NURSES’ ATTITUDES AND EXPERIENCES WORKING WITH WOMEN RECEIVING METHADONE MAINTENANCE THERAPY IN THE POSTNATAL PERIOD

by

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Abstract

When working with women and infants on methadone maintenance treatment (MMT), obstetrical nurses may encounter an array of challenges concerning preparation, assessment, workload, and fostering a positive relationship with patient families. Obstetrical nurses also have distinct ways in which they work with each woman to build rapport and provide quality, safe, and effective care. Many research studies have focused on how nurses’ attitudes toward addiction and substances use impacts the quality of care provided, but few studies have explored the experiences of obstetrical nurses caring for women on MMT. This study addresses this knowledge gap, providing insight into how obstetrical nurses provide health care to women and infants on MMT.

The findings indicated that most participants drew on personal ideals about mothering, a collaborative team approach, and a non-judgmental attitude to meet the needs of the families on MMT. That said, most participants also recognized their lack of education surrounding MMT and how this impacted the care they provided. Many participants also reported difficulty establishing a positive relationship due to structural constraints - such as workload and staffing - which affected the time required to provide effective bedside care. Finally, this study highlights opportunities to learn how to increase understanding of nurses’ experiences working with women on MMT.
Preface

This master’s thesis is an original, unpublished, independent work by the author, E. Dell.

This research study was approved by the University of British Columbia’s Research Ethics Board [certificate #H12-03721] as well as Interior Health Authority Research Ethics Board [certificate#2013-14-005-E].
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Chapter 1: Introduction

Nurses working in women’s healthcare are in a privileged position to help support and guide women through the transition of becoming a new mother. However, not all new mothers need the same types of care. The needs of new mothers who have a history of substance use and are now receiving methadone maintenance treatment (MMT) may be different from those of other postnatal women not on MMT (Dowdell, Fenwick, Bartu, & Sharp, 2007). This research focuses on nurses’ experiences caring for women receiving MMT. In this Chapter, I will introduce MMT, provide background information about nurses’ experiences working with MMT, provide my problem statement and its significance to nursing, and present my research question.

Hartwig, Haasen, Reimer, Garbe, Lichtermann, Wuellenweber & Dilg (2008) stated that MMT is considered the treatment of choice for women who are using opioids during the prenatal period, as it replaces the opioid, stabilizes the mother, and enables a level of prenatal care that has been found to result in higher gestational age and birth weight, greater success in breastfeeding, and less separation of mothers from their infants. Moreover, Abrahams, MacKay-Dunn, Nevmerjitskaia, MacRae, Payne & Hodgson (2010) provided evidence that only 6.7% of women actually stop street drug use in the first three months prenatally, with a high recurrence of drug use in the early postnatal period, evidence which supports the use of MMT.

As discussed further in Chapter Two, for women with a history of opioid misuse, MMT is an important method of harm reduction, an approach defined by the B.C. Ministry of Health (2005) as “Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use” (p.4). Women using this harm
reduction method rely extensively on healthcare, including inpatient hospital wards, for specialized care and support for themselves, their infants, and their families during this life transition. However, as Dowdell et al. (2007) described, caring for this population of postnatal women is often challenging. Women receiving MMT who have a history of substance use often feel isolated, have the tendency to withdraw from potential supports, and/or avoid developing nurturing relationships with health care professionals. Greaves, Pederson, Varcoe, Poole, Morrow, Johnson & Irwin (2004) also described challenges that health care providers face when working with women on MMT. They have discussed an interrelatedness of multiple health determinants such as poverty, mental illness, violence, and substance use, asserting that it is “vital that health care practitioners listen for what and how discourses are shaping the experiences of particular women in their particular situations and locations” (p.21). Maquire (2013) reported that women on MMT have less tolerance and ability to adapt to opioids; they also often have depression or other mood disorders. Psychologically, they have low self-esteem, unresolved grief or anger, and family conflict; environmentally, they have easier access to drugs through either peers or family members (p.12). Jambert-Gray, Lucas, and Hall (2009) described women on MMT as hostile and fearful and often coming from multi-generational drug using families where they have lacked positive role modeling. Moreover, such women may be isolated, more likely to have experienced foster care, and possibly clinically dependent. They have a higher incidence of physical, emotional and sexual abuse and have psychiatric co-morbidity with “…75-90% rates of depression and other mood disorders” (p.654).

Nurses have an opportunity to make a difference for these women; however, Norman (2001) noted that nurses’ attitudes might be preventing appropriate care being provided to these women and their families. When providing care to a mother who is receiving MMT, nurses may
sometimes react in a way that compromises care. Jambert-Gray et al. (2009) discussed the reluctance of women with a history of drug use – which includes those on MMT - to engage with health care professionals; this is understood as primarily owing to the fear of stigmatization and hostility arising from the nurses’ personal views about women receiving MMT, their negative stance regarding the MMT, and their lack of knowledge and understanding of issues involved in MMT. Research has portrayed the dominant attitude of nurses towards mothers receiving MMT as generally negative and judgmental and has shown that when empathy is low or is not apparent, some of the women may readily disengage (Jambert-Gray et al., 2009). Examining nurses’ experiences of providing care to women who receive MMT during the postnatal period may help to positively influence maternity services in acute care.

**Background**

There are a myriad of influences that impact the quality of care given by nurses. One such influence is therapeutic attitude, which is “a measure of nurses’ engagement with the patient” (Ford, Bammer, & Becker, 2009, p.112); this engagement is influenced by a number of factors, including nurses’ beliefs, values, and assumptions. In dealing with women on MMT, therapeutic attitude is wrapped up with beliefs, values, and assumptions not just of MMT but of opioid misuse and, more generally, “illicit” substance use, including the opioids such as heroin that many women on MMT have depended on. Boyd and Marcellus (2007) demonstrated that traditionally, programs created for women with a history of substance use in the prenatal period have been found to be inappropriate for many women. Due to the stigma associated with substance use, some women remain isolated and fearful of engaging with health care professionals, which ultimately can impact the provider-patient relationship and the care provided. This is further complicated by the ineffectiveness of mainstream hospital policy and
procedures for this particular client group. One successful program that is specific to women, however, is the Families in Recovery (Fir) Square Combined Care Unit located in BC Women’s Hospital (BCWH) in Vancouver.

Fir Square is the first unit of its kind in Canada to provide care, including detoxification and stabilization, for pregnant and postnatal substance-using women. Support for rooming in with infants is also provided (Abrahams et al., 2010). The rooming in of substance-exposed newborns has been demonstrated to have multiple benefits to mother and infant dyads, including a significant decrease in neonatal admissions to the NICU, increased likelihood of breastfeeding, and fewer withdrawal symptoms in the baby (Abrahams et al., 2010). This kind of support fosters health and well-being in mothers, infants, their families, and the community as a whole. Because an infant’s well-being is in large part dependent on the mother’s well-being, finding a way of providing safe, competent programs in a non-judgmental environment is of vital importance for nursing.

However, the environment at Fir Square is somewhat anomalous. In my work as the staff educator during the development of a specialized program for postnatal women receiving MMT, significant challenges were posed by the attitudes of some nurses in the development and provision of care towards mothers receiving MMT; these attitudes reflect current social discourses related to both illicit substance use and MMT. During this time, it came to my attention that there was a need to understand nurses’ attitudes towards women receiving MMT and factors that challenge and support the development of therapeutic attitudes. It is difficult to develop strategies that foster safe and effective programs with good outcomes for mothers, their infants, families, and communities without this knowledge.
Harm reduction programs such as MMT “open up opportunities for promoting the health of individuals who are often stigmatized” (Smye, Browne, Varcoe, & Josewski, 2011, p.1). To engage successfully in this harm reduction approach, Ford et al. (2009) stated that “nurses need the knowledge and skills to undertake thorough patient assessment, to engage in behavioral management techniques, to understand specific sedation strategies and to assess for, and respond to serious medical complications” (p.113). The nurse at the bedside is in a position to build rapport with the woman and initiate health promotion strategies, such as health education and parenting guidance and support. However, the care required for women who are receiving MMT during the postnatal period can be incrementally complex and challenging. Therefore, in addition to knowledge of MMT, obstetrical nurses need to be aware of the effects of drugs during the birthing continuum, including the effects methadone may have on the infant, specifically signs and symptoms of drug withdrawal (Happell & Taylor, 2001). Because nurses sometimes carry negative attitudes related to MMT during the postnatal period that can impact care and a patient’s willingness to receive it, understanding nurses’ attitudes and what influences those attitudes is crucial in this area of practice. Integral to this is gaining an understanding of what challenges and fosters the ability of the nurse to develop a therapeutic alliance with the mother.

**Problem Statement and Significance**

Providing effective care to postnatal women receiving MMT is challenging for a variety of reasons. Added to the multiple health determinants described by Greaves et al. (2004), including poverty, violence, mental illness, and substance use, and the issues described by Jambert-Gray et al. (2009), including patient hostility and fear, lack of positive role modeling, isolation, and trauma, effective care may be compromised by lack of health care providers’
knowledge related to MMT in pregnancy, lack of management support, and limited practice and policy standards (Ford, Bammer & Becker, 2008; Ford et al., 2009; Happell et al., 2001; Norman, 2001). Ford et al. (2009) stated that 80-90% of education programs designed for nurses have no impact on actual clinical behaviours of workers. They also noted that strategies and programs are more effective in the presence of positive contextual factors such as staff cohesion and communication. Moreover, it is important to provide nurses with resources to develop, sustain, and enhance programs that support and guide postnatal women receiving MMT into healthy relationships with their infants, such as rooming in. Go, Dykeman, Santos & Muxlow (2010) also discussed specific needs of women, describing these as an increased need to be assessed for psychological effects that often accompanies substance use. They stated that by “…combining psychological interventions and pharmacologic interventions, such as methadone, complete MMT treatment and improve overall health” (p.24).

However, there is a paucity of research regarding those factors that challenge and support the development of nurses’ therapeutic attitudes when caring for postnatal women who are receiving MMT in a clinical setting. In addition, to date, interventions to support the rooming in of infants with their mothers who are receiving MMT have been only moderately successful, as reflected in nurse and patient satisfaction surveys, the number of babies that have ended up in the neonatal intensive care for withdrawal management, and/or the number of foster care placements for the infants involved (Christine Moffitt, Clinical Obstetrics Educator, personal communication, 2012).

According to Ford et al. (2008), research has consistently found that nurses’ attitudes and lack of knowledge about MMT affect clinical management of patient problems, specifically pregnant women, birthing mothers, and their newborns. A review of the literature also identified
that there is a limited amount of research in this area. This was substantiated by my inability to find many articles specific to nurses’ attitudes and experiences caring for postnatal women who are receiving MMT to overcome opioid use. In addition, although there are many reviews and studies related to women and methadone maintenance therapy, there is a paucity of research from the perspective of nurses in this area. Without the consideration of the nurses’ attitudes and perspectives when developing new programs, our understanding of the central issues for workforce development is limited (Ford et al., 2008).

Research in this area is required to inform strategies to support the improvement of the relationships between nurses and postnatal women receiving MMT. To help address this issue, the purpose of my research is to examine obstetrical nurses’ attitudes towards and experiences of providing care in the acute care setting to postnatal women who are receiving MMT. It is my hope that this research may inform the development of safe and effective programs for perinatal and postnatal families in this group.

Research Questions

Given the importance of this issue and the lack of research in this area, the main research question guiding my research was “what are the attitudes and experiences of obstetrical nurses working with women who are receiving MMT in acute care settings during the postnatal period?”

In Chapter One, I provided background information to the issue, the problem statement and significance of the issue, as well as my research question. In Chapter Two, I present a detailed literature review where I discuss current evidenced-based information around MMT. Then in Chapter Three, I discuss my research design and implementation of my research as well
as ethics and the limitations to my research. In Chapter Four, I present my findings from the interviews with nurses who work with women on MMT. Lastly, in Chapter Five, I discuss my overall findings, connect them to the existing literature, and end with a summary of recommendations that surfaced based on the research findings.
Chapter 2: Review of the Literature

Introduction

In this chapter I will present research that outlines and illuminates the multifaceted, complex factors that foster, enhance, and prevent the provision of postnatal care for women on MMT. First I will describe how I uncovered evidence and found current relevant research in a review of the literature. I will then present the literature surrounding postnatal nursing in the current health care system, discuss MMT in the postnatal period, provide current research on stigma and how this impacts the provision of care, as well as explore nursing care through a critical social theory lens.

To perform an effective search that provided me with the most useful and relevant information, I decided that I would only include research that was specific to acute care nurses working in the labor and delivery room, neonatal intensive care, and postnatal units. I limited my search to articles that were peer-reviewed to ensure quality, where the abstract and full texts were available to access. I searched using particular data bases such as Cochrane Library, EBSCO, CINAHL, MEDLINE and PsycINFO using Boolean phrases. I searched articles from 2004 to the present to ensure the information was current. I searched articles written in English specific to North American culture so that the information collected could better represent the population I was researching.

I used both the Cochrane Library and EBSCO since they both offered a collection of separate databases. These reviews focused on health care interventions and provided me with research relevant to postnatal women and MMT. I searched CINAHL, MEDLINE and psycINFO to access resources specific to nursing and allied health literature, current information from a
medical perspective, and aspects of psychology and addictions. Key words included “postpartum”, “postnatal”, “nurse”, “methadone”, “illicit drug use”, “harm reduction”, “education” and “preparation.”

**Postnatal Nursing in the Current Healthcare Environment**

During the past three decades, postnatal care has changed due to several factors, including an increase in the number of women with comorbid conditions as well as women with substance use issues and the associated medical complications (Simpson, Lyndon, Wilson & Ruhl, 2012). Therefore, as Ford et al. (2009) noted, “[n]ursing workforce development needs to focus on strategies that provide role support for nurses as they work with challenging patient groups” (p.112), which includes many mothers on MMT. Interactions between mothers on MMT and nurses are shaped by the sensitivity of the nurses, the extent to which patient anxieties and concerns are addressed, nurse workload (how much time they have to provide the kind of care required), and whether advice is offered and helpful to the families (Forster, McLachlan, Yelland, Rayner, Lumley & Davey, 2006). These factors impact how care is organized and provided to new mothers and their infants.

Staffing, workload, and time management are significant, complex issues that have a major impact on the provision of care to postnatal families. Forster et al. (2006) noted that the way in which care is structured and organized impacts the number and type of staff required to provide safe, quality care to women and their infants. When nurses are faced with postnatal families that may have more complex needs, such as women on MMT, the quality of postnatal care is interconnected with these organizational structures. Currently, the nurses informal process of deciding patient to nurse ratios are adjusted and modified based on the acuity and needs of the dyad (Raby, Dows & Bennet, 2008). This informal decision-making process, which
affects maternal and infant health outcomes as well as the provision of care, needs to be addressed by policy makers (Forster et al., 2006).

Organizational decision-making processes that consider issues such as nurses’ work has been discussed by Bick, Rose, Weavers, Wray and Beake (2011). They stated that “[t]he core of quality improvement initiatives is recognizing the need to improve women’s experiences through [the process of] giving birth to transitioning home” (p.6). Improved access to quality treatment for postnatal substance-using women is enhanced by workplace development where the nurses themselves set priorities for action (Ford et al., 2009).

Opioid use during pregnancy has increased over the past decade; Savage and Platt (2014) noted that from 2000-2009 maternal opioid use increased from 1.2 percent to 5.6 percent per 1,000 births. In response, hospital processes have changed over the past decade to try and meet health care needs of such families (Duffield, Gardner & Catling-Paull, 2008). Some of these changes have impacted the work that nurses do, including how they use their time and skills (Duffield et al., p.3269). Nurses play an important role in patient safety, care, and support, and as the complexity of postnatal families increases so does the need for identifying the core elements of nursing work (Duffield et al., 2008). Caring for women on MMT is multifaceted, and to assist nurses working along the continuum of postnatal care, it is necessary to consider nurses’ workload, time management, and structural guidelines (Savage et al., 2014).

**Methadone Maintenance Treatment (MMT) and the Postnatal Period**

The literature presents ample evidence that nurses struggle with and have demonstrated concern about their ability to care for postnatal women with a history of substance use (Maguire, 2014; Jambert-Gray et al., 2009; Cleveland & Gill, 2013). Workplace support, education, and
applicable skill sets are clearly not enough. The literature demonstrates that nurses who work with women on MMT need to use a harm reduction approach to provide non-judgmental, client-centered care (Registered Nurses Association of Ontario [RNAO], 2009). Smye et al. (2011) stated that “the complexity of issues that shape practices and policies related to MMT are best understood using this harm reduction approach” (p. 4). As noted in the RNAO (2009) clinical practice guidelines regarding MMT, “[t]he principles of harm reduction were developed to reduce societal consequences and health related harms associated with particular activities or behaviors such as substance misuse” (p.18). Harm reduction includes a variety of strategies and programs that nurses can draw on, and nurses who use this approach effectively are more likely to foster a relationship that is collaborative and client-focused (RNAO, 2009).

Opioid substitution programs such as MMT follow the principles of harm reduction by providing an alternative to a patient’s opioid choice that has less risk associated with its use (RNAO, 2009). As Clearly, Reynolds, Eogan, O’Connell, Fahey, Gallagher, Clarke, White, McDermott, O’Sullivan, Carmody, Gleeson & Murphy (2012) stated, “[m]ethadone is the current treatment for opioid dependent pregnant women” (p. 762). Maguire (2014) noted that women on MMT access more prenatal care and their babies have better weight gain and birth outcomes compared to those that do not receive MMT (p.14). He attributed this to the pathophysiology of methadone; methadone prevents the “onset of withdrawal symptoms, eliminates drug cravings, and blocks the euphoric effects of illicit self-administered narcotics” (Maguire, 2014, p. 14). Using MMT as a harm reduction approach provides a framework that recognizes that opioid misuse in postnatal women occurs and will continue to occur (RNAO, 2009). In addition, guidelines that provide a philosophy for nurses working with women on MMT assist in the development of a comprehensive understanding of substance use and
methadone, which enhances the ability of nurses to provide holistic care\(^1\) to this population of women.

The specialized body of knowledge required to care for women on MMT helps to reduce risks that mothers and infants exposed to methadone experience. As Shainker, Saia, and Lee-Parritz (2012) noted, “[o]pioid dependence in pregnancy carries clear identifiable maternal and fetal risk” (p.817). The holistic care that nurses provide needs to encompass a vast amount of knowledge regarding substance use, MMT, clients attitudes, and the treatment process, as well as the ability to assess withdrawal in both mom and baby, psychological factors, and appropriate dosage of methadone (Go et al., 2011).

Although there is evidence that individuals involved in MMT experience positive benefits from treatment (Wilson, McIntosh & Getty, 2007), Go et al. (2011) stated that “persons enrolled in MMT programs often receive insufficient care and support from health care professionals” (p.18). To provide effective comprehensive care it is important for nurses to have a comprehensive understanding of MMT in the pre and postnatal periods and the particular associated needs of moms and infants and to have ongoing opportunities for education and further development of clinical practice (Go et al., 2011; RNAO, 2009).

Attention to particular needs of postnatal women on MMT and their infants includes, for example, understanding the appropriate dose of methadone and the timing of administration (Shainker et al., 2012). According to Shainker et al. (2012), most experts currently advocate for

\(^1\) A system of care that encompasses physical, emotional, social, and spiritual needs.
once-daily administration of methadone (p.821). In contrast, Bogen, Perel, Helsel, Hanusa, Romkes, Nukui, Friedman & Wisner (2013) have provided evidence that, considering the shorter half-life and larger clearances of methadone in postnatal women, many patients would benefit from split dosing and having their dosage lowered rapidly after delivery of baby (p. 441). Adjustment of methadone dosage in postnatal women is crucial to maternal health and function (Bogen et al., 2013). For example, during the initial postnatal period, women on MMT are often described by nurses as nodding off, oversedated, or sleepy. Bogen et al. (2013) stated that “higher than necessary doses may lead to tolerance, over-sedation, increased risk for overdose, and may interact with medications” (p.448). Nurses who are educated about these kinds of issues particular to women on MMT and who have, as a result, the skills necessary to assess for the appropriate dosage of methadone, are more likely to facilitate care that is safe, effective, and non-judgmental (Go et al., 2011).

Another important example that supports the need for nurses to have specialized education in this domain of practice is related to pain management. Tolerance to opioids impacts adequate pain control in women who have a history of opioid addiction (Shainker et al., 2012). Shainker et al. (2012) noted that there is “70% greater opioid need in post-cesarean delivery patients on methadone compared to nonmethadone patients” (p.823). However, in their study, Liberto and Fornili (2013) found that it was not uncommon for health care providers who administer opioids to women with a history of substance use to express the fear that they are increasing the risk for abuse through opioid use, a factor that has been seen to lead to inadequate pain management for persons on MMT (p.34). In regards to pain control in postnatal women on MMT, Shainker et al. (2012) stated that “postpartum analgesia should be tailored accordingly to achieve optimal level of pain control” and recommended the continuation of methadone, in
addition to a combination of oral opioids, acetaminophen, and nonsteroidal anti-inflammatories during the postnatal period as appropriate (p.823). Postnatal pain control in women on MMT is complicated but achievable; nurses need to tailor pain medication options to fit with individual patient need to foster a supportive environment where they can safely learn and participate in taking care of their infants. However, provider attitudes associated with societal views on substance use may challenge their ability to provide effective, non-judgmental approaches to care.

**Stigma**

Addiction is defined by Maguire (2013) as

the harmful or hazardous use of psychoactive substances that lead to a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes physical withdrawal state (p.12).

In their research, Chandler, Whittaker, Cunningham-Burley, Williams, Nigel, McGorman & Mathews (2013) found the challenges health professionals face when working with families on MMT to be related to the physiological effects of opioid dependence, structural constraints associated with treatment regimes, and the negative societal views about drug-using parents (p. 40). Nurses who have the knowledge to recognize addiction as a disease and understand the physiological effects of opioid dependence as well as the contextual factors that shape substance
use and how it is addressed in treatment programs and in society at large will be better prepared to provide care.

Stigma is defined by the Canadian Nurses Association (CNA) (2011) as “an outcome of social processes in which the person is marked as different or other on the basis of negative characteristics that result in social devaluing and spoiled identities” (p. 10). Social stigma is also defined by Bartlett, Brown, Shattell, Wright & Lewallen (2013) as a severe social disapproval of personal characteristics or beliefs that are against cultural norms (p.350). Patients with a history of addiction represent a vulnerable population and are frequently the recipients of social disapproval (Chu & Galang, 2013, p. 33). Social discourses that shape negative views about individuals that use substances have been noted in the literature to be related to a lack of knowledge about addiction, lack of understanding of substitution therapy such as MMT, as well as organizational constraints that shape negative attitudes and stigmatizing workplace discourses (Chandler et al., 2013; Olson & Sharfstein, 2014). Addiction is an emotional topic for health care providers. According to Bartlett et al. (2013), nurses (and other providers) take up the social discourses associated with addiction; stigma and discrimination are a consequence – sometimes reflected in the care they provide to patients on MMT. A lack of understanding of addiction and the inability to recognize addiction as a medical illness is overshadowed by the fallacy that addiction is a moral failing or a conscious choice (Bartlett et al., 2013).

Olson et al. (2014) described three consequences within healthcare that occur as result of the stigma associated with opioid use and its treatment (including MMT): a lack of understanding of addiction, ineffective treatments, and a lack of holistic care associated with a failure to recognize the diverse emotional, physical, and psychological needs of this population. In addition, Olson et al. (2014) noted that nurses often share the misconception that recovery
depends solely on abstinence. They discuss language used by nurses such as “clean” or “dirty”, which imply that treatment programs involving opioid substitution or the use of medications do not constitute being in recovery (p.1394).

Methadone is often an effective substitute treatment for women with a history of opioid addiction but it does not directly impact complex emotional and psychological needs. Women on MMT often come from disadvantaged circumstances where the layers of addiction are multifaceted. Olson et al. (2014) noted that often the focus of treatment with MMT is on medication administration, leaving other important issues unaddressed; as they stated, MMT “may cover only the most basic service, however, these women may need more counseling and care management” (p.1394). The failure to provide a supportive environment and collaborative team approaches to facilitate and enhance engagement of women in need of drug treatment services is often grounded in a lack of understanding related to MMT and/or addiction and substance use.

As noted above, nurses are not impervious to stereotyping and stigmatizing attitude, and because they play a vital role in the provision of service to women on MMT, workplace provisions/education such as the implementation of best practice guidelines are an important element of support within healthcare settings; this will enable nurses to effectively respond to, engage with, and inform families affected by addiction or substance use (Radcliffe, 2011, p. 505). The stigma and discrimination associated with addiction, substance use, and MMT needs to be seen and addressed.
Critical Social Theory

The values and traditions of nursing have related to the care of patients and being able to comprehend their lived subjective experiences (Sumner, 2010a). Acute care facilities are structured with rigid routines, and often social discourses taken up within the workplace further inhibit and constrain nurses in the provision of holistic care (Sumner, 2010a). According to Wilson-Thomas (1995), as cited in Marcellus (2003), nurse researchers began viewing critical social theory as a potential means for creating ways of knowing and understanding relationships within a social reality (p.442). Critical social theory (CST) is defined by Sumner (2010a) as a “methodology that enables the researcher to examine the pressures and constraints in any society” (p.17). Manias and Street (2000), as cited in Marcellus (2003) further describe CST as not one single theory, but rather as an interdisciplinary school of thought which seeks to explore phenomena through examining the contextual effects of power, knowledge, and values (p.441).

The goal of CST as a method of analysis is to try to understand both the historical context and the current social context (Marcellus, 2003). Sumner & Danielson (2007) encouraged the use of CST as a tool to explore caring in nursing, to question what is taken for granted, and to explore unchallenged norms as well as what works and what does not (p. 30). They further stated that using CST as a lens creates “an opportunity to probe for systemic suppression, for identifying the power structures in the health delivery system, and to identify those voices, which are silenced or marginalized” (p. 30). Using CST as a method also aids researchers in recognizing and acknowledging their own biases coming into the research. As Sumner (2010b) noted, the use of CST facilitates a reflective consciousness by “alerting one to one’s own values and beliefs, and those of the society in which one lives” (p.160). Alvesson and Skoldberg (2000) described three aspects to CST which they refer to as “triple hermeneutics” (p.20, as cited in
Sumner, 2010a and Sumner & Danielson, 2007, p.32): i) individuals interpretation of themselves and their reality and what it means to them; ii) the researcher’s interpretation of the reality; and iii) a critical analysis of this interpretation, ideologies, power within relationships, and expressions of dominance (p.160). This theoretical perspective guide the researcher into a deep reflection and a “meticulous interpretation and theoretical reasoning” (p.160).

A CST perspective offers a “means to question power in social relationships, whom power includes, and equally whom it excludes” (Sumner & Danielson, 2007, p.30). The patient and nurse roles have an inherent power imbalance because the patient is seeking support or guidance from the nurse and the nurse has the power of knowledge. When the nurse-patient relationship is explored through a CST lens, there is an acknowledgment of this power inequity and an effort to address it (Marcellus, 2003; Sumner, 2010a; Sumner & Danielson, 2007). Sumner (2010b) illustrated that this process facilitates “the examination of power controls that lead to oppression and injustice, within a broader framework of historical, societal and economic forces with political pressures readily acknowledged as part of unequal relationships” (p.161). It is an expectation of the professional nurse to be caring, empathetic, as well as highly knowledgeable and skilled. CST as a method can facilitate reflective questioning by nurses about the reality of nursing practice and whether they are meeting patient need (Sumner & Danielson, 2007). CST directs us to understand patients’ lived experience both historically and presently, as well as to examine societal forces that increase and/or reduce vulnerabilities for patients (Marcellus, 2003; Sumner, 2010a; Sumner & Danielson, 2007).
Chapter 3: Research Design and Implementation

Introduction

In this chapter I describe the study design, discuss data collection methods, explain the sampling and recruitment process, and describe data analysis. In this chapter I also present ethical considerations and discuss the scientific credibility of the study, drawing on how I ensured reliability, validity, and rigour.

Eakin, Robertson, Poland, Coburn and Edwards (1996) have stated that “[t]heories or perspectives in science bring with them often hidden, or at least unacknowledged, assumptions of how society functions” (p.158). My research is influenced by a critical social science perspective whereby the researcher continually works to reflect on his or her assumptions, beliefs, values, and practices during the research process using the process of reflectivity, particularly where the researcher focuses on particular relations of power, research assumptions, contradictions, and dialectic relationships (Eakin et al., 1996). The value of using a critical social science lens is that it posits the ideological and therefore political nature of human knowledge (Eakin et al., p.163). In this study, I examined the attitudes and experiences of nurses working with women on MMT during the postnatal period in an acute care setting to inform strategies for building positive nurse-patient alliances and a successful postnatal program.

In addition, an interpretive design, as discussed by Thorne (2008), was employed. The use of this type of design pushes the researcher to engage with the knowledge-generation and action-oriented goals of qualitative research, the purpose being to offer the potential to deconstruct prior knowledge and to generate new insights that will ultimately shape new inquiry to enhance clinical practice (p.35).
My research question is a good fit with both an interpretive descriptive design and a critical social paradigm because it is focused on generating knowledge that will influence practice. Moreover, I will engage in a research process that applies a critical lens to relations of power and the need to shift the status quo.

**Study Design**

Using an interpretive design, I combined existing knowledge within the literature in the field with the interpretation of the derived attitudes and behaviours of the nurses to deconstruct assumed knowledge and generate new visions that are shaped by new inquiries within an acute care context and the provision of postnatal care (Thorne, 2008). Thorne, Kirkham and O’Flynn-Magee (2004) offered insight into how important interpretive design is in constructing new practices pertaining to the subjective and patterned aspects of nurses’ experiences using an “inductive analytic approach designed to create ways of understanding clinical phenomena that yield applications implications” (p.1).

Moreover, in keeping with methods described by Polit and Beck (2008), interpreting and understanding nurses’ attitudes and experiences was done by entering into their world (in this case, the world of postnatal nurses) to discover the practical wisdom, possibilities, and understandings found within their perspectives. In keeping with the work of Thorne et al. (2004), the foundation of this study is a small-scale qualitative investigation of nurses’ attitudes for the purpose of capturing themes and patterns and generating an interpretation capable of informing clinical understanding to enhance maternity services in acute care for this population of women. Interpretive description differs from traditional qualitative descriptive approaches in that it assumes nurse researchers are rarely satisfied with description alone and are always exploring meanings and explanations that may yield application implications (Thorne et al.,
2004). Simply stated, using interpretive description allowed for illumination of themes, patterns, assumptions, and judgments that ultimately impact structures currently in place in acute care settings, and vice versa.

Sample and Recruitment

The sample for this study included obstetrical nurses that work directly with postnatal women who were receiving methadone maintenance treatment in an acute care setting. Nurses in the above area work with a diverse cross-section of women that come into their care. I conducted in-depth interviews with six nurses. Thorne (2008) describes the benefits of using a sample of this size to produce the knowledge being sought in the research. According to Thorne (2008), by engaging with a small number of participants who are particularly “experientially familiar” with the topic, the researcher is able to explore experiences more fully and “produce something worth documenting” (p. 94); in this case, I conducted the research with individuals working with women receiving MMT, individuals who could respond to the research questions because of their experiences providing care to this population.

Purposive sampling was employed for this study, as this kind of sampling is "based on the belief that researchers' knowledge about the population can be used to hand-pick sample members and the researchers might decide to purposely select subjects who are judged to be typical of the population of particularly knowledgeable about the issue under study " (Polit & Beck, 2008, p. 343). Using purposive sampling ensured that the sample involved nurses who have been impacted or have worked specifically with this population of women – nurses who could answer the questions associated with the overall research questions.
Recruitment of participants involved an email from the unit charge nurse to all potential participants that included a detailed information pamphlet. The participants were instructed to contact the researcher through the contact information in the pamphlet if they were interested in participating in the study. This was done to ensure that the nurses did not feel in any way coerced to participate; that is, whether a nurse did or did not contact the researcher was not known by the charge nurse. Posters (Appendix A), including information regarding what the research was and how to contact the researcher, were also posted in the staff rooms and nursing stations to capture the attention of those nurses who do not read their email.

In addition to purposive sampling in recruiting participants, I used theoretical sampling after the initial interviews were completed to explore some of the preliminary findings more fully with selected participants.

Following the caution brought forward by Polit and Beck (2008, p. 386), there was a need for me as the researcher to have an awareness of the emotional involvement with participants. In keeping with this perspective, I relied on reflexivity, which included self-reflection and a written form of my biases, judgments, and preconceived ideas. I revisited these reflections continually in an attempt to ensure that they were not impacting my research. In this way, I extended my understanding of how my position could affect the research at all stages of the research process.

**Data Collection**

Thorne (2008) outlined the advantages of providing multiple angles of vision in interpretive description design. I recruited a purposive sample of nurses from one urban acute care setting who have a minimum of six months experience working with postnatal women who are receiving MMT. The sample is purposive because the nurses who were recruited were able to
answer the research question; that is, they were able to articulate their attitudes and experiences through in-depth individual interviews. According to Thorne (2008) this is an adequate number of participants for a qualitative study using an interpretive design.

Combining data from the in-depth individual interviews as well as data through member-checking increases the reliability and validity of the study. Thorne (2008) stated that interviewing has become the primary source of data in qualitative inquiry and “finding ways to bring subjectivity derived knowledge into the disciplinary armament is a big draw for health care professionals” (p.78). Interviewing the nurses allowed for a rich description of their experiences working with this population of women to help facilitate an understanding of how we can change, adapt, or develop a program that prepares nurses for this type of specialty nursing care.

Sumner (2010) describes acute care nurses as “unhappy, voiceless, powerless and helpless to put the best interests of their patients first at the center of their care” (p.17). Using a critical social theory approach, the nurses’ needs were acknowledged and the interview process stimulated awareness of their own values and beliefs around MMT. Using CST as a guide, and using open-ended questions that offered insight into unchallenged norms within the facility and what works and does not work for nurses caring for women with MMT, created an opportunity to identify and analyze the historical and the current context of caring for women on MMT (p.31).

Despite my years of clinical experience and my knowledge gained through months of reviewing the literature, I entered the interviews as what Thorne (2008) described as “a curious learner,” confident about what I would learn from the interview process and seeking what could be expressed by the participants in their own context, way, and time (p. 130). Thorne laid out the need to have a set of predetermined questions to prompt further clarification or elaboration from
the participants in order to signal a sustained interest in their thought processes and experiences, encouraging some reflective interpretation and communicating an interest in the details they are providing (p.115). Using attentive listening was an important part of the interview process (Loiselle & Profetto-McGrath, 2007) and as the study progressed, modifications were made in the interviews based on the information that came from the initial set of questions and interviews.

After discussing consent to conduct the interviews, the individual in-depth interviews lasted for approximately one hour to allow sufficient time for the nurses to express their experiences without distraction or time restraint. Interviews took place in a safe, private setting to ensure confidentiality was maintained. All interviews were recorded, then transcribed. A digital copy was sent to the research supervisor, Dr. Victoria Smye, in a password protected email. The transcriptions were printed and kept in a locked cabinet with the tape recorder, while the digital (Word) transcriptions were deleted from my computer. Once the transcriptions were reviewed, a one-page summary was written to compare the actual interviews to the transcription and ensure accuracy.

Polit and Beck (2008) have supported the idea that in-depth interviewing is the most applicable data collection method. Recording the interview using a recording device allowed me (the researcher) to focus on the interviews instead of worrying about taking detailed notes. Theoretical sampling following the interviews included member-checking, which Polit & Beck (2008) described as a process whereby the researcher obtains participants reactions to the emerging interpretations found within the data, was done to ensure accuracy from the participants’ point of view and gave them the opportunity to reflect on the extent to which the interpretation was accurate and rang true. This member-checking involved writing a one page
summary of each transcribed interview and giving it to the nurse participants to review. Once the nurses approved the summary of their interviews deep analysis of the data took place.

**Data Analysis**

Data analysis was done using an approach outlined by Speziale & Carpenter (2007), which employs steps that fit well with methods employed in an interpretive description design. Firstly, I read the transcriptions of the participants’ experiences as they were transformed into language. Once all the interview data was collected, I then devoted time to read over each interview in order to gain a sense of the overall interview and the data being presented. I then produced descriptions that led to an understanding of the nurses’ experiences. Extracting common themes was done using editing analysis style, which Polit and Beck (2008) describe as a style whereby the researcher acts as interpreter who reads thorough the data in search of meaningful segments and units. Since the data was being collected from a small sample, the significant statements extracted were placed on different file cards that were placed in piles representing themes that were discovered. Once segments were identified they developed into a category scheme and codes were used to sort and organize data allowing for the data to be in more “manageable units that can be retrieved and reviewed” (p.510). I then categorized what was understood about the nurses’ experiences into essences, reducing the meanings of the experience to their essential structure. From there, I transformed those essences into a written document that captures what I believe reflects what the participants described. Once the data had been synthesized and the experiences of the nurses had been analyzed and interpreted into themes, the participants had an opportunity to review the findings to see if the interpretation resonated with their experience. Final findings were written to capture nurses’ attitudes and experiences working with women receiving MMT during the postnatal period.
Reliability and Validity

There are several steps I took to increase confidence in the reliability and validity of my study. Space triangulation consists of collecting data at more than one site. My study included interviewing nurses from an acute care women’s health unit, the labor and delivery room, and the neonatal intensive care unit (NICU). This allowed me to interview nurses who have different kinds of care experiences with women receiving MMT in the postnatal period.

Using in-depth interviews and providing a one-page document of my interpretation of each interview allowed me to speak to nurses individually to further explore some of my findings from the individual interviews. Using both data collection methods provides the researcher with the opportunity to evaluate the extent to which consistent and coherent pictures of the therapeutic attitudes and experiences of the nurses have emerged. Using these triangulation methods contributed to the rigour of my study.

To summarize and ensure that I am accurately representing the study participants’ experiences, I used: i) member-checking to enhance credibility and validity; 2) different triangulation methods to increase dependability; and iii) an audit trail to make clear what was done, including a clear decision trail that others can follow to ensure confirmability.

Beyond the above strategies, other techniques were in place that enriched and strengthened the study. Reflexivity was an important yet challenging process that I engaged in throughout the study. For example, as the researcher who is also a nurse who has expertise and is working in this area, I needed to be conscious of the questions I ask and the assumptions and values that underlie those questions. I kept a journal before and during the study to allow for a space to record and reflect on my responses to the interviews, my own experiences in this area,
and any bias or concerns that arose. This process of self-awareness was used to enhance the quality of research by acknowledging and working through, for example, my new role as researcher as different from my role working as a nurse in this context. I devoted time and energy to carefully analyzing and documenting the presuppositions, biases, and ongoing emotions through careful scrutiny of subjective responses and interpersonal transactions with the nurses (Polit & Beck, 2008).

**Rigour**

According to Morse, Barrett, Mayan, Olson, and Spiers, “without rigour, research is worthless, becomes fiction, and loses its utility” (2002, p.14). There is debate in qualitative methodology as to how to ensure rigour and goodness (Speziale & Carpenter, 2007). Morse et al. (2002) noted that by focusing on strategies to establish trustworthiness at the end of the study, rather than focusing on processes of verification during the entire study, the researcher risks missing serious threats to reliability and validity until it is too late to repair them. For this research, rigour and trustworthiness were built into the research process from the initial stages and were included in investigator responsiveness and the verification strategies of methodological coherence, theoretical and sampling adequacy, and maintaining an active analytical stance. These strategies, when used appropriately, force the researcher to correct both the direction of the analysis and the development of the study as necessary (Morse et al., 2002). The supervisory committee at UBC, consisting of three experienced researchers, was available to offer support throughout data collection and analysis to ensure rigour.

**Ethics**

Polit and Beck (2008) have clearly defined the importance of considering ethics, particularly when using human participants. Ethical conduct was crucial to ensure that the rights
of the nurses were protected and that the standards of ethical conduct, including beneficence, respect for human dignity, and justice, were considered throughout the research. While conducting this study, the researcher ensured that the nurses’ confidentiality was strictly maintained. Recruitment of nurse participants took place within a defined nursing unit with a small staff. Assuring confidentiality can be difficult given this is a relatively small group of nurses who work together closely. Therefore there were a number of procedures implemented in order to ensure confidentiality. The participants were asked to provide (if they were willing), a follow-up phone number, email or mailing address so that they could be contacted during the validation phase of the research. Each participant was assigned an identification number rather than using their names. The data from the interviews, including the recording devices, were held in a locked file; no computer files were used. All names used in interviews were deleted and assigned a pseudonym as necessary. Once potential participants contacted the researcher to be involved in the study, complete explanation of the study was given at that time and an appointment was set up to meet if they agreed to proceed. An informed consent (Appendix C) was signed by each participant and verbal consent was obtained just prior to the interview that was captured on the tape recording device. The participants were aware that they could withdraw from the study at any time without consequence. An employee assistance number that linked the participants to a counsellor was available if the participants experienced increased emotional stress during or after the interviews. Permission for the study was granted by both the ethics committee at UBC as well as the ethics committee in the Interior Health Authority where the study took place. Acting ethically, the researcher attempted to ensure that the research produced benefits to the nurses, protecting their right to self-determination and to full disclosure, as well as their rights to fair treatment and privacy.
Limitations

The limitations of the study must be taken into consideration when interpreting the research findings. In interpretive description methods, it is not unusual to have a small sample size. Therefore, in keeping with this approach I interviewed a relatively small sample of nurses. Although there is no reason to believe that this sample is not representative of nurses working in this and other settings, the findings may not be widely generalizable. However, generalizability is not a goal of this kind of qualitative work. The study is limited to one facility. In addition, I am the sole researcher for this study, which could impact the findings; however, I was guided by my supervisory team and will be sharing findings and analysis with them.
Chapter 4: Findings

Introduction

In this Chapter I will present the findings from in-depth individual interviews with six participants. A thematic analysis of the data generated from the interviews revealed five main themes: i) [Non]-judgment and a history of illicit drug use: a paradox; ii) Fostering a positive relationship: keeping personal feelings in check; iii) Time management, workload, and methadone; iv) Nurse, mom, and family education: timing is everything; and iv) Facilitators of success in the MMT program: team collaboration and genuine encouragement.

The hospital where the participants worked had established formal practice guidelines to direct the work of nurses caring for women on methadone maintenance therapy (MMT). Women on MMT agree to stay in the hospital a minimum of ten days postpartum in a private room where they room in with their infants, breastfeeding and actively engaging in caring for baby. They work with the hospital social worker, a general physician, a methadone physician, a lactation consultant, and the acute care nurses. Mothers also connect with their area public health nurse. With the exemption of the acute care nurse, who is rotating, all other health care professionals remain the same throughout a mother’s stay. Thus, practice guidelines at the hospital reflected an interdisciplinary team approach, which enabled the team to view patients from a wider perspective. The inherent benefits of interdisciplinary approach include enhanced decision making and timely referral of needed services, such as lactation support, social services, and community resources (Chan, Pang, Chi, Ching, & Lam, 2010).

Many participants described both positive and negative experiences working with women on MMT, and most identified the goal to care for the women by fostering a positive relationship in a non-judgmental way. All participants indicated they felt ill-prepared in that
they lacked the skill, time, and resources to provide appropriate and efficient care to women on MMT. In almost all of the interviews, participants indicated that time management was a huge constraint to the provision of care. Nurses who provide care for families on MMT must manage the increased care demands women on MMT present at the same time as they manage a heavy case load, most often working within a 10:1 patient to nurse ratio.

[Non]-Judgment and a History of Substance Use: A Paradox

Since MMT is an opioid replacement harm reduction strategy, postnatal women on MMT have histories of substance use. When I asked participants how a patient’s history of substance use affects how they provide care, most stated that they tried to leave any judgment behind so they could provide the same care as they would to any other woman. One participant summarized her approach as follows:

I think that I treat them like I treat my other moms. I still provide the teaching to them as I would, help them with breastfeeding. They usually need a little bit more TLC. But maybe I give them a little bit more care than the other moms because you are having to spend more time in the room with them checking on them more. Being around them more. I give them all the same information that I give all my other the moms, the same teaching. (P#3)

Evident in this participant’s interview and many others was compassion along with the belief that all postnatal women should receive the same care regardless of a history of substance use. The notion of equality emerged strongly in the interviews. Participant #2 articulated a similar point of view but with a slightly different focus:
I think, like the program in the developing of the tools and the knowledge, so then [that] erases biases and misinformation and mislabelling of families, because you become more educated and you have more insight into what their life is like. Every woman’s story is different. How you approach everyone, I believe should be the same, but it’s not, because you have to really get to know the mother. So that changes how you care for her, by caring for her as a human being with a newborn and she’s a mother.

This participant’s perspective reflects the belief that ongoing education of nurses is an important part of good practice. In a slightly different vein, another participant spoke to the provision of non-judgmental care in the following, which reveals underlying assumptions about the rightness and wrongness of substance use:

I would like to say that it does not affect how I do, however I am sure that in some ways it does. I try not to. I try to be aware of my own personal feelings and my own values and try not to make judgments. However, we see them in here in a very volatile place in their life. Their coping skills and their history impacts them and then how they interact with us impacts that relationship. It would be nice to say that I can isolate all of these different things and provide the care, but I do not know. It is hard. We spend a lot of time with these people. Sometimes they are very rude, very abrupt, lack social skills, defiant, and treat us like we are the ones who are doing something wrong. Sometimes it is really hard to keep all those different things segmented and not let it impact your care. It can be challenging. (P#3)

Here, the participant, although committed to the provision of a non-judgmental approach, points to underlying beliefs that make such an approach challenging; there is an underlying belief
that a particular set of characteristics can be attributed to women on MMT with a history
substance use. In addition, implicit in her statement is that the woman has done “something
wrong.” Although the nurse discussed the challenges to care, her response demonstrates
assumptions about the rightness and wrongness of substance use. Another participant went on to
explain how history matters in a slightly different way:

The history of drug use, the more that she will share with me enables me to support her
better. If she is not open to sharing her history with me and the drugs she is on, I may not
be able to provide the care for her baby that the baby needs. I try really hard not to judge.
I always tell them this is not about judgment, that this is just about providing the best care
we can for your baby. I don’t like there to be any surprises. (P#4)

Here, the participant is clear about the patient’s history being an essential component of a
thorough assessment. Paradoxically, although a thorough history is important to the provision of
assessment and care, it is the knowledge of that history (as in the previous example) that often
creates challenges to the health care relationship. Stigma and discrimination attached to MMT
and a substance use history can be highly problematic (Radcliffe, 2011). In addition, prior
negative treatment in other (healthcare) environments also imposes a challenge to the building of
a therapeutic alliance and the sharing of valuable historical information. Participant #4 went on
to explain the need for good assessment in the following:

I just keep awareness that if the use is recent, their pain medication tolerance is way
higher, so if they are telling me they are still in pain, I take that into account. I keep it in
mind for when I look at the medication record and what they are taking and how often.
In terms of dealing with those patients personally, I really don’t factor it in that much.  

(P#4)

Here the participant has provided an example to illustrate the need for a thorough history and the establishment of a trusting relationship to support the sharing of information important to care. Pain management is a common and important issue in the provision of care to people on MMT (Mate, 2009). This example also underlines the importance of nurses understanding the linkages between histories of trauma/violence, pain, and substance use (Mate, 2009).

In this study, most participants described taking care of women on MMT who have a history of illicit substance use as different than caring for other women. Non-judgment and the attainment of a thorough patient history was perceived as important; however, it was this history and associated relational issues (e.g., the ability to trust) and behaviours which presented challenges for some of the nurses.

**Fostering a Positive Relationship: Keeping Personal Feelings in Check**

All participants discussed the importance of fostering open and honest relationships with women on MMT in order to provide safe and effective care. Most participants stated that this was one of their main goals in their care of the woman-baby dyad and discussed different techniques for relationship-building. One participant discussed her approach as follows:

Establishing a relationship with them from the beginning, because if you do not have the relationship with them, the trust with the mom, it is almost impossible to get through your day because they do not want you in their room. Getting a good rapport with mom first. Letting them know that all your biases and personal feelings have to be put aside. Walking in the room telling the mom you are here to help whatever they need. Even
though I do have my own personal feelings on this I would never want my mom to know, and I would never want my care to reflect that. (P#1)

Here the participant points to the importance of building trust but also alludes to biases and personal feelings that need to be kept in check, a common approach by the participants. Another participant spoke about the myriad ways she establishes a relationship:

It is really important to make the effort to develop a personal relationship with them immediately. Sometimes you are tired, let me do my care and move on, and you do not put as much effort into developing that relationship with the parents. I think for these parents, when I first meet a methadone mom, especially if it is somebody who has been living on the street, they do not have the same amount of social skills and they are very intimidated by professionals so I really make the effort to connect with them. Eye contact, my name is, I am here to take care of you and your baby and really outline what my job is. (P#2)

Here, although relationship building is seen as paramount to the provision of good care, the categorization “methadone mom” suggests a particular stance that moms on MMT are a particular “other” sort of mom. Every participant demonstrated an understanding that fostering a positive relationship with the family was a primary goal in their nursing care and they spoke of the emotions that went along with taking the time to ensure that there was trust established between nurse and patient. One nurse shared a poignant moment in the following:

I think just the bottom line for me is that these are human beings, they are moms, they are vulnerable, and they often are not well-educated and they do not have the coping skills. We need to be very kind and gentle. I have had an experience where a mom has said to
me that I was her first positive role model, I like. She had never heard anyone say you have done a good job. It’s the truth. (P#3)

In the following interview excerpt, another nurse supported this approach:

Having a gentle approach that is not overbearing and assess what they need to learn and not trying to teach them everything that they might already know, because this is condescending, and treating them like children. Which nobody wants. Get the message across that they are trying their best, that’s why they are here, and your job is to help and not change their behaviour, they are already trying to change. (P#5)

It was very apparent throughout the interviews that rapport and trust between nurse and patient was sometimes challenging, as the nurses had to maintain a balance between fulfilling a task (e.g., assessing the patient, providing education, administering medications, and assessing infant feeds) and offering the extra care that some of the women on MMT required. The need to provide extra support was held as a feature of care provision by several participants. As one participant noted:

[They] are more demanding. They need more help. They need to be guided a lot more. They need reminders to feed. Prompted a lot more. They are hard to form relationships with when they do not seem happy to be there. Some are motivated and some are not. (P#1)

Generally, the nurses in the study noted that although mothers on MMT shared a similar need for more support/care, goals for being in the program sometimes differed, with a differential impact on the woman-nurse relationship. As one participant explained:
Every mom is different. Some moms need more hands-on, some moms need less. I find you really, really have to be honest with them, and they want you to be honest with them. They are always concerned, from my experience, that there is an alternative motive of removal of the baby. So their ability to trust you, you need to be pretty clear with them that your motive is to strictly help them and their baby. Build quite a big relationship with them. Overall being honest, me with her and her with me, it helps the mother and the baby do better. (P#2)

Many women using illicit substances – including opioids - have their babies taken into care (Mate, 2009), a fact underlined by Participant #2, who acknowledged the real fear that women live with on MMT regardless of its use as a treatment. Fostering a positive relationship was a challenge for most of the nurses in this study given these fears. As one participant elaborated:

They just want one nurse, not multiple nurses coming in, and they bond with the NICU nurse and they want just her; they do not want insight from the other nurses on the floor. Or, they want the lactation consultant. They are hard to form relationships with. (P#1)

This conveys the struggle some of the nurses had to women’s responses when they had multiple nurses caring for them and their baby; for some women, it was difficult to establish trust with more than one health care professional throughout their stay. However, another participant conveyed a slightly different perspective:

For so many nurses coming through, we do not have the consistency, so that there are variations of information being provided. There is confusion amongst the moms. Overall it helps a mom and baby do better when staff collaborate. (P#6)
For this participant, not only was collaboration an important aspect of nursing care and essential for building trust, but she also conveyed support for the idea of fewer different nurses with moms who were having this difficulty.

Another participant conveyed her perspective regarding challenges to relationship building in the following way:

They are lacking a lot of skills, just basic. I think too sometimes some of the women are a bit defensive coming in, because I think they know if they bring histories and parenting has not been the best, they feel more under the spotlight. Harder to build rapport with a woman who already feels defensive and guarded. In some respects the expectations for these moms who do not have coping mechanisms is even harsher than it is for just a primip coming in. (P#6)

Here women on MMT are categorized in ways that mimic some of the social discourses regarding substance use and mothering (Cleveland and Gill, 2013), as well as skills and coping mechanisms. Being perceived as defensive and guarded is attributed to women’s histories and poorer parenting practices rather than to the processes and practices within health and social systems that tend to stigmatize women in these circumstances. Another participant underlined the important role of the nurse in this regard:

I think that they come in either thinking or assuming that they are going to be judged, so they do have a wall up. But I think it is just a matter of having a certain way of being with them and letting them know that you are not judging.

Again, non-judgment is held as crucial to building a relationship of trust with the women in this setting.
Overall, most participants in this study described building a trusting relationship as somewhat of a challenge. They all described how much they valued this role in their nursing care even though they identified challenges in building rapport. Some held the perspective that by keeping their feelings in check, they were able to manage this relationship-building successfully.

**Time Management, Workload and Methadone**

In providing care to women and infants in the methadone maintenance program, time management is an important consideration. Nurses spoke of the frustrations of the timing and dosing of medications, readiness of the moms to learn, the ability of the women to retain information, as well as their overall nursing workload. For most of the participants, time management was the most frustrating aspect of caring for families in MMT.

While providing care, the nurses needed to juggle a full workload with the extra physical and emotional needs of the patients in the MMT program. One nurse described her frustration as follows:

They are taking up a lot of your time, giving them medication; we are supposed to be there for every feed. Checking the baby, making sure mom’s okay, that there is no withdrawal, they need more help. (P#5)

This participant went on to say that she sometimes feels she has to choose between the patients in MMT and other patients, to push them aside, because of the added support required for the patient in MMT. All participants agreed that the time it takes to assess, provide information, care for, and help these moms and infants was significantly greater than that required to care for mom-infant dyads not in the MMT program. As one nurse explained, for example, “they go
outside a lot, which is hard when you are always trying to find them to do some teaching or assess them.” Another participant shared this experience:

I don’t want to clump them all together, but they do tend to smoke, they need to go out a lot. It is hard to be consistent with assessments of feeds and timing of teaching when you go into the room and they aren’t there. (P #6)

Generally, participants articulated a workload problem connected to conflict between nurse workload / scheduling and patient needs.

When asked to speak about methadone, three of the participants were very vocal about considering the dosing and timing of the methadone and how this changed their care practices. As Participant #5 explained:

The challenges are timing sometimes, especially in the newborn period, because their schedule is based on baby schedule, which is not set in the least. So, if mom has been up all night, where she is usually getting rest, and then her methadone dose is in the morning. Does it get missed or is it late and now we are playing catch up, because her body is used to getting it at a certain time.

Participants tended to become more empathetic with the women as they came to understand MMT, and working with a mom on MMT involved more than just adhering to the rules and policies of the unit. Participant #5 provided an example as follows: “[if] the infant wakes up mom, mom’s irritable, in withdrawal, baby feeds off of that irritability. Then a snowball effect of everybody is upset and how do we get this back under control so we can function.” This nurse positioned herself as an advocate for the moms on MMT; she recognized the importance of keeping to the schedule and to dosing methadone within parameters that fit with the mom’s need.
Participant #3 provided another example to illustrate the complexities associated with being on MMT and caring for women on MMT:

> With MMT, postpartum moms are very sleepy and tired. Historically, their doses go up during pregnancy and then once they deliver they are still on the same maintenance dose, so if that does not get adjusted then it can impact their care with the baby. Nod off, drop the baby.

In a similar vein, Participant #6 explained the following:

> I think you still pose your questions, but you also recognize that there might be some variances just based on her cognitive function or dysfunction. Has she recently had her methadone, when she is more sedated? Really be assessing more of the safety factors. Her ability to maintain focus when [the nurse] is trying to teach her. Is it an appropriate time to teach? I suppose it is not that much different than a postpartum mom who is maternally exhausted because we have to remember that these mothers are also maternally exhausted plus they are taking methadone, which increases [their] sedation. So, you have to make sure that it is an appropriate time to teach. It is different; it takes more time because you have to have more hyperawareness of a lot of different factors.

Participant #6 identified the importance of nurse assessment to time teaching. Several participants suggested techniques they used in their practice that enabled them to assess that mom had the ability to care for her baby. This also indicates that nurses need to be assertive and direct with their care to ensure that the mom is receptive to teaching and that the dyads are safe.

Besides being present to assess mom and baby, nurses carry requests from the mom regarding her needs, such as what she feels she needs from the nurses to safely transition home.
with her baby. Regarding safety, participants mentioned the importance of simply asking the mom directly about her experiences as part of the process for assessing safety. Participant #6 provided the following example:

[I ask] you appear very sedated, very sleepy right now. I am watching you breastfeed your baby. Do you feel safe with your baby? You need to get them to be alert to the fact that they are sleepy. They are not safe. Baby could fall.

Fully assessing the mom’s readiness to learn and her ability to retain information was a priority for the participants. Part of this assessment involved attending to the timing of the mom’s methadone dose. Facing unpredictable reactions from some women regarding the information and when it was being taught was identified as a challenge. Timing of the assessments and teaching to the moms could be stressful, time-consuming, and, at times, out of the nurse’s control. Unable to predict the most suitable moments for teaching, the participants expressed feeling frustrated and helpless.

When asked about the challenges of providing care to women in MMT, many participants said that knowing the women’s level of sedation and their ability to cope was key to working well with the women. Participant #3 elaborated her perspective on this issue:

We say generally the withdrawal starts in 48 hours and then at that point when the babies start to withdraw a little bit more than we are going to give them one-to-one nursing care, but I think that they should have one-to-one care from the beginning. This would help some of the frustrations around workload, teaching, and preventing massive withdrawal in baby.

Another participant echoed this idea:
When a nurse has a family in MMT and has eight other patients as well, the MMT moms are not being supported as much as they need to be in order to avoid big withdrawals. When you have one nurse assigned to that family and that is her job for that shift they are able to provide the supports they need, the supports that the mom and baby need. I think sometimes when there are too many people going in and out of the room there are too many cooks in the kitchen.

Other participants had similar requests regarding how care ought to be provided. As one nurse said:

One of the most frustrating parts of the program is that we add them on to our basic workload. We know they take more time; they need more time with and from us. If they had only one nurse who could focus on their needs, we would see better outcomes. Instead, we are holding them off or holding other patients off. When timing is an issue, it would be easier to have one nurse per MMT family. It would work better.

Generally participants in this study were committed to the provision of safe respectful care to their patients regardless of their personal feelings associated with substance use and MMT. Most felt frustrated with time management and the constraints associated with inappropriate workloads given the specialized needs of women on methadone that were associated with the drug itself. Prevention of problems associated with workload was thought to reside in the system, i.e., a lack of attention to the particular care considerations associated with methadone. The more the nurses understood MMT, the more likely they were to be empathetic with the special needs of the mothers.
Nurse, Mom and Family Education: Timing is Everything

Working with women on MMT presented a variety of challenges to the participants. One common theme emerging from the interviews was the role of nurse and family education and how it either enhanced or diminished the experience of working with families on MMT. Very few participants felt prepared to provide safe, competent, and efficient care to these families. Participants asserted that preparation, for both the nurses and the families, made a difference in the relationship building, the care being provided, and the outcomes for the families.

When we discussed preparation that would assist staff in working effectively with women and infants on MMT, participants were adamant that the key to success of the program was the ability to understand the critical components of care that are specific to the women and baby dyads. Specifically, participants mentioned that understanding withdrawal symptoms, managing anxiety and coping skills, and managing the differing roles within the interdisciplinary team were factors associated with the success of the MMT program. As Participant #1 explained:

I think that the education could have been sooner. I remember in-services being done but I had already had three or four patients on methadone. So the education came after. We were expected to deal with these moms before getting the education on what it looks like when an infant was withdrawing… The more education you have the better the program is going to be. We should have had the training before those moms even stepped on the floor. The training was delayed. The booklets and in-services were useful information but that was after we already had a few moms on the floor. Everybody’s education level is different on the floor. This can really impact how a mom and baby do and if they can go home together.
Here the participant speaks to the importance of education and its timing on patient outcomes. Another participant also reflected on outcomes associated with education in the following:

Education about the whole withdrawal process for the baby, what you can do for the baby, all that stuff, but also how you can support the mom to provide for the baby the way the baby needs was poorly rolled out in terms of educating the staff. (P#2)

When asked if this impacted the care provided by the staff, the same participant responded as follows:

Yes, because the moms are struggling. They have no idea what to do and then the staff that are there to support them also do not know what to do. So then the baby gets these massive withdrawal symptoms and has to come into the NICU and be on morphine, which causes high emotions, and a lot of it was preventable if there was that teaching about methadone withdrawal and coping skills.

Although responses such as these stemmed from experience, emotions such as guilt and feeling like a failure were disturbing to some participants; it brought out feelings of remorse and helplessness if babies were admitted to another unit for withdrawal that may have been prevented with accurate education rolled out in a timely manner.

Participants generally felt that education was enormously important. One nurse (P#5), found accessibility to educational materials difficult and a hindrance to staff who felt that education was a “huge facilitator” in caring for the mom-infant dyads properly. She identified a direct correlation between education and level of nurse comfort and confidence. As she said: “We need education regarding looking for specific signs that we would see how to handle that. Early symptoms versus late symptoms. The hands-on tools are good; it is just difficult to find
the time to look at them.” She went on to note, “We don’t make a lot of time for education on
the floor. It comes down to when do we come in for it? Who is going to pay for all this
education?”

The pragmatics of education, cost, and timing fuelled the lack of timely access to
information. One nurse who had been part of the education of staff and had worked with many of
the women on MMT spoke about staff having a limited knowledge base; however, over time she
was hopeful of being able to advance the MMT program through education and associated tools
to support nurses and families to be more successful. According to this nurse, the key to the
success of an MMT program centers on ensuring that there is consistency in the messages to the
moms and families from the staff. She went on to elaborate:

Using concrete assessment tools to be able to completely assess the mom and baby and
have documents on a self-assessment tool for moms will increase the safety for mom and
baby and ultimately enhance the care being provided as the nurse gains confidence in her
ability to work with and treat these women and their infants.

Many participants indicated that they felt incompetent and ill-prepared when caring for
families on MMT. In addition, several nurses also explained that when families were more
educated on the processes of care, methadone, the nurse and other health care team, as well as on
expectations of themselves as parents, the MMT program was far more successful. As
Participant #2 emphasized:

Parents sometimes don’t know what they are supposed to do. They need certain supports
and those supports need to be in place before they come in to have their babies. They
need to know about withdrawal, how we are going to help the baby avoid it the best we
can, what happens if the baby needs morphine, how the care will change. When the plan is in place prior to the birth of the baby and all of those linkages of support, knowledge, and access is in place those women are far easier to care for and do so much better.

Education of nurses and families was seen to be one of the key ingredients to nurse and family confidence, comfort, and better outcomes for families.

Several participants noted the importance of physician and other health care providers’ ability and willingness to provide mom and family education. As Participant #4 explained:

One thing I see a lot of is them not having been prepared by their doctors. She didn’t know the baby was going to have some sort of withdrawal as a result of prenatal exposure to methadone. She didn’t understand that social workers are part of the supportive team. She was devastated. I think that doctors, nurses, and social workers need to make sure that the groundwork is laid out and pointed in the right direction. They are getting the right information and they are well prepared in advance.

Here the participant notes the importance of preparatory education by physicians and others to mitigate the potential harm associated with the lack of preparation of moms and families. Interdisciplinary collaboration was considered an important goal in this regard.

Most participants realized that there was a need for proper training in a timely manner, hands-on tools to assist with assessments, as well as collaboration among nurses and across the interdisciplinary team to support the mom-infant dyads in ways that support success in the MMT program.
Facilitators of Success in the MMT Program: Team Collaboration and Encouragement

Most participants saw an effective interdisciplinary team approach as important to the success of the methadone maintenance program. Respect for the expertise of the different team members was viewed as contributing to less severe withdrawal symptoms in baby, fewer admissions to the NICU, and the increased likelihood of the mom and baby going home together.

One participant spoke to this as follows:

I think having doctors on board, having the help from the lactation consultant, because we cannot be in there all the time for all the feeds. The NICU nurses and the transnurses assigned. Basically working as a team. Having people help them with feeding and watch them when we cannot. Having doctors and everybody on board. (P#1)

This team approach also applied across nursing. As the same participant explained:

I depend on my colleagues too. If I am drowning and need help I will ask. I prioritize my care at the beginning of my shift so I can make requests from the NICU, trans nurse, or lactation consultant in I need them to help out.

Lactation support was a considered a very important aspect of care. As Participant #3 stated: “[the] Lactation consultant is key. It is the connection with the lactation consultant, successful nursing, and that sense of confidence that they can do it and be supported.” Participant #6 elaborated further on this perspective:

Breastfeeding is critical and the establishment of breastfeeding is critical. Often these babies have challenges breastfeeding, because they are a bit uncoordinated, they have a high metabolism rate, so high hunger, hard to settle. They are irritable. Without lactation
support and consistent messaging we see early withdrawal, a need for morphine, and that changes the face of the program, what we are trying to achieve.

Some nurses included the community, which involves public health nurses and mothers in recovery support groups, as well as the parents as part of the health care team and felt that without embracing the role that they had in the team they would be missing various components of a collaborative approach. Participant #2 explained this as follows:

Our Patient Care Coordinator (PCC) is doing a really good job of making relationships with the community supports. The Family Tree program, she is on the board for that, and is building a relationship between our hospital and our units and that program. This is a great step and it helps the parents once they leave us and are at home.

Continuity of care and discharge planning were considered to be important to successful transitioning from hospital to home. Participant #3 explained why:

Without a liaison who connects and bridges that gap between hospital and home, a lot of women fall through the cracks. We have them here for a minimum of 10 days and if we were to just send them home, well then what... we lose them, Ministry gets involved, they lose their baby. Having supports within the community helps continue the care, offer support in a different way.

Nurses who supported this approach expressed the view that community linkages were essential and that hospital community system ties were key to successful family cohesion. Nurses also noted the importance of supporting the empowerment of the parents. One participant shared her unique way of interacting with the family to ensure the parents feel part of the care plan in the following:
Right from the beginning and throughout their whole stay here I make it clear that they are the primary caregiver, referring to them as much stuff as I can. How do you like to do the baby? What do you find works best: does she like to be patted and rocked, swaddled, held skin-to-skin? Finding out these little things and really making it clear to them that they know their baby better than I do. (P#2)

Here the nurse shares her approach in validating the expertise of the parents, something she found to be effective in bolstering confidence. Some of the participants felt that supporting parents to play an active role in the care of their babies increased bonding and attachment and prepared the way for a smooth transition home. As one participant noted:

Mom’s ability to sit long enough and have patience with the breastfeeding and infant care all play a role in being successful. That is my role: to help navigate some of those challenges. To empower the mom, to get the mom independent, like all of the mothers really, try to normalize the infant and the process of becoming a mother. When they feel empowered there is less anxiety and an easier transition going home.

Here the nurse works to normalize the mothering experience for moms who often are marginalized by stigma and discrimination. In her experience, this approach is much more likely to support the success of the mom-infant dyad. Another participant described the approach a little differently:

A lot of positive reinforcement for the moms is important when providing safe and effective care in an open and non-judgmental way. So many times they come in with esteem issues and they have not had a lot of positives in their lives. I think that positive reinforcement and encouragement like you can do this, keep going. And not be afraid to
hear what they have to tell you. It is not my job to judge her, it is to support and guide her in her process.

Here the nurse describes a positive reinforcement and encouragement approach to enforce the belief that the mom is capable; she thus operates from a strengths-based approach. Participant #5 also spoke of the importance of positive reinforcement:

I think that when we congratulate them and offer kind words of encouragement this empowers them and maybe they felt stigmatized and the old practice would be mom on the floor baby in the NICU, no relationship and any attempt at a connection was severed. By encouraging a women to be the best mom she can be with the supports she has in a way that is encouraging, over time, she will believe what she hears and her role as mom will start to surface.

All of the participants acknowledged the fact that women on MMT felt judged by people a lot and hurt by a lot of people in the course of their lives, so being a positive role model who offered encouragement, reinforcement, and a gentle approach was effective in decreasing fear and/or uncertainty of the staff by the patients.

Summary

Nurses who specialize in postnatal nursing must care for women on methadone maintenance therapy. During the process of caring for this population, many participants felt that there were both facilitators and challenges to the provision of effective and safe care. They had both positive and negative experiences. They also described feelings of vulnerability, helplessness, frustration, and stress throughout their encounters with many of the women in the MMT program. Many of the participants developed techniques to assist in dealing with any
feelings of inadequacy and guilt in themselves, but also with the feelings of the women on MMT. Their support for the patients and their performance at work included working within a team approach.
Chapter 5: Discussion

Introduction

In this chapter, I discuss the overall findings from the study: the experience of postnatal nurses who provide care to women on MMT. I have focused specifically on involving discourses on mothering, time management, lack of education, and the marginalization of women on MMT.

Discourses on Mothering

According to Varcoe and Doane (2007), the notion of mothering is “a social experience that is constructed and shaped by structural conditions and intertwined with competing and conflicting social discourses that have a significant implications for the health of women” (p. 297). In this study, mothers on MMT were often perceived by nurses as people without good coping or parenting skills. For example, the participants both implicitly and sometimes quite explicitly reported that good mothers and parents do not use illicit substances; thus women receiving MMT for treatment of opiate addiction were described as lacking in many ways upon admission and during their hospital stay and therefore require a particular kind of nursing care. The desired health outcomes for woman and their infants receiving MMT were defined by most participants as going home together after a ten-day stay in the hospital where supports in the community were set up. Participant responses may illustrate an overemphasis on the deficits of women on MMT and less attention on the myriad factors – both positive and negative - that influence and shape how women experience being a mother.

Participants saw their primary role as guiding and facilitating a plan that supported mom and baby to go home together. However, the nurses also noted that they were challenged in this endeavour by the many characteristics of the woman attributed to substance use and current
MMT. It was clear throughout our discussions that most of the nurses believed that woman on MMT lacked in parenting abilities; this included the ability to bond with their babies and respond to their babies’ cues, such as feeding cues or signs of withdrawal. Consequently, in this study, participants strived to be role models for the women to help facilitate what they perceived as “good” mothering. The nurses demonstrated caring abilities such as holding and talking to the baby as well as providing information about infant behaviour cues. This aligns with research that has consistently established that nurses should reflect upon the basis of mothering practices and help mothers identify their competencies and make supporting those competencies a nursing priority (Koniak-Griffin, Longsdon, Hines-Martin & Turner, 2006); that is, it is necessary to work from a women-centered, strengths-based approach. Participants in the study noted that most of the women on MMT had come from difficult circumstances – including poverty, unemployment, violence, and lack of access to appropriate community support – and may not have had the guidance or role-modeling to develop mothering skills; moreover, participants assumed this translated into an inability to parent without guidance in this domain. Participants recognized the need for women on MMT to be treated as “normal” mothers and perceived the discomfort of the women to be related, at least in part, to how they had been treated previously by others because of illicit substance use. That is, they did not fit within the societal scope of “normality.” As Aston (2002) noted, “a mother’s need to feel normal is rooted in the way she is positioned in society to accept subjectification of certain dominant notions of what normality means” (p. 284). Many of the mothers on MMT had past negative experiences related to illicit substance use and MMT, and although the nurses in this study worked hard not to convey their “personal biases,” they carried them nevertheless.
The variations in the experiences and perspectives of the nurse participants depended on their own feelings and beliefs about what a mother was or should be and what they felt the mother should learn in order to become a “good” mother. Varcoe and Doane (2007) remind us that “[f]or many women the experience of mothering is not so picture perfect. And the disjuncture may be great between what mothering is and what mothering is supposed to look and feel like according to dominant societal messages” (p. 298). The participants understood that there are multiple and varying forms of mothering but struggled to put aside or keep in check those beliefs about societal norms which shaped their own mothering practices.

Participants in this study reflected on their own maternal identity and their philosophy of normalcy; the notion of good mothering was intricately woven into each of the nurse’s experiences. All of the participants were mothers and their ideas of what constitutes a good mother was shaped by their personal experiences. Varcoe and Doane (2007) stated that “[t]he ideals of ‘good mothering’ are situated within a wide range of influential discourses that are contradictory and fluctuating” (p.301). In this study the participants viewed good mothers as mothers that bond with their babies, breastfeed, and display motherly love, all of which were a nursing priority when establishing a care plan.

Cleveland & Gill (2013) have suggested that maternal adaptation to the mothering role can be enhanced by making reasonable efforts to include the mother in the care of the infant, regardless of the woman’s history (p.200). Cleveland & Gill (2013) further suggest that “efforts to include the mother in the care of her infant may support the woman’s transition into the mothering role” (p.204). The participants accomplished this by encouraging the women to be involved in the care of their infants by including them in routine care of the infant such as bathing and diapering. Participants clearly acknowledged that including the mother was a key
factor in improving relationships and improving long term outcomes for the mom. The participants strived to be non-judgmental and move beyond the woman’s substance use and to recognize positive qualities that they could draw on to include moms in the caring process. Many of the nurses recognized that it was meaningful to include the families, and they hoped that it would help them claim their mothering role.

**Structural Constraints**

Significant healthcare restructuring has led to changes in the healthcare workforce with negative consequences for nurses’ work in hospitals. The ability of nurses to enact their scope of practice and skills has been negatively impacted by time and other constraints (Duffield et al., 2008). In the context of these changes and limited resources to support professional development, nurses do not necessarily get the education or required knowledge to provide specialized care. In this study, participants described feeling ill-prepared to care adequately for women on MMT. In addition, they were frustrated with the lack of time they had to spend with patients on MMT, given the heavy workload in the postnatal care setting.

Each nurse described a normal patient load as one nurse to ten patients - five moms and five babies - on any given shift. The participants’ poignant responses when asked about time management included the need for institutions to constantly reassessment what is a reasonable workload. They felt that with adequate nurse to patient ratios, care would not be compromised. Adjustments need to be made to nurse staffing requirements to accommodate the needs of not only the MMT patients, but those of the nurses as well.

Today, postnatal care has become highly specialized in some settings. As Simpson, Lyndon, Wilson, and Ruhl (2012) noted, there is a need to revisit nurse staffing guidelines in
these settings because “current nurse staffing guidelines are inadequate to meet the needs of contemporary postnatal clinical practice and require revision based on significant changes that have occurred since 1983 when the original staffing guidelines were published” (p.474). In this study, there was a general consensus that mothers and babies in the MMT program would be better served by ratios that included one nurse to one dyad. This ratio would accommodate the time required to be at the bedside, foster relationships, conduct thorough assessments, and be available to help support and guide the women in the methadone program.

**MMT, Nursing Competencies, and Specialized Knowledge**

This study illuminated the interplay of factors that complicate the delivery of care to women on MMT. Participants in this study recognized they lacked competencies to manage the increased needs associated with patients on MMT. Monks, Topping, and Newell (2012) stated that “[r]egistered nurses working in acute care settings require education and training to understand problem drug use and addiction, to manage withdrawals and related behaviour, and to initiate appropriate support for patients who use illicit drugs” (p.944). None of the nurses in this study had received any formal training or education to prepare them to provide safe, effective, and quality care to patients who were admitted into the methadone maintenance program. Virtually all of the nurses recognised the importance of being educated about addiction and how this would positively impact their confidence and their ability to care for their patients on MMT. As Maguire (2013) noted, nurses who have a working knowledge of this disease will provide more effective nursing care to the women they encounter and be better prepared to make a difference in the lives of both the women and their children (p.12).

The participants expressed confidence in their abilities to manage standard postnatal care with women on MMT but felt less confident monitoring and managing withdrawal symptoms in
mom and baby. Monks et al. (2012) discussed the importance of nurses being able to recognize withdrawal symptoms. This lack of knowledge of withdrawal could have serious outcomes for mothers, babies, and the staff providing care. For example, symptoms of withdrawal can result in agitation, restlessness, irritability, conflict, and aggression; symptoms could be mistaken for bad behaviour attributable to “those” women rather than as withdrawal (p.940). Such misunderstandings were described by many of the participants; women were deemed difficult and distrustful, rather than as suffering from the effects of withdrawal. In keeping with this awareness, Go et al. (2011) noted “[i]t is important for nurses to gain awareness of the characteristics of those clients who are enrolled in MMT programs. Such awareness promotes appreciation of the client’s life experiences, facilitating care delivery that is grounded in client centeredness” (p.19).

The nurses in this study were continuously revisiting how to approach women on MMT. They recognized the value of gaining their trust and the importance of being non-judgmental in order to help foster a positive relationship. What was lacking was the training and skills to fully understand addiction. Wilson et al. (2007) emphasized the need for specialized knowledge in this field. They asserted, for example, that as part of their training, nurses need to know how to be conscious and continuously examining the client’s attitude and perceptions regarding addiction and treatment. They went on to further state that “such understanding fosters a positive and therapeutic relationship with clients and improves client outcomes” (p.978).

The nurses in this study vocalized the desire for hands-on tools that would allow them to assess, manage, and work with women on MMT. The participants gave reflective glimpses into their clinical encounters with their MMT patients and offered suggestions for education that would help improve their understanding and ability to work with women on MMT. Suggestions
included some of those expressed by Monks et al. (2007): understanding of the addiction process, recognition of withdrawal, management of aggression, and an understanding of how negative attitudes potentially affect management delivery, to name a few. From the perspective of the nurses, this would improve their knowledge to not only provide better care, but to gain a sense of confidence and security when interacting with women on MMT.

**Marginalization of Women on MMT**

A lack of understanding of the complexities of illicit substance use and addiction, along with a lack of understanding of methadone, impeded nurse morale and care-giving processes, resulting in marginalization of women on MMT. Theoretically, marginalization involves social exclusion from the rules and norms that affect people’s lives and from meaningful societal engagement (Young, 2000). The study findings revealed that there is disapproval towards pregnant women and postnatal women who use or have misused substances, including opioids and methadone; both were perceived by the nurses as harmful to both baby and mom. Radcliffe (2011) has suggested that there is a “continued need for regular training for staff about substance misuse, opiate substitution therapy and the social and emotional experiences of a substance misusing lifestyle” (p.498) to address the lack of knowledge, misinformation, and relational processes and practices to support effective, safe care. There was a lot of confusion amongst many of the participants when it came to understanding the effects of methadone on the infant. Because of their lack of knowledge about MMT, many of the nurses questioned their professional judgments concerning assessments, their ability to design a care plan, foster a relationship, and engage with discharge planning. It was apparent in this study that social discourses regarding MMT and the lack of education regarding substance use and addiction reinforced nurse beliefs regarding MMT and the decisions nurse participants made. Radcliffe
(2011) notes that work practices must be aligned to best practice models of specialist care for this group of patients to maximize best care given to dyads utilizing methadone.

To come to understand addiction as a disease rather than as a moral or character failure and to maintain a non-judgmental approach are two important features of nursing in this area of practice (RNAO, 2009). Ford et al. (2008) found an inverse relationship between “nurses disapproval of illicit drugs and their therapeutic attitude to this patient group - as disapproval of illicit drugs increased, therapeutic attitude decreased” (p. 2460). Consistent with this finding, the nurses in this study described the mothers on MMT as demanding, and they were frustrated when they found the women unavailable, unreceptive, or closed off to care. Blunt (2009) has suggested that nurses have an ethical duty to provide care to the vulnerable mother-infant dyads affected by drug addiction and stated that beneficence is a key ethical principle in nursing (p.232). Although the nurses in this study were challenged by their attitudes to substance use and MMT, I want to underline that they demonstrated a commitment to “doing good” by providing bedside instruction, role modeling, including the mothers in the care of the infants, and by encouraging bonding and breastfeeding. This support was also extended non-verbally by establishing eye contact, active listening, and collaboration with a multidisciplinary team of health care professionals.

All of the nurses saw the value of women being on MMT, and they all insisted that they believed that methadone was safer than alternative drugs. They perceived their most important nursing tasks in the care of the mothers as the administration of methadone, observation of the moms’ and the babies’ conditions, monitoring the dosage of methadone, and offering support to encourage a safe environment for the transition to motherhood. What they lacked was a comprehensive understanding of drug dependency and the role that methadone has in the
recovery of women who have a history of opioid addiction. According to Go et al. (2011), an integral part of the nursing role in “assisting the client during the course of treatment for opioid dependency that includes methadone is having the necessary knowledge about the drug and its associated action” (p.23). In this study, this lack of understanding of methadone acted as a barrier to appropriate delivery of clinically sound methadone maintenance therapy.

Maguire (2013) has done extensive research on the theoretical explanations for drug-seeking behaviour and provided insight into the role of brain neurophysiology in opioid addiction. She has also provided detailed research on the use of methadone and offered education adjacent to behaviours that the nurses in this study described as having witnessed in women currently on methadone. The nurses described challenging behaviours such as nodding off, wanting only one nurse at a time, poor communication and coping skills, distrust, and low tolerance to pain as common to these patients. Overall the study findings support the work of Go et al. (2011), who have indicated that understanding the fundamental features of addiction, specifically methadone therapy, will help nurses enhance their delivery of care as well as prevent client incidences of withdrawal, which is congruent with the nurses’ perceptions of the patients’ safety and well-being. Indeed, it can be reasonably argued that participants sustained challenges of working with women on methadone maintenance therapy without fully understanding addiction or the treatment process. Ultimately, Go et al. (2011) have found that “understanding how methadone works, along with awareness of its associated impact towards other aspects of the client’s health, will promote holistic care delivery to this client population” (p.24).

Summary

Working with women on methadone maintenance therapy is challenging, and nurses often face barriers providing care to these women and their infants. Workload management
issues were seen to be a significant barrier to effective client care. Time management was seen as a significant issue in trying to fulfill the nurse’s role of being at the bedside and having the time it takes to fully assess their patients. Moreover, workload was a disadvantage for all nurse participants as they felt dissatisfied with the care being provided. They recognized the incremental needs of the population and asserted that sharing their time with up to four other dyads impacted safe and effective care. Being ill-prepared to assess and manage withdrawal impacted the participants’ confidence in caring for women on MMT as well as failing to appreciate the discourse of mothering. It was valued amongst all the nurses that fostering a positive relationship would provide the foundation for clinical practice and most were proactive in their efforts to initiate and maintain a caring role with these dyads. Understanding methadone and the discourse of addiction would provide the participants with new perspectives to enhance beneficence, a central component in their nursing practice.

**Recommendations**

Several recommendations can be made with regards to working with women on MMT based on the study findings. After interviewing the participants and carefully analyzing the data, it was evident that nurses need more support, more guidance, good role models, and more education about addiction, methadone, and MMT. Further research on the nurses’ role working with women on MMT, looking at current guidelines and policies that foster a supportive environment for both the nurses and the families on MMT, as well as appropriate staffing that enables nurses to feel satisfied with their job working with this population of women all may contribute to an increase in the provision of quality care.

The implications for nursing practice need to be considered when looking at nurses’ experiences and provision of care working with women on MMT. Strategies such as nursing
schools integrating education surrounding addiction, including the concept of harm reduction, may improve the ability to provide safe competent care. Furthermore, nurses need to have the opportunity for ongoing education and training about problem substance use and information about how to manage withdrawals and related behaviours, including counseling skills, when working with this population of women (RNAO, 2009; Bick et al., 2011; Monks et al., 2012; Jambert-Gray et al., 2009). The findings of this study may also inform other nurses working with addictions, including women on MMT, about how to provide care that is safe, effective and non-judgmental.

Nurses require a specific skill set and knowledge base working with women on MMT, specifically education and training to understand addiction, to manage withdrawal and related behaviours, and to initiate appropriate support for women on MMT. Education and training could include certification in advanced practice that would ensure nurses gain the knowledge and skills to advance their professional practice in addictions (RNAO, 2009). This study provides strong evidence that nurses need to have a better understanding of the pharmacokinetics and the pharmacodynamics of methadone. Understanding the absorption, distribution, metabolism and elimination of the drug will help nurses provide care that is safe and effective for each individual woman on MMT (RNAO, 2009). Furthermore, understanding how the social determinants of health impact health outcomes must be considered in everyday nursing practice. Nurses need to have knowledge of community resources that provide a continuity of care from acute care to community. This includes having knowledge about planning, advocating, and referring to resources that foster health and improve health outcomes. These resources should include housing options, access to health care, and positive family supports (RNAO, 2009).
In order to support the education and training needs of nurses that work with women on MMT, acute care facilities need to provide their nursing staff with mandatory orientation programs and provide ongoing professional development that are based on best practice guidelines. These programs must address health care staff perceptions and attitudes as well as treatment options such as MMT (RNAO, 2009). Having a strong cohort of nurses who are knowledgeable of current practices and policies that best manage addiction and treatment options will provide consistent quality care to women and their families currently on MMT.

This study was conducted using a critical social lens which explored and illuminated the social construction of the patient-nurse relationship within the power constraints of the current health care system (Sumner & Danielson, 2007). There are obvious gaps in understanding the power hierarchy in the patient-nurse relationship. This study provides a rich description of the nurse’s experiences but further research examining the patient’s role in programs such as MMT will promote further understanding of how the patient’s voice can contribute to improving nursing practice. Examining the nurse-patient relationship from the patient’s perspective will provide insight and further understanding of traditional values and roles that currently shape our delivery of health care.
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Appendix A: Recruitment Poster

Seeking:

RIH Obstetrical Ward

Registered Nurses
to participate in an interview and/or focus group interview for a thesis project on

Working with PostPartum Women on Methadone Maintanence Treatment

**Nurses must have a minimum of 6 months experience working with women on methadone maintenance and be currently employed at RIH

Interviews will take place October 1-8, 2013 in Kamloops-Please see email for information and consent process

Thank-you,

Erin Dell, RN, BSN, IBCLC

UBC Vancouver Graduate Student, Masters in Nursing Education
Appendix B: Interview Questions

Interview Questions:

1) Tell me about your work as a nurse in postnatal health care.

2) Tell me about your experience working as a nurse with women on MMT during the postpartum period.

3) How does a women’s history of illicit drug use affect how you provide care?

4) If the care is different from the care you provide to women who have never had a history of illicit drug use, why is it different?

5) What do you think about MMT? Benefits, challenges etc....

6) What are the facilitators of and challenges to providing care to women on MMT during the postnatal period?

7) What kinds of things do you do to work with women on MMT more effectively?

8) What are some specific strategies you would recommend to other nurses to ensure they provide safe and effective care to women on MMT during the postnatal period?

9) Is there anything else that you wanted to comment on that I have not asked you?
Appendix C: Consent Form

Information and Consent Form for Prospective Nurse Participants

To prospective nurses working with women on MMT study participants:

My name is Erin Dell. I am a Registered Nurse and I am also a graduate student in the Masters of Nursing Education at the University of British Columbia- Vancouver Campus. I am currently working on my thesis. In my thesis research I am examining nurses’ experiences working with postpartum women on methadone maintenance treatment (MMT) in Kamloops at Royal Inland Hospital; this to inform the development of safe and effective programs for perinatal and postnatal families in this group. Therefore, I will be interviewing registered nurses who are involved in the care of postpartum women on MMT. For this study, MMT is defined as women receiving methadone during the perinatal period as maintenance treatment for a history of illicit drug use.

If you would like to participate, please complete the attached consent form and leave it in a sealed envelope for me in the brown envelope in the maternity ward staff room. I will contact you and arrange a follow-up interview or focus group October 11-20 2013.

If you have questions, please do not hesitate to call or email me or contact my academic supervisor Victoria Smye.

Sincerely,

Erin Dell, RN, BSN, IBCLC
Masters in Nursing Education, graduate student

Victoria Smye, PhD., RN, Associate Professor
UBC Nursing

Project Title: Nurse’s Attitudes and Experiences Working with Post Partum Women on Methadone Maintenance Treatment

Date: October 1-8, 2013
**Principal Investigator:** Victoria Smye PhD, RN, Associate Professor, UBC

**Co-Investigator:** Erin Dell RN, BSN, IBCLC

Masters in Nursing Education Student, UBC

**Introduction:** You are being asked to participate in a thesis research project in the Royal Inland Hospital Obstetrics Ward that is being conducted by Erin Dell, graduate student in the Masters of Nursing Education Program at UBC. This study is for the completion of my Masters of Science in Nursing at the University of British Columbia Vancouver under the supervision of Dr. Victoria Smye, Dr. Vicky Bungay, and Dr. Susan Duncan. For this study, Methadone Maintenance Treatment (MMT) is defined as women, during the perinatal period, who are receiving methadone as part of a maintenance treatment for a history of illicit drug use. Nurses experiences working with women receiving methadone maintenance treatment is currently not well understood or studied. You are being asked to participate because RIH has been identified as a care facility that provides this care to women throughout the perinatal period on your delivery ward, postpartum unit and intensive care nursery. I will selectively interview obstetrical nurses, which includes nurses from labour and delivery, the postpartum unit and the neonatal intensive care, who are directly involved in the care and coordination of care for RIH inpatients who are receiving MMT during the perinatal period. Your participation is entirely voluntary, and a decision to not participate will not, in any way, be used against you. Whether you participate or not will not be disclosed to your charge nurse or unit manager.

**Purpose:** The purpose of my research is to examine obstetrical nurses’ attitudes towards and experiences of providing care in the acute care setting to postpartum women who are receiving MMT; this is to form the development of safe and effective programs for perinatal and postnatal families in this group.

**Inclusion/Exclusion Criteria:** The sample for this study will include obstetrical nurses who have a minimum of six months experience that work directly with post-partum women who are receiving methadone maintenance treatment in an acute care setting. The nurses will be currently working at one urban acute care setting but may have gained the minimum of 6 months experience from any acute care facility and will be able to articulate their attitudes and experiences through an in-depth individual and/or focus group interview. Nurses who do not work in this urban acute care setting, who have less than six months experience and/or do not
work directly with post natal women on methadone maintenance treatment will be excluded from
the study.

**Procedure:** The interviews and focus group will last a maximum of 1 hour. Questions are
included in this consent form for you to review and consider. The interviews and/or focus group
will take place on the participants own time in a quiet, reserved location at RIH at a pre-set time.
With consent a digital recorder will be used as a back-up for notes but can be turned off at any
time during the interview at the participant’s request. No personal identifiers will be used on any
notes or recordings or any other materials associated with the interview or focus group. Once the
information from the interviews is compiled a one page summary will be given to the
participants to ensure accuracy of the information gathered. The participants will have 2-3 days
to review this one page summary. If you agree to participate in this study, please check which,
or both interviews you would like to participate in, sign the consent form and place it in a sealed
envelope in the locked drop box on the Maternity Ward in RIH. This locked box will stay by the
main doors and will be monitored by the clinical practice educator from your unit daily. I will
contact you within 1-2 weeks by way of your preferred contact information (i.e., e-mail or
phone). I will meet you at a pre-arranged time to participate in either a private interview (6-8
participants) or focus group (6-8 participants) or both.

**Risks/Benefits:** There is a risk that the nurse participants may experience increased emotional
stress as a result of the interview as they recall experiences working with postnatal women on
MMT. If nurse participants experience increase emotional stress IHA Employee and Family
Wellness cards will be available with information on how to contact free counseling services,
this will be offered to all participants at the start of the interviews. As well, a follow up phone
call will be made two weeks after the interviews to check in with the participants. In the event
that the nurse participants disclose unsafe or unethical care practices, the researcher would have
a duty to report to CRNBC. You will receive a $5 Starbucks gift card as a thank-you for your
participation in the interview/focus group and cookies/snacks will also be available.

It is anticipated that the results of the study will be shared with others through publication in
healthcare journals. Study results will be sent to RIH obstetrical staff by way of an email as well
as a letter to the department upon completion of data analysis.

**Confidentiality:** Confidentiality will be respected. You may withdraw from the study at any
time without penalty. If an individual withdraws from the study, any data specifically linked to
that individual will not be used for the purpose of this research study and the notes will be
shredded.

Only I, my committee (Dr. Victoria Smye, Dr. Vicky Bungay, and Dr. Susan Duncan) and the
UBC and IH REBs reviewing the study will have access to my notes and files. Interview notes,
digital transcripts, and any other documents will be stored in a locked personal filing cabinet for 5 years as per ethics review policy. No names will be on any of these forms as each signed consent form will receive a numbered code. The code will be used on all other documents related to this study. Information from my notes will be typed into a password protected computer and also stored for 5 years. A linking key and the signed consent forms will be stored in a separate secure safety deposit box. These files and digital recordings will be destroyed by way of confidential shredding and digital erase at the end of 5 years.

In the case of participation in the focus group confidentiality may not be fully maintained. It cannot be fully controlled what participants may disclose about personal information and experiences that have been shared in the focus groups.

**Contacts and Questions:** If you have any questions about this research study, please feel free to contact Erin Dell at----------, ---------or by email at -------------or ------------------ If you have questions about your rights as a research participant, you may contact UBC Ethics Board toll free at 1-877-822-8598 or email UBC Ethics Board at RSIL@ors.ubc.ca. As well, you may contact the Chair of the IH REB at 250-870-4602 or researchethics@interiorhealth.ca

**Statement of Consent:**
Please check one option.
I agree to participate in the following interview(s);

__Individual interview __Focus group interview __Both individual and focus group

Your signature below indicates that you have read and understood the information provided above, have had the opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

___________________________       ____________
Participant Signature            Area of work (delivery room, ICN, postpartum unit)     Date

___________________________       ____________
Researcher (or witness) Signature Date

Preferred Contact Method: Name (printed) ____________ Email________________
Phone#__________