CENTRAL REGION

Infant and Maternal Mental Health Services

Environmental Scan

December 2023

Te Whatu Ora
Health New Zealand

Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addiction and Intellectual Disability Service

Contents

Purpose

This report was commissioned by Te Whatu Ora National Mental Health Commissioning to outline the current state of the Maternal and Infant Mental Health services in the Central Region of New Zealand. The Central Region 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 Manawataki and Te Waipounamu Regions.

As part of the $100 million package for mental health specialist services apportioned in Budget 2022 the government invested $10.1 million over four years for infant and maternal mental health across Aotearoa. This report will inform the Te Whatu Ora Mental Health & Addiction and Kahu Taurima – Maternity & Early Years commissioning processes nationally, regionally and at locality level. It will also help to inform quality improvement initiatives for perinatal specialist mental health and maternity services. Our ambition is that children, mothers and whānau can access specialist support services around New Zealand and access to appropriate Māori services will be improved.

Ngā mihi nui - Acknowledgements

Thank you to every person and service that participated to inform this report.

Thank you to the birthing parents and their support people who participated in the Maternal Mental Wellbeing Lived Experience survey across the Central Region. Thank you for sharing your information, and describing what is working and what can be better. You contribution will ensure parents in the future receive improved access to care and support if they experience mental well-being distress.

Thank you to Maternity, Mental Health and Primary Care service leaders and staff who shared their insights, challenges and aspirations.

Thank you to NGO leaders who provided insight and wisdom, and who continue to advocate for birthing parents.

Thank you to The Central Region Infant and Maternal Mental Health Advisory group – you have brought strength and integrity to this kaupapa. This report is built on your contextual knowledge and insights.

Thank you to the Mental Health, Addiction and Intellectual Disability Service (MHAIDS) support teams, Data and Analytics, Communications, and Commissioning.

Thank you to the other Project Managers across NZ for your collaboration and support.

Executive Summary

Context

This environmental scan was overseen by the Central Region Mental Health and Addiction Leadership Group, and supported by the Central Region Infant and Maternal Mental Health Advisory group. The environmental scan was conducted from August to November 2023 across services and communities in the Central Region.

Previous work undertaken by Central Region districts such as First 1000 days reports and plans, Maternity Quality and Safety reports, and Maternity and Mental Health Service reviews, were also used to inform the recommendations.

Approach

To ensure the environmental scan was delivered in a timely, ethical and well informed manner a short term Central Region Infant and Maternal Mental Health Advisory Group was set up to provide oversight, advice and expertise. This allowed wider stakeholder input and safeguarded transparency and relevance of the work to the sector. The Advisory Group also applied an equity lens and application to their oversight.

The voices of whānau across the Central Region that had experienced mental distress and illness associated with pregnancy, childbirth or having young children were collected to inform this report.

Clinical perspectives from the maternity, primary care and mental health sector, and community perspectives from NGO leaders were collected in person and with phone interviews, online surveys and feedback via the advisory group.

Data analysts supported the scan using data specific to the birthing population and specialist mental health service use in the Central Region. Lived experience information, operational insights and data were incorporated to ensure the insights derived reflected the whole context.

Findings

The scan has revealed that in the Central Region the current pathway from maternity, primary care, and community mental health into perinatal mental health is not working well for many parents, and discharge pathways back to community services needs improvement. This lack of integration impacts on the experience of parents.

There is a lack of supportive ‘respite’ services in the community where parents with mental distress can receive additional advice, help and support.

Tailored Access and Choice programmes in Primary Care are meeting the needs of parents with mild to moderate perinatal distress, however this approach is not evident across the whole region.

Perinatal mental health service models differ across the Central Region, some services have evolved to respond more effectively within the current mother and infant ecosystem, while others require a new design. The current regional coordination service model is no longer needed, although regional connection for the workforce is still helpful.

The needs of mothers with existing mental health illness, (described in the perinatal service specification) are usually addressed by community mental health teams and not by perinatal mental health teams.

Infant mental health services, especially for infants under one year are poorly understood and not frequently accessed in this Region. Significant work is required to resource, integrate and promote infant mental health in the Central Region.

We found low rates of access to perinatal mental health services for young Māori mothers. The Māori workforce in specialist perinatal mental health is limited, and there is an absence of a dedicated cultural advisor role in teams.

Resourcing, access criteria and service model design impact on how well services are able to respond to the needs of birthing parents (mothers) with mental distress. We stress that where services are meeting the population need, these initiatives should be maintained and where possible leveraged further.

Recommendations

Continuum of care and pathways

- Invest in and integrate Infant Mental Health services holistically into the current suite of specialist perinatal mental health services.
- Equip all Primary Care and Iwi/Māori Access and Choice teams to assess and respond to mild to moderate perinatal mental health distress and ensure these teams have an escalation pathway via the General Practitioner or directly into the perinatal specialist service.

Responding to the needs of Māori whānau.

- Develop a kaupapa Māori component to the secondary perinatal mental health service that incorporates mātauranga informed care and traditional modalities of healing for whānau during the perinatal period. Resource a Māori cultural advisor as part of the perinatal specialist service team, this role would participate in MDT's and attend whānau hui/assessments when appropriate.

Model of Care

- Ensure Perinatal Mental Health teams provide specialist perinatal mental health care plans for birthing parents who have existing mental health illnesses.

Address the needs of priority populations

- Ensure services are safe and welcoming for people from priority populations.
- More holistic approaches are required in perinatal mental health engagement, ensuring people of all cultures and genders feel welcomed, safe, and respected.
- Ensure the FTE and skill mix apportioned for perinatal mental health teams reflects the needs and diversity of priority populations.
- Include lived experience peer support roles in multidisciplinary teams.

Regional approach and Kahu Taurima

- Replace the current Regional Maternal Mental Health Coordination service with a regional (or national) Perinatal Mental Health Community of Practice (COP). This COP would enable clinical peer support, translate relevant research into practice and ensure consistency and connection across the region (or nation).
- Take a regional multi-system (maternity, neonates, mental health, primary care, public health & Te Aka Whai Ora) approach to design integrated operational models for perinatal mental health services, to ensure an integrated and proactive response to mothers and infants.

SECTION ONE - Introduction

In this report we set out the current environment of perinatal mental health services across the [1]Central Region of New Zealand. We look at the demographics of the birthing population and their access to specialist perinatal mental health services. We use the term mother and birthing parent interchangeably in this report, out of respect for Rainbow parents who find the gendered term of mother unhelpful.

We have rich information from the lived experience survey, with insights about what is most important to whānau. Whānau voice asserts that mental wellbeing distress needs to be attended too no matter what the severity. We found that mothers want to be asked about their mental wellbeing by clinicians, and they want to have access to safe and effective services. Mothers, and their partners want to be better equipped to anticipate and deal with their mental wellbeing needs.

There are barriers and challenges for parents to access perinatal mental health services, and these are described. Importantly birthing parents did not differentiate maternity services from maternal mental health services during this part of their journey in the health system. Rainbow birthing parents and parents born overseas described significant challenges navigating the maternity system as a whole. A significant number of mothers described how trauma impacted them in the perinatal period and how they felt unsupported and disrespected by the system (maternity and mental health) as a whole.

By cross matching the data of all the birthing parents in the region, with data in mental health and addiction services, we have a comprehensive picture of how many mothers are currently accessing mental health support services, and how many may be missing out. We also looked at how many infants are receiving mental health care, which showed there is significant room for improvement.

We used feedback from across maternity and mental health operations to help ensure we interpreted the data correctly, and also to help understand the current challenges and opportunities for services. We looked into the journey of parents from their home, interacting with community and primary care services, and then onto specialist services and home again. Referral pathways, eligibility criteria, service capacity and therapeutic modalities have been described. We also looked at each district in the Central Region separately to highlight their bright spots and challenges.

Overall this report outlines the perinatal mental health services in the Central Region, the parent's perspectives on these services, and data for the whole of region showing service provision and use. Described are the positive developments that are making a difference and the opportunities to improve so that birthing parents and their children can be supported to thrive.

[1] Whanganui, MidCentral, Hawke's Bay, Wairarapa, Capital, Coast and Hutt Valley.

Methodology

The objectives for this report were informed by the National Mental Health Commissioning Team Service Level Agreement (SLA). We were asked to provide a report outlining the results of an environmental scan of all infant and maternal mental health services in the Central Region, the purpose of which is to:

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

From the beginning project leads across the four New Zealand Health Regions worked closely together to provide national consistency and share learnings. The maternal mental health lived experience survey was developed in collaboration with the other regional project managers, nationally over 500 birthing parents responded to the survey.

We used a combination of lived experience survey feedback, service and NGO leadership feedback and relevant data to inform our findings. Our methodology was to identify the information we needed from the start and then seek out this information from the key sources. When we found something unexpected we investigated further to ensure we understood correctly.

This report has been guided by the Central Region Infant and Maternal Mental Health Advisory Group. This group was initiated to support the work programme and ensure perspectives from across the region and professions were included. All members work within the health system, and hold important contextual information on the pathway that birthing parents travel along when they experience mental wellbeing distress. To ensure equitable oversight the Advisory Group included a 50:50 mix of Māori and non-Māori members, and members represented all 6 Districts within the region. The [2]Ngā Paerewa national standards were used to help identify how services reflect Ti Tiriti in their operating models.

[2]https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standard

Information and insights

Information was gathered on the types of services offered through direct engagement with clinical teams and leaders across the six districts that included:

- Specialist Maternal Mental Health (MMH) Team Leads,
- iCAMHS/MICAMHAS Team Leads,
- Community Mental Health Team Leads,
- Commissioning Leads,
- LMCs and community midwives,
- Iwi Māori Providers with Māori Mental Health / Family Start services,
- Well Child Tamariki Ora Services,
- Primary Care/PHO Mental Health team leads,
- District Equity Leads,
- NGO provider leads.

We also undertook an in-depth analysis of the data available on birthing mothers and the mental health services they interface with. This analysis included referral rates, waiting times, referral sources and discharge destinations.

Relevant data sources included:

- Birthing parent data for the 2021/2022 year directly from the districts. This data covered births that had had some level of engagement with the hospital setting, either prior to, during or directly after the birth (including stillbirths). It did not cover all home births.
- Programme for the Integration of Mental Health Data (PRIMHD) to understand the use of secondary (specialist) mental health services[3]. PRIMHD contains Ministry of Health funded secondary mental health and addiction service activity and outcomes data. The data is sourced from District Health Boards and NGOs. Each organisation submits their data individually into the PRIMHD data base.
- Ministry of Health official birthing numbers when reporting high-level trends in this report[4].

The data added useful context to what we heard through interviews and also informed further lines of questioning. All data insights have been peer reviewed to ensure this work is repeatable and reliable to inform the readers of this report.

Constraints:

The timeframe available to complete this work impacted on the ability to reach some community services and advocacy groups. We prioritised gathering lived experience feedback, and technical data and analysis. We recognised that over the past 5 years a number of early years and maternity reports have gathered insights from the community already. This project was undertaken during a time of upheaval within Te Whatu Ora - Health New Zealand as the previous DHB model transitions into a National, Regional and Localities model.

[3] https://www.tewhatuora.govt.nz/our-health-system/data-and-statistics/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data/
[4] https://tewhatuora.shinyapps.io/report-on-maternity-web-tool/

SECTION TWO – Data and Analysis

Central Region Lived Experience Feedback

We invited birthing parents and their partners across the Central Region to participate in a survey about their lived experience of perinatal distress and access to mental health services. All participants surveyed had experienced perinatal mental health distress including anxiety, depression, intrusive thoughts, and difficulty coping with the necessary activities of life during their pregnancy or in the year after, and had given birth in the past 5 years. 221 respondents participated in the survey in the Central Region. Participants described their experience and insights, including when they didn't access a service. 70% accessed a service to help them with their mental health distress. (NB: Participants have consented to their anonymised information being used by Te Whatu Ora - Health New Zealand for improvement of maternal mental health services).

Ethnicity and age range of participants:

- 78% of survey participants identified as non-Māori/non-Pacific, including New Zealand born European, Asian, South American, and European born outside New Zealand
- 20% identified as Māori
- 2% identified as Pacific Peoples

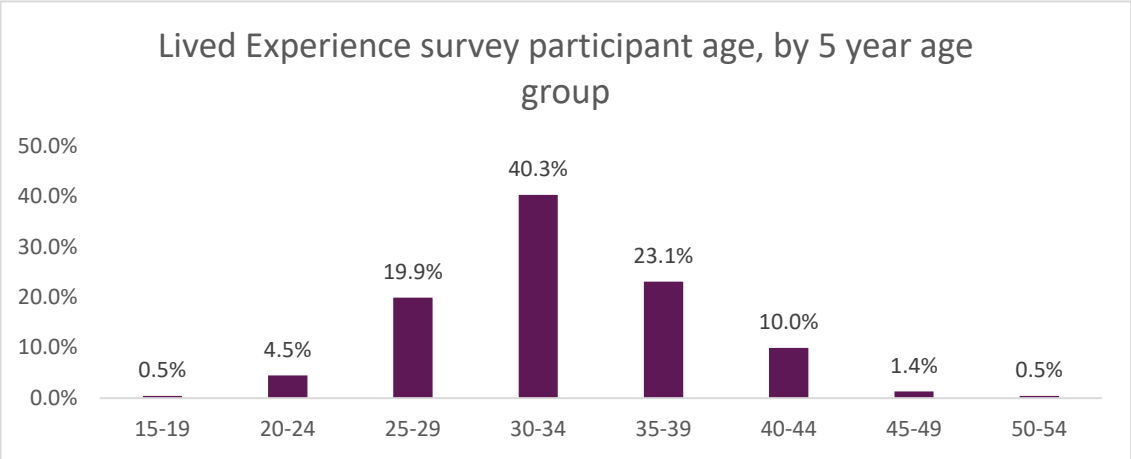


Figure 1.1 Age breakdown of lived experience survey participants

What makes a positive difference for parents with perinatal mental distress?

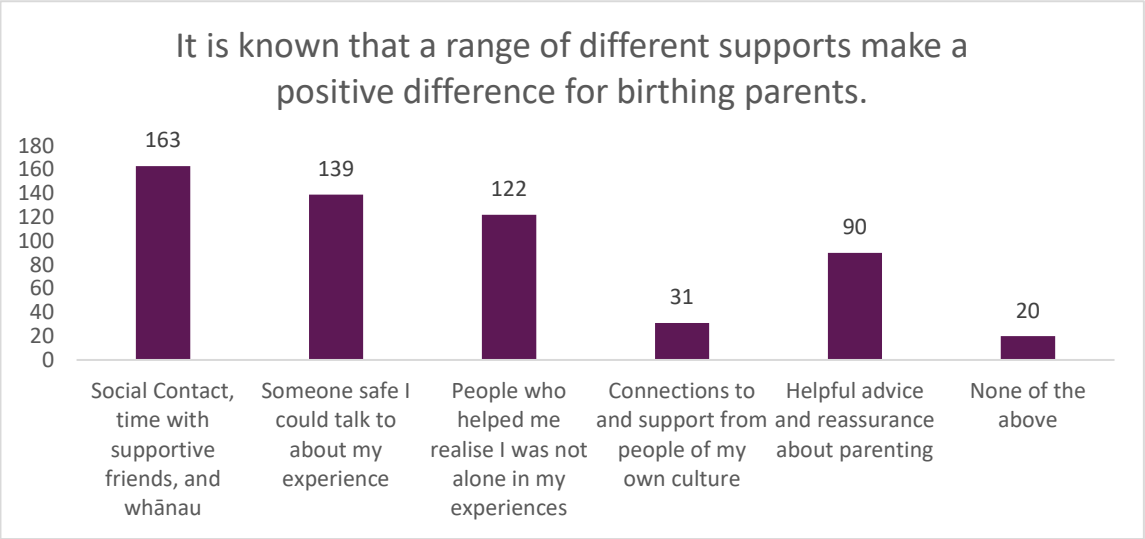


Figure 1.2 Access to different support in your community.

We asked participants about what supports they had access to that can make a positive difference to wellbeing (Figure 1.2). Many had social connection and a safe person to talk too, however for some they had no support at all, and access to support people from their own culture was lacking.

We also asked about practical support that can make a positive difference to people's wellbeing (Figure 1.3). Less than half the respondents had support so they could sleep, available child care, prepared meals to heat and eat, or time out with their partner. This practical support is an area where community based initiatives and investment could make a significant difference to the mental wellbeing of parents. This is an opportunity for the social sector and philanthropic sector to collaborate with the health sector to invest in wellbeing outcomes.

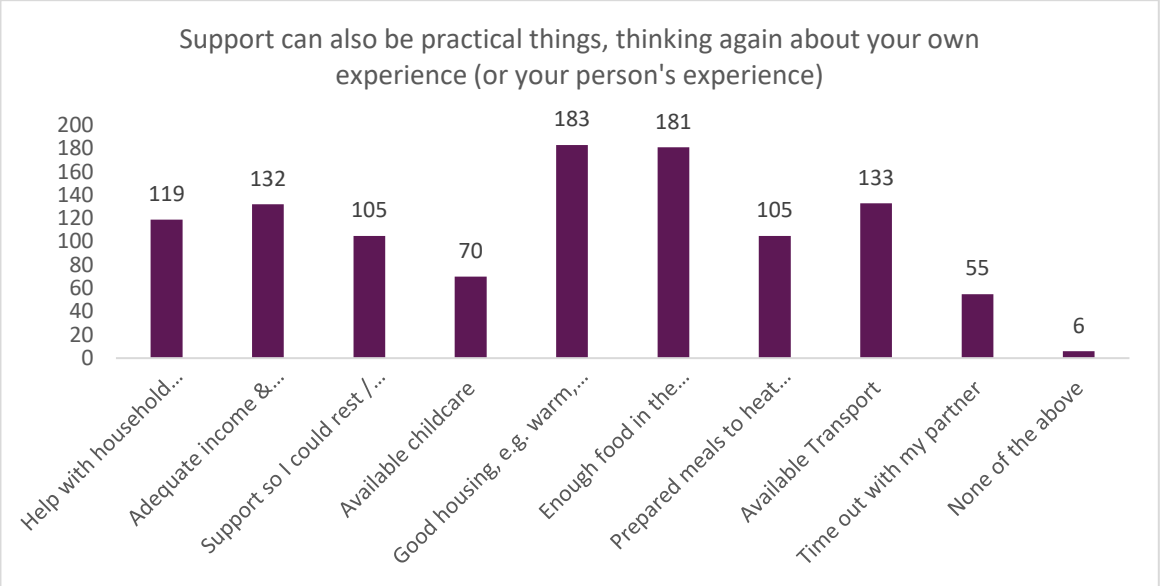


Figure 1.3 Access to Practical Support

Access to perinatal mental health services.

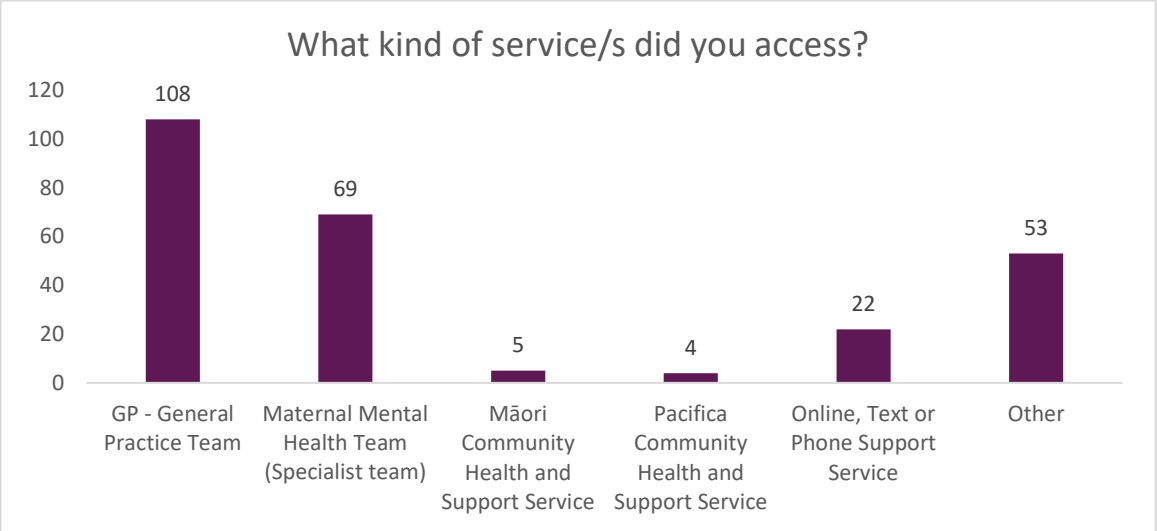


Figure 1.4 Type of service accessed for perinatal mental health distress

When asked about what kind of services parents accessed to help them with their mental health distress, about 50% of the respondents accessed their General Practice Team (GPT), and about 30% gained access to a maternal mental health (MMH) service (Figure 1.4). A cohort also mentioned other types of services they accessed to help with their mental health needs these other services included:

- Private Counsellor (self-funded, costs mentioned were $80 -$200 per session)
- Free and low cost community counselling services
- Workplace EAP counselling
- Community Mental Health Services
- ACC funded therapist

What was the best help?

We asked parents about the best help they received during their pregnancy, and then after the child was born for their mental health distress. The most frequent responses were support from their midwife in the antenatal period, GPT support in the post-natal period, and overall support from their family and friends. Practical support, health and social professional services and were also consistent themes.

However when reviewed with a specific lens across responses from Māori participants midwives remained frequent, but GP teams were not. This is important when considering designing service access pathways into specialist perinatal mental health services for mothers who don’t have access to the GPT, or who don’t use their GPT when they experience distress.

What could have been be better?

For those who were receiving perinatal mental health services we asked what could be improved. The top five key themes are:

- MMH specialist services need to be accessible for women experiencing MMH distress, regardless of severity.
- Services need to be safe, and responsive to individual needs.
- Access is needed to free/affordable specialist perinatal mental health professionals. General Practice visits (related to maternal mental health) should be free.
- Health Professionals need to be better informed, and actively screen for maternal mental health distress.
- Parenting preparation, and maternal mental health information should be made available in the ante and postnatal phase. Pamphlets are not the best way to provide this information.

Access to Maternal Mental Health Services

We asked participants about their experience with accessing maternal mental health services. While the survey questions were posited in the positive many participants described negative experiences, particularly disappointment with access to services and with the actual service received. The below comments reflect the themes regarding access to maternal mental health services:

- Accessing help was hard.
- I was told I was not eligible for services, but there was nowhere else to go
- I fell through the cracks.
- The waiting list was so long, I gave up

This feedback supports the need to ensure that pathways into appropriate services are strengthened. Specialist services need to have transparent and consistent criteria, and if a birthing parent does not meet the criteria then alternative referral pathways are needed. The opportunity is to develop more primary care and community services that are affordable and meet the needs of these parents.

Reflections on the service

We also asked participants about their insights after they finished with the mental health service (both GPT and MMH), only 43% agreed that staff were helpful and respectful, 32% indicated the service was available when they needed it and 21% agreed it was easy to find the help they needed. Only 5% said they were discharged to a community support organisation after they finished.

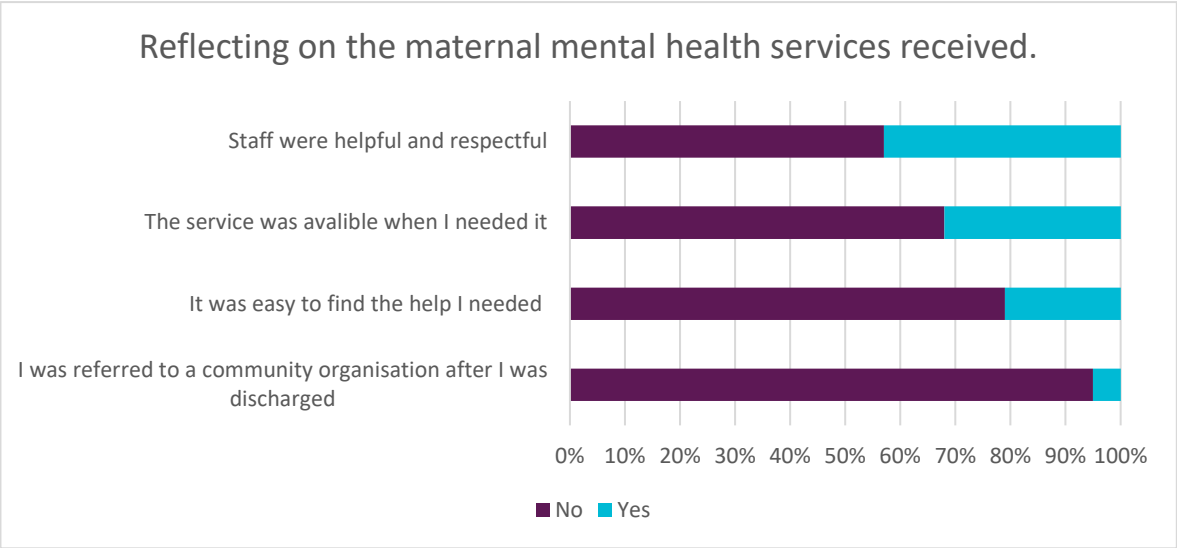


Figure 1.4 Lived experience survey participants reflect on the mental health services received.

While some mothers reported good experiences the percentage of negative feedback indicates the need to improve. Adopting kaupapa Māori manaakitanga approaches within the services that ensure all birthing parents regardless of ethnicity, sexual orientation, or age feel welcome, safe and respected is a good first step.

The survey also sought responses from participants who did not access any mental health services. Mothers and their support people described several themes that impacted them and prevented access:

- A lack of knowledge and awareness of what services are available
- Services were not available
- Family supports were adequate
- Rurality and distance prevented access
- Concerns with stigma and trust in the service ("I was worried about what might happen to my child if I asked for help")

Other barriers to accessing services were also identified in the survey. For these parents the issue wasn't availability of the service it was related to clinical practice, and affordability.

Barriers included:

- Financial
- Previous negative experience accessing MH services
- Delay in access to GPT
- Different GP/Plunket Nurse/Midwife delivering care = inconsistent relationships
- Limited or no MMH screening by Health professionals

Birthing parents' data:

Snapshot of the Central Region

Figure 2.1 shows that Māori whānau are having babies at a higher rate than non-Māori and non-Pacific whānau. Generally Māori and Pacific Peoples have their babies mostly in their twenties, while non-Māori / non-Pacific mothers have their babies in their thirties. This is important to note when designing perinatal mental health services to meet the population profile.

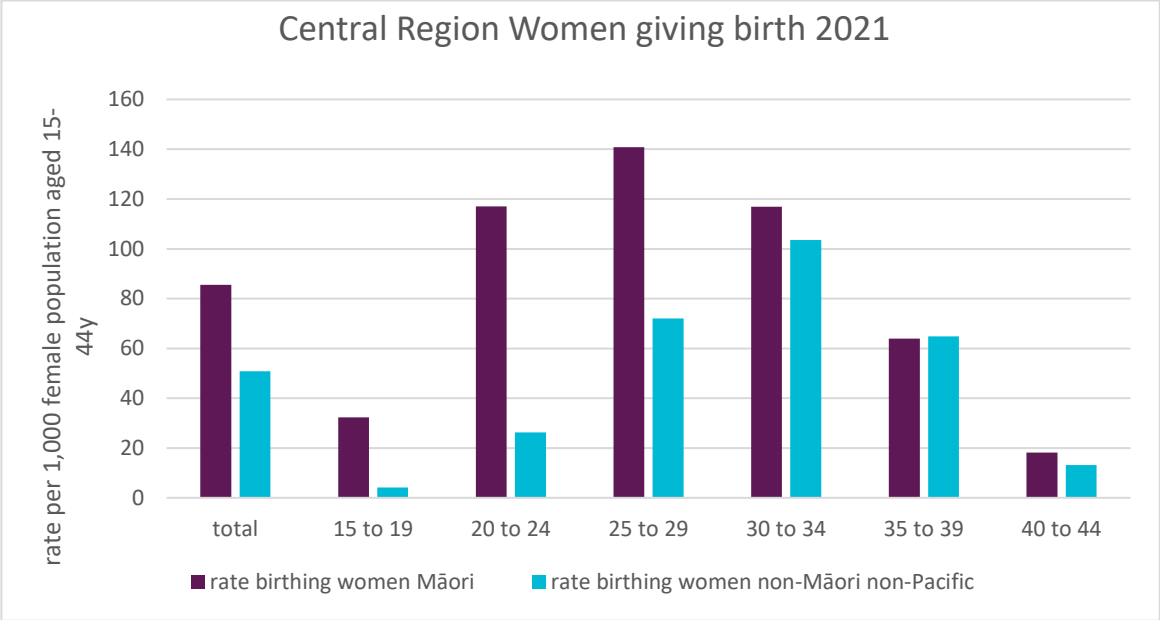


Figure 2.1 Central Region Women giving birth in 2021

In total 11,309[5] women gave birth in the Central Region in 2021
• 7,160 were non-Māori / non-Pacific (63%), • 3,347 were Māori (30%) • 802 were Pacific Peoples (7%).

Table 2.1 Breakdown of birthing parents ethnicity across the Central Region

For further insight we looked at ethnicity in each district so that leaders can ensure the perinatal mental health service reflects the diversity in the districts. Figure 2.2 identifies the percentage of mothers by ethnicity for each district in the region. The highest number of Māori birthing parents are in Hawke's Bay (959), followed by MidCentral (769). Capital Coast and Hutt Valley have the highest numbers of Pacific Peoples birthing parents (523).

[5] Data Source https://tewhatuora.shinyapps.io/report-on-maternity-web-tool/

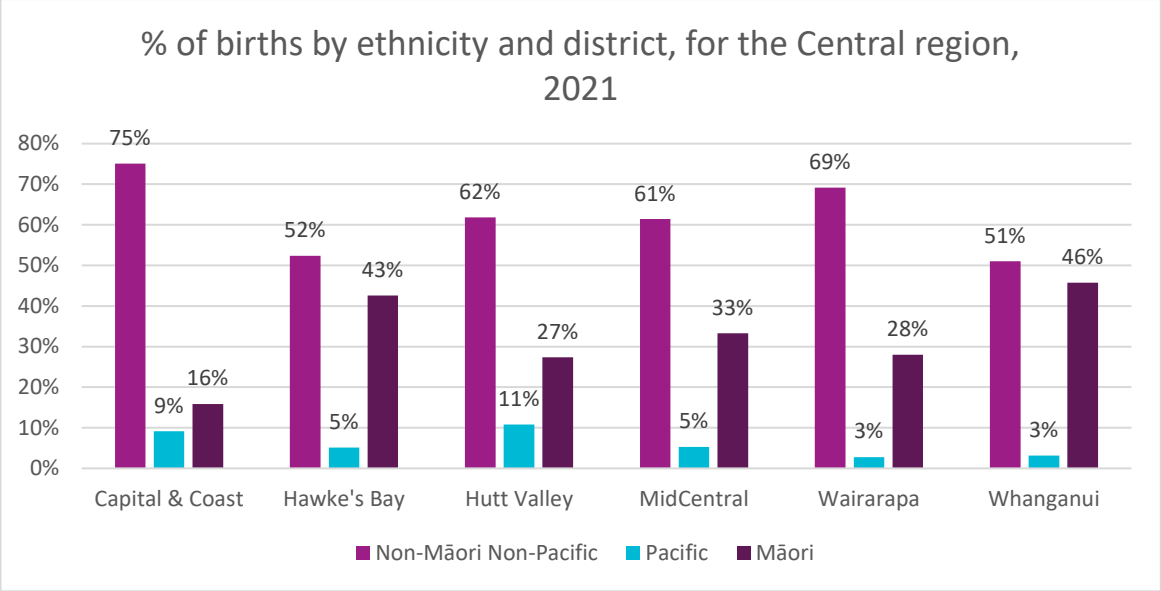


Figure 2.2 the % of Births by ethnicity and District across the Central Region, Ministry of Health maternity data.

Perinatal Mental Health Service Use

We expect 15% of the birthing parent cohort in the Central Region will experience significant (moderate to severe) mental health distress (Wilkinson, 2022). This equates to 1,696 birthing mothers in the region, the table below shows the figures broken down for the Districts.

Zone	Total Births 2021	15%
Central Region	11,309	1,696
Wanganui	815	122
MidCentral	2,308	346
Hawkes Bay	2,254	338
Wairarapa	571	86
Capital, Coast and Hutt	5,364	805

Table 2.2 Anticipated numbers for perinatal mental health service use using 15% indicator.

Actual activity for the region for the 2021/22 birthing cohort is 980 women or 10% (defined as anyone with any activity with any specialist mental health service use in the 9 months prior to 12 months after birth). Some mothers may be receiving mental health care in the community from Primary Care Teams, and some mothers may be missing out altogether.

To ensure we gathered the full picture of mental health service use by mothers in the region we looked at both the referrals accepted for triage into maternal mental health, and also the total referrals of mothers into all secondary mental health services, (inclusive of community mental health and addiction services).

Zone	Count all birthing mothers	Count all MHA contact (inclusive of MMH)	% of total	Count only Maternal Mental Health contact	% of total
Central Region	10227	980	10%	459	4%
Whanganui	753	132	18%	75	10%
MidCentral	2113	173	8%	83	4%
Hawkes Bay	2157	184	9%	83	4%
Wairarapa	520	66	13%	26	5%
Capital, Coast & Hutt Valley	4684	425	9%	192	4%

Table 2.3 Actual service access across the Central Region – please note that we used different data sets to accurately cross match the birthing population with mental health service use so the numbers do not align exactly with Table 2.2.

The figure below (figure 2.3) shows the volumes of referrals for the maternal mental health services in the Central Region for the three year period 2020/21 through to 2022/23.

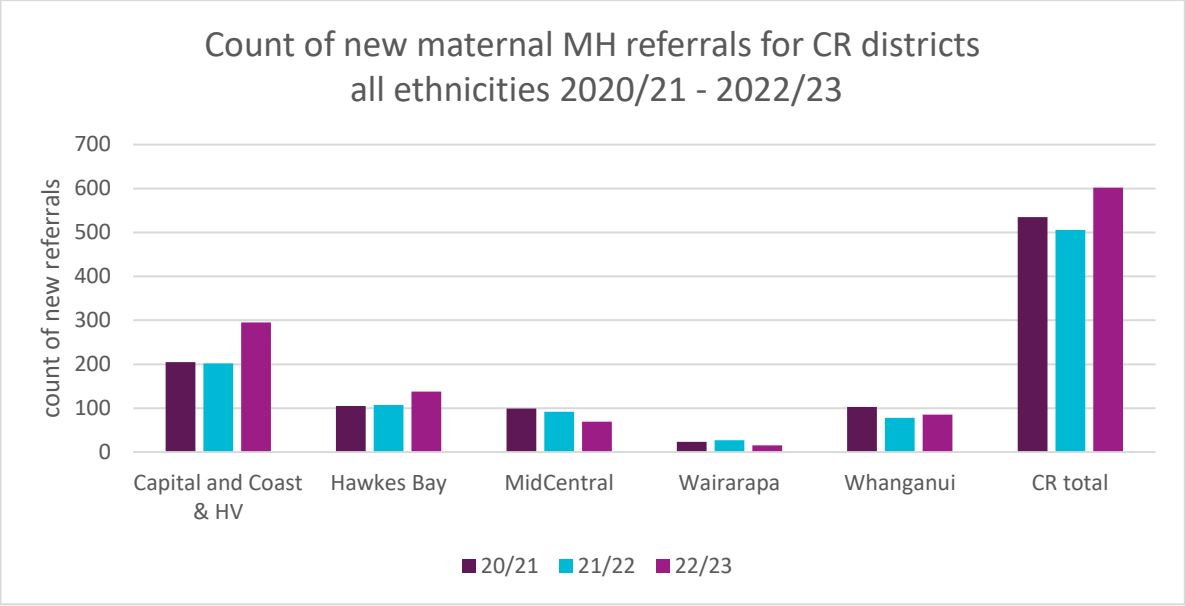


Figure 2.3 Volumes of MMH referrals across the region 2020/21- 2022/23.

Mothers with pre-existing mental health needs:

In the Central Region in 2021/22 for the whole cohort:

- 1 in 3 mothers aged under 20 years
- 1 in 5 Māori mothers
- 1 in 10 Pacific Peoples mothers
- 1 in 12 non -Māori / non-Pacific mothers

Accessed specialist mental health services in the 5 years before they became pregnant.

This insight indicates it is important to ensure that perinatal mental health services are working proactively with maternity and community mental health services to provide care planning for these mothers with known mental health needs. International best practice indicates 'anticipatory' care planning for these mothers (Highet, 2023). A plan to respond proactively to their needs; to be prepared with accessible support and services if they are required. What we found in this region was that these parents were more likely to be excluded from maternal mental health services, because of their previous relationship with community mental health teams. This approach does not align with the national perinatal service specifications.

Equity Lens

Any secondary mental health service use

In the Central Region overall Māori mothers access any specialist mental health and addiction support during the perinatal period at a higher rate than non-Māori/non-Pacific māmā from age 25 onwards. We checked the data for bias related to referring Māori mothers based on their ethnicity alone, and did not find any evidence to support bias. We are confident the referrals are based on need for support with significant mental health distress.

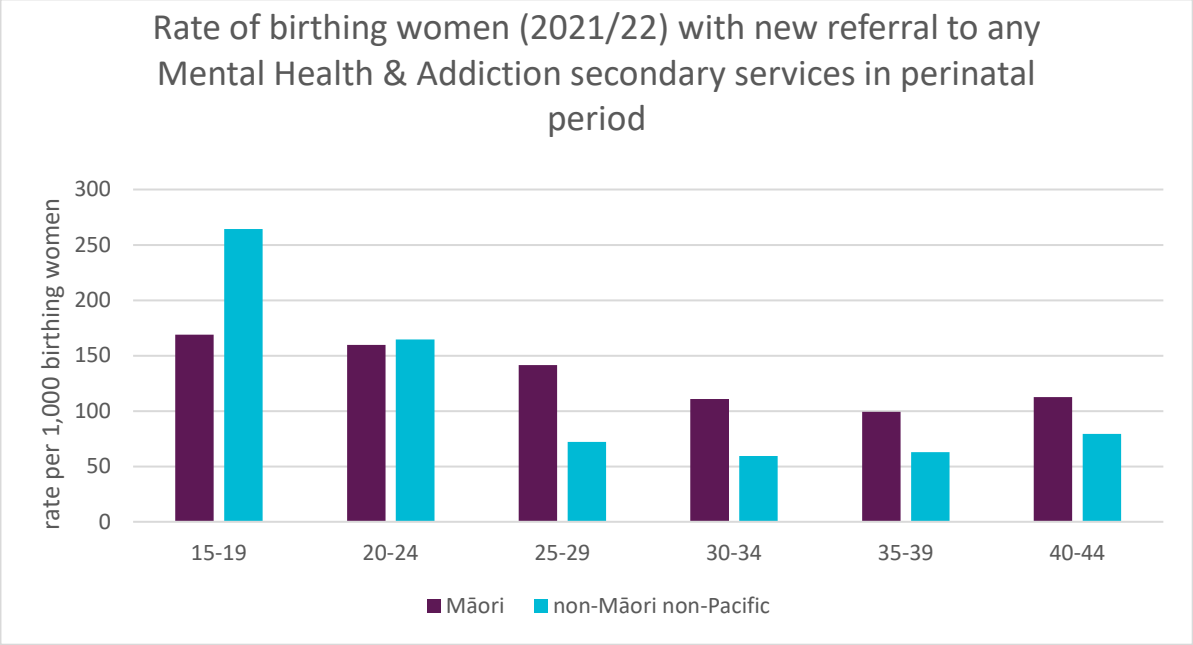


Figure 2.4 Rate of birthing women (2021/22) with new referral to any MHA secondary services in perinatal period

Perinatal specialist service use

Young Māori mothers are not accessing maternal mental health services in the rates we would anticipate (figure 2.5). To ensure accuracy, and because numbers are small we looked across three financial years to confirm the trend. We found that despite giving birth at higher rates, younger Māori mothers are not accessing maternal mental health services in a comparable way to their non-Māori/non-Pacific counterparts. Whilst some mothers may be cared for in other specialist mental health services during the perinatal period, it does suggest inequity in access to Maternal Mental Health services for Māori mothers under 25 year old. The reason for this is not clear, more lived experience insights about how these younger mothers view service accessibility, acceptability and affordability is required.

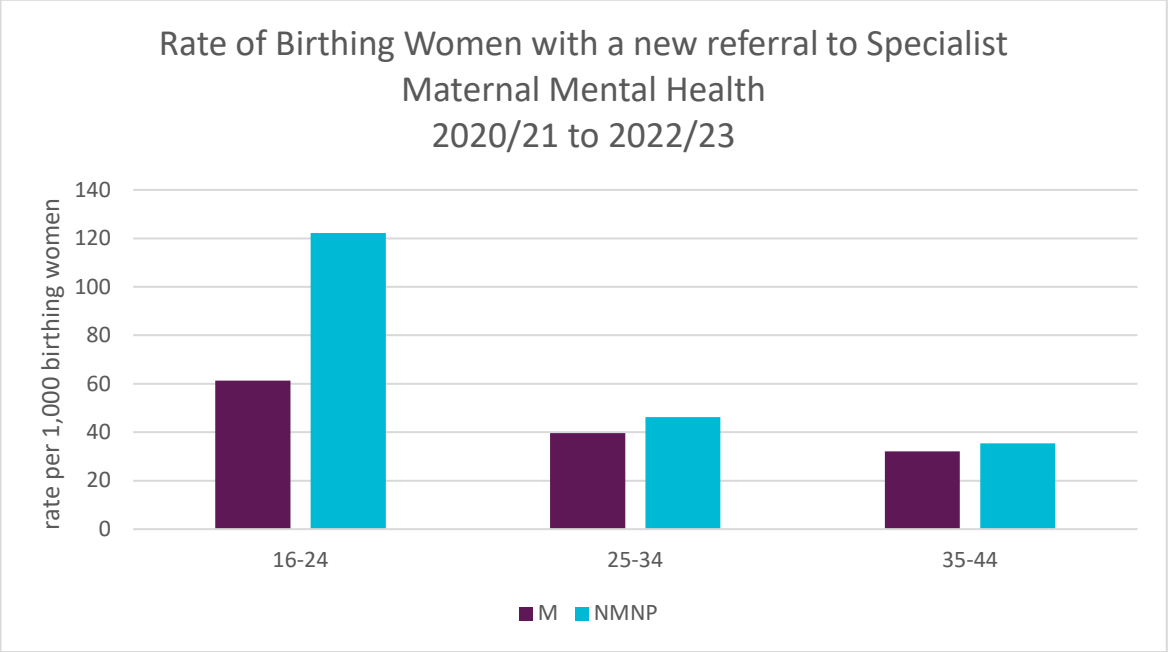


Figure 2.5 Rate of Specialist maternal mental health service use in the Central Region.

SECTION THREE - Current Specialist Perinatal Mental Health Services in the Central Region.

1 Introduction

All six districts provide Specialist Maternal Mental Health Services, however services differ in each district which is likely a consequence of the previous District Health Board structure and the differing priorities and responses implemented. Each specialist service is described separately in this section (for more detailed information about the differences between districts see Appendix 3). Currently the services are most often called maternal mental health (MMH) services and not perinatal mental health services.

We also looked at the regional coordination network and what its function is in the Central Region. Further information about this is covered in point 7 of this section.

We sought to compare services across the region to identify any commonalities in approach. It is not surprising that investment into specialist maternal mental health differs across the region and that there are significant differences in the operating models deployed.

2 Entry and Eligibility Criteria

In the Central Region specialist maternal mental health services (MMHS) usually support birthing parents who have not had any contact with MH&A services previously. Parents with an existing mental illness diagnosis will receive their care from Community and Alcohol & Other Drug (AOD) mental health teams. Community mental health and Addiction teams are looking for a greater level of specialist support in areas such as pre-conception planning, pregnancy and birth planning, medication advice for pregnancy and breastfeeding, and postnatal care.

There is variability in how the access and eligibility criteria (as per the Tier Two Perinatal Service Specification) has been applied across the region. This has evolved to give services flexibility to ensure services can respond to birthing parents with the highest need. However this flexibility does come with challenges that have been highlighted below:

- In some cases the criteria excludes birthing parents with existing mental health illness/ disorders who are already with another secondary mental health team. (This is not in alignment with the service specifications)
- The criteria interpretation and triage process is often dependent on a single person.
- Implicit bias is a risk with using a flexible criteria.
- It is dependent on the knowledge and key language use of referrers who often have to fill a generic ‘blank page’ referral form with what they hope is relevant information.
- Wording such as ‘Moderate’ and ‘Severe’ can be interpreted differently by different clinicians.
- Misunderstanding the Privacy Information Act 2020 can lead some clinicians to omit important information in referral documents.

- The consumer must always be aware of the referral and why this is being undertaken, this is not always the case currently.

The table below shows the current entry criteria for each district (more detail can be found in Appendix 3):

District	Entry Criteria
Whanganui	Women and Infants living in the Whanganui District who have an onset of an identified moderate to severe mood disorder or psychosis associated with pregnancy and or parenthood in the first year of the infant's life. Infants are seen who meet the criteria of moderate to severe mental health distress.
MidCentral	Women living in MidCentral District who have an onset of an identified moderate to severe mood disorder or psychosis associated with pregnancy and an EPDS of 17 or above. The service is provided for perinatal women – i.e. during pregnancy, or up to 12 months after giving birth. And / or Women with a mental illness who are receiving a mental health service who require additional maternal mental health support throughout pregnancy and/or up to 12 months after giving birth.
Hawke's Bay	Women living in Hawke's Bay who have moderate to severe mental health concerns during pregnancy, or up to 12 months after giving birth. Women with a mental illness and receiving a mental health service who require additional maternal mental health support throughout pregnancy and/or up to nine months after giving birth
Wairarapa	The service is for women, their infants and whānau that require additional mental health support during the perinatal period. [Women with moderate to severe mental health needs are referred to Adult Community Mental Health Service for clinical assessment and care planning / treatment.]
Capital Coast and Hutt Valley	The service is for women in the Kāpiti, Wellington, and Hutt District who are pregnant or who have an infant aged 12 months or less (at the time of referral) who are experiencing moderate to severe mental health symptoms, (who meet diagnostic criteria for a mental disorder) who are not under another mental health team, and who have the care of their baby and are experiencing significant impact on their daily functioning.

Table 3.1 Entry Criteria to Specialist Maternal Mental Health Services

3 Referral Pathways

The most consistent pathway into maternal mental health is via the General Practice team. Figure 3.1 shows the number of referrals by category. Over the past five years the majority of Perinatal Mental Health referrals are received from General Practice Teams, and a cohort from 'other'- which is understood to include midwives and community services. Hospital referrals are inclusive of Obstetric/Maternity referrals.

Well Child Tamariki Ora nurses and Midwives will usually refer to General Practice teams in the first instance. Mothers who do not have a General Practitioner can be referred directly, or self refer (however this is not easy for them). There is opportunity in equipping all Access and Choice teams in primary care to assess and respond to perinatal distress as the first step in responding to birthing parents with mental distress.

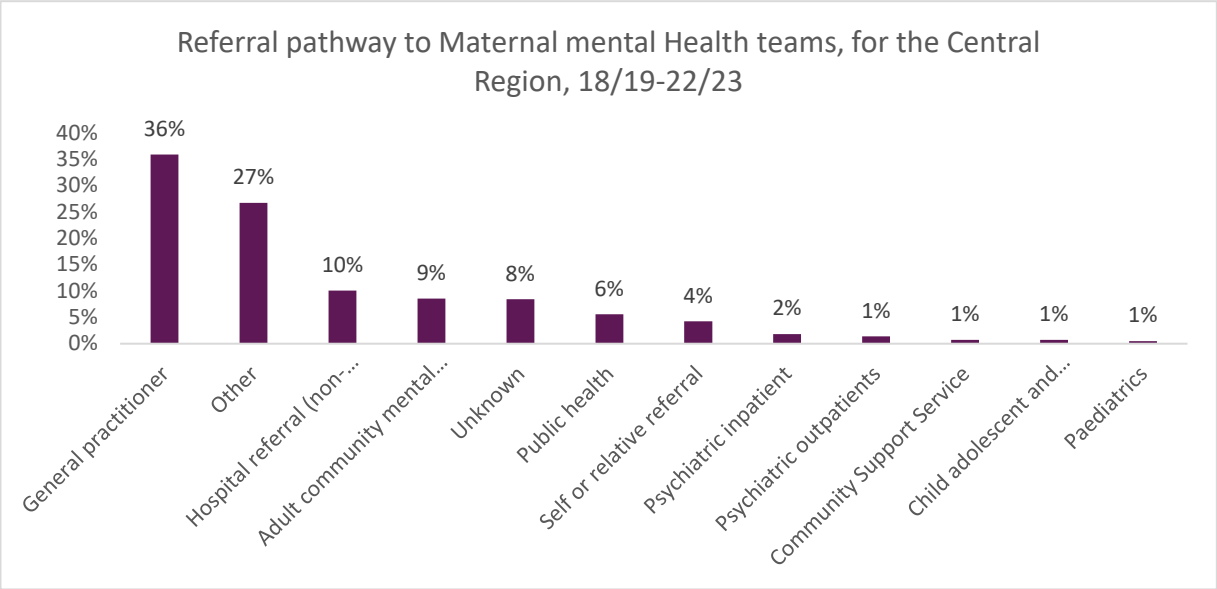


Figure 3.1 Referral pathway into maternal mentla health services

4 Current Specialist Service FTE and Workforce

Figure 3.2 shows the number of Clinical FTE per 1000 birthing mothers available in Specialist Perinatal Mental Health Services.

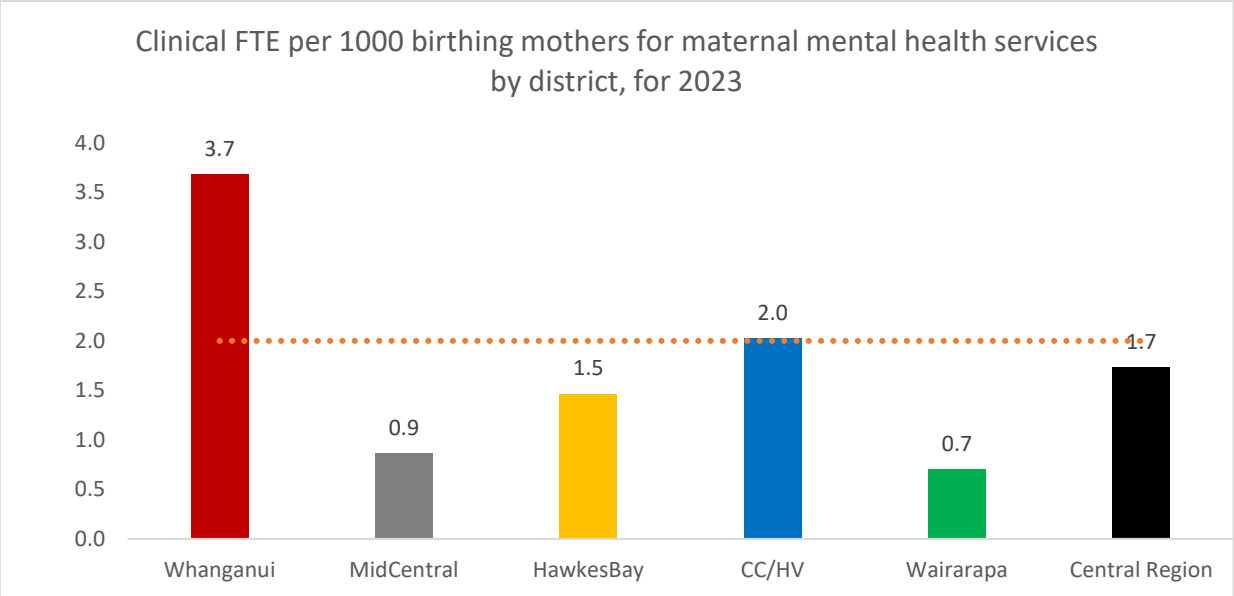


Figure 3.2 [6]Clinical FTE per 1000 birthing mothers in the Central Region.

Actual number of clinical FTE in maternal mental health teams for each district.

	MidCentral	Whanganui	Hawkes Bay	CC/HV	Wairarapa	Total Central Region
Clinical FTE	2	3	3.3	11.25	0.4	19.95

Table 3.2 Actual FTE Central Region

The clinical FTE for the whole Central Region is 1.7 FTE per 1,000 births, by way of comparison the rate per 1,000 births for the Northern Region is 2.2. To increase the Central Region comparable to this rate would require an additional 6.45 Clinical FTE.

Of note many districts in the Central Region (specifically Whanganui, MidCentral, Hawke's Bay and Wairarapa) have to contend with significant travel distances from the service base. These rurality challenges will further impact on FTE requirements over largely urban regions. Innovative solutions such as greater integration with services in situ such as primary care providers could also improve access in rural communities.[7]

[6] We used 2023 FTE numbers and 2021 MOH Birthing Mother Data to attain this rate.
[7] https://www.health.govt.nz/system/files/documents/publications/rural-health-strategy-oct23-v2.pdf

While workforce recruitment is a challenge in the current environment many of the perinatal mental health teams have remained very stable over the past 10 years indicating that this is an attractive and meaningful service to work in.

Using the Ngā Paerewa standards to review the workforce revealed that currently there is little to no cultural support offered to compliment the perinatal mental health clinical workforce, and this should be prioritised. The workforce is predominantly European New Zealanders, and recruitment of Māori and Pacific team members is also recommended.

5 How services are currently responding to the needs of Māori

Currently the service options provided for mothers who identify as Māori are to choose between a mainstream perinatal mental health service, and a specialist Māori mental health service. To ensure the perinatal mental health services are meeting the requirements of the Ngā Paerewa standards, they need to provide culturally responsive treatment options within their 'mainstream' service and also offer as a second option alternatives such as specialist Māori mental health services, or partner with community based Iwi/Māori providers. This is an area for improvement.

From the lived experience survey we know that Māori mothers are less likely to seek mental health help from General Practice Teams. Their Midwife is the main clinician they go to for mental health support. This means midwives need access to a pathway into primary and specialist perinatal mental health services that is not dependant of mothers having a GP. Support to ensure these mothers and infants are enrolled with a GPT provider is also important.

Māori participants highlighted these themes in the lived experience survey:

- Services need to be safe (culturally), and responsive to individual needs
- MMH specialist services need to be accessible for women experiencing MMH distress, regardless of severity.
- Access to free/affordable MMH health professionals and GP visits related to MMH were needed.

There is a gap in the options promoted for Māori mothers who experience mild to moderate mental health distress. The lived experience survey indicated that Māori mothers often did not know where to go to get help for their mental wellbeing, they were also concerned about stigma and judgement. Similar to non-Māori mothers, those who did not seek help felt they needed to 'tough it out'. Community based services such as Well Child Tamariki Ora and Family Start were mentioned as being helpful. Better screening by clinicians, proactive advice on mental health distress and explaining options for mental health help is recommended.

Example of a holistic response to Māori māmā

In the Hawkes Bay Mamia is a holistic wellbeing response that runs out of Waipatu marae in Hastings, māmā can access this service independently. This service can meet the mild to

moderate mental wellbeing needs of Māori mothers in a supportive 'non-clinical' environment. The space itself provides a korowai of aroha and a space of wairua to support healing of Whānau. Mamia is about achieving wellbeing for māmā by providing stability and guidance, and supporting them to assert their rangatiratanga. Other holistic kaupapa Māori maternity support options are also emerging across the Central Region, these offer an opportunity to meet the needs of Māori (and non-Māori) parents who experience distress.

Quotes that reflect the experience for māmā who identify as Māori, living in the Central Region are below:

> "I had big mental health problems but had no idea where or how to access them [services]. MH is a taboo subject in cultures. The only access I had was the Plunket teams however, they focused on the baby wellbeing. They only asked me how I was doing, and if I was having thoughts of suicide which felt invasive and that was it. I didn't have good rapport to be able to talk to them as they were focused on the health of the baby and felt they didn't have the time for my mental health concerns. If I knew how to get support becoming a new parent and the challenges of mental health I faced I would definitely access them." age 25-29, lives in a large town/city.

> "I know there are shortages and waitlists for these kind of services so didn't bother" age 30-34 lives in a large town.

> "Suffered from HG [hyperemesis gravidum] and that brought on anxiety and depression. Didn't access help because I couldn't physically get out of bed often. The services were not available at the time I needed them; I didn't realise I needed help but looking back I did need help for my mental wellness" age 25-29, lives in a large town.

> "In my pregnancy I had lack of support with my mental health. My OB team kept referring me to maternal mental health who pretty much said I was not bad enough. They did one check in with me just before birth but by that point it was too late. I needed more access to counselling through my GP, needed a woman's clinic and maternal mental health from the start" age 30-34, lives in a small town

6 Other Priority Populations

Pacific Peoples

In the Wellington Region where the largest population of Pacific mothers live there is a Pacific Mental Health service, other districts do not have this kind of secondary mental health service. Feedback from a Pacific Peoples clinician is that for Pacifica mothers who experience mental distress it is very challenging to move past the stigma and fear that surrounds asking for help. Numbers of pacific mothers who birth in the Central Region and who access maternal mental health services are small, and we have not produced graphs due to these small numbers. We do know Pacific Peoples mothers access any mental health services at a similar rate to Non-Māori/Non-Pacific mothers.

Rainbow community

In New Zealand Trans research has indicated that the perinatal mental health system is failing to deliver equitable and accessible services for Trans people and their Whānau who are at higher risk of experiencing perinatal distress than the general population. The Rainbow community respondents in the lived experience survey described significant distress involved in engaging with many aspects of the Maternity system. Sometimes the Maternity system was what caused them trauma, which they then needed mental health support for, this support was not always available to them.

Ensuring birthing parents feel welcome, respected and safe are all important to ensure that Trans birthing parents access perinatal mental health support. Services could prioritise partnerships with Rainbow community groups and networks to build a positive reputation and ensure they develop Rainbow friendly approaches (Parker, 2023).

Birthing Parents who experience disability

From the Creating enabling maternity care: dismantling disability barriers report (Morrison, 2021) we know that "disabled women and women who have babies born with impairments struggle to receive timely and appropriate mental health care as part of their maternity journey. Difficulties in accessing mental health services greatly impacts upon these women's maternity journeys."

Five participants in the Lived experience survey identified as experiencing a disability. Three accessed specialist services and two accessed their GPT. These participants identified the need for expert advice with breastfeeding, and support at home so they could care for themselves and their infant. Overall they expressed positive experiences with the mental health help they received.

One additional aspect relevant to people who experience disability is when birthing parents learn they have an infant who has a disability. This news needs a considered holistic approach that includes mental wellbeing care – but not necessarily specialist care from secondary MMH services.

7 Central Region Perinatal Mental Health Coordination Service.

The perinatal mental health coordination service was initiated in 2013. Based out of the specialist maternal mental health service (SMMHS) in Wellington, it provides regional support and training to perinatal Mental Health clinicians. In addition the service provided education to midwives, general practice teams, and community services across the whole Central Region.

Over the past 4 years, engagement with the regional perinatal coordination service has waned. There is a lack of understanding across the sector of its role and function. Utilisation of the service is low and there is a view that the service is no longer meeting the needs of the region as a whole. For example the consult liaison function is only used 3-4 times a year.

The service holds a repository of Perinatal Mental Health information and research complied over the past 10 years, and this information has been made available to the region.

Looking to the future a perinatal mental health community of practice (COP) would be beneficial for the clinical workforce. This could be developed at a regional or national level and would enable clinical peer support, translate relevant research into practice and ensure consistency and connection across the region (or nation).

In the current system where we have a regional Kahu Taurima / Early Years approach there is an opportunity to take a regional multi-system (maternity, neonates, mental health, primary care, public health & Te Aka Whai Ora) approach to lead and design integrated operational models and pathways for perinatal mental health services, to ensure a proactive response to mothers and infants.

8 Central Region Infant & Maternal Mental Health Specialist Services

Infant Mental Health Services

36 infants in the Central Region aged under 1 year were referred to a specialist service during the period from July 2018 to June 2023 (Figure 4.1), one quarter identified as Māori. Pacifica peoples are not represented in the graph due to the small numbers. The majority of these referrals occurred in Whanganui, where they have an integrated service.

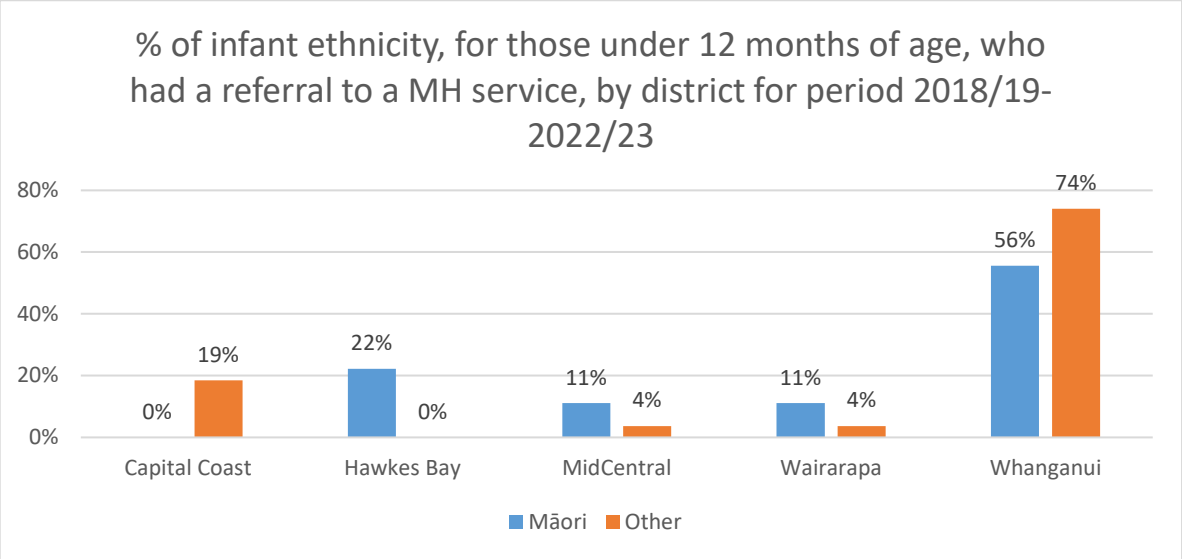


Figure 3.4 Infants under 12 months access to specialist services.

When reviewing the data for infants aged 0-3 years (figure 4.2) 666 infants were referred to a secondary mental health service over the same period. Most were seen by the (Infant) & Child, Adolescent, Mental Health (and addiction) service teams who have this cohort in their service specifications.

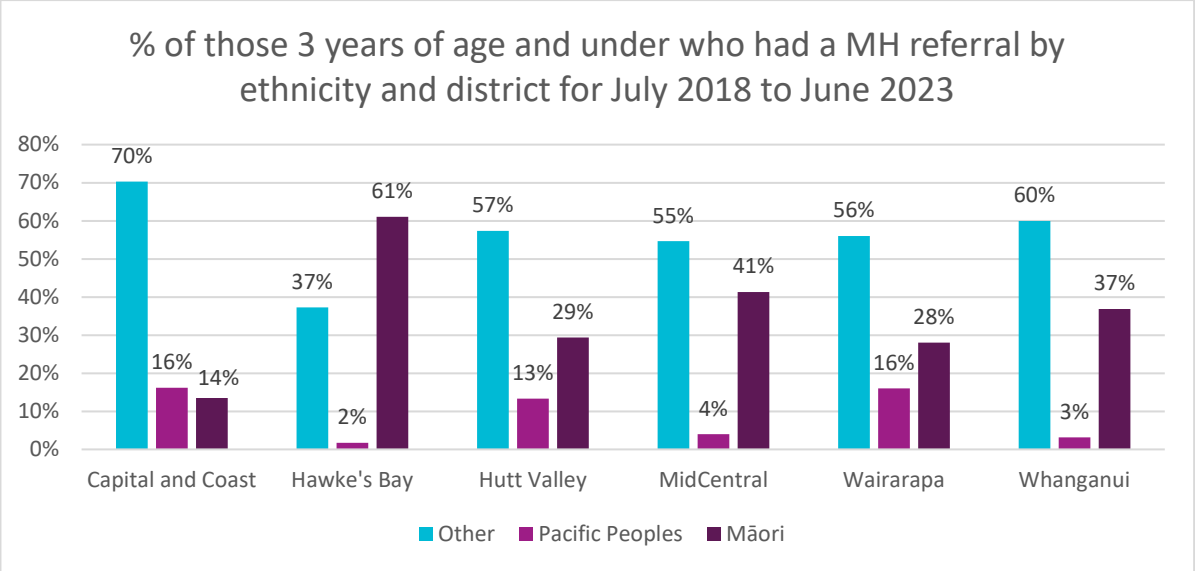


Figure 3.5 Infant under 3 years access to specialist services.

One secondary perinatal mental health service in the Central Region provides a dedicated Infant Mental Health intervention as part of their suite of services. This has been possible because the design of the service is one where maternal, infant, child and adolescent mental health and addiction specialist services are combined into one team – MICAMHAS[8] The benefits include a more joined up response for infants whose mothers require maternal mental health support, a supportive multidisciplinary team for the maternal /perinatal mental health clinicians, and a single pathway for referrers to send in a request.

In the other five Central Region Districts infant mental health clinicians work within CAHMS secondary services as per their service specifications, however they do not receive many referrals for infants, and services are not integrated with maternal mental health.

Multidisciplinary Teams

The **table below (table 3.3)** shows the Multi-disciplinary team makeup and FTE allocation by district:

District	Multidisciplinary Team	CLINICAL FTE	Co-Operation with other services
Whanganui MICAMHAS	Nursing Social Worker [*for Infant Mental Health*] Psychiatrist / SMO Team Leader Admin No Vacancies	3 FTE	Close connection with Child Adolescent Mental Health and Addiction team. All work in the same team, share office & clinic space, attend weekly meetings together.
MidCentral Perinatal MHS	Nursing One Vacancy	2 FTE	Close connection with Te Ara Rau Access and Choice. All

[8] (Maternal Infant Child Adolescent Mental Health and Addiction Service).

			Maternal mental health referrals now go through this pathway, Triage occurs in collaboration two times per week
Hawke's Bay Maternal MHS	Team Leader Social Work Psychology Nursing Peer Support Psychiatry / SMO One Vacancy – Peer Support	3.3 FTE	Close connection with Te Ara Manapou Pregnancy and Parenting Service. Service teams are located in the same building and collaborate. Some MDT team members work across both services.
Wairarapa Consult Liaison Service	Social Work	[0.4] FTE this is included in the SMMHS team below	Close connection with Adult Community Mental Health and with Maternity team. Small service that is not able to take a case load.
Capital Coast & Hutt Valley SMMHS	Social Work Psychology Nursing Psychiatry/SMO Registrar Team Leader Administrator Intake worker Regional Perinatal MH Coordinator One Clinical Vacancy	11.25 FTE Clinical	SMMHS partner with Health Pasifika and Te Whare Marie Specialist Māori Mental Health Service when working with Clients who prefer these services to be the lead service. SMMHS share a building with CAMHS Wellington/Kapiti Coast. The Central Region coordination service is located in this team.

Table 3.3 FTE and Multidisciplinary Teams

Perinatal Psychiatry/SMO FTE input is variable across the districts. Services that do have access to this speciality are able to provide a more comprehensive response to birthing parents who are mentally unwell and require psychiatry input.

Service approaches vary from standalone to fully integrated. Services that have integrated (Whanganui and Hawke's Bay) have seen benefits from being part of a larger supportive team, and have adopted newer models of care informed by a broader suite of services. For Whanganui this includes the CAPA model and close working relationship with Infant Mental Health and for Hawke's Bay a Te Whare Tapa Wha informed triage process and assertive outreach approach, alongside alcohol and drug services for parents.

The following table 3.4 provides a summary breakdown of the services provided in each district. Services provided do not reflect capacity so while they are available they may be significantly limited and not meeting all the existing moderate to severe perinatal mental health needs in the district:

Service Provided	Whanganui	MidCentral	Hawkes Bay	Wairarapa	CC/HV
Consultation & Liaison (virtual & face to face)	✓	✓	✓	✓	✓
Brief Intervention	✓	✓	No	No	No
Primary MMH services (Access & Choice)	✓	✓	✓✓	No	✓
Maternal Mental health Specialist services*	✓	✓	✓	No	✓
Community Respite Packages of Care	✓	✓	✓	No	✓
Specialised treatment modalities**	✓	✓	✓	No	✓

Table 3.4 Services provided in the districts

* 'Maternal mental health specialist services' is an umbrella term for a range of clinical-level services that might be offered through different settings. Functions provided include assessment, care / response planning and medication management. These are provided in range of different settings, hospital campus, GP practice, community organisations and virtually.

** Includes talking therapies, supportive psychotherapy and treatment modalities such as CBT, ACT, EMDR

✓✓ MidCentral Access and Choice services Te Ara Rau is providing a dedicated clinician and peer support role for perinatal mental health care. This team work collaboratively with secondary services to triage all perinatal mental health referrals for the whole district.

For more detail on the Treatment Options, & Service Models see Appendix 3 Table VI

9 Other Community settings and services for infant mental health.

There are a number of community based groups in the Central Region who work with parents and their infants to enable bonding, connection, and joy in parenting. One of these services is the Naku Ēnei Tamariki service in Hutt Valley, they have received specialist infant mental health supervision, which has led to positive whānau outcomes. In the Wairarapa, the Maternity service have contracted a private provider to provide Circle of Security groups, which is meeting a significant need in the community. Circle of Security is a programme that improves the development of children by strengthening the parent-child attachment. [9]. A number of services including Whānau Āwhina Plunket have provided circle of security parenting groups across the Central Region in the past. However since the isolation impacts of Covid-19, these have not been sustained. There are also quality kaupapa Māori parenting programmes that Iwi/Māori providers will be incorporating into their services, and these should be acknowledged and supported. One example is Tūpuna Parenting, "Tūpuna Parenting is a movement to reclaim traditional Māori parenting ways. We all want the best for our whānau, and our tūpuna can help us."[10]

Investment into and development of more group programmes that support bonding and attachment for parents and their pēpi is warranted. A stocktake of what is working well in each district would be a useful starting point.

10 Disability Services contributing to infant mental health

The Visiting Neurodevelopmental Therapist (VNT) service (part of the suite of Child Development services) is available in the Central Region. This service provides a VNT for infants who experience disability. These professionals often work with infants who require neonatal intensive care, and infants who experience developmental delay. Evidence on the effectiveness of this therapy shows that significant improvements in a child's development can occur with the VNT supporting the parents to 'work' with their child to strengthen function. While this therapy is not formally categorised as an infant mental health service it has a direct impact on infant mental health.

[9] https://www.circleofsecurityinternational.com/circle-of-security-model/what-is-the-circle-of-security/

[10] https://tupunaparenting.Māori.nz/

11 District Snapshots

Whanganui

Bright Spots

Whanganui has developed its specialist service under thoughtful leadership to a point where they now have an integrated model, called the Maternal Infant Child Adolescent Mental Health and Addiction Service – MICAMHAS. This is a collaborative service that provides specialist mental health care for both infants and birthing mothers in the same team. This team also uses the CAPA service model to ensure timely access and partnership with birthing parents.

Whanagnui is also one of only two districts in the Central Region who provide a specialist pregnancy and parenting service for parents who experience drug and alcohol addictions and are pregnant or have a child under 3 years old. The He Puna Ora pregnancy & parenting service, is a kaupapa Māori primary mental health & addiction service. It brings together an integrated approach to support whānau on their hauora journey. This service is available through several iwi/Māori Hauora providers across the Whanganui region.

Healthy Families Whanganui, Rangitīkei, Ruapehu is situated in Whanganui city and works within lead provider organisation, Te Oranganui Trust. Their goal is for all New Zealanders to enjoy health promoting social and physical environments that enable healthy food and physical activity choices, being smokefree, drinking alcohol only in moderation and increasing mental health, resilience and wellbeing. This team has led out two important programmes in the region.

- The Hapū Māmā Village programme – gathering wisdom from Whānau, services, and leaders to inform positive change.
- The Collaborative Design of Mental Health & Addictions approach, an initiative and priority within the Growing Collective Wellbeing Regional Suicide Prevention Strategy.

Whanganui General Practice teams are also leading the way with the Best Start programme which currently includes a research project led through HARC[11] to identify and respond to maternal mental wellbeing distress.

Challenges

Rurality is a challenge. Birthing parents in Waimarino and Rangitikei do not have direct access to the MICAMHS service. Specialist services are provided by Community Mental Health teams, who can call on the MICAMHS team for advice and support.

Stigma and fear impacts on birthing parents accessing Mental Health and Addiction services such as MICAMHS & He Puna Ora. General Practice Team access and support can also be a challenge for those living in the rural regions of Whanganui.

[11] https://www.harc.org.nz/

Te Pae Hauora o Ruahine o Tararua MidCentral District

Bright Spots

This District has an innovative & proactive primary care approach that has emerged over the past 18 months led from the primary care mental health service Te Ara Rau. A registered midwife has taken on a Mātanga Whai Ora (health improvement practitioner) role as part of the Te Ara Rau access and choice service model.

All perinatal mental health referrals for primary and secondary services are channelled through Te Ara Rau. Triage is undertaken by a multidisciplinary team, inclusive of primary and secondary mental health services, two times per week. This close perinatal mental health collaboration between primary and secondary mental health services is not found in any other part of the Central Region. We believe this is an innovation that could be adapted for other parts of New Zealand.

Packages of Care are resourced and used effectively to support mothers with counselling, and home based support. Teleconference counselling for moderate mental health needs allow parents to access services from their own home, mitigating travel and childcare barriers.

Maternal & Child health leadership have advocated for family units to be included in the new construction of the Palmerston North mental health inpatient facility. This will cater for very unwell mothers to stay together with their infants and have family support.

Challenges

Maternal mental health support was a key gap identified by communities across the MidCentral District in their First 1000 days report. (Deloitte, 2023)

There is no dedicated psychiatry, psychology or social work FTE for the specialist Perinatal MH service and the FTE per 1000 birthing mothers is significantly lower than other Districts. The current consult liaison service provides short term case management, but this capacity is inadequate to meet the needs of birthing parents in this District.

There is a theme of disappointment and lack of confidence in the specialist Perinatal MH service, and the community mental health service. Evidenced by the stakeholders interviewed, and from the lived experience survey 2023.

Clinicians describe needing to game to system to try and get women access to services that they need. Birthing parents describe trying to access private services when public services are not available however there are barriers of long waiting lists and high costs.

Birthing parents who live in Horowhenua and Tamaki nua a Rua (Tararua) both experience access challenges due to rurality, socio economic deprivation and lack of perinatal mental health services in the town centres of Levin and Dannevirke. These localities also experience General Practice Team shortages which leaves a significant gap for birthing parents who need support.

Te Matau a Maui Hawkes Bay

Bright Spots

In the past two years the maternal mental health specialist service has almost doubled its referral rate and are seeing more birthing mothers with severe mental health distress. One clinical leader described how “Maternal Mental Health Service has become more mother friendly over the past 2 years. They have also made a concerted effort to connect and build trust with the LMCs and community midwives.”

The service is located in the community in the same building as the Te Ara Manapou pregnancy and parenting service. Hawke’s Bay is the only other District in the Central Region that has a dedicated service for parents with addictions (Te Ara Manapou). The clinicians work as part of a multidisciplinary team between Maternal Mental Health and Te Ara Manapou, this generates good synergy. The timeframes for response from the service are prompt. The service engages in assertive outreach and will persist to ensure they meet with the referred mother and Whānau, and undertake in person assessment and planning.

The Childbirth after-thoughts service (ChATs), addressing the emotional distress of mothers who experience an unexpected birth event, was an innovative approach within maternity to support mothers with trauma and mental distress, and leadership are working to reinstate this service.

Challenges

There is no suitable inpatient service for mothers and their infants together (if a mother needs the inpatient mental health service they have to be separated from their infant). Supported accommodation options are limited e.g. a place with staff who can support the mother with the baby and often the service has to rely on the women’s family to support her (which is not always appropriate).

Well Child Tamariki Ora and Family Start leaders described an increasing number of whānau who experience multiple stressors including financial hardship, cyclone Gabrielle impacts, drug addictions, homelessness, family violence, and a prolonged impact of the covid 19 pandemic. The report from Hawke’s Bay DHB 2018 - Ngā Korero Ō Ngā Māmā, also reflected similar themes for mothers in the Hawkes Bay District.

In the Primary Care sector there is an identified “missing middle” or more accurately missing out in the middle– birthing parents who are not unwell enough to require secondary specialist mental health services, yet are significantly impacted by their mental wellbeing distress. These women have limited options to access services that are affordable and timely. Evidence about the impact of perinatal mental distress recommend that “Services should be available for women experiencing any degree of distress, not only those most severely affected” (Wilkinson, 2022). Women who are struggling with adjustment and parenting have no one to go to, those who have funds can pay for private support. This challenge is not isolated to the Hawkes Bay district.

Wairarapa

Bright spots

Wairarapa has led the way in developing the Pepe Ora collective response and website to ensure parents and whānau can find and access services to support their wellbeing.

Various community led NGO and charitable services are provided to parents in the Wairarapa alongside health and social services. These services make a difference to practical, social and mental wellbeing needs. Services include but are not limited to the Ruth Project set up to support families with perinatal depression, Kidz need Dadz a support group for fathers, and Circle of Security groups funded by Maternity services.

Recently through the Maternity Quality and Safety programme parents who experience disability have partnered with the maternity service to inform and improve processes to care for pregnant and birthing parents with a disability.

Challenges:

The district has been challenged with recruiting and retaining maternal mental health clinicians over the past 5 years and this has necessitated a closer working relationship between maternity and community mental health. This is also a bright spot as close working relationships have derived benefits with better communication between the two service streams, and better connection with community/NGO services.

Leaders voiced concerns regarding whether the current consult liaison model is working effectively to meet the needs of parents. This service is managed and led from the specialist maternal mental health service in Wellington. The current service model is designed to provide limited support to birthing parents. The intended ‘client’ in the consult liaison model is the health professional or service caring for the birthing parent and not the parents themselves.

While a smaller population than other districts it faces significant rurality challenges when designing and delivering services to birthing mothers and their Whānau.

Capital, Coast & Hutt Valley

Bright Spots

In addition to the SMMH services for women with moderate to severe mental health distress there is also the Maternity Wellbeing Clinic’s provided in Wellington, Kenepuru and Hutt hospitals. The maternity wellbeing clinic is a consultation service for Maternity clinicians regarding women who experience Mental Health distress

The Ora Toa Te Puna Wairua Hub holds a maternal mental health clinic every Tuesday afternoon, where a SMO is available to see women from Porirua with Mental Health distress.

Wellington Hospital NICU has recently employed an infant psychotherapist to support infants and parents during the tumultuous time of admission to and care in the neonatal intensive care unit.

Hutt Valley access to packages of care is a straight forward process and enables mother's access to support to keep them well at home.

Family start service Naku Enei Tamariki is a well-established service supporting Māori, Pacific and other parents in the Hutt Valley. This service applies infant mental health principles into the work they undertake with families.

Little Shadow is a Wellington NGO that connects those experiencing perinatal distress to emotional and practical support on their journey to wellness. This service has a positive reputation in the District and supports birthing parents that do not gain access to the Specialist Maternal Mental Health Service.

Tu Ora Compass health Access and Choice services are supporting some birthing parents in the community with perinatal mental distress, including bereavement support. This is currently dependant on the Access and Choice clinical capacity & capability.

Challenges

Concerns regarding lack of access, poor assessment processes, and poor communication were expressed by many parents who needed access to maternal mental health services in this district. Clinicians also expressed difficulty with the referral process, triage process, and poor communication between the services.

Community Midwives & LMC's have described extreme difficulty in accessing support for mothers with significant mental distress & illness. The relationship and communication channels appears strained with a lack of mutual respect among professionals, poor understanding about the referral criteria, triage process and service provision.

There are concerns that the referral criteria can be used to exclude birthing parents most in need of help who have existing mental health illness or addiction issues.

There is a desire for Māori community clinicians to provide a culturally responsive service but the not the capability or capacity to do so. It was also noted that there are specific kaupapa Māori Māmā and Pepe mental health service offerings available in the district but the MMH service has not formally established a relationship with some of them.

The maternity wellbeing clinic is misunderstood by some maternity clinicians who expect that if an assessment identifies that the birthing mother requires specialist MMH support, then this process will be actioned by the MMH clinician. It may be inefficient to ask that the midwife generate a new referral to the maternal mental health team, (who have already seen & assessed the client) because the maternity wellbeing clinic is considered a maternity service referral rather than a direct maternal mental health referral.

Summary and Recommendations

Across the Central Region in regard to the perinatal mental health environment we have found bright spots where services have developed to be effective and meet the needs of parents. We have also found challenges where services are under resourced, and require new service design and better pathways (from home to service, and home again), for the birthing parents who need them.

Continuum of Care and Pathways

It is important to include the needs of the infant in the perinatal mental health response, with pathways into specialist infant mental health services to ensure the mother infant relationship is supported. Infant mental health care is critical to ensure healthy and thriving infants, and to protect children's future mental wellbeing. Investment and integration of Infant Mental Health services into the current suite of perinatal mental health services is recommended.

In addition increasing non specialist community responses that support maternal and infant mental health such as parenting programmes, facilitated support groups, and specific infant attachment programmes is an opportunity to collaborate with other social and philanthropic sectors. Support groups were specifically mentioned as an unmet need by parents who undertook the lived experience survey. Intervening early (see appendix 5) can mean that parents and infants do not require specialist services, which is a victory for all involved.

Tailored Access and Choice programmes in Primary Care are meeting the needs of parents with mild to moderate perinatal distress, however this approach is not evident across the whole region. The opportunity is to scale up this support, and to resource and use more packages of care investment to fund community counselling and in home respite care.

These teams can then have an escalation pathway via the General Practitioner or directly into the perinatal specialist service for mothers with severe mental health distress. It is important that the region has transparent and consistent access criteria into specialised services and that this criteria includes mental distress caused by trauma.

Discharge pathways were most often to the GP team. There are missed opportunities to connect mothers with ongoing community mental health services when they are discharged. Perinatal Mental Health peer support groups, and whānau ora wrap around services provided after parents finish with the mental health specialist services have great potential to support parents on their continual journey to wellbeing.

Responding to the needs of Māori Whānau

We identified low rates of access to perinatal mental health services for young Māori mothers. We also identified that access to a GP team is less likely for Māori mothers. This indicates that alternative pathways are needed for Māori birthing parents for any level of severity. We found that the current Māori workforce in specialist perinatal mental health is

limited, and there is an absence of a dedicated cultural advisor role in teams. Developing a cultural advisor role and increasing the services capability to incorporate mātauranga informed care and traditional modalities of healing for whānau during the perinatal period are recommended.

There is an opportunity to develop strong reciprocal partnerships between Māori community services and the Perinatal Mental Health services to ensure better access and responsiveness for Māori whānau. Development of new pathways that provide close to home care, include peer support navigation, and coordination of care after discharge is an excellent opportunity to progress.

To help services achieve their objectives, that will align with the Ngā Paerewa standards we suggest that lived experience insights are gathered through annual focus groups with whānau Māori consumers.

Model of Care

Opportunities exist to strengthen, heal and respond ((The Southern Initiative, 2023) to birthing parents who experience pre-existing mental distress. However the current access pathways, and reactive service model approach means these opportunities are often missed. A proactive perinatal mental health service response to help prepare and support parents who experience mental health illness is needed.

The current approach for most parents with pre-existing mental illness is that they receive their mental health care from the community mental health and addiction teams, or GP teams. This approach is not in alignment with international best practice or current service specifications. Services such as pre-conception planning, pregnancy and birth planning, medication advice for pregnancy and breastfeeding, and postnatal care all need specialist perinatal mental health input. The current model of care should be amended to ensure Perinatal Mental Health teams provide anticipatory care planning - intentional specialist perinatal mental health care plans for birthing parents who have existing mental health illness

Priority Populations

The Lived experience survey revealed that many mothers fear having their child removed from their care if they reveal they are struggling with mental distress. Across the region we must ensure Midwives, Well Child Tamariki Ora teams and General Practice teams screen for perinatal mental distress. They also need to explicitly reassure birthing parents that accessing mental health support is safe, and that keeping them together with their baby is a priority.

Parents are seeking support and reassurance from their whānau, peers and trusted clinicians. The lived experience voices described processes of assessment, interventions and discharge that were mana diminishing and unhelpful. Priority populations were more likely to receive substandard services. Parents need to trust that services are safe and welcoming for all people, and especially for people from priority populations. More holistic

engagement processes, including how people are welcomed and triaged would benefit all parents who require services.

We found services do not always have internal capability to meet the needs of priority population's and therefore partnerships with community agencies and groups are imperative. For example migrant clinics and support groups, Asian health services, disability support groups, and rainbow support groups can all partner with services to support priority populations. In rural areas greater integration with services in situ such as primary care providers could also improve access.

Regional approach and Kahu Taurima

The existing Regional perinatal mental health coordination service was designed to meet the needs of the Central Region in 2013, ten years and one pandemic later the regional needs have changed and this service is no longer needed as it once was. To support the workforce a community of practice (COP) could be instigated regionally or nationally, which would enable connection, support and implementation of relevant research into practice.

Transitioning into the Te Whatu Ora - Health New Zealand model of nationally planned, regionally delivered and locally tailored means there is an opportunity to develop a regional Kahu Taurima approach to ensure integration of perinatal mental health services across the care continuum.

Leadership into a perinatal mental health clinical network (or design network) could be included from:

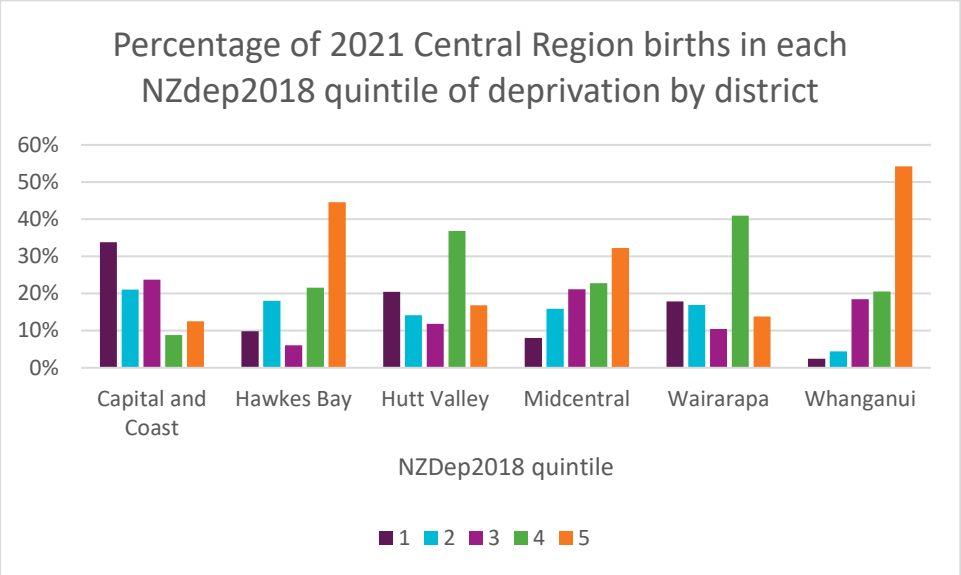
- Mental health
- Maternity
- Neonates (Child Health)
- Primary Care (General Practice Teams & Well Child Tamariki Ora)
- Public Health Service / Health Promotion Agency
- Te Aka Whai Ora
- Lived experience & Peer support

Together this group can be accountable to develop service responses to ensure parents and infants don't 'fall though the cracks'. Responding to the opportunities identified in this report alongside the wider Kahu Taurima – Early Years goals could inform the objectives for this group.

Ultimately birthing parents and their whānau want to experience mental wellbeing, and to be the best parents they can for their children. The purpose for all involved in commissioning and delivering perinatal mental health services is to ensure that mothers and infants are the priority, and that systems and services are designed to meet their needs. It is our hope that the insights and recommendations in this report will facilitate improved pathways of access across the perinatal mental health continuum of care.

Appendix 1 – Central Region Economic Environment

Additional data & Information - District Quintiles



This graph illustrates the different economic environments within the Central Region, of note Hawke's Bay and Whanganui have greater challenges.

NZDep is an area-based measure of socioeconomic deprivation in Aotearoa New Zealand 12. It measures the level of deprivation for people in each small area, based on nine Census 2018 variables (NZDep2018).

Here NZDep is displayed as quintiles, where quintile 1 represents the least deprived 20% of areas, and quintile 5 the most deprived 20% of areas. Note that NZDep estimates relative socioeconomic deprivation for areas, not people. For more information

Nzdep2018 quintile: https://ehinz.ac.nz/indicators/population-vulnerability/socioeconomic-deprivation-profile/

[12] Atkinson J, Salmond C, Crampton P. 2019. NZDep2018 Index of Deprivation. Interim Research Report, December 2019. Wellington: Department of Public Health, University of Otago, Wellington. URL: https://www.otago.ac.nz/wellington/otago730394.pdf

Appendix 2 – Location of Maternal Mental Health Teams

Table I Physical and Virtual Location of Maternal Mental Health Teams

District	Service Name	Hours of operation	Location	Website
Whanganui	MICAMHAS Maternal, Infant, Child and Adolescent Mental Health and Addiction Service	8am-5pm Mon-Fri Excludes Public Holidays	Whanganui Hospital Campus, 100 Heads Road, Gonville Whanganui	https://www.wdhb.org.nz/patients-and-visitors/our-departments-and-wards/mental-health-and-addiction/
Manawatū, Tararua & Horowhenua	Perinatal Mental Health Service	8am-4pm Mon-Fri Excludes Public Holidays	Te Papaioea Birthing Centre, 117 Ruahine Street, Palmerston North	www.midcentraldhb.govt.nz/HealthServices/MentalHealth/mentalhealthspecialist/Pages/Maternal-Mental-Health.aspx
Hawke's Bay	Maternal Mental Health Service	8am - 4.30pm Mon-Fri Excludes Public Holidays	409 Queen Street West, Hastings	https://www.ourhealthhb.nz/hospital-services/mental-health-services/pregnant-just-had-a-baby-feeling-overwhelmed/
Wairarapa	Perinatal Mental Health Wairarapa Consult Liaison Service	8.30am-5pm Tues-Wed (2 days per week)	Wairarapa Hospital Campus, Te Ore Ore Road, Masterton	https://www.mhaids.health.nz/our-services/specialist-

				maternal-mental-health-service/
Hutt Valley	Specialist Maternal Mental Health Service	8.30am – 5pm Mon-Fri Excludes Public Holidays	21 Hania Street, Te Aro Wellington	https://www.mhaids.health.nz/our-services/specialist-maternal-mental-health-service/
Capital and Coast	Specialist Maternal Mental Health Service	8.30am – 5pm Mon-Fri Excludes Public Holidays	21 Hania Street, Te Aro Wellington	https://www.mhaids.health.nz/our-services/specialist-maternal-mental-health-service/

All services provide a flexible location option when they first meet with clients who have been triaged and need an in-person assessment. Some services will see clients in their own homes, some offer clinic rooms options that are closer to clients homes than the base location.

Other websites also hold useful information for clients and Whānau searching for perinatal mental health support, as well as information on how to access the secondary services.
For Wairarapa, Hutt Valley & Wellington the Pepe Ora website is comprehensive: https://pepeora.nz/
For Whanganui the new Te Kakano site is now live https://tekakano.nz/
For Hawkes Bay the Our Health HB is a friendly and easy to navigate site with a range of links for support https://www.ourhealthhb.nz/
For all Districts the HealthPoint website has up to date information on the services: https://www.healthpoint.co.nz/
MidCentral District are currently developing a website similar to the Pepe Ora site with comprehensive information for parents looking for support.

Whanganui MICAMHAS and Wairarapa Consult liaison service are located on the hospital campus, while the other services are located off campus.

Appendix 3 - District Perinatal Specialist Service Comparisons

Table II Referral Pathways into service

- The majority of Perinatal Mental Health referrals are received from General Practice Teams, with a cohort from 'other'- which is understood to include midwives and community services.
- Hospital referrals are includsive of Obstetric/Maternity referrals.
- Well Child Tamariki Ora nurses and Midwives will usually refer to General Practice teams in the first instance.
- Mothers who do not have a General Practitioner can be referred directly, or self refer.

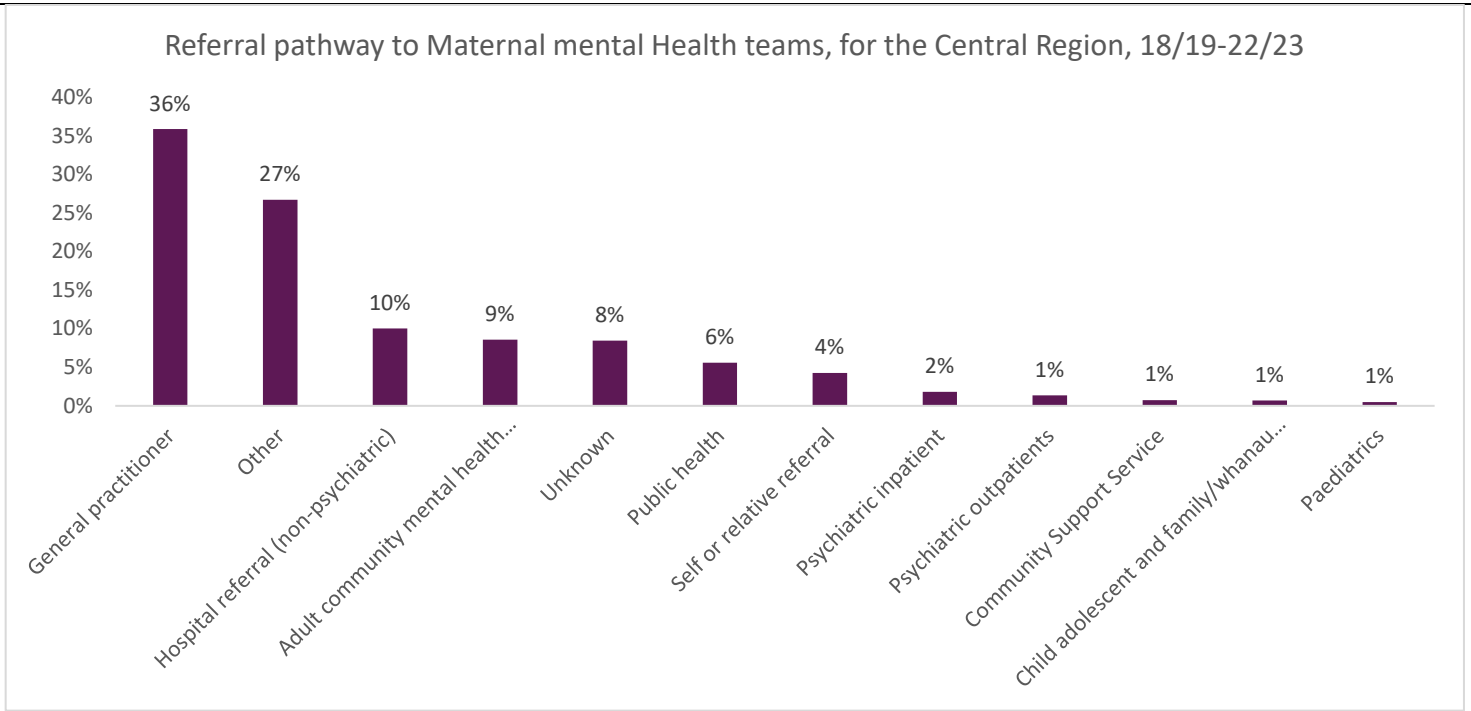


Figure 5.1

From the regional birthing parent data we have been able to calculate the rates of referral into Specialist Maternal Mental Health Services for every 1000 birthing mothers across the districts.

- Whanganui stands out because more women per 1000 birthing mothers are able to access the service. Importantly this was occurring before they had an increase in Perinatal Mental Health FTE.
- Hawke's Bay have had a significant change in approach in the last two years, they have almost doubled their referrals generated and accepted rate.
- Wairarapa has had significant fluctuation which we interpret as related to periods of time with no available Perinatal MH FTE for this District
- Please note with this data we do not have a clear idea of women who wanted to access the service but were not able to.

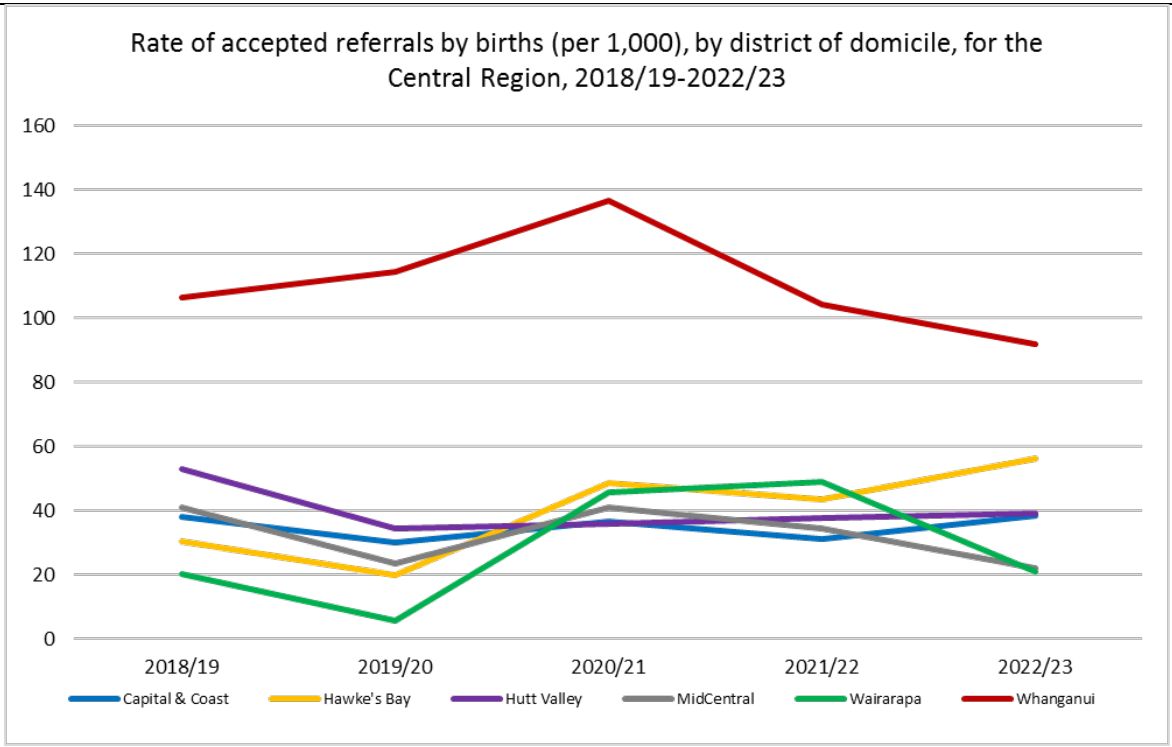


Figure 5.2

Discussion – referral rates received and accepted

Whanganui MICAMHAS manages their referrals differently to other services. As mentioned earlier in Table 2 this team use the CAPA service model. Using this model enables the team to meet clients in person and develop a responsive plan in partnership with them. The service also manages demand by working on client directed goals over an agreed period of time, and then discharging them. Clients are able to return again if required. Clients are welcome to self-refer, as well as being referred in by health professionals. There is a difference in length of time clients stay in the service, compared to other operating models, which we will show in figure 5.4 (median length of time in service)

We identified benefits to birthing parents and their Whānau with this model. Lived Experience feedback informs us that birthing parents in other districts experience significant distress because they are either not able to access the secondary service at all, are assessed over the phone in a way they feel is unacceptable, or have to wait a significant period of time for an assessment. Referring clinicians in other districts have also indicated that they choose not to refer clients to the specialist maternal mental health service because they do not have confidence that the service will accept them. The clinicians don't want to increase the mother's distress by being referred and then refused service. This can leave birthing parents in a distressed state with a sense that they is no help or options for them.

While not all birthing parents who are referred are seen by the Whanganui team, a much higher rate are seen. This in turn means that clinicians such as Midwives and General Practitioners are more likely to refer with confidence, trusting that the client will be assessed and that the experience is a positive one.

Feedback from maternity clinicians in Hawkes Bay is similar. Reflecting that there has been significant work undertaken by the HB Perinatal MH team to ensure trust and confidence in the service by referrers such as midwives, general practice and maternity services. This proactive relationship building, and co-location with the Te Ara Manapou service appear to be is what has influenced the significant increase in referrals received and accepted.

The emerging primary care led model in MidCentral also has high referral acceptance rates, which are not reflected in the above graph because it is a primary care service. For this District over the last 18 months all Perinatal Mental Health referrals are channelled through THINK Hauora (PHO) under the Te Rau Ora Access and Choice model. Almost all people who have been referred have received a

mental health service response, some from primary care, some through packages of care counselling, and others from Community mental health and the Perinatal mental health specialist services.

What is yet to fully develop in MidCentral is trust and confidence in this process, with Maternity clinicians adopting work around options for birthing parents who require support for moderate to severe mental distress. One example is of a hospital midwife directly referring women to a community Māori Health provider for mental health psychology services, as they have no confidence in the Perinatal MH service, and little knowledge of how the primary care service operates.

Table III Waiting times

Lived Experience Feedback
"It took 4 months for my referral to go to SMMH. I had no contact during this time." Rainbow Birthing Parent, 30-34, Large Town or City. "It was a bit of a wait to get in with the service, I understand the service is stretched thin but of course better availability would be beneficial…the team were absolutely amazing." Māmā, 25-29, NZ European/Māori large City/Town "Availability of maternal mental health counselling. Long wait time after referral made this service essentially useless." 35-39, New Zealand European, Large Town/City.
Figure no. 5.3 shows a Weeks Waited for first activity graph. This shows of the percentage of people referred to Maternal MHS and how many weeks they wait for a 1st activity by District. A first activity is usually a phone call or an in person assessment to connect with the client and arrange next steps in care. Hawkes Bay and MidCentral connect with most of their clients within the first week of referral. Hawkes Bay use an assertive outreach approach to ensure that birthing parents who are referred are reached. This means that even if they don't connect by phone call or text message, the team will engage with Whānau and drive to the person's house to connect with them. Wait times have been fairly consistent over the past 5 financial years. Waiting to be contacted has been highlighted in the Lived experience survey as one of the most dissatisfying experiences of consumers, alongside feeling rejected by services. **Pregnancy and the perinatal period is a time bound experience and waiting for help is not advantageous to mental wellbeing.** Timeliness in response should be a priority for quality in the perinatal MH services. The report on wait time measures for mental health and addiction services is clear that "Wait times are a key determinant of the experiences of tāngata whai ora in mental health and addiction services. Longer wait times are associated with a reduced likelihood of accessing mental healthcare" (Te Pou, 2022).

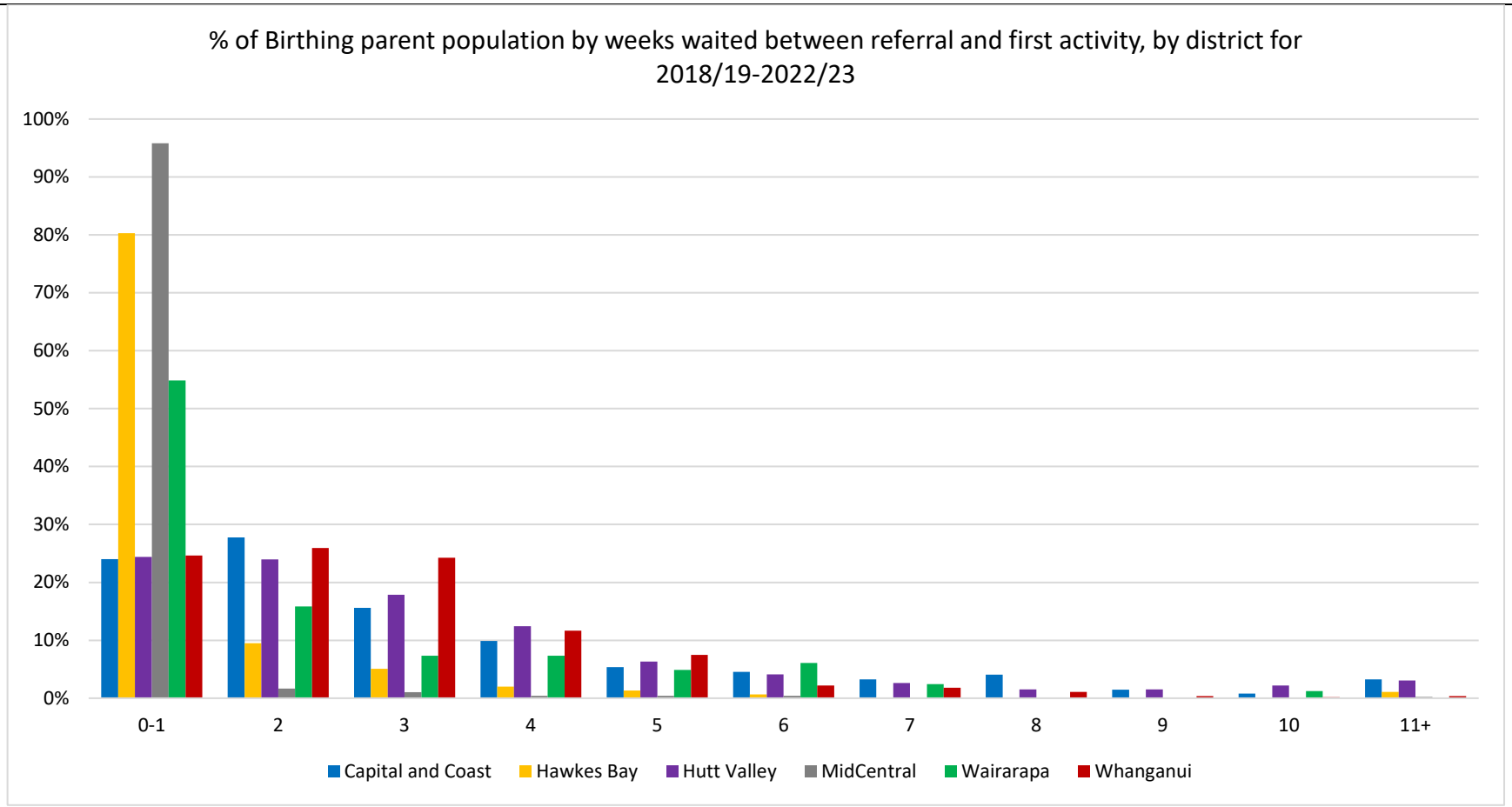


Figure 5.3 The % of Birthing parent population by weeks waited between referral and first activity, by district for 2018/19-2022/23

Table IV Number of Days in specialist service

Across the district different service models have led to variation in the number of days a client stays in a service.

Wairarapa and MidCentral operate a consult liaison service and the shorter average days in service reflects this model. The median result for Wairarapa is zero because of how consult liaison is captured by our data.

Whanganui and Hawkes Bay provide more intensive short term care, although they do have outliers with clients who have stayed in service in Whanganui for one year and in Hawke's Bay for one and a half years.

Hutt Valley and Capital and Coast have a higher length of time in service both pre and port birth as illustrated in the figure below.

Based on our data some clients appear to stay in the service just over two years for the Hutt Valley and just over one and a half years for the Capital and Coast service. This longer time in service means other parents may not be able to gain access.

People who enter the Maternal Mental Health service before the birth of their child tend to stay in the service for longer.

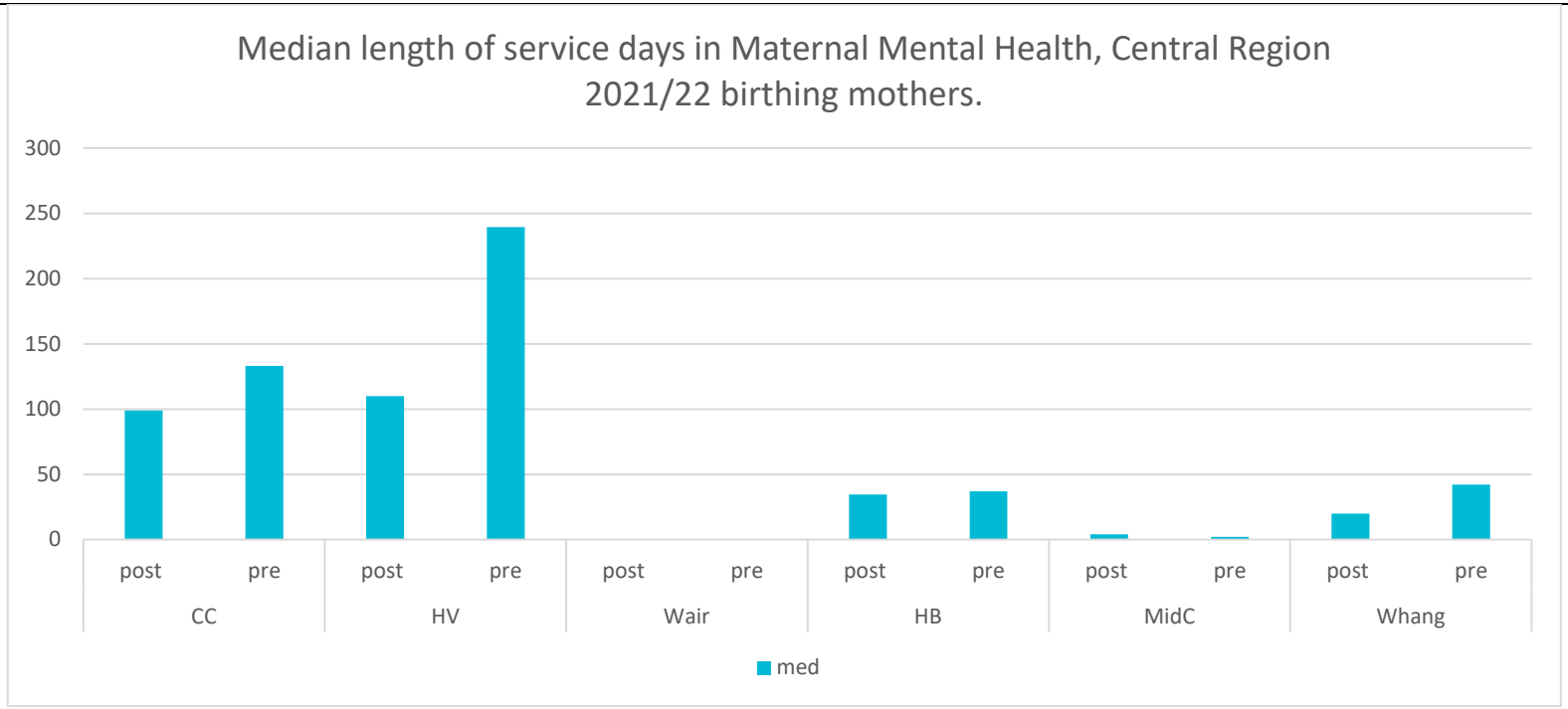


Figure 5.4 Median length of service days in Maternal Mental Health, Central Region.

Table V Entry criteria and triage processes

District	Entry Criteria	Referral Route into service	Referral Expectations	Triage and Prioritisation Process
Whanganui	Women and Infants living in the Whanganui District who have an onset of an identified moderate to severe mood disorder or psychosis associated with pregnancy and or parenthood in the first year of the infant's life. Women living in very rural centres i.e. Raetihi and Ohakune & Taihape will have their needs met by Community Mental Health. Infants are seen who meet the criteria of moderate to severe mental health issues	GP Teams including HIPs Community Midwives & LMCs, Adult Community or Inpatient MH services, Well Child Tamariki Ora, Community and Inpatient Maternity Services (Obs & Gyne Doctors, Lactation Consultants, Childbirth Educators, LMCs, Maternity Social Worker), Te Rerenga Tahi – maternal care & wellbeing group. - MH clinician attends this group. Iwi Hauora providers Self-Referral	Paper form / online form – can be emailed Referrals are treated on a case-by-case basis. All referrals need to have relevant clinical information to assist with triaging. Self-referrals are accepted and the MICAMHAS will work with Whānau to undertake an assessment. Phone call from referrer is welcome to discuss referral. If client not accepted by the service, they will be redirected to other agencies/community support	All perinatal I&MMH referrals are triaged every weekday morning by the MICAMHAS team leader, the service has an open referral system

			MICAMHAS does not provide a crisis/urgent service for maternal issues If the referral is urgent refer to Crisis Assessment and Treatment Team.	
MidCentral	Women living in MidCentral District who have an onset of an identified moderate to severe mood disorder or psychosis associated with pregnancy and an EPDS of 17 or above. The service is provided for perinatal women – i.e. during pregnancy, or up to 12 months after giving birth. And / or Women with a mental illness who are receiving a mental health service who require additional maternal mental health support throughout pregnancy	GP Teams including HIPs, Community Midwives & LMCs, Adult Community or Inpatient MH services, CAMHS, Well Child Tamariki Ora, Community and Inpatient Maternity Services (Obs & Gyne Doctors, Lactation Consultants, Childbirth Educators, LMCs, Maternity Social Worker) Iwi Hauora providers Self-Referral	Referrals are treated on a case by case basis. All referrals must have relevant clinical information and to assist with triaging the completion of an Edinburgh Post Natal Depression Scale Assessment would be of assistance. If the referral is urgent refer to Crisis Emergency Services. Written format preferred, phone call for consultation before referral is welcomed.	All perinatal MH referrals are taken to be triaged at a MDT meeting with Primary Care Mental Health Team Lead, Community Mental Health Team Lead and Perinatal Mental Health Nurse Specialist. Triage happens 2 times per week on Tuesday and Thursday.

	and/or up to 12 months after giving birth.			
Hawke's Bay	Women living in Hawke's Bay who have moderate to severe mental health concerns during pregnancy, or up to 12 months after giving birth. Women with a mental illness and receiving a mental health service who require additional maternal mental health support throughout pregnancy and/or up to nine months after giving birth	Any door is the right door GP Teams including HIPs, Community Midwives & LMCs, Adult Community or Inpatient MH services, CAMHS, Well Child Tamariki Ora, Community and Inpatient Maternity Services (Obs & Gyne Doctors, Lactation Consultants, Childbirth Educators, LMCs, Maternity Social Worker) Iwi Hauora providers Self-Referral	Keep it as simple as possible. After hours the client can be referred to the Crisis/ Emergency service. Urgent referrals are received if capacity allows. If we aren't able to respond quickly they go through the emergency mental health route Fax a completed referral form, screening tools (for example Edinburgh Postnatal Depression Scale) and any relevant maternity and/or mental health information. We also have a separate MMH email Phone to advise of any pending referral, or to	MMHS clinician (or team leader) will review and screen referrals Monday to Friday. Prioritisation is based on severity of impact on activities of living and risk to Māmā and pepi. Learning from Te Ara Manapou has led to Te whare tapa Wha also being used for triage. If referral declined - phone call with the referrer to identify other options for support, and with client consent a referral can be made to other services. If referral accepted – phone call to client to arrange meeting with MMHs clinician who will undertake assessment.

			discuss a referral or pending.	
Wairarapa	The service is for women, their infants and whānau that require additional mental health support during the perinatal period. [Women with moderate to severe mental health needs are referred to Adult Community Mental Health Service for clinical assessment and care planning / treatment.]	Referrals accepted from primary care providers and Maternity services for consultation	The role is to provide support and advice to Primary Care and Community Mental Health Services in the Wairarapa. Co-assessment, Consultation / Liaison offered to CMHT; and Consultation or brief intervention may be offered to Primary care Referrals.	Referrals are for consult liaison input. The service operates Tuesday/Wednesday and this is when they will be reviewed and actioned.

Capital Coast and Hutt Valley	The service is for women in the Kāpiti, Wellington, and Hutt District who are pregnant or who have an infant aged 12 months or less (at the time of referral) who are experiencing moderate to severe mental health symptoms, (who meet diagnostic criteria for a mental disorder) who are not under another mental health team, and who have the care of their baby and are experiencing significant impact on their daily functioning.	GP Teams including HIPs, Community Midwives & LMCs, Adult Community or Inpatient MH services, CAMHS, Well Child Tamariki Ora, Community and Inpatient Maternity Services (O & G Doctors, LMCs ,Women's Health Social Worker) Self-Referrals	If the referral is urgent the client will be redirected to CRS service Written referral emailed to the service by a healthcare professional Phone discussion possible, with follow up written referral in email (Previously all referrals came through Te Haika) SMMHS will follow up with referrer by phone to confirm acceptance into service or to decline following Triage / Intake.	SMMHS Intake clinician will review and screen referrals. Daily Mon to Fri. Prioritisation for pickup is based on severity of mental health symptoms, and impact on ability to function, eg activities of daily living. If referral is declined – letter to the client and referrer to identify other options for support, and with client consent a referral can be made to other services at times e.g. Family Start. When referral is accepted at Intake, then referral is forwarded to MDT for discussion, then allocation to clinician for assessment or waitlist for clinician. Clinician calls client to arrange Assessment appointment.

Table VI Treatment Options, Service Models and Discharge Processes

District	Treatment Options	Service Models	Discharge Process
Whanganui	Assessment and response plan development with client input Brief intervention talking therapy Infant mental health support – attachment programmes Facilitate medication review by a Psychiatrist Referral to Package of Care – home based respite or talking therapy Trauma therapy can be referred to adult psychology service and or ACC Liaison and consultation with GPs, LMCs, maternity wards & Community Mental Health Teams Connection to community mental health supports – He Puna Ora Advocacy e.g. with Oranga Tamariki	CAPA service model is implemented Psychiatrist input for diagnosis and medication Watch wait wonder programme to support attachment Circle of security programme to support attachment	Discharge to GP if they have one and /or community support services. Discharge as per the agreed plan with consumers.
Manawatū, Tararua & Horowhenua	Assessment and response plan development with client input Brief intervention, talking therapy Facilitate medication review by a Psychiatrist Referral to Package of Care – home based respite or talking therapy Liaison and consultation with GPs, LMCs, maternity wards & Community Mental Health Teams	Brief/short term interventions – ongoing monitoring of mental well-being, consult liaison. Motivation interviewing, anxiety management strategies, use of relevant apps Attachment theory Recovery model Relapse prevention and promotion of good mental health	A component of the service is consult liaison, these clients are not necessarily admitted into the service. The services also provides short term case management, these clients are admitted and discharged from the service The lead clinician e.g. the GP, LMC, Midwife is responsible for the care plan. Clients admitted to the service are either discharged back to the lead clinician or if needing long term care maybe transferred to a mental health community (locality) team for

	Connection to community supports Advocacy e.g. with Oranga Tamariki	Nursing models eg Peplau Theory were the nurse is the stranger, resource person, teacher, leader, surrogate, and counsellor	further follow up. MMH can stay involved up until the infant turns one year of age. Or clients can be referred to other community services depending on need e.g. Mothers Helpers, HIPS, Authentically U
Hawke's Bay	Assessments and care plan development with client input Talking therapies (e.g. CBT, ACT) Medication review and monitoring Case management Respite provision we are utilising a local business for in home support Liaison and consultation with GPs, LMCs, maternity wards & Community Mental Health Discharge planning and connection to community supports Advocacy e.g. with Oranga Tamariki	CBT Whānau led/ therapy informed interventions, whatever is going to work best for Whānau aligned to the assertive outreach process of Te Ara Manapau rather than classical mental health services." Te Whare Tapa Wha	Treatment is reviewed every 3 months unless needed more often Discharge will usually be into the care of the GP team Often referral to other community services e.g. Family Start, Te Korowai Aroha, Mamia
Wairarapa	Liaison and consultation with GPs, LMCs, maternity wards & Community Mental Health Teams Connection to community supports Advocacy e.g. with Oranga Tamariki	Consult Liaison	No discharge as this is not an admissions service.

Hutt Valley Capital and Coast	Assessments and care plan development with client input Talking therapies, Supportive psychotherapy Treatment modalities (e.g. CBT, ACT, EMDR), Facilitating Attuned Interactions / FAN model Medication review, initiation and monitoring care management Respite provision (home-based – Hutt only) Liaison and consultation with GPs, LMCs, maternity wards & Community Mental Health, Te Whare Marie, Pasifika MH Service Discharge planning and connection to community supports Advocacy	Approach is formulation driven to meet individual's presenting needs. Circle of security, brief interventions including linking into other services Family Start, Couple counselling, Women's Refuge, ACC Sensitive claims; Relationship based psychotherapy; Psychological treatments CBT, EMDR , ACT , all informed by Attachment theory.	Treatment is reviewed every 3 months at MDT. Conversations and preparation for discharge happen throughout contact and treatment, and is a collaborative and staged process ideally. Discharge will usually be back to the care of the GP team. Often referral to other community services e.g. Family Start during the course of the work. Consideration of what other services or supports maybe available / required is discussed prior to discharge.

Appendix 4 - 2021 Central Region: Specialist Mental Health and Addiction services review

(Francis Health & Associates, 2021)

(Copy, page 45 of report)

4.5.7 Maternal mental health services

Theme	Stakeholder	Insight
A significant and growing unmet need for a vulnerable population	3DHB	Reported rate of maternal suicide in New Zealand is five times higher per capita than that of the UK, with Māori women overrepresented
Service scope is very limited	3DHB	Access to care is challenging and should be close to home especially for acute and crisis responses - safety for mother and baby
	Regional service provider	A regional network model, not a regional specialist service
		Perinatal and some post-natal, but very limited
		Sub-region DHB's are funded for their own specialist clinicians but hard to secure
		Aim is to upskill and help Subregion colleagues to manage MMH clients close to home
Not culturally acceptable/safe	3DHB	Lack of culturally safe practice/lack of trained workforce in this area
	Sub-region DHBs	"A service designed for Pakeha middle class"
		Workforce does not reflect the served population
Not equitable	Regional service provider	Offers regional service across and direct patient care to 3DHB, and only consultation, liaison, and training to outer region DHBs
Mismatched service scope to Sub-region needs	3DHB	"It is a very specialist area for psychiatrists especially in regard to medication management across pre-pregnancy planning, ante natal, perinatal and post-natal"
	NGO	We need more support/expertise locally, our women are dying
		Need to support and fund specialist NGO capability for in-home
	Sub-region DHBs	Model requires further co-development with regions and wahine
		We used to have a great contract then suddenly all communication dropped off
Lack of engagement from Sub-region DHB's	Regional service provider	"We start each year with a session to identify what they need help with"
		They (Sub-region DHB) cancel trainings at last minute
		Subregions seem unmotivated unless they have specialist clinicians
		Specialist MMH clinicians based in sub-regions are often unsupported by the DHB leads

Appendix 5 - Improve the response to mental wellbeing earlier in the maternal journey

- The mental wellbeing of māmā can be greatly affected during antenatal and postnatal stages. Earlier interventions can occur if the ecosystem of services and supports have a seamless pathway for ensuring Māmā can access support when they are in need.

- We propose:
    - That there would be development around communications and engagement with Māmā earlier on within her antenatal care, checking for indicators of distress or symptoms of mild to severe mental distress.
    - Ensure villages of support, antenatal and postnatal classes are creating a safe space for Māmā to talk together and share their feelings and experiences. That group settings for reflection and sharing can support Māmā to make sense of their state of being, without judgement, or further stress.
    - Facilitate connectivity across mental wellbeing services (mainstream health and community services) to better respond to Māmā and whānau needs, including quicker response times and more personalised engagement and care.
    - Develop and implement warm handovers that are supported by an assessment tool.

- This information is taken directly from The Hapu Māmā Village report (Te Oranganui - Healthy Families, 2023) You can find the whole report here: https://www.healthyfamilieswrr.org.nz/general-6

Appendix 6 - Central Region Infant and Maternal Mental Health Advisory Group 2023

Te Kāhui Tapsell	Senior Psychiatry Registrar, Specialist Maternal Mental Health Service, Te Whatu Ora - Capital, Coast, Hutt Valley & Wairarapa
Jackie Foss	Pou Tārearea - Tamariki Ora Clinical Leader, Te Whatu Ora - Central Region
Lucie Zwimpfer	Psychotherapist, NICU, Wellington Hospital, Te Whatu Ora - Capital, Coast, Hutt Valley & Wairarapa.
Janice Bowers	Team Leader, Maternal, Infant, Child, and Adolescent Mental Health and Addiction service (MICAMHAS). Te Whatu Ora - Whanagnui.
Samantha Kahukura	Manukura / Māori Midwifery Advisor for Te Ata-rauru /Wairarapa Maternity, Te Whatu Ora - Wairarapa
Suzana Baird	Director Lived Experience & Engagement, Mental Health, Addiction & Intellectual Disability Service (MHAIDS), Te Whatu Ora - Capital, Coast, Hutt Valley and Wairarapa.
Samara Kelly	Mental Health Service Team Lead, Registered Social Worker, Health Hawkes Bay
Melissa Cragg	Acting Director for Commissioning within the Oranga Hinengaro Team at Te Aka Whai Ora (National).
Ruth Deverell-Stewart	Registered Midwife/ Matanga Whai Ora. (Health Improvement Practitioner). THINKHauora MidCentral District
Tusiga Sealiimalietoa	Partnership and Network Lead, Pacific Peoples Health, Te Whatu Ora - Central Region
Leilani Maraku	Manukura (Chief Executive) , Mana o te Tāngata Trust, (located in MidCentral District), and member of Mental Health and Addiction Leadership Group - Central Region

Te Iringa Davies	Regional Manager, Starting Well, Te Whatu Ora - Central Region
Jessica Sandbrook	Project Lead, Outworking Ltd., Central Region.

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