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AOTEAROA NEW ZEALAND RESEARCH

Caring in action: Midwives' approaches to supporting perinatal mental health in Aotearoa New Zealand

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ABSTRACT

Background: Pregnancy and the postnatal period are particularly vulnerable times for mothers' mental health, with an increased risk of women experiencing depression and anxiety. In Aotearoa New Zealand, midwives are uniquely positioned to provide support to women during this critical time, often filling gaps in mental health services.

Aim: The qualitative study, based on a select sample of midwives, aimed to explore the tools and resources that these lead maternity care (LMC) midwives find most helpful in supporting women experiencing mental distress during the perinatal period.

Method: Using a strengths-based approach, the study recruited seven Aotearoa midwives with a particular interest in mental health. These midwives participated in semi-structured online interviews to share their experiences and insights regarding the practices they find most helpful and the barriers they encounter. Data were analysed using inductive thematic analysis.

Findings: Five key themes emerged from the analysis: (1) Screening: "Sometimes we have to sit and unpack it"; (2) Being with: "A listening ear" and beyond; (3) Connecting: "A wraparound type of approach"; (4) Up-skilling: "It should be there for all of us"; and (5) Barriers: "You have to be at the bottom of the scale". The midwives' stories revealed their deep empathy and care, as well as the complexity of referrals and challenges in accessing mental health services, which were central to the midwives' frustration around their ability to fully support mothers.

Conclusion: The study highlights midwives' relational continuity of care as a key strength for supporting perinatal mental health. Their deep empathy and trust built with women underpin their role in mental health screening, advocacy and referral. Enhancing midwives' capacity, through targeted education, culturally appropriate resources and greater access to mental health services and resources, will help address existing gaps and build on these strengths.

Keywords: perinatal mental health, continuity of care, culturally appropriate services, holistic care, wraparound care

INTRODUCTION

Pregnancy and the postnatal period are times of significant physical and psychosocial change; most mothers cope well, but a substantial minority struggle emotionally, with an increased risk of developing depression and anxiety during this time (Al-Abri et al., 2023; McLeish & Redshaw, 2017). Estimates of the prevalence of antenatal depression range from 7% to 28.5% worldwide (Al-Abri et al., 2023; Dadi et al., 2020). In the *Growing Up in New Zealand* study, 7%, 14% and 12% of pregnant participants reported elevated depressive symptoms during the first, second and third trimesters, respectively (Waldie et al., 2015). In Māori women anxiety symptoms are notably higher, with 25% of Māori women surveyed in one study reporting anxiety during late pregnancy compared to 20% of non-Māori women (Signal et al., 2017). Postnatal depression is often described as one of the most common complications of childbearing and affects approximately 13% of all new mothers in international meta-analyses (Falah-Hassani et al., 2017; Liu et al., 2022). Anxiety is increasingly recognised as a common and serious source of distress, with clinically significant anxiety affecting an estimated 10% to 14% of perinatal women in high-income countries (Araji et al., 2020; Smythe et al., 2022). For affected mothers, poor mental health can have a wide range of detrimental effects, impacting their quality of life and influencing their relationships with their children, partners and wider family members (Smythe et al., 2022).

Early identification of perinatal mental health needs and timely referrals to appropriate services benefit the mother's health and

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wellbeing and the child's development (Mellor et al., 2019; Meredith et al., 2024). Various screening tools have been developed for early detection, hopefully leading to preventative support, including standardised questionnaires such as the Edinburgh Postnatal Depression Scale (EPDS; Lautarescu et al., 2022; Levis et al., 2020), verbal screenings during healthcare visits (New Zealand College of Midwives, 2021), and more informal methods like asking mothers about their general wellbeing and/or observing behavioural cues that may suggest mental health concerns (Hicks et al., 2022; Mellor et al., 2019). While the EPDS has been validated as a screening tool when applied using the English, Samoan and Tongan languages, its validity for Māori women has not been established, highlighting an absence of culturally appropriate screening tools for this population (Ekeroma et al., 2012). Many countries have implemented universal routine screening programmes aimed at addressing perinatal mental health (Austin et al., 2011; Inekwe & Lee, 2022; O'Connor et al., 2016), although the benefits and potential harms of such programmes remain a topic of ongoing debate (Blackmore et al., 2022; Tully et al., 2002; Venkatesh et al., 2016; Waqas et al., 2022). In Aotearoa, although midwives are mandated to assess for risk of postnatal distress (Ministry of Health, 2021b), there is no current policy specifying how perinatal mental health screening is to be conducted (Mellor et al., 2019; Ministry of Health, 2021a) and the appropriateness of implementing universal screening is debated due to significant challenges related to access to mental health services and cultural appropriateness (Austin et al., 2007; Blackmore et al., 2022; Mellor et al., 2019).

Research on Aotearoa midwives' experiences with mental health screening highlights challenges like those faced internationally, including time constraints, heavy workloads and limited secondary support or pathways for mothers with mental health issues (Holden et al., 2019; Mellor et al., 2019; Ministry of Health, 2021a). Mellor et al. (2019) interviewed 27 Aotearoa-based lead maternity carer (LMC) midwives, who reported feeling ill-equipped to provide the necessary support and stressed that maternal mental health should be managed by mental health professionals. Concerns about the availability of services for women with mild to moderate mental health issues were also raised (Mellor et al., 2019). In a separate study Holden et al. (2019) examined the perspectives of Māori and Pacific mothers and maternity carers on mental health screening practices and available supports. Barriers identified by maternity carers included stigma and discrimination toward people with mental health issues, inadequate midwifery mental health education, time constraints and a lack of secondary support or clear pathways for mothers with mental health problems (Holden et al., 2019). Mothers also identified similar barriers, as well as cultural barriers, noting that acknowledging depression was often not tolerated by their families (Holden et al., 2019). While midwives in Holden's study did not identify cultural factors as barriers, the inclusion of the mothers' voices within this study added a critical dimension.

In Aotearoa, the vast majority of women (95%) receive maternity care from an LMC. Of these women, most receive care from a community-based LMC midwife (over 95%), while only 3% receive hospital-based LMC care (Te Whatu Ora, 2024). LMC midwives are registered professionals who work autonomously in the community and provide continuity of care throughout pregnancy, labour, birth and the postnatal period, typically up to six weeks postpartum. This model is central to Aotearoa's maternity system and is distinct in being publicly funded, midwife-led and grounded in principles of continuity and partnership. Unlike many maternity systems internationally, where care is often fragmented and shared among general practitioners, obstetricians and hospital-based midwives, the LMC model enables a single midwife or a small team of midwives to provide consistent care across all stages of the maternity experience. This continuity fosters trusting relationships with women, creating a safe space for open communication. Such relational care provides a critical opportunity for midwives to identify signs of anxiety and depression, often using validated screening tools, and to refer women to appropriate services.

Problematically, access to mental health services is frequently hindered by long waitlists, high severity thresholds, geographical barriers and the high cost of private services (Ferris-Day et al., 2024; Holden et al., 2019; Mellor et al., 2019; Ministry of Health, 2019). As a result, LMC midwives often become the primary, and sometimes sole, source of support for women facing significant mental health challenges. This differs from some international contexts where mental health screening and management during pregnancy may fall under the scope of general practitioners or mental health specialists. While some midwives may feel under-prepared for this aspect of their role, some have developed strategies to provide care for women with mental health concerns. Given the growing recognition of perinatal mental health as a public concern, it is vital to explore how midwives can be better supported in addressing the mental health needs of mothers (Tripathy, 2020).

AIM

This project interviewed seven LMC midwives and aimed to identify their effective strategies and what they found to be barriers to care, with the aim of informing recommendations for midwives supporting women struggling with emotional distress.

METHOD

This qualitative study utilised semi-structured online interviews. 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). 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). A strengths-based approach informed the study's design, focusing on the resilience and coping strategies of midwives. The approach guided how interviews were conducted, allowing midwives to share their experiences in a way that acknowledged their strengths and resourcefulness, rather than focusing solely on challenges.

The researchers

When conducting qualitative research, it is crucial for researchers to clarify the perspective they use to interpret and analyse the data (Clarke & Braun, 2013). An aspect of this is acknowledging the researcher's background and experience with the subject matter. For the first author, as a descendant of Waikato Tainui and Ngāti Awa, I was able to draw on my whakapapa and utilise whakawhanaungatanga to recruit several Māori midwife participants. The second author is a mental health professional with clinical, research and advocacy experience in the domain of perinatal mental health.

The participants

Of the seven participants, five were currently registered and practising as LMC midwives, and two had previously practised as LMCs but had since transitioned to other roles. Including

their perspectives offered insight into the ongoing relevance and impact of the LMC model beyond active practice and reflected the participants' strong interest in sharing their experiences of working with women with emotional distress. The midwives were based across various regions of the North Island of Aotearoa. Interviews were mostly conducted one-on-one, except for three midwives who shared a practice setting and were interviewed together as a small group. Four midwives, identifying as NZ Māori, described their caseloads as predominantly Māori. The remaining three midwives – two identifying as NZ European and one of German descent – reported working primarily with NZ European mothers, alongside those of other ethnicities, including Pasifika and Māori.

Ethics

The study was reviewed and approved by the Human Research Ethics Committee (Health) of the University of Waikato (Reference 2022#11). Written informed consent was obtained from all participants prior to the interviews. Confidentiality was ensured by assigning pseudonyms to all participants and removing any identifying information from the data.

Data collection

The interviews, conducted online, were audio-recorded for transcription. Each interview lasted between 20 and 50 minutes. The study was completed between May and October 2022, during a period of significant community transmission of COVID-19 in Aotearoa, which posed challenges for recruitment. As a result, participants were primarily recruited through personal and professional contacts, using a snowball sampling method. This likely resulted in a cohort of participants who had a particular interest in mental health and were willing to share their knowledge.

Data analysis

Inductive thematic analysis (Clarke & Braun, 2013) was conducted in order to remain open to the concepts and priorities of the participants and to avoid, as far as possible, imposing a framework on their ideas. The first author initially coded the data and grouped them into preliminary themes. These were reviewed and refined through discussion with the second author. The thematic map was finalised, and illustrative quotes were selected to support the findings.

Cultural safety

To attend to cultural safety as a researcher, I drew on my lived experiences as a Māori woman, my knowledge of te reo Māori, tikanga and a te ao Māori worldview. During interviews, I spent time building rapport and ensuring participants felt comfortable and safe to share. I offered the option of having a support person present and I engaged with participants throughout the research process. Where appropriate, I shared my pepeha or aspects of my whakapapa to establish connections. To ensure participant involvement and accurate representation, I sent transcripts to participants for feedback and incorporated their views and corrections before analysis. I recognise Tūranga Kaupapa as an essential cultural competency framework guiding midwifery practice in Aotearoa and, while not directly adopted in my research, its principles of cultural respect, identity and relational practice informed my approach to building a culturally safe and respectful research environment.

FINDINGS

Five themes were derived that identified the key messages and summarised the interviews with the seven midwives.

Screening: "Sometimes we have to sit and unpack it"

Some midwives mentioned using screening tools such as the EPDS and the Generalised Anxiety Disorder (GAD-7) to assess distress levels. An experienced midwife, no longer practising, discussed how the EPDS effectively screens for mental illness in a practical and timely manner:

> *I know they're using the Edinburgh Depression scale… and I think that's just to try and speed things up because where you might just get information out of somebody by just having a conversation and saying, "how are you feeling?" or "what's going on for you emotionally?", sometimes going through a checklist actually just speeds up the process when you're pressed for time.* (Kate)

Midwives commonly gathered information about factors contributing to anxiety, depression and distress in clients. For Rachel, this included asking about a mother's history of mental illness, childbirth trauma, social support and any social issues linked to distress:

> *We have a screening tool or an assessment framework that we use during the pregnancy. So, we'll ask health questions, social questions, physical wellbeing questions and then we'd also ask about any previous history of anxiety and postnatal depression… 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 assessing for any emotional distress:

> *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 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, it can give us an idea of what we're looking at and what we're going to be dealing with. So just remembering to check in on that as the relationship goes on.* (Samantha)

All the midwives emphasised the importance of understanding their clients' emotional state. Those currently practising used various methods, including questionnaires, asking women about their mood and trusting their intuition to detect when something was wrong.

Being with: "A listening ear" and beyond

A theme emerged around the midwives' role as the first point of contact for mothers experiencing emotional distress. They prioritised being there to listen, address concerns and allocate time for these important conversations:

> *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" or "I'll make an appointment soon" or sometimes I'll have time to extend the appointment… but I think 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 a lot of it is just listening. And 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)

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 is helpful:

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

> *Just to* [have] *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… they come in here and just want to talk to a woman who understands.* (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* [saying] *right now we're going to make a plan going forward. I think we're good at doing that.* (Samantha)

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

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

By using techniques like letter writing, role playing or using the STOPP (Stop, Take a breath, Overall, Put in Perspective) acronym, sometimes the midwife can help the mother make sense of her own thoughts and emotions. This midwife was describing supporting women who have had difficult births:

> *I just use a breathing technique and then we come up with, for homework, depending on what they've found helpful in the past, like journaling, writing in a diary, writing a letter, speaking onto a tape, 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, "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 who's three months old now and she said, "I'm going to… tell her all about her birth and what happened" and so that was just a way of expressing how she felt about the whole thing.* (Anna)

> *The STOPP acronym is quite helpful and I put STOPP up on the whiteboard. S is for Stop… T is taking a breath. 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 because I'm actually in danger? Is it an opinion or is it a fact? The PP is to put things in perspective.* (Anna)

The midwives' interviews emphasised the importance of empathy, active listening, non-judgment and kindness in building rapport and trust with mothers. They also highlighted practical methods to alleviate distress, such as discussing self-care and encouraging mothers to write letters.

Connecting: "A wraparound type of approach"

This theme focused on how midwives support mothers by connecting them to mental health services, cultural resources and whānau. They emphasised the importance of linking to local community services and Māori healing practices, noting that a midwife's knowledge of available community support is crucial:

> *If there's a psychiatric history that mental health* [services are] *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, 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 we will keep monitoring that. If there is a multidisciplinary involvement already in her care, then we would link into those services as well and it'll be a wraparound type of approach to manage her ongoing care.* (Rachel)

Referring women to services that have a holistic approach to care was important to some midwives:

> *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)

> *You know, something is better than nothing and when you handle your tinana then ultimately you handle your hinengaro, so it's just giving us those solutions, and we would love a nice massage. We all love a nice massage.* (Rachel)

Mirimiri, a traditional Māori healing practice, was also described 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 have had some amazing, profound results for these ladies which has made their births healing. 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)

Some midwives emphasised referring mothers to services that offered a holistic approach, noting the positive impact on their clients. Those in smaller communities, where mental health services are limited, found that maintaining strong relationships with a variety of local service providers was especially beneficial.

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

> *Oh yeah one girl where I was worried, I still worry about her. She actually had all these networks involved with her and she just wasn't engaging in it… everyone was in her realm, but she wasn't taking up the help.* (Samantha)

> *So, we try to tap into their family or their own support network.* (Emma)

> *We just keep encouraging them.* (Samantha)

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

> *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 were gonna get this kid out of here, so we went shopping and we bought a laundry basket full of stuff for her,* [like] *clothes, pyjamas, and I think she cried, she was like, "I don't have anything"… Yeah, and we did that care package and then the kōrero was, "we need to get you out of here, babe," and so getting her to her family. So, we do that sometimes.* (Samantha)

Up-skilling: "It should be there for all of us"

A key theme was midwives up-skilling their practice. Some participated in mental health education, cultural workshops and family violence courses, and reflected their own te ao Māori journey to better support women in distress. Rachel shared that Māori health workshops helped her use Mātauranga Māori resources in her care for women:

> *I've done Mahi a Atua and I found that it was really good… it 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 Mātauranga Māori resources and artwork to help women.* (Rachel)

Courtney talked positively about the perinatal mental health workshops she'd taken and mentioned how important she believes education on mental health to be:

> *This workshop we had the other day was about lifting the veil of perinatal anxiety. I've been to different workshops from PADA* [Perinatal Anxiety and Depression Aotearoa] *and I have an interest in mental health because I think that's a really important subject. So, I think I've been getting quite a bit of education around that.* (Courtney)

Kate, a midwife who originally trained as a nurse, talked about the importance of mental health in her own training:

> *You know, it's a long time ago since I trained as a nurse, and had that component of mental health training, and these days, we have direct entry midwives that don't have any nursing background at all. It should be there for all of us, or for those of us to cope with some of the really distressing situations that we're exposed to.* (Kate)

Barriers: "You have to be at the bottom of the scale"

A final theme centred on barriers to referrals, with midwives facing challenges in accessing appropriate support for mothers experiencing emotional distress. They described issues with admission criteria and limited services. Courtney noted clear guidance on referral pathways for women who don't meet criteria would be helpful for midwives:

> *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* [the] *mental health* [services], *they can help with guiding me with where to send a woman.* (Courtney)

One midwife described how she felt that mothers were just being passed around within the referral process and how frustrating it can be when they 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 women just get pushed around and then they get hoha because it's another service coming in to ask the same questions and it may not be an appropriate resort.* (Rachel)

Rachel expressed frustration with culturally unresponsive services and those too stretched to meet mothers' needs. She described a situation where mothers had to have severe problems to receive appropriate help and, even then, services might not provide support if they didn't meet the criteria:

> *You find that right across the health sector it's just like you have to be really serious, to be able to get the service that you need.… 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. 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 and they only made three phone calls… their criteria is to ring them three times and if they don't answer, that's it. They're not going to pursue it.* (Rachel)

Midwives expressed concern about very limited maternal mental health services in some communities:

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

Samantha and Emma discussed how some of the women they work with may not 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 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 final theme highlighted the struggles midwives face in helping mothers access services, including gaps in mental health care, stigma and the complexities of young families' lives.

DISCUSSION

This study interviewed a sample of Aotearoa LMC midwives about tools and strategies they find most helpful to support the needs of the pregnant women they work with. The findings highlight the strategies and techniques they use to assist women experiencing emotional distress, while also identifying areas where these midwives themselves may require additional support. The themes that emerged from the midwives' stories reflected their values of care and empathy in their practice. Midwives shared how they relied on practical skills, such as active listening and offering validation and affirmation, to support women. Although there is a growing range of e-health tools and resources focused on perinatal mental health and wellbeing (Hennelly et al., 2020; McKellar et al., 2023), none of the midwives mentioned these tools, which may indicate a gap in up-skilling. Additionally, the complexity of referrals and access to mental health services emerged as a central frustration for midwives providing care for mothers.

Strategies and techniques

There are some particular strategies that were recommended by participants, such as breathing exercises, journaling and writing letters. There are also a number of online or mobile tools (Barber & Masters-Awatere, 2022; Just a Thought, 2023) that could be helpful to provide to women but were not mentioned in this study and may not be well known, even to midwives who are savvy about mental health. The Positively Pregnant app supports the mental and emotional wellbeing of pregnant women with tools for self-assessment, stress management and coping strategies to prevent antenatal and postnatal distress (Barber & Masters-Awatere, 2022). Knowing about the Positively Pregnant app allows midwives to offer a trusted tool they can recommend for self-reflection, early identification of distress, and ongoing mental health support between visits. It would be helpful to survey what books, applications and tools for emotional wellbeing are well-supported by research and could be useful for midwives to recommend to women with differing mental health issues that reflect their needs. It would also be helpful to identify potential barriers to accessing online or mobile tools.

Training in active listening, identification of perinatal mental health problems, and recognising the bi-cultural and multicultural needs of whānau were identified as priorities by participants in the Holden et al. study (2019). In Aotearoa, mental, physical, social and spiritual wellbeing are understood in diverse ways, reflecting Te Whare Tapa Whā model (Durie, 1994). Participants emphasised the importance of a holistic approach when recommending or referring wāhine Māori to culturally appropriate services, including traditional practices such as mirimiri and rongoā (Northland DHB, 2020).

"Wraparound" care in this study included the kinds of support midwives may provide that extend beyond their responsibilities, such as assisting with tasks like shopping or transport. For many midwives working within kaupapa Māori frameworks, these actions reflect manaakitanga and holistic practice. However, it often falls outside formal health system structures because it's not funded or expected within midwives' contracts and there are no extra resources allocated for it (Pairman, 2006). This also highlights the diversity in midwifery practice, and the extent to which some midwives go to support their clients.

Mental health services

The midwives in this study highlighted the significant challenges they face when attempting to make referrals and access mental health support services for women. Despite their best efforts to meet the needs of women in their care, it is a struggle to involve the mental health services when that seems the appropriate solution. It is evident that there is a strong need for clearer referral pathways and more accessible services within the maternal mental health sector, in line with recommendations from existing literature (Holden et al., 2019; Paterson et al., 2018; Ramalho et al., 2022). Previous research in Aotearoa has found that many midwives do not screen for mental health problems due to the lack of clear support pathways (Holden et al., 2019; Mellor et al., 2019). Midwives in this study had similar experiences with fragmented referral pathways. While these midwives were deeply committed to the emotional wellbeing of their clients, regularly asking the necessary questions and providing emotional support, they reported ongoing barriers to accessing mental health care. Midwives reported stigma and low engagement with mental health services among pregnant women, noting that some, despite clear emotional distress, were reluctant to seek help from these services. Efforts to involve support networks were often necessary, reflecting previous research highlighting barriers to access and reluctance to acknowledge symptoms (Button et al., 2017; Ford et al., 2019; Holden et al., 2019).

Providing mental health treatment falls outside the scope of midwifery practice, and it is not reasonable to expect midwives to possess extensive expertise in this area. However, it is inevitable that midwives will encounter women who are experiencing mental distress, and it is therefore essential for midwives to have knowledge of local mental health support services and how to access them. Additionally, midwives should be informed about options for women with mild to moderate symptoms who may not qualify for formal mental health services. Our participants found that compassionate care, active listening and a holistic approach were especially helpful in supporting these women.

Traditional Māori healing practices

The stories shared by the midwives highlighted the importance of culturally appropriate local healing practices and Māori-based providers in alleviating distress for wāhine Māori. Midwives emphasised the importance of a holistic approach to care, often incorporating traditional Māori healing practices such as rongoā and mirimiri. Māori midwives, in particular, highlighted the benefits of engaging wāhine Māori in these practices throughout their maternity care. Rongoā, which encompasses herbal remedies, physical therapies and spiritual healing, is a vital component of healthcare for many Māori. It adopts a holistic approach aimed at restoring wellness to the spirit, body, mind and emotional wellbeing (Marques et al., 2021).

Mirimiri, a traditional Māori form of healing, uses therapeutic touch, massage and spiritual connection to support wellbeing. It works by manipulating both muscle and energy, helping to release tension and physical and emotional trauma, and rebalance the body's mauri. Several midwives reported that these practices had a profound positive impact on wāhine Māori, particularly in helping to alleviate anxiety related to previous birth trauma and releasing physical discomfort experienced during pregnancy. While formal studies on the effectiveness of these interventions in reducing emotional distress are lacking – due in part to the challenges of measuring the outcomes of rongoā (Durie, 2010) – there has been growing recognition of the potential benefits of Māori healing practices. This includes their inclusion in Aotearoa's health system, as evidenced by support from the Accident Compensation Corporation (ACC, 2021).

Rural mental health care

Several midwives based in rural areas spoke about the lack of appropriate and accessible mental health services within their community, a challenge echoed in the current literature on rural health services (Adjorlolo et al., 2020; Bayrampour et al., 2018; Crowther et al., 2018; Galbally et al., 2023; Webb et al., 2021). These midwives highlighted the absence of clear referral pathways and barriers to accessing services, such as restrictive service criteria and reluctance to seek or accept help. Since most rural towns have access to wi-fi, it would be beneficial to raise awareness among midwives about the online tools available to support their clients. In addition to formal mental health services, midwives could consider other forms of support for mothers with mild to moderate distress, such as maternal support groups, peer connections with other mothers, and local community services. This underscores the critical role of community-based midwives, who are often familiar with the resources and options available in their local area.

LIMITATIONS AND FUTURE DIRECTIONS

This study faced several limitations, notably related to the COVID-19 pandemic, which significantly impacted the recruitment phase. The challenges of finding participants who had time available for interviews led to a smaller sample size than originally planned. Furthermore, the recruitment process was influenced by critical midwifery workforce shortages and the suspension of non-acute health services, which resulted in larger workloads for midwives (Crowther et al., 2021). These challenges led to a reliance on personal contacts, which, in turn, influenced the representation of Māori midwives and midwives working with Māori communities in the study. While this was not intended, the focus on Māori midwives and communities became a strength of the study. It would be valuable to explore whether the emphasis on cultural knowledge and the need for culturally safe services would be as pronounced in a sample of Pākehā or tau iwi midwives. Within this small sample, Māori midwives generally described a more in-depth use of tikanga Māori and culturally specific approaches, whereas non-Māori midwives emphasised cultural safety but at times noted limitations in their familiarity with kaupapa Māori models. Further research with a larger, more diverse group of participants would be needed to clarify these trends.

Future research should focus on understanding the specific needs of community-based midwives, both in Aotearoa and internationally, in terms of skills and resources they need to effectively support clients with mental health issues. Incorporating midwives' voices in the development of perinatal mental health support is essential to ensure that midwives feel equipped, supported and heard within their role. Additionally, a larger-scale study could investigate midwives' knowledge of, and attitudes towards, self-help tools for emotional wellbeing, which could further inform strategies for supporting mothers and improving maternal mental health outcomes.

CONCLUSION

The study highlights midwives' relational continuity of care as a key strength for supporting perinatal mental health. Their deep empathy and trust built with women underpin their role in mental health screening, advocacy and referral. Enhancing midwives' capacity, through targeted education, culturally appropriate resources and greater access to mental health services and resources, will help address existing gaps and build on these strengths. These findings reinforce the importance of equipping community-based midwives with the knowledge, skills and support needed to respond effectively to maternal mental health. Strengthening training, enhancing referral pathways and promoting culturally appropriate care are essential steps towards improving outcomes for mothers, babies and their whānau. A well-supported and informed midwifery workforce will be better prepared to navigate the complexities of mental health in the perinatal period.

DECLARATION OF INTEREST

The authors declare that there are no conflicts of interest.

GLOSSARY

Hinengaro	Emotional and mental wellbeing
Hoha	Annoyed or angry
Kaupapa Māori	Framework that is rooted in Māori culture, values and worldview
Kōrero	Conversation
Iwi	Tribe
Mahi a Atua	Indigenous framework of care
Manaakitanga	Hospitality, kindness, care
Mātauranga Māori	Māori knowledge
Mauri	Life force
Mirimiri	Traditional Māori massage technique
Ngāti Awa	Iwi based in the eastern Bay of Plenty region
Pākehā	New Zealander of European descent
Pepeha	Traditional Māori introduction
Rongoā	Traditional Māori healing system
Tau iwi	Non-Māori people of New Zealand
Te ao Māori	Māori worldview
Te reo Māori	The Māori language
Tikanga	Customary practices or principles
Tinana	Physical wellbeing
Wāhine	Women, females
Waikato Tainui	Iwi based in Waikato region
Whakapapa	Genealogy
Whakawhanaungatanga	Process of establishing relationships
Whānau	Family

KEY POINTS

- Midwives draw on empathy, active listening and trust to support mothers' mental health during the perinatal period.
- Strong community connections and Māori healing practices help midwives create holistic, culturally grounded care.
- Limited referral pathways and stretched mental health services remain significant barriers to timely support.

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