

# **Maternal Mental Health Service Provision in New Zealand**

Stocktake of district health board  
services

2021

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# Executive summary

## Why maternal mental health is important

Maternal mental health is one of the foundations of strong families, whānau, communities and the nation. Pregnancy and early parenting is a time of enormous change and, often, big challenges for parents, families and whānau – whether it is the first child or whether there are multiple children in the whānau. For children, the first 1,000 days, from conception to two years of age, are critical to long-term emotional, mental and physical wellbeing and are significantly influenced by caregivers' health and wellbeing.

In line with the Government's Child and Youth Wellbeing Strategy,<sup>1</sup> we want all our pēpi and tamariki to be loved, safe and nurtured, have what they need and be happy, healthy, learning and developing in their early years. This means that parents need to be supported alongside their children and have access to support when they need it. An estimated 12–18 percent of New Zealand mothers and 10 percent of fathers will, however, develop depression, anxiety or other mental health issues during the perinatal period. These figures are higher in some population groups, particularly Māori and Pacific and Asian peoples.

These findings matter because poor maternal mental health during pregnancy can affect mothers' ability to set themselves up for successful parenting. For example, poor maternal mental health in pregnancy can lead to inadequate weight gain, underutilisation of antenatal care, continuation of harmful habits (such as smoking, drinking or using other harmful substances), and preterm birth. These factors are associated with a range of negative outcomes for the infant as well as the mother. Poor maternal mental health post-pregnancy can also result in negative impacts on the mother-infant and/or father-infant relationships. In some instances, it can increase the risk of violence within the family.

Infants who have a parent with depression at this time are more likely to develop a difficult temperament, have poor health, have decreased intellectual and motor development and develop long-term behavioural problems. This does not set them up with the best possible chance for a lifetime of good wellbeing, learning and development and becoming parents themselves.

<sup>1</sup> DPMC. 2019. *Child and Youth Wellbeing Strategy: 2019*. Wellington: Department of the Prime Minister and Cabinet (DPMC). URL: <https://childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy> (accessed 20 October 2021).

Supporting parents' mental wellbeing in the infant's early years is a good way to support happy and healthy children, families, whānau and communities both now and into the future.

## What supports mental wellbeing and maternal mental health

Like general mental illness, there is no single cause of perinatal mental illness. The onset of perinatal mental illness is higher around the time of childbirth. During this period, women are particularly at risk of the onset or recurrence of mood disorders. Maternal mental health risk factors can include a history of mental health problems, lack of support, previous trauma, including physical, emotional or sexual abuse, isolation (physical, mental, cultural), stressful life events and a history of drug or alcohol abuse.

Mothers who have strong family and whānau connections and a reliable support system are more likely to fare better in their pregnancies and will be better equipped to handle the challenges of pregnancy and parenthood; this is a key insight that we can use to drive effective policy design and service delivery.

A second key insight is that early screening and intervention as soon as issues begin to present are critical to achieving the best outcomes for mothers, babies and the wider whānau. However, early screening in New Zealand is generally done in an ad hoc way, without consistent use of formal screening tools.

It is important to recognise that specialist maternal mental health interventions are generally only intended for mothers with moderate to severe mental health conditions. Dedicated specialist services that support both the mother and baby together, within the context of the family, are considered best practice for treating significant maternal mental health issues. Mothers experiencing mild to moderate distress can be better supported by primary or community-level services that focus on addressing environmental or situational risk factors.

# Stocktake of maternal mental health services

The Perinatal and Maternal Mortality Review Committee (PMMRC) has repeatedly recommended that the Ministry of Health (the Ministry) establish and fund a maternal and infant mental health network to undertake a stocktake of mental health services for pregnant / recently pregnant women. The National Maternity Monitoring Group (NMMG) has also recommended that district health boards (DHBs) improve access to primary mental health services for pregnant and postpartum women.

This stocktake is the Ministry's response to the PMMRC's recommendation and forms the basis for further work to address the NMMG's recommendation.

The stocktake required information not held centrally by the Ministry because of the devolved nature of the New Zealand health system. The Ministry therefore sent all DHBs an online survey asking a number of questions on what mental health services they provide in pregnancy and the postpartum period (up to 12 months), their eligibility criteria and what they saw as key gaps and issues. All DHBs responded to this survey.

Analysis of this data identified that more detail was needed in some areas, so we interviewed a range of maternal mental health leaders located in DHBs and other organisations. This qualitative data has been interpreted via thematic analysis. We also included complementary information gathered from some DHB maternity leaders. The findings of this stocktake therefore derive from a combination of quantitative and qualitative data from all DHBs, as well as other maternal mental health and maternity leaders.

## Scope of the stocktake

The stocktake covers maternal mental health services that are provided by DHBs, which may be delivered in a range of settings, including in a hospital or in the community. The information gathered for this stocktake provides us with good evidence about available DHB-provided services and identifies where the main gaps are. However, it should not be interpreted as a full assessment of maternal mental health services for several reasons as outlined below.

- To enable timely completion of a stocktake, maternal mental health services provided outside DHBs were deemed out of scope. We know that a wide range of mental health and other community and health support services are provided through a variety of community organisations / non-governmental organisations (NGOs). These organisations likely support clients with maternal mental health needs during other interactions and delivery of other services.

- Infant mental health services were also outside the scope of this stocktake. While these services are inextricably linked with maternal wellbeing, they are a separate specialty service and therefore were not within scope of a stocktake of maternal mental health services.
- We did not engage with tangata whai ora, mothers or other consumers of maternal mental health services about their needs and experiences with maternal mental health services and support because time limitations restricted our ability to do so effectively and safely.

We have included information in this report about other types of primary and community-level parenting and health support in order to provide the context within which specialist maternal mental health services is delivered.

## Key findings of the stocktake

The findings of the stocktake are discussed in detail in the body of this report under the 'How maternal mental health services are working in district health boards' section as the following subsections.

### There is an increasing complexity of need and unmet need and concern that service delivery is inequitable

DHBs are reporting increasing complexity in psychosocial and mental health need and believe that they are not seeing as many women who are likely to have higher levels of need as would be expected, especially wāhine Māori and Pacific and Asian women.

### Cultural models of care need to be strengthened

Only around half of the 20 DHBs reported that wāhine Māori in their region could receive mental health care through a kaupapa Māori service or provider, and very few DHBs reported having a specific focus on Pacific or Asian women. This is despite research indicating that these women likely have a high need for support.



## There are gaps in the continuum of care

DHB specialist maternal mental health services are seeing a higher proportion of the population than is usual for specialist services. They believe this is likely at least partly because of a lack of support in the community and primary health care sector, for example, in the areas of psychological therapy, systematic and effective screening, and early intervention in primary health care.

## We need to support and grow the wider maternal mental health workforce

All but one DHB raised this as an important issue. DHBs noted multiple issues, including a need for more staff of various kinds (a lack of psychiatrists and psychologists was noted in particular); a need for new kinds of professionals (such as a peer support and community support workforce); and increased training for maternal mental health staff and primary health care workers, including midwives and general practice (GP) and Well Child Tamariki Ora (WCTO) programme staff. DHBs also noted that their lack of staff was preventing them from taking up opportunities to provide additional supports in the community.

## Eligibility criteria to access DHB maternal mental health services require a live child

We need to support those who have lost a baby or who no longer have their baby in their care, and those suffering birth trauma, better and in the right setting. This may be through other mental health services.

## Looking forward

These findings speak to systemic inequities, including concerns that wāhine Māori, pēpi and whānau are not receiving the care to which they are entitled under te Tiriti o Waitangi. They also point to outdated models of care and funding mechanisms. However, it is reassuring that DHBs are aware of the issues and often have ideas for improvements but just have been unable to implement those ideas under existing arrangements.

There are opportunities through which we can make significant change in this area over the next several years. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*<sup>2</sup> (*Kia Manawanui*) sets out the Government's strategic approach to mental wellbeing and contains the system-wide vision of pae ora – healthy futures.<sup>3</sup> Pae ora is made up of three interconnected elements – wai ora (healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals). Maternal mental health is affected by and affects each of these areas.

With the long-term direction set by *Kia Manawanui*, the Ministry's next step is to detail what that direction means for the mental health and addiction system, including maternal mental health services. One of the first actions from *Kia Manawanui* is the development of a national mental health and addiction system and service framework to guide health organisations in delivering and integrating mental health and addiction services.

The upcoming transformation of the health and disability system provides another opportunity to address the findings of the stocktake. As the design of locality and regional networks progresses, as well as the design of service frameworks to guide the delivery of services at the local and regional levels, there will be opportunities to ensure that maternal mental health is considered in a holistic manner across the continuum of care and need.

As we work through both of these transformations, we will focus on meeting our obligations under te Tiriti o Waitangi, as this is necessary if we are to realise the health and disability system's overall aim of pae ora.

For maternal mental health, this means ensuring we deliver all our work based on the principles set out by *Whakamaua: Māori Health Action Plan 2020–2025*,<sup>4</sup> including:

- tino rangatiranga – enabling Māori to design and lead solutions for Māori
- equity – demonstrating a genuine commitment to addressing inequities for Māori
- active protection – evidencing how we are driving equity for Māori in our approaches, decision-making processes, investment and power devolution
- options – ensuring there is investment in kaupapa Māori solutions (noting this should be driven by Māori rather than mainstream providers)
- partnership – sharing power/decision-making and co-designing solutions with Māori.

<sup>2</sup> Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing](http://www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing) (accessed 20 October 2021).

<sup>3</sup> Ministry of Health. 2015. Pae ora – healthy futures. URL: [www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures](http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures) (accessed 20 October 2021).

<sup>4</sup> Ministry of Health. 2020. *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025](http://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025) (accessed 20 October 2021).

# Background

## Note on terminology

This report uses the words 'women' and 'mothers' because the information provided reflects and summarises information from research and service descriptions that have used this language. Proactively changing this language would create a risk that the summaries in this report are no longer completely accurate, particularly with respect to summaries of research evidence.

It is important to acknowledge, though, that not all people who give birth identify as female, and thus the commonly used gendered wording of 'women' and 'mothers' does not adequately reflect all people who give birth. People who give birth that do not identify as female are still at risk of developing maternal mental health conditions and may potentially be at increased risk due to additional stress that may relate to the experience of giving birth as a person not identifying as female.

## The effects of poor maternal mental health

Antenatal mental illnesses are associated with negative birth outcomes for infants (including increased risks of low birth weight and preterm delivery,<sup>5</sup> which are in turn associated with a range of poorer health outcomes) and for the mother (including post-traumatic stress disorder following birth).<sup>6</sup>

Following birth, infants show effects of maternal mood in pregnancy, and there is evidence of long-term impairment in children whose mothers experienced even sub-clinical levels of mood disturbance during their pregnancy.<sup>7</sup> Maternal mental illness during both pregnancy and post-birth has been shown to have negative effects

<sup>5</sup> Grote NK, Bridge JA, Gavin AR, et al. 2010. A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight and intrauterine growth restriction. *Arch Gen Psychiatry* Oct 67(10): 1012–24.

<sup>6</sup> Shaban Z, Dolatian M, Shams J, et al. 2013. Post-traumatic stress disorder (PTSD) following childbirth: Prevalence and contributing factors. *Iranian Red Crescent Medical Journal* 15(3): 177.

<sup>7</sup> Low F, Gluckman P, Poulton R. 2021. Intergenerational Disadvantage: Why maternal mental health matters. Auckland: The University of Auckland, Kōi Tū: The Centre for Informed Futures. URL: <https://informedfutures.org/wp-content/uploads/Intergenerational-disadvantage-maternal-mental-health.pdf> (accessed 20 October 2021).

on child development including behaviour and academic achievement.<sup>8 9 10 11</sup> These trajectories can have long-lasting and long-term effects on the infant that may even persist into adulthood and potentially influence the mental health of the next generation.

Further, there are known links between maternal mental health and intergenerational transfer of disadvantage.<sup>12</sup> Maternal anxiety and depression can have detrimental effects on the development of the child's executive function and:

... the ability to consciously control behaviour in working towards a goal. It involves a set of high-level neurocognitive processes such as flexible thinking, the ability to regulate attention and emotion, goal setting, planning and organisation, and the operation of working memory ...<sup>13</sup>

The skill of being able to consciously control behaviour is key for healthy development in many domains, including social and emotional behaviour and all learning.

Thus parents' poor mental health is associated with adverse outcomes for their children both due to the illnesses themselves and to the poverty and social exclusion that may be associated with such debilitating illnesses. These factors are often measured and reported in research under the terminology 'adverse childhood experiences'.<sup>14</sup> Maternal mental health has itself been shown to be related to the number of adverse childhood experiences mothers had when they were children themselves,<sup>15</sup> further emphasising the importance of both taking multi-generational approaches to wellbeing and of supporting family and whānau social and material needs broadly.

<sup>8</sup> Hay DF, Pawlby S, Waters CS, et al. 2010. Mothers' antenatal depression and their children's antisocial outcomes. *Child Development* 81(1): 149–65.

<sup>9</sup> Netsi E, Pearson RM, Murray L, et al. 2018. Association of persistent and severe postnatal depression with child outcomes. *JAMA Psychiatry* 75(3): 247–53.

<sup>10</sup> Closa-Monasterolo R, Gispert-Llaurado M, Canals J, et al. 2017. The effect of postpartum depression and current mental health problems of the mother on child behaviour at eight years. *Maternal and Child Health Journal* 21(7): 1,563–72.

<sup>11</sup> Psychogiou L, Russell G, Owens M. 2020. Parents' postnatal depressive symptoms and their children's academic attainment at 16 years: pathways of risk transmission. *British Journal of Psychology* 111(1): 1–16.

<sup>12</sup> Low F, Gluckman P, Poulton R. 2021. Intergenerational Disadvantage: Why maternal mental health matters. Auckland: The University of Auckland, Kōi Tū: The Centre for Informed Futures. URL: <https://informedfutures.org/wp-content/uploads/Intergenerational-disadvantage-maternal-mental-health.pdf> (accessed 20 October 2021).

<sup>13</sup> Ibid, page 2.

<sup>14</sup> Felitti VJ. 2009. Adverse childhood experiences and adult health. *Academic Pediatrics* 9(3): 131.

<sup>15</sup> McDonald SW, Madigan S, Racine N, et al. 2019. Maternal adverse childhood experiences, mental health, and child behaviour at age 3: The All our Families community cohort study. *Preventive Medicine* 118: 286–94.

Like general mental illness, there is no single cause of perinatal mental illness (or wellbeing). The onset of mental illness for women has been shown to be higher around the time of childbirth,<sup>16</sup> and women who have a history of mental illness are also significantly more likely to have a recurrence of illness during the first few weeks after birth.<sup>17</sup> Risk factors arising from the clinical, environmental and psychosocial domains interrelate; while women are particularly at risk of the onset or recurrence of mood disorders perinatally,<sup>18</sup> those who have strong family and whānau connections and a reliable support system are more likely to fare better in their pregnancy and early parenthood than those who are less supported.<sup>19</sup>

The effects of maternal mental health on the infant, mother and family and whānau are widespread and profound. However, maternal mental health is amenable to treatment and can be improved by a wide range of interventions. The science is clear that the psychological wellbeing of pregnant women and new parents needs to be looked after as carefully as their physical health during pregnancy and the early years of parenting, including through routine antenatal and postnatal care and WCTO services.

## Maternal mental health in New Zealand

According to the World Health Organization (WHO), about 10 percent of pregnant women and 13 percent of women who have just given birth worldwide experience a mental disorder, primarily depression.<sup>20</sup>

<sup>16</sup> Weick A, Kumar R, Hirst AD, et al. 1991. Increased sensitivity of dopamine receptors and recurrence of affective psychosis after childbirth. *British Medical Journal* 303: 613–16.

<sup>17</sup> Burt V, Quezada V. 2009. Mood disorders in women: focus on reproductive psychiatry in the 21st century. *Canadian Journal of Clinical Pharmacology* 16(1): e6–e14.

<sup>18</sup> Ministry of Health. 2011. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/healthy-beginnings-final-jan2012.pdf.pdf](http://www.health.govt.nz/system/files/documents/publications/healthy-beginnings-final-jan2012.pdf.pdf) (accessed 20 October 2021).

<sup>19</sup> Low F, Gluckman P, Poulton R. 2021. Intergenerational Disadvantage: Why maternal mental health matters. Auckland: The University of Auckland, Kōi Tū: The Centre for Informed Futures. URL: <https://informedfutures.org/wp-content/uploads/Intergenerational-disadvantage-maternal-mental-health.pdf> (accessed 20 October 2021).

<sup>20</sup> See the Maternal mental health webpage on the WHO website at: [www.who.int/teams/mental-health-and-substance-use/maternal-mental-health](http://www.who.int/teams/mental-health-and-substance-use/maternal-mental-health).

In New Zealand, the longitudinal Growing Up in New Zealand (GUINZ) study has reported that approximately 12 percent of mothers in its representative cohort experienced symptoms of antenatal depression in the third trimester of pregnancy, with Pacific and Asian populations twice as likely to report experiencing symptoms than New Zealand European women.<sup>21</sup> Around 8 percent of the cohort reported postnatal depression symptoms when their infants were around nine months old<sup>22</sup> with risk factors including being a young mother or having high levels of financial or relationship stress.

A 2016 research report using data from the E Moe, Māmā: Maternal Sleep and Health in Aotearoa/New Zealand study found 22 percent of wāhine Māori in this cohort screened positive for depression in late pregnancy (compared with 15 percent of non-Māori) and 25 percent screened positive for anxiety (compared with 20 percent of non-Māori).<sup>23</sup> The 2015 New Mothers' Mental Health Survey found that 14 percent of its respondents met the criteria for postnatal depression<sup>24</sup>. Those that identified as Asian or had a low household income were more likely to meet the criteria.

Taking a longitudinal view, the GUINZ study reported in 2017 that around one in five mothers in its cohort reported depressive symptoms at one or more of the three time points at which they were interviewed: during pregnancy, when the child was around nine months, and when the child was around four years old.<sup>25</sup>

The variation in these findings is probably due to methodological issues, but all the numbers indicate that this issue affects a significant number of women and hence children, families, whānau and communities. Our assessment is that an estimated 12–18 percent of New Zealand women (with even higher percentages in at-risk populations) will develop depression, anxiety or other mental health issues during the perinatal period.

<sup>21</sup> Waldie KE, Peterson ER, D'Souza S, et al. 2015. Depression symptoms during pregnancy: Evidence from Growing Up in New Zealand. *Journal of Affective Disorders* 186: 66–73.

<sup>22</sup> Morton SMB, Grant CC, Berry SD, et al. 2017. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Now We Are Four: Describing the preschool years*. Auckland: Growing Up in New Zealand (8% reported).

<sup>23</sup> Signal TL, Paine S-J, Sweeney B, et al. 2017. The prevalence of symptoms of depression and anxiety, and the level of life stress and worry in New Zealand Māori and non-Māori women in late pregnancy. *Aust NZ J Psychiatry* 51: 168–76.

<sup>24</sup> Health Promotion Agency. 2016. *Postnatal Depression in New Zealand: Findings from the 2015 New Mothers Mental Health Survey*.

<sup>25</sup> Morton SMB, Grant CC, Berry SD, et al. 2017. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Now we are four: Describing the preschool years*. Auckland: Growing Up in New Zealand (GUINZ).

Maternal mental health risk factors can include a history of mental health problems, lack of support, previous trauma (including physical, emotional or sexual abuse), isolation (physical, mental, cultural), stressful life events and a history of drug or alcohol abuse.<sup>26 27</sup> Protective factors include good social support systems for mothers, partners and whānau, parenting support and early interventions as soon as issues begin to present.

Some new fathers can also appear to be more vulnerable to depression than others. If a new mother is depressed, this can make the role of a father more stressful, which in turn can add to the risk of that person experiencing depression as well.<sup>28</sup> There is evidence from GUINZ that around 2–4 percent of New Zealand fathers experience mental health issues around the time of a child's birth.<sup>29</sup>

There is anecdotal evidence in the public domain (including media reports) suggesting an increase in maternal mental health issues in the New Zealand population. While there is limited data to support the hypothesis of increasing maternal mental health demand, Ministry data shows that calls to PlunketLine about maternal mental health in the first four months of 2021 already exceeded total calls on the same topic in 2020.

<sup>26</sup> Howard LM, Khalifeh H. 2020. Perinatal mental health: a review of progress and challenges. *World Psychiatry* 19(3): 313–27.

<sup>27</sup> O'Hara MW, Wisner KL. 2014. Perinatal mental illness: definition, description and aetiology. *Best Practice & Research Clinical Obstetrics & Gynaecology* 28(1): 3–12.

<sup>28</sup> Health Navigator New Zealand. 2021. Perinatal depression: Includes antenatal and postnatal depression and anxiety. URL: [www.healthnavigator.org.nz/health-a-z/d/depression-perinatal/](http://www.healthnavigator.org.nz/health-a-z/d/depression-perinatal/) (accessed 20 October 2021).

<sup>29</sup> Underwood L, Waldie KE, Peterson E, et al. 2017. Paternal depression symptoms during pregnancy and after childbirth among participants in the Growing Up in New Zealand study. *JAMA Psychiatry* 74(4): 1–10. doi: 10.1001/jamapsychiatry.2016.4234.

# About this report

## Why the stocktake was commissioned

The PMMRC has repeatedly recommended<sup>30</sup> that the Ministry fund a maternal and infant mental health network to develop a work programme that could include:

- a stocktake of current mental health services available across New Zealand for pregnant and recently pregnant women to identify both the strengths of services and gaps or inequity in current services and skills in the workforce
- development of a national pathway for accessing maternal mental health services.

The NMMG has also recommended that DHBs improve access to primary mental health services during pregnancy and the postpartum period, including developing referral pathways and auditing the referral process to improve equity of access.

This stocktake responds to some of these recommendations, as well as to a range of anecdotal reports that the maternal mental health system may be under strain. It summarises work undertaken in 2021 to understand the range of DHB-provided maternal mental health services across New Zealand, as well as gaps and issues. The stocktake will inform future action in this area, including through the health and disability system reform process and the development of the mental health and addiction system and service framework.

## How the stocktake was conducted

The findings of this stocktake derive from a combination of quantitative and qualitative data collected using multiple methods. First, the Ministry sent all DHBs an online survey asking questions about the maternal mental health services they deliver, including what they provide for pregnant and postnatal women, their eligibility criteria and what they see as key gaps and issues.

<sup>30</sup> Including in their 14th annual report (PMMRC. 2021. *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee* | *Te Pūrongo ā-Tau Tekau mā Whā o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki: Reporting mortality and morbidity 2018* | *Te tuku pūrongo mō te mate me te whakamate 2018*. Wellington: Health Quality & Safety Commission. URL: [www.hqsc.govt.nz/assets/PMMRC/Publications/14thPMMRCreport/report-pmmrc-14th.pdf](http://www.hqsc.govt.nz/assets/PMMRC/Publications/14thPMMRCreport/report-pmmrc-14th.pdf) accessed 20 October 2021).



In addition to the online survey, all DHBs with acute maternal mental health contracts were asked to provide further information. The Ministry then conducted follow-up interviews or regional site visits with maternal mental health leaders in 18 DHBs. This qualitative data has been interpreted via thematic analysis. The Ministry also gathered complementary information from some DHB maternity leaders who were made aware of the survey and consulted with the Northern Regional Alliance (NRA) about research they have under way or have recently completed.

While the data and information for this stocktake was collected on an individual DHB basis, this report presents the availability of services as the number of DHBs reporting availability of a particular service in each of four regions of:

- Northern: Northland, Auckland, Waitematā and Counties Manukau DHBs
- Te Manawa Taki: Bay of Plenty, Tairāwhiti, Lakes, Waikato and Taranaki DHBs
- Central: Whanganui, MidCentral, Wairarapa, Hutt Valley, Capital & Coast and Hawke's Bay DHBs
- Southern: Nelson Marlborough, Canterbury, South Canterbury, Southern and West Coast DHBs.

This approach has been followed because, looking forward with the changes coming in 2022 as part of the health and disability system reforms and the shift away from the DHB service delivery model, it is more important to understand the wider geographic availability of different services by region than by each DHB.

## Scope of the stocktake

The stocktake covers specialist maternal mental health services provided by DHBs, which may be delivered in hospitals or in community settings. Information from all DHBs is reported.

Information sought was high level and gathered from DHB representatives. While DHB representatives were asked about the numbers and types of services provided, this stocktake does not include a full survey of the maternal mental health services workforce or a review of funding arrangements. The questions asked were designed to provide an understanding of the currently available DHB maternal mental health services rather than to inform specific service design.

This stocktake should not be regarded as a full assessment of maternal mental health services or as the end of the Ministry's work to understand service provision and needs in this area. The evidence reported over the following pages aims to provide a good picture of the available services and assist in identifying where the main gaps are.

There are several community non-specialist maternal mental health services offered through various non-governmental (NGO) providers around the country, however, such services are beyond the scope of this stocktake, which focuses on specialist maternal mental health services provided by DHBs.

Infant mental health services were also not investigated for this stocktake. While these services are inextricably linked with maternal wellbeing, they are a separate specialty service and therefore were not within scope of a stocktake of maternal mental health services.

Supplementary information, for example, information about other types of parenting/health support available through the DHB as reported by DHB representatives, has been included in this report to set the provision of specialist maternal mental health services in context. This additional context helps to inform our understanding of the stocktake's findings.

# Stocktake of DHB maternal mental health services

The information that follows describes DHB-provided maternal mental health services across the country. The format is a description of the service type followed by a table setting out provision by region.<sup>31</sup>

## How to interpret the stocktake

The Ministry provides strategic direction, monitoring and funding for the DHBs and sets service specifications.<sup>32</sup> However, the DHBs use their discretion to provide the most appropriate service mix for their communities and populations, based on their in-depth knowledge and understanding of the needs, strengths and population characteristics in their districts. DHBs endeavour to make the best decisions possible to spend the resource they are provided from Vote: Health, taking into account other health and social services in their district. This means that all DHBs offer some type of maternal mental health service, but not all types of services are available in all DHBs, and there is variation in the way services are organised. For example:

- some DHBs have dedicated maternal mental health staff, whereas others deliver this speciality from community mental health teams or consultation-liaison services
- some DHBs have designed different models of working to leverage the resources of larger DHBs to deliver some services to the populations of smaller neighbouring DHBs (These models are designed to make efficient use of resources and to enable delivery of acute specialist services that would not be sustainable for smaller DHBs to deliver themselves.)

Larger teams in some DHBs are often multidisciplinary and provide consultant liaison support to other locations (for example, Canterbury DHB provides regional support for the whole of the South Island, and Capital & Coast DHB's perinatal educator facilitates virtual peer liaison and consultation monthly to all DHBs in the Central region).

<sup>31</sup> The numbers in the tables refer to the number of DHBs in the specified region that reported that women had access to this type of service, funded by the DHB. The regions and the DHBs that are listed in each region are set out in the section above 'How the stocktake was conducted'.

<sup>32</sup> Nationwide Service Framework Library. 2015. Perinatal mental health service specifications. URL: <https://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-services-specifications-1> (accessed 21 October 2021).

Descriptions of the service types the Ministry has defined are provided under 'DHB maternal mental health services' below, along with the regional availability of each type of service.

While the list of the types of services provided across the country appears long, some of these services are extremely small, with some consisting of less than one dedicated full-time equivalent staff person (FTE) who shares their work with other services. There is a strong reliance on NGOs to provide psychosocial support, which is out of the scope of this stocktake. However, some DHBs noted a concern that NGOs are overloaded, and some also commented that they would like to be doing more both directly in the community and in terms of education for community services.

The numbers of services shown below do not take account of FTE or access criteria. They therefore should not be interpreted as the only way of assessing the availability of services in a region but rather as an indication of the distribution of DHB-funded service models across the country.

In some instances where there appear to be no available services of a certain type within a region, DHBs stated that women could access other mental health services as needed. Similarly, when asked in what settings DHBs provided maternal mental health clinics, some DHBs responded that they provided them in whichever setting was most appropriate at a given time or in a specific community.

It is also important to note that the majority of DHBs reported that they did not transfer women who are already under general mental health care and become pregnant or give birth to maternal mental health services but kept them in the service with which they already have a therapeutic relationship and history, with consultation available to a specialist maternal mental health service.

## DHB maternal mental health services

### Perinatal maternal mental health inpatient service

This service is a hospital-based inpatient specialist mental health service for mothers and infants that provides acute assessment, treatment and support. The service is specific to the perinatal mental health needs of mother and infant and includes, but is not limited, to:

- focused active intervention, crisis intervention and prevention of the escalation or development of the individual's illness
- delivery of an inpatient service in accordance with a comprehensive system of risk management within which least restrictive intervention strategies will be determined.

There are two specialist mother and baby inpatient services, one based at Starship Hospital in Auckland and the other at Canterbury DHB. These services provide access for women in the Northern and Southern regions and are accessible to all DHBs in those regions.

**Table 1: Number of DHBs reporting availability of perinatal maternal mental health inpatient services, by region**

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	0	1	5
Postnatal	4	0	1	5

Notes:

Some DHBs may not have reported availability because the service may be provided regionally by a different DHB, while some DHBs may have reported availability despite the service being accessed through another DHB in the region. However, all regions do have a perinatal mental health inpatient service available.

Some mental health services will admit a mother but do not have facilities for the baby to be in the inpatient service as well.

## Perinatal respite service

This service includes a range of short-term crisis or planned respite options developed and maintained for mothers in crisis who are pregnant or who are in the first year postpartum and who require an alternative to an acute inpatient setting. Options include, but are not limited to, the provision of staff who will monitor and support the mother and infant in crisis in:

- their own home or elsewhere
- supervised accommodation
- a specifically dedicated respite facility.

These services should be made available in culturally appropriate ways to ensure appropriate options are considered and to assist with holistic crisis resolution. Assessment, treatment, therapy and support should be provided in collaboration with the specialist clinical team (and with other specialist clinical teams), as required during the period of respite care, with the aim of quickly resolving the need for the crisis service.

**Table 2: Number of DHBs reporting availability of perinatal respite services, by region**

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	0	2	0
Postnatal	4	1	1	0

Notes:

The services referenced in Table 2 are those that can host both mother and baby and exclude adult respite services that can accept a pregnant or postpartum woman without her child.

While only DHBs in the Northern region specifically reported offering perinatal respite services, some DHBs in other regions, such as in Te Manawa Taki region, described offering respite type services through different models. For example, Waikato DHB described using flexible funding to support the ongoing needs for māmā and pēpi, including respite and in-home care.

## Perinatal specialist community service

This service is a community-based mobile specialist perinatal mental health service that includes, but is not limited to:

- specialist assessment and diagnosis of mother and infant mental health
- specialist treatment, care and support, including attention to mother and infant relationship
- consultation, liaison and advisory functions to other service providers regarding the mental wellbeing of mothers and infants
- shared care and joint planning with other health and social services and agencies around the care of the mother and her infant.

**Table 3: Number of DHBs reporting availability of perinatal specialist community services, by region**

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	5	6	3
Postnatal	4	5	6	3

Note: Services that do not have a specialist maternal/perinatal mental health service usually provide some services for this population through the general mental health service.

## Pregnancy and parenting service

The pregnancy and parenting service is an intensive engagement and harm reduction service that aims to reduce risk and improve outcomes of parents who are experiencing the harms of substance use, have infants under the age of three or are pregnant and are marginalised or poorly connected to health and social services.

There are six current sites: one in Waitematā DHB (the original site, which has been running for over 15 years), three sites that were funded through Budget 2016 in Tairāwhiti, Hawke’s Bay and Northland DHBs and two sites that were funded through Budget 2019 in Whanganui and Bay of Plenty DHBs.

**Table 4: Number of DHBs reporting availability of pregnancy and parenting services, by region**

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	2	2	0
Postnatal	4	2	2	0

## DHB maternal mental services beyond the service specifications

DHBs reported providing several other services in addition to the services outlined in the Ministry’s service specifications. These include maternal mental health clinics in a variety of settings, counselling for women experiencing distress, telephone consultation services for general practices (GPs) and lead maternity carers (LMCs) and mobile app-based technologies.

### Maternal mental health clinics

‘Maternal mental health clinic’ is an umbrella term for a range of clinical-level services that might be offered through different settings. The exact clinical services delivered will vary by provider. DHBs were asked to report on whether maternal mental health clinics were available in the four settings of:

- hospital campus
- GP practice
- community organisation
- virtually.

Some DHBs described seeing a woman in whichever setting was most appropriate.

**Table 5: Number of DHBs reporting availability of maternal mental health clinics, by setting and region**

		Northern	Te Manawa Taki	Central	Southern
Hospital campus	Pregnant	3	5	6	1
	Postnatal	3	5	6	1
GP practice	Pregnant	0	0	1	0
	Postnatal	1	0	1	0
Community organisation	Pregnant	2	2	1	2
	Postnatal	2	2	1	2
Virtually	Pregnant	3	2	5	0
	Postnatal	3	2	5	2

## Counselling for women experiencing distress

For some mothers, counselling interventions can be extremely helpful in reducing stress and improving mental health and wellbeing. DHBs were asked to indicate whether DHB-provided counselling services, other than counselling already available through other DHB maternal mental health services, was available among their services. Some DHBs indicated that services might not be specific to maternal mental health but available to pregnant women and postnatal mothers through general mental health services.

This type of support is also now being provided through the Budget 2019 investment to expand access and choice of primary mental health and addiction support, including through GP services.

**Table 6: Number of DHBs reporting availability of counselling for women experiencing distress, by region**

	Northern	Te Manawa Taki	Central	Southern
Pregnant	2	2	6	3
Postnatal	2	2	6	3

## Telephone consultation services

Often, LMCs and GPs are at the front line as a first point of contact for a pregnant woman. Early screening to identify issues as they present combined with early intervention often results in the best outcomes and avoidance of escalation to crisis. However, LMCs and GPs are not experts or specialists in maternal mental health, so it is important for these practitioners to be able to connect and consult with maternal mental health specialists. DHBs were asked to report on whether they had a telephone consult service available for LMCs and GPs.



**Table 7: Number of DHBs reporting availability of telephone consultation services, by region**

		Northern	Te Manawa Taki	Central	Southern
GPs	Pregnant	4	2	5	3
	Postnatal	4	2	5	3
LMCs	Pregnant	3	2	4	2
	Postnatal	3	2	4	2

## Mobile app-based technologies

Only one DHB in the Southern region specifically reported having a mental health app, with information about mental health issues during pregnancy, available to be downloaded. While other DHBs did not report having such an app available, several indicated that they refer people to other mobile apps for maternal mental health that they are aware of and view as safe and trustworthy.

# How maternal mental health services are working in DHBs

In addition to asking DHBs to report about the services they provide, this stocktake also sought to gather information about how the services are operating, how women are able to access the services and key gaps or concerns from the DHBs' perspectives. The following discussion combines this qualitative information with the quantitative service information reported in the previous section.

## There is an increasing complexity of need and unmet need and concern that service delivery is inequitable

All our DHBs are aware of significant complexity in family/whānau needs, with only one DHB not specifically mentioning this as an area of concern. This included areas such as birth-related traumas including baby loss, as well as other issues, such as family violence and experiences of disability and environmental challenges to wellbeing, such as housing difficulties and substance abuse. This complexity is compounded by rigid service eligibility criteria and a lack of service availability. A number of DHBs reported a sense that complexity of need and acuity has increased in recent years, which they related largely to social issues, such as poor housing quality or insecurity and the COVID-19 pandemic.

At the same time, many DHBs reported concerns that they are not seeing enough women from non-Pākehā population groups, including Māori but especially Pacific and Asian peoples. One DHB (Nelson Marlborough) noted that it proactively contacts GPs to seek referrals, but others suspected that Māori and Pacific mothers are not accessing primary health care (either GP or maternity services), thus making referral pathways challenging. DHB maternity leaders who provided information also noted that Asian women were very unlikely to access maternal mental health services.

There is also reportedly unmet need across the continuum of care (see 'There are gaps in the continuum of care' below), although two DHBs noted specifically that the rollout of the Budget 2019 investment in primary mental health and addiction services is having a positive impact on addressing mild to moderate maternal mental health needs. One DHB (Lakes) noted that it was funding kaimahi roles in Māori organisations to provide early support for pregnant and postpartum wāhine Māori in communities.

DHBs felt that those who were missing out on services were largely wāhine Māori and Pacific and Asian women, particularly those who were young and at high risk. These women often have moderate need, which can be compounded by complex social issues, such as issues with alcohol and other drugs, family violence and housing. These groups tend to have poor connections with primary health care services, or the screening/support provided in primary health care services is not sufficient or appropriate. All DHBs noted a need for respite services, and almost all wanted to be able to provide wrap-around in-home services for māmā, pēpi and whānau.

## Women already under mental health care

The practice of transferring women already under the care of a mental health team to a specialist maternal mental health team when pregnant was mixed among the DHBs, with the majority (16 DHBs) indicating this was not their practice. This means that a significant proportion of women with high maternal mental health needs will not necessarily appear in maternal mental health service access data but will be receiving support. Not transferring care means these women can maintain a trusting relationship with their existing clinicians, who are in turn often supported by consultation liaison services from the DHB's maternal mental health service or co-management if required.

## Cultural models of care need to be strengthened

Over half of the DHBs (12) reported that they could provide kaupapa Māori models of care for pregnant and postpartum women, but there is variation in how this care is delivered. Few DHBs are offering kaupapa Māori models specifically tailored for maternal mental health. However, most reported working in partnership with local NGOs and/or using a consultation-liaison model, where cultural experts are added to the team that is supporting the woman. Alternatively, some reported they had Māori mental health services that could provide services to hapū or postnatal wāhine Māori with support from maternal mental health if required (rather than specific Māori maternal mental health services).

The region with the strongest focus on cultural provision was Northern, with a range of approaches. Some of the DHBs in this region have built strong relationships with local marae (Counties Manukau DHB), has taken a strong focus on cultural support for DHB staff, including cultural supervision (Auckland DHB) or partnered with NGOs (Northland DHB). Other DHBs in the North Island also have different approaches in place.

Only three DHBs interviewed, all in the Northern region, mentioned specific support for Asian women. One DHB in the Southern region that participated in the survey but was not interviewed, reported having an Asian-specific focus (South Canterbury DHB). Two DHBs mentioned they were developing or intended to develop a Pacific service (South Canterbury and Waikato DHBs).

The availability of different cultural models of care is important because, as noted above, the women the DHBs report as currently missing out on services appear most commonly to be the women who would be best served by culturally specific models of care. As well, the evidence in New Zealand demonstrates that these are also the women who are more likely to develop a maternal mental health condition.

When asked about ways to increase cultural support or reduce barriers for Māori and Pacific and Asian peoples, almost all DHBs talked about the need to build relationships with communities and primary health care and early intervention services, including Whānau Ora. There was a strong focus on the role of NGOs in this space.

## Availability of maternal mental health services from NGO providers

There is a wide variety of NGOs providing maternal mental health care, many of which are kaupapa Māori service providers. Only one DHB said that there wasn't an NGO that provided maternal mental health support in its region. The NGOs named provide a variety of supports, but there was no single NGO identified by DHBs that provides service nationwide (that is, the NGOs identified are delivering services tailored for their local communities).

## There are gaps in the continuum of care

A strong continuum of care is required to address the continuum of needs that women and whānau experience, which may range from mild 'baby blues' to more moderate distress to clinical mental illnesses, such as anxiety, depression, obsessive compulsive disorders or psychosis. Support and care are required at all levels of the environment in which women and whānau live, from homes to communities to health systems, and including the social, environmental and cultural support systems that wrap around and create these environments.

In line with the factors discussed above about the complexity of needs experienced by many women, families and whānau, there was a strong theme from the DHB reports that existing primary supports for young families need to be enhanced in the area of mental health and wellbeing. These services include primary maternity, the Well Child Tamariki Ora (WCTO) programme and GPs. Other services, such as Whānau Ora and Family Start were also mentioned as programmes that helped identify needs and either made referrals or delivered additional support (or both). A number of DHBs noted that there is need for more parenting education throughout pregnancy and postnatally, with one suggesting this should be covered in schools.

The need for earlier access to care and a 'no wrong door' approach was also strongly suggested in the feedback from DHB maternity leaders. DHBs in each region also mentioned a need for more support for women who have moderate maternal mental health needs.

At the same time, DHBs reported a significant gap in respite services, which are either inappropriate (that is, exclude the baby or require a family member to stay with the mother 24/7) or do not exist. Almost all DHBs mentioned the need for respite care, with the majority specifying that in-home respite care was needed rather than beds in a facility. DHBs were clear that women often do not want to leave their families, especially their baby or other children, and that having no other options for respite can add to their distress. Some respite options are clearly unsuitable, for example, requiring a family member to be present alongside the woman at all times.

Some of the DHB interview responses suggested that there may be issues around integration of existing services, as well as gaps. While many DHBs commented on the importance of working in partnership with other providers, some of the staff interviewed were unsure about other provider work in this area. We do not know if this is because the staff were unaware of others' work or if, as seems more likely, work in this space is not well coordinated, especially cross-sector work. It was also notable that only 10 DHBs said that they were able to make referrals to NGOs, but none were asked for reasons around this answer. Conversely, one DHB (Nelson Marlborough) mentioned that sometimes there were multiple agencies wrapping around a whānau in an apparently uncoordinated way, which increased the pressures on whānau.

Many DHBs would like to be able to do more work in communities, including offering outreach and more support for primary health care, but are restricted by staffing/resourcing levels. Some are looking for innovative ways to do this, for example working through staff in community services. Some DHBs also described situations where current work was mostly happening because of staff's personal interests or skills rather than as a result of being an integral part of their job description.

DHBs were also given the opportunity to provide additional comments in a free text field at the end of the online survey. Many respondents wrote about the need for integrated services across the first 1,000 days of life that support māmā, pēpi and whānau.

## We need to support and grow the wider maternal mental health workforce

Nineteen of the 20 DHBs expressed concerns about the availability (or lack) of a maternal mental health workforce in their district, indicating this is a critical issue nationwide. There were issues reported at all levels in both the initial survey and the follow-up interviews, including:

- insufficient numbers of specialised staff, especially psychiatrists, which often leads to minimal access or sharing staff across units
- a need for more ability to provide consultation/liaison and outreach work
- a need for more education for clinicians in maternal mental health and addiction
- a need for more training for the primary health care workforce that engages with pregnant and postpartum women, such as midwives, WCTO and GP staff
- a need for more trained support staff both within and beyond DHBs
- a need for a peer support workforce
- a need to upskill community workers who may come across pregnant/postpartum women
- recruitment and retention issues
- the critical importance of workforce in ensuring that equitable maternal mental health services are available across all locations.

The main types of workforce development needed from the perspective of DHBs are psychology and the primary health care workforce. DHBs were concerned about the insufficient access to psychological therapies in both the community and the specialist setting. Several DHBs identified a need for group treatment such as cognitive behavioural therapy, and several mentioned a need for day-treatment services.

With regard to primary health care, DHBs identified that midwives and WCTO workers required more training in maternal mental health, both initial training and education and ongoing professional development. DHBs reported that the key issue for GPs was a lack of access to support around prescribing medications for pregnant women with mental illnesses. DHBs also noted that many community workers are having to deal with situations for which they are neither trained for nor funded to cope with.

While DHBs indicated that maternal mental health specialist services are considered a desirable working environment, a view supported by anecdotal comments from staff in these services, one of the difficulties with respect to recruiting new staff to this area is that the roles as currently scoped are not practical for people looking for employment. For example, it is not uncommon for a role to be scoped as only 0.2 FTE or to require a single person to deliver services across multiple locations. DHBs also identified issues around needing to bring in experienced maternal mental health specialists, especially psychiatrists, from overseas due to the small pool of this speciality available in New Zealand.

## Eligibility criteria to access DHB maternal mental health services require a live child

We asked DHBs specifically about their eligibility criteria for accessing maternal mental health services. They reported varied criteria, ranging from the woman who is considering conceiving or is pregnant having a previous significant mental illness to the woman having been triaged by specialist adult or child and adolescent mental health services to the woman simply being pregnant or up to one year postpartum. One consistent eligibility criterion across almost all DHBs though was that postnatal women must have a living child in their care.

Eighteen DHBs said that women could self-refer to their services. While this is an important route of access, and self-referral indicates a level of confidence in the service, it was noted in the follow-up interviews that sometimes women appeared to present to specialist maternal mental health services without having accessed either maternity or primary health care services first.

### Services for women experiencing loss

In line with the eligibility criteria discussed above, the majority of DHBs reported little or no service provision via maternal mental health specialist services for women who have lost a baby either in pregnancy, still birth, sudden unexpected death in infancy (SUDI), adoption or by removal from care. Most commonly for these women, the DHBs indicated use of referrals to NGO counselling services (mostly Sands, miscarriage, stillbirth and newborn death support) or, where appropriate, adult mental health and addiction services. Only one DHB in the online survey reported having intake criteria for women without a baby, this DHB also reported providing pre-conception counselling for women with an existing severe mental illness. The vast majority reported that the reason for not providing services to these women was that the criteria for maternal mental health services required the person to be caring for a live baby.

It is important to understand though that the responses to the availability of services for women experiencing loss or who no longer have their baby in their care, specifically related to whether such services are actually available through the maternal mental health specialist services. DHBs identified that these are not necessarily the most appropriate services for such women. In fact, the experience of potentially being in a waiting room surrounded by pregnant women or new mothers could be harmful, causing increased distress, and might even deter these women from engaging further with the services.

DHBs have a range of practices for supporting women who lose a pregnancy or a baby separate from specialist maternal mental health services. However, the DHBs indicated that this group needs more support and service options in the right setting rather than as part of maternal mental health services.

The vast majority of DHBs interviewed also mentioned a similar need for support for women who had experienced pregnancy or birth trauma in either a current or past pregnancy (this was a specific question put to them). Again, these women do not always fit the maternal or general mental health criteria and are mostly being referred to community services. Maternal mental health services often do not become involved with these women until mental health issues arise in a subsequent pregnancy.

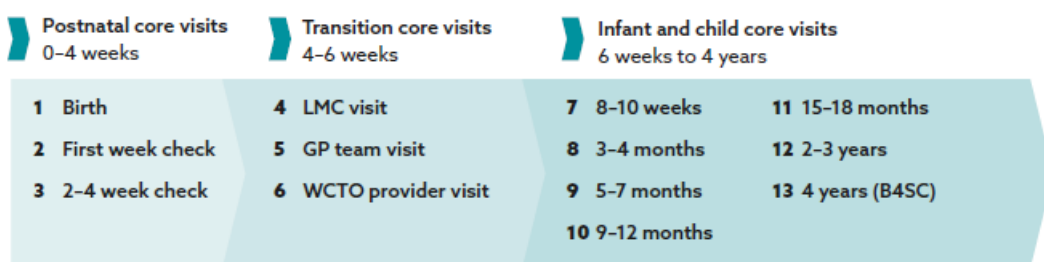
## Other available maternal mental health and wellbeing supports

### Well Child Tamariki Ora

The WCTO programme provides universal early childhood health and development services to all tamariki under five years old and their whānau. The primary objective of the current programme is to support whānau to nurture the early development of their tamariki, establishing a strong foundation for health and wellness throughout life. The programme provides the opportunity for early intervention through referrals to other primary, specialist or intensive health and social services.

A national schedule sets out the expected timing and content of WCTO visits from birth to five years for all pēpi, tamariki and their whānau as shown in Figure 1 below.

**Figure 1: National schedule of timing and content for Well Child Tamariki Ora visits**



The WCTO schedule is based on the presumption that a needs assessment, or a discussion about risks and resilience to various situations, is undertaken at each core visit. This assessment drives not only the emphasis of the content covered at the core visits but also the delivery of any additional visits, as well as potential referrals. Needs in maternal mental health, or related areas such as attachment or breastfeeding, may be identified at these times. Alongside regular review of maternal mental health at each visit, the Patient Health Questionnaire (PHQ-3) must be completed postnatally at the 6 weeks and 3-4 months checks to assess for the possibility of depression.

In 2021, a review into the WCTO programme was released, which found that a fundamentally different, whānau-centred system, inclusive of both intensive and universal services and support is required to support pēpi, tamariki and their whānau in the early phases of life.<sup>33</sup> Such a system would include: wrap-around services that are integrated with other social wellbeing supports, the flexibility to increase service intensity in response to need and improvements to simplify the pathway for all whānau to access universal screening and early intervention services. In the next phase of work, there will be actions to transform the early years' health and wellbeing system for pēpi, tamariki and their whānau.

## Well Child Tamariki Ora enhanced support pilots

The Budget 2019 mental wellbeing package included an initiative to pilot and evaluate enhanced support for parents and whānau with mental wellbeing needs in the first two years of their child's life. Funding of up to \$10 million over four years was allocated for an initial three pilots.

The Budget 2019 announcement indicated that the three pilots should be based on the extended WCTO service trialled in Hawke's Bay DHB in 2011. This pilot was based on New Zealand research into what young mothers want from the WCTO service.

Three providers who are already delivering the national schedule of WCTO services have been contracted to deliver the enhanced support pilots. These providers use an enhanced model of care that is whānau/aiga-centred, relationship-based and flexible enough to be able to respond to whānau mental wellbeing needs. The pilot site locations were selected for their high Māori and Pacific populations but have their own unique system contexts. They are:

- Lakes DHB – the service Tiaki Whānau is delivered by Tipu Ora (the WCTO arm of Manaaki Ora Trust) located in Rotorua
- Counties Manukau DHB – the service Vaka Ako is delivered by South Seas Healthcare (Start Well, another WCTO provider in Counties Manukau, provides advice as a stakeholder.)
- Hauora Tairāwhiti – in development.

The initiative supports each whānau with a kaitiaki (key worker), who may be a nurse or kaiāwhina, supported by a multidisciplinary team, who will ensure young parents and their whānau get the additional support they need for three years, starting in pregnancy. This support may be for mental health, health care, help with access to social services or education or helping whānau learn about parenting and child development. The service supports the holistic wellbeing of parents and their whānau and uses a strengths-based approach. It delivers service using a culturally appropriate model of care and an intensive and consistent relationship with a key worker and team. Despite the early stage of the service, positive changes are already becoming apparent.

<sup>33</sup> Ministry of Health. 2021. *Well Child Tamariki Ora Review Report*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/well-child-tamariki-ora-review-report-2020-jul21.pdf](http://www.health.govt.nz/system/files/documents/publications/well-child-tamariki-ora-review-report-2020-jul21.pdf) (accessed 21 October 2020).



## Primary health care maternity services

During an initial visit or booking visit, a midwife will gain a complete health history including the mental health of the woman in her care. At this point, if there are any mental health needs that are not being addressed, the midwife would refer the woman on to the appropriate service, if needed. Discussing mood and mental health is also a part of the ongoing health assessments that happen throughout pregnancy. If a midwife is concerned at any stage of the pregnancy or postnatal period, she would ask the woman to complete an Edinburgh Postnatal Depression Scale (EPDS). The midwife would communicate any mental health concerns with the woman's GP once the midwife discharges the woman, at between four and six weeks postnatally.

## Expanding access and choice of primary mental health and addiction support

Expanding access and choice of primary mental health and addiction support was a key focus of Budget 2019. This five-year programme is building a missing component in the mental health and addiction system for people with mild to moderate mental wellbeing needs.<sup>34</sup> While it is not specifically targeted at maternal mental health (or any other type of mental health issue), it is accessible and suitable for addressing maternal mental health issues.

As at the end of August 2021 (most recent figures available), new integrated primary mental health and addiction services accessed through GPs were operating in 268 sites around the country. These services have delivered over 183,000 sessions since the rollout began and cover an enrolled population of over 1.7 million people or around one-third of all New Zealanders.<sup>35</sup>

Contracts are also in place for 14 kaupapa Māori, nine Pacific peoples and 18 youth-specific services, as well as for mental wellbeing supports for Rainbow young people. In addition to new services, we are growing and upskilling our existing mental health and addiction workforces, as well as developing new workforces such as health improvement practitioners and health coaches who are working alongside GP teams.

<sup>34</sup> For more information on this programme, see the Expand access and choice of primary mental health and addiction support webpage on the Child and Youth Wellbeing website at: <https://childyouthwellbeing.govt.nz/actions/actions-outcome/expand-access-and-choice-primary-mental-health-and-addiction-support>.

<sup>35</sup> The Ministry is working with providers to improve reporting quality and consistency, so there may be retrospective changes to reported figures as capability improves.

## Telehealth services

In addition to the services described above, New Zealand has a suite of telehealth services that can provide advice, support and referral for maternal mental health issues. These include:

- Healthline – a 24/7 general health phone advice line staffed by registered nurses, paramedics and health advisors
- 1737 Need to talk? Depression Helpline – a 24/7 phone or text service focused on mental health and wellbeing, staffed by trained counsellors. This service provides brief one-on-one counselling, as well as care planning and transfer to other services, and has the option for callers to speak with a peer-support worker
- The Lowdown – a phone, text and online service that provides support to help young people recognise and understand depression or anxiety
- PlunketLine – this 24/7 parenting support and advice phone helpline is staffed by registered WCTO nurses and can provide support for all families and whānau, including maternal mental health support. It is available to anyone, not just Plunket clients.

## Services funded by other agencies

There is a range of services and support for families that are funded or provided by other government agencies and that can provide some of the support people with maternal mental health issues need. A good example of this is Family Start, which is funded by Oranga Tamariki, Ministry for Children, and delivered by a range of NGOs.

Family Start is a nation-wide early home visiting programme, primarily for whānau during the early stages of pregnancy (from three months) up to when a baby is one year old. Family Start may continue with the same family until a child is school aged if needed. The programme works with whānau to improve a child's health, learning and relationships.

Family Start can become involved when a parent or caregiver faces challenges, such as:

- mental health issues
- drinking, drugs use or problem gambling
- child abuse
- serious problems with partners, family or whānau
- knowing how to make sure a child is healthy and growing strong
- a child with a disability or needs special care
- needing Oranga Tamariki involvement
- needing extra support as a young parent.

Family Start does not provide specific maternal mental health services, but it provides services that support mental wellbeing, and it may be working with the same families/whānau as the DHB maternal mental health services.

Eight DHBs said that there were services such as this in their area that they could make referrals to. Eighteen DHBs said that they accepted referrals from these types of services. This reinforces the idea that the DHB-provided maternal mental health services contained in this stocktake only represent a part of the service environment that is available. There may be opportunities to create better links and referral pathways in this area.

# Looking forward

## Working towards equity and implementing te Tiriti o Waitangi

Both the health and disability and early years systems – the key systems that encompass maternal mental health – are delivering persistently unfair, unjust and avoidable worse outcomes for Māori, Pacific peoples, those with disabilities and those living in areas of high deprivation. It is apparent that the way these systems currently operate is to the detriment of these populations, and these systems are not delivering equity. Addressing these issues at a system level will be essential to improving maternal mental wellbeing and whānau ora in New Zealand.

With regard to Māori in particular, meeting our obligations under te Tiriti o Waitangi is necessary if we are to realise the health and disability system's overall aim of pae ora: healthy futures. This means ensuring we deliver our work based on the principles set out by *Whakamaua: Māori Health Action Plan 2020–2025*,<sup>36</sup> which were drawn from *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*,<sup>37</sup> and include:

- tino rangatiranga – enabling Māori to design and lead solutions for Māori
- equity – demonstrating a genuine commitment to addressing inequities for Māori
- active protection – evidencing how we are driving equity for Māori in our approaches, decision-making processes, investment and power devolution
- options – there is investment in kaupapa Māori solutions (noting this should be driven by Māori rather than mainstream providers)
- partnership – sharing power/decision-making and co-designing solutions with Māori.

Enabling and embedding these principles in the health care services provided to help mental health systems and parents, families and whānau through the early years of child rearing will ensure we are actively protecting and driving equitable health outcomes for Māori, whilst providing more options and better access to a range of primary, community and secondary health services.

<sup>36</sup> Ministry of Health. 2020. *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025](http://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025) (accessed 20 October 2021).

<sup>37</sup> Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*. Wellington: Waitangi Tribunal. URL: [https://forms.justice.govt.nz/search/Documents/WT/wt\\_DOC\\_152801817/Hauora%20W.pdf](https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf) (accessed 21 October 2021).

# Transformation as an opportunity

Both the mental health and addiction system and the wider health and disability system are undergoing significant transformations. While periods of major system change can create uncertainty, they also offer key opportunities for moving forward and reimagining how things could be.

## Mental health and addiction system transformation

In 2021, the Ministry published *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (Kia Manawanui)*<sup>38</sup> to set the broad vision of a shift in the mental health system from a focus on mental illness to a focus on mental wellbeing.

The system-wide goal of *Kia Manawanui* is pae ora: healthy futures. Pae ora is made up of three interconnected elements – wai ora (healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals). Maternal mental health is affected by and, in turn, affects each of these areas.

With the long-term direction set by *Kia Manawanui*, the Ministry's next step is to detail what that direction means for the mental health and addiction system, including maternal mental health services. One of the first actions from *Kia Manawanui* is to develop a mental health and addiction system and service framework to guide health organisations in delivering and integrating mental health and addiction services.

The Ministry is now working in collaboration with the team leading the wider health and disability sector reforms to develop the framework, which will contribute to the development of a national health plan for New Zealand.

## Health and disability system transformation

A new Māori health authority and a new organisation called Health New Zealand will be established as part of the health and disability system transformation. Together these entities will ensure the services that are procured and delivered are appropriate and meet the needs of the people accessing them, with a focus on improving equity for Māori. Services will no longer be delivered, or funded, through DHBs. Instead, there will be local and regional networks.

As the design of local and regional networks progresses, as well as the design of service frameworks to guide the delivery of services at the local and regional levels, there will be opportunities to ensure that maternal mental health is considered in a holistic manner across the continuum of care and need.

<sup>38</sup> Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing](https://www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing) (accessed 21 October 2021).