Infant and Maternal Mental Health Services Scan in Te Waipounamu

Report prepared for
Te Whatu Ora

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Executive Summary

This report, and many others like it, highlight the importance of quality, timely infant and maternal mental healthcare. A pēpi's brain is growing significantly around the perinatal period and is affected by their māmā's stress in late pregnancy as well as by the quality of relationships formed with caregivers in the first few months and years of life. A lack of healthy attachment will impact the life of the child, their long-term mental health, and their capacity to fit in and contribute to society as adults.

As a result, early, prompt interventions with pēpi and māmā will have a significant return on investment over the lifetime of that infant and their whānau. In addition, early interventions can prevent an escalation in distress and the many personal and social costs that go with that.

There is a severe lack or shortage of infant mental health services across Te Waipounamu. Some exist in Christchurch and Nelson, but respondents were strong in calling for more availability of these secondary services and for development of services in the primary/NGO sectors. Elsewhere, most areas have people with an interest and a passion for infant and maternal mental health, and they provide what services they can. However, their services are not ring fenced and often have to compete with a wide range of other mental health needs in the wider community. This is particularly bad for infants who may find themselves competing, say, with a suicidal teenager.

Any services in the other areas all emerge from interested individuals who put time into advocating for infant and maternal mental health services. However, without ring fenced or dedicated resources any local and/or individual responses are extremely vulnerable. Ideally, national policy would require all regions and subregions to have dedicated resources for infant and maternal mental health services.

While existing secondary services have the expertise to support the development of the sector, they need to be resourced to extend their work to include a larger percentage of education, supervision (as reflective practice), and consultations. Maternal mental health, too, is lacking and it seems that māmā and pēpi may not get help because their distress involves a range of factors, including those that have had them seen previously by mental health and addiction services.

Whānau may have difficulty in assessing their own mental health and may not think that their struggles merit attention – particularly if those around them put those struggles down to normal adjustments at a time of significant change. Routine screening by primary maternity providers and perhaps general practices would help parents understand what is going on and also help to capture the true numbers of whānau dealing with mental distress. Possibly also, this could be extended to partners. However, screening only means something if people can access the services they need. Routine screening is likely to uncover a significantly greater need for services around the motu, so steps must be taken to increase the timely availability of services.

For those that request assistance it appears that access to services may vary based on how well a referrer advocates for a patient using the referral process. If a referring GP does not have the expertise, they may not be able to fill in the referral form adequately to convince the person assessing the referral. Clearly there needs to be some way to plug this gap. The referral process will also be subject to variations in how people assess the referral as well as the patient. Finding ways to minimise these variations is important.

Currently, few services have clear, publicly available eligibility criteria, and even when they do, eligibility takes second place to availability and to interpretation so people may be eligible for a service but still may not get access.

There is a shortage of people to fill existing secondary mental health staff positions in Te Whatu Ora especially in smaller centres. This leaves people working in NGOs and primary health in those places with nowhere to go, and having to support people with high needs. While the gaps are unlikely to be filled quickly, it seems important to support those currently working with struggling whānau, to upskill them and to provide access to consultations, networks or telehealth options so that they are not working alone in situations that feel well beyond their capacity to manage. Existing secondary services in Christchurch are able to assist with this kind of support and need resourcing with extra time to do that.

Kaupapa Māori organisations are building their capacity and capability in this area and are working to develop programmes that braid cultural and clinical approaches. Currently, one programme that has been piloted focuses mostly on maternal mental health but the provider is actively working to consider the mental health of pēpi in their care as well. Other providers are looking to trial a similar programme structure for their whānau.

The South Island Perinatal Mental Health Service (SIPMHS), based in Christchurch, is working hard to provide equitable access for whānau across Te Waipounamu. However, there is still work to be done on this. It may be that the lack of secondary infant and maternal mental health services in the old DHB areas is part of this picture and that with better secondary services across the motu, referrals into SIPMHS from smaller centres would increase in quality and quantity, and as long as beds are available, would be more equitable. Potentially the service may face a growth in demand as assessment skills and access to secondary services increases.

Teams, collaboration, and local and regional networks are useful ways for many of the gaps described in this report to be filled. Working in teams is a good way to smooth out the differences in care that pēpi and their caregivers receive on one hand, and a good way to provide the kind of variation in care the pēpi and their caregivers may need, on the other. A team approach; helps with upskilling individuals in the team as they assess and work with different clients, will provide a way to help even out the *referee lottery*, ensure that patients get fair consideration for entry into secondary services, and will help with smoothing out the handovers needed as clients recover their mental health and come to rely more on the primary/NGO sector. Funding put into helping people collaborate better is likely to be a good

return on investment as families get the joined-up care that they need and feel comfortable with and staff benefit from working with others.

We note the importance of people with disability, the rainbow community, along with cultural communities such as Pasifika and Asian. Given the lack of secondary services available all around Te Waipounamu, we have focused on how to get a good baseline of services from which to build in future for minority groups with more specific needs.

Introduction

This report was commissioned to outline the current state of the Infant and Maternal Mental Health services across the South Island /Te Waipounamu. Te Waipounamu is one of four regions across Aotearoa defined by Te Whatu Ora for the purpose of organising health leadership and services. This environmental scan is part of a quartet, with 3 other reports coming from the Northern, Te Manawa Taki and the Central Regions. The Project Descriptor supplied to the project lead for Te Waipounamu is Appendix 1.

As part of a $100 million package for mental health specialist services, Budget 2022 invested $10.1 million over four years for infant and maternal mental health services.
This money is funding a mix of additional clinical, non-clinical and cultural FTEs for community-based specialist infant and maternal mental health services including Peer Support roles, as well as packages of care to include practical or more intensive home-based respite support to whānau with higher needs.

Te Aka Whai Ora and Te Whatu Ora are committed to work together to align the subsequent Years 3 and 4 investment of uncommitted maternal mental health funding, while Years 1 and 2 will work to address inequity of maternal mental health service access. A small amount of regional implementation support funding has also been made available to each region to support regional planning and development of maternal mental health pathways.

Pregnancy and childbirth mark the beginnings of significant changes in the lives of whānau/ families and also the beginning of new lives - lives which can be affected long term by the ways in which parents and children bond and interact at this time. Around 20 percent of new mothers and 10 percent of new fathers suffer some level of mental distress and, in many cases, if not addressed, this can have long term effects on the wellbeing of the tamariki, which in turn incurs a cost to wider society.[1]

Infant and Maternal mental health services vary around New Zealand. Rural and urban communities differ in what they offer whānau, while Māori also have particular needs, conditions and preferences around how they access services, as do different immigrant groups.
Women across the country come into contact with perinatal supports including mental health supports and services in many different ways depending on their age, their cultural groups, their location and/or their financial status, amongst other factors.

This report provides the results from an environmental scan of what services are available in what places around the South Island of New Zealand.

[1] Wilkinson et al. (2022)

Report structure

This report consists of a discussion of our methods, before we set the scene with a profile of the South Island, and an outline of the reasons why infant and maternal mental health need priority and quality services. After that we detail the services available and how whānau are experiencing them before providing a short list of recommendations.

Methods

The scan was completed using a mix of qualitative and quantitative data. Mostly the information in this report has come from interviews with 138 people. We spoke with people working in a wide range of settings in the maternal and infant mental health and wellbeing space. People in the scan were people working in NGOs and community groups, as well as people working in Kaupapa Māori organisations and in primary care, and in Te Whatu Ora secondary and tertiary services. We also spoke to people working in general mental health services, and some people representing national organisations such as the New Zealand College of Midwives. A few of these people were interviewed more than once as the scan progressed and more questions arose.

Interviews were completed in a range of ways. Many were completed face to face - the first author of this report travelled to different regions to talk with respondents on a number of occasions. However, the relatively short timelines for this work in the South Island, and the relatively long distances between regions, and the difficulties of trying to get a suitable time with some busy individuals meant capacity to do this was limited. As a result, many of the interviews were completed online on Teams or Zoom, and a few were completed by telephone.

Notes were taken during the interviews and many interviews were recorded and subsequently transcribed for analysis.

Alongside the interviews, multiple reports were reviewed as they were recommended through the interview process. Reports and information were also shared with the project leads completing similar scans in other regions in New Zealand. Data also came from Health NZ, Programme for the Integration of Mental Health Data (PRIMHD), and the National Maternity Collection using the Qlik Application (APP).
Whānau voice is heard in a variety of ways. Through the design of the kaupapa Māori maternal mental health service in Ōtautahi, from parents who have a child with disability, West Coast locality consultations, from a survey that was sent out by the contractors completing this work in the North Island which also captured respondents in the South Island.

Some way through the scan process, an advisory group was set up to comment and advise. Their collective input into the content, direction and scope of this work has been invaluable. Likewise, a mihi to the 138 people who were interviewed.

Limitations

Every effort was made to talk with people and to get a good overview of services throughout the South Island. However, the South Island is a large area with many small towns and rural areas and, like any study, putting boundaries around what is in and what is out of the study was necessary. In addition, every time we spoke to someone we learned more about the history and background to the current situation. It made us very aware that there is a lot we still do not know. The view we provide here is an overview of how communities around the South Island are working with māmā and pēpi who are struggling with their mental health.

We have focused mainly on provision of primary, NGO and secondary services that assist new mums and their babies with mental health issues specifically. However, there are many community groups and organisations that contribute to wellbeing and through that maintaining mental health. For example, social workers can provide help with food, housing, and social connections, etc. that also help a struggling caregiver or whānau. At times we have mentioned services like this but by no means have we listed all of them in our scan of services.

Setting the Scene: Infant and Maternal Mental Health (IMMH)

At the centre of this report are pēpi and their whānau and the reasons why it is so important that whānau can access mental health services during the perinatal period.

Infant Mental Health

Sixteen to 18 percent of children aged 1-5 are affected by mental disorders, with over half being severely affected. Most of these disorders do not go away with time and pēpi and toddlers with mental health problems are likely to have problems with their development, their emotional communication and they may also be very withdrawn with toddlers being angry, aggressive, and unhappy. A major concern is where an infant or young child does not seek comfort when distressed.[2]

Infant mental health is central to the importance of the services discussed in this report because the relationship between māmā and pēpi, or caregiver and pēpi, has an enormous impact on how the pēpi's brain develops.

> *Infant mental health is defined by the developing capacity of the child from birth to age three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn – all in the context of family, community and cultural expectations for young children*[3].

Definitions can differ in the length of time a child is considered an infant and may depend on the context within which the term is being used. These differences are explained in the Glossary of Terms provided in Appendix 3.

Relationship between Caregiver and Pēpi is Critical

A baby's brain is in development through pregnancy and for the first few years of life. The perinatal period is a critical time within that for brain development[4].

Pepi's brain development is affected by the relationships they develop with their caregivers, particularly in the early stages of their life, when the brain is developing especially quickly and when the foundations of future brain development are being put down. A lack of early attachment and attention disrupts brain development, and therefore has long term effects on the wellbeing of tamariki and their whānau.

Critically, a mother with mental health issues may struggle to bond with her pēpi and provide the loving attention it needs for normal brain development to occur. Every day counts in the life of a young pēpi whose brain is developing, so timely help is critical. Many respondents highlighted the return on investment provided by helping māmā and pēpi during the perinatal period, and the positive effects of

[2] IMHAANZ (2022)
[3] Zero to Three Policy Center (2004)
[4] https://www.ed.ac.uk/centre-reproductive-health/news/2020-news/stress-in-pregnancy

that help over the life of that child in terms of their mental health and wellbeing, the wellbeing for their future families, and their capacity to contribute positively to wider society[5].

People working in infant mental health argued that this neuroscience should drive all engagement and interventions, and that a good way to conceptualise this is to think of the *relationship between caregiver and baby* or *whānau and pēpi* as the focus of attention, while one person suggested *the client is the set of relationships around the pēpi*. Hence, a caregiver and baby may need the support of a team of people with different skills and capacities to support them and their newborn. Te Pā Harakeke work across the South Island has highlighted this and suggests that better care can be provided by such a team.

Many health practitioners understand this; however these are not the only people working with at-risk caregivers. Interviewees pointed to people working in other government departments such as Oranga Tamariki, MSD, family lawyers or housing providers as examples of people who can affect a mother's mental health in the critical perinatal period. Working with them as part of a team can help with increasing their understanding.

Devices and Parental Attention

One respondent working in infant mental health talked about the use of devices and what their use might take away from a caregiver's capacity to attend enough to their newborn infant. McDaniel and Radetsky[6], showed how device use negatively affected the quality of parent-child interactions, which increased parental stress and child behavioural problems. Likewise, device use has been linked with parental insensitivity to the needs of their infant[7].

In a similar vein, recent masters research at the University of Canterbury[8] indicates that the pull of devices such as phones is significant. For example, in 2019-20 pregnant women (n=65) used their phones for an average of 205 minutes/day, recording an average of 53 phone pickups per day After their babies arrived, new mothers used their phones an average of 253 minutes per day, picking up their phones an average of 58 times/day. Post natal use was less likely to involve simple distraction and more likely to be related to their needs or the needs of their child at the time.

Health promotion for Infant and Maternal Mental Health

Given these potential issues, health promotion work is warranted. Furthermore, another respondent talked about how health promotion on the topic of parenting might also help mothers worry less. A person who had been a HIP (Health Improvement Practitioner) said:

> *I really do wonder if some much broader messaging around parenting/birth/adjustment would help reduce these stats. One of the biggest "interventions" I provided as a HIP was validating and normalising feelings of lack of joy, worry, overwhelm etc and managing expectations of society/others - and often these one-off sessions were enough.*

[5] Wilkinson et al. (2022)
[6] McDaniel & Radesky (2018)
[7] Stockdale et al. (2020)
[8] McCale (2020)

I can see huge benefit nationally in a "like minds like mine" /"like minds like mums" type campaign across Instagram/Facebook/social media/other that is simply saying parenting sucks sometimes, parenting makes us worry, sometimes we don't bond early etc. Validation that what we are experiencing is normal, expected, part of being human and in many instances, we don't need meds for it.

Maternal Mental Health:

The Mental Health Foundation[9] suggests that up to 30 percent of pregnant women may have symptoms but fall within the sub-clinical range, while 10-20% of pregnant women will find themselves in need of some extra assistance with their mental health over the perinatal period.

- Some women are already at risk because of their history of trauma (which can include traumatic events, domestic violence, homelessness, addiction and the long-term mental illness issues that result from those).
- Women with physical disabilities or physical illness who normally cope well may have more to cope with through the perinatal period and find themselves struggling.
- Women who have been managing previous mental illness successfully may find their mental health deteriorating during pregnancy.
- Women who have not had their worries and fears addressed or their parental expectations met and are not classed as unwell enough to meet with a maternal mental health practitioner to manage their concerns may experience an escalation in their symptoms leading to more severe difficulties.

Anxiety

A respondent mentioned a one-off review done about four years ago that found *70% of women who give birth at Christchurch Women's Hospital were on anxiety medications.* An LMC said:

> *It is surprising the levels out there – we hear about it academically but it is another thing to be confronted with how much anxiety is out there. It is really astounding I'd say about 80% of our caseload are experiencing some kind of distress or anxiety, which is pretty significant.*

There may be many reasons for high levels of anxiety with our digital environment and high societal expectations of parenting and a mother's role. There may also be some impact from trauma related to the Christchurch Earthquake Sequence when they were teenagers. Likewise, trauma, addiction etc. can be the result of patterns of colonisation and poverty, and as such, they disproportionately affect Māori māmā.

[9] Mental Health Foundation (2021)

Traumatic Birth

Some women may experience issues in late pregnancy that leaves them anxious and worried, or they may experience a traumatic birth that leaves them vulnerable in the postnatal period and for subsequent pregnancies.
As an example, respondents told stories of mums in the southern region getting part way to one base hospital because the birth process was not going well, and finding themselves diverted to another and without anyone letting their partners know.

Medical interventions required for birthing can also be traumatic. One idea was that the birthing hospital provide debriefing opportunities prior to māmā going home. However, other respondents spoke of when a birthing whānau may be ready to do this processing, suggesting this could be some time after the event, and LMC's noted that a subsequent pregnancy can be a trigger.

The Accident Compensation Commission (ACC) recently started accepting claims for physical birth injuries however the number of claims is low and emotional distress cannot be claimed unless it is a direct result of the physical trauma. Information is available on the ACC website.

Prematurity

Prematurity can both affect, and be affected by, mental health of parents and is noted to be on the increase in the South Island[10]. Maternal stress increases the risk of prematurity. Women over 40, or under 20, years of age, Māori, Indian and Pasifika women, and women experiencing social and economic deprivation are all more likely to experience a premature birth than other women. Likewise, twin and multiple birth pregnancies are less likely to reach full term.

Preterm babies often need care in the NICU which itself can be a stressful experience for whānau and pēpi both during the time they are there and post discharge.

Debriefing with whānau who have experienced premature births and care in the NICU would be useful.

Isolation

For caregivers, the birth of a child can mean a severing of valued ties and supports, for example when a māmā is no longer at work. People working with whānau during the perinatal period often spoke of isolation being an issue. As such, an important part of caring for new māmā is helping them connect with others having similar experiences.

[10] Davie-Gray and Champion (2022).

Postnatal Psychosis

Postnatal psychosis typically starts in the first few days or weeks after giving birth. Only about one in 1000 people will experience postnatal psychosis. While having a history of bipolar disorder or schizophrenia increases the risk for postnatal psychosis, about half of people who experience postnatal psychosis have had no previous experience of mental health difficulties. Early recognition and quick entry into treatment, as well as support are very important.[11]

Importance of Dads/ Partners/ Whānau

Fathers/Partners can also experience depression around the perinatal period - statistics indicate about 10% are affected by this. This may increase stress on the family. As one māmā said,

> *I can cope with the sleeplessness, I can manage a baby and a toddler, I can manage the loss of contact with work colleagues, but I can't cope with my husband's depression, as well.*

Male/ partner perinatal mental health is often forgotten and we must expect that just as the māmā above noted the impact of her husband's mental health on her wellbeing, there will be significant impacts for new dads or partners when their partner is struggling. The perinatal period is a time of significant adjustment (and lack of sleep) for the whole whānau.

Profile of Te Waipounamu

With an estimated population of 1,210,900, Te Waipounamu/ the South Island of New Zealand is home to 22 percent of New Zealand's estimated 5,481,600 population. Table 1 provides a breakdown of that population in terms of ethnicity.

Table 1: Population of the South Island by ethnicity

	South Island	NZ	%
Total population	1,210,900	5,481,600	22
Māori	131,900	905,800	14.6
Pasifika	40,000	469,500	8.5
Asian	128,600	861,000	14.9

Table 2 shows the number of live births around Te Waipounamu over the last five years by region and by ethnicity.

[11] https://mentalhealth.org.nz/conditions/condition/postnatal-psychosis

Note: Data that is 5 and less has been withheld to protect the privacy of those persons

Table 2: Live Births by old DHB region and ethnicity (Data from Te Whatu Ora, National Maternity Collection, Qlik application)

Baby DHB of residence	Birth year	Unknown	Māori	Pacific Peoples	Asian	Other	Total
Canterbury	2018		1,132	378	1,101	3,673	
	2019		1,223	365	1,200	3,666	
	2020		1,095	356	1,179	3,516	
	2021		1,317	358	1,255	3,845	
	2022		1,296	347	1,260	3,576	
	2023 (to October)		812	259	853	2,167	
Nelson Marlborough	2018		383	49	131	932	1,495
	2019		359	43	149	912	1,463
	2020		356	35	137	904	
	2021		343	49	160	969	
	2022		294	58	140	896	
	2023 (to October)		191	32	84	552	
South Canterbury	2018		116	28	52	411	607
	2019		105	19	63	440	627
	2020		108	27	63	400	598
	2021		103	32	58	440	633
	2022		110	31	66	382	589
	2023 (to October)		65	22	46	236	369
Southern	2018		668	155	296	2,163	
	2019		685	146	368	2,250	3,449
	2020		707	146	396	2,058	3,307
	2021		709	128	369	2,322	
	2022		733	165	355	2,095	3,348
	2023 (to October)		422	72	240	1,214	1,948
West Coast	2018		59		22	239	
	2019		86	10	20	229	345
	2020		69		15	198	287
	2021		79	6	27	215	
	2022		79		21	188	
	2023 (to October)		41		14	91	

Rurality

This relatively small population spread over a very large area creates challenges for the provision of services. The South Island is a large area with a relatively small, widely spread population, a fact which is highlighted by the West Coast region.

The distance between Karamea at the top of the West Coast and Haast at the bottom, is the same as the distance between Hamilton and Wellington. People living in southern parts of the Coast may need to drive for three to four hours to get to services in Hokitika. This distance adds to the relatively low incomes that people have in this area, relative to the rest of the South Island. People may not be able to afford internet access or a computer. Only 76.5% of households in the West Coast Region have

internet access as compared with 86.1% of households New Zealand wide.[12] Likewise, 85.1 percent of people have access to a mobile phone as compared with 91.9 percent of New Zealanders overall.

In addition to this, the Coast is sparsely populated with only about 300 babies born each year. For those who need infant or maternal mental health assistance, accessing it becomes a distinct problem. Given the difficulties of doing so, even those who need it may choose not to access assistance. For those who are able to travel, services may not be available either because health services have been unable to fill positions or because there is simply limited capacity in local services.

As with the West Coast example, informants report that parents living in other rural areas around the South Island find it difficult to access perinatal mental health services. Mothers living rurally can live a long way from GPs and NGOs operating in the infant and maternal mental health space. For someone with other children, living rurally and caring for a baby at the same time as dealing with mental health problems is a significant load. As a respondent who works with rural māmā said, *finding a babysitter, finding money for petrol and making the trip to a city may simply be too much*.

Rurality can also be hard on providers of services. In areas with sparse populations, providers are more likely to be working as a lone professional and having to advocate for their specialty to people who don't understand their perspective, or working alone and having nowhere to get help for a patient who is unable or unwilling to travel.

A common discussion point was how to provide good services to rural māmā and pēpi. This is discussed later in this report.

Deprivation

Deprivation confers stress and also influences how people access and use services. The deprivation map below indicates that the South Island has an overall lower deprivation rating than the North Island. However, for an individual, having a low income in an area where others don't is even more stressful because funding goes to areas of higher deprivation and consequently services in less deprived areas are fewer and further between. People on very low incomes, for example are more likely to suffer poor mental and physical health because of the stress of that, find it harder to travel, are less likely to have access to the internet, are unlikely to be able to pay for private services and often are less able to navigate the system or advocate for themselves.

[12] 2018 Census data from Statistics New Zealand

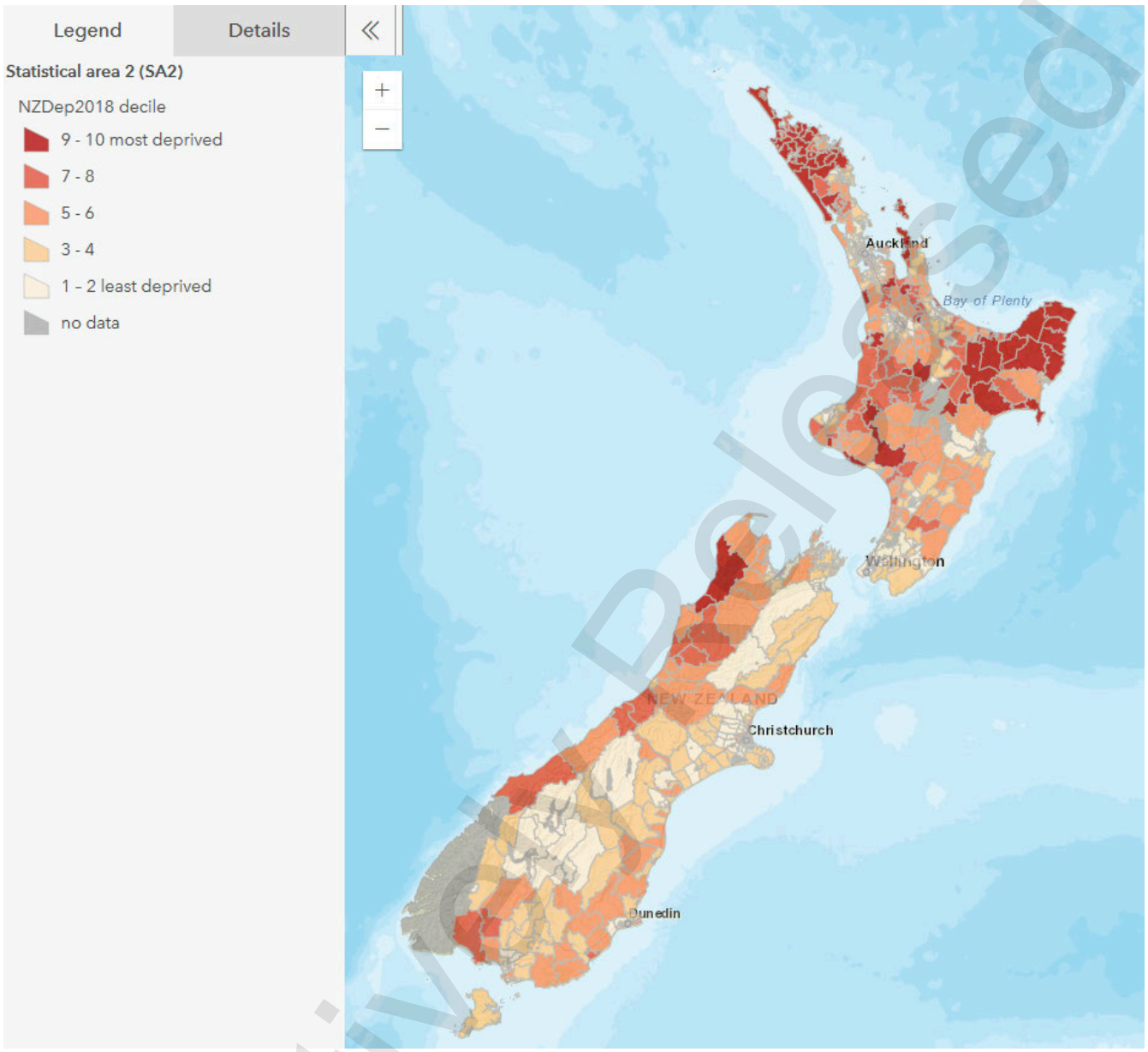

Figure 1: Map showing deprivation across New Zealand. From Massey University's Environmental Health Intelligence NZ

Current Services

Client centred approach

Many respondents talked about using a client centred approach to care where services *wrap around* the pēpi and their whānau as illustrated in Figure 1.
This framework was used to classify services as follows:

- Whānau are at the centre - all the relatives involved in providing care for the pēpi.
- The first ring includes community services that are easy for whānau to access.
- The second ring includes primary care provided by NGOs, general practice and others.
- The third ring contains secondary services and “specialist” care.

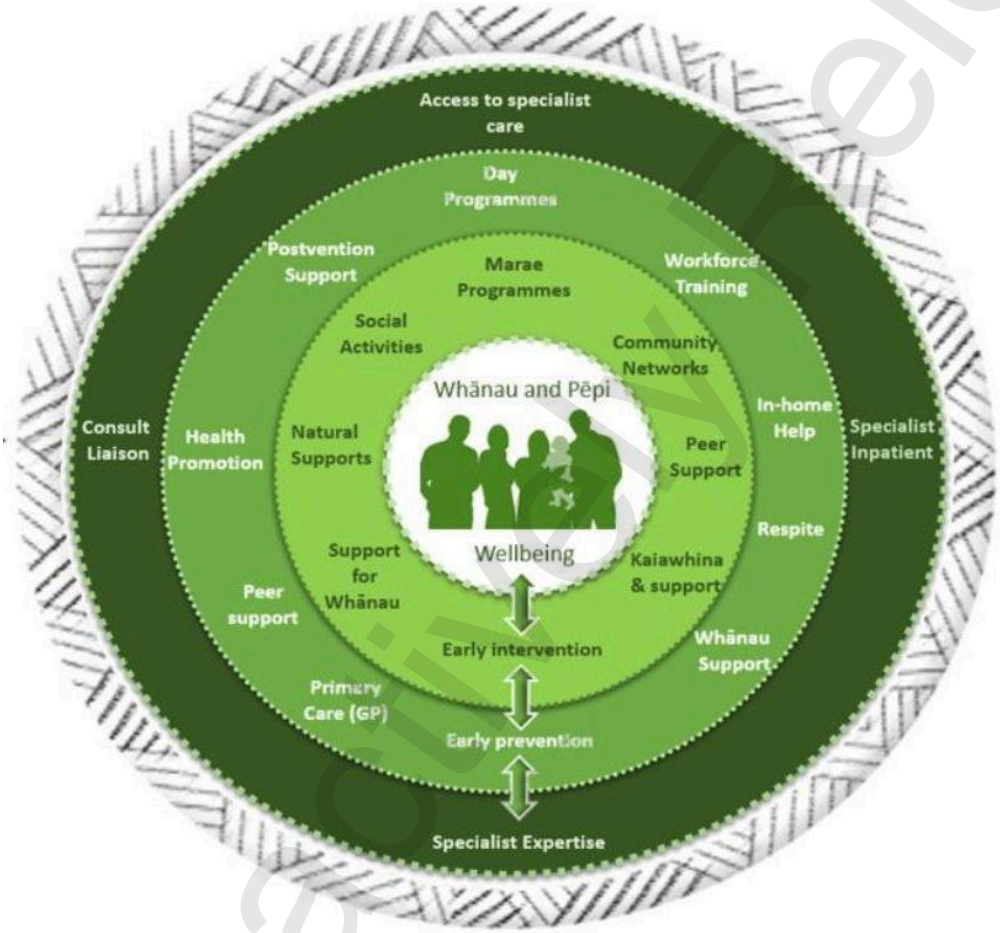

Figure 2: ***Framework from Te Manawa Taki Mental Health and Addiction Wellbeing Whānau & Pēpi Project Report 2022, p26.***

We have used this framework because it was helpful and logical for distinguishing services. At the same time, we found skilled “specialists” spread throughout the rings so we have chosen to refer to the rings or to talk about primary and secondary services.

In this section, we outline the infant and maternal mental health services that operate across the South Island. Christchurch is home to the South Island Perinatal Mental Health Service (SIPMHS - previously known as *the Mothers and Babies Unit*) that operates a ward that has recently moved to Hillmorton Hospital Campus and provides for women with severe mental illness and their pēpi to get 24-hour inpatient care.

The SIPMH Community Team provides outpatient care as a secondary service to whānau based in Christchurch with moderate to severe symptoms. Nelson Marlborough has recently developed a small IMMH outpatient service. The rest of the South Island has no ring fenced IMMH services with Te Whatu Ora staff working hard to provide some services, despite this.

Communities talked about their many different work-arounds to manage the lack of services and the significant need. Overall, the South Island is crying out for more ringfenced/dedicated secondary services so that māmā and pēpi can get the help they need quickly.

The Outer Ring: Multidisciplinary Perinatal MMH Hospital/ Inpatient and Outreach Secondary Services

The South Island Perinatal Mental Health Service (SIPMHS), previously called Mothers and Babies Unit, located on Christchurch's Hillmorton Campus provides specialist perinatal mental health care for mothers and babies from across the South Island. The structure is *hub and spoke* with the central hub in Christchurch and the spokes reach out across the South Island. SIPMHS is a centre of expertise providing treatment, supervision, clinical consultation and input into workforce development. Inpatient care is provided in complex moderate to severe maternal mental illness, with about 50 caregivers being admitted to the 5.2 bed ward per year.

Average length stay is 60 days and the Ward has 70 percent occupancy on average. Table 4 shows place of residence at time of admission, ethnicity and length of stay for 2013-2023.

Respondents discussed the high thresholds to get into hospital care, noting that once in there, the care is exemplary and high quality. One Christchurch māmā described how her GP responded quickly to her rapidly declining mental health which resulted in her and her baby being admitted the same day and they stayed as inpatients for six weeks.

Many respondents spoke well of the SIPMHS and the outreach they provide, however many also noted some issues with access.

Table 3: SIPMHS admissions as compared with live births in South Island areas

Mother's Place of Residence	Number Live Births since 2018	% live births in SI Live Births (%)	Number SIPMHS admissions (last 10 yrs)	% of SIPMHS Admissions *
Canterbury	36,248	53.0	417	80.7%
Nelson/ Marlborough	8,165	11.9	15	2.9%
South Canterbury	3,423	5.0	16	3.1%
Southern	18,865	27.6	51	9.9%
West Coast	1,725	2.5	18	3.5%
Other		0	3	

**These figures are indicative and reflect the data the authors received (Live births for last 5 years compared with MBU Admissions for last 10 years).*

Accessing the SIPMHS

Table 3 above indicates that SIPMHS inpatient service is not equally accessible to māmā across the South Island. Cantabrians are more likely to access the service, despite the fact that the service actively prioritises admissions from outside the Waitaha region in recognition of the additional barriers for people further away. (Note that while West Coast access looks reasonable, the much smaller numbers from the West Coast may amplify the way their proportional access appears in Table 4, since small differences in numbers will have a relatively large effect).

A second observation is that areas outside of Canterbury are clearly providing more care for severely unwell mothers and infants using their community, primary/ NGO and general adult mental health service beds, if they are being identified. The issue with this is that infants may not be seen or there may not be the expertise to care for infants who need assistance. It is also difficult to say whether sick mums are being identified. Judging by comments of respondents on how they work around the lack of secondary services, it would seem that many are being identified and supported by what is available locally.

Interviewees around the motu spoke of accommodating sick mothers and babies in their hospitals - which can work only if there are no other patients in the same mental health wards. Many of them spoke of *desperation*, long waiting lists, spending hours on the phone trying to arrange help for a patient, and a lack of infant mental health specialists. A rurally based Māori provider shared that due to the lack of response from mental health services, staff had slept over at the home of a suicidal māmā, even though this was outside of the scope of their service.

Another important question is whether areas without good infant and maternal mental health secondary community services, may not have effective pathways for helping patients access the SIPMHS. An added observation was that when the authors looked at the Health Pathways websites

across Te Waipounamu, they provided very different advice and information. For GPs looking for assistance in some places around the motu, it would be difficult to find.

This highlights the importance of strengthening services in the regions, and increasing the outreach work of the SIPMH service.

Table 4: Deprivation and access to SIPMHS inpatients 2013 -2023 (Data from PRIMHD)

Quintile	Number	Percent	From SI PHO enrolment data (%)	Enrolment data from Christchurch (%)
Quintile 1 least deprived	113	20.5	27	32
Quintile 2	109	20	22	21
Quintile 3	87	15.7	20	18
Quintile 4	185	33.5	19	18
Quintile 5 most deprived	57	10.3	11	10
Total	551	100		

The figures in Table 4 indicate that the numbers accessing SIPMHS inpatients roughly align with the deprivation data from South Island and Christchurch and Pegasus Primary Health Organisations enrolment data. There are two quintiles that look significantly different to what might be expected based on the PHO data:

- People in Quintile 1 - the least deprived, are less likely to become Inpatients in SIPMHS, and
- There are a surprisingly high percentage of people in Quintile 4 going through the ward.

These two observations are unexpected, the first because anecdotally, as a respondent from this service told us:

> *Many mother and baby units tend to have higher admission rates of women from middle to upper socioeconomic groups - no doubt due to fewer access barriers, and greater health and resource literacy*.

However, this pattern is not apparent in these figures, and the opposite seems to be happening here. Possible explanations for this might be

> 1) For whānau who can afford it, going to private providers might be the easier option given that it is clear that it can be difficult to get into SIPMHS inpatients and quintile 1 families may be more aware of the importance of getting urgent help; or
> 2) People in the *least* deprived Quintile may simply suffer less from ongoing mental health issues that make caregivers more susceptible to problems during the perinatal period; or
> 3) The service is working well to redirect caregivers and provide a *lighter touch* service for those who have access to more community and whānau based (rather than hospital based) resources and services.

In an ideal world, we should expect a higher rate of admissions from groups dealing with higher deprivation levels. While we see this is the case for the quintile 4 group, it is not so for quintile 5, even though Quintile 5 māmā are admitted at roughly proportional rates to what might be expected from the PHO enrolment data. An explanation for this may be that the enrolment data gives a lower estimate of people living with the greatest deprivation levels because they are less likely to be enrolled.

As one of our respondents pointed out, the people who are most likely *not* to be enrolled in a PHO are Māori and those who are severely mentally unwell and with addiction issues, people who are more likely to be part of quintile 5. As such, they will face barriers such as transport costs, use of the "right" language, a lack of whānau with the capacity to support their use of services, a lack of capacity or inclination to seek help, to name a few. These people may also have very complex needs, making it possible that secondary services may not take them on as clients as, some respondents noted, is the case at times. Hence these people are also less likely to get access to infant and maternal mental health services where they exist, or even adult mental health services, in general and so may not be referred on to the SIPMHS.

It is difficult to clearly explain the high Quintile 4 data without further research but possibly these are the people who both need the secondary support but with slightly less complexity of need, alongside some capacity to access support services and get referred through. People in this quintile level may also show up as being more in need of the secondary support

Māori

The ethnicity data provided in Table 5 indicates that Māori are slightly underrepresented as inpatients in the SIPMHS. However, these figures could be interpreted as being low because a greater proportion of Māori suffer from mental illness,[13] and this is also the case for Maternal mental health.

Table 5: Ethnicity of people in the SIPMHS compared with ethnicity of South Island Live births (Data from PRIMHD)

2013-2023 data	Number of Patients	% of patients	Live Births in SI since 2018 (%)
Māori	96	18.6	21.1
Pacific Peoples	23	4.5	4.0
Asian	26	5.0	11.4
Other	370	72	63.5
Total admissions	515		

[13] Russell (2018)

Respondents from Kaupapa Māori organisations identified that the pathway to tertiary and secondary care may not be one the clients will choose. Potential clients may prefer to stay near to whānau, may not feel comfortable in services that are not kaupapa Māori, may prefer to utilise local services, and /or may not be resourced to manage the associated costs of getting someone to the service.
It is also useful to note that the regions that show lower levels of admissions to the SIPMHS inpatients ward also have a higher percentage of births to Māori māmā (as per Table 2). In other words, the patterns of geography indicated in Table 2 may be contributing to these figures. Whatever the explanation, **there is a clear need for Māori NGOs to have access to support and advice from specialists.**

Outreach Services

Respondents said that the SIPMHS provides excellent inpatient care and outreach across the motu. The outreach service provides education, visits, virtual and actual clinical consultations out to the spokes. Respondents in the regions indicated that they would like more access to advice. Increased access to advice and education would strengthen the spokes which are important for supporting mothers in rural or regional parts of the South Island.

SIPMHS staff stated that:

> *Geographical distance has limited the ability to deliver clinical consultations. However, recently consultations have been extended to the regions for the mothers with the most severe illnesses through increased use of telemedicine. This approach requires the support of a sufficient level of local expertise to manage the ongoing needs of the women as maternal mental health relapses need a prompt local response. Within the model of delivery of specialist mental health care, telemedicine has a lot of potential.*

Table 6: Secondary community maternal and infant mental health services by region

Region	Multidisciplinary secondary community *maternal* mental health team	Multidisciplinary secondary community *infant* mental health team 0-1 & 0-5 yr old
Nelson Marlborough	Developing - yes Located in the Adult Community MH Team in Blenheim	Developing - yes Located in the iCAMHS team in Nelson, with focus on liaison and support across primary and secondary services
Waitaha	Yes South Island Perinatal Mental Health Community Team	Yes CAF has an Under 5's Team
West Coast	no	no
S. Canterbury	no	no
Southern	no	no

As Table 6 shows, only two areas in the South Island have secondary maternal and infant mental health services, with Nelson Marlborough being a very recent development. Any services that do exist in the other areas all emerge from interested individuals, who have actively advocated for providing some infant and maternal mental health expertise for their city, town or region. As a result, different places have a range of ways in which they have put together services to assist māmā and pēpi. Of concern, is that **without ring fenced or dedicated resources, any local and/or individual responses are extremely vulnerable**.

South Island Perinatal Mental Health Community Team SIPMHCT

The South Island Perinatal Mental Health Community Team (SIPMHCT) provides secondary outpatient treatment and case management targeting treatment of the caregiver's mental illness, while assessing the impact on the baby and other children in the family. It frequently works alongside other services with shared clients and has in-service training with various NGO and community services. They have a limited capacity to provide supervision to some of the Primary/ NGO e.g. Plunket Postnatal Programme.

The team has an annual Waitaha caseload of 70 clients of which approximately ten percent are Māori. The service gets an average 33 referrals per month and about one third of these are declined because they do not meet the severity threshold and/or there is insufficient information in the referral. The service has a waiting list which can vary in length within one month to four months, and referrals are actively triaged so that more severe cases are prioritised for treatment. The time māmā and pēpi are involved in the service can vary from three months to 15 months.

Children Under Fives Team, Child and Family Mental Health Services

According to the CAFMH Under Fives Team, Mental Health Services have 3% of the population as a benchmark for service provision.Three percent of the 0-5 age group in Canterbury region is around 1085 children. Clearly this number could not be seen by a fledgling service; in reality a target of the most severely affected 0.5% would be more realistic, about 180 children. However this figure is well under the estimated number of expected severe infant mental health cases. The Infant mental health team also need capacity to provide in-service training, clinical supervision and support to primary and NGO services dealing with pēpi and infants in the wider community.

Developing IMMH Service in Nelson/Marlborough

Nelson Marlborough has recently received a dedicated resource and assigned this as 0.5 FTE for maternal mental health, situated in their Blenheim adult mental health service and 0.5 FTE for Infant mental health into the Nelson Child and Adolescent Mental Health Service. A local Te Whatu Ora paediatrician highlighted the difference this is making:

I'm so pleased that we have something that we never used to have and I can now refer to them …Our waiting list for CAMHS is over a year for lots of things but infants are being seen as more urgent and they have a separate waiting list.

She and others also noted that as yet, this is not enough to meet the local need for these services but it is better than what they had. She highlighted the work of another paediatrician whose efforts have made a huge difference across their localities with their community paediatrics hours.

Regions without Dedicated Maternal and Infant Mental Health Services

Reliance on hospital-based paediatricians is typical in those areas without dedicated infant mental health personnel. This reliance also extends to individuals in other roles such as hospital based mental health teams, Adult Mental Health Community teams, Crisis Response, Primary Care and CAMHS/CAF. Not everyone in these roles has a good understanding of the urgency involved with infant and maternal mental health (outlined later in this report), but many do and find themselves working outside of the scope of their designated role or skill set in order to provide some response in their communities.

Paediatrics

For communities that lack ring-fenced Infant mental health time, respondents talked about referring infants with mental health issues to the nearest paediatrician. The Paediatricians that we spoke to indicated that as medically trained specialists, they are not always comfortable treating mental health issues which may be outside of the scope of their training.

An Invercargill based paediatrician, spoke of the struggle to get infants seen in an area without specialist infant mental health. As a result, he is:

…doing an awful lot of mental health work, because someone has to . . . I think desperation probably sums up how we find it. We use the children's ward. We use the neonatal unit. We've had a bizarre situation where a mother and a baby have been admitted to the adult mental health unit at the back of the hospital and we've been asked to go and examine and review the baby. That's happened more than once. It's quite ad hoc. It doesn't happen every week, so it doesn't get onto the radar.

A Dunedin paediatrician said she has struggled with referrals to mental health services and felt that the LMC got better results than her. She mentioned a colleague who spent most of a day on the phone trying to get a māmā into the Mothers and Babies Unit (now SIPMHS). Even a paediatrician in Christchurch said she found it a struggle to get infants seen by the overstretched local CAF under 5s Team.

Multidisciplinary Teams

Respondents working in this area often pointed to the importance of having access to multiple types of expertise to understand the complexities of client whānau contexts and to be able to undertake a

thorough assessment and respond appropriately to each. The South Island Perinatal Mental Health Community Team and the CAFMHS Team both have this variety of roles (See Table 7 and 8 below).

NICU also has a multidisciplinary team to assist new parents dealing with birth injuries or premature births whose babies are in care there.

Respondents also raised the matter of the actual skill sets that are required, such as skills to undertake assessment of neurodevelopment/intellectual function, neurodiversity/autism spectrum disorder. CAFMS teams noted they expect initial assessments to be undertaken by paediatrics.

Table 7: Current Roles and FTEs for the South Island Perinatal Mental Health Community Team

Role	FTE	Role	FTE
Psychiatrist	1.15	Psychologist	1.3
Social Worker	1.3	Physiotherapist	0.2
Registered Nurse	2.2	Psychiatric Registrar	0.5
Dietitian	0.1	Manager	0.5
Pukenga Atawhai	0.4	Administration	1.0
Infant Mental Health Specialist	0.3		

Table 8: Current Roles and FTE for the Child and Adolescent Under 5 Team in Christchurch

Role	FTE	Role	FTE
Psychiatrist & Clinical Lead	0.1	Infant Mental Health Clinician/ Clinical Social Worker	0.7
CAF Consultant Psychiatrist	0.45	Clinical Social Worker	0.5
Consultant Clinical Psychologist	0.8	Manager	0.2
Senior Child and Family Psychologist	0.6	Administration	0.2
Pukenga Atawhai	0.5		

Perinatal Respite Services

Respite services were something discussed in many interviews. There are none currently in Te Waipounamu, which is probably a reason for the wide range of responses. The range traversed the continuum from in-home respite to facilities that are not supervised, to dedicated supervised maternal and infant facilities. Some respondents felt that dedicated respite facilities were a thing of the past, whilst others felt they are helpful and prevent admission to hospital. Crisis Resolution in Christchurch said they could keep a house fully occupied if there was one. Planned and unplanned respite was also discussed.

A now closed facility for at risk young mums and their babies in Christchurch was noted as a loss to the community.

It was noted that sleep deprivation is common for new parents and anything that can assist with this would be beneficial. In-home respite was an example, as was the possibility that NGOs providing postnatal support groups could also provide a simple space for the caregiver to sleep whilst also caring for the pēpi and toddler.

Ashburn Hall in Dunedin currently has facilities that could be used to provide respite for māmā and pēpi.

The Middle Ring: Primary Health Organisations

South Island PHO's have mental health teams supporting their affiliated general practices. A brief overview of the PHO's is provided in Table 9. There may or may not be practitioners who are specifically interested and trained in infant and maternal mental health as part of the services. Several mentioned the need to have access to perinatal specialists.

Table 9: Mental Health Services provided by PHOs

PHO	Services Offered
Nelson Bays Primary Health	Brief Intervention Service Mild to moderate Multidisciplinary team Primary Mental Health initiative Contracted Counsellors
Kimi Hauora Wairau Marlborough Primary Health	Primary Mental Health Multidisciplinary Team
Te Tai o Poutini West Coast PHO	Primary Mental Health Counselling Multi disciplinary team Brief Intervention Service
Christchurch PHO	Triage - provides First Aid, reassurance, manage risk Intensive GP Liaison - incl. home visits

	Brief Intervention Counselling Refer to Psychologist - contracted Refer to AOD, NGOs Wait times are big challenge, 2-3 weeks Employ HIP's who are located in a general practice
Pegasus Health	Mental Wellbeing and Support Brief Intervention Talking Therapy (BITT) including at Rangiora and Rolleston Health Improvement Practitioner or Health Coach in a general practice
Waitaha Primary Health	Brief Intervention Coordination Services Rural Mental Health Specialists LInks to community supports Mild to moderate Via telehealth as required Consultant Clinical Psychologist Specialist care
South Canterbury Primary and Community	Integrated Primary Mental Health and Addiction services - appointments with HIP or Health Coach, at some practices Will do via phone if required
WellSouth	Brief Intervention Services - Mild to moderate Family Mental Health Services - referral from GP. Moderate to severe Access and Choice (Tòku Oranga) HIP and HC based in a general practice

Primary General Practice Services

Enrolment in a primary health organisation (PHO) is voluntary. Most New Zealanders are, however, enrolled through their general practice and gain the benefits associated with belonging to a PHO, which can include cheaper doctors' visits and reduced costs of prescription medicines.

Information on the number and percentage of the total population who are enrolled in a PHO for each of the five districts can be found in Table 9 below.

Table 10: People enrolled in PHOs at Oct 2022 by ethnicity

	Total			Māori			Pacific		
District of Domicile	Total Enrolled	Total Pop'n	%	Total Enrolled	Total Pop'n	%	Total Enrolled	Total Pop'n	%
Canterbury	584,360	597,385	98%	53,992	62,405	87%	17,580	19,605	90%
Nelson Marlborough	156,414	166,120	94%	16,027	19,390	83%	2,853	3,760	76%
South Canterbury	61,070	62,508	98%	5,094	6,240	82%	1,543	1,248	124%
Southern	337,121	353,465	95%	33,777	41,395	82%	8,776	9,255	95%
West Coast	32,346	32,775	99%	3,829	4,225	91%	410	388	106%
totals	**1,171,311**	**1,212,253**		**112,719**	**133,655**		**31,162**	**34,255**	

***Note**: The estimated coverage for a population is sometimes more than 100% as the underlying population comes from Stats NZ population projections and the enrolment number comes from the primary care data collection.*

Women suffering moderate to severe mental health issues under the care of a midwife are usually referred to their general practitioner (unless there is another pathway such as that provided by Te Puawaitanga ki Ōtautahi). Respondents mentioned that seeing a doctor in some areas can take a few weeks.

General practices are also changing to meet the challenge of a worldwide shortage of doctors and nurses, and of the longer-term effects of Covid 19 which saw practices bring in new ways of doing their work. One recent innovation, allied *Access and Choice,* includes Health Coaches (HCs) and Health Improvement Practitioners (HIPs) located in general practice, with the intention of improving the primary and community mental health landscape.

The HIPs are registered health professionals and provide mental health support. The Coaches are non-registered and support people to navigate what is available in the wider community.

The data for these roles show a very low uptake, typically 0.2 percent, assigned to maternity or parenting. From a data collection perspective, this could be because the presenting issues are recorded as *anxiety* or *stress* and the underlying causation is not recorded.

Some general practices are actively stepping up in this space. A HIP mentioned that in her practice, the nurse doing the six-week immunisations also screens using the Edinburgh Scale and refers any caregivers showing signs of stress to her. Likewise, a few general practices are getting their health coaches to ring women who are either pregnant or who have recently delivered, to check on how they are going and whether they may need any assistance. They are making this a routine pathway that is proactive and which may help them provide or obtain early support for any parents that are struggling.

Several respondents recommended that the current pathway "warm handover from RN or GP" to HIP's be expanded so that LMC's can refer directly to them. From an access and equity perspective, this seems a good idea, especially as there would be no cost involved. One PHO reflected that the referrals from General Practice to their mental health service had changed with the introduction of the HIP's and HC's, they now have fewer referrals with a higher level of acuity. They also noted the need for their dedicated mental health staff to have support from the local, secondary mental health staff.

Respondents found both pros and cons to these approaches. Some found the model of care by HIPs and BICs to be a little confined and difficult, and said it may not suit all women. This model also tends to be better suited for a focus on the mother and generally has little focus on the infant's needs. On a more positive note, some felt there could be some benefit if an LMC was able to refer directly to a HIP and avoid the cost of a GP appointment for their patient.

Respondents had further suggestions for the development of *Access and Choice*, acknowledging these would take it outside of the current design. One suggestion was that some HIPs could have dedicated time and expertise specifically for assisting with perinatal mental health. Once again, this included direct LMC referral and that HIPs across a community could form a virtual hub or referral pathway, thus shifting from the current general practice focus. The usefulness of a virtual HIP service to support access was discussed, that is the HIP would be available by phone.

Some general practices indicated preference to employ their own HIPs and HC's rather than the employer be the PHO or NGO's.

Brief Intervention Counselling (BIC) has been available for many years and forms part of a PHO's mental health service.

> *One consumer shared that her anxiety skyrocketed during her second pregnancy and this was linked to a traumatic birthing experience with her first child. She said Brief Intervention Counselling had been successful for her. She added that she thought it would not be helpful for those with more complex issues.*

Primary Maternity Services

Primarily maternity services are mostly provided by Lead Maternity Carers (LMCs), most of whom work as independent contractors to Te Whatu Ora.

Availability of LMCs

Respondents portrayed a mixed picture in regard to access to LMCs across Te Waipounamu. Table 11 shows that in some parts of the motu, there is a shortage of LMCs. At the same time, it is clear that there is no clear picture of the LMC workforce because of the way LMCs are contracted.

Christchurch is the best resourced as compared with other parts of the South Island with an estimated 150 LMCs. Alongside this, the Midwifery Resource Centre is funded to help women navigate to find a midwife.

Table 11: Availability of LMCs across Te Waipounamu

Place	Availability
Canterbury	Good, with 150 plus a midwifery resource centre. Registered nurses are working in the hospital due to shortage of core midwives.
Golden Bay	Good. There's a little PHO that runs the primary unit, providing a point of connection because it's identifiable.
Nelson	Ok, with concern for an ageing workforce
Blenheim	Poor, with concerns for longer term viability in community and in hospital
South Canterbury	Poor, locums are common, which is costly to the health system
West Coast	Has enough
Dunedin	Loss of staff across the board
Southern	Very short including hospital midwives.

Screening

Midwives that we spoke to suggested that they should be screening using one or more of the tools in Table 11, both prenatally and postnatally, as they are the core workforce in this perinatal period. A paper delivered at the 2023 Midwifery Conference suggested the same thing. Such routine screening would potentially pick up many women who wouldn't otherwise be picked up or seek help. Screening allows conversations about mental health and may help prevent suicides - the leading cause of death over the perinatal period. Respondents also pointed out that routine screening is only worth doing when they can refer a woman on to someone who can assist her - something that currently is not reliably available.

It is therefore important and logical that all LMCs have the skill, knowledge and expertise to screen for depression or anxiety in a pregnant woman or in a new mother and manage the conversation about that with people who are in distress. However, midwives we spoke to pointed out that midwifery education includes little on perinatal mental health. As a result, many feel out of their depth when dealing with moderately to severely unwell women. Although typically strong advocates for women, this lack of mental health training means LMCs cannot be effective advocates in this instance.

A general mental health worker summed it up:

> *Over the years I have been very keen to expand on what can be delivered by way of ongoing mental health education and supervision for midwives however all efforts have been thwarted for overall legitimate reasons, largely in relation to competing demands of what the educational needs are, and as is often the case, mental health frequently slides down the list of priorities.*
>
> *I speak with second year midwives for three hours annually and the resounding feedback from them is that they would like to have further mental health education at some stage, at least in*

the subsequent years. I have given their feedback to the midwifery department and I have spoken with the lecturers and explained I would be happy to provide more education, however, it seems the same issue is applicable in terms of what has to be fitted into the curriculum and there is no room for any additional mental health education.

If midwifery education is unable to provide perinatal mental health training, then LMCs need to be strongly connected to people who can provide this skill.

Appropriate Screening Tools

Another issue raised was the need for culturally appropriate screening tools.

Screening tools are typically a series of questions, for screening for anxiety and/ or depression (see Table 12), using a tool is considered preferable to clinical judgement alone, however screening tools in New Zealand are likely to be most suitable for use with NZ Europeans and less suitable for Māori, Pasifika and immigrant communities[14]. In addition, the effectiveness of such scales may be influenced by the language used, a mistrust of mainstream services or a fear of potential consequences of PND being identified.
The Edinburgh scale has been translated for use in Australia with Aboriginal and Torres Strait Islander women. So far, no work has been completed to assess whether the scale should be adjusted specifically for New Zealanders and perhaps more importantly, for Māori, however, Te Whatu Ora have initiated some work to develop screening tools for Māori.

Table 12: Screening tools

Tool	Notes
Postnatal Depression screening tool	Typically used by Well Child and LMC's in Aotearoa.
Edinburgh Postnatal Depression Scale (EPDS) -	Set of 10 questions that can indicate whether a parent has depression in the year following the birth of a child.
Patient Health Questionnaire-3 (PHQ-3)	
Patient Health Questionnaire-9 (PHQ-9)	Does not have the anxiety component but includes suicidal ideation.
Perinatal Anxiety Screening Scale (PASS) -	Screens for a broad range of anxiety symptoms
Antenatal (Psychosocial) Risk Questionnaire (ANRQ)	https://www.cope.org.au/wp-content/uploads/2017/11/ANRQ- Questionnaire.pdf

[14] Faulkner and Moir 2023

Integration

Respondents spoke of the different philosophies of medicine and midwifery. Simply put, midwifery places the consumer at its centre as experts in their lives, with the relationship key. It is an intentional power sharing approach.

As such, it is probably fair to say that medicine and midwifery attract different people. It is probably also fair to say that Pae Ora vision has excellent alignment with the midwifery philosophy. It is understandable that these differing philosophies have contributed to the location of Lead Maternity Carers (LMC's) outside of general practice providing some practice autonomy for them. However, some respondents felt this autonomy discourse is somewhat of an illusion, as the funding model and contracts in fact restrict LMC autonomy. Furthermore, concerns were raised about the variability in the standard of care between LMC's, something that a respondent pointed out can be a natural consequence of being autonomous.

Autonomy and Integration

Clearly, there are issues to be addressed to ensure perinatal care includes a high standard of mental health screening and response. It is urgent to have LMC's sufficiently skilled in this area and, if this is not a viable option, they need excellent integration with other key services. Respondents spoke of the current funding and contracting models for perinatal care that work against integration between general practice, LMC's and other mental health services.

Possible solutions

Integration with Primary/NGO and secondary services could be achieved if LMC's relinquished their autonomous way of working, and **relocated as part of general practice**. This would provide easy access to the likes of HIP's, doctors and nurses, and PHO mental health teams. It was noted that because of the different underpinning philosophies then it could take a lot of effort to make this work. However, the changes we've discussed in general practice has resulted in a wider range of roles and disciplines within many practices. In addition, some general practices have forged relationships with Allied Health Practitioners such as Physiotherapists, Chiropractors, Osteopaths and even Acupuncturists. These changes have influenced the general practice ways of working and thinking. On top of that, midwives have forged a strong sense of identity and common practice which may make it easier for midwifery to become part of a multidisciplinary general practice team.

Another option that was championed is to **collectivise the independent LMC practices** and build some kind of functional structure around the workforce. As sole practitioners, LMCs are isolated, so this option champions their coming together as a collective workforce to take some burden off them and support sustainability. The functions could include:

- administrative tasks
- a single point of contact for pregnant women to find an LMC, information and other services
- referral pathway to ensure that referral pathways are streamlined, that there were access points into the midwifery system from general practice for example, and to secondary services.

The Midwifery Resource Centre in Christchurch could be further developed to provide this support and the primary birthing units in rural areas would be the logical places as they are very identifiable.

This option would help resolve the current system that privileges those that can easily self navigate and disadvantages those who cannot. It would have visibility of local midwives, caseloads and so make sure places are found for people.

Other options involve NGOs.

- Purapura Whetu initiative called Pūmotomoto includes the co-location of an LMC practice, this option provides easy access to all other services that Purapura Whetu provides plus access to the services of those entities it has built relationships with.
- Another kaupapa Māori entity described the possibility of employing LMCs and their Section 88 income going to the NGO as a contribution to a larger salary. This would support LMC,to be paid for a broader range of tasks, such as attending client appointments with general practice and Hei Pa Harakeke hui. This would also support more streamlined access to the other services the NGO runs and has access pathways to.
- Some Māori entities also run or have MOUs with general practices and for LMC's to be located within this suite of services would clearly support integration

Pregnant women and those with new babies will continue to fall through the gaps until these matters are addressed.

Primary Care: Mental health services provided by NGOs

Mental health and addiction services provided by NGO's generally do not have an infant and maternal mental health speciality with a few exceptions.

- Whānau Āwhina Plunket provides its PPAIRS (Plunket Parent and Infant Relationship Service) and PPNAP (Plunket Perinatal Adjustment Programme) services in Canterbury, and PPNAP (Plunket Perinatal Adjustment Programme) in Timaru and Dunedin. PPNAP provides assessment, intervention and education in partnership with the māmā, partner and wider whānau and linking them with community-based services. PPAIRS provides two intervention programmes with the purpose to support parents to accurately interpret their tamariki communication cues and behaviour then respond in an appropriate way to their needs.
- One kaupapa Māori NGO in Christchurch has developed a maternal mental health service over the past three years. Kaupapa Māori approaches are holistic, so naturally include hinengaro, a limited translation of which is mental health and emotional wellbeing. Many NGOs work with the wider needs of whānau, thus addressing factors that cause distress.
- One NGO in Queenstown has a dedicated psychosocial response for perinatal whānau.
- Some NGOs providing Family Start/Early Start have built their own internal specialist pathways for counselling or psychology support, including ACC sensitive claims. Typically, the pathway for Family Start providers is to general practice for treatment and on referral, noting Family Start works across a range of whānau needs and they are not mental health specialists.

NGO respondents identified a need for support from secondary specialist services with their care of client whānau, and some identified they could on-support others, particularly those who regularly refer to them such as the pathway between LMC and Tamariki Ora/Well Child and Family Start Services.

The idea of a South Island perinatal network was supported by NGOs who named additional benefits when they are delivering the same contracted services such as Family Start, Healthy Homes Initiative, Haputaka/Pregnancy and Parenting Education, support to migrants and refugees, Whānau Ora and Mokopuna Ora.

Some respondents noted the loss of Whānau Awhina/Plunket antenatal and postnatal groups, seeing this as part of a wider feeling of loss for maternal support in our communities today. Respondents noted that valued postnatal groups are often run by community members and hence vulnerable to closing down as children move to school age.

Kaupapa Māori Services

There are a number of Kaupapa Māori organisations around Te Waipounamu that support hāpu whānau, new parents and their pēpi, and tamariki. People in these organisations spoke of the importance of perinatal mental health and assistance with parenting as part of their work to address issues of trauma. They also spoke of their commitment to creating this change for whānau.

In addition to kaupapa Māori organisations working in the community and primary/NGO spheres, there are Māori teams located in secondary services. CAMHS and Adult Community services described the contributions of these personnel. Such as assistance with waitlist management, brokering the relationship and developing trust with whānau, engagement with the multi-disciplinary case hui as well as bringing cultural expertise for staff development purposes. At times there appeared to be a high reliance on Māori staff for cultural processes.

The disparities that Māori communities experience in both access to health services and health outcomes are similar in the area of maternity services including infant and maternal mental health. Māori wahine may be less able to afford health care, may have less trust in services available to them, and are less likely to be enrolled with a general practice. Furthermore, many Māori also live rurally which further disadvantages them in terms of access to health services. As Te Whatu Ora's website states,

> *Nearly half of Māori women do not have a Lead Maternity Carer in their first trimester of pregnancy and more than half of Māori children have not received their vaccinations by 18 months of age.*

In addition, infant and maternal deaths are higher for Māori than for non-Māori New Zealanders. The relatively smaller numbers of Māori living in Te Waipounamu (as compared with Te Ika a Maui) also means that there is less access to Kaupapa Māori health services and less money available to help with setting those services up.

Māori providers described their continuum of care which include whānau with pēpi aged 0-5 and noted some of the resources that supports this care, being the recent Kahu Taurima funding, Te Putahitanga with its Mokopuna Ora and Whānau Ora. Some providers have Tamariki Ora/Well Child and Family Start contracted services. Some are providing hapūtanga/antenatal education, and wahakura wānanga. One provider has a rōpū of weavers and distributes over 600 wahakura to whānau each year, this is resourced by Te Whatu Ora.

The 2018 He Ara Oranga report notes that,

> *For **Māori health and wellbeing**, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasizing ties to whānau, hapū and Iwi.*

This IMMH project found one kaupapa Māori NGO with a program to specifically support māmā and pēpi with moderate to severe mental health issues.

Te Puawaitanga ki Ōtautahi Trust developed, piloted and subsequently embedded a programme in which they braided together Mātauranga Māori, Western clinical approaches, peer support, cultural learning opportunities and community development. In addition, the programme was co-designed at all stages with their client whānau. Whānau perspectives and needs formed the basis of the design of this whānau centred programme.

Whānau Whakapuawai: Perinatal Wellbeing Service Model of Care

Whānau Whakapuawai was established by Te Puawaitanga ki Ōtautahi Trust to meet the increasing demand for services addressing perinatal mental health distress experienced by whānau in Waitaha, Canterbury. Initially a pilot, this service is informed by both Mātauranga Māori and Western clinical approaches[15].

Whānau Whakapuawai was designed and developed to be a whānau-centred service. At its inception, a consultation hui was held with whānau and it was their voices and perspectives that informed the design and priorities of this programme. Their input was sought and used to inform an adaptive approach where staff added to the service as they learned where the needs and preferences of whānau lay.

Using a *Braided River* approach, Whānau Whakapuawai assists māmā and birthing parents who are experiencing distress or illness during the first 2,000 days of their infant's life. Whānau were clear that they wanted access to both cultural and clinical support alongside education and medications. The

[15] Ihi Research (2023). *Whānau Whakapuawai: The Threads of the Korowai Final Evaluation for Te Puawaitanga ki Ōtautahi Te Ao Auahatanga Hauora Māori: Māori Health Innovation fund.* Puawaitanga ki Ōtautahi Trust, Christchurch.

service is therefore designed to provide a 'braided river approach', integrating Mātauranga Māori with elements of Cognitive Behavioral Therapy and Dialectical Behavioural Therapy. The relationships that the programme has built up both internally to other services at Te Puawaitanga and externally to other practitioners and organisations helps to provide a wrap-around set of support for whānau.

The group-based programme provides continuity of support so whānau can remain in the Whānau Whakapuawai programme for as long as they want to. This allows them to maintain the community and relationships they have built, and, for those who want to, to support others. Manu Tohu Tau provides further opportunity to develop skills and train to become peer support workers. Whānau who have been through the programme have found that they can collectively find their own solutions to any crises/ wobbles, while also knowing that they have the support of the Whānau Whakapuawai rōpū. So far, 103 whānau have been through the pilot programme. Te Puawaitanga has ongoing funding and so will be carrying the programme forward. A more detailed outline of this programme written by staff from Te Puawaitanga is provided in Appendix 3.

The programme was described as a *game changer* for a midwife who works with high needs Māori whānau. She can refer pregnant māmā directly into the programme so that they start making connections and finding mental health support early. Because of the braided nature of the programme, new māmā and hapu māmā can be accepted into the programme more quickly. Even if there may be a wait for entry into specific braids such as the clinical work, it may be possible for a birthing parent in need of assistance to be supported by peers and kaimahi participating in other braids.

It has also been a *game changer* for people who have been in the programme

> *I've been in and out of the mental health system, done years of counselling and courses to help me try not to repeat the cycles for my children, all the different medications. I've tried lots, and it never really 'fixed' anything, they usually are very scripted, very.... Brain development focussed, very logical, ... by bringing in the spiritual side and the physical and mental, looking at the whole of a person, that is my Ah-ha moment, because the healing started.... it's a journey and I'm blessed to be a part of it, for myself and my whānau* (māmā feedback[16]).

For more details about the way the programme has changed the lives of programme participants, refer to Ihi Research's evaluation of the programme.

Building connections between Kaupapa Māori organisations in Te Waipounamu

Kaupapa Māori entities and kaimahi are connected through whakapapa and relationships, they are connected by their shared experience of the impacts of colonisation. Te Putahitanga o Te Waipounamu, the Whānau Ora commissioning agency for Te Waipounamu has encouraged connections between organisations since its inception and especially with its symposiums and Whānau Ora Navigator hui. At a recent Te Aka Whai Ora hui in Ōtautahi with the 8 providers (see Table 13) in receipt of Te Aka Whai Ora / Kahu Taurima resource there was a clear call for collaboration. As such, Te Puawaitanga ki Ōtautahi will share with Invercargill-based Awarua Whānau Services details of Whānau Whakapuawai. We note that Te Puawaitanga kaimahi are willing to share

[16] Ihi Research (2023). *Whānau Whakapuawai: The Threads of the Korowai Final Evaluation for Te Puawaitanga ki Ōtautahi Te Ao Auahatanga Hauora Māori: Māori Health Innovation fund.* Te Puawaitanga ki Ōtautahi Trust, Christchurch.

further if other similar organisations are interested. It would be good to see this kind of programme available to whānau in all areas.

Table 13: Kaupapa Māori organisations that received Kahu Taurima putea

Kimi Hauora Wairau, Marlborough PHO	Te Puawaitanga ki Ōtautahi Trust
Te Piki Oranga, Whakatù	Te Kàika Òtepoti
Te Tai O Marokura	Awarua Whànau Services
Purapura Whetu	Arowhenua Whànau Services – national project

Connections between Kaupapa Māori services and secondary services

Kaupapa Māori providers who are supporting whānau in community and primary services identified the need to have functioning links to secondary services to be able to access specialist advice to help manage the complex moderate and severe whānau in their services. Specialist knowledge in kaupapa Māori primary health is building as kaimahi who have worked in secondary services choose roles in the primary sphere. Direct support with secondary services will ensure care of māmā and pēpi and the development of the Māori services. The clinical leader of Whānau Whakapuawai shared how she can on-support the LMC and Tamariki Ora/ /WellChild referrers into the programme so that they can better support the mental health of birthing parents.

Put alongside the potential for supporting people in the regions to put in place their own version of the Whānau Whakapuawai programme, this begins to look like the Hub and Spoke model that SIPMHS operates and could lead to a **parallel Kaupapa Māori IMMH rōpū** that allows more Māori māmā, and others who want this kind of local service in the regions, to get assistance in spaces that they feel comfortable in. In the end, this begins to highlight benefits that can be reaped if Kaupapa Māori organisations can collaborate and share more around these services.

This work has already begun with the eight Hauora Partners with Kahu Taurima resourcing already starting to plan round how they can work together. One of these entities will be working on a national project rather than local, the current spread looks relatively thin on the West Coast, Central Lakes, Oamaru and South Canterbury areas. For a strong kaupapa Māori Hub and Spoke across Te Waipounamu, this will need to be addressed. We note the current mahi of Te Runanga o Ngāi Tahu and its Whānau as First Navigators programme with 10 entities across its takiwā supporting capacity building and development so they can do more work with whānau. Some of these entities are also in receipt of Kahu Taurima resource. As these entities develop, they will be contributing even more with whānau in their communities.

The idea of supporting a parallel *kaupapa Māori Te Waipounamu Hub and Spoke* recognises the growing expertise associated with supporting Māori whānau in a culturally appropriate way. Kaupapa Māori organisations need to have space and support to develop their models of care that may include choosing and braiding different approaches and understandings of mental health and how it fits with overall health. A parallel network would help organisations to share experience and ideas about what

best supports their clients to heal. While this would be a separate network, it is important that advice and hospital support would still be available for Māori parents at the severe end of the mental health spectrum if it was needed.

We note also that it is not easy to classify services like this that cross all of the rings in Figure 1, and perhaps this is a feature of kaupapa Māori services that are based on models such as *Te Whare Tapa Wha, and Whānau Ora* where there is a *joined up* approach to healing than would seem to not exist in more Western approaches (although please read on to look at how some regions are already working towards using a more joined up approach to support all birthing parents in need of mental health assistance).

Build Relationships with At Risk Māmā Early

Service providers, particularly those working with māmā with more complex issues after the baby is born, said it is useful to build relationships with at-risk mothers before the baby is born. An agency that runs a new kaupapa Māori Mental Health Service talked about this and noted that they had approached LMCs to find a way of doing this.

This long-term building of relationships contrasts with the model of care that is common in health services in general where a patient enters the system and leaves it again after an intervention. Brief interventions can work for some caregivers who, for example, might see a counsellor for a few sessions as part of a brief intervention to help them adjust. Other women may have more complex and ongoing needs for support.

Pasifika Focused Services

Pacific communities are not homogeneous and see themselves as a range of communities. They are spread around the South Island in relatively small numbers which makes it challenging to provide services. Respondents noted that the immigration status of some Pasifika people has big impacts on the availability of healthcare and mental healthcare

South Island Pasifika providers are well connected to each other and there is a South Island Director of Pacific Health who meets with them frequently. We note that Oamaru, Dunedin and Invercargill providers have formed a Southern Collective that has an MOU with Wellsouth. Most of these organisations do not specifically provide IMMH services. Some of these organisations expressed interest in developing services for the first 1000 days but this will need more capacity. Many of these providers also deliver outreach services which are an important touchstone for wider support.

E Tu Pasifika in Ōtautahi has a multidisciplinary general practice with a specialist infant paediatrician working two days a week.

Antenatal Education

Pregnancy and Parental Education is prescribed by Te Whatu Ora and contracted to external (NGO) organisations.

According to Research NZ 2023, 37 percent of their respondents reported having attended antenatal classes; a higher level of attendance than in 2014 (34%). Another two percent went to one or two classes, but did not complete the whole course, while 61% did not go at all. Māori, Pasifika, young, and disabled mothers and birthing parents were significantly less likely to have attended.[17]

Respondents noted that many pregnant māmā do not go to these classes. They advocated for changing what it contains to incorporate more about what happens after the birth of a child and the needs of the child. Kaupapa Māori entities spoke of the importance of connection to te ao Māori, traditional birthing practices and the early weeks of parenting. Muka cords, ipu whenua and making mirimiri oil and kawakawa balm is included in haputanga programmes.
A number talked about running alternative classes (not always funded by Te Whatu Ora where they spend time getting to know others in the class and then getting in speakers based on what the expecting parents in the class want to know. This assists whānau to know what is available in their community and respects whānau centrality. People spoke of bringing in a new mum or a new dad to talk about their experiences and what they wished they had known.

One of the main benefits that providers talked about is the connections that new parents make with other new parents which can provide a lot of peer support after the birth of their children. Added to this was the observation that where classes are run over a weekend rather than a series of weeks, expecting parents don't get to know each other as well.

The cost of antenatal classes run by private practitioners is a significant barrier for some. It was noted that where birthing parents can go to the place they are planning to birth, this is advantageous, and this being part of antenatal education or LMC care makes some sense.

There was a strong call for redesign of antenatal education as it exists in many communities, with some curiosity about why providers whose work is focused postnatally have the responsibility to deliver this education. There are some kaupapa Māori initiatives that are well attended, have outstanding feedback from participants yet limited staff capacity means they are struggling to meet demand.

The Level 5, NZ Diploma in Pregnancy, Childbirth and Early Parenting Education is the recommended qualification and there was discussion as to whether this was sufficient education or whether qualified midwives are the most suitable workforce, as some providers are utilising. It was noted that this diploma appears not to have a te ao Māori focus.

[17] Research New Zealand (2023)

The Inner Ring: Peer and Community Support

Peer Support/Lived Experience/ Kaiawhina

The health system loosely comprises an unregulated and regulated workforce. Regulation is under the Health Practitioners Competence Assurance Act.

The unregulated workforce has been part of the mental health services for some time largely known as community support workers. Similarly, the kaiawhina roles in Tamariki Ora/Well Child, Whānau Ora Navigators, and more recently the Covid-19 Vaccinating Health Worker (CVWUS) and kaiawhina roles in maternity wards are not regulated. These roles are supervised by those who are regulated.

The La Leche League Breastfeeding Peer Counsellor Programme (PCP) provides training to build community capacity to help and support mothers. Women graduate from this 24-hour weekly training as Breastfeeding Peer Counsellors. We learnt of a kaupapa Māori breastfeeding peer counsellor programme that is under design in Te Waipounamu.

Unpaid peer support roles sit in the first sphere and include community-based support groups, play groups, breastfeeding support groups and such. Some respondents described the reliance in some communities on individuals who established often quite successful initiatives. However, these initiatives often fell over once that person moved on, once again leaving a gap.

This workforce has gained prominence over the years as especially able to relate to others with shared lived experiences and support connection to the wider community.

Respondents spoke of the value of these roles and the opportunity provided to people who may not have had the opportunity or privilege to succeed in their schooling having a pathway into health sector roles. People working in these non-clinical roles spoke of the training they had undertaken which helped them with aspects of the role like professional boundaries, ethics and self-reflection, as well as gaining insight as to when to bring issues to a clinical practitioner. Conversely, some respondents raised concerns about this workforce's ability to work safely with distressed whānau. Some peer lead initiatives spoke of having a clinical or more experienced person as readily available, and an example of this is a Lactation Consultant running a clinic next door to the breastfeeding support group.

Hei Pa Harakeke: Fostering Service Collaboration in Nelson Marlborough

Some Kaupapa Māori providers provide a range of care and supports that represent activities throughout the three rings of Figure 1 in house, as illustrated by Te Puawaitanga ki Ōtautahi, Awarua Whānau Services and Purapura Whetu Trust in Ōtautahi. Similarly, Table 7 above shows the wide range of supports that are important for assisting and supporting whānau in IMMH specialist services. However, the current wider health ecosystem does not lend itself well to this joined up approach.

Health providers, with some cross sector partners, in Nelson Marlborough have put together a strategy[18] to provide more joined up, wrap around services for whānau in distress with an eye to ensuring newborn infants born to these families get the best start possible.

Hei Pā Hārakeke, which comes out of Te Pa Harakeke, is a work in progress in which the newborn infant is put at the centre. They describe the first 1000 days programme as taking:

> *An ecological approach to supporting whānau. It is a whole of system, multi-agency, stepped care programme of work which has a focus on strengthening the infant-caregiver relationship as the 'client'. (p2).*

Principles that stem from this approach are provided in Figure 2 below and are being developed and tested in three localities - Motueka, Victory in Nelson and Wairau/Blenheim.

When these principles are put into practice it is clear that the actual work is about strong working relationships and integration of services throughout the rings of care in Figure 1, something that many respondents pointed out was needed. For instance, an Ōtautahi based paediatrician spoke of the risk to a medically focused approach, which is accessed in the outer ring, when the problem actually needs a different response.

Hei Pa Harakeke seeks to turn around our current state including a commonly held belief that people are sometimes considered hard to reach and reframing this as seeing services as often hard to reach. It seeks to strengthen processes to identify vulnerable children including strong LMC engagement and through coordination to support identified families, it is a system wide approach.

A phased approach to its implementation is described as well as areas for strengthening. This mahi is aligned to the locality approach and PHO employed Care Coordinators play a key role with the service coordination.

Hei Pa Harakeke is a unique initiative in Te Waipounamu and provides an exemplar for other areas.

[18] Te Whatu Ora (2023). Integrated Maternity and Well Child Services. Hei Pa Harakeke Nurturing Care in the First 1000 Days Programme Strategy.

Figure 3: Fundamental principles of Te Pā Harakeke - final report of working group (https://nurturing-care.org/te-pa-harakeke)

Training

A recurring theme through this report is the need for increasing knowledge and skills across the ecosystem of initiatives, services and programmes. For example, a shortage of doctors, nurses and other professionals in different places has made accessing assistance more difficult for many. People in NGOs that once referred people for assistance with mental health issues are now finding that they are "holding" clients for the time they are waiting for an appointment for a more specialist service.

There are a number of training opportunities provided online for people wanting to upskill in infant or maternal mental health. A list of these are provided in Appendix 5.

Someone in a specialist service noted that taking some time out of a clinician's timetable for non-clinical work may actually increase the capacity of the system as a whole.

> *I recently visited two newly established IMH services and one that had been running for a long time [overseas]. The two new ones started off by deciding they would see fewer families, and put 30-40% of their time into providing reflective supervision, consults etc. to health visitors and other non-mental health groups e.g. NGOs working with babies and toddlers, and education and other non-clinical supportive services. The older team did not take this approach – and saw a small number of infants/toddlers in a very intensive way.*
> *I came away with the impression that non-clinical time meant that more community agencies were being upskilled to provide more infant mental health informed care to a wider set of families. There are arguments for and against, but I think when resources are limited, having non direct time to disseminate skills is vital.*

Another respondent added to this, saying that if she could get support from people working in secondary and tertiary services, she could, in turn, support people working in community and primary care in her organisation and in organisations that refer to hers.

Cultural training

Another area where upskilling is important is in providing culturally appropriate and culturally safe services for Māori and other groups. In this case, having more training in services right across the board would seem to be beneficial for improving the Māori use of IMMH secondary and tertiary services.

Sharing Clients as a way of Upskilling

Some respondents discussed the way that they both learn and teach by working jointly with clients. This would imply that while multidisciplinary teams are best for delivering a good service to caregivers and infants, they are also very good for helping to increase the skills and

understanding of team members about different perspectives that contribute to helping people recover and thrive.

Respondents in different parts of the ecosystem talked about the need for a perinatal community of practice across Te Waipounamu as a way to exchange learning and provide support for people working in the regions in particular.

Experiences of Whānau

A lot of feedback is gathered from whānau around New Zealand about the care they receive from health services. Being given routine opportunities for giving feedback can help empower whānau[19] and can contribute to service development and improvement[20] although one might assume that the best empowerment outcomes and outcome for whānau using future services would emerge when there are systematic and effective mechanisms for both and good transparency around how feedback will be, and has been, used.

Respondents mentioned that they feel that such feedback has not been well used and the issues that they raise are often not addressed. We've discussed some of the reasons for this in the *Barriers to Improvement* section below.

Much of the feedback we have comes from surveys completed by groups such as the Maternal Care Action group[21], and Research New Zealand[22] and readers are directed to those documents for the results of surveys of whānau who have had experience with IMMH-related issues and services. Another excellent resource is the Lived Experience Group set up in 2021 by the Child Development Network in the South Island. Their nine motivations for setting up the group provide a good summary of issues that are relevant in the IMMH space as well (see Table 14)

The Birth Afterthoughts Clinic[23] allows women to discuss and ask questions about their birth experience. It emerged from the Women's Health Consumer Advisory Group which will eventually be part of the new Whānau Voice Waitaha service which is aimed at gathering feedback from health consumers.

[19] https://www.mhakpi.health.nz/wp-content/uploads/2023/02/FINAL-whānau-literature-review.pdf
[20] Ihi Research (2023)
[21] Maternal Care Action Group (2022)
[22] Research New Zealand (2023)
[23] https://www.cdhb.health.nz/health-services/birth-afterthoughts-clinic/

Table 14: Key areas of concern identified by the Lived Experience Group, of the Child Development Network

- Marked inconsistencies across the South Island Child Development Services (CDS) in eligibility, what services are offered, volume and types of therapy leading to inequitable outcomes based on postcode. Even larger inequities between the ACC and public disability system.
- Lack of readily available information about CDS in terms of what is available and where to go if you have concerns around your child's development. Likewise, a lack of support resources available that whānau can access prior to being seen by services.
- Long waiting times to get into Paediatric and CDS in a crucially time sensitive period of life with criteria that don't fit the needs of a child with an evolving diagnosis.
- Whānau are getting lost in the system and there is poor dialogue and coordination between different services.
- Need for better support for parents from initial concerns, diagnosis, management, peer support and advocacy. Lack of guidance and support around what financial and wellbeing disability supports are available and advocacy in accessing them.
- Language used to describe our tamariki can be offensive.
- Lack of meaningful accountability for providers that are failing to deliver CDS to an appropriate standard. No national data record to objectively quantify the level of need and level of resources to address that need in each area of the motu to make CDS providers more transparent.
- No real resilience built into the system to help buffer for when there are therapist vacancies. whānau currently simply go without in underserved areas.
- Transitions between services, particularly from CDS into MoE early intervention and school are really difficult.

The issues outlined throughout this report are echoed by networks and organisations outside of Te Whatu Ora. Examples with recommendations for change can be seen by searching for terms such as *lived experience*, *whānau voice.* Many of these also reflect the things our interview respondents stated.

Some observations from this study

We have had access to a number of stories from people who responded to a survey that was run by project leads in the North Island. The South Island Advisory Group decided that the survey would not be run in the South Island because another survey was running around the same time, but 48 of the people who responded to the survey that was sent out through North Island Networks were South Islanders. Some of the responses from this survey can be seen in Appendix 4

The numerical results should be treated with some caution given that the sampling was non-random and also because the people who are able and inclined to answer any self-administered survey are also not random. People who respond to surveys are generally good readers and writers, and motivated to respond. In addition, human beings have a natural negativity bias[24] which, along with the way that mentally unwell people may experience the world, can skew the focus of the people who choose to do the survey. Another issue is that there are a very small

[24] Vaish et al. (2008)

number of responses (48) which is not enough to draw conclusions about the percentage of whānau experiencing the issues that have emerged from the survey. They only provide an indication of what may be going on. Further work would be needed to make any broader inferences. We've provided some of those results in Appendix 4, rather than here, for that reason.

Despite this, the results can tell us more if they are triangulated with information from elsewhere and if they are looked at for the kinds of responses and sometimes the balance of the different responses. This is illustrated by the kinds of responses that the survey elicited with open ended questions. For this reason, a series of responses to open-ended questions in the survey are provided in Table 15 below and more are provided in Appendix 4.

Table 15: What people in the survey said about their experience with Maternal mental distress

Having had a traumatic birth experience, I had a mistrust of medical professionals and fear around attending a clinic as it reminded me of the trauma. I also didn't know where to turn and I did not want to be prescribed medication as my pregnancy was highly medicated and this gave me further health issues. – (Chch, European)
Most of my distress stemmed from how I felt during the birth and about how I 'managed' the birth. My midwife was belittling and bullying during the birth and I felt very ashamed. I felt like I was at fault for 'not coping' during the birth. I didn't realise until my next pregnancy that I had PTSD and I think this was also a huge barrier to seeking help, I didn't want to properly talk about it or think about it. (Christchurch - European)
When my mental health was at its lowest, I wasn't in a space where I could recognise how bad things had become and I didn't have contact with support services that might have picked up on my anxiety and other mental health issues. I did get a referral from my gp for brief intervention counselling, however the person who contacted me was rude and made me feel uncomfortable, leading to a panic attack on the phone. I told them to forget about the appointment, and I was "discharged" from the service without receiving any help. I also didn't realise the post-partum services that were available and when I did learn about them I was outside the dates and no longer eligible. (Dunedin, European Māori)
I would have liked additional support after leaving nicu, had a 10 week stay in nicu after a traumatic pregnancy and loss of a twin and had access to support while baby was in nicu but after we left there was nothing. I had no support or contact with any service or GP after I was discharged. Better access to services, struggled to find someone privately and when I did, they are very expensive (Dunedin Māori/ European)
I tried to access MH services but my referral from over a year ago is still not processed yet. I tried to go private as I have insurance and there was no space for any psychology or psychiatry help specific with PPD and/or PPA. Believe me I tried and tried (Christchurch, NZ European)
Knowing they were there was helpful, however no one truly understands how debilitating HG is and the limited access to disability payments from WINZ is disgusting (HG sufferer, young, single European)
We used our midwife for support when pregnant. I was referred to maternal mental health services but the wait was upwards of 4 months We would have used maternal mental health services if the wait wasn't so long (Dunedin European)

Did not feel supported by the option most offered to me (ie Plunket). Had a bad experience with them with my first child, neutral with second. A second factor is understanding - despite all the information readily available and provided, I did not understand I was struggling until after the fact. (Christchurch European/ American)

It was a pride thing everyone I knew just flew through parenthood or so it seemed and I felt like I was failing already. This stuff isn't talked about before, during or after pregnancy and it should be so more people can reach out instead of being me and just trying to stick it out (European/ Māori Dunedin)

Much more effort is involved in writing answers to open-ended questions than to questions with tick-the-box options. Many people just don't answer these questions because they don't have the capacity or time to write what they want to say or they might not have things they want to say in their mind at the time they complete the survey. This also means we cannot infer how much of the population had these experiences from the numbers of responses to these questions, but we may get comments that help us understand the experiences of people. The following is a discussion of some of the things we can say about the experiences of South Island whānau.

Finding Help

A first observation is that there are positive responses that show that the people who filled in the survey got some help from someone that made a positive difference to their experience. A sizable proportion of people write positively about talking with a counsellor, while others found Plunket's Perinatal Attachment Programme worthwhile, and still others write positively about the midwife or GP.

It is also clear that some people have struggled and sometimes failed to access services and have got through with extra support from family and community. Friends and family are important supports for new parents. This also implies that new parents without those local connections are likely to be having a more difficult time. Four people in this tiny survey said that they had no access to this kind of support and even if this figure is high, it potentially still indicates that many new parents will be facing similar circumstances throughout the South Island. This is particularly important given our very high immigration levels at the moment and will be most important in places where there are a lot of new immigrants.

One or two of the responses reflect on how difficult people can find it to initiate and or carry through the process of finding help. There may be a number of reasons for this, based on the data in the survey.

- The more unwell a māmā is, the harder it will be to navigate finding help, and the more she needs support from others to assist her with getting help.
- Some people were able to put in the effort but still failed to get help for their perinatal mental health problems because of a lack of people able to work in the perinatal mental health space.

- A significant group of māmā noted that they did not recognise that they needed help at the time they were ill. For first time parents it can be hard to judge their situation since they have nothing to measure it against in their experience.
- Some respondents said they needed someone they could trust to talk about what they were experiencing and if they don't find that person, that may also stop them from trying to find help.
- One respondent talked about feeling better about talking to someone she didn't know indicating that close family or friends may not always be the most comfortable first option.

The reality is that all the people in this survey *did* find some form of help, however research outside of New Zealand suggests that most people suffering perinatal mental health issues actually go undiagnosed[25].

Likewise the CAF Under 5s team in Christchurch expressed concern that it is likely that there is a very significant gap in what is being provided and what is needed and that potentially there are many whānau out there who would benefit from help but are not getting it because the services are not there and or the way into them is difficult.

Routine screening, both prenatal and postnatal, and the conversations to go with that screening, could help to address many of the issues highlighted above, particularly if primary and secondary maternity services are better integrated with each other and with mental health secondary services.

Issues with Services

A significant number of women had difficult experiences with a range of services - both medical services and mental health services. Sometimes these problems stem from a lack of integration between services.

Traumatic birth experiences can have significant effects on women and on the way they want to interact with services after that. A lack of debriefing after such experiences also makes it harder for women to recognise what has happened and to recover. The Birth Afterthoughts Clinic is a good initiative that gives women a chance to ask questions, speak of their experience and potentially to help improve the system. The same goes for traumatic pregnancy experiences as described particularly in this survey by women suffering from issues such as *hyperemesis gravidarum*. Women with disabilities are also more likely to have problems with their pregnancy and may need extra support, both mentally and physically.

Different services may suit different people. For example, for some people, a brief intervention may be all that they need or want to help them adapt and adjust to new circumstances. For others, ongoing support and connection to services is desirable until they are confident to leave on their own terms. Women can quite often end up in a service that doesn't match well with their

[25] Manso-Córdoba et al (2020)

needs or preferences perhaps because what they need is not available in their area, or perhaps because their primary provider isn't aware of differences between services.

Barriers to Māmā Seeking Mental Health Assistance

The way health services are currently set up can make it difficult for whānau to trust service providers enough to disclose mental health problems. Mothers may not have a relationship with a general practitioner, for example. In addition, doctors are limited to 15 minute appointments which may not provide enough time for a māmā to disclose mental health issues, even if she is prepared to do so. One practice manager talked about a *continuum of caring* and said that his practice had provided longer appointments and as a result of that, they have to find significant additional funding.

Mothers struggling with their mental health may also be living in situations that make them reluctant to disclose their problems with anyone. For example, a respondent talked about a woman who did not want to get mental health assistance because she was worried that her estranged partner would use it against her in a custody battle. Others were worried about how Oranga Tamariki would view them if they admitted to mental health problems while still others did not want to disclose their problems because of their immigration status.

Co Design

Co-design[26] is a term that we heard often through this study. Designing and adjusting services with whānau provides a highly effective way of getting constructive feedback and finding ideas for improving services, and putting them into action. As shown by the Whānau Whakapuawai programme, co-design can be used very effectively to shape a programme from inception onwards. Not only does it make for an excellent programme, it can also help build empowerment for communities that often feel disempowered.

Another strength of co-design processes is that they help people consider lines of action and discuss problems within the bounds of the possible, which perhaps counterintuitively, can lead to innovation and creativity in the way things are done.

The Kia Kotahi Partnership in Design framework was developed by the Canterbury Clinical Network and has recently been used to gain feedback on the operation of the soon-to-be-opened Christchurch central city primary birthing unit.

Barriers to Improving Services

It is clear from interviews, and from the stories we have heard from whānau directly or indirectly that it is easy to blame individuals when things go wrong. Of course, human beings are part of

[26] https://ccn.health.nz/About-us/Kia-Kotahi-Partnership-in-Design

the problems being experienced by health consumers. They have bad days, get frustrated, make mistakes, may judge others too quickly, or may not always have the skills that they need for every situation. And in this setting, they may be dealing with clients who have a similar set of fallibilities and who are definitely having a bad time. However, it is also clear, as many many of our respondents have pointed out, the system also contributes to perverse outcomes and can set individuals up to fail despite their best efforts.

Changing human beings is complex. Changing systems is more so. Thus far the most reliable way to change a system positively is to keep gathering feedback from all concerned and keep experimenting with change based on best guesses as to what might work.

The health providers we spoke to value the input of whānau voices and want to see their services improve the experiences of whānau and create the outcomes that everyone wants - healthy, happy, well-functioning whānau, māmā and tamariki. New role/s in the health system have a focus on whānau voice which many feel will be helpful. However as one person said, *We don't have routine mechanisms to get feedback from service users/consumers included in a continuous improvement cycle.*

Current practices may be difficult to change in the face of regulations, funding or process requirements put in place for a range of reasons, and by processes that the different health bodies use to procure and assess services and service providers. For change to happen, action may be needed from people working beyond the frontline service providers.

Table 16: Barriers to change highlighted by respondents

- Current funding can make it difficult to provide the sort of services they'd like to provide, whether because the funding provided limits the time they can put into each client or because of prescribed service requirements that don't appear to meet the needs of their clients.
- Some community providers wanted to have the flexibility to meet the needs of the clients in front of them. However, this means they may not be paid for their work which limits their capacity to serve those clients.
- A respondent talked about feeling pressured by the *long line of babies outside the door* and feeling that she doesn't really have time to stop and think about doing things differently because that line would only get longer. When everyone has *babies waiting at the door*, organising a meeting and taking the time to think through how to implement a change can seem less immediately important.
- The competitive nature of funding: As one respondent put it, *There is a bun fight for funding,* which affects the way in which organisations collaborate and share information.
- Others talked about a shortage of people to deliver services. Many rural areas are struggling to recruit doctors, counsellors and specialists. This means that either the services don't exist at all, or people can't get into them because of long waiting lists. This increases stress on the people who are trying to deliver quality services, making it more likely that they will make mistakes.

Providing Quality Services in Rural Areas

As observed earlier, the South Island presents challenges for the delivery of IMMH services. These services often need input from a team of people who can work with both māmā and pēpi. Demand for these services in rural areas can be relatively small but when a mother becomes ill she and her child need urgent care. This means that people with training in maternal and/ or Infant mental health will probably also be working in general adult mental health or child and adolescent services.

The approach some respondents talked about was one of having staff who are generalists working in a service classed as *rural generalist.* As a result, staff often don't have specific skills related to infant and maternal mental health (amongst other aspects of mental health). A rural nurse noted that she has no-one to refer at-risk infants to in her area because there has been no-one with that kind of expertise there since their local expert left the area.

Another said:

> *It is important to have a 'minimum' level of specialist clinical expertise in regions - with extent determined by birth population and geographical size. It is really important that specialist clinicians in this area have protected time for this clinical work - both infants, toddlers and mothers will lose out in the general adult / CAMS service if service delivery is by clinicians who also carry other caseloads.*

An IMH specialist commented that being a lone professional can be difficult. She had found it difficult advocating for resources particularly where nobody else in discussions about resourcing understood the importance of keeping infant wellbeing central to maternal mental health services. Even more to the point being a lone staff member can be a lonely endeavour and if a lone staff member gets sick, goes on leave or leaves the job, there will be a significant gap in expertise for that area.

Options for Providing Rural Services

A South Canterbury informant discussed the idea of a mobile clinic that allows some face-to-face services for caregivers to be spread around the region, rather than asking clients to come into offices or premises far from home or that clients may find uncomfortable.

Staff in SIPMHS in Christchurch talked about providing support for people in the regions by using online forums for counselling/ advice. These may also take the form of sharing a client with local services so that the local service can learn more and provide local, face to face support and possibly also access to the internet for people who don't have it themselves. This approach also makes it easier for a small number of staff to provide services across a very wide area - more than they can if they actually travel to an area. It is also a model of care that has been used in the USA.

Some staff based in Christchurch also provided services by travelling to a region such as the West Coast for a day or two a week.

One option that people had recommended to some of their clients was an online workshop hosted by the Christchurch based Mental Health Education and Resource Centre (MHERC) called *Connecting through Motherhood.*[27]

A manager on the West Coast, reflecting on the issues of having all the IMMH expertise embodied in one person said:

> *If we got one FTE for maternal and Infant MH, we would split this speciality across our three localities, so three people have this knowledge and they form a community of practice, and back fill each other when on leave, if one resigns then we have two others. It is too risky when expertise sits with one person. Spreading the case load across all, helps people not to work out of scope/ drift as a result of isolation etc.*

Self-Referral directly to a Health Improvement Practitioner (HIP) could be helpful in a stretched general practice and HIP availability for those who are not enrolled would enhance access. Overall, there are multiple different ways in which services may be delivered and it may be useful to use a codesign approach to delivering rural services too, because there may be more good options out there.

Wharekauri/Chatham Islands - A Special Rural Area

Wharekauri/ Chatham Islands has a population of 730. Recently the number of pregnant families has increased; currently there are about 16. Pitt Island is more isolated and currently has about 40 people with 14 children aged 0-10, five of whom are under 5 years old.

The LMC providing care for hāpū māmā travels from Wellington every two to three weeks. If women choose to give birth on the Island, a second LMC needs to be arranged, or if the locum doctor at the health centre has obstetrics training, they can be the second person present for the birth. Most women give birth off the Island, and the LMC supports them to find midwifery and postnatal care wherever they choose to give birth in New Zealand. Māmā may go to Wellington where they are supported by the same LMC. More commonly, Christchurch is chosen as the place of birth.

Tamariki Ora /Well Child care is provided by a nurse who flies in from Christchurch three or four times per year, she typically works from the school. Whānau can contact her via Messenger between visits and if they are in Christchurch at any time. A Christchurch based Paediatrician visits the island twice a year and works out of the Waitangi based Health Centre when she is on island. The Well Child RN and the paediatrician maintain good links.

[27] https://mherc.org.nz/talktime/view-all-groups

As with any rural area, the viability of the use of telehealth must be considered. Well Child checks include physical assessments of the pēpi, so telehealth is likely not that suitable for the delivery of the Well Child Schedule. The Schedule has five checks in the first year after a baby's birth, suggesting there needs to be that number of visits to the island each year by the Well Child Nurse.One respondent suggested that to address this small number of visits and to enable some use of telehealth a permanent part time Well Child Kaiawhina role on island would support whānau wellbeing. The Kaiawhina could work under the guidance of the Christchurch based registered nurse.

Having a Kaiawhina role permanently on the Island could provide on hand, non-clinical support across the pregnancy and for the early days, weeks and years of growth and development. New mums in Wharekauri provided feedback to a haputanga facilitator who flew in from Christchurch to deliver some sessions. They indicated they would like to have someone on island who can weigh their baby so they can be sure/reassured the baby is growing appropriately and meeting milestones. This could be done with the Kaiawhina and the whānau working with the Well Child nurse via telehealth.

A Whānau Ora Navigator with Ngāti Mutunga o Wharekauri Iwi Trust regularly provides parenting courses, the new Kaiawhina would logically work closely with this Navigator. One former Chatham Islander said building on-island capability is more likely to develop local wellbeing, rather than relying on outside people. This person also noted that typically people who leave the island to undertake clinical type training do not return.

Eligibility and Referrals

One of the people in our survey said that her primary provider didn't put her referral in until months after she had asked for help. There may be other circumstances around this application but this comment also sits alongside the comment from the SIPMH Community Team that their service gets an average 33 referrals per month and about one third of these are declined because they do not meet the severity threshold and/or *there is insufficient information in the referral.* We also note a comment from a GP about having to be careful about how she filled in referral forms and how she framed things so that her patients could access services in her area. Clearly, then there is room for more clarity around eligibility and possibly also some way in which Doctors and other referees might have access to someone they can get advice from when making a referral or perhaps after a referral is turned down. (See the section on eligibility below).

The concept of eligibility is largely provider driven and put in place as a means of defining the scope of services or ensuring that services are provided to those who most need them. However, eligibility is not a straightforward concept. It requires a series of individual judgements; at least one made about a client's condition by someone in primary care and another by the receiving service based on the advocacy and quality of the referral that the primary care person provides for their client. Some patients may only access secondary services after a series of

referrals – for example someone may go from LMC to NGO to GP to HIP and then to secondary services. Each step may be subject to language and context differences in interpretation and may depend on the knowledge of the referrer about the language and context of the person receiving the referral. Respondents also mentioned that the sheer amount of time a referral can take may mean people *fall through the cracks.*

Some respondents suggested that screening can help with these kinds of problems. This could help two people who don't know each other to be able to share some common ways of measuring severity. However, as we have already mentioned, the accuracy of these tools may be affected by the language and culture of the client, as well as by the threats that a patient perceives if they tell the truth about their condition.

There are many places for variation to come into judging eligibility and for people to *fall through the cracks.* In fact, these are the perfect conditions for what Kahneman calls *noise.*[28] Research around the concept shows that different people at different times might arrive at widely different decisions because of small differences in the way they interpret and prioritise information. This problem would be lessened if the concepts of Te Pa Harakeke are used and providers from different services who know the client and each other can discuss options and priorities for a client. This work provides a means to *even out* the noise in any given situation.

From another angle, the concept of eligibility sets up expectations of the availability of a service. The reality is that patients are triaged because there are not enough services to go around all those who are eligible. Interviewees and survey respondents alike spoke of waiting times to get into secondary services. For those who can afford to pay, access to private services may be considerably quicker and easier and may provide a solution to this issue in some areas if the expertise in maternal and infant mental health is available privately and easily found. Some respondents in our survey found they were not available or findable, even in reasonably large cities.

Yet another angle on this is that there is a tacit assumption that all whānau want to access secondary services even if they could. However, interviewees pointed out that some choose not to go that route. Therefore, alongside the concept of eligibility is the concept of choice - whānau will vary in their preferences for using different kinds of services and may choose different options at different times depending on their previous experiences and current understandings of their needs and options.

These observations raise questions about how and where services are delivered and by whom and whether there are different ways that could be developed to provide choice, provide more effective care and prevent unnecessary damage to the wellbeing of the next generation. An example is the already developing network of kaupapa Māori organisations that are working to develop new kinds of Infant and Maternal Mental Health programmes. Another is the increasing number of services provided in primary care organisations including general practice which could

[28] Kahneman, D,Sibony, O. and Sunstein, C.R. (2021) Noise: a flaw in human judgement. : Little, Brown Spark, New York

be encouraged and supported. This would almost certainly assist with getting help to the (potentially many) whānau who are not accessing services but who might benefit from them, as discussed earlier in this report.

Importance of Good Working Relationships GPs and LMCs

Both midwives and people working in general practice mentioned that having more access to each other in managing a patient experiencing mental health problems would improve their capacity to care for the patient. This is particularly the case now that in many places, particularly rural areas, it can be difficult for a patient to see a doctor. There are a number of potential outcomes from a shortage of GPs. First a midwife may not refer a patient to a doctor because they can't get them in, or a patient may give up trying to get in or may choose not to even try.

Some patients are also unable to afford to visit a doctor partly because of the way funding works. Without a visit to the doctor, they may not be referred into secondary services. This lack of referrals between services will obfuscate the real needs in a community. In addition, there is a problem when a lack of referrals is used as an argument for not providing further FTEs into services.

Delays Because of Access Pathways

An interviewee working in an NGO talked about a previous approach where a hospital paediatrician would ring when an issue arose, and she would immediately visit the mother while she was still in hospital to begin to build the relationship. However, she said that now there is an access pathway which extends the time it takes for the caregiver to connect with the service, which in turn, delays getting help for the pēpi at a critical time.

Providers also told us that good relationships with each other can increase their capacity to access assistance for their clients, or to find other appropriate community services that can support a māmā and her pēpi. This is also important because clients can enter the system at many different points and need to be able to access different levels of assistance as they need them. This illustrates the point that a whānau centred continuum of care is non-linear. Health practitioners are working within an ecosystem - an interrelated web of relationships.

Using a "Common Language"

Different people in the ecosystem are using the terms *mild, moderate, severe* in different ways to mean slightly different things.

A manager who was a nurse working in this field commented that using screening tools is a good way to increase the quality of communications between herself and the GPs she supports her client to access. This minimises confusion about the seriousness of the problem her client is

facing and provides the doctor with information they can use when assessing a patient, providing treatment and referring through to any further services.

Transitions between services need care. Handovers between services can be critical points in the care of a māmā. One example provided was someone discharged from hospital care but whose GP was not notified of their discharge. Mothers may need ongoing support as they move through their recovery. Service to service conversations such as those facilitated by Hei Pa Harakeke in Motueka can assist with providing relevant support as needed.

Getting Help Quickly

For some mothers, mental health may deteriorate quickly and seriously after the birth of their child and for them getting access to the help that they need when they need it is important for the wellbeing of them and their child. Crisis mental health services are well established in the regions, however some informants noted that people working in adult mental health services may not understand the importance of the relationship between a caregiver and their baby. Where crisis services have staff with a particular interest and/ or experience in perinatal mental health, connections to specialist infant and maternal mental health services and personnel are stronger.

Building Strong Teams

Relationships and teamwork between providers is also important. The way funding for the care of pregnant māmā works, it is possible that the first time the practice sees new parents can be when they bring their baby in for their six-week immunisations (if they do).

As a respondent put it:

> *The current way we approach pregnancy is that women's health care becomes provision of an LMC for about 6 months and then she pops out the other end. This is not collaborative, not whānau focused, and does not allow wider professionals to be involved during pregnancy.*
> *Primary Care organisations have said they are shut out of pregnancy and then reengaging 6 weeks post-partum and using the infant 6 week check to do maternal mental health check, because they don't get any funding for this. This means they are gobbling up the infant's time to start looking at the mum.*
> *This is crazy! I know midwives are desperate to get assistance for māmā – lack of resources can be a reason. But there are systemic things that are not allowing midwives, general practice, and mental health teams to work together. It's not just availability it's the whole way the funding model is set up. It does not acknowledge that this work needs to be done hand in hand.*

Summary and Conclusions

This report, and many others like it, highlight the importance of quality and timely infant and maternal mental healthcare. Infant and maternal mental health needs need priority since early and prompt interventions will have a significant return on investment over the lifetime of that infant and their whānau. In addition, early interventions can prevent an escalation in distress and the many personal and social costs that go with that.

We note the importance of people with disability, the Rainbow community, along with cultural communities such as Pasifika and Asian. Given the lack of secondary services available at all around Te Waipounamu, we have focused on getting a good baseline of services from which to build in future for minority groups with more specific needs.

In particular, infant mental health services are severely lacking across much of Te Waipounamu and where they currently exist, in Christchurch and Nelson, there is a need for more in both the primary/NGO, and secondary sectors. Research from around the world and in New Zealand indicates that many whānau who would benefit from assistance are simply not getting into services, and many of those are not being diagnosed and referred. Even then services are not keeping up with demand.

Most areas have people with an interest and a passion for infant and maternal mental health, and they provide what services they can, however their services are not ringfenced and therefore may regularly add to already heavy workloads. This is not ideal, since without dedicated resources any local and/or individual responses are extremely vulnerable. It should be a matter of national policy that all regions have dedicated resources for infant and maternal mental health services.

While existing secondary services have the expertise to support the development of the sector, they need to be resourced to extend their work to include a larger percentage of education, supervision (as reflective practice), and consultations. Maternal Mental Health, too, is lacking and it seems that māmā and pēpi may not get help because their distress involves a range of factors, including those who have been seen previously by mental health and addiction services.

Researchers have highlighted, as has our survey, that whānau may have difficulty in assessing their own mental health and may not think that their struggles merit attention – particularly if those around them put those struggles down to normal adjustments at a time of significant change. There is a clear need for routine screening by primary maternity providers and perhaps general practices to capture the true numbers of whānau dealing with mental distress. Possibly also, this could be extended to partners as well. At the same time routine screening is likely to uncover a significantly greater need for services around the motu so steps must be taken to increase the timely availability of services.

For those that do request assistance it appears that access to services may vary based on how well a referee advocates for a patient using the referral process. GPs, who are most commonly charged with doing referrals, may not have a lot of mental health training, which puts them at a disadvantage when filling in the referral forms. The referral process will also be subject to variations in how people assess the referral. Finding ways to minimise these variations seems important.

Currently few services have clear, publicly available eligibility criteria, and even when they do, eligibility takes second place to availability and as outlined above may be affected by the chain of referrals, so people may be eligible for a service but still may not get access.

There is a shortage of people to fill existing mental health staff positions in Te Whatu Ora especially in smaller centres. This leaves people in NGOs and primary health with nowhere to go for help and hence many of them are having to manage the needs that they see. While the gaps are unlikely to be filled quickly, it seems important to support those working with struggling whānau, to upskill them and to support them with access to consultations, networks or telehealth options so that they are not working alone in situations that feel well beyond their capacity to manage. Existing secondary services in Christchurch are able to assist with this kind of support and need resourcing with extra non-clinical time to provide that.

Kaupapa Māori organisations are building their capacity and capability in this area and are working to develop programmes that braid cultural and clinical approaches. Currently the one programme that has been piloted focuses mostly on maternal mental health but they are actively working to consider the mental health of pēpi in their care as well. It is good to see plans made by other providers to trial a similar programme structure for their whānau.

SIPMHS, in Christchurch, is working hard to provide equitable access for whānau across Te Waipounamu. However, there is still work to be done. It may be that the lack of secondary IMMH services in old DHB areas is part of this picture and that with better secondary services across the motu, referrals into SIPMHS from smaller centres would increase in quality and quantity. Potentially the service may face a growth in demand as assessment skills and accessibility to secondary services increases.

Teams, collaboration and local and regional networks are a useful way for many of the gaps described in this report to be filled. Working in teams is a good way to smooth out the differences in care that pēpi and their caregivers receive on one hand, and a good way to provide the kind of variation in care the pēpi and their caregivers may need, on the other. A team approach helps with upskilling individuals in the team as they assess and work with different clients, will provide a way to help even out the *referee lottery* and ensure that patients get fair consideration for entry into secondary services, and will help with smoothing out the handovers needed as clients recover their mental health and come to rely more on the primary/NGO sector. Funding put into helping people collaborate better is likely to be a good return on investment as families get the joined-up care that they need and feel comfortable with.

Recommendations

Build a Greater Understanding of the Importance of Infant and Maternal Mental Health

Everyone who may provide services (health, mental health, housing, income support etc) for whānau during the perinatal period needs to **understand how brain development in infants can be affected** by the wellbeing of their hapu māmā in the last months of pregnancy and by the quality of relationships in the first months of life. Healthy brain development needs māmā to be well supported through their pregnancies mentally as well as physically and for pēpi to be supported to form a strong attachment with their caregivers. Without this, a pēpi may suffer lifelong problems with their mental health and overall wellbeing. **Investing in supporting whānau during this time will deliver a significant return on investment over the life of a newborn.**

Develop a health promotion campaign to build the understanding of everyone with a stake in this area about the importance of attention in the early months of a pēpi's life and the different issues that might affect a whānau's capacity to attend to their infant.

Steps to Improve Services

Ensure that **all Te Waipounamu communities have specific infant and maternal mental health service providers** across secondary, primary/NGO and community services and initiatives as a matter of course (i.e. as part of national policy and strategy). Within that, there is room for some variation between areas on the form that services take, so that communities have a range of options that suit their various needs.

Ensure all women are routinely screened to assess their mental health, prenatally and postnatally as part of perinatal care services.

Consistently ensure that **any patient that presents with mental health issues during the perinatal period (even those with complex histories and needs) is provided with treatment relevant to their perinatal status** and which includes their pēpi. This is a matter of prioritising a whānau, or individual, based on their perinatal status as opposed to their status as a drug user, for example and may require some upskilling of the entire secondary mental health workforce to achieve.

Foster collaboration and better working relations across community, primary and secondary services by:

- Prioritising the adoption of Te Pā Harakeke across the motu, as cited in Te Waipounamu Health and Wellbeing Plan 2024 – 2027, to ensure this pēpi centred framework is

comprehensively applied in health and other sectors, as an important model for improving infant development and mental health.
- Adjusting commissioning practice to specify collaboration between and within the secondary, primary and community system components of Infant and Maternal Mental Health services.

Provide more infant mental health information on the Healthpathways websites and clearer information for referring perinatal whānau to secondary mental health services and consistent information about the SIPMH service to all Healthpathway sites across the South Island.

Improve consistency around how clients are accepted into secondary services by **funding some administrative time to assist referrers to manage the paperwork** associated with a referral and encouraging and funding greater collaboration between services through the rings.

Embed a range of options for whānau to access specific infant and maternal mental health services. This may need some experimentation and adaptation and includes Individual telehealth, group telehealth, group telehealth with support from local on the ground NGO staff, upskilling NGO staff to deliver more effective services including infant mental health services.

Embed trauma-informed approaches that seek to understand what has happened to a person and their whānau in all infant and maternal mental health services to address the health disparities created by exposure to traumatic events.

Maintain local online directories of IMMH related services and facilities, both public and private, and make these accessible to the general public as well as to people working in IMMH services.

Strengthen the Spokes

In Te Waipounamu, **strengthen the "spokes"** in the hub and spoke model used by current IMMH secondary services by:

Increasing the number of people with expertise in infant mental health across Te Waipounamu. This will need a concomitant increase in those with expertise in maternal mental health.

Resourcing capacity and capability building for the community, primary and secondary sector organisations and individuals who provide some aspect of infant and maternal mental health. This can be achieved through telehealth consults, in person seminars, sharing of clients, webinars, or through papers at professional conferences. People in secondary services in Christchurch can provide these options and need to be resourced with additional non-clinical time to support that.

Resourcing staff across all sectors to take advantage of training opportunities provided online and listed in the accompanying document. Providers will also need to be resourced to attend training and upskilling opportunities.

Establish an **evaluation framework and collect data** to track both training and development of services across Te Waipounamu to plug current gaps in understanding of how effective services and training are.

Resourcing local organisations that provide respected key initiatives. Examples are Perinatal Wellbeing in Christchurch; Central Lakes Family Service in Queenstown; Whare Manaaki in Greymouth; Whānau Awhina/Plunket with its PPAIRS and PPNAP services.

Establishing and coordinating a Te Waipounamu-wide network of all providers working in IMMH services through which mutual support, capacity building, sharing of experience, innovation and ongoing service improvement can occur.

Establishing and providing coordination for **a parallel but connected network of Kaupapa Māori providers of IMMH services** and support to foster mutual support, capacity and capability building, sharing of experience, and innovation and ongoing service improvement in this sector.

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Appendix 1: Project Descriptor

Infant and Maternal Mental Health services scan

The project is to undertake an environmental scan of all infant and maternal mental health services across Te Waipounamu. The purpose of which is to:

- *Understand the existing continuum of care for infant and maternal mental health services across Te Waipounamu including* services delivered by Te Whatu Ora, by Iwi/Māori, and NGOs
- *Identification of any variation in models of service delivery/care, levels of service delivery, eligibility criteria – 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 addiction 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 Kahu Taurima on current pathways between current maternal and child health services and between specialist infant and maternal mental health services. This includes reviewing current referral criteria from maternal and child health services for all specialist MMH services to ensure consistency and ensure specialist services provide consult liaison services to well child and maternity services.*

It is important that lived experience and whānau perspective are included in this environmental scan, as well as a focus on access to specialist infant and maternal mental health services for Māori and other priority populations e.g., Pacific Peoples, Asian, rainbow and people with disabilities.

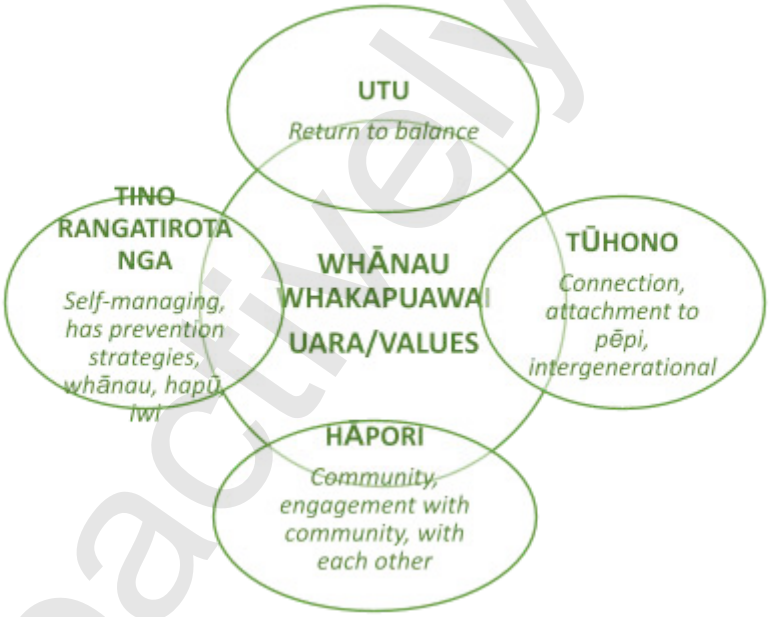
Appendix 2: Outline of Whānau Whakapuawai

Whānau Whakapuawai – Hauora māmā - Perinatal Wellbeing service Model of Care

Whānau Whakapuawai was established by Te Puawaitanga ki Ōtautahi Trust to meet the increasing demand for services addressing perinatal mental health distress experienced by whānau in Waitaha, Canterbury. Initially a pilot, this service is informed by both Mātauranga Māori and Western clinical approaches.
Whānau Whakapuawai was designed and developed to be a whānau-centred service. At it's inception, a consultation hui was held with whānau and it was their voices and perspectives that informed the design and priorities of this programme:

- **Uara | Values**

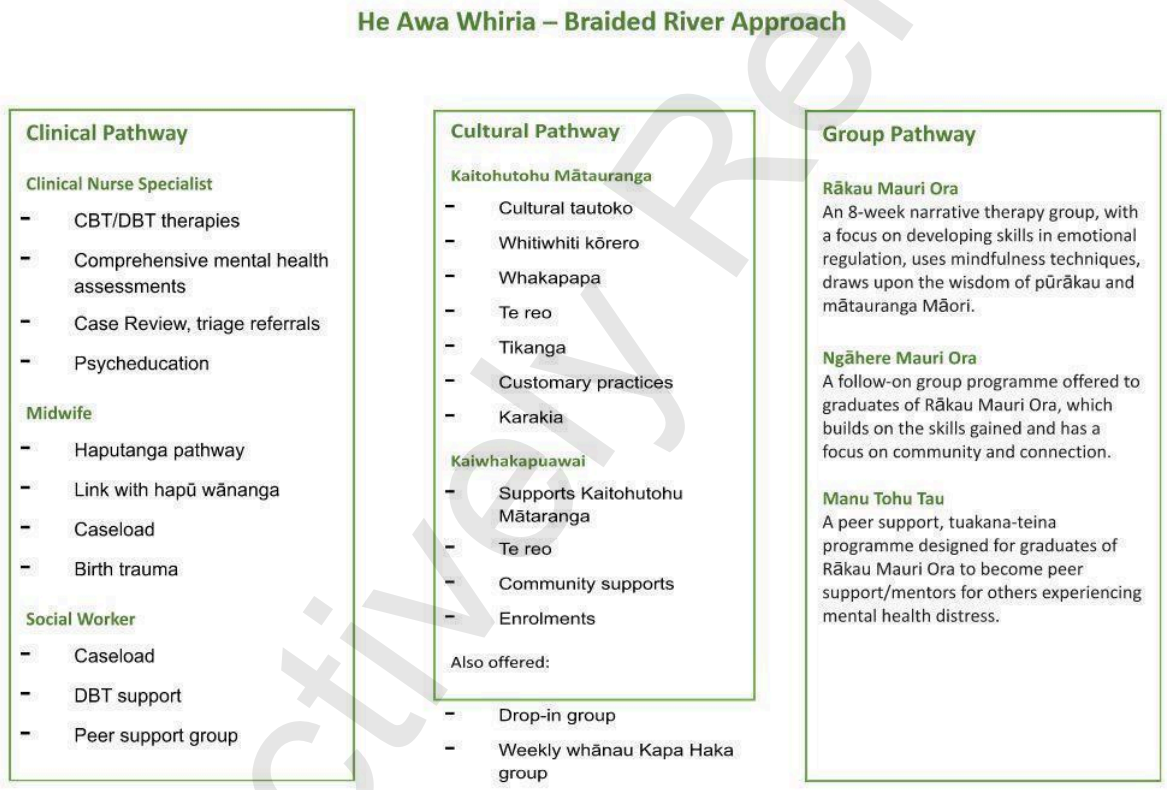
The uara that underpin and guide the programme were described clearly by whānau as their priorities for the outcomes they wanted to support them to achieve their aspirations.



- **He Awa Whiria – A Braided River Approach**

The programme provides holistic healing for māmā and birthing parents who are experiencing distress or illness during the first 2,000 days of their infant's life. Whānau were clear that they wanted a service that could offer both cultural and clinical support. Cultural support to support connection, strengthen identity and acknowledge the importance of te taha wairua. Whānau also wanted access to best practice for clinical support, alongside education around illness and medications. The service is therefore designed to provide a 'braided river approach', integrating Mātauranga Māori with elements of Cognitive Behavioural Therapy and Dialectical Behavioural Therapy.

The Whānau Whakapuawai team have been purposefully chosen to provide a multi-disciplinary approach and wrap around support for whānau:



The group pathway has developed to provide a continuum for māmā and birthing parents, This supports whānau to remain in the Whānau Whakapuawai programme for as long as they wish / need, and maintain the community and relationships they have built – supporting ongoing connection. Manu Tohu Tau provides further opportunity to develop skills and train to become peer support workers. Graduates of Manu Tohu Tau realise their individual tino rangatiratanga enabling support for new whānau entering Rākau Mauri or requiring support in the community. The reciprocity and manaakitanga displayed by whānau at this stage is a clear indicator of wellness. This pathway is an intervention that is naturally sustainable intervention. Whānau who have progressed through the program have the confidence to collectively find their own

solutions to inevitable crisis and wobbles, knowing that whānau Whakapuawai rōpū are still a korowai (safety net) around them.

- **Korowai of supports**

Whānau Whakapuawai has continued to be responsive to the feedback of whānau and has developed referral pathways and relationships to meet the needs and aspirations identified by whānau:

- ACC: Te Puawaitanga ki Ōtautahi is now an ACC supplier for sensitive claims, providing a direct pathway to known providers of ACC sensitive claims therapy
- Clinical Psychologists – we have a direct referral pathway to experienced clinical psychologists who provide long-term therapy to whānau with more complex needs
- Rongoā Practitioner – direct referral to our Rongoa Practitioners to further support whānau
- Supports for kaimahi within the team include regular clinical and cultural supervision, and support for professional development. Weekly team hui and twice yearly reflection and planning wānanga support and maintain connection within the team.

- **Relationships**

Crucial to the sustainability of the programme and ensuring that aspirations of whānau are met are the relationships Whānau Whakapuawai have to support whānau holistically. Internal relationships (with Te Puawaitanga ki Ōtautahi Trust) include Family Start, Legal Literacy, whānau Ora Navigators, and Rapuora Nursing. External relationships include Clinical Psychologists, Piki Te Ora Primary Care practice and Midwives.

Kingi Kiriona, Deputy Chief Executive – Mātauranga Māori from Te Aka Whai Ora, says whānau Whakapuawai is an example of how utilising mātauranga can result in more effective and holistic care that meets the needs of whānau.
“The Whānau Whakapuawai innovation was born out of a recognition that there was a significant gap in services to assist whānau experiencing maternal mental health issues in the Canterbury region.
“This funding is about creating spaces for Māori where they feel safe enough to access the support that they need.”

So far, 103 whānau have gone through the pilot programme, with continued funding allowing Whānau Whakapuawai to be offered as a service for midwives to refer in hapūtanga and beyond.

Mō tātou, ā, mō kā uri a muri ake nei

Appendix 3 Glossary of Terms

Perinatal period - the period from conception until the baby's first birthday.

First 1000 days - from conception to baby's second birthday. During this time the baby's brain develops more quickly than any other time of life.

First 2000 days - from conception to baby's fifth birthday

Perinatal Distress - an umbrella term to describe depression, anxiety or stress during the perinatal period

Mental Wellbeing - a component of broader wellbeing, whereby people feel safe, connected, valued and have hope for the future, to be distinguished from

Psychosocial support - addresses emotional, social, physical, mental and spiritual needs

Maternity facilities A maternity facility is a place that women/people attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as[29]:

- **Primary facility** refers to a maternity unit that provides care for women/people expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women/people assessed as being at low risk of complications for labour and birth care.
- **Secondary facility** refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births and caesarean sections plus specialist adjunct services including anaesthetics and paediatrics.
- **Tertiary facility** refers to a hospital that can provide care for women/people with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3, neonatal intensive care service.

PRIMHD: Programme for the Integration of Mental Health Data. This is the Ministry of Health's national mental health and addiction information collection of activity and outcomes data.

[29] Ministry of Health. 2021. *Maternal Mental Health Service Provision in New Zealand: Stocktake of district health board services*. Wellington: Ministry of Health

Appendix 4: Survey responses

Response to *Please select any of the following that apply to you*

Response	Number out of 48	Percent out of 48
I had mental health problems prior to becoming a parent	**24**	**50**
I didn't realise I needed help but looking back I did need help for my mental wellness	**7**	**14**
Didn’t feel safe asking for help	**8**	**16**
Didn’t know where to get help	**9**	**18**
I worried about what might happen to my child if I asked for help	**7**	**14**
Services were not available at the time I needed them	**5**	**10**

Response to *Thinking about when you finished receiving help from a mental wellbeing health service select all that apply for you*

Response	Number out of 48	Percent out of 48
I had no support or contact with any service or GP after I was discharged	5	10
I was able to care for my baby confidently	15	31
I felt safe and able to return to the normal activities of my life	10	20
I finished with the service when I was ready	13	26
The staff made sure I knew who to contact if I needed help after I was discharged	11	22
I was unhappy and dissatisfied with the help I received	4	8

Thinking about accessing health services to help you with your trouble with mental wellbeing, select all those that apply to you

Response	Number out of 48	Percent out of 48
The service was available close to where I/we live	16	33
The service was available to me when I/we needed it	13	27
The staff at the service were helpful and respectful	13	27
It was easy to find the help I needed for mental health distress	6	13
I/we was given options for different services to meet my/our needs	8	18
Staff at the service identified my/our cultural needs and treated my culture with respect	4	8
The service was affordable for me/us	15	31
Transport was available to get me/us to our appointments	8	16
Services I was offered did not work for me	1	2

Thinking about after the child was born for you personally, what help you received was the best for you? (Open ended question 30 responses)

GP	3
Midwife	3
Counsellor/ MH professional	13
Plunket	2
NICU nurse and social worker	1
Whānau/ help at home/ respite	6
Didn't really get help	3
Family support	1

What kind of services did you access?

Service	Number
GP - General practice Team (including HIP)	28
Maternal Mental Health Team (Specialist team)	10

Online, Text or Phone Support Service	3
Counselling	4
Plunket	2
Psychiatrist	1

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.

Response	Number out of 48	Percent out of 48
Social contact, time with supportive friends and whānau	37	77
Someone safe I could talk to about my experience	29	60
People who helped me realise I was not alone in my experiences	33	69
Connections to and support from people of my own culture	4	8
Helpful advice and reassurance about parenting	20	42
None of the above	4	8

More comments given in the survey:

Most of my distress stemmed from how I felt during the birth and about how I 'managed' the birth. My midwife was belittling and bullying during the birth and I felt very ashamed. I felt like I was at fault for 'not coping' during the birth. I didn't realise until my next pregnancy that I had PTSD and I think this was also a huge barrier to seeking help, I didn't want to properly talk about it or think about it. CHch

Did not feel supported by the option most offered to me (ie plunket). Had a bad experience with them with my first child, neutral with second. A second factor is understanding - despite all the information readily available and provided, I did not understand I was struggling until after the fact in the my first pregnancy / postpartum.

My father in law passed away suddenly and unexpectedly when my son was 3 weeks old. I struggled (and still do) with anxiety and intrusive thoughts from then but thought it was just something everyone goes through with their first baby

I felt like I would be judged for seeking help. Was worried of the repercussions of sharing my thoughts

I tried to access MH services but my referral from over a year ago is still not processed yet. I tried to go private as I have insurance and there was no space for any psychology or psychiatry help specific with PPD and/or PPA. Believe me I tried and tried (Christchurch, NZ european)

I felt that when I had approached my midwife for help I had been dismissed and told my symptoms were within the realms of normal. I felt I was a burden on the 24 hour clinic when I went to access IV fluids and was turned away multiple times without any treatment. I was told by my midwife and a GP that I should be glad I was pregnant and that it was only for a short time so I'd be fine in the end. I felt that the effect of my physical condition on my mental health wasn't really considered and I didn't have the knowledge at the time or the physical/mental capacity to advocate further for myself. I would have liked to have Access to diagnosis for HG earlier in pregnancy and access to medication and IV fluids. Access to financial support as I could not work and my husband also had to take unpaid leave to care for me at times. Access to mental health support as my HG was so bad at times I considered suicide or termination of my baby but was never referred for any treatment. (Christchurch European)

Was told at 8 weeks pregnant the referral to the mental health team hadn't been actioned. Didn't actually get actioned til 36 weeks pregnant so I'm still waiting for my appointment (Christchurch).

I wasn't listened to. I told them I wasn't ready for discharge. I was readmitted 3 times in the first 2 weeks since my baby was born.

Appendix 5: Pregnancy, Early Parenthood and Infant Mental Health Training in Aotearoa

Key:

Resources from Aotearoa
Resources from Australia
Resources from other countries

Training package/Resource	Cost	Modality	Target audience	Description/Comments	Currency of content
1. Foundations in perinatal mental Health https://wharaurau.org.nz/elearning/Perinatalmentalhealth	Free	Online	This self-paced learning course lays the groundwork for a deeper understanding of perinatal mental health and aims to provide valuable insights into how to support whānau.		2023
2. Educational video "listening to our stories" https://learnonline.health.nz/totara/catalog/index.php	Free	Online	Health professionals working with women and families in the perinatal period.	• Insight into the experience of perinatal distress from women's own perspectives • Confidence in having conversations with pregnant women and new parents about their mental health • Understanding of the parent-infant relationship and how to support this • Ideas of what interventions can support mental health and wellbeing in the perinatal period	2019
3. Common sense toolkit for support workers https://learnonline.health.nz/totara/catalog/index.php	Free	Online	Mental health support workers who work with women and their family and whānau, during pregnancy and the postnatal period. Health professionals or others with no specific mental health training or experience may also find this resource helpful.	Developing foundational knowledge and skills, to enable you to work effectively with the sometimes problematic changes in thinking, feeling and behaviour many women experience at this time in their lives. Designed to complete at your own pace, in consultation with a workplace learning supervisor (e.g your line manager/supervisor, or person who oversees your work).	Currently being updated

4. Fill Your Kapu While You're Hapū	Free	Online	General public	The six Māori and Pasifika women share their raw experience and resilience through tears and grit in the series called "Fill Your Kapu While You're Hapū".	2021
5. Key Concepts in Attachment	Free	Online	Staff in the ICAMH, AOD, NGO and PHO sectors with an interest in infant mental wellbeing.	This presentation focuses on key concepts underpinning attachment and includes a general overview of attachment, some information on assessment and on the impacts of attachment on development.	
6. PSME432 Introduction to Perinatal Psychiatry https://www.otago.ac.nz/christchurch/study/papers/index.html?papercode=PSME432	$2,889	Distance	Suitable for individuals who have a basic knowledge of the nature and extent of psychiatric disorders or individuals who have obstetric or paediatric health qualifications.	An outline of the full range of psychiatric disorders as they present during pregnancy and the first postnatal year. Also includes the adaptive demands on the mother and family during the perinatal period.	2021
7. Ko Awatea – Maternal Mental Health Resource	Free	Online	Maternal Mental Health clinical team workers in their development of 'Capable' level competencies	Resources • Engagement • Assessement • Intervention • Outcome/Evaluation	Needs updating
8. Goodfellow Talks https://www.goodfellowunit.org/search-categories/mental-health	Free	Online	Primary care onwards	Recorded webinars on a variety of topics. Category of Mental Health with some specific content on the perinatal period	Current
9. Look at You - Aroha Atu, Aroha Mai https://www.countiesmanukau.health.nz/our-services/maternity-services/look-at-you-aroha-atu-aroha-mai/	Free	Online	All	Babies are social and communicate right from birth. This video supports parents, whaanau and those working with babies to understand their social and emotional needs in the first three months of life. The video is based on 'Getting To Know You' by Australian, Dr Bijou Blick and has been adapted for our New Zealand population. The video is available in English, Maaori, Samoan, Tongan, Cook Island Maori and Niuean.	Current
10. Birth Trauma Workshop for Providers https://centerpsych.thinkific.com/courses/birth-trauma-workshop-for-providers?fbclid=IwA	Free	Online		***Limited or no evidence of rigour for resource*** This workshop is for perinatal providers who want to learn about birth trauma, including how to screen and refer birth trauma survivors appropriately.	

R0mHvsRXGFrDWgEnRMAuFOBO_XeSCl6ytLICCPs5KeBHNeVXT7Gd_NnCFM					
11. Postpartum Support International and 2020 Mom: Maternal Mental Health 101 https://www.postpartum.net/professionals/mmh-online-webinar/	Free/Paid	Online		***Limited or no evidence of rigour for resource*** Learn about the range of maternal mental health disorders, the prevalence, signs and symptoms and recommended treatment options	
12. Understanding Birth Trauma Basics: A beginners guide to birth trauma and birth trauma support https://healing-birth.teachable.com/p/understanding-birth-trauma-basics?fbclid=IwAR3HYcosLy0uyDEAU5Jts6wtKF-H4mV-eYh9iJ9hGlumQ7sJ6nX1LDXw4K8	Free/paid	Online		***Limited or no evidence of rigour for resource*** Note: New Zealand based midwife. Not sure of her training as she has not practised as a midwife for some years. There is paid training on her site also.	
13. Pregnancy Wellbeing and Postnatal Wellbeing courses https://www.justathought.co.nz/	free	online	Those with IT access.	Part of the WISE Group, utilizing CBT. Largely developed in Australia and adapted for NZ. Launched Dec 2023.	
14. Basic Skills in Perinatal Mental Health https://www.cope.org.au/course/basic-skills-in-perinatal-mental-health/	Free	Online		***Limited or no evidence of rigour for resource*** In this brief introductory module, we provide you with an overview of the COPE online training program developed out of the 2017 National Perinatal Mental Health Guideline: Mental Health in the Perinatal Period: Australian Clinical Practice Guideline. This course is made up of three core modules: • An overview of mental health disorders in the perinatal period • Psychosocial assessment and screening • Referral and treatment We briefly provide an overview of the course and Module content, outline the objectives and explain how you can use this training to improve your	

				practice. We will also provide you with details of how to complete the course and obtain accreditation.	
15. Mum and Baby Academy https://www.healthprofessionalacademy.co.uk/mum-and-baby/learn/perinatal-mental-health?utm_source=skills_platform&utm_medium=referral&utm_campaign=mentalMBA	Free	Online		***Limited or no evidence of rigour for resource*** After studying this CPD module you should: • Have an understanding of perinatal mental health problems and their effects on mum and baby • Be aware of the risk factors for perinatal mental illness • Know when to refer women for specialist or emergency assessment	
16. Krysta Dancy–Cabeal Therapist http://www.counselinginroseville.com/classes-and-groups.html	Paid	Online	• Birth professionals • Mental health professionals	***Limited or no evidence of rigor for resource***	
17. College of Perinatal Emotional Health https://www.tbrcollege.com/store	Paid	Online	• Health Care Professionals • Birth Professionals • Pre & Postnatal specialists	***Limited or no evidence of rigour for resource*** Range of courses on traumatic birth recovery Includes small group supervision and closed Facebook group	
18. Resilient Birth https://www.resilientbirth.com/workshops	Paid	Online		***Limited or no evidence of rigour for resource***	
19. SELENI https://www.seleni.org/maternal-mental-health-training-online	Paid	Online	Mental Health Professionals	***Limited or no evidence of rigour for resource*** Expert instruction in effective diagnosis and treatment of Perinatal Mood & Anxiety Disorders and perinatal loss and grief, mental health for expectant therapists and young parents, and dealing with grief and trauma in the context of the COVID-19 pandemic.	
20. Help me love my baby https://youtu.be/rZmb7SCreBk	One session free and one paid	Online		Two-part documentary series following two unhappy mothers as they attempt to repair and revive the maternal bond with their baby. Working with parent-infant therapist Dr Amanda	2015

				Jones, the two women admit their feelings of anger and resentment towards their babies and attempt to unlock the psychological clues from their own past that may have a bearing on their current behaviour	
21. Facilitating Attuned Interactions (FAN) | Erikson Institute https://imhaanz.nz/fan-training/cilitating Attuned Interactions Network (FAN)	1,265pp	2 day f2f, 3rd day Zoom, mentoring for the supervisor over 6 months	Well Child/Tamariki Ora; Family Start, Early intervention Programmes, Perinatal and Infant Mental Health Services, ECE Providers	Has an evidence base that it actually makes a difference. Based on concept of Experiential Learning and supporting increased reflective functioning for adults within whānau. Delivered in NZ by IMHAANZ	
22. Parents Under Pressure (PUP) PuP Home Page (pupprogram.net.au)	2000 australian	online &/or f2f	We provide training to practitioners working across the child, mental health and drug and alcohol sectors plus those working directly in the non-government sector providing family support. Practitioners who train in the PuP program have diverse backgrounds. Some have formal qualifications in social work, psychology or related fields. Others come with experience in community agencies and community work. Training in the PuP program builds on practitioner skill sets and can be tailored in the latter stages of training for particular organisational needs.	Has an evidence base that it actually makes a difference. Based on concept of Experiential Learning and supporting increased reflective functioning for adults within whānau.	

23. Attachment and Biobehavioral Catchup (ABC) ABC Intervention | Developmental Psychology Lab		online	Trainees are selected for the parent coach training, supervision,	Has an evidence base that it makes a difference. Based on concept of Experiential Learning and supporting increased reflective functioning for adults within whānau. critical to have an appropriate cultural lens, and embedded within a supportive collaborative structure. Cultural Humility recognised Mary Dozier	
24. Mellow Parenting Mellow Parenting		online & f2f	Practitioners	Has an evidence base that it actually makes a difference. Based on concept of Experiential Learning and supporting increased reflective functioning for adults within whānau. critical to have an appropriate cultural lens, and embedded within a supportive collaborative structure. Ohomairangi Trust have been running a version	
25. Solihull Approach - UK		f2f, online	Practitioners, Supervisors, Managers, Antenatal and Perinatal Teams, Nurseries and Early Years, Schools, Parents, Professionals, Foster Carers. Wide range of trainings	Has an evidence base that it actually makes a difference. Based on concept of Experiential Learning and supporting increased reflective functioning for adults within whānau. critical to have an appropriate cultural lens, and embedded within a supportive collaborative structure.	
26. Cool Little Kids and Cool Little Kids Online For preventing anxiety disorders in young children who are at risk because of inhibited temperament.		f2f and online	Parents with children 3-6 years old, facilitated by psychologists	Evidence base at https://pubmed.ncbi.nlm.nih.gov/28433091/	

Gap Analysis

- CALD training programme doesn't have a pregnancy and early parenthood specific module

- Werry Workforce Centre provides content on Infant Mental health but not maternal
- No culturally specific content identified so far
- Limited content on mental wellbeing for dads and other caregivers during this time

Additional Resources of Interest

- Talking therapies for Asian people (Te Pou)

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