WILEY | Hindawi

Research Article

Missed Opportunities for Addressing Maternal Mental Health: A Thematic Analysis of Mothers' Experiences of Using the Well Child Tamariki Ora Service in Aotearoa NZ

Bethany Clapham,[1,2,3] **Mary Breheny** ,[1,2,3] **Angelique Reweti** ,[1,2,3] **Christina Severinsen** ,[1,2,3] **and Felicity Ware** [1,2,3]

[1]*Massey University, Tennent Drive, Palmerston North, New Zealand*
[2]*Te Herenga Waka, Victoria University of Wellington, P.O. Box 600, Wellington 6012, New Zealand*
[3]*Hāpai te Hauora, Māori Public Health, P.O. Box 21-933, Henderson, Auckland 0650, New Zealand*

Correspondence should be addressed to Angelique Reweti; a.reweti@massey.ac.nz

Maternal mental health plays a vital role in the overall wellbeing of mothers, children, families, whānau (core support network) and communities. However, many mothers face mental health challenges during the transition to parenthood. In this study, we used an online story-sharing platform to collect the experiences of mothers who have faced unmet needs while using the Well Child Tamariki Ora (WCTO) service in Aotearoa New Zealand. From the 420 submitted stories, 125 stories related to mental health need while using the WCTO service. Using thematic analysis, we identified three main themes that highlighted the experiences of mothers with the service. This includes (1) making it seem that I'm coping: Mothers' fear of being judged; (2) i wish I had connected with my WCTO nurse: Fostering meaningful relationships to facilitate personal information sharing; and (3) beyond the baby: Mothers desire for recognition and support during WCTO visits. These findings point to several missed opportunities for WCTO providers to inquire about mental health and offer support needed by mothers. To address this, a relational approach to care would prioritise families and whānau as the focus of care rather than just monitoring the development of babies.

1. Background

The mental health of mothers is significant for the wellbeing of parents, children, families, whānau (core support network) and communities [1]. The transition into parenthood brings profound emotional, physical, spiritual, and relationship changes as mothers assume responsibility for their baby's growth, birth, feeding, and nurturing [2]. Establishing a secure physical and emotional connection with the baby requires additional effort to regulate emotions and can significantly impact the caregiver's well-being [3]. This vulnerability can extend from pregnancy to the early years of the child's life, influencing maternal physical, emotional, and mental health [3, 4]. Maternal mental health

is the ability to function productively, contribute to the community, and cope with normal life stressors [2]. Mental distress, including depression and anxiety, is experienced at varying levels by many mothers [2, 5, 6]. Mothers can face unique challenges, experiencing changes in identity and a sense of sole responsibility for their child's short- and long-term health outcomes [2]. However, each mother's experience of pregnancy and parenthood is unique, underscoring the importance of responsive service provision and early detection.

In Aotearoa, New Zealand, 12–18% of expectant mothers are likely to experience mental distress such as depression or anxiety during the perinatal period [7]. This incidence is higher among women of non-European descent, with Māori,

Pasifika, and Asian women more prone to antenatal depression than Pākehā women [8]. Māori women have the highest rates of maternal suicide [9], while Pasifika women have the highest rates of antenatal depression [10]. The impact of the transition into parenthood on maternal mental health is influenced by a diverse array of protective and risk factors, many of which are interconnected and systemic and have cumulative and complex effects [7, 11]. Protective factors, such as access to safe and affordable housing, secure support networks, education, freedom from violence, regular income, and secure employment, play a vital role in supporting mental health [12].

For mothers who experience threats to these basic needs through poverty, relationship breakdown, illness, violence, or substance abuse, the risk of experiencing trauma and distress is significantly higher [5, 6]. Low social support has been consistently linked to postnatal depression and anxiety [4]. This not only affects them as mothers but also impacts their families, whānau, and wider relationships [5, 13]. Mothers with a history of pregnancy-related trauma, adverse childhood experiences, or previous mental health problems face an elevated risk of distress, and they may revisit previous trauma during this time [5, 12–14]. Challenges faced during the postpartum period can also contribute to distress. Complications during childbirth, poor hospital experiences, ongoing difficulties with breastfeeding, increased sleep deprivation, and a lack of instant connection with the baby can all contribute to the emotional burden [6].

For Māori mothers, the impacts of colonisation and racism, intergenerational trauma, and historical experiences with paternal systems add additional layers of complexity to their caregiving experiences [15, 16]. The ongoing effects of historical injustices, marginalisation, and discrimination can profoundly impact the mental wellbeing of Māori caregivers, making them more vulnerable to distress and trauma during the postnatal period and less likely to seek support from state-mandated support structures [16, 17]. Moreover, the legacy of colonisation has led to Māori being disproportionately affected by violence, both as victims and perpetrators, particularly in domestic settings [18, 19]. Violence during and after pregnancy not only presents immediate dangers but also contributes to ongoing cycles of trauma, negatively influencing the mental well-being of whānau and their children [19]. Experiences like these contribute to the many health inequities Māori encounter across different health services in Aotearoa, New Zealand, including maternal mental health.

1.1. Mental Health Services. Early interventions to support maternal mental health are key as they can positively influence prenatal development, the connection between primary caregiver and baby, the mood and functioning of mothers, and parental self-efficacy [5, 6]. There is also increasing evidence that supporting babies and their families and whānau in the first 2,000 days of life, extending from conception to a child's second birthday, is crucial for the lifelong physical, emotional, and psychological wellbeing of people [3, 20–22]. Having patients, families, and whānau at the centre of care has been widely recognised, as one of the

key priorities for the future of mental health services [23]. To meet this goal, mental health service providers, both inside and outside the healthcare sector, will need to prioritise building relationships and understanding the people they are supporting in the context of their personal experiences, their families, their whānau, and their communities [23].

In Aotearoa, New Zealand, maternal mental health struggles are suspected to be under-recognised due to various factors, including inadequate screening methods, limited data, insufficient mental health services, and inadequate education [3, 5, 6, 24]. A recent report by the Ministry of Health [1] highlighted concerns regarding low numbers of non-European women accessing maternal mental health services, particularly young and high-risk women. Limited referrals to specialist mental health services are likely to be linked to limited primary healthcare uptake among Māori and Pacific caregivers [1]. Mainstream mental health services are often based on monocultural and biomedical processes, which marginalise and exclude other worldviews, resulting in significant inequities, particularly for Māori [7, 25]. This failure to honour Te Tiriti o Waitangi (In Aotearoa New Zealand, Māori (the Indigenous peoples) have a national treaty negotiated with the colonising British Crown. The treaty, Te Tiriti o Waitangi, guarantees continued Māori sovereignty, protects Māori interests, promotes Māori wellbeing, and guarantees the Crown limited kāwanatanga (governance)) obligations of kawanatanga (good governance, policies, and service provision that contributes to the health and wellbeing of all in Aotearoa) and ōritetanga (the rights of Māori to equitable health outcomes as the Indigenous people of Aotearoa) is evident. Although efforts have been made to incorporate broader cultural values and beliefs into mental health practices since the 1980s, recent data suggest that mental health challenges and support needs may be more widespread and complex than indicated by referrals and diagnoses alone [1, 3, 5, 12]. This evolving landscape calls for a comprehensive and culturally responsible approach to effectively address the maternal mental health needs in Aotearoa, New Zealand.

1.2. Early Intervention Programmes. The Well Child Tamariki Ora (WCTO) programme, led by the Ministry of Health, is a series of government-funded health checks and services in Aotearoa, New Zealand. It is a universal service available to all children and their families from birth to age five years, delivered by Whānau Āwhina Plunket and other non-governmental organisations, such as iwi-led (The term "iwi" in Māori refers to tribes or extended kinship groups, which are significant social units in Māori society with their own leadership, customs, and territories.) organisations that take an indigenous approach to parallel service provision [5, 20]. Service delivery is guided by a national schedule that indicates the timing and content of the programme, which includes screening for symptoms of postnatal depression [20, 26]. The lead maternity provider (midwife or specialist who provides maternity care) can refer the mother and baby to other services, such as specialist maternal mental health services, if they deem it necessary [1, 5]. The programme has

a core commitment to achieve equitable outcomes for Māori, Pacific children and their families/whānau, and those with disabilities living in state care [20].

However, a 2020 review of the WCTO service by the Ministry of Health found that Māori do not benefit equally from the programme, contributing to persistent, unjust maternal mental health outcomes in Aotearoa New Zealand [20, 27]. The low uptake of follow-up appointments for mothers referred to maternal mental health services suggests barriers to accessing these services [5]. Organisational aspects of the service can either facilitate or hinder women seeking mental health support during the postnatal period [28]. Barriers to accessing services like WCTO include transportation and financial constraints, low social support and access to resources, perceptions of cultural inadequacy or negative healthcare experiences, a lack of awareness, and stigma surrounding seeking help for mental health [5, 28, 29]. This implies that those at higher risk of mental health problems may be the least likely to access care [5]. While services alone cannot address all the complex factors influencing perinatal distress, the WCTO programme offers a unique opportunity for early intervention and influence on maternal mental health outcomes at a family level [3, 20].

To examine the role of early intervention services in supporting maternal mental health, the present qualitative study explores user experiences of the WCTO service in Aotearoa, New Zealand, focusing on barriers to the provision of mental health services for mothers.

2. Method

This study adopted a qualitative methodology to explore individuals' experiences with the WCTO (Well Child Tamariki Ora) program. Our research methodology is founded on the understanding that an individual's health, life circumstances, and societal context significantly shape their experiences. These personal experiences are influenced by the availability of resources and the strength of social connections.

2.1. Participants and Recruitment. Participants were recruited using a multifaceted approach aimed at engaging underrepresented communities, including young mothers and Māori. Recruitment included a social media campaign, referrals by word of mouth, and emails sent out through a collaboration with the community campaigning organisation Action Station. Action Station is an advocacy group in Aotearoa, New Zealand, that has an extensive database of members, facilitating outreach to a diversity of communities. This method resulted in the collection of 420 stories, mostly from women, with an average age of 34 years. Sixty-one percent of those who submitted a story indicated ethnicity. Of those who indicated ethnicity, 19% indicated Māori, 3% Pacific, 81% NZ European Pākehā, and 6% other ethnicity.

2.2. Data Collection. This study collected data through Wāhi Kōrero, an online platform designed to gather personal stories by asking specific prompts. These prompts are designed to generate stories about healthcare that might be otherwise missed or not shared. Because the platform allows people to share their stories anonymously, they can do so freely without a researcher's guidance. This approach limits researcher influence and allows people to share their experiences and perspectives openly and is as much detail as they want. In addition, the platform creates a community where storytellers and listeners can connect and share a sense of understanding and common experiences. For this particular project, we asked participants to share experiences they wished they could have discussed with their Well Child nurse. The project prompt opened on 29 August 2021 and ran for nine weeks, during which 420 stories were received. All the stories submitted as part of the project can be viewed on the Wāhi Kōrero website (https://wahikorero.co.nz/projects/korero-i-wish-i-couldve-had-with-the-wellchild-nurse/).

2.3. Ethics. The project received ethical approval from the University Human Ethics Committee (Application SOB 21/30). Wāhi Kōrero was monitored and moderated to ensure safety, anonymity, and proper use. The identities of participants posting stories and other people and organisations were protected by removing any identifying information.

2.4. Analysis. After reading through all 420 stories, we selected 125 stories that specifically addressed maternal mental health issues for this project. These stories encompassed a range of topics, including general mental health issues, postnatal depression, grief, loss, depression, anxiety, trauma, and stress. By adopting an all-inclusive approach, we analysed any story mentioning mental health concerns. Analysis followed Braun and Clarke's [30, 31] thematic analysis guidelines, employing their six-step process in Microsoft Excel to explore patterns within the data. This process involved getting familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming the final themes, and compiling the findings. The analytical process started with thorough readings of each story to become immersed in the material. Initial codes were created by the first author to highlight significant elements within each story. Some stories were coded with multiple codes. This engagement with the data allowed for a comprehensive understanding of key messages. These initial codes were then organised into meaningful groups in a separate spreadsheet, and these groups of codes were used to understand the thematic patterns present in the data. These themes were further refined through iterative discussions with the wider Wāhi Kōrero team, leading to a recoding of the data associated with each theme. Special attention was given to extracts that shed light on the unmet needs in service provision, marking them for more in-depth examination. This collaborative process refined our analysis, leading to the final thematic framework. Key analytical points from each theme were illustrated with exemplar extracts reproduced with their original grammatical constructions. Each extract is taken from the stories of different participants. Extracts are only edited for clarity or to anonymise any identifiable content. Material removed from extracts is indicated with (...).

3. Findings

This study explores the nuanced experiences of mothers navigating the WCTO service, revealing the complex interplay between societal expectations, personal struggles, and the healthcare system. Through the analysis, three distinct themes emerge, each shedding light on the pivotal aspects of mothers' experiences during this critical period. (1) Making it seem that I'm coping: Mothers' fear of being judged; (2) I wish I had connected with my WCTO nurse: Fostering meaningful relationships to facilitate personal information sharing; and (3) beyond the baby: Mothers' desire for recognition and support during WCTO visits. These themes not only highlight the challenges faced by mothers but also underscore the potential for enhancing the support structure within the WCTO visits to better cater to the diverse needs of mothers and their families and/or whānau.

3.1. Theme 1: Making It Seem That I'm Coping: Mothers' Fear of Being Judged. The stories shared by mothers illustrate a sense of losing their own identity after their baby's arrival and feeling disempowered when making decisions. Many hesitated to disclose their concerns to their WCTO nurse due to fear of judgment regarding their mental health struggles, the fear of being perceived as inadequate or unfit mothers, the pressure to conform to societal expectations of being a "good caregiver," and a lack of open conversations about maternal mental health.

One of the most common comments made by mothers is that they worried what people (including their nurse) would think of them if they were to admit they needed help, highlighting the significant stigma around maternal mental health. Many mothers felt that asking for mental health support would be seen as failing their baby since other mothers were seen to provide for their children on their own. For many, the fear of being labelled, as a "bad caregiver" by the health providers, along with a lack of confidence in themselves to speak up, led to them staying silent rather than asking for support. In some of the stories, mothers were worried the result of the nurses' assessments could result in their baby being taken from them.

"I was scared that if I opened up about how I was feeling that people would think I was incompetent or neglectful or a danger to my baby, so whenever my Well Child nurse visited, I would just say things were good and because I put on a good mask and my son was physically healthy and thriving, she never had any concerns. I wish I could have told her how much I was struggling."

Mothers discussed the lack of conversations about maternal mental health during WCTO visits and throughout pregnancy and antenatal care. Mothers described not knowing what the normal short-term emotional changes (or the "baby blues") should feel like in comparison to signs of postnatal depression and when to seek help. Commonly reported feelings were anxiety around leaving the baby, the fear of something bad happening to them, and struggling to bond with their new baby.

"I wish I could have told my Plunket [Well Child] nurse that I felt anxious to leave my baby. That I didn't know if this was normal, but the less sleep I got the harder it became to ask for and accept help. I felt stuck in a hole and didn't feel able to make changes to get out on my own."

In many of the stories, mothers compared themselves to others and felt they should be able to provide for their baby and wider family without any external support. This situation often resulted in feelings of guilt among mothers who required assistance or support after giving birth, as they were unable to meet the expectations placed upon them. The accompanying sense of shame compelled some mothers to put up a façade when interacting with their nurses, pretending they did not require any additional assistance.

"I felt a lot of guilt for not being able to care and support my whānau... I felt I was alone in this journey at times. And despite having older children, I needed a lot of reminding about baby basics. And yet I tried to make it look like I was managing motherhood and everything else. I'm sure our Plunket nurse saw what was really happening, but I wish I could have been honest and not been worried that I would be judged."

"I wish I could've told the Plunket nurse I really needed her to come to my house. I didn't want to make a big deal about going in for appointments, but I was exhausted I'd been sick and lugging the baby out was a nightmare. I didn't want to be accused of "not coping" so I didn't have the courage to speak up."

Due to the reluctance of many women to openly disclose their needs, they often received care that was not suitable for their specific requirements. Consequently, once the WCTO nurse had completed their visit, many mothers chose to disregard the advice provided, prioritising their mental health by avoiding further engagement. Mothers felt unable to share the truth about their actual circumstances with the nurse. As time passed, seeking help from the nurses became increasingly difficult, leading to heightened anxiety surrounding the WCTO visits. This, in turn, left mothers feeling more disheartened and disempowered.

I knew theoretically what I should be doing (I'd read all the research), but in practice I was sooooo tired... Nurse: "Are you breast feeding" Me: "Yes, I am breast feeding" (left unsaid: but only because my kid won't take a bottle.. and by the way it is killing me and I cry anticipating the next feed and our bond is probably suffering long term). Nurse: "Does baby have a separate bed?" Me: "Yes, of course" (left unsaid: But they're never in it because the only time I can sleep is when they sleep and that's when they're next to me.

This theme underscores the critical need for creating a more open, nonjudgmental space within the WCTO program. By fostering an environment where mothers feel safe to express their struggles, it is possible to bridge the gap between perceived and actual needs, setting the stage for a more supportive and understanding approach to maternal care.

3.2. Theme 2: I Wish I Had Emotionally Connected with My WCTO Nurse: Fostering Meaningful Relationships to Facilitate Personal Information Sharing. A core finding of the study was that mothers were more likely to seek help for their mental health when they had established a meaningful connection with their WCTO nurse. Those who had a favourable experience with their nurse described feeling integrated into a broader support network as crucial for raising their child. However, several mothers expressed that they were unable to form a meaningful connection with their nurse, despite their desire to do so, leading to a sense of disengagement. Several barriers, such as communication difficulties, lack of meaningful conversation, and service inflexibility, hindered this connection.

Talking about their mental health proved to be a challenging, uncomfortable, and deeply personal experience for many mothers. Numerous stories spoke of their desire for enhanced communication tools to better help them effectively convey their feelings to nurses, and they emphasised the importance of WCTO nurses using appropriate language that encourages the disclosure of emotions.

"I didn't have the words to describe or understand my experience. I needed someone to see what it was and ask the right questions and know I needed help."

"I wish my Plunket nurse had asked if I was ok. I was not coping at all, having terrible anxiety attacks, crying all the time, very highly strung. But both my babies were big chubby happy babies so I just got showered with praise while inside I was cringing thinking how wrong she was. I just needed a chance to say how I was feeling, then maybe I would've got the help I needed, when I needed it."

Mothers often faced difficulties when attempting to schedule appointments directly with WCTO nurses, often experiencing last-minute cancellations or rescheduling. Consequently, mothers felt frustrated, neglected, and overlooked. Many stories described nurses posing questions as a checklist, merely ticking boxes without creating an environment for discussing mental health. In contrast, stories where nurses actively listened and prompted mothers with open-ended questions, going beyond the standard "How have you been feeling?" inquiry, were particularly encouraging for fostering discussions about mental health. The communication techniques employed by nurses during these appointments significantly influenced whether mothers felt comfortable disclosing their mental health

concerns. The brevity of the appointments also presented another obstacle for many mothers when it came to disclosure, as they felt that the limited time did not allow for the development of trust with their nurse or an opportunity for meaningful conversations.

"Then came the checklist, it felt like a barrage of questions, rather than a conversation to develop a relationship, "are you depressed?" while I'm cowered on the couch, quietly crying, I was too ashamed to admit it, and that was that. That visit (and every subsequent visit) left me feeling even less supported than I did beforehand."

"On other topics they were more helpful, although the screening questions for PND are asked in a routine way that doesn't really welcome honest answers or opening up about mental health. Appointments feel rushed, and I feel pressure to give the "correct" answers to the Plunket nurse's questions— there's little space for sharing concerns or seeking advice in any in-depth way."

Experiencing empathy and respect from nurses, along with a genuine sense of care, was crucial before mothers felt comfortable disclosing their concerns. Caregivers desired to be treated as a person rather than patients. Simple gestures like learning the names of the caregiver and baby, sharing a genuine interest in their family and relationships, and sharing a cup of tea all contributed to creating a comfortable atmosphere for mothers. In many cases, the nurse's first impression of the family had a long-term impact on their use of the service.

"She said hello walked into my house but didn't know mine or my sons names. . .I wish I would of had the courage to tell her how her not introducing herself properly, lack of care and knowledge of our family situation led our family down a path of mistrust. . . You have one chance to make a good and lasting impression. Especially with new and vulnerable mums."

Mothers mentioned that one of the most important things that they wanted from their nurse was to hear words of encouragement regarding their progress through parenthood. Based on their stories, mothers felt that the structure of the service did not facilitate these types of conversations effectively.

"I just needed someone to hold a space for me to talk about what I'd been through, in a caring person to person informal manner, rather than immediately trying to label me with PND. I feel this was a lost opportunity to provide a new mum with a little pep talk and bit of encouragement, when that was all she was needing."

A recurring issue was the lack of continuity of care, with mothers frequently encountering different nurses during their visits. This constant turnover led to disengagement as they grew weary of repeatedly rebuilding relationships.

In contrast, mothers who had established a positive relationship with a specific nurse attempted to reengage with them for subsequent children. This familiarity with their history made discussions about their mental health much more comfortable and effective.

"I loved my Plunket [Well Child] nurse, she was kind, compassionate and non-judgemental. I often think back to our conversations and how much of a help she was for my mental health at the time. I ended up having her for both my daughters (5 and 7) and having that relationship already built with our first made it so much easier the second time around."

The provision of home visits by nurses to mothers presented both benefits and challenges. Most nurses in the stories conducted home visits, which mothers found comforting. However, some mothers felt that the service lacked flexibility, particularly for those who had returned to work after having their baby or lived far from a drop-in clinic. This lack of adaptability made them feel dismissed and unimportant. These relational struggles were exacerbated during the COVID-19 pandemic, as restrictions on face-to-face contact increased the physical and emotional distance between nurses and mothers, making it more challenging to establish meaningful connections.

"Just as we went into lockdown, it all came crashing down and I went for a full year before I got help. I never felt connected enough to tell her I was feeling like a shit mum. I was scared she'd judge me."

"I finally was able to get through to someone and was told I could visit a drop-in clinic if I wanted. I felt completely disregarded, that my baby and his wellbeing was not important and that we just fell between the cracks. I am a mother of 4 children, two at school, one at kindy and my now 21-month-old. I also work part time and did not have time to visit a drop-in clinic where I might have to sit around for an indefinite time to be able to see someone."

This theme underscores the importance of relational aspects of healthcare, particularly in postnatal care, where mothers are navigating the complexities of motherhood and their own mental health. Overcoming obstacles to meaningful connections and prioritising adaptable and consistent care are vital for enhancing maternal mental health support after childbirth.

3.3. Theme 3: Beyond the Baby: Mothers' Desire for Recognition and Support during WCTO Visits.

Understanding the purpose of WCTO nurse visits played a significant role in determining whether mothers sought help for their mental health concerns. Their stories highlight how it was apparent that the primary focus of these visits was on monitoring the physical growth and development of the baby, such as height and weight, with maternal mental health receiving minimal attention, if any. This left many mothers feeling ignored, as they wanted an opportunity to discuss their own experiences and to seek advice on various aspects of health, including mental health. Some mothers ultimately sought support elsewhere, feeling they needed more comprehensive assistance. Others expressed a desire for assistance navigating the healthcare system to access the support they needed. This highlights the importance of integrating maternal mental health and addressing mothers' needs holistically within the framework of WCTO nurse visits.

"I wish my well-being nurse made me feel like I had someone I could talk to, not just about the weight and size of our growing pēpi but about me, Māmā. Because although they ask the basic questions, and we do appreciate it, we also would like to hear about our bodies and the changes we will have to go through, the help we can get and how to keep healthy and head strong for our whānau."

Many mothers reported that they were not aware that they had the option to refuse or choose their WCTO nurse. Mothers often expressed uncertainty about where they could seek mental health support and whether this was within the scope of the WCTO service. This left them feeling lost within the healthcare system. Mothers were aware of the limitations of maternal mental health services and how difficult it was to access them. For those who did not continue with the WCTO programme, many turned to online resources such as Facebook groups and Google for assistance. The consensus was that these platforms provided more current and appropriate resources than the pamphlets and videos available through the WCTO Service, particularly for topics such as postnatal depression. One mother described the information provided by the service as simply "way off the mark." Others found their needs better met through friends or other healthcare services such as their local GP, Māori providers or Karitane nurses [childcare agency].

"Luckily, my firstborn was super healthy. I was not so lucky with my second, but this time I had a Māori health provider. This kuia [female elder] was amazing. She asked me what I thought was happening with my son. She listened then supported. She'd growl me for not taking care of myself and pushed the mantra "healthy, happy māmā equals healthy happy pēpi." She listened to my limitations and worked with me to come up with workable solutions."

Seeking care from outside the health care system was commonly discussed in the stories, with many mothers working with nonmedical professionals such as doulas for emotional and physical support during pregnancy and postnatally. These support networks provided a holistic view of health. Some mothers desired spiritual and Māori knowledge and practices to be incorporated into the visits to benefit them and their pēpi.

"I also would have loved support and strategies of after care that could of helped myself and son deal with mamae [hurt], attachment and anxiety. There's a lot of ages and

stages or milestone advantages with motor skills and cognitive but where is the emotional and wairua mohiotanga [spiritual understanding] that can also help prepare a mama pēpi or whānau."

In the stories, mothers expressed a desire for nurses to involve their extended whānau in the visits and discussions regarding their mental health. Some fathers also shared their struggles with mental health, feeling excluded from voicing their concerns as they perceived the visits to be solely focused on the baby. However, when nurses were proactive and took the initiative to include whānau in future planning, it was seen as exceeding the regular service provision and greatly appreciated by many mothers.

"I left that service and moved to a local Māori provider. The nurse came, she identified things in our home that were triggering my girl and making her so congested. She helped me with sleep, even so far as helping set up the room with a new co sleeper, she identified post-natal depression and sat with me and my family as we made a plan together. She even went to the milk bank to give them a heads up I might need some milk. Imagine if all our stories were like this. I am eternally grateful to have this woman in my village."

Theme 3 reveals a significant gap in the WCTO service's approach to maternal care, emphasising the need for a more holistic, inclusive model that recognises and supports the mother's mental, emotional, and spiritual well-being alongside the baby's physical health. Integrating these aspects into WCTO visits can enhance the overall effectiveness of the service, ensuring both mother and child receive the comprehensive care and support they need during this critical period.

4. Discussion

The experiences of mothers shed light on the complexities surrounding maternal mental health support in the context of WCTO nurse visits. Addressing these factors could help improve the overall experience and effectiveness of the support provided to mothers during this critical stage. The analysis described three themes that encompass experience engaging with Well Child visiting services: that mothers feel obliged to appear to be coping well to avoid judgment and surveillance; that nurse visits are of limited use to mothers without the establishment of meaningful relationships; and that mothers coping and wellbeing are not seen as the focus of concern to nurses. These themes point to areas of development within the WCTO visits to better cater to the diverse needs of mothers and their families and or whānau. Establishing a meaningful relationship between mothers and their WCTO nurses emerges as a critical factor in creating a safe space for open communication about mental health. Mothers who experienced a meaningful connection with their WCTO nurse felt supported and more willing to discuss their mental health concerns. Conversely, the lack of a meaningful connection resulted in many mothers expressing disengagement and discomfort, which hindered their ability to disclose their concerns. This is consistent with the literature regarding fear of judgment as a reason for not disclosing mental health concerns or wanting to share personal information with healthcare professionals [14, 28, 32, 33]. The results are also in alignment with research indicating that meaningful relationships between patients and health professionals not only enhance the quality of care but also alleviate anxiety and distress through the establishment of trust and rapport [25, 34–37].

The responses also highlighted the need for specific training for nurses to recognise and address maternal mental health, including implementing more suitable screening methods. For example, standardised questionaries that ask closed questions and incorporate a tick-box approach can prevent disclosure [14, 32, 33]. These insights underscore the importance of a relational and informed approach to service delivery built on foundations of trust and reciprocity [25, 36, 38]. Moreover, relationships of trust are shown to enhance clients' active participation in making decisions about their care, emphasising the importance of fostering such connections for overall well-being and healthcare outcomes [34, 35]. Therefore, it becomes evident that prioritising the development of meaningful relationships—characterised by respect, nonjudgemental attitudes, and client-centred care is crucial for addressing mental health concerns [24].

The purpose of the WCTO nurse visits was perceived by many mothers as predominantly focused on monitoring the physical growth and development of the baby, with limited attention given to the caregiver and their mental health. This imbalance left mothers feeling overlooked and in need of additional support. This feeling of neglect may be particularly keenly felt by mothers struggling with complex needs including trauma, adverse childhood experiences, or previous mental health problems. Fostering a comprehensive approach that prioritises the health and well-being of mothers alongside the baby's well-being would create a more balanced and supportive healthcare experience. A more holistic approach that transcends predefined parameters of a paternalistic view of maternal health would result in a more culturally responsive service better aligned with Māori perspectives of health [24, 36, 39]. This shift in approach could provide mothers with the necessary guidance, advice, and encouragement to navigate the challenges of parenthood more effectively [40]. Such an approach also holds the potential to address existing inequities in care. By acknowledging and valuing the diverse needs of mothers and considering their mental health as an integral part of the caregiving journey, maternal health services can become more inclusive and comprehensive. Aligning care with Māori perspectives of health may address the persistent disparities in maternal mental health outcomes experienced by Māori and Pacific families [8].

Barriers experienced by mothers in accessing and engaging with the WCTO service were evident in the stories. Difficulties in arranging appointments, a lack of continuity of care, and inflexible service delivery impeded mothers' ability to form trusting relationships and engage in

meaningful conversations about mental health with their nurses. Continuity of care is important, especially when people need to disclose personal information and do not want to be burdened with having to repeatedly retell their stories [14, 25, 34, 36, 41]. It is acknowledged that there has been an increased burden on maternal mental health services to keep up with demand for postnatal mental health support, in addition to general workforce fatigue and stretched resources following the COVID-19 pandemic which has affected service provision [24]. However, addressing the barriers experienced by mothers requires implementing strategies to improve their overall experience. Streamlined appointment scheduling, enhanced co-ordination of care, and increased flexibility in service delivery are essential steps to better meet the unique needs of mothers [7]. By taking these measures, the WCTO service can foster a more supportive and accessible environment, facilitating meaningful and lasting relationships between mothers and nurses.

The study also highlights the importance of involving wider support networks in WCTO visits and when discussing maternal mental health. Engaging family members and a wider support network in the care process can provide valuable support and contribute to a more comprehensive understanding of the mothers' mental health needs. The importance of including family and the wider support network in health decision making has been well recognised in the literature and was a key recommendation of the 2019/20 review of the WCTO programme by the Ministry of Health [7]. Healthcare providers should adopt a family-centred or whānau-centred approach that recognises the active role of the entire support network in promoting the wellbeing of both the primary caregiver and the baby [7, 12]. By doing so, healthcare professionals can create a more inclusive and effective support system for maternal mental health during the postnatal period [41]. Recognising and involving the wider support network in the care process also enhances the likelihood of early identification and intervention for any mental health challenges faced by the primary caregiver. This proactive approach can improve mothers' mental health outcomes, reduce the stigma around seeking support, and strengthen the family's ability to provide a nurturing and supportive environment for the baby's development [6, 25, 36, 41].

4.1. Policy and Practice. The stories analysed here point to ways in which the services as provided are structured to meet the needs of service providers and organisational priorities, which work to undermine positive experiences for families and whānau. Although health service reviews have previously identified the importance of acknowledging wider support networks and providing care holistically, services built on concern for monitoring the physical health of babies easily default to practices of recording objective wellbeing indicators. Practices of asking closed questions and completing checkboxes contribute to feelings of surveillance and judgment [42]. Many young and marginalised parents are subject to health service and welfare programmes that are predicated on monitoring their conduct to protect children from their potentially suspect parents [43–45]. Attending to maternal wellbeing holistically requires two key characteristics that health services may struggle to embrace fully: firstly, understanding of the complex interplay between societal expectations of mothers, their personal struggles, and the healthcare system; and secondly, a genuine trust in families and whānau and a desire to support them to achieve their own aspirations for their members. Unless these core characteristics are embedded in service provision, sustainable improvement may not be achieved.

4.2. Limitations. The findings reported here are from a convenience sample of caregivers who responded to a broad recruitment approach through social media, word-of-mouth promotion and through the campaigning of an advocacy organisation. As such, it is not possible to tell how widespread such experiences of maternal mental health are and whether they reflect the breadth of experiences of mothers in the early postpartum period and in the early years of caring. Although it was possible for people with accessibility needs to upload video and audio recordings of their experiences, most typed their experiences which required reasonable literacy and digital access. These accessibility considerations will limit the ability to reach mothers with the most complex needs and those most marginalised from health care services. Given these limitations, the feelings of judgment and concern with surveillance reported by these mothers are likely to be even more heightened by those with multiple marginalised identities who may be absent from this data collection.

5. Conclusion

Mothers described difficulties engaging with and feeling valued within WCTO services provided to improve the health and development of their babies. The three themes identified are all underpinned by a fear of judgment by health professionals, but a lack of openness and relationality between nurses and families, and by a sense that mothers themselves are instrumental to the wellbeing of babies rather than valued in their own right. To address these issues, it requires a reconfiguration of services from monitoring and concern for the growth and development of babies to a holistic service that grows the confidence and wellbeing of families and whānau. This requires a shift in the approach to postpartum care, with a greater emphasis on establishing meaningful connections, comprehensive assessments, and tailored support for maternal mental health. By prioritising meaningful relationships, adopting a holistic approach, and involving wider support networks, healthcare services can create a more supportive and effective environment for addressing maternal mental health needs during the postnatal period. Prioritising maternal mental health within the WCTO service can positively impact not only the individual wellbeing of mothers but also the long-term health outcomes of their children. This comprehensive approach holds the potential to improve outcomes for both mothers and their

babies, contributing to the overall well-being of families and society.

Data Availability

Conflicts of Interest

Acknowledgments

References

[1] Ministry of Health, *Maternal Mental Health Service Provision in Aotearoa: Stocktake of District Health Board Services*, Ministry of Health, Wellington, New Zealand, 2021.

[2] E. Neely, Y. Jin, C. Parton, and F. Ware, "Motherhood," in *Handbook of Social Sciences and Global Public Health*, P. Liamputtong, Ed., Springer, Cham, Switzerland, 2023.

[3] H. Walker, "Āhurutia Te Rito it takes a village," 2022, https://helenclark.foundation/publications-and-medias/ahurutia-te-rito-it-takes-a-village/.

[4] A. Ryan and C. Barber, "Postnatal depression and anxiety during the COVID-19 pandemic: the needs and experiences of New Zealand mothers and health care providers," *Midwifery*, vol. 115, Article ID 103491, 2022.

[5] S. Maessen, T. Wright, and T. Wouldes, "Parental mental health problems during pregnancy and the postnatal period," in *Brief Evidence Reviews for the WCTO Programme*, W. S. Cutfield, J. G. B. Derraik, C. Waetford, G. T. Gillon, and B. J. Taylor, Eds., pp. 96–119, A Better Start National Science Challenge, Auckland, New Zealand, 2019.

[6] C. Wilkinson, P. Gluckman, and F. Low, "Perinatal mental distress: an under-recognised concern," *Koi Tu: The Centre for Informed Futures*, University of Auckland, Auckland, New Zealand, 2022.

[7] Ministry of Health, *Kia Manawanui Aotearoa: Long-Term Pathway to Mental Wellbeing*, Ministry of Health, Wellington, New Zealand, 2021b.

[8] K. E. Waldie, E. R. Peterson, S. D'Souza et al., "Depression symptoms during pregnancy: evidence from growing up in New Zealand," *Journal of Affective Disorders*, vol. 186, pp. 66–73, 2015.

[9] Perinatal and Maternal Mortality Review Committee, *Fifteenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting Mortality and mMorbidity 2020*, 2020, https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc.

[10] F. McDaid, L. Underwood, J. Fa'alili-Fidow et al., "Antenatal depression symptoms in Pacific women: evidence from Growing Up in New Zealand," *Journal of Primary Health Care*, vol. 11, pp. 96–108, 2019.

[11] L. Briscoe, T. Lavender, and L. McGowan, "A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period," *Journal of Advanced Nursing*, vol. 72, no. 10, pp. 2330–2345, 2016.

[12] Government Inquiry into Mental Health and Addiction, "He Ara oranga," 2018, https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.

[13] Blackpool Better Start, "A good practice guide to support implementation of trauma-informed care in the perinatal period," 2021, https://hubble-live-assets.s3.amazonaws.com/birth-companions/file_asset/file/1/PMH-Trauma-Informed-Care-Guide.pdf.

[14] J. Cull, G. Thomson, S. Downe, M. Fine, and A. Topalidou, "Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: a qualitative evidence synthesis," *PLoS One*, vol. 18, no. 5, Article ID e0284119, 2023.

[15] L. Bécares and P. Atatoa-Carr, "The association between maternal and partner experienced racial discrimination and prenatal perceived stress, prenatal and postnatal depression: findings from the growing up in New Zealand cohort study," *International Journal for Equity in Health*, vol. 15, no. 1, p. 155, 2016.

[16] M. Tupaea, J. Le Grice, and F. Smith, "Invisibilised colonial norms and the occlusion of mātauranga Māori in the care and protection of tamaiti atawhai," *MAI Journal*, vol. 11, no. 2, pp. 92–102, 2022.

[17] D. Cormack, J. Stanley, and R. Harris, "Multiple forms of discrimination and relationships with health and wellbeing: findings from national cross-sectional surveys in Aotearoa/New Zealand," *International Journal for Equity in Health*, vol. 17, no. 1, pp. 26–15, 2018.

[18] S. Dhunna, B. Lawton, and F. Cram, "An affront to her mana: young Māori mothers' experiences of intimate partner violence," *Journal of Interpersonal Violence*, vol. 36, no. 13-14, pp. 6191–6226, 2021.

[19] D. Wilson, A. Mikahere-Hall, J. Sherwood, K. Cootes, and D. Jackson, *E Tū Wāhine, E Tū Whānau: Wāhine Māori Keeping Safe in Unsafe Relationships*, Taupua Waiora Māori Research Centre, Auckland, New Zealand, 2019.

[20] Ministry of Health, *WCTO Review Report*, Ministry of Health, Wellington, New Zealand, 2021c.

[21] T. E. W. Ora, "First 1,000 Days programme summary," 2022, https://www.hpa.org.nz/sites/default/files/1220423_1.pdf.

[22] T. E. W. Ora, "Kahu taurima: maternity and early years," 2023, https://www.tewhatuora.govt.nz/for-the-health-sector/maternity/kahu-taurima/.

[23] T. E. W. Ora and T. E. A. Whai Ora, "Te pae tata interim Aotearoa health plan 2022," 2022, https://www.tewhatuora.govt.nz/publications/te-pae-tata-interim-new-zealand-health-plan-2022/.

[24] Maternal Care Action Group, "Maternal mental health report 2022," 2022, https://www.productivity.govt.nz/assets/Submission-Documents/Sub-086-Maternal-Care-Action-Group-NZ.pdf.

[25] K. Stevenson, S. Filoche, F. Cram, and B. Lawton, "Te Hā o Whānau: a culturally responsive framework of maternity

care," *New Zealand Medical Journal*, vol. 133, no. 1517, pp. 66–72, 2020.

[26] Ministry of Health, *Well Child Tamariki Ora National Schedule 2013*, Ministry of Health, Wellington, New Zealand, 2013.

[27] Q. Smith and T. Stevens, "Māori health review: oranga Tamariki and the WCTO review," *The New Zealand Medical Student Journal*, vol. 34, pp. 41–43, 2022.

[28] T. Newman, J. Hirst, and Z. Darwin, "What enables or prevents women with depressive symptoms seeking help in the postnatal period?" *British Journal of Midwifery*, vol. 27, no. 4, pp. 219–227, 2019.

[29] L. Smith, "The literature review report on the design features to improve equity for Māori in the WCTO programme," 2020, https://www.health.govt.nz/system/files/documents/publications/literature-review-report-design-features-improve-equity-maori-wcto-programme.pdf.

[30] V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77–101, 2006.

[31] V. Braun and V. Clarke, *Successful Qualitative Research: A Practical Guide for Beginners*, Sage, Newcastle, UK, 2013.

[32] E. Carlin, D. Atkinson, and J. V. Marley, "'Having a quiet word': yarning with aboriginal women in the pilbara region of western Australia about mental health and mental health screening during the perinatal period," *International Journal of Environmental Research and Public Health*, vol. 16, no. 21, p. 4253, 2019.

[33] C. Chamberlain, G. Gee, D. Gartland et al., "Community perspectives of complex trauma assessment for Aboriginal parents: 'Its important, but how these discussions are held is critical," *Frontiers in Psychology*, vol. 11, p. 2014, 2020.

[34] B. N. Dang, R. A. Westbrook, S. M. Njue, and T. P. Giordano, "Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study," *BMC Medical Education*, vol. 17, no. 1, p. 32, 2017.

[35] S. Kildea, S. Hickey, L. Barclay et al., "Implementing birthing on country services for Aboriginal and Torres Strait Islander families: RISE framework," *Women and Birth*, vol. 32, no. 5, pp. 466–475, 2019.

[36] K. Stevenson, S. Filoche, F. Cram, and B. Lawton, "Lived Realities: birthing experiences of Māori women under 20 years of age," *Alternative: An International Journal of Indigenous Peoples*, vol. 12, no. 2, pp. 124–137, 2016.

[37] Z. Tipa, D. Wilson, S. Neville, and J. Adams, "Cultural responsiveness and the family partnership model," *Nursing Praxis in New Zealand*, vol. 31, no. 2, pp. 35–47, 2015.

[38] D. Wilson, E. Moloney, J. M. Parr, C. Aspinall, and J. Slark, "Creating an Indigenous Māori-centred model of relational health: a literature review of Māori models of health," *Journal of Clinical Nursing*, vol. 30, no. 23-24, pp. 3539–3555, 2021.

[39] F. Wadephul, L. Glover, and J. Jomeen, "Conceptualising women's perinatal well-being: a systematic review of theoretical discussions," *Midwifery*, vol. 81, Article ID 102598, 2020.

[40] E. Neely and A. Reed, "Towards a mother-centred maternal health promotion," *Health Promotion International*, vol. 38, no. 2, Article ID daad014, 2023.

[41] A. Adcock, F. Cram, L. Edmonds, and B. Lawton, "Culturally safe neonatal care: talking with health practitioners identified as champions by Indigenous families," *Qualitative Health Research*, vol. 33, no. 6, pp. 531–542, 2023.

[42] C. A. Severinsen, F. J. Ware, M. Breheny, and S. Aitken, *Wāhi Kōrero: Examining Experiences of Well Child Services*, Kai Tiaki Nursing New Zealand, Wellington, New Zealand, 2023.

[43] M. Breheny and C. Stephens, "Breaking the Cycle: constructing intergenerational explanations for disadvantage," *Journal of Health Psychology*, vol. 13, no. 6, pp. 754–763, 2008.

[44] M. Breheny and C. Stephens, "A life of ease and immorality: health professionals' constructions of mothering on welfare," *Journal of Community and Applied Social Psychology*, vol. 19, no. 4, pp. 257–270, 2009.

[45] F. Ware, M. Breheny, and M. Forster, "The politics of government 'support' in Aotearoa/New Zealand: reinforcing and reproducing the poor citizenship of young Māori parents," *Critical Social Policy*, vol. 37, no. 4, pp. 499–519, 2017.