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Midland
District Health Boards
MENTAL HEALTH & ADDICTION REGIONAL NETWORK
Service Development • Workforce Development • Partnerships & Relationships

Perinatal and Infant Mental Health and Addiction Project

Phase II

Primary Health Care and Community

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Final

Contents

Executive Summary

Perinatal and Infant mental health and addiction needs of women and infants in the Midland region are of concern to families, communities, and health and social agencies. This phase 2 of the Perinatal and Infant Mental Health and Addiction project, consistent with the Ministry of Health guidelines Healthy Beginnings (2012) seeks to make recommendations to improve outcomes to women, infants and their families.

This project engaged stakeholders from primary health care and community in a series of local workshops to consider services that were available. Risk profiles that highlighted the women and infants most at risk of a mental health disorder were used to focus discussion.

Best practice evidence in service delivery approaches for perinatal and infant mental health and addiction from the literature was communicated.

Stakeholders at the workshops were able to identify gaps in local service delivery and opportunities to improve their model of care including becoming more accessible and responsive, and strengthening the critical relationships and linkages.

Stakeholders at the workshops recommended:

1. A stepped care approach and the development and implementation of a perinatal and infant mental health and addiction pathway at local level
2. The development of local perinatal and infant mental health and addiction networks that promote collaboration and are aligned to other networks with similar interests such as addressing family violence through MOH Violence Intervention Programme (VIP)
3. Key contact/link/coordination personnel within each DHB district are identified for perinatal and infant mental health and addiction matters
4. Directories of Perinatal and Infant Mental Health and Addiction resources that are utilised
5. Map of Medicine is implemented
6. Community based care and treatment options that can be arranged with 'Packages of Care' funding are pursued
7. Metrics that demonstrate improvement in perinatal and infant mental health and addiction services are to be captured and monitored.

1. Introduction

This Midland region project has been established to identify the infant and perinatal mental health and addiction needs of the region and make recommendations about the most appropriate ways to address those needs at local and regional levels. The Ministry of Health in the document *Health Beginnings* (Ministry of Health, 2012) provides guidance to district health boards (DHBs), and other health planners, funders and service providers on ways to address the mental health and addiction needs of mothers[1] and infants.

This project has been structured in two phases. In Phase one using a stock take and drawing from *Healthy Beginnings* (Ministry of Health, 2012) and other sources of information, the project has sought to determine the options on how best to meet more acute and complex needs with a focus on secondary and tertiary service provision. The final report is available.

Phase two of this project focuses on the primary health care and community service provision in the health promotion, prevention, and non acute areas of care and support.

Phase two of this project includes:

- Literature scan specific to primary health care and community
- A review of current primary health care and community service delivery
- Analysis on where Midland sits within national and international best practice frameworks
- Break-down of individual Midland DHBs service delivery
- Identification of gaps in service delivery
- Development of model of care options at local DHB level including relationships, linkages and pathways.

Consistent with Phase one this project will be guided by the following documents:

- Perinatal and Infant Mental Health and Addiction Project Phase One, 2014
- Ministry of Health: Service Development Plan: Rising to the Challenge, 2012
- Ministry of Health: Healthy Beginnings, 2012
- Mental Health Commission: Blueprint II, 2012
- Midland Region Mental Health and Addiction Needs Assessment 2011
- Midland Region Mental Health and Addictions Strategic Plan 2008-2015
- Midland Region Mental Health Workforce Development Plan 2013 – 2016 (draft)
- Midland Regional Clinical Services Plan 2013/14.

Women have been shown to be at a higher risk for the onset or recurrence of mental illnesses during the perinatal period, more so than at other times (Burt and Quezada 2009). Furthermore maternal mental illness in this period has a detrimental effect on the emerging mother-infant relationship. It may cause delayed social and emotional development and/or significant behavioural problems in the infant, potentially leading to poorer outcomes.

[1] Throughout *Healthy Beginnings* the term **mother** is used for the simplicity as mothers are most commonly in the role of primary caregiver for their infants. However, fathers, grandparents, adoptive parents, foster parents and others may also undertake this role and may access services if eligible.

Healthy Beginnings (Ministry of Health, 2012) suggests that comprehensive perinatal and infant mental health services should include:

- health promotion
- screening and assessment
- interventions including case management, transition planning and referrals
- access to respite care and specialist inpatient care for mothers and babies
- consultation and liaison services within the health system and with other agencies.

It is thought that no DHB in the Midland region currently provides a full range of comprehensive services consistent with this list. The literature reinforces the importance of a comprehensive integrated range of services from early detection to intervention and treatment.

2. The Literature

Perinatal mental disorders are associated with poorer outcomes for women and their families (Murray et al. 2003). Poor infant outcomes including morbidity and mortality can be linked back to perinatal mental health problems (Rahman et al, 213).

The international literature describes the predictors or risk factors for perinatal and infant mental disorders and evidenced models of screening, assessment, stepped care and support to improve outcomes for women and their families.

Risk Factors

Risk factors of perinatal mental disorders in a number of significant international studies consistently include poor pre-pregnancy mental health (with over 50% of those women who experienced postpartum illness reporting a history of a mental health issue). When a mental health issue was experienced in the antenatal period, it was likely to also occur in the postnatal period if not diagnosed and treated (Witt et al, 2011).

Other common risk factors include being single and unsupported. One study found that women that were single, divorced or widowed were more at risk than those with a partner. However another study showed that the woman in a relationship with an unsupportive partner or subjected to family violence were at even greater risk of perinatal mental disorders than the single woman (Milgrom et al, 2008; Bilszta et al, 2008). Pregnancy was reported as a time for higher risk for family violence (Gartland et al 2011) and Edwards et al (2008) noted that violence was the strongest predictor of antenatal depression.

Socio-demographic factors such as lower income, unemployment and lower educational achievement all played a part as predictors of perinatal mental disorders. Physical illness influenced mental illness, with women who experienced pregnancy complications such as hypertension pre-eclampsia, anaemia, diabetes, or had a chronic medical condition were also more at risk of a perinatal mental disorder.

Determinants of maternal mood which contribute to wellbeing included social exclusion and isolation, infant behaviour, and maternal expectations (Eastwood et al, 2013).

Some suggested that obesity was a risk factor but a study found that there was no difference in depressive symptoms for those who were obese (Claesson, Josefsson, Sydsjo, 2010).

Perinatal Wellbeing is influenced across the life span and has the potential of intergenerational effects. But it is amenable to change so it is worthwhile identifying and intervening.

Identification and Screening

Universal screening (which is expected in New Zealand) allows for early detection of psychological distress (Ministry of Health, 2012). However screening must be followed with timely treatment and support. Health policy in states of Australia mandates screening for depression and a psychosocial assessment for all women in the antenatal and postnatal periods (Rollans, Schmied and Meade, 2013).

Implementation of screening and assessment in Australia may vary depending on whether care is provided in the public or private sectors. A study showed that women that gave birth in a public setting were more likely to be assessed across a range of domains including current mental health, drug or alcohol use and family violence (Reilly, Harris, Chojenta, Forder, Milgrom, Austin, 2013). This finding may be consistent with New Zealand practice.

In the efforts to identify and act on risk factors for perinatal mental health problems the way that an assessment is done in order to be more effective has received some criticism. Researchers suggested that health professionals would benefit from training on how best to engage mothers and ask the sensitive questions in an empathetic way (Rollans, Schmied and Meade, 2013).

Screening tools to assess for perinatal difficulties have been analysed. Studies showed that all tools had their limitations but what was more helpful was the consideration of combining the psychosocial assessment with clear integrated pathways to care. Tools identifying difficulties early could lead to timely interventions and treatment and improved outcomes. Tools were able to measure perinatal risk (Johnson, Schmeid, Lupton, Matthey, Kemp, Meade, and Yeo, 2012).

Early Intervention

The role of community providers in a stepped care approach with models of care at a primary health care level is believed to be important. A Stepped Care approach (similar to that used in a number of other countries) was taken in South Africa to make the best use of resources using mental health screening for all mothers engaged in antenatal care. 32% of those screened required further action (Honikman, van Heyningen, Field, Baron and Tomlinson, 2012). Those who screened positive were referred on to on-site counsellors for case management. Referral to a psychiatrist was available if required. The model of care focused on collaborative partnerships with an emphasis on problem solving and strengthening capacity in the primary health care system. Established systems of referral and protocols enabled more effective case management.

Evidence has shown that maternity health workers can be trained to screen. Integration of functions together with mental health services in primary care settings can be more effective in improving access to required skills and expertise in a timely way (Honikman, van Heyningen, Field, Baron and Tomlinson, 2012). Screening by maternity workers was a way of facilitating earlier detection and intervention.

There is evidence for effective non-mental health specialist led interventions involving nurses, midwives and lay workers. Several trials with lay workers have proven effective. *Thinking Healthy Programme* captures this (Rahman, Surkan, Cayetano, Rwagatare, and Dickson, 2013).

Enhancing collaboration between providers of perinatal mental health and child health, and developing ways to integrate screening and core mental health care into routine primary health care, is helpful. Coordinating visits to the maternity provider and the mental health provider was thought helpful to both staff and the mother (Rahman et al, 2013).

Bowen and Muhajarine (2006) describe supportive therapies that can be offered in the perinatal period such as exercise, adequate nutrition, sufficient sleep, and social support from friends and family. Talking or psychological therapies are important in depression only a few women will require pharmacological intervention it is thought. Other therapeutic interventions may be used drawing on an attachment based framework (Myors et al, 2014).

Integrating perinatal mental health into regular public health programmes was thought to be useful seeking inclusion in major public health initiatives (Rahman, Surkan, Cayetano, Rwagatare, and Dickson, 2013). WHO advocates for integrating mental health into primary health care (Abera, Tesfaye, Belachew, and Hanlon, 2014).

Parenting Centres

Residential early parenting centres have shown benefits in early intervention for difficulties with infant feeding and infant sleeping, and perinatal mental health problems. Mothers who attended the programmes usually had poor mental and physical health, limited family and natural supports and had an infant that presented with behavioural difficulties. Research showed significant improvements in maternal psychological functioning following attending a residential programme for 4 to 5 days at a centre in Victoria, Australia (Rowe and Fisher, 2010).

Training for Staff

Engaging staff in a stepped care approach made the requirements and workload more achievable. It was about matching need with the appropriate level of skill and expertise. Training programmes for staff were thought to reduce fatigue and burn out (Rollans et al, 2013).

Overall the literature has shown that perinatal and infant mental health and addiction needs feature internationally. A collaborative and integrated stepped care approach is required in order to identify problems and offer interventions early, reducing morbidity and mortality, and improving health and social outcomes for mothers, infants and their whānau.

3. The Approach

Stakeholders from the primary health care and community sectors including midwives and Well Child providers were contacted and invited to participate in phase 2 of this project. A group of midwives reported that the women in their communities most at risk of perinatal mental disorder and addiction fitted certain profiles. Three scenarios were developed focusing on the midwives' information. The scenarios were presented to participants at stakeholder workshops in each DHB district within the Midland region with the exception of Tairawhiti. Participants shared what services were available and what action would be taken for each scenario.

Scenario 1. A mother in the perinatal period has a previous history of mental illness and becomes unwell.

Scenario 2. A vulnerable young Māori mother socially disadvantaged and without a partner comes to your attention.

Scenario3. An eccentric mother who is reluctant to engage with services causes some concern.

The Workshop aimed to bring local stakeholders together to:

- Provide information about the regional project Perinatal and Infant Mental Health phase 1 and its findings which focused on DHB services
- Improve knowledge and understanding of what perinatal and infant mental health services are available in the local DHB district, including primary health care, LMCs, Well Child and NGO
- Improve knowledge about access and referral pathways thereby enhancing the quality of referrals and timeliness of responses
- Inform future service planning of where services could be improved, developed or enhanced
- Inform local knowledge repository for Map of Medicine development region wide.

4. Current Service Delivery for DHB Communities

This includes Primary Health Care, Midwives, Well Child Providers and NGO Providers.

The Midland region is served by five District Health Boards; Waikato, Bay of Plenty, Lakes, Taranaki and Tairawhiti. The contributing factors that increase infant and maternal mental health needs highlight the relevance of the local demographics in service planning.

Service Outcomes Sought

Stakeholders were asked what outcomes were sought in the delivery of services at primary health care and community level. They suggested the following:

- All (Mothers and Infants) to be functioning at their optimum
- Choices are available and offered
- Maternal infant bonding attachment occurs
- Appropriate use of prescribed medicine occurs
- Support network as a family or other is in place
- Coordinated timely and preventive care is received by mother and infant
- Comprehensive assessment tools are available with adequate follow up occurs
- Mother (and infant) are fully engaged in the processes

4.1 Waikato DHB

Waikato DHB serves a population of more than 360,000 people, stretching from the Northern tip of Coromandel Peninsula to south of Taumaranui, and from Raglan in the west to Waihi in the east. About 40 per cent of its population lives in rural areas.

4.1.1 Current Services

In addition to the secondary and tertiary services described in phase one of this project, a range of services is offered in the Waikato district.

Hauora Waikato whānau ora approach offers a range of programmes for women that fit the 'At Risk profiles'. This includes a mobile service with home visiting and additionally a community based hub facility. Women are able to attend the programmes and drop in for advice or a sleep while baby is supervised/observed. There is also a fathers' programme.

The Hamilton Central Cluster 0-18 collaboration deals with children and youth who have experienced emotional and behavioural issues.

Mothercraft service is provided which includes day programmes and supports.

Well Child Providers have a raft of programmes as well as linking the mother and her whānau into other agencies.

In rural areas the workforce works more creatively to deliver a service with similar expected outcomes as urban areas, due to the challenges of isolated rural communities.

4.1.2 Gaps in Service Delivery

While most providers (participating in the local workshop) thought that the overall range of Perinatal and infant mental health and addiction services were available in the district, the biggest barriers to access were travel and travel costs.

Greater awareness of what services (care and support) were available and the connection with the other components of the perinatal and infant mental health pathways were thought to be required and it was suggested that this would make a difference to current utilisation and outcomes.

4.1.3 Services/ Actions for At Risk Profiles

For Mothers with Previous History of Mental Illness

Pre-conception advice for Mental Health service users was available from the DHB specialist service.

Actions suggested included:

- Assess for severity of illness, and symptoms of distress
- Contact mental health provider/crisis team if necessary
- Enlist support of family, friends and community.

Provider should know their limitations and refer to another organisation/agency if necessary.

For Young Socially Disadvantaged Mother of Māori ethnicity without a partner

Actions suggested included:

- Assess the needs of the Mother and engage with offering the supports required
- Refer (with Mother's consent) to another health professional/organisation/agency/GP, if appropriate
- Offer Whānau support and possible assistance with financial situation.

For Eccentric Mother – may be older not engaging with services

Actions suggested included:

- Ascertain why the Mother is declining by listening to concerns and explaining options
- Develop a relationship and establish the level of partner support she is receiving
- Assess the risks; risks to the Mother and risks to the Infant
- Screen for Family Violence.

4.2 Lakes DHB

Lakes DHB is responsible for funding and providing healthcare services for the 102,000 people who live in its region. The Lakes DHB runs hospitals at Rotorua and Taupo. Other providers include primary care, private providers (dentists, pharmacists, and Allied Health providers), Māori providers, mental health service providers and non-government organisations.

Approximately one third of the Lakes population lives in the Taupo region and two thirds live in the Rotorua region. A total of 32 per cent of the Lakes population is Māori, and the Lakes region has a small (approximately 3,600) but growing Pacific population.

4.2.1 Current Services

In addition to the secondary and tertiary services described in phase one of this project, a range of services is offered in the Lakes district. Workshop participants suggested that a continuum of care was available for Mothers and their infants in the Lakes district.

For those with symptoms graded as mild: Open Home; Mana; NGO-Social /Mental Health services;

Mild to moderate: Well Child; Open Home, Child Youth and Family

Severe: Respite; Refer to DHB Specialist services

A Perinatal NGO service was established in 2004 and provides a group focused programme named Mother Matters with an emphasis on wellbeing. A partner session is also offered. However the service is only available for people during the postnatal period.

Recovery Solutions (NGO) has a respite service for mums on the inpatient unit who have babies – respite on Youth Site in a cottage and follow up in the community. A dedicated support worker is available to address some of the social issues and engage with agencies.

Collaborative inter agency activity such as the Family Violence Intervention Programme provides an opportunity for agencies to become more aware of problems and work together to problem solve. Examples include the link between Police Liaison nurse, Mental Health and the Police.

4.2.2 Gaps in Service Delivery

There were opportunities for improvement in a number of areas and at the outset it was suggested that service users were invited to advise what gaps they identified in terms of meeting their needs.

It was recognised by stakeholders at the workshop that Lead Maternity Carers within the Lakes district had a role to play but it was unclear whether they were all aware of what was available in the community for perinatal and infant mental health issues and how best to ascertain what was required. For example: what questions to ask the Mother and her whānau, how to document the information on the LMC booking form, what do they do when they identify a mental health problem?

Home based assessments were occurring and were positive but issues about consent/risk needed to be tackled. The welfare of the Mother and infant was thought as paramount. Are the mother and infant safe?

It was suggested that there was a lack of services that specifically met the needs of Teen Mums and Teen Parents. There was no access to Mothercraft type services.

There was some anxiety and a lack of trust in the community about engaging with services and potential implications with social agencies such as Child, Youth and Family services. Therefore there was a need to build good relationships, and establish and strengthen community networks.

4.2.3 Services/Actions for At Risk Profiles

For Mothers with Previous History of Mental Illness

Actions suggested included:

- Assess risk factors –risk to Mother, risk to infant, risk assessment for Maternal Mental Health Act; Child Youth and Family Act; Informed Consent
- Identify the need for a plan- multi-agency plan, including collaborative information sharing
- Integrate monitoring group which ensures the management plan is upheld
- Ensure all social services required currently being accessed? LMC; Well Child Service; Family Start; Tipu Ora
- Disseminate of information to all parties including copy to the family involved
- Identify support networks e.g. Whānau/family, church, marae, community

For Young Socially Disadvantaged Mother of Māori ethnicity without a partner

Actions suggested included:

- Referral to CAMHS
- Real

- Rotovegas – under 25yrs
- Access to Social worker, Sexual health, Midwife
- Engage Well Child provider
- NGO providers e.g. Open Homes – Mother Matters, Recovery Solutions, Galbraiths

For Eccentric Mother – may be older not engaging with services

Actions suggested included:

- Assess what support she has, is she accessing universal services e.g. church, alternative therapist
- Risk assessment - ? Maternal mental health - ? is the child in danger
- Business as usual (BAU) – unless proven otherwise with risk assessment
- Follow up with services involved with the children, if no concern this then BAU – GP/LMC
- Identify strengths/resilience in her circumstances
- Encourage GP relationship if not keen or other engagement.

4.3 Tairawhiti DHB

Located in Gisborne, New Zealand, Tairawhiti District Health (TDH) is responsible for funding and ensuring the provision of health services for those in need of personal health and disability services. This work is done in the community and from Gisborne Hospital. In the 2006 census, Tairawhiti had a resident population of 44,499 or 1.1 per cent of the national population. With a population density of 5.3 people square kilometre it is one the North Island's the most remote and sparsely populated districts.

4.3.1 Current Service

In addition to the secondary and tertiary services described in phase one of this project, a range of services is offered in the Tairawhiti district. Within the community it was believed that awareness of perinatal and infant mental health issues was increasing. There was a range of services focused at different levels to best meet the needs of mothers, their infants and whānau.

Infant Mental Health (0-3)

- Plunkett and TH Mama and Pepe
- Liaison with CAMHS
- Incredible Years programme
- LMC/GP
- Cross agency – case review process (happens once)

Perinatal Mental Health (pre and post partum)

- Teen pregnant mum home
- Liaison with Maternal mental health clinical specialist
- Pathway in place- sexual health service
- VPW group
- Teen pregnant unit at Lytton High
- Family start, Strengthening Families, Parents as First Teachers
- Plunket, Turanga Health, Te Hono Whānau- stretching resources
- Yummy Mummies social media network on Facebook
- MHN mental health Coordinators
- Well Child Provider- Tamariki Ora
- Te Hono Whānau, Barnadoes
- Womens Refuge, TAIN
- Tau Awhi- Peace out East
- Stand- health camp
- Te Kupenga
- Shared tool kit for screening- mental illness and addiction

There was a COPMIA programme for children whose parents had addiction issues (2006/7) but it is no longer provided.

4.3.2 Gaps in Service Delivery

Workshop participants suggested that there were service delivery gaps and aspects that needed more attention such as:

- Update the Referral pathways and policies
- Communicate the services available and entry criteria
- Ensure services are readily available and accessible
- Ensure pathway to service entry is known such as referral processes
- Promote smoother transitions from one service to another
- COPMIA- increasing awareness and service provision
- Increase early intervention and support including partner and family
- Review other service models- used in smaller DHBs and learn from them
- Implement Map of Medicine
- Strengthen Addictions workforce to respond to Mums
- Focus on the needs of Teen Mums and those in rural areas
- Consider access barriers- travel and cost of travel

(Refer to action plan in Section 10).

At Risk profiles were not examined at this particular DHB workshop.

4.4 Taranaki DHB

Taranaki DHB serves a population of 104,280 people, or 2.8 per cent of New Zealand's population. Between the 2001 and 2006 census, the population usually resident in the region increased by 1,266, or 1.2 per cent.

- 15.8 per cent of the population are identified as Māori (14.6 per cent nationally).
- 1.4 per cent identified as Pacific peoples (6.9 per cent nationally).
- 2.1 per cent as Asian (9.2 per cent nationally).
- 80.7 per cent as European and other (69.3 per cent nationally).

4.4.1 Current Service

In addition to the secondary and tertiary services described in phase one of this project, a range of services is offered in the Taranaki district. It was suggested that services for 0-3 age group were well covered.

Tui Ora, an NGO provider worked collaboratively with DHB services, with a focus on need and protection issues. Families were included in the development of a plan, an across service plan that involved everyone.

Plunket worked according to the Ministry of Health guidelines, screening mothers in their homes, working in partnership with families. Families are engaged and contribute to the planning processes.

Reference was made to Stratford where young Māori women had received the support they needed and were making a difference to their lives. Supports included wrap around services, assistance with getting a drivers licence, access to a bus service, and a free health service.

4.4.2 Gaps in Service Delivery

It was asked by workshop participants where the consumer and whānau voices were in the future developments? What do they want? Is it well understood? It was suggested that women and their families should be surveyed to gain this information. Gaps in service delivery and other aspects to improve were thought to include:

- Education and support for fathers
- Targeted services for High risk Mums (antenatal)- social and financial issues, sometimes Family Violence is a factor
- Coordination and cooperation amongst providers
- Funding to treat male youth expressing violent tendencies
- Groups to nurture emotional expression and self esteem, Mindfulness
- Below cost or free services for mums at GP in the perinatal period
- Access to communication and relationship courses
- Education and support for caregivers (consistent messages)
- Family Counselling/therapy

- Team of specialists from different agencies working together in a hub
- Infant mental health, healthy baby, healthy mum, healthy family, parenting support
- Circle of security groups, parents/infant/child
- Respite care in home
- Accessible services for dads and support for dad
- A referral centre into hub of social and health services with a coordinator
- Initiatives that address family violence (and children age 0-5 exposed)
- Revise perinatal pathway for clinicians to follow- covering mild to acute stage
- Inter-agency – case/treatment planning
- LMCs referral directly to counselling services
- Further development with the Kete programme – specialised assessment and triage service
- Mild to moderate, Māori appropriate, service delivered in the community/homes/marae
- Baby child family therapists to ensure milestones
- Great fathers/mates/group
- Debriefing services
- Midwives to refer to free counselling x 3 sessions and MHN services
- Liaison/consult/education role in community regarding infant mental health
- Formalising inter agency meeting
- Know what services are available how to refer referral directory
- Weekend call services
- PNMH Link nurse visible in maternity services
- Mother and baby unit possibly Stratford as mid Taranaki.

4.4.3 Services/Actions for At Risk Profiles

Mothers with Previous History of Mental Illness

Actions suggested included:

- Rapid response to health issues at primary level of care and/or secondary level SOS
- Screening first, assessment and triage
- Referral and support into appropriate service
- Sharing of information
- Access to consult/advice
- Change of triage priority
- Assessment – What's currently happening in life at present, family background – EPDS – how unwell, pregnancy assessment, Hb, thyroid, conversation with GP, risk to baby, CYF etc
- Support network – family friends? How Midwives are able to refer for 3 x free counselling sessions? What other services have the family, mother assessed/referred to.

Young Socially Disadvantaged Mum or Māori ethnicity without a partner

Actions suggested included:

- Assessment: go find her, line with Kaiawhina, encourage Whānau, family involvement, obtain thorough history, documentation
- Assessment includes: social factors, single, income, isolation, housing, education, A&D, Smoking, FV, transport issues, CFYs
- Engage with LMC (midwife)
- Refer – teen parent unit, pregnancy help, healthy eating, budgeting, contraception, long term.

Eccentric Mother – may be older not engaging with services

Actions suggested included:

- Assessment –Vulnerable as expectation of what they want, mental illness as result these expectations not met
- Need a health professional they can trust
- Engagement is vital, crucial to acknowledge the woman's autonomy, self-responsibility
- Provide options of care, extended outside of medical model.
- Professional responsibilities are communicated with woman. "Double responsibility". Greater issues – information sharing
- Professional exploration, clinical responsibility, assessing severity, makes a call, particularly if there are concerns for safety.
- Inter-collegial respect and acknowledgement develop trust between woman and other services
- Assess risk, mother and relationship – baby by primary worker already engaged, less threatening. Support workers in, work on building relationship with hope, accept help.

4.5 Bay of Plenty DHB

The Bay of Plenty DHB serves a population of 200,000 on the east coast of New Zealand's North Island, taking in the major population centres of Tauranga, Katikati, Te Puke, Whakatane, Kawerau and Opotiki. It has the second fastest population growth rate of all New Zealand's district health boards.

4.5.1 Current Services

In addition to the secondary and tertiary services described in phase one of this project, a range of services is offered in the Bay of Plenty district.

It was suggested that people don't necessarily recognise mental health issues in themselves. Stigma, isolation, family/domestic abuse, alcohol, substance misuse were concerns. There was a need to access the appropriate pathway via GP or other primary health care referrer.

- Assessment /screen by GP or LMC
- Mild- moderate (primary, Iwi, Plunket, Hauora, RS)
- What is the history? Have the Crisis Team been involved?
- Access services that are culturally appropriate, having identified the pathway
- Referrals to CMHT (Secondary) and ICAMHS
- Pathways and awareness of what is available- maternal networking forum- 3 monthly (midwives)
- Te Puke- cultural/translation issues
- Need to identify the stakeholders/people involved.

4.5.2 Gaps in Service Delivery

It appeared based on the discussion of stakeholders at the workshop that many providers were unaware of other providers and their roles and how to access the services that they provided. They expressed appreciation for the way the workshop had brought them together and increased their levels of knowledge and understanding.

Gaps identified included:

- Networking opportunities and connections of providers
- Knowledge of the perinatal and infant mental health specialist services and referral processes
- Training requirements
- Access to support with complex cases

4.5.3 Services/Actions for At Risk Profiles

Mothers with Previous History of Mental Illness

Actions suggested included:

- Referral to MMH – ICAMHS
- Input from Social worker, GP
- Crisis Team, (Adult service) ICAMHS
- Lactation service

Young Socially Disadvantaged Mum or Māori ethnicity without a partner

Actions suggested included:

- Red flags, social services, cultural support- appropriate agency
- Check GP enrolment
- Whānau support
- Teenage AN classes
- Ongoing support once baby born
- Tamariki Ora/Plunket
- Incentives
- Lactation service
- Whānau Ora, Hub
- Antenatal Educational Partnership

Eccentric Mother – may be older not engaging with services

Actions suggested included:

- Screen for Family Violence
- Social worker
- Mental Health Service
- Documentation
- CYFS - ROC
- Family Centre locally (similar to Waikato Family Centre model)

5.0 Themes and Priorities

The Ministry of Health (2012) outlined priorities in the guideline *Healthy Beginnings*. Given the national direction and guidance, and evidence from the literature Midland stakeholders at local workshops held in each DHB district considered the local context and the needs of their populations. They identified important themes and priorities to address the perinatal and infant mental health and addiction requirements, particularly pertaining to the at risk profiles. Their perspectives are described in this section.

- Promoting wellbeing and social inclusion of mothers and their whānau
  Engaging mothers, infants and their whānau in community is important to maintain wellbeing. There are many ways that primary health care, maternity and well child providers can do this.

- Early identification and screening of those most at risk

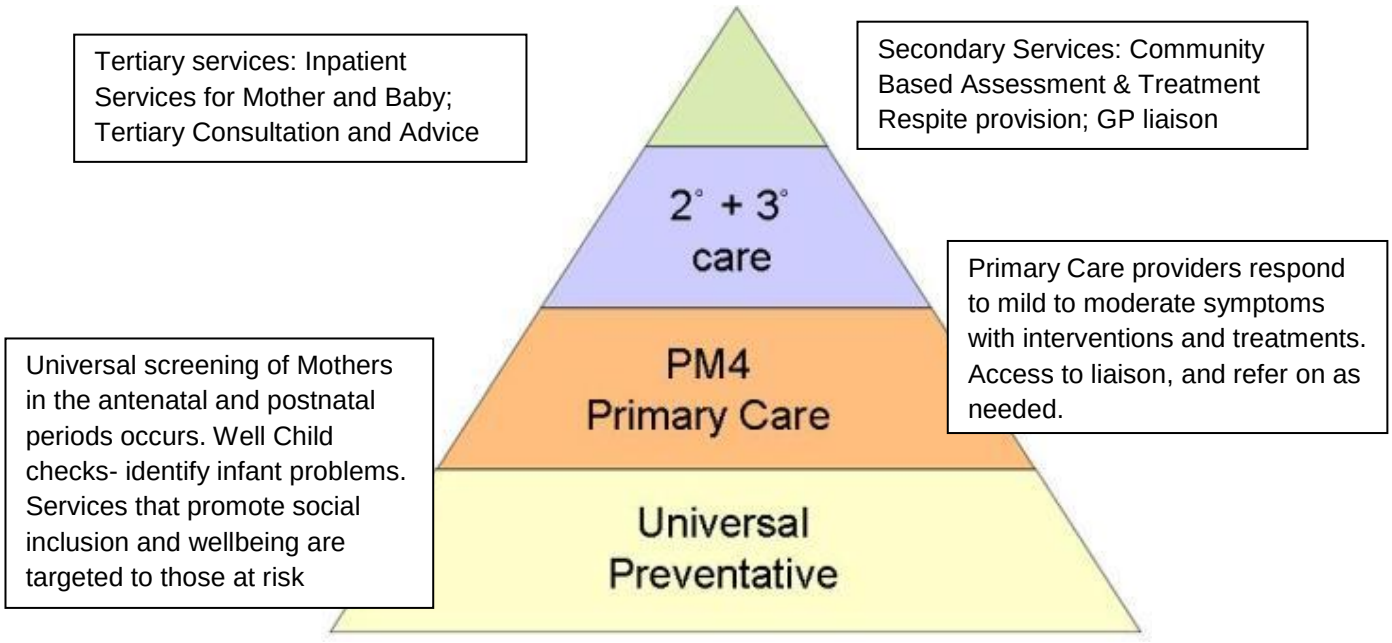
Risk factors for perinatal mental health disorders have been confirmed in the research and ways to identify those using screening tools have been tested. Screening can be undertaken by lay workers as well as clinicians within the community and should be part of a stepped care approach triggering early intervention.

- Early intervention at primary care level
  The literature showed that there are many interventions that can be offered at a primary health care level that are not all pharmacologically related. However medications may be offered if warranted.

- Awareness of symptoms when specialist expertise is required and the pathways to access
  All DHBs had specialist expertise to respond to perinatal and infant mental health and addiction issues, however the pathways to access were not always clear and well understood. There was some question as to whether all staff in the community were aware of symptomatology and what actions should be taken.

6.0 Developing a Model of Care

A stepped care approach is consistent with delivering services *to the right person in the right place by the right person with the right skills and expertise*. A model of care that embraces the stepped approach can be described using the pyramid or tiered model.



As described in Perinatal and Infant Mental Health and Addiction project phase one, services should be delivered according to a tiered model.

7.0 Conclusion

Perinatal and infant mental health and addiction services are provided in DHBs across the Midland region. At primary health care and community level, women and infants are being identified with screening and assessment methods as requiring further investigation and intervention.

Three profiles of mothers most at risk have assisted us to focus our attention in exploring the approach to providing care and support to women, infants and their whānau in the Midland region.

- Mothers with Previous History of Mental Illness
- Young Socially Disadvantaged Mum of Māori ethnicity without a partner
- Eccentric Mother – may be older not engaging with services

In many areas intervention services were available and being provided however they lacked the connection and collaboration within the system. Pathways were not always well understood and communicated. A stepped care approach within the tiered model of care is recommended supported by local and regional networks.

8.0 Recommendations

Stakeholders at the workshops recommended:

1. A stepped care approach and the development and implementation of a perinatal and infant mental health and addiction pathway at the local level
2. The development of local perinatal and infant mental health and addiction networks that promote collaboration and are aligned to other networks with similar interests such as Family Violence Intervention
3. Key contact/link/coordination personnel within each DHB district are identified for perinatal and infant mental health and addiction matters
4. Directories of Perinatal and Infant Mental Health and Addiction resources are utilised
5. Map of Medicine is implemented
6. Community based care and treatment options that can be arranged with ‘Packages of Care’ funding are pursued
7. Metrics that demonstrate improvement in perinatal and infant mental health and addiction services are to be captured and monitored.

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10. Appendices

10.1 Tairawhiti DHB Action Plan

	Actions	By Whom & By When
1.	Amend Project Phase 1 draft report	Roz By 22 March
2.	Review Pathway- referral, links, communicating if move to MoM Invite other key stakeholders including consumers Determine measures	(Ellen C, Anne, LMC/Mary Clare, Consumer Rep, Anna, Primary Mental Health Co-ordinator, Sunita, Reon/Annette, Mel) Meet in April Circulate draft
3.	Identify opportunities to build local capability and locally/regionally/nationally support practice and how that will be shaped and supported	Liz, Debbie, Frances
4.	Review capacity and demand in perinatal and infant mental health	Ellen M (end of May)
5.	Investigate local response- COPMIA	Ellen M, Debbie, Huhana, CAMHS
6.	Investigate other models used in similar DHBs/regions	Ellen M, Anne, Mary Clare

10.2 Bay of Plenty DHB Action Plan

	Actions	By whom & By when
1.	Information Sharing- network/forum Develop list of providers to be included Format- speakers, initiatives, topics, pathways Draft TOR	Marg & Suzanne Nikki & Sylvia Quarterly early July
2.	Presence of a Midwife – engaging midwives – able to refer to services and counselling sessions	Sylvia & Lesley – PHO discussions
3.	Maternity Quality and Safety Well Child Providers and Mental Health reps to join this group	Marg shortly
4.	Maternity Education sessions LMC, opportunity to educate/raise awareness of services available- include roles within the pathway	Tracey ongoing
5.	Directory of resources & services Web Health, Map of Medicine Agencies to add their details	Angela- coordinator ongoing
6.	DHB Crisis staff more oriented to perinatal and infant mental health	DHB Anya & Judy ongoing
7.	Clarification re access to specialist services- thresholds and criteria RFP - MoH	Lesley DHB ICAMHS & Adult services <6months
8.	VIP group Invite Mental Health representation	Marg shortly
9.	Drop in model similar to Turangi - Family Centre Day Stay One Stop Shop for women Peer support Find out about it and share info	Suzanne, Pat & Annette & Maureen
10.	Bay of Plenty website www.bopdhb.govt.nz	All