PERINATAL MENTAL HEALTH POLICY: YOUNG WOMEN'S MENTAL HEALTH SUPPORT DURING PREGNANCY

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Abstract

A woman's reproductive period is when she is most likely to suffer mental ill-health with this risk increased for young women. Mental ill-health in the perinatal period is identified as common but with significant implications for the young women and her family (Dearman et al., 2007; Petrillo et al., 2005; Riecher-Rössler & Steiner, 2005). From as early as a few weeks post conception, the foetal brain is found to be affected by maternal stress and mental ill-health. This continues to affect the infant postnatally and is exacerbated if maternal mental ill-health is not treated. Young women are more likely to experience impediments to their wellbeing in the perinatal period. Thus, introduction of suitable formal support perinatally can have a prophylactic effect on maternal and infant mental illness.

Through feminist research methods, utilising semi-structured qualitative interviews, four pregnant women thirty years and under in the perinatal stage of pregnancy and four health professionals working in the field of maternal mental health explore with the researcher their experiences of mental health support and education during pregnancy. This research demonstrates how services are currently unable to appropriately meet the needs of young pregnant women due to lack of attention to gender and youth issues and the dominance of a medical model understanding that has allowed this negation through minimising holistic, contextual treatment. The gendered construction of health services and recent market principles in state provisions are evidenced by the compartmentalisation of services, lack of collaboration between these services, competition for resources, and rigidly defined roles of health professionals that present access barriers for young pregnant women. A need to enhance formal supports and create policy frameworks and practice guidelines to direct this support is identified alongside recommendations for increased service provision, education, and screening at the primary healthcare level.

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Glossary

'At risk' or 'high risk': These terms have been used interchangeably to identify an individual's potential for development of poor mental and physical outcomes. Risk factors are characteristics that increase the probability of the occurrence, severity, duration or frequency of later disorder (Lewis, 2005; Magyary, 2002, p. 335; Zeanah, 2000, p.439). Due to the limiting and stigmatising nature of this terminology, as well as the culturally bound construction of such terms, 'increased vulnerability', 'vulnerable', or 'pre-disposed' is utilised as this reflects better the complexity of environmental interactions that may cause young mothers and their children to be more susceptible to poor outcomes.

Constructionism: View that knowledge is created by human beings who invent concepts, models and schemes to make sense of experience as opposed to discovering knowledge (as in a positivist understanding). A perspective that considers facts, descriptions and other features of 'objective reality' to be inescapably contingent and rhetorical. Follows the traditional view of **social constructionism,** a strand of **constructivism** where people are seen as produced (constructed) through social interaction rather than through genetic programming and biological maturation (Hepburn, 2006, p. 38). A constructionist view is argued for in feminist theory that sees gender issues and categorisation as constructed rather than as an essential nature. **Social Constructivism** stands that our constructions are also mental (as with constructivism) but created in our social relations and conversations similarly to how constructivism states understandings are created in relation to objects.

District Health Boards (DHB): Democratically elected boards of governance for secondary (hospital based) and some tertiary (specialist) health care services.

Epidemiology: The quantitative study of the causes, distribution, prevention and control of disease in populations (Swann, Bowe, McCormick & Kosmin, 2003; p., 60).

Evidence Based Research: The best current research information available based on a systematic analysis of the effectiveness of a treatment, service, or any other intervention and its use, in order to produce the best outcome, result or effect (Swann et al., 2003, p. 60).

Evidence Based Practice: An approach to service provision that is focused upon ensuring consumers are given the most effective and appropriate provision as indicated by current research findings (Swann et al., 2003, p. 60).

Incidence rate: Rate at which new disease events occur in a population for a particular disorder.

Infancy: The period of life from birth to five years.

Lead Maternity Carer (LMC): Health professional (usually a midwife) that takes responsibility for a woman's care throughout her pregnancy and postpartum period including the management of labour and birth (Health Funding Authority, 2000).

Mental health and maternal mental health: Specific mental health disorders are described as per the Diagnostic and Statistical Manual Volume 4 (American Psychiatric Association, 2004); however, where they are referred to as occurring during pregnancy this specifier will be added. For example, 'Adjustment disorder in pregnancy' or 'depression during pregnancy'.

The DSM IV uses the specifier "Postpartum onset" for diagnosis of current mental disorder if the individual is displaying the criteria for that disorder and onset occurs within four weeks of childbirth. For example, Postpartum Depression (also referred to as Postnatal Depression) or Postpartum Psychosis. The DSMIV differentiates the former from 'baby-blues' as this is not seen as impairing the individuals functioning. The term 'baby-blues', is felt to invalidate Mothers' experiences and is not used in this thesis. Instead specific disorders are identified and, where the criterion for such disorders is not met, yet mood or psychiatric difficulties are noted, the terms 'emotional difficulties' or 'psychological difficulties' or 'problems' are utilised. The absence of a mental disorder in mothers or children does not alone imply optimal emotional or psychosocial development, thus both mental and emotional/psychological health promotion is referred to (Jenkins, 2003, p. 189; Magyary, 2002, p. 346).

Morbidity: Assessment of the burden of disease.

Mortality: Rates of death amongst populations. Eg: Infant Mortality - death rates in the first year of life.

Obstetrics: The branch of medicine dealing with pregnancy, labour, and the puerperium (Saunders, 2001).

Parturition: Childbirth

Perinatal: Relating to the period shortly before and after birth: from the 20th to the 29th weeks of gestation to 1-4 weeks after birth (Saunders, 2001).

NOTE: when referencing 'perinatally' this spelling will be used. However, within the literature *perinataly* and *perinatally* is used interchangeably. For the purposes of this research spelling of *perinatally* is used to concur with the typical spelling of *postnatally*.

Perinatology: The branch of medicine (Obstetrics and Pediatrics) concerned with the perinatal period (Saunders, 2001).

Policy Practice: The effort to influence the development, enactment, implementation, or assessment of social policies (Chaplin, 2007).

Postnatal: Occurring after birth with reference to the newborn (Saunders, 2001).

Postpartum: Occurring after birth with reference to the mother (Saunders, 2001).

Prenatal: Preceding birth

Prevalence Rate: The amount of cases currently known for a particular disorder.

Preventative or early intervention: Process whereby family conditions, parenting behaviour, and/or individual's behaviour are altered to increase the probability of normal developmental trajectories and to decrease potential for later disorders (Zeanah, p. 439).

Primiparous: Adjective. Women who have had one pregnancy resulting in one or more viable young (Saunders, 2001).

Public Health Organisation (PHO): Not-for-profit organisations made up of health clinics and groups with an interest in primary (non-hospital or specialist) healthcare (Rose, 2004). PHOs are contracted to provide services to District Health Boards.

Puerperium: The period or state of confinement after childbirth (Saunders, 2001).

Social Justice: The means by which societies allocate their resources such as material goods and social benefits, rights, and protections to ensure a fair distribution of societal resources to all people.

Social Psychology: The broad description attributed to the study of various post-structuralist phenomenologies (see **Constructivist/Social Constructivist** as one of these).

Teenage: 13-19 years. In some studies teenage is operationalised as being from 12 years.

List of Abbreviations

CEDAW – Convention on the Elimination of all Discrimination against Women.

CBT – Cognitive Behavioural Therapy

DHB – District Health Board

DSM – Diagnostic and Statistical Manual

GP- General Practitioner

ICCPR - International Covenant on Civil and Political Rights

ICD 10 – International Classification of disorders

IPT – Interpersonal Therapy

LMC – Lead Maternity Carer

MMH – Maternal Mental Health

OCD – Obsessive Compulsive Disorder

OECD – Organisation of Economic and Cultural Development

PND – Post Natal Depression

PHO – Primary Health Organisation

PPD – Post Partum Depression

PTSD – Post-Traumatic Stress Disorder

UNCROC - United Nations Convention on the Rights of the Child

WHO – World Health Organisation

Introduction

Maternal Mental Health: The earliest of interventions

Introduction

Mental health is one of the most crucial health and social issues of our time (Travis & Compton, 2001). The human and economic cost of mental ill-heath, particularly within Westernised countries, is large, growing, and historically underestimated (Zubrick, Silburn & Blair, 2000). This burden permeates the individual, family, and societal levels of nations. Perinatal mental health policy presents a rare opportunity to treat women suffering maternal mental ill-health in pregnancy, as well as preventing mental illness and attachment issues in their children. Introducing interventions during pregnancy is necessary as the intrauterine environment is crucial to the development of the foetus and subsequently, a healthy child, physically and behaviourally: "There is accumulating evidence that environmental stress experienced by the mother during pregnancy can have deleterious effects on the later development of the child" (Linehan, 1993, p. 48).

There is, internationally, a lack of policy frameworks for women who are potentially vulnerable to suffering mental illness and poor adjustment in pregnancy (Scottish Intercollegiate Guidelines Network, 2005). The absence of guidance through policy affects the services provided to this population. This dearth of policy and practice is perpetuated by a lack of sound research in the area and thus there is little reliable guidance for professionals that assist pregnant young women. Due to the increasing economic costs of maternal mental ill-health, Nash (2001) reminds of the importance of establishing interventions for young pregnant women that are supported by sound research. The current research offers a contribution to the information base of maternal mental health policy and practice.

Aims of the research

The purpose of this research is to elicit young women's experiences of their professional mental and emotional support during pregnancy. To gather an alternative professional perspective, health professionals are also interviewed about their experiences of the suitability of the supports they provide and how young women respond to these. A feminist, qualitative, and interpretive method is employed to do this. By determining the need for early intervention in perinatal mental health care and support and the type of policy required, further pilots can be developed that utilise the recommendations to provide evidence-based services. Long term it is hoped that such services may prevent postpartum illness and trans-generational disorder, and break down the barriers that young women face in accessing appropriate perinatal support. This aim emerges from the researcher's identification of the gap in policy and service provision in this area and the potential benefits for women, and their children, of preventing later disturbance, saving state funds in the long term. A desired outcome of the research is that the importance of developing specific policies around early intervention maternal mental health will be realised triggering discussion of how to achieve the next step of policy development and implementation. There are many factors interfering with people's ability to provide emotionally and physically healthy environments to children that can be addressed through health and social policy.

Feminist Theory and Maternal Mental Health

Maternity and mental health are both core issues for women and Travis and Compton (2001) argue such health issues are entwined with women's inequality and marginalisation. Throughout history the problems associated with these health areas have been inextricably based on and determined by biology, as can be seen in Chapter Two with a review of the paradigms that inform maternal mental health. Essential developments have been made through feminism and the women's movement for improved access and inclusiveness of women and equitable treatment. Travis & Compton argue that as feminists we must reveal the subliminal power imbalance that operates in health care and illuminate how this affects health outcomes for minority populations.

Subsequently, a feminist paradigm will also be reviewed in Chapter Two and used throughout the thesis to explore how young pregnant women's receipt of mental health services is affected by these gender issues. A feminist stance illuminates real issues through systems and social constructivist theory (Travis & Compton, 2001). Feminist perspectives on maternal mental health and the bio-medical model will also be surveyed in Chapter Two.

The researcher: Theoretical basis and professional experience

My work alongside a maternal mental health specialist was the first introduction to maternal mental health care and service provision triggering this research. During this work I observed the impact of the lack of early intervention for maternal mental health, both during pregnancy and post-birth. This omission was lamented by many clinicians within the maternity and mental health fields, and amongst community workers attempting to access services on behalf of their clients. This led to the question held throughout this research of why perinatal mental health did not appear to receive the policy and service attention indicated by the literature base. Prior to commencing the research I had conducted social work interventions in statutory child protection, mental health services, and with youth and teenage mothers in non-governmental organisations. Within this work the compartmentalisation and structural inequities inherent in social policy and service delivery had become evident. The over-representation of women in many mental health, trauma, and care and protection statistics demonstrated how the basic biological and reproductive differences between men and women appear to disadvantage women.

A social work perspective implies a holistic, optimistic stance that intervention is beneficial to many populations. One way to achieve this is via a strengths-based perspective. According to Chaplin, the strengths perspective is a "philosophical approach to social work that posits that the goals, strengths, and resources of people and their environment rather than their problems and pathologies should be the central focus of the helping process" (2007, p. 2). Additionally, within a social work paradigm, themes of social justice are incorporated where changing unhelpful processes and systems is not only possible, but necessary. It is within the policy-making apparatus of the state that such intervention first becomes instigated, leading the way for organisational, cultural, and individual change that social workers, alongside their clients, attempt to create. Thus, the focus of this research is upon social policy and its implications. Engaging as a facilitator with a number of women in a group treatment for postpartum depression I found one of the most therapeutic tools for the group was the space to share the experiences of their pregnancies. Subsequently, this experience has influenced the design of the research with women being interviewed during their pregnancy, rather than post-birth, the time most studies are conducted (Scottish Intercollegiate Guidelines Network, 2005).

Systemic dysfunction is a view of mental illness that understands disorder with consideration of prior usual functioning and believes there is continuity along health and disorder with disorder stemming from many, complex factors rather than one, simple cause (Miller, Rathus & Linehan, 2007). A transactional view, such as that taken in social learning theory through 'reciprocal determinism' is also important as this focuses upon the transactions between the individual and their environment acknowledging that this is in constant change (Miller et al., 2007; (Linehan, 1993). Such an understanding of mental health, where both the biology of the individual and the effects of their social environment are deemed important, is termed a biosocial model.

The biosocial model emerges from the synthesis of psychiatric evidence, which has focused on heredity and biology, with psychological studies focused on behaviour and its determinants (Linehan, 1993). Travis & Compton (2001) and Murphy (2003) state mental health has both a social and a biological component with women's health issues exacerbated by continued lack of equality in all fields but particularly economically and in the health system. For this reason "researching the status of women within systems and identifying the policies and procedures that contribute to continuing inequities can provide necessary guidance for change" (Travis & Compton, 2001; p. 320). This is the intention of the current research; to discover how women's wellbeing perinatally is conceptualised under the current system and how policies and procedures affect maternal mental health support and provision. This will highlight where problems and inequities arise and suggest change.

Structure of the Thesis

Chapters One and Two will present the current context of provisions for young women's perinatal mental health. New Zealand's current policy and service provisions for this population are described in Chapter One. This includes the current maternity care system, its structure, funding, and public management. Chapter Two outlines the perspectives of health that inform this service provision and policy. This includes the paradigms and models that have informed understandings of maternal and perinatal mental health and the views of women and illness. This wider, paradigmatic understanding provides the foundation to review the international evidence-base of researched interventions for perinatal mental health of young women in Chapter Three. Chapter Three also contains the perspectives held within the literature base of young pregnant women and the issues they face. In particular the current literature around the vulnerability to mental ill-health and the implications of this ill-health on women and their children will be reviewed. Issues of poor perinatal health are considered both for young women and their children. How this literature informs current practice and policy will also be discussed.

The complete research design and methodology used to conduct the research is outlined in Chapter Four. Chapters Five and Six present the research findings. Chapter Five provides an overview of the key issues that emerged from the interviews with four young pregnant women while Chapter Six contains the data from interviews conducted with four health professionals. A discussion of these findings will ensue in Chapter Seven with recommendations and conclusions from these findings presented in Chapter Eight.

Conclusion

This research was conceived through a mixture of personal and professional experience; informal conversations with health and community professionals; the researcher's professional background and practice as a social worker; and a passion for women's health and maternal and infant mental health. The shape of the research was consolidated following completion of papers at Massey University in mental health and research methods. The theoretical underpinnings of feminist perspectives, a social work paradigm, and health promotion models inform the research design. To begin the current thesis, a discussion of the perinatal period and contemporary policy and service provisions in New Zealand for attending to women's needs in this period are outlined.

Chapter 1

Current context: The politics of pregnancy

Introduction

In 2002, 66 000 children were born in New Zealand to women under nineteen years of age (Statistics New Zealand, 2003). While this was a historical low for teenage fertility rates, New Zealand continues to have one of the highest rates of teenage pregnancy and early parenthood amongst countries of the Organisation for Economic Co-operation and Development (OECD) (Tables 1 & 2, Appendix 1). Psychiatric disorder is most likely to occur for women during their reproductive years with this risk higher for young women (Hendrick, 2006). Maternal mental illness is a public health and policy concern due to the burden of disease it brings about particularly in regards to human and financial cost. To set the context for this thesis an outline of the current public provisions for maternity and maternal mental health care is presented in this chapter. This includes the range of response levels for maternal mental health support and the implications of obligations under Te Tiriti O Waitangi and international covenants. Finally, the local provisions for perinatal mental health are identified.

The perinatal period

The perinatal stage of pregnancy refers to the time shortly before and following childbirth from twenty to twenty-nine weeks gestation to one to four weeks after the birth. Thus, perinatal mental health concerns itself with the psychological health of women and infants in this period. In some texts perinatal mental health is described as including up to once year postnatally (Dearman, Gutteridge & Waheed, 2007). Any mental health disorder can arise during the perinatal period triggered by matters related to pregnancy (Dearman et al., 2007; Petrillo, Nonacs, Viguera, Cohen, 2005). Similarly any previous or current psychological issue may be exacerbated by the changes associated with pregnancy (Dearman et al., 2007; Petrillo et al., 2005). Price identifies that "scant attention is paid to women with pre-existing mental illness of the impact their pregnancies may have on them and their mental health" (2007, p.2).

In many western countries perinatal mental health is receiving increased focus on public health agendas (Ross-Davie, Green & Elliott, 2005; Dearman et al. 2007). Cox (2007) identifies a number of potential explanations for this increased awareness including contemporary changes emerging within family and community structures. Feminists have had a significant role in calling to the attention of policy makers the importance of the perinatal period alongside a mounting body of evidence demonstrating the impact upon children's physical and emotional development (Perry, 2004). Despite this insight, there are currently minimal provisions in New Zealand for attending to young women's perinatal mental health, particularly within primary health care (Health Funding Authority, 2000; Te Rau Matatini, 2004).

International obligations

New Zealand is a signatory to a number of international conventions that it is compelled to acquiesce to in policy (Ministry of Women's Affairs, 2001). A brief outline of each of the conventions relevant to the current research is presented here beginning with the International Covenant on Civil and Political Rights (ICCPR). The ICCPR outlines the rights of people to be free from cruel or degrading treatment and to receive liberty and security, respectful treatment, freedom of movement and residence, and equal protection of the law. The ICCPR requires active promotion by governments being formalised in New Zealand through the New Zealand Bill of Rights Act 1990 and Human Rights Act 1993 and Amendment 2001 (Bell & Brookbanks, 2005). While economic poverty is not permitted as an excuse to neglect the ICCPR, Bell and Brookbanks identify it may not be enforced fully due to the costs of allocating resources to promote social rights.

The Adoptions by the Fourth World Conference on Women (1995) from the Beijing Declaration and the Platform for Action are also core in consideration of women's issues. At the Conference governments pledged to recognise the status of women and the inequality between women and men and commit to equal rights including within social and political spheres. The points of the Declaration that are pertinent to the current research are Point 17 that states "the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment" (Population Council, 1995, p.909). Additionally, point 19 states that "it is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes, including development of policies and programmes, at all levels that will foster the empowerment and advancement of women" (Population Council, 1995, p.909).

Women 2000: Gender Equality, Development and Peace for the Twenty First Century was a special session of the United Nations General Assembly. Here governments re-committed to the Beijing Platform for Action and towards the common goal of gender equality. The realisation was made that women's advancement needed to combine a focus on their conditions of life and basic needs through a holistic approach. To achieve this, an evidence-based, well-researched gender perspective was decreed necessary in policies, programs, and budgetary processes of governments. Certain areas were identified as requiring focused attention including: education; social services and health, including sexual and reproductive health; and violence against women. Another convention specifically concerning women's wellbeing is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW requires signatories to immediately eliminate all forms of discrimination against women including removing "laws, stereotypes, practices and prejudices that impair women's well-being" (United Nations, 2007, Article Two).

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care are significant as they provide for basic standards of treatment that mental health systems must provide including how people's rights are to be protected in mental health settings (Bell & Brookbanks, 2005). These principles apply to the human rights of mental health consumers and additional conventions have attended to the rights of specific groups such as children. The United Nations Convention on the Rights of the Child (UNCROC) is one of these and is the world's most ratified human rights treaty. It applies to the rights of those seventeen years and under to ensure children and young people's voices are heard on matters that affect them (Bell & Brookbanks, 2007). The rights include: the right to freedom from all forms of discrimination; the right to an opinion and to have their opinions heard in all contexts; the right to have their best interests met; and the right to life and development.

These international agreements are essential in providing a further measure of accountability to governments. By agreeing to the conventions the New Zealand government is legally bound to take steps to meet their requirements (Ministry of Women's Affairs, 2007). To monitor this, state representatives compile reports to Committees such as CEDAW and UNCROC who respond with directions on how governments can attend to any aspects of the conventions that are not being met. In response to New Zealand's 2003 UNCROC report, the committee stated the need to strengthen mental health services and make them accessible and appropriate to young people. How New Zealand governments attempt to meet these agreements through national and local policy is discussed next.

National provisions for maternity and mental health care

Within this section an outline of the current policy framework for delivery of maternity and mental health services in New Zealand will be made. The national framework is reviewed through consideration of specific legislation such as the Health and Disability Act 1993 as well as requirements of government under The Treaty of Waitangi. In New Zealand both national and local health care delivery is made through District Health Boards (DHB) so the role of DHBs in maternal and mental health care is presented. Localised service provision is discussed through non-government and primary health care initiatives.

Te Tiriti O Waitangi

Under the relationship established between the Crown and Máori through the Treaty of Waitangi, New Zealand government is obligated to provide maternity services to meet the needs of Máori women (Health Funding Authority, 2000). The principles of Te Tiriti O Waitangi call for practices that achieve participation and partnership of Máori within these health services (Mental Health Commission, 1998). The special status of Tangata Whenua and their self-determination is also protected under the Treaty (Orange, 1997). These principles and obligations are essential in all areas of the government sector but are particularly poignant for maternal mental health because Máori women in New Zealand are currently exposed to more predisposing factors for perinatal mental illness (Te Rau Matatini, 2004). Te Rau Matatini also identifies that Máori women are less likely to experience those factors that enhance mental wellbeing such as a secure cultural identity, safe social supports and partner relationships, and socio-economic resources. Thus, it is even more important that the state sector is addressing these issues to promote equality in health.

Travis & Compton (2001) believe health is a social *and* biological problem. In the New Zealand context this is evidenced by the ranging statistics for Máori, Pacific Island and Pakeha health outcomes (Ministry of Health, 2001b; New Zealand Health Information Service, 2007). Rural provisions also have to be accounted for here as the National Health Committee (1999) and New Zealand Health Information Service (2007) identify that many New Zealand women, particularly Máori women, live in rural areas with increased access barriers. The National Health Committee has identified that these women are less likely to receive the number of perinatal visits deemed best practice, thus extending health inequalities.

Iwi social and health services are growing in response to Máori health needs with primary health services provided by Máori being developed (Te Rau Matatini, 2004). However, the small number of Máori midwives is an issue considering Máori women have more contact with their midwife throughout their pregnancies. Chaplin (2007) argues for policies that increase mental health training for a variety of professions, particularly midwives and social workers, and across a number of ethnicities and cultures. This he believes would assist the provision of culturally sound services. The National Health Committee Review of Maternity Services in 2007 also recognised this need.

Policy

Maternity service provision is complex, but crucial because, for many young women, this is their first introduction to health services (Health Funding Authority, 2000). A negative experience could alienate them and their families from further access (MidCentral Health Ltd, 2005). New Zealand's health system is governed and funded by the Health and Disability Act 1993 and its amendments. Under this Act the Ministry of Health directly funds Lead Maternity Care (LMC) services (MidCentral Health LTD, 2005). The LMC creates alongside the woman a care plan within which assessments, such as screening for family violence, and education, surrounding matters such as Postpartum Depression, should occur (Ministry of Health, 2004). These provisions are required in legislation under Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002) and Section 51 of the Maternity Notice (Health Funding Authority, 2000) which outline the provision of maternity care in New Zealand including what is provided, by who, where, and at what cost.

The Health Funding Authority is the government agency that dispenses state funds to health and disability service providers including General Practitioner (GP), pharmaceutical, medical, disability support, and public and mental health services (Dunedin City Council, 2006). In 1999 they called for a report concerning the planning and future of maternity services in New Zealand. Annual reports of maternal and infant statistics are completed by the New Zealand Health Information Service (New Zealand Health Information Service, 2007). One of the recommendations made in the Review of Maternity Services in New Zealand completed by The National Health Committee (1999) was for Lead Maternity Carers to have improved training in the areas of mental health and alcohol and drug assessment. The report also calls for consideration to the special requirements of women experiencing mental health and alcohol and drug problems and whether it is realistic to address these solely in the core maternity service. National and regional forums are deemed necessary to determine the relationship between maternity and mental health services (Health Funding Authority, 2000).

Lead Maternity Carers (LMC)

Currently, in New Zealand, support throughout conception, pregnancy, and birth is managed by a Lead Maternity Carer (LMC) who may be a midwife, general practitioner (GP), or obstetrician (Chamberlain, 2006; Hutton, 2005; Ministry of Health, 2004; Health Information Service, 2007). This professional is responsible for a woman's care throughout her pregnancy, labour, birth, and up to six weeks postnatally including managing the woman's mental health care and referrals (Ministry of Health, 2004; New Zealand College of Midwives, 2005). While the Lead Maternity Carer role was designed to have one person coordinating a women's comprehensive maternity care, the National Health Committee (1999) states the LMC must be part of a wider health care team promoting health professionals working together.

Prior to 1990 midwives practiced within hospitals and GPs and obstetricians were responsible for women's ante and postnatal care in the community (National Health Committee, 1999). Policy changes in the 1990s afforded midwives maternity care expertise equal to GPs. GPs, women, and journalists such as Chamberlain (2006) and Hutton (2005) believe there are numerous problems arising within this system. Of primary concern is that GP's have largely ceased obstetric training and practice as it is no longer financially viable (Chamberlain, 2006; Hutton, 2005). Hutton and Chamberlain provide statistics stating GPs involved in providing maternity care decreased from 600 in 1997 to twenty in 2007. Conversely, statistics for the region within which this research was carried out are the inverse of those Hutton is concerned by. Instead, the midwife LMC rate has historically been significantly below the national average with the LMC rate amongst GPs and Obstetricians double the national average (See Table 4, Appendix 1). The reduction of GPs providing obstetric care and a national shortage of midwives is continuing to affect the area of the current research, as it is in the rest of New Zealand. These issues are made worse by experiences that minimal integrated care occurs between GPs and midwives (Chamberlain, 2006; Hutton, 2005).

A lack of collaboration between maternity providers and health professionals generally is identified as a concern (Health Funding Authority, 2000; National

Health Committee, 1999; Te Rau Matatini, 2004). The research Hutton (2005) reviews states women have displayed dissatisfaction with maternity care and called instead for a team approach between GPs, midwifes, and specialists. A lack of collaboration between midwives and GPs is particularly problematic for women who suffer mental health issues with the National Health Committee (2000) stating these women need their GPs *and* midwives involved in their maternity care. The review of maternity services for MidCentral Health Ltd also identifies the importance of increased integration of maternity services (MidCentral District Health Board, 2005). Hutton recognises that midwives practice solely in maternity care and believes they do not have the generic, and historical or familial knowledge of their clients that GPs can have and which is integral for mental health support. Price also feels that "little attention appears to be paid to promoting mental health within midwifery practice" (2007, p.2). Accessibility of primary services has been deemed by consumers as essential alongside good, professional relationships between LMCs and secondary services.

Evidence-based guidelines

It is suggested that legislation plays a minimal role in the delivery of good mental health care but standards and guidelines of care are more useful in ensuring sound practice (Delaney, 1985). The Health Funding Authority (2000) has identified that best practice guidelines have not been developed to offset the concern surrounding large variations in maternity and mental health practices. This appears to be an international problem as no guidelines for maternal mental health were found during the literature review of the current research with the Scottish Intercollegiate Guidelines Network (2005) realising the need for the development of guidelines. The Health Funding Authority recognised in 2000 that views on maternity services are polarised. They are explicit in their consideration of all opinions and their slow movement in this field. This slow progress, divergence of views, and concern not to offend interest groups holding those views, may be some of the barriers to establishment of a concise evidence base for maternal mental health. Hoagwood (2002) argues that evidence-based practice can be applied to preventative interventions also. The form in which the analysis of an evidence base has been utilised for other treatments, such as psychological interventions, is empirically indicated for prevention.

Primary Health Care

Primary health refers to professional health and preventative services delivered in the community. This includes health education, counselling, disease prevention and screening (Ministry of Health, 2007). Primary care is usually attributed to services provided by general practitioners and practice nurses. The Ministry of Health states that "a strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups" (2007, p.5).

The introduction of the Primary Health Care Strategy by the last Labour-led government altered the way in which primary health is funded and delivered (Rose, 2004). Patient care has slowly been transferred to amalgamations of health professionals who have become registered as Primary Health Organisations (PHOs) after changing to the new funding arrangements (Rose, 2004). This funding is population-based through targeting of impoverished areas or groups with poorer health outcomes. Rose believes the Primary Health Care Strategy has not been maximised as an opportunity to instigate preventative, primary health and its pitfalls mean many people are still not receiving the required support. This is particularly the case for the groups this research is concerned with. A lack of trained staff means mental health problems are not adequately addressed in primary care settings and young people do not fit the chosen age prioritisation to receive more subsidised care (Cumming & Gribben, 2007).

According to Dr. Ferguson, one of less than 20 GPs providing obstetric care in New Zealand, "supporting motherhood is the single most important thing a general practitioner does" (Cited in Chamberlain, 2006, p. 51). He identifies mental health care as the second most important health area. The Ministry of Health has made recommendations to GPs for enhancing their ability to meet the needs of youth including a 'whole-team' approach where everyone in the practice, including reception staff are involved with, and supportive of young people. Input from young people into the development of the service is also encouraged. Additionally, suitable training is identified as required alongside local services knowing the needs and characteristics of their youth populations. It is unclear from the recommendations how these recommendations will be encouraged or monitored. Despite the Minister of Health claiming all district health board areas would have a PHO by early 2003 (Young, 2002) some areas did not have these supports in place over four years later.

Secondary and tertiary health services

Under the current health provisions women's maternal health and mental health are separated. Maternity care is received as per the policies described previously with mental health support coming from the secondary or tertiary generic mental health services provided for the rest of the population. Embedded within some generic mental health teams are specialist positions such as the maternal mental health role. LMCs are expected to respond to women's psychological health in the primary sector until such point as secondary or tertiary services may become necessary.

The Mental Health (Compulsory Assessment and Treatment) Act (1992) Section 66 states "[e]very patient is entitled to medical treatment or other health care appropriate to his or her condition" (Bell & Brookbanks, 2005, p. 185). The lack of mother-baby inpatient units (there is one in New Zealand which is no longer accessible to many regions) could provide an argument that inpatient treatment in most areas is not appropriate to maternal mental health conditions. Also, use of medication to treat must be appropriate to a pregnant woman's condition as child-bearing. While the Mental Health (Compulsory Assessment and Treatment) Act 1992 is concerned with compulsory treatment this Section also relates to community treatment and states appropriate treatment is that which can cure disorder or prevent a decompensation in mental state (Bell & Brookbanks, 2005). If women demonstrate risk factors, there may be within the Act a responsibility to intervene to interrupt those factors that cause a decline in mental health.

Maternal mental health and gender constructions

In New Zealand from April 2001 any policy proposals before the Social Equity Cabinet Committee had to include a 'Gender Impact Statement' (Ministry of Women's Affairs, 2001). It was believed this would obligate the policy-making apparatus to realise the gender implications of new policies and "the importance of gender as a primary category of analysis in policy development" (Ministry of Women's Affairs, 2001, p.1). According to Fry (2001, p. 55) "[t]he government keeps motherhood myths alive to justify their reluctance to address the issues of childcare, child rearing and parental leave" (Fry, 2001, p. 55). This gender bias, where actions are based upon gender stereotypes, remains in New Zealand maternity and mental health policy despite the introduction of Gender Impact Statements where there appears to be little follow-up to what the statement discovers (Ministry of Women's Affairs, 2001).

A focus upon mortality rather than improving morbidity means the complexities of women's health are not taken into account when developing services and policy (Dearman et al., 2007). The Health Funding Authority (2001) calls for women's "voices" to be heard in maternity care but how to ensure these voices are heard at the level of policy making is not specified. The catalyst for the Gender Impact Statements within New Zealand policy came from the recommendations of the United Nations Convention for the Elimination of Discrimination Against Women (CEDAW). Despite this change there are still principles of CEDAW that are not being met within New Zealand, including the removal of discrimination suffered by women with disabilities.

Local provisions

District Health Boards

Under the Public Health and Disability Act (1993) District Health Boards (DHB) were created in nine geographical areas to fund secondary maternity services for New Zealand citizens and residents (MidCentral Health LTD, 2004). DHB services are provided to women within the local area throughout their pregnancy, birth, and the first six weeks postnatally with services provided both in the home and hospital. The services delivered depend on requirements of service provision from the Ministry of Health and the needs of the DHB's community. Thus, there is national variation to current provisions. At the time the current research was being conducted the local DHB funded the following services regarding maternity and mental health: primary and secondary maternity services and facilities; access to tertiary services; specialist neo-natal services; education surrounding pregnancy and parenting for at least 30 percent of women; and a consumer information service (MidCentral Health LTD, 2004). DHBs and PHOs are required by the Ministry of Health (2001) to have an understanding of the demographics of their regions to ensure efficient, useful policy is developed locally. A maternity services review conducted by MidCentral Health LTD (2004) found demand for pregnancy and parenting programmes exceeding supply with incongruence between rural and urban areas in the use and provision of LMC and community midwife support. It was believed that in more isolated areas there was little drive to provide such services or to give support with social issues (MidCentral Health LTD, 2004).

Provisions for maternal mental health

Maternal mental health provisions are considered specialty services. Recommendations for the creation of Regional Specialty Services (RSS) were made from the Blueprint for Mental Health Services in New Zealand (1998). RSS was thus developed to provide specialist assessment and treatment of mental health consumers who have special needs; deliver training to local community mental health teams; and increase the skills of those working in such teams (Central Regions Technical Advisory Services, 2005). In some areas specialist maternal mental health services were in place prior to the creation of the RSS. In the area of the current research specific secondary maternal mental health assessment and treatment is provided to women through a full-time clinician who is based within the adult community mental health team.

A number of difficulties have been identified within current specialty mental health service delivery including the ranging use of such services by different DHBs, unequal provision of services to DHBs, poor communication between

DHBs and speciality services, and the responsiveness and appropriate use of specialty services (Central Regions Technical Advisory Services, 2005). Recommendations to address these issues have included basing specialty services within DHBs and enhancing their resources. Concern has also been expressed that some cases are not seen within specialty services as they are not serious enough to meet criteria (Health Funding Authority, 2000; Central Regions Technical Advisory Services, 2005). Statistics reviewing all clients or patients that enter health services across primary, secondary, and tertiary care services found only one percent actually access tertiary level services (O'Gormon, 2006). When women do not meet criteria for secondary or specialty services they are limited to access support through their doctor or other services, with the National Health Committee identifying many women cannot afford to do this, or there may not be community resources available to them.

Local and community services

Throughout New Zealand there are a range of non-government organisations set up in response to identified need at a primary care level (MidCentral District Health Board, 2005). These providers obtain contracts from government departments such as the Ministry of Health for funding to provide certain services. Additionally, they may receive funding from DHBs or city councils, or rely upon volunteers and grants from funding sources such as the Lotteries Commission (R. Bailey, pers.comm. 13.10.07). Bailey has expressed the difficulties with such funding sources that are unstable and time consuming to apply for.

Some organisations have national offices and provide services throughout New Zealand. The Parents Centre and Plunket are two of these organisations that are relevant for young women in the perinatal period. In addition to national organisations there are local provisions to meet need. The difficulty with community-based provisions is that they often have limited and inconsistent funding. This impacts on the services they can provide, particularly on the sustainability and quality of these services as qualified staff and ongoing training may not be affordable. Services also have to be generic as providing services specific to populations such as young women, or adapting services and structures for young women is not sustainable financially.

Conclusion

This chapter has outlined the current provisions in New Zealand for maternity and mental health care of women. These include the national policy requirements for delivering maternity care and mental health treatment and how this manifests in District Health Boards for secondary and tertiary services and Primary Health Organisations and community-based services for primary interventions. Requirements of Te Tiriti O Waitangi and international conventions help to ensure health services are equitable and responsive to young women and Tangata Whenua. The determination of need, what health services should be funded, and who is responsible for the health needs of individuals and populations is influenced by the theoretical perspectives held. The national and local provisions for perinatal mental health outlined in this chapter are thus influenced by the dominant health philosophies of the current day. These paradigms of health and how they impact service provision and policy are outlined in the next chapter.

Chapter 2

Models of Intervention for Perinatal Mental Health

Introduction

The paradigms people use to conceptualise health issues influence their understandings of the appropriate way to address such issues. This includes who is responsible for attending to health needs and how to best do this. Thus, current theories of health become the basis upon which the social and health policy explicated in the previous chapter is developed. Many conceptualisations of health and illness exist and have been adapted over time including: the medical model, feminist theories, cultural understandings of health, and natural or holistic methods. This chapter opens with a discussion of the dominant paradigm used by the western world to explain illness, the medical model. This is followed by feminist challenges to the medical model, models of prevention and early intervention, and health promotion and public health. The chapter concludes with some consideration of the implications of these models for social and health policy.

The medical model

Since the sixteenth century, methods of delivering health services to individuals have focused on pathology and treating an organic problem within a person. This approach to health is termed the medical model. This section will discuss the medical model beginning with its basis in positivist science and the key principles of the model. The application of the medical model in mental health, particularly through the development of psychiatry and diagnosis, will also be outlined. The medical model holds that disorder occurs from an organic basis where conditions emerge due to changes in the brain or biology (Donnelly & McGilloway, 2007; Gutteridge, 2007). A person is seen on an individual level as receiving a disorder separate from the contexts of their lives outside of this organic condition. Following contraction of a problem, the individual is seen as needing diagnosis and treatment in a medical setting by medical professionals (Gutteridge, 2007). Such an understanding is aligned with positivist science which is individualistic, reductionistic, mechanistic (explains the whole by breaking it down into parts), static, and attempts to be objective (Cave, 2002; Parsons & Armstrong, 2000; Tomm, 1990; Weick, 1986). Linear causalities, where one thing leads directly to another, are inferred. However, as critiques of the medical model outlined later in this chapter identify, human lives are far more complex than this reductionism allows for (Cave, 2002; Weick, 1986; Wirth-Cauchon, 2001). This is made more difficult with the complexities of mental health.

The medical model and mental health

The biomedical framework has been utilised for mental health as it has for physical disease, where people's problems are believed to emerge through genetic, biological, and chemical imbalance (Eriksen & Kress, 2005; Gutteridge, 2007; Laing & Mitaera, 1994). One example is depression which is recognised as a disturbance in neuronal transmission and a biochemical process of reduced serotonin uptake (Gutteridge, 2007). The assumption of a medical model conceptualisation of mental health is that problems exist within an individual, subsequently excluding consideration of familial, social, and cultural contexts (Caplan & Cosgrove, 2004; Durie, 1994; Fry, 2001; Labrum, 1990).

Throughout feminist, anti-racial, and consumer movement critiques of mental health the significance of the effects of cultural, social, political, and historical contexts in all areas, particularly medicine and psychiatry, has been highlighted. Because psychiatry has not had large scientific breakthroughs in its science (with the exception of the development of psychotropic drugs) catalysts for change have been these social and cultural shifts identifiable throughout history (Styles, 1997). The ambiguous nature of mental health diagnosis and treatment where there are numerous competing theories, such as biological, social, or psychological understandings, has influenced the development of psychiatry (Styles, 1997). Psychiatry, more than any other form of medicine has had to work to prove itself as a 'science' and it is believed that, the defence of a medical, reductionist and categorical model is an attempt to do this (Labrum, 1990; Styles, 1997). Such a model is reflected in the key theories utilised by psychiatry to label, treat, and conceptualise the emergence of mental ill-health and subsequently the tools to achieve this such as the Diagnostic and Statistical Manual (DSM).

Diagnostic classification

The Psychiatric Associations' Diagnostic and Statistical Manual (DSM), now approaching its 5th Volume is, alongside the International Classification of Disorders (ICD-10), the most pervasive international diagnostic resource for mental illness. Nosogrophy, the description and classification of diseases, has informed construction of the DSM and ICD-10 on the basis of the medical paradigm (Parsons & Armstrong, 2000). The benefits of the DSM are that it intends to provide a common language for diagnostic communication, and reduce complex and chaotic symptoms into manageable forms, while providing insights into treatment approaches and effectiveness (Bowers, 1998; Eriksen & Kress, 2005; Tomm, 1990). However, diagnostic tools assume symptoms are polythetic, having equal significance, and static rather than existing on a continuum or coming and going as a model of systemic dysfunction identifies (Kendall, 1996; Lenzenweger & Clarkin, 2005; Miller, Rathus & Linehan, 2007). In more recent conceptualisations of maternal mental health illnesses have been identified as more likely to exist on a spectrum of symptoms, rather than as individual disorders (Fry, 2001).

Feminist conceptualisations of mental health

Feminist conceptualisations of health have arisen from discontent with the medical model and systems of diagnostic classification. Some interest groups argue that DSMIV has not always been utilised as intended and instead has had biased applications not evidenced by a sound scientific basis (Caplan & Cosgrove, 2004; Eriksen & Kress, 2005; Gutteridge, 2007). This has led to errors in diagnosis, questions of reliability (and thus validity), as well as accusations of sexism, racism, classism, and homophobia (Bowers, 1998; 2004; Durie, 1994; Gutteridge, 2007; Pilgrim & Rogers, 1999). In contrast "[f]eminist principles afford a way of thinking about gender and health that highlights concerns and issues that may be less visible when traditional frameworks are the basis of conceptualization" (Travis & Compton, 2001, p.312). The issues Travis and Compton refer to include consideration of how gender norms and socialised roles, particularly social and familial context, impact people's health. They also concern issues of power, hierarchy, and individualism, practices which create poorer treatment of women and other minority populations within health systems. These concerns held by feminists, and how they influence women's mental health will be discussed next, beginning with gender constructions, the core concern of all feminist theories.

Gender

In health, feminists have challenged gender role assumptions that have influenced the quality of health services women receive. Arguments have been made that marginalised groups, such as women and ethnic minorities, do not share in the same quality of health care as others with this reflected in health statistics (Ministry of Health, 2001b). Feminists thus highlight the role hierarchical power positions within society have upon provision of mental health services (Dearman, 2007; Gutteridge et al., 2007; Styles, 1997). One place in which such power hierarchies emerge is within psychiatric systems which are believed to reinforce patriarchy and a biological model that disadvantages women (Styles, 1997). Gendered constructions that associate mental ill health with feminine attributes do not recognise that these gender attributes are biased with women's vulnerabilities actually occurring from marginalisation based on gender and women's undervalued roles in society and the family (Dearman et al., 2007). Feminist analysis of the early history of medicine found little acknowledgement of obvious gender issues demonstrating that the consideration of 'normal' gendered behaviours and differences has been unquestioningly implicit within health and psychiatry (Marland, 2005; Showalter, 1985; Styles, 1997).

Social constructions of health

Feminist theory is one of the sociological paradigms that emerged as an alternative to the medical model. Sociological theories state an individual must be considered in the social context of their life including how the structures of society impact upon them (Gutteridge, 2007). Feminist paradigms declare knowledge is socially-constructed and relativist; that is culturally, socially, theoretically and historically bound (Aldridge, Griffiths and Williams, 1991; Hesse-Biber & Yaiser, 2004; McRobbie, 1982; Lather, 1986; Naples, 2003; Reinharz, 1992). Rather than being merely a biochemical process, health and mental health is seen by feminists as directly influenced by our standings and roles within society.

A socially constructed view of mental illness, as opposed to mental ill health being seen as 'scientific' or based in 'nature', forms a key argument made by feminists that women were placed into these roles as victims of a socially constructed mental health service rather than being sick due to any inherent biological dysfunction (Labrum, 1990; Marland, 2004; Showalter, 1985). Women's mental wellbeing is affected by the social and economic positioning of women in society (Dearman et al., 2007). Implications of different social status, career opportunities and pay, as well as being out of the workforce more regularly due to domestic constraints, such as caring for family members, mean women generally have lower economic resources than men (Dearman et al., 2007). When consideration is made of the impacts of domestic violence, traumatic incidences (which women are at increased risk of), discrimination, and, internationally, war and refugee status, the influences upon women's health become numerous and extend beyond biochemical frameworks (Dearman et al., 2007).

Women are over-represented in mental health settings. A social construction of mental health may provide one explanation:

> There have always been those who argued that women's high rate of mental disorder is a product of their social situation, both their confining roles as daughters, wives, and mothers and their mistreatment by a male-dominated and possibly misogynistic psychiatric profession (Showalter, 1985, p. 3).

McRobbie (1978) also highlights the complex interaction of sex and class as well as gender. The increased stress on women of highly constrained roles limited to domesticity and motherhood can be triggers for anger, and mental illness (Chesler, 1997; Travis & Compton, 2001). The majority of the literature, including recent works, reduce the issue of maternal mental health and young parenting to an individual level, where the mother is victimised, rather than addressing societal structures or the social causation of pathology as feminists would argue is required (Travis & Compton, 2001). One exception to this is Goodwin's (1996) thesis where systemic issues, such as the destruction of whanau and iwi systems through colonisation, are epidemiologic of the troublesome period in pregnancy that the Máori women she researched faced.

Labelling, power and control

The problem focus of the medical model is analysed by feminists as pathologising certain behaviours rather than viewing these behaviours as survivor techniques to cope with distress (Eriksen & Kress, 2005; Tomm, 1990). The pathologising nature of a medical model deflects attention away from the traumatic or invalidating situation a person has survived and focuses on individual behaviours that are grouped together and used to assign a diagnostic label (Cave, 2002; Wirth-Cauchon, 2001). This labelling affects certain groups more negatively than others, including women and cultural minorities, and can influence insurance, licensing, sick leave, assessments of parenting, and access to services and treatment (Caplan & Cosgrove, 2004; Parsons & Armstrong, 2000; Pilgrim & Rogers, 1999). Labelling can also elicit a 'self-fulfilling prophecy' where people accept their situation as hopeless (Caplan & Cosgrove, 2004; Eriksen & Kress, 2005). Studies indicate twice as many women are diagnosed with depression than men (Chesler, 1997; Llewellyn, Stowe & Nemeroff, 1997). Many groups and individuals, including feminists have argued that this is due to the socially constructed nature of psychiatry and mental illness and the use of insanity to oppress women. Adherents of DSM IV, in their claims it is objective, are not overt about the imposition of value judgements in determining what is normal or otherwise (Eriksen & Kress, 2005; Kendall, 1996; Rogers, 2001; Tomm, 1990).

Psychiatric authority represents the large power base surrounding the ability to diagnose and treat mental illness (Laing & Mitaera, 1994; Szasz, 2000). This power has been held in the hands of few with only a select part of the population theorising, diagnosing, and writing about issues consistent with their own values, norms, and culture (Babbie, 2001):

> Constructs are defined by whoever does the defining, and the power to make a definition stick resides usually in groups that have the most social, political and/or economic power (Caplan & Cosgrove, 2004, p. 20).

The power to make decisions about others' lives, such as how to treat, medicate or hospitalise them, has historically been abused, often to the detriment of women (Caplan & Cosgrove, 2004; Parsons & Armstrong, 2000; Szasz, 2000).

The determination of what is 'acceptable' or 'abnormal' behaviours always occurs in a historical and cultural context (Gutteridge, 2007). Because women's roles and acceptable actions are more constrained than men's, the ability for them to be seen as 'abnormal' is increased (Chelser, 1997). Women have been shaped through psychiatry into what is considered good and womanly behaviours (Chesler, 1997; Matthews, 1984; Showalter, 1981). However, the difficulty for individual women is that the ideals of what this is shift constantly (Coleman, 2005) and are mutually exclusive, so can never be achieved (Labrum, 1990). This is particularly concerning in motherhood and reflected in Fry's (2001) research as women strive to be 'good' mothers with the goalposts continually shifting and views on what demonstrates good motherhood debated. The trauma associated with marginalisation in health settings is compounded when women are blamed and pathologised for their situations (Chesler, 1997).

Medicalisation of reproductive capacity

Feminists have analysed how women's reproductive capacities have historically been medicalised to justify mental health treatment and diagnosis (Chesler, 1997; Labrum, 1990; Marland, 2004; Showalter, 1985; Styles, 1999). The mere fact that it is women that give birth has medical and social implications (McRobbie, 1978). Radical feminists, such as Dominelli (1991) have recognised how women's marginalisation occurs through their biological difference and reproductive capabilities. Thus, 'reproductive politics' are highlighted where women's reproductive roles are politicised and managed through health services and policy. Chelsler (1997) has identified how such reproductive politics lead to exploitation of women for their resources, unpaid labour, and reproductive capacities to the benefit of men. Emphasising an understanding of mental illness that is centred in heredity and environment exacerbates the feminisation of mental illness.

Prevention and Early Intervention

Zubrick, Silburn & Blair define prevention of mental illness as "those interventions that occur before the initial onset of a clinically diagnosable disorder" (2000, p. 576). There are three levels of preventative measures identified. Primary prevention occurs when a disease is prevented before any signs of it have emerged (Yarnell & Evans, 2007). Primary prevention in mental health would include measures that promote wellbeing before any mental illness has arisen. Secondary prevention impedes the total development of an illness once signs of it emerge or prevent the reoccurrence of an illness. This would include efforts that prevent further episodes of mental illness occurring. Finally, tertiary prevention attends to reducing the effects of a disorder once it is diagnosed, for example management of severe or chronic mental illness (Yarnell & Evans, 2007). Where prevention is referred to in this chapter it is surrounding primary or secondary prevention unless otherwise specified. This is consistent with much of the literature surrounding prevention and early intervention that does not specify the level of prevention but is referring to primary and secondary prevention.

Prevention and biological models

Magyary (2002, p.333-335) provides a thorough operationalisation of terms such as 'prevention' and 'mental health promotion'. He identifies a difficulty in exploring such interventions due to what he sees as pathologising and punitive models that exist in health, education, and care and protection services. Svanberg (1998) also believes the disease-focused model that reduces prevention to influencing risk for a particular illness using a medical paradigm, is not only costly but in-effective. Instead he argues, as does Eriksen & Kress (2005), for building strength in individuals so they are less vulnerable to mental ill-health and poor self-concept (Svanberg, 1998). The current knowledge base of maternity care and mental health is conceptualised through the medical model which does not promote primary or secondary prevention (Nash, 2001). Primary and secondary prevention has also been neglected through the prioritisation of searching for costly medical cures (Yarnell & Evans, 2007). The negative impacts of the medical model have become recognised with an increasing shift towards enhancing those things that maintain mental health and wellness (Zubrick, Silburn & Blair, 2000).

Aims of prevention

The aim of preventative intervention is to fulfil emerging developmental tasks and stages, not to alter individual behaviours (Beckwith, 2000). Studies reviewing preventative interventions have shown specific improvements diminished over time while "increased mastery motivation and enhanced emotional and behavioural regulation continue, as evident in increased involvement in achievement and good citizenship" (Beckwith, p. 447). Zeanah (2000) has developed an entire preventative intervention throughout human developmental stages and reviews the short and long term effectiveness of other interventions. What is also useful for the present study and well-developed in Zeanah's handbook is a plan for mental health interventions for young mothers and their infants. This is similar in design to the recommendations provided by Svanberg (1998) and both advocate for increased support, education and therapy to reduce risks of psychological problems during pregnancy.

Delivery of preventative interventions

A range of modes of delivery for maternal interventions have been identified in the literature. Home visits and parenting supports are specifically outlined in the following chapter. Despite this evidence base, Wakschlag and Hans (2000) found a lack of focus on mental health intervention and issues of family interaction within services and health policy. The best person to deliver the interventions recommended is also debated. Most of the current studies Beckwith (2000) reviews have used nurses or 'para-professionals'. Those studies that have incorporated consumers or reviewed consumer-led interventions have demonstrated these as less effective (Beckwith, 2000). The status of the provider may be less important than their inter-personal abilities. One of the most substantial mediators of the effectiveness of programs has been found to be the quality of the relationship between the participants and the service provider (Beckwith, 2000). Pharis and Levin (1991) also found younger women responded more positively to the relationship and face-to-face interaction inherent in receiving services than the practical rewards offered. This has a number of implications for maternity care policy as the relationship a woman has with her Lead Maternity Carer will have significant repercussions.

Midwifery care in New Zealand is influenced by outcome mediating factors such as duration and timing of involvement of professionals. Beckwith (2000) found that lengthier input, perinatally provided was most effective. However, there is some evidence that improvements diminish if lengthy interventions become unfocused or too comprehensive. Preventative interventions are most effective when they are introduced perinatally and have clear, focused goals that target the individual needs of the women and family by considering their current resources, abilities and motivation (Beckwith, 2000). Policy and program development also needs to incorporate an understanding of the heterogeneity of young mothers and their children to be effective (Beckwith, 2000; Zeanah, 2000).

Universal vs. targeted intervention

Magyary (2002), Durlak (1998) and Shore (1998) identify the different ways in which primary prevention is delivered. They differentiate between universal interventions, where entire populations are uniformly included, selective interventions, which are applied to groups displaying high risk potential for disorder, and indicated interventions targeted at high risk individuals (Magyary, 2002; Svanberg, 1998). Svanberg discovered targeted assessment of people who display certain risk factors, or are at critical life stages, is effective. He demonstrates that pregnancy and childbirth are one of these critical points by outlining success achieved through support visits to new mothers. However Wakschlag & Hans (2000) state universal interventions for young women will not be sufficient. Instead they argue interventions need to be adapted to address the different needs of the sub-groups within this population. Such interventions, according to Wakschlag and Hans, should be guided by the mental health issues of young women and the level of their psychological preparation for parenthood. Interventions targeted only at mothers were found to indirectly enhance child outcomes if they positively altered parenting behaviours or the mothers' lives (Beckwith, 2000). Swann, et al. (2003) encourage opportunities to provide support and education to young parents be maximised wherever they arise.

To be effective in achieving these goals, early intervention programs and policies must have active participation of the women and families they target. Both Stuart and O'Hara (2005) and Beckwith (2000) identify women partake in interventions to different degrees influencing the benefit they receive. Pregnancy is a developmental life stage where women may be more motivated for interventions as they consider their situation and unborn child (Sherr, 1995; Zeanah, 2000). However, there are many characteristics of both the participants, service providers, policies and programs that affect the quality of intervention. These include: the woman's and subsequent child's psychological resources, temperament and intelligence; the number of additional vulnerability factors including poverty and the age of the woman; number of protective factors, such as supportive family or partner; the timing, duration and components of interventions; and the extent to which barriers of access are reduced (Beckwith, 2000; O'Hara, 2005).

Prevention and social policy

Jenkins (2003) explores two broad ways social policy influences prevention. Firstly, there are those policies that target specifically mental health and disorder and secondly, those that influence other environmental variables that impact on mental health. Although preventative measures are advocated for within the literature they appear limited in social policy and service provision. Karen (1998) suggests social policy is mostly reactive to social problems and that the lack of preventative measures reflects the short-sighted nature of government policy. Jenkins also bemoans that health policy has mostly been delivered through specialist services and does not address the multi-systemic and inter-agency nature of psychological issues. Preventative measures, while costly initially, save money in inexpensive mental health treatments, forensics services, or implications from alienated youth in the long term (Karen, 1998). Preventative interventions can relieve suffering earlier for women and their children rather than waiting until disorder and problems are ingrained with some issues possibly prevented from occurring in the first place (Lester, Boukydis & Twomey, 2000; Swann et al, 2003). "The premise is that prevention is easier and results in less serious consequences for the family, the child, and the community than does treatment of a disorder" (Zeanah, 2000, p. 439). Jenkins (2003) believes early intervention in perinatal mental health is one of the most vital priorities for mental health policy.

Public Health and Mental Health Promotion

Health promotion

Instead of conceptualising around symptoms of mental illness and causes of dysfunction, health promotion examines what it takes for a population to be mentally healthy. Currently, funding tends to be allocated to illness rather than health promotion (Weick, 1986). Today, the World Health Organisation defines mental health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1981). Additionally, Weick sees health as "a manifestation of the continuous interaction between physical and social processes...it expresses the inherent capacity of individuals to grow and become more" (1986, p. 555). Mental health includes the achievement of a sense of potential and mastery in life rather than just the absence of illness (Gutteridge, 2007; Magyary, 2002; Maslow, 1999).

Health promotion is becoming more recognised in the world through both individual countries' health and social policy and within international organisations such as the WHO. Mental health promotion is now deemed a core standard in the British National Health Service (Price, 2007) and New Zealand is making attempts to promote health via media and public health processes. Gutteridge (2007) clearly favours the adoption of public health promotion within health policy. However, she recognises that such a model places the responsibility on individuals to be proactive with actions to enhance their health and wellbeing with provision of treatment required for those who cannot do this.

Public health

Improving mental health is a key public health concern for all populations. Within public health systems both physical and mental health can be attended to as interdependent (Gutteridge, 2007) rather than breaking down a person's health needs into reductionist categories. Public health has at its core the ability to promote social inclusion through dispelling discrimination (Price, 2007). Hall (2007) reviews different definitions of mental health under a public health model that include spiritual and emotional resilience to cope with painful aspects of life as well as feeling positive about ourselves. Swinton has identified the following conditions of mental health: absence of illness, appropriateness of social behaviour, freedom from worry and guilt, personal competence and control, self acceptance and self-actualisation, unification and organisation of personality, and open-mindedness and flexibility (Swinton, 2001 cited in Hall, 2007). According to Hall, public health is about how these things manifest and are promoted in populations rather than individuals.

Gutteridge states "public health is based upon social and political strategies that expose social determinants of health and illness by redressing inequalities using education and health promotion" (2007, p. 25). Such a model is appealing because it attends to the complexity of mental health through education to the wider population and collaboration across sectors of health, education, economics, and environmental and social development. Public health models present a strong alternative to the biomedical model and diagnostic classification as they state that mental wellbeing occurs at different levels for all people, on a spectrum, as an ongoing process. Building capacity for people to control their own wellbeing is the goal which can be achieved through wider mechanisms than the diagnosis of disorder and the instigation of medical treatment (Chaplin, 2007; Magyary, 2002; Weick, 1986). For young women in the perinatal period factors that assist them to achieve a level of wellbeing they desire may include having suitable accommodation, safety within their community, freedom from violence, ability to care for their children, social inclusiveness, and freedom of choice.

The health model/holistic alternatives

In 1986, Weick, a social work theorist, developed a "health model" based on bio-social theory (Chaplin, 2007). This model was presented as an alternative to the medical model which Weick saw as influencing social work practice even though it did not align well with social work values (Weick, 1986). Weick acknowledges the role of positivist science in social work, however, identifies another strand of epidemiology for the profession based on humanist models. Humanist philosophies value choice, personal development, and advancing human rights, philosophies that can conflict with the focus of the medical model as outlined previously. Consistent with both feminist and primary promotion and public health models, the aim of the health model is to empower people to be able to take control of their health. There is a belief in people's inherent ability to know they need to maintain positive health. This reflects the strengths-based model of social work practice. People are believed to have the abilities to heal themselves and this ability to resolve our own mental health needs, with supports, assists in the reduction of stigmatisation of mental health service consumers (Chaplin, 2007).

In Weick's (1986) approach the role for health practitioners is in identifying and addressing structural barriers to accessing health care such as cultural barriers and financial limitations. Health initiatives would, under such a model, take a mental health promotion focus; highlighting strategies that educate and advertise the steps necessary for sound mental and physical health, for example, encouraging physical and emotional care during pregnancy (Chaplin, 2007). Chaplin identifies many implications for health delivery and policy from the adoption of a health perspective model:

> A health perspective guides us to consider how we can establish policies that create an environment in which people have the maximum chance for good health and can develop their strengths more fully. Efforts to enact policies that support recovery for people with serious and persistent mental illness illustrated how the

strengths perspective can be used in crafting health policy (Chaplin, 2007, p. 299).

Implications for social and health policy

Theories and models of understanding issues such as maternal mental health directly influence social policy and the way in which resources are distributed (Zeanah, 2000). If we are to assume a social constructivist worldview resounding implications for the importance of social policy emerge. Social policy can reflect, influence, or reinforce public opinion, direct where attention is focused, and ultimately determine what is deemed acceptable or otherwise through the actions that are taken or avoided. The very fact of whether an issue is addressed by policy makers indicates its significance to the country and thus how it is viewed by the public.

The connections between mental illness, domestic violence, reproductive health, economic stress, and trauma are complex and not reflected in political or health systems. Similarly to the individual delivery of health services, the social policies that have determined such delivery have been based on a medical model of health and illness. Policy makers have characterised individuals and communities by their ‘problems’ such as with the ‘issue’ of teenage pregnancy rather than identifying the strengths and resources such individuals and communities hold and attempting to advance these (Chaplin, 2007). Eriksen and Kress also recognise that “the impact of diagnosis on public policy is striking” (2005; p.xiv). This influence can reinforce through policy the problems identified by consumer, cultural, early intervention, and feminist movements from the dominance of the medical model. To address this Chaplin purports; “policies are needed to support new approaches that aren’t based on pathology and deficits” (Chaplin, 2007, p. 298).

Conclusion

The bio-medical model has had an enormous impact on our modern understanding of ill-health and is critiqued by feminists and other groups, particularly cultural minorities and consumer groups, due to this influence.

Challenges made by women's and consumer movements have led to greater recognition that the medical model cannot fully explain mental health and that more dialectical, integrated understandings that can acknowledge the role and benefits of the different paradigms this chapter reviews are needed. Models that focus on promoting wellness may also reduce the increasing numbers of the population that receive acute treatments in tertiary mental health services. It is these treatments, and the implications for women and their children from suffering mental ill-health in the perinatal period that will be reviewed in the following chapter.

Chapter 3

Addressing Perinatal Mental Health

Introduction

Pregnancy is identified as a time of "emotional upheaval" (Karen, 1998, P. 367) as well as one of the core developmental stages of adulthood. Young pregnant women are one population at increased risk for mental ill-health, poor social support, violence, and alcohol and drug exposure during and following pregnancy. They are also one group who, as young and at times less socially and economically resourced, are often excluded from articulating their experiences in the policy arena. This research focuses upon giving a voice for young pregnant women. The current chapter explores the literature surrounding the importance of sound mental health for young women during the perinatal period. The implications of negative mental states and emotional experiences for young women and their children in this period are outlined. Consistent with the thesis topic, this chapter will focus upon early intervention methods to attend to young women's mental health needs generally in the perinatal period rather than interventions for those already diagnosed with a mental illness. Implications for health and social policy stemming from the evidence base will also be discussed at the close of the chapter.

Perinatal mental health and young women

Swann, Bowe, McCormick and Kosmin (2003, p. 38) found a "tremendous amount of evidence" demonstrating that more negative outcomes are experienced by young pregnant women and those that struggle with psychological issues, and their children. The perinatal period is a crucial period because of the changes that occur in how women see themselves, their partners, their families, culture, and bodies, as well as the unborn child (Dearman, Gutteridge & Waheed, 2007, Zeanah, 2000). Price (2007) laments that there is minimal literature or reports written from women's experiences of their maternal mental health. Accordingly, in conducting the literature review, no sources were located that were written by women with experience of perinatal mental ill-health.

Any psychiatric condition can occur during pregnancy and the reproductive years are when a woman is most likely to suffer mental illness (Beach, Henry, Stowe and Newport, 2005; Petrillo et al., 2005). Some women are likely to be more vulnerable to mood problems in the perinatal stage of pregnancy due to the nature of this period (Cohen and Nonacs, 1995; Sherr, 1995). In one study reviewed by Dearman et al. (2007) twenty three percent of women with postnatal depression had felt symptoms during their pregnancy. Additionally, Petrillo et al. (2005) review a cohort study of 14000 women that indicates depressive symptoms during pregnancy may be more prevalent than in the postpartum period. Suffering perinatal depression makes it more likely that young women will have reduced attendance at antenatal services and increased substance misuse (Beach et al., 2005; Petrillo et al., 2005). Zeanah recognises the critical period of pregnancy devoting a chapter of his handbook to the psychological implications: "There are probably few experiences in a woman's life more transforming than the experience of pregnancy" (2000, p.20).

While it has been argued that few women suffer high levels of acute mental illness during pregnancy, many do face emotional and adjustment difficulties.

> The adjustments to childbirth may affect the woman's psychological and social functioning and no matter how positive the birth experience is, it remains a very stressful time for some women (Dearman et al., 2007, p. 154).

These issues may be exacerbated by the myths of motherhood Fry (2001) identifies have become embedded within our society whereby women are expected to reveal a biological instinct when they become mothers and feel joy at pregnancy. This leaves those women, for whom pregnancy and mothering does not feel 'natural' or joyous, in a precarious position and may lead to feelings of guilt or shame. McRobbie (1978) identified how the responses of the young women in her research unwittingly fortified these myths. Both McRobbie (1978) and Fry (2001) believe governments and local bodies subtlety encourage the maintenance of these "myths" both for control purposes and so these complex issues do not have to be addressed.

Vulnerability factors

"Women face a clearly established risk of developing a new affective, or mood, disorder during pregnancy and following childbirth" (Kendall et al., 1987 cited in Dearman et al., 2007, p. 155). Predisposing factors of maternal mental illness and early pregnancy are paralleled and include significant environmental factors. Most of the literature surrounding maternal mental health and youth pregnancy refer to a pre-disposition to both stemming from: a breakdown of social support; low socio-economic status; poor educational attainment; issues surrounding the pregnancy, such as previous miscarriages and unwanted pregnancies; poor parent-child attachment in the young persons early life; alcohol or other drug use; unresolved trauma; and previous psychiatric illness (Cherry et al., 2001; Cohen & Nonacs, 2005; Elster, 1990; Sherr, 1995; Swann, Bowe, McCormick & Kosmin, 2003; Matthews & Meaney, 2005). A previous psychiatric condition is the strongest known indicator of perinatal depression with two thirds of women in the cohort study Petrillo et al. (2005) refer to having had an earlier episode of depression.

Pregnant women, eighteen years old or under, are at increased risk of psychological and social issues in the perinatal period (Beach et al., 2005; Barnett, Glossop, Matthey & Stewart, 2007, Te Rau Matatini, 2004). When women are not prepared for the pregnancy, as can occur with young pregnant women, even those who have planned to become pregnant, experiences can be negative and marked by anxiety, ambivalence or fear (Wakschlag and Hans, 2000). Nicholson, Anderson, Fox & Brenner (2002) and Bolton (1990) identify that younger, single women, with less financial and educational resources are more vulnerable to negative parenting. Mental health, adjustment and self-esteem are also indicators of parental competence (Wakschlag and Hans, 2000) to the extent that Aber, Jones, and Cohen (2000, p.119) refer to mental health as the "single most important mediator of the quality of mother-infant interactions".

Sherr (1995) believes the capacities of young, pregnant women are less related to their age than the social and environmental circumstances from which this population group often emerges. Low socio-economic resources has been demonstrated to increase predisposition to mental illness (Matthews and Meaney, 2005; Wakschlag and Hans, 2000). Phoenix, Woolett, and Lloyd (1991) also attribute a social construction to motherhood, particularly for groups such a young mothers and mental health consumers who are singled out. Poor life circumstances may exist prior to, and be risk factors for, early pregnancy or mental ill-health, yet can also be worsened by pregnancy (Matthews & Meaney, 2005; Swann, Bowe, McCormick & Kosmin, 2003). For example, Cherry, Dillon and Rugh (2001, p.48) found increased isolation caused by early pregnancy, while Sherr (1995) discovered greater stressors for younger women.

The reference to 'risk factors' in perinatal mental health is controversial. Nash (2001) believes the ingrained use of concepts including 'at risk' in policy arenas have done a disservice to women, particularly young women. This is due to the gaps identified in behaviourist methods from which 'at risk' variables have been gleaned. The generalisation of 'risk factors' to a group or population, such as identifying all young mothers as 'at risk', is seen as a misnomer due to heterogeneity even within the risk factors (Beckwith, 2000; Nash, 2001; Zeanah, 2000). "The 'at-risk' concept [...] has no explanatory value and gives support to a "cycle of deprivation" model that is not necessarily supported by the evidence" (Nash, 2001, p. 202). Knowing and recognising risk factors can be beneficial for preventative measures that may circumvent serious mental illness arising. The arguments surrounding the use of risk factors have extended to whether women should be screened in pregnancy for such factors.

Screening

Screening is defined as:

> The systematic application of a test of inquiry to identify individuals at risk of a specific disorder to benefit from further investigation or direct preventative action amongst persons who have not sought medical attention on account of symptoms of that disorder." (Peckham and Dezateaux, 1998, p. 767).

Screening in many countries, including New Zealand, has been focused on physical health issues such as cervical and breast cancer. Only recently has it been extended to psychiatric illness, particularly depression in the United Kingdom and U.S.A since 2002.

Throughout the western world investment in screening perinatally is mixed. Some areas of Australia and the USA have chosen to do so whereas the United Kingdom National Screening Committee continues to dissuade from screening until further research is completed (Shakespeare, 2005). Within the literature base, Cohen and Nonacs (2005), Sherr (1995) and Wakschlag & Hans (2000) are clearly in favour of antenatal screening. Cohen and Nonacs query why so few women are screened for possible psychiatric problems during pregnancy when the incidence and effects of undiagnosed mental ill-health is so well documented. Sherr (1995) supports this stating advances in ante-natal screening should be utilised to test for psychiatric difficulties so long as these tests have an accurate predictive value.

Controversially, systematic reviews conducted of antenatal screening have found insufficient evidence to support the introduction of universal screening perinatally (Henshaw and Elliott, 2005). In a text dedicated to screening for perinatal depression Henshaw and Elliott identify a number of ethical problems with screening that is not evidence-based including that screening can be invasive and seemingly irrelevant for many women who do not have mental health problems. However, the literature base -including Henshaw & Elliott's text- clearly states that what is necessary is clinical awareness of risk factors that can be appropriately assessed by health professionals with evidence-based and cost-effective solutions to the problems implemented (Sherr, 1995). Internationally there are few perinatal assessments or interventions to identify and treat young women who may be vulnerable to poor mental health and developing negative attachment relationships with their child (Boyce & Bell, 2005; Riecher-Rössler & Steiner, 2005). Jenkins (2003), Magyary (2002), and Zeanah (2000) report the need to identify the potential risk, as well as protective factors, in individual situations. For example, Karen (2005) identifies that when women have strong supports, whether that is from family, partner, or a support worker they respond and the parent-infant attachment is enhanced. The outcomes for children that are born to young or emotionally unwell mothers have been a concern to policy makers.

Implications for infants and children

Phoenix, et al. (1991) believe women's experiences and outcomes in pregnancy are often overshadowed by the large literature base surrounding child outcomes. However, Petrillo et al. (2005) state there has been minimal consideration of the effect of perinatal mental ill-health on children's well being. While the focus of the current research is on young women's experiences of their perinatal care, a consideration of the effects on infant and foetal health during pregnancy is necessary to demonstrate the significance of this period and provide holistic consideration for policy and program development.

Parenting

Research surrounding the epidemiology of mental ill-health demonstrates many illnesses have a genetic predisposition with intergenerational transmission of negative outcomes (Bolton, 1990; Erickson & Egeland, 2004; Matthews & Meaney, 2005; Sherr, 1995). Negative outcomes, including incidences of child maltreatment, are increased when mothers' suffer from depression (Aber et al., 2000). Developmentally, young pregnant women are in a key stage of their own while attempting to develop a child (Lindsay and Brunelli, 2004; Wakschlag and Hans, 2000; Zubrick, Silburn & Blair, 2000). Mental illness is shown to have a more negative effect than most chronic physical illness on a person's ability to function in key roles in their lives (Te Rau Matatini, 2004). Thus, a person may be impaired in their ability to parent effectively if suffering untreated mental illness.

Infant development

Perinatal maternal stress impedes the cognitive, behavioural, emotional and physical development of the child (Beach et al, 2005; Matthews & Meaney, 2005; Nelson & Bosquet, 2000; Petrillo et al., 2005). While there is some debate surrounding the polarised theory that all positive outcomes are determined for a child as a foetus and infant, most sources now recognise a synthesised view that the best possible foundation in each developmental stage is necessary (Crockenberg & Leerkes, 2000; Sameroff & Fiese, 2000).

Physically, perinatal depressive symptoms increase the risk of low birth weights, poor APGAR scores, and premature birth and result in smaller head circumference (Dearman et al., 2007; Petrillo et al., 2005). However, in a cohort study of over 5000 mothers it was not prenatal stress that was found to be the mediating factor but other risk factors during pregnancy such as smoking and intelligence levels of the participants (Krabbendam, Smits, de Bie, Bastiaanssen, Stelma and van Os, 2005).

Brain development begins within a few weeks of conception and is thus susceptible to impacts of maternal stress (Nelson & Bosquet, 2000). The specific parts of the brain found to be underdeveloped are those that assist attention, inhibitory control, self regulation (of emotion and behaviour), empathy, and fear and stress reactions (Matthews & Meaney, 2005; Nelson & Bosquet, 2000). It may be noted that many of these factors are incorporated in the DSM IV as signs of childhood mental illnesses such as Attention Deficit and Hyperactivity Disorders and those on the Autistic Spectrum (Kaufman & Henrich, 2000). In addition, Beckwith (2000) and Petrillo et al. (2005) recognise the effect of maternal anxiety disorders perinatally with children found to be at increased risk of behavioural problems, social fears and anxiety disorders themselves.

Both animal and human studies, as reviewed by Nelson and Bosquet (2000) and Matthews and Meaney (2005), have found that maternal stress during pregnancy alters key chemicals, such as monoamine, dopamine, norepinephrine, and serotonin, and the brain axis in the offspring thus impacting upon the stress responses. These changes likely remained throughout the lifecycle, impairing functioning of the animal offspring in all domains (Nelson & Bosquet, 2000). Nelson & Bosquet found these implications for animal offspring of prenatal stress isomorphic to the development of depression in humans. The chemicals that are changed by maternal stress or anxiety in animals are also known in humans to affect suicidal behaviours, aggressive disorders, types of personality disorders, Alzheimer's disease, anxiety disorders, emotion regulation, sleep, calmness, and feelings of well-being in infancy (Matthews & Meaney, 2005; Nelson & Bosquet, 2000).

Attachment

The long term effects of maternal stress or anxiety during pregnancy on the developing foetal brain has been found to be offset in humans by the quality of interaction between mother and infant (Beckwith, 2000; Matthews & Meaney, 2005; Nelson & Bosquet, 2000). Attachment and early experiences of key relationships has been found in the literature to develop a child's brain, resilience, adaptation, and ability to regulate emotion and achieve a balanced view of themselves and others (Leverton, 2005; Nelson & Bosquet, 2000; Nicholson, et al., 2002; Perry, 2004). However, parent-child interaction and a mother's ability to bond and care for children is impaired if mothers are suffering mental ill-health or have poor attachment histories themselves. Assessments of mothers' models of attachment prenatally predicted the types of attachment in the parent-child dyad one year postnatally and, in young mothers, their sensitivity to their infants' needs (Crockenberg & Leerkes, 2000; Karen, 1998).

The gestation period forms the starting point of the mother-child relationship (Perry, 2004; Zeanah, 2000). As early as 1974, a study conducted by psychologist, Byron Egeland using data collected by nurses from young, impoverished women found "depressed mothers and those who had been rated by nurses as having a low interest in their baby before it was born were more likely to have anxious children at one year" (Karen, 1998, p.184). Depression has been demonstrated to impair interpersonal relationships and mother-child interactions which are necessary for the attachment relationship and wellbeing of the wider family (Petrillo et al., 2005; Riecher-Rössler & Rohde, 2005). Due to the strong evidence base demonstrating the importance of the first three years of life, particularly in regards to the effects of positive interaction and loving, responsive relationships on infants' brain development, it is perinatal care and assessment that is viewed as a vital component to prevention that has been overlooked in policy (Nelson & Bosquet, 2000; Wakschlag and Hans, 2000).

Services and interventions for perinatal mental health

The unique circumstances of young women's mental health in the perinatal period require coordinated specialised interventions and the adaptation of standard treatment approaches (Riecher-Rössler & Steiner, 2005; Dearman et al., 2005). Research exploring the effectiveness of interventions for maternal mental health has focused postnatally (Goodwin, 1996). This is particularly the case for New Zealand research with some international texts surrounding perinatal mental health emerging while the current research was being conducted such as Hendrick (2006), O'Keane et al., (2006), Price (2007), and Riecher-Rössler and Steiner (2005). Cohen and Nonacs' (2005) is one of few studies that have focused exclusively on formal supports *during* pregnancy. Similarly, numerous support services exist in New Zealand and are implemented after women give birth, yet medical, social work and even midwifery support for psychological issues during pregnancy is limited (Health Funding Authority, 2000; Te Rau Matatini, 2004). Thus, there is a pivotal chasm in New Zealand surrounding formal supports and maternity policy during pregnancy, which this research aims to explore.

Introducing interventions in the perinatal period

Many countries have recognised the importance of introducing interventions in the perinatal period. Writing from Australia, Austin (2003) argues for perinatal psychiatry care and outlines a perinatal early intervention service based in eastern Sydney. Jenkins (2003) offers in his text, short, but poignant sections specifically on children's and women's mental health, and Sherr has a brief section attending to young peoples' "special circumstances" in pregnancy (1995, pp. 150-152). Pregnancy is the time of life in which women have the most consistent contact with health professionals (Garrod & Byrom, 2007). Introducing interventions perinatally is identified within the maternal mental health literature base as more effective because pregnancy is a time of change (Garrod & Byrom, 2007, Karen, 1998) and women may be more motivated to address their problems and accept support due to their desire to provide the unborn child with a good life (Lester, Boukydis & Twomey, 2000).

There are three modes of intervention for policy to target identified by Jenkins (2003) including: 1) mental health promotion in the community, 2) prevention and early intervention in primary care, and 3) specialist intervention for severe and chronic illness. Stuart and O'Hara state preventative interventions should be delivered to large numbers of pregnant women or targeted to those with vulnerability factors for postpartum illness as well as treating those women already diagnosed. The implication of these modes for intervention is important, as Svanberg (1998) and Nicholson et al., (2002) recognise that different parents will require different kinds of preventative intervention following assessment. Pregnant young women may need education, counselling, or psychotherapy with Riecher-Rössler and Rohde (2005) and Stuart and O'Hara (2005) stating the central focus should always be the mother-infant relationship. Karen (1998) also lists these different needs that can have implications for the mother-infant attachment such as lack of support and education. He lists lastly parental psychology which he believes transacts negatively with all other issues and is the hardest factor to alter. For those women who are experiencing lingering effects of violence, alcohol and drug abuse, trauma, or inter-generational attachment issues, psychotherapy will be necessary (Stuart & O'Hara, 2005; Svanberg, 1998; Wakschlag & Hans, 2005).

Early intervention and prevention

One method of intervention recognised within the literature is early intervention models.

> Early recognition of mental health need and greater management of mental health support through primary health care will help further facilitate early intervention, and reduce distress, disability and burden of illness, and also has the potential to increase the effectiveness and efficiency of secondary mental health services for all populations (Te Rau Matatini, 2004; p. 6).

Jenkins (2003) rates prevention of mental and neurological dysfunction, and delivery of services that intervene with such problems, as essential mental health concerns. Researchers including Beckwith (2000) and Nelson & Bosquet (2000) have identified the importance of introducing services as early as possible to prevent impairment and improve outcomes for mothers and children. Alternatively, the World Health Organisation identify there is minimal evidence to suggest primary prevention is effective for mental illness (2001, cited in Donnelly & McGilloway, 2007). Despite this, Donnelly and McGilloway acknowledge some early intervention methods are effective in reducing symptoms. They advocate for screening and education for at risk groups such as young women. These interventions are not commonly provided within primary health care, which is where Donnelly & McGilloway state they would be most appropriate.

Austin (2005) states interventions should occur as early as possible, even before conception. If this is not possible the point of conception should be maximised, according to Austin, as an opportunity for positive maternal intervention strategies. Abramowitx et al. also believe the prenatal period is an "ideal opportunity" to address maternal mental illness (2007, pp.84-85). If those women that are suffering psychological issues can be identified and worked with prior to the birth, or in the early stages of parenthood, the negative transactions between parental psychology and other environmental issues may be reduced, enhancing the outcomes for mother and child. Karen (1998) supports pre-birth interventions identifying that; if a pattern of attachment has been already established, the child may not be very affected by any changes in their mother or the environment, even if this change surrounds parental psychology.

Karen (1998) laments that social policy, governments, and agencies are reactive around preventative perinatal mental health preferring to fund mental health and justice systems later in people's lives to manage the effects of dysfunction that may have been prevented from occurring. Lester, Boukydis & Twomey (2005) review a study conducted comparing an intervention that occurred during pregnancy with the same intervention postnatally and showed how the children of the prenatal study did better in all areas tested and that costs associated were less. Swann Bowe, McCormick & Kosmin, (2003), in their review of the evidence base also found that perinatal interventions improved outcomes with more cost-effectiveness. Many of the interventions evidenced to enhance parenting and outcomes for young parents and their children can easily be incorporated perinatally, such as practical and socio-economic issues, including housing and poverty, and psycho-therapeutic interventions (Beckwith, 2000; Swann et al, 2003).

Attachment researchers have completed adult attachment interviews on pregnant women and with 75% success were able to predict the unborn child's attachment based on the parents attachment classification (whether they were likely to have had a secure, ambivalent, or anxious attachment relationship to their primary caregiver) (Karen, 1998). How the women were preparing for the impact of the pregnancy were based upon these attachment classifications. Often their own specific attachment issues with their caregivers were reflected in how they spoke about the unborn child. This demonstrates the intergenerational transmission of such issues. The implications of these studies is that women's individual needs can be identified and addressed prior to birth and long before disorder, insecure attachments, or relationship problems become ingrained (Wakschlag & Hans, 2000).

Parental support and interventions

Elster (1990) in a review of the interventions offered to young parents found that factors such as environmental issues, parenting styles, and relationship interactions can be influenced by effective service policy and interventions. While the underlying principles of the effective interventions Elster reviewed were similar, the type of professional that delivered the intervention and the practice setting changed. For maternal mental health these include group and individual treatment, family involvement, and delivery of support by consumers and midwives, nurses and other paraprofessionals.

Group treatment

Group treatment approaches focused on preparing young pregnant women for the changes associated with pregnancy and providing psychoeducation has been trialled. Stuart and O'Hara (2005) review one such study that targeted women with certain risk factors such as poor social support. This study, delivered through eleven group sessions from early pregnancy to six months postnatally, found significant improvement occurred for mothers three months into parenthood where their scores on the Edinburgh Postnatal Depression

Scale where lower than the control group. Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) has been trialled through both group and individual treatment to pregnant women. CBT has been demonstrated as effectively addressing any anxious and depressive symptoms during pregnancy (Cohen & Nanocs, 2005). Similarly, trials conducted with Interpersonal Therapy (IPT) found equivalent outcomes to CBT such as reduced rates of postpartum mood disorders (Riecher-Rössler & Rohde, 2005).

Home-based services

Home-based service delivery has been believed to be most effective by reaching the greatest number of women at the lowest cost and, in studies reviewed by Ciliska, Mastrilli, Ploeg, Hayward, Brunton and Underwood (2001), with no negative outcomes. Home visiting reduces the barriers to accessing services that youth populations and mothers encounter, such as transportation and fears of stigmatisation (Dearman et al., 2007; Fry, 2000; Swann et al., 2003; Travis & Compton, 2001). Swann et al. (2003) reviewed a study in the United Kingdom that examined the effects of home visiting conducted by nurses' perinatally to provide information, encourage family support, and introduce other resources and services. The results of this study showed that, in comparison to the control group, the participants were more involved in the workforce and had an 80 percent reduction in child abuse rates. Similarly, the home-based interventions Ciliska et al., review found improvements in the infant's mental, physical, and emotional development and the mothers' mood problems, education, employment, nutrition and general health behaviours. The interventions also saved government funds. Nurses were completing the visits with the most benefit found in higher intensity interventions with women who demonstrated some risk factors.

Some studies, as reviewed by Stuart and O'Hara (2005), have demonstrated the provision of social support as effective in reducing postpartum depression. However, other interventions not targeting specific mental health symptoms but instead designed to support parents and provide education do not appear to prevent later depression (Stuart & O'Hara, 2005). Thus, Swann et al. (2003) do not believe supportive home visits, on their own is a sufficient intervention.

Karen (1998) also identifies supports such as this are useful but do not help with what he feels is the most essential issue, that is, helping parents-to-be uncover their innate psychological deficiencies triggered by pregnancy. Many authors including Crockenberg and Leerkes (2000), Gutteridge (2007) and Swann et al. (2003) argue for a dual approach of alleviating negative social circumstances of young pregnant women in conjunction with psychotherapy. "It makes little sense to provide intensive, expensive psychotherapy for mothers without attempting to ameliorate ongoing life circumstances that undermine trust and self-esteem and adversely impact maternal sensitivity" (Crockenberg and Leerkes; 2000, p. 74).

Social Workers

Because the benefit of services is largely influenced by the policies that direct them, social workers must assist to shape social policy informed by their clients' perspectives (Chaplin, 2007). Swann et al., (2003) believe sound qualitative research and client perspectives are essential to add to the meagre evidence base that informs policy in this arena. These concerns have influenced the current research method as interviews with young women in the perinatal period, and the health professionals that work in this field are conducted to ascertain these perspectives and make policy recommendations. Social workers have skills to deliver many of the services and interventions outlined above appropriately and holistically, particularly social support, case management and therapy. Thus Chaplin states:

> Essential social work services should be available in both mental health and health care settings. The expertise of social workers should be recognised. Social work services should be reimbursed at rates comparable to those of other professions (2007, p.298).

A focus upon social justice means social workers have a core role in assisting clients to break down the barriers they face in political representation and the receipt of appropriate support and practical resources (Aotearoa New Zealand Association of Social Workers, 1993). This is important when considering young pregnant women who face numerous access barriers to appropriate supports.

Access barriers

From the meta-analysis conducted by Swann et al (2003), antenatal and perinatal care was found to be beneficial in improving outcomes for all women. However, it was discovered that young people entered such care much later than others, affecting benefits received from these programs (Swann et. al., 2003). This late entry is also evident in New Zealand's primary health system and may be due to a number of factors. Stigmatisation of both early pregnancy and mental health difficulties is identified throughout the literature and within the current research (Dearman et al., 2007; Donelly & McGilloway, 2007; Fry, 2001; Price, 2007). Dearman et al., (2007) differentiate between perceived stigma; which they define as the negative perceptions of others, and self-stigma; the person's own responses and views of mental illness. Perceived stigma includes the societal and media portrayals and views of mental illness while self-stigma can affect self-esteem. Both of these factors impact the receipt of appropriate supports. Similarly gender constructions of socially accepted characteristics influence access rates. Women may be expected to be more emotional and thus to manage this without seeking help. One of the aims of the current research was to explore how these access barriers, gendered constructions, and social norms emerge in the participant's experiences of support they received in the perinatal period.

A narrow view of what constitutes mental ill-health, such as that based on medial model diagnosis, may mean low to moderate levels of emotional distress are not attended to (Cohen & Nonacs, 1995). Due to both the debate around the prevalence and severity of maternal mental illness, and the arguments within the literature that even minor emotional disruption can cause significant upheaval for mother and baby, Magyary (2002) argues for a more inclusive definition:

> The simple absence of mental disorder does not necessarily make life worth living unless that life is characterized by other meaningful dimensions such as optimism about the future, creative expression of talents, connectedness to others, and positive self-regard (2002, p. 346).

Additional issues that may affect young women's perinatal mental heath and access of supports include the reality of pregnancy which, for some women, is not representative of the idealistic media portrayals; lack of information; and fear of discovery of early pregnancy, dysfunction, or abuse and violence (Dearman et al., 2007, Fry, 2001; Ministry of Health, 2001; Swann et al., 2003). Similarly young pregnant women face more practical access barriers such as lack of financial resources and transportation (Sherr, 1998, Swann et al., 2003). Due to the range of barriers to young women's uptake of services, policy and service responses must be much wider than merely maternal health policy but include social and economic policy considerations that have implications for young women's holistic well-being and ability to access services.

Implications for policy

There are more factors affecting mental health for young pregnant women that are outside the mental health sector than within (Brunton, 1985; Zubrick, Silburn & Blair, 2000). Factors impacting the wellbeing of young parents and their children occur at all levels and include, but are not limited to: physical health, particularly maternity care; education, including sex education; early childhood education and care; employment and economic policy; formal and informal support; as well as state systems such as care and protection and income support (Brunton, 1985; Wakschlag & Hans, 2000). Therefore, creating integrated policy that addresses or prevents maternal mental illness for this group is particularly complex (Wakschlag & Hans, 2000; Zubrick et. al, 2000).

Integrated national policy

Elster (1990) laments that interventions and social policy are uni-modal and targeted, for example towards reducing child abuse, rather than comprehensively introduced for a diversity of vulnerable women.

> Although some separatism among interest areas is necessary in order to obtain funding which tends to be categorical, better co-ordination of services needs to occur, due to scarce financial and human resources (1990, p.169).

While Elster (1990) writes from the United Kingdom, the compartmentalisation of needs, and competition amongst agencies to secure individual contracts to meet these needs, is prevalent in New Zealand also (Cheyne, O'Brien & Belgrave, 1997).

More eclectic and holistic viewpoints are argued for by Brunton (1985), Zeanah (2000), and Zubrick, and Silburn & Blair (2000) because the transformation of pregnancy and birth occurs across physical, cognitive, psychological, biological, and social domains with a number of factors influencing this adaptation. Subsequently, Magyary (2002), from an American perspective, and Svanberg (1998), writing in the United Kingdom, advocate for an integrated and in-depth national policy strategy for mental health prevention. Their posit, advocated also by Shore (1998), is that integration of policy and intervention for mental and physical health, social welfare, education and housing, and, in fact, all the aspects that impact women and children's functioning, is necessary to truly enhance outcomes for women and infants. Magyary's rationale for this is due to the lack of focus on early intervention historically, as well as the implications socially and financially of costs created by mental ill-health.

Addressing access barriers

Cherry et. al. (2001) describe the additional barriers and complications faced by pregnant young women globally, highlighting, as Swann, et. al, (2003) do, the need for accessible prenatal care. Young women's access to health services is generally worsening which Travis and Compton (2001) connect with attempts to reduce costs in health care provision and the consequent retraction of services. However; Swann et al. believe the many needs of young mothers are being met in some Western European countries by the introduction of comprehensive public health services (Cherry et al. 2001).

Chaplin (2007) advocates for financial reforms to enhance access to health care. She identifies two ways to reduce access barriers, firstly, by integrating mental health care with primary medical care and secondly, by increasing services to isolated areas. Throughout New South Wales, Australia, a 'Mother Infant Network (MINET)' has been in place since 1997 linking all relevant services for mothers from conception of their child until the child is five years of age (Barnett et al., 2007). With consent of the pregnant women consultations with mental and physical health professionals are loaded onto the network to be available for other health professionals interacting with the women. The principle is that women deserve integrated and full mental and physical health care (Barnett et al., 2007).

Screening and risk factors

Part of the New South Wales MINET plan included the Integrated Perinatal Care (IPC) program to afford mental health assessment the same routine status as physical health care in the perinatal period. The aim of IPC was to introduce universal assessment to avoid stigmatisation that occurred when only those women considered more 'at risk' were being screened for maternal mental health issues. Additionally the program was designed to ensure women in need of mental health support were not going undetected. Barnett et al. (2007) state that the focus is not constricted to predict then treat maternal mental illness but instead to provide early intervention for all families, not just those considered high risk. Thus, a number of responses are offered from information and education, extra appointments, or mental health service referrals. This system is being trialled in other parts of Australia.

Policy agendas

The ability to instigate a program like the IPC was based on "a political climate where parenting, pregnancy and the early years of children's lives were being recognized at state and federal levels in Australia, as well as internationally, as being crucial for optimal individual development" (Barret et al., 2007; p. 69). However, policy change has not been so forthcoming in other countries. Stiffman and Feldman (1990), from a United States perspective identify the inability of what they see as reactive, public services to meet the needs of young parents. Cherry et al. recognise that "in many developing countries, services for pregnant and parenting women of any age are inadequate" (2001, p. xvi). This is attributed, in-part, to the few comprehensive services that are available being implemented too late to be of benefit and being targeted individually, rather than at the wider social system that the young women is formed and existing within (Stiffman & Feldman, 1990). Thus, Nash (2001) identifies two focuses policy interventions should have; one upon micro-issues, altering specific variables and, additionally, those that address wider structural conditions from which dysfunction emerges.

Thompson and Peebleswilkins (1992) advocate for an analysis of the implications for policy of the support young pregnant women require. Their study is focused upon informal and formal support networks and identifies a need for service policies that incorporate both in the care of young women. However, the study is an American one and is nearly fifteen years old with the scope limited to African-American mothers (Thompson & Peebleswilkins, 1992). Bunting and McAutley (2004), in a similar vein to Thompson and Peebleswilkins, identify the importance of formal and informal support for improving the psychological health of young mothers. Zeanah (2000) questions studies that reduce issues of mothers' and infant mental health to simplistic models of support; identifying that some support can be unhelpful. In these cases, the interventions and formal supports identified in this chapter become even more important.

Conclusion

Pregnancy is a time of change and development where a woman's thoughts about herself, her own childhood and life, her partner and family, and the unborn child are triggered. Pregnancy may mean a person is "psychologically delicate" (Karen, 1998, p. 405) but also responsive and pliable to opportunities for change. While many studies are apparent in the literature surrounding treatment of maternal mental illness, few studies have been conducted concerning the perinatal period or mothers' mental health, in a positive sense, rather than disease-focused, during pregnancy. The best practice in regards to treatment emerging from the evidence-base is varied and inconclusive. However, general consensus is evident around certain points. The first is that more research, and a sound evidence-base collated into best practice guidelines, is required. Secondly, the location of young mothers mental health on the praxis of many fields including health, midwifery and obstetric care, primary and public health, care and protection and welfare, mean the issues identified in this chapter are complex and multi-faceted. Thus they require complex, multi-dimensional, and responsive, rather than reactive, services, interventions and policy frameworks. Comprehensive, integrated and well-coordinated maternal services, and precipitating policies, are clearly argued for in the literature.

Chapter 4

Methodology and Design

Introduction

The previous three chapters have provided a contextual background and review of literature relating to the conceptualisation and treatment of young women's perinatal mental health. Because mental health and reproduction are highly gendered issues, this study employs a feminist methodology. Conducting research with feminist, qualitative methods allows for the expression of young women's own experiences of the mental health support and education they receive in the perinatal period. Through an exploratory, interpretive approach using feminist principles that promote the value of experience and reduce researcher-participant power relations, rich data is gathered from four pregnant young women, under thirty years of age, and four health professionals working in the field of maternity and mental health. A feminist paradigm is further employed to assess the data emerging form these interviews through thematic analysis. In discussing the methodology of the current study this chapter provides an overview of the research process and design, and consideration of the ethical issues that arose. To conclude a brief outline of the interaction between policy and social research is made.

Methodology

Feminist research

While there are a range of theories within feminism and thus numerous forms of feminist research methodologies there are some principles common to all (Briggs, 1990; Dominelli, 1991; Hesse-Biber & Yaiser, 2004; May, 2001; Reinharz, 1992). Primarily the focus of feminist research is to explore the world from a women-centred viewpoint by illuminating the impact of gender constructs (Dominelli, 1991; Smith & Noble-Spruell, 1986). The goal is emancipation of women by giving voice to their experiences and celebrating this experience as a valid form of knowing (Alvesson, 2002; Eichler, 1988; Graham, 1984; Hesse-

Biber & Yaiser, 2004: May, 2001; Mies, 1983; Rosenau, 1992; Smith & Noble-Spruell 1986). Other common features of a feminist methodology are a focus on forms of oppression and marginalisation while working towards the deconstruction of power relations (Rosenau, 1992). Some of these principles: countering marginalisation, power relations, and the validity of experience, are presented here as they inform the feminist methodology utilised in this research.

Countering marginalisation

The potential for women's marginalisation to occur through their biological differences to men, primarily our reproductive capabilities, is recognised by feminists (Dominelli, 1991). A feminist theoretical basis and methodology is then essential when considering women's health issues in the fields of maternity and mental health which have strong gendered associations. Issues of pregnancy, childbirth, and women's health segue between the personal and the political spheres. This fits well with a feminist paradigm that directly identifies the interrelatedness of personal and political contexts. It is also important in this research which connects the personal experience of pregnancy and to the implications of social and health policy. Babbie (2001) considers a feminist research paradigm is an important alternative to other research methods that have not been able to explore the reality of social life as it is experienced by, and impacts upon, women.

Recognising the validity of experience

Within feminist research women's experiences must be explored as they experience them not as they appear in relation to men's experiences and understandings (Lewis, 1981). Qualitative research is helpful to feminists here as it allows for the deeper view points of the participant to be concentrated on as data (Denzin & Lincoln, 2003). In-depth, open interviews with pregnant young women allowed scope to discuss the pregnancy and supports as *they* experienced them and avoids fracturing experience (Graham, 1984). Exploration of women's own experiences has been an essential method for examining the impacts of gender constructed systems (Travis & Compton, 2001).

Feminist theory celebrates and validates both group and individual experiences of women. Hence, for this research, both professionals' perspectives *and* the young pregnant women's were elicited. Including both pregnant women and key informants allows for consideration of the differences between the women's personal experiences, and the perspectives that health professionals hold. Key informants are positioned in roles that contain differing access to institutional power and professional distance from clients. For this reason, they were able to provide their interpretations of their client's experiences, informed by their experiences as trusted confidants of pregnant young women. Due to the nature of the fields of practice researched (maternity and mental health) three of the four key informants were also women indicating again the importance of a feminist methodology to explore the realities of these women's work environments and experiences. These three female health professionals all had nursing backgrounds with nurses often practicing in a health field dominated by hierarchical relationships. Modelling how power relations could be reduced in the research relationship was thus essential.

Reducing the effects of power in the research relationship

Feminist researchers promote an equal relationship with their research participants by attempting to minimise the power differential through collaboration, co-operation, and reciprocal respect and involvement (Lather, 1986; Oakley, 1981; Mies, 1983; Reinharz, 1983; Smith & Noble-Spruell, 1986; Stanley & Wise, 1983). The transparency of the researcher is vital in facilitating this relationship and this may include self-disclosure (Kleiber & Light, 1981; Lather, 1986; Oakley, 1981; Smith & Noble-Spruell, 1986; Stanley & Wise, 1983). Guided by a principle of attempting to be more interactive the interviews were conduced in a transactional manner with myself as the researcher sharing aspects of my experience and knowledge where this was appropriate and requested by either the young women or key informants interviewed (Kim, 1997). Interview questionnaires were minimally structured with only a few core questions asked as the rest of the relevant information emerged naturally throughout the conversation. If this did not occur I would ask directly or guide the conversation to this point. Thus, the participants had more control in what they chose to disclose and discuss (Graham, 1984).

Qualitative methods

An exploratory, interpretive approach through qualitative research is preferred to a method that is more pre-occupied with what is 'measurable'. The real complexities of human situations cannot be effectively measured with numbers (Denzin & Lincoln, 2003). This is important for the current research as young pregnant women face complex physical, social, economic, and developmental conditions. Transferring such real human experience to statistics may minimise their true meaning and cause them to appear less meaningful and genuine (Denzin & Lincoln, 2003). Analysing statistical data, without evaluating the social contexts in which the data arises, leads to an incomplete understanding (Nash, 2001). Thus, the aim of this research was to attempt to gather in-depth information for a more complete understanding of the participants' beliefs about their own circumstances.

While qualitative research methods provide a number of means to interpret the world and are not connected to any one discipline or paradigm it fits well with a feminist methodology and also with social workers (Denzin & Lincoln, 2003). As a feminist social worker, qualitative methods were chosen to allow for the complexities of individuals experiences through the use of in-depth interviews. Because pregnancy, childbirth, and mental health are such value-laden subjects for young women, and the people that work with them, a qualitative, feminist methodology that considers subjective meaning was utilised (Denzin & Lincoln, 2003). Pharis and Levin (1991) found that inter-personal connectedness and relationships are more important when working with young pregnant women than other tangible outcomes that may occur. Personal, in-depth interviews were therefore chosen as the most appropriate research method for this group.

The qualitative interview completed with the four young women and the four health professionals was non-structured, open and in-depth. A questionnaire was piloted, however based on feedback from the interviewee this was amended to be less structured. The initial questionnaire devised for the interviews with the young pregnant women was thus replaced with a broad lead in question, of how the pregnancy had been to date. A list of desired topics was held by the interviewer with responses during the conversation gently directed toward these if necessary. Similarly, the key informants were asked a few core questions with further questioning and clarification emerging as necessary. All of the participant and key informant interviews were audio-taped and later transcribed.

Ethical issues

Human ethics application

Because this research involved human participants an application had to be made to the Central Health and Disability Ethics Committee for ethical approval for the research (Appendix Two). The rationale for applying to HDEC rather than the Massey University Human Ethics Committee (MUHEC) was because the participants would, due to being 5-8 months pregnant, be receiving health and disability services within the area. There are a number of issues an ethical researcher must attend to. These include principles of minimisation of harm, informed consent, confidentiality, and the need for consideration towards vulnerable populations where further disadvantage could occur (Massey University, 2003).

Minimisation of harm

In the ethics committee application the aims, scientific basis, and potential benefits of the study are outlined to weigh these against the possible risks. The research method is detailed in the ethics application to ensure this is relevant to the aims of the research and that the research is carried out in the least invasive way possible. As part of the informed consent and information sheet participants and key informants were made aware that no direct benefit could be promised to them from their involvement and the possible risks in participating were identified. These possible risks included psychological effects of discussing possibly distressing matters involved with pregnancy and emotional health. However, a plan was reported in the ethics application of how the researcher would manage such distress if it occurred. This included recognition of the researcher as a trained mental health professional with knowledge of supports and services within the community. Participants also signed consent to inform their midwives of their involvement in the research. All participants were aware that they could ask for the audio tape to be turned off at any time or that they could stop the interview.

Interviews took place at a location of the participants' choice. This could be within their own homes, which three of the four young women chose and one key informant, or at their workplace, which was chosen by one participant and three of the key informants. Additionally, a room was provided by a community birth service in the event that participants were not comfortable meeting in their homes or workplaces. The interview was conducted from a feminist paradigm by attempting to reduce the inherent researcher-participant power relationship. This was achieved through disclosure of information held by the researcher and open responses to participants' questions. However, the difficulty in maintaining ones role as a researcher and separating this from a role of social worker or support person was difficult at times when the participants did have questions or required support. It is not believed that this is against feminist research practice. Consequently, all participants were provided with a directory of maternity and mental health support services, contacts, and websites for their personal reference.

Informed consent

The second ethical consideration regards how consent to be involved is received from the participants. Decisions about who is participating, how they are selected to participate, any coercion to participate, how they are informed, how they consent, and how harm is minimised are covered here (Meltzoff, 2001). Both participants and key informants had to give informed consent with knowledge of the research and what they were consenting to. For this study participants volunteered willingly and were not offered any inducements to participate. Koha was provided *after* the period of right to withdraw consent so that participants would not feel they could not withdraw after being provided a gift for participation. Participants were also not aware that there was a koha so that this could not become an incentive. Signed and verbal consent were received from each participant and they were informed verbally and in writing of their right to withdraw consent even after the interviews were conducted. The signing of this consent form (Appendix Five) provided confirmation that the participant understood the research as per the information sheet (Appendix Four) and had been made aware of the potential risk but still agreed to participate.

There are debates within the academic community around capabilities of those under sixteen years of age to consent and this had to be resolved by the researcher because the lower age limit of participants could have included those under sixteen. The decision made by the researcher followed that taken by Munford and Sanders (2004) where those under sixteen, if pregnant, were deemed to be living adult lives and thus their own verbal and written consent was required. However, where appropriate, if the young person had an identifiable custodial figure, this person's consent could be volunteered also. This did not become an issue for the research as all participants were eighteen years or over. Due to inclusion of a key informant from one particular organisation, that organisation's ethics application was also completed and approved prior to their interview. In completing this ethics application the need for information and consent forms for key informants also was highlighted and these are included in Appendix Four.

Ethical principles impact on every stage of the research process, including how information is shared and published. In regards to dissemination of outcomes of the research the participants chose whether they wanted to receive a summary of outcomes of the research. Two women chose to receive this and a summary was subsequently sent to them at the completion of the study. Three of the four key informants chose to receive a summary of findings and some requested recognition of their involvement for demonstration of their contribution to professional knowledge.

Privacy and confidentiality

Women's privacy was maintained by the researcher putting the information out to the community via general practitioner and midwife practices and with the women approaching the researcher if they wished to be involved. Thus, there was not pressure to participate and the women's contact could be made privately on their own terms. The interviews were conducted at a place and time the participants chose. All information shared by the participants was kept confidential and their anonymity assured by being unidentifiable in the research as a participant and the researcher not divulging that they had taken part. The promise of confidentiality and anonymity was ensured also through the use of pseudonyms and avoiding inclusion of any identifiable information (Meltzoff, 2001). The professional transcriber, employed to transcribe the key informant interviews, also signed a confidentiality agreement (Appendix Six).

How to store the information gathered was also important in consideration of privacy and confidentiality. Participants could choose whether they wished to keep their audiotapes once transcribed by the researcher. None wanted their tapes returned so the researcher following transcription destroyed these. The transcriptions, consent form and personal information were kept in a locked case held by the researcher.

An ethical issue was identified whereby the participants or their children could be or become recipients of the service in which the researcher worked. However, this is an ethical issue already recognised within the organisation whereby clinicians with prior knowledge of clients are not involved with that client's care. The information gleaned from the research in regards to that person also could not be shared in any other setting due to the confidentiality provisions described above unless there were serious safety concerns that could be avoided by the sharing of this information.

Cultural and social responsibility

Human ethics approval requires research that is culturally appropriate and consistent with the Treaty of Waitangi. This consideration was important in the study as three of the four participants were tangata whenua and the primary researcher was tauiwi. Thus, cultural support and consultation was required and occurred through the appropriate networks known to the researcher and within the Massey University research process. These networks informed of other more appropriate cultural advisors where necessary.

Possible negative implications of the research for groups such as women, recipients of health and psychiatric services, and cultural groups had to be considered. Due to the research being conducted with a feminist methodology, the potential for further marginalisation of these populations was reduced, as feminist research attempts to reduce power differentials between researchers and participants while aiming for the emancipation of women and subjugated groups. As an anti-racist feminist, this strength based, equal approach was applied in consideration of all collective identities of the women. Some key informants and interested parties requested the researcher attend professional development meetings of their organisations to share the research outcomes. This was agreed upon once the purpose of the meeting was determined and the potential for the outcomes to be misconstrued or used against women, the participants, or mental health consumers assessed and minimised.

Selection and recruitment of participants

Young pregnant women

Participation criteria

The criteria for participation in the research were women, thirty years of age or under who were in the perinatal stage of their first pregnancies. The decision to interview women during pregnancy rather than in the postpartum stage of the perinatal period, which extends up to four weeks postnatally, was that women might be too preoccupied in such an early stage of motherhood to complete research. As identified in the literature review there have been numerous studies focused on the postpartum period meaning women during pregnancy may be neglected. Similarly, in the researcher's experience, it is beneficial for women to talk about their experiences of their pregnancy, an opportunity that is often lost after the birth as the focus becomes upon the baby. Exclusionary criteria included previous experience of miscarriage or trauma connected to pregnancy. This was decided due to the re-traumatising effect the interview could have for such women.

In the initial ethics application and recruitment process entry criteria was for young women 25 years and under. However, due to a lack of responses initially from this age group the criterion was extended to include women up to thirty years of age. Due to the rising average age of first pregnancy, women of this age group are still considered 'young women'.

Recruitment procedures

Four participants and four key informants were decided upon to provide a balance between pregnant young women and professionals. Interviews were designed so that data could be received from one interview each, taking one to two hours. To select participants, advertisements (Appendix Three) and information sheets (Appendix Four) were sent to every medical clinic and midwifery clinic in the local area. Information packages were also sent to the clinics so they could give these to any potential participants. Packages included contact details so that the potential participants could make direct contact with the researcher. Information was distributed in this way to avoid feelings of coercion.

No participants were identified from this initial attempt. Most general practitioners returned the information stating they could not help as they did not see women in this period or provide obstetric services. According to one GP only two general practitioners in the locality the research was conducted saw antenatal patients. A second mail out of information was then provided to all Lead Maternity Carers in the local phone book and the research information was presented at numerous antenatal and childbirth education classes in the region. The first four women who responded to these advertisements and met the research criteria were selected as participants. Three of the young women contacted the researcher directly by phone or cell phone messaging while the fourth made contact through a support worker.

There are some limitations of self-selected, snowball sampling including the possibility of reduced representativeness. This is because there may be certain characteristics of people that volunteer for research making them different from those that do not. This could lead to a lack of representation of the general, 'non-volunteering' public (Meltzoff, 2001). Two of the four participants were identified through antenatal classes but as not all pregnant young women attend ante-natal classes. This may also impact on the general representativeness of the participants. Given the limited number of participants, however, this research does not claim to be representative as would be the case for a study utilising a larger, random sample. As Meltzoff states, the best one can do when using a self-selected sample is identify what the implications of these limitations may be. Within different research methods there are levels of volunteering. For this research women were only requested to give up one to two hours of their time, a lower level perhaps than a study that requires travel, more interviews, more time, or more distressing content. Consequently, the differences between those women that do participate and those that do not may be less pronounced as it takes less effort to participate (Meltzoff, 2001).

Participant profiles

Full participant profiles are included in the following chapter. A brief description of the four participants follows. Names have been changed and some personal information omitted to ensure anonymity. Where they desired the women chose their own pseudonyms, however, if they did not wish to do so the researcher chose a name. At thirty years of age Meagan was the oldest of the participants interviewed. She was thirty weeks into her pregnancy at the time of the interview. Sarah was twenty years old and twenty weeks pregnant at the time of the interview being at the earliest of the perinatal period. Charisma was eighteen years old and was the youngest of the participants. She was the furthest into her pregnancy and was nearing her due date. Michelle was also eighteen years old and was interviewed two months before her due date.

Key informants

Participation criteria

Participation criteria for the key informants were that they needed to be a professional currently or recently involved in the field of maternity or mental health.

Recruitment procedures

The key informants were all professionals within the field of maternal and or mental health. They were identified and contacted by the researcher. In two incidents key informants identified other health professionals working in the field that would be suitable participants. Thus, the selection of the key informants may have been influenced by the limitations of the researcher's network. Information packs were sent to these key informants and they were also required to complete consent forms.

Key informant profiles

Two nurses, a midwife and a GP were interviewed. Fiona was a nurse employed by the local District Health Board. She was interviewed due to having two years prior experience as a maternal mental health specialist. Beth had been a Plunket Nurse for twenty years at the time of the interview. Sally qualified as a midwife in 1999 and had worked within community and hospital midwifery practices completing home and hospital births. At the time of the interview Sally was employed as charge midwife within a hospital setting. Clive was a general practitioner working from an independent surgery at the time of the interview.

Data analysis and triangulation

Thematic analysis

Once transcribed, open coding was completed on the interview transcripts (Babbie, 2001). In open coding the transcripts and tapes are closely examined for any common themes that emerge from the participants' responses and are coded and filed according to these categories. The similar themes amongst the participant interviews, key informant interviews, and between the key informant and participant interviews were analysed for emerging themes and meaning. For example, medication use in maternal mental health was identified as a theme as references were made in two participant interviews and two key informant interviews surrounding medication and these were reviewed and compared. Within a thematic analysis the emphasis is placed on content and what the text of the interview says. Language, in this research, is thus used as implying direct meaning by the participants' to communicate their stories and what is meaningful to them. Within this research eight stories where collected and groupings made of themes that arose directly from the text (Flick, 2006; Strauss, 1987). The specific content of these stories provides the in-depth explanation of the themes.

Feminist analysis

Once transcribed the data was assessed by the researcher using feminist analysis to identify the significance of the raw material and to collate it under key feminist themes. A feminist analysis holds at the forefront consideration of gender and how gendered constructions became apparent through the data and impact upon the research question. Other feminist analytical tools included exploration of how marginalisation of women and others' positions may be highlighted by the research findings. The feminist analysis employed in the current research attends to the operation of gender and the exercise of power, as evidenced through the maintenance of hierarchical relationships, reduction of women's autonomy, and invalidation of their experiences.

Triangulation

The data and the key subject categories emerging from it were then cross-referenced with the literature base surrounding perinatal mental health already reviewed. Triangulation, where the data collected is presented in connection with the already available research and literature, is important in feminist research to ensure its validity. As, already mentioned previously in the chapter, and re-iterated by the Ministry of Women's Affairs: "Gender research may need to have a strong qualitative component. This can be made robust by triangulating qualitative information with quantitative data and a literature review" (2001, p. 10). The outcomes are thus grounded in the current literature base. Data triangulation is also secured through use of both professional key informants and community participants (Denzin, 1989; Louis, 1982; Patton, 1990). The participants and the professionals interviewed were secured from multiple services and sites.

Limitations of the research

There are a number of limitations of the current research study which impact on the ability to generalise from the present study. These include the size and geographical confinement of the sample, as well as the impact of forms of recruitment and difficulties in recruiting participants.

Sample limits

The sample is limited in size with four participants and four key informants. While this number was deemed most effective within the ethics committee and proposal process considering resource and academic constraints, the number of respondents impacts on the ability to generalise results. Due to costs involved with scoping further, the sample was taken entirely from one region and thus limited to one District Health Board (DHB) catchment area. As different DHB's and areas have different services and policies studies in other regions may yield different results. However, one of the central concerns of this thesis is that maternal mental health policy and provision is not standardised nationwide and thus there is no consistency in service provision or clear, national guidelines or direction.

Participant recruitment

The research outcomes may also be affected by the majority of participants receiving the research information via their midwives rather than general practitioners meaning all participants were receiving midwifery care and support rather than alternative forms of lead maternity care. For example, it was important to attempt to select participants from different ante-natal classes and midwifery clinics, both hospital and community based, as well as ensuring women that were under general practitioner or obstetric care received the research information. While this was made more difficult by the limited response of GPs to the research it is also a reflection of the fact that midwives are now the primary maternity carer.

Difficulties in participant recruitment

There was some difficulty in finding appropriate participants for the research. The researcher advertised through GP and midwife practices and spoke at numerous antenatal and childbirth education classes in the community providing information about the research. Despite 1685 women less than thirty years of age giving birth per year in the area the research was conducted within (Statistics New Zealand, 2007), responses from women were minimal. Only two women were identified through the advertised channels; the other two were an outcome of snowball sampling. There are many possible explanations for this lack of response. Firstly, as Sherr (1995) identifies, pregnant women are often preoccupied with their pregnancy, child, and pending birth. They may also be fixated upon thoughts of physical and post-birth considerations. Sherr also identifies that young women in particular may be coping with more social stressors; either connected with or experienced prior to their pregnancies, that may inhibit the space they have to be involved in research. This was reflected in one interview where, despite being committed to completing the interview, it took four changes of appointment time and an alteration to the venue as the participant suffered relationship stressors and accommodation changes.

In researching postnatal issues Gous (2005) initially attempted a similar process in finding participants by advertising with leaflets in gynaecology clinics but received no responses. Despite this occurring in a South African context, her rationale for this lack of response may also be pertinent in any country in which research is being conducted as she believes people want to know that they are going to receive some benefit before they participate. For busy women, contributing to research and knowledge may not be sufficient motivation. As discussed previously, due to ethical considerations, women could not be informed of any gifts or be provided with any benefits from participating.

Participants may also be concerned about being involved in research and how it may affect them, particularly if they have concerns about being identifiable. For example, one key informant identified the shame that still exists around mental health issues which may prevent women choosing to be involved in such research. Women that may be suffering from low self-worth may not feel they have useful things to contribute to research. It may also be that research is not held with import in the community and certainly, in contacting some key people in the community, the burden of research was felt.

Impacts of qualitative and feminist methodology

Reliability and generalisation

While qualitative research is attributed with enhanced validity, research based on qualitative methods may be limited in terms of reliability. This is because of the strong component within qualitative research of interpretation of people's responses. When participants have the scope to present many, varied responses the researcher has to interpret exactly what they are saying, and categorise this. Such interpretations and coding may be done differently by different people. Attempts to minimise these limitations have been made in the research through comparative evaluations (Babbie, 2001). Looking at a range of perspectives in the community and both health professionals' and women's responses allow for a comparison of the women's responses to those that work with them. Also, women's experiences may be different depending on the types of lead maternity carers (LMC) and professionals they work with, for example, whether they have an independent or hospital-based midwife, a GP, or an Obstetrician. For this reason, a cross-reference of women with different types of LMC was attempted.

Researcher bias

While having one researcher interviewing all participants' increases consistency across interviews the researchers' own bias may affect the research. Due to resource constraints the researcher carried out all interviews. This bias may have influenced the questions asked. The personal presentation of the researcher may inadvertently reinforce participants to attempt to provide what they feel the researcher wants. Acker, Barry, and Esseveld (1983) and Coleman (2005) have reported on this phenomenon of participants identifying with the researcher and wanting to give apparently correct responses. This can be heightened in feminist research where a more reciprocal relationship enhances the participants' connection with the researcher and exacerbates desires to please the researcher and contribute something the participant feels is meaningful.

Relinquishing of control

Graham (1984) identifies that feminist researchers differ in their attempts to relinquish the control of information. Relinquishing of control is not fully achieved in this research due to requirements of university and ethics committee structures that require some control be kept by the researcher. To minimise this control women have been offered the opportunity to read their transcribed records or listen to and keep audiotapes to ensure they are a true and correct record. Also, a summary of findings was offered to participants. It was discovered that the participants had an interest in the research topic as women and change agents themselves, not merely because they were interviewed.

The Ministry of Women's Affairs (2001) Gender Analysis resource to assist policy analysts realises the importance of examining what women say about the particular policy issue and what they feel the problems, cause, and maintaining factors are, as this informs outcomes. Hence, the design of this research involves talking to pregnant women themselves of their experiences during pregnancy and using this to inform recommendations for policy change. The Ministry of Women's Affairs resource also recommends involving groups and individuals considered knowledgeable in the field and, again, this is achieved through key informant interviews with health professionals in the field of maternal mental health.

Conclusion

Feminist researchers have altered established methodologies as well as developed new methodologies that address issues of gender, subordination of women, control and power (Cook & Fonow, 1990; Mies, 1983; Reinharz, 1992; Smith & Noble-Spruell, 1986; Stanley & Wise, 1983). The research question of what mental health supports and information young pregnant women receive in the perinatal period is explored in this thesis through feminist, qualitative research. In-depth, unstructured qualitative interviews were used to receive a narrative of both personal and professional experiences through women-centred methods that reduce the power relations and invalidation of experience of scientific processes. While a number of limitations of the research have been identified, women appeared to respond well to the style of interview and to the qualitative, feminist methods. Participation in the research appeared to have more meaning for young pregnant women, as they were able to engage, ask questions and receive information themselves, rather than be used purely as data sources. Consequently, a rich discussion of young pregnant women's experiences during their pregnancy occurred. It is the findings from these interviews that are presented in the next chapter with the findings from the health professionals interviewed conveyed in Chapter Six. Feminist and thematic tools of analysis discussed in this chapter are then used in Chapter Seven to discuss the meaning of these findings including how gender constructions, power relations, and health inequalities are apparent.

Chapter 5

Perspectives of four young pregnant women

Introduction

As outlined in the previous chapter, this research involved four interviews with pregnant women, thirty years of age or under. It is these interviews that will be outlined in the current chapter. The second part of the research included interviews with four key professionals working in the field of maternal mental health and these will be presented in chapter six. Even with some similarities, such as age, ethnicity, and pregnancy, the women demonstrated different personalities and individual issues. However, some common themes remain apparent from the interviews, some consistent with the literature base and others less so. It is these themes that will be presented in this chapter beginning with the importance of partner relationships and other informal supports; the focus on physical and post-natal health issues; the extent of knowledge around mental health needs in pregnancy and expectations of pregnancy; the accessibility of support services; role of midwives, antenatal classes, general practitioners, and other formal support roles; and educational and vocational issues. While a brief synopsis of the participants was presented in the previous chapter, more details are provided next.

The Participants

Meagan

At thirty, Meagan was the oldest participant to volunteer after hearing about the research at a hospital-based antenatal class. She had been married for some time and her pregnancy was planned but the timing of it was a surprise. Meagan identified her partner as supportive but they had limited extended family support as she and her husband had migrated to New Zealand from the United Kingdom where the majority of their family remained. Meagan was employed as a University-level educator and had a professional qualification.

Sarah

Sarah was in her mid-twenties and was approaching her first wedding anniversary. While the pregnancy was not planned it was welcomed and Sarah had supportive family living locally. Her husband's family were in New Zealand and while not local were identified as supportive. Sarah identified as being of Máori ethnicity. Sarah was in her final year of nursing training when she became pregnant and hoped to finish this qualification.

Charisma

Charisma at eighteen years was the youngest participant interviewed. Charisma identified as Máori. She was eight weeks from her due date and her pregnancy was unplanned. Charisma lived independently with her partner; however, she reported significant conflict in this relationship feeling her boyfriend was unsupportive. Charisma had some local family support, although her relationship with her mother was conflicted also.

Michelle

The final participant, Michelle, was eighteen and due to turn nineteen just before her due date which was two months following the interview. Michelle identified as Máori descending from Ngati Porou and Ngāpuhi. She resided in her grandmothers' home with her grandmother and partner. Michelle saw her partner as supportive and while she initially feared the reactions of family to her pregnancy, she felt they were very supportive also. The pregnancy was surprising for Michelle and she was not aware she was pregnant until over two months into her pregnancy. This was because Michelle suffered a medical condition in which she had been informed she would be unable to have children. She was completing a beauty therapy course at the time of the interview.

An unintended outcome of the current study was that three of the four participants identified as Máori. While many of the issues identified in the literature review and outcomes of the current research are applicable to this population, Máori women have specific concerns within mental health and maternity provisions from the dual sites of marginalisation they face. Appropriate research has been and continues to be conducted surrounding issues of maternal mental health for Máori women and to assist the development of suitable interventions and policy. Major issues identified are the lack of Máori midwives providing lead maternity services to Máori women (Te Rau Matatini, 2004) and the breakdown of traditional support structures affected by colonisation (Durie,1994).

Partners and informal supports

The participants who self-reported as faring better in their pregnancy had the strongest informal supports. For example, Michelle felt she would not have difficulties emotionally as she had sound supports in her partner, partner's parents, and her own parents and grandparents. For Charisma, relationships were often chaotic and more damaging than supportive. While she remained in a relationship with the father of her baby she described this relationship as stressful. Her relationship with her mother was also volatile as illustrated through Charisma's disclosure of physical and verbal violence. Charisma and Michelle, who were very close in age, seemed to be faring differently depending on their social circumstances reflecting the importance placed, within the literature base, on appropriate partner and family support, sound family health history, and freedom from abuse, violence, and alcohol and drug misuse.

One of the key questions asked of the young women was who had been **most** supportive to them during their pregnancy. Meagan, Sarah, and Michelle, who all identified having a supportive partner and secure relationship, identified this partner as their primary and most effective support. They also appeared more stable emotionally and held a belief that this sound mental health would continue:

> I don't think that I'll get really stressed out really because I've got quite good support and stuff so I don't really think that will be a big problem for me [...] and if I do have a breakdown I think my mum and my partner would be quite helpful (*Michelle*).

For Sarah, Michelle, and Meagan, partners were utilised for emotional support rather than their knowledge of pregnancy, which was accessed through other avenues:

> If I was starting to feel low I'd probably tell [partner] that I was feeling a bit low and stuff like that (*Sarah)*.

At the close of the interview Charisma became distressed talking about the lack of support, emotional or practical, that she received from her partner. When asked what could change that would be most helpful to her in her pregnancy Charisma responded, "a better boyfriend". In this case extended family, particularly mothers, grandmothers and partner's mothers were identified as key supports, largely due to the knowledge and experience they held around pregnancy and birth.

When asked what she would do if she was feeling stressed during her pregnancy Charisma responded, "I don't know probably go stay at my Nan's, she's all good." Charisma identified that the nature of her relationship with her Nan meant that she could access her Nan at any time without forewarning. Similarly, Sarah talked at length about the strong relationship she had with her grandmother. Michelle was living with her grandmother at the time of the interview and had been for some time identifying that this worked better than residing with her nuclear family. However, she identified that at times her grandmother attempted to introduce things that were no longer relevant under modern circumstances:

> She [grandmother] used to be a nurse and she used to deliver babies and stuff so she thinks she knows everything but times have seriously changed since then and it's nothing like when she was [...] she thinks she knows everything but she really kind of doesn't (*Michelle*).

Three of the four women interviewed identified very strong relationships with their grandmothers':

> I'd talk to my grandma a lot too and I'm quite close to my grandma and my grandma usually knows everything that's going on. Yeah my grandma usually rings me a couple of times a week for a chat (*Sarah)*.

Where grandmothers were not available, it was other female supports, including partners' mothers and friends that were identified by both the young women and the health professionals, the latter having experience of young women brining other female support persons to appointments. Meagan struggled with not having these connections in the area:

> I didn't really have any friends around or anything like that [...] I was basically on my own really (*Meagan*).

All four of the participants identified their mothers, grandmothers, and other female informal support people as their first point of call, particularly to check things out before contacting their midwives and for matters connected to their mental or emotional health.

> If it was emotional [...] I'd talk to my Mum. Probably ring my mum first because I'd think 'Ok, it's a bad day', so I wouldn't want to go through the trouble of calling a doctor or midwife or anything unless it was something like throwing up or something I'd go to the midwife but if I was just really stressed out then probably my mum [...] she might have had something similar. She probably could just give advice and stuff because she might've been through the same thing (*Sarah)*.
>
> Yeah I'd probably talk to my mum first before I went to go and see [midwife] and my mum would say, you should go and see [midwife] (*Michelle)*.

Charisma did not have sufficient or appropriate biological family support, instead identifying her partners' mother as a key support. Michelle also had a strong relationship with her partner's family and utilised this. However, the difficulty for women at this stage surrounds those that do not have suitable informal supports as identified in the following comments by Meagan:

> [I]t makes sense, it is the whole thing about the support networks and I think it is a really good thing to look into and research you know especially for people who haven't got family and I'm not surprised that perhaps they are more prone to feeling that they need that kind of support from outside or from other people and that's certainly part of it for me definitely.

For Meagan and Charisma, who also did not have extensive informal networks, formal support services became even more important in supplementing the supports they did not have naturally occurring.

A focus on physical health issues and postpartum issues

The first question asked of the participants was how the pregnancy had been for them to date. When asked this question each of the four interviewees commented from the outset about how they were feeling physically, such as whether they had suffered morning sickness or any complications:

> Well physically at least I think I've been pretty lucky (*Meagan*).
>
> I didn't get any morning sickness or anything (*Michelle*).

Two of the four participants did not identify mental health issues that can be triggered by pregnancy and were quite surprised by the questions around this. When asked specifically to comment about emotional NOT physical difficulties that could arise in pregnancy Michelle stated, "you could go into early labour. I don't really know".

When the participants were aware of maternal mental health issues these were focused on depression and the postpartum period when Meagan and Sarah identified postpartum depression as a possible issue. Meagan and Sarah were aware of mental health issues that can occur during pregnancy:

> I know that some women can get depressed while they're pregnant, [...] that you are emotionally heightened so that things you feel you might feel them more intensely than you usually would (*Sarah*).

Sarah could not identify how she knew this but felt it may have been from women in her family or her nursing training. Henshaw and Elliot (2005) purposely refrain from referring to 'PND' (postnatal depression) or PPD (postpartum depression) as they recognise that these terms have become general descriptors for any mental health problems connected to pregnancy and childbirth and this was apparent in the young women's reference solely to post and ante natal depression. There was minimal verbalisation of other mental health issues that can arise in pregnancy.

There was also a misconception apparent that mental health matters may be of concern later in a woman's pregnancy or postnatally with three of the four young pregnant women believing they would receive mental health information later in their maternity care. Meagan particularly lamented a lack of community support targeted to the ante and perinatal period:

> [P]eople tend to focus on the postnatal depression rather than antenatal if you like people don't seem to focus on antenatal depression I mean obviously it can happen but I don't know for example if there's an antenatal depression support group available? No one really seems to focus on the antenatal depression possibility.

This lack of knowledge of mental health matters in the perinatal period was connected to wider issues surrounding the expectations and awareness the participants had about pregnancy.

First pregnancy: expectations and knowledge

One entry criteria for inclusion in the research was that women were interviewed during their first pregnancy so that information gleaned from previous pregnancies did not influence the data. When asked about their expectations and knowledge of pregnancy, all four of the young women identified a range of different expectations that appeared to create some anxiety if not met:

> I think I did expect things to be different. Maybe that's my fault for having these expectations *(Meagan)*.

Similarly, if the experiences of their pregnancy were not comparable with other women they knew, this created concern:

> I do have one other friend who actually is pregnant as well and is due about the same time as me and I feel like she is very organized, much more than I am I think *(Meagan)*.

Adjusting to the unknowns of pregnancy can trigger for young women feelings of anxiety and fear as well as a concern for reassurance that what they are going through is "normal". A number of times the participants asked the researcher what they thought of their experiences and whether this was usual.

Meagan and Michelle both felt they had little to no knowledge about pregnancy, or even very practical matters such as how to secure a midwife:

> I didn't know anything and I wanted a bit more information, like what happens now and a bit more of the process than just 'now you go to a midwife.' I wanted to know a bit more about pregnancy stuff and what to expect now. [...] I didn't know anything much. (*Michelle*).
>
> I did feel a bit kind of on my own and yeah and completely clueless as well cos [sic] I've never been pregnant before (*Meagan*).

The younger women, Charisma and Sarah, appeared less conscious of their lack of knowledge and did not express concern around this.

Waksclag & Hans, (2000) connect a lack of knowledge and information to young women's lack of preparation for pregnancy identifying that for this population pregnancies are often unplanned. Even those who have planned their pregnancies can find themselves unprepared which occurred for Meagan. Despite planning her pregnancy, it came as a shock to Meagan and "happened much quicker than we thought it would" with Meagan being overseas when she found out she was pregnant. It was important for Michelle and Meagan, as well as identified by Charisma, that they receive practical ideas and advice about what to expect and this helped alleviate anxiety:

> I did tell some friends that I was particularly close to. And that was great, it was nice to be able to share experiences so I did get some information from them which was nice I bought a book you know as well about what to expect (*Meagan*).

Resources

The four participants referred to the use of books and other practical resources including audio-visual materials, the Internet, and resources provided by the midwife. Charisma had also been provided with a DVD of childbirth by her midwife, which she found helpful and had shown to her partner demonstrating the importance of utilising modern technology to reach young people. Again, female informal supports were a key resource for information and many woman sought advice from female friends and family members, for example about midwives who had good reputations.

> My Mum's friend said a midwife was good (*Michelle*).

After discussing informal supports, the participants were asked which non-familial support person had been most helpful during their pregnancy. Three of the four participants pointed to the role of their midwives and all four of the participants were in regular contact with the midwife.

Importance of midwives

Midwives had a crucial role, second only to partners and families, in supporting the young women. Midwives were essential as the primary formal support that women accessed when concerned about anything, whether physical or mental with their pregnancy. However, a range of relationships with the midwives were identified and the service delivery provided to women changed depending on who the midwife was at the time and whether this was a hospital or community based lead maternity carer. Women who are nineteen years or under are less likely to feel they receive enough information when choosing a LMC (National Health Committee, 1999). The participants did not always have a completely open relationship with their midwife believing that the focus of this service was upon physical health needs and the baby, rather than themselves. They also did not feel they received all the information they could have from their midwife and Meagan had particular issues establishing a relationship with one midwife due to structural barriers that hampered her securing a consistent person in this role. Sometimes the disclosure of sensitive issues to the midwife was considered in a careful and tentative manner:

> If it [mental health issue] progressed where I didn't feel like I could deal with it just talking about it with [partner] I suppose I'd talk to [Midwife] (*Sarah).*

All of the four women found their midwives were approachable and contactable at any time:

> She kind of, because my Mum always comes with me, she [the midwife] kind of like takes an interest. She asks if I've got any names and stuff. She's really nice (*Michelle).*

Price (2007) recognises the importance of the midwife establishing this relationship with young women so that they can recognise subtle changes in the client's presentation as possible warning signs of mental decompensation. However the participants all demonstrated a desire not to bother the midwife with their problems. Charisma stated that she would not tell her midwife personal matters about her own emotional health and social issues, unless directly related to the baby, feeling that the midwife was only concerned with the baby's status and wellbeing:

> I don't feel that I can tell her my problems. I just have to see her and its all about the baby really (*Charisma*).

Instead, the young women looked elsewhere for support for themselves. For example, Meagan and Charisma accessed other counsellors. The participants also identified that they would not contact their midwife immediately, looking for answers first themselves or within their own networks (see section discussing informal supports) and would approach their midwife if the issues remained unresolved:

> What I'd do first is research it a little myself like on the internet and in the pregnancy books and just see if it was similar just so and then I'd go and talk to [Midwife] and say this is how I'm feeling (*Sarah).*

Meagan had particular difficulties securing a midwife and had two before her final midwife. The National Health Committee (1999) identifies that one third of pregnant women do not get the Lead Maternity Carer they want. The first change for Meagan was made because her due date was misjudged pushing the estimated delivery date into the next month and she identified that the midwives are very strict about keeping a set number of women delivering each month. Meagan's second midwife chose to leave her position with Meagan feeling this reflected the pressures of the job. The changes to her care were problematic for the relationship building process and sharing of information:

> Yeah, having to meet someone new and the fact that it wasn't the first time either it was the second time so that's three midwives [...] that was a bit frustrating because I guess I felt I got on fine with [first midwife] and I think it was more the thing that especially at the beginning I felt for myself that I wanted to have that continuity 'cos [sic] from what I understand the midwife is going to see me at my absolute worst you know (*Meagan*).

Meagan went on to say that she wished she could have built up more of a "rapport" with a midwife who was there for the whole of her pregnancy and childbirth experience. Meagan also felt the information received from her midwife was dependant on Meagan taking a proactive stance around this herself:

> I feel like it's partly because I feel like I don't know which questions I should be asking so while I feel happy with the way my midwife appointments have gone I don't feel like I'd been given all the information.

Despite specifically targeting participants who were not involved with mental health services, Meagan was concerned that she had in the past suffered depression and her midwife had not explored this:

> I was clinically depressed for a few years. I took pills and they diagnosed that and [...] that helped but that was something that I had to put that in you know when you fill in your first form when you first join up with a midwife and you have to say a bit about your medical history and stuff and its something that none of the midwives have picked up on [...] and I don't know if its their job to if you like or if its something that they yeah ought to be looking at. Oh well I think it is something that they ought to be looking at (*Meagan*).

When this did not happen Meagan began to question herself as to how much initiative she should take in addressing this with the midwife:

> I don't know you see if its that I should've said something or if its something that they should be trained if you like or you know told to specifically ask each time I'm not sure really (*Meagan*).

Antenatal education

Three of the four participants were attending or planned to attend antenatal classes with Sarah identifying a desire to do so due to this being her first experience of pregnancy. Charisma queried whether she "had" to attend classes and felt that if she was not required to do so she could get the information about what happens at the birth from the videos provided by her midwife. Sarah and Michelle were informed of the classes by their midwives and Meagan was informed by a friend who had completed the classes. The need to find antenatal and childbirth education classes also spurred women to contact different services and increased their awareness of what services were available.

There were some concerns expressed around the antenatal classes by Meagan, Sarah, and Charisma. Some classes had a cost associated with them. The Parents Centre childbirth education classes were for members of the Parents Centre which cost sixty dollars a year. One participant did not feel this cost was worth the benefits she would receive as a member. Young women that are struggling financially may not access services that will cost. Meagan had also received negative feedback from peers concerning the facilitator of one group:

> She [child-birth education facilitator] couldn't provide much in the way of information for the questions that people had and [...] I think she quite often said something like you know 'oh well I'm not sure I'll have to go away and find the answer out to that' and she did and she would tell them the next week but it didn't really strike me with a lot of confidence, especially when your paying for it (*Meagan*).

Women's choices of antenatal classes in the locality of the research is likely to be reduced as Sally, the midwife interviewed who facilitated hospital-based childbirth education classes, identified the funding to provide these was to be ceased.

Mental health information

The participants were all at different stages in the perinatal period but none had specifically discussed mental health issues either in their contacts with midwives or in the antenatal classes. Sarah and Michelle believed this information would come later in their pregnancy, close to their full term:

> My midwife hasn't really said anything like that [maternal mental health] yet. I don't think she will for a little while. [...] she doesn't explain stuff like that, like at antenatal group and stuff (*Sarah*).

When asked specifically whether Michelle's child-birth educator had spoken about matters that occur emotionally during pregnancy or post-natally Michelle responded, "[W]e haven't really covered that yet, we've covered other things, like stages of labour [...]". This is problematic considering studies indicate relapse of psychiatric illness during pregnancy most often occurs in the first trimester (Petrillo et al., 2005).

There were questions as to the extent of midwives knowledge surrounding mental health and support services. Meagan reported that, despite being aware that there were supports available and that she could talk with her midwife, this was determined by her initiative in accessing these, rather than them being offered to her by the midwife. When she directly asked her midwife what support services were available to her the midwife was unable to answer stating that no other women had asked this before, which was surprising to Meagan. The National Health Committee Review of Maternity Services survey in 1999 found eighteen percent of new mothers' felt they were not adequately informed of postnatal mood issues with thirteen percent stating they received no information, or misleading information postnatally. While the four participants often spontaneously talked about their midwives they did not tend to refer to their general practitioner. In response to this, in three of the four interviews, the participants were asked specifically about their involvement with their GP due to a desire to receive a clear picture of what professionals the participants were involved with and how they experienced this contact.

Role of general practitioners

All four of the participants had minimal or no contact with their GPs. Michelle claimed "[S]he [the GP] basically doesn't have anything to do with me now, it's pretty much my midwife and stuff". Similarly, Meagan identified that she had minimal contact with her GP and discussed this relationship:

> He's all right; I mean we get on ok. I've literally apart from that first time I got back from [overseas]; I literally haven't seen him at all during the pregnancy because I suppose I haven't needed to. I mean the one time that I went to see him just after I got back from [overseas] he just basically said I was pregnant then it was basically about putting me onto the midwife (*Meagan*).

In this situation the GP was obstetrically trained and experienced.

It appeared from the participant interviews that for three of the four women the GP role in the pregnancy was limited to diagnosis of pregnancy.

> I initially didn't find my G.P too helpful really cause like I – you know, my first pregnancy and everything and she did a urine test and said basically that I go to a midwife now [...] but I kind of wanted to know a bit more (*Michelle*).

Michelle eventually changed her GP and her new doctor was particularly responsive. She kept in contact with Michelle via text messaging and was happy for Michelle to text her when necessary. This use of text messaging is important due to text messaging being a primary means of communication of youth populations.

Cost and availability were a factor in the amount of contact the participants had with health professionals, particularly GPs. Michelle changed her general practitioner for free contact through the local Primary Health Organisation, both due to cost and the lack of relationship with her original GP. This interpersonal connection and relationship to the GP was a vital determinant in the level of contact the young women had with them. While most of the women had established relationships with their midwives and few were in contact with their GP's, Michelle did state that she preferred to contact her new GP for some concerns due to this relationship:

> Yeah, I'd actually find her easier to talk to than [midwife] because I saw her a lot when I was like at high school as well.

Conversely, Sarah did not feel the GP was a suitable person to discuss mental health matters with:

> I wouldn't go to my GP unless [...] I had to get a prescription for something, an antidepressant or something like that, just because I don't feel like my GPs someone you could talk to about that stuff someone who would talk stuff through with you and be a good person to have that initial contact if you were coming out with something like that [emotional or mental health concerns].

This quote also demonstrates how the GP was associated with medication and prescribing with a desire to avoid medication in pregnancy reflected in the participant interviews.

The midwife and GP were the primary health providers the participants identified they would contact if they had any mental health concerns during the perinatal period. Additionally, three of the participants had contact with other community support services or counsellors. Charisma, Meagan, Michelle, and Sarah were asked how they had connected with and experienced these specific health and support services they were engaged with, again to assess how accessible these services were in the community.

Accessibility of health and support services

While Charisma, Michelle and Sarah felt their midwives were easily accessible and responsive, the connection with additional services varied. None of the participants identified services they could contact if concerned about their emotional health but stated they would access their midwife or informal supports if this occurred. Thus, the general practitioner and midwifery roles described in the previous two sections had a primary function in connecting the young women with wider health and maternity services. This demonstrates the importance of midwives and GP's, as primary health care providers, being aware of additional supports in the community women can access. From the interviews conducted the process of attaining additional supports and midwives usually began at the point where the pregnancy was confirmed. Due to her medical condition Michelle took a flyer about a pregnancy support service from her GP at the time of having her pregnancy confirmed. Meagan also identified how she looked for resources in GP surgeries and other agencies.

Three of the four participants interviewed sought additional services to the midwife and GP. Meagan, due to a lack of informal supports wanted to access services that might connect her with other pregnant women her age. Sarah, one of the younger participants, was engaged with a youth pregnancy service in the community. Charisma was already engaged with a mental health clinician via a local alcohol and drug service prior to the pregnancy. This person was identified as her primary support due to Charisma having limited informal supports and was found to be supportive through their responsiveness, relationship with the client, flexibility, and abilities in assisting problem solving and providing options, rather than direction.

Meagan, due to her social isolation having the majority of her and her partner's family overseas, attempted also to meet other women and access support through pregnancy services but struggled to find what she was looking for:

> I asked right at the beginning is there anything in [local area] for pregnant women and I mean at the time I was 14 or 15 weeks just because at the time I didn't have anybody in my situation really actually pregnant that I knew in the town, I don't know what I was actually looking for some kind of support group (*Meagan).*

The participants did not appear to have a lot of knowledge around services that were available to them. This reflected both participants' lack of knowledge of support services available and a void of appropriate services. Meagan wondered about the level of support services available and felt this needed to be addressed:

> In thinking about it I don't know if that's partly because that kind of stuff isn't available in [area] and that's something to talk about (*Meagan).*

Meagan spoke of one service she was informed of in a positive light due to its comfortable and approachable appearance. Michelle, one of the younger participants, identified youth-friendly environments as important so that she could feel comfortable and connect with others her age. Having a warm, physical space that did not appear too clinical to attend to meet others and receive information was important and Meagan was put off by an agency that did not have a physical location, only contact details:

> What I was surprised at was that they don't [...] seem to have a base if you like. There doesn't seem to be anywhere you go [...] so there isn't literally anywhere you can go and talk to them to sort of drop in and I don't know see what information they can offer you *(Meagan*).

Meagan accessed a private counsellor due to matters from her own childhood that were being triggered by her pregnancy and felt this helped her resolve issues pertaining to her relationship with her mother. Fraiberg, Adelson, and Shapiro (1980), Karen, (1998), and Swann et al. (2003) believe young women must address any issues from their own lives that may surface in their pregnancies and early parenthood so that these do not affect the relationship with the child. Charisma also identified a desire to resist some of the transgenerational issues she felt in her own family of origin identifying that, if she had a son, she would not want him to be socialised to treat women in a demeaning way. These generational issues can negatively impact a young women's mental health (Hall, 2007).

When women were not aware of appropriate services, but thought they might require further support in the future they identified that they would ask their midwife. However, when Meagan attempted to do this she found her midwife knew as little about support services available as she did expressing "surprise" due to her belief other women would also need and ask for this information. Meagan wondered if this response was due to a lack of knowledge, or whether there were few services in the community to be aware of. Because Michelle and Sarah were studying they received additional support through their education provider and the plans for their ongoing education were supported through this contact.

Education/vocation

While the four participants were not directly questioned around their educational or employment plans, discussion of these matters usually arose when women were talking about the support they had in their pregnancy. Meagan was in stable, professional employment she planned to return to following her birth and Sarah and Michelle who were completing their studies, had support to do so with vocational plans following the achievement of their qualification:

> My Mum's going to start doing the massage part of the course of mine, so we want to set up like a home stay and kind of put that in with it (*Sarah*).

Michelle and Sarah were part way towards completing higher education when they became pregnant. Both received positive, supportive responses from their education providers:

> The teachers are nice [...] they kind of make special allowances and stuff for me [. . .] (*Sarah*).
>
> She [lecturer] was really good [...] she was really good about it and really helpful (*Michelle*).

For Sarah this support extended to the school arranging an alternative time for her to sit her exams because of her due-date "[W]e have exams like school but we do those exams just when he's due so I can't do them, I have to do them in November". This support and flexibility reduced Sarah and Michelle's stress levels and allowed them to complete the qualifications they had been working towards prior to their pregnancies.

Conclusion

The experiences of the four participants interviewed ranged from relaxed and generally problem free to those that struggled more, either with adjustment to pregnancy and anxiety about what was "normal" or "usual" to those that had significant conflict within their relationships or intergenerational problems. The primary themes that the participants identified were both in acknowledging their informal supports, particularly partners, and female family members and friends who supported and advised them as well as identifying those formal support persons and services they were in contact with. However, problems occurred when informal support networks were minimal or added further stress for women by being conflicted or unsupportive. Sometimes formal support services were difficult for women to access or not user-friendly. The participants referred often to postpartum or physical issues struggling to identify mental health issues that could arise in pregnancy. This lack of knowledge was openly acknowledged by the young women. While midwives provided a key source of support and information, this information sharing was inconsistently delivered and participants felt they lacked information relevant to their pregnancies and the support services available to them. There also did not appear to be strong links between the professionals women were involved in and they were primarily connected with midwives. These themes and issues will be analysed in Chapter Seven along with those identified from four interviews conducted with professionals working in the field of maternal or mental health. It is the data from these key informant interviews that are presented next.

Chapter 6

Perspectives of four health professionals

Introduction

Additionally to the participant interviews outlined in the previous chapter, four interviews with professionals working in the field of maternal or mental health support were conducted. These were aimed at receiving a balanced view of what is occurring in the field from both the perspective of pregnant women, and from the point of view of the professionals working with them. It is the findings from the interviews with these professionals that are presented next. The chapter begins with the perspectives the health professionals held about young women during their pregnancy and include; psychological development, including anxiety and adjustment issues; the role of informal supports; concern with physical and postnatal issues; and lack of knowledge and information. These themes mirror those presented in the participant interviews and are included to provide a counter-perspective from the point of view of the professionals. The health professionals were additionally asked about policies used in their work. Identified from these questions was a lack of suitable health and support services provided for young pregnant women and the impact this, along with stigmatisation of mental illness, has on women receiving mental health support. The respective roles and collaboration between maternal mental health specialists, midwifes, and GPs are identified. Issues pertaining to use of medication, perinatal screening, and early intervention are also reviewed. Interviews were conducted with two nurses, one GP and one midwife. Information pertaining to the professionals is outlined next.

The key informants

Sally

Sally was working as a hospital based charge midwife at the time of the interview and was in regular contact with pregnant women through facilitation of antenatal classes. She had previously practiced as a community lead maternity carer alongside general practitioners and had facilitated both home and hospital births.

Fiona

Fiona was chosen as a key informant due to her experiences as a maternal mental health specialist within a community mental health team. This role was within the hospital adult mental health outpatient team where she had been employed for over six years, initially as a generic community psychiatric nurse. Fiona had twenty years of psychiatric nursing experience.

Beth

Beth, the second nurse interviewed, had been a Plunket nurse for twenty years. She had experience working with women suffering postnatal mental illness, particularly postnatal depression through assistance with a postnatal depression support and therapy group. Additionally, Beth had been involved with the creation of a local education service for school-age parents and their children.

Clive

One GP, Clive, was interviewed to receive a range of professional experiences. He trained as a GP in 1987 after obtaining a Diploma in Obstetrics and Gynaecology in 1986. From 1990 Clive's practice included the provision of obstetric care delivering around thirty babies a year until 1996. At the time of the interview Clive did not provide obstetric care but did see women during pregnancy as necessary. Clive also had experience and training in treating mental illness.

Psychological development of young women

The health professionals identified that for young mothers pregnancy is a time of developmental and psychological as well as practical change. The health professionals were asked how they share information with young women about mental health issues that can arise in pregnancy. This triggered many of the professionals to discuss their experiences of how women receive such information. Beth (Plunket Nurse) queried whether young women were able to plan for negative aspects during pregnancy:

> Often we find that people that are pregnant can only concentrate on getting the baby from the inside to out.

Sally, Beth, and Fiona connected this lack of acknowledgement of current or potential mental health issues to the stigma associated with these issues.

The four key informants referred to most young women during pregnancy suffering "anxiety" and "adjustment issues". Beth, Fiona, and Sally thus referred to the need to "normalise" some of the anxiety women face at this time. The professionals identified that women's primary concern was to receive reassurance that what was occurring for them was "normal", "usual" or common". Fiona had experienced, in her practice as a maternal mental health specialist that, without assistance, these problems can develop into "serious long term mental health issues" including; "depressive illness", "obsessive compulsive disorders", "changes in their personalities", and "even more serious illness like psychosis, or becoming dependent on other things, like alcohol or drugs". Three of the key informants felt women who had adequate social support were less likely to suffer such issues.

Informal support

Clive, Beth, and Fiona recognised that the quality of informal supports a pregnant young person had available to them was a determining factor in how well they coped in this period. Clive stated in his experience "it's actually the people that are socially kind of unsupported that are at the most risk". This is consistent with the reports of the young women themselves. Karen (2000) reflects that the way women ask for help from their networks is also important. In Karen's research women whose relationships had communication that was deemed healthy by avoiding uncertain requests, manipulation, demands, or aggression, did better emotionally in their pregnancies. Clive also identified characteristics of a young women's personality that may reduce their support network including those people "that tend not to get on well with others, that tend to be kind of loners and the ones that aren't showing affection to their child".

Similarly to the participant interviews, the significance of mothers and grandmothers as supports was identified by the health professionals as important for young women. However, Beth, Fiona, and Clive felt that at times the involvement of informal supports was not always beneficial. Consistent with Michelle's comments in the previous chapter, Beth reflected that grandmothers can have misperceptions about how things happen due to contemporary changes. Clive and Fiona also reported on their experiences that the young women they were in contact with may have chaotic relationships with their immediate familial supports and intergenerational issues such as mental ill health or alcohol and drug misuse.

Stigma of mental health issues

Three of the health professionals identified the "stigma" and "shame" of mental health as presenting a barrier to treatment and access of mental health support. Beth commented on how historically ingrained this stigma has become:

> [T]here shouldn't be that stigma but its still very much alive and well that stigma around the place which is such a shame really that's been around for years [...] (*Beth*, Plunket Nurse).

Based on her experiences, as a maternal mental health specialist Fiona believed that only half of the women who suffer from mental health concerns present for treatment due to stigma. Due to this stigma, Beth felt it was important that services appeared less clinical with the label of "mental health" removed from services and professionals due to the "connotation" of this. Beth extended this concern to argue for separate facilities for young pregnant women or new mothers suffering from mental health issues. Stigma and negative labels may also influence the level of awareness of mental health issues that does not occur in physical health.

A focus on physical health and postpartum issues

Sally, Beth, and Fiona, believed health professionals and young pregnant women focus more on physical rather than mental health issues triggered in pregnancy. Sally, in her role as a midwife, felt more confident in helping young women with physical matters as opposed to emotional:

> I think a lot of it is it's [mental health] just an area that I think we're not comfortable in ourselves, we don't have a lot of knowledge and we don't have a lot of experience and we tend not to discuss [...] whereas we can discuss about bathing a baby or breast feeding and all those things (*Sally*, Midwife).

Sally, Fiona, and Beth saw this lack of visibility of mental health as related to wider social issues around the medicalisation of health within modern society. A focus on physical complications evident in the interviews may also be due to the dominance of such issues in media, education, health settings, and child-birth education courses as "[w]e have compulsory education about breast feeding but we don't have compulsory education about maternal mental health" (*Sally*, Midwife). One reason for this lack of information was because, similarly to the young women, the health professionals believed mental health issues emerged later in pregnancy with Sally also stating "mental health is just given a really low rating because it's something that happens often later down the track". However, the prevalence rates of depression during pregnancy are the same as in the postpartum period (Henshaw & Elliott, 2005).

Even when specific mental health issues are as prevalent as physical issues the health professionals do not always address them with Sally again recognising:

> We talk about things like pre-eclampsia which affect 1 in 10 women but we don't talk about postnatal depression that affects 1 in 10 women (*Sally*, Midwife).

It was reflected that the rationale for this was that some physical complications, such as pre-eclampsia could be fatal to the mother or baby. There is either a lack of knowledge or minimal willingness to recognise that mental health issues can be equally fatal if left untreated. Feminist writers in the field such as Chesler (1997); Marland (2004); Fry (2000); and Showalter (1985) found that there is an historical avoidance within western society to conceive that a mother's mental health can lead to her damaging the baby, either postnatally or in-utero, as this contradicts societal notions of motherhood.

The lack of concern at not having full information apparent in two of the participant interviews was experienced by Beth in her involvement with young pregnant women entering an education unit for school-age parents:

> (O)ften [...] the younger, the teenage mums don't know what they don't know and in a way ignorance is bliss sometimes (*Beth*, Plunket Nurse).

A lack of recognition of mental health needs was also connected to the lack of resources and skills in accessing services, which Sally had a resolution to:

> It would be about giving the women the education so that when they're six months down the track they actually recognise what's happening to them (*Sally*, Midwife).

However, this would be dependent on the suitability of support services and professionals in providing accurate information in a way that is easily received by young women. The research data suggests that the current provision of support services to do this is inadequate.

Suitability of health and support services

Knowledge of community support services appeared minimal with the GP, Clive, and Sally, the Midwife being unable to identify additional services available for young women in pregnancy. Concern was expressed by some of the health professionals at a perceived lack of services provided for pregnant and postnatal women in the community. Sally reported her experience of discharging women from her care as a midwife but not feeling there were alternative services for women to receive emotional and parenting support after this. Hence her role extended to setting up support networks "so that when you discharge them they're not just there floundering" (*Sally*, Midwife). Sally did go on to identify one service she was aware of, Tamariki-Ora, well-child services, which were important in providing wrap-around provisions to the child when other services were withdrawn.

How these services were delivered was identified as a factor in how successful they were in supporting women, for example, services based in the women's own homes. Sally and Beth made reference to the use of home visits to reduce access barriers for young women such as the stressors of travel for rural women. However, Beth identified this travel is not incorporated into the Plunket nurses' workload. A funding structure that required a certain number of women to be seen served to reduce home visiting within the agency. Beth recognised, as per the MidCentral Health Maternity Services Review (2004) and National Health Committee (1999) that, for young women especially, pregnancy can trigger their first contact with hospital services, which Beth stated, can be a "very scary" experience. Subsequently, Beth worked to create a non-clinical setting for the Karitane Family Centre she worked within: "it's just a house and we don't want it to be like clinical, we want it to be relaxed". She believed this was important for maternal mental health services. There is debate within the literature as to who is best to provide support services to young pregnant women. Beckwith (2000) believes professionals are more effective than other consumers or consumers' family at supporting women in this period. Beth had mixed feelings about consumer support identifying the possible pitfalls. She advocated for consumer support to be moderated by professionals whom she felt had skills in setting limits and knowing their "boundaries" as well as receiving professional support and supervision themselves.

Fiona, Clive, and Beth attributed a general reduction of support networks to societal changes:

> Societies changed so much so that there isn't the same amount of support there for people as much as there was [...] it's a lot more limited than it was (*Beth*, Plunket Nurse).

Beth and Fiona connect these changes in community living to individualism encouraged through the marketisation of health and social services.

Other key informants identified services particular to their organisations that had been reduced and, similarly to Beth's comments, attributed this to resourcing and contractual funding arrangements. Sally bemoaned the loss to midwives of after-hours social work support that was "cut". One primary service that Beth and Sally regretted the loss of was the maternal mental health support group that was ceased, Beth felt, because of lack of funding. Sally lamented "I know there's no postnatal depression group [...] I know there's no direct support here for women". These issues around funding were referred to frequently as a problem.

Funding and resourcing

The extent of services and support health professionals could provide to young women in the perinatal period was dependent on the contracts and availability of resources. Beth in her role as a Plunket nurse felt the funding contracts limited the "extra support" they could provide. She stated "[h]ealth never used to be a business but its run as a business now". Resource constraints not only include money, but human resources that some services were lacking. It appeared that midwives in the community were struggling with national issues of a reducing and ageing workforce. This was evidenced by statistics provided from Sally that her employer was attempting to run services without five full-time lead maternity carers being unable to recruit more. There were no reports of attempts to remedy this problem, other than to cease providing the services affected.

Maternal Mental Health Specialist role

The maternal mental health specialist role was situated within the district health board and created out of the Blueprint for mental health services and Regional Speciality Services. At the time of the current research there was one full-time equivalent maternal mental health specialist provided by the local DHB who received support from a part-time psychiatrist and psychologist. These professionals worked within a wider adult community mental health team and received input from a regional specialty maternal mental health service. Throughout New Zealand the provisions for hospital based maternal mental health are not standardised and depend on the decisions of the local DHB in determining what they will provide to meet the Ministry of Health requirements. This variability is apparent internationally also as Shakespeare (2005) and Ross-Davie, Green, and Elliott (2005) recognise this phenomenon in Australia and the UK: "at present the availability of specialist secondary care resources for perinatal women, including community psychiatric nurses, psychologists, psychiatrists, and mother and baby facilities, is variable throughout the UK and in many areas it is patchy or absent" (Ross-Davie et al., 2005, p. 31).

Clive, Sally, and Beth referred frequently and generally positively to the maternal mental health specialist role:

> With the actual maternal mental health nurse I've never felt brushed off, I've always felt they've been really supportive (*Sally*, Midwife).

It was often the maternal mental health specialist that was identified as the first point of contact for any maternity related mental health concerns:

> I tend to direct straight away to (Maternal Mental Health Specialist) because at least there's one person who will at a professional level who will slot in (*Clive*, GP).

However, there appeared to be no clear promotion of this role with Sally finding midwives only know about the service through word of mouth.

While the maternal mental health specialist was seen in a positive light, there were concerns around the limitations of this role as Fiona, who had spent two years in the position identified:

> More often than not I was quite limited to what I could do as a health professional working with a group of what I considered quite needy people [...] So I felt that at times, quite vulnerable to dealing with quite high risk families and more often than not I was dealing with them in an isolated role.

Beth and Sally also expressed their concerns about the limitations of this role in that the one specialist could not attend to the full needs of the young pregnant women struggling with adjustment and other more minor to moderate mental health problems as well as their families. Women were also excluded if they had a pre-existing mental health disorder reflecting Price's (2007) concern that minimal attention is received by such women despite the literature base stating clearly that pre-existing mental illness is one of the strongest predictors for postpartum mental illness.

Midwifery support

It was primarily the midwife that was connected to the young women in their pregnancies and this work was acknowledged by Clive who stated "I think the midwives are dealing with the care of the women very very well." This connection with midwives as the primary professional involved with women during pregnancy had implications for who is dealing with maternal mental health issues with both Sally and Clive believing "the midwives should be aware of maternal mental health issues and be very ready to either refer back to us as GPs or refer directly to [maternal mental health specialist]" (*Clive,* GP*)*. However, the midwife interviewed felt they lacked knowledge and skills surrounding mental health. Price (2007) recognises that few midwives have the training to effectively attend to mental health needs. Similarly, Dearman, Gutteridge and Waheed (2007) state health professionals generally have inadequate understanding of maternal mental illness. Sally thus felt midwives should be "educated about maternal mental health then that information could be transferred or shared".

The ability of midwives to attend to mental health needs of their clients is impeded by the lack of support they receive in their practice (Price, 2007). Sally identified certain practices completed in community midwifery practices that assisted midwives to deliver comprehensive services, for example how professional practice was supported:

> [t]he practice I used to work in we used to have weekly meetings and so any issues that we had we discussed there and it was a really supportive practice and a really safe place to talk. We would often talk about issues like that [mental illness] for women that we'd got (*Sally,* Midwife).

A number of difficulties of working in a hospital environment were expressed including the fact that such meetings did not occur in this setting:

> It's more like a chore list or a job list it's not about how's it going for you. Everything here's about just get on with it. Don't moan, just get on with it. I don't find it really incredibly supportive here (*Sally*, Midwife).

Shakespeare (2005) recognises these processes as vital in attending to risk and depression but that they are often not managed appropriately, instead, treatment approaches are changed.

Role of general practitioners

The research outcomes demonstrate a reduced role in maternity care provided by general practitioners. This was reported by the women; who were in little to no contact with their GP; from the GP interview; and in attempts to contact GPs to identify participants. The role of GPs in providing maternity care and support was limited from the reports of Clive, the doctor interviewed:

> We're just not seeing them the same as what we have before and the other thing is even for diagnosis of pregnancy I mean their doing it and they're getting in touch with the midwives directly straightaway [...] its just that women aren't coming through to the GPs as much.

Due to this limited number of women seen in pregnancy, Clive's comments were generalised to all age groups, as opposed to being specified to young women.

The reduced role of GPs in maternity provisions reflects the changing policy and funding structure within maternity care. Since 2006 women have had to choose one midwife, GP, or obstetrician to be their Lead Maternity Carer to ensure continuity of care and that numerous providers were not receiving maternity care funding for each woman. Many GPs have since ceased providing maternity care as it is not financially viable for them due to receiving half the fee that midwives do for this work with increased overheads (Chamberlain, 2006; Hutton, 2005). The GP interviewed recognised the impact of these policy changes. Clive felt that midwives and women in the local area regretted the changes identifying that some midwives were "in tears" at the cessation of his maternity practice and the loss of this working relationship. However, Clive felt pregnant women today have become acclimatised to the current provisions. The young pregnant women interviewed did appear to have adapted to these changes being unperturbed by the minimal contact with their GPs. However, they were concerned at the lack of information received initially from the GP when their pregnancies were confirmed being instead sent immediately to connect with a midwife. Hutton's (2005) article suggests women are not satisfied with only seeing a midwife and the four young women did appear to want to receive some information prior to connecting with their midwife.

Clive defended the practices of his colleagues and the role of the GP stating:

> [P]eople have incredible expectations about what they expect a GP to do in 15 minutes including you know six week check plus you know canvass for other problems including the referrals and all that other stuff and sometimes the logistics of what people expect from GPs isn't [realistic].

This time frame of fifteen minutes for an appointment is indicative of a medical model of health and disorder but is unrealistic for addressing mental health matters. There appeared to be a lack of understanding and support from other health professionals for this structure that the GPs were working under. Because the GPs' working environments were not structured to appropriately address mental health matters arising, Clive felt GPs needed to have up-to-date information on hand about what was provided in the community and who was working with this population, as well as a central reference point for referrals and information.

Hutton (2005) expresses concern that midwives only have maternity knowledge; lacking information of a person's health and family history. Clive as a GP felt that he did have such awareness:

> [T]hat's exactly how I see a GP working from woe to go and knowing pretty much whatever goes on whether its financial or psychosocial or medical or maternal its what we do and I think most of us do it well, but the world has changed.

However, he identified this knowledge as "less common" due to the "transient" and "mobile" nature of the population that both Clive and Fiona noticed. According to Clive health information does not follow people well when they make such shifts impeded also by the numbers of health professionals, contemporary or traditional, that young women see. Clive was concerned that the information was not returning to the General Practitioner whom he saw in the role of the "hub" holding all the information together. Chamberlain (2006) also found the personal knowledge of families GPs have, which cannot be obtained from training but only ongoing and consistent involvement with young women, has been lost. This she believes has had implications for maternal mental health as more women are suffering untreated maternal mental health which Chamberlain claims is demonstrated through the waiting lists for maternal mental health specialist treatment.

The other, nursing-based key informants did have some concerns about the involvement of GPs fearing a "scenario of someone having a baby and obviously getting unwell and going to the GP and getting prescribed pills and things rather than talking to people and referring them to other supportive agencies" (*Sally*, Midwife). However, when asked about how he would advise a young women who presented with mental health concerns during pregnancy Clive stated that he felt comfortable in treating women with such problems prescribing medication in approximately a quarter of the cases he saw. Clive was also clear that he would refer on to the maternal mental health specialist at other times when he felt that he could not assist the women through his own training in non-pharmacological mental health therapy.

Medication

Similarly to the participants, Sally and Beth reported some concerns around the safety of medication in the perinatal period recognising some women are "frightened about medication" (*Beth*, Plunket Nurse). Sally and Beth also suggested medication was overused by some health professionals with Beth stating "I do think that medication is very quickly used". Sally, Beth, and Fiona held an additional fear that the overuse of medication would cause women to miss out on other treatments alternative to pharmacotherapy:

> It (medication) needs to have something alongside it and that needs to be support [...] or some sort of group taking them through that process (*Beth*, Plunket Nurse).

Such concern is valid in a society that appears fixated upon a medical model with medication the predominant treatment for mental illness (Donelly & McGilloway, 2007).

Women are treated more often, with a wider range, and for a longer time on psychotropes compared to men (Travis & Compton, 2001). Travis and Compton suggest this use reflects a disregard of women's real complaints such as treating true physical complaints as somatic symptoms of mental illness.

These problems triggered recommendations from Cohen & Nanocs' (2005) and Hendrick's (2006) to introduce non-medical treatment to pregnant women first and Sally recognised this also asserting "it shouldn't just be that medication is required, shouldn't just be medication is the only answer". However; it would appear that the completion of non-pharmacological trials first is not always the case currently from the lack of access to alternative services the health professionals reported. When Sally was asked about whether she would refer clients back to their GP if they appeared to be suffering mental health problems she responded:

> I actually discourage it and I actually talk about this in the antenatal classes. I don't think it's a very valuable place for women to go because they just get written out a prescription for a pill and often they need to go and talk to someone (*Sally*, Midwife).

Collaboration between services

The four participants and four health professionals interviewed all identified that the services provided are not coordinated to ensure wrap-around service provision for young women. Clive felt it would be helpful to have one person who could be in contact with professionals and young pregnant women to coordinate their holistic health needs. While he did not specifically state it, what Clive referred to is a core social work role. Collaboration was discussed in the interviews, despite not being specifically asked around in the interview schedule, and was strongly advocated for by Clive to assist his role as a GP.

The criteria for young women to access services impacts upon the treatment these women receive, and how well agencies can work together. Sally, in her role as a midwife was disconcerted that, due to the pressures on them, some services were removed when women may still require them. In some areas women are not receiving the number of postnatal visits they are entitled to (National Health Committee, 1999). In particular women who are of Máori or Pacific Island descent, live rurally, or are on low incomes are not receiving the baseline number of visits (National Health Committee, 1999).

Interviewees were asked both what other agencies and professionals they worked with from within the field of maternal mental health and what they felt could be done better. The relationships between midwives, GPs, mental health services, and community agencies were often raised in connection with these questions. The two nurses interviewed made positive comments about their working relationships with other community-based professionals. Fiona, who had a lot of contact with midwives, GPs, and other health providers in her role as maternal mental health specialist considered she had a good working relationship with these health professionals.

When the key informants were identifying mental health services, or other government agencies, they were asked specifically how this contact had been for them and the response they received. Sally had rung the crises team on several occasions but unfortunately had received some unhelpful responses:

> I rang the crises team and I just felt completely brushed off, like we were just being over the top (*Sally*, Midwife).

This response was attributed to the lack of recognition of dual issues of mental health and pregnancy:

> She [the client] was obviously sick mentally but because they see a pregnant tummy they just send them all here [the maternity ward] (*Sally,* Midwife).

Sally felt that mental health services may have struggled to know what to do when a women was pregnant but did not recognise that maternity professionals struggle to know how to deal with mental health issues. Price (2007) states multidisciplinary collaboration between maternity and mental health services is essential. However, in the absence of this ability to work together, the role of the maternal mental health specialist in holding both fields of practice is important.

Clive, doctor, identified how funding and policy changes had negated collaborative efforts under a "continuity of care" policy. The National Health Committee (1999) identifies that female consumers, as well as health professionals, have expressed concern at the competition and conflict between services that can increase risk of unsafe outcomes. Where collaborative efforts were in place they appeared from the key informant reports to be highly beneficial for staff and for patient care and treatment, in particular multi-disciplinary and inter-agency meetings and treatment planning.

Lack of screening perinatally

What was evident from the key informant interviews was the lack of formal screening or identification of mental health concerns for women in the perinatal period. None of the four key informants identified that they conducted perinatal screening for mental health issues or risk factors. Consistent with this, the participants did not report being asked about mental health issues by their health professionals. One key informant believed they did routinely record mental health needs of the mother; however, this was focused postnatally. The midwife interviewed reported that midwives assess mental health histories through the medical history, although there is no guarantee women would be triggered by a review of their medical history to disclose mental health issues:

> The mental health issues would come out in their medical history but nothings addressed at all. It's something we talk about in their last week at antenatal classes [...] but other than that nothing's addressed as part of a women's antenatal and pregnancy care (*Sally*, Midwife).

Meagan in the participant interview also recognised, as Sally does here, that even when she disclosed a history of depression in the medical history, this was not picked up on in her maternity treatment.

A history of mental health problems, while the strongest predictor of further mental illness, is only one risk factor for perinatal mental illness. Cherry et al. (2001), Cohen & Nonacs (2005), Elster (1990), Henshaw & Elliott (2005), Sherr (1995), and Swann, Bowe, McCormick & Kosmin (2003) identify the following as additional indicators: breakdown of social support including poor marital relationships; low socio-economic status; poor educational attainment; stressful life events and issues surrounding the pregnancy, such as previous miscarriages and unwanted pregnancies; poor parent-child attachment in the young persons early life; alcohol or other drug use; and unresolved trauma.

Only Beth was able to identify formal screening or assessment procedures that they were required to complete as well-child nurses:

> We always ask about mental health [...] we have a stats page that we fill out [...] the paperwork has to always recognise and isolate if there's any mental health issues and refer accordingly (*Beth,* Plunket Nurse).

The three other key informants could not identify formal screening or assessment procedures or requirements for distributing information about mental health issues. Clive, doctor, did not see universal screening as necessary. However, Sally, the midwife did, expressing concern at the lack of formalised screening: "I don't know if there is any [screening]. I'm not aware of them [...] I think we're really poor at this". This reflects the controversy within the literature surrounding screening of young women in the perinatal period.

Fiona believed the antenatal period was a missed opportunity to support young women and prevent major mental illness:

> I think that there is a huge opportunity in the antenatal area to look at tapping into women when they first present to their GP [...] to look at that whole side of women actually having positive support right the way through their pregnancy when they are concerned about mental health issues (*Fiona,* Nurse).

What screening was occurring was domestic violence screening with every woman, over the age of fourteen who presented to the hospital. This screening had been introduced to midwives as a Ministry of Health policy targeting violence and Sally identified that midwives had taken this up, largely because the training associated with the policy provided extra professional development "points".

Policy

The participants were asked which, if any, health policies informed their practice. Sally referenced Section 88 of the Health and Disability Act requiring women be seen for a minimum number of visits and have a birth plan developed with them. Sally did not feel other professions were as aware of this legislation stating "because the doctors aren't even aware of the document, they're just looking for pinnacle things". The National Health Committee (1999) has identified twenty percent of women do not have a birth plan or cannot recall their plan.

There were some concerns expressed as to how maternal mental health policy directives impacted on the delivery of services. Fiona noted that the Ministry of Health were quite broad in the options of how maternal mental health specialists delivered their services:

> They weren't specific at all, it was basically that we did need to meet the criteria to do this for women that presented with moderate to severe psychiatric illness but what was moderate?

In the absence of specific criteria maternal mental health specialists and services around the country decided on their own definitions. The current policies for the resourcing of services may be ineffective. Contracts with funders appeared to limit the services that could be provided depending on what the contractors' expectations were. The services required by young women and recommended by the literature are currently inadequate and the key informants were calling for more preventative responses.

Lack of preventative measures

There was a lack of service provision reported at the primary level for maternal mental health and mental health issues generally. The maternal mental health specialist role was the only service identified that specifically addressed mental health in the perinatal period. However, there were a number of difficulties with the provision of this role that had implications for early intervention. Fiona lamented her inability in this role as maternal mental health specialist to assist women early, with the entry criteria meaning she would have to see women when they presented with more advanced issues:

> I considered that anybody that was presenting with some kind of psychiatric symptoms that were depressive symptoms, anxiety related symptoms, people that were clearly not coping with the situation that they were in, those sorts of people needed help and it was quite tragic I think that more often than not they presented in a very acute state of unwellness, either to our acute services or to a

> GP or emergency department, which I think is really sad again (*Fiona,* Nurse).

The maternal mental health specialist role being based at the secondary and tertiary level of health services meant the role was bound by the practices of tertiary mental health services it sat within. The strict criteria for entry into tertiary care and specialist services mean many women do not receive treatment. Thus, preventative measures are not introduced with women becoming severely unwell before they qualify for mental health services at this level. This is because, as identified in Chapter Two, psychiatric services are based on a diagnostic and medical based system focused on disease and deficit rather than health promotion. Instead, Falloon and Faddon (1993) recommend the placement of specialist staff at the primary health level rather than tertiary. Fiona agreed with such a change which could "look at women getting better antenatal care and getting better antenatal information for pregnancy related and postnatal issues related to their mental health".

A gradual "reduction", as Beth identified, in the support services available in the community has been noted. Due to this reduction of services and resources to deliver them, some key services have been ceased or reduced, such as home visiting. This is inconsistent with the literature that states services including home visits minimise access barriers to young women in receiving services and show beneficial effects for pregnancy related mental health issues (Fry, 2000; Sherr, 1995; Swann et al., 2003; Travis & Compton, 2001). Midwives continue to provide in-home support, however this is limited to twelve sessions. Other services providing home-based support, such as Plunket, have had to limit this due to resource constraints as evidenced in this quote from Beth:

> The nurses would go into the homes and do [...] whatever was needed to help take the pressure off the mum but we don't have any room for that now (*Beth*, Plunket Nurse).

This has occurred despite outcomes demonstrated by research, such as that conducted by Swann et al. (2003), showing an 80 percent reduction in child abuse rates and increased workforce participation amongst young women when home based nursing support was introduced perinatally.

Beth and Fiona likened current tertiary maternal mental health services to the "ambulance at the bottom of the cliff" where intervention is introduced after the incidence of disorder with little focus on how to maintain mental health. Beth felt "Preventative [interventions] is so much better". This inability to attend to women's needs in a preventative manner had some effect on Fiona in her role as maternal mental health specialist:

> I found at times that I felt frustrated and I felt disappointed with myself and our service because I didn't believe that we were actually dealing with what we should be really dealing with and that is I believe it should be prevention and education (*Fiona*, Nurse).

Conclusion

The data received from the four pregnant women, less than thirty years of age, and the health professionals working in the field of maternal mental health indicate a number of issues in delivery of mental health support in the perinatal period. The issues within and between agencies, such as lack of resources to deliver services even when they are demonstrated as effective, and poor collaboration between health professionals indicate how service structures defined through what is socially considered masculine traits continue to impede service delivery. The views of young women and their psychological processes identified by the health professionals in this chapter indicate how gendered constructions impact understandings of both youth and women. Using feminist and thematic analytical tools, examination of the themes presented in this and the previous chapter will be made in the next chapter. Recommendations for changes to policy and practice emerging from the analysis will be made in Chapter Eight prior to final conclusions and recommendations for further research.

Chapter 7

Analysis and Discussion

Introduction

Within the data collated for this research different priorities in perinatal mental health care and support have been identified between young pregnant women and the health professionals that work with them. While the young women may be seen by others as more vulnerable to negative effects while pregnant, they did not primarily see themselves in such a way. This reflects the different conceptualisations young women have compared to those within health services that continue to reflect gendered constructions of youth and women. In Chapter Five the young pregnant women also identified problems they saw within support services. The limited knowledge young pregnant women and health professionals felt they had regarding pregnancy related mental health issues and supports was concerning. Similarly, the responsibility for attending to this lack of knowledge was unclear amongst both the young women's and health professionals' reports.

In this chapter the above themes from the four participant interviews and four key informant interviews, alongside the information gathered from the literature review, are discussed utilising a thematic feminist analysis. The findings in Chapters Five and Six illuminate the praxis of a number of ingrained issues upon which young pregnant women's receipt of mental health support in the perinatal period stand. The way health services are constructed based on medical model and gendered assumptions regarding women and youth, reduces the support young women receive that could enhance their mental wellbeing in the perinatal period. How young pregnant women are treated in health settings is determined by these factors, and the prevalent views of young parenthood. Thus the chapter begins with perspectives regarding young pregnant women. Next, an analysis of the impact of gender constructions within mental health services is completed. The impact of medical model paradigms and how these, and market principles have influenced the construction of health services and policy is discussed.

Constructions surrounding young pregnant women

The health professionals interviewed held certain beliefs around the behaviours of young pregnant women. Societal views of young mothers as "at risk" or unable to recognise and attend to mental health and care and protection matters are prevalent throughout western cultures (Sherr, 1995). Young women are also more vulnerable to prejudices in the health system with judgments of what is "acceptable" behaviour placed upon pregnant young women and mothers (Price, 2007). This impedes young women's development of a socially and self-approved image of themselves without which sense of self is damaged (Chesler, 1997). This self-actualisation is essential for sound mental wellbeing within humanist approaches (Maslow 1999; Gutteridge, 2007).

Stereotypes of young pregnant women

The health professionals interviewed in the current research reinforced certain stereotypes of young pregnant women, including that they display more risk factors for negative health and social development. Both the Plunket Nurse and Mental Health Nurse interviewed felt young women carried increased risk factors for mental ill-health and other problems such as alcohol and drug misuse, with decreased insight into these problems. Within public policy and statutory services young women, particularly those who are suffering mental health difficulties, are seen as less able to care for themselves in pregnancy or for their children. Sherr (1995) and Price (2007) cite examples of this. Throughout the findings of the current research and within the literature 'risk' factors for young women are frequently identified. Risk factors become attributed to certain groups, such as young pregnant women, and are difficult for these populations to remove (Beckwith, 2000; Nash, 2001; Zeanah, 2000).

Risk factors are generally determined by health professionals rather than identified by young pregnant women. Within the participant interviews, pregnant young women were able to identify their own 'risk factors' some of which paralleled those the health professionals identified and some that differed as they were based on systemic issues. The participants identified costs of attending general practitioners and the lack of relationship building by GPs as concerns. However, the health professionals, reflecting how health models can focus on individual rather than systemic issues, did not overtly identify these systemic risk factors.

The health professionals indicated a range of preferred responses to 'risk factors' in young women. Clive, the GP, was clear that interventions should be targeted for high-risk women (such as teenage women, socially isolated women, and those with communication or personality issues) and that only those displaying certain risk factors should be assessed and referred for further input. Alternatively, Sally and Fiona, in their professional capacities as midwife and mental health nurse, preferred universally provided screening and assistance. Targeted interventions actively point out those populations deemed problematic (Leverton, 2005). This can reinforce stereotypes of what is acceptable or otherwise and makes it difficult for people to create an alternative framework of themselves. Universally introduced assistance indicates instead that seeking support is not abnormal but acceptable and at times required by all. Regardless of the debate about 'risk factors' any young woman may need increased support, psychologically or developmentally, to understand the infant and themselves and to work through the developmental stage of pregnancy.

The prevalent stereotypes of young pregnant women were not reflected in the interviews with the four participants. Instead, the four participants were motivated and focused on the wellbeing of their unborn child, often contending with difficult life circumstances. They demonstrated selflessness in wanting to be involved with the research so that they could share their experiences and help other young women. Shakespeare (2005) also found young women do not identify with the labels used to describe them. While health professionals utilise health jargon to criticise behaviours of young pregnant women, two of the young women interviewed attempted to frame their comments about health professionals in a non-critical way, even when they felt they had not been given full services.

Blame and stigmatisation

The young pregnant women interviewed tended to blame themselves for aspects of their situation. This self-blame was identified in the interviews when women were perceived as living within negative circumstances or not meeting others' expectations through their pregnancy and planning. Even if the young women's needs were not being met by health professionals the participants would question whether this was because of something inherently wrong with them. This reflects the ingrained women-blaming that occurs within western societies that blame the young woman for her individual actions, or blame the young woman's own mother for not socialising her correctly (Chesler, 1997). Such blame emerges from societal values inherent in matters of youth pregnancy that surround illegitimacy, perceived promiscuity and moral behaviour, and the family (Chesler, 1997; Sherr, 1998). The time spent with the participants demonstrated how the women were coping in sometimes very difficult circumstances and how their families supported and accepted them without buying into a cultural perception of the situation as an offensive one.

The trauma experienced by marginalised groups is compounded when they are blamed and pathologised for their situations within health and social systems. This is often the case for young mothers who are blamed for becoming pregnant and engaging in socially unaccepted behaviours (Sherr, 1995). Health professionals can become the enforcers used by society to resolve these behaviours (Chesler, 1997). A social work role becomes important in mediating this trend as one of the commitments of the Aotearoa New Zealand Association of Social Workers is "to advocate for full social justice in Aotearoa New Zealand and address oppression on the grounds of race, gender, disability, sexual orientation, economic status and age" (Aotearoa New Zealand Association of Social Workers, 1993, p. 22).

Young pregnant women who suffer decreased mental wellbeing have dual sites of stigmatisation through judgments of both youth pregnancy and mental illness. Young women are often held responsible for any health problems they suffer or when they are seen as not seeking help proactively (Gutteridge, 2007; Hall, 2007). This was reflected in the research findings as Fiona, Nurse, recognised that young women could be identified through their pregnancy as needing attention for certain issues thus triggering engagement with health professionals. The literature base surrounding young pregnant women identifies also how mental health services are used to pinpoint women who may be seen as unfit to care for the child (Sherr, 1995, Price, 2007). These methods of identification and intervention, both of which are seen as more acceptable to impose on young pregnant women, do not recognise the impacts of social contexts (Gutteridge, 2007; Hall, 2007; Phoenix, Woolett & Lloyd, 1991; Sherr, 1995; Travis & Compton, 2001; Wakschlag and Hans, 2000).

Physiological definitions

Pregnancy is a time of extensive physical change for young women and is the greatest physiological process women go through. The health professionals interviewed referred to levels of anxiety and adjustment concerns of young women due to pending motherhood; however, few recognised other contexts the young women were in that were not connected to their biological states. This conceptualisation is so ingrained in New Zealand society and the medical system that the young women interviewed unknowingly maintain it themselves by referring primarily to physical issues and minimising emotional responses to their social circumstances (Gutteridge, 2007).

Developmental stages of adolescence and early adulthood

Young women face conflicting messages. On the one hand, as was demonstrated in the key informant interviews, they are seen as naïve and dependent upon others. On the other hand, they are expected to be independent and contribute meaningfully to society, with judgements made if they are deemed too dependent. Health professionals may hold fears of creating 'dependency' in young female clients and at times provide limited treatment due to this fear.

Cheyne et al. (2007) identify 'dependency' as having highly judgemental connotations. Fears of creating welfare dependency in young parents have influenced government policy (Cheyne et al., 2000). The reduction of income support is one example of a shift in focus towards reciprocal obligations where receiving such support ceased to be a right of citizens. Both female gendered attributes and youth characteristics imply a state of dependency at times. This is particularly the case when reproductive capacities of women are considered as pregnancy and child-rearing are seen to cause the women and child to rely upon others. Pejorative terms such as 'dependency' do not account for the contribution of motherhood to society.

Giddens (1997) identifies that adolescence and early adulthood is a difficult time. Young people are completing adult activities but are often still treated as children in law and in the views of other adults. Similarly, they may be expected to cease engaging in what is considered childish activities despite their developmental levels. Fry (1998) also recognises the prevalent myth in New Zealand society that women automatically become adults when they become pregnant regardless of their age. These expectations also extend to contribution to the workforce with negative attitudes towards young pregnant women forming in consideration of their perceived economic contribution or cost. Three of the four young women interviewed referred spontaneously to their employment and educational plans despite this not being a part of the interview schedule. That the young pregnant women felt a need to justify their future plans demonstrates the devaluing of our society on women's work within the family for an economic focus that determines a person's worth by their contribution to the national economy (Price, 2007). On an individual level the references also reflect the importance of having a sense of mastery and productivity to wellbeing. However, overwork and stress are major triggers to women's ill-health (Hall, 2007).

Conceptions of health

What is considered healthy is an individual decision (Hall, 2007). The young pregnant women interviewed had very different backgrounds and cultures which impacted on their conceptions of what is healthy and meaningful to them. However, the health professionals had few mechanisms to capture this meaning of mental wellbeing for young women. When one of the participants, Sarah, referred to emotional lability connected with hormonal changes of pregnancy, she minimised this as not significant and labelled her emotions as overreactions. Sarah did not seek assistance with these matters, coping with them alone. Gutteridge (2007) has recognised the propensity of women to do this because their emotional health needs are ignored or seen as an individual problem by wider society and health professionals. The health professionals interviewed inadvertently strengthened this by avoiding attending to young women's social circumstances and mental health in the perinatal period.

The literature base warns that perinatal interventions can further marginalise minority groups. Three of the participants received information in pamphlets but women who do not have good literacy skills will not be able to discover support services and information in this manner. Similarly, women who do not have sufficient financial resources, such as for transport, may not access services they need. This, coupled with the reduction in home visiting identified in Chapter Six, further discriminates against poorer women and youth. Thus, health inequalities can be worsened (Shakespeare, 2005).

Gendered nature of mental health services

Women and mental health

Women are overrepresented within most mental health statistics both in New Zealand and other western countries. The age range in which women continue to outnumber men in mental health services is 10 to 39 years (Fry, 2001; Price, 2007; Styles, 1997). Travis and Compton (2001) question whether higher rates of certain mental health issues mean there is actually a higher morbidity in women or whether they are reflective of socially constructed gender roles or a gender bias in psychiatric diagnosis. Women continue to be treated subordinately under the biological model, which has dominated New Zealand's mental health system for many years even after other countries had become more eclectic in their understandings. Such a model pathologises women's behaviours as mental illness rather than socialised behaviours exhibited in a cultural context (Chelser, 1997; Marland, 2001; Showalter, 1981; Travis and Compton, 2001).

Mental illness defined through gender

A social construction of manhood affects how both males and females are treated within health systems, demonstrating the relationship between gender, psychiatry and the state (Bell & Brookbanks, 2005). Conceptions of "wellness" have been linked with masculine traits while the female form became culturally associated with hysteria and insanity (Chesler, 1997; Labrum, 1990; Showalter, 1985). Eventually the focus narrowed to motherhood and reproduction as, at no time is womanhood more obvious, physically, than during pregnancy and birth. Gendered constructs detract from the provision of effective services. Young women are expected to fit into services and health structures created by people who are not connected with youth issues but can carry negative stereotypes (Price, 2007; Shakespeare, 2005). Young women are often blamed for their lowered uptake of mental health and general health services; however, matters not acknowledged are the barriers that may be impeding this help-seeking. If services are not youth-focused young women are less inclined to seek help (Shakespeare, 2005).

Youth and health services

Creative ways to reach youth populations are required. Clinical experience shows that young women access supports for shorter periods of time. They often have limited transport or other access barriers and, as Charisma identified in her interview, they may have partners or family that are unsupportive of their therapy. Additionally, young women desire clear connections between the supports available and their goals. The young women interviewed all discussed aspects of health services they did or did not respond to. For example, interpersonal styles of some health professionals meant the young woman did not engage. As an alternative use of technology, such as text messaging was more helpful.

The current research revealed there were few services created by young women for young women. Reference was made to one youth-friendly pregnancy service and one women's centre the latter of which was resourced minimally and not specifically for pregnancy matters or mental health. Primarily, young women are expected to have their needs met in male-centred services (Price, 2007). The maternal mental health specialists being placed within the adult mental health team is one example and is concerning considering the specific mental health issues young pregnant women face. Many young women present with the impacts of trauma and domestic violence that can be triggered within services males attend and that are dominated by male professionals (Price, 2007). This occurs at a time when the young women are already emotionally vulnerable (Price, 2007).

Power and advocacy

The health professionals interviewed indicated an acceptance of attending to perinatal mental health and a desire to have services to do this. The literature base states addressing young women's perinatal mental health is essential and has beneficial outcomes for mothers, families, and infants. However, provision of services, policy, support, and education for perinatal mental health issues continues to be minimal (Price, 2007). If this is not being impeded by health professionals, consumers, the evidence-base, or funding, one further explanation is that it is being prevented from placement on the political agenda due to sexism within health and political systems.

There was little indication from either the health professionals interviewed or the young women participating in this study as to who is acting as advocates for young women within such systems. Price (2007) states an advocacy role is needed to ensure women-centred interventions are received by young women believing this is the role of the midwife. The interviews with young women indicated a level of frustration that minimal services were offered to them in the perinatal period but also a resignation to this. Similarly, while the health professionals interviewed indicated frustrations with the delivery of perinatal mental health support to young women, and clearly stated their beliefs as to the problems causing this, none identified action they took to act on behalf of their clients. This reflects the relative powerlessness of particularly the three female health professionals (the male GP interviewed indicated feeling more confidence in his work) and the young women, within health services.

Impact on health professionals

One of the implications of maternity care policy changes in the early 1990s is that midwives are now expected to care ante and postnatally for women's physical and mental health in pregnancy (Ross-Davie et al., 2005; McLaughlin, 1993). Midwives are required to have the skills in questioning and the sensitivity to screen for mental health and social issues such as domestic violence. Due to research demonstrating the effect on the foetus of alcohol and drug use they must have the skills of an alcohol and drug counsellor to assess this and complete policing roles for those issues related to socially unacceptable behaviour and the care and protection of the child. Authors such as Ross-Davie et al. (2005) and Price (2007) also believe midwives have an advocacy role for young women through negotiating contact with additional services that are becoming less available. Without discounting the varied skills of the midwife, and the benefit to women of having one health practitioner attending to their holistic maternal needs, this extent of intervention is unrealistic. The expectations placed on individual health professionals to work with less human and financial resources reflect the reduction of services and supports to young women in the perinatal period.

Concepts of pathology

In a particular cultural context, notions of gender influence the definition and, consequently the treatment of, mental disorder (Showalter, 1985). From the research data young pregnant women and health professionals referred to depression and anxiety as potential mental health issues faced by young pregnant women. Depression and anxiety have become more socially acceptable disorders for women, as reflected in the prevalence rates of the diagnosis of these disorders for women aged 10-39 years (Abramowitz, Larsen & Moore, 2006). There is a propensity to assign such diagnoses, which individualise problems rather than acknowledging their social causes. No recognition was made of other presenting mental health issues that may be less endearing or reflect 'non-feminine' behaviours, such as alcohol and drug addictions. Similarly trauma, which can be triggered during pregnancy and childbirth, was not referred to in the key informant interviews.

Shakespeare (2005) found evidence that women do not want to be screened, or labelled 'depressed' and in fact often do not consider themselves depressed. The young women interviewed did not appear to associate with such language instead identifying their own terminology that was meaningful to them. This demonstrates the importance of allowing women to categorise their own experiences, rather than having labels enforced upon them. Beth, Plunket Nurse, recognised this in her belief that support services should not be termed "mental health" but should have recovery-focused terminology chosen by consumers.

Social control

In Chapter Six it was identified that pregnancy can be a gatekeeper to identify young women who have difficulties. Using pregnancy to triage young women has been misused in the past (Naples, 2003). Enforcement of service access for young women at this stage brings an element of paternalism that Labrum (1990) identifies as reflecting New Zealand's early mental health system. Women have been targeted by health services when presenting in pregnancy to ensure they are being "good" prospective mothers. Chesler (1997) has identified mental health professionals as empathic police for society, monitoring social roles and expectations. Mental health policy and legislation has historically held this dual role of social control and care for patients. Young women can have valid fears of statutory services as this contact may be influenced by the stereotypes of young mothers discussed previously (Leverton, 2005).

Help-seeking

While help-seeking of women has generally been more accepted than that of men, this does not mean young women are always treated respectfully when they seek assistance (Chelser, 1997). Instead help-seeking behaviour of women has historically been deemed problematic. Sally, the midwife interviewed referred to "nuisance" patients being "labelled" as "demanding" by mental health services. A pejorative response may occur between women. While informing people of this research one female clinician in a leadership position warned me to be wary of "putting ideas into women's heads" suggesting the participants may take my interview and pathologise themselves. Such responses directly reinforce the self-stigma experienced by the young women interviewed where they were reluctant to seek help in fear of negative reactions from health professionals (Dearman, Gutteridge, & Waheed, 2007).

Validity of professional experience

Three of the four health professionals interviewed were women. These female professionals often undervalued their professional judgment. Sally, the midwife, made comments that she is not good enough with mental health needs whereas Clive, the doctor, repetitively verbalised his competence. It is more acceptable for male health professionals to do things on intuition and doctors have had the freedom to diagnose, treat, and medicate (Barker, 2005). This has continued even when there are extensive reports across history of inappropriate treatment by the medical profession (Showalter, 1985).

Influence of the medical model

The interviews conducted with health professionals illustrate how economic and ideological perspectives of major institutions influence clinicians in health settings. This includes psychiatry, which supports a medical model. Psychiatric constructs based upon male-attributed characteristics have been utilised throughout mental health. These have created narrow definitions of mental health based on disease as opposed to a health focus that affects the understandings of the community where more holistic, encompassing definitions of mental health continue to be lacking.

Compartmentalisation of health issues

The compartmentalisation of health services and lack of collaboration between services identified by Sally, Fiona, and Clive reflect a medical-diagnostic process of labelling young women's issues and separating them out to be treated by specialists. The separation of mental and physical health needs, and attempts to define a woman in parts, rather than holding a holistic view means women do not receive the treatment they require. Alternatively, as was reflected in the data, other professionals try to meet the wider needs despite lacking training and support to do so. Ross-Davie et al. (2005) recognise the negative effect the medical model has on the relationship between a woman and her midwife as midwives have medical and physical matters they attend to in a way that is consistent with medical model practices. This has weakened the extent of mental health support given to young women by midwives as identified by Sally, the midwife's comments. With these limitations alternative causal factors for perinatal mental illness that may exist outside of a medical model understanding are not attended to (Nash, 2001).

Medical authority and links with masculine attributes

The comments made by the participants regarding contact with the GP indicate the daily expression of a medical model. GPs are expected to consult with women in a very limited time frame. However, in fifteen minutes the doctor cannot, as recommended by Hall (2007), attend to the young women's physical, mental, spiritual, social, and cultural needs required for well-being. Instead, women see numerous health providers to have their needs met as recognised by Clive, the GP, in the number of "others" in addition to the GP women access.

Within health care systems there are clear hierarchies of authority delineated amongst medical personnel. These hierarchies can become rigidly defined and impermeable under a biomedical understanding but are unhelpful for young pregnant women (Hall, 2007; Zeanah, 2001). Cohen and Nonacs (2005) identify that doctors' roles are limited to medical treatments and this limitation was recognised by the other key informants in their reluctance to refer to the GP. Cohen and Nonacs suggest this is why mental health needs of pregnant women are not attended to by GPs as the dangers of medicating in this period mean other treatment options are required. The limited provision of non-pharmacological treatments enhances the dominance of a medical model, as women often have to engage with medical treatment because of a lack of available alternatives.

Avoidance of mental health and mental health promotion

From the data it appeared easier for the health professionals to attend to physical health issues, rather than mental. Such a focus on physical matters reflects problems inherent in a medical model understanding of health as mental health presentations do not easily lend themselves to a medical model analysis (Donelly & McGilloway, 2007). Rather than acknowledge the problems inherent in a medical paradigm, mental health matters are avoided as they highlight these deficits. Boyce and Bell (2007) lament a phenomenon where advances have been made in the physical care of young pregnant women but little is done towards mental health needs. Additionally, a disease and deficit focus leads to a lack of emphasis placed on promotion of mental wellbeing. It is not just the absence of mental illness that is necessary for wellbeing but the creation of a life worth living (Magyary, 2002). The earlier identification that pregnancy may trigger a young women's first contact with health services presents an opportunity to assess women at a critical period to ensure their overall health and psychological state.

Construction of health services

The key informant and participant data illustrated that the current health system did not allow for appropriate support, identification and treatment. Sally, midwife, realised that unsupportive working environments that did not promote a treatment team approach, ongoing education, and flexible conditions reduced the midwifery workforce and subsequently the ability to meet the needs of young women. Characteristics of current health services that impede delivery of appropriate services to young pregnant women included: poor quality improvement; issues with staffing such as, poor staff retention, limited ongoing education, and lack of flexibility of hours; low commitment of the institution to the mental health interventions; poor patient education; and processes of auditing and follow-up. Shakespeare (2005) states when these characteristics are resolved within health services there is a ten to thirteen percent reduction in risk and a seven to ten percent decrease in patient depression. This was reflected strongly in the key informant interviews with Sally, Beth, and Fiona bemoaning the lack of support to staff through the omission of process such as cohesive treatment teams, and cross-service and multi-disciplinary treatment plans.

Funding and competition

All four of the health professionals recognised barriers created for young women in accessing appropriate supports by the construction of health and support services. Beth, Fiona, and Sally in particular identified the constraints of contractual funding that impede collaboration. Under contractual funding arrangements services have to bid against one another for reducing resources. This directly decreases collaborative efforts and transparency by forcing services to compete for resources (National Health Committee, 1999). This directly disadvantages women with mental health needs as the National Health Committee state such women are best served by having both their GP and midwife involved throughout their pregnancy. The key informants also witnessed the effects of funding methods on the provision of secondary maternal mental health specialist services and the reduction of this, and key community-based services. Alterations to the delivery of perinatal mental health have focused upon the best therapeutic intervention rather than how changes to health systems and processes are necessary (Shakespeare, 2005).

Lack of preventative measures

The problems inherent in the current provision of perinatal mental health supports to young women due to the construction of health services was verbalised by Fiona:

> I think that if there is an opportunity to see people early on the piece, rather than ambulance at the bottom of a cliff, once you've got an illness then we see you, it's just all wrong, it just doesn't make any sense (*Fiona*, Nurse).

Fiona and Beth (Plunket Nurse) felt services were practicing in the reverse manner; they were reactive rather than preventative and medically based as opposed to holistic and client-centred. The lack of early intervention services identified in the research data mean women do not receive preventative services and are more likely to become acutely unwell. The low rate of diagnosis of maternal mental illness in primary care and subsequent lack of services is also identified in reviews of maternity care (Health Funding Authority, 2000).

Individualism

Shore (1998) attributes the minimisation of preventative measures, policies, and services to ideological changes within social and health policy. In New Zealand social reform of the mid 1980s undermined community and whanau structures in place of individualism and self-progress (Cheyne et al., 1997; Durie, 1998). Karen (1998) has identified a similar process occurred in the U.S.A. where ambition and competition reduced community living and attachments. This has had ongoing negative effects for many groups, particularly children and women, and has actually incurred increased costs in health and welfare (Shore, 1998).

> The public health consequences of...these effects are substantial, even if the effects themselves are subtle (Lester, Boukydis & Twomey, 2000, p. 171).

An essential component to women's wellbeing during pregnancy demonstrated by both the participant and key informant interviews was informal support networks. Connections to safe familial and peer supports and a local community are a key determinant of sound mental health (Magyary, 2002). A focus upon individualism and competition within health and social policy has directly intruded on whanau, hapu, iwi, and community relations and this must be addressed for strong communities and individuals (Cheyne et al., 2007; Durie, 1999). The problem identified by the health professionals was for those women who are isolated and do not have appropriate and consistent support. Such supports are not being re-created or attended to within health services. Instead, the onus is placed on family to attend to those areas health services cannot provide due to limited resources. Such practices exacerbated problems when the familial support to young women is either dysfunctional or ill informed which the key informants had experience of.

Policy

Young women have clear roles in production and domesticity making them vulnerable to effects of social, economic, and health policy (McRobbie, 1978). Biological sex runs through all other differences (Lewis, 1981) and women were more susceptible to changes in the family and economy, compounding these effects. Gender roles inherent in our societal organisation create misnomers and unwanted effects in policy delivery (Babbie, 2001). From the research the health professionals and participants noticed the effects of health and social policies and appeared to recognise and be frustrated by the implementation of policy, but have little input into it. Despite those health professionals involved in the research being affected by health and social policy on a daily basis, they struggled to identify those policies that inform their practice. In her awareness of the Health and Disability Act that directed aspects of her practice as a midwife, Sally recognised that other professionals were not meeting their obligations to women under this policy but there did not appear to be any means of addressing this

State sector marketisation

Since 1984 New Zealand's state sector has primarily followed a market allocation of goods and services. The effects of this marketisation, where social welfare services are opened to principles of supply and demand, payment for goods and services, and commercialism similarly to the private sector (Cheyne et al., 2000) is reflected in this research. Again, these principles governing market models, similarly to those within a bio-medical model, are associated with male-defined attributes and influence the delivery of services. Beth, Plunket Nurse, identified that health is now run "as a business" pointing out the difficulties with ascribing a market model to health.

Cheyne et al. identify that marketisation has reinforced the "multiple", "uncoordinated" sites of access, competition, and individualism of economic markets (2000, p.122). Hierarchies of control became more evident as chief executives were strengthened in social and health services to introduce managerial principles such as those utilised in market companies (Cheyne at al., 2000). This is identified in the research where the poor coordination and collaboration between services, retraction of government funded services, and competition for funding and resources are spin-offs of state sector reform that was designed to reduce the governments role in providing services and reduce state spending. Such control and hierarchical relationships are also reflected in the Health Funding Authority's recognition that midwives have been impeded from referring directly to mental health services in some areas (Health Funding Authority, 2000). However, New Zealand government currently acknowledges the failure of market principles in some fields, continuing to have a part in social welfare provisions through legislation and social and health policy.

Primary Health Organisations

The "Review of Maternity Services in New Zealand" (National Health Committee, 1999) recommended reintegrating maternity care into primary health settings. Fiona also advocated this for through the key informant interviews. The introduction of Primary Health Organisations (PHO) created an opportunity to follow through on this recommendation; however, it has taken sometime to establish PHOs in the locality the research was conducted. The GP interviewed was confused at the researcher's questioning about the PHO in the area and could not see the role this would have in perinatal mental health. However, the PHO, when implemented the way it was intended under the Primary Health Care Strategy has numerous implications for young women's perinatal mental health. Two of the aims of the Primary Health Care Strategy was to firstly reduce health inequalities, and secondly to increase utilisation of primary health (Cummings & Gribson, 2007). This is significant due to the concerns identified in this and the previous chapter of young women's low uptake of health services and the propensity of health services to increase marginalisation of youth and women.

A recent interim review of the PHO and Primary Health Care Strategy indicate that these two areas are improving (Cummings & Gribson, 2007). Consultation fees have reduced for all populations, an issue that one of the participants identified triggered her change to a GP within a PHO. While access to consultations has increased for all populations this increase is lowest for the age group this thesis is concerned with. This demonstrates ongoing access barriers for youth that are beyond to the barrier of cost. PHO's can receive additional funding for strategies that increase access for their population (Cummings & Gribson, 2007).

Conclusion

Within maternal mental health the problems inherent in mental health and maternity support and policy become apparent. These problems have arisen from the negative stereotypes of young pregnant women, the categorisation and compartmentalisation of services, competition for resources, rigidly defined roles of health professionals, and a hierarchy of authority in delivery of services and are influenced by the highly gendered constructs of youth and women. The messages received from these gendered constructions of social practices are often conflicting for young pregnant women. Services then become inappropriate in many ways for young pregnant women.

The examination of the structural and social processes impacting upon youth pregnancy and maternal mental health is vital in understanding epidemiology and service responses. Service structures subtly continue to control women's health and reproduction through the dominance of the bio-medical model and diagnostic criteria that further marginalise women. The medical model and diagnostic criteria do not allow for prevention or early intervention for young pregnant women, a provision that, if in place and created appropriately, could be empowering and reduce the burden of perinatal mental illness for women and families. The final chapter of this thesis outlines a number of suggestions of how to work towards achieving this and creating services that are preventative, and youth and women focused. Recommendations for adjustments to current service provision and policy are made as well as requirements for further pilot services and studies in this field.

Chapter 8

Recommendations & Conclusions

Introduction

Characteristics that are gender constructed, such as competition, individualisation, control, and roles that are hierarchical and rigidly defined have negatively impacted young pregnant women's receipt of mental health services in the perinatal period. These characteristics have become imbedded in societal and health systems through marketisation of the state sector and dominance of the bio-medical model in health. The impacts of these issues were analysed in the previous chapter from the data reported in Chapters Five and Six. These issues need to be altered to address the gendered construction of health services that impact young women's mental health. Recommendations of how to change these structures are outlined in this, the final chapter of the thesis.

Recommendation One

Incorporate feminist principles into women's health strategies by allowing for context, enhancing access, and meeting international obligations.

- Consider social context by including social and familial circumstances of young pregnant women in assessment.
- Reduce access and treatment barriers for minority and subjugated populations with attention to individual needs based on ethnicity, socio-economic status, or age.
- Retract disadvantageous funding schemes
- Reinstitute women and youth centred services ensuring consumer input into these.
- When confirming pregnancies health professionals should assess women for other health and social variables that may impact on their wellbeing.

Recommendation Two

Provide for early intervention and preventative efforts by strengthening primary mental health care in public health services and increasing mental health promotion and education. Incorporate risk reduction and protective enhancement within primary care.

- Continue to address mental health stigma by altering deficit-based labels.
- Increase multi-media campaigns to promote awareness of positive mental health during pregnancy to prevent wasted and ineffective costs at secondary and tertiary mental health levels.
- Educate primary health professionals to promote awareness of mental health in the perinatal period.
- Provide for community connections through promotion of support and networking services for young pregnant women and mothers.
- Continue to extend Primary Health Organisations (PHO) to be accessible to young women in the perinatal period.
- Maximise PHO's by incorporating mental health professionals to provide mental health services and assessment and facilitate referrals to secondary services.
- Incorporate social work positions within PHOs to complete social assessments and deliver relevant information and support options.
- Ensure mental health information and education is provided to all pregnant women.

Recommendation Three

Assess women for risk and protective factors as well as signs of mental ill-health regularly throughout pregnancy and postnatally.

- Educate primary health professionals of the demographics and factors that trigger increased risk for perinatal and maternal mental illness.
- Enhance midwifery practice to provide early identification and intervention for mental illness as part of the perinatal care midwives provide.

- Introduce evidence-based tools such as the Edinburgh Post Natal Depression Scale to screen all women as part of routine ante and postnatal care.
- Implement a national health policy to mandate the screening and assessment of emotional, psychological, and family and social issues in pregnancy with appropriate follow-up referrals. If managed appropriately this would not be costly but would enhance early identification and intervention for those women demonstrating risk factors for maternal and infant mental health and social issues.

Recommendation Four

Attend to the midwifery role and midwifery workforce issues.

- Provide compulsory maternal mental health training and education to all midwives and Lead Maternity Carers.
- Improve the compulsory assessment of mental health history at antenatal booking by providing guidelines surrounding effective and sensitive questioning and follow up referrals and support.
- Ensure midwives are aware of the support services available in their area through encouraging networking meetings, and development of local directories and social service mapping, preferably electronically based.
- Provide equal recompense to health professionals completing the same role, regardless of whether they are independent midwives, hospital midwives, or general practitioners.
- Provide equal funding allocations for each woman in pregnancy rather than having funding dependent on which professional the women chooses for their lead maternity carer.
- Allow for flexibility of hours, job-sharing options, and ensure fair pay for midwives.
- Incorporate policies encouraging young people to study midwifery such as incentives including subsidies for training costs for those prepared to remain bonded in New Zealand for a period of work.
- Encourage DHBs and other LMC employers to evaluate and explore supportive work place changes.

Recommendation Five

Improve the Maternal Mental Health Specialist role by exploring placement of the specialists, enhancing awareness of the role and altering entry criteria to be more responsive.

- Relocate specialist mental health staff to community and primary services.
- Recognise the above point through alterations to Regional Specialty Services funding by transferring funding to primary health.
- Ministry of Health collaborating with DHB's should assess the level of need in each geographical area and fund accordingly as well as assess access barriers in each community and work to reduce these. Prevalence and incident rates of maternal mental illness are known, as are statistics for pregnancy rates in District Health Boards. Thus estimates can be made of the number of women maternal mental health services should be treating and this can be audited ensuring services are balancing need and capacity.
- Standardise entry criteria across DHB regions to remove variability in current service provision.
- Resource maternal mental health speciality teams appropriately to ensure they have the capacity to meet the identified need in each region with multi-disciplinary input. If this is not allowed for under DHB provisions the maternal mental health specialist *team* could be contracted to another service more willing to utilise Ministry of Health funding efficiently.
- Ensure maternal mental health specialists are specialist trained and are given support to attend appropriate trainings, conferences, and specialist studies.
- Allow time for the maternal mental health specialists to promote the role and network with LMC's and appropriate services.
- Enhance national provisions for emergency and rapid responses to women in acute need by trained maternal mental health clinicians.

Recommendation Six

Utilise social workers to complete holistic and strengths-based assessments and increase social work services.

- Utilise social workers to complete assessments of social, cultural, and spiritual needs. Such assessment is a common practice of social workers who can explore the context of young women's lives.
- Utilise the social work role to coordinate services and advocate for women to reduce access barriers.
- Increase social work services including family therapy and solution-focused and other therapeutic assistance.
- Situate social work positions within Primary Health Organisations.
- Increase social work services, including after hours support, in secondary and tertiary services so urgent social issues, such as abuse or domestic violence, can be assisted.

Recommendation Seven

Reduce access barriers and enhance support services that are currently ad-hoc and uncoordinated causing wasted resources.

- Provide primary services free of charge or at very low cost.
- Increase home visiting and continued resourcing to agencies such as Plunket to maintain supportive home visits.
- Enhance women and youth-friendly services.
- Strengthen and coordinate current support services
- Alter competitive funding schemes of contracting to instead encourage and reward collaborative efforts. Allocate funds for the complete needs of women perinatally rather than for individual services.
- Encourage the building of professional relationships through dual trainings and conferences. Utilising the skills or specialist knowledge within services by having these services provide training to one another celebrates clinicians' knowledge and experience and is an economic form of training and networking.

- Introduce a national networking system such as the 'Mother-Infant Network' set up in parts of Australia. This would not be costly to introduce and systems have already been devised that could allow those working with women to follow electronically the other health and social services young women are receiving. The technology is available to follow through with such a recommendation which could also be utilised to track risk factors that have been assessed such as domestic violence and risk to self or others reducing repetitive, resource intensive assessments.
- Continue to support an after hours phone line to provide support and information to parents and young pregnant women.
- Utilise technology such as the internet, interactive sites, and text messaging to create more youth-centred services. Multimedia educative tools are also useful in presenting information in a way that is relevant for young people.

Recommendation Eight

Create a specific national directive and policy for maternal mental health through the Ministry of Health with directives to statutory primary, secondary, and tertiary services. The development of best practice guidelines for maternal mental health would publicise New Zealand as advanced in the field as other countries continue to recognise the need for such guidelines.

- Develop and implement an evidence-based national policy to provide resourcing and mandates to all geographical areas in maternity and mental health.
- Develop evidence-based guidelines for maternal mental health including referral to specialist services if women have previous personal or family history of mental illness and pathways for referral to additional services. These may include addiction services or other social and relationship services.
- Review every incident of maternal death for cause of death and, particularly when the cause of death is related to mental illness or

suicide, analysis of what occurred to explore gaps and problems in identification and treatment.

- Integrate maternal mental health policy across state sectors modelling collaborative efforts at the ministry level. Improved relationships and shared resourcing is necessary to key services and departments particularly between all mental health and maternity services and between these services and care and protection, family, and income support services.
- Provide education across relevant state sectors alongside memorandums of understanding between mental health and care and protection departments and services to produce guidelines on how to best respond to young pregnant women. These efforts will interlock with the goal of reducing stigma through the current Ministry of Health 'Like Minds Like Mine' project.
- Assess individual communities and geographical areas through DHBs, local councils and further research efforts to evaluate current resources within communities which may be extended while meeting the gaps identified. This would save resources as opposed to a model that enforces certain services in each community regardless of what is naturally occurring.
- Utilise strengths based models of social policy development to allow young women to take an extended role in shaping their own needs and subsequent services. This may be facilitated through the social work role or further research in the field.

Recommendations for further research

Nationwide the introduction of perinatal assessment of mental health history and risk factors at critical stages of pregnancy by lead maternity carers needs to be piloted and its effectiveness evaluated. Similarly piloting service provisions and supports containing the alterations recommended here and with education provided to young women in pregnancy would require longitudinal study of outcomes of this for women and their children to assess the long term benefits this has. Localised studies assessing community resources, strengths, and gaps in perinatal mental health and services for young women will be necessary. Simultaneously, larger exploration than that which this research could realistically provide needs to occur with young pregnant women and new mothers surrounding what they feel their needs are regarding mental wellbeing, and what this means to them. This is particularly the case for non-European women who will have specific maternal mental health issues and needs.

Conclusion

This aim of this research was to explore the mental health support and information provided to young pregnant women in the perinatal period from the perspectives of both young pregnant women and health professionals. Key findings of the research have been the inadequacy of maternal mental health services and information provided to young pregnant women caused by fragmentation of current service delivery, compartmentalisation of services and rigidly defined roles with these services, and a lack of preventative and primary care interventions. These issues are exacerbated by the continued dominance of the medical model and market principles within state health services. Pregnancy is a time of emotional, physical, and environmental change and personal development for young women. It is the infants' introduction to the world and, oftentimes for young parents, their introduction to hospital and health services and policy. Maternity and mental health services need to be developed in ways that reduce the barriers facing young pregnant women and new mothers for ease of access and improved identification of vulnerable women and what they require at different stages of their pregnancy, birth and postnatal experience.

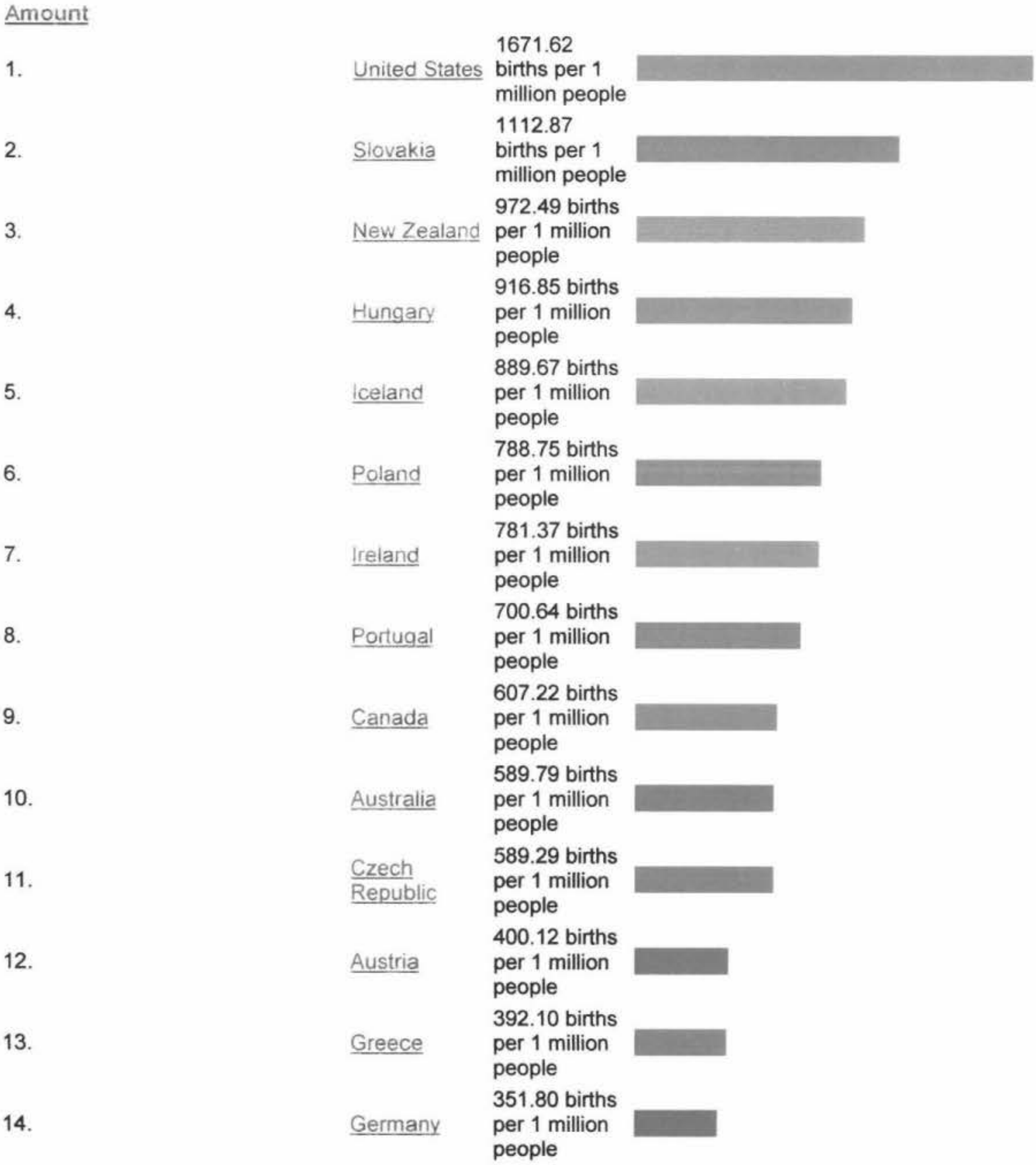
Appendix One

Figures and Tables

Table 1: International teenage fertility rates

Teenage Pregnancy Per Capita

Definition: Number of births to women aged below twenty. Data for 1998. Per capita figures expressed per 1000000 population.



Amount

1.	United States	1671.62 births per 1 million people	
2.	Slovakia	1112.87 births per 1 million people	
3.	New Zealand	972.49 births per 1 million people	
4.	Hungary	916.85 births per 1 million people	
5.	Iceland	889.67 births per 1 million people	
6.	Poland	788.75 births per 1 million people	
7.	Ireland	781.37 births per 1 million people	
8.	Portugal	700.64 births per 1 million people	
9.	Canada	607.22 births per 1 million people	
10.	Australia	589.79 births per 1 million people	
11.	Czech Republic	589.29 births per 1 million people	
12.	Austria	400.12 births per 1 million people	
13.	Greece	392.10 births per 1 million people	
14.	Germany	351.80 births per 1 million people	

15.	Norway	349.88 births per 1 million people	▬
16.	France	296.50 births per 1 million people	▬
17.	Belgium	287.05 births per 1 million people	▬
18.	Finland	284.31 births per 1 million people	▬
19.	Spain	279.21 births per 1 million people	▬
20.	Luxembourg	236.89 births per 1 million people	▬
21.	Denmark	213.73 births per 1 million people	▬
22.	Italy	191.95 births per 1 million people	▬
23.	Sweden	178.29 births per 1 million people	▬
24.	Netherlands	172.06 births per 1 million people	▬
25.	Switzerland	145.81 births per 1 million people	▬

Table 2: Number of teenage births per country

Number of Teenage Births

Definition: Average number of births for every 1,000 girls aged 15 to 19

Amount		
1.	United States	64
2.	Czech Republic	46
3.	Slovakia	44
4.	Hungary	41
5.	New Zealand	35
6.	United Kingdom	33
7.	Iceland	29
8.	Poland	28
9.	Canada	27
10.	Portugal	25
11.	Austria	23
12.	Greece	22
13.	Australia	21
14.	Norway	19
15.	Ireland	16
16.	Luxembourg	13
17.	Germany	13
18.	Finland	13
19.	Sweden	13
20.	Spain	12
21.	Belgium	10
22.	Denmark	10
23.	Italy	9
24.	France	9
25.	Netherlands	7

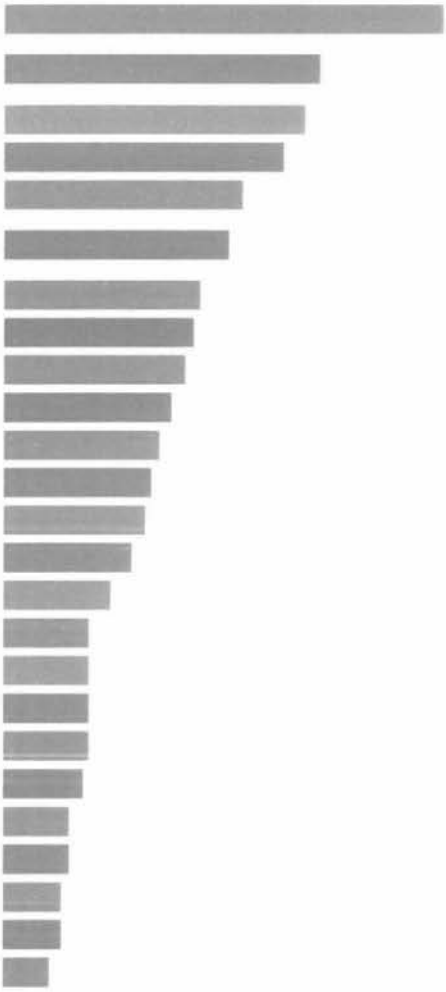


Table 3: Lead Maternity Carers (LMC)

Proportion of women registered with an LMC at first registration and at time of delivery by LMC type, 2004

Data source: MNIS

LMC type	At first		At delivery	
	Number	%	Number	%
GP	2504	5.6	2005	4.5
Midwife	33,482	75.3	33,715	75.9
Obstetrician	2727	6.1	2680	6.0
Other/unknown	2445	5.5	2463	5.5
Not stated	3297	7.4	3567	8.0
Total	**44,455**	**100.0**	**44,430**	**100.0**

Table 4: Proportion of women registered with an LMC at first registration, by LMC type and DHB region of mother's place of residence, 2004
Data source: MNIS

DHB region	**LMC types**											
	GP		**Midwife**		**Obstetrician**		**Other/unknown**		**Not stated**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Northland	24	1.5	1361	87.6	10	0.6	109	7.0	49	3.2	1553	100
Waitemata	259	4.7	3455	62.8	540	9.8	606	11.0	645	11.7	5505	100
Auckland	241	4.9	3130	63.9	767	15.7	452	9.2	306	6.3	4896	100
Counties Manukau	155	3.0	4090	79.6	266	5.2	430	8.4	197	3.8	5138	100
Waikato	151	3.9	3379	87.4	9	0.2	107	2.8	219	5.7	3865	100
Lakes	10	0.8	1200	94.3	2	0.2	7	0.6	53	4.2	1272	100
Bay of Plenty	28	1.5	1627	85.4	5	0.3	120	6.3	126	6.6	1906	100
Tairawhiti	2	0.3	573	95.8	0	0.0	2	0.3	21	3.5	598	100
Hawke's Bay	214	12.2	1291	73.4	2	0.1	89	5.1	164	9.3	1760	100
Taranaki	51	4.4	818	70.9	205	17.8	6	0.5	74	6.4	1154	100
MidCentral	242	15.2	897	56.5	141	8.9	171	10.8	138	8.7	1589	100
Whanganui	5	0.8	550	88.4	14	2.3	14	2.3	39	6.3	622	100
Capital & Coast	154	5.5	2025	72.7	261	9.4	55	2.0	290	10.4	2785	100
Hutt Valley	252	16.7	955	63.4	86	5.7	4	0.3	209	13.9	1506	100
Wairarapa	152	38.9	213	54.5	6	1.5	12	3.1	8	2.0	391	100
Nelson Marlborough	118	8.6	1070	78.0	44	3.2	47	3.4	92	6.7	1371	100
West Coast	5	1.6	252	79.2	1	0.3	0	0.0	60	18.9	318	100
Canterbury	253	5.3	4020	83.9	50	1.0	93	1.9	377	7.9	4793	100
South Canterbury	9	2.1	133	30.3	291	66.3	1	0.2	5	1.1	439	100
Otago	46	2.8	1369	84.3	17	1.0	22	1.4	169	10.4	1623	100
Southland	128	12.4	808	78.0	2	0.2	80	7.7	18	1.7	1036	100
Not stated	5	1.5	266	79.4	8	2.4	18	5.4	38	11.3	335	100
Total	**2504**	**5.6**	**33,482**	**75.3**	**2727**	**6.1**	**2445**	**5.5**	**3297**	**7.4**	**44,455**	**100**

Table 5: Clients seen by Mental Health team type, age and sex, total population, 2002.

			Five year age group																	
Team type code & description		Total	0-	5-	10-	15-	20-	25-	30-	35-	40-	45-	50-	55-	60-	65-	70-	75-	80-	85+
01 Inpatient Team																				
	Total	8,110	9	2	16	375	1,023	1,105	1,193	1,193	979	742	542	390	281	110	55	50	33	12
	Male	4,243	3	2	6	212	640	656	650	598	455	355	252	173	127	50	25	19	15	5
	Female	3,867	6	0	10	163	383	449	543	595	524	387	290	217	154	60	30	31	18	7
02 Community Team																				
	Total	49,235	24	147	593	3,018	5,073	5,517	6,615	6,673	5,994	4,688	3,661	2,598	1,881	1,002	641	530	348	232
	Male	22,733	11	107	292	1,325	2,518	2,736	3,117	3,065	2,735	2,165	1,617	1,093	834	406	272	212	145	83
	Female	26,502	13	40	301	1,693	2,555	2,781	3,498	3,608	3,259	2,523	2,044	1,505	1,047	596	369	318	203	149
03 Alcohol and Drug Team																				
	Total	16,716	3	9	252	1,476	1,889	2,371	2,881	2,762	2,235	1,343	747	374	197	87	53	26	8	3
	Male	10,611	2	8	145	982	1,275	1,539	1,781	1,703	1,358	863	489	230	130	57	30	15	2	2
	Female	6,105	1	1	107	494	614	832	1,100	1,059	877	480	258	144	67	30	23	11	6	1
04 Child, Adolescent and Family Team																				
	Total	14,160	497	3,496	5,794	3,666	182	77	109	117	85	58	35	19	12	5	2	5	0	1
	Male	8,517	331	2,523	3,802	1,610	68	37	27	29	37	26	11	8	5	0	0	2	0	1
	Female	5,643	166	973	1,992	2,056	114	40	82	88	48	32	24	11	7	5	2	3	0	0
05 Forensic Team																				
	Total	3,897	0	0	25	368	633	640	674	613	394	255	141	84	31	20	12	5	1	1
	Male	3,289	0	0	23	312	537	560	576	504	318	211	117	69	28	17	10	5	1	1
	Female	608	0	0	2	56	96	80	98	109	76	44	24	15	3	3	2	0	0	0
06 Kaupapa Maori Team																				
	Total	3,762	20	152	308	361	431	450	565	473	377	262	148	92	49	33	21	9	9	2
	Male	2,009	15	121	201	200	248	256	287	228	174	112	69	45	20	13	10	5	4	1
	Female	1,753	5	31	107	161	183	194	278	245	203	150	79	47	29	20	11	4	5	1
07 Pacific Island Team																				
	Total	619	0	1	4	35	119	102	92	79	68	36	23	23	16	11	4	5	0	1
	Male	356	0	1	2	21	80	68	49	43	41	14	10	10	8	4	2	3	0	0
	Female	263	0	0	2	14	39	34	43	36	27	22	13	13	8	7	2	2	0	1
08 Residential Team																				
	Total	200	0	0	0	1	11	20	26	30	38	28	18	14	7	5	2	0	0	0
	Male	127	0	0	0	0	6	15	20	24	20	17	8	10	4	2	1	0	0	0

Female	73	0	0	0	1	5	5	6	6	18	11	10	4	3	3	1	0	0	0
09 Alcohol and Drug Kaupapa Maori Team																			
Total	1,044	1	0	38	139	135	152	206	160	108	51	24	21	4	2	2	1	0	0
Male	633	1	0	18	83	86	95	113	106	63	31	18	15	3	0	0	1	0	0
Female	411	0	0	20	56	49	57	93	54	45	20	6	6	1	2	2	0	0	0
10 Alcohol and Drug Dual Diagnosis Team																			
Total	538	0	0	4	34	79	75	88	91	59	42	33	11	16	5	0	0	0	1
Male	336	0	0	3	21	49	53	56	56	33	27	19	6	10	2	0	0	0	1
Female	202	0	0	1	13	30	22	32	35	26	15	14	5	6	3	0	0	0	0
11 Youth Specialty Team																			
Total	2,126	4	20	348	1,411	216	63	25	10	8	6	7	5	2	1	0	0	0	0
Male	1,095	3	17	197	642	145	46	14	10	6	5	3	5	1	1	0	0	0	0
Female	1,031	1	3	151	769	71	17	11	0	2	1	4	0	1	0	0	0	0	0
12 Maternal Mental Health Team																			
Total	1,892	5	0	2	92	289	444	550	388	99	14	7	0	2	0	0	0	0	0
Male	30	2	0	0	0	9	7	1	3	4	3	1	0	0	0	0	0	0	0
Female	1,862	3	0	2	92	280	437	549	385	95	11	6	0	2	0	0	0	0	0
13 Eating Disorder Team																			
Total	329	3	4	27	85	71	46	28	28	17	10	3	3	3	0	0	0	0	1
Male	23	3	2	3	1	5	3	1	1	1	1	1	0	1	0	0	0	0	0
Female	306	0	2	24	84	66	43	27	27	16	9	2	3	2	0	0	0	0	1
14 Specialist Psychotherapy Team																			
Total	338	0	7	17	18	38	31	55	55	35	38	14	18	11	0	0	1	0	0
Male	150	0	4	12	8	14	13	22	20	16	15	7	10	8	0	0	1	0	0
Female	188	0	3	5	10	24	18	33	35	19	23	7	8	3	0	0	0	0	0
15 Children and youth, alcohol and drug services																			
Total	59	0	0	12	45	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Male	45	0	0	10	33	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Female	14	0	0	2	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16 Kaupapa Maori Tamariki and Rangatahi (child and youth) mental health services																			
Total	33	2	13	12	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male	23	2	8	9	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Female	10	0	5	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix Two

Health and Disability Human Ethics Application

NATIONAL APPLICATION FORM FOR ETHICAL APPROVAL OF A RESEARCH PROJECT

Part 1 : Basic Information

1. Full project title

Peri-Natal Mental Health Policy: Young mothers' formal mental health support during pregnancy.

2. Short project title (lay title)

Maternal Mental Health: Young mothers' mental health support during pregnancy.

3. Principal Investigator's name and position

Jane Parsons – Student: Masters of Philosophy (Social Policy)

4. Address of Principal Investigator

5. Principal investigator's qualifications and experience in past 5 years (relevant to proposed research)

Employed as a Psychiatric Social Worker within the Child, Adolescent and Family Mental Health Service with associated training and experience. Bachelor of Social Work (First Class Honours) Degree, Massey University Scholar. Completed paper (Massey University) in research methods. Involvement with Maternal Mental Health specialists with attendance and participation at their annual meeting. Completion of research project comparing international policy for teenage mothers, 2003.Interviewing and screening of teenage mothers for entry to the [locality] Teen Parent Unit (TPU) 2001-2002. Involvement in the establishment and maintenance of the trust established to create the TPU from 2002-present.

6. Co-investigators' name(s), qualifications and position(s) and, if more than one locality, Principal Investigator at each locality

No other investigators involved.

8. Where this is supervised work

8.1 Supervisor's name Dr. Carole Adamson and Jenny Jakobs (MPhil) Senior Lecturer and Lecturer, BSW Co-ordinator, Massey University

Day time phone number

8.2 Signature of supervisor (where relevant)

Declaration: I take responsibility for all ethical aspects of the project

9. Is this a Multi-Region application No

10. Is more than one Locality Organisation No

11. I wish the protocol to be heard in a closed meeting

12. If the study is based, in part or in full, overseas, which countries are involved?

N/A. Study is based solely in New Zealand

13. Has ethics committee approval overseas been sought or obtained? (attach if available) N/A

14. Human Tissue – Does the project

No

15. Gene Studies – Does this research involve any gene or genetic studies?

No

16. Consent - Are all participants able to consent themselves?

Yes

17. Summary

Give a brief summary of the study (not more than 200 words, in lay language)

Gaps in service provision and policy have been identified through social work practice. This research plans to elicit young, first time mothers' experiences of their professional mental and emotional support and education during pregnancy through the use of semi-structured interviews conducted with four women. Four interviews with professionals involved in the field will also be conducted to elicit their perspectives. These interviews will be interpreted so as to provide some insight into the most appropriate way to develop policy for promotion of positive mental health in pregnancy. It is hoped further studies can utilise the recommendations to pilot services and policies that may prevent post-partum mental illness and break down the barriers that mothers can face in accessing appropriate maternal services. Thus, the research forms a scoping exercise to determine the need for, and type of policy required to develop early intervention maternal mental health care and support. Potentially such research may prevent later psychiatric disturbance in pregnancy, motherhood and enhance social and health outcomes for children.

18. Proposed starting date (dd/mm/yy)	1.06.06
19. Proposed finishing date (dd/mm/yy)	1.11.07
20. Duration of project (mm/yy)	18mnths
21. Proposed final report date (mm/yy)	30/11/07

Part 2 : Ethical Principles

A. VALIDITY OF RESEARCH SCIENTIFIC BASIS

A1. Aims of Project

A1.1 What is the hypothesis/research question(s)? (state briefly)

The research question suggests that, within the Manawatu Region, there is insufficient formal education and support to young or new mothers for mental and emotional health during pregnancy. The support and education is believed to occur on an ad-hoc basis by community organisations or support people with little or no policy infrastructure to guide or support it. A narrow, illness focused mode of intervention, has potentially led to few women receiving vital information that may prevent dysfunction during pregnancy or in the early stages of child rearing. This lack of support, coupled with traumatic and invalidating situations young mothers may experience, causes increased risk of damage to mothers' and infants' health, wellbeing and care and protection.

A1.2 What are the specific aims of the project?

Through semi-structured interviews with four young, first-time mothers, the project aims to gain an understanding of participants' experience of mental health information and support received during pregnancy. The project includes interviews with four professionals from different sectors of the health community to elicit their understanding of current practice of maternal mental health support and their opinions on how to improve this field. It is anticipated that this project will contribute to the information base of health policy in this area. Longer term goals include the possibility of using this information to develop pilot programmes and policies for perinatal and maternal/infant mental health in future research.

A2. Scientific Background of the Research

Has this project been scientifically assessed by independent review? No

If no, is it intended to have the project scientifically assessed, and by whom?

No

Describe the scientific basis of the project (300 words maximum). Where this space is inadequate, continue on a separate sheet of paper. Do not delete page breaks or renumber pages.

The scientific basis of the research emerges from the researcher's experiences of working both with women who have suffered mental ill-health during or following pregnancy, and with children who have had parents who suffer from mental ill-health or emotional and social problems. During this work I observed the lack of provision in the primary or secondary health settings and this was discussed by other services and professionals. The scientific basis also emerges from national and international literature outlining the impact of the burden of disease triggered by maternal mental illness (Cohen & Nanocs, 2005; Jenkins, 2003; Magyary, 2002; Zeanah, 2000). The critical importance of the first three years of life is well-evidenced by the child development literature (eg. Linehan, 1993). Similarly, it is well documented that pregnancy and childbirth are periods of vulnerability for mental health issues. Cohen and Nanocs (2005) identify 10% of pregnant women suffer symptoms of clinical depression. This prevalence rate does not include anxiety or personality and trauma related disorders, nor does it account for all of the 'normal' emotional difficulties that arise at such a critical period and can be exacerbated if unaddressed. This impact has been negative for the women, children, their wider families, and the community, and may lead to the continuation of mental and emotional health problems (Lester, Boukydis & Twomey, 2000; Swann et al, 2003). However, internationally there is a lack of policy frameworks (and subsequently services and resources) for mothers who are vulnerable to suffering mental ill health and poor adjustment in pregnancy. Young mothers appear particularly at risk. Similarly, there appears to be minimal research that could support policy development in this area and thus there is little reliable precedent or guidance for professionals that may be involved with pregnant youth.

A3. Study Design

A3.1Describe the study design. Where this space is inadequate, continue on a separate sheet of paper. Do not delete page breaks or renumber pages.

The study will be conducted with a feminist methodology. Eight feminist, qualitative, and semi-structured interviews will be conducted with four professionals: a general practitioner, midwife, community or voluntary service representative, and a representative of the local District Health Board. These key informants within the community will be contacted and invited to be involved in the research. Interviews will also be conducted with four young mothers who are under 25 years, first time mothers, and 5-8 months pregnant. The four key informant interviews and four interviews with young mothers is an attempt to create a balance of staff and client views and to make recommendations on advice from both recipients of treatment and clinicians. Advertisements will be placed in General Practitioners' (GP) and midwifery clinics and both GPs and midwives informed of the project so that they may inform any women who may met the participant criteria and wish to be involved. Information sheets will be provided (see attachment 1). Consent forms (see attachment 2) will be required to be completed. All interviews will be audio recorded, with the participants' consent and then transcribed. The women's interviews will be transcribed by the researcher to assist with confidentiality of personal interviews. The key informant interviews will be transcribed by a hired transcriber. These interviews will then be analysed for any commonalities and generalisations that may inform future policy development or service provision.

A3.2 Is the method of analysis :

Quantitative

or qualitative? X

If the method of analysis is qualitative, go to question 3.3

If the method of analysis is wholly or partly quantitative, complete the following :

A3.2.1 Describe the statistical method that will be used

N/A

A3.2.2 Has specialist statistical advice been obtained?N/A

A3.3 If the method of analysis is wholly or partly qualitative, specify the method. Why is this method appropriate? If interviews are to be used include the general areas around which they will be based. Copies of any questionnaires that will be used should be appended.

A feminist methodology is deemed relevant due to the nature of the topic. Because the participant interviews will be conducted solely with women, and because of the focus on reproductive health and women's mental health, feminist methodology will be incorporated throughout the research. Qualitative interviews, which have historically been compatible with a feminist methodology, will be less structured with the mothers than with the key informants to allow them the space to discuss their own experiences, thus far, of their pregnancies. Semi-structured interviews will be utilised with the key informants to ensure that the information required is focused upon and to attempt to reduce tangentiality from the research topic. Thus, the general questions will be asked around the standard practices of the professionals in their service provision to young mothers and whether they routinely discuss emotional or mental health with pregnant women or the conditions under which they do so. Barriers to the provision of mental health support and education during pregnancy will be discussed with both the professionals and the mothers. The mothers' interviews will be less structured but will focus upon their experiences of the support they received during their pregnancies and from whom this support was received. A flowchart of the method is appended in attachment four.

A4. Participants

A4.1How many participants is it intended to recruit? (Include details for each locality organisation)

Four, first time mothers, between 16 and 25 years, and 5-8 months pregnant, will be recruited through advertising in GP and Midwifery practices in the Manawatu region.

Key informant interviews will be completed with four professionals: one GP recruited from local GP practices; one Midwife, similarly from local Midwifery clinics; a clinician from the local hospital involved wit h maternity care or mental health; and a community worker similarly engaged.

A4.2 If randomisation is used, explain how this will be done

N/A

A5. Expected outcomes or impacts of research

A5.1 What is the potential significance of this project for improved health outcomes?

The research will impact health outcomes by exploring the current practice of provision of mental health support and education peri-natally and assessing how this may be improved through policy and practice. This has implications for health outcomes, as improved early intervention for maternal mental health support can prevent post-natal mental illness and distress during pregnancy. This has positive effects for the mothers' mental and emotional health and also for their infants. Recent studies have demonstrated the importance of the first three years of a child's life in brain and social development, particularly the influence of positive attachment (Linehan, 1993; Zeanah, 2000). Where mothers are able to continue to effectively meet the needs of their children, this development will be improved. However, if mothers' are pre-occupied with emotional stressors or mental health problems that are not addressed they may be less able to meet these needs. There is also further care and protection issues that may arise in extreme circumstances and may be curtailed or prevented with effective peri-natal support.

A5.2What is the potential significance of this project for the advancement of knowledge?

The project will advance current knowledge in maternal mental health by providing qualitative information as to what women find beneficial, in terms of professional, emotional support during pregnancy and how the current services and maternal health policies are meeting these needs in the Manawatu. It may potentially inform policy development in this arena and advance knowledge of what is useful and available to realistically be implemented in the peri-natal stages of pregnancy for the advancement of women and infant's mental health.

A5.3 What steps will be taken to disseminate the research results?

The outcomes of the research will be shared with the participants and key informants through the provision of a summary of key findings. The researcher will provide the participants with a written summary of the report including the researcher's conclusions and recommendations. A summary of the findings will be provided to the key informants as well as disseminated to relevant local organisations alongside an offer to present the findings and outcomes of the research if desired. They will also be made aware that the completed thesis will be available in the Massey University Library.

A6. Publication of Results

Will any restriction be placed on publication of results? No

A7. Budget

A7.1 How will the project be funded?

The project will be partly funded by the researcher, the School of Sociology, Social Policy and Social Work, Massey University and the Graduate Research Fund of Massey University with the latter subject to acceptance of the researcher's ethics application.

A7.2 Does the researcher, the host department, the host institution or the locality organisation, have any financial interest in the outcome of this research? If "yes", please give details.

No

A8.Incentive Payments - before completing this question, have you read the relevant section in the Guidelines for Completing the National Application Form? Yes

A8.1. Will the researcher, the host department, the host institution, the locality organisation or any individual/organisation who recruits participants into studies but who will not be involved in the research as investigators receive payment (in money or kind) or reward in connection with this project – including any payment (in money or kind) or reward for recruiting participants into the project? No

Note: Details about any payment (in money or kind) or reward made to participants recruited into the project are to be provided in Question E10

B. Minimisation of Harm (Operational Standard Paragraphs 60-68)

B1. How many visits/admissions of participants will this project involve? Give also an estimate of total time involved for participants.

The participants will be required to attend one interview for duration of one to two hours. These interviews will be conducted at a location indicated by the participants as convenient and comfortable for them. Refreshments will be provided by the researcher during the interviews.

B2. Who will carry out the research procedures?

The researcher will carry out all of the research procedures with exception of transcription of the key informant interviews which will be completed by a paid transcriber.

B3. What other research studies is the lead investigator currently involved with? None

B4. Where will the research procedures take place?

The interviews will be conducted in the community, at the key informants' workplaces and women's homes or other neutral venue of their choice. The remainder of the research, data analysis, completion of results, and writing up of findings and conclusions, will occur in the researcher's home or Massey University.

B5. Give a justification for the number of research participants proposed, using appropriate power calculations.

A balance of professional perspectives and those of mothers is desired to ensure both realities are represented in the research. It is also important, for the purposes of the research, to achieve representation from across sectors of the community: service users, General Practitioner (GP), Midwife, Tertiary Sector (Hospital), and a community representative of a not-for-profit, non-governmental organisation. A sample size of eight is chosen to allow for representation from a range of sectors within the scope of this Masters research project. This sample size will also allow for in-depth interviews with the mothers to ensure they have the space to discuss their full experiences.

B6. Are participants in clinical trials to be provided with a card confirming their participation, medication and contact phone number of the principal investigator? N/A

B7. Is it intended to inform the participant's GP of individual results of the investigations, and their participation, if the participant consents? Yes

B8. How do the research procedures differ from standard treatment procedures? Not applicable

B9. What are the benefits to research participants of taking part?

The research may be beneficial to the women taking part as it will provide a space for them to discuss their experiences of pregnancy. Based on client self-report evaluations conducted by the researcher, Post-Natal Depression Groups have been reported to be empowering and therapeutic for women, particularly young women who, due to their vulnerabilities, may not have a voice in policy and health settings. The key informants will have an opportunity for their own professional development and policy consultation requirements by taking part as well as the opportunity to contribute to further knowledge in their field.

B10.Briefly describe the inclusion/exclusion criteria and include the relevant page number(s) of the protocol or investigator's brochure.

First time mothers, between 16 and 25 years of age who are in their 5th to 8th month of pregnancy and who live in the Manawatu region will be included in the research. Women who have suffered miscarriages or stillbirths during their pregnancies will not be interviewed due to risk of re-traumatisation and because there is already a body of research surrounding the devastating effects on mental health generated by such loss. It is intended to exclude mothers who are considering adoption or whangai following the birth due to the possibility that these issues may skew the purpose of the research and subsequent findings.

B11. Describe any methods for obtaining information. Attach questionnaires and interview guidelines (If NHI information is used, see Guidelines)

Information will be obtained from the four participants and four key informants through feminist, qualitative, semi-structured interviews. The process by which this information gathering will occur is depicted in the methods outlined in the two flowcharts attached (attachment four). Interview questionnaires are also attached (attachment three). Participants will be made aware of the project through advertising in GP and Midwife surgeries (see attached). GPs and Midwives will also be made aware of criteria for participation so that they might provide information packs as requested by potential participants. Key informants have been identified by the researcher and will be approached by, and informed of the project by the researcher.

B12. What are the physical or psychological risks, or side effects to participants or third parties? Describe what action will be taken to minimise any such risks or side effects. The participants may experience psychological distress if discussing upsetting aspects of their pregnancy during the interview.

Participants will be informed that they can have any support people they wish in the interview. The women will be supported by the researcher through a feminist research methodology and through social work skills and experience from working in the field. Thus, the researcher will use their assessment and mental health skills as an experienced mental health practitioner to subjectively identify any distress the participant is displaying. If the participant is demonstrating or verbalising upset they will be invited to cease the interview and discuss this. Any triggering issues will be discussed and psychological support and ways to manage this suggested. For example, a break and relaxation or stress reduction techniques may be incorporated to lower emotional arousal. If additional support is needed participants will be provided a resource list. The participants will be informed that they can pause or terminate the interview at any time and have the right to withdraw their consent at any point until December 15th 2006. If women have ongoing or unresolved difficulties from their pregnancies or the research process, the researcher's knowledge of social work and support agencies in the area will be drawn upon and the researcher will assist the women to access these. Midwifes and GPs will be informed, with the women's consent, and any necessary follow-up discussed with them and the participant. If deemed necessary between the researcher, participant, and GP and/or midwife, referral to the Community Mental Health Service will be made.

B13. What facilities/procedures and personnel are there for dealing with emergencies?

The researcher's knowledge of the local community and experience as a psychiatric social worker will be drawn upon in any emergency situation and the women will be directed towards the appropriate source of support such as the general practitioner or Community Mental Health Team. The researcher also has the support of two supervisors within the University. Participant involvement can also be terminated as outlined in question B12.

B14. What arrangements will be made for monitoring and detecting adverse outcomes?

The researcher will monitor for any adverse effects of the interviews during the period of the interviews from July to December 2006. The women will be asked from the outset for permission to have their Lead Maternity Carer (LMC) aware of their involvement with the project and the LMC educated appropriately as to the level and risks of the women's' participation. Should any difficulties arise during the participants' active involvement in the project, the LMC and GP will be accordingly notified so that they may continue to address any adverse effects. The participants will be informed of this notification and it will be discussed with them prior to the LMC being informed.

B15. Is the trial being reviewed by a data safety monitoring board? No

B16. What are the criteria for terminating the study?

As outlined in questions B12-14.

B17. Will any potential toxins, mutagens or teratogens be used? No

B18. Will any radiation or radioactive substances be used? No

B19. Will any drugs be administered for the purposes of this study? No

B20. Does the study involve the use of healthcare resources? No

B21. What effect will this use of resources have on waiting list times for patients ie., for diagnostic tests or for standard treatments? None

C. Compensation for Harm Suffered by Participants (Operational Std Paragraphs 83-91)(refer to Appendix 3 of the Guidelines)

Is this a clinical trial under accident compensation legislation No

D. Privacy and Confidentiality (Operational Standard Paragraphs 44-49)

D1.How will potential participants be identified?Key informants have been identified by the researcher. Advertisements will be placed in GP and Midwives' clinics and the mothers will self-refer after receiving a sealed research package that can be collected from GPs or Midwives or at their reception areas.

D2 How will participants be recruited? (e.g. advertisements, notices) Advertisements will be placed in GP and Midwifery clinics so women may self-refer after requesting an information pack and researcher's contact details from the GP, Midwife or receptionist all of whom will have some basic knowledge of the research through an information sheet.

D3Where will potential participants be approached? (e.g. outpatient clinic) If appropriate, describe by type (eg students) From the advertisements placed in Midwifery and GP clinics, women that may like to participate will be able to contact the researcher directly through the contact details provided on the information sheet.

D4. Who will make the initial approach to potential participants? Possible participants will be making contact themselves with the researcher after receiving an information sheet and contact details from their GP, midwife, or clinic reception. From this point the potential participant will be able to contact the researcher directly and all following contact will occur between the researcher and the participant.

D5.How will data including audio and video tapes, be handled and stored to safeguard confidentiality (both during and after completion of the research project)? Consent forms and audio tapes will be kept separately in a locked filing cabinet in the researcher's office. Only the researcher will transcribe mothers' interviews.

D6. What will be done with the raw data when the study is finished? Once the final research report is completed and marked, the participants can choose to have the tapes returned to them or destroyed.

D7.How long will the data from the study be kept and who will be responsible for its safe keeping?The researcher will be responsible for safe keeping of data which will be kept for ten years unless the participants wish to have their information returned.

D8.Who will have access to the raw data and/or clinical records during, or after, the study?Only the researcher will have access to the raw data of the women's' interviews. The transcriber and the researcher will have access to the key informant interviews. After the thesis is marked the data will be returned to participants or destroyed.

D9.Describe any arrangements to make results available to participants, including whether they will be offered their audio tapes or videos. Participants will be offered the return of their information and audiotapes at the close of the research. A written summary of results will be provided to participants.

E. Informed Consent (Operational Standard Paragraphs 28-43) Consent should be obtained in writing, unless there are good reasons to the contrary. If consent is not to be obtained in writing the justification should be given and the circumstances under which consent is obtained should be recorded. Attach a copy of the information sheet and consent form.

E1.By whom, and how, will the project be explained to potential participants? The project will be explained through initial conversations between the researcher and potential participants and via a detailed information sheet (attachment 1). GPs and Midwifery clinics will have a role in initially advertising the research, therefore they will be provided with enough information concerning the project to provide a sealed information package to the potential participants (attachment 2).

E2. When and where will the explanation be given? Explanations will be given at GP or Midwife clinics where the GP or Midwife is providing the information or over the telephone by the researcher if the participant contacts the researcher directly. Information and consent sheets will be provided to GP and midwife clinics to provide to potential participants.

E3. Will a competent interpreter be available, if required? No. All interviews will be conducted in English.

E4. How much time will be allowed for the potential participant to decide about taking part? Three days after initial contact with the researcher

E5. In what form (written, or oral) will consent be obtained? If oral consent only, state reasons. Both written and oral consent will be requested.

E6.If recordings are made, will participants be offered the opportunity to edit the transcripts of the recordings? Yes

E7. Will data or other information be stored for use in a different study for which ethics committee approval would be required? No

E8. Is there any special relationship between the participants and the researchers? e.g. doctor/patient, student/teacher No

E9. Will there be any financial cost to the participant, e.g. travel and parking costs? If so, will such cost be reimbursed? (refer to Guidelines)

Financial costs to the participants should not occur or will be minimal. If costs are incurred these will be reimbursed by the researcher.

E10.Will any payments be made to participants or will they gain materially in other ways from participating in this project? Yes

If yes, please supply details At the close of the study the mothers will be offered a koha in acknowledgement of their participation and to provide a token of remembrance for them of their involvement. This will not be used as an inducement as koha will not be proffered until the completion of the study.

F. Cultural and Social Responsibility (Operational Standard Paragraphs 73-82)

F1. Will the study drug/treatment continue to be available to the participant after the study ends? No

F2. Have you read the HRC booklet, Guidelines for Researchers on Health Research Involving Maori"? Yes

F3. Does the proposed research project impact on Maori people in any way? Yes

F3.1 Explain how the intended research process is consistent with the provisions of the Treaty of Waitangi.

The research process is consistent with Te Tiriti O Waitangi as it involves the participation of women alongside the researcher and professionals on an equal basis as their opinions and input is treasured and celebrated. This partnership will be evident as the researcher returns to the women and other key informants to ensure a shared interpretation of the data and understanding of the final research report. Participants will also be protected through confidentiality arrangements and through the provisions made by the researcher as the only one who is processing the raw data of the participants. This protection will extend throughout the research in the way that interviews and contact with Tangata Whenua is conducted in a culturally appropriate way according to tikanga Maaori where appropriate. Tino Rangatiratage of the young women is hoped to be advanced through providing them a mouthpiece based on an anti-racist feminist theoretical basis that acknowledges and celebrates difference while recognising the structural and social oppression the young women face. This will provide a safe space for the participants to discuss their experiences of treatment during pregnancy and to contribute to policy development in their own right.

F3.2Identify the group(s) with whom consultation has taken place, and attach evidence of their support.

Consultation has occurred with Massey University research supervisors and heads of papers as per requirements for conducting and embarking upon a Masters project and as indicated by the supervisors signing this ethics application. Within the School of Sociology, Social Policy and Social Work, Massey University, there are established cultural research resources available from qualified Maaori staff. In addition, the researcher's professional education and code of conduct require bicultural competency. At this stage of the research it is not known from which cultural or ethnic background the women who choose to be involved will originate. However, if, from the participants selected, there are a number that identify as Maaori or other ethnic or cultural populations for which the researcher requires additional cultural consultation, the researcher will utilise the appropriate resources within the school of sociology, social policy and social work, and from Massey University. The researcher's education and adherence to the social work and research codes of ethics will determine that interviews with participants from cultures for whom the researcher cannot obtain appropriate levels of consultation and support will not proceed.

F3.3Describe the consultation process that has been undertaken prior to the project's development

Consultation occurred with the Service Leader of the Child Adolescent and Family Mental Health and Alcohol and Other Drug Service, the Maternal Mental Health Specialists of the lower North Island, and Massey University research supervisors.

F3.4 Describe any ongoing involvement the group(s) consulted have in the project

The groups would be consulted throughout the project and, similarly to the research participants, will be provided with a summary of the research report.

F3.5 Describe how information will be disseminated to participants and the group(s) consulted at the end of the project

Due to researching from a feminist methodology and worldview, feedback will be elicited, as per the practices of feminist research, and a shared interpretation of the data gathered will be made alongside the participants. Key informants and participants will be provided with a summary of the research report.

F4. Are there any aspects of the research which might raise specific cultural issues that are not noted in Questions F3.1-F3.5 (eg for Pacific or Asian populations? No

F4.1 What ethnic or cultural group(s) does your research involve?

The participants that volunteer for the research may be of Máori or any other cultural group. Should the participants identify as Máori or with an ethnicity or culture that is unfamiliar to the researcher, cultural supervision, specific to that culture will be sought. The researcher also practices from a bi-cultural, ethical and feminist perspective that acknowledges and celebrates difference in a transparent manner.

F4.2Describe what consultation has taken place with the group(s) prior to the project's development None

F4.3Identify the group(s) with whom consultation has taken place and attach evidence of their support

Consultation with supervisors will occur following the choice of participants to determine what additional consultation or cultural supervision needs to occur following the choice of participants.

F4.4Describe any ongoing involvement the group(s) consulted have in the project As for question F 3.4

F4.5Describe how you intend to disseminate information to participants and the group(s) consulted at the end of the project

Due to researching from a feminist methodology and worldview, feedback will be provided to all involved in the research, as per the practices of feminist research. A shared interpretation of the data gathered will be made alongside the participants. A standard summary of the research findings will be provided.

Part 3 : General

Describe and discuss any ethical issues arising from this project, other than those already dealt with in your answers?

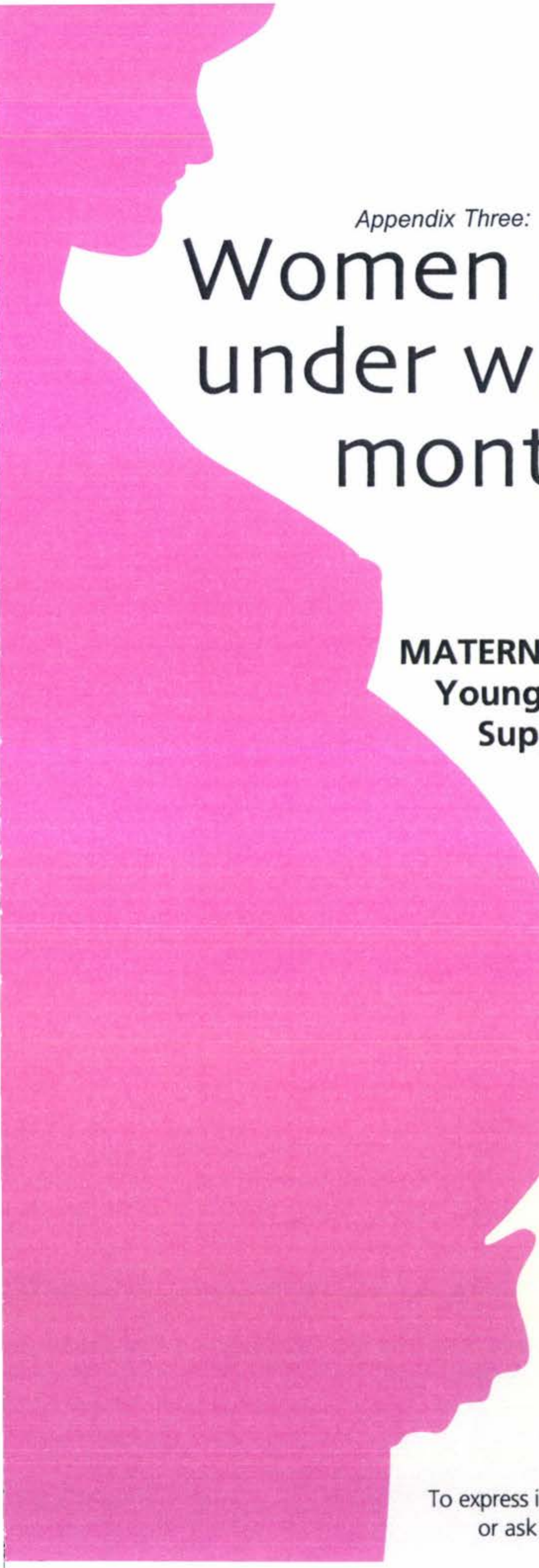
There is a possibility that the participants or their children may require treatment, at the time of the research or in the future, at the place of employment of the researcher. If this occurs, the normal agency protocols will be followed whereby another, unknown clinician is allocated to work with them. The researcher also would not release information gleaned from the research in another setting, unless there were safety concerns involved; however, the type of information being gleaned in the research is unlikely to be relevant or necessary here.

Thank you for your assistance in helping us assess your project fully

Please now complete:

- **the declarations (Part 4)**
- **a Registered Drug Form (if applicable)**
- **Form A or B relating to accident compensation**

Appendix Three: Research advertisement



Women 25 years & under who are 5-8 months pregnant

MATERNAL MENTAL HEALTH POLICY:
Young Mothers' Mental Health Support During Pregnancy

You are invited to participate in a study of young women's experiences of emotional support and education received during pregancy. This study hopes to learn ways in which mental health policy and services for mothers can be improved.

To express interest or for further information enquire at reception or ask your Lead Maternity Carer, Doctor or Midwife.

Appendix Four

Approval No CEN/06/07/064

Information sheets

PARTICIPANT INFORMATION (KEY INFORMANT)

Maternal Mental Health: Mental health support during pregnancy.

KiaOra. My name is Jane Parsons and I am currently employed as a Social Worker at Separate from my employment, as part of my study towards a Masters of Philosophy (Social Policy) degree I am doing some research about young mothers' mental health during pregnancy. I hope to learn ways in which mental health policy and services for mothers can be improved. This study has been approved by the Central Regional Health and Disability Ethics Committee.

As a professional working in the field of maternal mental health or maternity or mental health care and support you are invited to participate in this study of young women's experiences of emotional support and education received during pregnancy.

If you decide to participate, the research will involve;

- An interview by the researcher for around one hour at a time and place that is suitable for you (in your own home or at a place of your choice). This interview, with your consent, will be audio taped and you can have anyone you choose at the interview and ask for the interview to be stopped or the tape turned off at any time. Once the interview is transcribed the tape can be returned to you or, if you do not wish them to be returned, they will be destroyed.

- You checking the typed content of the audiotape to ensure it is accurate to your knowledge.

- Signing a consent form to say that you agree to be involved with the research and that you are aware that you can withdraw this consent at any time until May15th 2007.

I will be looking at the information from the interview alongside three other profession interviews, and four participant interviews, for ways that policy and services could be improved. You will also be sent a summary of these findings.

I cannot and do not promise that you will receive any direct benefits from this study. However, it is hoped that the research will assist the development of appropriate services and policy in the region.

Any information from the study that can be connected to you or your organization will remain confidential and will be disclosed only with your permission, except as required by law. I plan to publish the results as a Massey University Thesis and also will be discussing the overall findings with my supervisors, Massey University, and in places the research may assist such as District Health Boards, Maternal Mental Health Services, and community agencies. In any publication or discussion, information will be provided in such a way that you and the service you work for cannot be identified. You should not have any costs from being involved with the research. If there are costs, such as from travel, these will be paid.

If you have any further questions or wish to be involved please contact me on or . If you have any questions or concerns you can also contact my supervisors, Dr. Carole Adamson and Jenny Jakobs (MPhil) who are contactable at Massey University (0800 627 739 or 06 356 9099), or the School of Sociology, Social Work and Social Policy at Massey University. These supervisors have been involved from the planning stages of this research and will also be involved for the remainder of the research including for the analysis of results. If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, (For Mid and lower North Island telephone 0800 42 36 38 (4 ADNET).

If you have any additional questions later, I will be happy and available to answer them throughout the research and your involvement.

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Text "sspsw" to 5222
http://sspsw.massey.ac.nz/

Approval No CEN/06/07/064

PARTICIPANT INFORMATION

Maternal Mental Health: Mental health support during pregnancy.

KiaOra. My name is Jane Parsons and I am currently employed as a Social Worker at Separate from my employment, as part of my study towards a Masters of Philosophy (Social Policy) degree I am doing some research about young mothers' mental health during pregnancy. This study has been approved by the Central Regional Ethics Committee.

You are invited to participate in this study of young women's experiences of emotional support and education received during pregnancy. I hope to learn ways in which mental health policy and services for mothers can be improved. You have received this information because you are a new mother, 30 years or under and between 5 and 8 months pregnant.

If you decide to participate, the research will involve;

- The researcher interviewing you for around one hour at a time and place that is suitable for you (in your own home or at a place of your choice). This interview, with your consent, will be audio taped and you can have anyone you choose at the interview and ask for the interview to be stopped or the tape turned off at any time. The tapes will be returned to you if you choose, or will be destroyed.

- You checking the typed content of the audiotape to ensure it is accurate to your knowledge.

- Signing a consent form to say that you agree to be involved with the research and that you are aware that you can withdraw this consent at any time until May15th 2007.

I will be looking at the information from the interview alongside three other interviews for ways policy and services could be improved. You will also be sent a summary of these findings.

I cannot and do not promise that you will receive any direct benefits from this study. However, it is hoped that the research will assist young mothers, and mothers and their children by finding ways women and families/whanau can be assisted during pregnancy. In my experience, it is helpful for mothers to have an opportunity to talk about their experiences during pregnancy so I hope this would be useful for you too. If you have had any difficulties during your pregnancy, the interviews may cause you to be reminded of this. As a trained mental health social worker I will be conducting the interviews in a way that I hope will be supportive and encouraging. My knowledge of the community may also provide further assistance if needed with any issues that may arise during the interviews and, as an experienced mental health practitioner we can discuss these and I can inform you of some strategies to assist. This may include accessing your GP to act on your behalf. You are welcome to have any support people you wish at the interview.

Any information from the study that can be connected to you will remain confidential and will be disclosed only with your permission, except as required by law. I plan to publish the results as a Massey University Thesis and also will be discussing findings with my supervisors, Massey University, and in places the research may assist such as District Health Boards, Maternal Mental Health Services, and community agencies. In any publication or discussion, information will be provided in such a way that you cannot be identified and you will be able to choose a fake name to use in the research. You should not have any costs from being involved with the research. If there are costs, such as from travel, these will be paid.

If you have any further questions or wish to be involved please contact me on or . If you have any questions or concerns you can also contact my supervisors, Dr Carole Adamson and Jenny Jakobs (MPhil) at Massey University (0800 627 739 or 06 356 9099) who will be involved in the research and analysis of the overall findings. If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, (For Mid and lower North Island telephone 0800 42 36 38 (4 ADNET).

If you have any additional questions later, I will be happy and available to answer them throughout the research and your involvement.

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Text "sspsw" to 5222
http://sspsw.massey.ac.nz/

Maternal Mental Health Policy: Young mothers' mental health support during pregnancy.

My name is Jane Parsons and I am currently employed as a Social Worker at Separate from my employment, as part of the requirements for a Masters of Philosophy (Social Policy) degree, I am conducting research surrounding young mothers' mental health during pregnancy.

I will be advertising for four women, between 16 and 30 years of age who are in their 5th to 8th month of pregnancy. Alongside these women I will be conducting individual feminist, qualitative interviews of one to two hours in duration.

These interviews should not be distressing for the participants. However, any difficulties already associated with the pregnancy could be triggered. Subsequently, women who have suffered previous miscarriages or still-births should not be included. As a trained mental health social worker I will be conducting the interviews within a feminist methodology in a way that I hope is supportive and encouraging. If any issues arise that are deemed essential to the mothers' health in their pregnancy this will be discussed with them and their Lead Maternity Carer, Midwife or GP informed with the women's consent. This research has received ethical approval from the Health and Disability Human Ethics Committee (Approval No. CEN/06/07/064)

I have enclosed a number of sealed research packs for potential participants that contain my contact details and a detailed information sheet from which they can contact me directly to be involved or to access further information. I am hoping to place advertisements in your clinic so that potential participants can access this pack from you, or from your reception. Please can you distribute this pack, with your discretion, to women that fit the following criteria;

- 16-30 years old
- 4-9 months pregnant

Your assistance with this project is appreciated.

Jane Parsons
Researcher

Appendix Five

Consent forms

PARTICIPANT CONSENT FORM (KEY INFORMANT)

Peri-natal Mental Health: Young Mothers' Mental Health Support during Pregnancy.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I can withdraw my consent at any point until the 15th May 2007 and that this will not affect any future involvement with Massey University or the researcher.

I agree/do not agree to the interview being audio taped.

I understand that, at any point during the interview I can ask for a break or for the tape to be turned off.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

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

Full Name - printed ....

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PARTICIPANT CONSENT FORM

Peri-natal Mental Health: Young Mothers' Mental Health Support during Pregnancy.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I can withdraw my consent at any point until the 15th May 2007 and that this will not affect any future involvement with Massey University or the researcher.

I agree/do not agree to the interview being audio taped.

I agree/do not agree to my midwife being informed of my involvement.

I understand that, at any point during the interview I can ask for a break or for the tape to be turned off.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

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

Full Name - printed ....

Appendix Six

Transcriber's confidentiality agreement

Peri-natal Mental Health: Young Mothers' Mental Health Support during Pregnancy.

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I .... (Full Name - printed) agree to transcribe the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: ______________________________ **Date:** ______________

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