creative concepts” - With the opportunity to discuss openly and together as a group PHNs generated new creative ideas for programs to address issues raised. This was one of the benefits of group discussion as a whole.

4) “Diagnosing the potential problems with a new program, service or product” - For this study, PHN focus groups generated discussion on existing programs and whether these adequately addressed the needs of mothers with mental illness and discussion on their own professional development needs as PHNs.

5) “Generating impressions of programs, services of interest” - In group discussions, PHNs were encouraged to discuss existing programs for families and whether they were addressing the needs of mothers with mental health issues adequately.

Although focus groups are an appropriate method to address the research questions, there exist some disadvantages to this method. Group dynamics, particularly when members are familiar with each other such as in the case of colleagues, can lead to “group think” where certain members may dominate the discussion and “coerce” other members to agree or prevent others from responding altogether. This effect limits generalization of findings. Also in comparison with in-depth individual interviews, data collected in focus groups have been criticized as more superficial and generating only “surface” information on individual responses (Powell & Single, 1996). These authors

mention the argument that this would be true for research that is sensitive in nature; however for this study, the topic addressed was not sensitive in nature. The skill of the moderator will also affect the group process and responses. Focus group performance is a balance between moderator and member participation. Participants need to feel comfortable to share but not so comfortable that assumptions are made about their comments or comments are left unsaid (Denzin & Lincoln, 2005; Kruger & Casey, 2009). The moderator may influence results by inadvertently giving verbal and non-verbal cues during the session, thus a skilled moderator is recommended. For this study, the researcher (who was the moderator) had some experience in group facilitation from the mental health and public health fields. The PHNs appeared unaware of the researcher's previous knowledge of Public Health.

Procedure

Focus group interviews were conducted with the PHNs from the three purposely selected community areas (CAs) at their respective community office sites. This provided PHNs with a familiar and non-threatening environment (Kruger & Casey, 2009). Posters (Appendix C) were circulated via the Team Managers for each selected CA. The initial contact letter (Appendix D) and consent form (Appendix E) were emailed to each individual PHN from the selected CAs via the TMs and in the case of CA 3, the CAD.

Interview Guide

Focus groups provided the researcher with the opportunity to guide the interview following, but not limited to, a list of open questions on the topic. This guide set the agenda and the direction of discussion (Lewis, 2000). The researcher used the funnel approach to questioning where the researcher begins with general questions and moves to

more specific questions on the topic thus engaging the participants (Lewis, 2000).

Stewart et al. (2007) suggest having members introduce themselves and tell a little about themselves to “break the ice”. The researcher welcomed them, introduced herself, and reviewed the topic to be discussed and the ground rules concerning the group discussion (Lewis, 2000). Nyamathi and Shuler (1990) state, “In addition to well thought-out questions, providing a focused environment for the participants is necessary to ensure a successful outcome. For example, providing the purpose of the study early on is critical to eliminate assumptions about the nature of the study” (p. 1285). Questions were open-ended in order to promote discussion and “why” questions were avoided (Krueger & Casey, 2009) unless to show interest in the complexity of the discussion (Stewart et al., 2007).

Krueger and Casey (2009) suggested five types of questions: opening, introductory, transition, key, and ending. In this study, the opening question consisted of a round table with each PHN introducing them self, stating how long they’d worked as a PHN and what attracted them to this area of nursing. These questions were not analyzed. The introductory question introduced the topic to have the PHNs start thinking about their connection to it. The transition question helped to move the conversation into the key questions. At this point, the participants were already becoming aware of others’ views on the topic. The key questions were those that drove the study, between two and five questions. The ending questions provided closure to the discussion and helped participants reflect on comments made. Krueger and Casey (2009) suggest using “all things considered” questions where the moderator allows each participant to reflect on the comments shared and identify which aspects are most important or a priority to address.

As mentioned previously, the final question re-stated the study's purpose and asked the group if anything was missed that needed to be discussed (see Appendix B).

For this study, the moderator (who was the researcher) began with a brief introduction of self, the topic and ground rules, then allowed the PHNs to each introduce themselves including their length of employment in Public Health. These introductory questions started the discussion. Following this, the researcher continued with questions that were more specific to the topic. The complete interview guide is in Appendix B.

Role of the Moderator

“The role of the moderator is to ask questions, elicit responses, and encourage discussion within the group” (Curtis et al., 2007). As stated previously, the facilitator can influence group dynamics through his/her own verbal and non-verbal behaviours and therefore have an active function in the group that may bias the data. The discussion in the focus group will depend on the skill of the moderator, participants' individual characteristics and their emotional stake in the topic (Kidd & Parshall, 2000). Fern (2001) suggests the moderator be acceptable to the group, similar in appearance and dress, and relate to the group. In this study, the researcher was viewed as a peer as she was a nurse (former PHN) and was not in any position of authority over them. Krueger and Casey (2009) state focus groups are unsuitable when a hierarchy relationship exists, such as between managers and workers. The PHNs in these focus groups all had the same job descriptions and held equal positions, therefore minimizing hierarchal issues. The PHNs had a certain “emotional stake” in this topic, as mothers' mental health is a significant determinant of health in relation to the promotion of healthy families, this being a major

focus for PHNs. Also, the Perinatal Mental Health initiative (2007) which had been recently delivered was still vivid in their minds.

Krueger and Casey (2009) have formulated specific recommendations with regards to moderator skills which were followed in this study. For example, in order to minimize groupthink, they suggest the moderator encourage participation from all members in the group and ensure they are aware that there are no right or wrong answers and that the purpose of the group is to share all ideas and opinions versus reaching a consensus. This was done in the introduction. Using comments such as “does anyone else has a different take on this question?” may help elicit differing ideas from the group. The researcher tried to elicit responses using “anyone else?”. Short verbal responses and probes by the interviewer were done to encourage discussion. As a beginner researcher-moderator, aside from the interview guide, a comprehensive introduction to the groups allowed for better flow and ease. The group was made aware of the role of the research assistant and the rationale for note taking and recording for collecting data. Data collected were verified by providing brief summaries to the group at the end of certain questions, and a debriefing with the research assistant at the end of each group interview. At the end of the interview, a summary of the main points of the discussion was provided to verify the data. The moderator completed the interview by summarizing the purpose of the study and then asked the group “Do you think we’ve missed anything?” so as to uncover missed comments. Another suggestion by Morrisson-Breedy, Côté-Arsenault, and Fischbeck Feinstein (2001) is to ask, “Is there anything that we have not asked that you would like to tell us?” (p. 49). This was also part of the interview guide.

The researcher was attentive to other aspects of the group sessions such as non-verbal behaviours from members during interactions and the environment. Rooms were comfortable with minimal noise to limit distractions and promote accurate recording of data. Room availability was discussed and confirmed in advance with the PHN contacts (CA 2 and CA 3) and the TM from one CA 1 to ensure the environment was conducive to an interactive group session.

Focus Group Structure and Time Frame

As mentioned, the focus groups took place at the selected CA offices, in a conference room reserved in advance. This ensured privacy and minimized distractions in the workplace. Lunch was provided as the interviews took place over lunch hour. A research assistant was present to take thorough notes including non-verbal behaviours, and to assist with audio equipment and with any environmental issues such as noise and interruptions. Group sessions were audio taped for verbatim transcription by the researcher. Data were verified by providing brief summaries to the group at the end of each question, and debriefing with the research assistant at the end of each group interview.

The number of focus groups required for successful data collection varies amongst researchers. Stewart et al. (2007) suggest there is no optimal number and that the number of focus groups should be based on the homogeneity of the participants and the ease of research application. McLafferty (2004) uses the guiding principle of data saturation in which case, saturation is attained when no new information is being collected. Nyamathi and Shuler (1990) state four focus groups are sufficient but saturation should be considered after the third group. In the current study, data saturation

was considered after the third group. Group size also varies amongst researchers. Speziale and Carpenter (2007) suggest between six and 10 participants per group maintaining that large group sizes tend to preclude chances of speaking from all members and conversely, while small group sizes may place undue pressure on members to speak when they do not necessarily want to or they may feel that they cannot speak freely. Numbers of PHNs per CA office varied; all PHNs from the selected CAs were invited to participate to attain the desired size.

Although Krueger and Casey (2009) recommend interviews last up to two hours, the researcher conducted the groups over a one to one and a half hour period so as not to disrupt busy work schedules of PHNs. The researcher believed the groups' homogeneity helped maintain structure and focus thus keeping with the pre-established one to one and a half hour duration.

Ethical Considerations

Approval for this research study was obtained through the University of Manitoba Education and Nursing Research Ethics Board (ENREB; see Appendix G) and the Winnipeg Regional Health Authority (WRHA) Research Review Committee (see Appendices H). Approval was also obtained from the Acting Director of Population and Public Health Nursing, the Community Area Directors and the Team Managers for the selected sites.

At the outset of each focus group, the researcher reviewed the purpose of the study, the consent form, confidentiality, and reminded each member that participation was voluntary. All PHNs that volunteered were fully aware of the extent of their

involvement in the research and gave informed consent by signing the consent form prior to the group (Appendix E).

Data obtained from the focus groups were kept strictly confidential according to ethical research principles. The research assistant used for part of the transcription signed a pledge of confidentiality as part of her employment at the University of Manitoba. Audio recording was transcribed verbatim leaving out names or any other identifying characteristics. The term PHN replaced the names of participants for quotes used in the typed manuscript. All field notes and transcriptions were kept in a locked filing cabinet with no public access and will remain so for seven years prior to shredding as confidential waste as per ethical research guidelines. Results from the study will be available to participants at their request as presented in the invitation letter (Appendix D). All PHNs indicated they wanted a summary of results.

Data Analysis

Data analysis in qualitative research is both scientific and artistic (Sandelowski, 1995). It should be done in a systematic manner, following a prescribed, sequential process that is deliberate and planned so that findings reflect what is shared in the focus groups (Krueger & Casey, 2009). Analysis involves breaking up the data and permits the researcher to see it from a new perspective. In contrast, interpretation is the knowledge produced from the data through the creation by the researcher (Sandelowski, 1995). Krueger and Casey (2009) remind us that the purpose of the study is what drives analysis and therefore not all data is worthy of analysis. The researcher must keep the research question and study purpose in mind throughout analysis in order to ensure quality of the data.

Inductive content analysis was used to code and interpret the data following the method of thematic content analysis by Burnard (1991). The aim of this method is to produce a detailed systematic recording of themes and issues discussed in the interviews and link them under a category system. The stages for this procedure are summarized in Appendix F and were used as a step-by-step approach for data analysis in this study. For focus groups, the process of data analysis requires an integration of data from multiple sources such as transcriptions and field notes. As the group effect constituted a critical component in data collection, it was also part of the analysis. Dimensions such as the environment, group dynamics, process and content all were captured in the transcripts (Morrison-Beedy et al., 2001). Each focus group was viewed as a unit of analysis versus individual participants. Analysis was continuous (Krueger & Casey, 2009) which the researcher achieved by clarifying and summarizing comments during the focus groups with participants. This was also done after the group sessions, with the assistant, along with her related field notes.

The researcher was immersed in the data in order to fully re-experience the focus groups. In order to achieve this, the researcher transcribed the recordings with minimal assistance from the research assistant, and sufficient time was set aside to complete the analysis. In an attempt to be systematic, the researcher attempted to transcribe and analyze following each group session, so as to further explore issues raised in subsequent focus groups; however, this was not done consistently. The researcher also took notes after each focus group of any ideas or theories that came to mind to assist with categorizing. Groups of words of same or similar meaning were placed into broad categories. Constant comparative analysis was done by comparing comments made both

by individual participants within a focus group and between the three groups. Constant comparison helps to develop categories (Polit & Beck, 2004). Common themes were identified through this process. As data were grouped together, categories became apparent and the number of categories could be reduced under broader headings to develop significant themes. In the initial phase of analysis, the emerging categories or initial themes from transcripts and related field notes were reviewed and discussed with the thesis advisor to ensure accuracy. Comparisons of data between the different CAs were done if there were noticeable differences in themes amongst the groups. Once the manuscript for the results section was completed, the research assistant also reviewed for accuracy.

Demonstration of Trustworthiness

For qualitative research, trustworthiness or rigor is judged by credibility, dependability, confirmability and transferability (Guba, 1981; Polit & Beck, 2004). These criteria allow the researcher to present believable and meaningful findings and allow readers to draw similar conclusions from the data (Morrison-Beedy et al., 2001). Credibility refers to the probability that the findings are credible. With focus groups, this can be achieved by having group consistency, making comparisons across interviews, and by triangulating the data collected. Triangulation involves the study of the same topic from different vantage points to balance the margin of error. Person triangulation more specifically, consists of collecting data from more than one group. In this study, the groups were homogenous, consisting solely of PHNs within their CAs. Person triangulation was attained by conducting focus groups at three different CAs with different groups of PHNs.

Group consistency, interview comparisons and triangulation together help to enhance credibility of findings. According to Speziale and Carpenter (2007), once credibility is demonstrated, the criterion for dependability is met particularly with triangulation. Graneheim and Lundeman (2004) summarize dependability as the degree to which data change over time and modification decisions made by the researcher during analysis. This was enhanced through open discussions between the researcher, her advisor and the research assistant to ensure consistency of findings.

Confirmability relates to the audit trail that can be tracked in order to illustrate the evidence and thought processes that lead to the conclusions so that another researcher could reach similar conclusions (Polit & Beck, 2004). Krueger and Casey (2009) prefer the term verifiable analysis, and describe this as how another researcher would be able to arrive at similar conclusions using the same data. The researcher kept all documentation related to analysis to promote confirmability/verifiability. Lastly, the concept of transferability refers to the probability that findings will have meaning for others in similar situations. This was enhanced by a rich presentation of findings with appropriate direct quotes from the interviews (Graneheim & Lundeman, 2004). According to these same authors, it is the readers that ultimately decide whether findings are transferable to another context.

Summary

This chapter reviewed the methodology for this research study. Research design, procedures for sampling, data collection and data analysis were outlined along with ethical considerations. Together, these provided structure to guide the study. Findings are presented in the following chapter.

Chapter Four: Results

Introduction

This chapter will present the findings from this study. An overview of the sample used to collect the data will be provided along with the emerging themes produced by inductive analysis. The purpose of this research was to explore the experiences of Public Health Nurses (PHNs) working with mothers with mental illness and how these affected how service is provided to families. The research questions were explored and responses are presented throughout this chapter. Research questions included the following:

1. How do PHNs understand the needs of mothers with mental illness?
2. How do PHNs perceive their role in meeting the needs of mothers with mental illness?
3. What do PHNs perceive as the challenges or barriers to supporting these families?

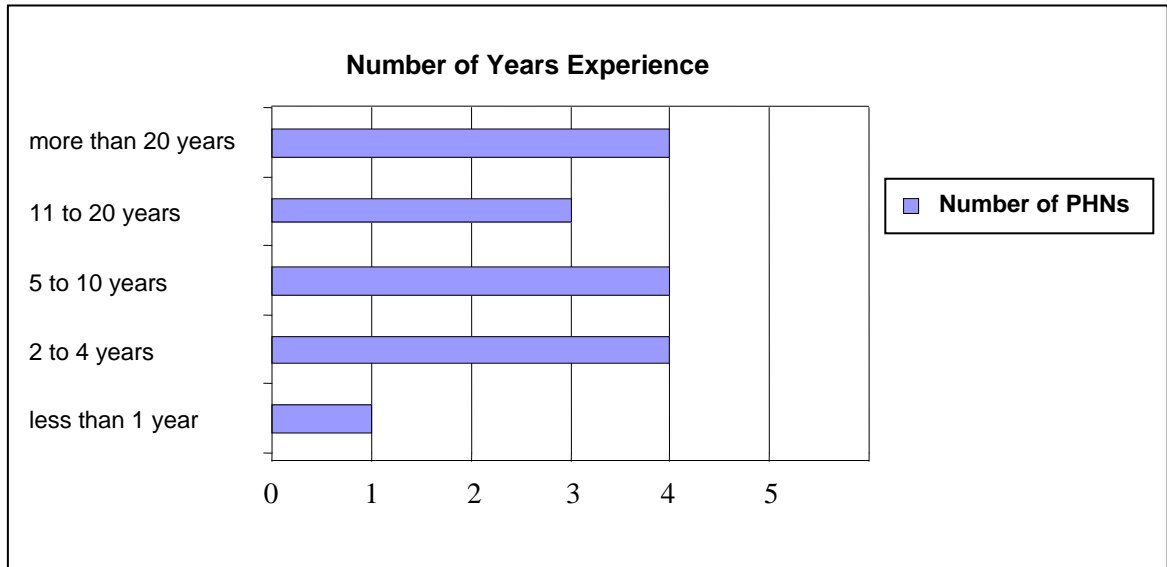
Following a brief description of the sample, this chapter is divided into the following sections in accordance with the above research questions: The Role of the Public Health Nurse, Challenges and Barriers, and The Needs of Mothers with Mental Illness. The major themes were: “dealing with where they’re at”, “treasure hunting”, “you can only do so much” and “I kept wanting more”. Together these themes resulted in a common broad theme, the perceived purpose of the PHN role, which is “helping moms succeed” (see Figure 1. p. 61). These themes will be outlined and substantiated with data provided by the PHNs during the focus groups.

Description of the Sample

The sample consisted of 16 PHNs in general practice from three community areas (CAs) within the Winnipeg Regional Health Authority (WRHA). All participants were

female with varying levels of experience in public health. The CAs were chosen based on the health indicators as determined by the WRHA community profiles (see Chapter Three). Four CAs were initially chosen and assigned individual numbers (CA 1, CA 2, CA 3 and CA 4). CA 4 was eliminated from the sample as only one participant from this area volunteered to participate in the study. As CA 4 is considered **above average** for both health status and health determinants according to the WRHA community area profiles, it is plausible to hypothesize that mothers with mental illness in this community are well-resourced and consequently the PHNs from this area did not feel that they had enough experience with the topic to share with the researcher. The sample thus included three CAs; two groups of five PHNs from CA 1 and CA 3 respectively and one group of six PHNs from CA 2.

The PHNs' work experience ranged from seven months up to 28 years in Public Health. From the sample of 16 PHNs: one PHN had under one year experience; one had two years, two had three years, one had four years, one had six years, three had seven years, one had 11 years, one had 15 years, one had 18 years and four had over 20 years experience in public health (see Table 1. p. 63). CA 1 had the most experienced group of nurses whereas CA 3 had the least experienced group. CA 2 and CA 1 both had at least one nurse with over 20 years experience and CA 3's most experienced nurse had 15 years. The average number of years experience for CA 1 was 19 years; CA 2 was 8.3 years and CA 3, 7.5 years. Most PHNs were employed full-time (12 PHNs), three worked half-time and one worked casual. Participation appeared equal among the PHNs.

Table 1: Number of PHNs by Years of Experience

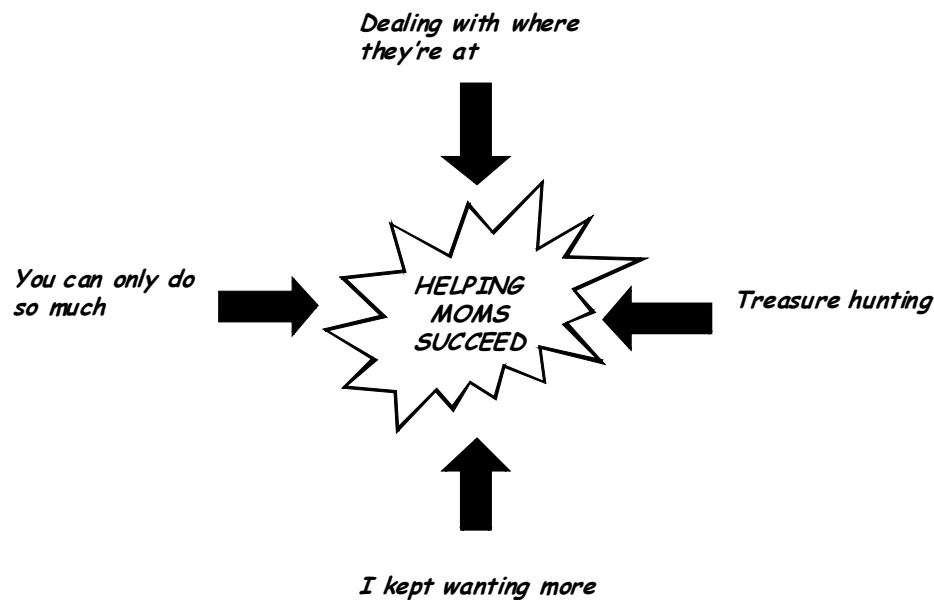
The following section outlines the main themes that developed in the focus groups substantiated by direct quotes from the PHNs. Emphasis by PHNs on specific words is indicated in bold. Their comments are identified according to the individual CA in which the PHN worked namely, CA 1, CA 2 or CA 3. As mentioned previously, this section is organized according to the research questions.

“Helping Moms Succeed”

There were four themes, “dealing with where they’re at” which encompassed building relationships with families and assessing their needs without judging or preconceived stereotypes; “treasure hunting”, where PHNs were searching for the most appropriate resources for the family; “you can only do so much”, for families who were not receptive to PHN service; and “I kept wanting more”, where PHNs wanted more education for themselves and better resources for families and communities, together formed a common goal of “helping Moms succeed” (see Figure 2).

“Helping Moms succeed” was an integral piece of the PHN role not only for mothers with mental illness, but to all mothers they visited in the community: “...I wanted her so badly to succeed...you want to see them together...” (CA 1). “Helping Moms succeed” represented the ultimate outcome to PHN intervention. This overall theme was sensed by the researcher throughout all the group interviews with PHNs expressing their desire to help Moms with whatever difficulties they were experiencing, whether as a support or referral person for professional or community resources.

Figure 2: Summary of Themes



The Role of the Public Health Nurse

Most PHNs were very clear about their role in working with mothers with mental illness. All PHNs agreed on being in the position to help mothers and their families recognize symptoms of mental illness, provide support and resources. Several PHNs also made it clear what they did not view as their role. In the following statements PHNs describe their perceptions of their role:

PHN: ...our job is a support person to someone who's having difficulty but really it's also a referral person, so we always need the next place to refer them to because we don't have that expertise to deal with that, so I don't feel I should be looked at as the person who can fix that problem, I'm there to identify it and support them and then try and help them find the next place... (CA 1)

PHN: ...it's not my role to be the primary health care provider for their mental illness. I'm not (other PHN: "equipped") equipped, qualified, or able to do that but it's to increase their awareness, and to increase their ability to access resources and then just to provide support to make sure that they are getting what they need. (CA 3)

PHN: I think helping them recognize what the symptoms are, that it's just not a normal situation that you should have to feel that way with your baby for an ongoing period of time... (CA 1)

With regards to parenting, PHNs viewed their role as supportive only and not to be the professional who assessed parenting abilities:

PHN: like our role is to engage a family primarily and so we're probably far less critical of issues (PHN: "especially in the beginning") ... (CA 1)

PHN: ...we could be **concerned** based on observations or risk factors but to actually make that judgement is **not** what we do. (CA 1)

PHN: ...we go back to what [name of PHN] said about safety [for mother and child] (PHN: "yah") and really that's our bottom line, and we can't really tell people how to parent. You can offer them many resources... (CA 1)

The group of PHNs from CA 2 felt that their role was not well-defined for mental health as illustrated in the following excerpt:

PHN: I don't really feel like our role is really defined when it comes to mental health really...a lot of times you are put into positions where you feel like you need to counsel someone and you're not trained to counsel someone (PHN: "yah, for sure") ... I feel like our role is more to liaison and to be the person who is kind of fanning them out to the right resources, but there are times...where you are pushed into a corner... this person is needing something from you right now...doesn't know what to do... is freaking out on the phone and crying...you can't get a hold of the psychologist...you can't get a hold of the doctor...what do you do at that point? So I think there needs to be a lot more clear boundaries as to what our role is when it comes to mental health...I think once you define what your role is with mental health then you can take it from there.

This PHN also wanted PHN role clarification for mental health in order to focus on developing specific education programs to support PHN practice.

PHN: ...What is my role and responsibility? And I think that within that, you then can educate in a targeted area, in a targeted way.

All focus groups spoke of the importance of their approach to families and the environment of home visiting as being significant factors in their overall assessment. For mothers with mental illness, PHNs all mentioned the Families First screen and Families First parent survey as valuable tools to assist them to discuss mental health. PHNs from

CA 3 spoke of the home environment and the specific questions related to mental health that they'd ask mothers:

PHN:they're more comfortable 'cause it's their environment so sometimes they'll just start saying things...they'll ask you something that triggers like 'oh well, like what exactly are you wondering about? And have you had a history of this? Or is there something that's bothering you now?' ...just the way our work is...with the home visiting.

PHN: I feel like I can ask somebody, have you ever had depression? Or what's going on? ...a lot more in-depth...in terms of like the assessments we do with families.

Similar comments were mentioned by CA 2's PHNs:

PHN: I find since incorporating the Family First screen...the assessment has opened up really and made it more consistent that we ask now if there's a history of mental illness. I can say truthfully I never always routinely asked that; I would ask how they are coping and get a sense, but it was never always part of a routine assessment.

PHN: assessment is so key and once you get them in their own home...your assessment abilities are opened up because you see them in the comfort of their own home around their supports or lack there of.

PHN: You can get a lot more information... one home visit in the client's home than you can spending hours in the hospital (PHNs: "u-hum") for sure.

Along with the Families First questions, this PHN mentioned questions that she used to open up a conversation about family history:

PHN: ...the Family First screen that we have that opens up some more conversation too, so that we have more questions that you're able to ask if someone... I certainly feel more comfortable these days saying... 'Do you have any thoughts of harming yourself?' or 'Would you harm the baby?' ... 'Are you really feeling sad?'... 'Are these some of the things you're feeling?' ... 'Are you okay by yourself?' ...even if you don't do the survey sometimes I would ask ... 'How were you brought up?' or 'Were you happy with the way you were brought up?' and you get a big family history. (CA 1)

“Dealing with where they're at”

Along with their approach with Families First, PHNs viewed their assessment as being fundamental to helping families. Mental health was viewed as part of the overall assessment of the mother within the family and the environment. “Dealing with where they're at” was a common thread throughout the focus groups where PHNs felt their assessments generally began with minimal information on a referral form to at times discovering mental health issues upon their initial home visit. Most agreed however, that unless moms had an extensive history of mental illness, they were not usually informed of mental health issues for mothers prenatally or postpartum.

PHN: ...there's lots where you'll do ...further assessment and then it's like 'well yah...I am on Celexa' ...none of that's written on the referral... (“u-hum” from the others in background) (CA 1)

One PHN from CA 3 found this to be the case for mothers even with a serious mental illness:

PHN: ... sometimes...you do an assessment with them and they say...
'oh yah, I was diagnosed with schizophrenia' and you know it never
came up in the postpartum.

Several PHNs from CA 1 questioned the reliability of the information they received on the referral hence the significance of finding out where "they're at":

PHN: We generally get very little information (PHN: "yah") about the
history unless it's a **huge** history (PHN: "u-hum") and then we get a
social work report maybe, but other than that we get a minute line of
information that says ...client is bipolar or client has a history of
depression and really very little.

PHN (in response): I always wonder too whether it's a question that they
actually ask them when they're leaving the hospital...or whether it's just
the ones that offer the information (PHN: "u-hum").

*Interviewer: so you're feeling sometimes not all the questions are asked
and there's not a lot of room to mark all that information 'cause you're
marking down all the physical things that are going on too so...*

PHNs: u-hum, yah

PHN: or if they have a history of something is that taken from an old
chart and what does that really tell you? ...Is that new? Is it old? Are they
stable? I mean it doesn't really tell you where the person's at...

Interviewer: Do they ever tell you on the referrals any more details if they're at risk for mental health issues or anything like that?

PHN: I think if it's a very at risk person they do, if they've seen the social worker at the hospital then there may be a social work report but that's not very common. I think a lot more people have mental health issues than are noted.

All PHNs stressed the importance of a holistic assessment including the family and their environment, without prejudice while ensuring safety of the family unit.

PHN: So when we're going at that it's to assess, but also to look at the whole picture not just their emotional, psychological health, but all the other pieces that could be impacted as well. (CA 2)

PHN: ...you're looking at all that...their physical well-being as well as their mental health...that's part of the overall assessment...when you go into the home. (CA 1)

PHN: *Carte-blanche* assessment; no pre-established thoughts of what to expect 'cause you don't know until you assess it. (CA 2)

PHN: you want to make sure that your assessment is thorough so that you know that that baby will be safe and that mom will be safe... (CA 3)

PHN: ...mental health is a such continuum...like it's not really foremost in my mind ...you're just dealing with where they're at ...sometimes you could be having a great day, sometimes you could be having a bad day, whether you have a mental illness or not...it just becomes more natural

to kinda find out where people are at today, and not kind of have that diagnosis in the front of your mind. (CA 3)

One PHN spoke of a need for more information yet also the importance of a “fresh start” for assessment so as to include family and less of a focus on the illness itself:

PHN: I usually want to get more information because it’s gonna depend a lot on if somebody says history of depression, that’s very vague, that could be anything from crying from a day to major depression, so that’s a little bit different from when they have a **label**...we always try and start kinda fresh in the sense that you would gather your information and also meet the family and find out where they’re at, because if somebody has been...a client for a long time with mental health services, makes a difference versus the kind of depression they’ve had, versus have they ever been on medication or not...you sort of have to look at the client and the family rather than just looking at the **label**... (CA 1)

PHN assessments for mental health involved questioning with Families First tools and “normalizing” to help open the conversation. Once again, the approach in their assessment proved to be most helpful:

PHN: and we address it much more (PHN interrupts: “much more openly”); more (PHN finishes: “confidently”) It’s like we used to say in prenatal classes, ‘you never used to use the word pain’ (chuckling), postpartum ‘you never used to use the word depression’ (laughing, another PHN says “word depression” in agreement).

PHN adds: it’s more normalized. (CA 1)

PHNs related the importance of asking questions related to mental health in a “routine” manner and providing mothers with the opportunity to talk:

PHN: [Families First] ...it brings it to the forefront ... ‘this is part of what we ask all moms...have you ever had any...involvement with a psychiatrist or psychologist or had any psychiatric concerns where you needed support or medication?’ And it’s a routine question, where as you might have a mom who just automatically would cover that up, thrown it out on the table and its there for discussion more candidly. (CA 2)

PHN: And sometimes as soon as you ask that question you see can see...the eyes start to well up, (laughs) you know and it’s kind of like, ‘oh!...I can talk about it ‘boo hoo’. (CA 2)

This PHN shared how she would assess for mental health with a mother who appeared to be coping well at the time of the visit:

PHN: see where they’re at...if it doesn’t seem like they’re having any symptoms now and they’re coping now and they have people they can call on...sometimes I’ll ask... ‘When you were going through that before how did you feel? And how do you feel different now? And how would you know if that was starting to affect you with this change in your life?’ (CA 3)

“You can only do so much”

All PHNs agreed that building a relationship with the family was crucial in determining whether or not mothers or other family members would contact them for assistance. This was particularly significant with regards to mental health issues which

PHNs all agreed most often occurred several weeks postpartum once the PHNs had completed postpartum visits with that family. In the following two situations, PHNs described cases where the relationship they'd developed with the family led to accessing help in crisis situations:

PHN:...you just never know with many families 'cause I had one when I first started in public health...she had family history of postpartum depression, but not herself and this was her second and ...how important it is to build the relationship. I think it was like a week later...dad had called me and I was a resource and mom was in the closet and didn't want to come out and she wanted to...harm herself... (CA 2)

PHN: ...both moms had a depression episode but much earlier like in their teens and were fine, and were totally floored by the experience after having the baby... phoned a couple of weeks later saying, 'you know I'm really not doing very well and I don't know what I'm gonna do'... '...well I won't hurt the baby'...and so you ask 'Will you hurt yourself?' and the mom said, 'I don't think so, but I don't think I should be alone'. So they recognize it, it doesn't happen right away, I don't often find it's a couple of weeks later. (CA 1)

This PHN explained how relationships correlated directly with receptivity of families to their service:

PHN: I think Public Health's involvement in the life of a family or a person is a tiny little speck of their grand scheme of their life and mostly it's gonna be built on relationship, and so if that family gets the sense that we care

about them, then they will keep our number and access us when they need to, and if they don't feel like we care we, they move on and continue with the coping in their life...if they feel like that relationship is a positive one, they may be receptive to trying out a program that we as a Public Health Nurse might suggest for them...but the baseline is relationship, and we are voluntary. (CA 3)

“You can only do so much” emerged as a theme as PHNs discussed situations where despite their approach some families were not receptive to public health, leaving PHNs feeling powerless and concerned about outcomes.

PHN: I had some initial concerns on the initial visit about postpartum depression and so he called me saying... ‘I think something’s wrong with my wife, can you please go and talk to her?’ So I called her and talked to her and she clearly had many symptoms of postpartum depression but when I said... ‘It sounds like you might be struggling with postpartum depression’ she said, ‘no I’m not, I’m fine’ and ‘oh can I come out and see you?’ ‘No that’s okay’ ...I was kind of like powerless, but I knew that the father (PHN: “the dad was on it”) was on it and knew something was wrong, so I kind of hoped that my conversation with her might have triggered something; ...her sisters came and took her in to the Doctor and she went on to antidepressants... when I saw her after she was a completely different woman from that initial visit! She obviously was right in the midst of a depression and wasn't functional but yah, sometimes our hands are kind of tied... (CA 3)

When this situation was mentioned in the group, the PHNs reaffirmed the value of building a rapport with other family members such as the father in this case. PHNs in the other groups also stressed the importance of these relationships in terms of recognition of symptoms and access to resources.

This PHN from CA 3 described a scenario where a mother was not receptive to discussing the topic of mental health; she associated this with the mother not having insight at the time of assessment:

PHN: but it is so difficult 'cause you hear that a lot 'oh, I had depression when I was 15' or 'I was abused' and 'I was on anti-anxiety medication through my teen years' ...but it's always... 'but I'm over that now'... and you'll talk about 'Have you ever had counselling?' '... sometimes postpartum is a time where some things resurface...Did you feel that way when you were pregnant?' ... a lot of the time we get the hand in the face (small chuckle)...they **don't** want to go there...if they don't see it's a problem, we can't (PHN: "force it upon them")...I do feel a lot of times that even when I think someone's maybe not doing as well or at very high risk, it feels like you can't go there because they're not seeing that.

Feelings of powerlessness were expressed by this PHN in CA 2 regarding a situation where a mom with mental health concerns was not receptive and she could not intervene against her will as there were no safety concerns at the time of assessment. The other PHNs in the group agreed as shown in this excerpt:

PHN: ...there is the family, there is the person, who you can't do anything for... they have to be open and they have to have insight and

they have to be willing... we'd love to know what we can do to [quote] 'support and rescue' this individual- harm reduction, you do what you can, you reduce the risk...and there's a point at which you have to say, let go and let um and (PHN: "they know how to reach you and...") they know how to find you and you **know** that this is going to have impact on the relationship between a mother and child down the road and you **know** that this is gonna... I had one mom a few years ago, who basically was in a depression for a **year** and she just had such a hard time and then when she got pregnant with a baby after she goes, 'Oh my God! I lost a year! I feel so horrible! I had no relationship with my child!' Well, now's the insight with her third right? So I find those hard, that's the time when I try to just let it out with one of you guys to give myself permission to let go and know there's nothing more I can do.

PHN: If they're not receptive you can't force them.

PHN: Or if they're not even in that frame of mind...they don't **know** until like say a year later, they're reflecting going 'oh yah, I was going through something, yah'

PHN: And that's maybe where that comes from having mental health issues with immediate family around me, is I know at the point at which...according to the Mental Health Act, we can't do anything if the person is not willing, only at which that point it tips (*Interviewer*: "safety") and the safety or the well-being of the people in the home is

being affected...when we have to initiate that phone call that we all dread [to CFS].

“I kept wanting more”

Being part of a team was seen as essential support for public health practice. Many PHNs talked about returning from visits and sharing complex family situations with each other for feedback and advice from their colleagues. PHNs referred to this as “informal case review” or “debriefing”. Situations could include mental health issues in families as well as other social issues, some related to poverty such as meeting the basic needs of family members.

PHN: I think we’re lucky we’re...each others’ good resources... I don’t think any of us are experts at it but we learn when we kind of share (PHNs together: “share”) the situations. (CA 1)

PHN: I think if you have a situation like that where you are worried, you come back to the office (PHN: “yah”) and you brainstorm with your colleagues, and look up your information, see if you forgot anything... (CA 3)

PHN: ...it’s necessary you can’t survive without it! (CA 3)

PHN: You rely on experienced colleagues and their past experiences to help you deal with the current situation, there’s not a designate. (CA 2)

Sharing as a group provided a release for nurses and many expressed a need to do this on a more formal basis as illustrated by this PHN:

PHN: Those situations can be very depleting as well for a professional, we call them sort of ‘heavy’ (laughs), but they can be very depleting and

I know for myself, I find it very helpful when I can bounce off and strategize with my team and my colleagues and you know...get that sort of reaffirmation of...is this the route you go? Because sometimes it's not that clear, dependent upon if this is a chronic mental health issue or situational or short term...so I value that. (CA 2)

PHNs in CA 3 felt "case reviews" would be beneficial to look at situations in a holistic manner with involvement of the whole team:

PHN: people could bring (PHN: "what does it look like?") one of their cases and like things that happened...with like their specific client and then hear from other PHNs... 'cause you do learn from each other (PHN: "u-hum") that way, and I think that's one thing we don't do very often, like we do the informal or like debriefing sometimes after a visit or whatever but just to actually come together and do more of a case review...

PHN: What did it look like? What did you do?

PHN: I know and it sticks in your brain better if it's a picture (PHNs: "yah, u- hum").

A PHN in CA 1 mentioned that case reviews were happening in other CAs and suggested they could do the same:

PHN: and perhaps that's something that we could do among ourselves because I know in another office where I worked, they have difficult case review every second week where they talk about their difficult cases,

(PHN: “you learn a lot from that I bet”) problem-solve...which I could see as a great value- huge.

In the crisis situation where a mother wanted to harm herself, this PHN found support from her colleague:

PHN: Thank goodness I had the support in the office of an individual who had an extensive amount of experience in mental health... (CA 2)

More education and training were also discussed in all focus groups. PHNs all agreed that the Postpartum Mental Health Toolkit/Pilot Project initiated in 2007 was helpful in their role in dealing with mothers with mental health issues in the postpartum period:

PHN: the toolkits have been great! And the postpartum booklet is great! The postpartum depression booklet and before... we had so little to even offer them that ...it was really difficult once you got into that situation, so I think that’s really helped at least having the new information.

PHN: And I think too just the pamphlet that we can hand out to them that came as a resource it (interrupted by PHN – “normalizes things”), normalizes it and you can you know just (interrupted by PHN “and you can talk about it a lot more”) exactly (in response to PHN) and just say... ‘this pamphlet’s really important for your husband to read and your family...if you have no concerns share it with your friends that are having babies’; just to again normalize, so that everybody is more aware... (CA 1)

PHN: I think as a new Public Health Nurse, I appreciated when we had the sessions just recently...that makes me feel a lot more comfortable (PHN: “yah”) in situations, and I think that mental health just like probably anything in nursing, you get better at it case by case, because everything is a little bit different and you learn each time a new resource or a new trick to help you... (CA 2)

PHN: I felt they really gave us some tools like things to ask, things to identify that tell you something’s wrong, we need to do something and it really helped. (CA 3)

Many felt however that postpartum mental health should be re-visited on an on-going basis with updates. Many PHNs wanted more education related to other mental health diagnoses which could affect mothers and families. In the following excerpt, CA 1’s PHNs talk about some of these needs:

PHN: I don’t know that much about it...I know what it is, and I know there’s some common medications but other than that, I’m no expert on mental health diagnoses of any kind...I think for us to know more about mental health and mental illness and the continuum...that would be good and not just postpartum depression (PHN: “right” “yah” “right”)... make it a broader field, so that we know a little bit more what we’re dealing with.

PHN: ...ongoing refreshers even if it’s the same, you know even if not much has changed since...it’s good...

The CA 2 group were particularly frustrated by what they perceived as the lack of follow-up to the Postpartum Mental Health pilot project in 2007. Here is how some of the discussion went:

PHN: ...the thing is that, and if I can be really candid, we had that pilot project, they found out that it was required, that we needed more focus on that, they knew what resources we needed, how long ago was that?

Interviewer: 2007

PHN: three years ago

PHN: Give me a break! I'm sorry! ... They wanted experienced nurses, two from each office to participate in the initiative, we did, it was valuable, the feedback reflected that it worked. The feedback reflected that the six weeks, and following up, and the additional little hand-out resources that we utilized and we had that nice book given to us and it's valuable. What happened to that?"

PHN: ... we had that and that was it!

PHN: But it's been dropped!

PHN: But there's been no follow up right? Mental health, just like everything else that we do, there's always changes and updates and...more current research ...we do have our education days, but I would like to see them more topic specific. ...let's spend some time on just mental health and lets see what's current now (PHN: "u-hum") because we haven't really looked at it since we did the pilot.

PHN: And not and not sign up if you want to, or your team manager will give you the day off, yah mandatory yah.

Many PHNs from all the groups felt they needed more education particularly with regards to what they referred to as the “grey area” in mental health. This was described as the point at which the mother was in fact becoming mentally ill versus manifestations being part of normal postpartum adjustment for this mother:

PHN: that grey area...the kinda normal variant...in the postpartum time ...we're not really sure if this is just...something that's passing or is this gonna get worse... because it is such a critical time where people do often show a lot of stress and ... often it's normal to have a lot of different emotions at that time so sometimes I find that the hardest part PHN: u-hum and you're just kinda waiting (PHN: “yah”) is it gonna get better or is it gonna get worse. (CA 3)

CA 1's PHNs expressed similar difficulties:

PHN: what's the parameter...of normal here?...even her mental health worker... thought she was fine so...it takes sometimes a crisis like they have to kinda do something before it becomes apparent that all these funny little niggly things, like ...she would rinse the baby off like turn the tub water to the right temperature and just kinda rinse the bum...and she had the baby lying there with all these stuffed animals around like just something (PHN: “something's just off”) yah, like so it takes a lot of expertise...

These PHNs from CA 3 felt a need for more specific tools to help assess such situations:

PHN: then you got the ones that are really vague, they're like 'oh, I'm not really feeling well' so you're not sure if it's postpartum blue-related ...family adjustment, or if it is going into something deeper, so it'd be nice to have little points to say ... cautious...may need referral to... (CA 3)

PHN: in the *Towards Flourishing* training it was really good but I kept wanting more...I wanted concrete operationalized tools like you know we talk about...a mom who might feel isolated... but all those symptoms and all those situations were quite normal to some degree in the postpartum process...it just felt like I wanted something more tangible, you know almost like a **list** (chuckles)...because you're kind of in a situation where you're never 100% prepared...you can't bring all your tools and it is a very vague kinda thing to deal with...it's obvious if it's a crisis, if it's not a crisis, it's a very vague situation to deal with. (CA 3)

Many expressed a need for education on other mental illnesses besides postpartum depression and how postpartum changes could affect mothers. CA 2's PHNs made the following comments about what they would like to see:

PHN: like I would like to know specifics about...depression versus bipolar versus ...a mom who's got...maybe schizophrenia...and then you're worried about...postpartum depression and what the differences might be or how they might manifest or...

PHN: ...I think it's really valuable to know this stuff because...it has great implications for how we might care plan for them...understanding what is their ability?...if somebody is unstable and is having...grandiose feelings and not able to focus and rambling two seconds a minute...you might not even understand that...at this point their medication is not working for them or there might need to be some stability in terms of...

PHN: And frequent training...I think that the Postpartum Mental Health Toolkit was great and it made me feel more comfortable but that was it!

PHN: Not just postpartum

PHN: I would like to know...surely there has to be some work done on...women who are parenting with schizophrenia, women who are parenting with bipolar condition, that would help me to understand how to best support them and care plan them; how that might have implications for child attachment, because for example, with bipolar condition there is such a self-focus, there is...racing thoughts and so there can be safety...like knowing all those little pieces maybe with common conditions...some type of resource manual or guidelines for that would be called for.

PHN: Have you guys seen a workshop on mental health and mothering? I haven't! (PHN: "no, no something like that would be wonderful for those education days!") Phewea! ...mental health and parenting!

Challenges and Barriers

PHNs described several experiences they had encountered in public health with mothers with mental illness, most in the postpartum period. Many of these experiences highlighted the lack of adequate resources to support these mothers in a time of adjustment to a new baby. Both community-based resources such as support groups as well as timely services from health professionals were seen as major gaps in terms of service for these families. Access to services and resources was also mentioned as a main barrier for the client population of CA 3.

“Treasure hunting”

Working with other disciplines at times presented barriers to providing adequate service. “Treasure hunting” emerged as a theme where PHNs felt that improved relationships and better communication with other disciplines were required in many situations they encountered. “Treasure hunting” for the most appropriate resource whether in terms of community groups or health professionals was a common thread in all groups. In CA 2, several PHNs spoke of wanting to deal with professionals who specialized in mental health as they found them more helpful and respectful than other practitioners:

PHN: ... so it's knowing the different resources and working collaboratively with the doctors...knowing how to jump through the hoops...who the gurus are, like in postpartum for example, we have our favourites that we refer to and we know how to do it...

PHN: I think that we're alert to go to the people that we feel are... specialized in the area because they understand and are more helpful...I

tend to maybe just skip the GP altogether and go straight to a either a psychologist or a... because things happen faster for that person and I like to get things moving as fast as possible for the client...

Child and Family Services (CFS) were viewed in some instances, as a barrier to providing service. One PHN described a case where planned support from CFS did not occur resulting in tremendous difficulties for this family:

PHN: it was obvious she was suffering with postpartum depression and the Public Health Nurse that was dealing with the case went through all of the things that we could do...referral to [name of psychologist] ...everything was getting put in place and services were offered to her really appropriately...she was...enrolled in a day program like an anxiety/depression...willing to go, and had been asking for the help but what fell through was Child & Family was supposed to provide her with respite (PHN: "and it didn't happen") and they never showed up (PHN; "oh really") and ...she ended up being evicted from her apartment (PHNs: "oh my gosh, oh") because of ...altercations with neighbours... (CA 1)

Another PHN from CA 3 felt that CFS involvement had a negative impact on their role as PHNs:

PHN: sometimes it sabotages our programs... when I tried to offer Families First she said 'no we don't want anyone else in the home, we told the support worker [CFS support worker] she can't come back because she was making...her feel upset and like she wasn't a good

parent so we don't anyone else doing this' and we're like, 'our program's completely different' but they couldn't switch the mindset (PHN: "yah")...she's just gonna be critiqued, she's just gonna be looked down on...and the approach would just be to tell her what to do right? So then it made it hard for us to provide service, which is unfortunate.

Other PHNs expressed frustration with CFS workers not being available to consult regarding specific family situations:

PHN: ...years ago, we used to call intake and we could kinda say 'this is my situation do I need to report it?' Now we're not allowed to do that, we have to phone and make a report and they'll decide if it is reportable, so they won't even tell us if it's necessarily a concern or not ...if we call and consult, they don't have to tell us what they're doing with it, so they don't want to even have to say if it is a concern (PHN: "oh"), so basically we feel like we're making a report even if we don't even know if a report needs to be made... (CA 3)

PHN: ...I've had someone say 'Are you reporting it or not?' I'd like to just have their permission to be able to call CFS just to ask them what they think. (CA 2)

For mothers with a previous diagnosed mental illness, PHNs reported a lack of mental health care specific to the postpartum period. PHNs expressed frustration that the arrival of a new baby appeared to have no effect on follow-up care for mental health for these mothers. In the situation below, this PHN from CA 1 related a situation where the lack of supports and follow-up in postpartum led to a temporary apprehension:

PHN: Sometimes...even if they've been a long term mental health client and everybody knows about them, they don't put anything in place for when they come home, because I had a couple like that and...for short term had their babies taken away because you know either their medication isn't altered **right away** or they don't have an appointment to see someone **right away** and so when we do the visit, there may be some issues or maybe not or something comes up...one mom she ended up... taking the baby to hospital and she hadn't done anything to the baby, but I guess the way she kinda presented it, they thought maybe there could be potential; they took the baby away short term...it was kind of unfair in a way...not enough support, it's sort of like Public Health will visit and she'll see her psychiatrist whenever, but it's a whole new anxiety-provoking experience and because she was kind of over-vigilant, it kinda went against her in a way...

This PHN reiterates this later during the group, reinforcing the gap:

PHN: I found these people had long term relationships with psychiatrists but there was no sort of thought given to...after this person has a baby both physically and emotionally it's gonna cause an upheaval (PHN: "right") so they don't need an appointment 2 months from now, they need to be...assessed when they go home... I would see that as a bit of a gap.

In the excerpt below a PHN describes a situation where she felt that the service needed to be implemented much sooner for this mother who had suffered from antenatal depression

and was experiencing severe symptoms in postpartum. By the time this mom was seen she had to be admitted:

PHN: ...she's having trouble functioning...they [the hospital] had set up an appointment with a psychiatrist for her but it was like two or three weeks down the road right? from when she got discharged... I encouraged her to call Mobile Crisis, she didn't want to, she was gonna wait for this appointment and maybe things would get better...eventually I think the husband called the psychiatrist to see if they could get in sooner and then once she had that appointment, they admitted her right away... (CA 3)

Community Mental Health Workers (CMHW) were seen as resources for PHNs; however all PHNs agreed that the CMHW role did not allow for interprofessional care planning. They were described as "consultants" but with limitations due to the more chronic nature of the client population they worked with:

PHN: I have used our mental health workers just to consult with myself ...but they can't go and take on a new client that needs to be caseload so well-established, so if I have a postpartum mom, we can't just refer to our mental health worker. (CA 1)

PHN: ...their role is basically situations involving chronic mental health, long-term mental health support, so our community mental health worker is not available to come out and do that, and I really miss that, it's really unfortunate. (CA 2)

PHN: ...a lot of times they can't necessarily give us the resources that are appropriate for ...our clients because they're dealing with such a different population... (CA 3)

The lack of community resources were described by all PHNs, particularly the extensive waiting periods for services to mothers in need of support which potentially could prevent a crisis situation:

PHN: just trying to figure out how to get them the best service in the quickest time and before something bad happens. (CA 3)

PHN: yah, I think there's just very little resources and they're bulging (*interviewer: "yah"*) so they have no choice but to put these wait lists

PHN: and a lot of resources are saturated, Family Centre of Winnipeg for example, the waiting list is six months for a support respite teaching homemaker, home support worker, **six months!** (CA 2)

Resources that were both available and accessible were of particular concern to PHNs in CA 3:

PHN: there's a lot of barriers to getting other resources besides the fact that they're not available in the first place (smiling), but even if they were available, they have to be available in a way that our clients can use them.

The changing nature of community resources was also seen as a barrier to providing adequate service. PHNs found it challenging to remain current on resources:

PHN: ...I'm curious to know how many other programs and how many other resources are in the city? (PHN: "u-hum") It's like you're going

treasure hunting all the time... (PHN: “you learn something new every time”)...yah it’s constantly calling around. (CA 2)

PHN: the resources are always changing (PHNs: “u-hum”) like...there’s this support group, oh! Now it’s not running...there’s this now oh, no! It’s not working and it’s like to keep on top of the resources is tough... (CA 3)

PHN: ...trying to manoeuvre the system and figure out where all the services are, I think that’s the hardest part. (CA 3)

Being knowledgeable regarding particulars of how to link families to resources was seen as a challenge as well. This PHN in CA 2 spoke of facilitating resources for families:

PHN: trying to get support into the families, knowing resources to link in to facilitate an admission (laugh) if you have to, and also afterwards to look at home supports to the families... that comes from us knowing how to word a letter just perfectly, so you can get that extra priority (laughs)...how to utilize Mobile Crisis effectively and to know that they can consult a psychiatrist and the psychiatrist can see them three times through the Mobile Crisis team, so there’s little ins and outs of knowing that.

This PHN in CA 3 spoke of their lack of knowledge regarding mental health resources:

PHN: ...we don’t know, we can’t manoeuvre our way around the mental health system ‘cause we have no idea...and everything’s so full...there’s waiting lists here and there...

The PHNs at CA 1 discussed a volunteer- run support group that had changed since the introduction of the Postpartum Mental Health Toolkit/Pilot Project in 2007. This was seen as a gap in service that previously existed:

PHN: [Blues & Beyond support group] that was run through Klinik and that it changed when this program came in and that group was ongoing (PHN: “yah and and it...”) and now it’s sort of sporadic, yah

PHN:then there were these big meetings over postpartum depression...to develop some sort of a strategy...they put out the booklet...the nice binder that we use...then basically shuffled the support aspect off to Women’s Health Clinic and now it’s a very structured program... I don’t think necessarily you can slot people who are needing support in a six-week session and the next session sorry, doesn’t start til next fall...

PHN: but we lost that support group idea altogether so (PHNs: “yes, yes”) and I know Women’s Health Clinic...I’m never quite sure what they’re doing (PHN: “yah”) ...I check their website...does that mean you have a group running? (PHN: “well it just says call”) Or you don’t now? ...Or can I call? (PHN in background: “yah”) Or is it the client? ... I find that section of Women’s Health Clinic hard to manoeuvre, so if I find it hard then I don’t know about the client!

PHN: ...when they do call Women’s Health...they leave a message (PHN: “message, yah”) and that message may not be returned for a couple of days and when someone makes that call (“u-hum” from

PHNs)...they need to talk to someone **now** (interrupted by PHN:

“they’ve usually waited for a specific point to call, yah”) not two days

ago, you know

PHN: it’s a big gap.

“You can only do so much”

Several PHNs spoke of challenges they faced with families considered “at-risk” that were not receptive to public health, how they tried to maintain contact or dealt with feelings of powerlessness. The theme of “you can only do so much” emerged from all three groups. This relates to public health services being relationship-based and voluntary:

PHN: we can pretty much convince someone that we should come in the first time ...and then and after that...you can’t jump in with too many negative things or things that we’re gonna tell them...it’s a totally voluntary program, and it’s no thanks or they don’t say no thanks, they just don’t answer the call (PHN: “u-hum”) and it’s often high-risk people who don’t... if you’ve asked too many questions or if they felt you were too intrusive then the phone just doesn’t get answered again (PHNs agree in background). (CA 1)

PHN: she was I think really suffering and for me, I just tried to keep in contact with her, ‘cause she wasn’t receptive to anything else at that point, so just keeping the door open in case she did want something else...I weighed the baby a lot more than I would have normally (laughs) weighed somebody’s baby, just to come out, just to have someone for her

to talk to (PHN: “Every mom likes her baby weighed” – big laugh) ‘I could come out and weigh the baby’... just for her to say how she was feeling and then she started...going out and going for walks and how that was making her feel better and she was starting to take some help from her mom and she was...very anxious about everything... (CA 2)

In CA 3, this PHN spoke of getting a sense as to whether the family would contact her:

PHN: ...I think that probably the people who are most at-risk are the people who aren’t that receptive to us, so I think that that’s always a challenge...there’s often a lot of people either we can’t reach them from the start, or we have trouble reaching them after and you always wonder if...they’re not coping that well...we can only do so much, so that’s always kind of in the back of your mind...so when you do that first assessment you kind of get an idea of how resourceful people are from their history and you get an idea whether they’ll they might call you if they were in trouble, but it’s those ones where you just don’t think that they’re going to, that you worry most about...

Interviewer: So you try and get as much information as you can and...

PHN (in response): yah...even if they don’t seem receptive you hope that if you know they’re not gonna be home next time you go by or if they don’t have a phone, at least you’ve given them that information (PHN: “yah”) and that’s about all you can do. (CA 3)

In CA 3, PHNs discussed the added social factors with their client population such as poverty and its associated risks. The researcher sensed strong feelings of

powerlessness from this group as they expressed openly how they wished they could do more to help these families. This is reflected in the excerpt below:

PHN: ...the hardest thing is when you get in to a situation like that... their life is already in a crisis when we see them because they're suddenly...looking after a new baby and a lot of it might be a lack of family supports and the reality is we can't change any of that immediately...I often feel very powerless in trying to help with a situation that's presented because...I can't change their life...I feel a sense of urgency to help them without having anything that I can say 'here (small chuckle) like go have a nap'... 'I'll take your baby for a couple days'... and sometimes it's hard...some of the moms have like three kids and no help (other PHN: "and the housing's not good and...") and the housing's poor and they don't have the money to get to the Doctor and they don't have money to get to the food bank and...

PHN (adds):...relationship issues, (PHN: "that's huge") substance abuse, like there's just usually multiple things happening at the same time and trying to differentiate what you need to help them with first (PHNs: "yah")...you gotta get through the immediate crisis and then...the rest will get done when it gets done.

This PHN reinforced the priorities of the family and finding out what they perceived as concerns:

PHN: ...when I see there's lots of concerns here and it could be mental illness related or it could be other things but they don't see it, that's the

big issue (PHN: “u-hum”) I think if the family can identify this is my concern, I feel very comfortable...being unsure about food for supper, but I feel very unsafe because of how I feel or something, if a family can name what their issue is...(PHN: “it’s so much easier”) yah very, but if the family feels like everything’s fine, but I’m seeing a bunch of concerns, it’s how to help that family move them along that trajectory of motivation realizing ‘oh, this is a problem’ (PHN: “right”). (CA 3)

As the Aboriginal population comprises the majority of the CA 3, these PHNs also addressed an aspect of cultural competence:

PHN: ...but then also that fine balance of... respecting that family’s (PHN: “yah, judgment”) culture...maybe their culture...living without electricity for a week and they feel okay about that ‘cause that’s what they had growing up, and it feels like camping (chuckle from PHNs)...somebody told me that... (PHN: “feels like camping! they were okay with it” PHNs chuckling in background).

PHN (adds): Sometimes it’s like what they’re familiar with and their background so...to us it looks like there is some concerns, but to them yah, they may not perceive them as concerns ‘cause that’s what they know right? ...

“I kept wanting more”

“I kept wanting more” was prevalent as a theme for all participating PHNs who offered suggestions for better resources for both themselves as professionals and the families they worked with. In relation to the predominantly low socio-economic group at

CA 3, PHNs emphasized the lack of resources particularly around access. As one PHN pointed out in this excerpt:

PHN: everything's piecemeal...we have to start looking at health care in a disadvantaged population...completely different so that we're putting those extra interventions or services or things to make it accessible, we need to put that across the board with everything, whether it's a mom's group, a Doctor's appointment a self-help thing, anything.

Interviewer: so it's fine to have the resources there but if they're not accessible (PHN: "exactly" "right") there's no point in developing new ones, so you really need to develop more resources that are about access.

PHN: Exactly, because [name of CA 3] is a very well-resourced community, but we go to a lot of different programs where there's often no one there...that's because...we've missed that whole piece again...it has to be more of a systemic-wide attempt to gain participation...

This same PHN provided a concrete example of how this should occur:

PHN: we don't put our money where are mouth is so for example, our clients...if we want them to get to the appointment n' get their children's immunizations, we need to put more service into getting that done whether it's a phone call, a bus ticket, following up, like we know that people will not get the same health care unless there's way more intervention involved, but we don't offer that intervention to get them to that level, to get them to the same health status as people who are the haves. (CA 3)

In CA 2, this PHN suggested a proctor service for mental health similar to the Families First home visitor:

PHN: it's just there's so little out there in terms of support and even if there was some type of proctor support system service that is available like we have the home visitor, but something specific to mental health the way they have their proctors would be really great.

A need for more interprofessional communication was expressed by PHNs from all groups with regards to CFS:

PHN: Well I'd like to just have their permission to be able to call CFS just to ask them what they think.

PHN: or if they had someone...there for consults...that could answer questions. (CA 2)

PHN: ...we should be able to work more as team and I think because we're...all bound by PHIA [Personal Health and Information Act]... 'cause we're all providers of health and social services, so it'd be nicer to be more integrated. (CA 3)

This PHN spoke of having had a positive experience working together with a CFS worker:

PHN: ...when I was at [name of other CA], I had a shared client with one of the social workers...we could go and talk to each other in person about this client, 'oh, I'm gonna be dropping by this week and so I'll see where things are at and I'll let you know' and he was like awesome!...like we were really working together about this client... (CA 3)

More knowledge concerning postpartum mental health amongst other professionals was also expressed as PHNs viewed general practitioners (GPs) in some instances as barriers, impacting PHNs' credibility and relationships with families. Here is an excerpt from CA 2:

PHN: they've called their doctor to talk about this...four weeks later and they've given them all the things that are going on...they're like they 'oh yah, he said it's just baby blues' and it's like, 'oh, okay' (chuckles) and nothing's changed for them, they're still incredibly anxious...not sleeping...well that's not helpful now that the doctor who I feel like, once the doctor says something sometimes that's...

PHN (completes phrase): Precedence

PHN: Yes...puts under the rug whatever I say. It's like 'oh well, he said it's this...you obviously don't know what you're talking about'. It's like 'oh, okay' so then...it's just better to go to Doctor [name of psychologist] and someone I think understands (PHN: "better") what's going on and I mean more...respectful of what we think.

PHN (adds): And what we do.

GPs were also criticized by PHNs for not supporting breastfeeding with mothers to whom they'd prescribed antidepressants. In this excerpt the PHN in CA 2 described a situation where she advocated for the mother and was able to make a difference:

PHN: a mom called me... 'my doctor said I have to stop breastfeeding' and she was going on...quite a standard medication that can be very safe for breastfeeding, and can be **safer** especially if the dosage isn't higher

than a certain level...so it's equipping the mother with the ability to make informed decisions and providing the information, so giving them information from the lactation mother's milk book and sometimes faxing that information over to the doctor (laughs)...so often they're thrown off breastfeeding... it's so counter-productive and it causes more guilt and stress...so I think it's working with people that are knowledgeable.

CA 2's PHNs stressed the need for more education for doctors with regards to prenatal mental health assessments to anticipate mental health needs postpartum and potentially prevent complications:

PHN: ...better teaching for primary care providers for example, knowing that if there's been depression issues or mental health issues...sure shooting, you marry that with the normal, wonderful, elevated stress of parenthood and having a new baby that that's gonna be exemplified; you know that once you've had two bouts of depression, research has shown that going on long-term therapy for depression is recommended, rather than this yo-yo treatment, so a lot of this isn't happening because there isn't the consistent education that's going on with practitioners and so you have moms that get pregnant, they're not properly assessed...

This PHN spoke of a situation where a prenatal mental health assessment was done and this mother had support in place for when she returned home postpartum:

PHN: ...in one situation we knew there would be stresses, we knew it would happen, so we set up for there to be already some respite in place once the baby was born to assist in coping (*Interviewer: "and that made*

a difference?”) ...that made a difference because we knew that there would be difficulties, because there had been challenges already prenatally... (CA 2)

CA 2's PHNs like the others felt there needed to be more immediate resources but added that a more comprehensive approach was also warranted:

PHN: and something quick but also something that will take not just the mom but (PHN: “the family”) the family...

PHN (interrupts): it impacts all the loved ones. It impacts the children you know.

All groups related that a resource person for mental health would be very helpful in supporting their role with families. Each group mentioned they had experienced this with the pilot project but that this person was no longer available. Descriptions of what they envisioned for this role varied from providing support and consultation to PHNs to a person who could do joint home visits with PHNs and be an actual resource for families in need of mental health services.

PHN: we don't have that 'go-to' person for that family crisis, you know family support kind of piece/ [slash] mental health emotional support piece. (CA 2)

PHN: It would be nice to have someone to liaise with that works in the mental health field...when we come into contact (PHN: “exactly”) with a client, if we have questions we could have someone to contact and say, 'Hey, I have this client exhibiting these symptoms' ... (CA 3)

PHN: having some sort of contact person that keeps up to date with the changes for mental health resources. (CA 3)

PHN: CNS for mental health wow! Wouldn't that just be bunnies butt!
(laughing) (CA 2)

PHN: I would like to have a mental health worker that we could use more than just run in because they're so overloaded. I think they could be good consultants or they could come out on a visit with us or ...even to plug people into those many services or to help assess which one would be best, that would be great! (CA 1)

The Needs of Mothers with Mental Illness

In discussing situations of mothers with mental illness, PHNs spoke specifically of a lack of immediate resources to refer families to when mothers were not necessarily in a crisis but perhaps needed some extra support to help them through difficult periods and possibly prevent crisis situations from occurring altogether.

“Treasure hunting”

PHNs spoke of medications being only one aspect of treatment but typically what Doctors provided:

PHN: ...even if you have primary care providers, well yah, they get medication, but medications...I don't believe that...everyone needs [medication] I think that that's the only thing people can offer so that's what they get, well maybe it's not the best thing or the only thing! (CA 3)

PHNs spoke highly of a psychology program which offered counselling for postpartum mothers. This program was mentioned by all the groups as a valuable

resource that PHNs could refer mothers to for service. PHNs were particularly pleased with the open communication of this service vis-à-vis the PHNs.

PHN: I love the fact that...we can do something, like the referral to [name of Doctor] ... (other PHNs say “that’s so great yah”) if you take that out of the picture, everything else is well...try and sleep when the baby’s sleeping, make an appointment with your doctor to get assessed and get some meds,...look through ...this list of counselling services and see if you could (PHNs in background, “u-hum”) you, you, you and at least there’s that one thing that we can say... ‘I can make a referral for you’...that’s huge I think... (“getting a response, yah” from another PHN) yah. (CA 1)

PHN: ...so could we support that her clinical psychology group? ... [psychology group] sent me a really great note back which is so nice too, that you hear back from someone, so if that department could be padded a little, that would be really helpful (PHN: “that’s fine”)...even if there was a mental health worker in that, as part of their department... (CA 1)

Concerns over this resource becoming saturated posed a concern for all PHNs:

PHN: ...I would feel lost if [name of Doctor] ever up and left and [name of Doctor] ever up and left. (CA 2)

PHN: and you see that wait longer and longer now, I find since...four years ago... you got clients in easily and now its four to six weeks then it’s months... (interrupted by PHN: “or they went to a different program”). (CA 1)

Many PHNs spoke of not being aware of existing mental health resources related to the changing nature of resources. Other PHNs spoke of a challenge to manoeuvre the mental health system to find the most appropriate resource for that family in view of the long waiting lists and meeting specific criteria.

PHN: in mental health, like a lot of the support groups...they're changing all the time and the rules for who we can refer to...for a long time Doctor [name] we couldn't refer to but now we can directly right? (chuckle) see! ...you kind of wait til you have the situation (PHN: "and then you run around") and then you deal with it, because if you learn everything right now, it's gonna change by the time you have a situation when you need to apply it. (CA 3)

Most evident in CA 3 was the need to have accessible resources and some that could meet certain basic needs of families living in poverty, so that mental health could be addressed.

PHN: ...you need things kind of like the groups have like outreach workers, people to help facilitate appointments, transportation and child care like those are the big things to coincide with the treatment otherwise...it's not gonna work... because (PHN: "u-hum")... they're looking after their basic needs... (CA 3)

PHN: ...a lot of these families have multiple issues (PHN: "u-hum") so you know what Families First is like down here (hand gesture), their housing, their food, their shelter, their phone, you know their bills and

everything are up here (hand gesture) and they just don't have time in their life... (CA 3)

“Dealing with where they're at”

PHNs viewed the needs of mothers with mental illness in a holistic manner where family, home environment and community played an important role in terms of getting the help they needed and accessing resources. “Dealing with where they're at” meant meeting mothers' mental health needs in a timely manner whether they are in crisis or not. As the home environment offered a more realistic view of the mother and family, some PHNs suggested mental health professionals come out on home visits with the PHN to do their assessments and offer appropriate resources.

PHN: It'd be so nice if you could actually bring somebody out to the house with you...so it's still again on her terms, in her house, she already knows you and now you're just bringing somebody else... (CA 2)

PHN: I have called the psychiatrist... 'this is a bit of a change' [with client] and it's just to run by them saying 'Would this be normal for your client? because I'm **very** concerned' (laughs) and then I think it twigs them in because they don't see them in the home (PHNs: “no, u-hum, that's right” “yah” in background) that's a totally different place to be!... (CA 1)

Prenatal assessment was viewed by many PHNs as an important piece to provide continuity of care and better meet the needs of families. Some PHNs discussed specific cases where appropriate assessments were done prenatally and resources were put in

place for the postpartum period. Unfortunately, prenatal assessments that include a mental health component are not done consistently according to the PHNs.

PHN: ...we are getting...prenatal referrals (PHN: “yah”)...our role is to phone them and introduce ourselves and community resources (PHN: “yah”) but really I don’t talk about mental health (PHN: “no, neither do I”)...it’s just not part of it, so maybe that’s something else that should be... (CA 1)

PHN: ...it’s been proven and they spoke about it even at the Healthy Child Manitoba provincial meeting that I went to in June...the key to prevention is prenatal assessment...it has a lot to do with what state they are in when they’re in the start of their pregnancy; a lot of these assessments can be done prenatally...so we’re not **chasing** after the situation once the horse is out of the fence, like it’s hard to catch up rather than anticipate... (CA 2)

This PHN in CA 1 describes a case where although an apprehension took place, the proper communication and planning prenatally made for it to be done in an organized manner:

PHN: this one at least had things in place prenatally and then as the baby was born still has had all the kids apprehended so she couldn’t manage but everybody was ready...it was a really good communication about what should we do, she’s gonna come home, something might happen, so at least there was lots of people in place...and something did happen...these people weren’t caught...

“You can only do so much”

With limited resources for mental health and limited access to resources for “at-risk” populations, PHNs often felt there is little they could do to support families for mental health. Non-receptive families, specifically those considered “at-risk” remained a concern for PHNs. Some PHNs did express the possibility of this being associated with the fear of families losing their children:

PHN: ...I haven't noticed it so much in this area but I know when I worked [name of CA] they thought we were CFS (CA 1)

PHN: ...sometimes if they're scared of the system or if there's other things happening, they'll avoid you... (CA 3)

PHN: ...I always ask 'Did the hospital let you know that the Public Health Nurse would be calling you?' and the ones that say no, I find that you have to do **a lot more** talking and probing to get information...

PHN (adds): and reassurance you're not **monitoring** and somehow they haven't been **referred** to you. (CA 2)

Most PHNs however felt that their strength-based approach separated them from CFS:

PHN: ...we're not Child & Family, so we cut people a lot more slack because we would want them to call us and get back to us more... (CA 1)

PHN: I find ours [approach] is more positive strength-based highlighting the positives. (CA 3)

Most PHNs felt the non-receptivity was mostly related to the multiple social issues that “at-risk” families face:

PHN: ...they might be struggling and you might not even get to that point because of all these other factors that are just kind of glaring at you...they don't even realize that they're not mentally healthy or...knocking on the door of mental illness, because they don't know what they're feeding their kids tonight and they need formula for the baby and they need diapers for the baby and he's threatening to come back and he hit her last week and now she's afraid... (CA 3)

In summary, this chapter reviewed the common themes which emerged from the data in the focus groups with PHNs. With the overall theme and PHN purpose as “helping Moms succeed”, PHNs expressed how they viewed their role in working with mothers with mental illness. They described the many barriers and challenges they faced to offer services and resources at the professional, community and family levels and lastly, PHNs provided information as to what they perceived as the needs of mothers with mental illness specifically in terms of resources.

Chapter Five: Discussion

This chapter focuses on discussing the results of this study in relation to the conceptual framework. A diagrammatic representation of the themes within the conceptual framework is provided to illustrate where and how the role of the Public Health Nurse (PHN) comes into play for mothers with mental illness (see Figure 3. p. 122). The overall theme of “Helping Moms Succeed” is discussed with the integration of relevant literature where similarities are found. Implications and recommendations for Public Health Nursing practice are presented in response to the purpose of the research and the research questions. Finally, limitations of the current study and brief recommendations for future research are discussed.

Application of Conceptual Framework

As the chosen framework for this study is the *Integrated Model of Population Health and Health Promotion* (Hamilton & Bhatti, 1995), results are discussed according to selected elements of the model that relate specifically to the PHN role and maternal mental health. Within this model, the PHN’s role is at each of the levels: who? how? and on what? These are described separately in the next section.

Who?

According to this model, “who?” represents the levels at which actions are to take place or “with whom” PHNs act. When working with mothers who have mental illness, PHNs intervened at the levels of the individual mothers, their families, and the communities in which they lived in order to promote access and/or changes to resources. Interventions thus included contextual factors that influenced family life. PHNs also worked with the sectors of Mental Health, Child and Family Services (CFS) and Primary

Care Providers, in terms of consultations with Community Mental Health Workers (CMHWs), primary care providers and CFS workers. Challenges and barriers for PHNs in this study involved establishing initial relationships with “at-risk” families, and the lack of interprofessional communication with treatment/care plan for families. These are discussed in further detail on page 129.

How?

“How” encompasses how PHNs take action. Actions from the model which were most appropriate for PHNs and maternal mental health involved: creating supportive environments, where PHNs performed holistic assessments; developing personal skills, where PHNs engaged in health promotion activities; reorienting health services where PHNs partnered with other agencies to provide appropriate resources.

Creating supportive environments. PHNs viewed mothers with mental illness within their social and environmental contexts and provided care accordingly. By “dealing with where they’re at” PHNs performed holistic nursing assessments which included coping and mental health. These assessments were done in a routine manner using tools from the Families First program. Their nursing assessments were labelled as “carte-blanche” as PHNs went into homes with very little information from a hospital postpartum referral form and viewed the mother in the context of her family and community environment. Interventions were planned according to the needs manifested, with the goal being to have a positive impact on health for the family unit as a whole. Challenges and barriers included the lack of information about mental health on referral forms, the lack of follow-up for mental health for previously diagnosed illness and the need to prioritize immediate physical needs of the mother and baby upon initial visits.

Developing personal skills. PHNs were involved in helping mothers develop personal skills. Health promotion activities by PHNs included health education, parenting and self-care skills to promote healthy parenting, and healthy child development. By “dealing with where they’re at”, PHNs provided education to moms with mental illness regarding signs and symptoms of mental illness which were geared specifically to the needs they presented at the time of prenatal and/or postpartum assessments. Education regarding self-care and stress management by PHNs also provided appropriate support for mothers to prevent isolation. Challenges and barriers for PHNs included the limited time frame for involvement in postpartum where mothers may not have presented symptoms at the time of the initial contact and may or may not have used the PHN as a resource if symptoms arose.

Reorienting health services. Within their holistic view and assessment of the mother, PHNs partnered with other health professionals to address mental health needs as appropriate. The theme “treasure hunting” involved the challenging search for the most appropriate resources for mental health. PHNs wanted to offer resources in a timely manner to best meet the needs of the mother and prevent further deterioration of health and effects on the family. Challenges and barriers included the lack of immediate resources for mental health to prevent crisis situations and the limited access for “at-risk” families.

On What?

Actions were taken on the determinants of health, which constitute the “on what?” piece of the model. PHNs’ actions for maternal mental health were aimed at: social

support networks, personal health practices and coping skills, healthy child development and health services.

Social support networks. Social support is crucial in helping mothers deal with mental illness. PHNs helped to foster family environments that supported mothers, by providing appropriate resources for their mental illness and parenting. PHNs were “treasure hunting” for the most appropriate resources that suited the mothers’ mental health needs to promote healthy family environments for children yet on the other hand, they “...kept wanting more” resources for mothers and families, which were seen as lacking, as evidenced by waiting lists and gaps in the system for immediate resources. Challenges and barriers included not only the lack of resources, but specific resources that were aimed at the family unit versus the mother who was experiencing symptoms. In view of the current study, the stigma of mental illness would constitute a barrier on the part of the mother and family as opposed to the PHNs.

Health services. Access to mental health services is essential in order to improve the mental health of mothers. The theme “I kept wanting more” involved the PHNs’ desire for better access to mental health resources for “at-risk” families where additional interventions were required to ensure successful access to care. More resources that were about access would assist in promoting access and participation in resources. Those mentioned included child care and transportation services.

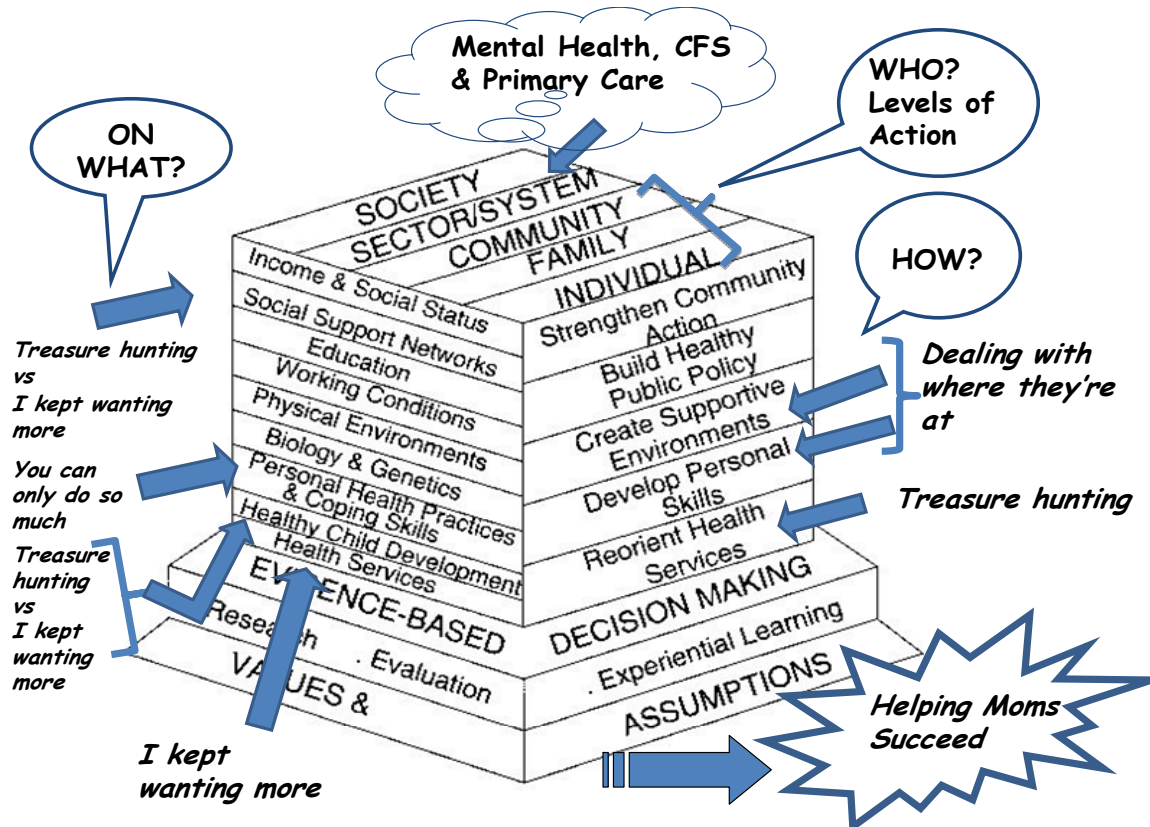
Healthy child development. Access to primary care services such as prenatal care can help prevent complications with mental illness in the postpartum period. Once again, PHNs “treasure hunt (ed)...” for the best mental health resources which could offer service in a timely manner to prevent complications yet on the other hand, they

“... kept wanting more” in terms of access to prenatal care and resources for mothers deemed “at-risk” for mental health problems such as those with previous mental illness. Prenatal assessment for mental health could potentially prevent complications of mental illness in the postpartum period. Early treatment in turn, could mitigate negative effects on attachment, an essential component of healthy child development.

Personal health practices and coping skills. PHNs promoted healthy choices and effective coping skills through health education and provision of resources to families. The theme “you can only do so much” related to families not being receptive to PHN intervention. This was associated mainly with the nature of the relationship with the PHN, social factors that interfered with accessing help, and possibly the fear of losing care of their children.

The quality of the relationship that was developed between the family and the PHN could affect whether or not resources were accessed by the family for support. In many cases, factors such as poverty interfered with accessing resources as families struggled to maintain their basic needs. The fear of losing care of their children was underlying many aspects of seeking help for mothers as they tried to balance their illness symptoms with meeting their children’s care needs. Stigma can also interfere with accessing resources as mothers fear they will lose their children if they are seen as mentally unstable. PHNs’ approach to mental health, as seen in this study can help to “normalize” mental health issues through education and support and thus help mothers seek appropriate treatment.

Figure 3: Application of Results to Conceptual Framework



Helping Moms Succeed

The common overall theme of “Helping Moms Succeed” constitutes the overall goal of the PHN in population health (i.e., promoting healthy families). PHNs in the focus groups all expressed a desire to help mothers by providing support and resources. Although their role in supporting parenting was limited to providing education and resources, their overall view of mothers with mental illness was positive in that these mothers were seen as needing additional support at a critical time of adjustment to a new baby. Moreover, PHNs stressed the need to “normalize” mental health issues with families by providing printed educational resources and open discussion. This is contrary to common stereotypes in society and with health professionals alike that these mothers

are incompetent parents by the simple fact that they suffer from mental illness. Nicholson and Biebel (2002) maintain that these mothers have similar goals and challenges to any other parent. They recommend professionals acknowledge strengths and facilitate access to treatment and education about illness and address other family topics such as child development.

Although initially this study intended to look at attitudes of PHNs vis-à-vis mothers with mental illness, the interviews did not reveal negative attitudes and stigma on the topic. In contrast, PHNs demonstrated empathy towards these mothers and expressed a sincere desire to want to support them. Since these were not identified, one would assume that the interactions they had with mothers and families were generally positive. Munroe and Baker (2007) found that nurses who were knowledgeable regarding aetiology and risk factors of mental illness had more positive attitudes. This was supported in the current study where many PHNs demonstrated knowledge about assessment for mental health in postpartum and were eager to learn more.

PHNs received training for Families First which includes a variety of assessment questions regarding family life, mental health and coping. All expressed this education as valuable to assess mothers and their families and helped to increase their comfort level dealing with mental health issues. Similarly, Kim and Salyers (2008) found that professionals who had received training on working with families had more positive attitudes towards families where mental illness was present. Professionals working in the community were also found to have more positive attitudes than those working on an inpatient unit (Slack & Webber, 2007). Results from this study reflected this finding. As working in the community provides professionals with a more holistic view of the client,

this view contributes to their positive attitude as they assess mothers in their home, as mentioned by this PHN: "...you see them in the comfort of their own home around their supports or lack there of" (CA 2). The family and the environment were all considered as part of the assessment versus the hospital environment where this type of assessment is not feasible.

Results from this study supported that the "lack of coordinated response" for PHNs dealing with postpartum mental health (as reported by the Winnipeg Regional Health Authority- WRHA) was most likely related to the lack of resources and the lack of interprofessional collaboration rather than negative attitudes on the part of the PHNs.

Implications for PHN Practice and Recommendations

The purpose of this research was to explore and describe the experiences of PHNs working with mothers with mental illness and how these affected how service was provided. The findings from the focus groups have implications for public health nursing practice with regards to the role of the PHN, the needs of mothers with mental illness, and the challenges and barriers to providing support.

Role of the Public Health Nurse

The PHN role was clear for most PHNs in terms of providing service to mothers with mental illness. They viewed themselves as a professional that supported the mother and her family by recognizing issues and acted as a liaison to community and professional resources. Chernomas et al. (2000) and Mowbray et al. (1995) maintain that the need for support is critical for mothers with mental illness to raising their children. Due to the lack of resources however, some PHNs felt their role became limited: "... this person is needing something from you right now... is freaking out on the phone and

crying...you can't get a hold of the psychologist... you can't get a hold of the doctor...what do you do at that point?" (CA 2). For such situations, a resource person for mental health would be helpful for consultation with PHNs and could provide direct service to families.

In view of parenting, PHNs did not view themselves as the professional that assessed parenting abilities but that they provided resources to support positive parenting. In cases where they were concerned about safety, PHNs referred to Child and Family Services (CFS). PHNs in this study expressed the need for improved communication with CFS in order to better support families.

As symptoms of mental illness can occur several weeks postpartum, PHNs felt they did not have the opportunity to assess mental health in a consistent manner due to the need to prioritize acute maternal/newborn physical needs, in relation to early postpartum discharge. The need for more follow-up postpartum was highlighted, according to these PHNs, in the Postpartum Mental Health Pilot Project (2007) where a trial follow-up at six weeks with regards to mental health proved to be successful at identifying mental health issues. This practice has since not been maintained due to the lack of staffing. The need for more staffing was also reflected in the pilot project (WRHA, 2008).

When initial relationships with families were positive however, families would contact the PHNs with questions or concerns about mental health later on. Those that did not seek out assistance for concerns were seen as the most "at-risk" and most worrisome for PHNs. As found in the pilot project, the six-week follow-up for mental health should be done routinely for postpartum mothers in order to help identify issues early on and

provide resources for treatment and support as necessary. The pilot project also recommended revising this follow-up for a dual focus to include both mental health and health promotion, illness/injury prevention topics (WRHA, 2008). This practice would promote more continuity of care for families for their mental health as well as any other health needs.

When families were not receptive to resources offered but had built a trusting relationship with the PHN, PHNs continued to maintain contact with them if they were concerned about mental health. This was done by “finding reasons” to keep in contact for example, offering to weigh the baby. Families who were not receptive to PHN involvement altogether were seen by PHNs as mainly part of the “at-risk” population who were already overwhelmed with meeting the basic needs of the family and did not see PHN service as priority in their lives: “...they don’t know what they’re feeding their kids tonight and they need formula for the baby and they need diapers for the baby...”. The literature also supports this multi-contextual view of parenting and parental competence where maternal mental illness itself represents only a small part of “at-risk” family situations (Canadian Incidence Study, 2003). Mowbray et al. (1995) also found that factors such as poverty and lack of support could be the mediating factors for poor parenting skills and negative outcomes for children.

Although the PHNs in this study did not demonstrate negative attitudes and stigma towards mothers with mental illness, the refusal of PHN service or other resources could be also be viewed as what Corrigan (2004) calls “self-stigma”; where mothers internalized the stereotype of being incompetent and therefore were afraid to seek help for fear of losing care of their children (Corrigan, 2004). According to Lintner and Gray

(2006) 25% of mothers do not seek help for postpartum mental health issues in relation to stigma. Although the stigma of mental illness has improved over the years, issues remain to be addressed particularly with regards to persons seeking help; the view changing to one of a sign of strength versus a weakness. “Normalizing” mental health issues with families as the PHNs have demonstrated in this study can help to minimize stigma and bring issues to the forefront for help to seek appropriate treatment.

Although negative attitudes were not expressed, it could be argued that PHNs may not have been candid about their views on the topic and that those families who were not receptive to PHN service may somehow have felt such attitudes on the part of the visiting PHN. Kim and Saylers (2008) confirm that attitudes of professionals can affect collaborative relationships with families.

The Needs of Mothers with Mental Illness

Highlighted in the current study were the needs of mothers with mental illness for immediate resources that could potentially help prevent crisis situations. Resources such as more professionals who specialized in postpartum mental health in particular were mentioned as well as the need for better prenatal assessment and postpartum follow-up for mothers with previously diagnosed mental illness. PHNs wanted more services similar to the psychology program for which they felt could not fulfill the current need. This was viewed as a valuable resource for mothers.

Early prenatal assessment was mentioned as being crucial to improve outcomes for mothers and families. Mental health assessment in the prenatal period would help to identify mental health concerns early on and mitigate symptoms postpartum with appropriate treatment and follow-up. Education for primary care providers about

perinatal mental health and the importance of mental health assessment would also be required in order to improve care. According to these PHNs, prenatal care did not consistently include mental health assessment. This would be an important step in providing comprehensive care to mothers and prevent complications postpartum.

Medications and counselling were viewed as equally important in the overall treatment for postpartum mental health issues however, some PHNs felt that only medications were offered by Primary Care doctors. More education amongst providers regarding comprehensive treatment such as support groups and counselling services for the entire family was expressed. Helping family members cope was viewed as equally important when working with a mother with mental illness. Singleton (2007) in her study on children of parents who had mental illness also recommended family-focused interventions in relation to their need for support.

Community resources for mothers with mental illness were seen as lacking as well. PHNs spoke of a mom's group for postpartum mental health recently centralized and centrally located as being too structured to meet the needs of mothers: "...I don't think necessarily you can slot people who are needing support in a six-week session and the next session sorry, doesn't start til next fall...". They also mentioned that the information posted for the groups was not clear, potentially affecting accessibility for clients: "...I find that section of *Women's Health Clinic* hard to manoeuvre, so if I find it hard then I don't about the client!"

As PHNs viewed accessibility as being significant factor for "at-risk" populations, resources surrounding "access" would need to be implemented in order to address mental health issues in mothers in a more systematic manner. As this PHN stated: "...putting

those extra interventions or services or things to make it accessible, we need to put that across the board with everything..." For "at-risk" groups, meeting the basic needs of their family took precedence over accessing resources for mental health. Nicholson et al. (1998a) in their research on mothers with mental illness had also considered the extent of the influence of poverty on parenting as unknown (Nicholson et al., 1998a). Resources for access would include such things as transportation, child care, and reminder messages.

Challenges and Barriers to Providing Support

Waiting lists for professional help for mothers were stated as a barrier to providing service. Supporting professional services such as the psychology group mentioned would be beneficial for mothers; however once again, for "at-risk" groups the added resources for access would need to be in place to be successful. Montgomery (2005) also recommends looking at the mother's total life situation including such factors as poverty in order to develop programs and resources for "at-risk" groups. The addition of such resources however could still prove to be futile if mental health is not seen as a priority by the mother or her family. Issues stemming from poverty supersede access to resources. Efforts at reducing poverty levels therefore remain a priority to positively affect outcomes for mental health for "at-risk" populations.

Lack of interprofessional communication was viewed by many PHNs as a significant barrier to providing adequate service to families. The need for consultation with CFS was expressed, as well as better communication with CFS workers with regards to shared clients. Interprofessional care would benefit families and professionals alike. Lewin and Abdrbo (2009) also confirmed in their study of mothers with SMI and child

protection issues, the need for coordination of services to address parenting and the support of children. Better knowledge amongst Primary Care providers such as physicians, regarding postpartum mental health was also suggested. Primary Care doctors for example, could provide prenatal mental health assessments and work collaboratively with PHNs with regards to prenatal and postpartum resources to potentially prevent complications versus working against PHNs in postpartum and minimizing their concerns such as seen in some of the results.

Although CMHWs were viewed as knowledgeable and helpful, their limited scope of practice allowed for minimal collaborative care planning with PHNs for postpartum families. Interprofessional collaboration would provide better service to families. Examples of collaboration were presented in this study where outcomes were positive: "...we knew there would be stresses, we knew it would happen, so we set up for there to be already some respite in place once the baby was born to assist in coping...that made a difference..." (CA 2). Blanch et al. (1994) also supported a similar service integration approach which they maintained could reduce out-of-home placements, reduce the need for mental health interventions with children, improve parenting skills and increase satisfaction for all involved. An interprofessional approach to child-bearing families would thus contribute to more continuity and comprehensive care and promote healthy families.

All PHNs found the Perinatal Mental Health Toolkit and Pilot Project to be beneficial to their role in supporting mothers particularly with new printed resources and access to the psychology group. Many expressed a desire to learn more about mental illness, specifically regarding pre-existing disorders that could be exacerbated

postpartum. PHNs also recommended ongoing training for mental health to maintain their competency and remain current on resources.

A suggestion was made by all three groups to have a mental health resource person available for them to consult with and/or do joint home visits. This person would remain updated on resources, consult with PHNs, provide direct service to clients as needed and also educate PHNs on an ongoing basis about current research in mental health specific to their practice. A public health-mental health model, in which a psychiatric nurse clinician works together with public health, acting as a consultant and providing service to families, has demonstrated success in the USA (Gaul & Farkas, 2007). In the WRHA, this resource person could be a Clinical Nurse Specialist or CMHW. Within the WRHA Mental Health Program, the idea of a “Mental Health Promotion Facilitator” is currently being explored as part of new project entitled Towards Flourishing, aimed at improving the mental health among women in the Families First Program (information provided by project leaders, Marion Cooper & Laurie McPherson, August, 2010). One focus group from CA 3 was aware of this information prior to the interview but the idea was mentioned by all three groups as a recommendation.

Formal case reviews were recommended by PHNs as helpful to link knowledge and practice with a team approach. Although this was done on an informal basis in all participating CAs, none had been doing these on a formal basis with specific time set aside to review a complex case as a team of PHNs. This recommendation could be initiated by Team Managers as a structured session for example, every two weeks as part of professional development by the WRHA Public Health Program. This recommendation should not require additional financial resources.

Limitations of the Study

This study contributes to the gap in research on PHNs perspectives of mothers with mental illness. Although the data were rich in content, the study has limitations. This study included a purposive sample of 16 PHNs from three different community areas (CAs) within the WRHA. Given the small sample size of PHNs, the views cannot be generalized beyond these groups.

Data were collected in focus groups following a semi-structured interview guide. Following the first interview, one question was modified to attempt to obtain more data on attitudes which in the end were not expressed or observed. Instead of asking what PHNs' first thoughts were when they received a referral which stated the mother had a mental illness, the question was replaced with what were their first experiences dealing with a person with mental illness? And if and how that had since changed? Although more data were provided, they did not reflect negative attitudes.

Group synergy was evident throughout all the groups, PHNs discussed openly amongst their colleagues about a topic related to their practice. This synergy affected some of the data in terms of inaudible comments on the tape recording when PHNs spoke at the same time. As the researcher did the transcription of the interviews, there was no difficulty identifying PHNs with the exception of when they were speaking all together.

PHNs discussed openly in the groups seemingly without knowledge that the facilitator was a former PHN despite this information being stated in the invitation letter. This proved to be beneficial in that the PHNs explained their role in great detail without assumptions that the facilitator had any previous knowledge about their role. In order to minimize bias with the researcher's past experience as a PHN, the findings were shared

with the thesis advisor and with the research assistant who was present during the groups, to confirm accuracy of the data, ensuring this did not shape the findings.

Despite previous experience working as a Public Health Nurse and Mental Health Nurse, the researcher had little experience as a group facilitator which may have affected results. For instance, some tangential discussion went on longer than it should have, as the facilitator was not able to consistently bring the conversation back to the original questions. Also, it is possible that some areas of discussion could have been further discussed with a more experienced facilitator.

The focus groups were done approximately three years following the Mental Health Postpartum Mental Health Toolkit/Pilot Project Initiative by the WRHA. Results from the focus groups would likely have been different prior to this initiative as this was discussed by all participating groups. The previous knowledge of this project by the researcher however was helpful in the discussions.

The project of Towards Flourishing by the WRHA Mental Health Program involved only CA 3 in which the PHNs admitted that the idea of having a mental health resource person available for consultation was reinforced by this project. The previous knowledge of this project by the researcher was useful in the CA 3 focus group where it was mentioned as part of their training.

Recommendations for Future Research

Results from this research generate more questions for future research. It would be important to consider the perspectives of CFS workers and other professionals regarding moms with mental illness in order to compare and evaluate the feasibility of the implementation of some of these recommendations. Exploring perspectives of mothers

themselves who have suffered from mental illness and their experiences with PHNs in postpartum would also be helpful in confirming how they perceive the PHN role and what they found most and least helpful for resources. Experiences of family members where the mother has a mental illness and their experiences postpartum with the PHN and/or the mental health system would also be beneficial to identify services that would best serve the needs of families.

The availability of a mental health resource person for mental health was part of the initiative by the WRHA however this person is no longer in that role. This role was as a consultant to PHNs only, and did not go on home visits with the PHNs. An evaluation of this has not been done by the WRHA as part of the initiative. A pilot program involving a mental health resource person available for consultation with PHNs could be tested and evaluated in order to validate the need.

Ongoing educational sessions could also be effective at meeting the needs of PHNs on this topic. Although nurses as professionals are required to maintain competencies individually, employers also have a responsibility to provide opportunities for professional development to meet the needs of the PHNs, particularly in view of their generalist role in the community. If the evaluation of access to a mental health resource person is shown to be positive, this role could be expanded to include in-home mental health assessments in postpartum and ongoing education for PHNs as suggested. This would of course, require more funding from WRHA Mental Health or joint funding with WRHA Public Health.

Conclusion

In summary, results from this study provided valuable information about the role of the PHN in working with mothers with mental illness, the needs of mothers with mental illness and their families, as well as the challenges and barriers to providing service. The conceptual framework of the Integrated Model of Population Health and Health Promotion (Hamilton & Bhatti, 1995) was useful in representing the role of the PHN within the system with regards to this topic. Implications and recommendations for public health nursing practice were presented along with the study's limitations and recommendations for future research.

Perspectives of PHNs on mothers with mental illness were important to study in view of the PHN role in providing service to mothers in prenatal and postpartum. PHNs are in a unique position to assess mothers in their home environment, with mental health being part of their holistic assessment. This study has provided important recommendations for public health nursing practice particularly in the areas of resources for families and for PHNs themselves as professionals who wish to provide the best care to child bearing families. More research is needed to look at how these recommendations can be implemented and evaluated to amend public health nursing practice and ultimately improve outcomes for these families.

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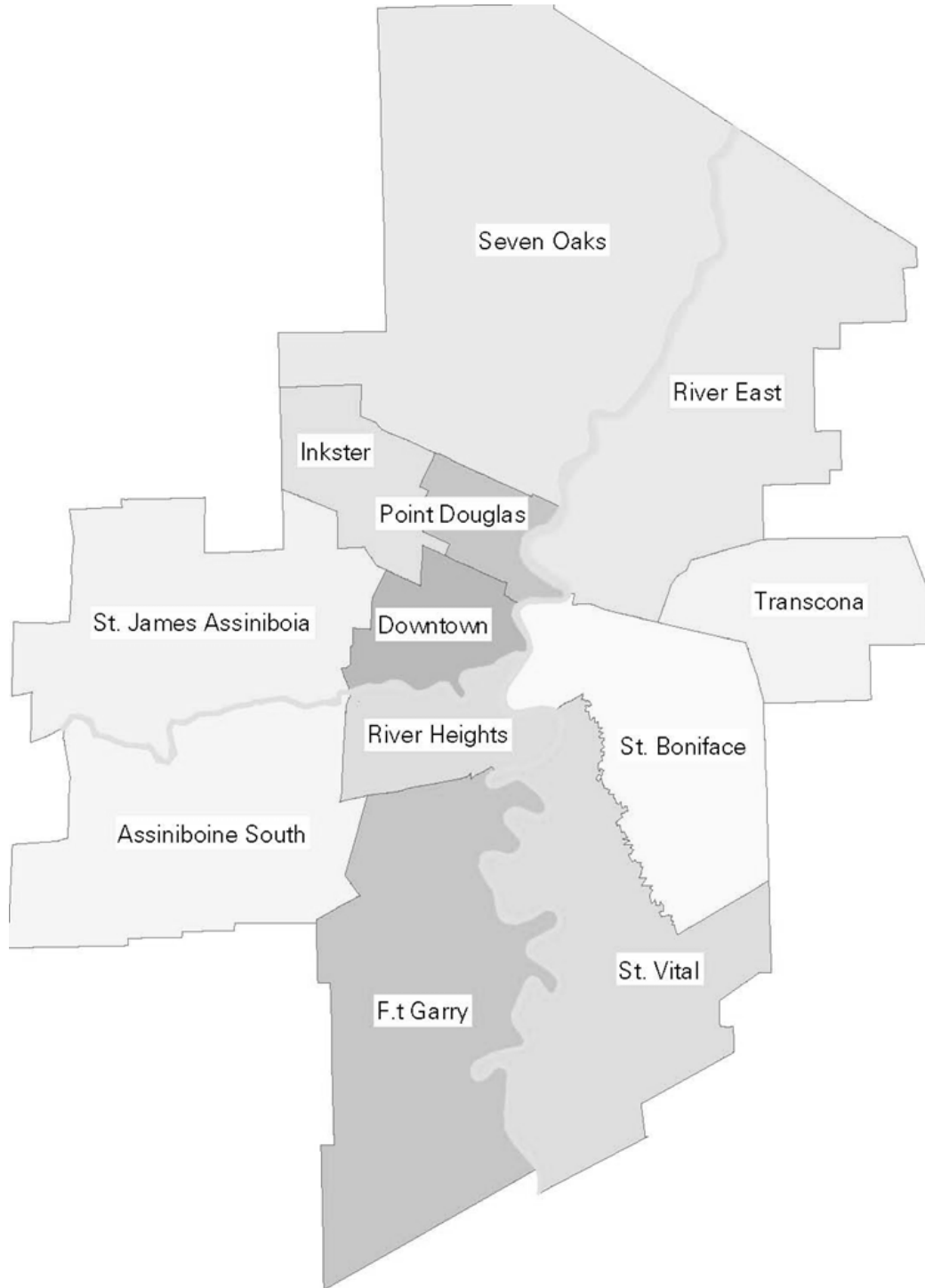
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Appendix A:
**COMMUNITY AREAS OF THE WINNIPEG REGIONAL HEALTH
AUTHORITY**



Appendix B:
Interview Guide
FOCUS GROUP INTERVIEW QUESTIONS:

Using focus groups with broad interview questions revolving around the mothers with mental illness will include but not limited to the following questions:

Opening questions

- 1) Tell me your name and how long you have been working in Public Health?
- 2) What is your current employment status? (full-time, part-time)
- 3) Think back to when you first started as a PHN, what first attracted you to this field?

Introductory question

- 4) When you find out via a referral (prenatal or postnatal) that a mother has a mental illness, what first comes to mind? * *modified following first interview to* – When you first encountered someone with a mental illness how did you feel? How has this changed overtime?

Key questions

PHN perceptions and role

- 1) What impact, if any, does the fact that a mother has mental illness have on your practice? *Cues* - any different preparation and service for visiting than for other mothers?
- 2) Tell me about some of your home-visiting experiences with these mothers?
Cues- your impressions of mothers who have mental illness, their parenting abilities

PHN role and supports

- 3) How do you see your role in providing service for these women? *Cues*- Is it any different than mothers who do not have mental illness? Is it any different for mothers with PPD versus mothers with persistent mental illness such as bipolar disorder or schizophrenia? How important is this role in your everyday duties as a PHN?
- 4) How do you feel about your role in dealing with mothers with mental health issues? *Cues*: Do you feel comfortable with your assessments of parenting for this particular client population? Do you have any difficulties with this role? Do you feel you are adequately prepared for this role? *Probes*- If not, what do you feel is needed to further support you as a PHN working with these women?
- 5) Is there any interdisciplinary involvement? (i.e.) mental health professionals, social workers. *Probes*: What is the extent of your contacts with these professionals? How is this helpful or not for you in your role with these women?
- 6) What supports and resources do you see are needed for families where mothers suffer from mental illness? *Cues*: What do you see are the gaps in services for this client population?

Ending questions

- 7) Of all we discussed today, what do you think is most important?
- 8) As the purpose of this study is to find out your perspectives of mothers with mental health issues, is there anything that we should have talked about and missed?

Duration: approximately one and a half hours

Appendix C:
SAMPLE POSTER

You are invited to share your views as a group on the topic of:

Mothers with mental illness: Public Health Nurses' perspectives

- ✓ Public Health Nurses deal with mothers on regular basis and come across this particular client population in their practice, yet there is no research on how PHNs perceive their role in dealing with this client population and what the issues are at hand for providing postpartum care and follow-up with these families.
- ✓ A mother with mental illness presents special challenges for parenting; she is trying to balance competing demands between her own illness and her children's needs.

You are invited to a group interview to discuss this topic with Patricia Bourrier, MN student, University of Manitoba.

If you are interested in participating in this study, please contact me directly via email.

THANK-YOU!

Appendix D:
INVITATION LETTER

INVITATION TO PARTICIPATE

My name is Patricia Bourrier. I am a student in the Master's program in Nursing at the University of Manitoba. As part of a requirement for this program, I am conducting a research study entitled, *Mothers with mental illness: Public Health Nurses' perspectives*. I have chosen this topic based on my experiences as a former mental health and public health nurse.

Little is known about PHNs perspectives regarding mothers with mental illness, yet PHNs encounter these women at a time when they are adapting to a new life situation, notably that of the birth of a child, a time when they are most likely to exhibit problems. In order to best address the needs of mothers who suffer from mental illness, and make recommendations, it is important to know what your thoughts are on this topic.

Study Procedures

Data will be collected via focus group discussions using an open-ended interview guide. Ideally, there will be approximately six to eight PHNs participating at each of the four selected WRHA community office sites. A single one and a half hour discussion will be held within your office over lunch hour for your convenience, lunch will be provided.

This discussion will be conducted by the researcher, Patricia Bourrier. You will be asked broad discussion questions as a group focusing on mothers with mental illness including your views regarding this client population and how you see your role as a PHN in working with these mothers. Some examples might be: Tell me about some of your home-visiting experiences with mothers who have mental illness. When you find out by referral that a mother has a mental illness, what first comes to mind? How do you prepare

for a home visit involving a mother with a mental illness? All mothers with mental illness are included in the discussion whether they are new parents or not. This discussion will be recorded using audio-taping and note-taking that will be used for verbatim transcription. Approval for this study has been obtained from the Education Nursing Research Ethics Board and the Winnipeg Regional Health Authority (WRHA) Research Review Committee. Approval has also been obtained from the WRHA Director of Population & Public Health. A summary of the study can also be provided if requested (see checkbox below).

Confidentiality/Anonymity

Due to the focus group format, confidentiality cannot be guaranteed; however the researcher will maintain confidentiality outside of the interviews. As a focus group participant, you are asked to keep the identities of other participants, their comments and the discussion strictly confidential. Anonymity of the data will be maintained by the researcher by removing any names and/or identifying information. Any assistant to the transcription process will be asked to sign a pledge of confidentiality. All information collected will be kept strictly confidential. If you agree to participate in these discussions, an individual consent form will also need to be completed. In order to be included in this study you must be a PHN in the general program of the Winnipeg Regional Health Authority (WRHA). Your participation is voluntary and there will be no implications for your employment status and no explanation will be required if you chose to withdraw at anytime during the study.

If you are interested in participating in this study, please contact me directly via email. If you have any questions or concerns regarding this research please do not hesitate to contact myself or my thesis advisor Dr. Diana Clarke.

Thank-you,

Patricia Bourrier, RN., B.N.

Appendix E:
**“MOTHERS WITH MENTAL ILLNESS: PUBLIC HEALTH NURSES’
PERSPECTIVES”**

CONSENT FORM

**Thesis Research Topic: “Mothers with mental illness: Public Health Nurses’
perspectives”**

Thesis Researcher: Patricia Bourrier, RN., B. N. Master’s Student, Faculty of Nursing, University of Manitoba This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of study:

The proposed research has three objectives: The first is to describe PHNs perspectives and experiences in dealing with mothers with mental illness. The second objective is to document issues in practice in relation to these experiences. The third objective is to make recommendations for better care for these families. This study is the researcher’s thesis research in partial fulfillment of requirements in the University of Manitoba, Faculty of Nursing master’s program. Results of this research will be presented for my thesis defence and may be presented in a publication. Results of the study will be presented to the WRHA Public Health Management in power point format respecting all confidentiality as outlined below.

Study procedure:

You understand that you will be participating in a focus group interview within your community office. The session will last approximately one and a half hours, as part of your agreed lunch hour availability. You will be asked open-ended questions for discussion on your experiences regarding mothers with mental illness. Group discussion questions will focus on your views regarding this client population and how you see your role as a PHN in working with these mothers. Some examples might be: Tell me about some of your home-visiting experiences with mothers who have mental illness. When you find out by referral that a mother has a mental illness, what first comes to mind? How do you prepare for a home visit involving a mother with a mental illness? All mothers with mental illness are included in the discussion whether they are new parents or not. You understand that the discussion will be audio-taped and that this will be transcribed verbatim.

Risk and discomforts:

You should not experience any discomfort by participating in the focus group. If the discussion becomes problematic for you in any way, you may refuse to participate and/or withdraw at anytime without any repercussions by a hand gesture to the researcher and leaving the room or telling the researcher directly during the group.

Benefits:

There are no direct benefits to participation in this study. However the information obtained by this study can provide valuable information for decision-makers on how to improve PHN practice and service delivery.

Costs of participation:

There should be no financial cost to you. The group discussion should take approximately one and a half hours.

Confidentiality:

You understand that due to the focus group format, confidentiality cannot be guaranteed; however the researcher will maintain confidentiality outside of the interviews. As a focus group participant, you are asked to keep the identities of other participants, their comments and the discussion strictly confidential. Anonymity of the data will be maintained by the researcher by removing any names and/or identifying information. Any assistant to the transcription process will be asked to sign a pledge of confidentiality. Access to the data will be limited to the researcher, the assistant, and my thesis advisor, Dr. Diana Clarke. All information collected will be kept strictly confidential. Direct quotes may be used in the typed thesis manuscript; in order to protect identities, fictitious names will replace those of participants. Data collected will remain with the researcher and be stored in a locked filing cabinet where there is no public access. The data will be stored for seven years until all publications from the study are completed and the period of audit has passed, after which time it will be destroyed as confidential waste.

Voluntary participation:

Your participation in this study is voluntary and if you decide to participate in the focus group, you may withdraw at any time with no explanation required or implication for your employment status. A summary of the study will be provided if requested.

Remuneration:

You understand that the WRHA has approved this study. The focus groups are to take place over lunch hour, up to one and a half hour duration. In appreciation for your participation, lunch will be provided during the sessions.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be

as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the Nursing Education Research Ethics Board. If you have any questions about this study, please speak with the researcher, Patricia Bourrier or thesis advisor, Dr. Diana Clarke, University of Manitoba, Faculty of Nursing. For questions or complaints about your rights as a participant in this study you may contact the Human Ethics Secretariat at the University of Manitoba Health. A copy of this consent form has been given to you to keep for your records and reference.

Participant's signature

Date

Researcher (or delegate's) signature

Date

I would like to receive a summary of findings:

_____ yes _____ no

My contact information is: _____

Appendix F:
STAGES OF ANALYSIS

Stage one: Notes are made after each interview regarding topics discussed as well as memory joggers for initial phases of analysis.

Stage two: The researcher is immersed in the data by reading through transcripts and making notes about general themes.

Stage three: Transcripts are re-read and headings are written down, categories are freely generated.

Stage four: The list of categories is grouped together under higher-order headings so as to reduce numbers of categories into broader categories.

Stage five: The new list of categories is worked through and similar headings are removed to produce a final list.

Stage six: Two colleagues generate category systems independently. The three lists are discussed and adjusted, in order to enhance validity of the categorizing.

Stage seven: Transcripts are re-read with the final list of categories and sub-categories to establish whether the categories cover aspects of the interviews, adjustments are made accordingly.

Stage eight: Individual transcripts are worked through with the list of categories and sub-categories and coded accordingly. Coloured highlighters are used to distinguish between each piece of transcript allocated to a category and sub-category. These categories can also be identified using a computer-based coding scheme.

Stage nine: Each coded section of the interviews is cut out of the transcript and all items of each code are collected. Copies of these are made to ensure contexts of this information are maintained.

Stage ten: Cut-out sections are pasted, headed-up with appropriate categories and sub-categories.

Stage eleven: All sections are filed together and kept available for referencing when writing up final report.

Stage twelve: The writing process begins. The researcher begins with the first section, selects samples of data from this section and offers commentary. This is done for each section and the researcher refers to raw data as needed for clarification and verification.

Source: Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse Education Today*, 11, 461-466.