

IMPROVING BREAST FEEDING RATES

Pay attention to the first week

I assessed new mothers' perceptions of infant feeding support in the first week in an area where a multifaceted breastfeeding promotion programme is in place¹ and the local maternity unit has held the Baby Friendly award since 2001. Initiation of breast feeding has increased (39% in 1998 v 59% in 2008), but the breastfeeding rate at 10 days shows continuing early abandonment of breast feeding (28% in 1998 v 31% in 2008).

Community midwives completed a questionnaire with all locally delivered mothers at 7 days during February 2008. In all, 121/180 questionnaires (67%) were returned, 92 from mothers who had breast fed at least once.

Twenty of the mothers who had breast fed gave the last breast feed on day 1 and 11 on day 2; 52 breast fed at least once after arriving home, and 37 were still breast feeding when questioned. The reasons for stopping breast feeding given by half of them fell mainly into two groups: baby reasons (19; jaundice, failure to settle) and maternal reasons (30; tiredness, pain). Only one mother mentioned a potentially insuperable barrier to breastfeeding (history of breast reduction). Only 26 of them said that they had been supervised throughout a breast feed by an informed helper, either in hospital or at home.

Just over half of all the mothers (65/121) said that, since delivery, they had not spoken to anyone who had ever breast fed (apart from a health professional). When asked who might be approached for help with breastfeeding problems 107 suggested a midwife, 36 family or friends, and 27 a peer supporter.

The early postnatal days are critical to the smooth establishment of lactation.² We need to identify effective elements of support for the first week, incorporate them into protocols, and direct scarce resources to this high risk period.

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Basic training of frontline staff needs to be better

Much like the experience of birth, women are not told the truth about how difficult breast feeding may be.¹ It is not enough to have breastfeeding specialists: every midwife,

paediatric nurse, and doctor should be able to inform on breast feeding opportunistically.

The subject of breast feeding should be better addressed at undergraduate level. It should also be incorporated into postgraduate paediatric, accident and emergency, and general practice syllabuses and competencies in a more structured and problem based way to ensure a better service for women and their babies.

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- 1 Cattaneo A. Promoting breast feeding in the community. *BMJ* 2009;338:a2657. (30 January.)

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Experience of a new mum

My husband and I dutifully went to NHS antenatal classes. The session on feeding began: "We all know breast is best." Then we were shocked to hear the midwife complain about how she wasn't allowed to teach us about bottle feeding any more and then not mention breast feeding again and promote bottle feeding anyway. On moving to a new area, I was asked by a health visitor what formula milk I gave our baby, and when he was upset after his 8 week immunisations the practice nurse said soothingly: "Give him a bottle to calm him down."

How can we expect a team of peer supporters to succeed in increasing breastfeeding rates¹

when the professional multidisciplinary team (doctors not excluded) doesn't consistently expect and reinforce breast milk as the norm?

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What do people think about breasts and breast feeding?

The editorial and research articles on breast feeding seem to be on a different wavelength from the mothers in the studies.¹ The interventions made no difference to behaviour, yet the recommendations for an effective intervention are more of the same with different timing and organisation.

What is needed is qualitative studies of what women and men in the UK think about breasts and breast feeding. A whole unexplored erotic/sexual penumbra seems to surround breasts which militates against breast feeding and needs to be explored. Otherwise there is the risk of labouring intensively and expensively in the wrong direction.

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- 1 Cattaneo A. Promoting breast feeding in the community. *BMJ* 2009;338:a2657. (30 January.)

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MEMORY CLINICS AND DEMENTIA

Memory clinics are all about stigma, not screening

Critics are right to question the evidence base for memory clinics if the only purpose of memory clinics is to screen for drug treatments.¹ However, they also provide an acceptable, accessible, high quality assessment, rehabilitation, and follow-up facility for people with memory concerns or suspected dementia and their families.²

If dementia is construed as a common long term disability of later life, then memory clinics can neutralise the double stigma of age and dementia and provide timely interventions that help people and their families to live well with the condition. A pan-European study of dementia noted that stigma associated with dementia

was linked to a lack of supportive interventions or their underuse and was less in countries with widespread memory clinics and other dementia care services.³ To counteract stigma, the dementia strategy recommends memory clinics to act as a reference point for people, carers, professionals, and the public and as a source of support and guidance on best practice in dementia.⁴ Properly resourced memory clinics can also provide a value for money service that raises expectations about living well with dementia for people and their families.⁵

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Competing interests: None declared.

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TEENAGE CONDUCT PROBLEMS, LATER

Predictions are overly dire

Colman and colleagues conclude: "Adolescents who exhibit externalising behaviour experience multiple social and health impairments that adversely affect them, their families, and society throughout adult life."¹ This seems an overly dire and alarmist conclusion.

There were no adult symptoms of depression or anxiety in about half of those with externalising behaviours (mild or severe) in adolescence, compared with 45% of those without such behaviours. Over 80% of those in all three groups had no problems with alcohol abuse as adults, and over 70% in all three groups did not have nervous trouble.

Over 87% of those with externalising behaviours were not teenage parents, compared with 93% without the behaviours. Over 60% of those with mild behaviours and half of those with severe behaviours were still in their first marriage. Slightly more than half of those without externalising behaviours, around half of those with mild externalising behaviours, and 40% with severe behaviours had no problems in relationships with others. Most (90%) of all three

groups had never been unemployed. About three quarters of those with no or mild behaviours and 50% with severe behaviours had never had financial difficulties.

The point is not that these behaviours do not have long term effects for some children. But many—by some measures a majority—had outcomes as good as those without any behaviours.

To predict that any child with these behaviours will have multiple lifelong problems does a great disservice to the interesting findings of the study.

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GETTY IMAGES

Authors' reply

Many adolescents with conduct problems in this cohort managed to avoid poor outcomes, and they may lead successful adult lives. We would hesitate, however, before painting a rosy future for these adolescents.

The study outcomes are likely an underestimate of the true picture of poor outcomes for adolescents with conduct difficulties. Those with the worst conduct problems were more likely to drop out of the study. They would also be expected to have the worst outcomes as adults, which contributes to an underestimation of the prevalence of problems in adulthood.

We captured only some of our poor outcomes at specific times in adulthood—for example, unemployment at ages 36, 43, and 53. This is not a comprehensive picture of employment throughout adult life but a useful indication for comparing groups. The prevalence of problems in adult life must be higher than we report, given the gaps in some of our measures. Therefore we can't support McClusky's suggestion that a majority of adolescents with conduct problems lead successful adult lives, particularly when a

majority of the adolescents with either mild or severe conduct problems in our study left school with no qualifications at all.

Furthermore, the size of our groups of adolescents with conduct problems was very large. Those with mild conduct problems comprised almost 30% of our population based cohort, and those with severe conduct problems comprised almost 10%. Given that the group with mild conduct problems was approximately twice as likely to suffer overall life adversity, and the severe group was three times as likely, the size of the groups is of utmost importance.

Dire predictions seem appropriate given our group of adolescents with conduct problems included almost 40% of the population.

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PATIENT PATHWAY IMPROVEMENTS

Patient centred comes at a price

The potential cost of more rapid access to services should not be overlooked.¹

Queueing models show how rapidly costs rise with the shortening of the queue. To see a dermatologist in two days means having a lot more dermatologists who either cost more or get paid less. Either way they have to be less busy to make sure there will always be free slots at short notice. In addition, the result of greater convenience for all would mean many more people working unsocial hours, or less convenience for many.

Part of the issue here is that the patient is depicted as a high powered executive whose work is so important that only a cancer scare can displace it.¹ How many of us really begrudge our colleagues, our postman, our builder time off to go to see a doctor? Perhaps we also need to put the importance of work in proportion and consider that our health might just be worth taking some time off to check it, particularly if the cost of a much more accessible system will be much higher.

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Competing interests: PAW is a health economist who works on a wide range of evaluations and projects for the NHS, other public sector bodies, and the private sector, including pharmaceutical companies. He is not working currently on patient pathway improvements.

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