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Service user experiences of short-term maternal mental health respite

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Abstract

Maternal mental health has been an international public health priority since 2000, however, in New Zealand it is only in the last five years that significant resources have been allocated to address this issue. Maternal mental health respite facilities are unique to New Zealand and cater for mothers and their babies during periods of perinatal distress between the second trimester of pregnancy to one year postpartum. Although formal audits and quality control measures have been undertaken, to date, there are no scientific studies concerning user experiences of this type of respite facility.

This study explores the experiences of residents of the short-term maternal mental health respite facility in Auckland 'He Kakano Ora' during their first postpartum year. Eight semi-structured interviews were conducted and analysed using interpretative phenomenological analysis. Findings show high user satisfaction with the services provided by the facility and highlight a number of themes significant to the respondents' experiences. The overarching theme, elicited from the interview data, was mental health recovery. Therefore, when mothers talked about their experiences at the facility, they described it in terms of their needs for mental health recovery. These needs included uninterrupted sleep, mothercraft support and social interactions with other residents. Additionally, the importance of the facility environment, direct mental health support and adjustment to the facility operations was described by mothers as important factors that influence their recovery while at He Kakano Ora.

These results highlight the significance of respite provisions from the users' perspectives and the essential role of the facility in the mental health recovery of postnatal mothers. It adds to the body of knowledge about the New Zealand postnatal population affected by mental health distress and highlights the need for further research in respite and maternal mental health settings in New Zealand.

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Chapter 1: Introduction

1.1 Maternal Mental Health

Maternal mental health has been an international public health priority since 2000, however, in New Zealand it is only in the last four years that significant resources have been allocated to address this issue (The Lancet, 2016; Wainbeerg et al., 2017; World Health Organisation [WHO], 2013, n.d.). One initiative that arose out of this resource allocation was the establishment of "He Kakano Ora", a maternal mental health respite facility in West Auckland. This facility was set up to cater to women experiencing perinatal distress in order to improve their recovery.

During the perinatal period, women are at higher risk of developing mental health difficulties than at any other time of their life (Burt & Quezada, 2009; Leight et al., 2010). It is estimated that in New Zealand, maternal psychiatric disorders occur in at least 15% of pregnant women (Ministry of Health [MoH], 2011). As well as this, almost 20% of new mothers experience depression during their pregnancy and postpartum period (PADA, 2017). The estimated perinatal prevalence of different types of anxiety disorders is 16.7 to 20.7%, with the highest prevalence being specific phobia at 4.8% (Fawcett et al., 2019). Nationwide study in Denmark found 0.6% of the maternal population without prior history and over 35% with history of affective disorders had been diagnosed with affective disorders during first 6 month postpartum (Rasmussen et al., 2017). Swedish population-based study found 4.84% mothers develop postnatal psychosis in a first 90 days after childbirth and 50% of those mothers had no previous history of serious psychiatric disorders (Valdimarsdottir et al., 2009).

Perinatal mental health disorders are one of the leading causes of maternal mortality internationally and in New Zealand (PMMRC, 2014; WHO, 2008). Every year since 2007 in New Zealand, the Perinatal and Maternal Mortality Review Committee has released a report providing detailed statistics and discussion on maternal and perinatal mortality. In the latest report (PMMRC, 2019), the total number of deaths directly related to pregnancy or childbirth from 2006-2017 were 66, with 30 (45%) deaths by suicide. The rates of maternal morbidity are not routinely reported, but there is evidence that maternal mental health conditions have a negative influence on physical health. A few small studies have found connections between anxiety, depressive symptoms, high stress and increased risk of preeclampsia (Qiu et al., 2009; Yu et al., 2013). There are studies associating mental health conditions with increased risk of hypertensive disorder (Horsley et al., 2019; Suzuki et al., 2015). However, due to the

small number of participants in the above studies no definite conclusions about the link between physical conditions and women's mental health during perinatal period can be reached.

Women with a history of severe mental health illness are at increased risk of relapse or deterioration in their condition during the perinatal period (Cristescu et al., 2015; Mongan et al., 2019). Research found that 43% of women with a previous history of a major depressive disorder relapsed during their pregnancy (Cohen et al., 2006). In women with bipolar disorder, the risk of relapse during pregnancy reached 50% (Di Florio et al., 2013). Moreover, this risk increased to 60% if women also had a personal or family history of postnatal psychosis (Jones & Craddock, 2001). Around 19% of women with schizophrenia required postpartum admission to a treatment facility and 12% of women were admitted during pregnancy (Rochon-Terry, Seeman, Gruner, & Ray, 2016). A preexisting personality disorder puts women at higher risk of depression and anxiety during pregnancy (Hudson et al., 2017). Other conditions associated with risk of relapse during the perinatal period are anxiety disorders (Wenzel, 2011) and eating disorders, especially postpartum (Chan et al., 2019; Crow et al., 2008; Ward, 2008).

There are several known risks factors for developing perinatal mental health disorders that influence access to maternal mental health services, including respite facilities. For women with severe mental health difficulties, the risk factors for relapse perinatally were an early or unplanned pregnancy, low socio-economic levels, family instability and lack of support from the partner (Pessoa et al., 2019). A population-wide study in Switzerland found infant crying problems and living without a partner were significant predictors of postnatal distress (Staehelin et al., 2013). Risk factors for anxiety during pregnancy are a high gestational age, low educational level, low family income as well as a high-risk pregnancy (Rezaee & Framarzi, 2014). A review of Australian and New Zealand longitudinal studies found the following risks for poor maternal mental health: low social support, unwanted pregnancy, a poor relationship with the partner and low socio-economic status (Schmied et al., 2013).

Because of a high prevalence of postnatal depression (PND), the majority of the literature regarding predictors of perinatal distress focuses on risks for this condition. The predictors for PND can be viewed in two categories: biological and psychological. The biological category of risk factors is connected to a sudden drop in reproductive hormones after delivery, leading to hormonal dysregulation and depressive

symptoms in vulnerable women (Yim et al., 2015). As yet, only individual studies confirm this relation, there are no randomised controlled trials or meta-analyses confirming it. Psychological risk factors, conversely, emphasise the role of stressors and cognitive vulnerabilities, considering psychological resources as a protective factor (Yim et al., 2015). There are two main groups of psychological risk factors, namely, maternal stress and interpersonal factors. Yim and colleagues (2015) in a systematic review of predictors of PND found the following stress related factors significant: exposure to catastrophic events like natural disasters; chronic stress related to work demands and low socio-economic status which is associated with financial strain, food insecurity and transportation difficulties. Another documented risk factor was high parenting stress, which is a perceived imbalance between parenting resources and the demands of childrearing.

Among the key factors contributing to high parenting stress were infants' excessive crying and colic. Along with maternal stress, Yim et al's (2015) systematic review also highlighted the following predictors of PND in the interpersonal group: low social support and partners' support in particular; low perceived support; high support needs; dissatisfaction with support received; single parenting especially for women of low socio – economic status; poor quality of relationship with a partner, including domestic violence and abuse; less secure and ambivalent adult attachment styles; low levels of parenting care and emotional support in childhood; history of trauma and abuse. Two antenatal factors consistently influencing the presence of PND are partner support and depressive symptoms (Yim et al., 2015).

Adverse pregnancy outcomes poses risks for maternal mental health. Two meta-analyses found that the most prominent risk factor for antenatal depression and anxiety is preterm birth (Grigoriadis et al., 2013; Grote et al., 2010). The risk is higher for women who have experiences of severe depression especially when this is coexistent with antidepressant treatment (Howard et al., 2014), and smoking (Riaz, Lewis, Naughton, & Ussher, 2018). Low birth weight at delivery was associated with depressive symptoms in low and middle income countries (Grote et al., 2010). In New Zealand's context this could be applicable to mothers from high deprivation areas. The reverse correlations between mental health and adverse pregnancy outcomes also had been found by researchers. Schizophrenia has been associated with risks of low birth weight, preterm delivery, stillbirth and infant mortality within one year postpartum (Howard, 2005; King-Hele et al., 2009; Webb et al., 2005).

According to the World Health Organization (2008) poor maternal mental health has a negative effect on the "physical, cognitive, social, behavioural and emotional development of children" (p.3). Infants of depressed parents adopt less mature emotional regulation strategies (Field, 2010; Gerardin et al., 2011; Goodman et al., 2011; Tronick & Reck, 2009; Velders et al., 2011), the most common of these is avoidance (Tronick & Gianino, 1986). Longitudinal studies connect parental PND to internalising disorders, inadequate social competence and increased risk of depression in adolescence (Kersten-Alvarez et al., 2010; Tronick & Reck, 2009; Verbeek et al., 2012). A number of studies reported correlations between antenatal depression/ anxiety and a child's externalising behaviour (Barker et al., 2011; Korhonen et al., 2012; Velders et al., 2011) and attention deficit hyperactivity disorder in particular (Cedric et al., 2012; Korhonen et al., 2012). Infants of parents experiencing PND and borderline personality disorder were found to be at higher risk of insecure, disorganised attachment (Atkinson et al., 2000; Hobson et al., 2005; Martin & Gaffan, 2000). PND has a consistent association with impaired infants' ability to learn and achieve developmental milestones (Quevedo et al., 2012; Hadley et al., 2008; Letourneau et al., 2013). Studies have shown different biological patterns of brain development in children of parents with perinatal mental health difficulties, in particular amygdala functioning and HPA axis (stress response systems) (Aktar et al., 2019).

One of the forces driving governments' response to maternal mental health is the significant economic impact. UK researchers calculated there was 8.1 billion dollars in maternal mental health expenses for each year of birth cohort (Bauer et al., 2014). Almost 72% of these costs related to adverse outcomes for children. 20% of the total costs related to the use of public services. An Australian study also found mothers with PND, especially single parents, accessing more specialised help (Le et al., 2016). An American study found there were almost 90% higher service costs related to women with PND by five weeks postpartum (Dagher et al., 2012).

One of the most concerning expenses associated with maternal mental health are costs associated with child protection services. Heightened risks for the maltreatment of children are associated with mental health difficulties some parents experience, that negatively impact on parenting skills, safety behaviours, mother and child attachment, mental health of the offspring (Huntsman, 2018; O'Donnell et al., 2010). As a result, there is significant overlap between women at 'high risk' receiving maternal mental health support and babies under child protection services (Judd et al., 2017). In New

Zealand, maternal mental illness was included in the top three concerns for child protection agency notifications for unborn babies and infants (Fraser-Jones, 2017). These notifications indicate a concern about a mother's ability to care for her child (Fraser-Jones, 2017). Consistent results from the child protection services in Australia show that in 50% of confirmed cases mothers had a previous or current history of mental health difficulties (O'Donnell et al., 2015; Jeffreys et al., 2011). The potential involvement of child protection services is a serious reason to consider when weighing costs and consequences of poor maternal mental health. Timely support during the perinatal period will help to prevent serious mental health disorders from occurrence and relapse. It will protect mother-baby relationship development from adverse effects of maternal mental health and save costs of healthcare and social services long-term.

1.2 Terminology

Before moving on to discuss the literature relevant to this research, it is important to first explain and define the terminology used in this study on service user experiences of maternal mental health respite.

1.2.1 Service User

'Service user' is a term used to describe people who receive mental health services in English speaking countries (Beresford, 2005; Dickens & Picchioni, 2012; McLaughlin, 2009). The term 'service user', has evolved from the dialog between people who use mental health services and service providers (Christmas & Sweeney, 2016). It is meant to empower people by changing their roles from the passive receiver of the services (patients), to an active role in relation to their illness and the support they receive. However, over time, the intended meaning of 'service user' has been criticised for a number of reasons. For one, it defines people's identity through their use of public services. Additionally, it suggests that their service use is voluntary, which is not always the case. Finally, there are negative connotations to the term 'user' because of a term relating to illegal drug use (Beresford, 2005).

There are a variety of alternative terms used to refer to people who use mental health services, including: clients, patients, people affected by mental illness, expert by experience, survivor, consumer, customer, recipients and attendees (Dickens & Picchioni, 2012; McLauglin, 2009). The choice of the term signifies the relationship and power dynamic between health professional and a person accessing services (Christmas & Sweeney, 2016). The choice of term can empower or stigmatise people, with the potential for long term consequences (Dickens & Picchioni, 2012).

Studies in to preferred terminology are inconclusive (Dickens & Picchioni, 2012). Their results seem to depend on the setting where research has been conducted. When people see psychiatrists, or attending psychiatric clinics, or hospitals, the majority prefer to be called ‘patients’ (Anczewska et al., 2011; McGuire-Snieckus et al., 2003; Simmons et al., 2010). For people in recovery, the terms ‘person with experience/lived experience/affected by…’ were the most preferred (Bradstreet, 2014). Researchers with lived experiences of mental health difficulties preferred to use “people with experience of mental health issues” in their study (Ghisoni et al., 2017). A number of studies could not definitely say what terminology was preferred (Covell et al., 2007). In a systematic review of the terms used to refer to people who use mental health services, Dickens and Picchioni (2012) did not come to a conclusion about preferences of the terminology. The reasons for this were inconsistency in methodologies between the research studies and small samples. Another limitation was that sample participants were restricted to inpatient or outpatient psychiatric clinics and hospitals as a convenience sample.

Despite the controversy around the term ‘service user’, it is the term utilised in this study for two main reasons. Firstly, ‘service user’ is commonly used in the current research literature. Secondly, the term highlights the voluntary nature of the use of the respite facility for research participants.

1.2.2 Perinatal Period

This study will adopt a definition of perinatal period which includes the period of pregnancy, not including conception, to one year postpartum. There are three main reasons for this adoption. Firstly, New Zealand maternal mental health services operate under this timeframe for perinatal service provisions (MoH, 2011). Secondly, this research is unrelated to the rates of perinatal mortality in New Zealand (Health quality and safety commission, 2017) and Australia (Australian Government, 2005). Which use different time from 20 completed weeks gestation to the 28 completed days after birth. Thirdly, recent research literature unrelated to mortality rates is consistent with the timeframe from pregnancy to the one year after the birth (Garcia & Yim, 2017; Thomson & Schmied, 2017).

1.2.3 Antenatal Period

There is no controversy in the definition of the antenatal period with most sources referring to this period as the period of pregnancy (National Collaborating Centre for Mental Health, 2018; WHO, 2016).

1.2.4 Postpartum Period

For the purposes of this research the postpartum period is considered to be from the birth of the infant to one-year post birth. This is consistent with the completion of perinatal mental health services provisions at one year postpartum (MoH, 2011), as well as definitions used by maternal mental health services and guidelines (National Collaborating Centre for Mental Health, 2018; MoH, 2011;). Another definition of the postpartum period is used by medical professionals referring to physiological changes in a woman's body reverting to a pre-pregnancy state after birth (Berens, 2018). For this reason, medical professionals define the perinatal period as being completed between six and eight weeks post birth (Mathai & Severin, 2010). It is important to mention that the postpartum period is interchangeably called the postnatal or puerperium period, although the latter term is specific to obstetrics and gynecology, as well as to veterinary fields.

1.3 Recent Changes in Perinatal Mental Health Service Provision in New Zealand

A number of guidelines and new legislation have been introduced in New Zealand in the past decade, which have led to the rapid development of maternal mental health services and the opening of the respite facility "He Kakano Ora". In 2012, the document "Healthy Beginnings. Developing perinatal and infant mental health services in New Zealand", was released by the Ministry of Health (2011). This document highlighted deficits in service provision for perinatal and infant mental health, and alcohol and other drug consumers. In addition, the document proposed new cost-effective models of care for the above groups. Four main implications arose out of the document guidelines. First, workforce development initiatives, like the establishment of a perinatal and infant mental health forum, were introduced to encourage communication and connection between people and organisations working in this area. Second, a refurbished mother and baby inpatient unit opened in Auckland in 2014. Third, additional full-time positions were added to maternal mental health (MMH) teams. Finally, the development of increased community support for perinatal women in a form of emergency respite facilities, home-based care and packages of care has been implemented (Watson & Mellor, 2017).

Planned respite care facilities are supposed to have "a safe degree of physical separation from other mental health consumers" (MoH, 2011, p.39) and cater solely for a perinatal population experiencing mental health distress. The tender for such a facility was won by Walsh Trusts and the newly established facility "He Kakano Ora", was

opened in West Auckland in July 2015. This facility serves MMH teams at Waitemata and Auckland District Health Boards (DHBs). In 2008, an initiative from Counties Manukau (CM) DHB, in an attempt to improve child and youth health (CMDHB, 2008), lead to the establishment of a maternal mental health respite facility “Awhi Rito”, located in Manurewa and managed by Affinity services. From the initial set up, the facility team worked in close collaboration with the MMH team at CMDHB. Although July 2015 was the official opening of a second respite facility in the Auckland region, work on staff development, policies, procedures, quality improvements, are continuing. As yet, there are no official documents available about this process.

There are a number of documents that indicate the government’s focus and recognition of the importance of perinatal mental health. In the document “The Mental Health and Addiction Workforce Action Plan 2017-2021” (2018a), the Ministry of Health indicate their commitment to the development of the workforce in perinatal mental health and especially primary and community services, which includes respite staff. A substantial amount of funding has been allocated to the development of perinatal community services. However, we are yet to see the initiatives arising from this document. In 2018, the Ministry of Health published “Advice regarding Perinatal and Maternal Mental Health” services. This document outlined a continuum of care for PIMH, funding avenues, as well as some statistical data. According to this structure, secondary services provide acute respite, packages of care, and specialist community mental health services. These services have been allocated a total of $16,259,105 in 2016/17. The Director of Mental Health’s Report 2017 (MoH, 2019), has shown that 92% of the people assessing mental health and addiction services used only community-based care with a further 8% using community and inpatient services. The report on “New Zealand’s Mental Health and Addiction Services” by Health and Disability commission (2019), shown that an additional 18.2 million dollars of funding has been allocated for maternal mental health services. This is to increase prompt access to services for acutely unwell perinatal women, and to sustain and develop mother and baby relationship in order to avoid future negative outcomes for the infants. Moreover, the New Zealand government, in their 2019 budget announcement, listed a number of mental health initiatives indicating a strong focus on this area, among wellbeing and addiction priorities (The Treasury, 2019). Unfortunately, there is no budget breakdown data to see what funding would be allocated to perinatal and infant mental health.

1.3.1 Recovery Approach

The Ministry of Health requires that all New Zealand mental health providers "must use" a recovery approach in their work with service users (The Mental Health Commission, 1998, p.16). This means that people engaging with mental health providers in any context in New Zealand, in hospitals or the community, have to receive support within the recovery approach. The 'Blueprint for Mental Health Services' describes recovery as a process "when people can live well in the presence or absence of their mental illness" (1998, p.1). Such is the importance of the recovery approach that every service user's recovery journey begins and ends with it. Ultimately, the recovery approach should improve the experiences of service users engaging with mental health providers. Part of this improvement comes from services being guided by users and their needs, giving them power over their own recovery journey, in contrast to the generic treatment approach previously employed.

The recovery approach has a number of principles, although the literature suggests that there is no complete consensus in exactly what principles the recovery approach is made up of. However, authors do share a common understanding of the recovery approach and the CHIME framework is the most widely used and endorsed (Slade & Wallace, 2017; Van Weeghel et al., 2019). The CHIME framework was developed in 2011 (Leamy et al., 2011) with the acronym standing for Connectedness, Hope, Identity, Meaning and Empowerment. Connectedness relates to relationships and belonging to groups including support from others and being part of the community. Hope relates to optimism about the future including a belief in the possibility of recovery, motivation to change, the idea of having dreams and aspirations, and positive thinking valuing success. The identity component consists of overcoming stigma, rebuilding and redefining a positive sense of identity, including different dimensions of identity. Meaning in life is comprised of spirituality, meaningful social goals and social roles, rebuilding life and giving meaning to mental health experiences. Empowerment includes control over life, focusing upon strengths, and personal responsibility.

There are some current additions to CHIME (Van Weeghel et al., 2019). For example, Ellison and colleagues (Ellison et al., 2018) found two additional components to recovery. The first, addresses trauma, in cases when traumatic event/s have been a precursor for the illness. The second, is culture, where values, traditions and beliefs of the person are incorporated in to the recovery process. It could be argued, however, that a cultural component could fit in to the 'meaning' component of CHIME framework.

Another addition to CHIME is proposed by Stuart, Tansey and Quayle (2017). They found that more than 30% of people's experiences of recovery did not fit into the CHIME framework. Thus, the theme of 'difficulties', which the recovery process involves, was particularly prominent in their review. This inevitably brings forth the CHIME theme of 'empowerment' and focusing on strength. However, the authors suggest that the CHIME framework based on positive outcomes of recovery, is not always the case. They therefore propose to include this theme of difficulties into CHIME-D, to incorporate those who struggle on their recovery journey. The multiple reviews show the CHIME framework needs to be modified and adapted to different populations and settings (Rayner et al., 2018; Van Weeghel et al., 2019). Yet, to date this framework is the best conceptualisation of recovery.

1.3.2 Recovery Orientation Measures

Due to difficulties in the conceptualisation of recovery, there are challenges in developing a reliable assessment of recovery (Noordsy et al., 2002; Slade & Hayward, 2007) and of recovery orientation in mental health services (Williams et al., 2012). The document "Recovery competencies for New Zealand Mental Health Workers" (O'Hagan, 2001), states that recovery is an approach to service delivery, which enables people to draw upon their own resources, and community resources with the support of mental health service providers. However, there are no clear guidelines of what recovery-oriented service is (Lakeman, 2010). In the area of service provision, there are a number of documents which talk about developing recovery-oriented systems of care (Edelman, 2013), highlighting that the recovery approach includes not only initial treatment, but a continuum of care provided within recovery-oriented systems (Berger, 2018). Such a development is considered to be an organisational change and should therefore be individually designed and implemented according to each community and organisation (Edelman, 2013; Farkas et al., 2005).

Maternal mental health respite is a recovery-focused service. The recovery approach in the researched facility, is initiated with each resident using a personal plan, which is completed by the resident with the assistance of staff during the arrival process. This plan outlines the goals of stays, the importance of the goals for an individual and the steps which can be taken to achieve these goals. During the stay, staff will follow the personal plan goals and suggest activities to a resident, in order to assist in meeting these goals. Common suggestions can prompt residents to sleep, relax,

attempt sensory modulation activities, improve their regular food intake and give attention to their baby.

1.4 Service User Experiences of Maternal Mental Health Services

In recognition of the importance of maternal mental health, specialised maternal mental health teams have been established in most developed countries. Unfortunately, the provision of such services is not consistent. In the United Kingdom, for example, provision depends on the individual's place of residence and only 15% of the geographical area is covered at the recommended level of care (Royal College of Obstetricians and Gynaecologists, 2016; Maternal mental health, 2016). In fact, maternal mental health services were found to be short of necessary resources and unable to provide adequate help in 41% of cases (Unite-CPHVA, 2016). In addition, professionals working with mothers reported an insufficient level of training in maternal mental health (PANDAS, 2017).

There is a small quantity of qualitative research exploring service user's perspective on maternal mental health services (Hadfield & Wittkowski, 2017; Higgins et al., 2016; Megnin-Viggars et al., 2015; Phillips & Pitt, 2011), with four universal themes throughout: barriers to disclosure of mental health symptoms, service user perspective of the structure of a mental health service, building rapport with health professionals, and availability of treatment options. These four themes are presented below in more detail. They reflect the general shortfalls of the services with one or two rare exceptions.

The main barriers to disclosure and help seeking were a fear of losing custody of the baby (Megnin-Viggars et al., 2015), negative experiences with general health services (Hadfield & Wittkowski, 2017), assuming that the purpose of postnatal visits is for baby's wellbeing only (Hadfield & Wittkowski, 2017) and the stigma attached to mental health in general (Hadfield & Wittkowski, 2017; Megnin-Viggars et al., 2015; Phillips & Pitt, 2011). In the New Zealand context, mothers have reported additional barriers such as being undermined by certain family members and friends and geographical isolation from specialised help (Phillips & Pitt, 2011). Additional barriers to attending therapy sessions reported are cultural beliefs and practical difficulties, such as finding childcare and driving (Megnin-Viggars et al., 2015).

The theme regarding the structure of maternal mental health services includes three central topics. The first relates to the difficulty in accessing maternal mental health services, with some rare exceptions where maternal mental health units were a part of

the hospital (Higgins et al., 2016). The second is the fragmentation of care, which can be seen when various health professionals are inconsistent with their input into the care of the individual mother (Hadfield & Wittkowski, 2017; Megnin-Viggars et al., 2015). The third relates to difficulties with the discharge processes, where women felt little control and reported a detrimental impact on their mental health (Hadfield & Wittkowski, 2017; Myors et al., 2014).

Building a rapport with health professionals in maternal mental health services was found to be an important part of the recovery process (Hadfield & Wittkowski, 2017; Megnin-Viggars et al., 2015; Patricia, 2016). However, when women perceived health professionals as judgemental, the experiences of care were less than desirable (Megnin-Viggars et al., 2015; Phillips & Pitt, 2011). In addition, there were preferences for discussion regarding postnatal mental health, symptoms, management, and treatments, rather than being offered information to read (Feeley et al., 2016). The need for education for health professionals was highlighted, especially when working with extended family and partners, which is necessary to improve connections and social support networks for these women (Phillips & Pitt, 2011).

There is a significant gap in the domain of information regarding treatment and treatment options. Women have asked to have treatment choices and the ability to discuss suitable and individualised treatment options (Megnin-Viggars et al., 2015). A common theme throughout various pieces of research is the reluctance of this group to use or take medication (Hadfield & Wittkowski, 2017). However, non-pharmacological treatments were not readily available and, in most cases, not offered (Hadfield & Wittkowski, 2017). This could partly explain a sub-theme of discontinuation of treatment without medical recommendations and subsequent failure of the available interventions (Megnin-Viggars et al., 2015).

Research has also highlighted that service users prefer support groups and peer support as modes of therapeutic intervention. The participants involved in recent studies expressed an appreciation for the opportunity to share their experiences by talking to others with similar difficulties and building support networks (Megnin-Viggars et al., 2015; Phillips & Pitt, 2011). Moreover, women gained a sense of hope and inspiration when they engaged with others who were further along in their recovery journey (Phillips & Pitt, 2011).

Although maternal mental health respite was not one of the options offered to mothers in the above studies, it is offered to mothers in Auckland, New Zealand

(Hawkridge, 2017). This setting is unique to New Zealand and has no known studies about it. However, we know of the benefits of respite services for mothers from Australian studies about early parenting residential programmes.

1.4.1 Australian early parenting residential programmes

Australian early parenting programmes is a type of the residential setting accommodating mothers and their children. These programmes admit mothers and babies with a variety of difficulties, including unsettled infant behaviour, long periods of crying, dysregulated sleep and feeding patterns (Rowe & Fisher, 2010). Many mothers admitted to this programme do not have enough emotional and practical support in their lives (Hanna & Rolls, 2001), while some have health concerns and others have a history of loss of a baby or psychiatric illness (Rowe & Fisher, 2010). There are also mothers that have had a traumatic birth experience or conceived using reproductive technology (IVF), which are considered to be risk factors for developing mood dysregulation after childbirth (Cairo, et al., 2012; Fisher et al., 2008). More than 25-39 % of the mothers admitted to the residential early parenting programmes, meet the diagnostic criteria for major depression (Fisher & Rowe, 2005; Phillips et al., 2007), while 25-30.5% meet the criteria for anxiety disorders (Phillips et al., 2007). Adjustment disorder and clinical exhaustion are also common diagnoses among admitted mothers (Fisher et al., 2004).

Rowe and Fisher (2010) explain that during the programme, mother and baby are accommodated in the facility for the duration of their stay and supported by the staff 24 hours a day. The team of support staff includes maternal and child health nurses as well as early childhood professionals. The programme is individually planned, but mainly focuses on safe childrearing practices and aims to increase parenting confidence in both group and individual settings.

Early parenting programmes have demonstrated high levels of consumer satisfaction with the services provided (Rowe & Fisher, 2010; Rowe et al., 2012). A qualitative review showed that women felt more confident, capable, and hopeful after a stay in the programme (Priddis et al., 2018). Women also reported that admission to the programme added insight into their own mental health and enabled them to identify their “own distress, anxiety or depression” (Fowler et al., 2012, p.68). Quantitative research also found a significant decline in participant anxiety and maternal distress between the start and the end of the programme, with a sustained decline at four weeks post discharge (Treyvaud et al., 2009).

1.5 Current Research About Maternal Mental Health Respite

Although there is no published research about maternal mental health respite facilities in New Zealand, there are two pieces of unpublished research about He Kakano Ora (Jackson, 2018; Lehndorf Moore & Sanches-Jimenez, 2019), which provided valuable demographic information related to residents and details about women's experiences at the respite. This information based on surveys and a focus group noted that out of 330 users completing the exit questionnaire, 52% were between 26 and 35 years old, 35% between 36 and 45 years, and 13% were between 18 and 25 years old. Most (almost 200 people) were New Zealand European, followed by Māori (just above 50 people) and European (50 people). Common themes relating to sleep, help provided by the staff and the physical environment were prominent in the women's accounts of their experiences. Overall the research indicated that although the women surveyed found the facility helpful, there were a number of highlighted themes showing perceived shortfalls in the services provided.

Both pieces of research highlight high user satisfaction with the respite service provided and especially the opportunities offered to meet self-care requirements including uninterrupted sleep. Although, the overall facility environment was positively appraised, there were themes related to noise and excessive light in the room, which residents found unhelpful. The topic of insufficient information prior to arrival at the facility was raised a number of times, when women did not know what to expect from the facility and what to bring. This uncertainty prior to arrival was found to negatively affect women's experiences at the facility (Lehndorf Moore & Sanches-Jimenez, 2019). Another prominent theme in both pieces of research related to the staff, which attracted positive and negative comments about residents' experiences, as well as comments about an insufficient number of staff.

Some of the important themes were not clarified within reports, which made it difficult to understand what factors made most difference in respondents' experiences of the respite. For example, the number of times desired services were not provided or managed by the facility procedures were prominent themes in the reports. When a breakdown of interventions was given there were no indication of rankings made against each other or frequency of mentioning each intervention. This made it difficult to ascertain the importance of each intervention for respondents. This would appear misleading for readers who are not familiar with details of the facility operation.

Both pieces of research gave an overall indication of the positive difference the respite facility makes in women's lives. However, it is difficult to ascertain the factors contributing to their experiences and the importance of these factors for the residents of the facility. Therefore, this current research focused on eliciting the in-depth experiences of the mothers and describing the most prominent themes/factors which contribute to mothers' experiences at the respite.

1.6 Relevance to the Current Research

Maternal mental health is a current concern in the New Zealand public health agenda as it is internationally. Since 2012 there has been increased attention paid to this area, with more government funding being allocated to improvements in support for women and professionals working in this space. Particular attention has been drawn to community services, as this is the setting serving the majority of mental health consumers. Part of the development of community maternal mental health services has been the opening of the maternal mental health facility "He Kakano Ora" in Auckland in 2015. Since then, continuous service developments and improvement measures have been employed at the facility. However, there are no published pieces of research to indicate recovery outcomes and women's experiences of the service.

The limited research studies that are available provide an indication of user satisfaction with the overall services provided by the facility, however, they give no detailed information about users' experiences in the facility. Therefore, there is a need for an in-depth exploration of service users' experiences at the facility, with an indication of which experiences are of most importance for the service users. This information will provide focus areas for future improvement measures and further research, as well as, highlight recovery practices adopted by the facility.

In New Zealand, a recovery approach provides an overarching framework to service delivery and planning (Reed & Field, 2017). The starting point to the exploration of recovery-oriented services is knowledge about the experiences of people who use the service (Thornicroft & Slade, 2014). This will enable researchers to gain knowledge about the benefits of service use, and the effects of these experiences on people's lives. This research is a first attempt to bring together bodies of knowledge surrounding maternal mental health respite care and service user perspectives on respite care in a specialised recovery oriented maternal mental health respite facility. In addition to this, as well as documenting the experiences of service users at HKO, this

research seeks to gain an understanding of whether these women's experiences reflect the recovery approach.

1.6.1 Study aims

The central goal of this research was to explore mothers' experiences of stays in a short-term maternal mental health respite facility. Special attention was given to experiences which mothers found helpful or unhelpful while staying at respite, as well as general expectations from their stays. Experiences which indicate facility adherence to the recovery approach were noted.

The focus was on in-depth exploration of the mothers' experiences of respite stays. Therefore, a qualitative methodology was required (Creswell & Poth, 2018). The desire was not to conform to any preconceptions, but to allow participants to tell their stories and expand understanding of their experiences.

Chapter 2: Methodology

This chapter outlines the research method adopted in this study, that is Interpretative Phenomenological Analysis (IPA), which is followed by a description of the maternal mental health respite facility where research was conducted. It continues with a description of the research process including the recruitment and interview procedure that was used to find participants. Next ethical considerations are discussed. After this, two consultation processes are outlined, these involved a group of ex-service users and a Māori adviser. Next an explanation of reflexivity as a necessary part of IPA and the quality assurance processes is given. The last two sections of the chapter cover the data analysis and quality assurance procedures undertaken by the researcher.

2.1 Interpretative Phenomenological Analysis

IPA is a qualitative approach developed for psychological research (Smith & Shinebourne, 2012). It is suggested that it is particularly suitable for the new research topics in areas which are underresearched (Smith & Shinebourne, 2012). IPA is used for three main reasons, namely, in-depth understanding of human experience (Crist & Tanner, 2003; Smith et al., 2009), elicit the meaning of the experience to the participant and understand the process of making sense of that experience (Smith, 2011; Smith & Osborn, 2008). The aim of IPA research is detailed exploration of the experiences, not the examination of hypothesis. Usually, this type of research has a small homogeneous sample size of participants with the same "lived experiences" which potentially can be examined further for similarities and differences (Smith et al., 2009). In the current study homogeneity was achieved by including women who stayed at the same respite facility with their babies during the six month period.

IPA incorporates three main theoretical features: phenomenology, hermeneutic, and idiography. Phenomenology is a philosophical approach developed by Husserl (Palmer, 1971). It focuses on detailed accounts of the lived experiences (Eatough & Smith, 2017; Mapp, 2008), within the social and historical contexts that these experiences have occurred and without any pre-existing theoretical preconceptions (Smith & Osborn, 2015). Phenomenology is concerned with an individual's personal perception of an event or an object, and the meaning that this individual attributes to the encounter or experience (Smith et al., 2009). This research focuses on the detailed exploration of mothers' experiences in a maternal mental health respite, which align with phenomenology as a framework.

Hermeneutics is the theory of interpretation (Smith et al., 2009). Hermeneutics acknowledges the interpretative nature of "doing research with people" (Shaw, 2010, p. 177). IPA assumes that meaning making is a necessary part of the experience and has to be expressed by language in written or oral form (Shaw, 2010; Tuffour, 2017). Meaning in IPA is constantly changing which can be interpreted and reinterpreted many times. Therefore, a researcher should be aware that the meaning which a participant attributes to an event or experience is valid only during the process of an obtaining that information and might change in the future. For this reason, meaning making cannot be generalised beyond the information collection point. However, observations can be made about similarity or diversity of meaning making within the group of participants. It is important to note that in conducting IPA, the researcher is involved in a "double hermeneutic", which comprises making sense of the participants' sense making (Smith et al., 2009). The researcher should be aware of their own assumptions and preconceptions in regards to the participants' experiences, and take this into account when making interpretations. Through the process of reflexivity, the researcher is able to acknowledge personal biases and beliefs in regard to the topic and recognise them during the analysis process. The reflexivity section of this chapter provides the researcher's relevant history and acknowledgement of topics needing special attention.

The idiographic nature of IPA allows researchers to produce analyses of an individual experience as a unique representation of the researched phenomena. It focuses on each case individually and the unique context the experience has occurred in (Pietkiewicz & Smith, 2012). IPA explores how the process of meaning making happened for each individual, before looking for similarities across all research cases. The initial detailed case by case analysis of the interviews in this research exemplifies the idiographic nature of IPA.

2.2 Description of a Short-Term Maternal Mental Health Respite Facility

The following section gives a short description of the maternal mental health respite facility where the research took place. It is important to understand the environment and general protocols of the facility in order to understand participants' accounts of their experiences in the respite.

The maternal mental health respite in West Auckland is a purpose-built residential facility, where mothers experiencing antenatal distress can stay with their baby/ies or from the second trimester of the pregnancy until one year postpartum. The facility is staffed 24 hours a day 7 days a week by a mix of registered health

professionals and mental health support workers, who are trained in the domains of mother craft and mental health. Mothers' who come to the respite have to be referred by their key worker from Maternal Mental Health (MMH) teams at Auckland or Waitemata DHBs. The reasons for referral and duration of stay vary, therefore respite plan is created for each mother individually. The duration of their stay can range from one day, when a mother comes in the morning and leaves in the evening, to ten nights, which is the limitation of the operational contract. There are two types of admission to the respite: acute and planned. The acute admissions always take precedence over planned admissions, as the mother experiencing a mental health crisis. Planned admission could be one off or regular planned stays, which are becoming quite popular modes of support among referring MMH key workers. There is always a possibility that a planned admission can be postponed, due to the limit of six rooms in the facility, if there is an acute admission coming.

The inside of the facility looks like a big family house. It has six bedrooms, each equipped for a mother with a baby under the age of one year old to stay. Each bedroom has its own en-suite. There is a big kitchen, two spacious lounges, and a group room. The main respite space is kept quiet and relaxed, as mothers and babies often rest during the day. One of the lounges is used for key workers and other health professionals' meetings with mothers and whanau, as well as for whanau visits. The structure of the day depends on mothers staying at the facility and their goals of stay. Breakfast is self-served by residents due to individual differences in waking up times, while lunch and dinner is cooked and served by staff. All cleaning in the facility is done by staff. For most of the day staff supports each mother to follow her plan, which reflects her recovery needs. For example, if there is a need for rest, staff will care for her baby and the mother will go to sleep/rest; if there is a need for mother craft guidance staff will spend time with the mother and her baby talking, guiding, pointing out significant cues baby is displaying.

The facility operates according to recovery practice. Therefore, all the plans and support are guided by mothers and developed in collaboration with the mothers during their entry process. Staff are guided by a key worker's referral to help a mother to formulate goals of stay. Goals are revised on a regular basis, usually during each entry to the facility, if mother is well enough to do that. In addition to activities outlined in the respite plan, residents can access weekly group activities like craft group, baby massage, mainly music sessions and two eight-week courses targeting mother craft

skills and attachment with the baby. There are individual sensory modulation sessions and other sensory activities like massage chair, bubble bath, exercise program available for all mothers in the respite. Cooking and baking activities are always available for those you wish to do it.

2.3 Process

Preparation part of the research consisted of two consultations, one with a Māori adviser and the second one with the group of ex-service users. These consultations provided sufficient information and rationale for the completion of the Ethics proposal. Upon receiving the ethics approval, the recruitment of participants began. Before starting interviews the researcher conducted a pilot interview with one of the ex-service users. Interview transcripts were completed by the researcher after each interview and transcripts returned to participants for editing. Data analysis commenced upon completion of the final interview.

2.3.1 Participants

Postnatal mothers who had an experience of the respite stay were eligible to participate in the research. The inclusion criteria were proficiency in English, to be able to answer interview questions without additional stress; history of the postnatal respite stay, as pregnant mothers were not included due to time and resource limitations of this research. Two inclusion criteria that ensured that mothers were well enough to participate in the research were absence of current plans to return to the respite, and mother living at home at the time of the interview, not at another facility.

The research sample consisted of eight participants following the suggestion for IPA study from Smith and colleagues (2009) to recruit three to six participants and to allow margins for participants withdrawal. This type of study had never been conducted at the respite facility and the researcher was unable to predict withdrawal rate. Therefore, generous allocation for this factor was planned in the number of participants. The recruitment for this study was successful and the number of participants wishing to take part in the study exceeded eight. Consequently, upon completion of the eight interviews the researcher informed the remainder of the mothers about the conclusion of the interviews and thanked them for the offer to participate.

Although demographic information for participants was not collected, from previous research at this facility, we know that 52% of women coming to respite are between 26 and 35 years old, and more than 57% of women in respite are of NZ

European ethnicity (Lehndorf Moore & Sanches-Jimenez, 2019). The group of interviewed mothers reflects this demographic.

2.3.2 Recruitment

All permanent staff members of the respite facility were trained by the researcher to introduce the research to the exiting mothers personally and over the phone. Staff received instructions on the inclusion criteria and the correct way of introducing the research to avoid coercion. Staff members explained the purpose of the research to all mothers meeting inclusion criteria and asked if they wished to participate. If the answer was positive, the information sheet (Appendix A) and the research consent form (Appendix B) were given to all mothers to take home and read in their spare time. Consent to contact (Appendix C) was also offered for signing. In cases of over the phone introduction of the research, the verbal consent to contact was obtained by a staff member, and preferred method of contact was passed on to the researcher. The researcher contacted mothers and asked for the most suitable way to send the information sheet and the consent form. All mothers chose using e-mail for the paperwork. For the general contacts about interviews most mothers preferred text messages, and one mother preferred an e-mail. Four consents to contact forms were obtained, and one of the mothers declined participation in the research at a later date. The rest of the mothers were recruited over the phone.

A sample of eight mothers had been recruited with the assistance of staff members at HKO community and respite services teams. Most mothers discharged from the respite facility had planned to come back to respite care, therefore the originally proposed way of recruitment during discharge, was followed through with one participant only. The remainder of the participants were recruited with the assistance of a community team, who went to visit the mothers at their own homes. The team members were able to offer participation to the mothers who had one or more respite stays and had no plans for respite stays in the future. A sample of eight participants was recruited and interviewed within three months. The staff commitment to support the research was evident, the updates about the number of participants in the study were given at the staff meetings by the facility manager. The e-mails from the facility manager to the staff members with the proposed research participants was a regular occurrence during recruitment period.

2.3.3 Interviews

Prior to conducting interviews, the researcher organised a pilot interview with one of the former service users from the consultation group. The interview took place in a

study room at the mother's local library. It was conducted in order to trial the interview prompts and for the researcher to have a first attempt of conducting the interview. The interview was recorded with mother's verbal permission. The researcher received supervisor's and mother's feedback about the way the interview was conducted; one of the most important lessons was to not to follow the script with prompts, but to follow the mother's story.

Subsequently, six research interviews took place at HKO respite facility and two at participants' own homes. Prior to each home interview, the researcher, with participant agreement, actioned a safety protocol. The safety protocol consisted of informing supervisors about the time, date and, the place of the interview, the name of the participant and the researcher's next of kin contact details prior of the interview. Upon completion of those interviews, the researcher sent an e-mail about the safe completion of the interviews to the supervisors. After the receipt of the e-mail, all communications related to the safety protocol, were permanently deleted by the researcher and supervisors.

On the interview day at HKO, the researcher welcomed the mother, helped to settle their baby with the childminder. Three mothers took advantage of the babysitter service, all at HKO facility. The researcher offered a drink and snacks to all participants before and after the interview. When interviews took place at mother's home coffee and snacks offered at the beginning of the interview. When in the interview room, the researcher explained the information sheet (Appendix A) and the consent form (Appendix B) and asked if the mother had any questions. The consent form was signed before the interview commenced. The researcher recorded all interviews on a digital recorder with the permission of the participants incorporated in the consent form. Before the interview began, the researcher reminded the participants that recorder can be turned off at any time, and also that participants are free to discontinue participation in the study at any point, take a break or decline answering any question. None of the participants requested for this to occur during the interviews. Before interview commencement, the researcher explained that the interview will be transcribed by the researcher, and participants would have an opportunity to check the transcript for accuracy. If a participant declined the opportunity to check the transcript, they were asked to give written permission to release their transcript (Appendix D) before the interview. Three participants were interested to check their transcripts and the transcript release form was e-mailed to them with the transcript. All participants signed transcript release authority form before analysis of the interviews were completed.

Each interview was conducted so that participants felt the power to respond in their own way without being constricted to the fixed responses (Mack et al., 2005). In order to assist with the progression of the interviews, a set of prompts for the semi-structured interviews was created (Appendix E). However, the only question asked at the beginning of each interview was "what have been your experiences in He Kakano Ora?" Other prompts were used as necessary to clarify or direct participants towards a description of their experiences in detail and according to their initial responses. The duration of the interviews ranged from 31 to 57 minutes, with an average of 40 minutes per interview.

2.4 Ethical Considerations

The research was approved by the Massey University ethics committee Southern A 19/12 (Appendix F). The initial risk highlighted the need for special considerations because the research participants were considered to be a vulnerable group. Therefore, a special consultation group, which included former service users, a member of the staff and the facility manager, was created to find a best way of addressing the vulnerability and the special requirement of the researched population.

2.4.1 Consultation Group

There is evidence, that consulting service users about research practices, improve the quality, relevance, and effectiveness of the research procedures (Evans et al., 2019; Harris, 2005). Improving the content and phrasing of the study by service users, ensures that the research can be explained to potential participants most effectively (Koops & Lindley, 2002).

The consultation group meeting took place on 23rd February 2019, at He Kakano Ora respite facility. The group included four former service users, the facility manager and the staff member who had worked at the facility since its establishment in 2015. The facility manager and one of the former service users, identify as Māori. The agenda of the group (Appendix G) was to discuss the service user involvement in the research. The discussion was guided by discrepancies in traditional ethical research practices, and the reality of the research with mothers in the care of maternal mental health teams. Previous research on this population found it difficult to recruit at the beginning or the middle of their involvement with maternal mental health teams, due to the distress they were experiencing at those times (Hannah, 2005). Moreover, in Hannah's (2005) research, written invitations to participate were 100% not effective, although some of the same mothers agreed to participate after a personal invitation.

The following topics were covered during the group meeting: recruitment procedure, the consent and the information sheet content and wording, interview questions and interview procedure. At the beginning of each topic, I explained the proposed proceedings and the rationale behind it, and then asked for the feedback. I was particularly interested in the barriers which might prevent service users from participation, and the considerations for the mental health of the potential participants.

The following changes to the process suggested by the group. The consultation group suggested that the researcher contact mothers who wished to participate in the research, instead of waiting for mothers to contact the researcher after the initial introduction of the research by facility staff. As a result, the consent to contact form (Appendix C), was developed in order for mothers to give permission to the researcher to contact them. I had planned a number of inclusion/ exclusion criteria. One exclusion criterion was “only mothers who are going home from respite” will be asked to participate in the research, not mothers who were going on to other places rather than home. The consultation group suggested another exclusion criterion for mothers who had plans for a future respite stay at the time of discharge. Regular planned respite stays are a common option of respite use for mothers who are unable to stay over consecutive days or need an intermittent support. For the interview process, the group suggested to arrange interview places outside of the respite in the community halls closer to participants homes, for the convenience of travelling.

There were number of suggestions about changes for the paperwork. Change of name for the information sheet was suggested. The original name was identical to the research name: “Service user experiences of short-term maternal mental health respite”, which was changed to “Mothers experiences at He Kakano Ora”. This change was suggested due to the stigma attached to mental health and preference by the group members for the documents, which mother will take home, to not to have any references to mental health or institutional language. The main changes in paperwork included: tick boxes in the consent form, rather than a paragraph of a written text; transfer of participants rights on the first page of the information sheet; including options for text and e-mail contacts, not only the phone as originally planned; and some rephrasing of the information sheet sentences to avoid participants getting pre-conceived ideas about expected answers. Some adjustments were made to the structure, wording, and a format of the consent form (Appendix B) and the information sheet (Appendix A). Some of the

interview questions were rephrased to avoid confrontational tone and negative connotations (Appendix E).

2.4.2 General Ethical Considerations

Special provisions were made due to vulnerability of the research population. For the assurance of informed consent, the participants were encouraged to take the information sheet (Appendix A) and the consent form (Appendix B) home and talk to their family, friends, or their health professional about the participation in the research. This was put in place to ensure that participants had enough time to consider the efforts required to participate in the research and consult with trusted people about it if they wish. The offer of participation was introduced with regards to vulnerability of participant and made by the facility staff member during the discharge procedure or after the discharge from the respite. It was considered that, at this time, mothers more likely to be at her best capabilities to make a decision about the participation in research, rather during a respite stay. Any potential harm to the participants was discussed with the consultation group and supervisors. Telephone numbers for mothers experiencing any distress after the interview were provided in the information sheet (Appendix A). Moreover, in advance of the recruitment procedures the separate information sheet was send to maternal mental health teams to inform key workers about commencement of the research (Appendix H). This was done to inform key workers about the possibility that mothers under their care might participate in the research or look for the advice on participation, as well as might require additional support after the interview.

Standard university policies were adopted in most areas concerning ethical proceeding of the research. In regard to anonymity and confidentiality following measures were implemented. The laptop used for the research purposes was password protected, with data backed up to a OneDrive account provided by Massey University. Paper data was mailed to the supervisor for a five-year storage in a locked cupboard. The informed consent about analysis of the data was ensured by the consent form (Appendix B) which included an agreement for voice recording during the interview process. A separate transcript release authority was signed by each participant, to allow the researcher to use quotations from their interview in the final document (Appendix D). Dissemination of the findings and uses of the information obtained from the interviews were outlined in the information sheet (Appendix A). Moreover, permission

from the CEO of Walsh Trust was obtained to identify He Kakano Ora respite facility in the final report.

Accommodation for babysitters was made for the mothers who wished to bring their children to the interview. Funding was obtained to cover the cost of a babysitter. Also, I had arranged the current respite staff members to babysit to minimise the mother's worry about the qualification of a babysitter, and based on common practice during the respite stay, which requires staff members to care for the baby.

In order to maintain the role of the researcher in this study, I had to suspend my employment at the respite facility for the duration of the recruitment process. By doing so, I attempted to avoid contamination of the interview data from any of the participants' personal feelings towards me. However, I had one mother who I cared for as a staff member on a few occasions six months prior to her interview. This did not seem to affect her willingness to talk to me about her experiences, as she focused mostly on full-time staff members, when we discussed the topic of staff.

2.4.3 Cultural Considerations

Cultural competency is an important ethical consideration and is a recognition of New Zealand's official bicultural state. This research complies with Te Ara Tika guidelines (Hudson, 2010), for the mainstream "minimum standards" of research. Contrary to the guidelines, ethnicity data was not collected in this research due to the small sample size. Planned consultations with the Māori adviser, and agreement for the future consultations should the need arise, were completed in January 2019. Consultation covered all aspect of the research related to culture. It also included the importance of equal access to the benefits of the research, and an explanation of the risks to all participants. In addition to Te Ara Tika guidelines, I included five methodological components which have been developed for Kaupapa Māori research about adverse experiences in childbirth (Stevenson, 2018). I found those components a good fit for the research procedures, and they enhanced presence of tikanga Māori in the research. Those components included: whanau, wahi haimaru, whakaaro, kaitiaki and hononga.

Whanau component involves the knowledge, acknowledgement and the support of my own family, my personal knowledge of who I am and my ancestors. This information is outlined in the reflexivity part of this chapter. In addition, including the participants' whanau was achieved through the invitation to the support person/s to attend the interview, which was included in the information sheet (Appendix A), and

general openness to the inclusion of whanau values in the way that wahine would feel appropriate.

Wahi Haimaru (safe place) is a component that was carefully considered for this research project. The respite facility group room is a safe place and known to the mothers. It also allowed childminders to care for their children in the next room, which is also safe, secure and known to mothers. There was also an option for participants to nominate another place for an interview if they wish. Kai (tea/coffee and snack) was offered before and after the interview as part of "creating a safe place" for the interview. Another aspect of creating "safe space" was the introduction of the research to mothers. As mentioned above, this was done by the facility staff member who had cared for the mother during her stay in the respite, and so there was already an existing relationship. The researcher had considered this way to be "safer" for vulnerable mothers, rather than the first contact by a researcher with whom they are not familiar.

Whakaaro (engaging in Māori philosophies) was present in the form of the researcher's developing awareness of the various aspects of te Ao Māori in regard to physical, mental and spiritual health. The chosen methodology for the research Interpretative phenomenological analysis (IPA) has been found to be Kaupapa Māori friendly by some researchers (Harris et al., 2016; Stevenson, 2018). IPA aims to interpret participants' own narratives within their frame of understanding with minimal involvement from the researcher's point of view.

Kaitiaki (being empathetic) is a central skill to conducting the interview and interacting with study participants. The expression of empathy depends on the participant/whanau and their needs. Some Pakeha research suggests that empathy can foster increased disclosure of information and is effective when an interviewer shows empathy combined with non-judgemental behaviour (Oxburgh & Dando, 2011).

Hononga (building and maintaining relationships) started from the first contact with wahine. This included taking the time to answer any questions a mother had and an explanation of who I am and why I was doing this research. The sharing of a Kai before and after the interview gave me an opportunity to develop the relationships with mothers, and simultaneously create a wahi haimaru (safe space).

2.4.3.1 Consultation with Māori Adviser.

The consultation with Dr Natasha Tassell-Matamua, Senior Lecturer at Massey University's School of Psychology took place January 2019. I had prepared a document outlining the proposed procedures and considerations for the research (Appendix I) in

advance of consultation and e-mailed it to the adviser. During the consultation, this document was discussed. Upon completion of the consultation, Dr Natasha Tassell-Matamua requested the Information sheets and the interview schedule. The proposed changes to those documents were made by the researcher and returned to Dr Tassell-Matamua. On 11th February Dr Tassell-Matamua e-mailed a letter of consultation (Appendix J).

2.5 Reflexivity

Reflexivity is an important part of qualitative research, especially for IPA (Smith et al., 2009). It helps researcher to acknowledge biases, preferences and predispositions, and their influences on the research process (Schwandt, 2007). It supports the construction of impartial ways of conducting IPA research and interpreting results as the researcher becomes more aware of the influences their personal experiences have on a research project (Etherington, 2004). Therefore, reflexivity is believed to improve credibility (O'Connor, 2011) and rigour of research (Etherington, 2004). As a part of reflexive process, I kept a reflexive diary where I made notes about my thoughts on the process of research. The diary started during the process of interview transcribing. I recorded my thoughts and feelings about each interview and transcription, especially at the times when I had an emotional response, or found myself identifying with the participant due to similar experiences in my life. I made a note of these occurrences, so I would be careful not to attribute my own meanings to this part of the data.

2.5.1 Positioning Myself

Reflexivity is equally an important part of the whanau component of this research. It consists of the knowledge of who I am and where I come from before working with other whanau. Therefore, I have included small descriptions of relevant parts of my life history to explain the personal context from which this research has emerged. My family is multicultural. In recent years, I have extended my predominantly Russian whakapapa with connections to Ngai Tahu Iwi, through my husband and father-in-law. I revel in the feeling of my family belonging to such a great Iwi with a long-standing history and universal humanistic values. Myself and my son, who is Ngai Tahu, attend a few Ngai Tahu gatherings each year and a Russian school once a week. We use these opportunities to connect and learn more about te Ao Māori and Russian culture. I believe that a multicultural upbringing creates more respect towards other people, and an ability to comprehend the variety of values that people possess. I have developed my value base through travelling and study. I was born in St.Petersburg,

Russia and graduated as a Social Psychologist in 2003 from St.Petersburg State University. During my study and up until leaving Russia, I conducted social skills development groups for adolescents with physical disabilities. At the end of 2003, I moved to London where I completed an MSc in Psychotherapy Studies and worked with children with learning disabilities. On moving to New Zealand in 2008 I have taken up postgraduate study at Massey University to allow me to register as a psychologist.

The most relevant to this research part of my history relates to the birth of my son in 2013. When I had an adverse mental health experience, leading to my interest in maternal mental health and effective support interventions for postnatal mothers. I had to be aware of this part during the interviews and not to attribute my own understanding of the experiences to that of mothers described. I have subsequently been employed with Walsh Trust maternal mental health respite for over three years. Which also created a need for acknowledging my role as a staff member and monitoring my understanding of the mothers' experiences from their perspectives rather than from a staff perspective. This research is an extension of my passion in this area of mental health. Before commencements of the study I have been researching Auckland perinatal mental health area by talking to professionals and attending networking forums and conferences for over two years. I aimed to understand current research needs, and consequently created the research which I believe, will make a difference in the field of maternal mental health as the first academic exploration of maternal mental health respite.

2.6 Data Analysis

The transcription of each interview was followed by qualitative phenomenological analysis using the Atlas.ti 6.2 software. Each interview was analysed individually to follow the phenomenological nature of IPA and eliciting an in-depth individual experience of the stay in the respite. The first read of the transcript followed suggested guidelines for IPA analysis, and allowed familiarisation with the data (Shaw, 2010; Terry, 2019). Notes were made to highlight interesting or significant parts of what was important in the mother's experiences at the respite, as well as personal assumptions that were related to the post interview notes recorded in the reflexive diary. The later process was particularly important as the researcher's aim was to understand the experiences from the mother's point of view, however additional knowledge about the facility, or reasons for certain procedures, sometimes diverted the thinking process

to an explanation of occurrences, rather than a description of the mothers' experiences. Comparison with the reflexive diary helped to highlight any discrepancies, and correct the process of coding, towards understanding mother's experiences. The researcher reverted to the reflexive diary when unsure whether interpretation came from the participant's experience or not, trying to develop new way of understanding the data.

The second read of the transcript was focused on eliciting the main topics of the interview and the generation of the codes. As expected, some parts of the interviews were richer in content than others (Smith & Osborn, 2015), therefore the generation of codes was not a steady process and depended on the context of the interview and its relation to the experiences in the respite. Preliminary interpretations of the data were recorded in the notes for easy access during the following analysis process. The next stage was the production of the themes by grouping the codes. Some themes reflected of the interview prompts and described the experiences related to the respite processes (arrival, group activities, meals etc.). Other themes related to the personal and the emotional components of the experiences (interactions with other mothers, perceptions of staff etc.). The following stage related to making interpretations in regards to the connections within each theme and the construction of clusters explaining the content of the theme.

Upon completion of the case by case analysis, themes were connected across participants and the common themes through the interviews were produced. When a final list of themes was established, the detailed description of the themes was produced including linking each theme to the current literature in order to illustrate and provide further interpretation. Important to note, that the results section using pseudonyms instead of real participants names to preserve confidentiality close of this research.

2.7 Quality Assurance

The concept of *trustworthiness* by Guba and Lincoln (1989), is most commonly used in the domain of qualitative research to address validity and reliability (Baxter & Eyles, 1997; Bergman & Coxon, 2005; Cypress, 2017; Korstjens & Moser, 2017). The concept was first presented in 1980, and since attracted the attention of many researchers. According to Guba and Lincoln (1985), trustworthiness in qualitative research is equivalent to reliability and validity in quantitative research. Trustworthiness includes establishing four main characteristics: transferability, dependability, confirmability, and credibility.

Transferability according to Guba and Lincoln (1985) is to show that the findings can be applicable in a different context. The researcher should provide a detailed explanation of the researched phenomenon, for other researchers to be able to generalise it to another contexts. It is suggested that the researcher provide a "thick description" of the participants and the research process, to enable judgement about transferability of findings. The description can include, but not limited to, settings for the interview, inclusion and exclusion criteria, characteristics of participants sample, interview procedure, and quotations from the interviews (Korstjens & Moser, 2017). The information related to transferability of this study is included in the IPA, the process and the findings section of this thesis.

Dependability is the equivalent of reliability in qualitative research. It is showing that findings are consistent and can be replicated. Dependability can be achieved through an "audit trial" technique, which include another researcher confirming the accuracy of the process, and the findings of the study (Amankwaa, 2016). In order to achieve dependability, the application of the IPA method with a detailed description of it is provided at the beginning of this chapter. Moreover, one of the supervisors of this research, closely monitored the methodological aspects of this research, and progression of the analysis.

Confirmability is a degree of neutrality (Guba & Lincoln, 1985) and equivalent of inter-rater reliability in qualitative research (Korstjens & Moses, 2017). The researcher must assure firm connections between findings and data and provide evidence that sufficient control measures have been applied to avoid contamination of the results by researcher's feelings, perspectives and preferences. A reflexive diary and the electronic notes explaining analytic decisions has been completed during the analysis stage of the research, and is available for the audit trail.

Triangulation is another strategy to ensure confirmability suggested by Guba and Lincoln (1985). In this research, triangulation consists of multiple data sources (Guba & Lincoln, 1985; Pope, 2017) of eight interviews from eight individuals about the same experiences of stay in the respite. The findings of the research included a summary of common themes from these eight interviews, and are likely to be similar for another researcher of this phenomenon in this context.

Credibility is concerned with the truthfulness of the findings and is the equivalent of internal validity (Korstjens & Moses, 2017) in qualitative research. Lincoln and Guba suggested "prolong engagement, triangulation, persistent observation,

negative case analysis, referential adequacy and member-checking" as techniques of assuring credibility (as cited in Amankwaa, 2016, p.122). Apart from triangulation technique, which was described earlier, this research has been established as a result of prolonged engagement and persistent observation of mothers in the respite facility. The researcher's employment with the facility for over three years, has given an opportunity to engage with variety of mothers, and create the research based on preliminary observations during the employment. Negative case analysis consists of eliciting themes that the data supports, not the themes the researcher is trying to see in the data (Pope, 2017). In the current research, and as previously mentioned, this was achieved through reflexivity and the overseeing of the data analysis by one of the supervisors. A member check was conducted by the way of participants reading their own transcript of the interview, to ensure that the researcher has an accurate understanding of the experiences that the mothers had talked about. Unfortunately, only three participants chose to take advantage of this option. There was no referential adequacy check conducted due to limited amount of data available, and the inability to leave portions of the data not analysed for comparison purposes.

Chapter 3: Results

3.1 Recovery Needs

The analysis showed that mothers found mental health recovery to be a predominant and overarching need while at the respite facility He Kakano Ora (HKO). This chapter describes mothers' experiences in the respite and highlights important components of their stays elicited from their interviews.

All participants talked about the way the respite met their needs and assisted in their recovery, as well as the challenges they experienced at HKO. The five themes that emerged from the interviews were: a place to go for support, sleep, mothercraft, social interactions and the facility environment (Table 1). Each of these themes includes sub-themes elicited from the mothers' accounts (Table 1) and supported by illustrations from their interviews. All themes and sub-themes are presented in detail in the subsequent sections.

Table 1

Themes and Subordinate Themes Across All Participants

Theme	Subordinate themes
Place to go for support	Lack of support at home
	Adjustment to HKO support practices
	Support during mental health distress
	Importance of HKO support for mothers
Sleep	Effects of sleep deprivation
	Sleep and perceptions of parenting ability
	Sleep support offered by HKO
Mothercraft	Stories of low confidence
	Building mothercraft skills
	Mechanisms of building confidence
Social interactions	Loneliness
	"We are all together in this"
Facility environment	

3.2 Place to Go for Support

HKO as a place to go for support was one theme which stood out from the data. The mothers talked about having low support at home (3.2.1) which impacted on

their mental health. It was the goal of HKO to help provide this support for the mothers' recovery needs. In order to achieve this, the mothers had to undergo a process of adjustment to HKO (3.2.2), which included building trust and relationships with the staff as well as creating recovery specific routines for their stays. During these stays, the mothers experienced mental health distress that staff needed to support them through (3.2.3). This staff support, and the overall support offered by HKO, was of real importance to the mothers' mental health recovery journeys (3.2.4), as is illustrated below.

3.2.1 Lack of Support at Home

The main reason for coming to HKO for mothers was a lack of support or very limited support at home after their child was born. Consequently, the respite facility became a familiar place for mothers where they could come for support. Having the knowledge that the facility was available to them if they needed it became a part of their coping mechanisms during times of struggle. Isla, one of the participants I interviewed, explained: "It's nice to know that there was somewhere to come… so it's having a backup… was the main thing. You know, there's food available, if you need help, you've got it". Another participant, Melany echoed this:

> I think a lot of the mothers who come here, don't have supportive partners …which was definitely the case for me. It's been a hard year for me in terms of, you know, my head. And yeah, it's been nice to have people walk that journey with me. … even just the idea of coming here for a day, …and just having an extra hand [is helpful].

Women made decisions to come to the respite facility because they had urgent needs for rest and support with their babies, and an understanding that without this, their mental health would be compromised. This was illustrated by three participants Paula, Dianne, and Catherine. Paula explained: "It was, [in] the back of my mind, like, if you're really not coping if he [is] teething or anything, it's getting too much, like you can always go back … and I would leave [HKO] feeling better, able to deal with everything". Mothers described high stress levels leading to the respite entry. Dianne said: "So I wasn't coping at all, and for a long time, I relied quite heavily on HKO for support". Catherine described it as: "the point of just breaking …emotionally and mentally break[ing], just from exhaustion… In trying to do the right thing all the time… just exhausting". Interestingly, for Catherine, it was not only the respite itself, but also the anticipation of a respite stay, that was helpful:

> as long as that's booked and it's in my head and I've got it coming up, you know, it makes me go ‘OK. I can hold on until I can go there’ …that gave me that like oomph to get to that day.

HKO became a place of refuge that the mothers knew they could rely on for support that they were not getting at home. Paula noted: “I think once he got to like six months [there was] nowhere else I could go. No other help I could call on”. Laura reported a similar lack of support: “[It was a] huge relief coming back the second time… [a] weight off your shoulders’. You know, just a little bit of stress off going ‘OK, I know I'm in good hands here’…I’m coming to a safe place: a place that's relaxing, that is good for you, good for the baby. I was really relieved to get here”. For Hilary

> [it was] important to be able to just have that support, and just go and whether you need to rest or whatever. …I know that a lot of us come here and just go, ‘Oh my God, there's some actual help with our newborn or a baby!', you know, because you don't get it at home.

Nevertheless, two mothers mentioned that their family could have provided support if HKO was not available, although for both mothers their support people resided outside of Auckland, which was an additional barrier for the support provision. Coshima said: “I think my family probably would have stepped in and helped more if I didn't have this sort of support. …my family live up north.”. Hilary thought if she did not have HKO support her mother would need to fly from Wellington “more often. My husband needed to stay at home during the day from work. He might have had a few phone calls saying, ‘come home early’, but I think potentially that would have put a strain on our relationship more”. Hilary mentioned that her attendance of the respite provided a rest for her husband “which, I think, was just as important”.

Interestingly, many mothers compared HKO to a home with good support for them and their babies. Isla said that the facility was like a “grandmother figure in itself. It’s kind of like having the grandma that you never had …who's there with the answers... that wise knowledge about something…a lot of people don't have that. That little kind of nucleus support”. Hilary also perceived the facility as a “family support unit that most people… a lot of people get …like your mom coming over and being like, ‘hey, let me take the babies so that… you can sleep’ or ‘hey, why don't you lie down and read a book for an hour? While, I take the baby”.

A number of mothers mentioned HKO in the context of getting away from their home life to a place which enabled them to rest. For some mothers this rest resulted in increased capability to deal with their duties at home. Hilary explained: "[HKO] gives me that kind of break from everyday life that I need. I think, when I came back [home] I was more relaxed". Melany saw the facility as an opportunity to have "time out, you know, it was the first time in a long time. I actually had some time to myself." This time out allowed Catherine to go back to home routines and do more for her family:

> I would go back, and I'd be able to cook dinner that night, you know. And I struggled for that first year to cook dinner even with a well behaved, good baby…. So yeah, would just help me it just give me that little bit of brain capacity to do another... to do something else that's for my family.

3.2.2 Adjustment to HKO Support Practices

To be able to achieve their recovery goals, mothers had to go through an initial period of adjustment to the facility procedures and development of daily routines. This required the mothers to, as Melany noted, "adjust [to the fact] that someone else was helping with the baby". In order to do this, they had to develop trust for the staff's ability to care in the "right way" for their babies, as well as build confidence to ask for support when needed. The first procedure to aid this process was the completion of entry paperwork, which included information about their babies' routines for staff to know what mothers preferred and what babies were used to doing. Melany's paperwork was completed at the beginning of her first stay, which gave her a sense of comfort that staff "were doing things, the way that I would have done it at home. …if you go into a facility like this, you've usually got so much anxiety… [I was] reassured that… everything could just go the way I was used to". The process of gaining confidence in the staff's ability to handle their baby without mothers' support described by Paula: "I realized… whatever they're doing is... that's working, he's fine and he's happy and settled… nobody ever came to get me and ask…'we can't do anything for him'. So, I… got comfortable with asking them to help and accepting [it]". Several mothers described their baby's positive response to the staff's actions which allowed them to feel comfortable and relaxed at the facility.

After the initial period of adjustment, mothers mostly talked about staff caring for their babies as a part of their routine in the facility. Catherine said: "someone was always around, if they weren't you knew, that there was someone in the office. They can always take your baby or tell you in 10 minutes they could take a baby. [The procedures

were] really straightforward and [the staff were] very approachable." For the mothers, their routines involved staff taking care of their babies. Hilary's experience was typical of the mothers: "I'd often hand him over to one of the staff so that I could go and rest". These routines allowed mothers to focus on their recovery needs. Paula said: "[you] wake up at that [later] hour and then just sort yourself out and have a shower…. I'm really not able to do it in that order, you know, with a baby at home. So yes, just nice, relaxed routine".

A key part of the adjustment process was developing relationships with the staff, which led to routines specific to mothers' recovery needs established and executed promptly upon arrival, something that would evolve over time. Isla noted: "when moms were coming quite regularly, it seemed like there was a lot more rapport [with staff] and kind of follow through with their mental health". Melany confirmed this: "The positive experience is the arrival, we're just, you know, seeing the same people that I knew… and kind of knowing what the routine was. …[they knew] what I need for my mental health". Paula explained that it was about "creating the relationship with some people that work here… [I] definitely became more relaxed, the more I came". Regular HKO staff were regarded as very professional by mothers, well trained and good at prioritising needs of mothers as well as remaining calm. Hilary summarises that: "I just think, for the most part, the staff were amazing and just willing to help and even if they were appeared to be busy, they still offered to take [my baby] from me".

When relationships between mothers and staff members were not established, negative experiences occurred. This happened when regular staff members were absent and other staff did not follow a mother's routine. Isla described this:

> they are having some random other person just coming in to help babysit… and I'd come in that day especially… to have the support from people that I know, not a random. [That staff member] let [my baby] stay awake for the whole day and I had to deal with a very grumpy baby that afternoon.

Hilary had a negative experience with an "agency nurse" (a staff member contracted for only one shift at HKO) who "hadn't followed my routine". Dianne said "one of the staff members was quite new and very eager to help. [Using] the knowledge that they had gained themselves in their own parenting, [instead of] doing what a parent is comfortable with". Relationships were also compromised when there was a lack of connection with staff. Isla described an impersonal process where at times she did not

have enough attention from the staff to provide her with emotional support and understand her mental health 'triggers'.

Some mothers experienced barriers to accessing staff support even when relationships were established. Paula described internal struggles leading to difficulties asking for help from the staff "I feel like I'm burdening people when I ask for help… I felt like [I'm] unwilling or bad... for asking and having to ask all the time". Isla, Paula and Dianne revealed their need for staff to be more proactive in directing them towards meeting their recovery needs and being more "forthcoming with offering help". Dianne, Paula and Coshima's relationship with the staff had an unexpected adverse consequence on their routines, in that they focused on the staff's daily responsibilities and tried not to ask them for help if they could. For Dianne for example, it meant she hurried her morning routine and "worried about staff needing to get their stuff… done. So, I have to take [my baby] as quickly as possible".

The lack of support with the baby was experienced not only during the respite stay, but also when mothers attended group sessions at the facility. Isla and Melany described their difficulties with attending craft group sessions due to baby being very active and needing constant attention they were unable to do craft activities. However, when group facilitator was able to assist with the baby Isla had positive experience. She describes: "me and [my baby] did the sensory class together. That was really fun! And hey, I really enjoyed... she actually held him for me, which is really nice".

3.2.3 Support During Mental Health Distress

Mental health crisis resolution is not an official function of HKO, however, there were detailed accounts of situations which were contained by HKO staff. These accounts were a significant part of mothers' experiences at the facility and reflect the importance of the support provided. The most commonly described critical situations that could lead to crisis, involved staff intervening to reduce the distress that mothers experienced in response to their babies' behaviours. Hilary described arriving at HKO in tears after a group activity outside the facility, which she had to leave early, because her baby was crying for a prolonged period of time. The HKO facility manager met Hilary at the door, spoke with her and took her baby, which resulted in Hilary going to sleep and her baby being taken care of by staff. Hilary indicated that her going to sleep and her baby being settled was a desired resolution of this stressful for her situation and "…it was the staff, I think, that really kind of made it...work". Less commonly, crisis situations at HKO were caused by the involvement of other [external] organisations. For

example, Coshima described a staff intervention related to child protection representatives meeting her at HKO. "I felt really pressured…and my anxiety levels were really high. I was in the middle of a mental health breakdown" she recalls. The facility manager decided to attend the meeting with Coshima, which helped her remain calm: "I wouldn't have remained as calm as I was. I probably would have hurt somebody, like that's how worked up I was getting". The meeting was concluded at the manager's request when Coshima was unable to continue due to her emotional state. As a result of the manager's presence, Coshima recalls that after meeting: "I was able to resume my baby duties and I was fine". HKO's support was invaluable for Coshima:

> [If HKO didn't exist] I wouldn't have my son. He Kakano Ora was the safe place for me to begin losing it [experience postnatal psychosis], in order to understand that I needed help. From there I went to the hospital, the mental hospital, with the confidence that I was going to get [my baby] back, because I'd already been to He Kakano Ora and I knew, it was an option.

3.2.4 Importance of HKO Support for Mothers

From the perspective of the mothers, HKO and its services largely left them feeling satisfied in terms of providing the support they needed. Laura's comments reflected this: "It's just… an incredible [and] unbelievable place…thank God for it. [It] does an amazing job. You can see it for yourself [and] you can see it with other mothers coming in…the difference that it makes to people and has hugely to me". Paula reiterated this by saying: "it is amazing! It's such an amazing thing that people [who] are struggling have this on offer, this sort of support. I'm really grateful that I had this opportunity and got to use this facility." Dianne had the same sentiments: "It's a great facility. And it helped me so much". Catherine called HKO a "…magical place, out west. You can go and all your troubles... will disappear just for the time that you're here". Although not all the support at the facility was suited to Isla's needs, she thought it was important to mention: "I think it's a fantastic idea having a center for people".

In their descriptions of departure from HKO most mothers mentioned feeling sad, because they were leaving an environment which was set up for mothers and their babies, with staff support readily available. Many mothers worried about their ability to cope without HKO support. Laura said: "[I felt] a little bit sad. A little bit hesitant, you know, cause I'm kind of leaving like a bubble. You know, you're in a sort of bubble here, well looked after". Leaving HKO last time was an uneasy experience for Paula: "I was concerned about… the fact, that I could no longer come here. And that was the only

support that I really was worried about, because even if I wasn't here, I knew I could come here". This was echoed in Dianne's description of her feelings about leaving: "I think it was bittersweet, because you knew you were going back to a tricky situation, but you also missed home. But you knew that you had to go. [HKO] felt like home quite a lot, for quite often."

When asked: "How would it be different for you, if He Kakano Ora didn't exist", the women's answers indicated the significance of the facility's support, which was directly related to their mental health and wellbeing prognoses. Melany suggested that not having the facility's support might have led to the suicidal thinking and behaviour:

> I can't ever say that things will get, you know, so bad. But… if you follow things through to the worst possible scenario, you know, they'll be mothers who, you know, end up killing themselves. Because you just, you know, if you're not sleeping properly, you're not thinking clearly, if you've got terrible depression, and you've got no help, yeah. It's a ... yeah. Can be quite a dangerous time for mothers.

Paula thought: "I really would have been suffering, like mentally. I would have been very exhausted. I don't know, I might not have gone off meds, I might have really spun out." Other mothers predicted increased pressure on their family, deterioration in mental health and loosing their baby due to child protection services involvement if HKO was not available for them.

The theme of HKO support highlights mothers' lack of support at home and the support available at the respite. Women described a deterioration in their mental health when they did not have the desired assistance with baby care at home. They described HKO in the context of getting away from home to a place where they could relax and rest because needed support was available to them. Mothers compared the nature of the support to the sort of support from "parents, family, grandmother", which they did not have. Two important aspects of HKO support highlighted by mothers were the processes of adjustment to the facility support practices and support during mental health distress. Those aspects positively contributed to the mothers' abilities to achieve their recovery needs, with some exceptions. Finally, mothers described the importance of HKO support for their mental health, which for some of them meant the ability to recover from mental health difficulties, and the opportunity to care for their babies at the same time.

3.3 Sleep

Sleep was mentioned by all women and, for some, the opportunity to sleep was the most significant support offered by HKO to improve their mental health. Mothers attributed mental health difficulties before coming to HKO as directly related to sleep deprivation (3.3.1). The women saw sleep as a sustained period of rest where they did not have responsibility for their baby. Sleep was usually discussed within the context of an uninterrupted night's sleep and its positive effects on mothers' mental health. A number of mothers mentioned the HKO facility was able to support them in getting uninterrupted hours of sleep overnight and during the day (3.3.3). For many, it was their first uninterrupted sleep since their baby was born. Mothers explained that having enough sleep directly led to a number of positive outcomes such an increased cognitive ability, resilience to stress factors, and improved quality of life. Moreover, respondents described improvements in their perceptions of their parenting abilities as a result of improved cognitive abilities (3.3.2). This was due to the fact that the level of sleep deprivation they experienced decreased with staff taking care of their babies while they were sleeping.

3.3.1 Effects of Sleep Deprivation

A number of mothers described their experiences before coming to HKO as directly related to sleep deprivation. Melany talked about her inability to sleep during the day "when baby naps" which compounded the lack of sleep caused by the new-born's nighttime routine when she had to get up and feed the baby. She noted:

> I was so sleep deprived at one point, I was starting to hallucinate. Getting no sleep would sometimes be tough, [it] would start kind of like a bad cycle of depression and suicidal thoughts. I was really losing my mind and don't even remember how many days [first stay at HKO] was.

For Melany the effect of sleep deprivation was the occurrence of extreme cognitive symptoms including hallucinations, suicidal ideations and short-term memory loss.

Other mothers described sleep deprivation due to their babies' sleep patterns as impacting their mental health in different ways, with anxiety and depression being common denominators. Isla described herself as "anxious and flustered… quite wired" when she was deprived of sleep. Similarly, Dianne and Paula recounted their experiences of anxiety and depression at three or four months postpartum before coming to HKO. Dianne noted that her baby "wasn't sleeping very well", while Paula commented that her baby "was a terrible sleeper". This led to only four hours a night of

sleep for Dianne and "five and a half hours of broken sleep at night" for Paula since their babies was born. Dianne described her sleep deprivation as resulting in "a bit of postnatal depression" as well as an increase to her pre-existing anxiety. Paula also indicated: "After four months of no sleep… I was always crying. I think, I would have gone crazy [if did not get sleep at HKO]… sleep deprivation I was really struggling with."

3.3.2 Sleep and Perception of Parenting Ability

One of the most detrimental effects of sleep deprivation for mothers was their negative perception of their own parenting. Sleep provision at HKO for some mothers resulted in improved psychological functioning which in turn led to a more positive perception in their ability to be a parent. Dianne and Paula described their confidence to raise their babies and ability to parent as very low when they first arrived at HKO: "when I arrived, I started crying because I felt a failure [as a mother]" said Dianne. Paula explained that: "it's only so much sleep deprivation… you can take before you just feel so burnt out and it affects your parenting, mental health". After a number of sleeps in the facility, mothers talked about the effects of sleep on their parenting. Melany described an increased ability to engage with people and her baby in particular, which she felt improved her ability to be a parent. Paula acknowledged improvements in her parenting ability, by saying: "so, coming here, I could be a parent, instead of somehow getting through…[what] I wanted to come for, is to feel recharged. So, I could go back to being a better mum". Sleeps at HKO contributed to Paula's ability to cope "with upsets and sickness… [good sleep] makes it feel that much more bearable and you're able to handle that".

However, not all the mothers experienced a benefit of improved perception of their parenting. One mother was conflicted when it came to her need for sleep and her role as a mother. Isla saw staff caring for her baby as a display of her inadequacy as a mother, which became an additional barrier to overcome when she needed sleep. "I'm also really concerned that I'm failing [my baby], because if I leave him with someone [I'm] not being there for him. So those were quite big feelings for me." She described herself as being worried and perceived herself as a failure as a mother, because staff took care of her baby while she was resting. Her guilt about needing staff support prevented her from having sleep.

3.3.3 Sleep Support Offered by HKO

Several mothers mentioned the HKO facility was able to support them in getting uninterrupted hours of sleep overnight and, for some, during the day. For many, it was their first uninterrupted sleep since their baby was born. According to Paula sleep at HKO “was most helpful thing that happened. That was the best thing that happened, was that to get a full night sleep.” Dianne also noted that HKO gave her “first [full] night of sleep… in four months. It was pretty amazing, you know, coming here and being given the opportunity to have a sleep”. The importance of this support was highlighted by Laura who said: “when they helped in the night with baby that’s been crucial… to catch some sleep that’s been really, really important”.

Mothers described immediate benefits of sleep at HKO, when staff looked after their babies. Melany recounted her experience after a few uninterrupted nights as a “real game changer”. She commented on her improved state of mind with remarks like: “not losing my mind was nice”. Dianne noticed after first night of uninterrupted sleep: “my head started to become clearer. It was just amazing”. After having uninterrupted sleep at HKO, this mother talked about an increase in her resilience to stress: “I think your resilience is a lot more if you have had sleep”. Catherine echoed this comment by explaining: “I’ve had a sleep and so I feel more able to cope with it [life at home] better”. She also mentioned when staff looked after her baby she was able to fully rest: “when someone else [is] looking after your baby, your brain switches off properly”. This sentiment was echoed in Paula’s interview when she noted: “it was just relaxing when I knew that he was not going to be in my presence all night.” Mothers experienced improvements in their psychological functioning after uninterrupted sleep, for some mothers more restful sleep occurred when staff was looking after their babies.

An additional benefit of the night support at HKO was the opportunity to try sleep medication. Melany took up this opportunity because she considered the HKO environment to be “a safe place” compared to her own home. Having night time care allowed her to start this medication without worrying about not being able to wake up during the night for her baby. Being at HKO allowed her to both start this medication and adjust it to find the optimal level, which enabled Melany to feel confident about safely caring for her baby during the night at home.

Although mothers described a range of support benefits provided by HKO, staff allocation at the facility was an issue for women whose goals of stay included sleep. On occasion, these women did not have predictable access to nighttime care for their babies

and this uncertainty, created by staff to mother ratios and the process of nighttime staff allocation at HKO, affected these mothers' mental health. Paula shared her experience with nighttime staff allocation: "worst thing for me… they didn't have the staff overnight. They would be only equipped to take one baby at night… it was like a gamble... I though, it would be more help at night… that's what every mum wants." Paula described one night, when the night staff was not available for her baby and, because of safety rules at the facility prevented her from co-sleeping with her child as was the norm, baby were unable to sleep for long periods in the facility's cot. This led to sleep disruption for Paula and she had to ask for support from a night staff after she was awake "for hours", which was provided. However, this experience influenced her decision to leave facility during the following stays when she thought that nighttime care for her baby is not available. "I ended up packing my bags and going… I was coping ok with everyday life, it was the night still that I really, really struggled with and needed support". She preferred to take care of her baby at home if night staff were not available for her.

This issue related to staffing was raised by two other mothers who struggled with staff availability at HKO and the impact of this on their sleep. Dianne described her difficulty with the night staff allocation procedure, which led to deterioration of her mental health. Due to her anxiety, she preferred to know at the beginning of the day whether her baby would be cared for that night. However, because the information about allocation of nighttime care for infants was only available in the afternoon, she experienced an escalation of anxiety symptoms whenever it was not clear if her baby would be taken care of during the night. She described it as a "waiting game. You are looking around…and trying to count amount of mum in the house, and their level of desperation and requirements… [I] often…end up in tears in the afternoon, not knowing whether or not I'd be getting any sleep". Melany also felt desperate for sleep during her visits to HKO. During one visit she described how she was faced with a single staff member on shift supporting two mothers. The staff member was not aware of her needs and her baby's routine: "she didn't really know what I needed". This resulted in the staff member being unavailable to take Melany's baby when she wanted to go for a sleep, which ultimately resulted in Melany leaving the facility: "So I just left, because it's more relaxing at home". Both Dianne and Melany's need for sleep and expectation that staff would follow their usual sleep routines meant on occasion the women's mental

health was negatively impacted by individual incidents that occurred during their stays at HKO.

Another important aspect of the sleep support at HKO was that regardless of staff availability some mothers' mental health and physical exhaustion prevented them from sleeping. Isla explained: "when you're overtired and you haven't slept for a long time, or you've been like, you know, wired that being in a bedroom can quite a… put a lot of pressure on you to fall to sleep". Instead of sleeping, Isla sometimes ruminated about her inability to fall asleep feeling "different to some of the other people that came in who could sleep really well." As well as these internal factors, she also mentioned that external factors added to her inability to fall asleep: "I find it hard with noise and it takes a lot to wind down… I could take three hours sometimes to wind down… at that peak of being really exhausted or anxious and takes a lot to bring you down". This recollection shows that even though HKO supported some mothers' sleep, the experience of being at the facility could hinder other women's abilities to sleep.

In summary, the most common theme mentioned by the interviewees related to sleep including the effects of sleep deprivation, changes in perceptions of parenting abilities due to sleep, and the benefits and difficulties of sleep support offered by HKO. The women described their experiences of sleep deprivation before arriving to HKO, the most common of which involved symptoms associated with depression and anxiety. Other individual experiences included hallucinations, suicidal thoughts and short-term memory loss. One of the most detrimental effects of sleep deprivation for mothers was their negative perception of their own parenting, which improved with uninterrupted sleep at HKO, although not for all mothers. The mothers' descriptions of immediate sleep benefits related to improved cognitive functioning and stress resilience. As well as these benefits, a number of respondents described their difficulties with staff allocation for nighttime care. Mothers experienced an increase in their anxiety as well as general dissatisfaction with this HKO process.

3.4 Mothercraft

Mothercraft refers to a set of skills and knowledge required to take care of a baby, usually learned from other women by getting involved in or observing the process of childrearing. Some first-time mothers are not exposed to these skills prior to giving birth, which makes it more difficult to navigate through the volume of information and advice on this important topic. A lack of knowledge and confidence can affect both mothers' effectiveness of care for their babies and their perceptions of their own

mothercraft skills, which can be detrimental to their mental health (3.4.1). Some mothers who stayed at HKO were in need of mothercraft advice and skill development in this area, this included bathing, feeding, putting babies to sleep, and joining groups for mothers and babies in the community (3.4.2). HKO exposed these mothers to mothercraft skills and improved their confidence in implementing those skills (3.4.3). It is important to note that mothers who talked about mothercraft as the goal of their stay focused on this aspect in their interviews as opposed to those who had sleep as a main goal of stay.

3.4.1 Stories of Low Confidence

A lack of knowledge and confidence can affect both mothers' effectiveness of care for their babies and their perceptions of their own mothercraft skills, which can be detrimental to their mental health. This was illustrated by interviews with Laura and Coshima. Laura explained her feelings upon arriving at HKO: "my whole confidence about being a first-time mother was at an incredible low. You doubt that you have [it] in yourself, you know, about what you're doing [with your baby]". Laura took the big step of moving to a friend's house from another city for support with mothercraft, because she did not have experience with babies, and this was a major concern for her. However, before she gave birth, she left this environment because her expectations of assistance were not being met and her mental health was compromised. She was anxious about returning to her friend's house where she felt her mental health might go "backwards…I would not have had the help there at all really… [it] would have not helped my mental health at all". For Laura, not having experience with mothercraft and not having a stable environment in which she could learn these skills, was the main reason she came to HKO. Coshima came to the facility with similar experiences: "I felt nervous being alone with my baby… I'm a solo mum, and didn't have a lot of help, my family live up north, [and I'm a] first time mother." This lack of mothercraft experience increased on Coshima's fears around being an incompetent mother and escalated her anxiety: "Because I've had very high levels of anxiety and I panic a lot over little things that make them big things". These mothers described challenges connected to the low confidence in mothercraft skills which were addressed at HKO by supporting them with gaining confidence in mothercraft.

3.4.2 Building Mothercraft Skills

Coshima discussed four specific examples of mothercraft skills that she learned at HKO. The first was bathing her baby:

> I was a bit nervous about bathing him in the bath. So, at first, someone would be with me, which was great. Because when you're nervous… you really do need someone with you, and.... it took a few times. But now I'm confident with bathing baby.

Next she described introducing new food to her baby: "they trialed different foods [for the baby] with me at HKO before we left. So that I was confident when I came home." Thirdly, she talked about introducing a sleep routine:

> They taught me about sleep routines. For a long time [baby] ruled the house. I didn't know what the sleep routine was, then I learned leaving him to cry it out for a couple of minutes was ok… He'd go back to sleep. So I was, at times, making my job harder and HKO taught me that there were other options which I wouldn't have otherwise known because I had no experience.

Finally, the social side of mothercraft was covered for Coshima: "I didn't really know what playcentres were or things like that. [Staff 's name] one lady bless her, went home and did a whole bunch of research on the resources that are close to me, and bought them in the next day". Similarly, in the baby massage and mainly music groups Laura enjoyed talking to "instructors" and getting information about classes relevant to her planned area of residence.

One aspect of mothercraft that particularly impacted Coshima's mental health was discovering self-care strategies while caring for her baby. Coshima learned about balancing the needs of her baby with her mental health by taking breaks: "If I didn't learn this two things, we'd be having a very difficult time. I got used to being without him… time by yourself, gives you time for reflection, I think." Time by herself allowed Coshima to put her:

> own coping mechanisms in place instead of taking medicine…but instead of relying on [medication], you can just breathe through it. And for me walking and listening to music is a big part of my recovery. And so, I found that by doing that I was I was okay.

The manifestation of this skill is unique to each mother, and in Coshima's case, her strategy for self-care enabled her to eliminate medication without compromising her mental health.

A number of mothers commented on how their need for mothercraft skills were met at HKO. Laura talked about her development of mothercraft skills: "so being here with actual hands on support, helping with my baby. Helping with changing, sleeping,

eating, you know, everything like that. Like learning to be a mother, basically. So that's what I need". Isla did not expect "too much [mothercraft] advice" from the staff, but said: "if I mentioned, 'Oh, I am struggling with this', or you know, like [staff] would try and follow through with some advice, which was really helpful. And maybe towards the end, on occasion, that was really good." Melany also mentioned helpful advice from a particularly "knowledgeable" staff member which changed her evenings for the better. During an evening when her baby experienced prolonged crying, this staff member suggested: "giving him a change of scene like, change nappy or something". Which Melany was skeptical about at first, because her baby did not need to be changed, but it worked. "It was amazing! It changed everything!". Baby's crying spell was interrupted by mother's actions. After this, Melany's nighttime routine "became a lot more manageable".

3.4.3 Mechanisms of Building Confidence

HKO exposed these mothers to mothercraft skills and improved their confidence in implementing those skills as a result of three main factors: mothers had trust in staff's knowledge, they took the opportunity to learn mothercraft skills and received positive encouragement from staff in regards of their mothercraft skills. Coshima said: "I found going to respite was a good way to access resources like people who knew things that I didn't." Laura perceived staff as being "like big sisters or mothers… role that you kind of need at this time to help you… they're just sort of filled that role of a female… assisting and knowing what they doing, and you kind of learning off them." The staff support and daily structure at HKO allowed Laura to focus on her mothercraft skills. She emphasised that staff took "care of me. The meals, the laundry all that sort of stuff…is taken off your shoulders. You can just focus on…trying to figure out how to be a mum in those first few weeks". She recalled encouragement and reassurance provided by staff while working on her mothercraft skills: "you know you're doing an OK job and don't be too hard on yourself". For some women, improvements in confidence around their skills were enhanced when they were proactive in their queries about mothercraft. Coshima noted: "I just made sure, to talk to them about everything that was making me anxious. So that when I did leave, knowing that I wasn't coming back, that I was going to be OK." Laura had similar confidence in her skills upon leaving HKO: "I just think I'm doing a pretty amazing job [with my baby], which I could not do [before]… A lot of practical stuff I take with me".

Mothers who did not have prior knowledge about baby's care benefitted from support with mothercraft skills while staying at HKO and were prepared to use them at home. Their confidence with baby care improved as they had the opportunity to engage with HKO staff who were knowledgeable in mothercraft and supportive of the mothers' development of skills such as bathing, feeding, sleeping and joining baby groups. The women noted that this support had three main components: trust in staff knowledge, opportunity to learn mothercraft skills and positive encouragement provided by staff. Mothers noticed an additional increase in confidence when they enquired about mothercraft tasks which they were unsure about.

3.5 Social Interactions

Mothers described motherhood as an "insular" experience with a lack of social connections. HKO provided opportunities for mothers to be social which majority of mothers enjoyed. Social interactions were an important aspect of recovery for most mothers after more immediate needs for sleep and mothercraft were attended to. The main benefit of the socialising for mothers was a sense of connection with other women at the respite due to commonality of difficulties they were experiencing.

3.5.1 Loneliness

Most mothers found HKO provided their only opportunity for social interactions and described experiencing loneliness before coming to the facility. Coshima noted:

> being at He Kakano Ora was our social part of life…that was a big thing for us. I don't know any other moms and babies…we relied heavily on it in terms of our social life, which is largely our only interactions with other moms and babies, at this point.

Isla found her experience of motherhood before HKO isolating, saying: "when [my baby] was younger, I found I was very alone and isolated like there was no peer support for me". At HKO mothers' daily routines varied, but a number of women described their chosen routines involved socialising with other mothers on a daily basis. Coshima described, when she was unable to sleep during the day at the facility, one of her preferred options was to "go hang out with other mums". Laura talked about a similar scenario when at the end of the day, while waiting for the baby to wake up, she would be sitting in front of the TV "sometimes interacting with the other mums, you know, just having a chat or whatever".

3.5.2 "We are all together in this"

A number of mothers described the benefits they received from socialising with other mothers at the facility and particularly the sense of connection they experienced by interacting with women who shared their difficulties. Catherine described a feeling of "real connection with" other mothers as she saw them "struggling". She talked about her reasons and need for social connection: "[I] want that connection as well…you don't have that at home…with your husband. But with the…other women that are going through the same thing, that connection is so lovely. And you go home to, you know, an empty house with no connection". Laura and Dianne echoed this notion that through socialising they could interact with women who shared similar challenges. Dianne said: "At first, I felt like a failure when I got [to HKO] and then… I looked around… I saw other moms like me, and I realised that it wasn't abnormal, what I was going through… [we] are all together in this". Laura explained this in her own words:

> other mothers' situations were quite an eye opener…it does that old thing of 'you're not alone'. You might have a different scenario, but in the wider scheme of things, you know, you're not alone, you not the only person struggling… [knowing that] makes you feel a bit better.

As well as creating a sense of connection through socialising at the facility, Coshima and Catherine described additional benefits they received. Catherine felt that she "had a lot to offer" from her experiences with her first child and that she could "really help [mothers]" with the difficulties they were going through. Providing advice was a positive experience for Catherine since she "really enjoyed" giving this kind of support. Socialising at HKO provided Coshima and her baby "a lot of help…because it showed me where [my baby] was in terms of his progress [and also, interactions with babies] was another way for him to learn things". She found that meeting other mums at HKO "gave [me the] confidence that having a social life and being a mum is totally manageable, whereas beforehand, without the experience [at HKO], I would have put it in the 'too hard' box and just soldiered on". These social interactions persisted after Coshima and other mothers left HKO, Coshima noted: "I've got a couple of friends from [HKO]. [We have] coffee and hang out with our babies".

It is important to mention, that some mothers felt overwhelmed by the social interactions at HKO and avoided socialising with other mothers. Isla felt this aspect of HKO stays was the "hardest". She explained: "I would meet moms there and they're having troubles, I immediately want to help. So therefore, [HKO] did not become a

place of relaxation for me, because I felt quite overwhelmed by all the personalities that I was meeting.” Isla felt uneasy during certain interactions with other mothers: “Sometimes I did find it a little bit awkward, like you sort of sit in front of these women that you haven’t seen the whole other time… you not sure what to talk about.” Hilary preferred to stay in an environment that limited her interactions with other mothers: “I prefer to stay when there were less people. So, I… went later in the week, and it was generally quiet. In fact, I think it was just [my baby] and I one night without anyone's there”.

Social interactions at HKO were important for most mothers. Experiences of loneliness prior to arrival led some women to desire connections with others and resulted in socialising becoming a part of their daily routine. The experience of common difficulties facilitated the process of normalization for some mothers when they felt that their difficulties are normal part of motherhood and many mothers going through them. On the other hand, some mothers experienced social interactions at the facility as overwhelming.

3.6 Facility environment

The theme of physical environment of HKO was commented on by most mothers, with many expressing surprise to see nearly new well-thought through facility design. The facility design was developed with focus on women’s recovery needs which included three components most commented by mothers. First, was the physical environment of the facility, which mothers found comfortable and relaxing. Second, provision of variety of self-care options and group activities which prompted mothers’ focus on their recovery needs. Third, taking care of women’s physical needs like food, washing and cleaning which was completed by staff and allowed time for mothers to focus on their recovery.

The mothers’ expectations of the physical environment of the facility building were much lower than what they encountered. Some mothers described thinking that the respite would look like a “run down cottage”, “shabby”, “more clinical” and “a hospital type place”. Instead they experienced “the completely opposite”, “a great building, like really comforting”, “much more like a home environment”, with some mothers expressing their surprise to see a newly purpose-built facility. Paula described her feelings when she went to the facility for the first time: “I was pleasantly surprised when I got here, the actual facility was so nice”. These physical aspects of the

environment were described as an important factor for the decision to come to respite. Isla said:

> I was quite excited by the space… it's kind of feels how you probably want your own house to feel. [It's nice to] be able to come to an environment that is beautifully set up… [it's a] nearly new build, it's got nice carpet, you know, all that stuff that adds to the experience. It's like a warm embrace.…that was probably another reason why I think a lot of the moms are like 'ok, come back' [laugh]. You just need to feel comforted.

The feeling of comfort and relaxation facilitated by the HKO environment assisted the mothers' focus on their recovery needs. For Laura the "very relaxing" facility environment helped her to overcome her initial worry of arriving to an unknown place (HKO). For Coshima and Paula, the size of the bedrooms (large) and fact that they had en-suites, meant that they had enough privacy when they did not want to socialise with other mothers. Coshima and Catherine found the beds added to the feeling of comfort in the facility. Catherine also appreciated the overall "cleanliness" of the facility, where "you [do not] have to clean up after yourself", which she found appealing and compared it to her home environment where she "didn't even have time to make beds".

The facility provided mothers with opportunities to engage in self-care, where each mother found her preferred time out options. Isla appreciated the availability of the bath, garden space and the ability to enjoy sensory modulation. She used the "sensory cards, the little relaxation cards…those kinds of sensory things are quite important to me to feel relaxed". Laura shared her appreciation for the outside space: "the space out there is really good. …and important…I do like to get outside". Melany found showers helpful: "getting some time [to myself] was just like so relaxing". The massage chair in a quiet lounge was enjoyed by several mothers. Melany enjoyed the massage chair, as a part of pampering sessions with her friend who also stayed at HKO.

> We had one day… I had that massage chair, I did our nails and it was like, nice [it was] like the first time I'd even looked at my nails for like a year, you know. …I really felt like 'oh. I'm back to my old self', you know, it's just a little little bit of self-care. [I had] a long time of just doing no makeup, not washing my hair properly, like sweat pants and like just looking gross and feeling really gross.

Time for self-care and the provision of resources allowed mothers to enjoy activities unrelated to their baby and relax which was an important part of recovery while staying at HKO.

Provision of group activities at the facility for their residents and community mothers were another option for mothers to meet their recovery needs. Those who were able to attend groups described sense of purpose and achievement from the work they did, which in turn made it a relaxed, enjoyable experience for them. Coshima talked about the craft group:

> I loved it, I felt relaxed, I felt centered… and when you complete a project, it's really satisfying. You feel like you've achieved something for the day. [It] was just easy to relax, seeing [my baby] just in front of me in the same room [as opposed to] getting a massage, knowing your baby's awake [somewhere else in the house]. Because in your head, you think I should be doing something for him.

Isla said:

> “I've often been an active relaxer. So, like if I'm coming in, I have a goal. Like if [there is]… an outcome at the end, I feel more relaxed about it. Because I'm learning but I'm also getting to have ‘me time’. I think, sometimes when you come without a reason, you tend to feel… should I be here?

Melany summarised most enjoyable aspects of the groups for her: social connection with other mothers and facilitators, learning something new at a baby massage group and “doing something you already liked doing” when referring to the sewing projects at a craft group. These accounts described benefits of group attendance for mothers’ recovery which included sense of relaxation, achievement, satisfaction and connection with other mothers.

HKO provisions of the physical support was built into staff’s responsibilities for cleaning, washing, cooking meals and availability of a “Koha Cupboard” with baby clothes and other baby items mothers might need. There were a lot of positive comments about this type of support, including from Isla who said: “real positive here, is that I have set the table and they get you to come out and eat with everybody and make sure you’re fed. …because you often have missed meals when you've got a new baby”. For Laura, staff’s responsibility for housework, meals and cleaning added to the sense of relaxation in the facility. She didn’t “really having to worry about… practical stuff”. The ‘Koha cupboard’, played an important role for one mother, whose financial

situation was less fortunate than others. Coshima was just one of a mother who used the cupboard when she needed something for her baby [wipes, clothes or items she forgot to bring to HKO], and staff used it "instead of coming into my room and waking me up to get [nappies], they use their own, out of the Koha Cupboard. So... I didn't have to be disturbed. …that Koha Cupboard was really handy".

Noise was the one common difficulty mothers experienced in regard to the physical facility environment, many women described high noise levels and described the lack of soundproofing for the rooms. They experienced noise affecting their stays in three main ways. Firstly, it was difficult for Hilary and Catherine to rest in their rooms: "I was just wanting kind of peace and quiet… I just want quiet". Secondly, mothers' sleep was affected by noise transfer during the day and at night. Dianne said: "I didn't sleep during the day I couldn't, because there was too much buzz going on around and people in the passages". Hilary did sleep but found this sleep was disturbed: "even with earplugs, I could still hear when [my baby] kicked off". Lastly, mothers complained about ambient noise from nearby rooms affecting their babies' sleep. For example, Hilary noted: "The noise of people walking from like the day room space down passed the rooms…[if] the baby was asleep or something I used to find that quite tricky".

Despite difficulties experienced by some mothers, the physical environment of HKO was generally positively received. Mothers expressed that the comfort and relaxation provided by HKO supported their recovery needs. Provisions for self-care and group activities as well as physical needs were supported, which allowed mothers to focus on their recovery.

3.7 Summary of findings

Mothers' experiences at HKO reflected the way the facility assisted their mental health recovery at the time of their stays, when no other support was available to them. Upon first arrival at the respite, the mothers described an adjustment process that included building a rapport with the staff members and developing facility specific routines, which were suited to their recovery needs. The benefits the mothers acquired from this process increased depending on how many times they returned to the facility. These mothers described three recovery domains which HKO was able to support them with: sleep, mothercraft and social interactions. Sleep took priority for the majority of the mothers, whereas mothercraft skills were a priority for two of the women interviewed. Social interactions were a background need for mothers that became important when support for sleep and mothercraft was provided. For some mothers

socialising at HKO was the only social interaction available, they found sharing their experiences of common difficulties, facilitated a sense of connection with other mothers. Many mothers mentioned the role of the facility environment in their recovery, because they felt it was a well set up and welcoming environment that fostered a feeling of comfort and relaxation. Taking responsibility for meals, washing and cleaning away from mothers, allowed them time to focus on relaxation and self-care, which was an important part of their recovery.

Chapter 4: Discussion

The purpose of this research was to elicit women's experiences of their stays in the short-term maternal mental health respite 'He Kakano Ora' (HKO). Eight mothers were interviewed about their respite experiences, and these interviews revealed a number of aspects of their experiences that are focused on facility support for their mental health recovery. These experiences discussed in this chapter within the context of current research literature. This includes research about experiences of postnatal distress, the general postnatal population, as well as research about the general population, in cases where no specific research was available. Special attention is given to studies about Australian early parenting programmes, which are residential programmes for mothers with babies who require additional support to care for their children. Although these respites are not mental health focused, they are significant to the respite setting of this research and covered in more detail in chapter one.

4.1 Components of Mental Health Recovery Provided by HKO

The women in this study were clear that support from HKO was an important part of their recovery. In their interviews, mothers focused on recovery goals that were important to them during their stay at the facility: sleep, mothercraft and social interactions. Woven through those themes were perceptions of being a "good mother" which were described as "perceptions of a parenting ability" and "stories of low confidence". Equally entwined in mothers' experiences were influences of the facility environment on mothers' recoveries.

The four themes presented in this thesis (sleep, mothercraft, social interactions and perceptions of a "good mother") resemble those noted in a systematic review of qualitative literature about mothers' experiences of recovery from postnatal mental health illness (Plunkett et al., 2016). Of particular relevance was the theme of sleep and the importance of "sharing with others like me", which were found to be valuable recovery factors for many mothers in the review. The mothers' abilities to care for their babies (mothercraft skills) were also included as one of the coping strategies for achieving recovery and an indication of positive recovery progress. Perceptions of a "good mother" were described in terms of the change from pre-motherhood understandings of this conception to ones that supported recovery. In comparing this research to the literature, there seems to be a resemblance of experiences of mothers in respite to those of postnatal mothers in different settings, but with similar mental health

difficulties. In addition to this, there is much literature about each of the recovery themes, which will be presented below.

4.1.1 Sleep

Sleep was a subject that all of the mothers' commented on, with the majority of the women seeing it as the most important part of their stay at HKO. The mothers' preoccupation with sleep is consistent with findings in the literature and indicates the impact that changes in sleep have on mothers' mental health. Generally, changes in sleep patterns postnatally are characterised by disturbed patterns of sleep and less sleep in general (Bei et al., 2010; Williamson et al., 2019). Mothers in the current study described the adverse effects of sleep deprivation on their mental health, which ranged from elevated frustration levels, fatigue, and excessive crying, to more severe symptoms like hallucinations, suicidal ideations and short-term memory loss. Other studies also described the negative influence of sleep disruption on mood and cognitive abilities (Watling et al., 2017; Xu et al., 2020).

All the mothers in this research appreciated the opportunity for uninterrupted sleep at HKO when staff took care of their babies. Their appreciation was related to the benefits of sleep and was commented on regardless of whether sleep was the main goal of their stay or not. When mothers described the benefits of uninterrupted sleep, they talked about their ability to parent better, having more energy for their babies and better coping with their babues' behaviours, which is the opposite of what is known about the effects of poor sleep quality, tiredness and sleepiness (Nash et al., 2008). The critical review of research into sleep and perinatal mood disorders concluded that reduction of sleep deprivation for the prevention of depression and psychosis postnatally is effective (Ross et al, 2005).

However, there are some exceptions to the general benefits of sleep provision experienced by the mothers at HKO. One mother commented about her inability to sleep and rest during her day stays due to physical exhaustion and ruminating thoughts. High levels of fatigue in postpartum women are associated with disturbed sleep patterns, where physical exhaustion correlated to mothers' perceptions of their sleep quality and duration (Hunter et al., 2009). General population research also reports the connection between physical and emotional exhaustion (burnout) and sleep complaints (Brand et al., 2010; Xu et al., 2020) and the role of sleep problems in physical exhaustion (Li et al., 2020).

Staff support for sleep provisions did not always meet mothers' expectations, and when this happened, some mothers described increased anxiety levels, negative thoughts and lower satisfaction with the facility support. The role of client preferences in service provision and how this affects client satisfaction with the services has been identified in a meta-analysis (Lindhiem et al., 2014; Thompson & Sunol, 1995). Moreover, because a big part of satisfaction with mental health service depends on relationship with the staff (Blenkiron & Hammill, 2003; Megnin-Viggars et al., 2015), the presence of staff members unknown to mothers affected how satisfied they are with the stay. However, not much known about relation of unmet expectations about mental health service provision on their users. Moreover, the description of the mothers' expectations and availability of staff are unique to the respite facility and so far, has not been generalized to different settings.

4.1.2 Mothercraft

Another important support acknowledged by mothers at HKO was mothercraft, which became a primary goal of two mothers' during their stay. They described low confidence in mothercraft skills and a lack of support at home that led to deterioration in their mental health. First time parents often face difficulties and a low confidence of one's own ability to parent in relation to caring for their infants (Buultjens et al., 2017). Being overwhelmed with responsibility, the fear of being alone with their baby and a lack of knowledge about mothercraft are experiences which has been described in other qualitative research (Coates et al., 2014). Perceptions of one's own ability to parent has been found to be an important factor influencing postnatal mental health and wellbeing of mothers (Jones & Prinz, 2005). Parenting interventions are known to improve those perceptions and the overall psychological health of a parent (Barlow et al., 2005; Barlow et al., 2014). During their stay at HKO, mothers described receiving assistance and coaching about sleeping, feeding and bathing their babies, as well as information about mother and baby groups available in their areas of residence. This assistance and staff support led mothers to feel more confident about caring for their babies, which meant they could continue to apply new skills without assistance from HKO staff.

4.1.3 Social Interactions

Mothers described their lives with their babies as isolating experiences, where they did not have much social contact, especially with other mothers. The arrival of a new baby is known to disrupt social relationships (Lee et al., 2019). Exacerbating this, the stigma attached to postnatal mental health difficulties poses a barrier when accessing

support, particularly social support, which often intensifies loneliness (Halsa, 2018). For some mothers, contacts at HKO were the only social interactions with other mothers they had at that time. They described a special connection with other women at the respite due to common difficulties, which revealed the "commonality" of the challenges that mothers faced, resulting in the dissolution of their beliefs that their experiences were abnormal. Mothers involved in qualitative studies about postnatal interventions for mental health difficulties, as noted in chapter one, expressed an appreciation for the opportunity to build support networks by sharing their perspectives when talking to other mothers with similar difficulties (Megnin-Viggars et al., 2015; Phillips & Pitt, 2011). It is important to note that there were two mothers who preferred not to socialise with other mothers and focus on their needs while in respite.

4.1.4 Perceptions of a "Good Mother".

Negative perceptions of their own parenting were described by mothers within the sleep and mothercraft themes, and are well established in research about experiences of postnatal depression and anxiety (Homewood et al., 2009; Wardrop & Popaduik, 2013). Within the sleep theme, mothers described their parenting abilities as being affected by a lack of sleep. Negative perceptions of mothers' parenting practices may be impacted by a lack of sleep, however, they are also connected to their pre-parenting expectations of motherhood, and societal pressure that requires mothers to sacrifice their own needs to put the needs of their babies first in order to achieve unattainable mothering standards (Finlayson et al., 2020; Newman & Henderson, 2014). This pressure is seen in the accounts of two first time mothers in relation to mothercraft who described low confidence, doubt, fear and increased anxiety about their ability to care for their infants in the appropriate way. Other researchers associate mothers' unmet expectations with a more difficult period of adjustment to motherhood and a deterioration in mothers' mental health (Delmotre-Ko et al., 2000; Kalmuss at al., 1992).

Mother's need to be a "good mother" played a role in their mental health. HKO supported mothers in their recovery journey that involved building realistic expectations of motherhood by getting enough rest and accepting support from staff and others, as well as getting reassurance on parenting practices. A systematic review (Plunkett et al., 2016) showed changes in the "model of motherhood" when mothers were able to move from their pre-motherhood perceptions of being a "good mother", to new understandings which allowed them to sustain their recovery. An implication of this

finding for the facility staff, is the need to be more proactive in offering practical help and support to women in respite. This is because the pre-motherhood perception of being a “good mother” restricts some mothers from asking for help. The changes in perception of a “good mother” within the facility environment need to be investigated further as this was not covered by this research.

4.1.5 Facility Environment

The facility outlook and internal spaces made a positive difference on mothers’ experiences at HKO. The architecture and environment of mental health facilities is known to impact users’ experiences in a positive way, enhancing well-being and promoting the recovery process (Mazuch & Stephen, 2005; Novotna et al., 2011). Mothers also described positive changes in their mood influenced by the use of self-care options offered by HKO, that included individual or group format. According to Orem’s self-care model, self-care tasks are meant to improve or maintain individuals’ well-being and health, where the environment can facilitate positive changes in self-care practices (Orem, 2001). Leisure activities are found to be one of the components of self-care (Querino et al., 2016), which is associated with decreased postnatal tension and stress, and as a result of it better mental health (Ribeiro et al, 2014, as cited in Querino et al., 2016).

Meeting the physical needs of the mothers, including their meal requirements as well as cleaning and washing needs, was an important part of their facility stays. This gave mothers the time to focus on their needs, and relax. This practical support is usually mentioned by researchers in the context of social support that mothers receive postpartum, and its effects on mothers’ mental health (Razurel & Kaiser, 2015; Schwab-Reese et al., 2017). There are only a small number of studies that connect psychological distress in postnatal mothers to a deficiency of practical support at home for things like housework, cooking and cleaning (Harrison et al., 2012; Gjerdingen & Chaloner, 1994). There are no studies correlating household chores and level of psychological distress in postnatal mothers in other settings. Therefore, further investigation needs to be undertaken into the connection between practical support at a respite setting with a decrease of psychological distress among its residents.

4.1.6 Place to Go for Support

Mothers in this research did not have extended support beyond their nuclear family: most of them were either solo mothers or mothers with full time working husbands, so for many HKO was the only support available. They described first

coming to respite in order to reverse the deterioration in their mental health that they experienced because of the lack of support they had at home. Once they had made an initial recovery visit, mothers returned to HKO when they felt the need for support and rest in order to avoid a deterioration in their mental health. The connection between a lack of support and adverse postnatal mental health is well documented, although historically, most research in this area has been carried out in relation to postnatal depression (National Collaborating Centre for Mental Health, 2018). Studies conducted in residential settings in Australian early parenting programmes showed that in a similar way to mothers at HKO, many mothers admitted to these programmes did not have enough emotional and practical support (Hanna & Rolls, 2001). In addition to this, studies about the postnatal population showed that low levels of support postnatally are considered a risk factor, and one of the predictors, for the development of mental health difficulties during postpartum (Pessoa et al., 2019; Schmied et al., 2013; Staehelin et al., 2013; Yim et al., 2015).

Mothers described high satisfaction with the support provided by HKO, which they linked to their positive recovery progress and improved mental health, predicting unfavourable outcomes for themselves and their families if access to the respite was not available. The majority of randomised controlled trials (RCTs) exploring the connection between postnatal support and care as usual showed better improvements when interventions targeting mothers' needs were implemented as opposed to care as usual (National Collaborating Centre for Mental Health, 2018). This link was reiterated in a more recent systematic review of effectiveness of peer support on the treatment of perinatal depression (Huang et al., 2020). The results from research on an Australian early parenting residential programme also showed a significant decline in participants' mental health symptoms between the beginning and the end of the programme with a sustainable decline at four weeks after completion (Treyvaud et al., 2009)

This research found that there is an adjustment stage to HKO for mothers that includes establishing routines and relationships with staff. It also revealed connections between the degree of adjustment (or the way facility provisions were able to meet mothers' needs) and mothers' progress towards recovery goals. Mothers who adjusted better were able to achieve their goals in part by creating and sustaining relationships with the staff. One mother suggested that frequency and duration of the stays were important factors for adjustment. The more frequently mothers came, and the longer their stays, the greater the benefits they were able to gain from their stays were. In other

research, high satisfaction with postnatal support provided, correlated to the number of support contacts mothers had (Huang et al., 2020), as well as the nature of the rapport with health professionals providing interventions (Hadfield & Wittkowski, 2017; Higgins et al., 2016; Megnin-Viggars et al., 2015; Phillips & Pitt, 2011).

Mental health support at HKO was significant for those mothers who experienced crisis or distress while at the facility. Some mothers described distress which could lead to crisis, but because of staff interventions, this crisis was adverted. One mother described the development of a mental health crisis, and her feeling of safety because it happened at HKO. The impact of HKO's support on the stabilisation of individual crises for the residents needs to be investigated further. Previous studies about mental health respite facilities indicated a reduction and stabilisation of psychiatric symptoms while in care, but highlighted the uniqueness of this process to the particular respite facility (Grant & Westhues, 2012; Rosen & O'Connell, 2012).

4.2 Implications for Future Research and Practice

This research focused on mothers' experiences of stays in a short-term maternal mental health respite. Although it produced detailed descriptions of their experiences, future research should be completed to gain more thorough understanding of the needs of postnatal mothers who experience mental health distress and decide to use respite settings as a part of their support. Each theme highlighted by this research (sleep, mothercraft, social interactions, perceptions of a "good mother", role of the facility environment, general support needs, and adaptation to the facility) requires more detailed exploration. The questions about sustainability, impact and suitability of the facility interventions, as well as effectiveness of support for different demographic groups of mothers and pregnant women should be explored. The adjustment stage outlined by this research requires further exploration in terms of the importance of this period, support required for quicker adjustment, and the role of duration and numbers of stays in the adjustment process. In light of these findings, the effectiveness of one short stay at the facility should be researched. Based on the recovery needs outlined in this research, work on development of preventative measures for mental health deterioration for mothers who attend respite stays can begin.

In order to provide context for the interventions within HKO, there is a need for detailed descriptions of recovery practices and the effects of wider organisational culture on staff within the facility. Further research on staff – residents' interactions and the impact of these on recovery should be conducted with special attention given to the

impacts of "new" or "unknown" staff members on the residents' experiences at the facility. Factors which influence the wellbeing of staff and the connection of their wellbeing to the quality of service provision should be researched in the respite environment. This is due to individual characteristics of staff having an influence on user experiences.

There is a limited amount of research about service user experiences in New Zealand maternal mental health settings, as well as about mental health respite settings. Therefore, any studies exploring these areas would be valuable additions to the New Zealand body of knowledge as well as supporting the development of effective evidence-based practices. There is a need for comparative research to ascertain if the needs of mothers attending respite, are different from those who have chosen another form of mental health support, or do not require or want respite support. It would be useful for this future research to establish if respite settings are beneficial for mothers and pregnant women in comparison to other supports available.

In terms of the practical implications of this research for the HKO operation, I would recommend the revision of staff allocation practices for the provision of night care, or additional work on setting or adjusting mothers' expectations in regards of this provision. Another practical recommendation would be considering the introduction of additional interventions to address sleep deficit, as a difficulty highlighted by most mothers in this research. For example, the provision of evidence-based sleep education programmes like PIPIS designed by the Sleep-Wake research centre at Massey University (reference), might be a useful intervention to assist adjustments in mother – infant sleep patterns. A further practical implication relates to mothers' perceptions of being a "good mother", that sometimes prevent mothers from asking for help from the staff. In these cases, staff need to be aware of this barrier and offer help to mothers who might be struggling. I recommend looking at additional support for mothers who desire social interactions, as for the majority of mothers this kind of support was only available during their stays at the respite. I suggest running peer support or user-led support groups for mothers.

4.3 Limitations of The Research

This study did not collect mothers' demographic information, which appeared as a limitation during the analysis stage, when mothers mentioned their lives before their babies were born. It became apparent that mothers' working status before the baby, age, number of children and availability of extended family support were important

factors contributing to their needs at HKO. From previous research in this facility, we know that 52% of women coming to the respite are between 26 and 35 years old, and more than 57% of women in respite are of NZ European ethnicity (Lehndorf Moore & Sanches-Jimenez, 2019). The group of interviewed mothers reflects this demographic, in contrast to the New Zealand maternal mental health statistics where younger mothers and non-NZ European mothers were found to be in a risk group for postnatal mental health difficulties (Deverisk & Guiney, 2016; Underwood et al., 2015).

Despite Māori mothers being the second biggest ethnic group attending the respite, comprising above 16% of mothers (Lehndorf Moore & Sanches-Jimenez, 2019), there were no Māori mothers participating in this research. This could be due to the short recruitment timeframe of three months, when no Māori mothers met the inclusion criteria or made a decision to participate in this research, however I could not be informed about this due to confidentiality. Therefore, it would be valuable to replicate this study with Māori mothers to see if the respite is suitable for this group and to gain more understanding of cultural diversity, which is required for the New Zealand context. Due to resource limitations, this research did not include pregnant mothers who stayed at the respite. Therefore, experiences of expectant mothers who stayed in the respite were not accounted for and also require future investigations.

One of the limitations of this research would be my proficiency in interviewing techniques. Although, I had a trial interview and thorough preparation, during the transcription of participants' interviews I noticed threads of conversation that could be explored further to achieve more in-depth understanding of the experiences. As a remedy for this, second interviews with the same participants would be helpful, however due to time constraints these were not possible.

The last limitation is related to the IPA method and interpretative nature of this research. Whilst quality assurance measures were undertaken to ensure that final results reflect meanings and intentions of the participants, it must be acknowledged that the nature of the interpretative process requires active analysis by the researcher, which would have impacted the final results.

4.4 Researcher Reflections

A significant aspect of my research experience as a qualitative researcher was a constant need to separate my role as a staff member at HKO from that of the researcher who analyses the data from the participants' points of view. I constantly had to return my focus to the data and dismiss my knowledge as a staff member. Keeping my focus

on the participants' experiences was a vital part of my research process from the early stages of conducting interviews with mothers to the final writing of the discussion chapter.

Surprisingly, my own past experiences of maternal mental health difficulties were beneficial to the research process. It supported building a rapport with the mothers during the interview process and accelerated my analysis of the mothers' experiences when writing the final document. I did not feel that my experiences unduly influenced the research process, but these experiences did provide me with a feeling of compassion towards the mothers and an acceptance of their experiences in the way that they were described.

I have to acknowledge the impact Covid-19 had on this thesis. Although more than a half of the thesis has been completed by the time the first New Zealand lockdown occurred, it was a time of dramatic life changes and slowed down progression of this thesis. During the second lockdown in Auckland, I was struggling to write the discussion chapter, in particular the part about perceptions of a being "good mother". My beliefs about being a good mother to my son contradicted my lived reality that involved hours of time allocated to the thesis. Consequently, that part brought tremendous experiential insight into the power of the beliefs around being a "good mother", and the difficulties they create when your experiences are not aligned with these beliefs.

4.5 Conclusion

This study sought to describe mothers' experiences of their stays in the short-term maternal mental health respite "He Kakano Ora". The purpose was to uncover and document in-depth experiences of their stays in the facility, which resulted in data that has been thematically separated into sleep, mothercraft, social interactions, perceptions of a "good mother", facility environment and place to go for support. This study revealed an overarching concept of recovery, which influenced all the experiences described by mothers.

This research is the first to examine the experiences of mothers in a maternal mental health respite facility in New Zealand. It is hoped that the New Zealand research community will be encouraged to follow more closely the demand for new services and produce more relevant research to inform best practices and evidence base care protocols in mental health respite and maternal mental health settings. Although maternal mental health has been an international public health priority since 2000, in

New Zealand it is only in the last five years that significant resources have been allocated to address this issue and He Kakano Ora is part of this solution. Without research into its value for mothers, we will not understand whether this crucial part of the solution is operating as expected or truly contributing to improvements in maternal mental health. As this has been earmarked as an area of priority for the New Zealand government, further research into the space of maternal mental health is a necessity.

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Appendix A

Information Sheet for Participants

Mothers' experiences of He Kakano Ora.

INFORMATION SHEET

Hello. Kia ora. My name is Katya Gus, and I am currently completing a Master of Science in the School of Psychology at Massey University. As a part of the qualification requirement I am undertaking research about mothers' experiences at the He Kakano Ora (HKO) respite facility. I have been employed by HKO as a casual mental health support worker and am familiar with the facility.

I am hoping to talk to 8 mothers who have been discharged from HKO. I would like to hear your opinions and thoughts about staying in the respite facility. Through your participation, I aim to establish what was helpful and what mothers found hard, as well as any extra support mothers wish they had.

I would like to invite you to participate in my research. Participation is entirely voluntary, and non-participation will not affect any current or future care or treatment you receive. Participation involves an interview with me that will take 1-1.5 hours. I anticipate that total time commitment from you should not exceed 3 hours in total. This includes: reading the information sheet, making a time/date for the interview, travelling to the interview and the interview itself. Before you decide you may want to talk/kōrero about the study with your whānau, friends, key worker or others. Please feel free to do this. You are welcome to bring a support person and/or whānau to the interview.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give me permission;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

This invitation has been given to you because you have stayed in the HKO with your baby/pēpi, you are comfortable conversing in the English language and you are now returning or living at home.

What will you be asked to do?

- To sign the consent to be contacted if you wish to get more information about the research or contact me directly. My contact details on the next page.
- To make arrangements to come for the interview.
- <u>To sign participant consent form before the interview</u>
- To take part in an individual interview that will take approximately 1 – 1.5 hours.

The interview can take place anywhere that is convenient for you, or in the HKO group room. I will provide refreshments, assistance with childcare for the duration of the interview and the transport cost associated with attendance of the interview.

During the interview, I would like to talk about helpful and unhelpful aspects of your stay in the respite. If the subject topic is distressing in any way, we will stop the discussion, or find another way to talk about your experiences. Please feel free to tell me about your feelings during the interview, and at the end when there will be time to reflect on it.

How will confidentiality and anonymity be kept?

All personal identifying details will be removed during the writing up of the interviews by me. The information you provide will not show your name, and you will not be identified in any

reports resulting from the study. You will have an opportunity to review the final transcript of your interview and make changes that you think are necessary or correct any inaccuracies. After writing up the interview, the recording will be erased. All electronic information will be securely stored under the password on my laptop. The interview consent forms and any other paper documents generated in the course of the research project will be stored securely in a locked cupboard in my supervisor's office, then destroyed according to university policy.

Non-identifiable information collected from the interviews will be shared with my supervisors and examiners of this research report. A summary of the findings will be provided to the Walsh Trust who operates the HKO facility, and Maternal Mental health teams at DHBs. Results from the interviews will be published as part of the thesis process and may be presented at future conferences. If you would like to receive the summary of the findings, please tick the box on the consent form and provide your contact details. The consent forms will be kept separate from your interview transcript.

Importance of this research

At present, there is very limited information about the experiences of people who have used mental health respite. Moreover, there is no known research about mental health respite in New Zealand. This research will be the first exploration of mothers' experiences related to maternal mental health respite care. It will provide valuable insight into factors that can either delay or promote mental health recovery for mothers. It is anticipated that this research will help to improve support practices within the HKO respite facility, and also the wider Maternal Mental Health services.

Project Contacts

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Katya Gus, researcher
0211685348
Email: ekaterina.gus.1@uni.massey.ac.nz

Or

Dr Joanne Taylor, supervisor
06 9518068 or 0800 MASSEY (0800 627739) ext.85068

Email: J.E.Taylor@massey.ac.nz

Or

Prof. Christine Stephens, supervisor

06 9518059 or 0800 MASSEY (0800 627739) ext.85059

Email: C.V.Stephens@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/12. If you have any concerns about the conduct of this research, please contact Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 356 9099 x 85094, email humanethicsoutha@massey.ac.nz.

Useful contacts:

If you find anything in the interview to be distressing, you can contact your MMH Key worker, or

- Crisis team:
    - Auckland central 0800 800 717
    - West Auckland 09 822 8501
    - North Shore 09 487 1414 or after hours 09 486 8900
- Lifeline free 24/7 counselling support: 0800 LIFELINE (0800 543 354), 09 522 2999, free text 4357 “help”.
- Call or text 1737 any time for support from a trained counsellor
- Samaritans 0800 726 666

If you want to talk to someone who isn’t involved with the study, you can contact an independent health and disability advocate on:

- Phone: 0800 555 050
- Fax: 0800 2 SUPPORT (0800 2787 7678)
- Email: advocacy@hdc.org.nz

Appendix B

Participants Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Mothers' experiences of He Kakano Ora.

PARTICIPANT CONSENT FORM

- □ I have read and understood the Information Sheet.
- □ I have had the details of the study explained to me.
- □ Any questions I had have been answered to my satisfaction.
- □ I understand that I may ask further questions at any time.
- □ I have been given enough time to consider whether to participate in this study.
- □ I understand that participation is voluntary and that I may withdraw from the study at any time.

1. I agree to participate in this study under the conditions set out in the Information Sheet.
2. I agree/do not agree to the interview being sound recorded.
3. I wish/do not wish to have my recording returned to me.
4. I wish/do not wish to receive a copy of research findings. My e-mail/postal address: ____

Declaration by Participant:

I ______________________________ hereby consent to take part in this study.
[print full name]

Signature: ______________________ Date: ________________

Appendix C

Consent to Contact Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Consent to contact for research purposes.

Title of the research: Mothers' experiences of He Kakano Ora

Sponsor: The School of Psychology, Massey University

The researcher: Katya Gus

You are being invited to give consent for Katya Gus to contact you within the next month to invite you to participate in a research study about your experiences at He Kakano Ora.

Would you like to know more about the study? Yes No

I like to be contacted at a later date. My preferred contact details are below:

Mobile / Text: ____

E-mail: ____

Home phone: ____

This form will be kept confidential in a locked cupboard in Katya's office. After the contact has been made, it will be forwarded for five-year storage to the research supervisor's office, then destroyed.

I have been made aware of the reasons why the contact information is needed.

I have been given the Information sheet and the consent form for the research to read at home.

This consent is effective immediately.

I can revoke my consent at any time.

I ____________________________ hereby consent to be contacted about this study.

(print your name)

Signature: _______________________ Date: ________________

Appendix D

Transcript Release Authority Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Mothers' experiences of He Kakano Ora.

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... **Date:** ....

Full Name - printed ....

Appendix E

Interview schedule

Service user experiences of short-term maternal mental health respite care.

Interview guide

A phenomenological interview consists of only a few lead questions. The focus is on eliciting the participants' own experiences from their perspectives. The following prompts may or may not be used during the interview, depending on its progression.

Lead questions:

What have been your experiences in He Kakano Ora (name of the respite facility)?

How would it be different for you, If He Kakano Ora didn't exist?

Prompts:

1. What were your experiences in He Kakano Ora?
   a. What was it like to arrive at the respite for the first time (some mothers have planned regular respite stays)?
      i. How did you get to the facility?
      ii. How did you feel when you arrived? What made you feel that way?
      iii. What were the positive experiences during your arrival process?
      iv. Were there any unhelpful experiences during your arrival process?
      v. In a perfect world, how would arrival process look like for you?
   b. Can you describe your typical day at the facility?
      i. Can you describe how respite life fitted with your needs?
      ii. Can you describe your experience of staff at the facility?
      iii. Can you describe your experience of the environment at the facility?
      iv. Can you tell me about being involved in new (for you) activities while staying at the respite (sensory modulation, baby massage class, craft group, had a bath, used massage chair e.t.c)
      v. Was there anything that you didn't like/was not helpful?
      vi. Is there anything at the facility would you say helped you a lot?
   c. What was your experience of leaving He Kakano Ora?
      i. How did you feel about going home? What made you feel that way?
      ii. Can you describe your experiences of getting home from the facility?

2. If He Kakano Ora didn't exist, how would it be different for you?

   a. Would you consider going to the hospital/adult only respite or stay at home?

3. Additional questions for the clarification of experiences
    a. What do you mean by that?
    b. What… means for you?
    c. Can you describe what do you mean by …..?

Appendix F

Massey University Human Ethics Committee (MUHEC) Approval

Date: 18 April 2019

Dear Ekaterina Gus

Re: Ethics Notification - **SOA 19/12 - Service user experiences of short-term maternal mental health respite.**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Thursday, 18 April, 2019**.
On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

Appendix G

The Consultation Group Agenda

The consultation group about the research project "Service user experiences of short-term maternal mental health respite." The meeting outcome.

Date: 23/02/2019

Duration: 2.5hours (3.30p.m. - 6p.m.)

Participants: Four ex-service users, Service manager, Facility staff member. The researcher facilitating the meeting (do I need to write their names?)

1. The consultation group members suggested the researcher create a permission slip which mother can tick/ fill up to agree for the researcher to contact her. The slip will be presented to the mother by the facility staff member during the discharge procedure and include permission to contact mother in regards of participation (it's not a consent). The slip will allow mothers to choose the best method of contact (phone, text, e-mail) and indicate a timeframe they would like to be contacted (in 3 days, one week, three weeks, one month). The group anticipated service users with young babies will be unable to contact the researcher even if they willing to participate in the research.

   This suggestion did confirm my suspicions about mothers with babies who experience mental health difficulties and being too busy to contact the researcher. Similarly, another researcher A. Hannah (2005) who wanted to research mothers under maternal mental health teams had to change her original recruitment plan and ask maternal mental health key workers to get agreement for the research as no mother contacted her about participation after invitation letters being send out.

2. The following changes has been suggested for the Information sheet:

- Change the name "Mothers' experiences at He Kakano Ora". The group members suggested make no references to maternal mental health respite in the documents mothers will take home. Stigma is attached to the "service user" term. It evokes institutionalised associations.
- Move "participants rights" to the first page.
- Move information that researcher employed by HKO from the first paragraph. It looks like researcher doing the research in collaboration with or for HKO.
- Make first page shorter, so for the mother wouldn't be so overwhelming to read it
- Change "talk to me over the phone" phrase to phone/e-mail or text message
- Add phone numbers in case mother feeling distressed after the interview: Lifeline, crisis team, key worker.
- Change the sentence "I would like to talk about positive and negative aspects of your stay…" to other which doesn't make assumptions that negative experiences had happened.

3. The following suggestions were made in regard to the consent form:

- Make a first paragraph in to tick boxes. This will prompt mother to ask questions if she wasn't clear on something.

4. The following changes has been suggested for the Interview process
- Make sure I have available places if mother doesn't want to come to HKO for the interview. It will depend on mother's area of residence.
- Talk to supervisor about strategies to manage mother who wants to talk only about negative experiences at the interview and getting angry and emotional about it.

5. The following suggestions were made in regard to the interview questions.
- Change or delete "why did you feel ….." to avoid justification. "Why" questions put people in defensive position….
- "Were there any positive experiences" change to "what were the positive experiences"
- "negative experiences" change for "unhelpful experiences"
- Prepare explanation about meaning of the last question if mother asks:
  "at the time of your life when you came to HKO, if HKO didn't exist how would you think your life have progressed from that point".
6. In the general discussion about research inclusion criteria was discussed and the following suggestion made:
- Add another exclusion criteria: if mother has a planned respite stay in the future at the time of the discharge.

Appendix H

Information Sheet for MMH Key Workers

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Service user experiences of short term Maternal Mental health respite care.

Information sheet for Maternal Mental Health Key Workers

Hello, my name is Katya Gus and I am currently employed as a casual mental health support worker at He Kakano Ora, and have been for over three years. Separate from my employment, as a part of the requirement for a Masters of Science at the School of Psychology, Massey University, I am undertaking research concerning mothers' experiences with maternal mental health respite care.

This study is aimed at exploring the experiences of mothers in the He Kakano Ora (HKO) maternal mental health respite facility. I would like to conduct qualitative interviews with eight mothers to gain an understanding of what mothers found helpful at the facility and what did not meet their expectations.

At present, there is very limited information about the experiences of people who have used mental health respite. Moreover, there is no known research regarding mental health respite in New Zealand. Therefore, this research will be the first exploration of mothers' experiences related to a maternal mental health respite stay. The study will provide valuable insight into factors which hinder or promote mental health recovery in this type of facility. It is also anticipated that this research will help to improve recovery support practices within HKO and the wider Maternal Mental Health services.

I will be inviting mothers who are exiting HKO and going home to participate in my research. Participation is entirely voluntary, and mothers are free to withdraw from the study at any time. Involvement in the research will include participation in an individual interview with myself and will take approximately 1- 1.5 hours. All interview content will be kept confidential, and the final report will not include any identifying features. Refreshments, assistance with childcare, and the cost of transport will be arranged for all participants.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/12.

This information sheet has been developed for all key workers of Maternal Mental Health teams to inform about this research. I anticipate that some of the respite mothers, might

mention being invited to participate in the research and ask for your advice on participating in the study.

If you would like any further information or have any questions or concerns, about the study at any stage, please do not hesitate to contact me.

Warm Regards

Katya Gus
Mobile: (*021)1685348*
Email: ekaterina.gus.1@uni.massey.ac.nz

Appendix I

Māori Consultation

Service user experiences of short term maternal mental health respite.

The Treaty of Waitangi obligations and principles.

(document prepared for the consultation with Dr. Natasha Tassell-Matamua, academic Māori adviser for this research)

Introduction:

The purpose of the project is to explore mothers' experiences of stay in the short-term Maternal Mental Health respite facility in West Auckland. I am interested in the mothers' perceptions of helpful and unhelpful factors in their recovery process from a mental illness experience during their stay in the respite facility. This research will help to identify factors that may improve or impede on the recovery process. Additionally, this study will be the first of its type to explore service user experiences in the New Zealand respite.

According to the Te Ara Tika guidelines (Hudson, 2010) this research falls into the "mainstream" category, as it does not have direct relevance to Māori, but Māori could engage as research participants.

To improve the quality and utility of the research, a consultation group will be created, consisting of a Māori facility manager, a former Māori service user and other former service users. The proposed group will meet to discuss the appropriateness of the proposed recruitment process, interview questions and the user involvement in research.

Relevance to Māori:

Maternal Mental Health has particular relevance to Māori. According to the recent maternal mortality review, 56 percent of women who died by suicide in pregnancy or during the six weeks postpartum period, were Māori (PMMRC, 2017). These high rates of maternal mortality also indicate that there may also be a high rate of maternal morbidity among Māori wahine (Barnes, Barnes, Baxter, Crengle, Pihama, Ratima, & Robson, 2013). Unfortunately, rates of morbidity are not routinely reported and there is no data available.

Other research has shown 1 in 7 Māori mothers experienced Postnatal depression at four weeks postpartum, compared to 1 in 16 non-Māori mothers (Webster, Thompson, Mitchell, & Werry, 1994). At present, there is no official data available on the topic of Māori wahine access to specialised Maternal Mental Health services. However, maternal mental health professionals frequently discuss low disproportionate access of Māori and Pacific mothers to these services (Watson & Miller, 2017). Most mothers staying in the respite facility, are of New Zealand European descent (Hawkridge, 2017)

The difficulties in accessing Maternal Mental health services for Māori wahine have been attributed to higher levels of deprivation in Māori communities, poverty and lack of transport (Barnes, Barnes, Baxter, Crengle, Pihama, Ratima, & Robson, 2013). According to Ministry of Health information, 45 percent of Māori women giving birth in 2010 lived in the most deprived areas of New Zealand, compared to 22 percent of non-Māori (2012). This deprivation has most likely contributed to restricted access to health care, and in particular, access to maternal health services. This is reflected in lead maternal care (LMC) statistics for this year, where only 83 percent of Māori women had LMC, compare to 92 percent of Pakeha women (Ministry of Health, 2011), including low attendance of antenatal classes by Māori women compared to non-Māori women (Dwyer, 2009).

Another reason for such a discrepancy in service users could be the particular values Māori hold in relation to health. One qualitative study on such values, identified four areas important for Māori women: connecting through whanau, nurturing wairua, using matauranga (knowledge), and undertaking self-care activities (Wilson, 2004). Therefore, the first line of care for wahine is through whanau, not health professionals or medical services. This could lead to delayed assessment and support for this group of wahine.

Another barrier to access to health services for Māori people is the lack of cultural responsiveness of health services. Many services generally do not include customary practices that focusing on physical and spiritual needs of Māori people (Stevenson, 2018). Jackson (2002) suggested that increased Māori health needs have arisen as a "consequence of their indigenous rights being breached" (Reid & Robson, 2007, p.5). Preferential health benefits are ensured by a Pakeha build health system, which "marginalised, reclassified and scrutinised" Māori people as "outsiders" (Reid & Robson, 2007). Through colonisation, a new system has redistributed resources to a "more privileged" part of the society, leaving indigenous communities underserved by contemporary health services (Reid & Robson, 2007).

A resent article published by the Māori health equity advisor G. Baker (2018) confirmed these points, and the state of the New Zealand health system. She suggested shifting resources from a largely "European" health system to culturally suitable services for Māori in order to increase access to health services.

As a Russian person, I might encounter a lack of trust from Māori participants (Katoa Ltd, n.d.), due to previous dissatisfactory experiences of Māori being researched by non-Māori researchers (Walker, Eketone, & Gibbs, 2006). I hope that the chosen methodology and customary practices for this research will minimise those feelings and will allow Māori wahine to participate.

These considerations have informed my thinking about how this research is relevant to Māori and what I may need to be aware of in conducting it. I will now outline the specific procedure for the research and the ways in which I am planning to be responsive to the needs of participants in my study, including Māori participants.

Procedure:

All permanent staff members of the respite facility, will be given information about the research, which outlines the goals of the research and what will be involved. The aim is that the staff members will become familiar with the study content from the information sheet and would be able to confidently present it to potential participants during the time of discharge.

In order to recruit participants, when a mother is discharged from the respite facility a staff member, who has an established relationship with her, will inform the mother of the study and explain that the research is aimed to explore service user perspectives of women's experiences at the respite facility. The staff member will explain that the study will be conducted in order to learn more about mothers' needs within the service and in order to make research-based changes and improvements in the service. The interview will take up to 90 minutes, arrangements for childcare will be made in advance, and will be available for all participants. Interested mothers will be asked to contact the researcher to indicate their interest in participation. All potential participants will be informed that the researcher is conducting this study under the supervision of the Faculty of Psychology at Massey University. They will also be informed that this research is a partial requirement for the fulfilment of a Master of Science degree in Psychology.

Mothers who have contacted the researcher about participation will be contacted by phone to arrange an interview time, place and to arrange childcare if required. The mother's engagement in the research project, will involve participation in a one-on-one confidential interview with the researcher (Katya Gus).

The consent form must be signed before the interview commences. Participants will be informed that they are free to discontinue participation in the study at any point.

The researcher will record all interviews on a digital recorder with the permission of participants. The data will be transcribed verbatim and analysis of the data will follow.

Collection of ethnicity data.

Ethnicity data will not be collected due to the proposed small sample of 8 mothers and the focus on describing the mothers' experiences in the respite facility.

Risks of engagement:

Risks in regards to Mana Tangata (autonomous individual) will be identified with the assistance of the Consultation group, and the Māori academic adviser to this research from Massey University.

All participants in this research project, will have equal and free access to Kai (refreshments) before and after the interview, assistance with childcare for the duration of the interview and any transport cost associated with attendance of the interview will be covered.

One of the main risks of the interview for all participants is the feeling of discomfort when talking about experiences in respite, especially when describing negative experiences. To metigate negative affect, the researcher will outline the interview topic and procedure in the information sheet and highlight that negative experiences will be discussed as well. Participants will have the opportunity to dicuss their involvment in the study with whanau and friends, when deciding if they wish to participate in the study. An information sheet will communicate that the mother can bring a support person or whanau member to the interview. This in turn will provide further support to the participant, further mitigating any negative affect the study may produce. During the interview, the researcher will watch for signs of distress and stop the interview if required. Participants will be able to discuss the process of the interview with the researcher after completion of the interview and during the sharing of Kai.

In addition to the above, as a non-Māori researcher, I am planning to adhere to principles of Kaupapa Māori research, as much as possible. The following principles were created specifically for the research about postnatal Māori mothers /whanau and explored adverse experiences around childbirth (Stevens, 2018). The research included five components in their methodology: Whanau (family), wahi haumaru (providing safe space), whakairo (engaging in Māori philosophies), kaitiaki (being empathetic), and hononga (building and maintaining relationships).

The following part is a breakdown of the above principals in my research.

Whanau component involves the knowledge, acknowledgement and the support of my own family, my personal knowledge of who I am and my ancestors. In addition, including participants' whanau, which I am planning to achieve through the invitation of the support person/s to attend the interview and general openness to the inclusion of whanau values in the way that wahine would feel appropriate.

Here is part of who I am:

I was born in St.Petersburg, Russia and graduated as a Social Psychologist in 2003 from St.Petersburg State University. During my study and up until leaving Russia, I conducted social skills development groups for adolescents with physical disabilities. At the end of 2003, I moved to London where I completed an MSc in Psychotherapy Studies and worked with children with learning disabilities. On moving to New Zealand in 2008 I have taken up postgraduate study at Massey University to allow me to register as a psychologist here.

After the birth of my son in 2013, I had an adverse mental health experience, leading to my interest in maternal mental health. I have subsequently been employed with Walsh Trust maternal mental health respite for over two years to date. This research is an extension of my passion for this area of mental health. I believe it will make a difference in the field of maternal mental health as a first academic exploration of maternal mental health respite, which is unique to a New Zealand facility.

In recent years, I have broadened my Māori knowledge by involvement with Ngai Tahu Iwi, through family connections, in particular my husband and father-in-law. I revel in the feeling of my family belonging to such a great Iwi with a long-standing history and universal humanistic values, which our Kaumatua projects and promotes among our people. Myself and my son, who is Ngai Tahu, attend a few gatherings each year. We try to use these opportunities to connect and learn more about te Ao Māori, including the traditions that we have been blessed to be part of.

Wahi Haimaru (safe place) is a component that was carefully considered for this research project. The respite facility group room is a safe place and known to mothers'. It also allows childminders to care for their child/children in the next room, which is also safe, secure and known to mothers. There is also an option for participants to nominate another place for an interview if they wish.

Kai (tea/coffee and snack) will be offered before and after the interview as part of "creating a safe place".

Another aspect of creating "safe space" will be the introduction of the research to mothers. As mentioned above, this will be done by the facility staff member who has cared for the mother during her stay in respite, and so there is already an existing relationship. The researcher has considered this way to be "safer" for mothers, rather than the first contact by a person they are not familiar with.

The respite facility itself is created as a "safe space" for mothers and pregnant women. During the facility opening ceremony, the building and all the spaces in the respite were blessed by Kaumatua. The six rooms for mothers and babies are named after Māori trees: Kauri, Manuka, Rimu, Kowhai, Kohekohe, Totara.

Whakaaro (engaging in Māori philosophies) component in this research will be present in the form of the researcher's developing awareness of the various aspects of te Ao Māori in regard to physical, mental and spiritual health.

The chosen methodology for the research is Interpretative phenomenological analysis (IPA) which is the best suitable for this type of explorative research. It also has been found to be Kaupapa Māori friendly by some researchers (Harris, Macfarlane, Macfarlane, & Jolly, 2016; Stevenson, 2018), it should preserve original meanings of experiences without much interference from the researcher. IPA aims to interpret participants own narratives within their frame of understanding with minimal involvement from the researcher's point of view.

Kaitiaki (being empathetic) is a central skill to conduct the interview and interacting with study participants. The expression of empathy will depend on the participant/whanau and their needs.

Some Pakeha research suggests that empathy can foster increased disclosure of information when an interviewer shows empathy combined with non-judgemental behaviour (Oxburgh & Dando, 2011).

Hononga (building and maintaining relationships) will start from the first contact with wahine. This will be about taking the time to answer any questions a mother might have and explaining who I am and why I am doing this research. The sharing of a Kai, before and after the interview, will give me an opportunity to improve the relationship with mothers and simultaneously create wahi haimaru (safe space).

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Appendix J

Letter of Māori Consultation

11th February 2019

Chairperson
Massey University Human Ethics Committee

Tēnā koe.

re: Ekaterina Gus – Mothers experiences of short-term maternal mental health respite

This letter is to inform I met with Ekaterina Gus on 22nd January 2019 and one of her supervisors, via Skype, to discuss her proposed research.

Ekaterina provided me with an overview of her research, including aims, proposed methodologies, recruitment procedures, and proposed analyses. We discussed in-depth the importance of ensuring equitable opportunity for participation by Māori. Together, we reviewed her recruitment and interview procedures, as well as discussing the importance of how her data is analysed and interpreted.

Ekaterina has since met with her supervisors, discussed my suggested amendments to some of her materials and processes, and made the necessary changes, which I have cited. I am very confident Ekaterina has done all she is able to at this stage to ensure the recruitment and methodology of her research ensures equitable and culturally-sensitive participation by participants identifying as Māori.

However, should any additional and unforeseen issues arise in relation to Māori participation and participants during the course of the research, I am available to consult with Ekaterina as required.

Ngā manaakitanga,

N A Tassell-Matamua

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