Supporting Maternal Transition: Continuity, Coaching, and Control

Jennifer Rowe, PhD, MPhil, Grad Dip Ed, BA, Dip Ed, RN

Margaret Barnes, PhD, MA Soc, RN, BNED RM

Stephanie Sutherns, BNurs, MHMgt, RN, RM

ABSTRACT

The transition from maternity services to community child health services on discharge from hospital occurs at a potentially vulnerable time for women in their transition through the childbearing/early parenting continuum. Their experiences contribute to their developing maternal efficacy and parenting skill. The ideal attributes of services that aim to support women and their families during this time include continuity of care, service integration, and birth in accessible, community-based contexts. The purpose of this study was to investigate aspects of maternal experience of mothers attending with their infants a publicly funded drop-in postnatal health-care service, as well as their reasons for attending and their perceptions of its usefulness to them as a mechanism of continuity and a source of support.

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The importance of promoting the health and well-being of infants and young children to sustain longer term individual, family, and community health is a widely accepted foundation for global health priorities. Integral to this development is the ability of an infant's primary caregiver, most usually the mother, to provide sensitive and responsive caregiving (World Health Organization [WHO], 2004). A mother's ability to provide responsive care may be affected by a range of internal and external factors, including respectively, psychological well-being, parenting efficacy, and the availability and usefulness of social support (Salonen et al., 2009; WHO, 2004). In Australia, these premises form an important plat-

form for health policy and service interventions. A range of universal and targeted maternal and child health services are available to mothers, their infants, and families. The ideal attributes of services that target women and their families across the childbearing continuum include continuity of care, service integration, and birth in accessible community-based

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contexts (Schmied et al., 2011; Schmied et al., 2010). There are numerous programs and services that are designed to support families. However, evaluations are limited and outcomes variable (Schmied et al., 2010). To further inform service planning, there is need for evidence of the effectiveness of these services as a mechanism of continuity and as a source of support for mothers during the early months following the birth of their babies, a crucial time in maternal transition.

This article reports on a study that examined new mothers' well-being, parenting efficacy, and their use of an existing, publicly funded postnatal health service known as the Newborn and Family Drop-in Service (NAFDIS), a service developed and implemented in regional South East Queensland, Australia (Queensland Health [QH], 2008). The NAFDIS is a community-based service designed to provide continuous and integrated postnatal support. Midwives and child health nurses provide the service in a collaborative partnership model to address the needs of women with young infants from birth to 8 weeks. This model is based on a framework that embeds the importance of early intervention to promote parents' decision making and support for parenting transition in services that share control and engage families as partners in meeting their needs (Hirst, 2005; QH, 2005). In this study, mothers' reasons for accessing this universal service and their perceptions of its usefulness to them during the months following the birth of their babies were investigated.

LITERATURE REVIEW

To support maternal decision making and transition, services need to focus on the challenges faced by women in developing maternal efficacy. These challenges concern their sense of self, their parenting competence, and their ability to form secure attachment with their infants (Salonen et al., 2009). Maternal efficacy, or a mother's belief in her ability to "mother," is a product of a complex dynamic relating to personality, sociocultural factors, and the interplay of formal and informal support (Salonen et al., 2009; Tarkka, 2003). There is strong evidence that links self-efficacy and parenting competence (T. Jones & Prinz, 2005). For instance, through success in taking care of her infant, ongoing breastfeeding, a positive relationship with a partner, and a support network, a mother gains in confidence and therefore competent in infant care (Tarkka, 2003). The importance of the early relationship between

mother and infant (i.e., secure attachment) as an indicator of later child and adult health is accepted (WHO, 2004). Evidence also suggests that it is not only psychosocial well-being that is influenced by secure attachment but also an infant's neurological development, which occurs in response to social and interpersonal processes (Landry, Smith, & Swank, 2006; Nelson & Bloom, 1997; Schore, 2001).

Education, a lynchpin in health service across the childbearing continuum, has been the focus of inquiry for some time for its ability to support maternal decision making, behavior, attachment, and infant health. Svensson, Barclay, and Cooke (2009) confirmed women's interest in exploring baby care and parenting education topics during pregnancy and reinforced the need for parenting education across the continuum. There is evidence that perinatal education can have a positive influence on breastfeeding continuation, parenting self-efficacy, and parenting knowledge, bonding and attachment, and women's attitude and satisfaction (Lin, Chien, Tai, & Lee, 2008; Renfrew, McCormick, Wade, Quinn & Dowswell, 2012; Rosen 2004). However, there is also evidence of limited impact. Gagnon and Sandall (2007), for example, were unable to identify any impact made by antenatal education on parenting ability. More recently, Bryanton and Beck (2010), found some support for education positively influencing infant sleep time and maternal knowledge, but were unable to draw clear conclusions between postnatal education and maternal-infant relationships.

There is evidence linking professional and lay support to prolonged breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2007). Both professional and lay or peer support are considered by parents to be important to clinical and education-based services (Schneider, 2002; Schott, 2002). Women receive information, feedback, and can observe other women in these contexts. Findings from studies of postnatal groups provide evidence that new parents form social networks from these postnatal peer group networks that are a source of support (Barnes, Courtney, Pratt, & Walsh, 2004; Fabian, Rådestad, & Waldenström, 2005; Hanna, Jackson, & Newman, 2002; Rowe & Barnes, 2006). Findings from breastfeeding studies exemplify the influence of these activities on maternal practice. In addition, peer support in group and one-to-one situations has been associated with improved breastfeeding outcomes (Hoddinott, Chalmers, & Pill, 2006a; Hoddinott, Lee, & Pill, 2006b).

Currently in Australia, there is wide variation in perinatal and child health services designed to support the needs of mothers and their families across the continuum. Services vary from state to state and across different health service districts. One study (Homer et al., 2009) identified a lack of mechanisms to support collaboration and communication among maternity and child health services, in turn affecting service efficiency and efficacy. They also identified issues for mothers establishing partnership in the services. A further study examined the impact of an Open Plan Approach (OPA) to service (Australian Catholic University [ACU] & QH, 2007a, 2007b), staffed by child health nurses. Similar health outcomes in terms of breastfeeding rates and maintenance were found when comparing the OPA with an appointment plus group meeting model of service (ACU & QH, 2007a). This evaluation concluded that the OPA approach was effective in supporting low-risk families' needs, but did not provide data concerning peer networking or continuity of services. In a service evaluation study of a multidisciplinary one-stop family care center, support for the continuity of care model was demonstrated (North Lakes and Surrounds Health Partnership Precinct Project [NLSHPPP], 2007). However, although these evaluations provide data about satisfaction with elements of services provided, there was no investigation of maternal efficacy or competence. The investigators identified the need to investigate relationships among formal and informal support, information giving, maternal well-being, and successful transition.

This study examined these issues by exploring the experience of women using the NAFDIS. It aimed to develop a profile of the mothers attending the service in terms of their psychological well-being, maternal efficacy, and sources of social support, as well as to explore their reasons for accessing the service, and its contribution to their maternal experience.

METHODS

The study was undertaken in 2010 using a longitudinal, mixed methods design. This enabled us to develop a profile of women who were accessing the NAFDIS in a post hoc analysis on measures for psychological adjustment, parenting efficacy, and satisfaction with social support available to them. It also enabled us to identify aspects of the NAFDIS that contributed to participants' maternal experience.

Sample

Sampling of women attending the program for the first time was purposive and recruitment was conducted on a convenience basis. Exclusion criteria included women younger than 20 years and women with demonstrable evidence of drug or alcohol dependence or ongoing maternal illness. Each participant was asked to complete two structured surveys, one at the time of their first visit and the second approximately 2–4 weeks after the 8-week service period covered by the program, and to indicate their willingness to take part in an interview. Seventy mothers were recruited into the study on their first visit to the program with their infants. This represented approximately 67% of the eligible population who were approached to take part. Fifty-four women returned surveys at both time points and of those women, 20 took part in a semistructured interview.

Procedure

Ethics clearance for this study was obtained from the institutional human research ethics committee in the relevant health service district as well as the university human research ethics committee. In addition to collecting demographic information that included the participant's age, obstetric history, family/household membership, income, educational attainment, referral source, current infant feeding practice, and infant age at time of attendance, the survey incorporated three standardized measures that have been used in previous research with similar cohorts.

The Parent Expectations Survey (PESP). Maternal efficacy was measured using this 25-item scale (Reece, 1992). Participants are asked how much they agree that they can perform a range of parenting tasks on a 10-point Likert scale. The scale has good internal reliability (alpha 0.86–0.91) and good concurrent and predictive validity. In this study, the Cronbach's alpha coefficient was 0.87–0.93.

The General Health Questionnaire (GHQ). Psychological well-being was measured using this 12-item scale (Goldberg & William, 1988). Participants are asked to describe how often they experience 12 different psychological health symptoms on a 4-point Likert scale. The measure has good reliability and concurrent validity. In this study the Cronbach's alpha coefficient was 0.87.

Family Support Scale (FSS). Social support was measured by the 20-item scale (Dunst, Trivette, & Hamby, 1994) in which the participants are required to indicate the helpfulness of various sources of social support that are available to them on a 5-point Likert scale. This measure has good reliability, with an alpha of 0.79, and test-retest correlation of 0.91 for the total score and 0.75 for individual items.

Participant Interviews. Twenty participants chose to participate in a one-on-one interview that was conducted at the second survey time point, either in person or by telephone. The interview was semistructured and facilitated the collection of additional information about key concepts such as social support, continuity, effectiveness, and value of the professional services used in the early weeks following the birth of their babies as well as about feeding practices. Women were asked about their use of the NAFDIS program, their use of other services, both at the same time and following, and their perceptions of the influence of the NAFDIS on their maternal competence and practices.

Data Analysis

Means, medians, and standard deviations for each of the three standardized tests at both Time 1 and Time 2 were calculated and compared. Where variance was identified, a paired samples *t*-test was conducted with a significance level of $p < .05$. Interview data was analyzed using a descriptive content analysis approach to identify key themes relating to the participants' experiences with NAFDIS. Each de-identified transcript was read and open coded by one member of the research team. Coded data were then collated into categories of information that addressed the responses to key interview questions. These categories or themes were checked for reliability by two other members of the research team who had also examined the transcripts.

RESULTS

Demographics

Demographic results are reported here for participants who completed surveys at both Time 1 and Time 2 (see Table 1). The sample was overrepresented in the 25–29 year group and underrepresented in the 30–34 year groupings in comparison to national and state figures at the time of data collection (Laws & Sullivan, 2009). Most participants identified the existence of protective factors in terms

TABLE 1
Summary of Demographic Characteristics

Variable	<i>n</i> (%) ^a
Mother's age	
20–24 years	8 (15.1)
25–29 years	21 (39.6)
30–34 years	9 (17.0)
35–39 years	13 (24.5)
40+ years	2 (3.8)
Baby age Time 1 data collection	
0–7 days	24 (46.1)
1–2 weeks	16 (30.8)
≤4 weeks	10 (19.2)
5–6 weeks	2 (3.8)
Marital status	
Partner/spouse	50 (94.3)
Single	3 (5.7)
Other children	
Yes	25 (50.9)
No	28 (49.1)
Household income per annum	
≤\$35,000	6 (12.0)
\$35,000–\$65,000	31 (62.0)
>\$65,000	13 (26.0)
Mother's educational attainment	
Secondary	26 (49.1)
Postsecondary technical	11 (20.8)
Tertiary undergraduate	11 (20.8)
Tertiary postgraduate	5 (9.4)

^aThere were 54 surveys returned. One participant did not provide demographic information.

of support from partners, income, and education. The profile of the cohort also suggests good fundamentals for quality early parenting in terms of maternal efficacy and psychological well-being. Just more than half of the participants had other children (numbering 1–4).

Survey Findings

Scores for the GHQ within the sample were well lower than the threshold for psychological distress (15/36); demonstrating participants were experiencing reasonable psychological well-being during the first 2–3 months following the birth of their infant. Although there was a slight improvement in the mean GHQ at Time 2, a paired sample *t*-test revealed that this change was not significant. A detailed examination of the results indicated that 12 (22%) mothers were experiencing some distress and a further 2 (4%) were experiencing significant levels of psychological distress at Time 1. At Time 2, just 3 (6%) mothers were experiencing some distress

and 2 (4%) were demonstrating significant distress. Further examination of the data suggest that the two scores >20 at Time 2 are possibly scoring effects as both women demonstrated excellent parenting efficacy and had a range of social supports that they perceived as helpful. The scoring effects potentially relate to the ambiguous nature of the negative items in the GHQ-12 (Hankins, 2008).

Prior to analysis, data in the PESP were examined and revealed that at Time 1 and Time 2, two items were identified as not available by most participants ($\geq 30\%$) and were therefore removed from the analysis. These items were confidence in decision making about weaning and babysitting. A paired samples *t*-test was conducted and demonstrated a significant difference in mean scores from Time 1 to Time 2 ($t[23] = -4.56, p < .001$). The mean difference in PESP scores was -0.90 with a 95% confidence interval ranging from -1.31 to -0.49 .

Responses to the Family Support Scale (FSS) revealed that support indicated by higher item scores was perceived as helpful or extremely helpful from a small number of sources. Mothers perceived as most helpful the support from their partners and their "kin," that is, their relatives and parents. In each case, the helpfulness of this support was perceived to be less at Time 2 than Time 1. Paired sample *t*-tests were conducted and revealed the following significant changes: perceived helpfulness of kin decreased from Time 1 to Time 2 ($t[26] = 2.6, p < .02$); perceived helpfulness of spouse/partner decreased from Time 1 to Time 2 ($t[47] = 2.9, p < .01$; Table 2). Only the availability of support from General Practice Services (general practitioners [GPs]) and parent groups increased over time but were not statistically significant.

A series of independent sample *t*-tests were conducted and determined that there were no significant differences in general well-being, parenting efficacy, or perceived helpfulness of social support when comparing first-time and experienced mothers. Furthermore, no significant differences were found in well-being or parenting efficacy relating to age.

Breastfeeding support was the most frequently cited motivation for participants to attend the NAFDIS. Breastfeeding initiation rates were excellent and the maintenance of breastfeeding was consistent with national data. Participants were asked at both Time 1 and Time 2 to indicate how they were feeding their infants. A chi-square analysis

TABLE 2
GHQ, PESP, FSS Formal Kins' Scale and Spouse Item Support
Time 1 and Time 2: Means and Standard Deviations

Variable	Cronbach's alpha	Range	Time 1	Time 2
GHQ ^a	0.87	1– 29/36	11.3 (5.84)	10.43 (5.40)
Parental efficacy (PESP) ^{b***}	0.93	5.9–10/10	8.03 (1.20)	8.90 (0.79)
Formal kinship subscale for social support (FSS) ^{c*}	0.78	1–5/5	3.85 (1.08)	3.43 (1.21)
Spouse/partner item for social support (FSS) ^{c**}		2–5/5	4.73 (0.61)	4.23 (1.20)

Note. GHQ = General Health Questionnaire; PESP = Parent Expectations Survey; FSS = Family Support Scale.

^aLow scores indicate better psychological health.

^bLow scores indicate lower levels of efficacy.

^cHigh scores indicate greater helpfulness.

* $p < .01$. ** $p < .02$. *** $p < .001$.

of difference was conducted but there was no significant difference in feeding patterns between first-time and experienced mothers. The results indicate breastfeeding initiation rates for this group are consistent with Australian data (most recent national breastfeeding initiation rates of 96%; Australian Institute of Health and Welfare [AIHW], 2011). However, this data represents *any* breastfeeding that may include supplementary feeds. The more useful comparison is with Queensland perinatal statistics, which indicates that for the program group, the rate of exclusive breastfeeding was higher than the 2008 Queensland rate of 78.8% exclusive breastfeeding on discharge (QH, 2010). The Time 2 rate (see Table 3) is higher than national rates, most recently reported at 39% exclusively breastfeeding at 3 months (AIHW, 2011).

TABLE 3
Feeding Type at Time 2

Feeding Type	Other Children	No Other Children	Total
Breastfeeding $\pm$ EBM	12	16	28
Breastfeeding with breastmilk substitutes	7	4	11
Breastmilk substitutes	5	6	11
Introducing other foods	0	3	3

Note. EBM = expressed breastmilk.

Interview Findings

Continuity. Both first-time and experienced mothers attended the NAFDIS with 49 (92.5%) of the women indicating that they attended following referral by their maternity service provider. Nearly half of the women attended the service for their first postnatal visit within a week of their infant's birth and a further 30% attended within 2 weeks, suggesting good service uptake and thus continuity of professional support for women in this important transition period. When asked to identify their motives for attending the service, and what role or influence on their parenting they perceived it had to play, participants reported that in general terms the NAFDIS fulfilled several roles from specific breastfeeding assistance or getting a blood test done to the provision of support and help. Interview data revealed the following themes:

- Having somewhere to go for conversation or information about their experience. As one participant stated, it was “. . . originally somewhere to go for a bit of support and in the gap prior to home visits starting” (P11).
- Reassurance. As one mother commented, “I had such a great time there last time with the other baby I thought it would be great to have that little bit of backup again” (P34).
- Accessing and sharing information. One participant related her early need for support of this nature:

. . . the first night I came home, I had her home and my milk hadn't come in and it was that night that it came in and she was going quite crazy, feeding all night, and my husband and I, well we probably didn't even sleep that night. We just went, “we're going to the drop in centre in the morning and getting some help.” (P21)

The NAFDIS was perceived as providing an accessible source of information. Both first-time and experienced mothers commented that they had questions to ask and that they valued the quality of the knowledge shared with them. As one mother stated, “Every week I would have things I wanted to know” (P21).

For both first-time and experienced mothers, reassurance was an important aspect of the coaching work undertaken by the staff, particularly having the assurance that all was normal or correct.

Coaching: Breastfeeding Support. Participants described a range of activities that they encountered when they attended the service that went beyond knowledge sharing and did influence the way that they cared for their infants. These included the demonstration of techniques, affirmation or positive reinforcement, helping, and gentle guidance. This theme was reinforced with the responses to questions concerning how the women used the service. For some, time at the center included being helped and shown techniques, including demonstration, and having the chance to stay and “practice” their infant feeding. During the process, the women described being encouraged by the staff, having questions answered, and being helped to “meet goals.” These activities, considered together, can be described as coaching.

The starting point for each participant was a different one, depending on her previous experience and her needs at the time. However, for the experienced mothers, it tended to be about trying to do things a little differently with their new baby, particularly to ensure that breastfeeding would be maintained for longer. As illustrated by one participant who had an 8-week-old infant fully breastfeeding for the first time:

. . . they taught me all, well basically she would be formula fed by now if I hadn't been there . . . they helped heaps, just because you've got that point of reference and then every time you go, all the ladies say the same thing, so you get consistent advice whereas the last two kids that I've had it's just been a multitude of things and I was so confused.” (P48)

For experienced mothers, the nature of the coaching was remedial—or more of a “refresher”:

[I] . . . went twice because of engorgement and early breastfeeding issues . . . to get going—to perfect it and be able to breastfeed as long as I can . . . I was just reminded of the right things to do re: breastfeeding and to avoid mastitis. (P25)

For both first-time and experienced mothers, reassurance was an important aspect of the coaching work undertaken by the staff, particularly having the assurance that all was normal or correct.

The encouragement given by staff helped one woman to bond with her infant, a process that she

believed had been slow because of the problems she had early with breastfeeding:

I feel like I can read her cues and her signs better, interact with her more, that we've bonded. In the beginning [my baby] was having trouble with breastfeeding. I didn't feel a bond with her at all . . . so the first few days [it] was like, I was a fish out of water . . . I didn't know what I was doing. But after a while it got better and then when I eventually did go . . . then things got better as well. (P46)

Control: A Service With Flexibility. This theme was generated from questions that were asked of each participant concerning what they would particularly like to see continued in the NAFDIS and what suggestions they had for change or development to the service. The “drop-in” characteristic was very popular and key to its flexibility. The reasons women gave were associated with the behaviors of their very young infants, and the ability to take the baby when the need was evident or when the baby was awake, “because you can go, drop in any time . . . the other center . . . if you want to make an appointment you have to make one at a certain time . . .” (P17). As another participant stated,

Yes, because in that early age you don't know when they're going to sleep and if you had an appointment say at 1 p.m. and all of a sudden she's fallen asleep, you don't particularly want to wake her up and take her over there, so it's good to go, “she's awake, let's go.” (P21)

Flexibility was also at the heart of some of the suggestions for changes that could be made or ways the service could be developed. The comments concerned extension of the service in a range of dimensions such as time of day and locations, so as to provide even more flexibility.

Moving on From the Service

This theme relates to discussion generated from questions about what services women might be using after they moved on from the NAFDIS. The transition at the end of the provision of the NAFDIS service could be a significant change because women moved away from service providers whom they trusted and valued. A couple of women appeared not to be sure about what was available. As one woman put it, “I've got to go somewhere else now

and I've got no information about where I'm supposed to go” (P32). From the discussion, there were four contexts that depicted where women might go with their infants. The first reflected “a no set plan” option. In addition, participants identified midwives working for chemists, GPs, as well as publicly funded child health services including home visiting programs.

DISCUSSION

The study set out to examine aspects of maternal transition of women attending a community-based, open access, drop-in postnatal service and to understand how that service was used, and might contribute to maternal support and transition. The participants in this study would be considered to be low-risk parents based on their demographic profile. An interaction among risk and protective factors is thought to influence a child's health and well-being in their early years (Barnes & Rowe, 2013). Furthermore, the findings revealed that overall the women did not exhibit high rates of psychological distress. This was matched with good maternal efficacy that demonstrated a positive trend between the first and second survey points. Given the association between maternal efficacy, parenting competence (T. Jones & Prinz, 2005; Salonen et al., 2009), and responsive parenting (Gondoli & Silverberg, 1997), this is a protective factor for families in this study.

The interview data provided insight into how the service was functioning to support women's transition through birth, the postnatal period, and into the early months of parenting. The results demonstrate good service uptake and therefore continuity of professional support for both first-time and experienced mothers in this important transition period.

The participants reported helpful or extremely helpful support from their spouse or partner and, where they were available, from their kin (i.e., their parents and relatives). Not surprisingly, women with their first child perceived that they had greater support from their parents and relatives than those with other children. By the time their infants were 2–3 months of age, mothers were reporting these sources were perceived as less helpful. At this time more women identified GPs, other parents, and parenting groups as available sources of support. These findings support evidence that maternal efficacy and competence are enhanced in environments where

women have good support (Leahy-Warren, McCarthy, & Corcoran, 2009).

The interview data suggested that the service provided women with not only informational support but also emotional support in the form of conversation and reassurance. It also was a place to go for women with specific needs or problems. Leahy-Warren et al. (2009) identified the importance of social support and its positive impact on maternal efficacy, particularly for first-time mothers, and recommended the facilitation of peer support forums where mothers can share experiences. In this study, experienced mothers identified that they were motivated to attend as part of a preventive strategy; that is, to avoid problems they had previously experienced. The range of motivations for attending the service speaks to the client-centered focus of the service, a feature that also enhances continuity.

The emphasis placed on hands-on practical support for breastfeeding is a key element of the practice approach taken by the midwives and nurses in the service that appeared to support mothers' needs and effectively promoted maternal and infant health and well-being. The successful completion of tasks or mastery is thought to contribute to strong self-efficacy (Bandura, 1997; Freeman, 2006). Mastery is achieved through a range of activities including repeating a task and accessing resources. The coaching quality of the support provided by staff to mothers and reported in the interview findings typifies the process of mastery. This activity conducted in the context of woman-identified need and schedule, we argue, may contribute to maternal efficacy. This, in turn, promises to promote attachment between mother and infant and also to promote practices such as sustained breastfeeding, which optimize infant health.

The drop-in system, along with its accessibility, being open across a wide range of opening hours in the working week creates a time frame that is client centered. Women in this study perceived that they could take action in the context of their everyday experience and the needs that arose for them. Together with the early presentation with their newborns, this was a strength of the service.

The exit point from the service is an important issue. The service is available for 8 weeks post birth. This exit or transition point came at a time when women's confidence with their parenting was increasing, and also when breastfeeding appeared

to be decreasing and the social supports available to women and their usefulness were changing and decreasing. A seamless transition from maternity to child health services is an important issue (Homer et al., 2009). The NAFDIS appeared to be facilitating continuity in the postnatal and early weeks period, but a further transition was required. Women were managing this in various ways; the question remains whether their parenting continued to be sufficiently supported. These findings suggest that there are issues similar to those found by Homer et al. (2009) regarding communication between maternity and child health services that may negatively affect service continuity through infancy. Home visiting programs and child health services offer support through this period, but women need to connect with these services. Furthermore, the potential to provide support for women to maintain breastfeeding to 6 months may well be linked to service continuity, and the outcomes suggest a need to consider the timing and process for transition for women from the service at 8 weeks.

Limitations

This study had several limitations that need to be taken into consideration. The use of the FSS as a measure of social support was limited because it does not provide a clear indication of overall level of support but rather the perceived helpfulness of support from a range of sources. Furthermore, the usefulness of the FSS scale in research in the context of early parenting is limited because of the number of items identified as unavailable, a problem that has been encountered in other recent research (L. Jones, Rowe, & Becker, 2009; Rowe & Jones, 2010). Further work is needed to develop appropriate measures in early parenting contexts.

The researchers suspect that a level of error occurred in participant scoring for the GHQ, particularly at Time 2. Because the GHQ contains six questions that are negatively phrased, it has been suggested that this introduces some ambiguity and response error (Hankins, 2008). In this study, this may have affected scores relating to the threshold for psychological distress. To counteract this, participants with GHQ scores that indicated a level of psychological distress had their scores for both social support and maternal efficacy examined. Looked at together, it would appear that ambiguity indeed did impact GHQ scores for a few participants; however, using the measures in tandem

provides confidence in the overall profile for this cohort.

The questions relating to infant feeding were ambiguous in two ways. The figure reported for fully breastfeeding in the sample at Time 1 is $n = 44$ (86.3%). Women could choose between two items: fully breastfeeding and breastfeeding with complementary expressed breastmilk (EBM). The response rate of $n = 11$ (21.6%) indicating breastfeeding with complementary EBM was curious given the young age of the infants when women were presenting and completing the survey. It is most likely a function of the way participants interpreted the option in the question; that is, that because they had been taught how to hand express, they indicated this option rather than fully breastfed. New mothers are taught hand expressing prior to discharge as part of the breastfeeding promotion strategy. After checking about regular practice and presentations, there is no evidence of regular complementary feeding for these young infants. Thus we have reasonable confidence in the figure reported for fully breastfed infants at Time 1.

Implications for Practice

This study has highlighted the usefulness of an open access, drop-in, community-based postnatal service because it supported the maternal transition of women with young infants. The women accessing the service were both first-time and experienced mothers, and their reasons for attending were varied. The importance of hands-on assistance or coaching, and good quality information on breastfeeding and other infant care practices, was clear. This type of service appears to enhance service continuity from maternity services following birth, in a community context and in a client-centered manner that facilitates women's ability to control the how, why, and when for seeking support. However, transition away from a service when infants are 2–3 months of age is an area that requires further investigation to ensure the provision of services that provide continuous and integrated family-centered care and support.

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JENNIFER ROWE is an experienced nurse academic. Drawing on her postgraduate qualifications in sociology, Jennifer's research focuses on maternal and family transition in a range of community and preterm contexts. She researches in close collaboration with midwifery colleagues and industry practitioners and partners. MARGARET BARNES is an experienced and influential academic and midwife. Margaret's research interests center on midwifery and maternal and child health, specifically the transition to motherhood and breastfeeding promotion. STEPHANIE SUTHERNS is the former Director of Maternity and Children's Services in The Sunshine Coast Hospital and Health Service in Queensland, Australia.