What works for midwives supporting māmā through emotional distress?

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Abstract

Pregnancy and the postnatal period are particularly vulnerable times for mothers' mental health, with an increased risk of women experiencing depression and anxiety during this time. Therefore, understanding the level and type of service midwives provide to māmā who experience emotional distress is vital to know what midwives need in order to provide the right care to their clients.

The aim of this study was to find out what tools and resources community-based midwives find most helpful to support the needs of māmā. Seven semi-structured interviews were conducted, including four Māori midwives, who were able to provide insight on their experiences caring for mothers with mental health needs. Overall, the interviews reflected a strong sense of care and empathy from midwives during their time caring for mothers. Midwives appeared to rely on their interpersonal skills and intuition about emotional distress, and emphasised the importance of connecting with people and utilising support from their communities. Whilst midwives were interested and engaged with providing appropriate care to mothers, they were unbeknown to some of the clinical resources that could be available to their clients. The complexity of referrals and access to mental health services was central to the midwives' frustration around caring for mothers, as well as a lack of education relating to kaupapa Māori, cultural competency, and mental health processes.

Recommendations based on this study are to provide midwives with education and training on topics like kaupapa Māori, on social and mental health resources and processes for referral to increase their ability to support and care for mothers who experience emotional distress. Improvements to the pathways for referrals and access to mental health services is essential. Future research should focus on understanding why midwives aren't using a range of online apps and tools, and increase awareness of the available modes of support available.

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Introduction

Depression, anxiety or emotional distress during pregnancy and the postpartum period is common and has a significant impact on the mother and child. Therefore, understanding the level and type of service midwives provide to māmā (mother) who experience emotional distress is essential in order to enable midwives to link māmā to resources, modes of support, and services midwives find helpful. This introductory chapter will cover maternal mental health problems and their effect on the woman and child, as well as the prevalence of perinatal mental health problems both internationally and in New Zealand. The current state of mental health screening as well as the barriers to screening for mental health will then be discussed. The New Zealand midwifery model of care will be described, focusing on the role midwives have to support distressed mothers during pregnancy. Lastly, the rationale for this study will be discussed.

Maternal Mental Health

Pregnancy and the postnatal period are particularly vulnerable times for mothers' mental health, with an increased risk of women developing depression and anxiety during this time (McLeish & Redshaw, 2017; Deverick & Guiney, 2016). Becoming a mother is a life changing transition that can be difficult to navigate and circumstances such as low social support, a prior history of depression or anxiety, financial stress, and the dyadic relationship changing between the parents, are just a few factors associated with the risk of having poor maternal mental health (Schmied et al., 2013).

For some māmā, poor maternal mental health can be detrimental in a variety of ways, affecting their quality of life, and having lasting effects on their relationship with their children, their partner and wider family members (Schmied et al., 2013). It is evident that experiencing symptoms of depression, anxiety, or stress during pregnancy increases the risk of adverse

effects on postnatal maternal mental health and pregnancy outcomes (Waldie et al., 2015; Schmied et al., 2013). Poor maternal mental health has been reported to have an association with a child's development (Kingston & Tough, 2014), their health, and well-being, and an increased risk of pre-term birth (Yaari et al., 2019) and low birth weight (Grote et al., 2010). A correlation between prenatal maternal stress and anxiety symptoms in offspring was also found (McLean et al., 2018). Women that experience emotional distress may also come up against feelings of shame and stigma, which can act as barriers to addressing psychosocial issues related to emotional distress and receiving mental health care (Anderson et al., 2006; Schmied et al., 2013). With the broad range of changes and risks that are associated with pregnancy, it makes this an important time to identify any mental health issues or concerns the mother may be having.

Prevalence of perinatal mental health problems

Antenatal depression and anxiety

The prevalence of antenatal depression differs amongst studies, populations, and trimesters. Based on two systematic reviews and meta-analyses of 173 studies with 182 reports across 50 countries, the global prevalence of antenatal depression was estimated at 20.7% (Yin et al., 2021). Prevalence was found to be higher for low-income countries at approximately 30.3% than high-income countries at 18.1%, which may be explained in part by high-income countries having access to more high-quality interventions and treatment options for depression (Yin et al., 2021). The prevalence of antenatal depression revealed ranges from 7-20% across the three trimesters throughout the pregnancy (Woolhouse et al., 2015; Underwood et al., 2016; Dadi et al., 2020). Within New Zealand, data from The Growing Up in New Zealand study found that of 5,664 pregnant participants, 7%, 14%, and 12% reported elevated depressive symptoms during the first, second, and third trimester (Waldie et al., 2015). In the Maternal

Mental Health Service Provision in New Zealand report (2021), it was estimated that during the perinatal period, 12-18% of New Zealand mothers will develop depression, anxiety, or other mental health issues, with prevalence increasing in some population groups, particularly Māori, Pacific and Asian people (Ministry of Health, 2021).

Antenatal anxiety is a common diagnosis among the pregnant population worldwide, and often found to be comorbid with depression (Pampaka et al., 2018; Falah-Hassani et al., 2007). Leach and colleagues (2017) conducted a systematic review of the prevalence of literature reporting the prevalence of perinatal anxiety. Findings reported that between 6.8% and 59.5% of pregnant women experienced elevated anxiety symptoms. Variation in measures used, subpopulations, and definitions within the studies account for the large range; for example, the study reporting a prevalence of 59.5% included teenage women, a population known to have higher rates of perinatal mental health (Faisal-Cury & Rossi Menezes, 2007; Leach et al., 2017). In Canada, Fawcett et al. (2019) found that 20.7% of pregnant women in the study met a diagnosis for 1 or more anxiety disorders. In a study conducted in New Zealand, Signal and colleagues (2017) described the prevalence of anxiety found within a sample of 406 Māori and 738 non-Māori women in late pregnancy. Results showed that anxiety symptoms were more prevalent in the sample of Māori māmā (25%) than in the sample of non-Māori māmā (20%). Additionally, it was found that depressive symptoms, significant life stress, and a period of poor mood were more prevalent for Māori pregnant women than non-Māori pregnant women in the study (Signal et al., 2017).

Rates of perinatal depression and anxiety during COVID-19

In recent years, examining the prevalence of perinatal mental illnesses during the COVID-19 pandemic has been of interest for researchers. Studies have found increases in the prevalence of depression and/or anxiety symptoms among pregnant women in a range of

countries (Berthelot et al., 2020; Lebel et al., 2020; Wu et al., 2020; Davenport et al., 2020). In an integrative review of 30 studies by Suwalska et al. (2021), the prevalence of depressive symptoms during the COVID-19 pandemic ranged from 5.3% to 56.3%, while anxiety symptoms ranged from 6.8% to 77%, though variation in the ranges may have been due to the differences in ethnicity and socioeconomic statuses of the participants. Notably, a cross-sectional study conducted in China by Wu et al. (2020) examined the impact of the pandemic on the increased rates of depressive and anxiety symptoms of pregnant women, prior to and following the declaration of the pandemic. Using the Edinburgh Postnatal Depression Scale (EPDS), they assessed 2839 women in their third trimester prior to the declaration of the pandemic, and 1285 women following the declaration of the pandemic. The study found significant increased rates of depression and anxiety once the pandemic was declared (Wu et al., 2020). Research relating to the increased prevalence of antenatal depression and anxiety in New Zealand during the pandemic could not be found; however, it is noteworthy that 2022 was when NZ experienced a large wave COVID-19 in the community, which is therefore when the health system began to feel the strain.

Tools and methods of mental health screening

Early identification of perinatal mental health needs and appropriate referral to services benefit the mother's health and wellbeing, as well as the development of the child (Eastwood et al., 2017; Mellor et al., 2019). Screening tools assist primary care clinicians to identify people who may be showing signs of a mental health illness and may need further support.

The most commonly used screening tool for early detection and preventative support for those who may be at risk of perinatal mental health issues is the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987; Lautarescu et al., 2022; Levis et al., 2020). The 10-item screening tool is used across a variety of clinical and community settings, as well as

many cultural groups, due to its strong reliability and validity within many countries around the world (McBride et al., 2014; Cox, 2017). Another approach to screening involves asking exploratory questions in the course of a health care visit as a way to understand the woman's past mental health history and current mental health status. An example of such questions can be *"during the past month have you often been bothered by feeling down, depressed, or hopeless?"* and *"during the past month have you often been bothered by little interest or pleasure in doing things?"* (New Zealand College of Midwives, 2021[a]).

Practitioners may also opt to use more informal methods of assessing emotional wellbeing, like asking mothers about their general wellbeing through questions such as 'how are you feeling?' or looking for different cues that may indicate a mental health need (Mellor et al., 2019; Hicks et al., 2022). Maessen and Wilson (2019) suggest that pen-and-paper questionnaires may be culturally inappropriate and therefore recommended a general conversation and relationship building prior to the use of questionnaires. Further research is needed to validate and determine the acceptability of measures of perinatal mental illness in New Zealand.

Approach to screening overseas

Over the past decades, there have been advances made in the development of universal and routine screening programmes aimed at addressing perinatal mental health. Routine and universal screening during pregnancy is recommended in high-income countries, including Australia (Austin et al., 2011; Inekwe & Lee, 2022), the United States of America (O'Connor et al., 2016), and the United Kingdom (NICE, 2021). For example, in Australia, National Clinical Guidelines for perinatal depression recommend the implementation of universal screening for perinatal depression and anxiety. Additionally, all women identified with mental health issues should be provided with a comprehensive mental health assessment (Inekwe &

Lee, 2022; Austin et al., 2007). These policy responses to address maternal mental health were put in place following the release of the National Action Plan for Perinatal Mental Health (beyondblue, 2008). In the same year, the Australian Government of Health had established the National Perinatal Depression Initiative (NPDI) to provide routine depression screening for all women within pregnancy and postnatal care and training for health professionals (Highet & Putell, 2012). Around the same time, the American College of Obstetricians and Gynaecologists' made guideline recommendations for screening for depression to be conducted at least once during the perinatal period (Rompala et al., 2016). However, the US Preventive Services Task Force made recommendations for screening for depression to be conducted, but only when significant support is in place for accurate diagnosis, accurate treatment, and follow-up (O'Connor et al., 2016; Waqas et al., 2022). Such recommendations advocate for mental health systems to be in place to provide adequate screening for the mothers' needs. Guidelines based in the UK, from the National Institute of Health and Care Excellence (NICE) (2014) recommend that all women are screened for maternal mental health problems at their first antenatal appointment, and early in the postnatal period. As per the recommendations, the mental and emotional wellbeing of the woman is also to be assessed every time they meet with a primary care provider (National Institute of Health and Care Excellence, 2014; Mellor et al., 2019). In contrast, recommendations against screening for perinatal depression were made by the Canadian Task Force on Preventive Healthcare, due to a lack of studies showing both the clear benefit and potential harms which may result from implementing routine screening (Joffres et al., 2013).

Benefits and barriers to routine perinatal screening programs

The benefits and potential harm of perinatal screening programs have been widely debated (Waqas et al., 2022; Blackmore et al., 2022; Venkatesh et al., 2016). Perinatal

depression screening programmes have been shown to improve the identification of women at risk, and increase engagement with services, which has a positive impact on mental health outcomes (Reilly et al., 2020). A prospective observational cohort study was conducted with women screened at 24-28 weeks and again at 6 weeks postpartum (Vankatesh et al., 2016). The study demonstrated that the universal depression screening, using the EPDS, was appropriate for identifying positive depression during both antepartum and postpartum periods (Vankatesh et al., 2016). Importance of screening at both periods and having available mental health professionals for further evaluations was emphasised within the review. A recent mixed-methods systematic review and meta-analysis was conducted to examine the evidence for screening programmes for perinatal depression and anxiety (Waqas et al., 2022). It was found that identifying women with perinatal depression could lead to timely interventions for perinatal depression, which could have direct health benefits for women (Waqas et al., 2022). However, Waqas and colleagues (2022) found no studies designed specifically for screening perinatal anxiety and came to a tentative conclusion about screening programmes for perinatal anxiety.

Barriers identified by studies examining the effectiveness of routine screening programmes included short consultation times (Tully et al., 2002), inadequate funding (Tully et al., 2002), and insufficient mental health training (Fisher et al., 2012; Blackmore et al., 2022; Kim et al., 2009). Kim and colleagues (2009) investigated the attitudes of obstetric care (OB) providers towards perinatal depression screening in the US and found that OB providers found it to be effective at identifying women at risk of perinatal depression. However, a considerable proportion of OB providers (95%) felt that they overestimated their own screening rates, and (67%) inaccurately thought they had achieved universal screening (Kim et al., 2009). There were concerns made about the availability of pathways and services in areas to follow up women who identified as high risk (Tully et al., 2002). The lack of an established clear referral

pathway following the identification of perinatal mental health issues was a prominent barrier (Tully et al., 2002; Austin et al., 2007). Apprehension from primary care providers within a range of studies stems from the evident gaps in screening identification and appropriate mental health referrals for treatment. As discussed above, this was consistent with the US Preventive Services Task Force guidelines that screening is recommended only when there are sufficient services to access and treat mental health problems (Joffres et al., 2013).

Practice of screening in NZ

While it is the recommendation that regional District Health Boards develop and provide appropriate guidelines for screening and referral pathways, there is no current formal perinatal mental health assessment or screening program in New Zealand (Ministry of Health, 2021[a], Mellor et al., 2019; Barber, 2009). Auckland DHB's guideline for best practice recommends that women are screened for mental health conditions at least once during pregnancy, and again at 10-14 days postpartum (Auckland District Health Board, 2019). Similarly, the Lakes DHB's guidelines recognise the importance of screening women, with emphasis on early identification in the postnatal period (Lakes District Health Board, 2021).

There is a growing body of research discussing the potential need for the development of a universal screening approach in New Zealand (Mitchell & Coyne, 2009; Blackmore et al., 2022; Mellor et al., 2019). However, it would need to align with New Zealand's unique maternity context, be culturally appropriate, and time efficient to align with the demands of midwives' work (Mellor et al., 2019). Additionally, it is also important that when midwives screen for those particular areas, there are appropriate services and pathways available to ensure that māmā are receiving appropriate care (Mellor et al., 2019; Blackmore et al., 2022; Austin et al., 2007). Despite the need for routine and universal mental health screening, and the progress made to show the importance of it within maternity care, it is not mandated within

New Zealand. In the feedback on the 'Government Inquiry into Mental Health and Addiction: Oranga Tangata, Oranga Whānau.' (Paterson et al., 2018), the College of Midwives states that they do not support mandatory mental health screening for mothers (New Zealand College of Midwives, 2018). The NZCOM believes that there needs to be a level of reliability of referral processes and access to effective treatment for screening programs to be introduced, and that these have not been properly met, consistent with barriers identified overseas (Blackmore et al., 2022; Austin et al., 2007).

There have also been recommendations from The Ministry of Health for regular and routine screening for family violence during both prenatal and postpartum care (Maessen & Wilson, 2019). Additional training on family violence has been made a priority for those within primary care to ensure early identification and appropriate referral and intervention is facilitated (Lauti & Miller, 2008).

Previous research interviewing New Zealand midwives about their experiences and opinions about screening for mental health problems suggest that NZ midwives face similar issues to that of midwives overseas, including time constraints, workloads, and a lack of available secondary support and/or pathways for mothers experiencing mental health issues (Mellor et al., 2019; Ministry of Health, 2021[a]; Holden et al., 2019). Mellor and colleagues (2019) interviewed 27 New Zealand LMC midwives about their perspectives on screening and assessing women for maternal mental health risks during pregnancy. Midwives in the study felt that they were ill-equipped for providing additional support that the mother needed and felt that they were carrying the weight of maternal mental health needs, which needed to be provided by mental health workers (Mellor et al., 2019). Availability of appropriate maternal mental health services for those experiencing mild to moderate mental health issues was an additional concern midwives had from the study (Mellor et al., 2019). A qualitative study focusing on the perspectives of Māori and Pacific mothers and maternity carers was conducted to understand

their current maternal mental health screening practices and supports in place (Holden et al., 2019). Barriers identified by maternity carers for mothers with mental health problems included: stigma and discrimination against people with mental health problems, lack of midwifery mental health education, time constraints, as well as a lack of available secondary support and/or pathways for mothers identified as having a mental health illness as barriers to screening (Holden et al., 2019). Mothers interviewed identified similar barriers as well as cultural barriers, in which they felt that acknowledging depression was not tolerable by their families (Holden et al., 2019). Midwives in this study did not identify cultural factors as barriers for mothers; however, the inclusion of the mothers' voices within this study was a strength.

Midwifery model of care

The New Zealand health care system provides free maternity care to all New Zealand residents and citizens, unless the mother chooses a specialist obstetrician (Ministry of Health, 2021[b]). The most common avenue for maternity care is self-employed community-based Lead Maternity Carers (LMC)). The midwifery continuity of care model includes monitoring of physical, psychological, spiritual, and social wellbeing of the women and their families during pregnancy; providing parenting education; providing ongoing care for women and whānau during the postnatal period; and identifying and referring women with additional needs to support services (Cibralic et al., 2023). LMC midwives support women during their pregnancy, labour, and birth, as well as 4-6 weeks after their baby is born (Ministry of Health, 2021[b]; PMMCR, 2019). Statistics from The Ministry of Health (Ministry of Health, 2019) show that 94.2% of women chose an LMC to be their midwife. LMC midwives are an integral part of care during pregnancy as they have an important role in identification, support, and referral of women with mental health problems. Midwives have a responsibility to work in partnership with the women, building rapport and creating a safe environment for women to open up. It is expected that midwives will pick up on symptoms of anxiety and depression, screen mothers

accordingly, and refer them to primary mental health services. However, midwives may be left in a dilemma if they are told things they don't have the resources to respond to. Some clients who are anxious or depressed may not want to be referred to mental health services because of discomfort when talking with a mental health professional, and some who experience distress don't meet the high level of acuity required to be eligible for services, and others who have a referral may be on a waitlist (Holden et al., 2019; Mellor et al., 2019). They all still need the midwifery care, and the nature of the relationship means that their anxiety or depression will be present in various ways. Community based midwives are vital in providing mothers with appropriate care and a positive birth experience, which ensures the best start in life for the child and an overall happy whānau.

The current study

Because of the current pressures in the system and barriers to screening (Holden et al., 2019), midwives end up being the frontline caregivers for anxious, stressed, and depressed women during pregnancy. Many feel unprepared (Holden et al., 2019), but there are also many who have an interest in mental health and have found ways to support these women. With perinatal mental health being recognised as a public health risk; it is important, then, to try to understand what can be done to support mothers who experience mental health conditions, and to recognise the modes of support midwives provide for mothers.

This project aimed to interview Lead Maternity Carer (LMC) midwives to understand techniques and strategies they find useful when providing support for mothers who struggle with emotional distress. Overall, we wish to find out what they perceive as helpful to support perinatal maternal mental health. These findings will have implications for emerging recommendations for midwives, working alongside mental health services, to provide support for pregnant women.

Method

The aim of this study was to interview New Zealand LMC midwives who provide a level of support and service for māmā who struggle from stress, anxiety, or depression, to find out what tools or resources they find helpful in supporting these māmā.

Qualitative Research Methods

Qualitative research methods were used to collect data through semi-structured interviews. Following data collection, interviews were transcribed and analysed using thematic analysis (Braun & Clarke, 2006). Qualitative research seeks to understand people's beliefs, experiences, attitudes, behaviour, and interactions (Pathak et al., 2013) in a way that allows the researcher to collect rich data and have a deeper understanding of the participants' experiences (Clarke & Braun, 2013). Focusing on the participant's own framing of issues, reality, and meaning of their experiences (Clarke & Braun, 2013) is a vital aspect of the qualitative research process, as it values personal involvement (subjectivity, reflectivity) (Clarke & Braun, 2013). Qualitative research methods were chosen in this study to explore midwives' experiences and opinions of screening for and supporting māmā who struggle with perinatal mental health problems. This approach aimed to identify the key resources, modes of support, and services midwives find most helpful, and how their experiences can be improved.

A semi-structured interview format is a frequently used interview technique in qualitative research, as it enables the researcher to be flexible when asking follow-up questions based on the participant's answers and has been found to be successful in supporting reciprocity between the interviewer and participant (DiCicco-Bloom & Crabtree, 2006). Just as reciprocity is important within the researcher-participant relationship, an awareness that everyone brings their own subjectivity to the research process is important (Clarke & Braun, 2013) to ensure that bias is recognised and minimised. Subjectivity is a strength within qualitative research and

always present, though careful consideration and awareness of its influence is always recommended (Clarke & Braun, 2013). Awareness of subjectivity can be increased by being reflexive, which refers to the process of critically reflecting on the knowledge produced (Clarke & Braun, 2013). Other ways to increase awareness of subjectivity is to share transcripts with participants to ensure their experiences have been captured correctly, and support themes with direct quotes from participants (Noble & Smith, 2015).

The Researcher

In qualitative research, being clear about the researcher's articulation of their worldviews (Austin & Sutton, 2014) through which they interpret and analyse the data is important. An aspect of this is acknowledging the researcher's background and experience with the topic.

My aspiration is to become a clinical psychologist stems from an interest in helping people who experience mental illnesses with their journey to positive change. As a descendant of Waikato Tainui and Ngāti Awa, I was able to draw on my whakapapa (genealogy) and utilise whakawhanaungatanga (process of establishing relationships) to recruit a significant number of Māori participants in this study. While I have no children of my own just yet, my mum shared with me that she experienced postnatal depression after my younger sister was born. Having to navigate through that, as well as caring for five children at the time, she was also healing from the trauma associated with the miscarriage of my older brother a few years prior to me being born. This made me think about the families, and the mothers, that experience emotional distress in relation to pregnancy, perhaps in similar situations to what my mum experienced, and has made me wonder about the level of support and service they receive. Coming from a big family myself, the midwives that helped deliver my cousins, siblings, and nephews were considered and treated like family. Therefore, my hope for this research is to

help shed light on the work midwives do and understand what they find helpful to provide this support, and to make recommendations that might lead to improvements for maternal mental health care.

Recruitment

Potential participants were recruited from the New Zealand College of Midwives (NZCOM) and Perinatal Anxiety and Depression Aotearoa (PADA)[1] through an email (*Appendix A*) to colleagues of my supervisor. The recruitment poster (*Appendix B*) was posted on social media platforms and circulated through word-of-mouth snowball recruitment. Interested participants texted or emailed me, and I screened them for main inclusion criteria (working in New Zealand as an LMC midwife). Two potential participants were not currently practicing as LMC midwives, but had previous experience in this role, and were included because of their interest and expertise in the subject of perinatal mental health. All interested participants were sent the Participant Information Sheet (*Appendix D*) and Consent Form (*Appendix C*). They were asked to read through the information and complete the consent form and return it via email if they were to continue. A convenient time and date for the interview to take place via zoom was then set up.

Recruitment was conducted from early May to late October 2022. Recruiting for participants was extremely difficult due to the large wave of community transmission of COVID-19 and the impact of that transmission on health and maternity care within New Zealand. This significantly reduced the number of midwives available to interview, and despite not reaching saturation, the time frame of this thesis and the nature of the health crisis meant that recruitment ended when 7 midwives were interviewed.

[1] New Zealand organisation providing professional development on perinatal mental health.

Ethics Approval

The study was reviewed, approved, and overseen by the Human Research Ethics Committee (Health) of the University of Waikato (Reference 2022#11) on 13th May 2022.

Informed consent.

Informed consent was obtained to meet the standards of ethical research, and the New Zealand Code of Ethics for Psychologists working in New Zealand (New Zealand Psychologists Board, 2002). If potential participants showed interest in participating, the Participant Information sheet (Appendix D) and Consent Form (Appendix C) were emailed to them. Participants were asked to read through the information, and if they were happy to continue, to complete the consent form and return it via email. If participants had signed the consent form but were yet to return it, I would ask for verbal consent prior to the beginning of the interview. Participants were given the chance to review the transcript and make any changes up to one month prior to the information being used for the study. Participants were made aware that they were free to withdraw from the study at any point until one month following the end of their participation.

Confidentiality.

To protect the participants' identity, all identifying information was removed and participants were provided with a pseudonym. Any identifying information provided, including interview transcripts, have been restricted in access, limited to myself and my supervisor.

Cultural safety.

Conducting interviews in a culturally safe manner is a vital aspect of appropriate qualitative research and creates a culturally safe space for participants. As a Māori woman

myself, I was able to draw on my own lived experiences and personal understanding of te reo Māori, tikanga concepts in respect to hauora, and a te ao Māori worldview. Alongside this, I have experience working with Māori and Pacifica people through my employment as a psychology assistant at Ara Poutama and have also sought further guidance from current literature for best practice (Pere & Barnes, 2009). In the interviews, I would ensure that significant time was spent building rapport with participants before beginning to make them feel comfortable and safe; being open about the potential of a support person being present if the participant wished; and including them throughout the entire research process. In some interviews, where appropriate, this meant introducing myself with my pepeha or weaving in aspects of my whakapapa to make connections in some ways. To all participants, this meant sending the transcripts of the conversations and making changes based on their feedback. Two participants provided some clarifications and corrections on their transcriptions prior to analysis.

Participants

Participants in this study included seven midwives, five of whom are currently registered and practicing as LMC midwives, and two that had previously practiced as midwives but are now in other roles. All of the midwives are currently living in New Zealand, and practicing around the Waikato, South Waikato, Hawke's Bay, and Bay of Plenty regions. It is important to acknowledge the large representation of Māori midwives in the study. All midwives stated that they work with NZ Māori and NZ European mothers. Four midwives, identifying themselves as NZ Māori, describe their caseload as being predominantly NZ Māori. The other three midwives, two identifying as NZ European and one of German descent, state they work with NZ European mothers and other ethnicities, including Pacifica and Māori.

Interview Procedure

Interviews were conducted online due to the busy nature of midwives' work, as well as my location being in a different area to participants. The duration of the interviews was dictated by the discussion and ranged from 20 to 50 minutes. Interviews were recorded via Zoom and transcribed by an audio transcription software Otter.ai (https://otter.ai/). Participant consent was obtained for the use of Otter.ai prior to the interview. To ensure accuracy of the transcriptions, they were read over whilst listening to the audio recording to make corrections. Three of the midwives who practiced together were interviewed together.

Interview Outline

Semi-structured interviews were used to collect data from participants. The sections of the interviews used for the study are outlined below.

Part 1: The first section of the interview was used to build rapport with the participant, confirm consent with them, and answer any questions they had. Building rapport began by introducing myself, which included sharing my pepeha or a summary about my background and interests within the topic, as well as giving the participant an opportunity to introduce themselves. I then explained the aim of the study, provided them with an idea of the questions I'll be asking, and then asked if they had any questions. When all questions were answered, the interview would continue.

Part 2: The second section focused on asking how they would check on the emotional wellbeing of the clients in their care, such as using any questionnaires or tools, how useful or not useful they were, and lastly, if the way they checked on their clients was a mix of something curated throughout their practice or if it was something provided by previous training.

Part 3: The third section asked what they do when they find out someone is emotionally distressed or vulnerable, including whether they seek a referral or not, what they do when referrals are hard to get, and anything else they do to help māmā with mild to moderate levels of anxiety or depression, alongside a referral or if they don't get one accepted.

Part 4: The participant was then asked if they have had any previous training that has enabled them to care for clients who are struggling, including training from outside their midwifery training, and were asked what they do with their clients based on that. The participant was also asked how the training changed their practice, or what has been added to their training to help māmā.

Part 5: This section focused on the experience of participants in trying to get help for clients struggling, linking to any techniques or strategies they've used to get the referrals met.

Part 6: This section asked participants what they think they might need, or what would be helpful for them to support clients, including professional workshops, more allocated time, and community resources.

Part 7: In the final section, the participant was asked what advice they would give to other LMC's who are supporting māmā with anxiety or depression and might have less experience in the field. The purpose of this section was to allow the participant to end the interview with some key messages related to the techniques and strategies they had notably found helpful in their practice.

Thematic Analysis

Semi-structured interviews were analysed using thematic analysis. Thematic analysis is a method for identifying themes and patterns of meaning across a dataset (Clarke & Braun, 2013). An inductive approach was used, meaning that the data itself generates the themes

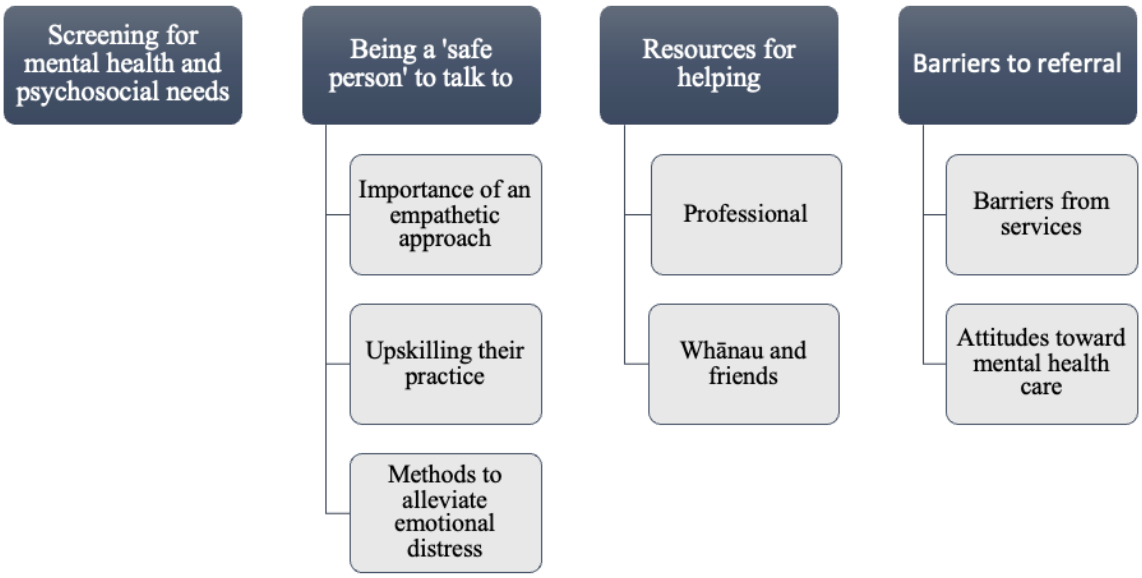
without trying to fit it into the pre-existing coding frame (Clarke & Braun, 2013). The first step was reading over the transcripts and listening to each audio to become familiar with the dataset. The next step was to take pieces of the interviews and form them into codes. Codes were then grouped together to create themes. Themes were discussed during supervision and changes were made. The thematic map was then made with each theme and subtheme and again received feedback from my supervisor, then results were reported.

Results

The following chapter described the six themes and subthemes that were derived from the interviews using thematic analysis, as shown in Figure 1. Quotes from the midwives are provided as evidence for each theme and subtheme, with pseudonyms used for each woman to protect their identities. Quotes have been edited to remove any identifying information.

Figure 1.

Themes and subthemes of interviews with LMC midwives.



Screening for mental health and psychosocial needs

Midwives described incorporating screening tools such as the Edinburgh Postnatal Depression Scale, and the Generalised Anxiety Disorder (GAD-7) in their practice to measure the woman's level of distress. One of the experienced midwives who was no longer practicing spoke about her own understanding of the EPDS being used in practice, and how useful it can be accurately screen for mental illness in a practical and timely manner:

I know they're using the Edinburgh Depression scale. That's being used and I think that's just to try and speed things up, you know, because where you might just get information out of somebody by just having a conversation and saying, you know, "how are you feeling?" Or you know, "what's going on for you emotionally?", sometimes going through a checklist actually just speeds up the process when you're pressed for time. Yeah, even though it can be a little bit clinical. (Kate)

Courtney described how she finds the EPDS useful both antenatally and postnatally to detect distress that may not have been identified otherwise. She then follows up with additional questions to understand why the mother may be experiencing emotional distress:

So, I do the Edinburgh depression score with women in the pregnancy and if that is quite high, then I repeat that and get some support organised. So, I do it at least once in the pregnancy and at least once postnatally, sometimes more often if I feel like the woman needs more checking. So yeah, that is actually quite a good tool because I have often not picked up that something is not right until I've used that tool and then a conversation has started. You know, "why do you cry a lot" or "why do you constantly beat yourself up about things?" (Courtney)

Obtaining information about other areas of the client's life relevant to them experiencing anxiety, depression and emotional distress was also common practice for midwives. For Rachel, this meant asking questions about the mothers' previous history of mental illness, previous childbirth trauma, the level of social support they have, and any social issues related to experiencing distress:

We have a screening tool that we use, or an assessment framework that we use during the pregnancy. So, we'll ask obviously health questions, we'll ask social questions, we will ask physical well-being questions and then we'd also ask about any previous

history of anxiety, post-natal depression relevant to the subsequent pregnancy and we will go into that space and obtain information that way and dependent on the information that we're given, (that) will direct the path that we'll take. (Rachel)

Samantha, Lily, and Emma, three midwives working for the same practice, identified intuition as a core skill to have when accessing for any emotional distress:

... so, the first thing we have is intuition. Sometimes from the get-go right, first meeting with a woman, you can tell if something's not quite right. And sometimes someone will tell you and sometimes we have to sit and unpack it. Mostly they're quite open with their anxiety and mental health, and because we have questions around that and about the medication that they're taking for that, so that can give us an idea of what we're looking at and what we're going to be dealing with. And so just remembering to check in on that as the relationship goes on. (Samantha)

Screening for mental health and psychosocial needs of mothers was common practice or supported by the midwives interviewed. For those midwives currently practicing, they used a range of tools which included: questionnaires, asking māmā questions related to their mood and how they're feeling, and following intuition to know when something was wrong.

Being a "safe person" to talk to

A theme relating to the role of midwives emerged, as they are the first port of call for mothers who experience emotional distress, the one who deals with any issues or concerns they may be having, and essentially the safe person for mothers to talk to. This theme developed into three sub themes which were relevant to being a safe person for mothers, including the importance of an empathetic approach, undertaking training to provide care to mothers, and methods they use to alleviate distress from mothers.

Importance of an empathetic approach

The importance of building rapport with clients was reflected in the midwives' care and reported to be important to ensure that mothers were comfortable enough to disclose information with their midwives. It was also important in ensuring mothers could set goals and expectations around the birth they desired, which the midwives could advocate. The discussion around rapport was mentioned early on:

> *I guess for me, I think the first thing we do is we have to build the rapport. That's the difference between LMC midwifery and anything else is sometimes for us it's not the first visit but as the relationship develops. (Courtney)*

Letting māmā know that someone was there to listen to them and trying to allocate as much time as possible to have those conversations was also a priority for midwives:

> *I think a big one is conversation and having time for conversations… So usually, if I find that my appointment doesn't allow enough time to explore that, I either say look, I'll ring you in the next few days when we have a chat about that, or I'll make an appointment soon or sometimes I'll have time to extend the appointment… but I think sometimes really just having a listening ear is actually what is needed for the woman to clarify what the issues are… (Courtney)*

> *A lot of it is just talking it through and listening and sometimes it's just being aware of the anxiety and choosing your words and just a lot of it is just listening. And just often it is just a woman just to sound off her concerns and just to go blah and then move on and just have somebody sympathetic to listen to her… (Rachel)*

Being non-judgemental and showing kindness towards mothers was also an important aspect to a midwife's practice:

> *A small amount of kindness goes a long way. If they can leave here, feel listened to know that their baby is safe, then they can go so it's just [giving] time really, I think. (Emma)*

> *I think a hug. I think wrapping them up in your arms and giving them a big hug and telling them that it's going to be alright, and then right now we're going to make a plan going forward. I think we're good at doing that. (Samantha)*

> *And non-judging, like not being judgmental. Like, I see quite a lot of Facebook posts about midwives complaining about these women that are really struggling. And like it's really judgmental. It's like, I can only do so much and so just like Emma just said be kind, then the woman feels heard. (Lily)*

When asked what they find helpful to alleviate some distress for mothers, Samantha, Lily, and Emma said that listening and allowing mothers to share their stories helpful for mothers:

> *… And letting them get it out. Often, they just share their story. (Lily)*

> *Just to somebody who's listening because they're with kids all day and probably a partner who's not that interested to hear what's going on with her but sometimes, they come in here and just want to talk to a woman who understands. (Emma)*

Upskilling their practice

Midwives upskilling their practice was an important sub theme that emerged from the interviews. This included some midwives participating in mental health and cultural

workshops, family violence courses, and reflecting on their own journey with te ao Māori. Midwives also identified a need for education for themselves on mental health and cultural competency. When asked what training Rachel had received to support mothers, she says that she'd taken Māori health workshops, which had enabled her to utilise Matauranga Māori resources in her care with māmā:

> *... I've done mahi atua[2] and I found that it was really good... so, I have done mental health workshops that have enabled me to have a better insight from an indigenous lens around working with atua Māori and reflecting in those spaces, so recognising because predominantly the women that I work with are Māori and drawing on those Matauranga Māori [Māori knowledge] resources and artwork to help women. But actually, doing a workshop on mental health in the midwifery space, no. (Rachel)*

Courtney, identifying with a non-Māori ethnicity, discussed her journey with te ao Māori and how that has positively impacted her practice:

> *It's more about learning about the world of Māori and about the culture and about the depth of what they've lost and understanding why they don't speak their own language because the kids were beaten up at school. And also understanding why there's, you know, so much pain and so much poverty, it's all connected with what has happened in the past and while I sort of knew that before, still you open your heart to it more when you learn the language and you learn the about the pain and the history of what has happened. (Courtney)*

[2] Refers to the Māori mental health model.

Emma mentions the varying training she'd received working in a rural community. Though not specific to mental health, it was important for her to have this training to recognise the māmā that are in crisis situations:

> *I think you know; those courses are about recognising instantly who's getting beaten up and who's not... whose home is not safe and who's anxious.*

Courtney talked positively about the perinatal mental health workshops she'd taken through PADA[3] and mentions how important she believes education on mental health to be:

> *... Yeah, for example, this workshop we had the other day, was about lifting the veil of perinatal anxiety. I've been to different workshops from PADA, and I have an interest in mental health, that's why I contacted you, because I think that's a really important subject, so I think I've been getting quite a bit of education around that, but I wouldn't call myself qualified in any therapy. (Courtney)*

Kate, a midwife who originally trained as a nurse, talked about the importance of mental health training for midwives in training, to provide them with the ability to cope with the distressing situations midwives are exposed to:

> *... You know, it's a long time ago, since I trained as a nurse, and had that component mental health training, and that um in these days, we have direct entry midwives that don't have any nursing background at all and so, you know, I haven't been through that training process so I can't speak to the amount of mental health training that is involved, but I'm not aware of it. Yeah, I mean, it should be there for all of us, or for*

[3] New Zealand organisation providing professional development on perinatal mental health

those of us to cope with some of the really distressing situations that we're exposed to. (Kate)

Rachel spoke strongly about a lack of education around cultural competency, indigenous knowledge, and about pathways for Māori. She suggested that there needs to be an increase of cultural education and a better understanding of pathways for midwives to take based on the high mortality rates of Māori women:

So, I'd like to see, to start to indigenise the spaces and to start having education around mental health and making it mandatory. So, for midwives, we have to do so many professional developments per year. Some of its mandatory, and some of it is professional development, so you can pick and choose what you want to do. If suicide is the leading cause of maternal deaths, for Māori woman, then mental health should be a compulsory paper. So far, compulsory papers are your clinical papers, which is um, emergency workshops, which yeah, I get that. Also, along with that there should be cultural competency, indigenous knowledge. Yeah, and specifically, mental health for Māori woman should be compulsory, and then once they do that, then there should be frameworks in the DHB, models in the DHB that we should be able to link, you know if somebody's got anxiety, this is the pathway to take, rather than us guessing it. Yeah. Because we're guessing that. We're thinking, okay we'll send [her to the] DHB, and then you get a bottleneck at the DHB, or you don't fit that criterion at the DHB, so you get pushed back.

Kate responded to a question about what she needs, and responds about the need for culturally appropriate services and cultural training for midwives:

… So, we need more places that we can refer people to, um culturally appropriate places so for every culture that we're dealing with, you know, in town, obviously, we

have a higher Māori population, and so we need lots more Māori providers but in the absence of having highly skilled professionals to refer to, having more training ourselves so that we feel like we can have more sensitive competent conversations that don't just open a can of worms for people and send them away feeling like they've been emotionally exposed, but you know, been no, no strategies. (Kate)

Methods to alleviate emotional distress

Courtney mentioned the use of self-help books and other resources:

…Sometimes the issue is actually not mental health, they're more a social issue or a relationship issue. Sometimes I recommend books to read and self-help books, and it has been quite helpful for some women as well. (Courtney)

Another midwife described using the S.T.O.P.P acronym as a strategy for women to have some awareness of their feelings:

So, then the S.T.O.P.P acronym is quite helpful, and I've got a little whiteboard and I put S.T.O.P.P up on the whiteboard. S is for stop, so when you're getting this anxiety, I talk to them about the limbic system and talk about what's happening in their adrenaline response to this abnormal thing that's happened and I say," this is a normal response". Stop. T is taking a breath so doing this breathing that we've just learned. O is what's the overall perspective that you have like a helicopter view, looking down on the whole situation. Is this feeling of being unsafe due to the fact that I'm actually in danger? is it an opinion or is it a fact? Am I in danger? …The PP is to put things in perspective so the fact that I had a pretty bad time, and it was a harrowing experience that brings me into this place where I'm sitting here talking

about this experience and this person is going to listen to me, and they can use that acronym… (Anna)

Additionally, Anna described how she used some techniques like letter-writing or role playing to help mothers to get some perspective:

I just use a breathing technique and then we come up with- for homework, depending on what I'll ask them if they've found different things helpful in the past, like journaling or writing a diary or writing a letter or speaking onto a tape or talking to a friend or role playing. One of the quite useful things if a woman's got very negative self-efficacy, is to say, well, if your friend was telling you these things, and she said, "oh if a friend was saying these things to me, I'd tell her she was crazy", but she says, "I just can't tell myself that". So, the role playing is useful, and this particular woman had actually started writing a letter to her daughter that she'd had who's three months old now and she said, "I'm going to write these letters and tell her all about her birth and what happened" and so that was just a way of expressing uh- how she felt about the whole thing.

One midwife found that the use of a mental health box filled with leaflets and printouts of different community services was helpful to keep:

This is my mental health support box and every time I get an email, or, you know, find out about a service that is in the community, I either print out the email or get a leaflet from anywhere and I put it all in here… all sorts of things like every time I find out something I put it in here, so it's quite a busy box now and I find the best thing is actually just to, once I hear from a woman what the story is, I then say" give me a bit of time to work out what's best for you and I will give you a ring and we'll talk about what feels right for you" and then I go to my box. (Courtney)

A conversation about self-care is a conversation was important for Kate, as she discussed how crucial it is for māmā to know that it is okay to ask for help if they're struggling:

> *The conversation about self-care is always really important. You know, mums always feel like they've got to be everything to everybody and be providing for everyone and they don't like to ask for help but it's always good to remind people that the most important thing that they can do is look after themselves and I've always said, you know, if your wheels fall off, who's looking after the baby. You know, you're actually the most important person in the whole relationship and you need to make time for self-care… You know, because not reaching out for help and getting yourself into more and more worked up and feeling like you're not coping and you don't know what to do, that's when really horrible things happen. So yeah, those are really important conversations, just keeping it real. (Kate)*

The level of support the mother requires can differ significantly amongst women. Samantha, Lily, and Emma describe the help they provided to a māmā who was in a dire situation:

> *So, one girl pops into my mind. She was living in the garage with a really unsupportive in-law family. She had nothing and we knew we're gonna get this kid out of here, so we went shopping, and we picked, we bought a laundry basket full of stuff for her clothes, pyjamas, and that was the first thing we dropped in. And I think she cried, she was like, "I don't have anything"… Yeah, and we did that care package and then the korero [conversation] was "we need to get you out of here, babe" and so getting her to her family. And so, we do that sometimes. (Samantha)*

The midwives' interviews emphasised the importance of having empathy, using listening skills, being non-judgemental, and showing kindness to build rapport and a trusting relationship with mothers. Where possible, midwives upskilling their practice to provide appropriate care and support to mothers was also emphasised. There was a common experience of a lack of education in mental health and cultural competency for midwives, which they identified as a need for themselves and other practicing midwives. Practical methods to alleviate distress from mothers, like having conversations around self-care or ensuring mothers are provided with basic needs, was highlighted as a valuable role midwives play as the safe person for mothers to talk to.

Resources for helping

This theme described the process in which midwives provide care for mothers, through professional avenues such as involving mental health services and social services, appropriate cultural services, and whānau and friends. Midwives were able to link local community services, Māori healing practices, and family to provide mothers with appropriate care.

Professional

Rachel discusses how a comprehensive type of approach to care, which means providing women with services that are culturally appropriate, local and community based, as well as engaging family and friends within care, is important to ensure that they feel supported:

> *So, if there's a psychiatric history that mental health is involved with already, then we will probe those questions and see who's involved in that care already… If it's a history of postnatal depression, once again, we'll look at how that evolved, what sort of services were involved in that space and how we would manage that going forward, and just keeping tabs throughout their pregnancy, whatever their mental*

health concern is, we will keep monitoring that. And if there is a multidisciplinary or involvement already in her care, then we would link it into those services as well and it'll be a wraparound type of approach to manage her ongoing care.

The importance of consulting with other midwives to get more support to provide to clients in their care was mentioned. Courtney talked about the advice she would give to other LMC's:

Making sure that they have a place where they can access all the information of what's there. We do have a WhatsApp where the community midwives connect with each other and on that WhatsApp often, a midwife says, "I've got this woman I'm really worried about it and mental health doesn't want to know her", so you know, that's when I might say, give me a ring and I can talk to you about what might be the right thing and I need to find out some more information about the woman before I tell the midwife there might be a pathway.

Samantha, Lily, and Emma found that a good relationship with service providers was helpful when working in a small community:

And I think about communicating with the agencies like I think I rang Family Start and she went and made a home visit the next day, you know, like, "hey, we're discharging this lady, but we're worried" because there's nothing more you can do. (Emma)

So, I guess that's one good thing about small towns is that we kind of have a good relationship with those providers where you can contact them and say, "hey", because I feel like we just mostly were doing the referrals and making sure they're okay, but that's not our core business. Our core business is looking after the

pregnancy, the labour and birth, the pos- and they're only with us postnatal to six weeks, and then we can't help them anymore. (Samantha)

Referring māmā to services that were culturally appropriate and had a holistic approach to care for mothers was important to some midwives:

You know, something is better than nothing and when you handle your tinana [physical wellbeing] then ultimately you handle your hinengaro [emotional and mental wellbeing] so it's just giving us those solutions and we would love a nice massage, we all love a nice massage and there's a place here where they have Māori rongoā as well as mirimiri. And it's something that women can pass in the back of their mind and think okay, that's something that's free, I'll access it. (Rachel)

Plus, we, I think we're quite spiritual too so it has to be the right practitioner that can not only deal with the physical but can sometimes unpack the emotional… yeah, they have to have the element of a holistic here rather than just a physical. (Lily)

Mirimiri, a traditional Māori healing practice as a service to provide some relief to māmā was also commonly used by midwives:

We have a lot of alternative practices that we send our women to. So, we have a few practitioners and mirimiri locally and we send them there and we have had some amazing, profound results for these ladies which has made their births, healing. You know because there's a lot of birth trauma that carries through… So, we've worked really hard in trying to alleviate that anxiety around that for them. (Emma)

For some midwives, referring mothers to services that valued a holistic approach to care was important and was highlighted by the positive impact it had on their pregnancy. Midwives

working in smaller communities, where mental health services are limited, found that maintaining a good relationship with service providers within the community was beneficial.

Whānau and friends

At times, for various reasons, women won't engage in the formal support services that are around them. Samantha, Lily, and Emma described a time when they became worried for one māmā who was not engaging with the support networks around her. The midwives addressed this by trying to engage her family and support network to provide encouragement to take up the help:

> *We try to tap into their family or their own support network, I think and-. (Emma)*

Kate illustrated a situation where she provides support to a mother who expressed concerns and initial shock to the idea of being pregnant, and how important it was for the māmā to let her friends and family in, to ensure she was supported:

> *I had a conversation with a woman the other day that was feeling really anxious about being pregnant and she was finding it really difficult that everybody she spoke to about her being pregnant was so excited for her, and expecting that she should feel excited too and she said, "I just don't feel excited" and she started to cry and she was like, "I just feel bad that I don't feel excited". So, you know, just having a conversation around validating her own experience and saying you know, if people say, "oh, you must be so excited". It's actually okay, if they're your friends, to say, "actually, I'm feeling really anxious", you know, it's okay to be truthful and we're all different and it might be actually really good for your friends to realise that you're feeling anxious, that you haven't let excitement in because your anxieties are overriding all of that. So, you know, just having a level of honesty with those people*

that are closest to you, so that they can tune into you and provide you with that support.

Barriers to referral

A final theme of barriers to referrals emerged from the interviews relating to the difficulties midwives had trying to get support for mothers experiencing emotional distress. Midwives described barriers with admission criteria and services not being available to appropriately care for mother's needs. When asked what would be helpful for midwives, Courtney talked about there being a lack of guidance for pathways to help women who don't meet the criteria for a referral:

Yeah, I think the mental health service being better resourced so they can help us. Even if they say this is not severe enough for mental health, they can help with guiding me with where to send a woman.

Rachel discusses how working in a small community instils a sense of responsibility for the people you care for, so when referrals are difficult and are not helping māmā who need it, not knowing what to do can be hard:

I think, working in a small community, like I mentioned before, that you have a sense of loyalty to your māmā that you're working with and in the communities, you have a sense of community and a sense of duty, because you see them you want to do right by them… And in a small community it's quite hard to just walk away from things. And you know, because you see, the whānau that you work with in the supermarket and rugby games, and waka ama [outrigger canoeing] so you really want to make sure that you do everything right by them, and how do you do things when you know that

the system isn't going to work for them or that a referral is going to take a lot of work? Yeah, and they don't meet the criteria.

One midwife described how she felt that mothers were just being passed around within the referrals process and how frustrating it can be when māmā are not getting appropriate support:

Yeah, we're ticking a box and we're referring, and the thing with referrals is because we've done what we can, we're just pretty much passing the buck and like we've said before, woman just get pushed around and then they get hoha [annoyed or angry] because it's another service coming in to ask the same questions and it may not be an appropriate resort. (Rachel)

Courtney explains how difficult it can be to fill out a referral form, considering that midwives are not trained to make comments on areas that are specific to those trained in mental health. Discrepancies like this make it difficult for midwives to write referrals, as illustrated:

I've learned a bit more about how to write a good referral and it is quite, like writing a referral to mental health service is an assignment. You need to understand what all the questions are, you need to do an assessment that you're actually not qualified in, in doing like… So here, the questionnaire says first of all, you do a depression score, which is fair enough. Then you need to comment on the appearance, the behaviour, the facial expressions, speech, the mood, the sleep, thought form content… So, some of the things like bonding with the baby that obviously I can assess but, you know, there's stuff like perception, illusions, distortion of senses, like I have not learned as a midwife to assess that. I think you've got a bit of common sense as a person who works with people but what they are asking in this referral is actually quite challenging.

Barriers from services

Rachel felt frustrated with culturally unresponsive services and services that are so stretched they can't respond to the mother's needs. She described a situation where the mother needed to be really severe to get appropriate help and even then, services may not provide that support if mothers don't follow their rules:

> *You find that right across the health sector, and you find that even in social situations with the community, it's just like you have to be really serious, to be able to get the service that you need. That's like in housing you've got to be at the bottom of the scale before you get a house, or accommodation so then you start pushing yourself to meet their criteria. Yeah, and I had someone who had postnatal depression, and I sent them to the hospital to do the Edinburgh score chart, which she didn't score well, so she needed to be referred. I sent the referral through. They said, yep, yep, yep. And, yeah, they only made three phone calls, their criteria are ringing them three times, and if they don't answer that's it. They're not going to pursue it.*

There appeared to be a lack of maternal mental health services prominent as mentioned by midwives working in some communities:

> *I feel like… I wish maternal mental health would play a bigger part in our community. Like, rurally I feel like that service. I mean, mental health services in [town] are pretty limited anyway, but that maternal side I wish they were more available for us. (Samantha)*

Rachel described one situation in which the māmā in her care was suffering and needed support as soon as possible. Rachel was able to arrange support for her client only because she had knowledge of mental health and networks in the system, which may not be the case for many midwives who are less interested in mental health:

I can only just go on early, early last year I had a mother who had a serious anxiety attack, and she wasn't coping. She actually has a history of postnatal depression with her other babies and so she had a really severe anxiety attack and that needed to be dealt with immediately and so, I had to ring up the hospital and pretty much ring around to the delivery suite to see if they can take them, they said they couldn't and I was only lucky that on the day the hospital registrar was there and was sympathetic to my case enough to get her in to be seen because once she's in the system, then they can direct the pathway. (Rachel)

Referrals can also be difficult to manage due to limited resources within health and social services:

There's not much services here compared to like Hamilton where there's two, three, A4 pieces of paper of numbers to call. Here there's very few, so I think our role is even more needed to help support them. (Lily)

Attitudes toward mental health care

Samantha and Emma discuss how some of the māmā they work with are not always able to be vulnerable or accept help due to the other roles and responsibilities they have:

I must say though, our women down here are pretty hearty, like they are really resilient. You know, they're poor. They've usually got lots of social issues going on, but they tend to just, you know, get on with life. Yeah, and the mental health stuff. Yeah, it is there but it's almost like I'm just gonna put it in with the rest of it. (Samantha)

This is their lot, and they know how to deal with it. It might be a luxury for a lot of our women to fall down if they had to. They can't fall down. They've still got to keep going with everything else. (Emma)

Similar frustrations were expressed by Rachel who described:

... There are somethings you don't want to share with your whanau or let other people know, so they're reluctant to access those services or those services are funded differently where they can't look after hapū [pregnant] māmā. (Rachel)

Additionally, there can be feelings of frustration related to trying to get appropriate support for māmā when living in rural communities:

I feel like it's all just a phone call, right? They don't come down anymore… maternal mental health. (Samantha)

Well, not even just maternity services, we don't have a diabetic team. (Emma)

We don't have a scanning place. (Lily)

I mean, which is very common for rural midwifery health care anyway. (Emma)

This fourth umbrella theme, barriers to referrals, described the struggles and difficulties midwives have accessing services for mothers and making referrals in which mothers are either not able to be accepted because they don't fit the criteria or there are not enough services around to care for the mother's needs. Additionally, the attitudes towards mental health care which included mothers experiencing stigma and also not believing in mental health care, or thinking you just need to muscle on through made the barriers to referrals and services difficult for midwives.

Discussion

The results of this study highlight the strategies and techniques midwives use to support māmā who experience emotional distress, and at the same time reveal some areas in which midwives themselves may require support. The themes which emerged from the stories shared by the midwives reflected a strong sense of care and empathy which midwives carry during their practice. Midwives described how they relied on practical skills such as listening to māmā and providing validation and affirmation to help them, without awareness of the range of online and other self-help tools that may be helpful for women. The complexity of referrals and access to mental health services was central to the midwives' frustration around caring for mothers. Therefore, themes revealed a need for more training and education for midwives, as well as needing referrals and services to be culturally appropriate and available, especially for māmā who experienced mild to moderate symptoms of depression or anxiety. This section will discuss these findings in relation to current literature and highlight the recommendations for practice, limitations, and directions for future research.

Strategies and techniques

It appeared that the primary methods used to support māmā who experience emotional distress were related to characteristics and skills that midwives had, such as having empathy, building rapport and careful listening. Midwives found this to be extremely helpful when building relationships with mothers who experience mild to moderate levels of anxiety and depression, as it was effective when working together to find solutions or resources for the mother's needs. This may not be a mental health referral, but could be related to mirimiri, meeting the woman's basic needs, or supporting her to open up to her whānau and friends. Research supports these strategies (Artas & Pasinlioğlu, 2021; Erenoğlu & Başer, 2019) finding, for example, a link between empathetic communication skills training for midwives

and improved maternal satisfaction with birth among mothers (Charitou et al., 2019). Empathetic and understanding professionals who show clients respect make it easier for patients to feel accepted and understood and express their true feelings, which allows them to be more open-minded to treatment and interventions (Jin et al., 2022). Having empathy training also allows midwives to understand things from a woman's angle (Charitou et al., 2019), which helps to build a good relationship with a mother and provides midwives with the skill and confidence to talk about the woman's mental health issues (Higgins et al., 2016). Empathy and careful listening are supported by current literature (Schulz & Wirtz, 2022; Charitou et al., 2019; Artas & Pasinlioğlu, 2021) as useful methods to support mothers who may experience emotional distress, consistent with the accounts from the midwives in this study.

Screening for mental health and psychosocial needs

The use of appropriate tools and measures by midwives to screen mothers for mental health conditions was common in this study. All of the midwives in this study were aware of the EPDS, an assessment tool that aided them in identifying symptoms of depression and anxiety in mothers (McBride et al., 2014). Midwives in this study also found screening questions and trusting their intuition to guide prompts helpful throughout care. Since the midwives recruited for this study had an interest in maternal mental health, it is not surprising that they were aware of screening options and prioritised them. As previously mentioned, evidence has found screening mothers during the perinatal period to be useful for early detection of depression and anxiety (Vankatesh et al., 2016; Waqas et al., 2022). However, it can concluded from recommendations made from the US (O'Connor et al., 2016), Canada (Joffres et al., 2013), and the New Zealand College of Midwives that midwives in New Zealand should not formally screen for depression and anxiety, since there are not appropriate resources available.

Most midwives also asked about psychosocial factors such as family violence, housing, and financial situations. These midwives talked about how these factors contributed to stress for mothers. Midwives working in rural areas spoke of a focus on screening for family violence and having training around recognising those māmā who are in crisis situations relating to violence and unsafe homes. In a 2010 systematic review, Lancaster and colleagues identified 7 studies which addressed the relationship between domestic violence and antepartum depression. Lancaster et al. (2010) concluded that there was a small to medium positive association between domestic violence and antepartum depression. Other psychosocial factors, such as low social support (Bayrampour et al., 2015; Biaggi et al., 2016), financial stress (Crosier et al., 2007), marriage status, stressful life events (Robertson et al., 2004), and low socioeconomic status (Verbeek et al., 2019), have been associated with increased depressive and anxiety symptoms during pregnancy. This link between psychosocial factors and the need for wellbeing support makes it understandable why education on topics such as family violence and related psychosocial factors was important for midwives in this study. Research from other contexts is consistent with what midwives described and underlines the need for all midwives to screen for psychosocial factors.

Upskilling practice

Interviews with midwives, particularly those working with a Māori demographic, revealed the need for more mandated kaupapa Māori focused training for midwives to learn how to appropriately support the emotional and psychosocial needs of Māori māmā through cultural competency education, indigenous knowledge, and mental health training. One midwife spoke of her recent journey with learning about te ao Māori, and how understanding the history of Māori people and how to interact with them has been impactful on her practice. Another midwife spoke of the use of Matauranga Māori resources and other Māori concepts

that she draws on during her time with māmā to make connections, and ensure she feels safe within the space. With such a high proportion of Māori midwives in the current study, it is understandable that many participants made the point that there was a need for upskilling on specific mental health strategies, relating to people, and cultural safety.

Midwives advocated for mandated cultural competency. With Māori midwives underrepresented in midwifery education (Tupara & Tahere, 2020), there is a lack of Māori midwifery representation and perspectives in the curriculum in midwifery programmes in New Zealand (Kenney, 2011; Cairns, 2005). There are no compulsory recertification requirements for cultural competency within New Zealand, which therefore means that the profession relies entirely on the preparation midwives receive in midwifery education (Tupara & Tahere, 2020). Across the 20 District Health Boards throughout New Zealand, Auckland District Health Board was the first to implement a mandatory Tūranga Kaupapa education programme from 2018 to 2019 (Auckland District Health Board, 2019). There are only voluntary opportunities for cultural competence education in the other District Health Boards (Tupara & Tahere, 2020). In the latest Perinatal and Maternal Mortality Committee (PMMCR) report, priority recommendations were presented related to "mandated cultural safety education programs for the maternity and neonatal force" (Perinatal and Maternal Mortality Review Committee, 2022). To date, training programmes are yet to make a statement about the progress of this recommendation. This literature supports the need for more mandated Māori education expressed by these midwives and the time and effort they put into ensuring their Māori māmā feel safe.

Interviews with several of these participants revealed a need for mental health education, especially in the absence of clear referral pathways, for training on how to support women who experience mild to moderate perinatal mental health concerns. Several midwives in this study made it clear that they had not received formal mental health training, though

wished they had, while others revealed that they sought out additional training due to having a specific interest in the education on mental health. It was very common for the midwives in the current study to have women in their care who did not meet referral criteria for specialist services and fall into a category in which they often get missed, and midwives are left to support them without any mental health training. Midwives in the current study had a special interest in mental health, and even they feel ill-equipped, even though they are very proactive in their approach. This fits with Mellor et al.'s (2019) findings with a broader sample of NZ midwives who spoke about feeling ill-equipped for providing additional support needed by the women, and how they felt they were carrying the weight of maternal mental health needs which they believed needed to be provided by mental health workers, not midwives. Mellor et al. (2019) also focused in on what midwives find helpful while they are in this situation, consistent with the current study. Incorporating training for midwives to know the referral pathways is needed to recognise and support women while they await referrals.

Perinatal Anxiety & Depression Aotearoa (PADA) is an organisation that provides professional development workshops in perinatal mental health to care providers. Since approximately 2020, PADA has held Māori maternal mental health huis (meeting) for providers, as well as brought in educators from Māori and Pacifica backgrounds to provide workshops about working with those cultures (Perinatal Anxiety & Depression Aotearoa, 2022). One midwife in the study spoke about being involved with the PADA workshops on different occasions, and how important they were in providing her with education on perinatal mental health. Prioritising the incorporation of further or specialised education within the midwifery space is needed to help reduce the barriers of mothers accessing mental health help (Perinatal and Maternal Mortality Review Committee, 2022).

Traditional Māori healing practices

The stories from midwives revealed how important culturally appropriate local healing practices and Māori based providers were to alleviate some distress for māmā. Midwives also valued a strong holistic approach to care and often utilised services that valued a holistic approach such as rongōa and mirimiri. Māori midwives working with māmā engaged them in traditional Māori practices of rongōa (herbal remedies) and mirirmiri (massage) throughout their care for mothers. Rongōa, which encompasses herbal remedies, physical therapies, and spiritual healing, is an important aspect of health care to many Māori. Rongōa utilises a holistic approach to restore wellness to the spirit, body, mind, and emotional wellbeing (Durie, 2010). Mirimiri is a form of traditional Māori massage, which manipulates spiritual energy and aids in releasing and restoring negative energies (physical, psychological, and generational pain) that are stored in different parts of the body. Several midwives spoke about the profound positive results these practices had for women as they reportedly helped mothers to heal from and alleviate anxiety related to previous birth trauma, and/or release some physical pain felt during pregnancy. To date, there are no formal studies on the effectiveness of these interventions on lowering emotional distress due to the outcome of rongōa being difficult to measure (Durie, BPA Issue 28); however, there has been an increased recognition that health outcomes can be improved by Māori healing practices, as offered by the Accident Compensation Corporation (ACC) in New Zealand (ACC, 2021).

Barriers to referrals

The midwives in this study highlighted the profound difficulties and struggles they experienced when trying to make referrals and get access to support services for women. There is a strong need for clear referral pathways and accessible services within the maternal mental health sector in order to meet women's needs, consistent with current literature (Mellor et al.,

2019; Holden et al., 2019; Noonan et al., 2017; Paterson et al., 2018). Midwives spoke predominantly about struggles in relation to māmā with mild to moderate distress they support, and often how difficult it is to refer them to appropriate services because they do not meet criteria for specialist services. Often midwives would refer mothers who are distressed to public mental health services, who would be unable to take the referral, due to mothers not meeting the severity criteria. Mellor and colleagues (2019) found that NZ midwives reported similar experiences in finding services that could support mothers who did not meet criteria for diagnosis. Untreated sub-clinical depression is associated with increased risk of future major depressive episodes and increased use of health care (Davey et al., 2011). Therefore, ensuring that strategies for prevention, support and treatment are aimed at women who are missed due to not meeting criteria is essential (Davey et al., 2011). The midwives in the current study felt dissatisfied regarding the referral process and pathways to access maternal mental health care for women, as they were sometimes unclear, and the process could be difficult for the midwives. There may be some services that these midwives are not aware of, and if they weren't aware, it's likely many others are also not aware, which speaks again for training about the options within the health system for mental health care, as well as how to support mothers who are awaiting care to be prioritised.

Stigma and low engagement with the wider network of social and mental health services from mothers was also described by midwives. One midwife spoke about being worried for one young woman in particular who wouldn't engage in the services around her, despite experiencing emotional distress. Midwives tried to engage her support network, such as family and friends, to provide some encouragement for her to get help. Another midwife spoke about how reluctant women can be to access help. This aligns with previous research that found pregnant women with mental health needs reluctant to access help due to barriers in accessing

services (Ford et al., 2019) and reluctance to acknowledge symptoms (Ford et al., 2019; Holden et al., 2019; Button et al., 2017).

Rural mental health care

The interviews with midwives working in rural communities spoke of the difficulties they encountered having appropriate mental health services to utilize for mothers. This aligns with previous research, that has found unavailability of mental health services (Adjorlolo et al., 2020; Crowther et al, 2018; Galbally et al., 2022) and a lack of clear pathways to mental health services (Adjorlolo et al., 2020; Webb et al., 2021; Bayrampour et al., 2018) as barriers to rural maternal mental health care. Some midwives in the current study also spoke about how difficult barriers relating to mental health services can be, especially when working with a community that can have reservations about asking or accepting help. Current literature supports the experiences of these midwives (Cheesmond et al., 2019; Daellenbach et al., 2020; Jesse et al., 2008) and the need for more appropriate pathways and services for women in rural areas.

Though midwives from rural areas are faced with many barriers whilst caring for mothers, it was evident in both the current study and in literature that midwives in rural areas have a strong sense of belonging, connectedness, and responsibility for their community (Daellenbach et al., 2020). Midwives in the current study described knowledge and support of local community services and forming relationships with other rural midwives as strategies used to counter the difficulties found in rural maternity care. Daellenbach and colleagues (2020), in a study of rural midwives in NZ, also found that midwives reported developing relationships with rural midwives and having support from local services as strengths. Additionally, it was found that several Māori midwives from Daellenbach et al.'s (2020) study described their role as rural midwives to be compatible with the commitment they have to the principles and values of te ao Māori (Daellenbach et al., 2020). This was a common theme for

midwives in the current study, who wove kaupapa Māori practices, Matauranga Māori resources, and the importance of people and the land, within their practice as a midwife.

Recommendations for practice and research

The results from this study suggest that increasing education and training for midwives on topics like Kaupapa Māori, on social and mental health resources and processes for referral, and how to support women with mental health problems could help keep midwives informed and feeling equipped to handle more complex issues māmā may be having. Continuing professional development (CPD) increases the likelihood that midwives are adhering to safe practice, continuously updating, and learning new skills, and may help them to meet the needs of the person in their care (Calvert, 2014). Therefore, it should be a priority for midwives in community practice to undertake such education to ensure they are equipped with the best information to care for māmā. This aligns with the views of the midwives in the current study who felt there was a need for more education on the mental health processes and how to refer to services, cultural competency, how to appropriately support mothers with mental health problems, both within the midwifery program, and through professional development (Mellor et al., 2019; Holden et al., 2019).

Aside from one midwife identifying the use of self-help books as a resource to give to women, no midwives talked about the range of online and other self-help tools that are available. There are a number of electronic self-help tools, some designed for during the pregnancy (Barber & Masters-Awatere, 2022) and for the perinatal period (Mum2BMoodBooster, 2023). There are resources that are free and could be provided to mothers by their midwives (Just a Thought, 2023), which midwives in this study did not mention. Therefore, another recommendation from this study is to increase the awareness of self-help tools which midwives could utilize, and for future research to find out why they

midwives aren't using them, whether they aren't aware of them, or they have found them unhelpful, or not culturally appropriate.

Another recommendation from this study is the need for more streamlined referral pathways and access to support services for those who aren't meeting criteria for secondary mental health services. It's evident that there needs to be a place for prevention (e.g., an ambulance on top of the hill), as well as staged interventions, or different types of interventions (e.g., online based apps, support groups). Midwives are already working with women, so they have a relationship and may be well placed to know about their needs, but they aren't trained or paid to provide mental health services, so there is more support needed. Providing midwives with education on mental health resources and processes would allow them to have a better understanding of how to support mothers who experience mild to moderate symptoms of anxiety or depression while they're getting access to mental health care; however, it is important for there to be a streamlined network of services which can appropriately care for mothers who experience emotional distress. This aligns with the views of midwives in this study who wish to provide support for māmā, are feeling ill-equipped to deal with it, feel that there is a need for mental health education, and wish there were more accessible services.

Limitations and directions for future research

There were a number of limitations in this current study that need to be addressed when interpreting the results. Firstly, the study was significantly impacted by COVID-19 during the recruitment phase, with notable difficulties finding participants who were interested and had the time available to meet for the interview. As a result of the pandemic, the NZ government mandated vaccines against COVID-19 for jobs or workplaces that are high risk, such as health practitioners dealing with patients in person (Te Tatau o Te Whare Kahu, 2021). Losing a subset of midwives who refused vaccination and so could not practice was an unfortunate

outcome of the mandated vaccinations (Preston, 2021; Cook, 2021). The mandated vaccinations were lifted in September 2022 (Te Tatau o Te Whare Kura, 2021), though the critical nature of the midwifery workforce shortages meant that midwives have been impacted long-term by larger workloads and difficulties adapting to the changes in how they work with women (Crowther et al., 2021). Additionally, daily reports of high rates of COVID-19 among both health professionals and within the community has caused an overall strain on the healthcare system and on midwives' caseloads. Due to recruiting in a high-stress time, it was likely that only the midwives who were most interested and committed to mental health would have participated in this study. This was expected and accounted for in the design of the study; however, a larger and more typical group of midwives might have identified more and/or different strategies and issues.

Difficulties with recruitment led to a reliance of my own personal contacts, which led to a significant number of midwives in this study who were Māori and/or working with Māori. Though not intended initially, a focus on Māori midwives and communities is a strength of the study. It would be interesting to see if the factors relating to increased Māori education would be so strong if there was a larger and less Māori-focused set of midwives that, potentially, are less attuned to these issues pertinent to Māori.

Further research examining the implementation of formal screening processes for depression and anxiety in New Zealand is needed. It is recommended by this study that only those midwives who feel they have the training and knowledge about linking māmā up to resources should be screening. However, screening for depression and anxiety during the pregnancy and postnatally is important, so if services were to be set up, and/or training for midwives about how to support and refer māmā to mental health services was provided, it is possible that formal screening programmes within New Zealand may be beneficial.

Future research should also focus on understanding what community practice midwives, both from New Zealand and overseas, need to feel supported as they work with these particular women. Incorporating their voice to inform the development of perinatal mental health support is important to ensure that midwives feel equipped, supported, and heard within their role. Lastly, limited awareness of the available self-help tools and other online resources available to midwives, or their clients was identified, whereby future research should identify why midwives aren't using the available tools and resources.

Conclusion

By hearing the strategies and techniques midwives found helpful to support women struggling with perinatal mental illness, this study sheds light on the level and type of service midwives provide to māmā, as well as the importance of the role midwives play within maternal mental health care. This study recruited a meaningful number of Māori midwives, who were able to provide insightful knowledge on issues related to Māori maternal mental health.

The results show that midwives were not aware of the primary mental health services their clients could access and that even these very interested and engaged midwives didn't know about some of the clinical resources that could be available to their clients. Consistent with previous research, the midwives' experiences reflect a lack of mental health and cultural competency training, and referral pathways to mental health services that do not meet the needs for those experiencing mild to moderate symptoms. Recommendations based on this study are to provide midwives with education on mental health to aid them when supporting and caring for mothers who experience emotional distress. Improvements to the pathways for referrals and access to mental health services needs to be a priority.

Knowing the impact perinatal mental illness has on mothers and whānau, ensuring that midwives are aware of the available modes of support and having accessible services available

for mothers, will increase the likelihood that equitable health outcomes, for the mother and baby, are met. Community-based midwives, under New Zealand's continuity of care maternity model, are vital to providing mothers with a quality of care that enables a positive childbirth experience, which has long-term benefits for society.

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Appendices

Appendix A: Email to LMC midwives

Kia ora colleagues,

I am working with a masters student, Tiaan Roia, on a study aimed to understand the level of service and support midwives provide for mothers who struggle with emotional distress during pregnancy. We are looking to interview midwives to find out what strategies or techniques they find most useful to support pregnant clients who are experiencing emotional distress. The study will involve one interview via zoom that will take approximately 30-40 minutes. Participants will receive a $20 voucher as kōhā to thank them for their participation in the study.
If you or any women that you support would be interested in participating, please see the attached poster and information sheet for further information. We are looking for 6-12 LMC midwives.

Thank you for your help!

Carrie Cornsweet Barber, Ph.D.
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Appendix B: Recruitment poster

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

WHAT WORKS FOR MIDWIVES SUPPORTING MAMA THROUGH EMOTIONAL DISTRESS?

We would love to talk to New Zealand midwives about the techniques or strategies they are using to support pregnant clients who are experiencing emotional distress. We hope to understand the best level of service and support for maternal wellbeing.

If you are interested please contact Tiaan Roia at tmmr1@students.waikato.ac.nz or 0273060886

This research is being completed for a masters thesis supervised by Dr Carrie Barber (carrie.barber@waikato,ac.nz) Participants will receive a $20 voucher as koha

Appendix C: Participant consent form

Research Project: What works for midwives supporting māmā through emotional distress?

Please complete the following checklist. Tick (✓) the appropriate box for each point.	**YES**	**NO**
1. I have read the Participant Information Sheet and I understand it.		
2. I have been given sufficient time to consider whether or not to participate in this study.		
3. I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		
4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any point until one month after the completion of my participation, when data analysis will be in progress.		
5. I have the right to decline to participate in any part of the research activity.		
6. I understand that the interview will be recorded and transcribed and I will be given a chance to review and correct the transcript if I wish to.		
7. I understand that the interview will be transcribed using a third party speech-to-text transcription application (Otter.ai – for more information please see https://otter.ai/). **Please** note all responses transcribed in third party applications will be kept secure, confidential and anonymous. If you do not agree to this, please tick no and the interview will be transcribed manually by the researcher (i.e. not using third party software).		
8. I know who to contact if I have any questions about the study in general.		
9. I understand that the information supplied by me could be used in future academic publications.		
10. I understand that my participation in this study is confidential and that no material which could identify me personally will be used in any reports on this study.		

11. I wish to receive a summary of the findings.		

Declaration by participant: I agree to participate in this research project and I understand that I may withdraw from the study at any point until one month after the completion of my participation. If I have any questions about this research, I can contact Dr Carrie Barber at carrie.barber@waikato.ac.nz or Tiaan Roia at tmmr1@students.waikato.ac.nz. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.

Participant's name (please print): _____

Signature: _____ Date: _____

Declaration by member of research team: I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (please print): _____

Signature: _____ Date: _____

Appendix D: Participant information sheet

What works for midwives supporting māmā through emotional distress?

Thank you for your interest in participating in our study. This study aims to interview LMC midwives in New Zealand to understand the level of service and support midwives provide for mothers who struggle from stress/anxiety/depression, and to recognise the alternative modes of help they find most useful to support mothers. This study will fulfil the requirements of a Master's thesis for Tiaan Roia, a postgraduate psychology student at the University of Waikato.

The postnatal period is a particularly vulnerable time for mothers, with an increased risk of developing anxiety, depression or emotional distress during this time. With mental health services currently stretched and difficult to access, midwives can often be the first port of call and lead support for the mothers' mental health. Therefore, we would like to interview midwives with the aim to find out what they do that works, within their scope of practice, to support women around their emotional distress.

Study procedures:

If you participate in the study, you will be asked to complete a 30-40 minute interview with Tiaan (the researcher). This will be done via Zoom and if required, you are welcome to bring another person along to interview, whether that is for support or just to have someone else listen in. The interview questions will focus on your experiences of the strategies and techniques you have found most useful to support mothers with emotional distress. The interview will be recorded and transcribed verbatim by a confidential audio transcription software called Otter.ai. Permission to use Otter.ai during the interview will be asked prior to the interview, and you will be given the chance to review and make any changes up to one month prior to the information being used for the study.

Any information you provide will be confidential as your name will not be stored with any data collected. Data will be kept in password-protected computer files for at least five years after the study is completed. You are free to withdraw from the study at any point, without a given explanation until one month following the end of your participation. It is within the participants right to decline to answer any question or questions, and ask for the recording to be stopped at any point during the study.

If you have any questions about this research, please feel free to contact Carrie Barber at

carrie.barber@waikato.ac.nz, or 07 837 9221, or Tiaan Roia at tmmr1@students.waikato.ac.nz or 0273060886. ***This research project has been approved by the Human Research Ethics Committee (Health) of the University of Waikato under HREC(Health)2021#15. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.***