Women's Health Goulburn North East

THE LOOKING AFTER MOTHERS PROJECT (The LAMP)

January 2001 – December 2002
Final Report

Prepared by Elizabeth Wheeler
Community Development Worker

Looking
After
Mothers
Project

A collaborative effort between Women's Health Goulburn North East and communities in Mitchell and Murrindindi to build a culture of support for women with babies.

Women's Health Goulburn North East (WHGNE) was established in July 2000. Previously known as NEWomen, Women's Health Goulburn North East is the government funded, specialist women's health service for the Goulburn Valley and North-East Victoria.

Further copies of this report are available from:

Women's Health Goulburn North East

PO Box 853 Wangaratta 3677
Phone: 03 5722 3009
Fax: 03 5722 3020
Email: whealth@whealth.com.au
Webpage: www.whealth.com.au

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executive summary :

Motherhood should be a time of change, growth, care and nurturing; a time for pleasure, sensuality and great joy. It's a time when new identities can be forged, relationships strengthened and deepened, and new strengths and priorities found.

Above all, motherhood is about love.

Yet mothers, when they talk about motherhood, do not always speak of it in such glowing terms. They speak of exhaustion, boredom, isolation and despair. Occasionally they talk about rage, frustration and feelings of suffocation.

This report highlights the ambivalence, hard work, challenges and difficulties of motherhood. In talking about these negatives, we seek only to increase the chances that more women will be affirmed, cared for and supported in their roles as mothers. Despite its occasional pessimism and despair, this report is about a Project founded on love, care and respect for women; a Project that assumes that all mothers are entitled to the best possible experiences of motherhood; a Project that sees motherhood as a positive, beautiful part of life.

In Mitchell & Murrindindi shires in the Lower Hume region of Victoria in 2001 and 2002, Women's Health Goulburn North East undertook the Looking After Mothers Project(LAMP). Staffed only on a part-time basis, the Project promoted a culture of support for mothers of babies. It encompassed community development, professional development and service enhancement approaches. Project activities included training for professionals, workshops and presentations for women, the development and distribution of a resource guide and a sub-project called "Picturing Motherhood".

As a project of a women's health service, The LAMP had an agenda of social change. Part of what we hoped to achieve was a greater critical discussion about the socially constructed roles that women have in this society. This meant, amongst other things, challenging women and workers to consider the myths of motherhood and discussing ways of mothering that can promote wellbeing – for mothers, babies and their families. Over the course of the Project, it became increasingly clear that women needed spaces to talk honestly about their own experiences as mothers, and in doing so, to confront the myth of "perfect mother". The second year of the Project saw a marked turn in Project activities towards emphasising the role of imagery, ideology and culture in women's experiences.

Taking a gender-sensitive lens to the issues of motherhood was challenging in Lower Hume. In many parts of the health and community sector there is not a strong culture of reflection, nor are there many opportunities for values-based discussions. There is a prevailing sense of workers doing the very best they can in the face of limited resources.

Furthermore, early motherhood is (understandably) not a time for activism. Feminist women at this time of life mostly face the same pressures, constraints and challenges as other women. In rural areas, especially the rural fringe, there appears to be fewer activist and politically minded women, which reinforces the isolation of women who think differently. This means that there is not an organised voice of mothers that might act as an impetus for managers, planners and service providers to do things differently.

The Project took place at a time of great flux in the health and community sectors in Lower Hume. The Primary Care Partnerships were absorbing a great deal of time for managers and planners, and there were significant staff shortages, especially in maternal and child health (MCH) and hospitals. Despite interest and enthusiasm for the Project amongst key stakeholders, few could devote much time or energy to Project activities, or to the broader agenda of change. Nevertheless, many professionals across the two shires participated in training, attended LAMP meetings, and organised visits by The LAMP project worker to new mothers' groups and playgroups.

Lack of resources continues to be a difficulty across the two shires. There are many highly skilled, committed and enthusiastic professionals working in Mitchell & Murrindindi, however their resources are spread very thinly. The shires need more MCH hours, more GPs, more midwives and more community development workers. Professionals need more time to debrief and reflect on their work, improve their services and develop new skills and approaches. They also need adequate time for administration, home visits, and for driving long distances.

The LAMP turned a spotlight onto communities in Mitchell & Murrindindi and found them wanting. Lack of occasional childcare, local employment, social connections, exercise options and daily practical support are just some of the difficulties experienced by mothers in the two shires. These are compounded by lack of respect for mothers, positive role models, affirmation of choices in motherhood, and spaces to talk honestly and openly about motherhood.

A plethora of research suggests that at least one in ten women experiences major depression in the twelve months after childbirth, and that another two or three experience minor depression. The rates of postnatal depression (PND) in Mitchell & Murrindindi are not known and it seems that it is considerably under-diagnosed; however there is nothing to suggest that rates would not follow those identified in comparable communities. There is not a generalised program of screening for PND via MCH services in either of the shires. This is mostly due to a lack of resources and therefore time, although in Murrindindi some nurses are not convinced that routine screening using the Edinburgh Postnatal Depression Score (EPDS) would be beneficial.

Some women will approach their GP directly if they are feeling depressed, however it may take a number of visits for them to actually talk about their feelings or concerns. Where PND is suspected by a MCH nurse (as a result of EPDS or discussion), a visit to a GP is usually suggested. Anecdote suggests that most GPs are likely to prescribe anti-depressants, and that very few GPs assist women to get practical support and/or counselling to help them manage or fully recover from the effects of PND on themselves and their families. There is a great need for GPs to improve their identification, management, and treatment of mental health problems generally. It is hoped that the Primary Mental Health and Early Intervention team will be able to assist, although its resources for Lower Hume are terribly inadequate.

Some MCH nurses and midwives would also benefit from further skilling in mental health issues, however it must be acknowledged that there are also systemic barriers such as lack of time that impact on their capacity to engage with the inner lives of mothers. Whilst new mothers' groups could provide opportunities for discussion of mental health issues, only some groups fulfil this function. This patchiness is mostly attributable to the skill and inclination of individual workers, however neither shire's MCH service has explicitly prioritised mental health of mothers. There is still an overwhelming emphasis on infant health and wellbeing in MCH services. This largely originates with the Department of Human Services (DHS) and is perpetuated by funding agreements that are based largely around completion of the Child Health Record.

When women living in Mitchell & Murrindindi shires are depressed during early motherhood, they generally have a reasonable level of access to local counselling services ***if*** they can get the information that they exist ***and if*** they have transport ***and if*** they feel comfortable that their anonymity and confidentiality will be preserved. It is pleasing to see that many services do provide outreach counselling services, including home visits. In Mitchell shire, when MCH nurses are aware of PND, they will often arrange extra support via the Enhanced Home Visiting Service. All relevant local and statewide early motherhood services were publicised via a Resource Guide published by The LAMP. Nevertheless, anecdotally, lack of information, transport, and confidentiality continue to be barriers for some women (numbers unknown) and there are sometimes waiting lists for services.

After-hours and acute services are limited in the two shires. The closest in-patient facilities for women who are acutely depressed are in the northeast of Melbourne; outpatient support (medication reviews and some counselling) is provided via the Goulburn Valley Area Mental Health Service.

Generally speaking, the creation of special mothers' groups or activities has met with limited interest. Whilst PND support groups might seem like a good idea, the reality is that in small townships, the population size is generally far too small to make groups viable and sustainable. In Seymour, The LAMP has assisted in the creation of a supportive group program for women who want to enjoy

motherhood more. This group is being facilitated by two local workers who intend to conduct programs on a semi-regular basis in the future.

The activity that captured the interest of local women was "Picturing Motherhood", in which women photographed aspects of their own lives and experiences of mothering, and exhibited these works in locations across the shires of Mitchell and Murrindindi. This fantastic project is the subject of a separate report and how-to manual. Twenty-five women were involved in the activity and evaluation shows that it was immensely valuable in stimulating reflection and discussion about mothering, fostering networks and friendships and offering women a chance to develop skills and community.

One of the greatest challenges for the Project and for service providers, is that the two shires exist on the rural fringe of Melbourne. Each shire is actually a collection of discrete townships, between which there is very minimal movement. A few of these townships have remnant rural lifestyles, however some of the most significantly sized townships (Wallan and Kinglake) are culturally and geographically closer to the city. Residents travel in all directions to go to work and to access services. There needs to be greater collaboration between all levels of government to find new ways to represent and serve the needs of people living in these rural fringe areas.

Whilst The LAMP was mostly concerned with women's experiences after birth, it inevitably addressed issues around pregnancy and birth. This report includes some discussion about women's experiences of birthing locally and in Melbourne, and some recommendations for improvements. Of most significant concerns is the lack of choice in models of care. Another concern is the quality of care and treatment at the Northern Hospital.

The LAMP has provided many opportunities for WHGNE, early motherhood professionals and women to reflect on issues in early motherhood. It has confirmed that WHGNE can play a key role in awareness raising and training for early motherhood professionals, and in offering innovative activities that foster discussion and connections amongst women. This report is intended to communicate and reflect upon all that has been learned and understood over the last two years, and to provide inspiration and encouragement for future work. Accordingly, this report is divided into four sections:

1. Project outline and background
2. Values, issues and ideas arising from The LAMP
3. Outcomes, strategies and activities of The LAMP
4. Recommendations

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project background and outline :

History

The Looking After Mothers Project was inspired by an earlier project "Ports in a Storm", undertaken by Women's Health Goulburn North East (then called NEWomen) in 1995. That project, funded by DHS (Hume Region) researched the value of:

- a satisfactory system of services for helping women affected by PND
- a balanced range of treatment and support options for women
- improved recognition and detection of PND
- coordination and linkages within the PND service system
- preventive strategies.

After the production of the above report in 1996, NEWomen became aware of particular problems in the provision of services to women at risk of or experiencing PND in Mitchell and Murrindindi shires. The issues identified in "Ports in a Storm" were not being addressed in Lower Hume. Anecdotes from health and welfare workers in the two shires suggested that there was a significant unmet need in terms of women's access to PND services. This situation was of concern to local workers as well as to WHGNE.

There are no dedicated services for women experiencing PND in either Mitchell or Murrindindi shires. A number of services can support women who feel they are not coping following birth or dealing with stress or demands of having a new or young baby. However these same services reported that there was no local professional development or support for health professionals to assist them in the prevention, early identification or appropriate treatment of PND. Lack of co-ordination amongst existing services was highlighted as another problem in these shires.

To respond to these issues, WHGNE applied to DHS (Hume Region) for funding to conduct a PND project in Lower Hume.

The express purpose of the proposed project was to enhance protective factors and reduce risk factors for mental health problems and disorders amongst families by addressing the needs of women at risk of, or experiencing, PND in the adjoining Murrindindi and Mitchell shires. WHGNE proposed using a community development approach in order to develop healthy community environments in which women at risk of or experiencing PND, and their families, would be supported by a network of community resources.

The emphasis of the project was on prevention. The proposal suggested a public health approach in aiming to increase knowledge amongst health professionals and awareness in the general community and by fostering a commitment in key agencies to address the broader socio-cultural aspects of health and wellbeing for women. It was hoped that the project would identify gaps in services and develop strategies that will permanently fill these gaps.

WHGNE's application was ultimately successful, and in August 2000, $76,000 was granted for a two-year project.

Staffing and setting up the new project

I (Elizabeth Wheeler) commenced work for WHGNE on 7 January 2001.

I have a Bachelor of Arts and a Graduate Diploma in Women's Health, and have had extensive experience in project development, management and evaluation. My previous project work has included mental health and postnatal care. Upon graduating from university, I worked in overseas aid and then in divisions of general practice. My skills and experience include:

- Experience in program development, management and evaluation
- Experience in conceptualising and writing Strategic and Business Plans
- Conceptual, research, writing and presentation skills
- Interpersonal skills such as group facilitation
- Experience working in cross-cultural environments, including working with interpreters

In addition to this professional experience, I have been involved in community based activism for fifteen years. Women's health has been my passion for over half my life and I have a particular interest in birthing and early motherhood. I was delighted to have the opportunity to work on this project and to relocate from Melbourne to Yea.

I spent most of the first month in Wangaratta, familiarising myself with the organisation and the project. This included coordinating a presentation for the 4th National Women's Health Conference in late February.

It was arranged that I would work three days per week on the project, with an additional one day a fortnight spent in Wangaratta. The day in Wangaratta is spent in staff meetings, professional development, administration, core business (eg primary care partnership) and meeting with the executive director to discuss matters relating to project development and implementation. In practice, this has meant that there have been approximately 24 hours per week towards direct project implementation.

The Project began in earnest in March, when Murrindindi shire provided an office in Yea (adjacent to the MCH Centre) for my use. A laptop computer, desk, filing cabinet, and telephone were installed and I set to work. (In March 2002 my office moved to Kinglake.)

Project planning

In these early stages of the project my work involved meeting service providers and learning about how they perceived issues surrounding PND. I also brought myself up-to-date with recent research and debate surrounding PND and early motherhood, although I decided not to prepare a formal literature review given the extensive work already undertaken by Ruth Barr in "Ports in a Storm".

From its very beginnings, the Project had clear philosophical and theoretical underpinnings:

- Wellness and prevention
- Woman-centred approaches
- Social model of health
- Dedicated women's health services
- Partnerships
- Community development
- Sustainable change
- Evaluation

Yet there were other aspects of the project that needed clarification and discussion. This was an important aspect of gaining local commitment and ownership.

Whilst the project in Mitchell/Murrindindi has its roots in "Ports in a Storm", it was clear from the beginning that this would be a very different project. "Ports in a Storm" was conducted in the Rural City of Wangaratta, which has a large mental health service and an extensive network of birthing and postnatal support services.

That setting is very different to the diverse and dispersed townships that comprise the shires of Mitchell and Murrindindi. Here, we have smaller and fewer services. Each township has a unique culture, influenced by geography, history and demographics. The region covers an area spanning the rural fringe of Melbourne, through to holiday towns such as Eildon. Service usage patterns are idiosyncratic, and shaped by many factors, including geography. It was obvious that community development activities would need to be undertaken at a township level, rather than shire-wide.

Most of services in Lower Hume are based on local government areas. Most professionals work in multiple townships, and often across whole shires. Some work across both shires, with offices based in Seymour. Issues concerning professionals' time, morale, travel time, identity, support and skills have an impact on local women, and would also impact upon the success of the project itself.

After discussions with the key stakeholders, I prepared three documents:

1. A summary of the philosophical & theoretical underpinnings for the Project
2. An options paper
3. A planning document

The Reference Group was charged with finding a name for the Project. After much discussion and laughter, we settled on "The Looking After Mothers Project", fondly known as "The LAMP". We felt that this name evoked many of the central ideas of the project.

With support from the Reference Group, we decided on five intended outcomes for The LAMP:

1. Local communities promote mental and emotional wellbeing for families with babies (community development)
2. Families with babies have access to services and activities that promote their mental and emotional wellbeing (direct service delivery)
3. Relevant professionals feel supported to provide services that support and promote the mental and emotional wellbeing of families with babies (professional support)
4. Relevant parts of the service system are well-integrated and have the capacity to deliver quality services (system enhancement)
5. Relevant professionals are skilled to provide services that support and promote the mental and emotional wellbeing of families with babies (professional development)

These outcomes, along with their strategies, possible activities and indicators, would guide me in the Project's implementation, and form the basis for this report.

Values, issues and ideas arising from The LAMP

Many questions about values and ideas have arisen in this Project. I would like to address a few here, with a view to opening up these issues for further discussion by women, WHGNE staff, early motherhood professionals, managers and DHS.

Feminism & gender sensitivity

Each woman who works at WHGNE brings her own individual values, beliefs and experiences to our organisation. Yet we have commonalities as well as differences, and this is one of the organisation's greatest assets.

Our first commonality is that we are feminist. Feminism means different things to different people, and as a staff we are still exploring our feminisms. Yet we have in common a desire to empower women, hear their stories and acknowledge their real, lived experiences. We see gender as implicated in violence, exploitation and oppression, and recognise that women's power is also mitigated by their class, culture, (dis)ability, religion, sexuality and life experiences.

Our feminist approach is premised on a social model of health. This does not deny medical or physiological aspects, but acknowledges that social, economic, cultural, political and spiritual factors also influence people's experiences of health, disease, (dis)ability and illness.

At WHGNE, we do not speak of clients, customers, cases or consumers. Instead, we talk about women and girls. Our work is woman-centred in that we focus always on achieving improved outcomes for women. We strive to hear the voices, experiences and needs of women – as individuals and collectively. In our work with other service providers and organisations, we encourage others to recognise and respond to gender in order to provide services and activities that are useful and accessible to women.

Our reason for existence is that women need gender-specific services.

Australia's diverse cultures are gendered. There are many subtle and not-so-subtle influences that shape and reinforce our gender identities: family and friends, education, media, marketing and systemic forces.

In most parts of Australian society, this gendering has harsh effects on women. They are more likely to be poor, to be unemployed, to be sole parents, and to work in positions which are poorly paid and which have few opportunities for advancement. They undertake most of Australia's domestic labour, including most child-rearing. They are less likely to have access to positions of power and influence. They are many times more likely to experience family violence, rape, sexual assault or sexual harassment. Their bodies and their sexuality are exploited for power and profit.

In the health system, men dominate decision-making. Medical research traditionally uses male bodies as the norm, with findings then applied to women with little or no regard for their difference. Health practitioners are not immune to the ideology of our society, and often have gendered attitudes and sexist behaviours. This means that most women find that the health system does not meet their physical, social, emotional or spiritual needs.

This was my first experience of working in a women's health service. It took some time for me to feel comfortable taking the explicitly gender-sensitive and pro-feminist approach to communities in the local area, and in particular to workers. It was only in the second year of the Project that I really felt able to incorporate my feminism into my work, and thus the Project has perhaps not met its full potential in terms of taking gender-sensitive approaches to professionals, women and communities. Nevertheless, many of the activities I have initiated about images of motherhood have been based on feminist approaches, and the issues outlined in this report are seen through a gender-sensitive lens.

Motherhood – a radical critique

I would like to suggest that the negative experiences of motherhood are largely socially constructed. Exhaustion is inevitable when mothers cannot sleep or rest when their baby is sleeping or resting; when they must do things other than tend to their baby and themselves. The impact of a crying baby is felt much more when a mother cannot get away from it; when there is no one else to share the load. Leaving home becomes difficult when mothers are shamed because of their crying babies; when there is nowhere to breastfeed or change nappies. Returning to paid work is hard when babies or breast pumps are not welcome in the workplace; when part-time, flexi-time and family leave are rarely available; when childcare costs more than most women earn. Time alone is impossible when there is no one else to look after the baby; when childcare is seen as a right only for working women.

So many negative experiences that women have of motherhood could be mitigated or avoided. One of the great difficulties is that most of the time, problems are characterised as belonging to the individual, rather than the society. Too often, service providers promote acceptance; they see their role as helping women fit in or manage the demands of family, work and society. They encourage women to make compromises. Service providers rarely help women to discuss why such compromises are necessary, how they might be negotiated, and at what cost.

These are radical ideas, but they are not new. In each generation of mothers there are women and men who recognise the social origin of many components of the experience of parenting. The challenge is to mobilise a critical mass of voices for change, and to convince service providers, planners, managers, politicians, employers and funding bodies that these issues matter.

Access to professional services

Accessing professionals is difficult for many women in Mitchell & Murrindindi. One of the difficulties is that there are simply not enough services. We especially lack services that can operate on an outreach basis. Service delivery is often further hampered by distance, time constraints, poor remuneration, and difficulties attracting and retaining suitably qualified staff.

A second difficulty is the lack of public transport between rural townships. A significant number of women living in Mitchell and Murrindindi shires either don't have cars or lack money for petrol.

The third, very significant barrier to access is lack of confidentiality and anonymity. Citizens of small and/or tightly knit communities may be reluctant to visit local services for fear of being seen entering the building, being overheard or having their stories disclosed. Their fears are not unfounded. I experienced a number of breaches of confidentiality during the Project, and met other women who felt that their experiences of professional consultations were compromised by the fact that their partners were well known in the district. There is also a huge dilemma posed by workers living and practising in the same area.

The role of professionals

Women are often advised to discuss their individual situation with their doctor and/or MCH nurse. One would hope that women could and would talk with these people about their health and wellbeing, but "discussion" is predicated upon a whole lot of factors. For meaningful discussion to occur, professionals need to be:

- Willing to hear women's experiences and concerns
- Able to give information in plain language
- Aware and informed of current research and critiques of that research
- Willing to be challenged and questioned, to accept that their opinion may not prevail
- Aware of their own values and personal beliefs, and the impact these can have on clients

Even if we were to overcome all of the barriers that stand in the way of using professional services, there is a possibility of developing a 'culture of reliance' on professionals. There is a fine line between providing help and fostering dependence, and professionals' own values and skills play a big part in

the ultimate outcome for each woman. In all of my work, I have tried to emphasise the importance of non-professional resources. In the Resource Guide, we put it like this:

> "We all have our own inner resources like courage, experience and knowledge, that we draw upon in troubled or difficult times. As well, there are external resources, like friends and family, who can also give assistance. Sometimes professionals can also provide a helping hand.
>
> If you need some extra assistance, you might wish to think about getting information, advice or support from some of the service providers listed over the page.
>
> Social support is important! Everybody needs friends close by. Good places to make friends include Neighbourhood or Community Houses, playgroups, exercise groups or walking groups. If you're not a group person, you could ask your Maternal & Child Health Nurse to link you up with some other mums."

This approach originates in a fundamentally different value base, in which the emphasis is on encouraging, assisting and supporting people to do the work of helping themselves. It reflects some of the priorities of the Ottawa Charter on Health Promotion.

Regrettably, few health professionals work within a social model of health. Even fewer regard themselves as health promotion workers. Those who trained in medical models often take a problem-solving approach, in which problems are labelled, categorised, managed and (theoretically) solved. Such workers seem to feel uncomfortable with "opening a can of worms" and are reluctant to "sit" with issues rather than try to "fix" them. In doing so, they underestimate the value of their own role as listeners and supporters.

Of course there are also many systemic barriers to taking a different role, and we appreciate the carefulness and interest of many professionals around the shires who overcome these in order to encourage women to speak their emotions and experiences.

Networking and partnerships

WHGNE's partners are service providers, local organisations and local communities. We try to model collaborative approaches and resource sharing, and to facilitate the development of lasting and meaningful relationships. We offer a gender "lens" or approach that complements the skills and expertise of our partners.

This project occurred at a time of immense change and activity in the health and community sector. The Primary Care Partnerships process placed considerable demands on the stretched resources of local agencies, and there was very little time or energy for other collaborative processes, including The LAMP. This situation affected managers and workers in most agencies.

There were also indications that some workers were sick and tired of short-term projects, and would have infinitely preferred the money to be used in recurrent funding of direct service delivery. Many early motherhood workers were disparaging about the most recent Maternity Services Enhancement Strategy, and at least some of those who were most closely involved in that process were deeply disappointed in its outcomes.

When the project began, I learned that many workers had expected this to be a direct service initiative, and that I would provide clinical services (i.e. counselling). They were quite disappointed to learn that this was not the case, and it was a constant struggle to promote the need for culture change and community development with some workers. I feel that I never really managed to secure a widespread interest in and commitment to The LAMP across the early motherhood sector.

Despite the best of intentions, and the skills and commitment of many individual workers, Lower Hume continues to be a difficult sub-region in which to forge partnerships. There is not really a culture of collaboration between agencies, and in the past, competition and parochialism between the shires have hampered the development of positive relationships. No single organisation or person can be blamed for this situation, and we can only hope that the continued work of the Lower Hume Health & Community Services Forum will eventually yield results. To date, there has been very little work within the PCP process that will impact on MCH. We hope this too will change in the future.

On a more positive note, individual workers have quite strong relationships, and there have been some gains during the life of the Project. There appear to be much stronger relationships between: Goulburn Valley Family Care and Mitchell shire MCH nurses; and Kilmore Hospital and Mitchell MCH nurses. I do not claim these as successes for The LAMP, however some Reference Group members believe that the Project was a factor.

Understanding and identification of PND

In my experience, service providers often talk about PND as a continuum of states, with "not coping" at one end, and major depression at the other. In some ways, this can be helpful, in that it reflects the importance of early intervention and support in preventing depression. However issues such as "coping" are very complex. "Not coping" is a well-used phrase, but few people can define what coping is or identify what it takes to cope. Even fewer ask "why must I cope", "what is wrong with not coping?".

There are many women in this area who are not depressed, but who are not happy, not coping or not happy about not coping. They do not need to have their feelings pathologised or labelled, nor do they necessarily need to have their situations dealt with or managed. They do need spaces and places in which they feel encouraged to discuss their experiences and emotions, and to find resolution of these if they so wish. Frustration, rage and ambivalence are reasonable responses to the situations that many women live in; they are not symptoms of PND.

There is generally consensus amongst researchers that 80-90% of women experience transitory "baby blues" between three and five days after birth. Whilst this is considered normal, there is increasing evidence that a percentage of women who are depressed at three to six months after birth had never recovered from the "baby blues" or have become depressed at a later point. At least one in ten women have a major depression in the postpartum period, and probably another two have a minor depression, often associated with difficulty adjusting.

There is an ongoing debate in medical literature between self-identified depression and clinician-identified depression. From a woman-centred perspective, women's lived experiences are essential to consider.

In 1996 a survey was undertaken of women in the Mitchell shire who had given birth in a designated period in 1995/96. At the time of the survey, these women had infants aged four to ten months. The project was undertaken by Leanne Sheeran, a Mitchell shire MCH Nurse, in partial fulfilment of a Master of Arts (Women's Studies) degree with Deakin University.

The study explored women's experiences of being mothers and women's experiences of PND. It sought to find out what women themselves identified as helpful during their experiences of early motherhood or PND and what else they considered may have helped them at that time.

The study found that 55.4% of women felt they had experienced some depression since the birth of their baby. Over half of the women who documented the length of their depression said that it lasted four to six months or longer, or was still present.

In 2002, in the course of The LAMP, prevalence of depression in mothers of infants and toddlers (as reported anecdotally by GPs and MCH nurses) was considerably less than this or other research would suggest.

In the absence of factors that could be seen as protective against depression, and given the findings of the 1996 survey, it seems that depression in early motherhood is probably under-diagnosed in Mitchell & Murrindindi shires. There seems to be a belief amongst some professionals in

these shires that PND is not a significant problem, and in the early stages of the Project, I heard many comments such as "don't see much of it up here".

MCH nurses in Mitchell shire feel that screening all women via the EPDS at eight weeks and eight months is highly desirable, but at the moment there just are not enough MCH hours available to provide that level of care. Most MCH nurses in Murrindindi shire do not endorse routine screening via the EPDS, nor do they have the resources to undertake such screening.

In our research, 64% of respondents (mostly MCH nurses, midwives and family support workers) would generally refer to a GP when they suspected PND, 55% would offer a referral to a counsellor, 37% would counsel the woman themselves, 67% would arrange practical support and 28% would offer referral to acute services. Over half of respondents said they would provide literature.

Management of PND

Research has demonstrated that therapy – talking or pharmacological – has a positive impact in the treatment of PND (ie something is better than nothing). Cognitive- behavioural therapies and counselling approaches have been found to be as effective as pharmacological treatments, and multiple counselling sessions have been found to be more effective than one.

Certainly, women can benefit from psychological therapies to manage and overcome factors that might have contributed to their depression and to manage the effects of the experience of having PND.

There is an emerging consensus that while in some circumstances pharmacological treatments can assist women to be able to engage in psychological therapies, they should not be first-line treatment for women with minor depression.

However anecdote suggests that in Mitchell & Murrindindi shires, the most common approach by GPs to minor depression is prescription of anti-depressant medications. It appears that counselling is not routinely provided or recommended. This may be because GPs are not aware of services, or because they feel their patients would be unable to overcome barriers to access, or because they doubt the value of counselling. It is important to emphasise however that anecdote may not reflect the real situation. It would have been valuable to audit GPs' processes for management of PND, however this was beyond the scope of this Project.

Generally speaking, it seems that few practitioners routinely try to help women make connections in their local community that would provide emotional or practical support. I suspect that this is mostly because it doesn't occur to them, but two practitioners expressed fear of liability or responsibility for any negative outcomes arising from facilitating such connections.

Risk

Risk is a frequently used concept in pregnancy, birth and early motherhood. Although "risk" - as used in research – actually means chance, it is most frequently used within the sector to refer to danger. Such danger is generally couched in terms of the infant, although often it refers to the chance of litigation against service providers, especially hospitals.

These are the contexts in which risk assessment and risk management take place.

In the case of PND, known risk factors include: past personal or family history of mental health problems; unresolved past issues (such as sexual assault); current relationship difficulties; current isolation – especially lack of practical or emotional support; difficult pregnancy or delivery; unsettled or ill baby; recent or unresolved loss and grief; and being over the age of 35 for the experience of first-time motherhood.

Given the breadth and complexity of risk factors, and the likelihood that any woman might have at least one of these risk factors in her present or past, there is a strong case for universal screening for postnatal depression, probably in the form of the Edinburgh Postnatal Depression Score. It is important to emphasise that routine screening must never be seen as a substitute for asking open-ended, probing questions at every opportunity.

The nature of project funding

At the conclusion of two years of The LAMP, I have a very strong network of local women and service providers who are keen to make further progress on early motherhood issues. I have a clear sense of what might be possible and what is needed. I have the benefit of hindsight to understand how the Project could have been improved and where things could have been done differently.

Yet the nature of project funding is that the LAMP is now over. Further progress is reliant on the goodwill and enthusiasm of workers and women who are already feeling stretched. Whilst some workers will take on elements of my work, there is no-one to coordinate efforts across the two shires, despite our efforts to achieve sustainable outcomes,

Internal issues for WHGNE

My fortnightly trips to Wangaratta have been extremely valuable, and I am appreciative of the efforts of all of the team to involve me in WHGNE activities. This is a wonderful group of women: highly skilled, committed and very open to reflection and discussion. I have learned greatly from everyone and have valued the interest and enthusiasm that all the staff have offered.

Yet this has been a learning process, for myself and WHGNE as an organisation.

The location of the Project in the Lower Hume sub-region, 230 kilometres from the Wangaratta office, has been difficult. For most of the Project, I have worked alone, with no regular contact with other workers. The experience of having no-one to talk/debrief/brainstorm with has been challenging. I feel that this has to some extent slowed the learning and development of the Project, and at times has resulted in me feeling lonely and low in morale.

During some periods of the Project, there was considerable upheaval at WHGNE. Being based elsewhere, I sometimes felt peripheral to the process and the team. I was also conscious of not discussing my difficulties and concerns about my Project, given the other challenges with which the organisation was contending.

WHGNE is indebted to both Murrindindi shire and Goulburn Valley Family Care for making office facilities available for my use. Regrettably, the level of project funding meant that we did not fully fit out these offices. The lack of some facilities (a second phone line, fax and photocopier) created some practical difficulties. It also reinforced the Project's temporary nature and at times my low morale.

I strongly recommend against undertaking outreach projects like this in the future unless there is a very strong support base for the worker and project, and even then, only if the worker is able to be co-located with another significantly sized agency.

Personal issues

This report would not be complete without reflecting on what I have experienced during the Project.

My involvement in early motherhood is to some extent 'vocational'. I have been drawn to women's health generally, and birthing and early motherhood in particular, since childhood. I want to do work that is woman centred, nurturing and empowering – of myself and of other women. In this sense, being with women before, during and after birth is just another expression of my way of being in the world.

I count myself lucky that I have been able to find paid work in which I can combine the personal, professional and political. One of the most challenging aspects of my work has been trying to relate to women as they are now, whilst at the same time putting forward some sort of critique of their own and society's expectations of Woman-as-Mother. I have become particularly passionate about the need to find alternate sources of imagery and story telling to counter the pressures of mainstream media and popular mythology. Most professionals I work with can acknowledge that these pressures exist, however they mostly seem at a loss about how to challenge them. I have been privileged to work in a position and an organisation in which I can freely think, talk and act to challenge the mainstream.

Motherhood is such a tangle of complex issues with emotional, psychological, political, spiritual, ideological, and economic dimensions, and so this has been complicated and difficult work. I felt greatly the lack of everyday contact with like-minded workers that would enable me to debrief and bounce ideas around. At times, I felt very isolated and alone in my work, especially when my ideas and ways of doing things seemed so radically different to many of the professionals I encountered.

I am not yet a mother, and I was careful always to disclose this fact, and to avoid making judgements and giving advice. As the Project concludes, I am ambivalent about childless workers doing this type of work. I certainly felt that I had to prove my understanding of the complexities of motherhood – to service providers and women – in ways that I would not have needed to, had I been a mother. I understand and endorse them seeking credibility, however at times it felt like this added to the burdens of the Project. On the other hand, my childlessness forced me to articulate ideas more clearly and to go beyond the "we're all in the same boat" mentality that often prevails in circles of mothers. I hope that this was beneficial to some women.

This has been a journey of intellectual and emotional growth for me. I have heard stories of such love, care, heartache, compromise and hope. I have felt privileged that women have been willing to share their stories, thoughts and feelings with me. I have learned so much from each of them.

The LAMP was also a physical journey. I moved from Melbourne to Yea to Kinglake and back to Melbourne over the life of the Project. Whilst this had its share of stresses, I am pleased that I had opportunities to actually experience some of the pleasures and pitfalls of living in small rural communities.

outcome 1 :

Local communities promote mental and emotional wellbeing for families with babies

key values/messages	agents	strategies
All families with babies can experience stress and distress Communities have an important role in supporting families with babies	Citizens (women with babies and their families, extended family, friends, neighbours and community leaders)	Community development Information dissemination

discussion

In previous generations, people learned about babies, children and the tasks of parenting from those around them. Extended families did not necessarily live together, but they generally lived nearby, and social contact between families (especially neighbours) was more frequent and more casual. There may have been a more communal or collective responsibility for child rearing.

Over the past fifty years, childbearing and childrearing have become increasingly privatised and individualised. Today, people parent in much greater isolation and lead busier, more complex lives. Social contact, especially that involving children, appears to be more structured. The media has become increasingly influential as a source of information and role models, and opportunities to learn about childrearing by example have declined.

In the absence of opportunities to learn about the complexities of motherhood from real people, many women are unprepared for the demands of caring for a baby. The pictures we carry around in our heads often come not from reality, but rather from sanitised images in the media: models and actors portray clean, tidy, organised, thin, happy mothers who can single-handedly meet all of the needs of their clean, smiling, cute, beautiful babies. Events in the lives of real women are mostly shared as stories, told with hindsight and lacking the impact of witnessing the actual event.

Many women find that their own authentic experiences of motherhood do not match the pictures in their heads. They are rarely thin, tidy, and organised. Sometimes they are tired, unhappy, enraged, or ambivalent. Their babies aren't always clean, and often they don't sleep. Just getting through the day can be a challenge. Yet when this happens, many women are reluctant to speak about the mismatch. Rather than question their assumptions about ideal motherhood, their self-talk is much more likely to go along the lines of "I'm not getting it right".

Shame, self-blame and fear of judgement are powerful pressures on women to pretend to cope. Asking for support or help is seen as tantamount to admitting defeat. Many women struggle on alone, telling no one of their difficulties, or making light of tough situations. Their reluctance to disclose their true feelings is often partly due to a fear that this might result in a child protection notification or an unwanted visit from a social worker.

The sense of aloneness is a huge concern for women who are mothering a baby, especially if they are first-time mothers or new to their community. The social context in which women in Mitchell & Murrindindi are mothering babies is perhaps not too different to that of other women of their class, educational background, and culture. Their experiences are also influenced to varying extents by issues such as the small population size of each township, commuting, and the lag time between housing and infrastructure development.

For many women in Mitchell & Murrindindi, their sense of aloneness is compounded by geographical and social isolation, which further limits opportunities to share and learn from each other. Lack of transport, lack of footpaths, difficulties meeting other like-minded women, dislike of group activities, reluctance to be seen as "having no friends" and the day-to-day pressures of housework and parenting are all barriers to social contact.

Lack of child-friendly spaces is also a problem. In many places in these shires, options for physical activity are limited even for childless and able-bodied people. Women with young children are especially restricted, particularly if they do not want to use childcare. Physical activity, craft, or reading groups are implicitly childfree settings; ie women feel that their children are unwelcome unless otherwise stated. Similarly, there are few child friendly settings in the shires. There are no permanent wet weather play areas, few children's play areas and few paths suitable for prams. Anecdote suggests that despite the wealth of our local natural parklands, few women take their babies or children to these places for play.

In Mitchell & Murrindindi, many women do not have family living locally. This compounds their loneliness and deprives them of the possibility of an important source of practical help and support. Their parents – especially mothers – often come up for a short period after the birth of a child, and then visit infrequently thereafter. Some are available during crisis or difficult times, however most women do not have consistent help from their own or their partner's family. Also, of course, many women cannot rely on family, even if they live nearby.

There is very little in Mitchell & Murrindindi that might compensate for this lack of family support. In previous eras, women with young children would have been assisted with household tasks and childcare by other women, especially those of older generations. This kind of assistance is still the norm in many non-Anglo cultures.

Some ten years ago, there was an initiative coordinated by Mitchell MCH Service called "Mums' Chums." This was a small-scale, very successful service in which more experienced mothers befriended new mums, gave them practical help, and introduced them to the local playgroup. Its primary purpose was to break down isolation, but the service also provided for the possibility of women offering practical support to each other. The project ended due to burnout of volunteers and lack of funds for the coordinator.

In Mitchell & Murrindindi in 2002, it seems that most women neither expect nor want this kind of practical support. Their lack of expectations for practical support would seem to be well-founded: with older women staying longer in the workforce and/or living more demanding lives, there seem to be fewer women available to help out. (I had difficulty on the odd occasions when I did need to seek out women to give support to other mums.)

Yet women who are mothering babies also seem to have accepted the idea that women should be able to single-handedly perform all of the tasks of motherhood and homemaking. There is clearly a sense of shame in needing/wanting help, and homemaking is so much individualised that some women say that they wouldn't want ***someone else*** doing ***their*** household tasks. Others feel that they might accept help if they could overcome their sense of shame.

This issue of practical support is a good example of the dilemmas we have confronted in the course of the Project. For starters, most women seem to neither expect nor ask for care and support from their communities. We cannot tell women what they need. Furthermore, it might be unethical to suggest to anyone that she should have expectations for care and support, when there is doubt that such expectations can be fulfilled. Yet it is important for us to acknowledge that early parenthood is hard work and that the expectations of primary care givers (usually women) and the community as a whole are unrealistic. Implicit in The LAMP is the idea that raising babies should be a social activity and thus a concern of the community as a whole. This paradox has become clearer over time,

however the answers continue to elude us. In the meantime, I can only continue to convey the key messages and values of the Project. Some of the activities I had planned at the beginning of the Project (such as setting up supportive networks such as "Mum's Chums") were clearly not relevant to the women I spoke with, and were subsequently let go.

In The LAMP, we have sought to inspire community reflections about the nature of existing connections and support in early motherhood, and to help to develop new initiatives to respond where there is a perceived lack or opportunity. The challenge has been to work out how to do this in ways that are both achievable and sustainable.

Theoretically, the lack of social connections and social spaces for women with their children can be addressed by providing new opportunities and places. Yet this is not as easy as it might seem. For many women, the logistics of just getting out of the house with a baby seem just too hard. In small townships, the number of women who might be attracted to any one activity, or who get along well enough to meet regularly, is often quite small. Playgroups to some extent fulfil a social function for mothers as well as children, however women with very young children often don't participate, and many women say that the playgroup atmosphere is not always conducive to sharing and support.

Sustainability is also an issue for concern. It is not good enough to organise activities via The LAMP, only to have activities die off when the worker leaves. This is where community development becomes interlinked with professional development and service enhancement: we believe that local workers are best placed to conduct ongoing activities, and need to be encouraged and assisted to do so. Part of my focus in presentations at new parents' groups and in liaising with neighbourhood houses has been to encourage initiatives that lead to greater social connectedness.

As a project of a women's health service, The LAMP has an agenda of social change. Part of what we hope to achieve is a greater critical discussion about the socially constructed roles that women have in this society. This means, amongst other things, challenging women to consider the myths of motherhood and to discuss ways of mothering that promote wellbeing.

An inherent challenge of community development is finding people who wish to be instrumental in community change. This is especially difficult when the community development worker does not live in the township concerned, and also in areas that do not have a tradition of community connectedness. One of the notable things about many Mitchell & Murrindindi communities is that in any one township there is rarely a critical mass of people interested in community activities. Put simply, there are not enough volunteers and too few 'movers and shakers'. To compound the difficulty, in the area of early motherhood, women's unwillingness to ask means that there is not a coherent voice for change.

This situation is probably worst in Wallan. This is partly due to its nature as a commuter township, but some locals and service providers have suggested that people who are moving to Wallan are not very community minded. There are anecdotes about couples buying land without asking, knowing, or caring anything about the local facilities or services. The neighbourhood house has a small core of dedicated volunteers. This lack of community spirit makes it difficult to organise the local community, but also heightens the imperative of doing so.

In Kinglake, there is a greater sense of community, with an active Neighbourhood House and recently, the establishment of a community development network. A small number of women keen to challenge the myths of motherhood, became involved in the Picturing Motherhood sub-project.

In Flowerdale, the Lower Hume Primary Care Partnership is undertaking a township based mental health promotion project. This project is taking a whole-of-community approach to mental health promotion, beginning with a community planning process, and developing community mentors and facilitators. Over time, this may become a more activist community.

Skip to M'Loo : An audit of public toilet facilities in Murrindindi & Mitchell shires

The quality and accessibility of public toilet facilities speaks volumes about attitudes to the community generally and in particular to people who have a disability or who care for a baby or a small child.

We undertook an audit of public change facilities across the shires of Mitchell and Murrindindi. Our interest arose not only from curiosity about baby change facilities in the shires, but also because (in)continence is a major health issue for women after childbirth.

We produced a report on the methodology and findings of the study, and made recommendations to the Councils of both shires for actions to enhance access to appropriate baby change and toilet facilities. Both shires put forward these recommendations for consideration for their next budget.

Yea MCH redevelopment

In Yea, there is a severe shortage of occasional childcare services and there are no comfortable and welcoming places where parents with young children can meet.

With the Yea Neighbourhood House and the MCH Nurse, we explored options to redevelop the Maternal and Child Health Centre as a multipurpose parent-baby centre. This centre could be used for regular MCH services, playgroups, and mothers' groups, Take-a-Break and even as an informal drop-in centre for parents.

I assisted the Neighbourhood House to develop a process for seeking the redevelopment. This included developing a petition and background paper. The latter was sent to Murrindindi shire Council, seeking in-principle support to fund up to one-third of the redevelopment, with a view to applying for capital works funding from other sources. Whilst Council initially allocated $15,000 to the redevelopment, to enable us to seek funding via the Adult & Community Education Capital Works Grants, this commitment was withdrawn, and at the time of writing, there are no immediate plans to seek funds for redevelopment.

Visits to local services

I met with local service providers across the two shires to raise awareness about the Project, PND and issues in early motherhood. I supplied all providers with copies of the Post- and Ante-natal Depression Association (PANDA) leaflet (purchased with Project funds).

"Picturing Motherhood"

The activity Picturing Motherhood is the subject of a separate report, included as Appendix 1.

outcome 2 :

Families with babies have access to services and activities that promote their mental and emotional wellbeing

key values/messages	agents	strategies
All families with babies can experience stress and distress Families with babies can benefit from community support and professional services	Families with babies Whole communities	Community development Direct service Information dissemination

discussion

The experiences of women during early motherhood are very gendered and social in nature. However, services in Mitchell & Murrindindi do not specifically take this into account in their policies and service delivery. Service uptake is influenced by many different factors, and the decision to ***not*** use services is not necessarily problematic.

In the course of the Project, we have tried to emphasise that professional services are only one possible avenue of resources. We have suggested that all women have resources within themselves (experience, values, skills, coping mechanisms) and around them (friends and family), as well as professional resources. These values were articulated in the Resource Guide developed by the Project, and are reiterated in all group activities.

Service delivery to women and their babies in this area continues to be a challenge. Lower Hume is not necessarily under-funded on a per capita basis, however service delivery ***is*** patchy. There is not the population density to create a significant "demand" for specific services for mothers (other than MCH).

Counselling services are generally provided on a one-to-one basis and there are few, if any, opportunities for supportive group programs. The Reference Group has identified this as a need, and several agencies have expressed interest in contributing worker time to running groups. Four workers from three agencies will be involved in conducting program(s) for women who are experiencing mild to moderate PND and/or are not coping in early motherhood.

There is most certainly a need for services that can respond to women experiencing acute depression or anxiety. The Goulburn Valley Area Mental Health Service in Shepparton manages after-hours crises. This is especially difficult for communities on the rural fringe. We have made suggestions to address this in the West Hume Community Mental Health Plan.

Childcare in all its forms is still in short supply in many parts of the two shires, especially in smaller townships. In places such as Flowerdale, family day care is limited to one or two providers and occasional childcare is non-existent.

Whilst The LAMP is technically a postnatal project, the reality is much more fluid. A considerable part of my role focuses on talking about women's birth experiences. Whilst my presentations in antenatal classes are intended to focus on the families after birth, we inevitably discuss the expectations of birthing women and their partners. In new parents' groups, many women tend to use the sessions to reflect on their experiences of birth, especially if they have not had a prior opportunity to do so. In the course of the Project, we have therefore had many opportunities to learn about and reflect upon women's experiences of pregnancy and birth. Some common themes have emerged:

- The availability and cost of professional indemnity insurance is affecting maternity services for rural women. Fewer doctors are able to carry the cost of PII and there are consequently fewer GPs practising obstetrics. Most midwives in private practice are now uninsured. Women's options for birthing are being restricted accordingly.
- Fear of litigation is also impacting upon women's birth choices. Smaller rural hospitals are now unable and/or unwilling to accept bookings from women who are categorised as at risk of having a complicated birth (eg vaginal birth after caesarean). Rates of intervention, especially caesarean births, are unacceptably high.
- For these reasons, in the rural fringe of Lower Hume (eg Alexandra, Yea, Kinglake), many women are choosing to birth in metropolitan hospitals. With declining use of local birthing facilities, we fear that some local hospitals may choose to close their birthing services.
- This declining use of facilities is associated with problems in the morale, recruitment and retention of midwives. In each of the local hospitals, midwives are required to perform general nursing tasks whenever they are not occupied with birthing and physical postpartum care. The other tasks of midwifery (supporting women and their families, answering questions, providing lactation support) are rarely recognised by managers or other nursing staff as being important.

The expectations of women articulated in the Maternity Services Enhancement Strategy, for more birthing options, greater control and continuity of carer, have clearly not yet been met. These and other issues are being identified more fully in the Australian College of Midwives Project that is currently underway in Seymour and Kilmore.

It is notable that women who do give birth locally are generally very happy with their experiences. This is in sharp contrast to the experiences of women who have given birth at Northern Hospital. These women's reports are consistently poor. There is an urgent need to address the quality of inpatient care that women receive at this hospital.

activities

Resource guide

Local workers were keen to have an up-to-date list of resources for mothers. I collected information from a range of sources to produce the "Resources for Mums in Mitchell & Murrindindi shires". This A4, folded brochure was produced cheaply. Laminated copies were provided to workers to pin up and/or photocopy. The resource guide is also available via the WHGNE website and has been distributed to workers in other shires to modify for their own local use. The resource guide was reviewed and republished at the end of 2002 and will be maintained by Goulburn Valley Family Care hereafter.

I felt it was important to promote the idea that women need to tap into their inner resources and support from family, friends and community as well as professional services. We also included some guidelines on getting the most from professional services. The Reference Group discussed the merits of providing details of websites, and ultimately chose to include only a few that we felt were reputable and worthwhile. We continue to have reservations about how many women in this area have regular and/or easy access to the Internet.

The Resource Guide is included with this report as Appendix 4.

Gentle exercise group (Wallan)

Women with young children often find it difficult to participate in physical activity because they are caring for small children. In Wallan, there are few facilities for physical activity: there is no gym or pool and there are no paths for walking. Women who are mothering small children would benefit from learning how to exercise with their children at home. These women may also benefit from increased social contact, as there are few opportunities for women with young children to meet and make friends.

These issues were raised in a discussion group of mothers in Wallan. There was considerable interest amongst the group for gentle exercise. Planning for this activity commenced late in 2001 and weekly sessions began in term two 2002, jointly sponsored by Wallan Neighbourhood House, Mitchell Community Health Service and Women's Health Goulburn North East. The sessions were minimally subsidised by Project funds and will be subsidised by Mitchell Community Health Service in 2003.

Antenatal class presentations

I conducted antenatal sessions on emotional and psychological issues in antenatal classes at Seymour (2001) and Alexandra Hospitals (2001/02). These have included providing information on PND. A number of different approaches were used, each with mixed success. This is partly due to the nature of different groups, but also because of the structure of the sessions. I feel that spending one session on parenting and emotional issues is not particularly useful. I wonder whether it might work better to take a more holistic approach: to discuss emotional issues and "the future" in each session. Classes are often didactic, and I get the impression that psychological aspects of birthing are overlooked. An ongoing difficulty is that antenatal classes are time-consuming and expensive to conduct. At Seymour Hospital, responsibility for conducting courses is rotated amongst the midwives. This means that few midwives are able to build up the skills and confidence to conduct courses, and there is little incentive to reflect upon course structure and initiate change.

First time mothers' groups

I conducted many sessions on emotional issues in early motherhood for first time mothers' groups. These were all positively received by participants, but I believe they were more successful as I have gained experience and confidence.

Theoretically, each session of a first time mothers' group provides time to discuss emotional issues. However in practice this varies according to facilitation, group cohesion and trust. Each MCH nurse runs the groups in her own way, according to her skills, confidence, interest, and time available. I feel that the groups vary greatly in their quality and usefulness. Some groups continue to meet informally after the program finishes; others go their separate ways.

Whilst I was generally invited by MCH nurses to talk about PND, I tried to cast this in a broader context of the challenges and joys of early motherhood. This was sometimes difficult because (despite my requests to the contrary), I was often introduced as "This is Elizabeth and she's here to talk about PND."

Over the second year of the Project, I became increasingly concerned with the place of imagery in women's experiences of motherhood.. In my first year of the Project, I felt that more needed to be done to create spaces for women to acknowledge the full gamut of emotional and material responses to the challenges of motherhood. I used several different approaches, each of which is briefly outlined below.

Individual drawing:

I provide oil pastels and A3 sheets of paper and invite women to draw (for example):

- Their pre-baby and with-baby selves
- Themselves as a mother
- Their family
- A tree, with what they need to flourish drawn/written in the roots, and the fruits & flowers of their lives in the branches

Women generally seem to enjoy this activity greatly. I was initially concerned that women would be intimidated or fearful ("I can't draw"), however this has rarely been the case. Even women who say they can't draw still appear to have fun. Whilst I always say that they are welcome to write or doodle if they prefer, almost every woman has ended up drawing something.

After drawing, I allow time for women to talk about their images – if they wish – and to reflect on their responses to the drawing task.

Collective drawing:

In this exercise, I pin up a piece of butchers' paper and arm myself with a box of crayons. I introduce the exercise by saying that most women have some picture in their heads of the "perfect mother" and that we're going to jointly draw her to see if our pictures are the same. I then ask a series of prompting questions ("how tall is she?", "what are her boobs like?", "what's she wearing?") and draw a picture based on the agreed responses.

I have been startled by the uniformity of responses across the four groups in which I have conducted this exercise. Three groups have agreed that the perfect mother has a belly-button ring (implicit in this is that she has a flat stomach). All groups have made her white and there is almost consensus that she has blonde or highlighted hair. All groups listed the things the perfect mother has around her (nice house, clean house, 4WD/nice car), but had to be prompted to remember and then describe the perfect mother's baby.

I use this exercise to point out the level of commonality in our collective imagination. I suggest that whilst she is somewhat shaped by each woman's class and culture, there are commonalities in our images of the "perfect mother" because she is all around us in the media.

I suggest that we all carry this woman around within us to varying extents, and that her presence is felt at different levels according to our mood, experiences and confidence. Most of the time we know intellectually that we cannot ***be her*** (nor do we want to be her!). However there are still times when we take our measure against her. This is disempowering and undermines women's sense of value and achievement.

Magazine images:

I take piles of magazines and invite women to look through them to locate an image that reflects a positive aspect of their experience of motherhood, and another that reflects a negative aspect. This activity generates much hilarity, but becomes more serious as women turn inwards and reflect on their own experiences. I generally find that women subvert images, taking them out of context in order to relate them to themselves. For example, a picture of a sleeping baby becomes a negative aspect "this is how my baby never is". There are very few images that are straightforwardly negative or difficult experiences.

A variation on this task is to ask women to find pictures of women that remind them of themselves, or to find pictures of women-as-mothers.

These activities are followed by a discussion about the pictures of motherhood that we carry round in our heads. Women need very little encouragement to talk about the unrealistic images they see in front of them and to name the pictures that are missing. They are quick to note that the audience for these magazines is not reflected in the images on the pages. We usually move on to discuss where women learn about and prepare for motherhood, and to talk about what does/doesn't match the expectations of these women.

Relaxation activities:

Relaxation activities have been very successful, a surprise to me given that we have a roomful of mothers and tiny babies. I have generally used "awareness meditation" because it is simple and seems very appropriate to the needs of mothers. This form of meditation acts as an antidote for all the time that we don't spend "in the moment". It enables us to recognise that most of what we do, we do without thinking, without awareness, with no appreciation of what is happening within and around us. Awareness meditation gets us to focus on the Now. For women who are finding it difficult to value the ways that they spend their time, it can bring new appreciation and insight to mundane, everyday tasks.

Birth stories:

In many groups, women are keen to re-tell aspects of their birth stories, especially if they have grievances or unfinished business. This does not necessarily mean that they have not already discussed birth stories in the group (people are always telling me their birth stories!), however it may indicate that in some cases they may feel unresolved about their grievances. In one instance, I subsequently invited the midwifery charge nurse from a private hospital in Melbourne to come up to Kinglake to meet with women who were unhappy with their recent experiences. The MCN met with one woman and we were able to resolve her concerns.

These activities can affect women quite powerfully and occasionally women do become quite emotional. By inviting women to reflect on change or needs or their resources, we do open up the possibility for them to talk about issues that are difficult or highly emotional for them. I am acutely conscious of the need to be able to refer easily and appropriately, and to normalise the need for extra support. I always distribute the resource guide and PANDA leaflets to the whole group in the context of these discussions, and often make suggestions within or outside the group about what services might be useful. I have always found group participants to be supportive and nurturing of each other, however I don't discount the possibility of dynamics being otherwise.

One of the most valuable aspects of the activities is the level of discussion they generate. Sadly, a significant number of workers seem reluctant to create spaces for women to discuss their real experiences. I must note here the range of skill and commitment in facilitating individual and group discussions. Some professionals are highly skilled, whilst others appear to be very fearful of emotional discussions. There are myriad reasons for such fear, some well founded. They include the potentially explosive nature of some subject areas and not knowing how to manage and/or defuse highly emotional discussions. Some workers have said that they are wary of triggering a ripple effect in which women "upset each other" or in which already-pressured women feel they need to look after the distressed woman in the group.

Issues of the skills, preparedness and values of workers are also discussed in Outcome Five. Here, I would like to note that I do not believe this is such highly skilled work that it should be left to counsellors and psychologists. I have found that much can be done to create spaces for women to discuss their experiences, and that having such discussions in the context of existing groups such as new parents' groups and playgroups helps to normalise rather than pathologise women's experiences.

Creating such spaces however does require organisational commitment and culture, appropriate resourcing, and a structure of professional and personal support for professionals. These are not always available to early motherhood professionals in Lower Hume. The planning and conduct of these types of activities in the future is yet to be resolved. I am hopeful that the newly created position at Goulburn Valley Family Care may be able to take up some of this work. There is also most certainly a place for training and awareness raising amongst some MCH nurses and midwives. Other structural issues need to be addressed within individual agencies.

Seymour Enjoying Being a Mum? *group*

One of the activities mooted from the beginning of the Project was a supportive group program for mothers. As a community development worker, I was aware that I did not have the skills or experience needed to conduct a group by myself, and in any case, I wanted to ensure that any group programs that did arise could be sustainable past the end of The LAMP. I hoped to identify local workers who might be interested and available to co-facilitate a group with me.

The greatest barriers to finding co-facilitators were workers' confidence and time commitments. In the latter part of 2001, all of the Mitchell MCH nurses said they could see value and need for a supportive group program, however they variously reported lack of time and lack of skills to facilitate. Two MCH nurses expressed interest in attending the program at the Infant Clinic at Austin & Repatriation Medical Centre to further develop their skills in preparation for conducting a similar program in Seymour. However, we soon realised that this would be far too time consuming. I believed that both MCH nurses were already suitably skilled, and encouraged them to consider co-facilitation with a counsellor from another agency such as Goulburn Valley Family Care or Mitchell Community Health Service.

Soon afterwards, Kate Lewer's position at Goulburn Valley Family Care changed, and she became available to run parents groups. Kate, together with Angela Wallis (MCH nurse, Seymour) stepped forward to assist in planning and then running the group. I guided the initial planning process and assisted in the development and dissemination of publicity.

The "Enjoying Being a Mum?" group met weekly for twelve sessions, facilitated by Kate and Angela. The venue was the Seymour Aquatic & Recreation Centre, which was chosen because it offers occasional childcare. The costs of childcare ($3.40 per session) were borne by the participants, with the capacity to subsidise second and subsequent children from Mitchell MCH Service's Enhanced Home Visiting fund. Costs for the venue itself ($15 per session) were also funded from that source. Six women participated in the group.

The group was found to have positive effects on participants' self-esteem and confidence in their mothering roles. Another group series will be held in the southern end of Mitchell shire in early 2003 and in the Seymour area in the second half of the year.

Wallan women's group & babysitting club

I met with a group of women in Wallan to discuss early motherhood issues and identify options for locally based activities. Many issues were raised on the day, including social isolation, lack of occasional childcare, relationship difficulties, transport problems, and few options for physical activity.

The women decided to try to meet fortnightly on Mondays for morning tea in the Wallan Neighbourhood House (a child-friendly space). Six women attended at least one session, but only two attended at any one time! The decision to meet on Mondays was a result of the availability of the Neighbourhood House, but all of the women felt that Mondays were not suitable. This group has since been replaced by the Gentle Exercise Group.

The Kilmore/Broadford area has had a successful babysitting club for years. Their club has given many opportunities for families to have reliable, free, and local childcare. At a meeting of women in early motherhood in Wallan, some women were interested in establishing a babysitting club. I subsequently met with two women to try to start such a club. Two meetings of local women were organised, but there was insufficient interest to continue. This activity took place late in the year (November) and we wondered whether there might explain the lack of interest, however there was no real momentum to try at again.

Other activities

I reviewed and contributed to a pre-conception information guide for women for the Royal Women's Hospital.

We ordered and distributed 300 PANDA leaflets amongst MCH nurses, midwives and other early motherhood support services.

A further 200 leaflets with PANDA's new contact details were distributed at the conclusion of the project (with Resource Guides and a summary of this report).

outcome 3 :

Relevant professionals feel supported to provide services that support and promote the mental and emotional wellbeing of families with babies

key values/messages	agents	strategies
All professionals need support, constructive feedback and opportunities for debriefing	Professionals	Personal support for professionals

discussion

With hindsight, perhaps this outcome was beyond the Project's reach. We have undertaken activities that we hoped would help workers to feel supported and affirmed in their work. However these can never compensate for the daily realities of under-funding and over-work.

Professionals in Mitchell & Murrindindi have uniformly heavy workloads. There are simply not enough workers to provide the level of individual support and community development work that would fully support and promote mental and emotional wellbeing of families with babies. This means that at any time, some workers are stressed, distressed and burnt-out.

In addition, almost all early motherhood professionals are women and mothers. This means that they often experience similar demands of parenting, home making, home management, relationship management and paid work as many of the women they provide services for.

In the course of professional development activities, I have encouraged workers to reflect on their own values, images and experiences about motherhood. This has provided a limited space for women to reflect on their own situations. However addressing the impact of the combined personal and professional workloads has largely been beyond the scope of this project.

There are different policies and procedures amongst organisations for professional support and supervision. Workers who have a formally defined role as counsellor tend to receive some level of supervision (usually monthly with their manager). Others use informal debriefing or staff meetings to discuss difficult or complex issues, with mixed success. MCH nurses are essentially solo practitioners and have limited access to daily support and debriefing. Whilst these arrangements suit some workers, I wonder about the long-term impact on individuals – both personally and professionally.

I had hoped that we would be able to establish networks of early motherhood workers at either a sub-regional or LGA level. Regrettably, very few workers felt that regular networking activities between professionals would be viable given the constraints of time and distance. The part time nature of this workforce was also a constraint in this regard.

Baseline survey

In the early stages of the Project, we distributed a survey to examine current awareness of PND and approaches to management. We also asked about professional development needs. 75 workers who had contact with mothers of babies completed the survey. These included midwives, MCH nurses, early childhood workers, and allied health workers. Most of these workers would like to discuss cases more, and a considerable number felt that their work was lonely. Most workers preferred half-day forums on an ad hoc basis.

Reference group

The role of the Reference Group was to provide advice and critical support to the Community Development Worker and Women's Health Goulburn North East in the planning, implementation and evaluation of the Postnatal Mental Health Project. The Group also doubled as a supportive network for workers in early motherhood, and there was a good deal of sharing of information and ideas.

The Reference Group met monthly for most of 2001 and infrequently in 2002. It comprised the following professionals:

- Dee Basinksi, Executive Director, Women's Health Goulburn North East (resigned Dec 2001)
- Anne Cox, Program Manager, Mitchell Community Health Service
- Jane Douglas, Psychiatric Nurse, Goulburn Valley Area Mental Health Service
- Leonie Feery, Midwife, Seymour Memorial Hospital
- Marg Findley, Manager, Goulburn Valley Family Care (Seymour)
- Margaret McLauchlan, Community Access Worker, Murrindindi Community Health Service
- Leanne Sheeran, Maternal & Child Health Nurse, Mitchell shire Council

Maternal & Child Health Nurses from Murrindindi shire Council were not involved in the Reference Group due to their other work commitments, however they all receive minutes and meeting notices.

One-on-one discussions with workers

A key component of The LAMP was building up relationships with local early motherhood workers. When the project began, I learned that many workers had expected this to be a direct service initiative, and that I would provide clinical services (i.e. counselling). They were quite disappointed to learn that this was not the case. One of my first challenges was to overcome their disappointment and to facilitate productive discussions about what we could jointly achieve.

Since that time, I built positive relationships with most of the key professionals. By the end of the Project, they would initiate invitations to speak to their groups, and I could approach them with questions or ideas. There was sufficient trust between some workers and myself for me to be able to suggest changes in practice.

Relationship building is to some extent shaped by personalities and systemic issues. I had least success in building relationships with workers who appeared to feel greatly overloaded and/or who were disinclined to reflect on themselves and their work.

A Day for the Life of Michelle

This professional development and networking activity was planned and organised in consultation with The LAMP Reference Group. Our objectives were to:

- Increase awareness of professionals and consumers about the many different perspectives and approaches to emotional & psychological wellbeing in early motherhood
- Gather input from professionals about needs and directions for service enhancement
- Facilitate communication and sharing between professionals from different disciplines and organisations
- Promote WHGNE

A number of problems in the existing service system were identified, and workers began to develop ways to address some of these.

Participants had formal and informal opportunities for sharing information, ideas, and experiences. The evaluation survey and informal discussions indicate that these opportunities were greatly appreciated.

Many of the participants have had little or no previous contact with WHGNE. Through the introduction to the event, they were able to hear about the work of the organisation, and to be introduced to other WHGNE workers.

Most importantly, workers felt supported and encouraged by their participation. Many were inspired to take new approaches and ideas back to their workplaces, and to continue their efforts to improve early motherhood services for all women.

A full evaluation report is attached as Appendix 2.

outcome 4 :

Relevant parts of the service system are well-integrated and have the capacity to deliver quality services

key values/messages	agents	strategies
Families and professionals benefit from a well-integrated and appropriate service system	Agencies Professionals	Service enhancement

discussion

There are few formal protocols or mechanisms for referral or secondary consultation amongst primary and acute providers in either mental health or early motherhood. Communication mostly appears to be ad hoc. Most takes the form of a telephone call between workers. Whilst most staff seemed to feel that this works most of the time, there is some concern that some individuals might "fall through the gaps".

Communication between GPs and other service providers continues to be extremely patchy. A few GPs are very good at referring to allied health and counselling services, most however continue to operate as though in a vacuum. On the other hand, it does not always occur to midwives, MCH nurses, and allied health providers to liaise with a GP.

This project has occurred at a time of heightened interest, awareness, and activity about partnerships and collaboration. A number of projects were being undertaken by the Lower Hume Primary Care Partnerships towards service mapping and initial needs assessment. The Primary Mental Health and Early Intervention Team (PMHEIT) had commissioned a community mental health plan and commenced secondary consultations on depression and anxiety. In this environment, it seemed a likely duplication of effort to attempt to address integration in the context of early motherhood. We were doubtful that there would be sufficient interest and staff time to address these matters given competing claims of the PCP and PMHEIT.

For this reason, I did not attempt to work directly with GPs or with other mental health services. By mid 2002, it became apparent that the extremely limited resources available to Lower Hume will restrict its capacity to reach out to GPs. By this stage however, it was too late to implement GP education strategies. We will provide a set of information and messages on PND for the PMHEI Team to provide to GPs, including information on prevalence of PND, the role of the EPDS, and potential partners in care and support for GPs and women with PND. Many GPs still appear not to know about relevant local service providers and anecdote suggests that many GPs are taking a medication-only approach to the treatment of PND.

I have represented WHGNE at meetings of the Lower Hume Health & Community Services Forum and PCP over the period of the Project.

Networking activities

The Reference Group meetings and professional development activities have enabled early motherhood and mental health workers from different parts of the sector to meet. There have been informal and formal discussions about ways to improve integration and communication between professionals and organisations.

Response to Women's Health and Wellbeing Strategy

The draft Victorian government's Women's Health and Wellbeing Strategy was distributed in late 2001. I focused on pregnancy, birth and early motherhood as part of WHGNE's broader response to the draft strategy. WHGNE took the position that the Victorian government should:

- Locate birthing in the context of wellness, not illness
- Endorse a community midwifery model of care
- Fund primary care providers to offer childbirth preparation
- Develop regional & sub-regional strategic plans for maintaining and improving birthing services in rural areas
- Support state-wide and local action to address the training, recruitment and retention of MCH nurses and midwives in rural areas
- Develop a statewide strategy to provide professional indemnity insurance for private midwives
- Support expansion of models of support such as Wangaratta Early Motherhood Project

Response to Royal Women's Hospital consultation

The Royal Women's Hospital (RWH) also conducted a consultation in 2001, as part of its redevelopment strategy. I prepared a response on behalf of WHGNE, in which we commented that:

"The RWH is old, tired and has an institutional atmosphere that we feel is most probably beyond remedy. The current state of the facility speaks volumes about the lack of respect and regard for women in our society, especially for birthing women.

A new, purpose built hospital in central Melbourne with more extensive birthing centre, antenatal and health promotion facilities would ensure women had more positive experiences of birthing and/or a stay in hospital. We believe this would improve health outcomes.

WHGNE feels that co-location with the Royal Children's Hospital is not desirable. Not all women are mothers. Furthermore, whilst always recognizing the contexts of women's lives, we believe women should be regarded, cared for, and treated as women, not only as mothers.

Refurbishment of the existing site would be preferable to moving from central Melbourne.

Whilst physical infrastructure is very important, if we are to ensure improved health outcomes for women, then appropriate staffing levels, experienced and qualified staff, effective systems and responsive management are all equally important."

outcome 5 :

Relevant professionals are skilled to provide services that support and promote the mental and emotional wellbeing of families with babies

key values/messages	agents	strategies
All professionals need opportunities to extend their knowledge and skills	Professionals	Service enhancement Professional development

discussion

Professional development is undertaken in many different ways, and participation is affected by organisational needs and professional accreditation requirements in addition to workers' perceived needs. Many workers undertake professional development (such as reading journals or attending conferences) in their own time. Others fulfil only the minimum requirements of their profession. These factors combine to result in an ad hoc experience of professional development across the sub-region, and wide-ranging levels of skills and confidence.

As well as the issue of professional development, there is also the question of culture change and value transformation. The agenda of social change within the Project developed over time as my awareness and confidence grew. Whilst the agenda of social change increasingly informed my approach to women's groups, I feel that many local workers may have been left behind in this process. There has not been enough time to share learning and discussion about issues in early motherhood.

In our experience, workers have been very appreciative of locally developed and locally conducted training and professional development activities. I have taken care to ensure that these activities are in pleasant venues with good catering. Participants have appreciated the care and support that this represents.

We have been able to offer several partly subsidised training activities, all of which have been well received. We have also offered a number of in-house training opportunities. These have the advantage of being specific to an organisation's needs and context, and of allowing workers to share their training experience with their colleagues.

One of the greatest challenges for this project was motivating early motherhood professionals to reflect upon and even change their practice. Attitudes to the endeavours and activities of the project ranged from extremely enthusiastic to lukewarm to disinterested. Most probably, this represented the personalities and workplaces of the area, however there were times when I felt I had failed to adequately connect with local workers, and to inspire their commitment. Whilst I do hope that the project has helped some local workers to change their everyday practice, I am hesitant to ascribe too great a significance to my work in this area.

The values and views of professionals can greatly affect women's experiences. This vulnerability means that we need to reflect carefully on the values and messages disseminated by professionals in the course of their work. What we do and don't say has lasting implications. For example, when a woman says that she feels she isn't being a good mother, there are any number of possible responses, including:

- Silence – giving tacit endorsement to her view
- Denial ("oh no you're not, you're a great mum") – ostensibly affirming her work but at the same time not accepting her reality or engaging with her fears
- Open response ("what makes you feel that?", "what would a good mother be doing?") – offering to engage in discussion about her fears and perceptions as well as your own

Reflecting on one's own values, approaches and messages is challenging work for professionals. It necessitates a high degree of self-awareness, commitment, and courage. In the course of the Project, I encountered many professionals who were committed to reflection. Others were disinclined to evaluate or reflect upon their own work.

For some people, critical reflection does not come naturally. Barriers include fear of strong emotions or unresolved personal issues, lack of time and reluctance to open oneself up to criticism (from self or others). Yet reflection is a question not only of individual processes. Reflection requires a supportive environment, a culture of critical thinking, and time. In my experience, these enabling factors are rare in Lower Hume.

activities

In-house training : Goulburn Valley Family Care

At the invitation of Margaret Findley, I presented an afternoon in-house training session on PND for workers at Goulburn Valley Family Care (Seymour). Twenty-two workers, including some who had travelled from Shepparton, attended the training.

The presentation took the form of a semi-structured interactive discussion, covering: naming PND, signs and symptoms, diagnosis and treatment, risk and prevention.

In-house training : Mitchell shire Maternal & Child Health nurses

I felt that the Early Motherhood Project of the Wangaratta Area Mental Health Service provides a very inspiring and innovative example of supporting women during early motherhood. The Department of Human Services specially funds the project. It enables the Service to provide group work and individual counselling for any woman who is experiencing difficulties as she mothers a baby or small child. The project workers collaborate with other members of the Area Mental Health Service team when supporting women who are experiencing depression, anxiety or other mental illness.

Jenny Ahrens and Rose Mogford from the Early Motherhood Project visited the Seymour MCH Centre to talk about their work. All of the Mitchell shire MCH nurses attended the meeting, as did several other Reference Group members. We discussed in some detail how we might apply aspects of their model in our shires, and agreed to run a six-eight week group program in 2002, led by MCH nurses.

I was pleased to note that the MCH nurses were keen to try approaches such as relaxation, drawing and role plays in their First Time Parents' Groups. One Mitchell MCH nurse participated in the Group Facilitation Skills workshop in May 2002, which incorporated training on these activities.

A Day for the life of Michelle

"A Day for the Life of Michelle" is described under Outcome 3. A full evaluation report is attached as Appendix 2.

"Tapping Into the Power of Groups"

In May 2002 I conducted two interlinked training sessions on group facilitation. Entitled "Tapping Into the Power of Groups", the sessions covered the following topics:

- Opening/convening the group
- Ground rules
- Planning a group
- Drawing and relaxation activities based on the theme of worker self-care
- Closure & evaluation

Feedback from participants about their experience of the training was very positive and suggested that the content, format and delivery of the course met their needs very well. Measures showed a strong increase in confidence as a result of the training.

A report on the training is included as Appendix 3.

In August 2002, I repeated this activity as a one-day training session for Murrindindi Community Health Service. Six workers participated and once again, the evaluations were very positive.

In-house training – Wangaratta Community Midwifery Project

At the invitation of Wangaratta Community Midwifery Project, I conducted a half-day training session on gender and early motherhood. This received positive evaluation, and a number of midwives intend to incorporate some of the drawing and magazine activities into their own antenatal classes.

In-house training – Murrindindi shire Council Family Day Care Workers

I was the guest speaker at the 2002 Murrindindi shire Council Family Day Care Workers' dinner. I spoke about the role of a Family Day Carer when mums aren't coping, the warning signs of depression, and what FDC workers can do if they think a woman might be depressed. We used the collective drawing process described earlier to look at how women's experiences of depression tie in with the expectations that women and society have of mothering, and how we can reinforce or challenge these in small communities. Eleven workers participated in a very spirited discussion.

In-house training – Women's Health Goulburn North East

Our organisation has a practice of continual professional development. As one of our regular fortnightly professional development activities, I presented a workshop on feminist approaches to PND. We used drawing and magazines to explore workers' own experiences of motherhood. The experiences and ideas raised in the session were consistent with others I have conducted.

core business / other activities :

The LAMP is a project of WHGNE, and it is important for me to contribute to fulfilling the vision and values of the organisation. To this end, I have been involved in many organisational development activities, including:

- Attending and facilitating fortnightly staff meetings, professional development activities and collective evaluation exercises
- Editing a WHGNE newsletter and writing a 'think-piece' on leadership
- Writing a section of the 2000/2001 Annual Report
- Presenting on The LAMP at the WHGNE 2001/2002 Annual General Meeting
- Writing a section of the 2001/2002 Annual Report
- Presenting a "Women's Health View on Risk" at the WHGNE 2002/2003 Annual General Meeting
- Contributing to the Publicity & Promotions Working Group
- Convening the Pay & Conditions Working Group
- Coordinating the organisation's presentation to DHS on the Draft Women's Health and Wellbeing Strategy

recommendations :

What you say and do makes a very real difference to the lives of women who are mothering a baby. Your support, values, words and ideas **all impact** on her practical and emotional experiences. We invite you to **reflect** on the impact that **you want to have** and encourage you to strive to achieve it.

It is time for our society to change its ways. It's time for everyone to **reach out and explore** issues beyond the safe middle ground; to acknowledge the **huge ranges of emotion** and experience of women as mothers. It's time for each of us to listen and see, feel and sense. It's time for thoughtfulness and care.

Without change, there will be more unhappiness, more depression, more grief and more loss. Change happens one person at a time. **We ask, "What could you do differently?"**

For practitioners … MCH nurses, family support workers, midwives, GPs

Help women to talk about their real feelings and emotions by asking more open-ended questions and giving more time in consultations

Talk about the pressures that society places on mothers and say that parenting is hard work

Initiate discussion about taboo subjects like body image, sexuality and relationships

Use the Edinburgh Postnatal Depression questionnaire routinely at six weeks and six months, as well as at any time that you feel a woman might be depressed (but don't let it be a substitute for real conversation)

Use the Resource Guide yourself and offer it to all mothers

State the value of talking things over with a counsellor and make appropriate referrals

Be patient and persistent … it often takes a while for women to open up or to take a referral

Consider whether a client might benefit from closer collaboration between her different service providers; initiate case conferences where indicated

Review process, content and structure of antenatal sessions and new parents' groups

Be pro-active in helping women to make new friends and connections – not just women of their own age and circumstance, but also with mums of older kids and women of their mum's age (service clubs and neighbourhood houses are good sources of the latter)

Offer more group activities and opportunities for women to get together

Ensure that your place is welcoming and nice to be in

Use pictures and posters that reflect women's real, lived experiences

Be creative in your approaches … use drawing, pictures, clay, photos, music, dance, role plays

Develop your skills … in interpersonal communication, facilitation, training and presentations

Share your experiences, values and ideas with other practitioners

Celebrate and affirm the good work that you do and the important role that you play in families' lives

For planners & managers

Integrate early motherhood issues into municipal public health plans and other plans

Provide mother, baby and toddler-friendly public spaces (indoor as well as outdoor)

Initiate options for practical help (perhaps this could be achieved via a volunteer service run by the Home & Community Care Coordinator)

Require regular professional development for all practitioners in areas such as interpersonal communication

Ensure that those who conduct training or small groups are trained to do so

Celebrate and affirm the good work that practitioners do and the important role that they play in families' lives

Understand and value the role that you also play in family wellbeing

For politicians and the Department of Human Services

Change MCH funding agreements to include outcomes around maternal mental health and wellbeing and to accommodate lengthy travel time in rural areas

Fund more appropriate, local, affordable childcare (especially occasional care in Yea, Flowerdale and Wallan)

Fund community development hours in maternal & child health

Extend Home & Community Care services to mothers of babies under six months

Increase core funding to MCH, community health and acute mental health

Change funding agreements and provide extra funds for case coordination by mental health services

For everyone

Be brave enough to tell the truth about your own experiences and feelings

Volunteer for specific tasks – say exactly what you'll do and when, then keep your word

Give positive feedback – all mums need thanks and encouragement

Ask people about what they are experiencing and feeling

Be a good listener – respond to what a person's saying

Be gentle and supportive if people are not coping

Consider your own priorities and challenge those of the society we live in

Become a media activist … ring, write, picket, boycott businesses whose practices or advertising discriminate against or disempower mothers

For mothers

Make connections – isolation is one of the most difficult things about being a mum of a baby; if you don't know people in your area ask your MCH nurse to put you in touch with other mums and with some older women

Talk to people you trust, respect and like – talk about the good things and the bad things and the things you're not sure about

Voice your fears and worries – often they're not as scary in the open

Take time out from being the primary carer – even very young babies can be left with a trusted person whilst you have a sleep, a haircut or a massage

Ask for help – not just from immediate family, but from friends and extended family across generations

Use Council-provided Family Day Care – it's good quality, very cheap and available on a casual basis

Make a list of things other people could do around the house – vacuuming, washing, cleaning, general tidying – then ask friends and family to take on a task each on a regular basis

Have special time with your partner – sometimes this takes a bit of planning, but spontaneity is good too!

Go for walks!

Make a list of what you enjoy or what makes you happy – then do something from your list every day

Have someone give you a massage – feet, shoulders, head or if you're lucky, all-over

Go along to a new mums' group or support group

Organise to have coffee with some other local mums after a visit to the Maternal & Child Health Centre

If you're new to an area or don't have many supports, ask around for names and contact details of other mums or grandmothers, then make new friends

You are a good mum! Use lipstick to write this message on the mirror or post a sign on the fridge

Share your worries and fears if you think you're not a good enough mum

Shower and get dressed each morning, even if you're feeling bad

Eat well, and get others to cook for you

Give thanks and positive feedback when family and friends do something that makes you feel good

Talk to a friend or professional if you're feeling unhappy, stressed or experiencing other symptoms of postnatal depression

Above all, do things that show love for yourself and your baby

appendix 1 :

Picturing Motherhood

appendix 2 :

A Day for the Life of Michelle: A full evaluation report

appendix 3 :

Tapping into the Power of Groups

appendix 4 :

Resource guide