NORTHERN REGION
Infant and Maternal Mental Health Environmental Scan

January 2025

Health New Zealand
Te Whatu Ora

Contents

Executive Summary

Purpose

This project was commissioned by Health New Zealand |Te Whatu Ora National Mental Health Commissioning to Health New Zealand | Te Whatu Ora Northern Regional Mental Health and Addiction Network on behalf of the four districts of the Northern Region. The Northern Region, as well as the other three regions of New Zealand defined by Health New Zealand |Te Whatu Ora, were tasked with outlining the infant and maternal mental health and addition services within their region.

Budget 2022 provided $10.1 million of funding for specialist maternal and infant mental health and AOD services to increase availability of services and to trial new models of care. There is currently significant variability of investment across the district maternal mental services relative to population size and need, therefore budget 2022 funding will be allocated across regions using a methodology that ensures movement to equity of funding per capita nationally.

This programme of work has been aligned to Kahu Taurima | Maternity and Early Years, the priority programme within Te Pae Tata. It contributes to the deliverable to improve access to specialist mental health services, as part of the development of a maternal mental health and wellbeing pathway.

Context

The environmental scan was guided by the Pregnancy, Early Parenthood and Infant (PEPI) Mental Health Regional Governance Group and supported by a project advisory group.

Previous work carried out by the Northern Region including the development of the PEPI Regional Governance Group work programme, and research supporting equitable perinatal mental health outcomes for Pacific and Asian Women were used to inform the recommendations within this report.

Approach

To ensure the delivery of a well-informed report, a project advisory group was established to provide subject matter expertise and support. Membership reflected representation from all four districts of the region and consisted of clinical and community workforce within the infant and maternal health care system.

Clinical and community stakeholder perspectives across the continuum of care were gathered through interview either in person, over the phone or via email. Over 40 stakeholders were engaged providing perspectives from mental health, alcohol and other drug services (AOD), primary care, community sectors and Māori, Pacific and Asian populations.

Insights were gathered from 131 whānau who had either experienced mental illness or AOD problems during pregnancy or postpartum or had supported someone through this. These insights were used to inform this report.

Data analysts provided population, birthing and service usage information to shape the bigger picture and when combined with stakeholder and whānau insights, identify areas of need.

Findings

The Northern Region faces a fragmented continuum of care, with gaps between services leading to high demand on some providers and underutilisation of others. This environmental scan reinforces the need for robust support at the community and primary health care levels, increased awareness of available services, and enhanced professional development in infant and perinatal mental health and AOD problems**.** Furthermore, culturally aligned services with staff trained in culturally safe care are crucial for achieving equitable health outcomes for Māori, Pacific, and Asian populations, as well as disabled and rainbow communities. In the current fiscal environment, greater connection and collaboration across services, as well as prioritising funding to replicate successful models, are essential to better meet the needs of māma, whānau, and pēpi.

Recommendations

These recommendations have been developed based on the brief for this environmental scan and the insights shared by māma, whānau, and the workforce. We recognise that bringing these recommendations to fruition will require considerable effort in planning, development, and implementation. We also acknowledge that similar initiatives may already be underway and any work on these recommendations will need to align with and consider these ongoing efforts.

Continuum of Care
1. Increase infant mental health services across the region 2. Increase lived experience workforce 3. Enhance specialist knowledge and competency throughout the continuum of care
Health Pathways
4. Establish regionally aligned multiagency forums as a pathway into care 5. Promote wellbeing and raise awareness of support services through community and primary care settings 6. Build awareness of community-based specialist infant and maternal mental health and AOD services within the healthcare sector 7. Enhance referral processes by specialist and triage teams 8. Co-locate maternal mental health services within maternity and early years services 9. Develop a regional infant and maternal mental health and AOD network to support relationship-building and enhance collaboration across services
Addressing the needs of Māori and other priority populations
10. Services adopt culturally prioritised ways of working 11. Increase service provision for culturally specific supports 12. Invest in our workforce

Introduction

The largest cause of maternal death is suicide, and māma Māori are almost three times more likely to die by suicide compared to NZ European mothers according to the 2022 report from the Perinatal and Maternal Mortality Review Committee (PMMRC)[1]. Further exploration of case studies indicated that that less than half of these women were known to mental health or drug and alcohol services prior to their death, demonstrating an alternative approach is needed to identify those at risk. The PMMRC has recommended a comprehensive assessment of risk factors at confirmation of pregnancy and/or first presentation of antenatal care.

Perinatal mental health is foundational to a strong whānau unit with significant influence on the strength and development of intrafamily relationships. Women have been shown to be at higher risk of mental illnesses during times of hormonal fluctuation, including pregnancy and the postpartum period.[2] An estimated 15% of people in New Zealand develop depression, anxiety, or other mental health issues during the perinatal period[3] with Māori, Pacific and Asian māma disproportionately affected.[4,5,6,7]

Substance use during pregnancy can have adverse health outcomes for both the pregnant person and their developing child with impacts varying depending on the specific substance used. The most common substances used are alcohol, tobacco, cannabis and opioids.[8] There is limited data available on substance use in pregnant people in New Zealand, however findings from the *Growing Up in New Zealand* study found that 23% of women reported consuming alcohol[9] and 9.9% reported smoking tobacco during pregnancy.[10] The full impact of substance use on infants during pregnancy remains unknown. Some known outcomes include fetal alcohol spectrum disorder, infant drug withdrawal, growth restriction, birth defects and developmental disabilities. Additionally, pregnant or postpartum women have an increased risk of adverse health outcomes themselves including spontaneous pregnancy loss, breast cancer, infertility and ectopic pregnancy.[8,11] Women with substance use disorders often have unique concurrent risk factors including mental illness, history of trauma or family violence and poverty; highlighting the importance of holistic and collaborative care in services.

Infant mental health is defined as the young child's capacity for social-emotional development within the context of the system of relationships that form their environment.[3] Early adverse environments including perinatal mental illness and alcohol and other drugs (AOD) problems but also poverty and domestic violence are significantly influential on the development of early relationships between child and primary caregiver/s. Factors specific to the child including developmental or genetic disorders, prematurity and fetal alcohol spectrum disorder are also influential. 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. Evidence for effective clinical intervention is multipronged, with a focus on both strengthening parent-infant relationships and those with wider whānau as well as treating mental health disorders via these relationships.

Studies internationally and in New Zealand have identified the incidence of early mental health problems in infants and toddlers to be between 10 and 18% with tamariki Māori and children with disabilities more likely to have emotional or behavioural problems than non-Māori, non-disabled children.[12,13]

Infant and maternal mental health and AOD services, how they are accessed and by who vary across the Northern Region. This report presents the findings of an environmental scan of these services.

Methodology

Objectives

The expectation is that the key delivery will be a report outlining the results of an environmental scan of all infant and maternal mental health services in the Northern Region. The purpose of which is to:

- Understand the continuum of infant and maternal mental health services across the Northern Region, including identifying any variation in models of service delivery and levels of service delivery – including services provided and funded by Te Whatu Ora
- Identify current pathways between primary mental health services (including Access and Choice services) and specialist infant and maternal mental health services, including eligibility criteria
- Identify opportunities to streamline and align services and ensure clear pathways to and between specialist infant and maternal mental health services as well as opportunities for strengthening the relationship between primary mental health and AOD services and specialist infant and maternal mental health services
- Identify how services are currently addressing the needs of Māori and other priority population groups and any areas for improvement
- Link with the work on current pathways being undertaken as part of Kahu Taurima programme between current maternal and child health services and specialist infant and maternal mental health services. This includes reviewing current referral criteria from maternal and child health services for all specialist maternal mental health services to ensure consistency and also ensure specialist services provide consult liaison services to well child and maternity services.

The environmental scan utilised a combination of consumer feedback, stakeholder engagement and relevant data to inform findings.

Data analysis

Internal analysis was carried out to understand engagement with infant and maternal mental health and AOD services including referral rates, wait times and respite utilisation.

Data was obtained through the following sources:

- Programme for the Integration of Mental Health Data (PRIMHD) to understand the use of specialist infant and maternal mental health and AOD services (provider arm and NGO). PRIMHD contains Ministry of Health funded infant and maternal mental health and AOD service activity and outcomes data. Each organisation submits their data individually into the PRIMHD data base.
- Birth data was obtained through QLIK Maternity App. The most recent year where data was accurate for reporting purposes was 2022.
- Specialist infant mental health services provided data specific to their service.
- Population level data is from the official estimates and projections used by Health New Zealand | Te Whatu Ora, based on 2018 Census, 2023 update, provided by Stats NZ according to assumptions agreed to by Health New Zealand | Te Whatu Ora. As with all estimates and projections there is an element of error that should be considered when viewing the data.

Consumer Voice

Consumer voice data was obtained through interview and survey feedback.

Interviews took place in two tranches May – October 2023 and October – November 2024, with 79 māma and whānau who were currently working with infant or maternal mental health specialist services, specialist maternal AOD services or maternal respite providers. All participants had experience of mental distress associated with pregnancy, childbirth or having young children, AOD problems during the perinatal period or were parents/caregivers of infants/young children experiencing mental distress. Key workers within each service identified those to be approached for feedback and interviews were, except for one service, conducted by consumer advisor teams. Interview questions (Appendix 1) were determined through consultation with clinicians and consumer advisers. Interviews were conducted either in person, over the phone or via email.

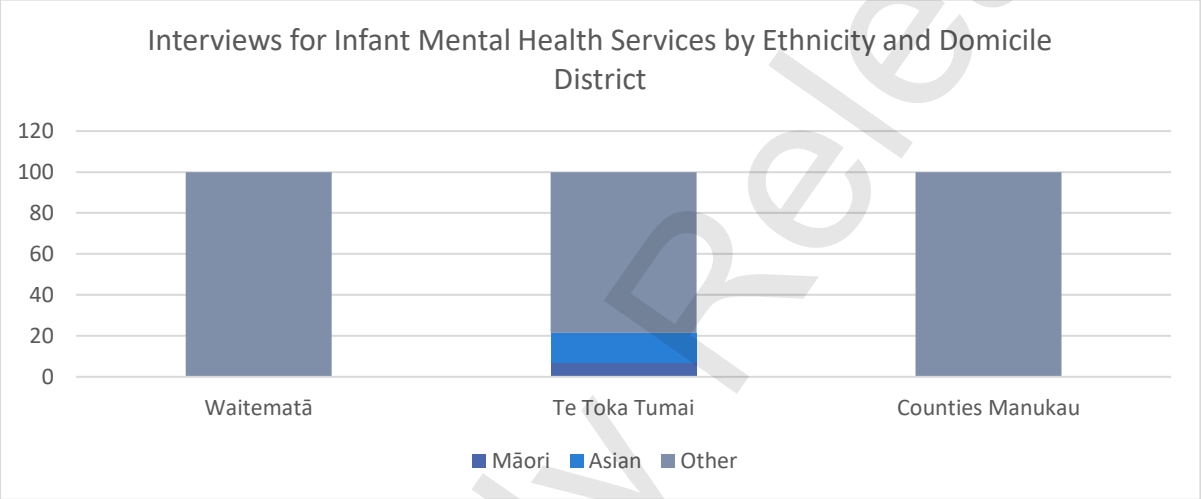

Figure 1: Breakdown of infant mental health service interviews by domicile district and ethnicity

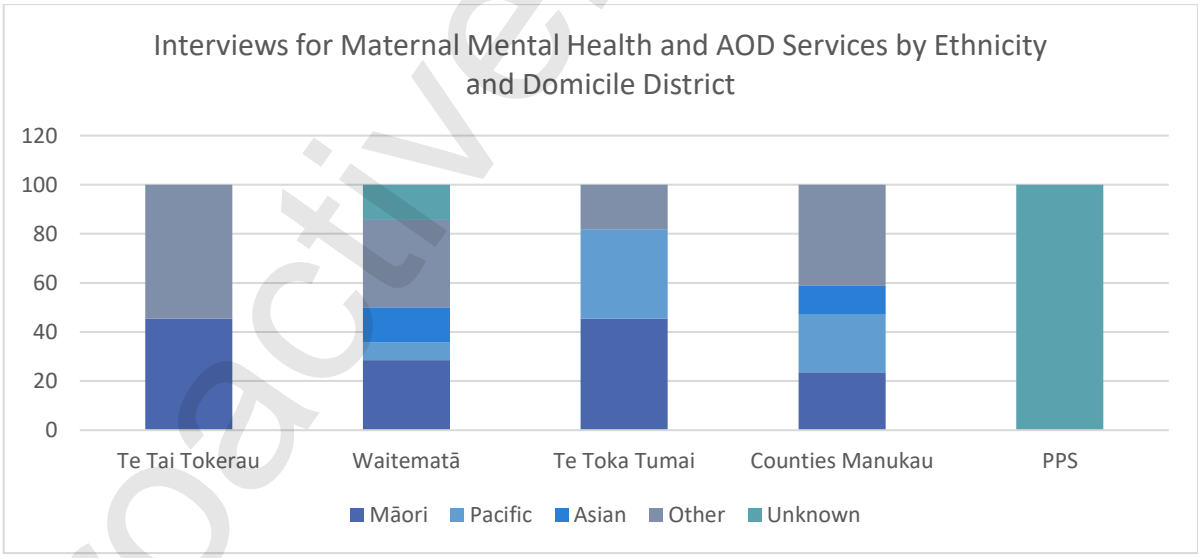

Figure 2: Breakdown of maternal mental health and AOD service interviews by domicile district and ethnicity

Electronic surveys were completed by 52 māma and whānau from the Northern Region. All participants had experience of mental distress associated with pregnancy, childbirth or having young children. The survey was developed by the team of project leads nationally, reviewed and tested by māma with lived experience of mental illness and whānau Māori. Survey links were disseminated

through the networks of the Te Manawa Taki and Central Regions Project Working Group members. Responses from those whose domicile district was within the Northern Region were analysed as part of this environmental scan. See Appendix 2 for survey questions.

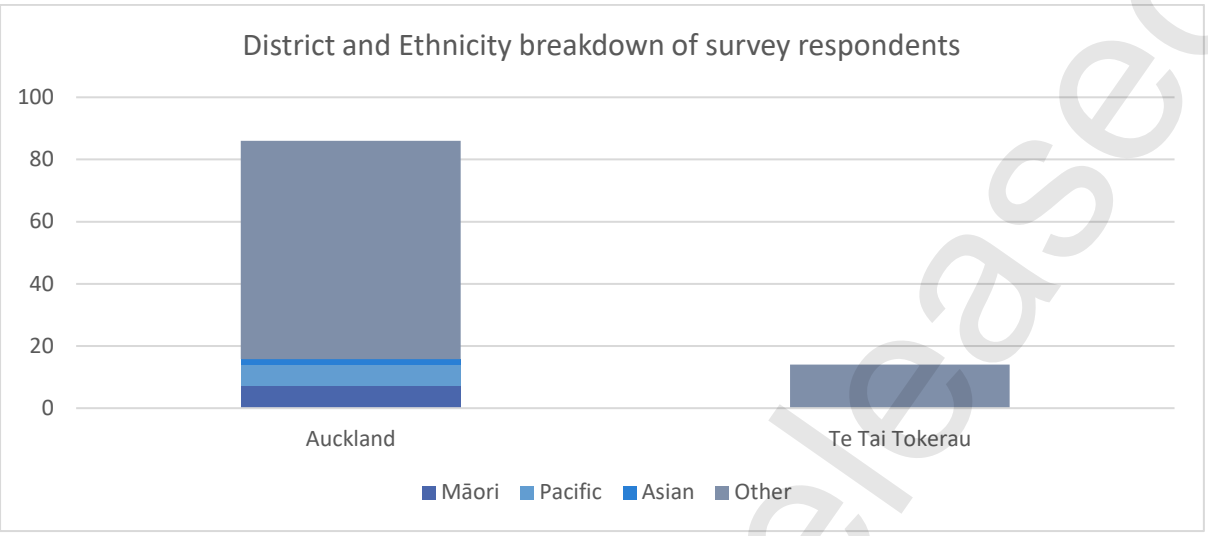

Figure 3: Breakdown of survey respondents by domicile district and ethnicity

Stakeholder engagement

A series of stakeholder hui took place in May 2023. Workforce from infant and maternal mental health and AOD services (NGO and specialist teams) were invited to participate in a series of three hui focussed on the current model of care across the Northern Region and to identify key priorities to improve health equity, accessibility and regional alignment.

One of the key outputs of the hui was a set of agreed principles and shared regional aspiration for PEPI mental health and AOD services (Figure 4). These principles were revisited at each session.

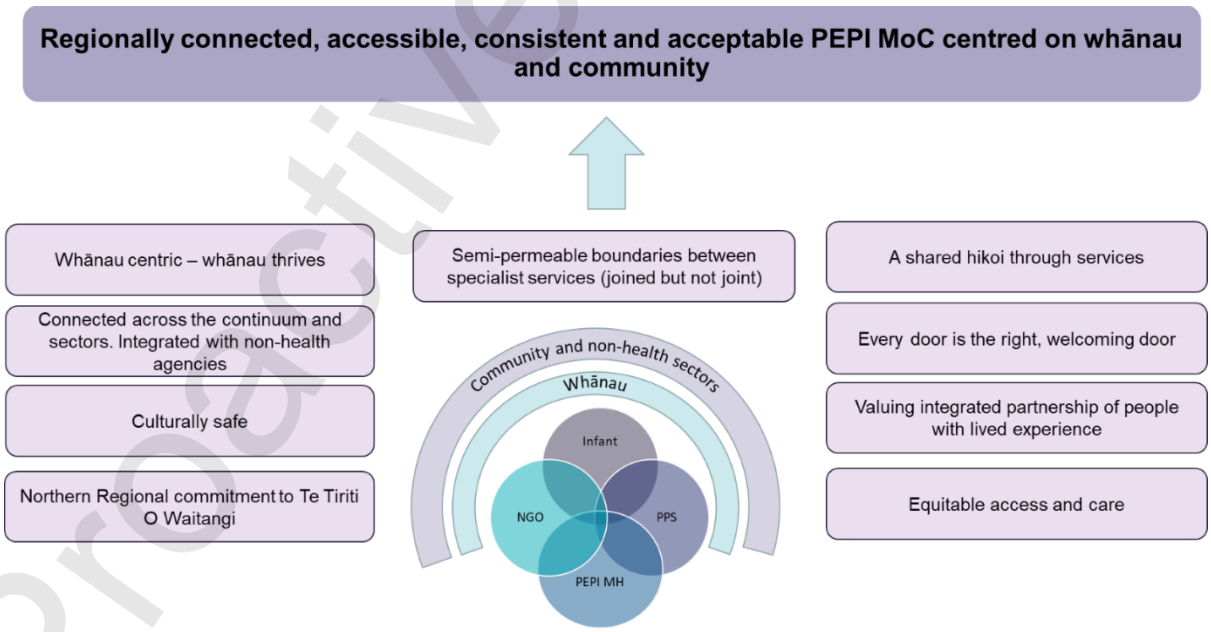

Figure 4: Agreed principles for PEPI mental health and AOD services in the Northern Region

The principles above and the recurrent theme of 'access' informed the development of the PEPI Regional Governance Group's work programme for 2024/2025. The work programme is divided into three priority areas, each with a dedicated working group.

Health Pathways: Ensure mental health and AOD support for all PEPI is accessible, consistent and seamless between primary and secondary services and informed by clinical and cultural PEPI expertise

Te Tiriti Enabled Journey: Ensure PEPI mental health and AOD services are culturally appropriate and prioritise the holistic needs of Māori Tāngata whaiora, pēpi and whānau

NGO Partners: Enhance mental health and wellbeing outcomes for Tāngata whaiora and whānau through strengthening pathways and partnerships between NGO providers and specialist perinatal and infant services

The PEPI Regional Governance Group work programme has been instrumental in providing an avenue for continued stakeholder input into the environmental scan and will continue to shape infant and maternal mental health and AOD services within the region going forward.

Additional engagement was conducted with over 40 stakeholders from within the healthcare system, using various methods including a provider template, free-form conversations, and email correspondence. Stakeholders represented a wide range of services, including:

- Infant mental health services
- Maternal mental health services
- Maternal AOD services
- Cultural health services
- Consumer engagement services
- NGO providers - Specialist maternal mental health and AOD
- NGO providers - Primary mental health and primary care
- Midwives
- Paediatricians
- Primary care
- Training providers

Te Tiriti O Waitangi and Equity

The service level agreement for this environmental scan references section 7 of the Pae Ora (Healthy Futures) Act 2022. This section outlines the Health Sector Principles which describe key outcomes and actions intended to meet our responsibilities under the Articles of Te Tiriti O Waitangi, as articulated by the courts and the Waitangi Tribunal. The Act requires that all health entities implement initiatives that give effect to the principles and that are aimed at improving the health sector for Māori and improving Hauora Māori outcomes.

As outlined, there are significant inequities in health outcomes for Māori compared to non-Māori in the infant and perinatal mental health space. The Northern Region remains committed to enacting the principles of Te Tiriti O Waitangi and will use this project and the wider PEPI Regional Governance Group work programme to contribute towards the shared vision of equitable access, levels of service and health outcomes for Māori.

Additional priority populations exist within the Northern Region. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve

equitable health outcomes. This project acknowledges this disparity and has considered it throughout any recommendations put forward.

Limitations

Although significant effort was placed on ensuring insights were collected from services across the continuum and a diverse range of lived experience whānau, there may be some services or feedback that is limited or missing due to time constraints. What is also important to note, is that necessary boundaries were required to ensure the scope of this project remained specific. We have focused mainly on infant and perinatal mental health and AOD providers however acknowledge that there are a broad range of general mental health and AOD services and community providers that contribute to maintaining mental health and wellbeing during the pregnancy and postpartum period that haven't been mentioned specifically.

Due to data limitations, we were unable to investigate the use of primary mental health and addiction services relating to infant mental health and perinatal mental health and AOD problems. As such we are unable to comment on how well these services are meeting the needs of these client groups from both an intervention and pathway to specialist perspective.

It's important to note that not all māma receiving support for perinatal mental health or AOD problems are using specialist maternal services. Service usage data excludes māma who have a history of mental illness or AOD problems and are retained under the care of their current service provider when pregnant or postpartum, rather than receiving support through maternal mental health or AOD services.

Terminology

While most pregnant and post-partum people identify as women and mothers, we recognise that others have diverse gender identities. Throughout this report we use the terms māma and mother/s and in this context, it is not exclusive to women but includes all who identify as pregnant or a postpartum parent.

Acknowledgement

This project was guided by the PEPI Regional Governance Group, with support from the Project Advisory Group. We extend sincere thanks to all those involved for their dedicated efforts.

Special acknowledgement to māma, whānau and workforce who were interviewed or completed surveys as part of this project. Thank you for taking the time to share your thoughts and experiences with us.

Findings

Profile of the Northern Region

Population

The Northern Region has the largest and fastest growing population of the four regions in New Zealand. Home to approximately 38% of New Zealand's total population (n=1,969,320 estimated residents in 2023), it includes New Zealand's largest city as well a significant rural population (Figure 5). Covering a geographical area of 17,448 km^2 from the top of the North Island to the Franklin District, the Northern Region is divided into four districts: Te Tai Tokerau, Waitematā, Te Toka Tumai and Counties Manukau.

The Northern Region is the most ethnically diverse region in New Zealand with Māori, Pacific and Asian communities (Figure 6) making up 56% of the region's population. The ethnic profile varies across the districts with Te Tai Tokerau having the highest proportion of Māori (36%), Counties Manukau having the highest Pacific population (23%) and Te Toka Tumai and Counties Manukau having the highest Asian population (35% and 31%). Conversely, Te Tai Tokerau has both the lowest proportion of Asian and Pacific within the region (5% and 2%). The region's diversity also extends beyond ethnicity with significant multiformity in social deprivation (Figure 7), life expectancy, ethnic makeup and rurality of the population.

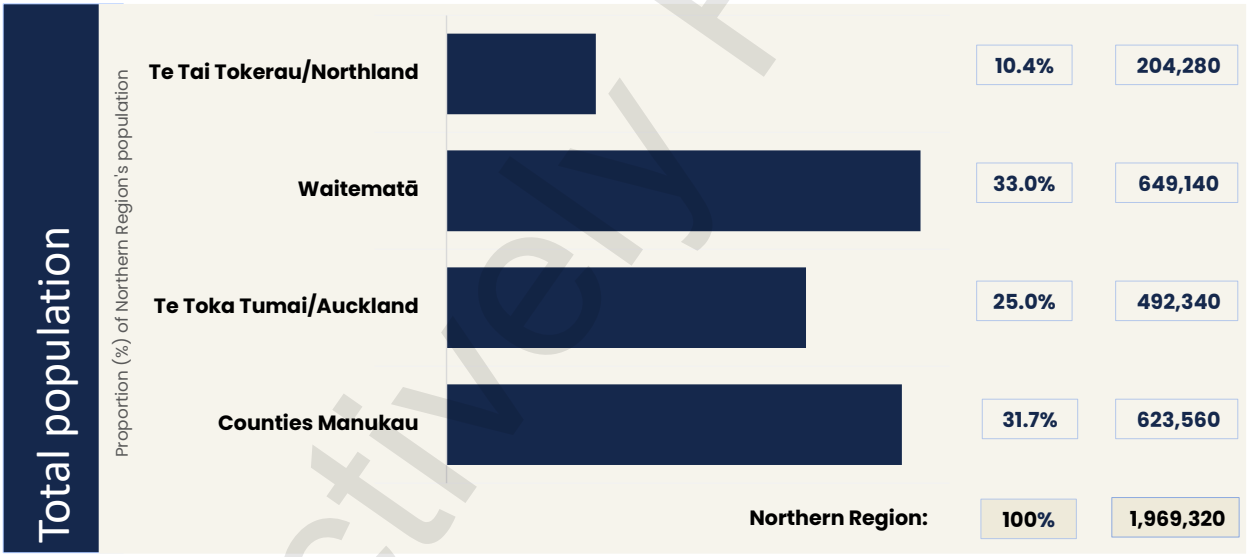

Figure 5: Northern Region Population Data for 2023 (Data Source: Demographic Profile of the Northern Region)

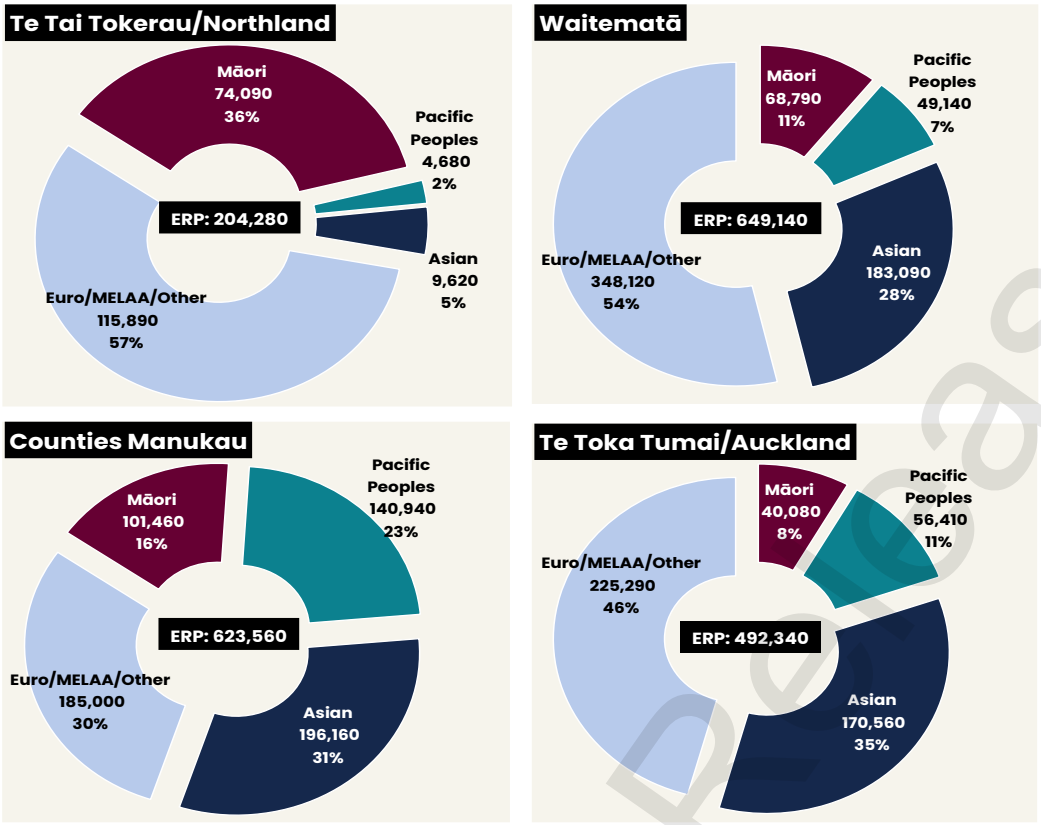

Figure 6: Distribution of population by Ethnicity in the Northern Region 2023 (Data Source: Demographic Profile of the Northern Region)

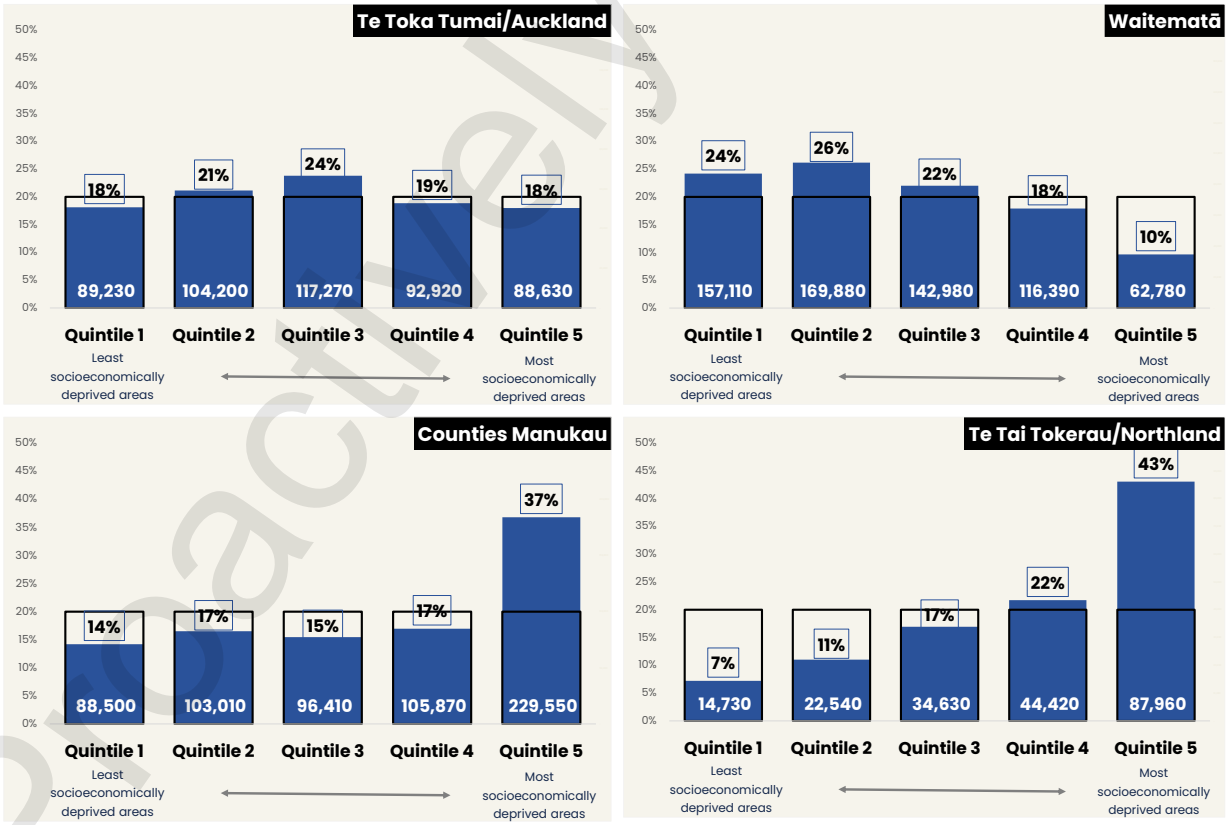

Figure 7: Socioeconomic deprivation by district using data from NZDep2018 (Data Source: Demographic Profile of the Northern Region)

Birth Data

In the 2021/2022 year, there were 23,653 live births across the Northern Region, with the highest birth rate recorded in the Counties Manukau district. Counties Manukau had a birth rate of 140 per 10,000 people, compared to Waitematā, which has a similar total population but a lower birth rate of 121 per 10,000 people (Table 1). When examining live births by ethnicity, Māori and Pacific populations had significantly higher birth rates—168 per 10,000 and 178 per 10,000, respectively—compared to Asian and European/MELAA/Other populations (Table 2). The considerable Māori and Pacific populations in Counties Manukau (Figure 6) are likely contributing factors to its significant birth rate.

To assess births by socioeconomic deprivation, the NZDep index was used. Births over time (2018 – 2022) were analysed by deprivation. Quintile 1 representing the least deprived through to Quintile 5 for the most deprived. In the Northern Region a higher proportion of the population live in areas of highest socioeconomic deprivation[14] and similarly, the number of births has consistently been highest among mothers living in 'Quintile 5' areas (Figure 8). When assessing socioeconomic deprivation by district, Te Tai Tokerau has the highest proportion of people living in the most socioeconomically deprived areas at 43%, followed by Counties Manukau at 37%.[14]

With 15% of women expected to experience significant (moderate to severe) mental health distress during the perinatal period[15] we would expect that a large proportion of these women would be wāhine Māori or Pacific and live in areas of high socioeconomic deprivation within Counties Manukau district. Following this theory, we would also anticipate that support for infant and maternal mental health is more concentrated in these areas.

Table 1: Birth data and access to maternal mental health (MMH) services for the Northern Region (2021/2022)

District	Total Population	Number of Live Births	Birth Rate per 10,000	Number of māma referred to MMH services	% birthing women accessing MMH services
Te Toka Tumai | Auckland	486360	5233	108	649	12%
Counties Manukau	601580	8394	140	479	6%
Te Tai Tokerau | Northland	200230	2342	117	203	9%
Waitematā	634170	7684	121	237	3%
Total	1,922,340	23,653		1850	36%

Table 2: Birth data for Northern Region by Ethnicity (2021/2022)

Ethnicity	Total population	Number of live births	Birth rate per 10000 people
Asian	496310	6366	128
Māori	278840	4681	168
Pacific	246590	4246	172
European/MELAA/Other	900600	8355	93

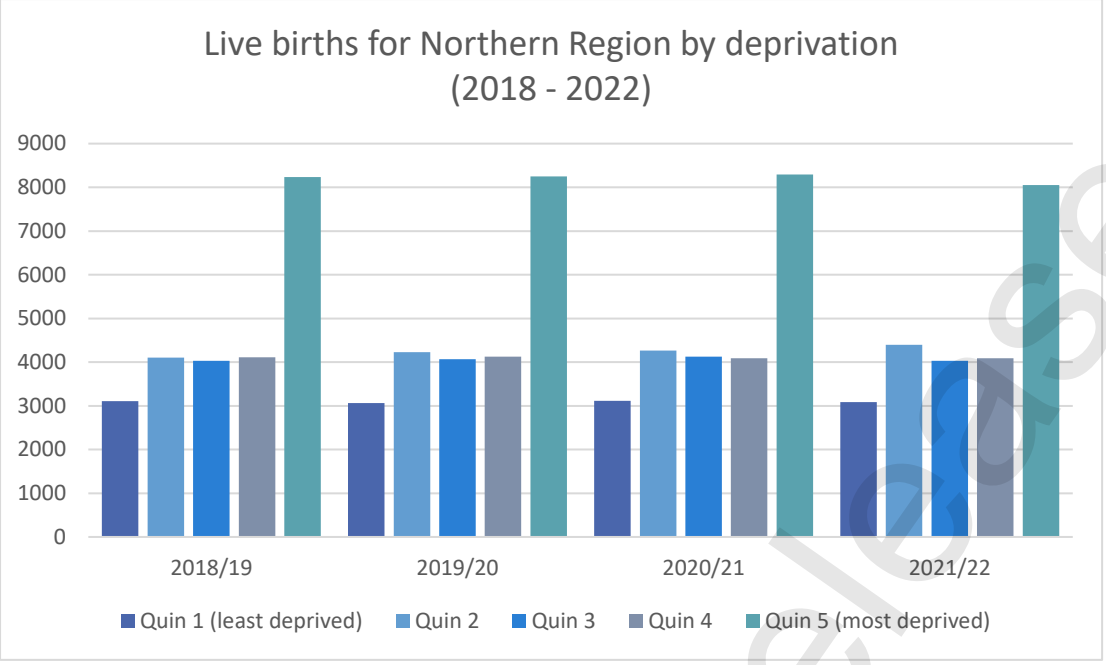

Figure 8: Birth data for Northern Region by Deprivation (2021/2022))

Service Usage

Maternal Mental Health

When assessing the number of referrals to maternal mental health services as a percentage of live births (23,653) for the year 2021/2022 (Table 1) if using the anticipated percentage of 15% experiencing significant maternal mental health distress you would expect to see 3548 women being referred to maternal mental health services. Actual percentage of birthing women referred to maternal mental health are in all districts bar Te Toka Tumai considerably lower than this. Counties Manukau –perhaps the district with the greatest need –receiving referrals from only 6% of the birthing population, while Waitematā receives referrals from just 3%. While some māma may be receiving support through alternative community services, there is a possibility that a portion of the population with expected needs are without care. Both Counties Manukau and Waitematā are considered tertiary services, with separate referral management teams (RMT) responsible for triaging, suggesting a potential link between triaging processes and referral numbers. Further investigation is needed to better understand the reasons behind this variability.

Te Tai Tokerau and Te Toka Tumai districts have the highest proportion of referrals per 100,000 people in the region for the 2023/2024 year (Figure 9). This suggests that a larger proportion of their populations are seeking help for maternal mental health issues. Despite high referral rates, the proportion of referrals for each ethnicity does not align with the ethnic population distribution within these districts. There is a noticeable skew, with higher referral rates for māma Māori and much lower rates for Asian māma across all districts.

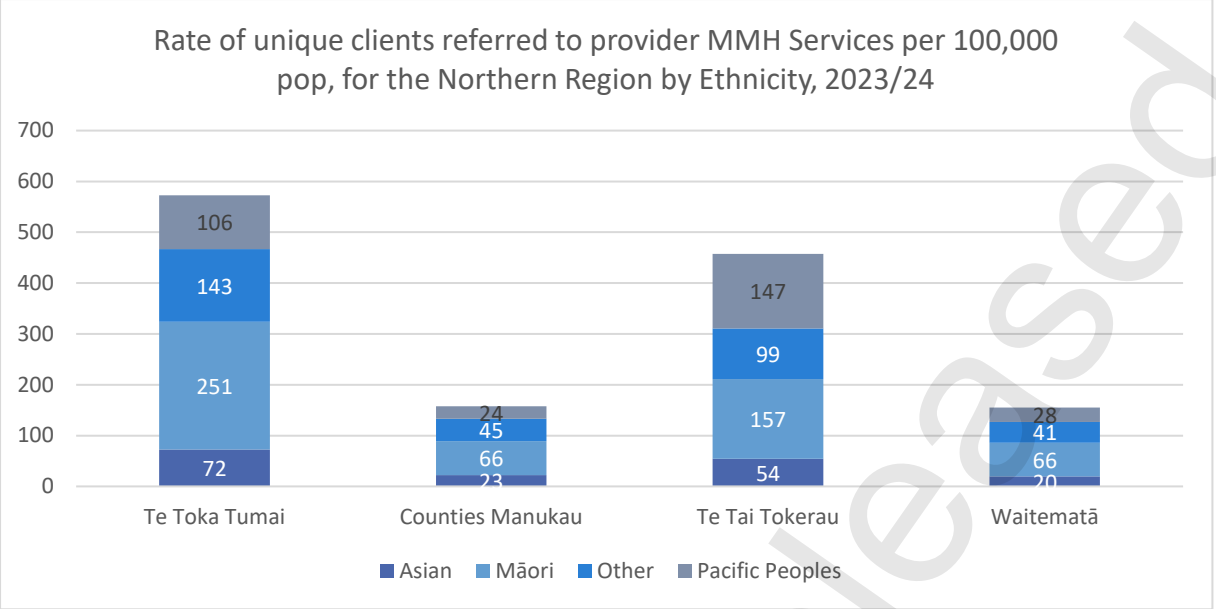

Figure 9: Rate of Referrals to provider arm maternal mental health (MMH) services by Ethnicity, 2023/2024

Maternal AOD Services

The *Pregnancy and Parental Service (PPS)* provides support across all three districts in Auckland, resulting in a significantly higher rate of referrals compared to its Te Tai Tokerau counterpart. Like maternal mental health services, māma Māori represent a significant proportion of referrals in maternal AOD services, with referral rates more than double that of other populations in Te Tai Tokerau and more than five times higher in metro Auckland (Figure 10). In contrast, referral rates for Asian māma remain notably low across the region.

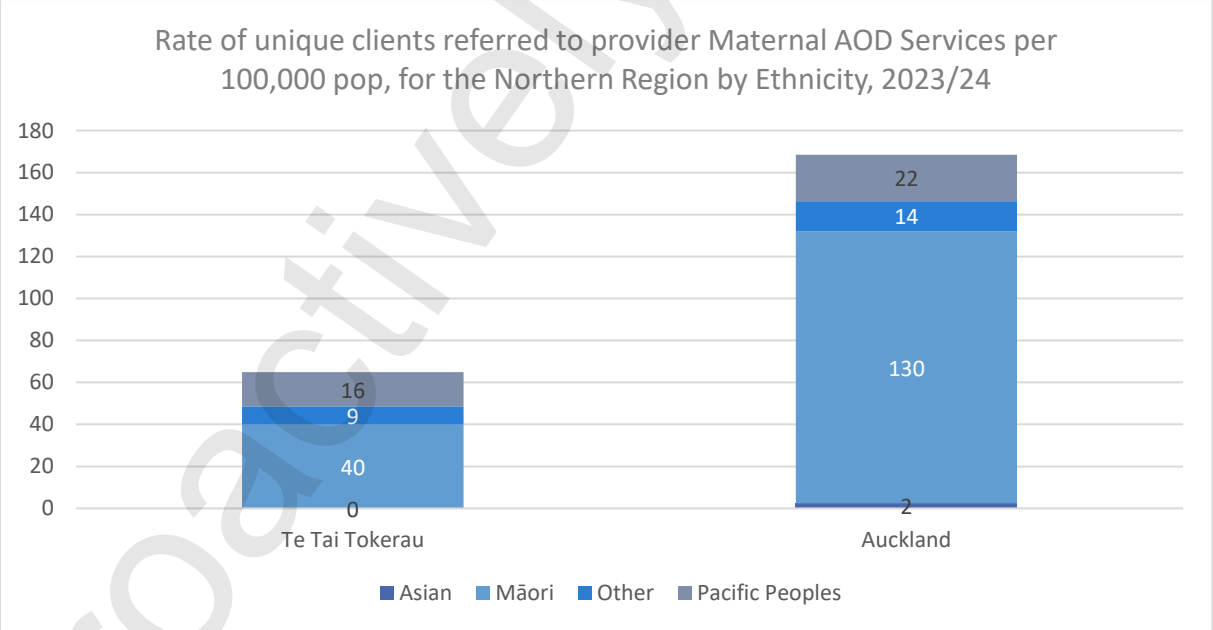

Figure 6: Rate of Referrals to provider arm Maternal AOD Services by Ethnicity, 2021/2022

Infant Mental Health

The referral rate to Waitematā Infant Mental Health Service (*Mātua Tūhonongā*) is notably higher compared to the other two Auckland services (Figure 11). *Mātua Tūhonongā* also receives referrals

from a diverse range of ethnic populations, with a particularly high rate of referrals from Asian whānau, which contrasts with the trends observed in maternal mental health services. Similarly to maternal mental health services, Pacific whānau make up a much smaller proportion of referrals, a trend that is especially evident in Counties Manukau given population make up.

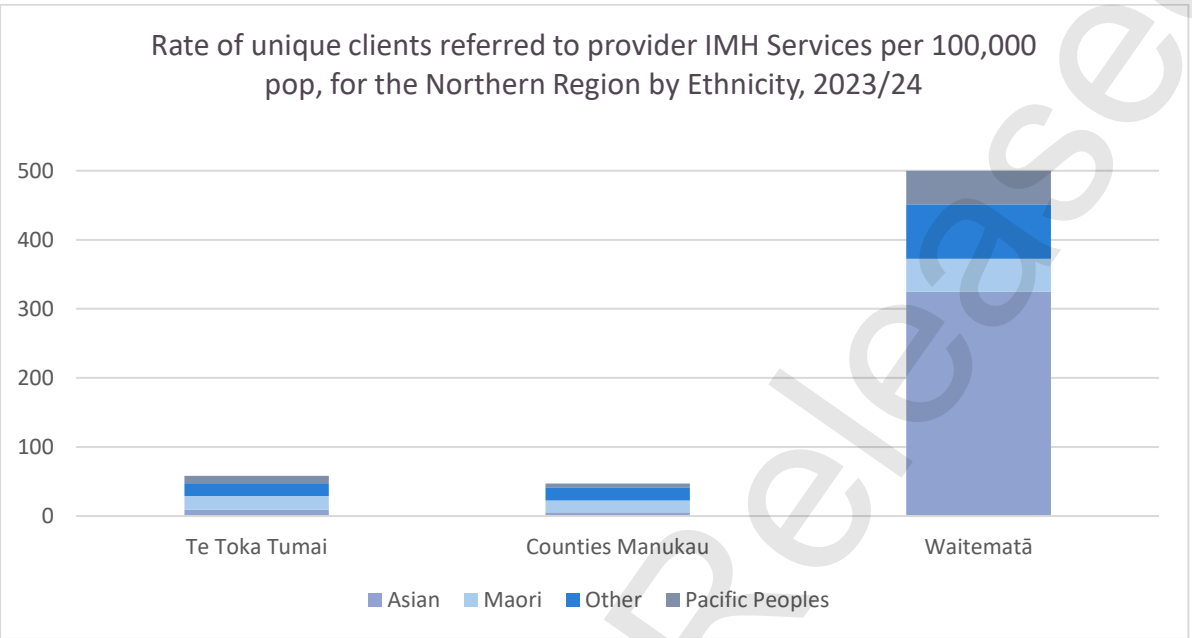

Figure 7 Rate of Referrals to provider arm Infant Mental Health (IMH) Services by Ethnicity, 2021/2022

Continuum of Care

This next section describes the continuum of care for infant and maternal mental health and AOD services in the Northern Region using information gathered through service stocktakes, stakeholder engagement and consumer feedback. We have utilised the Staying Well – Keeping Well – Being Well framework (Figure 12) published in *Te Manawa Taka Mental Health and AOD Wellbeing Whānau and Pepi Project Report 2022* to categorise services along the continuum. The framework breaks down services from promotion and prevention within the community in the inner circle, through mild intervention with community and primary care in the middle, to acute intervention with specialist services in the outer.

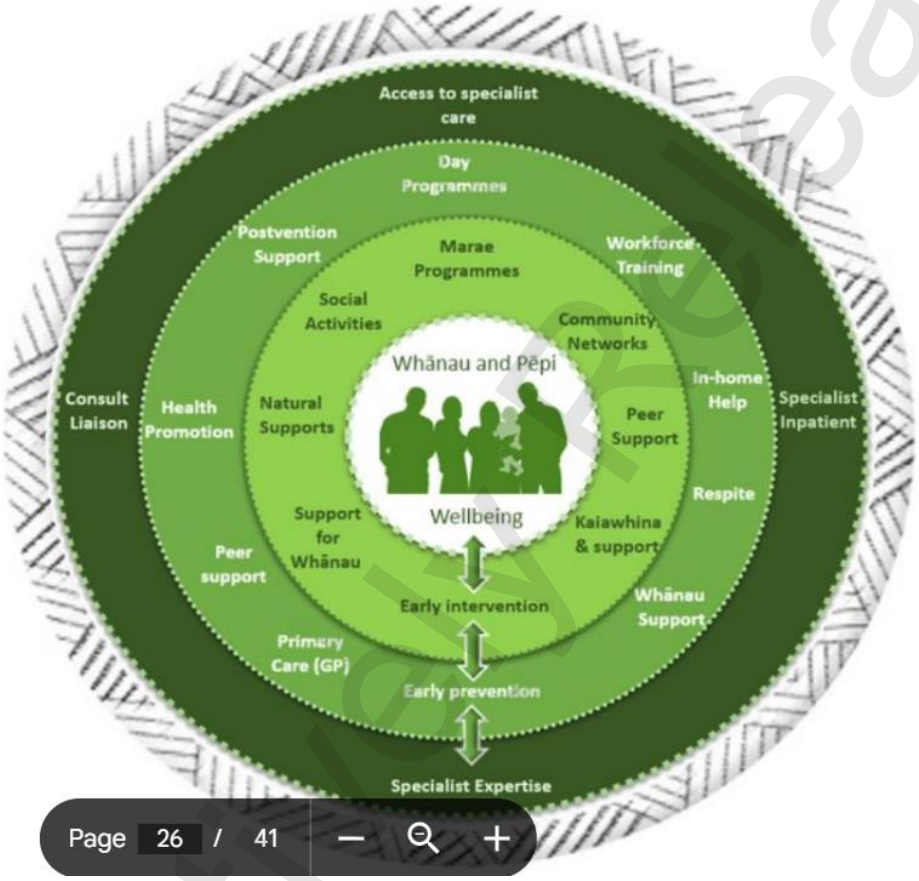

Figure 12: Staying Well – Keeping Well – Being Well framework[16]

The Centre – Focus on Wellbeing

The centre of the framework focusses on whānau and pēpi wellbeing, primarily through practical and social support by friends and whānau. National surveys aimed at understanding mental health supports for māma found that access to practical supports was most important, including warm and dry housing, meals, time to rest, help around the house and financial support. Emotional support and social contact were also deemed helpful with survey respondents commenting on the importance of talking with friends and family and connecting with those with lived experience. When asked about what was missing and would be useful, respondents highlighted the need for financial support, mental health knowledge and expertise at a primary care level, access to specialist support and better connection with support groups.

The Inner Ring – Focus on early prevention

The Inner ring focusses on support for māma and whānau to stay well. In the Northern Region these services are delivered through non-government organisations, community services (including marae-based programmes and community networks) and primary care providers (including midwives). While these services offer invaluable support, they are not well-integrated or accessible across the entire region. Access to or availability of these services is limited, affecting their reach and effectiveness.

- Integrated maternity and early years services provide whānau centred wrap around health and social supports (including Turuki Health Care and The Fono)
- Whānau focused programmes such as Family Start, Well Child Tamariki Ora, delivered through a variety of providers including Kaupapa Māori (Whai Maia and Te Puna Hauora) and Pacific led providers (The Fono)
- Hapu Wānanga providing Mātauranga Māori insights into traditional pregnancy, birthing and parenting practices. Delivered through a range of providers across the region including E Tipu E Rea and Ngāti Hine Health Trust
- Classes and Community Groups specific to postpartum māma and whānau

Parenting programmes

A variety of parenting programmes are delivered across the Northern Region varying in intensity and focus, ranging from attachment and bonding through to strategy focused parenting. Based on attachment theory, Circle of Security Parenting and Mellow Parenting programmes are particularly important in supporting whānau with infant mental health concerns. However, these programmes aren't available everywhere with notable gaps in Te Toka Tumai and Te Tai Tokerau districts. Additionally, there is a lack of awareness of existing programmes with specialist teams struggling to get information on what is being run and when.

Table 3: Parenting Programmes delivered within the Northern Region

Name of Programme	Focus	Area delivered	Providers including
Circle of Security Parenting (COSP)	Attachment and Bonding	Online NZ Wide In person - Waitematā	Various online providers Dayspring Trust
Mellow Bumps and Parenting	Attachment and Bonding	Counties Manukau	Ohomairangi Trust# Anglican Trust for Women and Children
Incredible Years	Social and Emotional Skills and Behaviour	Counties Manukau Waitematā Te Toka Tumai	Ohomairangi Trust# Te Whānau O Waipareira# Family Works
Triple P Parenting	Behaviour and Management	Waitematā Counties Manukau Online NZ Wide	Te Whānau O Waipareira# CNSST Foundation Fresh Minds
Toolbox parenting	Strategy focussed parenting	Online NZ Wide	Parenting place
Healthy Babies Healthy Futures	Nutrition and Movement	Waitematā Te Toka Tumai	CNNST Foundation The Asian Network Inc. (TANI) The Fono HealthWEST - Te Puna Manawa#
Whānau Mārama Parenting Programme	Effective Discipline	Waitematā	Whānau Mārama Parenting

#Kaupapa Māori Framework

The Middle Ring – Focus on early intervention

The middle ring focusses on early intervention supporting māma and whānau with mild to moderate mental health or substance use issues. In the Northern Region these services are delivered by non-government organisations and primary healthcare contracted services including integrated primary mental health and AOD services, general practitioners, respite and residential programmes.

Specialist Non-Government Organisations

The Northern Region funds 12 non-government organisations (NGO) to provide specialist maternal mental health or AOD packages of care. These services are usually accessed via or in partnership with specialist maternal mental health and AOD teams and offer an array of supports from more intensive live-in respite and residential facilities through to community support via groups, educational programmes and support workers.

Access criteria and referral expectation stringency vary depending on the type of supports provided however all services require clients to be pregnant or postpartum and be experiencing mental health or AOD problems. Similarly, referral sources vary between services with some accepting only referrals from specialist teams while others also accept referrals from primary care and community services. Generally, referrals from maternal mental health tend to be prioritised over others when waitlisting.

Table 4: Summary of Northern Region specialist non-government organisations

Service Name	District(s) Serviced	Level of care	Supports provided
Arataki Ministries	Te Tai Tokerau – Kaipara and wider Whangārei and Bream Bay area	Primary and Specialist	Community services Brief intervention Parenting programmes Whānau support
Dayspring Trust	Waitematā	Primary and Specialist	Community services Brief intervention Parenting programmes Day programmes
Odyssey Family Centre	Te Tai Tokerau Waitematā Te Toka Tumai Counties Manukau	Specialist	AOD residential rehabilitation
Awhi Rito (Kāhui Tū Kaha) #^	Counties Manukau Te Toka Tumai*	Specialist	Residential respite* Day programmes Community services
He Kākano Ora (WALSH Trust)	Waitematā Te Toka Tumai	Specialist	Residential respite Community services Brief intervention Whānau support Specialist care Day programmes Parenting programmes
Penina Trust	Counties Manukau	Specialist	Specific for Pacific Populations Community services
Hokianga Health#	Te Tai Tokerau - Mid North	Primary and Specialist	Community services Brief intervention Whānau support
Te Mana Oranga#	Te Tai Tokerau - Kaitaia	Specialist	Community services Brief intervention Whānau support
Emerge	Te Tai Tokerau - Whangārei	Specialist	Community services Day programmes
Apex Care	Te Tai Tokerau - Whangārei to Kaikohe	Specialist	In home respite
Higher Ground Mother and Baby programme | Te Whare Taonga	Waitematā Te Toka Tumai Counties Manukau	Specialist	Residential rehabilitation

#Kaupapa Māori Framework, ^ Iwi organisation

Most specialist NGOs focus on maternal mental health, with the exception of two who are specifically designed for supporting māma and pēpi through substance use. Health New Zealand | Te Whatu Ora funds all but Higher Ground Mother and Baby programme | Te Whare Taonga.

Residential AOD rehabilitation services specifically designed for māma and pēpi are scarce with only two Auckland based providers - Te Whare Taonga and Odyssey Family Centre - serving the region. Te Whare Taonga is funded solely through Oranga Tamariki, creating a barrier to access for many and leaving only one other option –Odyssey Family Centre –which at times can have a wait period of up to 8 weeks.

Te Tai Tokerau has no māma and pēpi specific residential rehabilitation providers. Māma in Te Tai Tokerau requiring treatment for substance use must attend adult detox (Timatanga Hou) or residential programmes (Ngāti Hine Health Trust) without their pēpi, often with significant wait times. Alternatively, they may travel to Auckland to attend Odyssey Family Centre. Barriers, such as transport, childcare and accessibility can hinder uptake of these options.

AOD specific respite options to support māma and pēpi are absent within the Northern Region. Māma either have to attend abstinence based residential treatment as described above or leave their pēpi to enter adult AOD respite. Attending maternal respite isn't an option either as māma do not meet the criteria for maternal mental health.

Furthermore, there is a gap in support for māma with co-existing mental health and AOD problems. There are no options to support this specific client group in a way that concurrently treats both issues whilst prioritising development of the māma-pēpi relationship.

There is a notable gap when it comes to community support for whānau who are experiencing infant mental health concerns or accessing infant mental health specialist services. No NGO providers in the Northen Region specifically cater for the needs of this population. Currently this gap is partially bridged through whānau-centred community providers, however there is a significant need for both early intervention programmes with a preventative focus on strengthening early attachment and continued community support for whānau exiting specialist infant mental health services.

There are two maternal mental health respite facilities in the Northern Region, both located in Auckland and restricted to residents of the three metro Auckland districts. Te Tai Tokerau has limited respite options with Apex Care, the sole provider of in-home respite for māma and pēpi. In-home respite is dependent on kaimahi availability and is further complicated by the requirement for suitable housing for in-home care. Many māma in Te Tai Tokerau live in emergency housing, garages or with others that have family harm or substance use problems, making it challenging to provide appropriate respite support.

He Kākano Ora and Awhi Rito are Auckland's maternal mental health respite facilities. Collectively they have 10 beds, offering day and overnight stay as well as day programmes and community support. Despite broad offerings, uptake of overnight stays is significantly limited (Table 5). Barriers such as age of pēpi, childcare requirements for older children, separation from parenting partners and whānau, and transport challenges likely contribute to the lower utilisation rates.

Table 5: Utilisation of bed nights across residential respite care in the Northern Region

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
% Bed night utilisation	31%	33%	26%	20%	24%	27%

Respite facilities aren't the only providers experiencing underutilisation with one Te Tai Tokerau NGO also seeing significantly low uptake. This stands in clear contrast to the significant demand of other maternal mental health and AOD services within the community who have waitlists of up to 12 weeks and considerable pressure on their workforce. Part of this disparity may be attributed to the significant gaps in the areas these services cover. In Te Tai Tokerau, a vast, largely rural area with limited resource, community support options are far and few between –Whangārei has three community support workers and the Mid and Far North have just one. Furthermore, Te Toka Tumai and significant portions

of Counties Manukau districts –who as previously mentioned, have the highest birth rate in the region and considerable populations of high socioeconomic deprivation—lack specialised NGO to meet the needs of māma in these areas. However, there is likely more contributing factors to this disparity, suggesting a need to better understand what māma and whānau within the Northern Region need and to align services accordingly.

The connection between NGO and specialist maternal mental health and AOD teams varies across the region. Findings indicate that strong relationships between providers facilitate connection and collaborative care of māma and whānau ensuring smooth transitions between services and enhancing positive outcomes. As an example of this, Waitematā district has a broad suite of services including specialist maternal mental health and AOD services, respite, residential care and specialist NGOs. Well-connected provider arm and NGO teams within the district enable a smooth pathway through care as māma transition between services.

Further details of the NGO service stocktake can be found in Appendices 7-9.

Non-Specialist Providers

The Northern Region also has several providers whose services aren't specifically designed to support maternal mental health or AOD problems but provide general mental health and AOD supports or whānau focussed supports beneficial for māma and whānau experiencing mental health and/or AOD problems. The services these providers offer range from a focus on prevention to early intervention.

Table 6: Summary of Northern Region non-specialist non-government organisations

Name of Provider	District	Type of Service
Equip	Waitematā	Mental Health Support
Ember	Te Toka Tumai Waitematā	Mental Health and AOD support
Mothers' helpers	Te Toka Tumai	Support recovery from perinatal, antenatal and postnatal depression or anxiety
Karitane Nurses	Te Toka Tumai Counties Manukau Waitematā	In home support
Barnados - LEAP	Te Tai Tokerau Te Toka Tumai Counties Manukau Waitematā	Support for children and families affected by parental mental health and AOD problems
Te Ha Oranga #^	Te Tai Tokerau - Kaipara Region Te Toka Tumai Counties Manukau Waitematā	AOD support. Offer Ngā Kākano, a specific programme for hapu māma, parents and tamariki under 3 from their Auckland office.

#Kaupapa Māori Framework, ^ Iwi organisation

Oranga Tamariki fund several māma and pēpi services which maternal mental health services refer to. Although not specifically focussed on infant or perinatal mental health, these services provide wrap around support with a whānau focus for those under the care of Oranga Tamariki.

Table 7: Summary of Oranga Tamariki funded services

Name of Provider	District	Type of Service
Iosis whānau Service	Te Toka Tumai Counties Manukau Waitematā	Residential parenting programme for māma
Granger Grove	Te Toka Tumai Counties Manukau Waitematā	Three-stage residential, family care programme for māma and pēpi
Incourage	Te Toka Tumai Counties Manukau Waitematā	Residential support for māma and pēpi at risk of entering care system
Te Whare o taonga	Te Toka Tumai Counties Manukau Waitematā	Residential programme for vulnerable and at-risk teen mothers and their Tamariki
Waipareira Trust - Armour Bay	Te Toka Tumai Counties Manukau Waitematā	Residential support for māma and pēpi

Primary Health Organisations

The Northern Region has 11 Primary health organisations (PHO) who provide primary healthcare services for the enrolled population within their geographic location. Primary mental health services available through PHOs include support through general practice clinics, integrated primary mental health and AOD services and therapists.

The Northern Region is home to over 390 GP Practices with 1,948,002 enrolments regionwide as of January 2025.[17] For most people GPs are the first port of call when seeking medical assistance, forming an integral part of the continuum of care for mental health and AOD problems. As such, those who aren't enrolled with a GP will be at a disadvantage when seeking support.

GP was the most commonly reported support accessed by survey respondents when seeking help for mental distress. Feedback from māma and whānau highlighted the variability in the service provided by General Practice Teams when seeking help for perinatal mental health and AOD. Some felt heard and supported by their GP who offered multiple support options, informed them of specialist services, and guided them for the duration of their journey. However, others felt there was a lack of knowledge and support from GPs, with several māma expressing feelings of not being taken seriously. Not all māma were made aware of specialist maternal mental health and AOD services, and the support options offered were often limited, reflecting the well-known gap in services for mild to moderate mental health support. Limited support by GPs may suggest a deficit in specific perinatal mental health and AOD knowledge and/or awareness of additional supports available within the continuum of care.

"…so many services out there that could tell that you're not feeling OK and they don't do stuff and I find that really sad because that's how people get missed"

"Felt the GP didn't take me seriously. I had asked so many times and was told I was just tired saying I'll be fine but I needed more help and kept telling the GP"

Although feedback from whānau indicates that access to infant mental health services via the GP was a straightforward process, low specificity in referrals and duplication of referrals to paediatrics suggests lack of awareness of infant mental health services and what they offer among GPs.

IPMHA and Awhi Ora

The Integrated Primary Mental Health and Addictions (IPMHA) service was developed in response to He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addictions, and focuses on providing easy access to mental wellbeing support in GP sites across the country. IPMHA services utilise Health Improvement Practitioners and Health Coaches to target mild to moderate needs with the intention of if not immediate, then access to support within 3 – 5 days. According to the Wellbeing Support Website (https://www.wellbeingsupport.health.nz/#find-support) the Northern Region had 181 GP sites, 12 Kaupapa Māori services and 7 Pacific-led services providing IPMHA supports as of January 2025.

Awhi Ora is a free 'walk alongside' support service focused on wellbeing and providing wrap-around support for people experiencing distress from underlying social, personal, or physical challenges. Available to Auckland residents, Awhi Ora is provided by a collaboration of NGO health and wellbeing organisations. Whānau are referred by their GP and triaged to determine what provider is best suited to meet their needs.

Although these services exist, little to no mention of them came through in interviews and surveys suggesting lack of awareness or enrolment with GP practices might be a barrier to their uptake.

The Outer Ring – Focus on inpatient care and clinical service delivery

The fourth ring focusses on the most acute presentations, providing support for the top 4% of māma, whānau and pēpi experiencing mental health or substance use issues. The Northern Region has four specialist maternal mental health services, one in each district; three infant mental health services, all districts with the exception of Te Tai Tokerau and two maternal AOD services, one in Te Tai Tokerau and one based in Waitematā servicing the three Auckland districts. The Northern Region also has Haumaru Ōrite, a specialist Mother and Baby Inpatient Unit (MBU) located within the Child and Family Unit at Auckland's Starship Hospital.

Table 8: Summary of specialist services in Northern Region

Service Name	Districts serviced	Focus of service
Pregnancy and Parenting Service	Waitematā Te Toka Tumai Counties Manukau	Maternal AOD Service
He Tupua Waiora	Te Tai Tokerau	Maternal AOD Service
Mātua Tūhonongā	Waitematā	Infant Mental Health
Koanga Tupu	Te Toka Tumai	Infant Mental Health
Whakatupu Ora (Infant Mental Health)	Counties Manukau	Infant Mental Health
Haumaru Ōrite | Mother and Baby Unit	Waitematā Te Toka Tumai Counties Manukau Te Tai Tokerau	Maternal Mental Health
Manaaki Kakano	Te Tai Tokerau	Maternal Mental Health
Maternal Mental Health Service | Waitematā	Waitematā	Maternal Mental Health
Aronui Ora	Te Toka Tumai	Maternal Mental Health
Maternal Mental Health Service | Counties Manukau	Counties Manukau	Maternal Mental Health

Maternal and infant mental health and AOD specialist providers and their service delivery objectives are defined by Ministry of Health Service Specifications. These specifications form the core overarching document which guide each provider. In addition to this, each provider will have a model and level of service delivery unique to them.

Infant mental health services

Infant mental health services exist in three out of four districts within the Northern Region with Te Tai Tokerau being the exception. Although child and adolescent mental health services exist in Te Tai Tokerau, they support children and adolescents between the ages of 5 – 18. Unless māma are engaged with *He Tupua Waiora*, Te Tai Tokerau's pregnancy and parental AOD service, seeking support for substance use, then support for pēpi ends when they reach 12 months of age as per the access criteria for maternal mental health services.

Within the Auckland area, there is variability in the structure of infant mental health services. Services either function within child and adolescent mental health services portfolio (*Mātua Tūhonongā* | Waitematā and *Koanga Tupu* | Te Toka Tumai) or within maternal mental health services (*Whakatupu Ora* |Counties Manukau). Regardless of the structure, it appears that all three services are closely linked with their associated maternal mental health service, with some districts utilising shared roles across specialist teams.

Infant mental health services across the region appear well aligned in access criteria, triaging, interventions and discharge process. Only slight variances were seen in referral routes, wait times and resourcing.

There is a slight variation in the targets for time to review and respond to referrals with all services aiming to have initial contact within three weeks of referral. Average wait times from the time of referral until first consultation appear to have decreased over time with all three services seeing whānau in less than 38 days in 2023 (Figure 12). It should be noted that wait times may not solely reflect service capacity with factors such as whānau availability or extenuating circumstances contributing to delays in being seen.

Services spoke of their adaptable and mindful approach to engage whānau and support their readiness and availability to attend. Specialist teams work to mitigate barriers to access through accommodating childcare, work commitments and individual circumstances. Feedback from whānau echoed this with many expressing gratitude for this consideration.

"I appreciated that they were able to work with the time I had available and made the appointments suit my work schedule."

"The timing was convenient, if I couldn't make it, I could reschedule. This made its easily accessible and the staff were lovely about it."

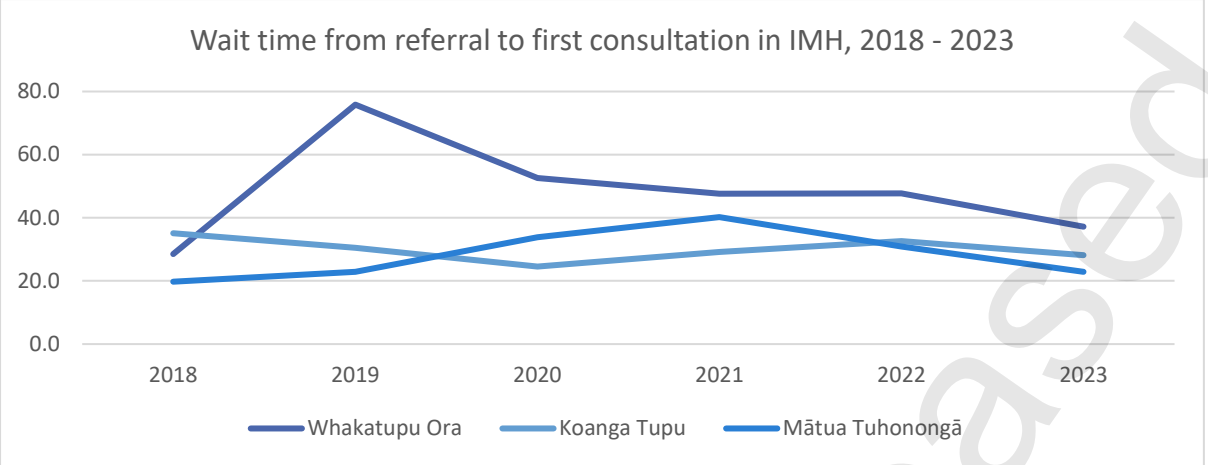

Figure 12: Time to first consultation with infant mental health services over time (2018 – 2023)

Composition varies slightly between teams with Waitematā and Counties Manukau employing a multi-disciplinary workforce, while the Koanga Tupu team consists solely of clinical psychologists. Additionally, Mātua Tūhonongā have access to a whānau advisor within the child and youth portfolio and Counties Manukau Infant Mental Health Service have a peer support specialist available for whānau. There also appears to be variability in FTE count across the region however this seems to be somewhat consistent with district population size and birth rate (Table 9).

Table 9: FTE counts across specialist teams in the Northern Region

	Te Tai Tokerau	Waitematā	Te Toka Tumai	Counties Manukau
Infant mental health service FTE Count	N/A	6.4 FTE budgeted 0 FTE vacant	3.0 FTE budgeted 0.2 FTE vacant	7.2 FTE budgeted 1.6 FTE vacant
Maternal mental health service FTE count	6.7 FTE budgeted 2.3 FTE vacant	14.2 FTE budgeted 2.7 FTE vacant	17.96 FTE budgeted 0.19 FTE vacant	12.39 FTE budgeted 2.29 FTE vacant
Maternal AOD service FTE Count	6.7 FTE budgeted 0 FTE vacant	13.8 FTE budgeted 8.6 FTE vacant	N/A	N/A
Population (2022)	200230	634170	486360	601580
Birth Rate (2022)	117	121	108	140

Maternal mental health services

All four districts in the Northern Region have a dedicated maternal mental health service which operate independently of each other but have shared access to Haumaru Ōrite | Mother and Baby Inpatient Unit (MBU). The MBU services the entire region with four dedicated beds, one allocated to each district, for māma and pēpi to stay together whilst receiving treatment for acute mental health presentations and to support the development of the parent-infant relationship. Management of māma into Haumaru Ōrite is through district maternal mental health teams.

Although the MBU has a dedicated bed for residents of Te Tai Tokerau, external influences have a huge impact on utilisation. Barriers such as distance from home, transport, childcare and whānau support can prevent service uptake. To bridge the gap there are a couple of options made available to support Te Tai Tokerau māma. Kaitaia's maternity ward provides support for māma to stay later in the post-partum period. Alternatively, admission to the adult mental health inpatient unit (IPU) is available for māma, however pēpi cannot stay with them and the length of stay could be significant. Recently a breastfeeding policy has been implemented providing postpartum māma access to breast pumps and connections with lactation consultants while in the adult inpatient unit. The PEPI Regional

Governance Group is looking to understand and align support for māma in IPU regionwide as part of their work programme in 2025.

The presence of a multi-disciplinary team is consistent across maternal mental health services including MBU with functions in some services being shared across specialist teams (e.g. Maternal AOD or Infant mental health services). MBU, in addition to the disciplines shared with maternal mental health teams also has access to doctors, midwives and paediatric care. Peer support specialists are an integral part of the teams in *Aronui Ora* | Te Toka Tumai and Counties Manukau Maternal Mental Health Service.

FTE counts vary across the region with Te Toka Tumai the most well-resourced and Te Tai Tokerau the least (Table 9). The reasons for this variation are unclear however referral volume, population size and birth rate may play a role. Despite serving the smallest population, Te Tai Tokerau's birth rate – similar to Waitematā, which has double the resource—along with its large geographical area, suggests that *Manaaki Kakano* would benefit from additional resources to better serve its community.

Feedback from māma further highlights the need for additional staff and better continuity of care, with many commenting on the negative impact of workforce turnover on their ability to build trust and connection with the service. This constant change can lead to exhaustion from having to repeatedly share their stories. While those interviewed spoke highly of the skilled workers that supported them, there is a clear and consistent desire for a larger and more stable workforce to ensure continuity of care and better support for whānau.

"[we need] more people like her that helps our wāhine open up"

"…and every time I talk to a doctor. It's someone new. That's really hard, because you have to start over every single time and it sucks."

A wide array of interventions is provided by maternal mental health services with limited variation across the region and all services mentioning linkages with other providers for additional supports. Of note, Counties Manukau has recently set up a peer support led coffee group for māma under the care of their maternal mental health service. This group meets weekly with the purpose of facilitating connection and providing a place of support in an informal setting. Rolling out similar groups across the other districts would be well received with feedback suggesting a benefit in connecting with others of similar experiences and a desire for more community groups.

The process for managing contact to referred māma varies between services with initial contact following acceptance into service varying from two days through to two weeks. Additional variances in wait time to first appointment also exist between services depending on level of acuity with some services taking up to 6 weeks to complete full psychiatric mental health assessments.

<u>Maternal AOD services</u>

Maternal AOD services operate using a client-led assertive outreach model to accommodate māma readiness to engage with the service. These services provide wrap around support, coordinating multiple providers to meet the needs of their māma. Māma are predominately seen in their own home and are supported to navigate barriers to access including court orders, transport, poverty and rurality.

Maternal AOD services in the Northern Region demonstrate clear alignment with limited to no variation in model of care, interventions, length of treatment, involvement of whānau and discharge planning. Like infant and maternal mental health services, specialist teams are multi-disciplinary with many functions similar between districts however, *Pregnancy and Parental Service (PPS)*| Auckland

has additional peer support specialist functions. *PPS* has a considerably higher budgeted FTE (Table 9) perhaps to reflect population size or demand. However, significant vacancies within the service have brought the actual FTE count in line with that of Te Tai Tokerau's *He Tupua Waiora* service, who support a much smaller population. Despite running a managed waitlist to prioritise support, reduced resource continues to limit the reach of *PPS*.

Relationships within the continuum

Perinatal mental distress and AOD problems, and perinatal, pēpi and whānau mental illness can and do occur concurrently. To ensure māma, pēpi and whānau receive the best support, specialist infant and maternal mental health and maternal AOD teams within districts work closely, meeting regularly, consulting to provide a collaborative care approach. They also hold strong relationships with hospital and community teams including paediatrics, detox, youth mental health and AOD specialists, residential programmes and adult mental health services, providing consultation with workforce, joint appointments with māma/whānau, professional development and support with transition between services.

People experience mental distress and substance use at many points in their journey. Having timely access to appropriate advice across a wide range of interfaces may enable successful care at a community level and prevent escalation and the requirement of specialist services. A large component of the function of specialist services is liaising with other points of the continuum of care to both provide advice for māma/whānau accessing care at a community level, as well as coordinate additional support for māma and whānau within their care. Maternity and Well Child services are frequently engaged along with Family Start, GPs, Plunket, youth and adult focussed NGOs, respite and Oranga Tamariki.

Further details of the specialist service stocktake can be found in Appendices 4-6.

Consumer voice - Experience within the Continuum of care

Women surveyed about their experiences accessing mental health services during the perinatal period identified support from friends and whānau, midwives, specialists, and GP practices as the most helpful. They also mentioned community resources such as Plunket, NGOs, Karitane nurses, support groups, child health professionals, as well as practical and financial assistance. However, not all respondents accessed mental health support. Common reasons for not seeking help included a lack of mental health literacy, poor mindset, insufficient awareness of available services, service capacity issues, and a preference for whānau support. Barriers to those who wanted help but couldn't access it included the support offered not meeting their needs or values, lengthy wait times, being declined from specialist care, lack of knowledge or support from primary care, and the absence of culturally responsive care.

"I thought my anxiety was just the postpartum norm and it would eventually subside so didn't seek help."

"When I walked into the room, I was the only Maaori in the room – imbalance of power. I felt colonised. No offer of Maaori support, or referral to Maaori service. This is important to me."

Despite recent efforts to improve mental health support at the primary care level, feedback suggests more work is needed, particularly regarding mental health concerns during the perinatal period for both māma and pēpi. Lead maternity carers and GPs who work with whānau during this critical time would benefit from ongoing professional development to enhance their knowledge in this area.

"Obstetrics or medical care during pregnancy should regularly monitor mental health and establish clear pathways for support."

"Counselling would probably have made a huge difference. I accessed some free sessions through Southern Cross, but my counsellor had no experience with birth trauma or postpartum depression, so it was not the best experience."

A common theme in feedback was a general lack of public awareness about services that support māma and pēpi with mental health and AOD problems. Respondents expressed a desire for increased promotion of available support services through commonly accessed perinatal community providers (including Well Child services, midwives, and antenatal facilitators). They recommended greater clarity on services offerings and how to access them. Additionally, there was significant support for increasing education for māma and whānau during the antenatal and early postpartum periods, focusing on the development of infant-primary caregiver relationships, as well as signs and symptoms of mental health and AOD problems.

"This should also be provided to all women after they give birth. There is so much going on for women during this period, and the mental load is overwhelming. Having a clear list of maternal mental health support would be useful."

"Would strongly suggest a booklet with tips and phone numbers for other resources and learnings around addictions"

Support through maternal mental health services was sometimes limited, with many expressing a desire for additional services, more frequent contact, and longer duration of support. Workforce and service capacity throughout the continuum was cited and at times was inhibitory to māma/whānau seeking help.

"My midwives were so extremely busy because of their workload that I didn't feel confident calling them for reassurance."

"They [māma] can get picked up by their well child providers.... That's hit and miss as well. Because sometimes our providers, aren't able to get to our māma because they've got such a huge caseload"

When asked about their experience with specialist services, māma and whānau felt that they generally received adequate, easy-to-understand information about the support available, with many mentioning that their key worker guided them through the information and encouraged questions. However, this often appeared to be the first point at which clients understood the scope of infant and maternal mental health and AOD services, revealing a broader lack of awareness of these services by referrers. Several interviews revealed inconsistencies in the information provided by primary care providers, with some respondents stating that had they known about these services earlier, they would have accessed them sooner.

Once accepted into infant and maternal mental health and AOD services, more than two-thirds of respondents reported positive experiences. They felt they were in partnership with the service, in control of their support, and involved in goal setting. Clear, judgment-free, and regular communication, along with a good rapport with specialists, were frequently mentioned as factors that contributed to a sense of support. Additionally, cultural alignment with the service, the services model of care and workforce played a crucial role in whether individuals felt truly connected with maternal mental health and AOD services.

"There is never any judgement, and it feels like sitting down with a friend and discussing some hard topics in a comfortable environment."

"She helps me understand where the problem is and how to view things differently to help cater to my oldest daughter but most importantly for myself. My key worker has carried me through the last 3 months because I don't think I would be able to do it without her."

"They were always in communication with me, so I knew where I stood with it. If they weren't able to provide me with xyz, they would give me other options instead. It was never a closed door. Really good."

"The communication between me and my key worker is open and easy, there is lots of ways to reach out or change times and it works well for me and baby especially when I was feeling very sleep deprived."

The importance of providing information on additional supports and tools was also strongly emphasized, though experiences of this varied. Some whānau benefited from well-considered wraparound support, while others felt disconnected from additional resources (including cultural supports), or experienced a lack of collaboration between different support services, leading to miscommunication and confusion. Infant mental health services users spoke positively of the wraparound care they received, particularly highlighting the Circle of Security parenting programme.

"Wrap around kind of service. You know like you can tap into a doctor, psychologist, psychiatrist, all this stuff. I just felt like I could tap into any of it"

Overall, feedback indicated that services prioritized and encouraged whānau involvement at a level that felt comfortable for those involved. Users of infant mental health services particularly appreciated the inclusion of, and support for, partners and tamariki. However, there was a clear desire for additional therapeutic supports for whānau impacted by or providing care to Tāngata whaiora, highlighting the need for more comprehensive care that extends to the entire whānau unit.

Connecting with others who shared similar experiences was particularly valued by māma accessing maternal mental health services. Many respondents appreciated the opportunity to meet others in the community and take a break from being at home. Feedback across all services indicated that there is a strong desire for more peer support offerings and support groups—not only for Tāngata whaiora but also for those supporting whānau—highlighting the need for broader community-based support.

"I'm accessing other supports offered by the service. It's getting me out of the house more and there's a mother's group which I'm enjoying. I get to be around other moms"

Medication is frequently used to treat perinatal mental distress, and feedback highlighted both positive and negative experiences. Clear communication and strong partnerships between services and clients were particularly important. Those with negative feedback often cited a lack of information about medications, including side effects and mechanisms of action, or felt pressured to take medication to access other support services.

"I lied about taking the medication because I was worried the talking therapy would be withheld."

"I felt more tired taking the meds when I needed to look after the kids, so I lied about still taking the medication just to get therapy."

Physical and financial challenges are consistently reported as barriers to accessing specialist care. Feedback on how services are addressing these barriers is mixed, with both positive and negative responses. While users noted that the inclusion of home visits, online appointments, programmes, and transport assistance enhanced their experience when accessing specialist services, there is still work to be done in this area. Opportunities for improvement include addressing limited operating hours, transport issues, and parking availability for infant mental health services. Additionally, expanding local options for support services and offering more online therapy options, as well as improving parking for maternal mental health and AOD services, would further enhance accessibility for māma and whānau.

Health pathways

Accessing mental health services

National surveys aimed at understanding mental health supports for mothers demonstrated that just over half of respondents sought a mental health service for support and of those, a variety of supports were accessed. GP and maternal mental health services were the most common with culturally specific community supports and tele health services accessed significantly less. EAP, private psychologists and in patient support were also mentioned.

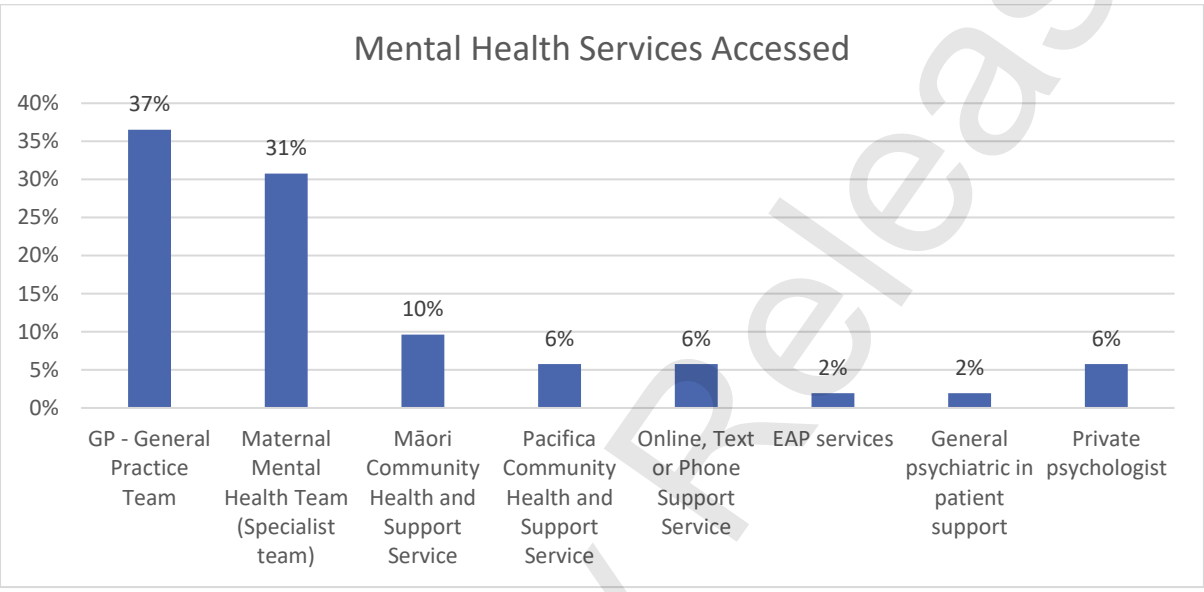

Figure 13: Mental Health Services accessed, 2023 survey results.

When asked about access to mental health supports most respondents felt that staff were helpful and respectful, and services were near where they lived. Conversely, transport availability, ease of finding help, identification and respect of cultural needs by workforce and availability of multiple support options were least commonly identified. Not all who sought help received it however, with lack of awareness of support options, financial barriers and being declined from maternal mental health services frequently mentioned as reasons.

"I should have been given pathways where I could get help."

Access criteria

Although the term 'Maternal' is included in the title of specialist teams, this does not mean their services are exclusively for women. *Manaaki Kakano* | Te Tai Tokerau, *He Tupua Waiora* | Te Tai Tokerau, *Aronui Ora* | Te Toka Tumai and *Pregnancy and Parental Services* also accept referrals from non-birthing partners as their primary clients.

When reviewing access criteria both maternal AOD services and infant mental health services were closely aligned with little to no variation across the region. Maternal mental health services had some variation between services as described below.

All maternal mental health services require māma to meet the following criteria: they must reside within the district catchment area of the service they are accessing (with the exception of *Aronui Ora* | Te Toka Tumai, which accepts māma from other regions accessing Auckland-based specialists), be pregnant or a caregiver of a child under 12 months of age, and meet the criteria for a moderate to

severe 'mental disorder' as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM). There were slight variations when considering the following aspects:

Table 10: Variation in access criteria to maternal mental health services

Criteria	Variation
Access for inpatients of maternity wards	All services but Waitematā include this criterion. Waitematā utilises the psychiatric liaison service and adult mental health crisis team to meet the needs of māma with mental health requirements whilst in a maternity ward.
Period of support	Te Tai Tokerau states 2nd and 3rd trimester through until baby is 12 months, whilst all other services state pregnancy through until baby is 12 months
History of severe mental illness and planning pregnancy	Additional criteria for Waitematā
Risk of disorder impacting mother-baby bond	Addition criteria for Te Tai Tokerau
Non-birthing parents	Non birthing parents are included in Te Tai Tokerau and Te Toka Tumai
Age of māma or whānau	Waitematā Maternal Mental Health Service requires māma or whānau be over 18 years of age. Teenage mothers are supported through Marinoto Youth Mental Health Service.

As part of the PEPI Regional Governance Group model of care workshops that took place in March - May 2023, stakeholders identified an ideal set of entry criteria for maternal mental health services in the Northern Region (Figure 14). Next steps would be to understand the gap between current and ideal entry criteria and implement changes to bring the region into alignment.

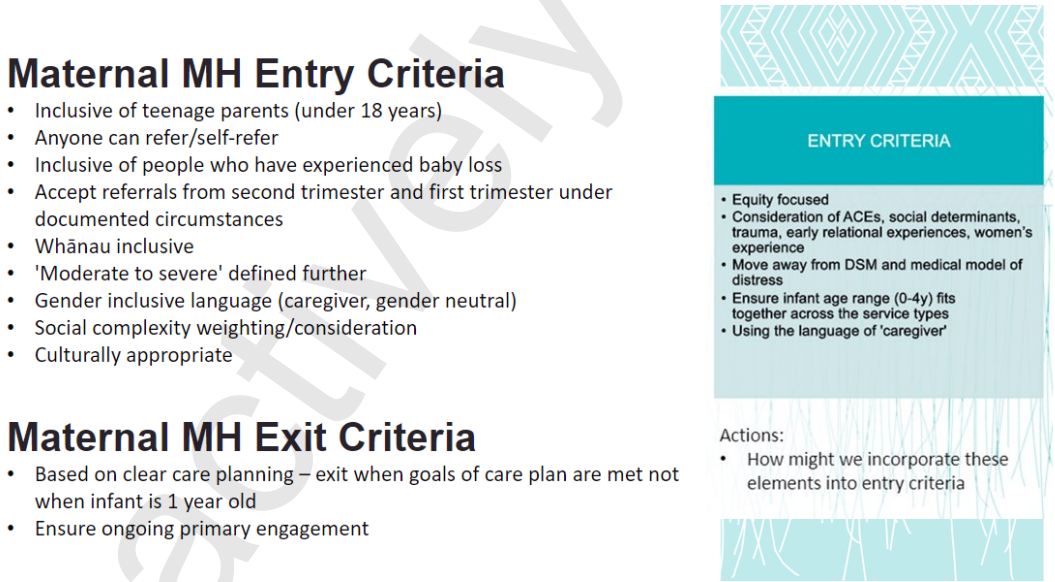

Figure 14: Proposed regionally agreed set of entry criteria into Northen Region maternal mental health services

Referral Pathways

Service stocktakes defined a wide range of accepted referrers to specialist services that can be broken down into the broader categories below:

Table 11: Summary of accepted referral routes into specialist services

	Infant Mental Health	Maternal Mental Health	Maternal AOD
Self-referral	✓ (not all)	✓ (not all)	✓
Whānau referral			✓
General Practitioners	✓	✓	✓
IPMHA		✓	
Maternity Services (community and hospital)	✓	✓	✓
Mental Health Services	✓	✓	✓
Paediatric Services	✓		
Hospital	✓		
NGOs and Whānau services (Well Child providers, Family Start)	✓	✓	✓
ECE Teachers	✓		
Consult Liaison Teams	✓	✓	
Government Agencies (Oranga Tamariki, Ministry of Education, Police)	✓		✓

Several multi-agency forums exist across the region, meeting regularly with the purpose of connecting vulnerable women with the right supports. These forums may include maternal mental health and AOD services, Oranga Tamariki, Police and Social Housing supports. Te Aka Ora (Waitematā), Whiria Te Muka (Kaitaia), Aranga Tetekura (Te Toka Tumai) and Te Wai Waiora (Counties Manukau) all provide pathways into maternal mental health services.

- Te Aka Ora – Waitematā forum including midwives, Oranga Tamariki, maternity services, social workers, *Pregnancy and Parental Service* and maternal mental health service
- Whiria te muka – Kaitaia based forum that meets 2-3 times per week. Focused on family harm. Includes Police, Oranga Tamariki, *He Tupua Waiora*, housing, *Manaaki Kakano*
- Aranga Tetekura – Te Toka Tumai forum for pregnant and post-partum women
- Te Wai Waiora – monthly Counties Manukau forum for vulnerable pregnant women, includes midwives, maternal mental health services, Oranga Tamariki

Multi-agency forums provide a valuable link for women who may otherwise fall through gaps in the continuum and remain unsupported. Although several robust models exist in the Northern Region there is a notable gap in Whangārei, Kaipara and the mid-north, areas of particularly high socioeconomic deprivation.

Accessing specialist services

Māma and whānau interviewed were referred to specialist services through a variety of routes with GP referrals the most frequently utilised pathway to infant and maternal mental health and AOD services. Maternal mental health services also received a significant portion of their referrals from midwives.

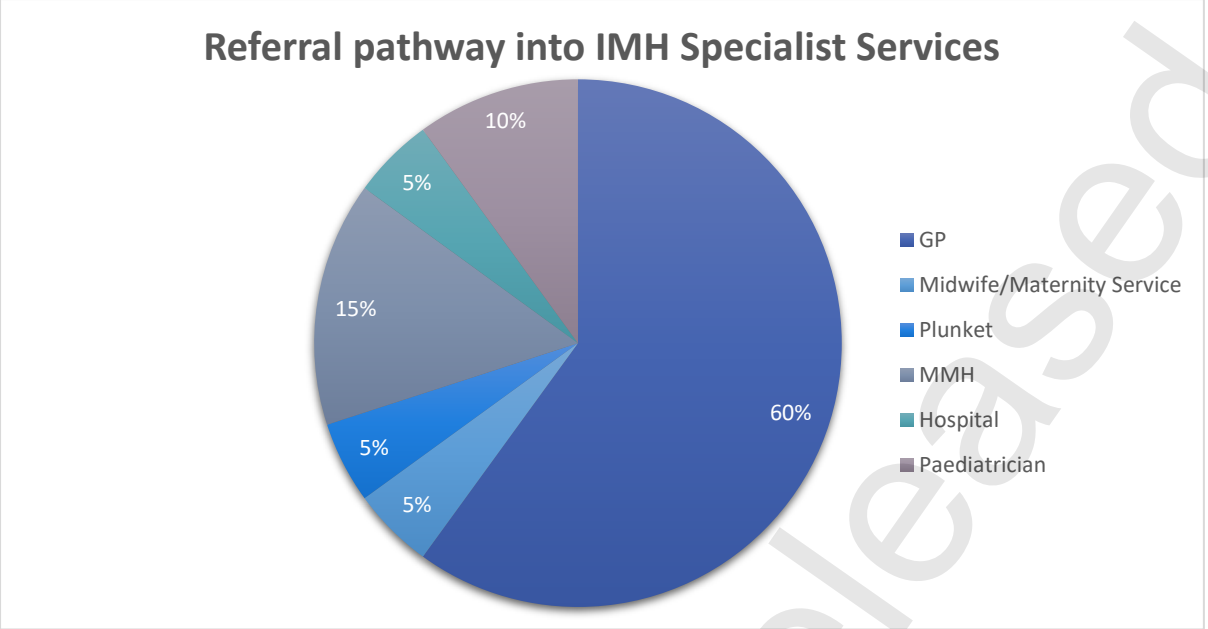

Figure 15: Referral pathways into Infant Mental Health specialist services

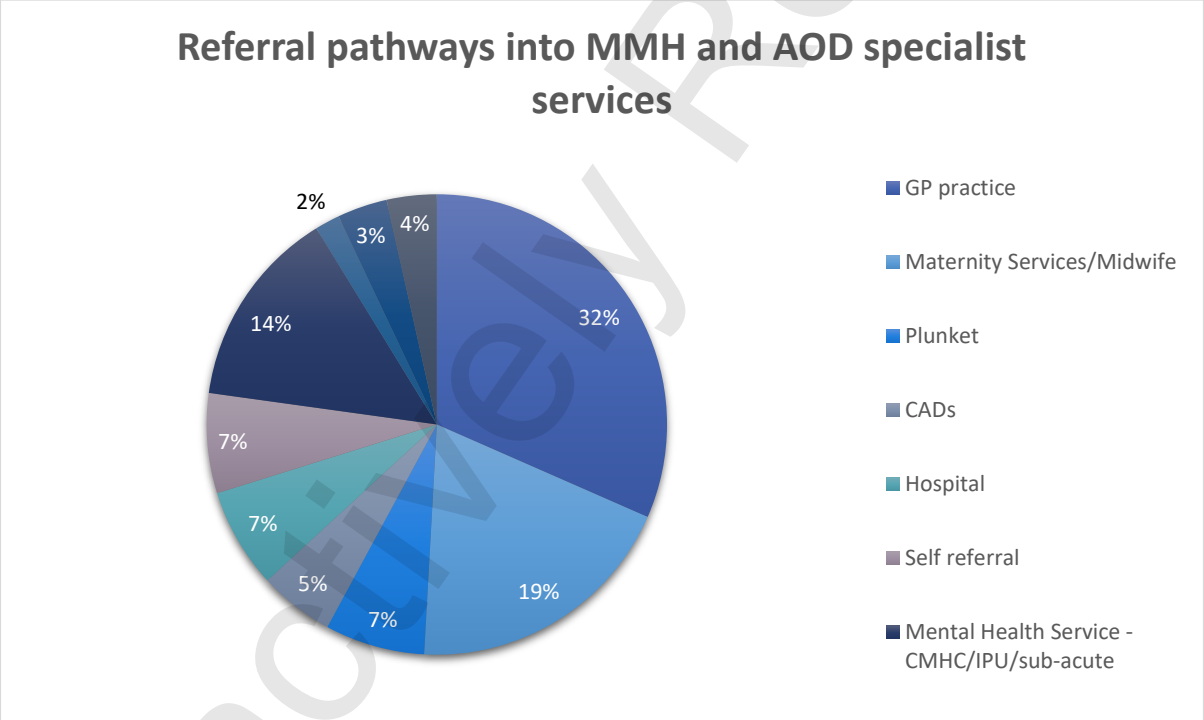

Figure 16: Referral pathways into Maternal Mental Health and AOD specialist services

When discussing ease of access to specialist services, approximately a quarter of respondents found the process to getting help quick and easy. Conversely, those that experienced issues with the referral process to maternal mental health services commented on; referrers having little or no knowledge of specialist services available, interactions with multiple referrers before referral or repeated referrals before acceptance.

The Edinburgh Postnatal Depression Scale tool is the most common screening tool for perinatal depression and anxiety, and completion of this assessment is required for referral to maternal mental health services in the Northern Region. Accurate assessment using this tool requires women to answer honestly, however feedback suggests that the nature of the questions asked are restrictive. When

coupled with a commonly experienced fear of outcome women are more likely to withhold information, thus scoring lower and ultimately being excluded from receiving much needed care. Additional feedback also suggests that the assessment wasn't suited to all cultures and that language barriers negatively impacted the accuracy of the assessment.

"But because I didn't score high enough on The Edinburgh score I couldn't get the care and the help that I needed"

"Initially declined service, had to get worse and re-referred by midwife before being admitted."

"it was impossible to access public mental health services until I'd attempted suicide and been taken to hospital for that"

Navigating pathways through the continuum of care poses challenges not only for service users but also for referrers. To address this, maintaining the clinical guidance platform HealthPathways, ensuring alignment with corresponding clinical pathways within hospital settings, and fostering robust communication between referrers and specialist services are key strategies to improve system efficiency and accessibility.

"The escalation pathway that we have to go through. It's too difficult, even as a medical professional"

Access criteria regarding stage of gestation and age of infant were also commonly reported issues when accessing maternal mental health services. Some māma had to wait significant periods of time to reach the gestational age where they could be accepted whereas others felt that they had only just started seeing results from their support when they had to exit the service as their child had turned 1.

"My child would get to 1 and by 6 months you're only just starting to build that relationship, you know and by the time a year comes, you're comfortable enough to talk to that person, and then you're discharged. So I think that probably the hardest bit is time."

Other common themes were lengthy wait times to access specialist care resulting in māma/pēpi experiencing significant declines in mental health and wellness during that period.

<u>Triage processes</u>

Referral management for specialist services in the Northern Region operate in two different ways – internally or using an additional service to provide an initial screen.

- Both maternal AOD services (*Pregnancy and Parental Service* and *He Tupua Waiora*), Te Toka Tumai's infant and maternal mental health services (*Aronui Ora* and *Koanga Tupu*) and Waitematā's infant mental health service (*Mātua Tūhonongā*) receive and manage their own referrals.
- Waitematā's Maternal Mental Health Services and Counties Manukau's infant (*Whakatupu Ora*) and Maternal Mental Health Service utilise additional teams to manage their referrals.
- Te Tai Tokerau's Maternal Mental Health Service (*Manaaki Kakano*) manages most referrals internally however referrals from the Mid North have a single point of entry (Whakaruapuna) where all mental health referrals are managed collectively.

Upon receipt of referrals from referral management teams, services then complete an additional screen for appropriateness regarding infant or perinatal concerns before accepting or declining

māma/whānau into service. Referrer and māma/whānau are notified if referrals are declined and services provide declined referrals with alternative support options.

Although triaging referrals though a separate team may reduce the number of referrals the specialist mental health teams receive, there is potential –due to limited infant or perinatal mental health knowledge by triaging teams –for māma and whānau who meet criteria to be falsely declined before specialist teams see the referral.

Infant mental health teams follow a two-step process in which referrals are reviewed for acceptance at two separate points. Firstly, a multi-disciplinary team (MDT) review of referrals determines if an initial appointment is offered. This appointment is where the service can explain the supports offered and understand whānau concerns. Secondly following MDT review of the initial appointment, a collaborative decision is made with whānau to determine continued input from the service. Initial appointments are usually carried out in the home and for some services, inclusion of the referrer and cultural liaison services (if required) is prioritised.

It is also noted that a number of specialist teams provide additional cultural screening whereby māma and whānau of priority populations may be prioritised to receive stronger engagement, be seen sooner or if declined, connected with suitable supports outside of specialist mental health. More details can be found within the priority populations sections.

Further details of access and triage processes for specialist services can be found in Appendices 4 – 6.

Addressing the needs of priority populations

Kaupapa Māori

Specialist Services

Access

All services within metro Auckland have implemented Informal screening/review processes whereby māma and whānau Māori are critically considered upon referral and prioritised to be seen sooner. Services recognise that the client population doesn't always reflect the district population and acknowledge that there are significant stigma and access barriers to overcome. As a result, services are making a concerted effort to push access and continued engagement with māma and whānau Māori. Counties Manukau is home to a large Māori population and Intake and Assessment teams use a prioritisation tool to screen for ethnicity. Additionally, infant and maternal mental health services ensure culturally suited recommendations for supports outside of specialist care are given if declined.

Cultural Clinical Supports

All specialist services in metro Auckland have connections with additional cultural support for māma and/or whānau as well as workforce. The nature, strength and process of these partnerships varies by service. Te Tai Tokerau's maternal mental health and AOD services (*Maanaki Kakano and He Tupua Waiora*) utilise their predominantly Māori workforce, whereas other teams seek support through specialist roles or teams. Te Toka Tumai's maternal mental health team (*Aronui Ora)* have a cultural liaison role within the specialist team structure. In other services –*Pregnancy and Parental Service, Koanga Tupu* | Te Toka Tumai, *Whakatupu Ora and* Maternal Mental Health Service| Counties Manukau, *Mātua Tūhononga ā and* Maternal Mental Health Service | Waitematā—specialist teams' partner with cultural clinical liaison teams to provide collaborative care for māma and whānau.

Collaboration with cultural clinical liaison teams is focussed on engagement with māma and/or whānau however there is acknowledgment that length of time involved varies case by case but is also capacity limited. Services described the importance of engaging with cultural clinical teams early and working closely in collaboration to enhance outcomes for māma and whānau Māori through supporting both the workforce and client. Counties Manukau infant and maternal mental health teams include cultural clinical liaison in MDT reviews, acknowledging the importance of ensuring cultural perspective throughout māma/whānau journey.

Services spoke of the importance of cultural clinical teams providing first contact with māma/whānau to bolster engagement and provide a link between specialist teams and culturally aligned community supports.

For some teams the relationship with cultural clinical supports could be better and there has been the suggestion that workforce capacity may be a limiting factor. For other teams the partnership with cultural clinical supports has seen increased engagement and/or duration of service by māma/whānau Māori.

Workforce and Training

Workforce make-up varies district to district with some services having a large Māori workforce and other little to none. Te Tai Tokerau is home to the largest Māori population in the Northern Region and at least half of referrals for their maternal mental health and AOD services are Māori. Their specialist teams prioritise Māori workforce and the majority of staff whakapapa Māori. Conversely specialist teams in the Auckland district have a little to no Māori workforce, despite serving areas with Māori communities that make up 8 - 16% of the district population.

The structure and approach to cultural competency training varies across districts and disciplines with some districts offering comprehensive training across multiple topics and providers, while others may only require completion of a single online course. All services have some form of mandatory training staff are required to complete. The integration of tikanga practices into services is similarly inconsistent, largely dependent on the priority each service places on this.

As part of the PEPI Regional Governance Group's work programme, the Te Tiriti Enabled Journey roopu is compiling a stocktake of cultural competency training across the region with the intent of providing recommendations to bring the region into alignment.

Additional Projects/Pilots

Across the region there are a several additional projects focussed on enhancing services to better meet the needs of māma, whānau and pēpi Māori.

- A large proportion of māma in adult inpatient units are Māori. The PEPI Regional Governance Group are undertaking a project this year to understand how eligible wāhine Māori in inpatient units can be admitted to Haumaru Ōrite |Mother Baby Unit sooner.
- Whangārei hospital is piloting a Kaiāwhina role based at the Whangārei Maternity Ward Te Kotuku and linking with hospitals in Kaipara, Bay of Islands and Kaitaia. This role is designed to support māma and whānau Māori within Te Tai Tokerau, offering culturally tailored support and enhancing access to services across the region.
- Te Toka Tumai has an ongoing piece of work focussed equity and response to Te Tiriti o Waitangi. This Kaupapa has been part of Kāhui o te Ihi's business plan over the past four years and has several outputs including training for staff and senior leaders, workforce recruitment, development of equity plans and generation of IT systems to support improved ethnicity monitoring and analysis**.**
- Counties Manukau is currently undertaking an internal project to assess the supports provided to māma and whānau upon acceptance into service. While this initiative is not specific to Māori, it is designed to benefit all priority populations accessing specialist services. Recognising that the level of support can vary depending on the clinician's skill set and experience, as well as staffing availability, the team is working to establish clear guidelines for the support offered across different mental health presentations. This includes coordination with NGOs and identifying any training gaps within the team.
- The PEPI Regional Governance Group work programme for 2025 includes an initiative seeking to understand and provide recommendations for regionally aligning culturally prioritised care. This initiative seeks to enhance access and deliver a more supportive and enriching experience for Māori māma and whānau.

Community providers

The Northern Region has one Iwi provider organisation, Kāhui Tū Kaha, which operate a residential respite facility for māma and pēpi (Awhi Rito) in Counties Manukau. Additionally, several Kaupapa Māori NGOs including Te Mana Oranga, Hauora Hokianga, Ohomairangi Trust, Te Whānau O Waipareira, and Te Ha Oranga, provide specialised support for māma and whānau experiencing infant or perinatal mental health and AOD problems across the region.

Kaupapa Māori services are grounded in a whānau-centred model of care, leveraging Māori knowledge and culture to address the holistic needs of māma and whānau. A few notable initiatives within these NGOs include:

- *Hoki ki te Rito,* a culturally adapted version of the Mellow Parenting programme aimed to meet the needs of Māori māma and whānau. This programme is currently delivered by Ohomairangi Trust and Franklin Family Support services in Counties Manukau.
- Te Ha Oranga runs a weekly programme called *Ngā Kakano* for hapū māma, parents, and tamariki under three. This programme covers life skills, parenting education from a Te Ao Māori perspective, and support for the challenges parents face. In addition to the programme, the service offers one-on-one wraparound support for whānau. This programme is only available to those able to visit the Auckland office.

Non-Kaupapa Māori specialist NGO providers also support the needs of māma and whānau Māori through a range of initiatives. These include noho marae, cultural classes (such as kapa haka, te reo Māori, and raranga weaving), the incorporation of cultural celebrations and practices, Mātauranga Māori practices (including mirimiri, rongoā, and wānanga), access to kaiārahi, prioritisation of a Māori workforce, the integration of Te Tiriti o Waitangi in organisational policies, and cultural training for staff.

At a primary care and community level there are a number of health and wellbeing offerings intended to meet the needs of Māori in the Northern Region including Integrated healthcare services, marae-based services, Hapu Wānanga, Whaia Te Ora Wānanga, community events/groups for specific audiences, Rongoā Māori services and Māori Well Child Tamariki Ora providers.

<u>Key Challenges for Māori</u>

Despite the presence of Kaupapa Māori services in the region, the number of these services dedicated to supporting perinatal mental health and AOD problems is limited with none for infant mental health. This coupled with variability in the support provided, means that many individuals remain unsupported. The low proportion of workforce that whakapapa Māori, particularly in metro Auckland, and limited referral pathways from both primary and specialist care to Māori-specific supports create significant barriers to engagement. Additionally, existing services may not be fully meeting the needs of the population, with a clear demand for more practical, accessible supports.

"It looks like kaiawhina. It looks like whānau. Yeah, it looks like them coming in to check on you every other day. If you need it."

Whanaungatanga or absence of it, is pivotal in Māori accessing and engaging with specialist care. Lack of connection or fear of disclosure can influence how a māma scores in the Edinburgh Postnatal Depression Scale (EPDS) and therefore the resulting care she may receive.

"…the reason why they [Māori māma] don't fit [EPDS] is because you're too scared to actually be honest about them in the first place"

"First time to service. First consultation – nerve wracking for me…I was alone, by myself; no whaanau with me… there were two psychologists, asking questions, staring and writing."

As previously discussed, General Practitioners (GPs) are the most common primary mental health providers and referrers to infant and maternal mental health and AOD services. However, Māori populations consistently demonstrate lower enrolment rates with GPs compared to New Zealand European and other ethnic groups.[17] Low GP enrolments present a significant barrier to accessing perinatal mental health care, with Māori being disproportionately affected.

Māori in the Northern Region are disproportionately represented in areas of high socioeconomic deprivation, particularly in the Te Tai Tokerau and Counties Manukau districts. This, combined with

the vast and rural landscape in some areas of the Northern Region, presents significant physical and financial barriers to accessing infant and maternal mental health and AOD services for Māori communities.

Pacific

Specialist Services

Access

All services within metro Auckland have implemented informal screening/review processes whereby Pacific māma and whānau are critically considered upon referral and prioritised to be seen sooner. Services acknowledge that there are significant stigma and access barriers to overcome and recognise that the client population doesn't reflect the district population, because of this, services have made a concerted effort to push access and continued engagement with Pacific populations. Counties Manukau is home to the largest Pacific population in the Northern Region and Intake and Assessment teams use a prioritisation tool to screen for ethnicity while specialist services will ensure suitable recommendations for supports outside of specialist care are made if declined.

Cultural Clinical Supports

All specialist services in metro Auckland have connections with additional cultural support for māma and/or whānau as well as workforce. The nature, strength and process of these partnerships varies by service. Te Toka Tumai's maternal mental health team (*Aronui Ora)* have a cultural liaison role imbedded within it and are piloting a pacific peer support specialist role. In other services (*Pregnancy and Parental Service, Koanga Tupu* | Te Toka Tumai, *Whakatupu Ora and* Maternal Mental Health Service | Counties Manukau, *Mātua Tūhonongā and* Maternal Mental Health Service | Waitematā) specialist teams' partner with cultural clinical liaison teams to provide collaborative care for māma and whānau.

Collaboration with cultural clinical liaison teams is primarily focused on engaging with māma and/or whānau, although the duration and nature of involvement can vary on a case-by-case basis. Ideally, this collaborative relationship would continue until it is no longer required, but resource capacity often influences this. Services emphasized the importance of engaging with cultural clinical teams early in the process and maintaining close collaboration to improve outcomes for māma and whānau.

Cultural liaison teams play a crucial role in supporting both clients and the workforce. Services highlighted the importance of cultural supports in providing initial face-to-face contact with māma and whānau, helping to build trust, strengthen engagement, and offer reassurance. These roles also serve as a valuable resource for educating clinicians on specific cultural aspects, reducing the risk of cultural misunderstandings, and fostering a stronger connection between māma/whānau and clinicians. Additionally, cultural liaison teams help link whānau and specialist teams with culturally aligned community supports, ensuring a holistic approach to care. They also provide cultural information that enhances the clinician's perspective, supporting more culturally competent and effective care.

For some teams, the relationship with cultural clinical supports could be improved, with resource capacity often identified as a limiting factor. In contrast, other teams have seen improved engagement and longer service durations for māma and whānau through effective partnerships with cultural clinical supports. Ideally clinical cultural roles would be embedded in specialist teams, providing both cultural expertise and perinatal clinical knowledge, ensuring a more integrated and comprehensive approach to supporting māma and whānau.

Community providers

The Northern Region has one Pacific led NGO providing specialist perinatal mental health support. Penina Trust, located in Counties Manukau provides both primary mental health support through their Awhi Ora and Ora'anga programmes and perinatal mental health support for Pacific māma and pēpi. Established following recommendations from the *Equitable Perinatal Mental Health Outcomes for Pacific Women*[18], Penina Trust works in close collaboration with the Counties Manukau Maternal Mental Health Service, with a Pacific Peer Support Specialist bridging the gap between the two services.

Health and wellbeing support for Pacific families is limited in number and largely concentrated in metro Auckland. These services include integrated health services, NGOs, and church-based community organisations.

Key Challenges for Pacific populations

There are significant gaps in the perinatal mental health service provision, with limited community support in Counties Manukau and little to no support in other districts. For those services that do exist, their reach is constrained by the capacity of their workforce. Infant mental health and maternal AOD services specifically tailored to Pacific populations are currently non-existent.

Stigma surrounding the topic of mental health and low mental health literacy often prevent Pacific māma from accessing mental health supports early, leading to acute levels of unwellness before seeking help.

> *"…from Pasifika point of view, we don't talk about mental health issues, but it would have been nice to see more awareness because it's not a weakness. I hope to see something in place to motivate our people of what supports are available because with what's going on it can prevent suicide and encourage getting help early."*

Pacific populations have the highest birth rate in the region and a large proportion live in areas of high socioeconomic deprivation. These factors create substantial physical and financial barriers which negatively impact access to and continued engagement with mental health services.

Asian

Specialist Services

Cultural support for Asian māma and whānau varies greatly across the region with the most established support in Waitematā. Waitematā has a dedicated Asian Mental Health Service (AMHS) which provides cultural and linguistic support for service users under the care of Waitematā mental health services. Accepting referrals from a wide range of sources, AMHS provide support through short term intervention with counsellors, psychologists and social workers as well as engagement and communication support between the service users and their mental health clinicians. AMHS is available to Chinese, Korean, Indian, Pakistani, Thai, Indonesian, Vietnamese and Japanese whānau.

The development of a dedicated perinatal team within AMHS arose from the recognition of unmet needs within the local population. Although Asian families accounted for 30% of births in Waitematā, only 13% of referrals to maternal mental health services came from Asian families.[19] AMHS work closely with Waitematā Maternal Mental Health Service to ensure culturally informed triage of referrals, facilitating access to specialist care for Asian and Ethnic māma experiencing acute mental health issues. AMHS' perinatal team also provide community peer support groups, health seminars and workshops, parenting programmes and connect māma with several community NGOs specific for the Asian and Ethnic populations.

Outside of Waitematā, support for Asian māma and whānau in specialist services is less developed and provided through various approaches. These include the involvement of internal team members who identify as Asian, Asian services within broader mental health directorates or contracted NGO

providers, and Clinical Cultural Liaison teams. Te Tai Tokerau currently lacks specific support for Asian māma and whānau.

Community providers

Healthy Mother Healthy Future (HMHF) is an Asian Perinatal Mental Health and Wellbeing programme developed by Asian and Ethnic Health Services after health data demonstrated significant accessibility issues for its Waitematā Asian community. Piloted in 2022, the programme aligns with the recommendations published in *Supporting Equitable Perinatal Mental Health Outcomes for Asian Women 2021*[6]; enhancing referral pathways to maternal mental health services, improving health literacy, mental health awareness and accessibility and promoting early help-seeking and intervention. The programme is delivered through community NGOs, CNNST Foundation and The Asian Network Inc. Since its inception, HMHF has grown the number of Asian women accessing maternal mental health services from 13% to 22.55% of all referrals.[20]

Several NGOs are dedicated to supporting Asian and Ethnic communities within the Northern Region, though all are based in the Auckland area. CNSST Foundation and The Asian Network Inc. provide specialist care for māma and whānau, as well as primary mental health support through social work and counselling services. Ember, Kāhui Tū Kaha, and Umma Trust offer community and social support services, including health literacy assistance and the delivery of parenting programmes. Additionally, Waitematā's Whānau Mārama Parenting organisation offers its parenting courses in Mandarin, Cantonese, and English.

Key Challenges for Asian populations

There are significant gaps in cultural supports for Asian and Ethnic māma across the region. While Waitematā has established support for those accessing maternal mental health services, support is less robust in other Auckland districts, and there is no support available in Te Tai Tokerau. Workforce capacity is a key factor limiting the impact of existing services. Furthermore, infant mental health and maternal AOD services specifically tailored to Asian populations are currently non-existent.

Te Tai Tokerau's maternal mental health and AOD services (*Manaaki Kakano* and *He Tupua Waiora*) as well as metro Auckland's *Pregnancy and Parental S*ervice spoke of low numbers of Asian māma referred and those that are, tend to be severely unwell and/or are health professionals themselves. This may reflect previously reported barriers including mental illness and AOD stigma, low mental health and AOD literacy and lack of linguistic and cultural support.

Linguistic barriers and fear of disclosure can hinder the accuracy of assessment tools used to refer māma or pēpi to specialist services, thereby preventing access to crucial care. To address these challenges, adapted referral forms with tailored prompts, along with linguistic and cultural support during assessments, would be beneficial in improving access to these essential services.

Asian and Ethic populations commonly present with atypical and/or somatic symptoms of mental ill-health. Specific cultural expertise is required to understand the context and provide support to such populations.

Other Priority populations

Disability

There are limited or no specific supports available for parents with disabilities in the Northern Region, particularly when accessing specialist infant and maternal mental health and AOD services. To address this gap, some services have leveraged the expertise of internal team members or collaborated with Starship Community Services to support whānau. Services have highlighted the challenges of working

with and meeting the needs of māma and whānau with disabilities, emphasizing the importance of collaborative care with disability agencies such as Taikura Trust and Blind Low Vision NZ.

Rainbow

Support for the rainbow community within infant and maternal mental health and AOD services in the Northern Region is variable. Some services are particularly advanced in providing inclusive care, while others have no specific supports in place but acknowledge the need for greater focus in this area.

Te Toka Tumai's infant and perinatal services (*Koanga Tupu and Aronui Ora*) and *Pregnancy and Parental Services* are meeting the needs of the rainbow community through rainbow workforce, champions, training, resources and a prioritisation process to support rainbow māma and whānau referrals. Additionally, Te Toka Tumai is involved in a three-year project with Victoria University, *building system readiness for trans inclusive perinatal mental health services*, aimed at improving healthcare access and outcomes for trans individuals experiencing perinatal distress.

Adolescent

Maternal mental health and AOD services vary in their approach to supporting adolescent māma. Most services provide support for those under 18 in collaboration with adolescent specialist teams. Waitematā's Maternal Mental Health Service access criteria exclude māma under 18 years of age but have a pathway in place to support pregnant māma under the care of Marinoto Youth Mental Health Service. Haumaru Ōrite is governed by the access criteria of maternal mental health services and will accept women based on the referring service's standards.

Maternal mental health services have connections with community supports for adolescent māma including several teen parent units in the metro Auckland region (Table 12) and Oranga Tamariki's residential programme, Te Whare o taonga.

Table 12: Community supports for adolescent māma

Name of IMMH specific Provider	District	Service notes
Living and Learning Whānau Centre	Waitematā	Provides parenting programme tailored to teen māma
Connected Learning Centre (TPU)	Counties Manukau	Links with Ohomairangi Trust for parenting programmes
Eden Campus	Te Toka Tumai	Links with parenting and social education
Teen Parent Unit	Counties Manukau	Collaboration between James Cook High School and Taonga Education Centre Charitable Trust. Education centre for teen mothers and their tamariki (ECE centre) which includes parenting programmes
He Wero Teen Parent Unit	Waitematā	Provides parenting programme

Overall challenges for priority populations

The environmental scan found varied levels of support available for Māori and other priority populations when accessing services within the infant and maternal mental health and AOD continuum of care.

Within specialist services there are significant disparities in what supports are in place and offered for both workforce (consultation and training) and māma/whānau. Some services are well connected with specialist supports for priority populations whilst others acknowledge the gap that exists and the need to improve this.

Although community services purpose built to meet the needs of specific populations exist in the Northern Region, the impact and reach these services can have, is limited by resource capacity. With significant gaps geographically, there are large communities missing out on specialist support. These gaps are partially filled through a variety of other providers including integrated healthcare services, NGOs providing primary mental health and AOD support and community services.

The importance of having a workforce that represents the population they are serving is evident. Positive experiences and stronger connection to their journey were expressed by those who interacted with workforce who were of or had ties to a shared culture. Conversely others expressed a desire to have had someone of their culture involved in their care and would have felt more comfortable had that been the case.

"I felt seen and validated that I was suited with someone who can understand my culture and not have to explain myself about why we do things differently."

"Would've been helpful to have a poly parent aid when offered. Emotionally the island way who understand where you're coming from, the difficulties and felt I could've been myself more."

"It would be good to have an islander, where I felt more relaxed and could rest. "

The majority of non-Pākehā/NZ European māma and whānau interviewed felt that their cultural needs and values were being met by the service. Participants commented on staff acknowledging, respecting, and supporting their culture, with some services incorporating cultural practices such as language and karakia, as well as Mātauranga Māori models of care. However, continued emphasis on cultural safety and competency is necessary with some māma expressed feeling that they were providing cultural support to staff rather than receiving it.

"Auckland is behind with cultural support. It felt like I was supporting them."

"She tried her best but I would teach her Reo. It wasn't the same."

The importance of offering cultural supports from the outset was emphasized, with only a few of those interviewed mentioning being offered additional cultural support at any stage.

The desire to feel safe and understood is crucial to engagement and positive mental health and AOD outcomes for priority populations. Addressing linguistic and cultural barriers through the development of well-connected and culturally aligned services is imperative to this.

"She made me feel culturally safe and I didn't have to explain myself or feel judged."

Kahu Taurima

The Northern Region has several integrated initiatives funded by Kahu Taurima, supporting whānau from pregnancy through to early childhood (Table 13). Additionally, there are several initiatives underway within the wider Kahu Taurima area in maternity and early years services, which are expected to include linkages and pathways to mental health supports in the future. One such example is the recently established project focused on developing a national bereavement care pathway to support māma and whānau following pregnancy and infant loss.

Feedback from this environmental scan suggests that developing linkages between maternity and early years integrated providers, and infant and maternal mental health services, including the possibility of physical co-location, could facilitate these pathways. As mentioned earlier, access criteria, referral pathways to and between specialist services, and liaison coordination services provided by these teams help support linkages with child and maternity services.

Table 13: Stocktake of Kahu Taurima providers in the Northern Region

Provider	Service Delivery Area
Manurewa Marae Trust Board 2008 Incorporated	South Auckland
Ngāti Hine Health Trust Board	Mid Northland
Turuki Health Care Limited	South Auckland
E Tipu E Rea Whānau Services	West Auckland
Te Hauora O Te Hiku O Te Ika Trust	Upper Northland
Te Hau Ora Ō Ngāpuhi Limited	Mid Northland
HealthWEST Limited	West Auckland
The Fono	Auckland

Summary and Conclusions

This environmental scan reflects previously reported findings[21,22], reinforcing the need for robust support at the community and primary health care levels, increased awareness of support services, and enhanced infant and perinatal mental health and AOD training across the continuum. It also highlights the importance of facilitating greater connection and collaboration between services, with a strong emphasis on providing equitable care for all.

The Northern Region currently faces a fragmented continuum of care for infant and perinatal mental health and AOD services, with numerous gaps within and between services. This has led to high demand on some providers and significant underutilisation of others. Despite these challenges, there are several well-designed service models and initiatives offering tailored support to māma, pēpi, and whānau, which the region could benefit from leveraging and replicating.

A lack of awareness about available supports—both within the public and among the community and primary health care workforce—impedes help-seeking behaviour and limits access to key pathways into care. Furthermore, the absence of infant and perinatal mental health and AOD knowledge at the community level likely contributes to the gap in support for those with mild to moderate conditions. This can increase the severity of illness for those left unsupported and places additional pressure on specialist teams.

Having culturally aligned services, with staff competent in providing culturally safe care, is essential for achieving equitable health outcomes for our Māori, Pacific, and Asian populations. Equally important is ensuring that services and staff are well-equipped to offer safe, holistic support for disabled and rainbow communities. Despite the efforts of a dedicated and knowledgeable workforce, significant gaps remain in the continuum of care, preventing equitable support for our priority populations.

In the current fiscal environment, effective connection and collaboration across the continuum of care are essential to meeting the needs of māma, whānau, and pēpi. By understanding and utilising existing services and resources, alongside prioritising funding to replicate successful service models, the sector can better position itself to address these needs more effectively.

Recommendations

These recommendations have been developed based on the brief for this environmental scan and the insights shared by māma, whānau, and the workforce. We recognise that bringing these recommendations to fruition will require considerable effort in planning, development, and implementation. We also acknowledge that similar initiatives may already be underway and any work on these recommendations will need to align with and consider these ongoing efforts.

Continuum of Care

Overwhelmingly there is a need to increase workforce throughout the region to plug the gaps and enable māma and whānau to access care at all levels of the continuum. Although some teams or areas are well resourced, the overall picture appears fractured with various community supports stretching to fill the gaps. Of note two areas require specific focus – infant mental health services and lived experience workforce.

1. Increase infant mental health services across the region

Investing in infant mental health services across the region is essential to strengthening the continuum of care within this specialty. It is critical that the needs of infants are addressed at both the community and specialist levels. Currently, specialist services are unavailable in Te Tai Tokerau, and community support options are extremely limited across the region, with varying levels of provision. Expanding and standardizing these services will ensure comprehensive and equitable care for pēpi and their whānau at all levels**,** region wide.

2. Increase lived experience workforce

The value of a lived experience workforce within the infant and maternal mental health and AOD continuum of care is undeniable. Feedback from consumers emphasized the importance of lived experience as a means of fostering connection, offering understanding, and providing comfort in ways that health practitioners may not be able to. Lived experience peer support roles are essential for bridging gaps in care, particularly at the community level, by offering support to priority populations and individuals who may not be engaged with general practices or specialist services. At present, these roles are sparse and with varying levels of visibility and consistency. Additionally, feedback highlighted a significant demand for consistent access to peer lead support groups and activities for both mama and whānau, such as coffee groups, parenting programmes, educational seminars, and whānau-focused events. Investing in NGO based peer support roles would enable this, while providing a flexible and supportive environment for people in these roles.

> *"We need more people with lived experiences to get in there. Because they've got way, way broader reach than any type of health practitioner. You know, because they're more likely to be able to interact with whānau and engage with them on like a level that those whānau are, like, actually comfortable with."*

3. Enhance specialist knowledge and competency throughout the continuum of care

Early intervention and a focus on prevention through education is key to sustaining whānau wellness and reducing the demand on specialist infant and perinatal mental health and AOD services. Leveraging the strong connection that midwives have with māma by equipping them, along with other primary care professionals, with specialist knowledge and practical tools to support māma and whānau of all cultures earlier on will be crucial in addressing these gaps. Additionally, strengthening infant and perinatal mental health knowledge within triaging teams would enhance referral pathways

and ensure better support for māma and their whānau. Funding and promotion of current training offerings and ongoing support by training providers to primary care providers is key.

Availability and access to specialist training for the infant and perinatal mental health and AOD workforce is currently limited. Increasing availability and funding for professional development in this sector will ensure that the most up-to-date knowledge and practices are accessible to support the Northern Regions diverse māma and whānau. Furthermore, establishing a joined up professional development approach for specialist and NGO providers will promote alignment, foster collaboration and enable services to collectively meet the needs of māma and whānau.

Health Pathways

4. Multiagency forums as a pathway into care

The development and/or enhancement of multiagency forums across the region would play a vital role in connecting māma and whānau to support services, particularly in rural and remote areas where gaps in the continuum of care exist. Key members of such a forum might include midwifery, maternity services, infant mental health, maternal mental health and AOD services, as well as Oranga Tamariki, to create a comprehensive support network for māma and whānau.

5. Promote wellbeing and raise awareness of support services through community and primary care settings

Many people are not aware of the 'normal' spectrum of parenting emotions and when this is requiring specialist intervention. Similarly, so there is a lack of awareness about infants having their own mental health needs which may or may not co-occur with parental mental health issues. Additionally, māma experiencing substance use problems may not know where to seek help in a way that supports them and their pēpi. It is essential that people have access to unbiased information at the whānau and community level about infant mental illness, perinatal mental health, and AOD problems, as well as guidance on how to access support. This information should be delivered in a variety of languages through commonly used primary and community channels, including GPs, midwives, Well Child, and antenatal providers. Furthermore, developing postnatal courses that focus on promoting wellness and prevention in a variety of cultural and community settings will further enhance knowledge and build awareness for māma and whānau.

> *"No. I wish a midwife told me, as I meet with a few of them. And the one I stuck with; she wasn't aware of such service. These women tend to get to know you, and even if they don't get to fully know you, they could provide it as a pamphlet or similar, as they usually give lots of information/ booklets to you."*

6. Build awareness of community-based specialist infant and maternal mental health and AOD services within the healthcare sector

A variety of support options are available to individuals throughout the continuum of care; however, these options are not always effectively communicated to māma and whānau. Building knowledge at key entry points to the continuum of care can be achieved through several approaches, including leveraging existing clinical platforms such as *Community HealthPathways*, developing a centralized repository of information about service providers across the continuum of care, and establishing health system navigator roles to assist referrers in connecting with the right services or resources. These measures will help prevent unnecessary referrals between services, reduce wait times, and facilitate earlier intervention.

7. Enhance referral processes by specialist and triage teams

Implement signposting to other providers at referral point

Many individuals do not meet the threshold for specialist infant and perinatal mental health and AOD support; however, māma, pēpi and whānau still require assistance. Specialist services have a crucial role in linking referrals to appropriate community-based supports, as part of the triaging or early engagement process. This is particularly important for individuals from priority communities. This support may complement or serve as an alternative to specialist care. Currently, there is an inconsistent approach to this, resulting in many individuals receiving little or no support, particularly when declined by specialist teams. Developing a comprehensive resource of service providers, as previously discussed, along with improved triage processes, will support māma and whānau to receive necessary care.

Improve quality of referral information at triage

Accurate screening relies on both the quality of referral information provided and the specialist perinatal knowledge of the team at the triage stage. It is essential to establish a process that ensures sufficient information is gathered during triage, prior to classifying referrals as primary/secondary or non-urgent/urgent. This step is critical to ensuring the best possible outcome for māma and whānau.

8. Co-locate maternal mental health within maternity and early years services

Maternal mental health services in the Northern Region are currently co-located with general mental health services, which, while practical in some ways, does not effectively address the unique needs of māma and whānau. It is recommended that maternal mental health services be integrated within Kahu Taurima or integrated maternity and early years services. Co-locating these services within community hubs would not only provide wrap-around care, but also help overcome physical barriers to access, reduce burnout from multiple service interactions, and minimize the need for repetitive storytelling. Such an approach would raise awareness of maternal mental health services, increase engagement with whānau, and foster a more collaborative and connected system, better equipped to meet the diverse needs of families.

9. Develop a regional infant and maternal mental health and AOD network to support relationship-building and enhance collaboration across services

Effective and collaborative care throughout the healthcare continuum is essential to supporting the journey of māma and whānau. Establishing an infant and maternal mental health and AOD network would create a platform to strengthen relationships between services (particularly in vast areas with significant rurality), promote the development of a shared vision and common objectives, and eliminate existing silos. This approach would ultimately streamline the experience for those navigating the system, ensuring more cohesive and integrated care.

Addressing the needs of Māori and other priority population

10. Services adopt culturally prioritised ways of working

Shifting the way services operate to prioritize Māori, Pacific, Asian, Rainbow populations and people with disabilities is crucial for achieving equitable health outcomes across the Northern Region. This prioritization should be reflected both at the engagement stage—ensuring these populations have timely access to services—and throughout their experience within the service. It is recommended that specialist services formalize the implementation of screening processes at triage to ensure priority access to care for these populations. Additionally, developing referral support systems that facilitate

smoother pathways into specialist care is crucial, with models such as those within Asian Mental Health Services in Waitematā serving as a valuable reference.

The development and implementation of regionally aligned co-designed cultural frameworks is essential to delivering care in a culturally nourishing manner. These frameworks should uphold individuals' cultural identity and facilitate understanding and engagement by māma and whānau, while ensuring a connected and consistent approach across all services. Furthermore, as previously highlighted, services across the continuum of care must routinely engage culturally specific organisations to strengthen cultural support provided to māma and whānau, ensuring their needs are comprehensively met. It is recommended that funding be allocated to ensure access to these culturally specific supports, allowing for their consistent and effective integration into care pathways.

11. Increase service provision for culturally specific supports

Cultural support is essential to the success of maternal and infant mental health and AOD services, significantly impacting the experience and outcomes for māma and whānau. Current provisions for culturally specific services are inconsistent across the region. There are no culturally specific infant or perinatal mental health or AOD specialist services within the Northern Region and culturally specific specialist NGOs are scarce. While existing services do provide well aligned models of care, funding constraints restrict their reach. Increasing the availability of culturally specific specialist NGO services tailored to meet the needs of priority populations is critical for achieving health equity.

Cultural support options within infant and maternal mental health and AOD services are variable and inconsistently offered. To address this, we recommend strengthening the approach and duration of cultural support offered to māma and whānau. Fostering collaborative relationships between specialist teams and cultural support services, as well as developing clinical cultural roles within specialist teams will ensure a timely, comprehensive and integrated approach. Additionally, increasing resources, ensuring that supports are routinely offered, and shifting from a focus on engagement to sustained support throughout the duration of the journey will better address the ongoing needs of māma and whānau.

12. Invest in our workforce

Feedback from māma and whānau highlighted a strong preference for a workforce that reflects their culture or community, noting that such alignment leads to a deeper understanding, enhanced communication, and more efficient and effective outcomes. Current staffing levels do not consistently enable these matches. Ideally, services would be staffed in a way that mirrors the composition of the population they serve, ensuring more tailored and responsive care. We recommend focusing on the recruitment and retention of Māori, Pacific, and Asian workforce, as well as individuals from Rainbow and disabled communities.

Identifying, respecting, and holding space for a person's culture is essential for building trust and connection which can positively impact experiences and outcomes within the continuum of care. Developing regionally aligned training recommendations to build cultural safety and competency, as well as a system to ensure culturally safe care is consistently provided, will ensure that all individuals—regardless of their culture or needs—receive care that is respectful and supports their opportunity to attain equitable health outcomes.

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Appendices

Appendix 1: Interview Questions

2023 Questions

1. How were you able to get help from this service? Was it easily accessible?
2. Did you understand clearly what support you would get from the service? Or when you began using the service?
3. Did you feel you were in partnership with the service and felt you were in control of support and goals?
4. Was the support an easy process for you/whānau? Did you receive enough information that was easy and clear to understand?
5. Did the service support your cultural needs and what is important to you?
6. Did you feel your whānau was included as much as you would have liked them to be involved?
7. What worked well for you/whānau?
8. What did you find unhelpful?
9. Do you have a clear idea of what your support will look like when you no longer needed the service?
10. Can you think of anything that was missing in your support that could have helped better your needs from the service?

2024 Questions

Infant mental health services

1. How were you able to get help from this service? Was it easily accessible?
2. Did you feel you were in partnership with the service and felt you were in control of support and goals?
3. Did you receive enough information about our service that was easy and clear to understand?
4. Was working with the service an easy process for you/whānau?
5. Did the service support your cultural needs and what is important to you?
6. What worked well for you/whānau (family)?
7. What did you find unhelpful?
8. Did you have a clear idea of what your support/child/family will look like when you no longer needed the service?
9. Can you think of anything that was missing in your support/child/family that could have helped better your needs from the service?

Maternal mental health and AOD services

1. How were you able to get help from this service? Was it easily accessible?
2. Do you feel you were in partnership with the service with regard to support and goals?
3. Did you receive enough information about our service? How easy or difficult was it to understand?
4. How did you find your experience of working with the service? How easy or difficult was it for you?
5. Did the service support your cultural needs and what is important to you?
6. Did you feel your whānau was included as much as you would have liked them to be involved?
7. What worked well for you/whānau?
8. What did you find unhelpful?
9. Did you have a clear idea of what your support will look like when you no longer needed the service?
10. Can you think of anything that was missing in your support that could have helped better your needs from the service?

Appendix 2: Survey Questions

1. We understand that some groups in our community may have more difficulty getting support and we would like to understand this better. Please select any of these options that apply to you.
2. Did you experience any problems with mental wellbeing around the time of your pregnancy and during the early years of your child's life (up to 3 years of age)? For instance, anxiety, depression, intrusive thoughts, difficulty coping with the necessary activities of life.
3. It is known that a range of different supports make a positive difference for birthing parents. Thinking about your own experience please select from below the supports that you had access to.
4. Support can also be practical things, thinking again about your own experience (or your person's experience) select all those that you had access to.
5. Anything we missed? What else did you need or needed? (There could be something you found very useful during this time, or something you needed that wasn't available for you).
6. Did you or the person you support access a service/s to help you with your mental health or wellbeing distress?
7. What kind of service/s did you access? Select all that apply.
8. Thinking about accessing health services to help you with your trouble with mental wellbeing, select all those that apply to you.
9. Thinking about your pregnancy / hapūtanga for you personally or for the person you supported, what help that you received was the best help for you (or your person)?
10. Thinking about after the child was born for you personally or for the person you supported, what help you received was the best for you (or your person)?
11. Thinking about the help and health service your received, was there anything that could have been better, e.g. cultural support?
12. How could it have been better?
13. Was there anything more that you might have wanted (but didn't get) to support your mental health?
14. Thinking about when you/ your person finished receiving help from a mental wellbeing health service select all that apply for you / your person.
15. Please tell us in your own words why access to a health service to help you with your mental health and wellbeing was not the path for you.
16. Even though you didn't use a health service, were you able to get help from your own friends, whānau and community?
17. What barriers to accessing mental health services did you experience? Please select any of these options that apply for you or your person.
18. Please tell us what was helpful and met your needs, from your own friends, whānau and community?
19. Is there anything more you want to tell us about mental wellbeing, and what you need/needed when you were pregnant or had a young child, or supported a person like this?
20. What is your age in years?
21. Which ethnic group do you belong to?
22. How would you describe where you live?
23. What is the nearest town to where you live, or the name of the town you live in?
24. What is the name of the region you live in?

Appendix 3: Supporting Documents

1. Government Inquiry into Mental Health and AOD. He Ara Oranga: Report of the Government Inquiry into Mental Health and AOD. 2018. [cited 2024 Dec 14]. Available from: https://www.mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/
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Appendix 4: Stocktake of Maternal Mental Health Services

Manaaki Kakano Te Tai Tokerau	Maternal Mental Health Service Waitematā	Aronui Ora Te Toko Tumai	Maternal Mental Health Service Counties Manukau
Access Criteria			
Is eligible to receive public health services in New Zealand OR Requires mental health assessment associated with emotional distress related to pregnancy, birth or parenting in the first year of an infant's life AND Is residing within the Northland District catchment area OR An inpatient at a maternity ward at a Northland Hospital AND Is in the second or third trimester of pregnancy OR Is a caregiver of an infant under twelve months of age AND Would likely meet criteria for a moderate to severe 'mental disorder', as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND There is a risk of this disorder impacting on the mother-baby bond AND The identified needs would not be better served by a more appropriate service provider • Referrals for non-birthing partners are accepted. • The person would benefit from a pre-pregnancy consultation (i.e. medication review)	Is eligible to receive public health services in New Zealand OR Requires maternal mental health assessment and intervention associated with emotional distress related to pregnancy or parenting in the first year of an infant's life AND Is residing within the Waitematā District Health Board catchment area AND Is pregnant, OR a caregiver of an infant under twelve months of age OR Hx of SMI and planning pregnancy, AND Would likely meet criteria for a moderate to severe 'mental disorder', as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM); AND The identified needs would not be better served by a more appropriate service provider • Qualifying Inpatients at North Shore and Waitakere Hospital maternity; are seen by psychiatric liaison service in hours and the adult mental health crisis team after hours. • Is over 18 years of age • Access for teenage mothers via the Marinoto Youth Mental Health Service.	Is eligible to receive public health services in New Zealand OR Requires urgent risk assessment associated with emotional distress related to pregnancy or parenting in the first year of an infant's life AND Is residing within the Te Toka Tumai/Auckland District catchment area OR Is an inpatient at a maternity ward at Auckland Hospital AND Is pregnant OR Is a caregiver of an infant under twelve months of age AND Would likely meet criteria for a moderate to severe 'mental disorder', as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM); AND The identified needs would not be better served by a more appropriate service provider • The person would benefit from a pre-pregnancy consultation (i.e. medication review) • Accept referrals for non-birthing partners in addition to care for māma (Aug 2024)	Is eligible to receive public health services in New Zealand OR Requires urgent risk assessment associated with emotional distress related to pregnancy or parenting in the first year of an infant's life AND Is residing within the CMDHB District Health Board catchment area OR Is an inpatient at a maternity ward at Middlemore Hospital AND Is pregnant, OR a caregiver of an infant under twelve months of age OR Hx of SMI and planning pregnancy AND Would likely meet criteria for a moderate to severe 'mental disorder', as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND The identified needs would not be better served by a more appropriate service provider
Referral route into the service (how are referrals made into your service e.g. self-referral, GP, Community Mental Health, LMC).			
Referrals for the majority are received and managed by Manaaki Kakano. In the mid north there is a single point of entry where MH referrals are triaged. GPs, Midwives, Adult Community or Inpatient MH services, CAMHS, Consult-Liaison Psych dept, Whānau Awhina | Plunket, Community Maternity Services (Lactation Consultants, Childbirth Educators, LMCs, Maternity Social Worker), self-referral.	Referrals are managed by adult services Waitematā referrals management team. Plans for MMH to take direct referrals from primary care – on hold. Referrals that are referred from management team come from GPs, midwives and Plunket. Te Aka Ora Forum (multiagency forum for high-risk pregnancies).	Referrals are received and managed by Aronui Ora. Referrals are received from General Practitioners; lead maternity carers; secondary mental health services; and involved health and social practitioners in consultation with the person's General Practitioner. Aronui Ora does not accept self-referrals.	Referrals are received and managed by Referrals Management team and/or Intake and Assessment Team. GPs, Midwives, Adult Community or Inpatient MH services, CAMHS, Dept of Psyc med, self-re-referral, CMDHB CMHCs inpatient Referrals are taken directly from CMDHB CMHCs, inpatient, Department of Psyc medicine, CAMHS Intake and Acute Assessment team as above.

Manaaki Kakano Te Tai Tokerau	Maternal Mental Health Service Waitematā	Aronui Ora Te Toko Tumai	Maternal Mental Health Service Counties Manukau
Referral Expectations (what core information/processes are needed e.g. screening tools)			
Referrals are screened with consideration given to level of risk, the presence of perinatal stressors and attachment / bonding difficulties. The degree to which primary and secondary health has been trialled is also reviewed e.g., has the woman been given an adequate amount of time for medication to be of benefit? Has the woman been referred to community supports? Edinburgh Postnatal Depression Scale tool alongside Manaaki Kakano referral form completed.	Referrals are screened with consideration given to level of risk, the presence of perinatal stressors and attachment / bonding difficulties. The degree to which primary and secondary health has been trialled is also reviewed e.g., has the woman been given an adequate amount of time for medication to be of benefit? Has the woman been referred to community supports? Edinburgh Postnatal Depression Scale tool used.	Referrals are screened with consideration given to level of risk, the presence of perinatal stressors and attachment/bonding difficulties. The degree to which primary and secondary health has been trialled is also reviewed e.g., has the woman been given an adequate amount of time for medication to be of benefit? Has the woman been referred to community supports? Edinburgh Postnatal Depression Scale tool. The UK Mental Health Triage Scale is adapted and utilised to determine response and response times.	Referral process includes information around current presentation, mental health history, family history, risk factors, bonding with child/baby and any treatment have trialled before
Triage process (how are referrals to your service triaged/prioritised?)			
Manaaki Kakano receives and manage referrals daily between 8-4.30pm. Duty allied/nursing clinicians are allocated this work per day. Non-urgent referrals are discussed within a wider multi-disciplinary team once per week. Acute presentations not open to Manaaki Kakano are managed by the local Community Assessment Treatment Team until we process the referral. Referrer notified if referral is to be declined with recommended alternative supports.	Clients are referred to Maternal Mental Health as per the Adult Referrals Management policy level E (Low risk of harm in short term or moderate risk with high support/stabilising factors Non urgent mental health response – Within 4 weeks). Referrals are managed through adult services referrals management teams.	Aronui Ora receives and manages referrals daily. A duty SMO and allied/nursing clinicians are allocated to this work per day.	Referral are initially triaged by Referral management team or Intake and Assessment teams for acuity and appropriateness. Both teams can consult with MMH when triaging. Maternal MH then screens triaged referrals for appropriateness regarding perinatal concerns. Referral and history reviewed to determine if they meet criteria or not. Declined referrals are provided with alternative support options.
Wait times			
Referrer and client are contacted by key worker within 2 business days of referral being allocated. Contacted by allocated clinician and plan appt time + contacts.	As per team process, the allocated clinician is expected to have engaged the clients within 2 weeks of referral to Maternal Mental Health. A full psychiatrist mental health assessment may take up 4-6 weeks.	Referrer and client are contacted by Duty clinician within a week and then the referral is allocated or declined. 0-3/4 weeks – for non-acute referrals	Women are contacted by Maternal Clinician within 2-5 business days of referral-given name of allocated clinician plus appt time + contacts. Maternal completes some acute assessments (within 48 hrs, can join Intake team for same day if capacity). Non acute is up to 3-4 weeks from referral.
Interventions used			
• Groups currently on hold – COS-P, ACT • Talking therapies (e.g. CBT, ACT, CFT, CAT) • All clinicians have completed Decider Skills training and use these in interventions (CBT, DBT and ACT skills) • Majority of clinicians are trained and have external supervision in Video Interactive Guidance • Medication - Discussion of risks/benefits during perinatal period, monitoring of medications.	• Key worker support 1-1 follow up including COSP, CBT,DBT, ACT, IPT dependent on individual clinician skill set. • Group support with a mix of CBT, Dealing with distress, adjustment to parenting. • Psychotropic medications • Psychiatrist assessment. • Individual psychological support • Single Session Family Consultation (SSFC)	• Key worker 1:1 support • Groups – COS-P, Dealing with Distress, ACT Therapy Group and Walking Group • Talking therapies (e.g. CBT, ACT, EMDR, SSFC, DBT informed) • Medication review and monitoring • Maternal nurse (0.6) • Peer support • Cultural assessment and support (Māori and Pacific)	Treatment options are tailored to meet individual/family needs and include: • Group treatments (Mood disorders, Dealing with distress) • Education about mental health Diagnosis and symptoms • Discussion of risks/benefits during perinatal period • Psychological therapy • Brief episode of care (BEC) – Dr review, brief intervention and liaison with GP

Manaaki Kakano Te Tai Tokerau	Maternal Mental Health Service Waitematā	Aronui Ora Te Toko Tumai	Maternal Mental Health Service Counties Manukau
• Support during adjustment to motherhood / bonding with child. • Access to NGO CSWs with Arataki Ministries, In-Home respite, and Haumaru Ōrite as required.	• NGO support with Walsh Trust (Respite and community support) • NGO CSW support with Equip and Ember	• Inpatient admissions • Consultation or referrals to Koanga Tupu – Infant mental health team • Liaison and consultation with CMHCs, GPs, LMCs, maternity wards at ACH • Case management • Respite provision (home-based and respite facility)	• Medication • Support during adjustment to motherhood / bonding with child • Cultural assessment and support to appropriate cultural services/ treatments • Consultation to inpatient teams during admission periods • Referral and liaison to other services as required • Local respite care + day programme
Whānau involvement			
Whānau and family are actively included in assessment and treatment with whaiora consent.	Not embedded but encouraged.	Whānau and family are actively included in assessment and treatment with client consent.	Yes
Discharge planning			
Recovery plan is shared with client, GP, and NGO (if involved). Dr to Dr letter provided to GP if medication prescribed. Recovery and Transition Plans are commenced in the first 3 months of treatment and are reviewed regularly prior to discharge,	Collaborative Care plans in preparation for discharge planning are initiated around the time of the first 3-month review. Discharge letters to client and GP include information on Early Warning signs and where and whom to contact in the event of deterioration.	Embedded in the MDTM review process. Use of Collaborative Care Plans to inform treatment and discharge planning	Any client under the service will be having regular follow up by case managers and consultant. We review the client and check the mental state. If there is an improvement in mental state and no risk of concern, we discuss with client and whānau regarding transferring care back to GP (discharge) and discuss in our MDT so we agree as a team that client is safe to discharge form the service.
Volumes of patients seen			
Referral numbers 2018/2019 – 221 2019/2020 – 275 2020/2021 – 256 2021/2022 – 263 2022/2023 – 245	Referral numbers 2018/2019 – 333 2019/2020 – 385 2020/2021 – 445 2021/2022 – 396 2022/2023 – 461	Referral numbers 2018/2019 – 626 2019/2020 – 628 2020/2021 – 764 2021/2022 – 712 2022/2023 – 629	Referral numbers 2018/2019 – 525 2019/2020 – 432 2020/2021 – 585 2021/2022 – 479 2022/2023 – 362
FTE			
6.7 FTE budgeted 2.3 FTE vacant	14.2 FTE budgeted 2.7 FTE vacant	17.96 FTE budgeted 0.19 FTE vacant	12.39 FTE budgeted 2.29 FTE vacant
Workforce			
Social workers Nurses Psychiatrist Clinical Psychologists.	Psychiatrist Nurses Psychologist Social worker Occupational Therapist	Psychiatrist Psychologist Social workers Occupational therapist Psychotherapist Nurses Peer support Cultural advisors	Nurses Social workers Psychiatrist Clinical psychologists Occupational therapists Work alongside Māori and Pacific Clinical Cultural supports
Hours			

Manaaki Kakano Te Tai Tokerau	Maternal Mental Health Service Waitematā	Aronui Ora Te Toko Tumai	Maternal Mental Health Service Counties Manukau
Mon – Fri 0800 – 1630 For urgent matters after hours, advised to call Mental Health Line.	Mon – Fri 0800 – 1630 There is a Duty Clinician available for urgent calls via our main office - Ph (09) 488 4634 Afterhours and weekends please contact the mental health acute/crisis team via North Shore Hospital Ph (09) 486 8900	Mon – Fri 0800 – 1630 For urgent matters after hours, please call the Urgent Response Service on 0800 800 717.	Mon – Friday 8:00 – 17:00 Urgent help outside these hours please ring 0800 775 222
Location			
Woman are seen in clinic, in homes, via Zoom / Telehealth, and in hospital settings. We also have a clinic at the NDHB Community Maternity Hub (co-located with Lactation Consultants, Community LMCs, newborn hearing check clinic, childbirth education classes, and "coffee group". It is currently on hold due to staff vacancies). We have clinic bases in Kaitaia, Kaikohe and Kerikeri, and Whangārei. We travel to homes in the Far Far North, Bay of Islands, Kaipara, and Bream Bay.	The service has an office at 124a Shakespeare Road and Waitakere Hospital in the Child Health Unit. Women can be assessed and seen at venues convenient to them e.g. WDHB facilities, home, community setting.	Greenlane Clinical Centre; telehealth; community-based visits; maternity wards	Woman are seen in clinic, in homes, hospital settings, respite

Appendix 5: Stocktake of Infant Mental Health Services

Te Tai Tokerau	Mātua Tūhonongā Waitematā	Koanga Tupu Te Toka Tumai	Whakatupu Ora Counties Manukau
Access Criteria			
No infant mental health service	Children 0-4 years who are experiencing social and emotional difficulties that are outside of the expectations for normal development. Parents who are experiencing significant difficulties in their relationship with their child	Moderate to severe mental health symptoms for the infant/ child (as defined by DC:0-5) AND/OR Significant relational issues between parent and child that are having a discernible negative impact on the social/emotional/ mental wellbeing of the infant/child. Referrals accepted if infant/child is under the age of 4yrs at time of referral.	Moderate to severe mental health symptoms for the infant/ child (as defined by DC:0-5) The child displays emotional or behaviour difficulties that are: • Much worse than difficulties seen in other infants of the same age and • Have been persistent AND/OR The infant's primary caregiver: • Has significant difficulties bonding with the child, or • Has mental health difficulties likely to have a significant negative impact on the infant's social and/or emotional development or • Has past or current adversity likely to have a significant negative impact on the infant's social and or emotional development. Significant relational issues between parent and child that are having a discernible negative impact on the social/emotional/ mental wellbeing of the infant/child. Referrals accepted if infant/child is under the age of 4yrs at time of referral.
Referral route into the service e.g. self-referral, GP, Community Mental Health, LMC,			
No infant mental health service	Self-referral, Health Practitioners, Early Childhood teachers, Oranga Tamariki, maternal mental health services, adult mental health services.	Referral via Koanga Tupu (infant mental health team) referral form which is received and triaged by the team (with admin support to open in HCC). Referrals received primarily from Aronui Ora (maternal mental health service), GPs, Developmental and General Paediatric services, Starship Community team, Consult Liaison team at Starship Hospital and Gateway. Other (less frequent) referrals received from Plunket, Ministry of Education, Early childhood centres, Home visiting services (Family Start), Oranga Tamariki and Adult CMHCs	GPs, Community/ Maternal Specialist Mental Health Services, Department of Paediatrics, Gateway, self-referral, Oranga Tamariki, Plunket, Ministry of Education and early childhood centres/ kohanga reo
Referral Expectations			
No infant mental health service	That intervention has been tried in primary care. The issues are clearly outside of what can be provided in primary care.	Complete Koanga Tupu referral form (which includes some detail about the infant/child's presentation as well as details about referrer's expectations and some family background).	All external referrals are triaged by team, discussed in Multidisciplinary team (MDT) for appropriateness. Any referrals declined would be directed to appropriate service or GP with recommendations.

Te Tai Tokerau	Mātua Tūhonongā Waitematā	Koanga Tupu Te Toka Tumai	Whakatupu Ora Counties Manukau
	Completion of a referral form or direct contact with the service (Clinical Coordinator)	If the referrer has an established relationship with the whānau, we try to liaise and schedule the first home visit/triage meeting with them to enhance engagement. We work closely with many referrers to provide consultation about appropriate referrals, support the referral process (how to explain to the families who we are and what we do) and to enhance engagement.	Referrals are also made via initial consultation by Maternal MH team members either in MDT or through case consultation slot that can then be escalated to a referral in discussion with caregivers and clinical team
Triage process			
No infant mental health service	Referrals discussed with Clinical Coordinator, Senior Medical Officer (SMO) and Team leader. Accepted referrals allocated to Keyworker All new clients coming into the service are given an initial appointment where the presenting concerns are reviewed with the client/whānau. The whānau are informed of what we can offer and from then an agreement is made as to whether we continue or not. **Declined referrals:** Clinical Coordinator contacts referrer and/or family to discuss other options. Followed up by a letter to referrer/family and GP if not the referrer.	The co-ordinator receives all referrals and review to see whether additional information needs to be obtained from the referrer or whether background information needs to come from Regional Clinical Portal. The referral is then reviewed and discussed by the team in MDT. The decision is made about whether or not to offer an initial appointment (CHOICE) – this is an opportunity for the family to meet one of the team, hear about what it is that we offer and our approach and for us to hear about their concerns. This first meeting usually takes place in the home. *Triage is not conducted over the phone as we have found that this negatively impacts on engagement.* If referred infant/child is Māori or Pacific, we will liaise with our cultural team for one of them to take part in this first visit – we also consult them about who should make first contact with the whānau to arrange this meeting. A collaborative decision is then made with the family, following MDT review of the CHOICE appointment, about moving forward to work with our service. A partnership clinician is then allocated in our MDT to begin working with the whānau on the comprehensive assessment (this may or may not be the same as the CHOICE clinician, depending on caseload).	Triage process may involve phone consult, face-to-face triage assessment or acceptance to service. Initial triage by co-ordinator, review to see whether additional information needs to be obtained from the referrer or whether background information needs to come from Regional Clinical Portal. The referral is then reviewed and discussed by the team in MDT. The decision is made about whether or not to offer an initial triage appointment (phone or face-to-face) – this is an opportunity for the family to meet one of the team members, hear about what it is that we offer and our approach and for us to hear about their concerns. This first meeting usually takes place in the home. If referred infant/child is Māori or Pacific, we will liaise with our cultural team for one of them to take part in this first visit – we also consult them about who should make first contact with the whānau to arrange this meeting. Triage assessment is shared at MDT and decision about continued input decided. **Declined referrals:** Clinical Coordinator contacts referrer and/or family to discuss other options of support. Followed up by a letter to referrer/family and GP if not the referrer
Wait times			
No infant mental health service	3 weeks or less	Around 2 weeks for a CHOICE apt. and then around 2 weeks for allocated clinician to schedule first assessment (Partnership) appointments.	Initial triage appointment to be booked/ seen within 3 weeks of received referral.
Interventions used			
No infant mental health service	Child Psychotherapy, Sensory Modulation Therapy, EMDR	Comprehensive IMH therapeutic assessment (including developmental history, parent's own parenting histories, observations of the child at home and at ECE	Treatment options are tailored to meet individual/family needs and include:

<table>
<tr><th>Te Tai Tokerau</th><th>Mātua Tūhonongā
Waitematā</th><th>Koanga Tupu
Te Toka Tumai</th><th>Whakatupu Ora
Counties Manukau</th></tr>
<tr><td></td><td>Watch Wait Wonder, Secure Beginnings, Dyadic Play, Video Interactive guidance,

Circle of Security – Parenting (COS-P),

Parent Child Interaction Therapy (PCIT).</td><td>and a relational assessment – Strange Situation Procedure, Crowell or Still-Face).

Therapeutic formulation and feedback meeting with parents following this assessment.

Specific dyadic (parent-child) interventions - Watch, Wait and Wonder, Video Interactive Guidance, Mentalisation Based video interaction sessions, Theraplay and Dyadic work informed by Greenspan's Floor time model.

Specific parent interventions - Parent-Infant Psychotherapy, Circle of Security (DVD) Parenting group, psycho-education, consultation with early childhood providers and other professionals involved.

We also refer to other clinicians in the service who can provide Parent Child Interaction Therapy (PCIT)</td><td>• Education about mental health Diagnosis andsymptoms
• Psychological therapy
• Medication
• EMDR
• Watch Wait Wonder
• Video Interactive Guidance
• Family therapy
• Support during adjustment to motherhood / bonding with child
• Group treatments (Circle of Security, Tuning into Kids, Mother and Baby group)
• Cultural assessment and support to appropriate cultural services/treatments
• Psycho education
• PCIT

Referral and liaison to other services as required.</td></tr>
<tr><td colspan="4">Average length of treatment</td></tr>
<tr><td>No infant mental health service</td><td>
<table>
<tr><th>Year</th><th>Average days referral open</th></tr>
<tr><td>2018</td><td>210.2</td></tr>
<tr><td>2019</td><td>309.6</td></tr>
<tr><td>2020</td><td>293.0</td></tr>
<tr><td>2021</td><td>227.4</td></tr>
<tr><td>2022</td><td>214.8</td></tr>
<tr><td>2023</td><td>117.0</td></tr>
<tr><td>2024</td><td>43.8</td></tr>
</table>
</td><td>
<table>
<tr><th>Year</th><th>Average days referral open</th></tr>
<tr><td>2018</td><td>275.6</td></tr>
<tr><td>2019</td><td>248.3</td></tr>
<tr><td>2020</td><td>305.1</td></tr>
<tr><td>2021</td><td>285.6</td></tr>
<tr><td>2022</td><td>183.1</td></tr>
<tr><td>2023</td><td>171.1</td></tr>
<tr><td>2024</td><td>63.6</td></tr>
</table>
</td><td>
<table>
<tr><th>Year</th><th>Average days referral open</th></tr>
<tr><td>2018</td><td>256.5</td></tr>
<tr><td>2019</td><td>294.0</td></tr>
<tr><td>2020</td><td>249.5</td></tr>
<tr><td>2021</td><td>232.8</td></tr>
<tr><td>2022</td><td>249.5</td></tr>
<tr><td>2023</td><td>106.3</td></tr>
<tr><td>2024</td><td>79.6</td></tr>
</table>
</td></tr>
<tr><td colspan="4">Whānau involvement</td></tr>
<tr><td>No infant mental health service</td><td>All children have parents or foster parents involved. Often grandparents are included.</td><td>We always aim to involve all of the primary caregivers who are directly connected to and involved in the infant's care and life. For many families this means carrying out the assessment with two parents (mother and father, two mothers, two fathers); for others it means involving whānau carers, grandparents, whangai parents or adoptive/foster parents.

Following our comprehensive assessment and feedback to parents (sometimes separately if there is significant conflict between them), we begin intervention with whichever parent-infant/parent-caregiver dyad is</td><td>Yes</td></tr>
</table>

Te Tai Tokerau	Mātua Tūhonongā Waitematā	Koanga Tupu Te Toka Tumai	Whakatupu Ora Counties Manukau
		indicated by the assessment. Often this is with the parent where the struggles are greatest but sometimes it may be with the parent who is available (and willing) to do the work if this is seen in the infant's best interest. The work may then switch to the other parent-infant dyad if indicated following the completion of the first piece of work.	
Discharge planning			
	As indicated. Care Planning. Some clients need support to transition to schools.	Discharge may occur following the assessment if the needs identified would be better met elsewhere (e.g. if the primary issue is the parental relationship or the primary caregiver does not have capacity to engage in parent-child work and needs their own therapy/CMHC intervention first). We also sometimes refer out to developmental paediatrics so that a comprehensive developmental assessment can take place prior to being re-referred to our service. Discharge can then occur following the completion of a particular intervention – this usually follows a review with the parent/s to assess what has changed in the child's presentation and to assess what goals have been met. Additional triangulation of this information is sometimes also gained from consulting with ECE providers or other professionals involved. If additional needs are identified, additional work will be discussed and contracted – either with the clinician or via a referral to other community-based services.	Any client under the service will be having regular follow up by case managers and discuss in MDT either every 3/12 or if any concerns. We review the client (with family) and check the therapy plan and progress. If there is an improvement in behavioural concerns and no risk concerns, we discussed with client and whānau regarding transferring care back to GP (discharge) and discuss in our MDT so we agree as a team that client is safe to discharge form the service.
Volumes of patients seen			

Year	Referrals Accepted	Referrals Declined	Total Referrals
2018	103	1	104
2019	88	0	88
2020	93	0	93
2021	92	0	92
2022	69	14	83
2023	72	22	94
2024*	58	7	65

Year	Referrals Accepted	Referrals Declined	Total Referrals
2018	36	15	51
2019	36	15	51
2020	30	9	39
2021	38	3	41
2022	30	5	35
2023	37	1	38
2024*	29	2	31

Year	Referrals accepted	Referrals declined	Total referrals
2018	117	4	121
2019	106	3	109
2020	58	2	60
2021	75	1	76
2022	30	4	34
2023	41	0	41
2024	29	1	30

Te Tai Tokerau	Mātua Tūhonongā Waitematā	Koanga Tupu Te Toka Tumai	Whakatupu Ora Counties Manukau
	*Up to end August	*Up to end August	
FTE			
	6.4 FTE budgeted 0 FTE vacant	3.0 FTE budgeted 0.2 FTE vacant	7.2 FTE budgeted 1.6 FTE vacant
Workforce			
	Child psychotherapists SMO Registered Nurse Social worker Child and Family Therapist Occupational Therapists Clinical Psychologist	Four clinical psychologists	Nurses Social workers Psychiatrist Clinical psychologists Occupational therapists Work alongside Māori and Pacific Clinical Cultural supports Access to Maternal PSS
Hours			
	Mon – Fri 0830 – 1700	Mon – Fri 0830 – 1630 Clinicians work according to their individual FTE hours and organise their own diaries, but all of the team are present on Mondays and Thursdays. This ensures that there is time to support each other with assessments (e.g., being the "stranger" for a Strange Situation Procedure, assisting with set-up and taping of assessments) and to be able to organise joint home visits when needed.	Mon – Fri 0800 – 1700
Location			
	124a Shakespeare Road (North), Waitakere Hospital (West and Orewa using Marinoto Rodney facilities) plus home and preschool visiting.	Kari Centre – Greenlane Clinical Centre Te Toka Tumai, Auckland	Tangata Whaiora/ whānau are seen in clinic, in homes, hospital setting, day care/ early childhood centre, respite

Appendix 6: Stocktake of Maternal AOD Services

Pregnancy and Parenting Service (PPS) Metro Auckland	He Tupua Waiora Te Tai Tokerau
Access Criteria	
• Are residing in the Auckland region • Are pregnant and/or have children under 3 years of age (do not have to currently be in their care if they are engaging in a return-to-care plan) • Are experiencing concerns about substance use (including concerns about risk of relapse) impacting on parenting • Are experiencing difficulty accessing health care and social services or needing support and advocacy in their interactions with other services • Have complex psychosocial needs/vulnerabilities	• Concerns about substance use (including concerns about risk of relapse) impacting on parenting • Pregnant (any gestation), or the parent of children aged under 3 years (does not have to currently be in their care if they are engaging in a return-to-care plan) • Poorly connected with other services, or needing support and advocacy in their interactions with other services (Police, probation, Oranga Tamariki, Kainga Ora, Work and Income, women's refuge, etc)
Referral route into the service e.g., self-referral, GP, Community Mental Health, LMC	
Direct referral from any source; self-referral, family/ whānau, GP, maternity/health services, Police, Oranga Tamariki, Mental Health and AOD Services, Well child providers, Any method convenient to referrer; phone/ email/ online	Referrals are accepted from all sources, including self-referral. Common pathways are via Oranga Tamariki, NGOs (Family Start, iwi providers etc), Whānau Awhina | Plunket, GP, Te Ara Oranga (Police / Te Whatu Ora meth intervention programme), Community Assessment Treatment Team (Crisis Team)
Referral Expectations	
Referrals are screened with consideration given to the Impact of substance use and whether pregnant or parenting (e.g.: if pregnant and using alcohol this would be prioritised). Referrals are also screened for the degree to which the person may be able to access health and social services themselves Consideration given to other support services involved and child protection concerns.	Complete referral form with information re: current substance use concerns, pregnancy/children details, whānau strengths, and involvement with other agencies / socioeconomic concerns (see previous list).
Triage process	
Self-manage referrals and triage during business hours	Self-manage referrals. Respond to crises of current clients during working hours.
Wait times	
All referral information is reviewed and allocations made by senior team members in the weekly PPS referrals meeting. The allocated clinician attempts to contact with the client within 2 working days and to schedule a meeting within 2 weeks. Assertive outreach will be considered if clinician is unable to make contact with the client	Referrals are processed each week and allocated at MDT. At times, internal waitlist is utilised due to capacity. A wait of 2-4 weeks can occur if there is no capacity for allocation. Waitlist is reviewed alongside capacity at weekly MDT. Contact attempts made within 48 hours of allocation, and clinicians work from an assertive outreach model of care.
Interventions used	
• Engagement, building trust, establishing rapport • Strengths based assessment and identification of needs and support required. • Modalities used: Motivational Interviewing/Strengths based goal planning/CBT	• The number one "intervention" really is genuinely connecting with these whānau in a way that acknowledges their strengths, hopes, and potential. Providing a space to hear their voice and their experience and then advocating for them in spaces which are often disempowering and traumatising.

Pregnancy and Parenting Service (PPS) Metro Auckland	He Tupua Waiora Te Tai Tokerau
• Referral to, and co-ordination of other services • Psychiatric assessment/intervention (eg: medication) • Psychological intervention • Peer Support • COSP/attachment support • Referral to residential treatment i.e., Odyssey Family Center or Te Whare Taonga • Harm reduction • Education: Home safety, safe sober care, healthy relationships/ Safe sleep/never shake a baby education • Referral to detox or other services • Professionals' meetings/co-ordination of services • Relapse prevention • Strengths based goal planning with a view to improving outcomes for children – could be related to substance use, healthy parenting and healthy relationships or whichever goals are identified	• He Puna Whakataa / Kaupapa Māori approaches • Social work++ - advocacy with other agencies involved, referrals and connecting up with services indicated (eg ACC sensitive Claims, Women's Refuge), consult and liaison, involvement in birth and post-birth planning, involvement with OT processes • Access to Psychology / therapy (CBT, ACT, CAT, Schema, EMDR, art therapy etc) • Access to Psychiatric review and medication • Parenting-specific approaches (CoS-P, PCIT-Toddler, emotion-coaching parenting) • Psycho-education re: substance use (and often also violence in the home) and impacts on neurodevelopment and parenting • Connection with detox and rehabilitation services in the community • Access to CSWs and in-home respite where needed • Access to Haumaru Orite where needed
Average length of treatment	
Aim for 12 months engagement with PPS with flexibility according to client's needs.	Varies from very brief, to multi-year.
Whānau involvement	
Clients are encouraged to include family/ whānau in their assessment and ongoing treatment and are offered the CADS info sheet *How can you be included? Info for family and support people.* Clients are offered, during their time with PPS, the opportunity to take part in a *Single Session Family consultation,* a structured family whānau meeting. Families and whānau are offered information about CADS Family whānau and friends groups and support they can receive for themselves.	Yes, embedded in engagement and treatment and support. Particularly re: safety planning.
Discharge planning	
PPS aims to support clients to transition out of the service in a planned way. This process includes the review of: - risk issues - treatment plans - transfer of care as appropriate. - Recovery capital i.e.: safe social supports A discharge summary will be sent to the GP with a copy to the client. Client feedback is sought via the CADS-endorsed consumer experience survey. Where an unplanned discharge is considered, PPS MDT consultation will occur and subsequent communication with the referrer and/ or other stakeholders as indicated. All effort will be made to inform the client of the discharge.	Community Discharge Summary / Plan is provided to whānau and GP and other agencies involved as needed.
Volumes of patients seen	

Pregnancy and Parenting Service (PPS) Metro Auckland	He Tupua Waiora Te Tai Tokerau
149 referrals accepted from year 1 July 2024 – 30 June 2024	1 August 2023 – 31 August 2024: 74 Referrals
FTE	
13.8 FTE budgeted 8.6 FTE vacant	6.7 FTE budgeted 0 FTE vacant
Workforce	
Psychology AOD clinician Nurses Social Workers Doctor Peer Support Specialist	Social Workers Nurse AOD Counsellors Psychology Psychiatrist Team Leader Clinical Coordinator Close links with CSWs in NGOs (funded maternal-specific contracts)
Hours	
Mon- Fri 0800 – 1730 No afterhours service.	Mon-Fri 0800 – 1630
Location	
Pitman House 50 Carrington Rd Pt Chev. We are a mobile outreach service that services the Auckland Region.	Bases in: Whangārei (3 clinicians) Kaitaia (2 clinicians), and Kaikohe (2 clinicians)

Appendix 7: Stocktake of NGO Providers – Mental Health – Metro Auckland

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
Access Criteria			
Te Toka Tumai and Waitematā Residents • Residents of the WDHB/ADHB Maternal Mental Health clinical services (mainstream and cultural services). • 12+ weeks pregnant and/or have an infant less than 12 months of age. • Medically and obstetrically stable. • Experiencing an acute period of distress as a result of a serious mental illness or post-natal mental illness. • Vulnerable or disabled by mental illness to the extent they require 24-hour intensive support and treatment (residential) or extended periods of supportive home-based respite. • Have capacity to provide some of the necessary care of their infant (and other children). • Have been assessed by the WDHB or ADHB Maternal Mental Health clinical services as needing acute residential or home-based support services but who do not need the intensity of clinical care of an acute hospital admission. • Are able to and have consented to receiving support hours and/or residential respite services.	**Counties Manukau and Te Toka Tumai Residents** • Residents of the Counties Manukau Maternal Mental Health clinical services and Intake and Assessment (mainstream and cultural services) • Residents of Te Toka Tumai Maternal Mental Health Services can access respite support. • 12+ weeks pregnant and/or have an infant less than 12 months of age. • Medically and obstetrically stable. • Experiencing an acute period of distress as a result of a serious mental illness or post-natal mental illness. • Vulnerable or disabled by mental illness to the extent they require 24-hour intensive support and treatment (residential) or extended periods of supportive home-based respite. • Have capacity to provide some of the necessary care of their infant (and other children). • Have been assessed by the CMDHB Maternal Mental Health clinical and Intake and assessment services as needing acute residential or home-based support services but who do not need the intensity of clinical care of an acute hospital admission. • Are able to and have consented to receiving support hours and/or residential respite services. • Can receive referrals from Primary care and other NGOs without mental health diagnosis. Maternal exhaustion and/or increased anxiety is sufficient for referral – however, referrals from Maternal Mental Health are always prioritised over other referrals.	The Service Users will be eligible women of any age who are pregnant, or in the first year postpartum, and their infants.	Mothers of 0-4 year olds who are 18+, are residents of the WDHB catchment area, and are struggling with perinatal mental health such as postnatal depression/anxiety/isolation. To access the activity based recovery programme they must be receiving CSW support or have had initial CSW assessment.
Referral route into the service e.g. self-referral, GP, Community Mental Health, LMC.			
Service users/ Tāngata whaiora will be referred to the WALSH Trust Birth Parent and Baby Respite and Support Hours Service via the WDHB/ ADHB Maternal Mental Health Teams. However, there may be occasions where service users/Tāngata whaiora access this service outside of working hours and this must be facilitated via the after-	Maternal Mental Health Service, Intake and Assessment team, HBT South and HBT North	GP, integrated primary mental health and AOD services including health improvement practitioners and health coaches, Well Child services, whānau ora, Lead Maternity Carers (LMC), community mental health teams, and self-referral.	Referrals accepted from other NGO's, Plunket, GP's, Psychologists/Psychiatrists, Hospital mental health teams, Oranga Tamariki, Midwives

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
hours Maternal Mental Health Advisory support service.			
Referral Expectations			
District Clinical Teams will provide a verbal overview of client's presentation inclusive of: • Presenting mental state • Current risk issues to birth parent and/or baby • Current physical health of birth parent and baby • Birth parent's Mental Health Act status (if applicable) • Any known/potential AOD concerns • Any known Child Protection concerns • Midwifery/ Well Child provider information • Proposed plan while in the WALSH Trust Birth Parent and Baby Service. A referral checklist/form will be completed by the referrer (Attached Appendix XX) and sent to WALSH Trust. WALSH Trust to confirm receipt of referral (for both residential or community support within 2 hours (during the hours of 0800 – 1630) Upon acceptance of the referral, entry to the service will be made available within 4 hours. **For Residential Respite** – the following arrangements will be made by the DHB staff including: • Ensuring a complete referral form, respite plan and risk plan with a level of detail that ensures safe and informed service delivery. • Ensuring the service user/Tāngata whaiora has a clear overview of the respite service (the expected length of stay in Respite. Anticipated arrival time. Transport arrangements. Involvement of family/whānau during entry to service. • Ensuring that the service user/Tāngata whaiora has sufficient clothing and personal toiletries for birth parent and baby for their stay at WALSH Trust • Ensuring that the service user/Tāngata whaiora has adequate disposable nappies, infant formula and bottles • Medication supply (blister pack) for prescriptions written by the maternal mental health psychiatrist and medication chart (see medication section)	CMDHB Clinical Teams and GP Services will provide a verbal overview of client's presentation inclusive of: • Presenting mental state • Current risk issues to mother and/or baby • Current physical health of mother and baby • Mother's Mental Health Act status (if applicable) • Any known/potential AOD concerns • Any known Child Protection concerns • Any Family Harm concerns • Respite goals while in Awhi Rito Maternal Respite A referrals form will be completed by the referrer and sent to Awhi Rito via email only. Awhi Rito Registered Health Professional/Manager to confirm receipt of referral (for both residential or Package of care within 1 hours during the hours of 0900 – 1630) Upon acceptance of the referral, entry to service will be made available immediately. **For Residential Respite** – the following arrangements will be made by DHB and GP services including: • Ensuring a complete referral form, respite plan and risk plan with a level of detail that ensures safe and informed service delivery. • Ensuring the Tangata has a clear overview of the respite service • The expected length of stay in Respite and any planned reviews • Anticipated arrival time • Involvement of family/whānau during entry to service • Ensuring that the Tangata has sufficient clothing and personal toiletries for mother and baby for their stay at Awhi Rito Maternal Respite • Ensuring that the Tangata has adequate disposable nappies, infant formula, and bottles	There is the ACLS/CSS referral document from Counties Te Whatu Ora that was used and during our screening we will have the Perinatal Team to respond. OR the referrer may send an email with the presenting issues OR from our primary mental health team it will be an internal referral via email. The services and supports that are put in place must be culturally appropriate and safe for each individual The cultural and spiritual needs of the individuals utilising this service will be recognise differences especially as they relate to linguistic, cultural, social, and religious practices will be respected.	Completed referral form including information regarding current diagnoses, medications, safety concerns, client goals for referral, involvement with other services. CSW Team Leader/Support Worker ability to contact referrer to discuss referral if necessary.

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
• The referring clinician will ensure that the service user/Tāngata whaiora has made relevant arrangements including having sufficient money or access to this, personal items, smoking patches etc. In the event that any of the above items are not available, it is the DHB's responsibility to ensure they are provided. WALSH Trust will invoice the respective DHB's for these costs e.g. medication on a monthly basis. **For Community Support Hours Service** • Completed Referral document, Respite Plan, risk assessment and Birth Support Plan (if applicable). • Any other relevant health information (including any safety issues for providing support hours services at the home of the service user) to support service delivery tailored to the needs of the service user/Tāngata whaiora.	• Medication supply (blister pack) for prescriptions written by the maternal mental health psychiatrist and sent to the Pharmacy for delivery to Awhi Rito Maternal Respite. For package of care with Awhi Rito Staff or Karitane Nurses • Completed Referral document, Homebased support plan, risk assessment • Any other relevant health information (including any safety issues for providing support hours services at the home of the service user) to support service delivery tailored to the needs of the Tangata.		
Triage process			
Maternal Mental Health staff will be responsible for the final prioritisation for the Residential Service where the number of service users/Tāngata whaiora requesting access is greater than available beds. Consideration will be given to the 'mix' of service users currently accessing the service. WDHB and ADHB will negotiate bed availability based on service user acuity and risk.	Maternal Mental Health staff and Service Manager will be responsible for the final prioritisation for the Respite Service where the number of Tangata requesting access is greater than available beds. Priority sits with Maternal Mental Health Tangata. A safe transition plan for GP service Tangata with be arranged by Service Manager.	Women of any age who are pregnant, or in the first year postpartum, and their infants	All referrals are reviewed by CSW Team Leader when received. Referrals received from WDHB Maternal Mental Health are prioritised. Referrals that suggest immediate safety risk to mother or baby are prioritised. Other referrals are seen in order of referral received date. Some referrals may be discussed at MDT meetings as part of triage process. Clients added to Group waitlists on a first-come basis, with urgency of group support needs being taken into consideration where limited places are available.
Regular points of interface (from referral to discharge) i.e. other NGOs, PEPI specialist services, AOD providers			
		Supporting others to access to PEPI specialist services, liaise with cultural clinical support (Faletoa Services – Counties Te Whatu Ora)	This is dependent upon the client and so there can be multiple points depending upon their clients' situation
Wait times			
Variable	Due to low occupancy, we do not have wait times. Referrals are processed as they are received. When at full capacity, the Service Manager and the Referrer	Nil	Can be up to 12 weeks exceptions noted under 'triage process'.

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
	discuss urgency and/or available admission dates and an updated referral is made.		Wait time from first assessment to being able to attend Group is variable
Interventions used			
• Groups – COS-P (all staff are trained on a COS-P framework), Baby Massage, and Understanding My Baby (mothercraft) • Couple Counselling • Respite provision, where the service provides supervision, support/assistance and guidance in the care (both physical and emotional) of the baby while birth parent is unwell • Support during adjustment to parenthood / bonding with child • Referral and liaison to other services as required. • Provide parent-craft education • Sensory modulation (delivered alongside Waitematā team) • Mindfulness	• Groups – Occupational Therapist provides relaxation groups for mothers using respite and homebased support. • Maternal Mental Health provide training for staff and deliver to mothers. (Dealing with destress, Perinatal and anxiety) • Respite provision, where the service provides supervision, support/assistance, and guidance in the care (both physical and emotional) of the baby while mother is unwell • Support during adjustment to motherhood / bonding with child • Referral and liaison to other services as required. • Provide parent-craft education • Sensory modulation • Mindfulness • Art therapy	• Support work • Talanoa • Spirituality • Access to matua support • The use of language or access to other Pacific languages • Liaise with mental health clinicians, WINZ, extended whānau, baby gift packs, transport and the use of flexifund • The information sharing with other pregnant mothers in the community found the talanoa about mental health and wellbeing applicable in their lives	• SMART goal setting • Advocacy support • Support with food insecurity (food parcels) • Connection and collaboration with other relevant support networks • Support to maintain wellbeing • Wellness and Safety planning • EPDS Assessments • Holistic approach taken, working within Te Whare Tapa Wha framework • Referral to other Dayspring services i.e. Groups • Circle of Security – Parenting Programme, • Counselling (incl. couples and eating disorders) • Referral to other services as required Recovery Groups include weekly Physical Wellbeing, Mindfulness, Connection and Craft groups. Special interest and one-off groups such as Nutrition and Cooking, Self Defence, Art Therapy, Child and Infant First Aid. On site crèche enables mothers' respite while attending these recovery groups
Average length of treatment			
The Length of Stay (LoS) per stay for service users'/Tāngata whaiora will be negotiated between WALSH Trust and the WDHB/ADHB clinical teams. It is expected that the LoS will not exceed 10 days. Should there be a need for the LoS to exceed 10 days, this will be for clinical reasons and will be agreed to by the DHB and WALSH Trust. Review of service users/ Tāngata whaiora by the district teams will be undertaken daily.	The Length of Stay (Los) per stay for Maternal mental Health, intake and assessment and CMMHC Tangata will be managed by Maternal Mental Health. It is expected that the LoS will not exceed 7 days. Should there be a need for the LoS to exceed the 7 days, this will be for clinical reasons and will be agreed to by Maternal Mental Health and CMMHC. Review of Tangata by the DHB teams will be undertaken daily. The length of stay for GP services is a maximum of 3 days. Should there be a need for the LoS to exceed 3 days, this will be negotiated between Awhi Rito Service Manager and GP referrer. If secondary support is required, Awhi Rito Staff/Manager will contact Crisis Services for further assessment and inform the GP referral within working hours. (0900 – 1630)	6-12 months	Variable between approximately 6 months to 3 years.

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
Whānau involvement			
While the primary focus is the birth parent-infant dyad, this will be considered in the context of the wider family and/or whānau (partner/father, other children, grandparents) and fathers and other primary carers may also receive support from the service.	We encourage Whānau involvement and support. We have a whānau room which can be closed off from the main living areas of the house with separate toilet access. While the primary focus is the mother-infant, this will be considered in the context of the wider family and/or whānau (partner/father, other children, grandparents).	The involvement of fathers is encouraged and where there is a need for whānau hui it is supported.	Primary focus is on the mother but the wider context of whānau is considered during treatment. Whānau is welcome to be present if the client wishes and there are no safety concerns. Children are often present during visits. Our on-site creche cares for client's children 0-3years while they attend Activate Based Recovery Groups if needed Clients are unable to have whānau/other support person present in Group. On-site creche cares for client's children 0-3years while they attend Activity Based Recovery Groups if needed.
Discharge planning			
A plan for exit including service responsibilities should be established during the daily review and planning meetings throughout service user/ Tāngata whaiora stay in WALSH Trust. Ideally this should commence on entry to the service. Once a decision is made to exit a service user/ Tāngata whaiora from WALSH Trust, this should occur in a timely manner without interruption. On exit from the residential respite facility a service user/Tāngata whaiora may continue to receive additional support hour's services provided by WALSH Trust. This plan will identify the following: • Where the service user/Tāngata whaiora and their baby will be going to after they leave the WALSH Trust residential facility. • What supports the service user/Tāngata whaiora will require to successfully returning to living in the community. • Staff responsibilities for exit implementation. • The assessment and management of any risks associated with the service user/ Tāngata whaiora being exited. • All support services who are involved with the support of the family are notified of the exit. It is anticipated that an exit meeting will be held involving: • the service user/Tāngata whaiora, • family/ whānau	A plan for exit including service responsibilities should be established during the daily review and planning meetings throughout Tangata stay in Awhi Rito Maternal Respite. In most cases this will commence on entry to the service identified in the referral form. Once a decision is made to exit a Tangata from Awhi Rito Maternal Respite, this should occur in a timely manner without interruption. On exit from the respite a Tangata may continue to receive additional support hour's services provided by Awhi Rito (onsite as a day stay) or Karitane Nurses. This plan will identify the following: • Where the Tangata and their baby will be going to after they leave Awhi Rito Maternal Respite. • What supports the Tangata will require to successfully return to living in the community (Homebase Support provided by Awhi Rito or Karitane Nurses). • Staff responsibilities for exit implementation. • A discharge Summary including their completed respite goals. • Tangata to receive their Wellness Management Plan as a relapse plan for self-management of any risks, stressors, or early warning signs. • Tangata to complete an online survey and receive an exit letter. • All support services who are involved with the support of the family are notified of the exit.	As discussed with the mother and the healthcare provider	Exit from support hours are well planned and managed and varies based on individual clients.

He Kākano Ora - WALSH Trust	Awhi Rito - Kāhui Tū Kaha	Penina Trust	Dayspring Trust
• Any other community services who are involved with the service user/Tāngata whaiora care in the community.	It is anticipated that an exit meeting will be held involving: • The Tangata whaiora • family/ whānau • Any other community services who are involved with the Tāngata whaiora in the community		
Volumes of patients seen			
Occupancy rate for respite for 2023/2024 financial year - 31% (bed nights) + 875 hours of day-stay + 3,020 hours of community support provided	Respite: 37% utilisation	Currently there are 28 service users on the Perinatal Services. The year ending June 2024 there were 24 mothers in the Perinatal Service with 2 discharges. From September 2022 to October 2024 there had been 10 discharges.	Up to a maximum of 40 clients at any one time. Up to 12 participants per group session
FTE			
8.6 FTE	9 (including a Registered Health Professional or RHP)	1 FTE Pacific Perinatal Support Worker (non-clinical) 1 FTE Peer Support Specialist – Lived experience	CSW service - 2.25FTE Activity based recovery programme - 0.4FTE
Workforce			
The staff at HKO are a mix of Registered health professionals (social workers, psychotherapist) and mental health support workers	The Staff at Awhi Rito Maternal Respite are mainly Mental Health support workers, a Peer Support Worker and a Registered Health Professional (Social worker). Diverse cultures and languages inclusive of Māori, Pacific, Asian, Middle Eastern, Muslim.	Niue staff, 1 Samoa staff (Lived experience) Staff attended all the mandatory core training required of support workers	Registered Social Workers Counsellors
Hours			
24-hour facility Contracted to provide: • Respite 6 beds per day • Non-clinical support hours: 2985.44 per year • Clinical support hours: 746.36 per year	24-hour facility Contracted to provide: • Respite 4 beds per day • Non-clinical support hours: 975 hrs per year • Clinical support hours: 415 hrs per year	Mon - Fri 0830-1700	Mon - Fri 0900 -1500 Groups normally run during school terms and ad hoc activities take place during school holidays
Location			
Te Atatu Road, Te Atatu	Respite residential, Manurewa	186 Russell Road, Manurewa	2 and 2a Seabrook Ave, New Lynn, Auckland

Appendix 8: Stocktake of NGO Providers – Mental Health – Te Tai Tokerau

Arataki Ministries	Te Mana Oranga Trust	Apex Care	Emerge	Hokianga Health
Access Criteria				
Te Tai Tokerau Residents • 12+ weeks pregnant and/or have an infant less than 12 months of age. • Infant medically and obstetrically stable. • Experiencing an acute period of distress as a result of a serious mental illness or post-natal mental illness, or where the presence of history of AOD problems will have an impact on the mother infant relationship • Are able to and have consented to receiving support hours services	Any whānau member that is pregnant or already had the baby and is suffering and requiring mental health support. We support until the baby is 1 year old at which time we work on a plan of discharging. The whānau member could be suffering anxiety, burnout, PND, etc	Te Tai Tokerau Residents that are in care of maternal mental health and AOD services (Manaaki Kakano or He Tupua Waiora)	Te Tai Tokerau Residents Meet MIMS and PPS criteria and receiving service provision.	Whānau and mums who are expecting baby those who are experiencing PND or experiencing distress
Referral route into the service e.g. self-referral, GP, Community Mental Health, LMC.				
Service users will be referred to Arataki via the Te Whatu Ora- Te Tai Tokerau Maternal Mental Health Team, or Pregnancy Parental Service. Referrals for primary level support can be received from GP's, LMC, Plunket, HIP or Health Coaches	All referrals come from either Community Mental Health services, LMC, GP, Health Coaches etc	Manaaki Kakano or He Tupua Waiora, Te Roopu Taurima, Emerge.	Referred to us by MIMS or PPS	Self-referral, in-house CMH referrals, Hokianga family harm table, midwives, Plunket, Tamariki Ora.
Referral Expectations				
Referral form completed inclusive of • Presenting mental state • Current risk issues to mother and/or baby • Current physical health of mother and baby • Mother's Mental Health Act status (if applicable) • Any known/potential AOD concerns • Any known Child Protection concerns • Midwifery/ Well Child provider information	We have a referral form that we have given to both primary and secondary services along with the process when sending the referral.	Phone call with referrer. Completed client support plan for client including expectation, risks etc	Referral form which we can provide, plus a referral goal and current risk assessment	Clinical and Needs Assessment
Triage process				

Arataki Ministries	Te Mana Oranga Trust	Apex Care	Emerge	Hokianga Health
All MIMH's referrals (both primary and secondary) are triaged by our Secondary services co-ordinator. Referrals will be acknowledged within 24hrs. If pēpi is outside of age criteria (12 months) then refer whaiora to GP or primary adult services (IPMHAs)	The triage process is as follows: The referral is emailed to our service manager who sits with the MIMS kaimahi and starts the initial warm handover with the client and whānau. If there is a waiting list, then the MIMS kaimahi and our service manager look at which referral has the highest need in terms of risk and that is who gets support first.	Interview with referring organisation to obtain more detailed information. Ensure we have kaimahi that would suit the tāngata whaiora and their needs. Accept or decline into service	Mental Health Professional and/or Service Manager at Emerge processes the referral. Will contact the referrer if any further info required. Client must consent (verbal and/or written) before referral is accepted and CSW allocated.	Triage by Te Whare Awhina referral process for wraparound support
Regular points of interface (from referral to discharge) i.e. other NGOs, PEPI specialist services, AOD providers				
Manaaki Kakano, He Tupua Waiora.	Te Rarawa – First start, Breastfeeding support, mama fitness programme Anglican church – Feed my lambs a mama pēpi play group Te Hiku Hauora – Mama pepi group for coffee group, breastfeeding help, garden planting and growing, walking groups etc Te Whare Ruruhau O Mere and Waitomo – counselling and social worker support Waitomo – Emergency housing for mama and pēpi Ngapuhi social services – Family Start Kaikohe playcentre group Ngāti Hine and Te Hauora or Ngapuhi breastfeeding support and social and fitness groups for mama pepi	Referring organisation e.g. Manaaki Kakano, He Tupua Waiora. Daily notes and regular contact are provided to referrer to ensure collaborative care.	Community and/or Inpatient agencies as required to meet goals	Full range of interface across services and products
Wait times				
Less than 1 week for new referrals	Try to contact and have them seen within 1 week Can we up to 6 weeks when there is a waitlist	Once referred usually within 4 hours. Limited by caregiver availability. After hours staff are based on Kerikeri and Kaikohe. 24/7	None	No longer than one week
Interventions used				
• Groups – Circle of Security, Walking Group and Coffee Group • Support during adjustment to motherhood / bonding with child • Referral and liaison to other services as required.	Some interventions are group therapy, one to one therapy, psychologists, counselling, etc	Respite provision, where the service provides supervision, support/assistance, and guidance in the care (both physical and emotional) of the Tāngata	Person Centred Goal Planning, interventions as directed by clinical team (within CSW scope of practice)	Wrap around response to the Whānau and mum/ baby's needs Link into specific groups – AOD, Anger Management, Mental Health

Arataki Ministries	Te Mana Oranga Trust	Apex Care	Emerge	Hokianga Health
• Mindfulness • Sensory modulation				
Average length of treatment				
Average length of stay in support hours service is 90 days.	If perinatal mental distress could see clients for up to 18 months	Dependant on need of tāngata. Could be days, overnights, weeks.	Not identified as nil clients over the last 12 months. Can support clients as long as they meet MIMS and PPS eligibility criteria (and being followed up by their service).	Brief intervention less than 3 months
Whānau involvement				
Whānau involvement and support is highly encouraged. The primary focus in the mother-infant relationship this is considered in the context of the wider whānau	Where the parent is open to having other whānau involved in the plan then whānau involvement is welcomed.	Dependant on tāngata whaiora and referrer. There is a preference for whānau to be involved as long as it is appropriate and safe.	If part of the goal planning, or any time whaiora would like whānau involvement	Whānau involvement at every step of care
Discharge planning				
Exit from support hours services are well planned and managed. At exit the mother will have reconnected or established natural supports, and have a process for reconnection to support services if necessary.	Prior to the baby turning 1yr old, we start the discharge planning with the parent and other services who may be involved, looking at who needs to be involved if anyone moving forward.	Planning to ensure a smooth transition away from the support of the service. Doesn't always happen. Working to refine this further.	Exit planning with Whaiora and referrer present once person centred goals are completed/near to completion.	Starts from the beginning to ensure hand over and follow up is in place
Volumes of patients seen				
	Have a cap of 20 māma but dependant on where they are located. We have 1FTE that is available 40hrs a week to support the child and parents but travelling time is factored into the 40hrs.	We work within the capacity of how many kaimahi we have available who are appropriate to the Tāngata needing support.	Nil over last 12 months	
FTE				
2 FTE CSW (1 FTE for extended continuum of care including primary and 1 FTE secondary services)	1 FTE CSW	We have currently 12 qualified kaimahi in your region – with others available if we can give them enough work.	0 (To note, this is a user pay type contract)	This is shared through our team no contracted FTE
Workforce				
Two experienced support workers with additional training in perinatal and infant mental health	Mental Health Support Worker	Kaimahi (support workers)	Level 4 Qual Community Support Workers.	INCLUDES Maternal MH Nga Tini Whetu Whānau Ora Youth Worker Nurse Practitioner
Hours				

Arataki Ministries	Te Mana Oranga Trust	Apex Care	Emerge	Hokianga Health
	Mon to Fri 0800 - 1630	Available 24/7. Have after hours team to manage calls outside of normal business hours.	0800 - 1630	Mon-Fri 0830 – 1630
Location				
Office 35 Norfolk Street, Whangārei. Coverage Kaipara district through to Dargaville and the wider Whangārei and Bream Bay area as far north as Hukerenui.	Mid and Far North covering from Cape Reinga out to Paihia, Russell then down to Kawakawa and over to Kaikohe. A huge area.	Whangārei to Kaikohe – currently travel to Kaitaia when required.	Office is 39 Norfolk Street Whangārei. Coverage area is same as TWO Whangārei and Kaipara area.	Rawene Campus Hospital

Appendix 9: Stocktake of NGO providers - AOD

Higher Ground | Te Whare Taonga	Odyssey Family Centre
Access Criteria	
Te Whare Taonga is for wāhine hapū and new māma who have severe AOD problems and associated complex challenges. Eligibility is dependent on a primary diagnosis of substance dependence.	Meets criteria for substance dependence although this is more flexible with family centre referrals due to the considerable variables and potential for harm. Inability to manage AOD concerns in a community setting ie; CADS Tamariki must be under the age of 12 years. Up to 3 tamariki per parent, mum dad or caregiver If OT involved or children are placed with caregivers / whānau must be agreement that the tamariki can join the parent in the family centre.
Referral route into the service e.g. self-referral, GP, Community Mental Health, LMC etc.	
At this stage we are only able to accept referrals from Oranga Tamariki sites in the Auckland/Waitematā area. Referrals outside of this may be considered – dependant on availability.	Any referral pathway accepted including those from corrections.
Referral Expectations	
Wahine have agreed to the referral being made. Wahine have a level motivation for recovery/living clean Referrals are made for wāhine hapū or new māma with one pēpi (under age 3yrs).	Those in community we require basic contact information to book an assessment. Prison referrals must have summary of facts for any active charges and conviction history. Must be eligible for release / parole. Accept all variations of release from prison, bail, em bail, supervision, HD, parole etc. Exclusions are significant violence, murder, sexual offending.
Triage process	
Referral emailed through to the Te Whare Taonga MDT team for consideration before progressing to assessment.	Community: Referral received via email, walk in, phone call etc. Assessment booked- priority given to community referrals and those at risk.
Regular points of interface (from referral to discharge) i.e. other NGOs, PEPI specialist services, mental health providers	
Transitional support from other involved agencies prior to admission and during the entry/stabilisation phase of treatment. Re-engagement with community supports during the later stage of treatment (post treatment planning) to support transition from a residential setting to the community. Pēpi are support with any ongoing wellbeing needs as required.	Continuous liaison with all stakeholders involved throughout the treatment journey including but not limited to MSD, Oranga Tamariki, Ministry of Justice, Pregnancy and Parental Service, Community Mental Health Centres, Family Action On entry, all whaiora are connected with PHO for overall physical health assessments and intervention. We also contract a psychiatrist who assesses all whaiora on entry and follows up as needed. Have a psychologist that is on site 2x per week for sensitive claims counselling and have a relationship with Family Action who provide counselling for victims of family harm.
Wait times	
Varies	Dependent on bed availability but currently approx. 4-8 weeks. Priority given to high-risk referrals.

Higher Ground | Te Whare Taonga	Odyssey Family Centre
Interventions used	
The programme is underpinned by therapeutic community values and delivered with a bi-cultural approach, whānau inclusive focus and evidence-based therapies used and proven effective at Higher Ground. It includes an enhanced focus on safe parenting, drawing on Attachment Theory to develop clear pathways for secure relationships between māma and pēpi (age 0-3 years).	Therapeutic community model of treatment with recovery capitol.
Average length of treatment	
The programme consists of pre-admission support, 24-week residential treatment and continuing care post treatment	12-14 months for the whānau programme to account for days where tamariki are sick and are home from school
Whānau involvement	
Engagement is encouraged from the outset. Wahine are invited to bring support to their initial assessment. The Family Education Group is for family / whānau / significant others. It is a four-week education group that runs fortnightly. Family therapy sessions - as part of the programme wāhine have the opportunity to participate in two of these with whānau. Whānau inclusion in pōwhiri and graduation ceremonies is encouraged. Visits are in the weekends (afternoons). We can support with other Tamariki visiting overnight in the weekends (depending on programme numbers)	Whānau are invited to be a part of the admission process and then visit weekly. Whaiora are then offered to include their whānau in their treatment planning group and ongoing case reviews. Whānau can attend a weekly information-based group to understand what treatment looks like for their loved one in the programme. Where applicable outings with whānau are encouraged to strengthen relationships. We also support whānau who live out of town with visits by providing accommodation on site.
Discharge planning	
Te Whare Taonga wāhine complete a Continuing Care Plan to support their on-going recovery after treatment on or about week 12. Once the plan is developed clients meet with the Continuing Care Team to discuss their plan. Continuing care programme is to assist clients in maintaining quality recovery. The continuing care programme involves individual counselling and continuing care group. Higher Ground also runs a support house for continuing care wāhine.	Ongoing engagement throughout treatment to support with discharge planning. Eligibility to Continuing care post exit regardless of exit point.
Volumes of patients seen	
We have 8 beds: 4 for wāhine hapū and 4 for new māma with one pēpi (under age 3yrs).	Assess approximately 25 whaiora per week. Family Centre- 10 bed facility, each room has two bedrooms and a bathroom. Shared living, kitchen, laundry facilities. Number of clients 10 and up to 3 kids each.
FTE	
	8.0 FTE
Workforce	

Higher Ground | Te Whare Taonga	Odyssey Family Centre
Clinical Manager Case Manager Social Worker Registered Nurse Residential Support Workers	Clinical Manager (AOD Practitioner/Clinical Supervisor) Advanced AOD Practitioner AOD Practitioners Support Workers Overnight Support Workers Registered Nurse
Hours	
Te Whare Taonga is a 24/7 residential service. Clinical staff are on site Monday to Friday 0730 - 1600. Outside of these hours a manager is on-call for clinical support.	All our residential programmes run 24/7 and are staffed 24/7
Location	
c/- Higher Ground, 118 Beach Road, Te Atatu Peninsula	New Windsor