

ARTICLE

Reflective Capacity: An Antidote to Structural Racism Cultivated Through Mental Health Consultation

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ABSTRACT

Effecting a paradigm shift from “reproductive health” to “reproductive justice” within the perinatal field requires changes simultaneously at the levels of the individual healthcare provider and the system of care. The Infant-Parent Program at the University of California, San Francisco (UCSF) has extended its pioneering infant and early childhood mental health consultation to perinatal service systems applying an infant mental health approach to programs caring for expecting and new parents. In partnership with two nursing programs, UCSF consultants direct their efforts at supporting reflective practice capacities and use-of-self in patient–provider relationships. Both nursing programs serve vulnerable groups of expectant and new parents who grapple with challenges to health and well-being stemming from structural racism. As reflective capacities are supported within the consultation case conferences, providers spontaneously identify the need for tools to effectively address issues of race, class, and culture and to combat structural racism throughout the healthcare system. Policies and procedures that uphold structural racism cease to be tolerable to providers who bring their full selves to the work that they are trained to do. Using these nurse consultation partnerships as organizational case studies, this article describes a range of challenges that arise for providers and delineates steps to effective engagement toward reproductive justice.

KEYWORDS

mental health consultation, reflective capacity, reproductive justice, self-awareness

RESUMEN

Llevar a cabo un cambio de paradigma de “salud reproductiva” a “justicia reproductiva” dentro del campo perinatal requiere cambios simultáneamente al nivel individual del proveedor de cuidados de salud y el sistema de cuidado. El Programa Infante-Progenitor de la Universidad de California en San Francisco (UCSF) ha extendido su pionera consulta de salud mental infantil y la primera infancia a sistemas de servicio perinatal con la aplicación de un acercamiento de salud mental infantil a programas que les sirven a progenitores nuevos y que esperan un niño. En colaboración con dos programas de enfermería, los

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consultores de UCSF dirigen sus esfuerzos al apoyo de las capacidades de la práctica con reflexión y el uso de sí mismo en las relaciones entre proveedor y paciente. Ambos programas de enfermería les sirven a grupos vulnerables de padres nuevos y que esperan los cuales luchan con retos a la salud y el bienestar provenientes del racismo estructural. A medida que las capacidades de reflexión son apoyadas dentro de las conversaciones de casos consultados, los proveedores espontáneamente identifican la necesidad de herramientas para hablar con efectividad de asuntos de raza, clase social y cultura y combatir el racismo estructural dentro del sistema de cuidado de salud. Políticas y procedimientos que sostienen el racismo estructural dejan de ser tolerables para proveedores que se dan por completo al trabajo para el cual han sido entrenados. Por medio de usar estas colaboraciones de consulta con enfermeras como casos de estudio organizacionales, este artículo describe una gama de retos que surgen para los proveedores y delinear los pasos para un involucramiento eficaz hacia la justicia reproductiva.

PALABRAS CLAVES

consulta de salud mental, justicia reproductiva, capacidad de reflexión, conciencia de sí mismo

RÉSUMÉ

Procéder à un déplacement de paradigme d'une "santé reproductive" vers une "justice reproductive" dans le domaine périnatal exige des changements à la fois au niveau du service de soin individuel et du système de soins. Le programme Nourrisson-Parent de l'Université de Californie à San Francisco (abrégée avec ses initiales UCSF) aux Etats-Unis a élargi sa consultation pionnière de santé mentale du nourrisson et de la petite enfance aux systèmes de soins périnataux en appliquant une approche de santé mentale du nourrisson à des programmes s'occupant de parents attendant un enfant ou à de nouveaux parents. En partenariat avec deux programmes de soins infirmières, les consultants de l'UCSF dirigent leurs efforts vers le soutien de capacités de réflexion sur la pratique et l'utilisation de soi dans la relation patient/prestataire. Ces deux programmes de soins infirmiers servent des groupes vulnérables de parents attendant un enfant ou de nouveaux parents qui rencontrent des difficultés et des défis à leur santé et bien-être du fait d'un racisme structural. Puisque les capacités de réflexion sont soutenues au sein des conférences discutant les cas de consultation, les prestataires identifient spontanément le besoin d'outils afin d'aborder de manière efficace les problèmes de race, de classe et de culture et afin de combattre le racisme structurel au sein du système de soins médicaux. Les mesures et les procédures qui maintiennent le racisme structurel cesse d'être tolérable pour les prestataires qui amènent au travail pour lequel ils ont été éduqués leur être tout entier. En utilisant ces partenariat de consultation avec les infirmières en tant qu'études de cas organisationnelles, cet article décrit un éventail de défis qui se posent aux prestataires et présente les étapes nécessaires pour un engagement efficace vers la justice reproductive.

MOTS CLÉS

consultation de santé mentale, justice reproductive, capacité de réflexion, conscience de soi

ZUSAMMENFASSUNG

Um einen Paradigmenwechsel von der "reproduktiven Gesundheit" zur "reproduktiven Gerechtigkeit" innerhalb des perinatalen Bereichs zu vollziehen, bedarf es gleichzeitig Veränderungen auf der Ebene des einzelnen Leistungserbringers und des Versorgungssystems. Das Programm für Säuglinge und Eltern von der UCSF hat seine wegweisende Beratung zur psychischen Gesundheit von Säuglingen und Kleinkindern auf perinatale Servicesysteme ausgeweitet, die einen Ansatz zur psychischen Gesundheit von Säuglingen auf Programme anwenden, die sich um werdende und neue Eltern kümmern. In Kooperation mit zwei Pflegeprogrammen richten die UCSF-Berater ihre Bestrebungen darauf aus, reflektierende Praxisfähigkeiten zu unterstützen und selbst in den Beziehungen zwischen Patient und Anbieter zu nutzen. Beide Pflegeprogramme dienen

vulnerablen Gruppen von werdenden und neuen Eltern, die sich aufgrund von strukturellem Rassismus mit Herausforderungen für Gesundheit und Wohlbefinden auseinandersetzen müssen. Da die Reflexionsfähigkeiten im Rahmen der Fallkonferenzen unterstützt werden, identifizieren die Anbieter spontan den Bedarf an Hilfsmitteln, um Fragen der Rasse, Schicht und Kultur effektiv anzugehen und strukturellen Rassismus im gesamten Gesundheitssystem zu bekämpfen. Richtlinien und Verfahren, die den strukturellen Rassismus aufrechterhalten, sind für Anbieter, die sich voll und ganz der Arbeit widmen, für die sie ausgebildet wurden, nicht mehr tolerierbar. Unter Nutzung dieser Pflegeberatungspartnerschaften als organisatorische Fallstudien beschreibt dieser Artikel eine Reihe von Herausforderungen, die sich für Anbieter ergeben und skizziert Schritte hin zu einem effektiven Engagement für reproduktive Gerechtigkeit.

STICHWÖRTER

Beratung zur psychischen Gesundheit, reproduktive Gerechtigkeit, Reflexionsfähigkeit, Selbstwahrnehmung

抄録

周産期領域において「生殖保健」から「生殖の公平性」への発想の転換をもたらすには、個々のヘルスケア提供者とそのケアシステムのレベルにおいて同時に変化を起こす必要がある。カリフォルニア大学サンフランシスコ校 (以下 UCSF) の乳幼児—親プログラムは、それまで開拓してきた乳幼児と小児期早期の精神保健コンサルテーションを、親になる人や親となった人をケアするプログラムに乳幼児精神保健アプローチを適用する周産期サービスシステムへと拡大してきた。2つの看護プログラムが協力し、UCSF 相談員は内省的な実践力と、患者と医療従事者の関係性のなかで自己を利用した関わりを支持することに務めている。両看護プログラムは、構造的な人種差別にまつわる健康や幸福の問題に取り組んでいるこれから親になる人や新しい親たちの弱者的立場にあるグループを支援する。症例検討会議を通じて内省的能力が支持されるにつれ、医療従事者は、人種、階級、文化の問題を効果的に汲み上げ、ヘルスケアシステムを通じて構造的な人種差別と闘う手段へのニーズを自発的に究明する。構造的な人種差別を堅持する政策や手順は、訓練されて行う責務を果たすのに自己の全てを用いる医療従事者にとっては許容しがたくなる。組織的な症例研究としてのこれらの看護コンサルテーションのパートナーシップを用いることで、本研究は医療従事者が立ち向かう様々な困難を示し、生殖の公平性に効果的に関わる道筋を提示する。

キーワード

精神保健的コンサルテーション, 生殖の公平性, 内省的な能力, 自己の意識

摘要

在圍産期內實現從“生殖健康”到“生殖公義”的範式轉變, 需要同時改變個體醫療保健提供者和護理系統的水平。加州大學三藩市分校的嬰兒—父母計劃已將其開創性的嬰兒和幼兒心理健康諮詢擴展到圍産期服務系統, 將嬰兒心理健康方法應用於照顧準父母和新父母的計劃。加州大學三藩市分校的顧問與兩個護理計劃合作, 努力支持反思實踐能力和患者/提供者關係中的自我使用。這兩個護士計劃都為弱勢群體提供服務, 幫助他們應對結構性種族主義帶來的健康和福祉挑戰。由於諮詢案例會議支持反思能力, 提供者自發地確定是否需要有效解決種族、階級和文化問題的工具, 並在整個醫療保健系統中打擊結構性種族主義。堅持結構性種族主義的政策和程序對於那些將自己全部投入到他們接受過培訓工作中的提供者來說是不能容忍的。本文使用這些護士諮詢夥伴關係作為組織案例研究, 描述提供者面臨的一系列挑戰, 及有效參與生殖正義的步驟。

關鍵詞

心理健康諮詢, 生殖公義, 反思能力, 自我意識

ملخص

يتطلب إحداث تحول نموذجي من "الصحة الإنجابية" إلى "العدالة الإنجابية" في مجال ما حول الحمل والولادة إجراء تغييرات متزامنة على مستوى فردي لمقدمي الرعاية الصحية ونظام الرعاية بشكل عام. وقد وسّع برنامج الرضع والوالدين التابع لجامعة كاليفورنيا-سان فرانسيسكو استشارته الرائدة في مجال الصحة النفسية للرضع والطفولة المبكرة لتشمل نظم الخدمات في فترة ما حول الولادة التي تطبق نهج الصحة النفسية للرضع على برامج رعاية الآباء المتوقعين والجدد. وبالشراكة مع برنامجين للتمريض، يوجه استشاريو الجامعة جهودهم إلى دعم قدرات الممارسة التأملية واستخدام الذات في العلاقات بين المرضى ومقدمي الخدمات. ويخدم كلا البرنامجين الفئات الضعيفة من الأمهات الحوامل والجدد الذين يتصدون للتحديات التي تواجه الصحة والرفاهية الناجمة عن العنصرية الهيكلية. وبما أن القدرات التأملية مدعومة في مؤتمرات الحالات الاستشارية، فإن مقدمي الخدمات يرون تلقائياً الحاجة إلى أدوات لمعالجة قضايا العرق والطبقة والثقافة معالجة فعالة ومكافحة العنصرية الهيكلية في جميع أنحاء نظام الرعاية الصحية. ولم تعد السياسات والإجراءات التي تدعم العنصرية الهيكلية مقبولة لمقدمي الخدمات الذين يجلبون أنفسهم بالكامل إلى العمل الذي يتدربون على القيام به. وباستخدام هذه الشراكات التشاركية مع الممرضين كدراسات حالة تنظيمية، تصف هذه المقالة مجموعة من التحديات التي تنشأ أمام مقدمي الخدمات وتحدد الخطوات اللازمة للمشاركة الفعالة نحو تحقيق العدالة الإنجابية.

الكلمات الرئيسية

استشارة الصحة النفسية، العدالة الإنجابية، القدرة التأملية، الوعي الذاتي

1 | INTRODUCTION

Nurses and midwives working in community settings are on the forefront of supporting the most marginalized women and young children and therefore can be influential in addressing reproductive justice. As medical providers, they have long recognized the importance of their personal relationships with patients in providing optimal care. With the focus on the relationship between nurse and midwife and patient as part of what helps and heals, a natural partnership for collaboration with mental health professionals trained in the use-of-self and in addressing issues of reproductive oppression and justice arises. Dewane (2006) defined the use-of-self as the combining of knowledge, values, and skills with aspects of one's personal self, including personality traits, belief systems, life experiences, and cultural heritage. Although the importance of the therapeutic alliance between nurse and patient has been a long-standing part of training, nurses receiving consultation have endorsed the modeling that the consultant provides as critical to translating theory into practice, helping them to bring their full, authentic selves to the forefront of healing relationships.

Through an extension of our pioneering infant and early childhood mental health consultation approach, the Infant-Parent Program (IPP) at the University of California, San Francisco (UCSF) brings an infant mental health lens, which has the provider-patient relationship as central, to a nursing and midwifery program. This article explores the impact of both case-specific and programmatic consultation on developing reflective practice capacities and use-of-self in the patient-provider relationship in programs serving vulnerable groups of expectant and new parents. As reflective capacities are supported through consultation, the provider's capacity to address trauma, mental health, and substance use is strengthened. It is through the nurse's capacity to reflect on

her own personal and professional experiences that she comes to more fully understand the intersecting oppressions facing her patients, thus applying the work of reproductive justice. Heightened sensitivity to the sociopolitical factors contributing to these issues leads providers to spontaneously identify the need for tools to effectively address issues of race, class, and culture and to combat multiple levels of oppression such as structural racism, sexism, and reproductive oppression throughout the healthcare system.

Mental health consultation aims to increase capacity within providers and programs. It also focuses on impacting the larger systems in hopes of reducing reproductive oppression and creating community systems functioning from a premise of reproductive justice, be it access to healthcare, choice in labor and delivery, the intersection with criminal justice, and the child welfare system. "Reproductive justice is the complete physical, mental, spiritual, political and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Asian Communities for Reproductive Justice, 2005). This framework is nested in the struggle for social justice and human rights as it identifies how reproductive oppression is the result of the intersections of multiple oppressions (Ross, n.d.). Age, class, race, religion, and sexual orientation are all considered in the reproductive framework as interconnected issues that affect how a woman has or does not have control of her reproductive health and rights (Mahoney, n.d.).

2 | FINDING EACH OTHER: HOW IT BEGAN

2.1 | The IPP: Who we are and what we do

In existence since 1979, UCSF's IPP is San Francisco's pioneering mental health organization specializing in treating

children birth to 3 years of age. The IPP has a strong and distinguished commitment to underserved, vulnerable, and at-risk populations. The program provides important services to this population, including infant-parent psychotherapy, therapeutic shadowing, developmental therapeutic playgroups, and hospital-based perinatal mental health services. It also provides vital consultation to childcare programs, domestic violence and homeless shelters, family resource centers, and residential substance-abuse programs, thereby influencing the development of over 3,000 multiethnic young children impacted by poverty. Through our already established consultation work with vulnerable pregnant mothers and babies in the hospital and community programs, extending our consultative work to the Nurse-Family Partnership (NFP) nurses and the hospital's midwives was a natural outgrowth. However, establishing the structure of consultation, developing the relationships in which collaboration is embedded, and securing funding took time to mature into the models presented here.

IPP's approach to consultation focuses on supporting the provider's ability to deliver care that takes into account the needs of both the parent and child and enhancing coordination among all of the service providers involved with a family, including the network of hospital providers serving children and their families and the wider community agencies such as Child Protective Services (CPS). Consultation also focuses on addressing the providers' personal experiences working with their patients. By exploring and addressing the complex and often strong emotions that providers experience when working with highly stressed, often traumatized and very vulnerable families and their infants, the consultant helps providers "metabolize" and process their experiences so that those experiences are less likely to interfere with providing optimal care. The self-reflection required to comprehend and address these strong emotions fits within Hildegard Peplau's (2004) pioneering theory of nursing, which posits that the extent to which a nurse understands her own functioning will determine the extent to which she comes to understand the situation confronting her patient.

Most of the women who give birth at this hospital struggle with multiple and serious stressors, including mental health and substance-use issues, isolation and limited social supports (which may arise from immigration, homelessness, involvement with the criminal justice system, bias, and/or racism), and current and historical trauma. To ameliorate these difficulties, medical providers first need to be able to identify them. A provider's ability to identify these problems can be obscured by a lack of knowledge about the patient and her personal history; however, providers may fail to comprehend their patients' suffering as a self-protective mechanism which inhibits the transfer of important information. Consultation addresses both the provider's lack of knowledge and the inherent desire to protect oneself from the emotional trauma that

patients suffer by helping providers tolerate pain, relinquish judgment, and challenge defenses.

In addition to a pattern of disrespect and abuse toward pregnant and birthing women, including forced surgery (Diaz-Tello, 2016), reproductive oppression occurs in the subtly demeaning, dismissive ways that providers treat women regarding pregnancy, childbirth, and parenting. Providers are often unaware of how they are behaving and how their behaviors impact the feelings of their patients. As the capacity for self-reflection deepens, nurses have reported noticing more examples of the subtly demeaning ways that their patients are treated within the various systems. Numerous groups (e.g., United Nations, feminist ethicists, reproductive justice scholars, public health advocates, and human rights groups) have considered larger scale structural and systemic oppression to be a form of gender-based violence, which can be played out in provider-patient relationships. Mental health consultation is an effective intervention for interrupting these patterns, as it provides a safe place for providers to reflect on and explore feelings, reactions, and behaviors toward their patients. As providers' self-awareness and understanding of interpersonal dynamics increase, they are better able to build therapeutic alliances with patients in ways that are respectful and empowering. Further, providers who receive mental health consultation are increasingly apt to engage in advocacy, as they become more able to recognize reproductive oppression. Maintaining consistent meetings over time, consultation affords providers opportunities to refine their skills in addressing challenging situations by providing language to use with patients and other professionals as well as ideas about how to address difficult issues.

2.2 | Consultation to the midwives

The Nurse-Midwives are the longest standing hospital-based midwifery practice in San Francisco. In 1975, midwives from the community and obstetric faculty joined to bring midwifery care into the obstetric practice at the hospital. From the beginning, they served a diverse and predominantly low-income population of women and families. Since then, the practice has grown in proportion of patients served and influence of the midwifery model of care on all perinatal services at the hospital. Currently, midwives provide prenatal care at the hospital's Women's Health Center, a community clinic and in partnership with a community agency.

In 2008, leadership of the IPP and the midwives began talking about how they might join forces to bring support for those providing care for the pregnant patients collaboratively served. The IPP and the midwives obtained collaborative grant funding to support this project and began building the formal relationship between these two programs.

A second grant funded IPP to provide direct consultation work with the midwives, something that has continued

because it has proven to be so valuable. In the current model, the consultant joins the midwifery monthly staff meeting to discuss particular cases and to explore use-of-self in the caring relationship. The consultant provides both individual and group formats and addresses systemic as well as case-specific needs, with particular focus on caring for immigrant families and patients with mental health difficulties, including substance use, and expanding the focus on the baby throughout prenatal care.

2.3 | Consultation to the NFP program

San Francisco public health nurses attended a pivotal training in Spring 2013, where they encountered IPP mental health practitioners/educators and began envisioning greater opportunities for incorporating mental health interventions and consultation into Maternal Child Health home-visiting programs such as the NFP. The NFP program pairs a registered nurse with first-time, low-income mothers, prior to 28 weeks' gestation, and continues with home visits until the child's second birthday. The model builds on the client's own strengths and desires for a healthy, happy baby and supports the mother's goal setting to achieve greater opportunities for herself as well as for her baby. The opportunity to establish a sustainable, formally supported structure for collaboration arose when the foundation funding the IPP's existing midwives' consultation efforts invited the IPP to extend consultation services to other medical providers. After careful consideration, IPP clinicians and NFP leadership mutually decided that the consultant would join the bimonthly NFP case conference. The consultant's role was to offer reflective practice that underscores the use-of-self in the patient-provider relationship in addition to expanding nurses' understanding of infant development, infant mental health, and the infant-parent relationship.

3 | ELEMENTS OF CONSULTATION

Although the work of the midwives differs dramatically from the work of NFP nurses, their experiences of mental health consultation and its profound effects on their work are similar. For both nursing groups, having dedicated, predictable, and protected time with the consultant provides a regular opportunity for reflection. Within the safety of the consultation relationship developed over time, nurses and midwives feel more able to explore thoughts, feelings, and actions that arise within the context of the helping relationship. Self-reflection within the context of their relationships with patients is a newer experience for many of these providers, one that shifts the frame with the patient-provider relationship becoming central. Both midwives and nurses have long-term relationships with their patients that serve

as the foundation for using the relationship as a transformative process. Their training, however, does not primarily focus on the skills necessary to use their relationships with patients as the central *therapeutic* intervention. Oftentimes, especially in hospital and clinic settings, the demand for productivity interferes with the wish to have more time to really connect with patients. Evidence has demonstrated, however, that the more present, attentive, and empathic a medical provider can be with the patient, the higher the satisfaction reported by patients (Kim, Kaplowitz, & Johnston, 2004).

The reflection on the provider's work encompasses different levels important in the care and support provided to women and their young families. These levels include attending to the nurse/midwife and patient, parent and baby, and coworker and collaborative partner. Another level addresses influences on the larger system, including hospital, child welfare, criminal justice, housing, and so on. The consultant holds these various levels in mind regardless of which one may be overtly discussed in the moment because justice for the patients served can only truly come when all these levels are touched by the light of awareness.

3.1 | Impact of consultation on interpersonal relationships in nursing practice

The power of hope for the future and the desire to provide a better life for her firstborn child is an incredible catalyst for building and strengthening the relationship between the nurse and the mother-to-be, and later with the mother and her firstborn child. Whereas the nurse focuses on improving pregnancy outcomes, enhancing child health, and development and guiding the parental life course, mental health consultation is increasingly needed to help the nurse home visitors further develop the capacity for self-awareness and reflection that they need to be effective in this delicate work.

Mothers participating in the NFP often suffer maternal depression, anxiety, addiction, and other mental health problems. Due to the long-term relationship, clients are more inclined to share the challenges and traumatic experiences sustained throughout much of their life. Sadly, the trust that is established between the client and her nurse may be the first trusting relationship the client has experienced and is a hallmark of the program. As a result, nurses are highly likely to be exposed to their clients' problematic mental health issues, and consultation helps them deal with the emotional impact of those issues. While NFP nurses receive training in motivational interviewing techniques and reflective practice skills, consultation with the mental health practitioner is extremely beneficial in translating the training into practice. This is particularly true when nurses feel conflicted, triggered, or challenged by repeated exposure to traumatic stories.

3.2 | Being versus doing

When consultation first began, nurses wanted trainings on specific topics and answers to questions. Supervisors commented that the nurses were initially resistant to engage in self-reflection, preferring a “quick fix” to the dilemmas they faced. The preference for a quick fix was understandable given their large caseloads and the intense needs of the families. Through the consultative stance of wondering rather than knowing and attending to the subjective experience of all participants (Johnston & Brinamen, 2006), the nurses embraced reflection and exploration rather than feeling pressured to solve the problem. Taking time in case conference to consider the diverse experiences of the nurse, the adult client, and the fetus/baby fosters the ability to understand the feelings and thoughts of the other, leading to greater empathy and engendering a culture of curiosity about reasons for behavior (Johnston & Brinamen, 2012). From a transactional perspective, successful consultation depends on the quality of the consultative relationship as well as the consultant’s way of being (Johnston & Brinamen, 2005, 2006, 2009). The consultant’s way of being with nurses has an effect on the way nurses respond to their clients, thereby utilizing the parallel process as a transformative experience (Brinamen, Taranta, & Johnston, 2012).

The three NFP nurses responsible for providing reflective supervision articulated the many benefits they receive from consultation. Of critical importance, they report increased patience with dilemmas presented by supervisees and expanded comfort sitting with silence. Nurses and nursing supervisors, like many other healthcare professionals, are trained problem solvers, and silence can seem antithetical to their training. However, the capacity to sit with silence allows space to open up for exploration and understanding, leading to more effective action.

Supervisors find that this practice in patience and willingness to explore results in their supervisees demonstrating the same skills in their relationships with the families they serve. The families feel a deeper sense of being heard and are helped to develop their own reflective and problem-solving abilities in the face of many obstacles and struggles. Through the consultant’s practice of returning again and again to the relationship with mom and baby, supervisors are reminded of the importance of coming back to the relationship between the dyad, both in pregnancy and postpartum. It is easy to imagine how the focus on the relationship can be overtaken by the myriad of needs that families have that feel both immediate and insurmountable to the nurses. Understandably, by the nature of their roles and training, nurses frequently feel pulled to act and fix. While there are times when doing takes precedence over reflecting, reflection helps inform action. Through consultation, the nurses come to recognize that how they are in the relationship is as important as what they do (Pawl & St. John, 1998).

3.3 | Therapeutic relationship as facilitator of change

Mental health consultation practices developed at the IPP rest on the foundation of psychodynamically oriented therapeutic skills and interventions utilized in infant-parent psychotherapy. In contrast to the therapeutic alliance taught in medical training, the therapeutically oriented consultation efforts aim to optimize early childhood attachment between infants and their primary caregivers by strengthening relational and reflective capacities in the nurses and midwives who provide ongoing care for the families and by transforming policies in the larger systems.

Research has shown that the single most influential driving force for change in both psychotherapy and consultation is the relationship between the therapist/consultant and the client/consultee regardless of the theoretical orientation of the practitioner (Johnston & Brinamen, 2005, 2006, 2009; Safran, Muran, & Proskurov, 2009; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The means through which change occurs in therapeutic and consultative relationships between adults is comparable to the ways that secure and attuned attachment with caregivers shapes the infant’s socially oriented brain, provides affect regulation, constructs a sense of self, and supports all domains of development in the first few years of life (Cozolino, 2010; Johnston & Brinamen, 2012; Schore, 1994). As the consultant’s nonjudgmental, curious, reflective stance provides safety for the providers to reflect on both their clients’ and their own experiences, intensive and overwhelming emotions become increasingly tolerable for the nurses. This tolerance strengthens their capacity to understand these experiences and to base action on this new understanding. Within the safety of the consultation relationship, nurses express and explore their own biases, values, and motivations, which helps them to see both personal and structural impediments to reproductive equity. This self-exploration is the work of reproductive justice. Reproductive justice has its roots in the Black women’s self-help movement and, as such, has self-reflection as a part of its theory of change. Allowing the nurse to feel and explore the full range of emotional responses to both clients and systemic challenges in the presence of the consultant allows for greater self-understanding aligned with the implicit values of reproductive justice, public health nursing, and maternal care in a community hospital setting.

On a neurobiological level, relationship translates to the communication of two social brains that, through attunement, begin to synchronize and mirror one another (Cozolino, 2014). With her regulated presence and the capacity to hold multiple perspectives and the larger context in mind, the consultant serves a role similar to the executive function of the brain that allows regulation and integration of complex and overwhelming emotional experiences and supports the

development of similar capacities in the providers to utilize with their clients.

This coregulation function is especially important in the context of trauma prevalent in the lives of the families served, not only on individual levels but also in the context of intergenerational and ongoing racial and systemic oppression. Trauma is an overwhelming experience perceived as threatening to one's own safety and survival (Ogden, Minton, & Pain, 2006; Pearlman & Saakvitne, 1995). In an attempt to cope, the brain limits higher cortical functions and mobilizes more basic neural structures to initiate a quick response to the perceived threat. When these physiological reactions fail to restore safety, caregivers continue to rely on an activated nervous system that has diminished capacities for integration and regulation. As a result, the ability to provide attuned support for their infants becomes restricted.

In the same way, intense stress from exposure to the families' traumatic experiences often interferes with the provider's ability to pause, reflect, and be curious because these capacities rely on higher level brain functions that become restricted under fear. The consultant utilizes the coregulation function of the attuned relational experience to support the providers to integrate their own reactions to the families' often-overwhelming emotions and to find meaning in their presentation, resulting in greater empathy and understanding. As the midwives and nurses cultivate these capacities, their ability to use themselves and their attuned relationship to help the infant–parent dyads to regulate and develop greater connection increases.

With an increased capacity to use their own selves and the relationship created with the client, the nurses are better able to meet a central component of the NFP model—that of developing a therapeutic relationship. Supervisors commented that seeing themselves in a therapeutic role is a new concept for many of the nurses. Although the nurses are not trained as therapists, they are charged with cultivating therapeutic relationships. One supervisor commented that just recognizing this growing edge “gives permission to acknowledge the therapeutic relationship for what it is and gives permission to have those hard conversations with clients.” The consultant's modeling in case conferences around conversations such as personal and historical trauma, anxiety, stress, substance use, race, and bias has proven effective as a tool for supervisors to replay in supervision and for nurses to call upon in their home visits. The nurses report avoiding these topics due to fears that talking about them will harm the mom and/or baby. However, the consultant's modeling has made these previously challenging topics approachable. Consultation helps the nurses explore their own feelings and attitudes around these issues. In developing their skill and self-regulatory capacities around sitting with their own discomfort in the safety of case conference and supervision, they are more prepared to have the difficult conversations previously avoided and to provide

support to their clients in ways that enhance reproductive justice.

One nurse shared her experience of the impact of consultation on having difficult conversations:

It has been eye opening to have your voice in case conferences. I know it has helped me grow professionally. One, in how I address trauma with clients, and two, in how I sit with my own discomfort over a certain topic or issue during a home visit. I can think personally of my own case conference where we discussed my African American client's misunderstanding of her son's milestones, expecting him to crawl at two months. You opened my eyes to seeing this not only as an opportunity for education on child development, but a way for me to tie in her fears of raising a Black boy in the US, and how her own trauma as a young girl might impact her perception of her son's development. It allowed me to open a discussion that I might have missed. She feared that letting me and other services into her life would result in a CPS call. After discussing milestones and child development, I asked her why she felt it was so important for her son to develop quickly. She shared that he needed to be smarter and stronger to avoid the trauma that she endured. The idea of her son experiencing time in foster care and being victim to the trauma that she experienced was the driver of her fear and expectations. She lacked confidence in herself as a mother, and felt that if she and her son were ever separated, he would need to be strong and smart enough to fight the trauma that could arise. Her thought processes were dominated so much by fear. I was able to really dig into that fear.

As reflected in this nurse's comments, her comfort in attending to issues around structural racism and historical trauma provided an opportunity for this young mother to express and explore her deep concerns around raising and protecting her Black son in the United States.

3.4 | Cultivating self-awareness

Self-awareness is essential to reflection, as our attitudes and values impact the how and the why of what we do (Howaston-Jones, 2010). Self-awareness includes self-knowledge combined with an awareness of one's own subjective experience and the needs of the patient. Self-awareness leads to greater capacity to manage strong emotions in a thoughtful manner rather than being overwhelmed by them, resulting in more

effective responses to clients. Developing self-awareness is a key component to the capacity for reflection and is a necessary tool for uncovering implicit bias. Supervisors emphasize the impact of consultation on cultivating self-awareness. One supervisor noted the change over time in her supervisees' capacity for self-awareness and reflection on the emotional experience in the moment:

There is an openness to do more honest work about how they react in the moment with their clients. Nurses are getting tools on how to face the anger and other uncomfortable feelings. The consultant helps nurses hold their own feelings, and then we model the practice of reflection on those feelings. They come to feel more effective in their conversations with their clients. And, as a result, the risk of nurse burnout decreases.

It is not only support but also self-awareness that lead to a greater sense of job satisfaction and thus lowers burnout for providers (Novack, Epstein, & Paulsen, 1999).

The consultant's participation in case conference has provided an in vivo experience around developing therapeutic relationships, as she reflects with the group through open-ended questions and a wondering stance, about underlying thoughts, attitudes, and feelings fueling actions—both in the nurse and in the parent and baby. As their self-awareness increases, nurses are less likely to react from a place of judgment or implicit bias and more able to empower and support the self-determination of their clients. By mirroring what they learned in case conference, supervisors model newer ways of interacting with patients. In turn, the nurses are using more therapeutic communication in their work during home visits. One supervisor spoke directly about the parallel process occurring between the collaboration with the consultant, within the supervisory relationship, and between the nurse and client:

The biggest change I've seen is the parallel process. You [consultant] inquired why nurses weren't asking difficult questions related to interpersonal violence. This gave me the green light to sit with that concept and apply it to supervision. What did it feel like to the nurse in the moment with the client? It has been important to have that moment of pause and uncomfortable feelings in supervision and to sit with it. It's very powerful to have them consider their feelings around these hard issues. Out of consultation, I decided to go on a home visit with a supervisee and felt some of the fear in that home. I heard the nurse talk about safety planning and the relationship with the unborn child. Having a

shared experience of the fear present in the room allowed the nurse to be less rigid and more able to speak even when uncomfortable.

This account not only reflects the parallel process occurring within consultation, supervision, and the nurse–client relationship but also highlights the importance of coregulation within the consultative process and reflective supervision in helping nurses to be able to metabolize intense feelings and to respond rather than react out of fear.

3.5 | Vulnerability leads to growth

According to the supervisors, nurses are more vulnerable in their presentations since the consultant joined the case conference meetings. The consultant's nonjudgmental and curious stance provides a sense of safety that allows the nurses to reflect on their own experiences and that of their clients. As a result, case conference evolved from problem-solving and outcomes to discussing the moment-to-moment experience of the nurse and the dyad. This expanded discussion creates space for more vulnerability, self-reflection, and a higher sense of safety among the group. Nurses are better able to sit with painful feelings without being overwhelmed by them. In so doing, they can tolerate and hold a fuller understanding of what the client feels and experiences. In addition, they have become much more courageous and willing to bring up hard conversations in supervision. Through reflective supervision and consultation, the program has been better able to recognize and support the needs of the home-visiting nurses. In one-on-one supervision, supervisors explore the intimate experience held by the nurse, thus supporting more vulnerability in case conference and as a team. One supervisor reflected on her own experience with vulnerability, as follows:

I learned that being vulnerable is critical and the only way to push myself to grow. Until I allowed vulnerability to happen, my needs were more superficial as I was holding a lot in. My guard was up, protecting who I was inside. We need to face our own bias and experience. Being able to feel safe and vulnerable is how my practice changed.

Through the stance of curiosity and compassion in exploring the experiences of the nurses, the consultant is supporting growth of the whole program as the nurses demonstrate more vulnerability and courage within other venues. The regularity and consistency of the consultant's presence in addressing individual cases allow for wondering and reflection around broader issues as well. The consultant openly wonders about issues of race and culture in both individual and case presentations. Although this has given tacit permission for these issues

of race, power, privilege, and oppression to surface in supervision and other team meetings, challenges have come up in how this culturally diverse group of nurses enters into conversations on race. Nurses have requested more training on these topics, especially with the recent shifts in the political climate leaving clients even more vulnerable and frightened. Expanding capacities to have challenging discussions among themselves opens the door to have these conversations with clients. Further, the willingness to explore, personally and professionally, these issues of oppression and implicit bias creates a platform for addressing systemic issues interfering with reproductive justice. Although research has suggested that unconscious racial bias does not shift by merely increasing self-awareness, awareness of the impact of one's actions is the first step toward openness to be altered by direct experience that can lead to a shift in attitudes and behavior.

3.6 | Skill-building

Although all the NFP nurse supervisors have specific training in reflective supervision, mental health consultation helps them to translate that training into more effective supervisory practice. Participating in the case conference with the consultant, the supervisors are repeatedly exposed to a multiplicity of ways to cultivate and deepen reflective capacities. In addition, they have come to value a fuller exploration of the nurses' and clients' experiences because they see that it leads to greater effectiveness, increased comfort in the work, and more connected relationships. Recognizing these gains, conversations have shifted from quick problem-solving to more spacious inquiry. As one supervising nurse stated:

To increase my abilities as a supervisor, I have to practice patience, pausing and waiting. I discovered that it is more helpful to ask just a few probing open ending questions, as the consultant models, to elicit reflection in my supervisee. I'm able to take this modeling from case conference into reflective supervision. This process is skill building at the supervisory level. My hope is that through the parallel process nurses are incorporating patience, pausing and waiting in conversations with clients.

Another charge nurse reflected on her own capacity for tolerating intense emotions within the supervisory relationship:

Previously, I didn't know that I had the skill to support a hard moment in supervision where a nurse was angry, hurt and emotional. Recently, a nurse came in angry with a client. I was able to sit in the silence and then ask one or two questions. The nurse repeatedly apologized for

expressing her strong feelings though I was not upset that she was sharing her anger with me. Now, it feels positive that nurses are sharing their feelings in supervision. It's empowering as a supervisor, versus three months ago when I felt like I didn't know what to say.

Given that these nurse supervisors oversee 231 cases, further increasing their capacity to hold the emotional experience of the frontline nurses and to create a space for reflecting and exploring can have a ripple effect throughout the entire program, benefiting not only their supervisees but also the young mothers and children enrolled in the program.

3.7 | The Consultant's Reflective Practice

Regular supervision and formal reflective group conversations with colleagues are essential components in increasing the consultant's own self-awareness capacity on ways of being with consultees. The consultant confronts her own experience, unconscious bias, and unique cultural and racial positions in relationship to her consultees and their clients through the very same process that she provides to her consultees. In addition to grappling with the practices of social and reproductive justice within the program, consultants at the IPP attend trainings and seek various forms of consultation focusing on multicultural and racial issues from the mental health provider's experience.

4 | IMPACT OF CONSULTATION ON MULTIPLE LEVELS

4.1 | Individual impact of consultation

Consultation works at multiple levels at the same time. The most immediate effect is at the individual level. This happens between the consultant and the providers as well as between the providers and their clients. Similar to the NFP nurses, midwives have looked deeper into their feelings and reactions in a nonjudgmental way particularly around patients with substance-use disorders. This exploration serves as a role model for approaching difficult conversations with these patients. Conversations in consultation offer a forum for exploring strategies for engaging and partnering with pregnant women struggling with substance use, resulting in an increased ability to highlight patient strengths, personal goals, and self-determination. Midwives find themselves reflecting on consultation conversations and using those insights to create better relationships that help their patients to effect changes in their lives. Similar to how patients feel supported by their providers' containing presence, the midwives benefit from the consultant's recognition of painful experiences as well as highlighting the small successes. This helps them to

grow in their practice and to dissipate some of the secondary trauma encountered in their work.

Through consultation, midwives increase their knowledge about the developmental impact of trauma and the developmental impact of pregnancy, and how the two intersect with one another. Weaving a subtle didactic thread throughout the ongoing consultation conversations results in midwives developing a better understanding of individuals with substance-use disorders and other mental health problems. This knowledge leads to a fuller understanding of their patients and the development of more empathy, admiration, and respect for the women they care for. Furthermore, through modeling by the consultant, midwives have better tools to help them in their interactions with patients. Midwives report an increased sense of personal resilience in the face of trauma, allowing them to be more present with patients and to truly meet them where they are.

Similar to the experience of the NFP nurses, as self-awareness grows in the midwives, their ability to recognize, reflect, and address issues around race and reproductive oppression also grows, leading to deeper and more authentic relationships with patients and more possibility for advocacy on their behalf. In addition, using the safety of the consultation forum to explore unconscious bias and racism within their own group promotes deeper understanding of each other and more honest exploration of how race, power, and privilege are enacted among themselves, with their clients, in the larger hospital system and at a structural level. This deep exploration is possible, in part, because this seasoned group of midwives has been working together for many years and is committed to exploring these experiences together. One midwife commented on her experience of this progression in consultation:

It is so unusual to make time for this type of self-reflection. I feel like our natural progression from concrete and practical ways to work with patients struggling with substance use issues morphed into a bigger and more difficult topic for our service on exploring ways to address issues of race, class and culture that effect many of our patient/provider relationships.

4.2 | System impact

Beyond the impact of consultation on midwives' individual relationships with their patients, there is clearly an impact on the larger system due, in part, to the way that consultation activates midwives to step up as leaders in their healthcare teams. On a broader level, midwives report increased capacity to be concrete advocates for their patients, especially those with mental health issues including substance use, within the system of care. An early example of this was illustrated by a case brought forward by a midwife at a consultation meeting.

She felt uncomfortable while in the Labor and Delivery Unit hearing other staff talk about a "difficult patient" in ways that created a negative story and that were not supportive of this woman engaging in a therapeutic way. As a result of the work done in consultation, the midwife observed that the staff was not in touch with ways that this patient triggered them. Until providers are able to reflect in the moment on their experiences with patients, they are more likely to respond with judgment and unconscious bias, making it difficult to provide empathic and attuned care. Her question for the consultation group was how she might have responded in the moment to both advocate for the patient and to support staff to gain insight into their own feelings and how those feelings influenced their behavior. As a result of consultation, she and others respond in new ways in these situations, modeling reflective practices and helping to guide others to new insights. In addition, deeper understanding cultivated in consultation about the impact of trauma and its tendency to fragment exemplified by this "difficult patient" prompted a new protocol whereby a provider can call a quick team meeting on the floor to regroup around these challenging moments. This protocol was aptly named *Code Lavender* for its intention to calm providers, provide a space for reflection, and promote an integrated understanding of the patient.

4.3 | Structural impact

Another level that consultation aims to impact is the larger systems of care. Again, this opportunity supports midwives to emerge as important leaders in efforts to create more sensitive systems of care for women with trauma, substance-use disorders, and other mental illness within the hospital setting. Lu et al. (2010) found that fragmentation in service delivery deters access to care for low-income women with other competing needs. Therefore, consultation efforts emphasize the importance of integration of obstetric, pediatrics, and mental health services.

Change initiatives have come directly out of conversations at consultation meetings (e.g., recent efforts to reconsider policies related to urine toxicology screening of pregnant women). The policies currently in place, examples of the intersecting oppressions of racism and sexism, continue practices of reproductive oppression as they focus on specific past behaviors frequently associated with women of color and women living in poverty rather than current indicators of possible substance use. Incarcerated women, young women in juvenile hall, and women with a mental disability including drug addiction are the most likely to be disempowered and disrespected and have to battle for the right to carry their pregnancies and receive the support that they need (Oparah & Bonaparte, 2016). The work of attending to structural racism and bias has primarily focused on these psychosocially higher risk women and on how the system can

best support them to become healthier during pregnancy and be prepared for the birth and care of a baby. Examples of results of these efforts include interprofessional meetings with CPS leadership, training and guidelines development around breast-feeding in women with substance-use disorders, and creation of a patient-centered Family Care Plan (FCP). This plan provides a high-risk woman (usually a woman suffering with addiction, other mental health issues, and/or is homelessness) the opportunity to collaborate with her prenatal and mental health providers to create a clear record of her intentions around caring for her new child, thereby enhancing her self-determination. It clearly outlines the expectations of how the system will approach and interact with the patient during the intrapartum and postpartum experiences. The FCP has been extremely helpful because all the midwives, doctors, nurses, social workers, and pediatricians are expected to read and understand this document when caring for a patient.

Anecdotally, the midwives experience a disproportionate number of women of color having a call made to CPS upon delivery. This is in line with research that has found differential treatment at each point in the child welfare decision-making process (Roberts, 2002). For example, Black women are much more likely than are White women to be reported by hospital staff for substance abuse during pregnancy, leading to removal of their babies by CPS (Roberts, n.d.). The creation of the FCP was an attempt to bring a fuller picture of the individual woman from her healthcare team providing care over time, thus combating the potentially racist practices in child welfare where a disproportionate number of children of color are forcibly separated from their families (Roberts, 2002). With this plan in place, the hope is that professionals unfamiliar with a patient, but charged with making a decision about reporting to CPS, will be less influenced by structural racism and better able to make informed decisions, moving closer to a system of reproductive justice for all women.

5 | CASE EXAMPLE

The following case illustrates the impact of consultation on the different levels discussed in this article. An NFP nurse reached out for individual consultation on a case involving a 20-year-old African American woman incarcerated at the county jail. This is the first time that the San Francisco NFP program enrolled a pregnant woman while incarcerated. The nurse expressed her shock and dismay at the limited services available to pregnant inmates. Although the nurse initially intended to support the maternal role only upon release, when she first met her client, she encountered the harsh reality faced by pregnant women in jail, leading her to be more active during the period of incarceration. The nurse expressed her sadness and anger for the little attention paid to the unique experi-

ence of a pregnant inmate and the few opportunities available to learn about pregnancy outside of brief encounters with the jail obstetrics medical provider. Throughout the first visit, the nurse was horrified that her client remained handcuffed and had to sign consents with her hands shackled. By sharing her initial reaction of shock and dismay with the consultant, the nurse reflected on and metabolized the intensity of her experience and created space for being curious about the client's experience and the possibilities of addressing her needs within the system. In addition to the nurse finding ways of being in the challenging environment of the jail, she found important ways to act on behalf of her client. The nurse advocated for the handcuffs to be removed in subsequent visits. What she came to learn was that California Penal Code restricts shackling, requiring handcuffs and chains to be removed for medical care, delivery, and recovery.

While California has laws on the books protecting rights of pregnant inmates, there are many states that continue to use this form of reproductive oppression. According to the American Congress of Obstetricians and Gynecologists (2016), only 23 states and the District of Columbia have statutes or policies prohibiting restraints in labor; 37 states and the District of Columbia have statute or policy prohibiting or strictly limiting the use of restraints during pregnancy, labor, birthing, and recovery, or a subset of these stages (Saavedra, 2016). In 28 states, pregnant women can be chained as they walk from their cells to their prenatal appointments or as they deliver a new life into this world and hold their babies for the first time. Among these states, nearly half do not have any restrictions on the indiscriminate shackling of pregnant women (Cook, 2016). Even where there are statutes or policies regulating shackling, the implementation varies widely. To protect the rights of pregnant inmates is a challenge nationwide. This case presents one example of how consultation helped a nurse promote reproductive justice in the experience of an incarcerated pregnant woman facing systemic racism and sexism.

There were additional ways in which the system undermined this woman's right to have the pregnancy that she desired and the opportunity to care for her child once born. For instance, the NFP work focused on the importance of her pregnancy and her health, but the mother-to-be missed many appointments due to lack of transportation. When she did make it to her appointments at the county hospital, she waited many hours while other inmates had their appointments. During this waiting period, she was given a place to sleep on the floor. Although this seems like stark care to most people, the client expressed appreciation for her time resting on the floor as she was given "soft pillows." This speaks to the incredibly low expectations that this mother-to-be had for caring and supportive attention. During the reflection with the consultant, the nurse formulated a better understanding of this woman's internal experience. Feeling into her client's

subjective experience helped the nurse relate to her from a more empathic place and gain understanding of what it must be like for this woman given her experiences and the structural racism and sexism that she had already encountered in her young life. She had no concept of how to advocate for herself, and the jail staff did little to help her. As this was the first case of an incarcerated pregnant woman, the nurse was just learning about the treatment given to this population. While the client was appreciative of the soft pillows provided to her, the fact that she was forced to rest for hours on the floor mobilized the nurse to advocate for better treatment of pregnant inmates while receiving care at the county hospital. The conversations in consultation helped the nurse feel empowered to attend to this lack of appropriate care for inmates at the hospital and to further see her work within a reproductive and social justice framework.

The consultant supported the nurse to gather more information about the circumstances around this expectant mother's incarceration to better understand her current experience and needs. As a result, the nurse learned that this young woman had endured other forms of reproductive oppression while incarcerated. Due to concern around this client's potential for violence when first incarcerated, she spent her entire time in administrative segregation—meaning that she was locked in her cell throughout the day. Although there was initial concern about her behavior, she received psychiatric care early in her incarceration that greatly improved her symptoms. She did not have further indicators of dangerous behavior, yet remained in administrative segregation. This restriction prevented her from participating in any supplemental programs such as drug-treatment groups and GED classes, both of which could have provided her with much-needed skills to change her life and potentially care for her child. Further, the restrictions prohibited her to get the walking exercise she needed to address her gestational diabetes. In addition to these restrictions limiting this pregnant woman's ability to attend to her physical health, there also was no regard for how her untreated diabetes impacted the unborn child.

Perhaps one of the most egregious ways in which this pregnant woman was caught in a web of bias and racism was the plan that had been crafted around her delivery and release. Under this plan at the time of delivery, the newborn would be removed and placed into foster care while the mother would go to an adult residential mental health treatment program. The consultant helped the nurse explore the legal and ethical ramifications of making a CPS report based on the mother's past when the current situation had not yet presented clear risk or danger to the child. The system was deciding the fate of this pair without even giving this mother an opportunity to parent her newborn or considering the impact of a separation on a newborn baby. The client did not know that there were other options, and she desperately wanted to get out of jail and thus agreed to what was initially presented to her.

Motivated by the consultant's inquiry about how the crucial decisions in this plan were established, the nurse identified the decision makers involved and found ways to advocate for the client's specific needs while holding the unborn child in mind. The behavioral health team included a social worker, attorneys, and a provider from an adult residential program who devised the plan.

Through the conversations with the consultant over the past year and the individual consultation around this particular case, the NFP nurse felt more empowered to advocate for her client within the criminal justice system. Although it was unclear if this client could, in fact, care for her baby, she had not yet done anything to warrant a plan for removal of her child at birth. The consultant's knowledge of the collaborative court programs as well as community resources provided useful information for the nurse regarding how to advocate for her client. The nurse contacted the professionals involved in crafting the plan, and included the supervisor from the Behavioral Health Court. The nurse offered a different possibility, one which would allow her client to have a safe place to live and support in parenting a newborn to see if she would be capable of caring for her child. Fortunately, San Francisco has a residential program for mothers with mental illness and their young children. Through the nurse's advocacy, which grew out of a sense of responsibility as well as a sense of possibility conveyed through consultation, she was able to address systemic bias and racism, paving the way for her client and her newborn son to go from the hospital to this treatment program together.

Shortly after the pair entered the treatment program, the NFP nurse presented the case in case conference. For a brief period of time, worries that this mother had disengaged with the providers surfaced. In the presentation, the nurse wondered if she had made a mistake erring on the side of advocacy while disregarding the numerous concerns about her client's history of being in the child welfare system as a young girl, years of homelessness, substance abuse, and psychiatric illness. Ultimately, though, the reflection on affording this mother the opportunity to finish her jail sentence, deliver her baby, and have a chance at parenting her newborn spoke to the importance of advocating in a system mired in reproductive oppression and "multiple levels of social injustice" (Crenshaw, 2016). In the case conference, the nurse expressed her intense feelings around this case and explored her reactions both to the client and the oppressive system while giving voice to the worry about this fragile pair.

A few weeks after giving birth, this new mother came to the conclusion that she needed more support in caring for her newborn son and asked the nurse to help her call CPS. Although this was a sad turn of events for mother and baby, that this mother could make this decision herself rather than having it forced upon her by the system empowered her to make an incredibly difficult decision with her child's needs at

the forefront of her mind. The nurse reflected on her client's decision in individual consultation and was able to see how this was an example of her young client's ability to act protectively for her child. Furthermore, the mother's ability to self-refer to CPS to address her child's needs was influenced by her experience working with the nurse whose advocacy provided space for this mother's voice to be heard.

6 | CONCLUSION

The reproductive justice movement has called alarming attention to the structural racism and other forms of oppression prevalent in the healthcare system that further increase the burden on already-vulnerable women and young children of color, preventing them from maintaining optimal health, development, and, most important, a position of choice for crucial reproductive decisions. Due to their direct service to marginalized families, nurses and midwives are in an especially influential position to combat the forces of multiple levels of oppression, yet many of these professionals lack the support needed to better understand and respond to the families' experiences.

Mental health consultation to public health nurses and midwives enhances their reflective and relational capacities and allows them to better support their clients' self-determination. Consultation helps the nurses and midwives process their personal and emotional experiences working with patients so that they are better able to serve their patients and address systemic problems. Further, it helps them to uncover and counteract structural impediments and to promote reproductive justice. The partnership developed between the IPP and both the midwives and the NFP program is an example of interdisciplinary collaboration in the service of personal and professional growth, resulting in greater healing and wholeness as well as advocacy for social change and reproductive justice.

The burden on the medical professionals regarding time and productivity rarely allows opportunity for regular and programmatic self-reflection. As represented by the voices of these two groups, creating space for examining their own experience and ways of being in relationship with their clients has been critical to their ability to be aware of and analyze their judgments, examine their bias, and consider the families' experiences with compassion and understanding. It is within the safety of this protected space for self-reflection where the silent voices of the unborn child and the parent's marginalized experience can be heard and incorporated into formulating the best care and advocacy for their needs. Creating supportive venues for self-reflection, such as consultation, can lead to an increased sense of competence in moment-to-moment interactions with clients as well as empowerment to effect change at the systemic and structural levels.

The case presented in this article, though just one example, demonstrates the need for future interdisciplinary collabora-

tions and research. Utilizing the robust data collected over the years on the impact of the NFP model, future research is needed to address the impact of regular mental health consultation on program outcomes, effectiveness of client care, job satisfaction, and staff retention. Better understanding of the elements of care provided to vulnerable families could offer direction to changes in protocol and systemic structures, thus ensuring social and reproductive justice at all levels of patient care.

CONFLICT OF INTEREST

Miriam E. Silverman and Margaret S. Hutchison declare that they have no conflict of interest.

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