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AOTEAROA NEW ZEALAND RESEARCH

Women's experiences of living with maternal mental health conditions and accessing maternal mental health services in Aotearoa New Zealand

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ABSTRACT

Background: Maternal mental health (MMH) conditions affect 12-18% of women in Aotearoa New Zealand, with suicide being a leading cause of maternal death in the perinatal period. The intersection of social, psychosocial and health issues increases complexity in care requiring a multi-faceted approach. In New Zealand no formal national screening programme for MMH exists and the availability of guidance for best practice is variable.

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

Method: This qualitative study was guided by Thorne's interpretive description methodology. Seven women who had been diagnosed with MMH conditions in the Canterbury region of New Zealand participated in the study. Criteria for the study were that they had had a baby within the period 2020-2022 (during the COVID-19 pandemic); were not at that time pregnant or within the six-week postpartum period; had been referred to, or had accessed, MMH services; and had not required a transfer to obstetrician-led or psychiatric-led care. Semi-structured interviews were conducted to understand their experience.

Findings: Four main themes were identified: **Lifestyle challenges** such as preparing for parenthood, external factors and perinatal experiences; **The impact of relationships** such as whether they were helpful or unhelpful; **Burden carrying**, including being labelled as a bad mother, self-blame and needing advocacy from support people; and **Logistics of access**, including the impact of education, barriers to accessing care and the experience of services.

Discussion: The findings acknowledge the impact that education, screening and referral to MMH services have on women. By the women being better prepared for parenthood, and by open discussion about MMH conditions being encouraged, the stigma felt by new mothers could be reduced. The study highlights that midwives are in a good position to screen and educate women about MMH conditions. Despite this being a small regional qualitative study, findings clearly indicate how consideration must be made to addressing barriers to accessing care, to fostering collaboration amongst health professionals, and to providing midwives with compulsory New Zealand-specific MMH education and screening tools. As this was a small study in one region, further countrywide research in this domain is urgently required.

Conclusion: This study concludes that midwives play a crucial role in MMH care through education, screening and referral. Addressing barriers to care and standardising screening tools can improve quality and accessibility of MMH services and improve health outcomes for New Zealand women.

Keywords: mental health, Aotearoa New Zealand, mothers, experience, midwifery

BACKGROUND

Aotearoa's midwifery system operates under a unique, government-funded model that emphasises autonomy and continuity of care. Midwives complete a four-year Bachelor of Midwifery degree and usually work either as hospital-employed midwives or as community-based, self-employed Lead Maternity Carer (LMC) midwives (Eddy & Tracy, 2023). Hospital midwives provide care within rostered shifts and may also work in continuity models, while LMC midwives offer full primary maternity care from early pregnancy until six weeks postpartum, working both autonomously and collaboratively with other health professionals (Eddy & Tracy, 2023). Partnership with women and their families is central to midwives working in either role, underpinning education, shared decision-making and support throughout the childbirth continuum (Dixon, Daellenbach et al., 2023; Eddy & Tracy, 2023). The term "women" is used throughout this study; however, the researchers acknowledge that not all people who experience pregnancy identify as women. The use of this term is not intended to exclude individuals who identify as gender diverse.

Maternal mental health (MMH) conditions affect 12-18% of

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New Zealand mothers and suicide is the leading cause of death for women in the perinatal period (Ministry of Health, 2021; Perinatal and Maternal Mortality Review Committee [PMMRC], 2022). MMH conditions include, but are not limited to, anxiety, depression, psychosis, bipolar disorder and post-traumatic stress disorder. Consequences for women who have MMH conditions include potential suicide, living with conditions such as anxiety and depression, and significant relationship breakdown (Stein et al., 2014). There is also significant potential for health consequences for babies; these include an increased risk of low-birth-weight babies and premature births (Langham et al., 2023; Voit et al., 2022).

Women in New Zealand have increasing complexity in their social and psychosocial health needs. These include increased rates of family violence, poor housing and substance abuse (Bird et al., 2021, Black et al., 2020, Ministry of Health, 2021). Compared to other women, those who experience complexity also have increased rates of disability and previous birth trauma, due to less accessibility to healthcare and the current MMH system not being equitable (Ministry of Health, 2021). Although there is some detail on the nature and extent of increasing complexity in the commentary of the available sources, these commentaries only provide generalised comments about the increases without explicit defined causation. The current MMH system in New Zealand has been designed using a European health model. Women of Māori, Pasifika and Asian ethnicities are less likely to access services than European women (Holden et al., 2019; Ministry of Health, 2021); yet Māori women are 2.91 times more likely to commit suicide in the perinatal period than women of other ethnicities (PMMRC, 2022). In Aotearoa, there are no official recommendations for how or when to screen for MMH conditions. The Ministry of Health (2021) suggests early intervention and screening using the Edinburgh Postnatal Depression Scale (EPDS) if midwives have concerns but acknowledges that MMH screening in Aotearoa is inconsistent and without formal guidance.

In the United Kingdom, MMH screening is recommended during early antenatal and postpartum periods (National Institute for Health and Care Excellence [NICE], 2020), using questions similar to those suggested by the New Zealand Ministry of Health (2021). In addition, UK midwives are also encouraged to include the Generalised Anxiety Disorder 2 item (GAD-2) for anxiety. Australia advises maternity care providers to use the EPDS at booking, later in pregnancy, 6-12 weeks postpartum, and again within the first year (Australian Clinical Practice Guideline, 2023).

The current midwifery education for MMH screening is inconsistent across Aotearoa. Different regions also use various documentation systems. Although many hospitals use Badgernet (Health Informatics New Zealand, 2021), which includes some MMH screening questions for the midwife to complete, in the Canterbury region, some LMCs use Badgernet, although Christchurch Women's Hospital currently does not, and offers no routine MMH screening. Some MMH education is provided in undergraduate midwifery programmes, and a postgraduate course is available at Otago Polytechnic and was previously available at Auckland University of Technology, although the effectiveness of this education remains unevaluated. No ongoing MMH training is currently provided by the New Zealand College of Midwives or mandated by Te Tatau o te Whare Kahu | Midwifery Council (New Zealand College of Midwives, n.d.; Te Tatau o te Whare Kahu | Midwifery Council, 2024).

The current New Zealand health sector is poorly equipped to support women with MMH conditions (Ministry of Health, 2021). This 2021 Ministry of Health report explored what MMH services were available in each region of New Zealand and found that psychosocial and mental health needs are increasing for women, whilst services are inequitable due to multiple barriers to access. These barriers included strict referral criteria, few equipped health professionals able to refer to services, and geographical isolation.

A systematic scoping review was undertaken to understand the extent of information that is available in New Zealand and overseas (Taynton et al., 2024). This review identified key themes, including barriers women face in accessing MMH care. Fear and stigma – especially from healthcare providers and peers – were major deterrents to seeking help (Ford et al., 2019; Higgins et al., 2016; Mellor, 2016; Oh et al., 2020; Taylor et al., 2019). Many women also felt that having MMH issues made them a "bad mother," further discouraging disclosure (Baldisserotto et al., 2020; Hore et al., 2019; Law et al., 2021; Oh et al., 2020; Viveiros & Darling, 2018). Antenatal education on MMH requires review, as many women felt unprepared, while midwives reported insufficient training to confidently screen or discuss MMH (Koire et al., 2022; Law et al., 2021; Mellor, 2016; Savory et al., 2022). Trusting relationships with healthcare providers or peers, and strong support networks, increased the likelihood of women disclosing MMH concerns (Ford et al., 2019; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Oh et al., 2020; Savory et al., 2022; Viveiros & Darling, 2018). System-level barriers – such as referral difficulties, lack of clear pathways and long wait times – limit access to care. Alternative approaches, like digital tools, drop-in sessions or support groups, may help improve accessibility (Koire et al., 2022; Viveiros & Darling, 2018).

The systematic scoping review clearly indicated several gaps in the New Zealand literature, requiring a dedicated programme of MMH research. To contribute to this programme, a regional study was proposed that focused on the experiences of women in the Canterbury region of being diagnosed with MMH conditions and accessing supports.

AIM

This study investigated the experiences of women being diagnosed with MMH conditions and accessing MMH services in the Te Whatu Ora - Waitaha Canterbury region, in the South Island of New Zealand. Research questions were:

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

METHOD

The study was guided by the qualitative methodology of interpretive description (ID) developed by Thorne et al. (1997). Interpretive description methodology focuses on understanding a clinical phenomenon through identifying themes and patterns, culminating in an increased awareness of the phenomenon and leading to the generation of a practical application for the clinical setting (Betero, 2015; Thorne, 2016; Thorne et al., 2004).

Ethical approval was granted by Auckland University of Technology Ethics Committee on 18 July 2022, AUTEC Reference number 22/151, with cultural support from Māori Midwives ki Tahu to ensure the research was appropriate and safe for Māori. Written informed consent was obtained and all data were anonymised. Participants were recruited through clinical and community MMH providers and general practices in Canterbury, using posters

and flyers. Māori and Pasifika health providers were included to support diverse recruitment. At the time of the study there were no MMH services or support groups specifically for gender-diverse people in the region.

A purposive sample of seven women with mild to moderate MMH conditions, and who had accessed services, participated. All were former clients of a community organisation providing clinical MMH support. Study information and eligibility criteria were emailed to previous clients, and interested participants contacted the primary researcher (ST) directly. Eligibility criteria included: aged ≥ 18 years, English-speaking, having had a baby during 2020-2022 (which happened to be during the COVID-19 pandemic), not currently pregnant or within six weeks postpartum, and having accessed MMH services without requiring transfer to obstetrician-led or psychiatric-led care. Participants lived in urban and rural areas, had different LMC midwives, and none had received hospital-led midwifery care. Participant characteristics are shown in Table 1.

Table 1. Participant characteristics

Category		No.
Age		
	25-30 years	2
	31-35 years	4
	36-40 years	1
Ethnicity		
	New Zealand European	4
	Other European	2
	Indian/Asian	1
	Māori	0
Parity		
	1 child	2
	2 children	4
	3 children	1

Individual semi-structured interviews were conducted by the primary author, a midwife, using open-ended questions aligned with the study aims (Table 2). Interviews were conversational, with prompts used as needed. Participants chose the interview location.

Table 2. Questions and prompts used in interviews

Can you tell me about the experience of when you were diagnosed with a maternal mental health condition?
How did this experience make you feel? Was there anything about that experience that was significant for you?
Did you feel that maternal mental health services were available to you?
What did you know about mental health services?
Could you tell me what the experience of accessing maternal mental health services was like for you?
Was this a positive or negative experience for you?
What would you change for women in the future accessing maternal mental health services?

Written and verbal consent were obtained prior to interviews. Participants could pause or stop at any time and were given contact details for free counselling. Interviews were conducted in English, audio-recorded on two devices, transcribed verbatim using Otter AI, then checked by the primary researcher. Participants selected pseudonyms and were offered the opportunity to review their transcript; five accepted and requested no changes.

Field notes recorded reflections and emerging ideas (Thorne, 2016). Analysis occurred alongside data collection (Thorne et al., 1997). Transcripts were coded and organised in Microsoft Visio, with themes reviewed by the two additional authors (NW and SC) to support credibility.

FINDINGS

The women in the study reported that having a diagnosis of MMH impacted on many aspects of their lives. These were identified from the data as four main themes and eleven associated sub-themes (Table 3).

Table 3. Main themes and associated sub-themes

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

Lifestyle challenges

Preparing for parenthood

Lifestyle challenges were one of the key issues participants identified as contributing to their MMH experiences. A prominent sub-theme discussed by several participants was preparing for parenthood. Sophie emphasised the importance of preparation, stating: *Preparedness is really important for mental wellbeing and for building resilience.* In addition, Dolly highlighted how societal expectations can place unrealistic pressure on new mothers: …*those society norms that were put upon us that crushed us with* [first baby]. *It crushed us…* [yet] *it's okay to be an okayish mother and have an okayish day and just survive, take the pressure off.*

For Dolly, reducing these expectations and allowing herself to simply "survive" the early newborn period were protective for her mental health. Many participants described feeling unprepared during their first pregnancy, yet reported greater confidence during subsequent pregnancies, including feeling more able to advocate for their health needs. However, for some women, previous MMH experiences also created apprehension about future pregnancies. Amy, for example, described feeling anxious about the postpartum period with her second child, referring to pregnancy as "the calm before the storm".

Participants also acknowledged the significant relational changes associated with becoming a parent, as well as the impact that MMH conditions can have on relationships. Dolly emphasised the importance of partner support, stating: *And actually, the only way you're going to survive having kids is having a strong relationship.*

Several participants felt that they had received insufficient information about postpartum recovery, which contributed to feelings of unpreparedness. Sophie reflected: …*like it makes me mad at previous generations of women. Because no one told me… I'm a highly educated person and I didn't know it.*

External factors impact MMH

External factors also influenced women's MMH experiences. For three women, the COVID-19 pandemic significantly limited access to social support during pregnancy and the postpartum period. These women described deliberately restricting contact with others to minimise the risk of infection for themselves and their newborns. While this decision was made to protect physical health, it also resulted in increased social isolation during a time when emotional and practical support are often most needed.

In addition, New Zealand's national COVID-19 lockdowns prevented whānau members from travelling to visit or provide assistance following the birth. As a result, women were unable to access the practical help, shared caregiving and emotional reassurance that extended family often provide during the early postnatal period. For some women, this absence of support increased feelings of loneliness, exhaustion and being overwhelmed while adjusting to the demands of caring for a newborn and recovering from childbirth. These experiences highlight how broader societal disruptions, such as the pandemic, can intensify existing vulnerabilities in the perinatal period and further impact maternal mental health.

Perinatal experience shaped the postpartum period

Several women felt that their perinatal experience – particularly their birth experience – significantly shaped the postpartum period and their subsequent mental wellbeing. For Trish, Roxanne and Kate, giving birth was described as disempowering and traumatic, which created a challenging transition into the postnatal period. These experiences contributed to feelings of fear, confusion and emotional distress immediately following birth. Kate explained:

> *I guess it's all just such a whirlwind. You go through labour and you don't know what's happening, then you have an emergency c-section and you don't know what's happening, and baby's not well and you don't know what's happening… then you go onto the ward and you still don't know what's happening. It's a feeling that you're out of control because it's so routine for everyone at the hospital… but for us it's our first time… it's just like, whoa, very overwhelming.*

Infant feeding was another emotionally significant issue raised by participants. Charlie described poor communication with her healthcare provider (HCP), which left her feeling dismissed when she experienced breastfeeding difficulties: *You get it this kind of shoved down your throat that breast is best, but when you actually really want to and you're having trouble, nobody cares.* Other women similarly described breastfeeding challenges as negatively affecting their mental wellbeing. Dolly reflected: *I remember crying in the corner when* [husband] *fed him his formula bottle and I just felt so useless. And again, I thought these were normal feelings that you feel during motherhood.* Charlie also reported feeling judged for using formula, stating that she perceived a message that only: *second-grade parents give formula.*

The impact of relationships

The impact of relationships was acknowledged by many of the women, as it affected their MMH condition. Within this theme it was identified that relationships can be unhelpful or helpful.

Unhelpful relationships

Participants identified that they had experienced unhelpful relationships when attending mothers' groups and/or during encounters with HCPs. They felt some mothers' groups were "toxic" and not a safe space to be vulnerable. Dolly experienced a lot of comparisons occurring between mothers and babies in her mothers' group: *You enter in this weird competition between mothers when you have a baby, to see who the best mum is.*

The manner of healthcare professionals played a crucial role in whether women felt comfortable sharing their MMH concerns. Many expressed anxiety about how providers might respond. Trish, for example, would carefully "test the waters" by hinting at her struggles before fully opening up. Some women felt dismissed or overlooked, which discouraged them from speaking honestly. For those who did share, it was often because they had built a trusting relationship with their HCP.

Helpful relationships

An aspect that contributed towards having helpful relationships was sharing and validating experiences with others. Amy describes this need to share:

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

Dolly also felt the importance of sharing:

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

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

Burden carrying

Bad mother

The women described experiencing a heavy emotional burden associated with their MMH conditions, alongside a persistent fear of being perceived as "bad mothers". This fear often shaped how they presented themselves to others and influenced their willingness to disclose their struggles. Several participants described deliberately concealing the extent of their distress from friends and family, feeling pressure to appear as though they were coping well with motherhood. For some, "presenting well" was a way of maintaining a sense of control and protecting themselves from potential judgement or stigma. Other women described withdrawing from others entirely, as Charlie explained: *I isolated myself. I wasn't in a mental health position to be social*. Her experience highlights how MMH challenges can lead to social isolation, further reducing opportunities for support during the perinatal period.

Self-blame

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

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

Kate also felt overwhelmed as she struggled with her new babies and her mental health: *Parenting is not easy, for anyone, whether you struggle with mental health or not. Just to add that on top of it, just makes everything just unmanageable. Makes it feel impossible.*

Amy felt the same: … *it affects everything you think it will and more, it's an overwhelming shift. And even for me the wave of the depression and how heavy that is and how consuming it can be as well.*

Questioning her decision to become a mother, because of the burden of being mentally unwell, Kate shared:

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

Support people to advocate

The perceived need to not burden support people was felt by many of the women. Sophie described: *It's not fair to talk to my husband about it... like someone doesn't want to hear your issues all the time.* Other women also did not want to share about their condition with family or friends as they did not want to burden them.

Many of the participants suggested that having others advocate for their mental health and accessing support were of upmost importance. Charlie valued her MMH support worker and husband advocating for her:

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

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

Logistics of access

The impact of education

Education from midwives, other HCPs or antenatal childbirth educators impacted access to MMH support for the participants. The participants felt that they had not been provided with any, or enough, information about MMH conditions, what to look for and how to access support if they needed it. Trish shared: I *did not realise how common it was…I think we were told maybe 1 in 10* [get a MMH condition], *you're like, oh yeah, there's someone in this room but it won't be me*.

Kate described how she was not provided with any information about MMH services: *I'd heard about post-natal depression before... it's kind of different when you're in it yourself... you don't have the capacity to figure out how to access services*.

For Kate, lack of early targeted screening delayed support for her mental health concerns:

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

Barriers to accessing care

Participants reported encountering several barriers when attempting to access services, particularly long wait times. Roxanne described feeling that she had already delayed seeking support for her mental health, only to feel discouraged upon learning that the waiting list for services was several months long. As she reflected: *Two months... is a long time in a baby's life… and the days feel very long*. Kate reported a similar experience, describing the waiting period for MMH services as especially challenging: *The first three months were pretty horrific* [waiting for MMH services]. Sophie waited four months to see a MMH worker and felt challenged when she was seen: *But I did feel slightly guilty... because I knew there's a woman out there right now that needs you, like, I needed you four months ago and now I'm taking up your time. So, I felt guilty about that*.

Experience of services

The experiences of accessing services were varied among the participants. Several of the women were referred to psychiatric services when primary MMH services could no longer support them due to their worsening condition. Charlie shared how she received a rejection letter from the psychiatric service in the mail and exclaimed: *I'm on my own now*. Sophie too felt shocked by her rejection letter: *And I was like, oh, okay, so no one cares*. Both women felt abandoned by the psychiatric service as they required more support than what could be provided by primary clinical MMH care.

The women felt that MMH services in Aotearoa needed to be reviewed, with a focus on improving accessibility. Solutions they put forward included increasing funding to existing services to shorten wait times, and consideration of alternatives, such as the use of digital MMH services.

The women were shocked that MMH services were not available in all regions of New Zealand. Dolly described her surprise:

> *I'm surprised that Christchurch is the only place in New Zealand that offers this [clinical MMH service]. Really surprised, I think this should be national. And I think it should be brought up for every pregnancy regardless of the fact that you've got a predisposition to it or not. I think it should be just there.*

Despite the challenges reported above, women in the study shared mostly being happy with the support received from the MMH service they engaged with. They appreciated the advice, the support and being taught coping mechanisms that they found to be valuable. As Sophie stated referring to the clinical MMH service: I *felt like someone cared!*

DISCUSSION

The findings indicate that multiple factors shaped these women's experiences of accessing MMH services. Many felt unprepared for parenthood, reporting that information from healthcare providers and antenatal education were inadequate and that societal expectations of motherhood were unrealistic. Although much of the available literature on this topic originates from the United Kingdom and differences exists, it is relevant to the New Zealand maternity system. Antenatal education should better reflect women's needs during the transition to parenthood (Jones et al., 2019). Reviews of antenatal education have also noted limited attention to maternal mental health (Barrett et al., 2022; Larkai et al., 2025). Partners reported mixed experiences of antenatal education and often felt excluded, as classes largely focused on the woman and baby (Smyth et al., 2015). Greater inclusion and support for partners may improve their wellbeing and strengthen their ability to support women and infants. This was reflected in this study, where women valued their partner's support and advocacy during experiences of MMH difficulties.

The COVID-19 pandemic had a lasting negative impact on the women interviewed, increasing feelings of isolation due to reduced social contact and restricted access to support people. This finding is supported in New Zealand research on women's experiences during the COVID-19 pandemic. Women reported feeling stressed, anxious and isolated from support people; however, guidance from midwives was valuable (Dixon, Jackson et al., 2023, Sakalidis et al., 2021).This mirrors global findings showing a rise in maternal anxiety and depression during the pandemic, linked to limited support and reduced MMH services (Barbosa-Leiker et al., 2021; Cameron et al., 2020; Davenport et al., 2020). As a result, many women around the world experienced untreated MMH conditions with minimal support.

A participant described a subsequent pregnancy as the "calm before the storm" and highlighted the importance of asking pregnant women about their history of mental health in previous pregnancies. New Zealand Guidelines Group (2008) recommended (in a now-archived guideline) that all HCPs inquire whether women have a pre-existing mental health condition, family history of mental health conditions or previous mental health condition in the perinatal period. This allows insight into the type of preventative care women may need and how best to support them (Wilkinson et al., 2022). It is important that HCPs are familiar with what support services are available in their area. Clear communication from health care professionals and having an opportunity to debrief birth experiences are important parts of postnatal care (Waller, 2019). This may have enabled participants in our study to have a deeper understanding of their experience. The incidence of post-traumatic stress disorder may be reduced if women can debrief their birthing experiences and/or are offered counselling (Abdollahpour et al., 2019; Baxter, 2019). At Christchurch Women's Hospital, a birth afterthoughts clinic was created in 2023. This service is led by midwives who have additional counselling education and an interest in birth trauma. Through this clinic and having the opportunity to discuss their birth, women are able to feel heard and to process their birth experience (Te Whatu Ora - Waitaha Canterbury, 2023a).

There was an overlap of sub-themes between participants who felt dismissed by HCPs (unhelpful relationships) and those who described increased self-advocacy in subsequent pregnancies (preparing for parenthood). This highlights the complex needs of women during the perinatal period. For some participants, feeling dismissed prompted them to draw on internal resources and become more confident in advocating for their health needs in later pregnancies. However, not all women have the capacity or confidence to self-advocate, placing them at risk of worsening MMH. Relationships with HCPs are therefore critical, as they influence women's willingness to disclose concerns and engage with care, a finding also supported in the literature (Ford et al., 2019; Oh et al., 2020; Pilav et al., 2022).

Breastfeeding can be a source of postpartum stress and guilt, particularly when women are unable to meet their breastfeeding expectations (Russell et al., 2021). One participant described the belief that "only second-grade parents give formula", reflecting stigma linked to perceptions of poor motherhood and adverse maternal mental health (Jackson et al., 2021; Pilav et al., 2022). Reduced support during the COVID-19 pandemic may have exacerbated these experiences (Atchan et al., 2023; Dixon, Jackson et al., 2023). Support for women to achieve their preferred feeding outcomes is associated with improved maternal mental health (Brown, 2018). These findings highlight the importance of antenatal education, external influences and postnatal support in shaping feeding experiences.

The impact of relationships both helpful and unhelpful was evident in the findings in this study. "Toxic" mothers' groups and the "best mum competition" were used to describe how a participant felt about her mothers' group not being a safe space to share her MMH concerns. This is supported in the literature as women are unlikely to disclose their MMH concerns to other mothers for fear of judgement (Law et al., 2021; Oh et al., 2020). Conversely, the opposite is true when women have good supportive friends and other support people. The affirming impact of sharing has been shown previously as women with strong support networks are likely to look to these networks for support during times of mental health issues (Oh et al., 2020; Savory et al., 2022).

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

The importance of education about MMH conditions was raised by several women in this study who felt the antenatal education they received was inadequate. This is reflected in other studies that also indicate the importance of women being provided with MMH information, including the signs and symptoms and how to access support if it is needed (Koire et al., 2022; Law et al., 2021). It is concerning that the women in this study report that their midwives did not screen them for MMH conditions. Assessing for risk of postnatal distress is a compulsory aspect of care in the perinatal period under DA53 Service specification: Postnatal care (1)(c)(ii) of the Primary Maternity Services Notice (formerly Section 88) (Primary Maternity Services, 2021). Therefore, it could be argued that the experience of the women in our study, of not being screened, reflects inadequate (or a gap in the) MMH education midwives currently receive.

In the context of Aotearoa, midwives have two challenges to provision of appropriate MMH care: firstly, midwives are not provided with any compulsory MMH education post-registration and, secondly, are only able to refer to community MMH services such as GPs and primary MMH services (should such services be offered in their locale). They are unable to refer directly to secondary psychiatric MMH services (Mellor, 2016; Te Whatu Ora Health New Zealand, 2023b). The lack of education contributes to midwives having a perceived low confidence when screening and referring women for MMH conditions (Mellor, 2016). However, it is suggested that midwives offer the EPDS questionnaire if they have MMH concerns (Ministry of Health, 2021). Within a New Zealand context, the EPDS has been validated for use within the Samoan and Tongan community (Ekeroma et al., 2012). However, it has not been validated for Māori, which is relevant to obligations under Te Tiriti o Waitangi and connects with deficiencies identified in the Wai 2575 report (Waitangi Tribunal, 2023).

In Aotearoa, MMH services vary between regions, with most services being in main cities and only accessible to the women who live there. This has been acknowledged as an issue by the Ministry of Health (2021). Koire et al. (2022) also identified distance and transport as barriers to women receiving MMH care and suggested digital MMH psychotherapy to mitigate these barriers. Other barriers such as long waitlists to MMH services also affect New

Zealand women (Ministry of Health, 2021). This is comparable to literature overseas where access to MMH services is often impacted by long waiting times, resulting in deterioration of women's mental health whilst waiting (DeRoche et al., 2023; Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018).

This research echoes the findings of the recent scoping review by Taynton et al. (2024). The scoping review identified broad international barriers such as stigma, fear of judgement, inconsistent screening and limited-service accessibility. This study offers a more contextualised understanding of how these issues are evident within the Aotearoa New Zealand health system. In addition, it highlights sub-themes not included in the scoping review, including the influence of birth trauma, breastfeeding pressures, isolation related to COVID-19, and the emotional burden of "carrying" MMH symptoms while attempting to maintain the appearance of coping. There were system barriers such as inconsistencies in screening practices, long waitlists and the limited referral pathways available to midwives. This research links systemic issues to personal stories, providing a deeper, more practical look at the problems in MMH care. Overall, our findings add emphasis to the urgent need for consistent national MMH screening, better training for midwives and equitable access to services throughout New Zealand.

STRENGTHS AND LIMITATIONS

This study demonstrated a trustworthy and ethical process, offering valuable insights into our participants' experiences of accessing MMH support. However, several limitations were evident. While it offers meaningful understanding of a group of women diagnosed with MMH conditions in the New Zealand context, caution is needed in generalising from a small regional study. The aim was not to provide generalisable findings, but rather transferable insights to inform further region-specific research and bespoke recommendations. Several participants identified that COVID-19 reduced their MMH and family support, therefore this may have impacted their MMH condition. Despite wide recruitment efforts, there were no Māori, Pasifika, single or gender-diverse participants. Nonetheless, the study generated insightful findings, increased awareness for women and HCPs and practical suggestions applicable to similar contexts and future research.

CONCLUSION

The findings of this study provide an opportunity to understand the experiences of a sample of the women who are diagnosed with MMH conditions and who have had access to MMH services in Canterbury, New Zealand. Consideration must be made to explore differences in services' accessibility within other regions in New Zealand and across other ethnicities, especially Māori. This study contributes to the knowledge that there are many factors that can impact and improve outcomes for women, including more robust education for HCPs, screening women for MMH conditions, understanding the importance of de-briefing birth or other potentially traumatic situations, and considering how infant feeding information is presented. There is clearly a need to monitor how prepared women are for parenthood. Through antenatal education, robust and honest information can be provided to women about how to maintain mental wellness, how to identify issues with their mental health and how to address these. It is crucial that the voices of women stay central to co-designing MMH service provision.

KEY POINTS

- The lack of current MMH screening guidelines for midwives leads to inconsistent screening timing, approaches and support from midwives for women.
- Stigma, fear of censure, self-blame and logistical issues hinder access to MMH care; supportive relationships and education help improve experiences.
- Training for midwives and nationwide research are needed to standardise and improve access to care across Aotearoa New Zealand.

DECLARATION OF INTEREST

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