Women’s Experience of Accessing Maternal Mental Health Support: An Interpretive Description Approach

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Abstract

Maternal mental health conditions affect 12-18% of New Zealand mothers and suicide is the leading cause of death for women in the perinatal period. Although maternal mental health conditions affect so many New Zealand mothers, little is known about the experience of New Zealand mothers who have a maternal mental health condition.

This research study examines the experience of women being diagnosed with a maternal mental health condition and their experience of accessing support services. Interpretative descriptive methodology was used throughout this research.

Maternal mental health conditions are mental health conditions diagnosed within the perinatal period – the period from pregnancy up to a year postpartum. A scoping review examined the experiences of women accessing maternal mental health services within a global context and provided the literature to underpin this qualitative research in a New Zealand context.

Seven women who had been diagnosed with a maternal mental health condition and had accessed maternal mental health services were recruited within the Canterbury region, New Zealand. Semi-structured interviews were used to collect their stories for interpretation and analysis. Four themes that affected the women's experiences were drawn from the data. These themes were: lifestyle challenges, the impact of relationships, burden carrying and the importance of support people to advocate.

Recommendations to policy makers and health care professionals are made to improve maternal mental health outcomes for New Zealand mothers. This is through education for pregnant women, education for midwives in undergraduate and post-graduate programmes and providing a national maternal mental health pathway with services in all regions to improve accessibility and care for New Zealand women.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning. This thesis is written in format 2; that is two chapters are prepared for publication. I have contributed at least 80% of each chapter. Both research supervisors contributed to this research by each providing 10% contributions throughout.

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Key

The following abbreviations and conventions are used within the thesis:

Abbreviations

AUT- Auckland University of Technology

EPDS- Edinburgh Postnatal Depression Scale

GP- General Practitioner

HCP- Health Care Professional

ID- Interpretive Descriptive

LMC- Lead Maternity Carer

MCNZ- Midwifery Council of New Zealand

MMH- Maternal Mental Health

NICE- National Institute of Care Excellence

PMMRC- Perinatal and Maternal Mortality Review Committee

PPNAP- Plunket Postnatal Adjustment Programme

PNA- Perinatal Anxiety

PND- Postnatal Depression

PRISMA- Preferred Reporting Items for Systematic Reviews and Meta-Analyses

WHO- World Health Organization

Conventions

Italics Indicates the speech of the participants.

(n=) Indicates the sample size used.

… Indicates the words removed from literature or a transcript.

Inclusive Language

For this research the words ‘mother’ and ‘woman’ are used to refer to the pregnant and birthing person. This is to avoid confusion as the literature and the most recent Ministry of Health documents also use mother and woman (Ministry of Health, 2021). It is acknowledged that not all pregnant and birthing people identify as a woman or mother.

Chapter One: Introduction to the research

Introduction

This research is the thesis part of my practice-based master's degree. The study reported in this thesis provides insight into women’s experience of being diagnosed with a maternal mental health (MMH) condition and their experience of accessing support services. For this research mild-moderate MMH conditions/mood-disorders are focused on, particularly anxiety and depression. Two of the thesis chapters are articles prepared for publication. Article one in chapter 2, is a systematic global scoping review. The second article prepared for publication is chapter 3 and reports on an original piece of qualitative research investigating women’s experiences in the Canterbury region, New Zealand. This chapter will briefly explain the background and context that situates this study, present the research aim, questions and objectives, impetus of the study, my preunderstandings and highlight the importance of reflexivity in this study. Finally, this chapter ends with an outline of the two articles and structure of the thesis presentation.

Background

Maternal mental health refers to a women’s mental health in the perinatal period. We define this as the period during pregnancy and up to a year postpartum. Globally, MMH conditions affect up to 1 in 5 women (20%) (World Health Organization [WHO], 2022). New Zealand is no exception to this, 12-18% of mothers and 10% of fathers experience perinatal mental health issues (Ministry of Health, 2021). Suicide is the leading reason mother’s die in the perinatal period in New Zealand and Māori mothers are 2.91 times more likely to commit suicide compared to other ethnic groups (Perinatal and Maternal Mortality Review Committee [PMMRC], 2022).

Maternal mental health conditions include anxiety, depression, bipolar disorder, and post-traumatic stress disorder (Stein et al., 2014). The mother’s wellbeing is central to her baby and the wider family. It is shown that the first 1000 days in a child’s life which is conception up to age two are the most important for their development. The perinatal period is included in these first 1000 days and a window of opportunity is provided to midwives and other health care professionals (HCPs) to provide MMH support (Matvienko-Sikar et al., 2023).

There are many influences that can impact mothers MMH condition. Women with MMH conditions are more likely to develop placenta praevia, have antenatal or postpartum haemorrhages and low-birth weight babies (Rusner et al., 2016; Voit et al., 2022). Breastfeeding can have both a positive and negative impact on MMH. It can be positive experience by supporting the bond between the mother and baby and provide an overall empowering experience. However, many mothers feel pressure to breastfeed, and this may lead to feelings of being a failure if they are unable to breastfeed. A negative breastfeeding experience can lead to self-reported poor attachment with their baby (Scarborough et al., 2022; Yuen et al., 2022). Sleep is another influence that can impact MMH, and poor sleep can contribute to adverse MMH for new mothers (Andrade Correia et al., 2023). The mother-infant attachment can also be impacted by MMH conditions. By identifying mothers who are at risk of MMH conditions in the antenatal period and providing them with support, postnatal MMH conditions and mother-infant attachment may improve (Hazell Rain et al., 2020).

The support of partners and the wider family can be a protective factor for developing MMH conditions. Women who have grandparental support are less likely to develop MMH conditions due to their support, the ability to share childcare and developing intergenerational relationships (Riem et al., 2023). Having a supportive partner is also protective of developing MMH conditions (Martin & Brock, 2023). Women who have more helpful and supportive partners are more likely to find the transition to parenthood easier (Kirova & Snell, 2019). They are also more likely to have reduced stress in pregnancy and have better mother-infant bonding and attachment postpartum (Martin & Brock, 2023).

Maternal mental health conditions can have adverse effects on the developing fetus and neonate including an increased risk of morbidity, 5-minute APGAR scores <7 and neonatal hospital admission (Heuckendorff et al., 2021). Other adverse outcomes include premature birth, low-birth weight, poor neurodevelopment and mental health conditions as adults (Betts et al., 2015; Caparros-Gonzalez et al., 2022; Stein et al., 2014). Children born to mothers with MMH conditions are more likely to have anti-social behaviours as adults (Morgan et al., 2021). Alternatively, children of mothers who do not have MMH conditions are less likely to develop behavioural or mental conditions (Lähdepuro et al., 2023). There are also links between mothers with MMH conditions and poor-quality sleep for infants. This can develop into worsening sleep habits for children and lead to consequences such as short attention spans, behaviour and learning problems (Andrade Correia et al., 2023). The health and social consequences for children born to mothers with MMH is profound, therefore, increasing resourcing for mothers with MMH conditions is important.

MMH conditions can be difficult to diagnose. This is often due to barriers such as maternal shame and stigma, lack of understanding of MMH conditions and difficulties such as accessing an HCP due to barriers such as transportation and cost of paying for appointments (Ford et al., 2019; Holden et al., 2019; Sambrook Smith et al., 2019). Other barriers include HCPs having low knowledge or confidence to screen for MMH conditions. Many HCPs do not formally screen women for MMH conditions and midwives may feel reluctant to screen women for MMH conditions due to limited MMH services available (Holden et al., 2019; Mellor et al., 2016).

Screening for MMH conditions is variable with many different recommendations. In a New Zealand context there are several recommendations. The use of 2-3 mental health screening questions at the booking visit and six-week postnatal check or the use of the Edinburgh Postnatal Depression Scale (EPDS) if the HCP has concerns (Ministry of Health, 2021; New Zealand Guidelines Group, 2008). United Kingdom based National Institute of Care Excellence [NICE], (2020) recommends screening for MMH conditions using two MMH screening questions at the booking visit/early pregnancy and at least once during the postpartum period. Whereas the Australian Clinical Practice Guidelines (2017) for mental health care in the perinatal period, recommends screening for MMH conditions using the EPDS and screening at the booking visit/early pregnancy, later in pregnancy, six – twelve weeks after birth and at least once in the first postnatal year.

Fathers should also be screened for MMH conditions as 5-10 % of fathers experience perinatal depression and 5-15% experience perinatal anxiety (Darwin et al., 2021). Fathers whose partners have a MMH condition are more likely to develop a MMH themselves and experience depressive symptoms. Therefore, including fathers in MMH care for their partners and screening fathers/other significant support people for MMH conditions is worth considering (Battle et al., 2021). It is acknowledged that mental health conditions in the perinatal period present differently for men than for women. Men who are struggling with their mental health in the perinatal period often manifest in behavioural changes (Dhillon et al., 2022). However, more evidence is needed to make recommendations for mental health screening tools and timeframes for fathers/ other significant support people in the perinatal period (Darwin et al., 2021).

Psycho-social and cultural influences have been addressed within the literature (Tikka et al., 2022; Xu et al., 2023). However, the focus of this research is on the experiences of women being diagnosed with MMH conditions and accessing MMH services within one region of New Zealand.

Once a MMH condition is diagnosed for a woman it can be treated in a range of ways. This may be something like mindfulness or yoga to reduce anxiety or holistic programmes focusing on MMH and mother-infant attachment (Aylward & Williams, 2023; Van der Riet et al., 2020). Online groups such as peer support groups can also be a source of support for women and reduce the risk of developing MMH conditions (Jiang & Zhu., 2022). In person peer support groups are also important. Meeting other mothers with MMH conditions removes the perceived stigma. It also allows women to connect with others and learn coping strategies to help with their mental health (Coe & Barlow, 2013). Community MMH support services are a valuable and provide care for women typically with mild-moderate MMH conditions. These services often provide home visits and regularly check in to see how the mother is coping mentally. Sometimes practical home skills are offered but it is often combined with counselling and supporting the mother-infant bond (Mugweni et al., 2019).

Inpatient psychiatric mother-baby units where both mother and baby are admitted for care is a service that may be available depending on the region. These units are staffed with specialist MMH care worker and provide wrap around supports for mothers that are significantly mentally unwell. Mother-baby units are considered the optimal model of MMH care as they address the mental health conditions as well as supporting parent craft and the transition to parenthood (Branjerdporn et al., 2022). There are good outcomes in the first three months for mothers admitted to mother-baby units including marked improvements in mental health and parenting behaviours (Reilly et al., 2019; Yadawad et al., 2021). However, many mothers had anxiety or depressive symptoms return and had a self-reported decline in the mother-child attachment (Reilly et al., 2019). Therefore, post-discharge community follow up support may benefit these mothers.

It is evident in the literature there is significant impact of MMH conditions on mothers and their offspring; however, care and support are not consistent across regions. In a New Zealand context, maternal mental health services are variable between regions. Due to the population of birthing women becoming more complex, services are not equitable or available in all regions (Ministry of Health, 2021).

Impact of the COVID-19 pandemic

The COVID-19 pandemic has also had a noticeable impact on MMH conditions for mothers. Women were more likely to develop a mental health condition over this time (Davenport et al., 2020). This is due to factors such as increased stress and anxiety related to contracting the virus, being an essential worker and many women leaving the workforce to be at home with children, increasing financial hardship (Barbosa-Leiker et al., 2021).

The COVID-19 pandemic also saw a reduction of most MMH services and supports for mothers (Cameron et al., 2020). This meant that many mothers had untreated MMH conditions and minimal support (Barbosa-Leiker et al., 2021). MMH conditions during the COVID-19 pandemic was associated with poorer infant socioemotional development and there are concerns about the impact of this long-term on the children born during this time (Duguay et al., 2022; Kerker et al., 2023).

Other ways of working with and supporting mothers have been highlighted from the pandemic. It is evident that support groups and therapy through distance is an important consideration for the future (Barbosa-Leiker et al., 2021)

It is evident from the literature that there are many adverse health outcomes for mothers who have MMH conditions and their babies which can have lasting implications. By supporting women with MMH conditions, health outcomes for mothers and babies may be improved (Aytac & Yazici, 2020; PMMRC, 2022).

New Zealand Midwifery Care

New Zealand has a unique model of midwifery care that is funded by the Ministry of Health. A four-year Bachelor of Midwifery is required and following this most midwives work in one of two settings. Hospital employed midwifery - midwives who are employed by a hospital providing maternity care on a 24-hour shift roster. Hospital employed midwives may also be employed to provide midwifery care under a continuity of care model. The other way of working is in the community as a lead maternity carer (LMC) midwife. LMC midwives book/register women once they find out they are pregnant and care for them until their baby is six weeks old. LMC midwives work autonomously but also collaboratively with other HCPs. Both models of care are based around a partnership that is formed with the woman and her family providing her with maternity care, education and supporting her decisions during the childbirth continuum (Eddy & Tracy, 2023). The midwifery continuity of care framework supports positive MMH. Women who have a midwife providing continuity of care are less likely to be anxious or depressed in the antenatal period and may contribute to be protective of developing postnatal MMH conditions (Cibralic et al., 2023). Midwives are also well positioned to provide education and screen women for MMH conditions as they have a partnership and relationship with them (Mellor., 2016). The continuity of care framework also supports the development of a trusting relationship between midwife and woman which may encourage women to discuss their MMH concerns (Savory et al., 2022; Viveiros & Darling, 2018).

Research Question

From the initial overview of the background, it is evident that further research with a New Zealand focus is justified in the domain of MMH. Moreover, women's experiences of being diagnosed with maternal mental health conditions and their experience of accessing services have not been investigated sufficiently within a New Zealand context. With the recent investigations into New Zealand's MMH services during the Ministry of Health's stocktake (2021) it was evident that it was important for the woman's voice and opinion to be captured to contribute towards the way that services and care may be implemented in the future. Therefore, the overarching aim of the study raised two research questions and three subsequent objectives:

Aim

To explore women's experiences of being diagnosed with maternal mental health conditions and accessing maternal mental health services in Aotearoa New Zealand.

Research questions:

What is currently known about women's experiences of being diagnosed with a maternal mental health condition?

What are women's experiences of accessing maternal mental health services in the Te Whatu Ora - Waitaha Canterbury region?

Research Objectives:

- To explore women's experiences of having a maternal mental health condition.
- To explore women's experiences of accessing maternal mental health (MMH) services in Te Whatu Ora - Waitaha Canterbury region.
- To be able to make recommendations around improving the experience of accessing MMH services for women.

Personal Impetus for this Research

Reflexivity is important when conducting qualitative research (Olmos-Vega et al., 2023), therefore the impetus for this study includes my own preunderstanding of the domain. During my years of working as a midwife I have cared for many women with MMH conditions or women who were at risk for developing MMH conditions. One woman comes to mind. I had been caring for Mary* as a new graduate hospital employed community midwife. She was a young mother who scored highly on the EPDS and had minimal support. As her midwife although I had identified her distress, I was unable to refer to psychiatric MMH services although I could refer her to her family doctor. There were not MMH community supports at the time where I was working, and she had no transport to access her family doctor who she had minimal relationship with. When I was a new graduate midwife, online services and resources were also minimal and Mary continued throughout the postnatal period with minimal support and postnatal depression. It led to me question the support parents get when they transition to parenthood, and how they are cared for by health care professionals. The birth of my own son provided me a new perspective on how MMH is cared for and supported during the perinatal period. A willingness to improve MMH outcomes for New Zealand women and families has been the motivator for me to undertake this study.

New Zealand Maternal Mental Health Context

In a New Zealand context there are variable recommendations for MMH care. This includes 2-3 screening questions about mental wellbeing or the use of the EPDS if the midwife is concerned (Ministry of Health, 2021; New Zealand Guidelines Group, 2008). Currently there is some MMH education provided in New Zealand midwifery undergraduate degrees although this has not been formally evaluated. There is also no compulsory MMH education for midwives although several universities (Auckland University of Technology and Otago Polytechnic) offer a postgraduate course if the midwife or any registered practitioners has a special interest in this topic. Currently midwives can refer to other MMH services such as general practitioners (GP) or community MMH services but cannot refer to psychiatric MMH services (Te Whatu Ora - Health New Zealand, 2023). There is no national pathway or guidance on MMH care despite strong recommendations from the PMMRC (2022). Mellor (2016) examined midwives' perspectives of mental health and maternal mental health, but the experience of women has not been investigated. This justifies the current qualitative research (Chapter 3) into women's experiences of being diagnosed with MMH conditions and their experience of accessing services in the Canterbury region.

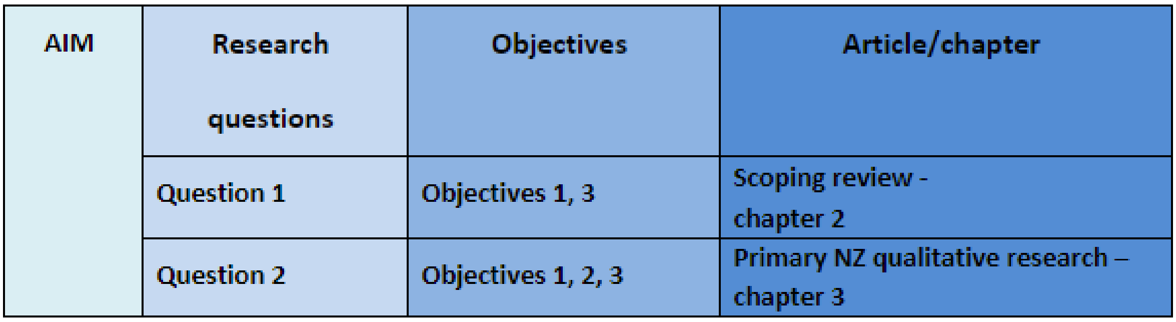
Context of MMH Services in Canterbury Region

There are many MMH services in the Canterbury region that offer different levels of care. This is represented well by the Maternal Mental Health Pathway published by Te Whatu Ora - Waitaha Canterbury (2023a) (APPENDIX 1). For women in a MMH crisis they can be reviewed in the Emergency Department by the Psychiatric service. For clinical support for women with MMH conditions, there is a Mothers and Babies Mental Health service. This is for women with complex-moderate to severe MMH conditions - referrals must be from a doctor, this unit has an inpatient psychiatric and outpatient MMH support unit. The Plunket Postnatal Adjustment Programme (PPNAP) provides clinical care to women in the community experiencing MMH conditions. Plunket also provide parenting-based programmes to help with parent-infant relationships. Perinatal

Wellbeing Canterbury offers non-clinical peer to peer support in the community through in-person support groups. There are also several other community based clinical mental health organisations such as Te Puawaitangi ki Ōtautahu Trust, Purapura Whetu Trust, Etu Pasifika – Pacific service and He Waka Tapu who offer culturally appropriate mental health care for Māori and Pasifika people and their families.

The Present Study

The aim, questions and objectives are addressed in the thesis by the foci and alignment of questions, objectives and chapters as presented in Figure 1.



AIM	Research questions	Objectives	Article/chapter
	Question 1	Objectives 1, 3	Scoping review - chapter 2
	Question 2	Objectives 1, 2, 3	Primary NZ qualitative research – chapter 3

Figure 1: Alignment of questions, objectives, and chapters.

Methodology

The research used interpretive description (ID) methodology developed by Sally Thorne (Thorne et al., 1997). Interpretive description methodology allows the researcher to identify themes and patterns within the data and then interpret them to understand a deeper meaning. The deeper meaning challenges the researcher to look at a clinical phenomenon in new and creative ways. This is applicable for health research as ID gives a practical application which helps to inform clinical understanding (Thorne, 2016; Thorne et al., 2004).

For the original piece of qualitative research, reported in manuscript two, chapter 3, seven women were selected through purposive sampling to participate in semi-structured interviews. This allowed the women to share their MMH diagnosis and their experiences of accessing MMH services in the Canterbury region. Their interviews were transcribed and analysed using thematic analysis informed by Thorne's interpretive description methodology (2016). This allowed the common themes in the research to be gathered and interpreted. By understanding the women's experiences, knowledge and how to guide and enhance care of women with mild to moderate MMH conditions is enhanced.

Structure/Organisation of the Thesis

The structure of the thesis is arranged as format two - manuscript structure as outlined by Auckland University of Technology (AUT). This is a non-traditional thesis structure and two of the thesis chapters are articles prepared for publication. Article one in chapter 2, is a systematic global scoping review. The second article prepared for publication is chapter 3 and reports on an original piece of qualitative research investigating women's experiences in the Canterbury region, New Zealand. Therefore, as they are both prepared for publication the included literature and information in these manuscripts does overlap in each chapter. The layout of chapter 2 and 3 are also slightly different due to different requirements from the journals they will be submitted to. Quotations throughout the thesis are in italics and quotations over 20 words are indented for clarity when reading.

Chapter one: The introduction includes the context background to the thesis. It provides insight into the influences that impact MMH conditions and the potential health consequences for mothers and babies. The chapter concludes with an outline of the structure of the thesis.

Chapter two: The first article prepared for publication includes a global scoping review into women's experiences of accessing MMH services. This uncovers multifactorial reasons that impact women's experiences such as barriers to care, facilitators to accessing care and system related barriers to accessing support. It makes recommendations for further research in a New Zealand context.

Chapter three: The second article prepared for publication is an original piece of qualitative research investigating women's experiences in the Canterbury region, New Zealand. This provides four main themes identified through interviews and thematic analysis: lifestyle challenges, the impact of relationships, burden carrying and the logistics of access.

Chapter four: This chapter reviews and discusses the outcomes of manuscript one and two and makes recommendations for practice. In this final chapter the overall aim of the study and research questions are revisited. The challenges and limitations of the study and my own learning are presented. Finally, the chapter provides implications for future research and practice.

Prelude to Manuscript 1 (Chapter 2)

Manuscript 1 (Chapter 2) is a systematic scoping review that provides the context in which the qualitative research is situated. The manuscript explores sixteen articles within a scoping review framework to gain knowledge and insight about women's experiences of accessing mental health support services within a global context. Three themes emerged from the research and suggestions for further research are provided.

Chapter Two: Scoping review (Manuscript 1)

Manuscript for submission to the New Zealand College of Midwives Journal.

Abstract

Women's experiences of accessing mental health support services: A scoping review

Authors: Stephanie Grace Taynton, Dr Nimisha Waller, Professor Susan Crowther.

Background

Maternal mental health (MMH) conditions affect up to 1 in 5 women in the perinatal period. This scoping review analyses the literature related to the experiences of women accessing MMH services in a global context.

Methods

Seven databases were searched in July and August 2022 and May 2023. Only studies focused on the experiences of women with perinatal mental health conditions were included. Key information and findings from published studies were extracted and meta-synthesise was conducted using thematic analysis.

Results

Sixteen studies were included, and three themes emerged. a) Barriers to accessing care, such as fear, stigma, and logistical difficulties. b) Facilitators to accessing care, such as trusting relationships, social support, and education. c) System related barriers to accessing support, such as difficulty getting referrals, accessibility to services and long-waiting times.

Conclusion

The evidence suggests women's experiences of accessing MMH supports is multi-factorial. Findings suggest further research is needed to understand women's experiences and what support would be beneficial for them. Pursuing this program of focused research may improve health outcomes for women with MMH conditions.

Keywords

Maternal mental health, perinatal mental health, midwives, experience, access

Introduction

Maternal mental health (MMH) is an important area of maternity care, which affects up to 1 in 5 (20%) of women in the perinatal period (WHO, 2022). The numbers are slightly lower for women from high - income countries where 1 in 10 (10%) of women experience MMH conditions in the perinatal period (WHO, 2022). In New Zealand, 12-18% of mothers and 10% of fathers experience perinatal mental health issues (Ministry of Health, 2021).

MMH conditions include but are not limited to anxiety, depression, psychosis, bipolar disorder, and post-traumatic stress disorder. Consequences for mothers who have MMH conditions include potential suicide, living with MMH conditions such as anxiety and depression and significant relationship breakdown (Stein et al., 2014; PMMRC, 2022). However, in the literature there appears to be many factors that negatively influence mothers' experiences of accessing MMH support. These barriers include negative self-perception of MMH conditions, fragmented services that are under resourced with long waitlists, language barriers and care that was culturally inappropriate (Ford et al., 2019; Sambrook Smith et al., 2019). It is evident that there is literature available to assist with the scoping review of qualitative studies about the experiences of women with mild to moderate mood disorders and their experiences of accessing support services.

This article reports on the findings of a systematic scoping review that sought to gain an understanding of the extent and type of evidence available in relation to women who have mild to moderate mood disorders and/or have accessed maternal mental health services. Adopting a global perspective, the review focuses on women in the perinatal period. The perinatal period is defined as pregnancy and up to one-year post-partum (WHO, 2022).

Methods

Research question

What is known about women's experiences of accessing MMH support when they have mild-moderate mood disorders?

Search strategy

The scoping review protocol was completed with guidance from the Joanne Briggs Institute (JBI) protocol for scoping reviews (Peters et al., 2020). The JBI protocol has 9 steps in their framework that was developed by Arksey and O’Malley (2005) and then reviewed by Peters et al. (2020). The 9 steps followed were: 1) Defining the research questions and objectives; 2) Developing the inclusion criteria; 3) Describing the approach to searching for literature, selecting evidence, extracting the data and presenting the information; 4) Searching for the literature; 5) Selecting the literature; 6) Extracting the data; 7) Analysing the data; 8) Presenting the results; 9) Summary of the evidence in relation to the review including implications of the findings.

The scoping review protocol was then submitted to Open Science Framework (ref b4yq5). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used to create a PRISMA flow diagram to visually summarise the screening process (Appendix B). Six databases were searched: Scopus, Medline (via National Library of Medicine), Pub Med-advanced (via National Library of Medicine), British Medical Journal (BMJ) Journals, Auckland University of Technology (AUT) Google Scholar and AUT Library. AUT Google Scholar and AUT library were searched to ensure no additional literature was missed and the reference list of eligible papers were searched. Grey literature such as government documents and conference papers were also considered. The search was conducted with key words such as “maternal mental health” “perinatal mental health,” “women’s experiences mental health,” “access maternal mental health” “mood disorders” “postnatal depression” and “maternal mental health diagnoses.” These key words were revised with a librarian and were narrowed down to “perinatal mental health” AND “experiences” AND “women” as the initial search indicated over 700 articles. Following this, the reviewed studies were summarised as a table so that the data could be thematically analysed (see Table 1).

Number	**Title/Author /Year/Country**	**Aim**	**Study Design/ Methodology/ Participants**	**Relevant Findings or Results/Themes**
1	Barriers to seeking and accepting treatment for perinatal depression: A qualitative study in Rio de Janeiro, Brazil. Baldisserotto, M, L., Theme, M, M., Gonez, L, Y., & dos Reis, T, B. Brazil, 2020.	The aim is to investigate the factors influencing the decision not to seek or refuse treatment for perinatal depression in a low-income country in Rio de Janeiro, Brazil.	Focus group discussions, Content analysis, 26 women, pregnant and postpartum.	-Stigma and misconception. -Self-image as a mother. -Lack of knowledge. -Lack of MMH services. -Fear of children being removed. -Self-denial of MMH condition.
2	Introducing and integrating perinatal mental health screening: development of an equity-	Evaluate a perinatal depression and anxiety screening programme.	Semi-structured interviews, The Standards for Reporting Implementation Studies (StaRI)	-Stigma is a barrier to receiving care. -HCP need more education about MMH screening and referral.

	informed evidence-based approach. Blackmore, R., Boyle, J, A., Gray, K, M., Willey, S., Highet, N., & Gibson-Helm, M. Australia, 2021.		Checklist. 28 Health care professionals and 9 women in the perinatal period (pregnancy to 1 year postpartum) of refugee background.	-More bicultural MMH HCPs. -Continuity of care is important for ongoing engagement.
3	Examining the gaps in perinatal mental health care: A qualitative study of the perceptions of perinatal service providers in Canada. DeRoche, C., Hooykaas, A., Ou, C.,Charlebois, J., & King, K. Canada, 2023.	To understand perinatal MMH HCPs perception of women's experiences of the MMH system in Canada.	Survey, qualitative analysis, 435 perinatal mental health HCPs.	-Services do not serve the LGBTQI+ or ethnic community well. -Wait-lists for services. -A need for more community support services. -Lack of national MMH guideline.
4	Understanding barriers to women seeking and receiving help for perinatal mental health problems in UK general practice: development of a questionnaire. Ford, E., Roomi, H., Hugh, H., & Van Marwijk, H. United Kingdom, 2018.	To develop a questionnaire to measure quantitatively barriers and facilitators to women's disclosure of perinatal mental health problems in UK primary care. To pilot and evaluate the questionnaire for content validity and internal consistency.	2 studies; Cognitive debriefing interviews and questionnaire. Mixed methods Study 1-Cognitive debriefing interview- 5 women. Women were eligible if they had given birth in the last three years. They were eligible to take part, whether or not they had experienced anxiety or depression and whether or not they had seen their GP. Study 2- Questionnaire- 71 women. Women were eligible if they met the following criteria:	-Barriers to accessing care included fear and stigma of having a MMH condition. -Logistics of traveling to and attending an appointment. -Trusting relationship with a HCP.

			female; >18 years of age; had a baby in the past two years; any symptoms of distress or feeling unable to cope whether or not help was sought.	
5	Mothers with mental health problems: Contrasting experiences of support within maternity services in the Republic of Ireland. Higgins, A., Tuohy, T., Murphy, R., & Begley, C. Ireland, 2015.	To explore the views and experiences of women with mental health difficulties, in the Republic of Ireland, accessing and receiving care from publicly-funded maternity care services during pregnancy, childbirth and immediate postnatal period in hospital.	Qualitative descriptive design, Face to face interviews, 20 women with a range of MMH conditions, had to have birthed within the last 2 years.	-Lack of MMH services. -Feeling misunderstood from others. -Shame about having a MMH condition. -A need for specialist MMH services. -Lack of antenatal education about MMH conditions.
6	Brief Report. A qualitative study of maternal mental health services in New Zealand: Perspectives of Māori and Pacific mothers and midwives Holden, G., Corter, A, L., Hatters-Friedman, S., & Soosay, I. New Zealand, 2020	To explore current maternal mental health screening practices and supports for Māori and Pacific mothers and midwives.	Thematic analysis, Semi-structured interviews. 9 midwives-interviewed by phone. 13 women-interviewed in-person in a focus group.	-MMH services are variable and inconsistent. -Cultural understanding is a barrier to accessing MMH support. -Lack of family support to seek MMH treatment. -Cost, transport, and time a barrier to accessing services.
7	Women's experiences of anxiety during pregnancy: An interpretative	To explore women's experiences of anxiety during pregnancy.	Interpretative phenomenological analysis, Semi-structured interviews,	-Unrealistic expectations of pregnancy/motherhood. -Trusting relationships enable disclosure.

	phenomenological analysis. Hore, B., Smith, D, M., & Wittkowski, A. United Kingdom, 2019		7 women who reported having anxiety in pregnancy. English-speaking pregnant women, over 18 years of age, and who identified as experiencing anxiety.	-Continuity of care with a HCP supports disclosure.
8	Longer wait time after identification of peripartum depression symptoms is associated with increased symptom burden at psychiatric assessment. Koire, A., Nong, Y, H., Cain, C, M., Greeley C, S., Pouryear, L, J., & Van Horne B, S. America, 2022	To assess the influence that time accessing reproductive psychiatry services has on the mental health of peripartum women.	Retrospective observational study, Reviewing data from obstetric, paediatric, and reproductive psychiatry practices screening for postnatal depression (PD) using the Edinburgh Postnatal Depression Score (EPDS). 490 women were included in this study.	-Increasing MMH funding. -Investigating other care options such as home visits and digital psychotherapy. -Delays in care result in worsening MMH and an increase in self-harm.
9	Dread and solace: Talking about perinatal mental health. Law, S., Ormel, I., Babinski, S., Plett, D., Dionne, E., Schwartz, H ., & Rozmovits, L. Canada, 2021	To understand how individual and cultural narratives of motherhood and perinatal mental health can be sources of shame, guilt and suffering, but also spaces for healing and recovery.	Descriptive study, Semi-structured interviews, 21 women with perinatal mental health conditions.	-Unachievable expectations of motherhood. -Feeling like a failure for having a MMH condition. -Unlikely to disclose to other mothers due to the fear of judgement. -MMH support groups were helpful. -More resources and support that encourages disclosing MMH concerns. -Fear of children being removed.
10	Midwives' perspective of mental health and maternal mental health: An interpretive descriptive study.	To explore midwives' perceptions of mental health and the assessment of maternal	Interpretative descriptive, Focus groups, 25 midwives working as lead maternity carers in a New Zealand context.	-Lack of appropriate MMH services. -Not enough services for midwives to refer women to. -Midwives reluctant to screen when there's

	Mellor, C. New Zealand 2016.	mental health during pregnancy.		limited services to refer to. -Trusting relationships with women and midwives are important. -Potential for dependency on midwife.
11	Maternal mental health service provision in New Zealand: Stocktake of district health board services. Ministry of Health, New Zealand. New Zealand, 2021.	To undertake a stocktake of MMH services in NZ and understand what services in different regions provide.	Multiple methods, thematic analysis used to analyse the data. An online survey was sent to DHBs asking about their MMH services- what they provided, eligibility criteria and what they see as gaps and issues. This was followed up with interviews and site visits.	-Increasing complexity of MMH needs. -Services are inequitable between regions. -Minimal primary MMH services. -A need for more MMH care workers. -Mothers with good support networks adapt to the challenges of parenthood better.
12	Exploring women's experiences of identifying, negotiating, and managing perinatal anxiety: a qualitative study Oh, S., Chew-Graham, C, A., Silverwood, V., Shaheen, A., Walsh-House J., Sumathipala, A., & Kingstone, T. United Kingdom, 2020.	To explore women's experiences of the identification and management of PNA (perinatal anxiety) and their engagement with healthcare professionals.	Qualitative study, Semi-structured interviews, 17 women (aged 25–42 years) with self-reported anxiety during pregnancy and/or up to 12 months postpartum.	-Barries to disclosure: stigma, fear of judgement, shame. -lack of screening of follow up from HCPs. -Maintaining the 'good mother' identity. -Established and trusting relationships with HCPs support disclosing MMH concerns.
13	A qualitative study of minority ethnic women's experiences of access to and engagement with perinatal mental health care. Pilav, S., De Backer, K., Easter, A.,	To improve access to perinatal mental health services across the UK, by exploring the multi-level barriers Black, Asian, and	Thematic analysis, Semi-structured phone interviews, 18 mothers of minority ethnic group who have experienced MMH conditions.	-Loss of identity and shame for struggling with mental health. -Being dismissed by a HCP. -Lack of family understanding. -Fear of children being removed from their care. -More cultural understanding from HCPs about MMH.

	Silverio, S, A., Sundaresh, S., Roberts, S., & Howard, L, M. United Kingdom, 2022.	minority ethnic women experience when accessing mental health services in the perinatal period.		-MMH peer support groups are good for removing stigma and providing support.
14	Women's experience of mild to moderate mental health problems during pregnancy, and barriers to receiving support. Savory, N, A., Hannigan, B., & Sanders, J. United Kingdom, 2022.	To explore the experiences of women during pregnancy with mild to moderate mental health problems and describe the barriers to receiving support in relation to their mental health.	Thematic analysis, Written questionnaire followed up with a semi-structured interview, 20 women with MMH conditions, over 18 years, English speaking, viable pregnancy over 18 weeks gestation.	-Trying to appear as a good mother. -Little education on MMH conditions and where to get support. -Fear of being misunderstood or unsupported. -Long wait-times for MMH services. -Not being mentally unwell enough to be seen by the MMH team. -Continuity of care supports disclosure.
15	Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. Taylor, B, L., Billings, J., Morant, N., Bick, D., & Johnson, S. United Kingdom, 2019.	To understand women's, their partners and the wider families experience of MMH services in supporting women with MMH conditions.	Qualitative, semi-structured interviews were conducted with 52 women who had accessed the National Health Service (NHS) treatment for a variety of perinatal mental health difficulties, and 32 of their partners/ family members.	-It was felt family was marginalised by services and could be included better in care. -Sometimes family will out pressure on women to not receive treatment due to fear of judgement or children being removed from their care. -Women and their families wanted their family involved in their care. -Considerations to be made to support the support people for women who have MMH condition.
16	Barriers and facilitators of accessing perinatal mental health services: The perspectives of women receiving continuity of care midwifery.	To explore what factors midwifery care recipients, perceive to prevent or facilitate access to mental health care in the	Qualitative descriptive, Semi-structured interviews, 16 mothers who had received or were currently receiving midwifery care. Eligibility criteria were being 18 or	-Lack of MMH specialists and HCPs. -Stigma and the fear of the perception of others. -What makes a 'good mother' and how motherhood should be experienced. -Inadequate referral pathway and limited MMH services.

	Viveiros, C, J., & Darling, E, K. Canada, 2018.	perinatal period.	older and self-identifying as having experienced or experiencing perinatal mental health concerns.	-Midwifery continuity of care was helpful to disclosing MMH concerns.

Table 1: Summary of reviewed studies

Eligibility criteria

This scoping review included qualitative studies to provide a broad overview of the literature. Quantitative studies were not to be included as this research's focus was on the experiences of women. The studies selected were published within the last 10 years (2012-2022) and were accessed in July and August 2022. An additional search was conducted in May 2023 to ensure no additional literature had been published following August 2022. The literature included had to be published in the English language. Articles where abstracts were only available without a full text were excluded from the scoping review. This is because it cannot be assumed that the abstract is an accurate representation of the article in its entirety.

Study selection

EndNote was used to assist with the reference list and storing relevant research ensuring duplicates were removed. The titles and abstracts were searched for relevance, and the eligibility criteria were applied to the full-text articles.

Quality appraisal and data extraction

The quality and relevance of the selected research was examined using a checklist in a data extraction form (Appendix B). The data extraction form checklist included a range of criteria including information about the research, type of research and the relevance to the scoping review objective (Joanna Briggs Institute [JBI], 2015). Several other criteria such as the type of research, methodology, experience of participants and key findings that related to the scoping review.

Findings

Search results

A total of 225 articles were retrieved from the initial search results, and 40 additional articles were retrieved in the subsequent search totalling 265 articles. The subsequent search was conducted in May 2023 to ensure no additional literature had been published following the initial search undertaken in July and August 2022. There were 222 articles that were removed during the screening process as the titles and/or dates were not relevant to the search criteria. Following this, 43 articles were sought for retrieval and 8 of these were excluded from the abstracts are they were deemed irrelevant. There were also 2 studies identified from research prior to this project and a further 12 from searching citations. Of these 14 additional studies 7 were sought for retrieval and 7 were excluded. This meant 35 full text articles were screened against the data extraction form. Following this screening, 19 articles were excluded for reasons such as insufficient detail, quantitative research or grey literature that didn't fit the inclusion criteria. This included five meta-synthesis studies as they included research outside of the ten-year inclusion criteria. See PRISMA diagram of search results as presented in Figure 2.

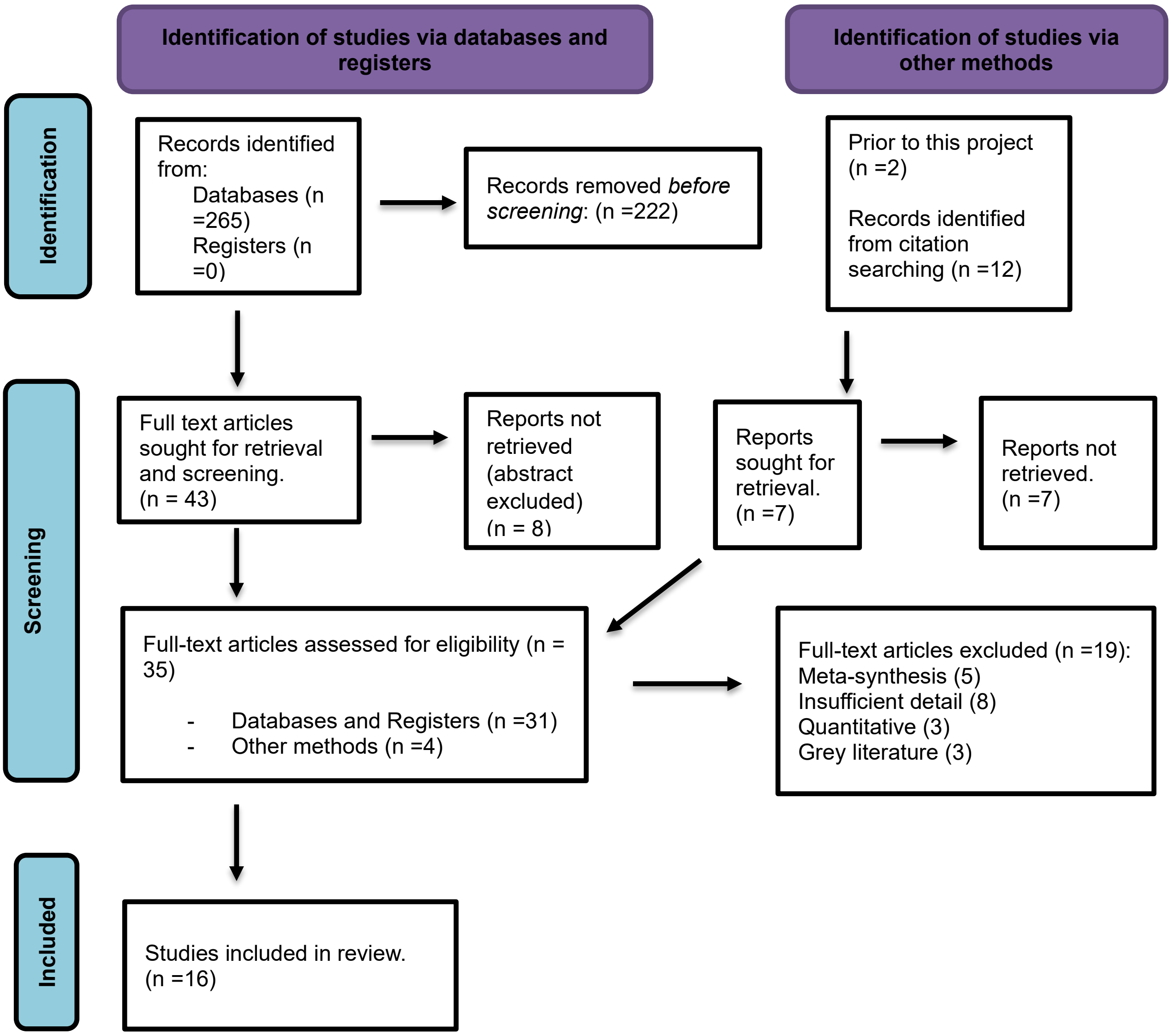


Figure 2: Prisma diagram of search results.

Study characteristics and assessment

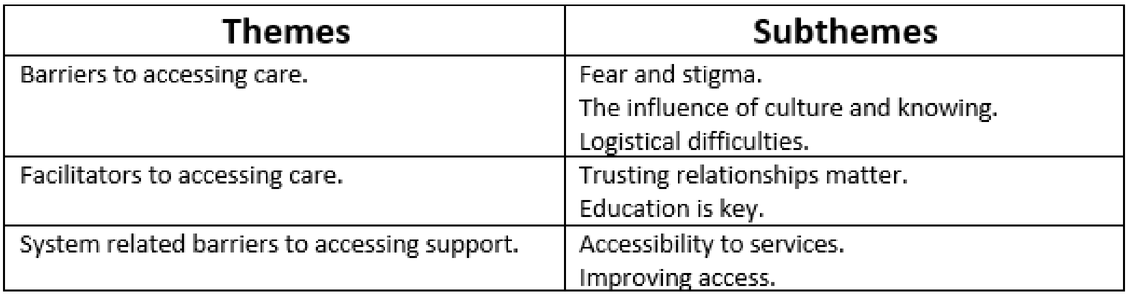
Sixteen articles were included in the scoping review, and the selected research was then examined by two independent reviewers - Nimisha Waller and Susan Crowther, to ensure that the studies were appropriate and met the checklist requirements. Of the 16 articles, 15 were qualitative studies and 1 was quantitative. The decision was made with the two supervisors to include one quantitative study (Koire et al., 2022) as it was specific to the research question. This was because it examined women's mental health outcomes and their retrospective experiences of accessing MMH support services. The studies included had a range of methodologies including descriptive, thematic analysis and interpretative phenomenological. The most common way of collecting data was interviews and 8 of the studies used interviews. Three studies used multiple ways of collecting data such as questionnaires that allowed written responses to share experiences and digital or in-person interviews. Two of the sources used focus groups. One New Zealand Government document published by the Ministry of Health (2021) was included as it provided an overview of MMH services, cultural appropriateness, and the needs of the MMH sector. Overall, the studies were conducted in the United Kingdom, Ireland, Canada, Brazil, America, Australia, and New Zealand.

Data extraction and synthesis

The chosen literature was then read carefully, and themes were identified within the data. The literature was then organised thematically and reported according to Sally Thorne's interpretive descriptive methodology (Thorne, 2016). Interpretive description methodology allows for deep reflection and for the researcher to see beyond the obvious and search for meaning within the literature (Thorne, 2016). Once themes had been identified they were all written down and then grouped together. The themes and sub-themes were then reviewed and critically analysed by the researchers ensuring that the themes were both accurate and reflected the intended meaning within the original studies.

Description of findings

There were three themes that were derived from the literature. These were organised into main themes and subthemes (see Table 2).



Themes	Subthemes
Barriers to accessing care.	Fear and stigma. The influence of culture and knowing. Logistical difficulties.
Facilitators to accessing care.	Trusting relationships matter. Education is key.
System related barriers to accessing support.	Accessibility to services. Improving access.

Table 2: Themes and sub-themes identified in the scoping review.

Barriers to accessing care.

There are many personal and social barriers that women experienced when they identified they needed support with their maternal mental health condition. These included the fear and stigma of not being perceived as the perfect mother, the fear of children being removed from their care, mental health not being acknowledged as a health condition and logistical difficulties such as transport and making it to appointments on time.

Subtheme 1: Fear and stigma.

Fear and stigma was a prominent theme across the literature review. This was not a generalised anxiety state or mood but specific fears of something in the accessing of care. There was a fear of being judged by the health care professional (HCP). How the HCP reacted when the mothers in the studies voiced their MMH concerns strongly impacted their likelihood and comfort when engaging with HCPs further (Ford et al., 2019; Oh et al., 2020; Pilav et al., 2022). The wider family was also fearful of this judgement and reluctant at times for the mother to be seen by HCP for MMH concerns due to this fear of being judged and stigmatised (Pilav et al., 2022; Taylor et al., 2019). Other HCP such as midwives perceived that the fear of stigma acts as a barrier to women accessing MMH care (Mellor, 2016). For example, in Mellor's study a midwife Lisa* shared that,

> *Showing them that it's OK for them to talk about it, it's OK to have a mental health issue, it's not the end of the world, and just making them feel safe about talking about it, because I've has some women when I've said about mental health services they've said, I'm not mental! It's got so much stigma attached. (p.100).*

Likewise, women were reluctant to share their MMH concerns with friends or family due to fears of being mis-understood or/and unsupported (Higgins et al., 2016). The fear of children being removed from a mother's care was also another reported barrier in the literature. This fear of having children removed has prevented some women and families seeking help for MMH conditions (Baldisserotto et al., 2020; Pilav et al., 2022; Taylor et al., 2019). There is also a fear amongst women that having a MMH condition prevents them from being a 'good mother' (Baldisserotto et al., 2020; Law et al., 2021; Pilav et al., 2022; Savory et al., 2022). "A woman with depression can't be a good mother." (Baldisserotto et al., 2020, p. 103.)

Motherhood can be a complex time for new mothers as they navigate their changing sense of self and can feel challenged about what a 'good mother' is and how motherhood should be experienced (Law et al., 2021; Pilav et al., 2022; Viveiros & Darling, 2018). The societally imposed ideology of being a 'good mother' along with a personally imposed idea of what being a good mother is, only adds to the fears of getting it wrong, adding further stress on women (Hore et al., 2019). Due to this pervasive ideology, women who have a MMH condition may feel inadequate and judged by other people, particularly other women. This means women with MMH issues are unlikely to disclose their MMH concerns to other mothers to maintain this 'good mother' identity (Law et al., 2021; Pilav et al, 2022; Oh et al., 2020). Often women who have a MMH condition may seek control in other areas of their lives such as being very organised or presenting themselves well (Oh et al., 2020; Savory et al., 2022).

Subtheme 2: The influence of culture and knowing.

In the literature it was evident that MMH education and screening was not consistent for Pasifika and Māori women. The women in Holden et al. study (2019) felt that not enough culturally appropriate education was provided for them. The midwives felt that there was a lack of understanding about MMH conditions from women and their families. HCPs having cultural awareness/being culturally safe increase their likelihood of engaging with a woman from another ethnic group (Holden et al., 2019; Pilav et al., 2022).

An interesting aspect apparent in the literature is that MMH conditions are considered only for 'rich' women and that 'poor' women 'just get on with it' (Baldisserotto et al., 2020). WHO (2022) disputes this reporting that 1 in 5 women in low-middle income countries get a MMH condition compared with 1 in 10 women in high-income countries. A lack of education and knowledge about MMH conditions and where to access support was common among women in the perinatal period. Women also felt that there needed to be increased antenatal education for women about the importance of MMH and where to go to for support (Baldisserotto et al., 2020; DeRoche, 2023; Higgins et al., 2016; Savory et al., 2022).

Subtheme 3: Logistical difficulties.

There were multi-levelled logistical difficulties which created barriers that prevented women from accessing MMH care. These include being able to attend appointments in the allocated time slot while managing a small baby. The cost associated with accessing care such as transport and paying for the appointment with the HCP was also an issue. The location of the appointment with the HCP was also a factor that impacted if the women would be able to access care (DeRoche et al., 2023; Ford et al., 2019; Holden et al., 2019; Viveiros & Darling, 2018).

Facilitators to accessing care.

There were many facilitators that supported women to access MMH care. Trusting relationships with HCPs encouraged disclosure, a strong social support network was vital, and being provided with antenatal education about MMH conditions were all important aspects of supporting women to speak about their MMH concerns.

Subtheme 1: Trusting relationships matter.

The midwife played an important role in diagnosing and supporting women in the perinatal period with their mental health. When women had a trusting relationship with their midwife, they were more likely to disclose their mental health concerns to them (DeRoche et al., 2023; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Savory et al., 2022; Viveiros & Darling, 2018). Continuity of midwifery care encouraged a trusting relationship where women felt comfortable to discuss their concerns (Savory et al., 2022; Viveiros & Darling, 2018). However, there was a risk for women with MMH conditions to build a dependency on their midwife. Therefore, professional boundaries and working with other services was important (Mellor, 2016).

That lifted the burden you know... (working with other HCPs) it's not my role. I'm a midwife, I'm not a social worker... I can't do all of that by myself." (Mellor, 2016, p.86).

Other HCPs, such as general practitioners (GPs), also had a significant impact on women accessing care. Trusting relationships where the woman felt heard and respected was paramount to having a positive experience and encouraged women to continue engaging with the HCP (Ford et al., 2019; Oh et al., 2020; Pilav et al., 2022). Moreover, the trusting relationship with a HCP was so important to women, that some needed to see several HCPs before finding one that they could trust and build rapport with (Viveiros & Darling, 2018). Women also appreciated an open discussion rather than a tick box exercise with transparency about how the information was going to be used or passed on (Hore et al., 2019).

Trusting relationships within a strong social network was also an important aspect of supporting mother's mental health. Women who have strong established support networks are likely to look to them for support with their mental health and often feel more supported by them (Oh et al., 2020; Savory et al., 2022). Mothers who have trusting relationships with family and friends are also more likely to cope with the challenges of parenthood (Ministry of Health, 2021).

Subtheme 2: Education is key.

Across the literature it was clear that there needs to be more education about MMH conditions for pregnant women and their families. There also needs to be information provided to new mothers about MMH conditions and how to access services, encouraging them to ask for help when needed (Koire et al., 2022; Law et al., 2021). Consideration should be made to other ways of information sharing, such as public health campaigns (Holden et al., 2019). However, there is a need for further research to evaluate the effectiveness of these other ways of sharing information.

Increasing the education for midwives is a vital consideration as many women look to their midwife first for support (Mellor, 2016). However, it appears midwives are not routinely provided with education about providing MMH care and would benefit from additional education (Mellor, 2016). Although MMH education in New Zealand undergraduate midwifery programmes is provided by universities, it is not reflected in the literature and its effectiveness has not been evaluated. A search into MMH education for midwives revealed that a recent Australian study evaluated a trial MMH course as part of the midwifery undergraduate degree. The students were provided with education about MMH conditions including how to administer and score women with the Edinburgh Postnatal Depression Scale (EPDS), interview women to assess their wellbeing and provide information, recommendations, and resources about MMH support. The students were examined with the use of an Objective Structured Clinical Examination (OSCE) and the MMH course was evaluated with the outcomes of the OSCE and the additional feedback the students provided. It was identified that students' knowledge and confidence to screen women for MMH conditions increased and the MMH education was beneficial (Fox et al., 2023). This would also be beneficial for registered midwives as there is no compulsory post-graduate education in New Zealand. It could be anticipated that knowledge and confidence when caring for women with MMH conditions would be increased if education was supported (Higgins et al., 2016; Mellor, 2016).

System related barriers to accessing support.

The women who participated in the included studies had varied experiences of accessing MMH support. Accessibility to services was impacted by factors such as difficulty getting a MMH referral, few HCP's able to refer directly to MMH services and long-waiting lists. These all served as system related barriers for women to access support from services they were referred to/had to access. Lack of MMH services and culturally inappropriate services were barriers for women (Holden et al., 2019).

Subtheme 1: Accessibility to services.

Within the literature review it was evident that there are barriers to get a MMH referral so that support can be accessed. In the context of Viveiros and Darlings (2018) Canadian study, to have funded perinatal psychiatric care the referral had to be from the GP. This was a barrier for some women who did not have relationship or access to their GP. This was similar to the New Zealand context where midwives do not have the ability to refer to specialist MMH services directly as the referral must come from the

GP (Mellor, 2016). Although this was evident in Canada and New Zealand, it was unknown whether this extended globally as it was difficult to discern from the published and accessible sources identified.

Many HCP's felt there was a lack of guidance for screening women for MMH conditions and were therefore more reluctant to screen as they were unsure of which support service they should refer to (Blackmore et al., 2022; DeRoche et al., 2023). This was echoed in midwifery care where there was perceived reluctance among midwives to screen for MMH conditions in case the midwifery partnership was jeopardised (Mellor, 2016). Midwives were concerned that if the women were not 'severe' enough for MMH services they would be left carrying the burden of their condition (Holden et al., 2019; Mellor, 2016; Savory et al., 2022). There was also limited access to MMH support and in a New Zealand context you must have a live child to be able access MMH services. Therefore, women who had a still born baby, or termination of pregnancy were not eligible for support (Ministry of Health, 2021).

MMH services were also overrun with long wait lists for women. These long-waiting lists meant that either the services were irrelevant by the time the woman was reviewed or by the time she was seen her MMH condition had deteriorated significantly (DeRoche, 2023; Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018). The average time between being diagnosed and then being seen by services was five weeks. Each week that care was delayed resulted in a worsening postnatal depression (PND) score of 13% and 9% of self-harm (Koire et al., 2022). In DeRoche (2023) Canadian study in some regions there was a one-year MMH service waiting list. Added pressure to services such as the Covid-19 pandemic and increasing social needs also puts pressure on MMH services (Ministry of Health, 2021). Increasing the amount of primary MMH services such as community MMH organisations, counselling, and GP availability would hugely benefit women with MMH conditions as well as increasing psychiatric MMH care availability (Koire et al., 2022; Holden et al., 2019; Mellor, 2016).

The Ministry of Health (2021) acknowledged when undertaking its stock take of MMH services in New Zealand that there needs to be an increase of MMH care workers. This included psychiatrists and psychologists and other specialist workers such as midwives, GPs, well-child providers and community support workers. There is also a need to increase the number of services that provide specialist MMH care to women. This will enable access to be improved for women (Baldisserotto et al., 2020; DeRoche et al., 2023; Higgins et al., 2016; Holden et al., 2019; Viveiros & Darling, 2018). In a New Zealand context accessibility is varied between regions. MMH services are mostly in main cities and there is a lack of culturally appropriate services with only 50% of

District Health Boards (DHBs) offering a Māori service and very few offered an Asian or Pasifika service (Ministry of Health, 2021). Another aspect to consider is MMH care for the LGBTQI+ community. Many people included in DeRoches et al. study felt that the MMH care system was not appropriate for the LGBTQI+ community due to the heteronormic nature of the service. Therefore, that community of people are unlikely to engage with services. “There are not enough options for the gender diverse community.” (DeRoche et al., 2023, p. 3).

Subtheme 2: Improving access.

To improve access to MMH services for women, different strategies of providing care must be considered. Women who live rurally are often unable to receive MMH support due to their geographical location (DeRoche et al., 2023). Removing barriers and providing care via digital psychotherapy (phone or video) could be one way to improve access for women (Koire et al., 2022). A drop-in service or providing home visits could also be another consideration. The wider family is an important part of MMH care for women. Women like to have their families involved in their care, but it needs to be on their terms. Many family members felt marginalised by MMH services and wanted to be included in treatment as they are a part of on-going support for women once they are home (Taylor et al., 2019). Some women may also prefer a support group rather than one on one MMH care so that experiences can be shared with other women (Law et al., 2021; Pllav et al., 2022). Women are also more likely to disclose when they have continuity of care from an HCP (Blackmore et al., 2022). New Zealand LMC (lead maternity carers) midwives who provide community-based continuity of care, are in a good position to refer women to community agencies and have a good knowledge of these services (Ministry of Health, 2021).

Discussion

Main findings

It is clear throughout this research that there are many disparities for women who need to access MMH support. The stigma and judgement that women felt from their peers and HCPs impacted their decision to access MMH support, this theme was evident strongly throughout many sources of literature in this scoping review (Ford et al., 2019; Higgins et al., 2016; Mellor, 2016; Oh et al., 2020; Taylor et al., 2019). How motherhood should be experienced and what makes a ‘good mother’ is an ideology within society that needs to be challenged. This ideology means that women with MMH conditions are less likely to disclose to others and access MMH support (Baldisserotto et al., 2020; Hore et al., 2019; Law et al., 2021; Oh et al., 2020; Viveiros & Darling, 2018).

More work needs to be undertaken to educate women, their families, and the public about MMH conditions to help minimise the stigma that women feel. One source from Holden et al (2019) discussed the impact of Māori and Pasifika culture and knowledge around MMH conditions however it would be beneficial for further research to be undertaken with other ethnicities to understand their cultural knowledge on MMH conditions. This would mean that culturally appropriate education could be provided for women.

Trusting relationships create the foundation for disclosure and this theme was also strongly evident throughout the research (Ford et al., 2019; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Oh et al., 2020; Savory et al., 2022; Viveiros & Darling, 2018). It would be interesting to further explore how women create trusting relationships with their peers and HCPs and how these are established. Finally, the logistical impact of accessing services needs to be reviewed. The obstacles of accessing support were vast and this served as a roadblock for many women throughout this scoping review who needed MMH support significantly (Koire et al., 2022; Ministry of Health, 2021; Savory et al., 2022; Viveiros & Darling, 2018). Investigations and considerations to other ways of working such as home visits, drop-in clinics or digitally may reduce these barriers (Koire et al., 2022; Ministry of Health., 2021; Viveiros & Darling, 2018).

Strengths and limitations

This scoping review provided many insights that women face when accessing MMH care. A limitation of this research was that only English published sources were included and by not including non-English sources, findings may have been regionally biased. It is possible non-published and non-accessible sources exist yet were not identifiable in the searches and that understandings from low resourced regions were potentially excluded. Otherwise, this scoping review gives a broad overview of the relevant literature in relation to women who have had mild-moderate mood disorders and/or have accessed maternal mental health support in a global maternity setting.

Conclusion

The evidence of this scoping exercise suggests women's experiences of accessing MMH supports is multi-factorial. Findings suggest further research is needed to understand women's experiences and what support would be beneficial for them. This review was conducted as part of a New Zealand study and further research would be beneficial in both a New Zealand and global context.

Prelude to Manuscript 2 (Chapter 3)

The following chapter presents the second manuscript prepared for publication and focuses on original qualitative research that responds to the findings of the systematic scoping literature review reported in manuscript one. This qualitative research investigates women’s experiences of being diagnosed with maternal mental health conditions and their experience of accessing services in the Canterbury region in New Zealand. As stated in the introduction, this chapter has some duplication and overlap with other parts of the thesis when all chapters are read together due to the format style of the thesis. The layout of this chapter is also different from the previous chapter due to different journals having different submission requirements.

Chapter Three: Manuscript for publication (Manuscript 2)

“Women’s experiences of being diagnosed with maternal mental health conditions and accessing maternal mental health services in New Zealand.”

Abstract for submission to Women and Birth published by Elsevier.

Abstract

Problem

Maternal mental health (MMH) conditions affect 12-18% of New Zealand mothers and suicide is the leading cause of maternal death in the perinatal period.

Background

The increasing complexity in New Zealand women due to a variety of social, psychosocial and/or health issues has resulted in a diverse range of needs. In New Zealand there are variable timeframes for midwives to screen for maternal mental health conditions in the perinatal period and variable guidance for best practice.

Aim

To examine the experiences of women who have been diagnosed with maternal mental health conditions and accessed MMH services.

Methods

Seven women who had been diagnosed with maternal mental health conditions in the Canterbury region of New Zealand participated in the study. Semi-structured interviews were conducted to understand their experience.

Findings

Four main themes were identified. 1. Lifestyle challenges, 2. The impact of relationships, 3. Burden carrying, 4. Logistics of access.

Discussion

Findings acknowledge the impact that education, screening, and referral to MMH services have on women. By better preparing parents for parenthood and encouraging open discussion about MMH conditions the stigma felt by new mothers could be reduced.

Conclusion

Further research is needed to investigate the experiences of women in other regions of New Zealand. Maternal mental health services and their accessibility for mild – moderate mood disorders require review in New Zealand.

Key words

Mental health, New Zealand, mothers, experience, midwifery.

Statement of Significance

Problem

Maternal mental health conditions affect 12-18% of New Zealand mothers and suicide is the leading cause of maternal death in the perinatal period.

What is already known.

International studies have found that women's experiences of seeking help for maternal mental health conditions are multi-factorial.

What this paper adds

This study acknowledges the complexities for women with maternal mental health conditions. It points to the need for effective education, screening, and referral for women in the perinatal period.

Introduction

Maternal mental health conditions affect 12-18% of New Zealand mothers and suicide is the leading cause of death for women in the perinatal period (Ministry of Health, 2021; PMMRC, 2022). Maternal mental health conditions include but are not limited to anxiety, depression, psychosis, bipolar disorder, and post-traumatic stress disorder. Consequences for women who have MMH conditions include potential suicide, living with MMH conditions such as anxiety and depression and significant relationship breakdown (Stein et al., 2014). There are also significant health consequences for babies, these include an increased risk of low-birth-weight babies, behavioural issues as adults and cognitive delays (Baibazarova et al., 2013; Betts et al., 2015; Kingston et al., 2012).

Maternal Mental Health System in New Zealand

New Zealand women have increasing complexity in their social, psychosocial health needs. These social needs include increased rates of family violence, poor housing, and substance abuse. Women are also more likely to have increased rates of disability, have previous birth trauma and are less likely to access healthcare due to accessibility. The needs of New Zealand women are increasing and the current MMH system is not equipped to meet these needs (Ministry of Health, 2021). The current MMH system in New Zealand is also designed from a European health model and women of Māori, Pasifika and Asian ethnicities are less likely to access services than women from other ethnic groups (Holden et al., 2019; Ministry of Health, 2021). Māori women are 2.91 times more likely to commit suicide than women of other ethnicities. (PMMRC, 2022).

In New Zealand there are variable timeframes for midwives to screen for MMH conditions. The New Zealand Guideline Group (2008) suggests the use of 2-3 verbal screening questions if the health care practitioner (HCP) has any concerns about a person's mental health. Women in the perinatal period are more likely to develop mental health conditions and therefore require screening. The screening questions about depression include asking questions such as in the last month have you felt down depressed or hopeless or have you felt little interest or pleasure in doing things? The suggested question about anxiety is, in the last month have you felt you have been worrying a lot about everyday problems? These questions provide some guidance and a starting point to lead into a discussion if concerns are raised about mental health. The Ministry of Health (2021) in their MMH services stocktake suggest that midwives screen women using the EPDS if they have concerns.

In the United Kingdom, an antenatal and postnatal mental health guideline was developed by NICE (2020). They encourage MMH screening at the women's booking visit/ early antenatal period and in the early postpartum period. Their screening questions are similar as those suggested by the Ministry of Health New Zealand, but they also encourage considering using the 2-item Generalized Anxiety Disorder scale (GAD-2). The questions have a correlating point score and are to be answered; not at all (0), several days (1), more than half the days (2) and nearly every day (3). A score of more than 3 indicates mental distress and referral to a mental health HCP (NICE, 2020). The recommendation from the Australian Clinical Practice Guideline (2017) is that women are screened using the EPDS at booking/early pregnancy, and then repeated later in pregnancy, six -twelve weeks postpartum and sometime during the first year.

Maternal mental health education and suggested screening for MMH conditions in New Zealand for midwives is also variable. In New Zealand, different regions use different documenting software for writing notes. Many hospitals in the North Island use software called Badgernet- Clevermed (Health Informatics New Zealand [HiNZ], 2021). This software has incorporated MMH screening questions as part of the routine antenatal and postnatal assessments. It is used by many independent midwives in the Canterbury region although it is not used by Christchurch Women's Hospital. Maternal mental health education is provided in some of the midwifery undergraduate degrees however this has not been evaluated for effectiveness. There is also a perinatal mental health course offered by Auckland University of Technology and Otago Polytechnic. There is currently no elective post-registration midwifery education offered by the New Zealand College of Midwives or education enforced by Te Tatau o te Whare Kahu Midwifery Council.

The current New Zealand health sector is ill-equipped to support women with MMH conditions. The Ministry of Health (2021) recently explored what MMH services were available in each region of New Zealand. Psychosocial and mental health needs are increasing for women however, it was evident services are inequitable due to multiple barriers to access. These included strict referral criteria, few health professionals able to refer to services and isolation due to geographic location.

Existing literature

A scoping review was undertaken to understand the extent of information that is available. Through this review main themes were identified. Many women in the literature experienced barriers to accessing MMH care. Fear and stigma was one barrier identified in the literature. The fear and stigma women felt from HCPs and their peers reduced the likelihood of engaging in MMH care (Ford et al., 2019; Higgins et al., 2016; Mellor, 2016; Oh et al., 2020; Taylor et al., 2019). There was also evidence in the literature that women with MMH conditions cannot be a good mother (Baldisserotto et al., 2020; Hore et al., 2019; Law et al., 2021; Oh et al., 2020; Viveiros & Darling, 2018). This reduced women's likelihood of disclosing their MMH concerns.

The education provided to women by midwives and education providers needs to be reviewed as many women did not feel that they received adequate antenatal education. However many midwives felt they did not have adequate training and education about MMH conditions to confidently discuss and screen women for MMH conditions (Koire et al., 2022; Law et al., 2021; Mellor, 2016, Savory et al., 2022).

Faciliators to accessing care was also acknowledged in the literature . Trusting relationships with HCPs or peers increased the women's likelihood of disclosing their MMH concerns (Ford et al., 2019; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Oh et al., 2020; Savory et al., 2022; Viveiros & Darling, 2018). Moreover, women with strong support networks were also more likely to discuss their mental health (Oh et al., 2020, Ministry of Health, 2021; Savory et al., 2022).

There are wide-spread system related barriers that women experience when trying to access support. These include difficulty in getting a referral, no direct referral pathway, and delays in care due to long wait lists (Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018). Considerations to other ways of working such as digitally, drop-in groups or support groups may help to further improve access for women (Koire et al., 2022; Viveiros & Darling, 2018).

The literature review highlighted lack of New Zealand research in relation to understanding women's experiences of MMH conditions and what support would be beneficial for them. Therefore, the study investigates the experiences of women being diagnosed with MMH conditions and accessing MMH services in the Te Whatu Ora - Waitaha Canterbury region, New Zealand. We sought answers to the following questions:

- What are women's experiences of being diagnosed with a maternal mental health (MMH) condition?
- What are women's experiences of accessing MMH services in the Te Whatu Ora - Waitaha Canterbury region?

Study design

This study sought to capture the experiences of women being diagnosed with MMH conditions and accessing MMH services. The study was guided by the qualitative methodology of interpretive description (ID) developed by Thorne et al. (1997). As ID is combination of several methodologies, grounded theory, phenomenology, and ethnography, it encourages researchers to move beyond rule structures from traditional methodologies and replace them with meaningful logic (Betero, 2015; Thorne, 2016). Interpretive description methodology strengthens qualitative research by understanding a clinical phenomenon through identifying themes and patterns and generates a practical application to inform a clinical understanding (Betero, 2015; Thorne, 2016; Thorne et al., 2004). This relates well to the research question and aims as it enables a comprehensive and insightful overview of women's experience of being diagnosed with MMH conditions and their experience of accessing MMH services. This means that valuable information / recommendations for improving experience and access to services can be revealed.

Ethics

Ethical approval was granted by the Auckland University of Technology Ethics Committee on 18 July 2022, AUTEC Reference number 22/151 prior to research commencement (Appendix F). Subsequent changes to the approved ethics instruments were required due to New Zealand health reforms (Appendix G)[1]. Support was also granted by Māori Midwives ki Tahu to ensure the research was appropriate, safe, and supportive for Māori. Written consent was obtained from all the participants and information anonymised to support participant confidentiality.

Participants

A purposive sample of seven women who had been diagnosed with mild-moderate MMH conditions and accessed services were included in this study. These participants were all ex-clients of a community organisation that provides clinical MMH support to women. The participants were emailed information about the study from the community organisation. The participants then contacted the researcher if they were interested in participating via email. Eligibility criteria included having a baby from 2020 onwards, not pregnant or within six-week postpartum period. They must have been referred to/accessed MMH services and had not required a transfer of care to obstetric or psychiatric led care. The potential participants needed to be older than 18 years of age and English speaking. Prior to recruitment, flyers and recruitment posters were distributed to the members of the New Zealand College of Midwives, Canterbury region, individual general practices and community MMH services. They were

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[1] Research title was changed from "Women's experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand." to "Women's experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Te Whatu Ora - Waitaha Canterbury region."

encouraged to send the information to ex-clients who had been discharged from their service. The seven recruited participants, lived in both urban and rural settings. After making initial contact they were phoned to ensure they understood the research. The contents of the participant information sheet were discussed including the purpose of the research, eligibility criteria, the interview process and how any potential risk would be mitigated (Appendix C). See Table 2 for participant characteristics.

Age categories	**Number in each**
25-30 years	2
31-35 years	4
36-40 years	1
Ethnicity	
New Zealand European	4
Other European	2
Indian/Asian	1
Māori	0
Parity	
1 child	2
2 children	4
3 children	1

Table 3: Participant characteristics

Data collection

One-on-one semi-structured interviews were conducted by the primary author who is a midwife. Open-ended questions were used to form the semi-structured interviews (Appendix J). This included questions such as: “Can you tell me about the experience of when you were diagnosed with a MMH conditions?” and “Could you tell me what the experience of accessing MMH services was like for you?” This enabled the interview to have some structure so that the aims of the research would be considered but enough flexibility that the interview was conversational to gain an understanding of women’s experiences. Several key questions were also included if they were not answered naturally within the sharing of experience. All the participants were interviewed at a location of their choice. Consent was gained verbally and written prior to the commencement of the interview (Appendix E). Understanding the sensitivity of this topic, participants were able to stop or pause their interview at any time and contact information was given to them for free counselling sessions if required. The interviews were conducted in English and were recorded on two digital recording devices. The interviews were then transcribed verbatim by the primary researcher using Otter Ai transcription software and edited to ensure clarity and readability. The participants were also able to choose a pseudonym. Initial themes, points to return to and interviewer feelings were written in field notes. This provided a reference point for the analysis and another back up option for the data (Thorne, 2016). Following the interview further themes, reflections, and ideas were also written down in the field notes. Data analysis was completed concurrently (Thorne et al., 1997). The participants were offered a copy of their transcripts following the transcription process to check for accuracy and if any sections needed to be redacted prior to further analysis. Five participants requested a copy of their transcriptions, and no further changes or redactions were requested.

Data analysis

Thorne (2016) encourages researchers to keep the purpose of the study central to analysing themes. For this research, understanding how the women felt telling their stories was important. A field journal was kept where the researchers' initial thoughts, feeling and themes were written during and following the interview process. This is part of Thorne's process where surface and deeper levels of understanding and meaning are searched for. During the transcription process further themes and meanings were recorded. This is an important part of interpretive description methodology as Thorne encourages researchers to deeply analyse the data, critically reflect on it and then investigate possible interpretations and meanings (Thorne, 2016).

Following this, the participants were all given a colour code as identification and their quotes and themes were collected on a VSD document (Microsoft Visio Drawing File) (Appendix D). Categories were created and themes were identified. Throughout this process, the transcriptions, themes, and interpretation were reviewed, agreed, and verified by the other two authors (NW and SC). This group verifying process helped ensure a thorough trustworthy analysis had been completed and that plausible interpretation of the data had been achieved. Each of the themes were critically analysed and how they integrated formed the bases for the discussion

Findings

Themes extracted from the data were organised into four main themes with associated sub-themes. See Table 3 for the themes and associated sub-themes.

Themes	Sub-Themes

Lifestyle challenges.	Preparing for parenthood. Exterior factors impact MMH. Perinatal experience shapes the postpartum period.
The impact of relationships.	Helpful relationships. Unhelpful relationships.
Burden carrying.	Bad mother. Self-blame. Support people to advocate.
Logistics of access.	The impact of education. Barriers to accessing care. Experiences of services.

Table 4: Themes and sub-themes identified in the original qualitative research.

Lifestyle challenges

Lifestyle challenges were one of the many issues the participants identified that contributed to their adverse MMH experience. A key subtheme within the lifestyle challenge's theme was preparing for parenthood. This revealed itself through several participants sharing their feeling of being unprepared for parenthood. This challenge was shared by Sophie, "Preparedness is really important for mental wellbeing and for building resilience." The feeling that society had un-realistic expectations of women was shared by Dolly,

> *"… those society norms that are that were put upon us that crushed us with *first baby. It crushed us…[yet] It's okay to be an okayish mother and have an okayish day and just survive, take the pressure off. "*

Taking the pressure off herself and surviving with a new-born baby was empowering for her mental health. As many of the women felt un-prepared with their first pregnancies there was a sense of confidence going into subsequent pregnancies that they felt more confident to advocate for their own health needs. However, some mothers felt apprehensive with subsequent pregnancies and felt they needed to prepare themselves for MMH conditions again. Amy expresses how she felt nervous about the post-partum period with her second child referring to pregnancy as *"the calm before the storm."* It was also acknowledged that there is a huge shift on relationships when becoming a parent but also the impact that MMH conditions also have on women. Dolly describes the significance of her partner’s support, *"And actually, the only way you're going to survive having kids is having a strong relationship.”.*

There were also exterior factors that adversely impacted the mother's mental health was another important subtheme. Three of the women specifically mentioned the impact of the COVID-19 pandemic. The women removed themselves from social support to minimise the risk of getting COVID-19 and the New Zealand COVID-19 national ‘lock downs’ resulted in family being unable to come and help with the new baby and recovery in the post-partum period.

It was shared by several women that they felt that their birthing experience shaped the postpartum period and their mental wellbeing. This was another important subtheme that was acknowledged within the lifestyle challenge’s theme. Trish, Roxanne, and Kate linked their births that were felt as unempowering and/or traumatic to a negative start to the postnatal period. Kate shares

"I guess it's all just such a whirlwind. You go through labour, and you don't know what's happening and then you go, and you have an emergency c-section, and you don't know what's happening and baby's not well, and you don't know what's happening and then you go after the ward, and you don't know what's happening. And it's a feeling that you're out of control because it's so routine for everyone at the hospital, just what they do all day every day. But for us, it's, you know, it's our first time, it's in our lives we've experienced any of this. It's just like, whoa, very overwhelming."

The importance of clear communication from HCP and an opportunity to de-brief the births may have been valuable for these women. Therefore, consideration should be made to create conversational space for women to discuss their birth if they choose to do so. An example of issues in the postnatal period highlighted infant feeding as a highly emotional touchstone for women. For example, Charlie experienced poor communication with her HCP who made her feel dismissed for having difficulties with breastfeeding.

"You get it this kind of shoved down your throat that breast is best, but when you actually really want to and you're having trouble, nobody's cares."

Other women also felt that difficulties with breastfeeding negatively impacted their mental wellbeing. Dolly reflects on her experience,

*"I remember crying in the corner when *husband fed him his formula bottle and I just felt so useless. And again, I thought these were normal feelings that you feel during motherhood."*

Charlie shared that she felt significant judgement for giving her baby formula and that only *“2nd grade parents give formula.”* The pressure to continue breastfeeding despite it negatively impacting mental health was also shared by Roxanne.

Sophie felt she was not provided with enough information and therefore felt unprepared for her postpartum recovery,

"...like it makes me mad at previous generations of women. Because no one told me like I'm a highly educated person and I didn't know it."

The impact of relationships.

The impact of relationships was something many of the women acknowledged had affected their MMH condition. Within this subtheme it was identified that relationships can be unhelpful and helpful. Unhelpful relationships were identified by the participants from mother's groups and encounters with HCPs. The feeling that many mothers' groups were unhelpful as they were 'toxic' and not a safe space to be vulnerable was shared by women in this study. Dolly experienced this in her mother's group where there was a lot of comparison between mothers and babies,

"You enter in this weird competition between mothers when you have a baby to see who the best mum is."

Health care professionals also had a huge influence on whether the women would disclose their MMH concerns. Many of the women felt the pressure of not knowing what the HCP reaction would be if they shared their concerns over their mental health. Trish shared that when she would take her baby to the doctor, she would talk around the subject of mental health to see if this was a safe person to share her concerns with. Other women in the study felt dismissed or not heard by the HCP or felt that a blind eye was turned towards their MMH. It appears that having trusting relationships with HCP positively impacted the participants likelihood to disclose their mental health concerns.

The subtheme of sharing and validating experiences with others, and the importance of being part of a community or support network was valued by the participants and considered helpful to their MMH. Several of the women felt that sharing their MMH concerns with other women was important, Amy describes this need to share,

"And then friends that are becoming new mums. Just to try, I don't know, normalize it or try and help them to recognize the signs and acknowledge that it's really hard 'cause don't know that is acknowledged enough either."

Dolly also felt the importance of sharing,

"I'll tell anyone, now at this point. What happened to me because it helps someone else, and it rings true. But it is my experience, and I'm no lesser of a person. And I think less women talk about it, because that's what they think that they will be a lesser person, or lesser mum and no new mum wants to feel it."

In addition, the women reported having deeper friendships after their MMH conditions and being more selective with those that they spent time with. Interestingly, by sharing experiences with others, the fear of MMH medication was also minimised for the women in the study.

Burden carrying.

The women who participated in the study all felt the burden of their MMH condition. Many of them felt that they were perceived as a ‘bad mother’ for having a MMH condition and this was acknowledged as a subtheme within the data. The women in this study felt they still had to present well in front of friends and family and not tell anyone about their MMH condition even if they were not feeling well. By presenting well it may make mother’s feel that they have some control in their lives. However, for Charlie her MMH condition meant being social and leaving her home was difficult *"I isolated myself. I wasn't in a mental health position to be social."*

Many of the women felt some element of self-blame for their MMH condition. This subtheme of self-blame was acknowledged as part of burden carrying. Amy felt a sense of responsibility for her MMH condition *"It's my fault that I feel like this.”* Carrying the burden of her MMH condition while having a new baby and navigating motherhood was challenging for Dolly,

"Because the first time round I'm like, you kind of just tell yourself, well, this is just a baby. Like this is how they are or yeah, it's just motherhood. Like why would I ask for help? I'm supposed to be able to cope with this."

The feeling of being overwhelmed was also felt by Kate who struggled with her MMH with her new babies,

" Parenting is not easy, for anyone whether you struggle with mental health or not. Just to add that on top of it, just makes everything just unmanageable. Makes it feel impossible."

Amy felt like this also,

"… it effects everything you think it will and more, it’s an overwhelming shift. And even for me the wave of the depression and how heavy that is and how consuming it can be as well.”

Charlie blamed herself for the delay in bonding with her child due to her mental health condition *“My child didn’t like me or want to be around me.”*

Questioning her decision to become a mother because of the burden of her MMH condition was shared by Kate,

"You just can't get your head above water. You do feel like Oh, have I made the wrong choice? Or should I not have become a mum. This is not for me. Is this what my life is like now? Have I just ruined everything? Am I the right mum for these babies?"

Not burdening support people was also felt by many of the women. Sophie describes, *"It's not fair to talk to my husband about it... like someone doesn't want to hear your issues all the time."*

This was shared by other women who didn't want to share their condition with family or friends as they didn't want to burden them. However, due to feeling the burden of their MMH condition it was suggested by many of the participants that having others advocate for your mental health and accessing support was of upmost importance. A support person/people to advocate for care was a subtheme within this data and was valued by the women in this study. Charlie valued her MMH support worker and husband advocating for her,

"Even things like you know, making appointments to the doctor, and the doctor knowing what it was that the appointment was for was incredibly helpful. I don't think I would have gone because just simple things like making an appointment, it was just too much for me."

It was important for the women that someone knew about what was going on with their mental health to ensure their wellness and safety.

Logistics of access

There were many logistics that impacted accessing support for the participants in this study. The impact of education was identified as an important subtheme. This education could be from midwives, other HCPs, or antenatal childbirth educators and this impacted the logistic of access for the participants. The participants in the study felt that they had not been provided any or enough information about MMH conditions, what to look for and how to access support if they needed it. Trish shared,

"I did not realize how common it was…I think we were told maybe 1 in 10 (get a MMH condition), you're like, oh yeah, there's someone in this room but it won't be me."

Kate describes how she was not provided with any information about MMH services,

"I'd heard about post-natal depression before... it's kind of different when you're in it yourself... you don't have the capacity to figure out how to access services."

For Kate early targeted screening was lacking that delayed support for her mental health concerns,

"Earlier more proactive screening, make it routine. So that the midwife doesn't have to think about it, it's just part of the check list." She continued to say "I think if I'd asked my midwife to refer me or to do something, then she probably would have. But again, we don't know, we just think it's our new normal..."

Another logistic the participants in this study had to navigate was barriers to accessing services, such as the waitlist to access services. The barrier of accessing services was another subtheme within the data. Roxanne felt she had waited until the last moment to ask for help with her mental health only to be defeated when she found out the waiting list was several months long. *"Two months... is a long time in a baby's life… and the* *days feel very long."* Kate also had a similar experience, *"The first three months were pretty horrific [waiting for MMH services]."*

Sophie waited four months to see a MMH worker but felt challenged when she eventually was seen,

"But I did feel slightly guilty... because I knew there's a woman out there right now that needs you, like, I needed you four months ago and now I'm taking up your time. So, I felt guilty about that."

The experiences of accessing services was identified as a subtheme within the data and experience were varied between the participants. Several of the women were referred to psychiatric maternal mental health services when primary MMH services could no longer help them due to the women becoming more unwell. Charlie shared that she received a rejection letter in the mail and exclaimed, *"I'm on my own now".* Sophie too felt shocked by her rejection letter *"And I was like, oh, okay, so no one cares."* Both women felt abandoned by MMH services. They then continued to engage with the primary MMH service, and their GP however they both felt they needed more support than what these services could offer them.

The women felt that MMH services in New Zealand needed to be reviewed with a focus on improving accessibility to services. This included increasing funding to existing services so that wait times were shortened and consideration to other ways of working such as digital psychotherapy from MMH support services.

The women were also shocked that MMH services were not in all regions of New Zealand. Dolly describes her surprise,

"I'm surprised that Christchurch is the only place in New Zealand that offers this (clinical MMH service). Really surprised, I think this should be national. And I think it should be like, it should be like people should be referred, like, you know, as in like, it should be brought up for every pregnancy regardless of the fact that you've got a predisposition to it or not. I think it should be just there."

Despite the above challenges reported by women in the study, it was shared that they were, for the most part, happy with the support received from the clinical MMH service. They appreciated the taught coping mechanisms, advice and support provided by the service and found this to be valuable. As Sophie states, referring to the clinical MMH service, *"I felt like someone cared!"*

Discussion

The findings of this study demonstrate that there are many influences that impact the women's experiences of accessing MMH services. Feeling unprepared for parenthood was felt by many of the women. Many of the women felt the information provided by HCPs and antenatal educators was not adequate and that society has unrealistic expectations on mothers. It is important that antenatal education reflects what is important for parents as they transition to parenthood (Billingham, 2011). Partners also had mixed experiences of antenatal education reporting that their experiences were not always helpful to prepare them for parenthood. Partners often felt excluded, as the classes were mostly focused on the woman and baby's needs (Smyth et al., 2015). By offering partners more support and education which would aid their own wellbeing and enable them to be a better support person for the women and babies. This is supported by the women in this study as they valued the support of their partners and their advocacy when they were unwell with their MMH condition.

The COVID-19 pandemic also had a lasting impact for the women in my study. By not being allowed to see support people or removing themselves from social situations the women felt more isolated, and this negatively impacted their MMH. This experience is comparable to global literature where it identified that there was a significant increase in self-reported maternal anxiety and depression from pre- COVID-19 to during COVID-19 period, resulting in reduced support people and services for women (Davenport et al., 2020). The COVID-19 pandemic also meant a reduction in MMH support services, leaving many women had untreated MMH conditions and minimal support (Barbosa-Leiker et al., 2021; Cameron et al., 2020).

In this research Amy* described a subsequent pregnancy as the "calm before the storm". HCPs have an opportunity to ask pregnant women about their mental health in previous pregnancies. New Zealand Guidelines Group (2008) recommend that all HCPs enquire whether women have a pre-existing mental health condition, family history of mental health conditions or previous mental health condition in the perinatal period. This would allow the HCP to gain some insight into what care the women may need and how best she can be supported. If a woman discloses previous MMH conditions, preventative care should be offered to them in the form of psychosocial and psychological interventions (Wilkinson et al., 2022). In the Waitaha Canterbury region this could be through midwives referring women to a clinical or non-clinical service as well as referring women to their GP (Te Whatu Ora - Waitaha Canterbury, 2023).

The opportunity to have a conversational space created to debrief their births may have been valuable for the women in this study (Waller, 2019). This leads to a deeper understanding of the midwife's role with this. Having an opportunity to debrief birthing experiences and be offered counselling reduces the likelihood of developing post-traumatic stress disorder (Abdollahpour et al., 2019; Baxter, 2019). At Christchurch Women's Hospital, a birth afterthoughts clinic was created in 2023. This is led by midwives who have additional counselling education and an interest in birth trauma. It is hoped that through this clinic and having the opportunity to discuss their birth, women will feel heard and be able to process their birth better (Te Whatu Ora - Waitaha Canterbury, 2023).

Breastfeeding is a known source of stress for women in the postpartum period as well as perceived guilt for not breastfeeding (Russell et al., 2021). A participant in this research shared that only *"2nd grade parents give formula."* This guilt has been associated with the ideology of not being a good mother and leading to worsen MMH (Jackson et al., 2021; Pilav et al., 2022). These findings demonstrate the importance of how breastfeeding information is presented antenatally to women and how their feeding choices are supported postnatally.

The impact of relationships both helpful and unhelpful was evident in the findings of my study. 'Toxic' mothers' groups and the 'best mum competition' was used to describe how one participant felt about her mother's group not being a safe space to share her MMH concerns. This is supported in the literature as women are unlikely to disclose their MMH concerns to other mothers for fear of judgement (Law et al., 2021; Oh et al., 2020). Conversely the opposite is true when women have good supportive friends and other support people. The affirming impact of sharing has been shown previously as women with strong support networks are likely to look to these networks for support during mental health issues (Oh et al., 2020; Savory et al., 2022). Relationship with HCPs are also known to impact the women's engagement with them. This is evident in the literature and reveals their influence on mother's likelihood and comfort for engaging further with them (Ford et al., 2019; Pilav et al., 2022; Oh et al., 2020).

This stigma of being perceived as a 'bad mother' in the findings is reflected in the literature. The intense societal imposed ideology of what motherhood should be, how it is experienced and what makes a good mother only adds further stress and anxiety on women with MMH conditions (Hore et al., 2019). Further research is needed to understand how to remodel this ideology within society. Women with MMH conditions also may also present themselves well to uphold the 'good mother' image (Oh et al., 2020; Savory et al., 2022).

The importance of education about MMH conditions was raised by several women in this research as they felt their antenatal education was inadequate. Other researchers have indicated the importance for women to be provided with information about MMH conditions; including the signs and symptoms and how to access support if it's needed (Koire et al., 2022; Law et al., 2021). The women in my research indicated that their midwives did not screen them for MMH conditions. Therefore, the MMH education midwives are provided with has been investigated and reflected on. In the New

Zealand context midwives have two challenges to provision of appropriate MMH care: firstly, midwives are not provided with any compulsory MMH education post-registration and secondly, are only able to refer to community MMH services such as GPs and primary community MMH services and unable to refer directly to secondary psychiatric MMH services (Mellor, 2016, Te Whatu Ora Health New Zealand, 2023). This contributes to midwives having a perceived low confidence when screening women for MMH conditions and a potential reluctance to do so (Mellor, 2016). However, it is encouraged that midwives use a 2-3 questions MMH screening tool or the EPDS (Ministry of Health, 2021; New Zealand Guideline Group, 2008). Within a New Zealand context, the EPDS has been validated for use within the Samoan and Tongan community (Ekeroma et al., 2012). However, it has not been evaluated for other ethnic groups.

In New Zealand MMH services vary between regions, with most services being in main cities and are only accessible if you live there. This has been acknowledged as an issue by the Ministry of Health (2021). Koire et al. (2022) also identified distance and transport as a barrier to women receiving MMH care and suggests the consideration of digital MMH psychotherapy to mitigate these barriers. Other barriers such as long-wait lists to MMH services also affect New Zealand women (Ministry of Health, 2021). This is comparable to literature overseas where MMH services are available are often impacted by long waiting times and subsequently women's mental health can deteriorate whilst waiting (DeRoche et al., 2023; Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018).

The results of this study provide an opportunity to understand the experiences of women who are diagnosed with MMH conditions and access MMH services. This study contributes to the knowledge that there are many aspects that can impact and improve MMH conditions and outcomes for women, including improved HCP education, screening women for MMH conditions, the importance of de-briefing birth or other potentially traumatic situations and considering how breastfeeding information is presented. There is a need to better prepare parents for parenthood through antenatal education and provide them with robust and honest information about how to maintain, improve and identify issues with their MMH.

Strengths, limitations, and recommendations for further research

The following are the strengths, limitations, and recommendations from the study. This study was conducted in the Te Whatu Ora - Waitaha Canterbury region and may not be representative of other regions in New Zealand due to variability in service offered in each region. A nation-wide study may be beneficial to understand complexities of

MMH care in other regions. The participants of this study were recruited through one clinical MMH service despite attempts to widely recruit. Therefore, experiences may differ for other women in the Canterbury region. Most of the women in this study were New Zealand European or other European and there was no Māori or Pasifika participants. A study investigating other ethnic populations such as Māori or Pasifika should be considered for future research. The participants in this research were all women that were partnered in heterosexual relationships. Their experience may not be representative of people who are single, in same sex relationships or identify as other genders in the LGBTIQ+ community.

Several of the participants in this research felt that breast-feeding education and perceived pressure to breastfeed had adversely impacted their MMH. Considerations must be made with how breastfeeding education is taught to families and the impact this has on MMH. The participants in this research felt that their antenatal education was not informative, research into how antenatal education is provided, received, and evaluated for women and their partners is worth considering. Maternal mental health services are not available in all regions of New Zealand, therefore other ways of providing MMH care such as digital psychotherapy should be considered to mitigate this barrier.

There needs to be consideration by the Te Tatau o te Whare Kahu Midwifery Council, New Zealand College of Midwives, Tertiary Education where postgraduate courses are offered, for provision and evaluation of the education provided to midwives and with Ministry of Health re referrals by midwives to psychiatric MMH services. Another consideration is validating and examining context specific screening tools for MMH conditions in pregnancy within the New Zealand context.

Acknowledgments and Disclosures

This research was written by a midwife completing her Master of Health Science in Midwifery and hence this research has a midwifery lens. There were no sources of funding aside from a small research grant from Auckland University of Technology. There are no conflicts of interest.

Chapter Four: Discussion and Recommendations

The chapter revisits questions and aims for this research and how these were achieved. I extend the discussion sections in the previous manuscripts (Chapters 2 and 3) and present implications for practice, education, and policy. This is followed by considering future research agendas that have arisen in relation to this study. Finally, I provide my personal reflection on what I have gained from completing this research thesis.

Research Questions & Aims:

The study aimed to gain insight into women's experiences of being diagnosed with a MMH condition and their experience of accessing services in the Te Whatu Ora - Waitaha Canterbury region. The study aimed to be able to make recommendations for policy and practice to help to improve outcomes for women in the perinatal period.

The main question of this study was:

"What are women's experiences of being diagnosed with a maternal mental health (MMH) condition and their experience of accessing MMH services in the Te Whatu Ora - Waitaha Canterbury region?"

The participants were recruited through purposive sampling which enabled a range of experiences to be captured ensuring rich data. There were 3 women who expressed interest in the study however were not eligible to participate. Effort to recruit Māori and Pasifika participants was unsuccessful despite recruitment posters in Māori and Pasifika primary health providers and MMH community service facilities. Lead maternity carer midwives were also approached through the New Zealand College of Midwives meetings and email networks to share information with their ex-clients who had MMH conditions. The combined findings of the study and scoping review highlight the varied experiences women had of being diagnosed with a MMH condition and specifically the experiences of accessing MMH services at Te Whatu Ora – Waitaha Canterbury.

What are women's experiences of being diagnosed with a MMH condition?

Trusting relationships facilitate diagnosis and treatment.

Trusting relationships are an important aspect of being diagnosed with a MMH condition. Women are more likely to ask for help and have a positive interaction with their HCP when they have a trusting relationship (DeRoche et al., 2023; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Oh et al., 2020; Savory et al., 2022; Viveiros & Darling, 2018). The women in this study were likely to have a positive encounter with their HCP when a trusting relationship was established.

Having a strong support network of friends and family also means that women are more likely to look to them for support (Ministry of Health, 2021; Oh et al., 2020; Savory et al., 2022). The women in this study felt a sense of responsibility for other friends having children and establishing that they were a trusting person they could go to for help. It was also felt that deeper friendships were established after being diagnosed with a MMH condition.

HCPs appear to have limited MMH knowledge.

In a New Zealand context, midwives are not routinely provided with MMH education and therefore appear to lack confidence when screening women for MMH conditions (Mellor, 2016). This was also the experience of participants in this study who felt that they were not provided with enough information or screened for MMH conditions. It would be likely that confidence when screening women and therefore treatment outcomes would be improved if MMH education was provided for midwives and other HCPs (Higgins et al., 2016; Mellor, 2016).

What are the barriers that women experience when accessing MMH services?

Reaction and influence of health care professionals impacts engagement.

The impact of HCPs reaction and the influence was widespread in both this research and in the scoping review. The unknown of how the HCPs would react to their MMH concerns meant some of the participants in the study were reluctant to share due to fear of stigma and being judged. Many of the mothers felt a blind eye had been turned to their mental health. This avoidance of being stigmatised and judged is reflected in the research. Ford et al. (2019), Pilav et al. (2022), and Oh et al. (2020) have highlighted that the HCPs reaction influenced the likelihood of mother's being able to continue on-going engagement and relationship with HCP's.

Moreover, the perinatal period can be very overwhelming especially for first-time mothers due to the unknown. In this study *'very overwhelming,' a 'whirlwind'* or *'being out of control'* has been used to describe such experiences by the mothers in this study. Opportunity to debrief following birth with the HCP involved in their care has been suggested by mother's in the study. HCP's also have a role in improving MMH outcomes for mothers and hence should discuss MMH concerns and offer an opportunity to debrief labour and birth experience. This means that ease with disclosure of mental health concerns to a HCP is important; however this is not always easeful.

Influence of others, negative and positive

The profound effect of feeling a 'bad mother' has been highlighted in the literature and was a finding in this study. This can create reticence to speak to other women.

Research has highlighted that women are unlikely to disclose their MMH concerns to other mothers for fear of judgement (Law et al., 2021; Oh et al., 2020). A participant in my own study was reluctant to share her MMH concerns with her *'toxic mum group'* due to *'weird'* competition that would result between mothers to see who the best mum was. The feeling of judgement was shared by a participant in Baldisserotto et al. (2020) research where a participant appears to have been informed that *"A woman with depression can't be a good mother."* (p. 103).

In addition, the scoping review also highlighted participants reluctance to share MMH concerns with friends or family for fear of judgment and being misunderstood (Higgins et al., 2016). The societal imposed ideology of what makes a 'good mother' and how motherhood should be experienced only exacerbates adverse MMH for mothers (Hore et al., 2019).

Conversely, women in this research felt the need to have a positive influence on their friends having children by being open about their MMH. This was through sharing and validating their experiences with others, by normalising it or try and help them to recognise the signs and acknowledge it, as it is not acknowledged enough and that can be hard.

The not knowing – education and screening.

There was a sense of not knowing about MMH conditions, not being screened and difficulties with MMH service referrals highlighted in both the scoping review and shared by the participants in this research.

Overall, a lack of education and knowledge about MMH conditions and where to access support was common among women in the perinatal period. This is reflected in various studies where women have indicated a need for an increased antenatal education for women about the importance of MMH and where to go to for support (Baldisserotto et al., 2020; Higgins et al., 2016; Savory et al., 2022). A woman in my own study shared that she did not get adequate MMH education antenatally and did not feel that information about 1 in 10 having a MMH condition included her. Likewise, participants in the scoping review as well as in my own study reported wanting more information to be shared with them through discussions antenatally. Law et al. (2021) study confirms this and suggests raising the topic of MMH and providing information in the antenatal period to normalise and destigmatise it. This suggests that some form of pro-active screening is desired.

Pro-active screening from midwives and information about MMH services including the appropriateness of a referral has been suggested by a participant in my own study because it would have meant earlier support for her mental health. However, it is possible that her midwife did not feel confident with screening for MMH conditions. The New Zealand Guidelines Group (2008) suggests the use of 2-3 screening questions or the use of the EPDS if midwives or other HCPs have concerns about a woman's mental health (Ministry of Health, 2021). It is recommended in the Te Whatu Ora – Health New Zealand (2023) Referral Guidelines, that women whose wellbeing is affected by MMH conditions are offered a referral to a primary service provider such as GPs or community MMH support service. This would ensure that women are supported/provided with MMH care and can be referred to other services such as secondary psychiatric services if required.

Referral to MMH services is recommended when concerns are raised about a women's mental health. This may be due to positive response to an HCP or midwife using the MMH screening questions or an increased score on the EPDS. Furthermore, it is important to consider partners and families insights into MMH as they may identify changes in mental health and are often the woman's source of social support (Taylor et al., 2019). Yet, screening is not sufficient to receive MMH care. Unfortunately, although midwives may be screening women across regions in New Zealand, the New Zealand MMH services are not consistent and remain varied between regions (Ministry of Health, 2021). Different regions offer different services such as counselling, community MMH service that offers support and counselling and tertiary level psychiatric MMH care that may include in-patient care. Fortunately, in Canterbury region, where my study was conducted, a variety of services, albeit limited, are available including peer support, a community MMH service and a psychiatric unit. The next section now examines the experiences of women accessing MMH care in the Te Whatu Ora – Waitaha Canterbury region.

Women's experiences of accessing MMH services in the Te Whatu Ora – Waitaha Canterbury region.

The impact of long waiting lists

Long waiting lists for services was one barrier that impacted women's experience of accessing MMH services. This was shared by a participant who had to wait two months to have MMH support. This was a common theme in the scoping review and mother's MMH often deteriorated during the time they had to wait for access to MMH services (DeRoche et al., 2023; Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018). Koire et al (2022) research reports mothers waited on average five weeks and

DeRoche et al (2023) up to one year before they received care however the participants in this research reported waiting between two and four months before they were reviewed. A participant described this waiting period as *"pretty horrific"*.

Maternal mental health services in Canterbury

In the Canterbury region there is a "Mothers and Babies Unit" which provides psychiatric care to mothers with significant MMH conditions. Several of the mothers in this research were referred to this service when their MMH became worse and the clinical MMH service felt this was no longer within their scope. However, both mother's received rejection letters in the mail and were not even reviewed in person. This led to a feeling of hopelessness, a woman feeling that she was on her own and the other being shocked by the rejection letter feeling that no one cares. This was supported by the Ministry of Health's (2021) review of MMH services. They acknowledged that MMH services are under resourced and there is a need for increasing MMH care workers such as psychiatrists and support workers so that there is more support and services for women struggling with their MMH conditions.

Maternal mental health services are also variable between regions (Ministry of Health, 2021). This means that MMH services are mostly available in main cities and are only accessible if you live there. The participants in this study were surprised that MMH services were not offered in all regions and that clinical MMH services were also not offered nationally. A participant shared her surprise that Christchurch was the only place in New Zealand that offered this clinical community MMH support service. She felt community MMH support services should be offered nationally, and all women should be screened in pregnancy and postnatally and be offered the option of extra MMH services if needed. There is a need to continue the initial work of the MMH stocktake that the Ministry of Health (2021) undertook and evaluate the MMH services provided in Canterbury. It is worth considering implementing services such as PPNAP nationally.

Implications for practice, education, and policy

Both the scoping review and my qualitative NZ study in the Canterbury region highlight a number of implications for practice, education, and policy. This can be separated into three categories- the impact of antenatal education, implications for midwives and improving outcomes for mothers in New Zealand.

Impact of antenatal education

Not feeling prepared for parenthood or having the knowledge about how to manage life changes and their MMH was a common theme in this research. Antenatal education and how it is provided and presented for women and their family's needs to be reviewed. However, not all women attend antenatal education and therefore may not be provided with MMH education. One way to mitigate this is promoting the use of phone applications such as Positively Pregnant. Positively Pregnant is a New Zealand based app that provides pregnancy advice and tools to support mental wellbeing (Barber et al., 2020). If antenatal education was reviewed and phone applications such as this were promoted, awareness would improve for New Zealand women.

Implications for midwives

New Zealand midwifery schools need to review what MMH education is provided for students. The polytechnic in Christchurch (Ara – Te Pūkenga) offers some MMH education in a women's health learning module and the students may have this assessed. This is similar to other midwifery undergraduate programmes in New Zealand. A specific MMH learning module needs to be provided and evaluated such as that one being trialled in Australia where MMH is examined using an Objective Structured Clinical Examination (OSCE) (Fox et al., 2023). A MMH component to the annual compulsory elective midwifery education for midwives should be considered for implementation by MCNZ. This would help in educating/refreshing midwives' knowledge on the use of the 2-3 screening questions and/or the use of the EPDS (New Zealand Guidelines Group, 2008; Ministry of Health, 2021). By offering MMH education that is applicable for midwives, it is hoped that more midwives have the confidence and knowledge when screening women for MMH conditions.

Improving outcomes for all New Zealand women across all regions

Currently MMH services in New Zealand are sporadic, inconsistent, and inadequate. This is due to a lack of funding and regional variation in services in different regions in New Zealand (Ministry of Health, 2021). The development of a national pathway for MMH conditions is vital for improving outcomes for New Zealand mothers (PMMRC, 2022). The Ministry of Health (2021) are continuing their investigations of mental health care and services in New Zealand and hope that through Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing, outcomes could be improved for women. This needs to be closely scrutinised and challenged. Although maternal mental health is a part of wider mental health care service delivery, the perinatal period which is defined as the period from pregnancy up to a year postpartum is a sensitive and challenging time for women and their families. Therefore, guidelines are needed to support screening and appropriate referral pathways for women with MMH conditions.

A simple solution to providing accessibility to MMH services is specialist MMH phone/digital psychotherapy service. This approach was supported in the scoping review and by the participants in my study. This is also an opportunity to provide culturally appropriate services in the form of a MMH counsellor that identifies with your culture because there is currently a lack of MMH services for Māori, Pasifika, and Asian cultures (Ministry of Health, 2021). By offering a specialist MMH phone/digital psychotherapy service, barriers such as geographic location and transport are removed (Koire et al., 2022). Implementing and evaluating a service like this could be a valuable service for women with MMH conditions.

Trustworthiness and ethical considerations of the study

Trustworthiness criteria are appliable to this study. Throughout the research process the credibility was checked. This included regular check in with the two other authors- Nimisha Waller and Susan Crowther. They also reviewed all the research material including the research articles and participant interviews to ensure the information retrieved from these was accurate and interpreted correctly. The data provided is specific to the Canterbury region and therefore may not be transferable to other regions. However, it is evident that the experiences of the women who participated in this study are comparable to the experiences in the literature. It would be worth undertaking further studies to uncover women's experiences in other New Zealand regions. The research is traceable, logical, and well documented so that it can be audited, this ensures dependability. A clear audit trail is evident throughout the study. I have aimed to take the reader on the journey about how decisions were made, documented and how each stage of the study was reviewed throughout the research process (Connelly, 2006; Nowell et al, 2017).

Future research and take away considerations.

It is evident that any research agenda in this domain requires an explicit multi-disciplinary and community approach. With this in mind, suggestions for future research include:

- Research validating and examining screening tools for MMH conditions in pregnancy.
- Research investigating midwives' views of MMH education in their under graduate training and their feeling on this being a part of on-going midwifery education.
- Research investigating women's partners and children's experiences of having a mental health condition in the perinatal period in the Canterbury region to provide comparisons on experiences and care.
- Research investigating the experience of women declined from psychiatric services.
- Service evaluations and audits are also necessary to monitor effectiveness, acceptability, and accessibility across regions of any interventions regarding MMH screening tools/processes and referral pathways.

What I have gained from completing this research thesis

I have gained many insights from completing this research thesis. Becoming a parent and the transition to parenthood is an unknown and challenging time for all parents. Having a MMH condition adds another layer of complexity when transitioning to parenthood. There is a need to lessen the maternal suicide rates in New Zealand, a need to improve the mental health of our mothers and their family. When we get mental health right for mother's, the whole family benefits. MMH conditions need to be known about by pregnant women and their families and services need to be easily accessible. This research journey has encouraged me to reflect on the care that I provide within a tertiary level hospital. Although it is my everyday environment, it is an unknown environment for women and their families. I have self-reflected about the importance of offering a debrief with families following birth or other potentially traumatic situations. I am more intentional with asking women how they are coping, and more thoughtful in the way that I support the feeding decisions made by women. This research journey has made me even more passionate about improving care and outcomes for women. Finally, to the women who shared their precious stories with me, thank you for your vulnerability and your drive to make things better for others. I hope we can do better.

Conclusion

MMH is multi-layered and multi-factorial with many different aspects influencing it. This is evident from the scoping review and from my qualitative study. The main themes that answered the research questions and identified in the scoping review and my study were the reaction and influence of HCP impacts engagement; the influence of others - negative and positive and the not knowing – education and screening. Accessibility is impacted by long waiting lists, not being 'unwell enough' to be seen by psychiatric MMH services and questions why services are not offered nationally. Women need to be provided with better antenatal education and an awareness of MMH conditions and where to get support. Education provided to midwives needs to be reviewed and annual elective education to upskill in MMH screening and referral requires consideration for implementation in MCNZ Re-certification Programme. This study challenges the Ministry of Health to prioritize a national MMH pathway in conjunction with the New Zealand College of Midwives to improve services and accessibility for women in New Zealand.

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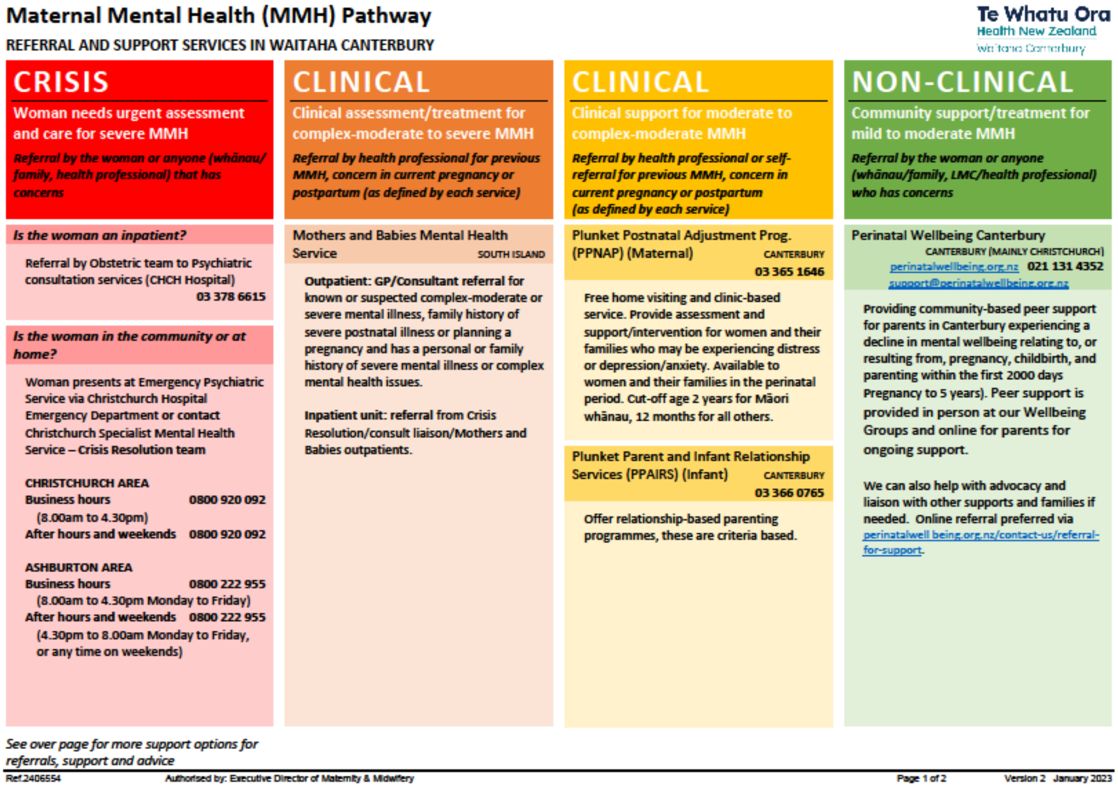
Appendices

Appendix A: Maternal mental health pathway.



Maternal Mental Health (MMH) Pathway

REFERRAL AND SUPPORT SERVICES IN WAITAHA CANTERBURY

Te Whatu Ora
Health New Zealand
Waitaha Canterbury

CRISIS

Woman needs urgent assessment and care for severe MMH

Referral by the woman or anyone (whānau/ family, health professional) that has concerns

Is the woman an inpatient?

Referral by Obstetric team to Psychiatric consultation services (CHCH Hospital)
03 378 6615

Is the woman in the community or at home?

Woman presents at Emergency Psychiatric Service via Christchurch Hospital Emergency Department or contact Christchurch Specialist Mental Health Service – Crisis Resolution team

CHRISTCHURCH AREA
Business hours **0800 920 092**
(8.00am to 4.30pm)
After hours and weekends **0800 920 092**

ASHBURTON AREA
Business hours **0800 222 955**
(8.00am to 4.30pm Monday to Friday)
After hours and weekends **0800 222 955**
(4.30pm to 8.00am Monday to Friday, or any time on weekends)

CLINICAL

Clinical assessment/treatment for complex-moderate to severe MMH

Referral by health professional for previous MMH, concern in current pregnancy or postpartum (as defined by each service)

Mothers and Babies Mental Health Service SOUTH ISLAND

Outpatient: GP/Consultant referral for known or suspected complex-moderate or severe mental illness, family history of severe postnatal illness or planning a pregnancy and has a personal or family history of severe mental illness or complex mental health issues.

Inpatient unit: referral from Crisis Resolution/consult liaison/Mothers and Babies outpatients.

CLINICAL

Clinical support for moderate to complex-moderate MMH

Referral by health professional or self-referral for previous MMH, concern in current pregnancy or postpartum (as defined by each service)

Plunket Postnatal Adjustment Prog. (PPNAP) (Maternal) CANTERBURY
03 365 1646

Free home visiting and clinic-based service. Provide assessment and support/intervention for women and their families who may be experiencing distress or depression/anxiety. Available to women and their families in the perinatal period. Cut-off age 2 years for Māori whānau, 12 months for all others.

Plunket Parent and Infant Relationship Services (PPAIRS) (Infant) CANTERBURY
03 366 0765

Offer relationship-based parenting programmes, these are criteria based.

NON-CLINICAL

Community support/treatment for mild to moderate MMH

Referral by the woman or anyone (whānau/family, LMC/health professional) who has concerns

Perinatal Wellbeing Canterbury
CANTERBURY (MAINLY CHRISTCHURCH)
perinatalwellbeing.org.nz **021 131 4352**
support@perinatalwellbeing.org.nz

Providing community-based peer support for parents in Canterbury experiencing a decline in mental wellbeing relating to, or resulting from, pregnancy, childbirth, and parenting within the first 2000 days Pregnancy to 5 years). Peer support is provided in person at our Wellbeing Groups and online for parents for ongoing support.

We can also help with advocacy and liaison with other supports and families if needed. Online referral preferred via perinatalwell being.org.nz/contact-us/referral-for-support.

See over page for more support options for referrals, support and advice

Ref.2406554 Authorised by: Executive Director of Maternity & Midwifery Page 1 of 2 Version 2 January 2023

Appendix B: Sample of extraction form.

Extraction form.

Date accessed	
Keywords/search strategy used	
Other search decision making	

	Further Information	Yes	No
Database			
English language			
Full copy of article			

Literature title	
Author	
Year of publication	
Origin/country of origin	
Aims/purpose	
Study population and sample size	
Methodology/methods	
Intervention type	
Key findings and outcomes and details of these	
Experience of participants or data gathered (examples)	
Other references to investigate	

<u>Key findings that relate to the scoping review objective and question</u>

Appendix C: Information sheet.

TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Date Information Sheet Produced: 20/04/2022

Project Title

Women's experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand.

An Invitation

Kia ora, my name is Steph Taynton, I am a midwife of six years, a wife and mother to one. I have been on a post-graduate study journey the past few years with a particular interest in maternal mental health (MMH). I am now commencing my Master's research thesis on what are women's experiences of being diagnosed with MMH conditions and accessing MMH services in the CDHB region. I am interested in your experience of being diagnosed with maternal mental health condition (for e.g. depression, anxiety etc) and how accessing these services make women feel. I would appreciate if you would consider being a participant in my study. This would involve an interview/discussion in a location of your choice. I look forward to hearing from you.

What is the purpose of this research?

The purpose of this research is to understand women's experiences of being diagnosed with MMH conditions and accessing MMH maternal mental services in Canterbury. This research is part of a Master's research thesis. This research focuses on women who have had no complications in pregnancy and had midwifery-led care. The aim is to gain insight into the participants experiences of having maternal mental health condition & access to services. This research has the potential to influence future maternal mental health policies within Canterbury and keep women at the centre of decision making. This ultimately will improve mental health outcomes for mothers and babies. The findings of this research may also be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You may have been provided some information from your midwife or seen a poster and contacted me. To ascertain your eligibility the follow inclusion and exclusion criteria are set out below:

The inclusion criteria are:

- Women who have been referred to/accessed current MMH services in Canterbury over the past 2 years.
- Women over 18 years of age who speak English.

The exclusion criteria are:

- Women who are currently pregnant or are within the six-week postpartum period.
- Women who require/required a transfer of care to obstetric or psychiatric led care.
- Women who are currently experiencing acute mental health concerns requiring in-patient psychiatric care or primary ongoing psychiatric services.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You will need to complete a consent form which the researcher will go through with you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This project involves a recorded interview that will be 1-1.5 hours long at a location of your choice. This will likely be in your own home or another location where confidentiality can be maintained. The researcher will ask you some questions but the interview is able to be led by the participant. Following the interview, the recorded interview will be transcribed by a transcriber who signs a confidentiality agreement form. On return the researcher will analyse all of the research interviews and produce the collective findings from all of the participants interviews.

What are the discomforts and risks?

There is a risk that some women may still feel some distress about their experience of mental health. If this is the case, I have several local supports that I can refer you to.

These community supports are the Plunket Postnatal Adjustment Programme, contact (03) 365 1646 and Te Puawaitanga ki Otautahi Trust who provide care to Māori and Pacifica mothers. Their contact number is (03) 344 5062.

How will these discomforts and risks be alleviated?

If women are still affected by the MMH condition and feel unsupported, they will be referred with their consent to their general practitioner (GP). As stated above here are also several local contacts the researcher can refer women to for support. These include the Plunket Postnatal Adjustment Programme and Te Puawaitanga ki Otautahi Trust. Both of these organisations provide MMH supports to mothers.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to: email counselling@aut.ac.nz or call 921 9998. Let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

The benefits for the participants include being able to share their experiences. By sharing these they may feel some closure and feel that they have contributed towards potential change. This research has the potential to enhance care and improve outcomes for women who need support with their MMH in the postpartum period. Another benefit is to ensure postpartum women have access to MMH in the postpartum period. The wider community will benefit from the recommendations for practice any and any potential change that may occur. By improving access to MMH services for women health outcomes may improve. If women's experiences accessing services in Canterbury are positive, then this could be used as a framework for other regions in New Zealand. This research will also enable the researcher Steph Taynton to complete her Master's in Health Science.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the

Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

The participants of this study will be given a pseudonym (a different name) so that the participant is unable to be identified in the research results. If the researcher has immediate concerns about the participants mental health, she reserves the right to refer to appropriate services in discussion with the participant. Signed consent forms will be kept in a locked cupboard in the researcher’s office and data analysis/findings in a password protected file. No identifiable information will be included in any research outputs for the study. Consent forms will be shredding six years following the completion of the study.

What are the costs of participating in this research?

The only associated cost in this study is the participant’s time. This will be 1-1.5 hours for the interview and potentially another 30 minutes to clarify or for you to change/add any information in the interview transcript.

What opportunity do I have to consider this invitation?

You will be given 10 days to consider this invitation.

Will I receive feedback on the results of this research?

You will be provided with a one or two page summary of the findings of the research if you indicate this in the Consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Nimisha Waller nimisha.waller@aut.ac.nz, 09 921 9999 ext 7210

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Steph Taynton, stephtaynton@gmail.com, 0273454113

Project Supervisor Contact Details:

Dr Nimisha Waller nimisha.waller@aut.ac.nz, 09 921 9999 ext 7210

Approved by the Auckland University of Technology Ethics Committee on *18 July 2022*, AUTEC Reference number *22/151*.

Appendix D: Example of initial themes and subthemes.

Education, access and experience

- The impact of education (giving, screening)
  - Lack of education and information about MMH services
  - Sense of responibility to provide MMH info to friends who are pregnant
  - The importance of information sharing with women about MMH conditions and preparing them for parenthood as no one else will do it
  - MMH conditions should be talked about for every pregnancy
  - Antenatal education wasn't informative or helpful
  - Improving education about MMH for midwives
  - Regular MMH screening for women
  - Routine MMH screening to pick up conditions early and treat rather than waiting for women to 'crash and burn'
  - Midwife knew she was struggling but didn't screen or refer her
  - "Earlier more proactive screening, make it routine. So that the midwife doesn't have to think about it, it's just part of the check list."
  - Midwives need to actively screen for MMH conditions
  - "I think if I'd asked my midwife to refer me or to do something, then she probably would have. But again, we don't know, we just think it's our new normal..."
  - Not aware of MMH services/supports and a lack of knowledge in the community about them also
- Barriers to accessing care
  - MMH services should be in all regions
  - Long wait-lists are a barrier to accessing care
  - Hard to wait for 2 months for care
  - Felt each day without treatment MMH was getting worse
  - MMH services accessibility needs to improve
  - You're not bad enough (to be seen by the MMH unit). "I'm on my own now"
  - You are alone, even when you seek help it won't be given to you.
  - Massive wait list for MMH services
  - "The first three months were pretty horrific." re waiting for MMH services to be in contact
  - Getting a rejection letter from the Mother's and Babies unit was really upsetting. "And I was like, oh, okay, so no one cares."
  - Consider phone/online MMH services to make it more accessible for new mothers.
- Experiences of services
  - Found MMH services helpful and practical
  - Wait lists and criteria that are too specific are barriers
  - "I felt like someone cared" re having care from a MH service.
  - "I'd heard about PND before.. it's kind of different when you're in it yourself... you don't have the capacity to figure out how to access services "
  - Waited until last moment before asking for help
  - "But I did feel slightly guilty..(because I knew) there's a woman out there right now that needs you, like, I needed you 4 months ago and now I'm taking up your time. So I felt guilty about that."

Appendix E: Participant consent form.

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant consent form

Project title: Women’s experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand.

Project Supervisor: Dr Nimisha Waller

Researcher: Stephanie Taynton

- I have read and understood the information provided about this research project in the Information Sheet dated 20 April 2022.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes ○ No ○

Participant’s signature: ....

Participant’s name: ....

Participant’s Contact Details (if appropriate):

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 18 July 2022, AUTEC Reference number 22/151. *Note: The Participant should retain a copy of this form.*

Appendix F: AUT Ethics approval.

18 July 2022

Nimisha Waller
Faculty of Health and Environmental Sciences

Re Ethics Application:

Dear Nimisha

22/151 Women's experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand.

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 18 July 2025.

Non-Standard Conditions of Approval

1. On the Information Sheet, supply the contact details of the support services so that participants do not have to request them.
2. In the 'How was I identified' section, say something like 'You may have received information from your midwife or saw a poster and contacted me to express your interest in taking part in my study. To ascertain your eligibility the following inclusion and exclusion criteria are set out below...

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be reviewed by AUTEC before commencing your study, but please forward a copy of updated Information Sheet for our file.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: stephtaynton@gmail.com; scrowthe@aut.ac.nz

Appendix G: AUT Ethics research title amendment.

22 February 2023

Nimisha Waller
Faculty of Health and Environmental Sciences

Re: Ethics Application:

Dear Nimisha

22/151 Women's experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand.

Thank you for your request for approval of amendments to your ethics application.

The change to the title has been noted.

Standard Conditions of Approval

9. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
10. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
11. Any amendments to the project must be approved by AUTEC prior to being implemented.
12. A progress report is due annually on the anniversary of the approval date.
13. A final report is due at the expiration of the approval period, or, upon completion of project.
14. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
15. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: stephtaynton@gmail.com; scrowthe@aut.ac.nz

Appendix H: Recruitment flyer.

Women’s experiences of being diagnosed with maternal mental health (MMH) conditions and accessing MMH services in the Canterbury District Health Board (CDHB) region, Aotearoa New Zealand.

What is this study about?

Maternal mental health impacts the health and wellbeing of mothers and babies. This study seeks to gain insight into the experiences of women who are diagnosed with MMH conditions and their experience accessing services.

Why participate?

- You will be able to discuss your experiences.
- You may help other pregnant women requiring maternal mental health support.
- You may be able to contribute valuable information that could impact how services are created and implemented.

Who can participate?

- Women who have had a baby within the last two years.
- Women who have accessed maternal mental health services in the Canterbury.

District Health Board region.

- Women over 18 years of ages who speak English.
- You cannot participate if your care has been transferred to obstetric or psychiatric led care.
- You cannot participate if you are requiring on-going mental health support.

Steph Taynton
Primary Researcher
Midwife,
0273454113
stephtaynton@gmail.com

What does the study involve?

The study involves an interviews that is 60-90 minutes long. This will be at a location and time of your choice. Steph may require a further 30 minutes of your time for further clarification. Your input into this study has the potential to change how future maternal mental health services are designed and offered to women.

Approved by the Auckland University of Technology Ethics Committee on *18th July 2022*, AUTEC Reference number *22/151 .*

Appendix I: Recruitment poster.

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Would you like to share your experience of being diagnosed with a maternal mental health condition and accessing services?

Kia ora! My name is Steph Taynton, I am a midwife with an interest in maternal mental health. I am conducting a study on women's experiences of being diagnosed with maternal mental health conditions and accessing maternal mental health services in Canterbury. This involves an interview of 60-90 minutes at a location of your choice. I would love to hear from you!

Why participate?

- You will be able to discuss your experiences.
- You may help other pregnant women requiring maternal mental health services.
- You may be able to contribute valuable information that could impact how services are created and implemented.

Who can participate?

- Women who have had a baby within the last two years.
- Women who have accessed current maternal mental health services in the Canterbury District Health Board region.
- Women over 18 years of ages who speak English.
- You cannot participate if your care has been transferred to obstetric or psychiatric led care.
- You cannot participate if you are currently requiring psychiatric services.

For more information or if you are interested in participating in the study please contact Steph at— stephtaynton@gmail.com or 0273454113 **Approved by the Auckland University of Technology Ethics Committee on *18th July 2022*, AUTEC Reference number *22/151 .***

Appendix J: Sample interview questions.

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Interview Guide and Prompt Sheet

- Meeting for interview - Face to face introduction
- Any questions/clarifications from the Information Sheet
- Signing of the Consent Form

Starting question

'Can you tell me about the experience of when you were diagnosed with a MMH condition?'

'How did this experience make you feel?' 'Was there anything about that experience that was significant for you?'

This would be followed by:

'Did you feel that maternal mental health services were available to you?'

'What did you know about mental health services?'

'Could you tell me what the experience of accessing maternal mental health services was like for you?'

Was this a positive or negative experience for you?

'What would you change for women in the future accessing maternal mental health services?'

'What advice would you give to another pregnant women accessing maternal mental health services?'