

Literature review

Mothers and their babies Women's experiences

Ministry for Women

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1. Introduction

This literature review considers New Zealand and international literature on the experiences of younger mothers, their perceptions of the issues they face as well as their views on what would work best to improve their situation.

Most of the literature is from New Zealand, but also includes research reports from Australia, Canada, the European Union, the United Kingdom, and the United States of America.

The review provides a brief discussion on how vulnerability is defined. This is followed by sections on women's perceptions of the challenges they face and what worked best to improve their situation.

The review highlights the negative impact of judgemental attitudes towards vulnerable mothers which inhibits their ability to be given, or to receive and act on, information. In contrast, long-term stable relationships based on trust help facilitate change.

2. Definitions of vulnerability

There is no agreed definition of a vulnerable mother and/or her child. There is, however, agreement on the risk factors that can contribute to vulnerability. These risks relate to the mother's situation, the home environment and factors relating to the pregnancy, birth and postnatal care.

Knitzer and Lefkowitz (2006) set out three commonly used approaches to identify levels of risk for young children, based on empirical and theoretical developmental science. They are:

- risk indices that reflect some combination of demographic, child, family and environmental risks; for example, being a single parent, receiving public assistance, being neither employed nor in school or in job training, being a teenage parent and lacking a high school diploma or basic qualification
- identifying young children in circumstances known to place them at risk by virtue of their exposure to ineffective parenting or parental absence; for example, in foster care, children in homeless families or with a parent in prison

- using prevalence data based on parental risk factors known to impair effective parenting, such as maternal depression, substance abuse and domestic violence.

The Growing up in New Zealand (GUINZ) study has adopted a risk index approach, acknowledging that “defining child vulnerability requires a multi-dimensional framework that considers characteristics specific to the child and their family as well as their broader environments, including their communities, services, informal and formal societal structures and the policy context in which they grow” (Morton et al., 2014b, p. 8).

The authors note that:

- Risk factors used to define vulnerability tend to cluster, in the New Zealand context, according to: maternal characteristics and behaviours; features of the proximal home environment; and pregnancy-specific conditions including poor maternal mental wellbeing and poor physical health in late pregnancy.
- Exposure to clusters of risk factors differs across population subgroups in New Zealand, with marked variation in exposure according to maternal ethnicity.
- Māori and Pacific children tend to be exposed to a greater number of risk factors for vulnerability than New Zealand European or Asian children at each time point and across multiple time points.
- Clustering of risk factors that define vulnerability is common, but risk factors do not cluster uniformly across the population.
- Relative exposure to vulnerability can be estimated by summing the total number of risk factors that children are exposed to at any one time point or over time. (In a subsequent report, Morton et al. (2015) rate exposure to between one and three risk factors as “medium risk” while exposure to four or more is rated “high risk”. That report showed that approximately 1 in 10 of the cohort children were exposed to four or more risk factors, either before their birth or at nine months or at two years of age.)

The risk factors identified in the GUINZ study relating to the mother and the home environment are:

- Age – Teenage mother at time of pregnancy
- Relationship status – Mother with no current partner
- Education – Mother with no formal secondary school qualifications
- Smoking – Continuing to smoke regularly after the first trimester of pregnancy
- Income-tested benefit – In receipt of an income-tested government benefit
- Depression – Edinburgh Postnatal Depression Scale score of 13 or over
- Physical wellbeing – Self-rated health as poor or fair
- Unemployment – Mother not on leave, actively seeking work but not currently working
- Financial stress – Reporting highly stressful money problems
- Tenure – Living in social housing
- Overcrowding – Having two or more persons per bedroom
- Deprivation area – Living in NZDep2006 area deciles 9 or 10.

The GUINZ authors cluster these risk factors into three groups according to frequency of occurrence:

- Most common – young, single mothers without formal educational qualifications, who are likely to continue smoking in pregnancy and be in receipt of an income-tested benefit
- Second most common – mothers who are living in areas of high deprivation, in overcrowded, rental housing
- Third most common – mothers experiencing high levels of physical, emotional and/or financial stress during late pregnancy or during the postnatal period.

The GUNZ study suggests that it important to intervene early to reduce exposure to all 12 risk factors during pregnancy, or before, rather than waiting for problems to develop in the postnatal period before providing support.

A 2010 paper on sole parents (Ministry of Social Development, 2010) makes a similar point, noting that:

A broad focus on improving the wellbeing of both vulnerable parents and their children appears likely to offer the best prospect of improving the overall wellbeing of sole parent families into the future. This need not require a trade-off between investing in the needs of the current generation of vulnerable parents and investing in the current generation of vulnerable children. (p. 9)

Internationally, researchers add a number of other risk factors, some of which are based on women's experiences. These include:

- feelings of isolation and lack of social support (eg, from family members, friends, neighbours or colleagues)
 - exposure to stigmatisation or discrimination (on the basis of age, culture or immigration status)
 - limited language and communication skills, and services that are not culturally responsive
 - limited access to facilities such as shops, medical services, libraries and schools
 - being a victim of crime, including family violence
 - physical or intellectual disability in parent or child
- (Andrews, 2009; Barnardo's, 2011; Families Commission, 2011; Ministry of Health, 2011, 2015; Ministry of Justice, 2010; Mynarska et al., 2015; New Zealand Government, 2012; Raising Children Network, 2014; State Government of Victoria, 2010; Statistics New Zealand, 2012).

3. Issues facing vulnerable mothers with young children

Issues identified by the women

As noted above, most risk indices use indicators that are easily and reliably measurable. For example, mothers have a state rental or they don't; mothers do or do not receive a benefit; mothers do or do not smoke. The indices pay little attention to personal challenges that face women, even though these may affect women's behaviour and child outcomes.

Various research projects have sought to address this gap by asking women to describe their experiences at different stages of their pregnancy as well as during and post-delivery. These studies include: in New Zealand, studies exploring the maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers at Counties Manukau Health (Pacific Perspectives Ltd, 2013); exploring the experiences of young Pākehā and Pacific mothers (Banks, 2008; Taufu, 2015), and interviews with 44 young Māori mothers (Makowharemahihi et al., 2014); studies in Australia including where young mothers were asked to describe their experiences during and after pregnancy and birth (Boulden, 2010; McArthur & Barry, 2013); and a UK study exploring the experiences of the parents of 44 young children (Hogg & Worth, 2009).

Stigma and judgement

All the studies highlighted the importance of people's attitudes and the effect that negative attitudes have on vulnerable mothers' ability and willingness to get information, access services and gain support. This is particularly true for young mothers.

Many young mothers report experiences of judgment or even hostility in their dealings with social service institutions, education providers, and health care. (Price-Robertson, 2010, p. 1)

The young mothers who spoke at a symposium organised by Boulden (2010) described their reactions to finding out they were pregnant. They often experienced deep anxiety, confusion about available options around their pregnancy and fear about having to tell someone about the pregnancy. The author noted that this fear contributed to prolonged delays in telling someone about the pregnancy, leading to delays in accessing antenatal care, which increased the associated risks of complications in the pregnancy, as well as limiting options to terminate the pregnancy.

Rejection from school, lack of family support, housing difficulties, poverty, isolation, exhaustion, self-doubt, low self-esteem, and social stigma still create barriers to equitable outcomes for them and their children. Each of the young parents who spoke at the symposium recounted experiences of being scrutinised and judged by strangers. They expressed a strong need to defy the stereotype and to prove their capability. They often perceive negative public judgements as a risk factor they must defend against by demonstrating to the world at large that they are not just good parents, but perfect parents. It was described variously as 'impossible' and 'exhausting' to meet these perceived expectations, which many of them had internalised. (Boulden, 2010, p. 13)

A study by McArthur and Barry (2013) of 35 interviews and a series of focus groups with young mothers found that the majority of participants felt stigmatised and judged for their mothering abilities. This included being given 'dirty looks', unsolicited lectures on parenting, receiving verbal abuse, being barred from shops and having their pram searched. They felt that younger mothers were stereotyped as being irresponsible and immature, languishing on welfare payments (and only becoming pregnant to obtain welfare payments) and being ignorant and incompetent at raising children. Many of the younger mothers talked about the effects of this stigma, feeling humiliated and undermined as parents.

Women felt that they did not have sufficient access to the information they needed for engaging with health services or for parenting. Many mothers saw significant shortcomings in the quality of maternity care services they received. Vulnerable young mothers felt staff stereotyped, judged and stigmatised them (Pacific Perspectives Ltd, 2013).

Young Māori mothers reported that they had significant issues with health professionals. They felt that the nurses were 'authoritative', 'bossy' and patronising (Strickett & Moewaka-Barnes, 2012, p. 13). The mothers wanted to be treated like any other mother and expected staff to recognise that they often had additional needs. Because these needs were not met, they often avoided using healthcare services.

In Makowharemahihi et al.'s (2014) study, participants avoided providers that they had previously had a negative experience with. They sought help from more familiar sources. Participants said:

It wasn't my GP that I saw. I didn't want him to growl me ... cos he's quite scary, so I went to a locum doctor.

I used to go and see a nurse [at the community-based youth health service] all the time. I used to go and talk to her about my contraception and stuff so I went back to her 'cause I didn't really have a GP. (Makowharemahihi et al., 2014, p. 56)

Cultural factors also played a role. Low health literacy was a particular issue for Pacific mothers of all ages. The Tongan participants in Taufu's (2015) research referred to the challenges of getting information from their parents, where there was often limited discussion on sex education.

In the environment that I'm in no one talks about it. Even now, I can't talk about it because it's disrespectful, and I'm embarrassed to talk about it (laughs). I would hear girls that were married, talk about their first time experiences with their husbands, I'd hear about how a girl bleeds, but that was it. (Taufu, 2015, p. 326)

Well for my first one, I didn't realise I was pregnant the first time ... I didn't go at first ... and I went to see my nurse because the nurse was my auntie ... My auntie asked me 'when was the last time I had my period' and I said 'what's that?' I know I had my period but that's when I realised 'ahhhh that's how women know ... (Pacific Perspectives Ltd, 2013, p. 50)

Prior to pregnancy, some Pacific mothers had very little engagement with health services; for others, navigating maternity services in New Zealand was significantly different from their experiences in the Islands.

She told me I had to find a midwife and I was like what is this word? I have never heard this word before. (Pacific Perspectives Ltd, 2013, p. 49)

Accessing services

Māori, Pacific and Asian, women younger than 20 years, women in their first pregnancy and those in lower socioeconomic households often have delayed access to a maternity care (GUINZ, 2015; Malatest International, 2012). The Malatest International report identified barriers to accessing services as a disproportionately common contributory factor for Māori and Pacific perinatal deaths (Perinatal and Maternal Mortality Review Committee, 2012).

The majority of mothers who participated in the in the Counties Manukau study did not access maternity services within the first 10 weeks of pregnancy (Pacific Perspectives Ltd, 2013). Many of the mothers said that they were scared of a positive pregnancy result.

I was 3.5 months when I found out ... I was in denial because I didn't want to find out I was pregnant. I had no symptoms I just missed my period hoping it would come the next month.

I don't know, I was nervous, scared. Scared of being pregnant.

Historical and ongoing relationships with agencies such as Child, Youth and Family (CYF), the Police and Work and Income also prevented some mothers from accessing services. These mothers were very sceptical about the ability of services, like maternity care, to meet their needs in a competent and transparent way.

When I told her my age she looked at me funny and I was a bit terrified because she asked me who's my supporters and I was worried in case she was going to get CYF. (Pacific Perspectives Ltd, 2013, p. 52)

*I stand on my balcony having a smoke and when I see people that look like they are official coming up my driveway I just start yelling '***** off, we don't want you here, get the ***** out of here'. That usually scares them off. (Pacific Perspectives Ltd, 2013, p. 52)*

Earlier studies have shown that Māori women face greater barriers than other women in accessing information about how to select a Lead Maternity Carer (LMC), what to expect during pregnancy and making key decisions about pregnancy care (National Health Committee, 1999, cited in Ratima & Crengle, 2013). They indicated that it was difficult asking general practitioners for information (Ratima & Crengle, 2013).

In their research with young Māori mothers, Makowharemahihi et al. (2014, p. 57) found that transitioning to an LMC was often fragmented. One of the main barriers was the lack of adequate information about the process. One participant said:

[The doctor] didn't give me much information. He just said ring a midwife and gave me a book with three people on it.

Primary care providers often missed opportunities to assist these young women to make their journey less complicated and, ultimately, provide a better health service.

The 'one-way' process of communication, where the participant was dependent on the midwife to return her call, created barriers and often left participants with limited options when deciding who was going to provide their maternity care. In some situations the lists of midwives were unhelpful because they were all unavailable. Some participants were forced to go to extraordinary lengths to find a midwife and subsequently had to settle upon whoever was available. (Makowharemahihi et al., 2014, p. 57)

Earlier studies also identified communication problems for Māori women, noting that these were of particular concern when the provider was non-Māori and when information was not actively provided to the women (Ratima & Crengle, 2013). Some did not know about antenatal classes, others did not receive enough information to make an informed choice about antenatal tests. Māori women identified a lack of empathy on the part of providers.

Māori women continue to identify cultural issues as an area of concern in their experience of maternity services, including ignorance, insensitivity, and rudeness (Health Services Consumer Research, 2008). Māori women have expressed their desire for services that meet their cultural needs, including the need for Māori providers, and high levels of dissatisfaction at being unable to access culturally

responsive antenatal care and maternity care more generally. (Ratima & Crengle, 2013, p. 357)

Young women felt that their age prevented some providers from talking with them and providing information.

They think I don't care about my baby, but the truth is I can see they don't talk to me properly. With my mum they talk more serious than when they are with me, give her more information and I know this will help my baby more. So I let them think I don't care so that my baby gets help. (Pacific Perspectives Ltd, 2013, p. 57)

I felt I wasn't taken seriously, in situations, like going to the doctor ... feeling like doctors wouldn't listen to me or, you know, that I didn't know best about my child. Yeah, it felt like other people thought they knew better because they were older, so I got a lot of comments from well-meaning older people, who thought because I was so young I didn't know anything and I needed everybody's advice. (Banks, 2008, p. 63)

Teen and young mothers, Pacific and vulnerable mothers in the Counties Manukau study also faced challenges in staying engaged with maternity care providers.

I never had a midwife, due to when I did have a midwife she was very judgemental because of my age being pregnant young ... I felt uncomfortable so I just basically looked after myself through the whole 9 months and gave birth in my own bath tub. I didn't go to the hospital ... I just did it on my own. (Pacific Perspectives Ltd, 2013, p. 54)

I went for the scan and I asked if I was having a boy or a girl. The lady said to me, 'It's got a diddle, that's all you need to know'. I was like, shame! I was referred back to the same place for a scan at 7 months but I didn't go because I didn't want to go back to Mangere and the next closest was Manukau which is too far. Funny thing is no one even noticed I didn't go for that check. (Pacific Perspectives Ltd, 2013, p. 55)

During labour, delivery and the period immediately after delivery, young mothers felt they needed support and care from health professionals and their families. However, sometimes they didn't receive this and services often failed to use family support.

In many cases when births occurred at night, partners and families were sent home, (or charged an unaffordable fee to stay the night). This left vulnerable young women alone in an unfamiliar environment with staff who could not or would not respond to their needs due to other work pressures ... Mothers who had also delivered at Auckland District Health Board (ADHB) facilities, described a marked contrast in their experience of the maternal care services provided at ADHB. In particular staff attitudes were different, including welcoming their families and going the 'extra mile' to make them feel comfortable and provide care and support in the period immediately after delivery. (Pacific Perspectives Ltd, 2013, p. 9)

One woman commented:

So I had my baby at midnight and she told me I could stay until I went to the toilet. At 4am after I went to the toilet she told me to leave. It was the middle of winter and I

am sitting in the foyer waiting for my mum to come back and pick me up with my new baby. My mum only just left two hours before because they said she can't stay the night. I was thinking of her petrol. (Pacific Perspectives Ltd, 2013, p. 56)

A young mother in Australia made a similar point:

When I was leaving hospital with my son, he was only three days old ... a couple of nurses had been quite abusive towards me while I was in labour and when we left the hospital they said to me, 'You know what, you're actually not as bad a mother as we thought you'd be, you're doing all right' and I thought I can be offended or I can take it as a compliment because they expected me to fail. But it did make me really angry that they would say that because you'd never say that to a married woman in her 30s when she's leaving a labour ward. (McArthur & Barry, 2013, p. 3)

Māori women also wanted access to whānau-centred services during their pregnancy that recognise the value of whānau support throughout pregnancy (Ratima & Crengle, 2013).

Strickett & Moewaka-Barnes (2012) noted that a study by Aldridge et al in 2009 which identified that Maori parents in particular felt hesitant to ask staff for help. There is also the potential for negative reactions from busy staff if parents asked for support. In comparison Pakeha parents often felt they had adequate information about their child. One parent stated that:

There was actually no one, they were all busy, they had how many patients to one nurse, they were so busy you couldn't ask them, 'Is she gonna be ok?' Or that kind of stuff. (Strickett & Moewaka-Barnes, 2012, p. 16)

Sometimes they give you a pamphlet, you don't have time to read it, and you need someone to say it out loud. Like there are services available for you and your child, you know. But they should have some people like these based in the hospital that can inform people about these services that can help them. (Strickett & Moewaka-Barnes, 2012, p. 16)

The Pacific Perspectives Ltd (2013) report found that women with English as a second language and/or with low health literacy were not able to access additional resources to meet their needs.

Few mothers made formal complaints.

While there are a range of existing channels for feedback, these were almost never utilised by the mothers in this research. Patient surveys and complaint mechanisms are often predicated on assumptions that are incompatible with the cultural beliefs and worldviews of diverse cultural and vulnerable mothers. For example, for many Pacific cultures respect for hierarchy, clinicians and those who are in authority, prevents the voicing of concerns or complaints. (Pacific Perspectives Ltd, 2013, p. 10)

Social isolation

McArthur and Barry (2013) noted that many of the parenting challenges younger mothers raise are common to all mothers: feeling tired, unprepared and overwhelmed; having no time

for themselves; getting into a routine; feeling isolated; and having difficulties with breastfeeding. However, these challenges increased if younger mothers were socially isolated and parenting alone.

Many of the younger mothers in their study experienced mental health issues, financial stress or hardship, unstable and inadequate housing and relied on public transport; all of which can be barriers to accessing support services.

Some mothers had limited social networks, or did not have family and friends who could assist with parenting and childcare. Many did not access activities such as playgroups and mothers' groups because they felt they did not 'fit in'.

I was excluded from the normal things that mothers got to do which was go to Playcentre or go to mothers groups, nobody invited me into those things and I was too young to insist ... (Banks, 2008, p. 65)

Many of the women could not pay a babysitter which limited their ability to have time out from their children and socialise with other people (Banks, 2008, p. 84), as well as their ability to engage in further study or employment.

In a British study (Hogg & Worth, 2009), parents of 44 children took part in interviews or small group discussions on the challenges they faced. They said that having self-confidence, previous experience of caring for children and an effective social network of family and friends were essential for successful parenting. Social isolation was highlighted as the main cause of difficulty.

Housing

Sole mothers are vulnerable to overcrowding. Research has shown that sole parent households are more likely to be living in single bedroom dwellings with parent and children sharing bedroom space (Saville-Smith, James, Warren, & Fraser, 2008). Inability to access safe and appropriate housing not only exposed the young mother to risk but also had an impact on the health and wellbeing of her children.

The house has cockroaches. It's been fumigated but they won't go away, so we're moving.

It's cold in the sleep out and there's not enough room for baby. The section is not suitable for baby. (Saville-Smith et al., 2008, p. 28)

Participants in the study referred to unaffordable housing costs, high upfront costs, the negative attitudes of real estate agents and landlords, a lack of accommodation that is easily accessible to public transport and employment, education/training and facilities such as shops, health centres and, for young mothers, facilities for early childhood education. Mothers' comments included:

I'm just coping with the finances. There's no left over money at the end of the week. I can't pay to fix the car.

The biggest barrier is the bond, \$1,600. (Saville-Smith et al., 2008, p. 21)

Young mothers also wanted safe accommodation. Some felt they had to take Housing New Zealand Corporation¹ accommodation in what they considered to be unsafe areas, simply because they cannot see any other option. Other young mothers took up private rental accommodation because they felt safer.

Housing New Zealand [sic], you don't get to choose, often it's not safe ... doesn't take into account that families should be in safe environments.

I didn't even think of going to Housing New Zealand [sic] because I needed a house immediately and didn't want to go into an unsafe area. So I went private, but it's more expensive. (Saville-Smith et al., 2008, p. 28)

In 2015, the Ministry of Social Development issued a set of service specifications for supported housing for vulnerable teen parents and their children. The aim is to provide specialist supported, safe, stable and affordable housing for this group which will help them adjust to parenting and develop knowledge and skills for independent living.

Other issues identified in the literature

The literature identifies other challenges for vulnerable mothers and their children: mental health and addiction issues; poor nutrition; high levels of stress; and poor parenting skills.

Mental health and addiction issues

In 2011, the Ministry of Health published guidelines for developing perinatal and infant mental health services in New Zealand. The rationale for the strategy came from an extensive body of research. Its findings included:

- The onset of mental illness for women has been shown to be higher around the time of childbirth. During this period women are particularly at risk for the onset or recurrence of mood disorders.
- Maternal mental illness during pregnancy and the postpartum period has been shown to have a detrimental effect on the emerging mother–infant relationship and other family and whānau relationships.
- The disruption of this relationship in the absence of other nurturing primary caregiving relationships can result in delayed social and emotional development and/or significant behavioural problems for the infant.
- Poor early social, emotional and behavioural development predicts early school failure which in turn predicts later school failure.
- Social, emotional and/or behavioural problems that emerge during early childhood have been associated with mental illness, chronic health problems, unemployment and offending that may persist into adulthood.
- Early adverse environments often have a cluster of risk factors that co-occur with maternal mental illness and/or AOD problems, such as prematurity, poverty and domestic violence. These risk factors threaten the mother's psychological wellbeing and, in turn, the emerging mother–infant relationship.
- Early intervention builds strength and resilience, which can reduce the need for later high-cost interventions for both mother and infant (Ministry of Health, 2011, p. 3).

¹ Note: Arrangements for social housing have since changed but the issues remain the same.

The paper identified feeding problems, excessive crying and parents' response to that, relationship problems and attachment, behavioural problems and developmental disabilities as contributors to poor parental mental health and stress. It notes that the incidence of non-accidental head injury is particularly high among Māori, who also have a higher rate of mental illness generally. One study suggests Pacific children may have a higher than average rate of problem behaviour. Associated risks for poor mental health include poverty, social isolation, young parenthood, family and whānau violence and alcohol and drug abuse.

Ministry of Health (2015) guidelines aimed to support and promote positive family relationships and the social and emotional development of the children of parents with mental health and/or addiction issues. The guidelines set out the rationale on which they are based:

A study of the mental health risks associated with mothers with serious mental health issues makes it clear that a diagnosis of a mental health issue is likely to be only one component of the overall vulnerabilities that they and their families and whānau experience. Mothers with serious mental health issues are also more likely to experience family disruptions and conflicts, single parent status, social isolation, and financial and other stressors associated with living in poverty. Similarly, families in which parents are involved in problematic substance use often have an assortment of stressors that will impact on parenting ability and family functioning. These adverse environmental factors mean that many children of parents with mental health and/or addiction issues can experience intermittent or permanent separation, inadequate accommodation and/or frequent changes in residence and schools. (Ministry of Health, 2015, p. 3)

Mothers' views on how services to support mothers with mental health and addiction issues can work best with families and whānau are discussed in Section 4.1 below.

Nutrition

The Growing Up in New Zealand (GUINZ, 2014) policy brief looked at the dietary intake of pregnant women in New Zealand, and where they received their information about diet and nutrition. The research explored women's consumption of the four major food groups: vegetables and fruit; bread and cereals; milk and milk products; and lean meat, meat alternatives and eggs.

The authors found that:

- approximately 38 percent of the pregnant women met guideline recommendations for one food group
- 25 percent met the recommendations for two food groups
- 10 percent met the recommendations for three food groups
- 3 percent of pregnant women met all four food group serving recommendations.

Overall, 24 percent of pregnant women did not meet the Ministry of Health recommendations for daily servings for any of the four main food groups.

Almost all pregnant women within Growing Up in New Zealand made deliberate changes to their diets during pregnancy, with 87 percent deliberately avoiding certain food or drinks – most often alcohol, caffeinated beverages, deli and processed goods, raw foods and shellfish. Mothers who had the highest educational qualifications were more likely to avoid foods that could potentially be harmful in pregnancy. The most common source for dietary information (for three-quarters of women) was their midwife. Other frequently cited sources of dietary information were family doctors (GPs), printed media and friends and family.

4. What works to support vulnerable mothers

Strategies identified by the women

Having long-term trusting relationship with a provider or service

Vulnerable mothers thought the most effective way to support them is through building positive relationships. The Counties Manukau research, for example, recorded many examples of excellent practice based on long-term care relationships.

We were told about continuity of care, with mothers choosing one provider for maternity care across a number of pregnancies; vulnerable mothers able to access general practice care daily for concerns in the newborn care and infant health period; and culturally competent care integrating health, social and educational needs. We noted that these ‘champions’ of maternity care worked in private and public midwifery practices, general practices and secondary care settings and were readily identified by mothers. (Pacific Perspectives Ltd, 2013, p. 12)

Interviews with young Māori mothers concluded that the role of a primary care practitioner (GP, primary care nurse) had a considerable influence on a woman’s pregnancy (Makowharemahihi et al., 2014). Some health professionals went beyond pregnancy testing and provided additional antenatal support. When this happened, participants were more likely to experience a continuous maternity care pathway.

Participants in the Makowharemahihi et al. (2014) study were often long-term users of school-based or community-based youth health services and had established relationships with the doctors and nurses. These prior relationships with their primary healthcare provider influenced the decision about which service they engaged with. For example, a nurse helped identify, contact and organise a midwife (Makowharemahihi et al., 2014, p. 58).

Younger mothers appreciated when workers were able to understand their particular circumstances, and when services provided a range of ways they could access support (Boulden, 2010).

Mothers were very positive about the Family Start programme:

Family Start ... have just been absolutely brilliant, they are wonderful, wonderful people, really, really huge help if you’re frustrated with your child and you don’t know where else to turn, you pick up the phone and you ring one of those ladies, and they’re just so calm and peaceful and patient, and can help you with whatever. (Banks, 2008, p. 94)

Local community groups can also support young mothers. The Thrive Teen Parent Support Trust in Auckland has 300 young parents on its database and connects with them via newsletters, Facebook and programmes. Of the 15 staff at Thrive, 13 either were, or currently are, young parents. “*This means we have an empathy and understanding for everyone who seeks our support.*” One staff member commented:

Thrive has helped me develop my skills and confidence as a parent. It is a great, positive environment and I have had so many training opportunities that have set my life on a new path. Thrive has opened doors for me and I am now able to teach infant massage, which is exciting, challenging and rewarding. Thrive helped me to figure out what kind of parent I wanted to be, and my daughter is happy because she knows I am happy. (See <http://tindall.org.nz/thrive-teen-parenting-centre-empowering-young-parents-to-build-thriving-families/>)

A Families Commission (2011) paper concluded that teenage parents need access to coordinated social services that respond to their complex needs. The report noted that young parents often find it difficult to access legal advice, benefits, secure and affordable housing, health services, education or training opportunities, childcare and employment. Research strongly supports having dedicated services for young parents and offering support via a specific person (case worker), mentor or network. The paper described the Hawke’s Bay Teenage Parenting Network which provided a local example of a successful operating network.

It has strengthened links between existing services, developed interagency relationships and joint case planning to meet the needs of teenage parents and their families and whānau, and provided teenage parents with referrals to services and support. (Families Commission, 2011, p. 3)

In Australia, McArthur and Barry (2013) found that younger mothers involved with statutory child protection services had mixed views about their engagement. Those who saw visits by statutory services to be investigatory rather than supportive were more defensive and fearful of having their children removed, compared with those who had been supported by statutory services to access early intervention programmes. The authors identify five strategies to support young mothers:

- **Reduce stigma and recognise the importance of caring for young children.** As stigma and disapproval was shown to have a detrimental effect on younger mothers’ willingness and readiness to access support, policies and services should be cautious about future directions that further stigmatise younger mothers. Services should celebrate younger mothers’ courage against the odds, their devotion to their children and their achievements as mothers.
- **Leverage child health and wellbeing services to reach younger parents.** Hospitals, general practitioners, health services and other universal services are best placed to reach vulnerable younger mothers, who will be more likely to take up play-groups, parenting education and other activities from these settings.

- **Make it easy for younger mothers to access a range of services through service hubs and outreach.** Getting around to services, and paying for them, can be difficult for younger mothers with limited financial resources. Younger mothers suggested that services be placed together in 'hubs', that workers provide active outreach (including home visits and phone calls) and provide more online information and opportunities.
- **Prioritise relationship assistance to younger parents.** Very few younger mothers knew about or had accessed family relationship services; some had tried but had not been able to access assistance due to long waiting lists.
- **Offer voluntary, individualised 'futures planning'.** Many younger mothers would benefit from voluntary, non-stigmatising planning and support that would respond to their individual circumstances, hopes and aspirations, and assist them to plan for their own and their children's futures.

Getting support from a trusted individual

A study of nine young Māori mothers found that most mothers had good support from their family and friends (Casey, 2007), with immediate family members as the main source of support. Most support was provided by mothers, sisters, friends and midwives. Family members provided childcare support, where there was always someone available to care for children at short notice.

Most younger mothers preferred to go to friends and family for advice and support rather than see a counsellor (McArthur and Barry, 2013). However, those who did seek counselling preferred to see someone young or who understood their position. They felt it was important that support services build positive, trusting relationships, have non-judgemental attitudes and acknowledge that being a mother is a learning curve for mothers of all ages. They wanted workers to focus on what was going well, rather than what wasn't. Some spoke positively about the support they had received from smaller, targeted services, such as family support services and crisis services.

The Counties Manukau study found that mothers were more likely to act on information if the 'messenger' was similar to themselves in age or behaviour or demonstrated a comprehensive, non-judgemental and practical understanding of the mothers' background and worldview (Pacific Perspectives Ltd, 2013)

Peer support and mentoring

Support from individuals is sometimes organised on a more formal basis through peer-to-peer support and mentoring programmes.

In Australia, Mentoring Mums is a volunteer mentoring programme offering social, emotional and practical support to vulnerable, new or expectant mothers. In a recent evaluation, participants all said they accepted referral into the programme because of their feelings of loneliness and isolation, lack of support, distance from their families and anxieties about coping with their first baby (Absler, Mitchell, & Humphreys, 2011).

One said that at that time, she was “*freaking out. I didn’t want the baby and thought I would be the world’s worst Mum.*”

All the mothers were positive about their experience with the programme, describing it as very helpful and making it “*easier for me to cope*”. For one mother, having the mentor in her life had been “*... a godsend. I adore her. She brings joy to everything.*”

They described the benefits of the programme:

1. The mentor comes to their home and provides a diverse range of services. These include:
 - a. practical assistance – caring for the child while she has a shower, providing guidance – information, talking about solutions, ‘how to look after my baby,’ helping with the baby’s sleeping problems.
 - b. emotional support both in a general way through providing company and ‘...someone to talk to’ but also promoting a sense of safety that allows the women to share their concerns and difficulties – ‘I can talk to her about my feelings.’ ‘She calms me,’ ‘she helped me through a difficult time.’
 - c. interacting with her baby – one mother identified that when her mentor is present her baby is more talkative.
2. The mentor provides support outside the home by:
 - a. taking her shopping, for coffee, lunch, taking her to appointments. In relation to the latter one mother said ‘... When I first met her I was 7 months pregnant and hadn’t been to see anyone. She said I must go and made sure I did.’
 - b. As one of the mothers explained, ‘providing the sort of support you would have if you had your family around’ e.g. ‘...helped me home from hospital after I had my baby (Absler et al., 2011, pp. 43–44).

In the United Kingdom, a number of family support services offer peer-to-peer support or mentoring. In a review by McLeish and Redshaw (2017), the 47 participants included refugee, migrant and ethnic minority women as well as young mothers. The age range was 19 to 40 and most participants were single mothers. Volunteers worked with the mothers on a one-to-one basis.

The women’s concerns fell into four areas: emotional distress; stressful circumstances; lack of social support; and unwillingness to be open with professionals. The impact of peer support included: social connection; being heard; building confidence; empowerment; feeling valued; reducing stress through practical support; and the significance of mental health peer experience.

A home visiting project in the United Kingdom relied on paraprofessionals – health visitor or midwifery assistants – rather than nurses. Clients could be referred into the project if they were a first-time mother aged 17 to 25 years at level 1 or 2 vulnerability on the local child concern model (where the carer was under stress that might affect their child’s health and

development). Typical problems encountered included isolation, lack of confidence, housing stress, financial problems, unstable relationships and chaotic lifestyles. The intention (determined by funding rather than the evidence base) was that one-to-one support could be delivered until the baby was six months old. Interviews with the clients showed that the 'listening ear' and approachability of the link workers was a highly valued element of support:

[The link worker] was really easy to talk to, I felt comfortable and she was very welcoming.

I can talk to [the link worker] about anything, I can. It's like not just being there to help, she's more like a friend ... I can just ring her, text her and just let her know that I need someone to talk to. (Halliday & Wilkinson, 2009, p. 30)

Teen Parent Units

There are now 22 Teen Parent Units (TPUs) in New Zealand, which provide young parents with an opportunity to continue their secondary education. The other options for young parents include mainstream schooling, alternative education or Te Aho o Te Kura Pounamu – The Correspondence School.

In 2014, the Education Review Office (ERO) concluded that most of New Zealand's TPUs are performing well.

Fifteen of the 21 units in this evaluation demonstrated practices that led to better educational, social and health outcomes for students. Many of the students had previously struggled in mainstream education, and following the birth of their children, would have been unlikely to return to normal secondary schooling. Five of these 15 TPUs were particularly 'innovative and cohesive' in their approach. These TPUs had coordinated systems, teaching and support. They responded well to student needs and aspirations. (Education Review Office, 2014, p. 8)

Students at highly performing TPUs were often very successful.

At 16 I left school, was never going back. I fell pregnant and found this place. I had no NCEA [National Certificate of Educational Achievement] at all. Being here for two years I have gained my NCEA Level 1 and 2 and am working on my Level 3. I also got my [driver's] licence here too. (Education Review Office, 2014, p. 10)

If it wasn't for [the TPU] I wouldn't have gotten a job from doing work experience. [The TPU] has really made me look at things in a whole different light. I came here with no credits or confidence, now I'm on [NCEA] Level 3, have a part-time job, also have my own house, sorting out money issues all while getting an education to follow my career path. (Education Review Office, 2014, p. 11)

TPUs such as the Taonga Teen Parenting Unit in Auckland have been established specifically to educate and nurture young Māori parents and their children, guided by the theory of Kaupapa Māori (Strickett & Moewaka-Barnes, 2012). This approach is responsive to the needs of the parent and child, where they are both valued.

In Rawiri's (2007, p. 135) study of young Māori mothers, easy access to multiple avenues of education, like apprenticeships and post-secondary school courses, allowed participants to pursue their education. It also meant some participants were given more options.

Parenting programmes²

The Campbell Collaboration Policy Brief (n.d. p3) noted that “parenting programmes are provided to parents to enhance parents’ knowledge, skills and understanding and so improve both child and parent behavioural and psychological outcomes. These programmes are typically offered to parents over the course of eight to 12 weeks, for about one to two hours each week. Most use a standardized, manual-based programme or curriculum. The brief concluded that parenting programmes are effective in improving aspects of parents’ psychosocial functioning (eg, depression, anxiety, stress, anger, guilt, confidence and satisfaction with the partner relationship) in the short term.

The results for young mothers are less certain.

The evidence with regard to the needs of specific groups of parents such as teenage parents and parents with intellectual disability looks promising, with improved outcomes for both parent and children. However, further research is still needed. (Campbell Collaboration, n.d., p. 3)

Supporting mothers with mental health and addiction issues

Some mothers are vulnerable because they have mental health and addiction issues. In 2015, the Ministry of Health prepared guidelines on supporting parents with mental illness and addiction and their children. The guidelines drew on the views of young people and parents on how services can work best with families and whānau. They collated their suggestions under three headings:

Ask about our family and whānau and include them in ways that work

The first time I entered services I wasn't even asked if I was a parent (I was 21 and had two children). The second time they asked and then asked, 'Have you got that covered while you stay in hospital?' and that was it. Don't assume people who use your services aren't the type to have kids – we often are and no one has asked us about it. Initiate conversation about how our families are doing. Involve and support our wider family and whānau (p.15).

Acknowledge and respect our strengths

I believe that having my daughter helped my mental illness, particularly when my depression has worsened. She has given me purpose, a reason to get up in the morning, and has been cause for happiness, and an incredible amount of pride (p. 16).

² Note: This review does not consider formal parenting programmes in detail. These have been reviewed in: Robertson, J. (2015). *Effective parenting programmes*. Wellington: Superu – The Families Commission, see: <http://www.superu.govt.nz/sites/default/files/What%20Works%20Effective%20parent%20programs.pdf>; the Campbell Collaboration policy brief, see: https://www.campbellcollaboration.org/images/pdf/Campbell_Policy_Brief_1.pdf

It's about so much more than protection

Services need to be able to support us to stay well and that means supporting us to parent well too, rather than just waiting until there is a crisis to intervene with care and protection concerns at the fore ... The thought of a care and protection referral is daunting for parents using services. We often have no idea of the threshold for concerns to be passed on to Child, Youth and Family, and this uncertainty, combined with our low self-esteem and self-stigma, can make it hard for us to talk about issues and get support for our families (p. 17).

5. Conclusion

This brief literature review has focused on vulnerable women's experiences of pregnancy, birth and parenting. It has highlighted young women's experiences of stigma, discrimination and being patronised or ignored.

Vulnerable women appreciated people in health and social services who took time to listen and engage with them, who were willing to walk alongside them without judgement and recognise and build on their strengths. Family members, including extended family particularly for Māori and Pacific mothers, provided valued practical and emotional support, as did mentors or peer supporters who had shared similar experiences.

Support workers will need to be carefully selected and trained, with access to networks and a willingness to commit to their clients for a reasonable time. Building long-term trusting relationships should be given the highest priority. These relationships will provide a conduit for passing on information and encouraging its uptake.

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