

Perinatal and Infant Mental Health and Addiction Project

Phase 1 **Secondary and Tertiary Provision**

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Final Draft

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Executive Summary

More women and their families in the Midland region are affected by perinatal and infant mental health disorders and addiction. This is not just a Midland region issue but consistent with other populations nationally and in other parts of the developed world. Burt and Quezada (2009) estimated that 15 per cent of pregnancies are affected by some form of maternal mental disorder.

This project has been established to increase knowledge and understanding of the Midland region's perinatal and infant mental health, and addiction services needs. A stock take was undertaken which confirmed that mental health and addiction services across the five DHBs in the Midland region had referral processes in place to support women with perinatal mental health disorders. This was specific to accessing secondary level assessment and intervention. Infant mental health services were less developed in the smaller DHBs and more often integrated with general paediatric service provision. Services for children who had parents with a mental health or addiction issue were being provided in one DHB only.

The literature suggests that a comprehensive and integrated service should be accessible for women, infants and their families to improve wellbeing (Ministry of Health, 2012). A service design and plan were recommended (Oates, 2008).

A workshop attended by Midland region stakeholders considered stock take information and evidence from the literature. In DHB specific groups stakeholders discussed and debated opportunities for future service delivery. The specific needs of Māori younger child bearing women who have a history of mental illness were raised as an area of concern. Māori women generally experienced higher rates of mental illness and were therefore at increased risk of illness during the perinatal period. Healthy Beginnings (Ministry of Health, 2012) suggests that investment in what works to achieve whānau ora is necessary to reduce the negative impact and improve health outcome. Workshop discussion also included perspectives about inpatient mother and baby units' requirements, location and accessibility.

A second workshop was held to increase understanding of infant mental health service provision and whānau ora approaches to improve perinatal and infant mental health.

The outcomes of this project provide overarching guidance in the provision of perinatal and infant mental health for the Midland region. Using a tiered approach Midland DHBs will identify what services will be delivered consistently across the region and what local variation is required to meet the specific demographic characteristics of local populations. A plan will be developed for implementation. Meaningful data will be captured to better understand demand and utilisation.

1. Introduction

Perinatal and infant mental health disorders and alcohol and other drug (AOD) problems are affecting the wellbeing of women and their families in the Midland region and other regions within New Zealand. It is estimated that 15 per cent of pregnancies are affected by some form of mental disorder (Burt and Quezada, 2009).

This Midland region project has been established to identify the infant and maternal mental health and addiction needs of the region. Using a stock take and drawing from *Healthy Beginnings* (Ministry of Health, 2012) and other sources of information, the project will also determine options on how best to meet those needs. *Healthy 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 mothers¹ and infants.

This project will include:

1. Meeting with the Midland Clinical Governance Group and discuss *Healthy Beginnings* and what would be the best model of care.
2. Undertaking a stock take of current services and how at present services support mothers and babies if hospitalisation is required.
3. Undertaking a gap analysis of the stock take and the proposed model.
4. Discussing and amending the model of care.
5. Reviewing linkages with primary maternal mental health services to the model and develop referral linkage pathways.

This project will be guided by the following documents:

- 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

During the perinatal² period women have been shown to be at a higher risk for the onset or recurrence of mental illnesses than at other times (Burt and Quezada 2009). Maternal mental illness in this period has a detrimental effect on the emerging mother-infant relationship and can result in delayed social and emotional development and/or significant behavioural problems for the infant, potentially leading to a range of negative outcomes that may persist into adulthood.

Research has demonstrated the importance of effective intervention for mothers and infants with mental disorders and/or AOD problems. The developing mother–infant relationship is often an

¹Throughout *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.

²The perinatal period is defined as pregnancy and the first three to 12 months following birth by most, hence perinatal mental illness is an umbrella term encompassing a range of conditions of differing levels of severity

essential part of clinical intervention. This means clinicians in these services must be multi-skilled and able to assess and treat the mental disorders of the mother and the infant as well as the relationship between the mother and her infant.

No DHB in New Zealand currently provides the full range of perinatal and infant mental health and AOD services as documented in *Health Beginnings*. It 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 understood that developing perinatal and infant mental health services, including access to specialist inpatient facilities within a model of care for mothers and babies in the Midland, will take time and significant planning and co-ordination.

2. Literature Scan

2.1 Incidence and Prevalence

2.1.1 Perinatal Mental Disorders

Perinatal mental disorders are experienced worldwide and they pose “a huge human, social and economic burden to women, their infants, their families and society and constitute a major public health challenge” (World Health Organisation, 2008, p.1). Mental disorders affect 15% of pregnancies with the risk of the severity being far greater for women in the first 3 months postpartum than at any other time. Studies suggest anxiety and depression affect 5% of non-pregnant women, 8-10% of pregnant women and 13% of women during the year following delivery. Postnatal relapse of depression is estimated at 30-50%. Further to this suicide is a common cause of maternal death (Oates, 2003).

The incidence of mental disorders also increases when there are other factors present such as a history of mental disorder, and more so with Bipolar disorder (Munk-Olsen et al 2006), when the pregnant mother is much younger (under 20 years of age), and where alcohol and substance use is a feature. Additionally, when a pregnant mother is experiencing poverty and lacks social supports (Ministry of Health, 2012).

Table 1: Mental Disorders for Women

Disorder	12 month Prevalence
Any anxiety disorder	17.9%
Any affective disorder	7.1%
Any substance use disorder	3.3%
Schizophrenia and related disorders	0.5- 1.0 %
Bipolar Type 1	1.0-8.1%
Bipolar Type II	2-3%
Border Line Personality Disorder	4.5%

(Judd, n.d)

United Kingdom (UK)

In the UK about 15% of women will experience a mental illness in the first trimester of pregnancy and mostly anxiety and depression. The estimated prevalence of postnatal depression is 10-15%. [Table 1](#) shows the estimated prevalence of what is commonly referred to as Baby Blues, Postnatal Depression and Puerperal psychosis. 10% of women postpartum experience a major depressive illness and of that 3-5% will be moderate to severe. It has been suggested that many women who experience mild to moderate depression are not identified or do not access help (Bedford Borough JSNA, 2012).

Of the women in the postpartum period, 2 per thousand will require admission with puerperal psychosis. Additionally 2 per thousand women postpartum will have pre-existing severe, chronic or enduring mental illness such as schizophrenia. However referral to psychiatric services is considerably less than expected (Bedford Borough JSNA, 2012).

Table 2: Prevalence of perinatal mental disorders in UK

National estimates of the prevalence of mental disorders	Estimated prevalence
Baby blues	80%
Postnatal depression	10-15%
Puerperal psychosis	0.1-0.2%

(Bedford Borough JSNA – Children and Young People 2012)

Women with obsessive compulsive disorders, social anxiety and panic disorder are at risk of a relapse of their symptoms of mental disorder in the postnatal period. There is also gathering evidence that traumatic childbirth can cause post-traumatic stress disorder.

Australia and New Zealand

In Australia and New Zealand the incidence and prevalence of mental disorders in pregnancy and the perinatal period is comparative with other developed countries. A research study showed the proportion of women reporting depressive symptoms in the first year after birth was between 10 and 20%. Previous history of depression and poor partner relationship were the two strongest indicators of depression postnatally in this study. Becoming a mother at a young age was significant when coupled with social disadvantage. Women reported a high number of stressors in pregnancy and following birth and the rate of intimate partner violence reported was concerning high (Schmied et al, 2013).

Table 3: Predictors of Postnatal Depression

Predictors- of greater significance	Predictors of significance
History of psychopathology	Low social status
Antenatal psychological disturbance – anxiety, depression, or dysphoric mood	Personality type and attribution style
Poor marital relationships	
Low levels of social support	
Stressful life events	

(NSPCC report, 2012)

New Zealand

NZ Māori experience higher prevalence of perinatal mental disorders than non Māori (Oakley Browne et al 2006). This is likely due to the presence of more contributing risk factors for Māori women such as childbearing at a young age, increased prevalence of mental disorder (Kake et al 2008) and social disadvantage. Māori women are also more likely to experience alcohol and drug issues.

2.1.2 Infant Mental Disorder

There is strong evidence in the literature of infant mental disorders that are recognised by the following:

- Excessive crying- the prevalence is 1.5 to 17.8 %, while common often serious for parents.
- Feeding disorders- the incidence is 25-45 %.
- Attachment issues- the poor development of attachment results in significant health and social issues longer term.
- Behavioural problems- the prevalence is 12-24%. A New Zealand study confirmed 16% of Pacific 2 year olds had behavioural problems.
- Developmental delays-the prevalence of a mental disorder with other disabilities ranges from 40 to 64%.

(Ministry of Health, 2012)

Infant mental health can be defined as documented by Merry et al 2007) as:

“The developing capacity of the child from birth to three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn - all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development”.

2.1.3 Parents with Mental Disorders

There is evidence that confirms the impact that parental mental health has on the mental health of the infant. Studies cited by Fudge in 2012 found that 10% of women and 6% of men in UK with a known mental disorder were parents. In Australia 28% of those accessing a mental health service were parents (Fudge, 2012). In Scottish studies it was found that depressed mothers may be less responsive affecting the infant's attachment to its mother (Scottish Government, 2010). It was also considered difficult for a depressed mother to maintain a consistent, nurturing and empathic relationship. If the depression becomes overwhelming safe and healthy parenting is threatened (Mental Health America, 2008).

Children of parents with depression were more likely to have depression, anxiety and or substance dependence when compared with children of parents without depression. They may act out more, have difficulties establishing their own friendships and have learning problems. These difficulties and problems become even more significant when maternal depression co-exists with other risk factors (Mental Health America, 2008). It has been suggested that this is due to a range of influences including family and parent context as well as the specific characteristics of the child (Reupert et al 2012).

2.1.4 Addiction

The consumption and misuse of alcohol and substances during pregnancy is concerning as it adds risk to the physical and mental development of the infant (Ministry of Health, 2012). A syndrome known as Fetal Alcohol Syndrome has been found in infants where the mother has consumed high levels of alcohol during pregnancy. Features of this syndrome include both physical and mental developmental delays (Ethen, Ramadhani, & Scheuerle, 2008).

Attempts have been made in USA to curb the excessive use of alcohol and illicit substances in pregnancy through legal means such as criminal prosecution. However clinicians suggested this was ineffective and what was required was access to comprehensive alcohol and drug services that were safe, affordable, available and effective (Guttmacher, 2010).

In New Zealand studies have examined the impact of alcohol in pregnancy (Parackal et al, 2009). Recommendations have included policy development and raising awareness of the dangers of alcohol by improved labelling of alcohol products with the appropriate warnings. Within the Auckland region the community alcohol and drug service has a specific pregnancy and parental service. This service offers intervention, long term case management and service coordination to socially limited substance using parents with an infant under 3 years and pregnant women. The aim is to improve health outcomes for women and reduce harm to themselves and their children (Healthpoint, 2013).

2.2 Strategies to Improve Perinatal and Infant Mental Health

Health care divisions within governments in UK and USA, and more recently NZ with the publication of Healthy Beginnings (Ministry of Health, 2012) have provided guidelines on how best to improve the mental wellbeing of mothers and infants.

2.2.1 Established Pathways

Several recommend the development of a maternal or perinatal mental health pathway. The pathway articulates the steps of care and support available to mothers from the antenatal period to the first months of an infant's life (Department of Health 2011; Ministry of Health, 2012). The points of interface with health professionals such as midwives and Well Child Providers are identified and collaborative ways of working and linking are specified.

The pathway includes early identification using screening processes and early intervention.

2.2.2 Early identification

Given the significant predictors of perinatal and infant mental disorders, health care professionals should screen for predictors when a woman comes in contact with the service at both the antenatal and postnatal periods (National Institute for Health and Clinical Excellence, 2007).

2.2.3 Early intervention

Where intervention is required this should be undertaken seamlessly with health professionals and agencies sharing information and working collaboratively. Community partners, midwives and other health professionals require more education and support to better respond to mental health needs as well as physical health needs (Department of Health, UK. 2011)

There are new evidence based interventions being developed for the mother, the infant and family. These should be introduced early and continue as required (Department of Health, UK. 2011). The Healthy Child Programme (2009) is an example and includes supportive and targeted services to families where there is mental health need. An improvement in the wellbeing of the childbearing mother and their ability in childrearing will improve maternal and infant outcomes (Siegenthaler et al 2012).

2.2.4 Specialist Services (community based and Inpatient service)

General principles, Guidelines and Standards

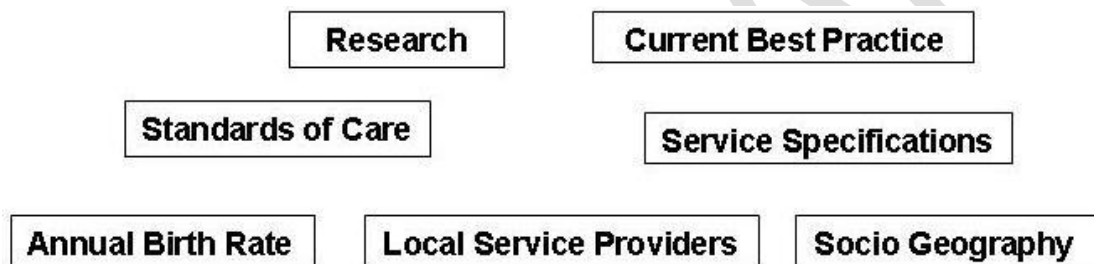
The Ministry of Health (2012) identified eight guiding principles within a framework for application. Foremost, services need to be mother and child centred, considering the relationships of mother, father and child, and those within the wider family and whānau.

Standards need to be established based on research and best practice, and communicated in order for consistent services to be delivered (NICE, 2007).

Resources

Estimations of the resources required to deliver a service may be determined by a number of factors. They include: the geographical size and population distribution; numbers of women of child bearing age; the annual birth rate, levels of morbidity, levels of reproductive activity and levels of mental disorders (Oates, 2005).

Figure 1: Influencing Factors in Perinatal and Infant Mental Health



(Oates, 2005)

Service Design

Some suggest that due to the changing nature of health services it is difficult to prescribe a standard model for the delivery of perinatal mental health services (Oates, 2005). However each district or locality would need to develop a strategy to ensure that all necessary core functions are provided and that women can access a comprehensive and fully integrated service (Joint Commissioning Panel for Mental Health, 2012). A hub and spoke design being one way to achieve this. The local strategy would reflect the local context such as the population size, numbers of women child bearing age, geographical spread, prevalence of mental disorders, and economic and deprivation factors as mentioned earlier. A specific role was suggested- a Link worker who would work with mother and baby to facilitate early discharge from inpatient services and support a comfortable transition to after care.

The Ministry of Health (2012) has provided four configuration options to guide DHBs in their development of perinatal and infant mental health services. Consistent themes across the four options include flexibility and collaboration. Opportunities and challenges of each option are highlighted.

2.2.5 Provider Networks

Networks are recognised as an effective method for communicating and connecting providers internal and external to a system. It is suggested that they will also support the integration of providers across the perinatal mental health care continuum thereby strengthening clinical outcome (NICE, 2007).

Within a network structure providers are able to access education and skills training. They are also able to share and receive information (Joint Commissioning Panel for Mental Health, 2012).

2.2.6 Community Development

Support systems within our community need to be more accessible for the socially disadvantaged and the most vulnerable. The Ministry of Health (2012) suggests that the more vulnerable include mothers who have alcohol and or substance misuse problems and may have co-existing mental illness, and those women who are in prison. Healthy Beginnings (Ministry of Health, 2012) outlines specific interventions that incorporate screening, assessment and treatments for this group.

The literature has shown that perinatal and infant mental health and addiction is affecting mothers, infants and their families in New Zealand. This is consistent with that experienced by other developed countries. Research has informed the development of guidelines to assist health care organisations in establishing and connecting local services specific to local need, to reduce harm and improve health outcome.

3. Current Situation for Specialist Services

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



3.1 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.

3.1.1 Current Service

Secondary and tertiary services provided for women, during pregnancy and the postnatal period, who have a history of mental illness and/or substance abuse that require more than education or a brief intervention include:

Table 4: Waikato DHB Funded Perinatal Mental Health Services

Purchase Code	Unit	Service Name	Service Description
PHOMH001		Primary Mental Health	Service co-ordination and packages of care
MAOR0104		Support services for high-needs mothers and their pepi	Kaupapa Māori services
COOC0002		Waikato Family Centre	Advocacy/peer support - Not specifically for Mental Health – But addresses sleeping and feeding problems for babies under 12 months and alleviates maternal distress.
WO3012		Mother Craft Services	Not specifically for Mental Health however does provide live in parental assistance for new mothers in a home like supportive environment.
MHM90		Maternal Mental Health	Specialist MH service - Women who are experiencing severe perinatal mood, anxiety disorder, or postpartum psychosis up to 12 months postpartum. Significant maternal distress related to a second trimester termination, birth trauma and or a still born loss.
MHI40		Hauora Waikato Programme	Women experiencing perinatal mental health problems are engaged in a Monday to Friday day service with ongoing support in their own homes. In addition a weekend programme on parenting and coaching is available for mothers, babies and whānau.

Purchase Unit Code	Service Name	Service Description
COOC00770	Family Violence Intervention Programme (FVIP)	<p>All maternity and child health services of Health Waikato are included in this programme which means all women in antenatal and post natal services are screened for family violence and referred as appropriate</p> <p>Emergency department staff are also participating in FVIP</p>

The following skilled workforce is engaged to support the current service.

Table 5: Waikato DHB Funded Specialist Perinatal Mental Health Workforce

Workforce Type	FTE
Specialist Perinatal Mental Health – Senior Medical	0.6
Specialist Perinatal Mental Health - Clinical	5.7

Data available on the utilisation of specialist services has been limited.

Referrals to these services are received from: Mental Health Services, Primary Health Care, Self-Referral, Lead Maternity Carer, Paediatrics or New Born Unit and neonatal paediatric community resource nurses, Plunket and Tamariki Ora Nurses. Integration with primary care services is not yet well developed.

Supporting MH clients in their role as parents: A contractual requirement from 2013/14 is to consider and develop policy to guide the implementation but no significant/concrete/visible change in service delivery is evident at present.

Rural women and babies who would benefit from either the Family Centre or Mother Craft Unit (both of which can support mothers requiring this service) can access from Hamilton.

Secondary and tertiary services provided for infants and young children with delay in social and emotional development and problem behaviours as set out in the DC: 0-3R and their parents (primary caregivers) include those listed in [Table 6](#).

Table 6: Waikato DHB Funded Infant and Child Health Services

Purchase Unit Code	Service Name	Service Description
	Child Development Centre	Ministry of Health funded
COCH0025a	Gateways Programme	Children in CYFS care
M55001/2	General Paediatric Services	Inpatient & Outpatient Services Health Waikato
COC01001b	Audiology Services	Newborn Hearing Screening & Referral (Secondary) Service

The Workforce engaged to provide these services are described in [Table 7](#).

Table 7: Workforce engaged in part to support Specialist Infant Mental Health Service

Workforce Type	FTE
Paediatricians	Unable to identify FTE from general multi-disciplinary teams involved.
Psychologists	Unable to identify FTE from general multi-disciplinary teams involved
Occupational Therapists	Unable to identify FTE from general multi-disciplinary teams involved
Speech and Language Therapists	Unable to identify FTE from general multi-disciplinary teams involved
Physiotherapists	Unable to identify FTE from general multi-disciplinary teams involved

Please note Waikato DHB has a project plan in place led by a community paediatrician to implement the Child Action Plan which will address this area as well.

Data available on the utilisation of specialist infant mental health services has been limited.

However some reporting on access and referral rates has been captured for some service lines (Appendix 8.5).

Some access and boundary issues between paediatrics and mental health exist for the following services: parent child interaction PCIT therapy.

Waikato DHB stakeholders' perspectives

What is working well?

- Infant- ICAFMHs through provider arms, centralised
- SPOE referrals urban/rural

- Hauora Waikato able to provide seamless service for mothers: Choice and option continuum provided for families – DHB/Hauora Waikato Regional maternal meetings: Day respite at Hauora Waikato; Regional Mothercraft unit
- Gender appropriate services
- Kaupapa Māori service
- Whaea support Mothers priority - OST programs (Opiate Substitute treatment)
- Motivation and drive to developing joint training initiatives between DHB and Hauora Waikato
- Close relationships with CYFS

Challenges

- Processes require reconfiguring to better meet mothers' need
- Connections between CADS/Maternal - perinatal/ICAFMHS need to be developed

Service Gaps

- COPMIA
- Increased FTE infant MH
- Increased FTE - Kaupapa Māori
- Increased resource to include services in the rural area
- Maternal inpatient unit access Mothers/babies, fathers, Whānau Maternal MH/CADS - mothers on methadone combined clinic - CADs/ maternal/ perinatal
- Mothers with children (1-4yrs) difficulty accessing Adult Mental Health Services
- Single dads - forgotten about and less likely to access

3.2 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, 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.

3.2.1 Current service

Secondary and tertiary services provided for women, during pregnancy and the postnatal period, who have a history of mental illness and/or substance abuse that require more than education or a brief intervention include: dedicated staff in two locations. There is 1.5 FTE in Rotorua, and 1.0 FTE in Taupo. The health professionals that make up the team are representative of nursing, social work and psychology. Additionally there is a dedicated perinatal support worker with Recovery Solutions (based with Mother Matters).

Access is via the usual secondary services pathway (either self or agency referral). The Team triages all referrals

Data available on the utilisation of specialist services has been limited.

Secondary and tertiary services provided for infants and young children with delay in social and emotional development and problem behaviours as set out in the DC: 0-3R and their parents (primary caregivers) include no dedicated FTE but expectations of ICAMHS to respond.

Data available on the utilisation of specialist infant mental health services has been limited.

What is working well?

- Use of CAPA (in part)
- Meeting principles 4-8 quite well
- Training from Dr Denise Guy for the whole team
- People trained in "Watch, Wait, Wonder"
- Building links with perinatal and other services
- Good links with midwives etc
- Links to Mother Matters group
- Strong clinical communication dedicated FTE – Multi disciplinary team make up
- Good links with community services which enables us to offer intensive support and treatment to women while keeping mum and baby together.
- Good, well established links with primary services
- An MDT approach that includes input from and NGO
- Ability to work from a practice based evidence approach
- Continued education both individually and as a team
- Good referral base
- Good regional connections
- Access (or will soon have) to community based offices away from mental health
- Able to provide a broad range of interventions to individuals and dyads
- Lowered entry criteria
- Able to provide specialist input in triage process.

Challenges

- Referrals – low volumes
- Referred to other services and lost
- Links to Perinatal services need to be stronger
- Review of mental health services
- No dedicated FTE for infants
- Environmental challenges- space, waiting room,
- Adding cultural components

- Educating management about processes and requirements
- Strengthening clinical leadership
- Co-working across services to capture (mother and infant and father and infant interaction)
- Disparity of services
- Reaching rural communities
- Perinatal emphasis- with mission statement, illness prevention and health promotion
- Despite growing FTE, capacity at times still a problem
- Access to acute services
- Access to mother craft
- Need for more links across services i.e. iCAMS
- Still limited awareness from some potential referrers
- Presentation to service still doesn't reflect demographics of area
- Referrals still do not reflect numbers of woman we know are experiencing difficulties
- Referrals are often made very late, which allows limited intervention time.

Service Gaps

- Threshold for access is high.
- The team is not well accommodated by adult MH but also poorly linked with iCAMHS i.e. attachment work
- More suitably qualified/experienced staff needed.
- Lack of local options for respite (that accommodates babies, infants and children) or inpatient admission
- No dedicated and skilled non regulated workforce offering home based support options.
- Flexi-funding to support a range of options for women e.g. child care as form of respite.
- Dedicated work with fathers needed.
- Current information is Rotorua based and needs to cover Taupo
- Need interface with PRIMHIS
- Linking across sector
- Current model is siloed
- No developmental approach to assessment and treatment evident in Mental Health and Addiction

Other Demands

- KPI project
- Prime Ministers Youth Project
- Rotorua is a demonstration site for Children's Team

3.3 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.

3.3.1 Current Service

Secondary and tertiary services provided for women, during pregnancy and the postnatal period, who have a history of mental illness and/or substance abuse that require more than education or a brief intervention include:

Table 8: Perinatal Services Provide by Tairawhiti DHB

Purchase Unit Code	Service Name	Service Description
MHM90C	TDH Community Mental Health & Addictions Service	Perinatal mental health specialist community service
MHA094	TDH Community Mental Health & Addictions Service	Community mental health services (senior medical)

Table 9: Workforce engaged to provide these services

Workforce Type	FTE
Clinical specialist (CMHAS)	0.5
Psychiatrist (CMHAS)	Less than 1.0

For women without a history of mental illness or addiction, when pregnant they are assessed by the Lead Maternity Carer at 28 weeks gestation using Kessler 10 assessment tool. If the scores less than 20: require no further action required.

Score 20 - 24: there is a discussion and a repeat Kessler 10 at the next visit. If the score is the same or worse, referral is made to GP.

Score 25 – 29: there is a discussion and a referral is made to GP

Score 30 or more: discussion and telephone consultation with GP and/or Psychiatric Assessment Team for advice and triage.

Repeat Kessler 10 at 2 – 3 weeks postpartum.

For women with a history of mental illness or addiction when pregnant:

- Lead Maternity Carer liaises with the Clinical Specialist with the women's consent
- A woman is offered an appointment with the psychiatrist to develop a plan for pregnancy and birth with shared care as required.

Data available on the utilisation of specialist services has been limited

Access issues/Waiting list

- There are apparently low referral numbers into secondary services from LMC/GP
- Data is not collected on referrals for maternal mental health into CMHAS
- There is no provision of residential mother & infant facilities if required
- It is not clear how much screening is performed by LMC/GP

Secondary and tertiary services provided for infants and young children with delay in social and emotional development and problem behaviours as set out in the DC: 0-3R and their parents (primary caregivers) include

Table 10: Services provided for Infant Mental Health by Tairāwhiti DHB

Purchase Unit Code	Service Name	Service Description
MHI44C	Ngati Porou Hauora (NPH)	Infant, child, adolescent & youth community mental health services (other clinical)
MHC137F	Te Kupenga Net Trust (TKNT)	Advocacy/peer support – child and youth consumers
MHD144C	TDH Child & Adolescent Mental Health Service (includes infants)	Infant, child, adolescent & youth community mental health services (nursing/allied)
MH144A	TDH Child & Adolescent Mental Health Service (includes infants)	Infant, child, adolescent & youth community mental health services (senior medical)

Table 11: Workforce for Infant Mental Health in Tairāwhiti DHB

Workforce Type	FTE
AOD (NPH)	2.0
Nursing/allied (CAMHS)	11.6
Senior medical (CAMHS)	1.2
Community support worker (TKNT)	1.0

Data available on the utilisation of specialist infant mental health services has been limited

Other Impacts

- All referrals go directly to CAMHS; mostly from GPs and schools
- All referrals go directly to NPH
- There is no provision of residential mother & infant facilities if this is required
- It is unclear whether all or most infants requiring secondary or tertiary care are captured by services currently provided.
- There is not an accurate view of the level of need in Tairāwhiti

Gaps

- Lack of COPMIA provision
- Don't have an accurate view of consumers who have children in their care

3.4 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).

Secondary and tertiary services provided for women, during pregnancy and the postnatal period, who have a history of mental illness and/or substance abuse that require more than education or a brief intervention in Taranaki DHB are described in [Table 12](#).

Table 12: Taranaki DHB Funded Perinatal Mental Health Services

	Purchase Unit Code	Service Name	Service Description
DHB	MHA09C	Community Clinical MH Service –Nursing	CMH Adult Intake Coordination – Provider Arm
	MHM90C	Specialist Community Team – Perinatal MH	Perinatal Service – Provider Arm
	MHA09A	Community Clinical MH Service – Senior Medical	Consultant Psychiatrists – Provider Arm
	MHA11C	Mobile Intensive Treatment Service	Acute Home Based Treatment Team – Provider Arm
	MHA11D	Mobile Intensive Treatment Service	Inpatient – Provider Arm
	MHA01	Acute 24 hour Clinical Intervention	Inpatient – Provider Arm
	MHA02	Intensive Care	
	MHAD14C	Co-existing Disorders (MH & Addiction)	CEP Nursing – Provider Arm
	MHD74C	Community Based Alcohol & Other Drug Services	AOD Services – Provider Arm
	MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment	OST Programme – Provider Arm
	MHCR07	Residential Treatment – Alcohol & Drug Service	Bed Days – various
	MHA20D	Adult Community Support Services – Non clinical	- Mobile Support (NGO)
	MHW68D	Family whānau support, education, information & advocacy	- Mobile Family Support (NGO)
	MHA03	Adult Crisis Respite	a. NGO
	MHA17	Planned Adult Respite	b. NGO
	MHA18C	Needs Assessment & Service Coordination	c. NASC : Provider Arm & NGO

Table 13: Taranaki DHB Funded Perinatal Mental Health Services

	Purchase Unit Code	Service Name	Service Description
NGO	MHM90C	Perinatal Mental Health Service	1.0 FTE Registered Social Worker provides services for women who are pregnant or have a baby less than 12 months of age, who have developed a moderate to severe mental health illness related to the experience of pregnancy, childbirth and/or the adjustment to parenthood and who live in the Taranaki Region. Fathers and other family/whānau members are also supported by this service.

Table 14: Workforce engaged to provide Perinatal Mental Health Services

DHB	Workforce Type	FTE
	Registered Nurse – Perinatal	1.0
	Social Workers – Perinatal	1.7 (includes 1.0 co-located from NGO)
	Clinical Psychologist – Perinatal	0.3
	Consultant Psychiatrist – Perinatal	0.5

Table 15: DHB Funded Workforce within NGO sector

NGO	Workforce Type	FTE
	Registered Social Worker	1.0 FTE

Access/referral sources and processes are consistent with Taranaki DHB Local Referral Pathway (Oct 2011). The Perinatal service sits within a Taranaki DHB, adult MDT mental health team and links into the TDHB Perinatal mental health resource. Perinatal interface includes co-location of TOL 1.0 FTE in provider arm MDT. Management and support provided.

Referrals follow the TDHB triage process; however the service also receives referrals from our own internal Tui Ora Tamariki Ora Nurses, GPs, LMCs and other providers.

Data available on the utilisation of specialist services has been limited.

Secondary and tertiary services provided for infants and young children with delay in social and emotional development and problem behaviours as set out in the DC: 0-3R and their parents (primary caregivers) are outlined in [Table 16](#).

Table 16: Secondary and Tertiary Services for Infant Mental Health

NGO	Purchase Unit Code	Service Name	Service Description
		Infant, Child, Adolescent and Youth Service:	The service provides a community-based mental health treatment and therapy service across a range of settings for infants, children, adolescents and youth, that is strengths based and resilience oriented.
	MHI44C (ICAY)	X3 Registered Social Workers X1 current vacancy	We can also provide support for alcohol and/or other drug problems and/or dependence.
	MHDI48C (ICAY/AOD)	X1 current vacancy	Tui Ora utilises a holistic and integrated approach to Mental Health issues for infants, children, adolescents and youth.

Table 17: Workforce contracted to provide Infant Mental Health Services

	Workforce Type	FTE
DHB	Consultant Psychiatrists	2.0
	RNs, Clinical Psychologists, Family Therapists	17.8

Table 18: Workforce in NGO contracted to provide Infant Mental Health Services

NGO	Workforce Type	FTE
	X3 Registered Social Workers (x2 north Taranaki/x1 south Taranaki)	X3 FTE
	X2 current vacancies	X2 FTE

Data available on the utilisation of specialist infant mental health services has been limited.

The Child & Adolescent Mental Health Service (CAMHS) is one of the sub-groups operating within the Child & Adolescent Centre (CACC).

It provides comprehensive outpatient service primarily from Taranaki Base hospital Monday – Friday, doing visits to home and schools as required. Staff also delivers outpatient clinics at Hawera Hospital and Stratford Health Centre for our rural families.

Referrals are received from GPs, health & social agencies and schools. The service operates a daily duty system, including crisis response, during the hours of 8.00am - 4.30pm.

Offering a range of services to children and young people (also working closely with the family/whānau), the Team works with clients from the age of 0-18yrs inclusive who have moderate to severe mental health problems, (as defined in DSMI-IV). These include:

- Major mood disorders including depression & Bipolar Disorder
- Severe and debilitating anxiety disorders
- Suicidal ideation/attempts
- Early psychosis with or without drug involvement
- ADHD & Attention Deficit Disorder
- Post Traumatic Stress Disorder
- Alcohol & Drug problems.
- Assessments are available for pervasive developmental disorders (i.e. Asperger's Syndrome and Autism).

All completed assessments are discussed by the Multidisciplinary Team which consists of Clinical Psychologists, Psychiatrists, Mental Health Nurses, Social Workers and other Mental Health Practitioners. Each client is case managed closely with their families, and has a clinical management plan that clearly outlines the goals of treatment and therapy.

The general philosophy of care which guides the Child & Adolescent Mental Health Service is based upon valuing the individual. It is acknowledged that every individual, including children and adolescents, have rights and unique needs and wishes that must be respected. It is recognised that services that are accessible and adaptable are more likely to meet the needs of the community. We also recognise that the friends, family, whānau and carer's of those with mental health difficulties may also need professional support and advice and we work collaboratively with other agencies to ensure that the most appropriate services are involved to provide support and guidance.

The ICAY service sits within a Taranaki DHB, CAMHS MDT mental health team. The ICAY/AOD position is able to link in with other Tui Ora AOD/CEP services.

Referrals follow the TDHB CAMHS triage process, however it also receives referrals from Tui Ora Tamariki Ora Nurses, GPs, schools etc.

Linkages with Family violence intervention Programme, Child Protection services:

- Major issues exist at a community level regarding the structure, systems & workforce skills for parenting programmes
- No qualified staff in CAMHS offering this service for infants and up to 3yrs old.
- Little or no Mental Health input for this age group, but seen by paediatrics

CAMHS staff occasionally assess children in age group 3yr and older but these are occasional and no regular service exists.

- Need for specific infant mental health training e.g. Watch, Wait and Wonder and Circle of Security
- Lack of coordination between primary and secondary service providers
- Lack of respite care options for this group

Recruiting appropriate/experienced staff to fill current vacancies has been problematic.

Services provided for infants and young children with mothers, fathers and extended family members severely affected by mental illness, alcohol and other drug use, domestic violence shown in [Table 19](#).

Table 19: Services provided for infants and youth people with their families

DHB	Purchase Unit Code	Service Name	Service Description
			<p>No service provision as no COPMIA services available in Taranaki.</p> <p>No referrals of such adults occur to our CAMHS service.</p> <p>There may be some future capacity to address this service gap. It has been identified as a deficit in our service development and planning processes and aligns with the Whānau Ora model of care currently being implemented across the organisation</p>

Tui Ora is a Māori health and social service organisation providing various, integrated whānau ora services across primary and secondary settings.

Particularly services provided:

- Perinatal Mental Health
- Infant, Child, Adolescent and Youth / AOD
- Tamariki Ora
- Mama and Pepi
- General Practice
- Primary Mental Health
- Kaiawhina
- Strengthening Families
- Breast Feeding Support
- Health Promotion

What is working well?

- Relationships and networks across sector and perinatal team and dedicated FTE
- Passion and enthusiasm
- Referrals - any door is the right door
- Perinatal coverage
- Emerging areas
- Great outcomes
- KPIs
- Good compliance of data capture
- CEP Acute intervention service acute home based service
- Whānau Ora framework in Tui Ora

Challenges

- Location of teams
- Dedicated doctor who has passion and interest
- Generalist resources
- Entry pathway through adult intake worker
- Lack of universal services - what should they be, early intervention and prevention, assessment in universal space
- Infant client - how to fit in service
- Attitude of adult services
- Family therapy training LMC - risk assessment
- Specific training - circle of security, watch wait and wonder, incredible years
- COPMIA recruitment and retention
- Lack structure to meet guidelines - adhoc – formalize

Service Gaps

- Integrated Perinatal & Infant MHS needs further development with adequate resourcing for workforce skills development
- Target population for assessment needs widening to include parents with a disturbed relationship with their babies & infants
- Perinatal screening & assessment needs to include the mother – child interaction using validated tools
- Infants & children who have delayed social & emotional development need a more robust response from primary care through secondary & tertiary services
- Major service gaps exist regarding Family Therapy resources across the primary / secondary spectrum
- Service development for infant mental health
- No access to a local mother and baby treatment unit
- No access to a local mother and baby crisis respite facility
- Integrated Perinatal & Infant MHS needs further development with adequate resourcing for skills development
- Need for specific infant mental health training to support Perinatal service e.g. Watch, Wait and Wonder and Circle of Security
- Lack of coordination between primary and secondary service providers
- Lack of respite care options for this group

Taranaki DHB has developed an agreed integrated pathway for the Perinatal and Infant Mental Health (Appendix 8.4).

3.5 Bay of Plenty DHB

The Bay of Plenty DHB serves a population of 212,000 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. The Western Bay of Plenty has the second fastest population growth rate of all New Zealand's district health boards.

The number of registered births in the Bay of Plenty in 2012 was 2,790 – of this number 1,250 were Maori, nearly 45% of all registered births. Although the number of births decreased since the 2006 census, the predicted number of births will remain near this level through until 2026 with Maori births continuing to account for the largest number of registered births by ethnic group.

Using the international and New Zealand specific prevalence figures (pp. 7 – 8 in this document), it is estimated that in the Bay of Plenty, around 5 women per year will develop a puerperal psychosis and another 5 per year will have a pre-existing severe, chronic or enduring mental illness (such as schizophrenia) when they become pregnant. Using the British prevalence figures of 3-5% of all women who develop postnatal depression will develop a moderate to severe depression then BOPDHB can expect a further 84 – 140 woman to develop a moderate to severe mental health condition in the post natal period.

These women and their babies, a high proportion of who are Maori, form the priority focus for secondary specialist mental health services; however, there will be at the most, an additional 418 additional women who are likely to be diagnosed with a mild to moderate form of postnatal depression for whom consultation/liaison with specialist services may be necessary.

Current service provision

1. Specialist Community Team – Perinatal Mental Health – Nurses & allied health
2. Infant, child, adolescent and youth community mental health services - Nursing and/or allied health
3. Services for children, adolescents and youth of parents with a mental health disorder or addiction

The maternal mental health service provides secondary and tertiary services for parents/caregivers during pregnancy and the postnatal period, who are presenting with mental illness and/or substance abuse. These clients require complex and intensive interventions.

Table 20: Secondary and Tertiary Services

Purchase Unit Code	Service Name	Service Description
MHM90C	Specialist Community Team – Perinatal Mental Health – Nurses & allied health	Service to provide direct specialist perinatal mental health care in conjunction with other providers to meet the needs of the mother and her infant in the context of her family and whānau and or other natural support. The service is provided by nurses and allied health staff.

The workforce engaged to provide these services is 3.0fte nurses and allied health.

Data available on the utilisation of specialist services has been limited.

The referrals usually come through health professionals such as LMC's GP Plunket, primary sector providers, NGO's and CYFS.

The intake coordinator triages accordingly and refers to the maternal mental health professional for a comprehensive assessment. The maternal mental health professional will complete the assessment and present this to the multi-disciplinary team. Appropriate clients will be accepted into the service for case management and therapeutic intervention while those who are better supported by primary sector providers are referred on accordingly.

The secondary and tertiary services provided for infants and young children with delay in social and emotional development and problem behaviours as set out in the DC: 0-3R and their parents (primary caregivers) are included in [Table 21](#).

Table 21: Secondary and Tertiary Services for Infants

Purchase Unit Code	Service Name	Service description according to healthy beginnings guidelines.
MHI44C	Infant, child, adolescent and youth community mental health services - Nursing and/or allied health	<p>Services need to be centred on the mother and child and consider the triadic relationship of the mother, father and child, and other relationships within the family and whānau.</p> <p>Mothers, infants and families require access to comprehensive and integrated range of services. Services should address the mother's mental health needs and her ability to promote her child's development. These services should also address each child's unique physical, emotional, social and educational needs in accordance with their potential.</p> <p>A developmental approach to assessment and treatment is required.</p> <p>Perinatal and infant service provision should be guided by a tailored intervention plan and be provided within the least restrictive, most normative environment that is clinically appropriate. Use of the Choice and Partnership Approach (CAPA) is recommended.</p> <p>Early identification and intervention with mothers and their infants should be promoted by the system of care in order to build resilience and enhance the likelihood of positive outcomes</p> <p>Families, including non-kin caregiving families, of children with behavioural, developmental and emotional disorders should be full participants in all aspects of the planning and delivery of services, supported by case management to ensure that multiple services are delivered in a coordinated and therapeutic manner so they move through the system of services in accordance with their changing needs.</p> <p>Services need to be culturally appropriate and provided in a way that strengthens whānau, improves Māori health outcomes and reduces disparity for Māori.</p> <p>Services need to be evidence based, goal focus and accountable, acceptable to those using them, and accessible.</p>

The workforce of 1.0fte of allied health is engaged to provide these services

Data available on the utilisation of specialist services has been limited

Currently, our referrals mostly come from, Paediatricians, Plunket, public health nurses, maternal mental health nurses and NGO's such as Teen Parenting.

Using the CAPA model, families attend the choice appointment with a health care professional from the infant-child team. This assessment will be discussed in the triage meeting and will be allocated to the Infant Mental health keyworker for partnership if appropriate.

The treatment pathway or care bundle is informed by various evidence based therapeutic modalities such as Watch Wait and Wonder, circle of security, and Incredible Years parenting program.

Secondary and tertiary services provided for infants and young children with mothers, fathers and extended family members severely affected by mental illness, alcohol and other drug use, domestic violence are included in Table 23.

Table 22: Services for Children of Parents with Mental Illness & Addiction

Purchase Unit Code	Service Name	Service Description
MHI57D	Services for children, adolescents and youth of parents with a mental health disorder or addiction	The service offers age-specific support groups for children and young people/individual support and support to their family/whānau. It aims to positively impact on the health status of children being brought up in homes where there is a parent and/or children who are identified consumers of mental health and addiction services

The following workforce is engaged to provide these services in [Table 23](#).

Table 23: Workforce Engaged to Provide these Services

Workforce Type	FTE
Non clinical support worker	.5 FTE (WBOP)
Non clinical support worker	.5 FTE (EBOP)
A flexi fund of \$4000 p.a. is available for each service	

Initially the referral process was via the secondary mental health and addiction services (adult; CAMHS and Addiction Services) of the DHB. Getting adequate numbers of referrals proved challenging in spite of many efforts to develop a champion in each team and multiple presentations of the service. Referrals are increasing slowly but community-based organisations and government agencies have more quickly seen the value of the service and have referred in directly to the service. Agencies such as the Police (domestic violence where there is mental illness and/or AOD use); CYFS (families in which a parent is identified with mental health and/or

AOD use issues); Strengthening Families (as part of the process of determining where needs will be met) and Iwi-based services have been assertive in referring into the service and seeing its value.

The main issue still remains getting adult Mental Health Services to view their individual adult clients holistically and take into account the needs of children in such families. The activities in the current 13/14 Annual Plan which will see a process set up and audited for identifying adult clients, who are caring for dependent children and support offered with parenting, will assist to broaden the outlook of adult staff.

The service gap is going to be offering a clinical component to the COPMIA service which could be done in conjunction with a CAMHS and see family based therapies offered to complement the support offered to children. The other gap is in information/education and training in meeting the needs of those children living in homes where there is an addiction.

What is working well?

- Dedicated nursing and allied FTE
- passion and commitment to grow and develop Maternal and Infant Mental Health Services
- Ongoing networking and collaboration with internal and external services

Challenges

- Dedicated medical FTE
- Access to respite bed at local level
- Access to in home support services that offers respite to appropriate clientele.
- Balancing the growth of the service delivery with resource needed and training development
- Training and development of COPMIA resource/people around addictions
- Education around appropriate information for referrals
- Vulnerable services with one FTE in CAMHS (cover issues)
- Perinatal services forging relationships with paediatrics
- Change management process with maternal mental health becoming part of CAMHS services.

Service Gaps

- Availability of respite for mothers and babies in secondary services
- Consistency of assessments, particularly with identifying and having knowledge of the risks of the insecure adult attachment patterns that may and probably impact on the infant/child attachment patterns.
- Having a designated team (a full time Psychologist and access to a Psychiatrist who both have an interest in adult and infant attachment patterns) that acknowledges and includes

the treatment and recognition of early intervention for insecure attachment patterns with both the infant and adults

- Individualised home based solutions as an alternative to treatment if indicated or respite

3.6 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 a workshop held in July 2013 considered the local context of their districts and the wider Midland region. They identified important themes and priorities to address the perinatal and infant mental health requirements. Their perspectives are described in this section.

There was agreement that confirming a position for the region was necessary. In order to do so the perinatal and infant requirements needed to be identified and then better understood and communicated. It was thought that each DHB should engage service users to understand what they need not what we think they need.

Data collection to inform planning

It was suggested that current pathways in each DHB are mapped to inform planning for future pathways. Specific Midland data should be collected to inform service design and resource requirements.

Based on this information, discussions could take place about what outcomes services are currently achieving, what resource would be required, what they would look like and how they would be accessed according to a tiered approach. An emphasis should be on local and regional solutions that fit the specific demographic characteristics. Māori people have the highest rates of mental illness in the Midland region.

Establish a structure with foundations

Foundations need to be established in the community with linkages to and relationships with Primary care, Midwives, Well Child Providers and other health and social agencies. This will ensure pathways for mothers and whānau are seamless and connected. Referrals to expertise and other resources need to be timely.

Identify resources

Having confirmed the current allocated resources, discussions need to be had regarding location and configuration of services and what additional resource is required. Stakeholders raised that perinatal psychiatrists and other clinicians with perinatal and infant mental health interest were in short supply. How can they be recruited and retained in the Midland region. How can best use be made of what resource we have?

The role of kaumatua and kuia needed to be explored. Conversations about housing, finances and social supports needed to be conducted in a sensitive way to ensure mothers and their whānau were adequately supported. It was thought that kaumatua and kuia were respected and best placed to assist.

Community parenting programmes such as Watch Wait Wonder, Circle of Security, and Incredible Years needed to be more available. Supports such as access to Mothercraft units needed to be increased and the unit model of care should include the mother, father and wider whānau. Wrap around support packages have the potential to provide the right level of support flexibly when it is needed. This could also include respite options and home based support and treatment.

Programmes that support children whose parents have a mental illness or addiction were needed in most DHBs. These programmes would build self esteem and resilience.

Stakeholders had concerns about proposed North Island or regional services, conscious of dislocation risks for mother and whānau when out of options chosen. There was recognition that key components of the services need to be determined for local and regional delivery.

All service options should be accessed by needs assessment processes to fairly manage entry to the system and future caseloads.

Collaboration

It was acknowledged that perinatal and infant mental health was not just a health issue. Therefore other agencies across sectors and the Gateway programme. Agencies such as Child Youth and Family, Ministry of Education and Ministry of Social Development needed to be engaged by DHBs in more collaborative ways of working and problem solving.

Workforce Development

It was suggested that the perinatal and infant mental health competencies in *Healthy Beginnings* (Ministry of Health, 2012) and UK Antenatal and Postnatal Mental Health Clinical Management and Service Guidance (NICE, 2007), and accessed. Furthermore inform consistency of training opportunities and competencies for the Midland region.

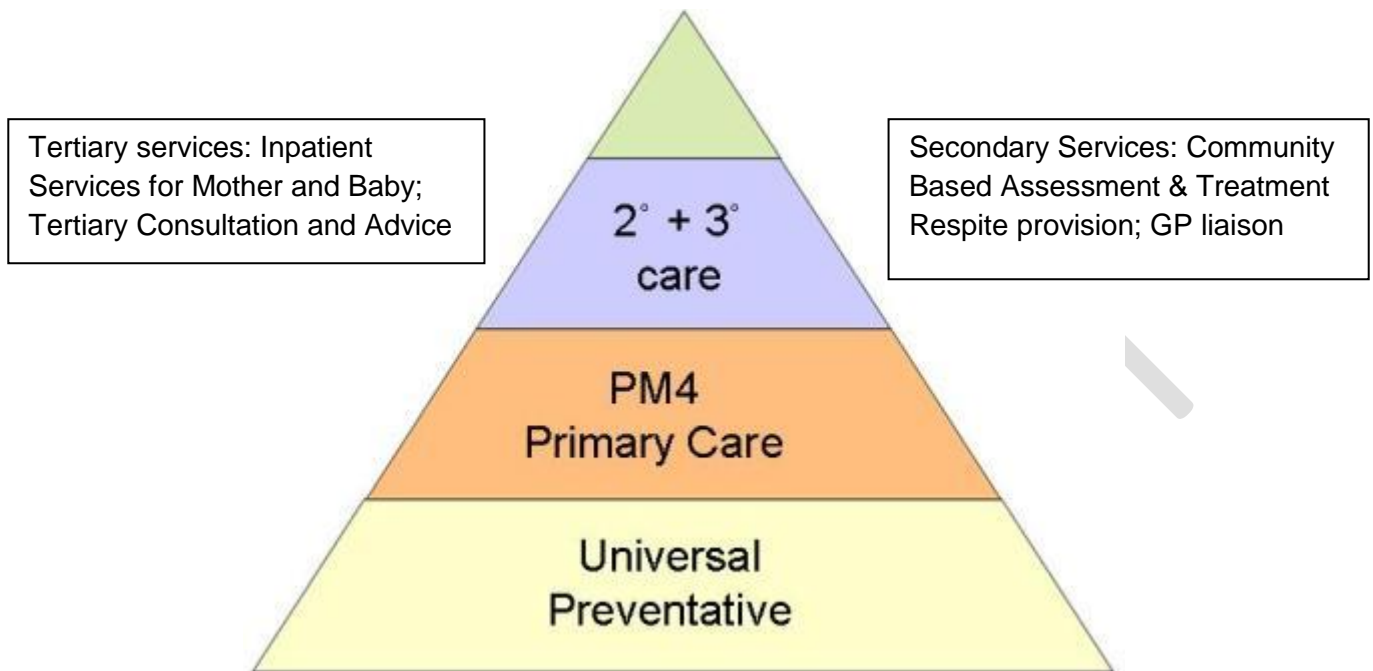
Funding Opportunities

Stakeholders suggested that there were ways to pool funding to strengthen the Midland region's resources such as combining training resource via the Werry Centre's initiatives.

Potential funding opportunities from the Ministry of Health should be explored and collaborative efforts proposed.

4. Developing a Model of Care

Tiered Provision for Perinatal and Infant Mental Health Services



It is proposed that perinatal and infant mental health and addiction services are delivered according to a tiered model.

5. Conclusion

Perinatal and infant mental health and addiction services have been provided in DHBs across the Midland region. However increased incidence and prevalence in mental disorders and alcohol and substance misuse has resulted in pressures on the current services. The Ministry of Health (2012) published guidance on perinatal and infant mental health and addiction services. A stock take of service provision in the Midland region according to Ministry guidance identified service gaps. Research evidence provides a compelling reason to address the service gaps including the specific needs of Māori mothers using best practice approaches.

DHBs in the Midland region are keen to respond to improve services to better meet the needs of mothers, infants and their whānau using a stepped tiered model of care.

6. Recommendations

1. It is recommended that Phase II involving primary and secondary NGO's is undertaken to ensure the development of full continuums of care at a local level.
2. It is recommended that an action plan is developed for implementation to address the service gaps and future perinatal and infant mental health and addiction needs, in a

planned, integrated and collaborative way thereby improving health outcomes for mothers, infants and their whānau.

3. Further work is recommended to enable the capturing of meaningful data about service demand and utilisation, particularly in view of the new funded FTE allocated.

FINAL DRAFT

7. References

- Austin M, Kildea S, Sullivan E. 2007. Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *Medical Journal of Australia* 186(7): 364–67.
- Baxter J. (1998). Culture and women's mental health: International perspectives for Aotearoa / New Zealand. In: Sarah Romans (ed), *Folding Back the Shadows: A perspective on women's mental health*. Dunedin: Otago University Press.
- Baxter J. 2008. *Māori Mental Health Needs Profile: a review of the evidence*. Palmerston North.
- Bedford Borough (2012) Joint Strategic Needs Assessment (JSNA). Retrieved 18/06/13 from <http://www.bedford.gov.uk/health> and social care.
- Burt V, Quezada V. (2009). Mood disorders in women: focus on reproductive psychiatry in the 21st century. *Canadian Journal of Clinical Pharmacology* 16(1): e6–e14.
- Department of Health (2011). No health without mental health; a cross government mental health outcomes strategy for people of all ages. Retrieved 18/06/13 www.dh.gov.uk/prod_consum_dh/
- Department of Health (2009) Healthy Child Programme: Pregnancy and the first 5 years of life. Retrieved 18/06/13 from [http:// www.gov.uk/government/publications](http://www.gov.uk/government/publications)
- Elliot L, Coleman K, Suebwingpat A, et al. (2008). Fetal Alcohol Spectrum Disorders (FASD): systematic reviews of prevention, diagnosis and management. *HASC Report* 7(9).
- Ethen, M.K., Ramadhani, T. A., Scheuerle, A.E. (2008). Alcohol consumption by women before and during pregnancy. *Maternal and Child Health Journal* 13 (2) 274-85.
- Fudge, E. (2012) COPMIA forum presentation. Retrieved 18/06/13 from <http://www.werrycentre.org.nz>
- Guttmacher (2010) U.S. Teenage Pregnancies, Births and Abortions: National and state trends and trends by race and ethnicity. Retrieved 18/06/13 from <http://www.guttmacher.org/pubs>
- Healthpoint (2013). Community alcohol and drug services. Retrieved on 18/06/13 from <http://www.healthpoint.co.nz>
- Henderson, T (2012). "Family Focus": An evaluation of an e-learning resource for professionals working with families where a parent has a mental illness. Retrieved on 18/06/13 from <http://www.compi.net.au>
- Ihimaera LV. (2007). *Whakarato Whānau Ora – Whānau wellbeing is central to Māori wellbeing. (A companion paper to Te Raukura: Mental health and alcohol and other drugs: Improving outcomes for children and youth, Ministry of Health)*. Palmerston North: Te Rau Matatini.
- Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of perinatal mental health services. Volume Two: Practical mental health commissioning. Retrieved on 18/06/13 www.jcpmh.info
- Judd. F. (nd) . Maternal perinatal mental health presentation. Retrieved 18/06/13 from <http://www.earlyyears.org.au>
- Kake TR, Arnold R, Ellis P. (2008). *Estimating the Prevalence of Schizophrenia amongst New Zealand Māori: A capture-recapture approach*. Dunedin: Otago University Press.

Knitzer J. (2000). Early childhood mental health services: a policy and systems perspective. In: JP Shonkoff and SJ Meisels (eds), *Handbook of Early Childhood Intervention*. Cambridge, England: Cambridge University Press.

Matthey S, Barnett B, Howie P, et al. (2003). Diagnosing postpartum depression in mothers and fathers: whatever happened to anxiety? *Journal of Affective Disorders* 74(2): 139–47.

Mental Health America (2008). Position statement 38 Perinatal Mental Health. Retrieved on 18/06/13 from [http:// www.liveyourlifewell.org](http://www.liveyourlifewell.org)

Merry, SN; Wouldes, T; Elder, H., Guy, D., Faleafa, M., Cargo, T. (2007). Assessing the social and emotional needs of infants in Counties Manukau District Health Board . The CMDHB Infant Mental Health Project. Unpublished.

Ministry of Health. (2007). *Te Raukura – Mental health and alcohol and other drugs: Improving outcomes for children and youth*. Wellington: Ministry of Health.

Ministry of Health. (2008). *Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*. Wellington: Ministry of Health.

Ministry of Health. (2010a). *Alcohol and Pregnancy: A practical guide for health professionals*. Wellington: Ministry of Health.

Ministry of Health. (2010b). *Service Delivery for People with Co-existing Mental Health and Addiction Problems: Integrated solutions*. Wellington: Ministry of Health.

Morgan VA, Jablensky AV. 2006. Exploring the role of reproductive pathology in the etiology of schizophrenia: what happens when mothers with schizophrenia give birth? *Directions in Psychiatry* 26: 1–14.

Munk-Olsen T, Laurensen TM, Pedersen CB, et al. (2009). Risks and predictors of readmission for a mental disorder during the postpartum period. *Archives of General Psychiatry* 66(2): 189–95.

National Institute for Health and Clinical Excellence (2007). Antenatal and postnatal mental health, Clinical management and service guidance. NICE

NSPCC (2012). Annual Report 2011/12. Retrieved on 18/06/13 from <http://www.nspcc.org.nz>.

Oakley Browne M, Wells J, Scott K (eds). (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

Oates M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British Medical Bulletin* 67: 219–29.

Oates M, Rothera I. (2008). *Specialised Perinatal Psychiatric Services; Service Model, Organisation and Challenges*. PowerPoint presentation by Margaret Oates, 29 October 2008, at a Perinatal and Infant Mental Health Seminar, Auckland. URL: [www.pmmrc.health.govt.nz/moh.nsf/pagescm/7489/\\$File/perinatal-psychiatric-services.pdf](http://www.pmmrc.health.govt.nz/moh.nsf/pagescm/7489/$File/perinatal-psychiatric-services.pdf) (accessed 14 January 2010).

O'Hara MW. (2009). Postpartum depression: what we know. *Journal of Clinical Psychology* 65(12): 1258–69.

Parackal S., Parackal M., Harraway J., & Ferguson E. (2009). Opinions of non-pregnant New Zealand women aged 16-40 years about the safety of alcohol consumption during pregnancy. *The Drug and Alcohol Review*, 28(2), 135-141.

Robertson E, Jones I, Haque S, et al. (2005). Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal (postpartum) psychosis. *British Journal of Psychiatry* 186: 258–9.

Ross L, McLean L. (2006). Anxiety disorders during pregnancy and the postpartum period: a systematic review. *Journal of Clinical Psychiatry* 67(8): 1285–98.

Royal College of Psychiatrists. (2000). *Perinatal Maternal Mental Health Services*. Council Report CR88. London: Royal College of Psychiatrists.

Reupert et al (2012) Intervention programs for children whose parents have a mental illness: a review. Retrieved on 18/06/13 from <http://www.mja.com.au>

Schmied, V; Johnson, M; Naidoo, N; Austin, M; Matthey, S; Kemp, I; Mills, A; Meade, T; Yeo, A. (2013) Maternal mental health in Australia and New Zealand: A review of longitudinal studies. **Women and Birth** Volume 26, Issue 3 , Pages 167-178

Scottish Government (2010). Growing up in Scotland: Maternal mental health and its impact on child behaviour and development. Retrieved on 18/06/13 from <http://www.scotland.gov.uk>

Siegenthaler, E; Munder, T; Egger, M. (2011). Effect of Preventive Interventions in Mentally Ill Parents on the Mental Health of the Offspring: Systematic Review and Meta-Analysis *Journal of the American Academy of Child & Adolescent Psychiatry*

Skovgaard A, Olsen E, Houmann T, et al. (2005). The Copenhagen County Child Cohort: Design of a longitudinal study of child mental health. *Scandinavia Journal of Public Health* 33(3): 197–202.

Sroufe, L.A. (2005). Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attachment and Development* 7(4): 349–67.

Tipene-Leach D. nd. *A Decade of Māori SIDS Deaths (1989–1999) – Undercounting in action*. Auckland: University of Auckland.

World Health Organisation (2008) Maternal mental health and child health and development. Retrieved 18/07/13 http://www.who.int/mental_health/prevention/suicide/MaternalMH

ZERO TO THREE. (2005). *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised edition (DC:0-3R)*. Washington DC: ZERO TO THREE Press.

8. Appendices

8.1. Project Scope



MENTAL HEALTH & ADDICTION REGIONAL NETWORK

Project Title	Midland Infant and Maternal Stocktake of Secondary Services Project
Prepared by	Eseta Nonu-Reid, Midland Regional Director –MH&A Network
Date	18 April 2013
Version	Final

Project Statement

Objectives	<p>The objectives of the project are to:</p> <ul style="list-style-type: none"> • Meet with the Midland Clinical Governance Group and discuss Healthy Beginnings and what would be the best model of care. • Undertake a stock take of current services and how at present services support mothers and babies if hospitalisation is required. • Undertake a gap analysis of the stock take and the proposed model. • Discuss and amend model of care. • Review linkages with primary maternal mental health services to the model and develop referral linkage pathways. • (This refers to phase 1 of the project. Phase 2 will include Primary Health Care, Well Child and Whānau ora providers).
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Strategic Accountability	<p>The project will be guided by:</p> <p>Ministry of Health: Service Development Plan: Rising to the Challenge, 2012</p> <p>Ministry of Health: Healthy Beginnings, 2012</p> <p>Mental Health Commission: Blueprint II, 2012</p> <p>Midland Region Mental Health and Addiction Needs Assessment 2011.</p> <p>Midland Region Mental Health and Addictions Strategic Plan 2008-2015.</p> <p>Midland Region Mental Health Workforce Development Plan 2013 – 2016 (draft)</p> <p>Midland Regional Clinical Services Plan 2013/14</p>
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Background	<i>Healthy Beginnings</i> provides guidance to district health boards (DHBs), and other
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health planners, funders and providers of perinatal³ and infant mental health and alcohol and other drug (AOD) services, on ways to address the mental health and AOD needs of mothers⁴ and infants. The document is not a clinical guideline but it is informed by current literature and experience in clinical best practice.

During the perinatal period women have been shown to be at a higher risk for the onset or recurrence of mental illnesses than at other times (Burt and Quezada 2009). It is estimated that maternal psychiatric disorders occur during the perinatal period in at least 15 percent of pregnancies. Maternal mental illness in this period has a detrimental effect on the emerging mother-infant relationship and can result in delayed social and emotional development and/or significant behavioural problems for the infant, potentially leading to a range of negative outcomes that may persist into adulthood.

Research has demonstrated the importance of effective intervention for mothers and infants with mental disorders and/or AOD problems. The developing mother–infant relationship is often an essential part of clinical intervention. This means clinicians in these services must be multi-skilled and able to assess and treat the mental disorders of the mother and the infant as well as the relationship between the mother and her infant.

In New Zealand mental health services for mothers and infants do not exist in some places and where they do exist development has been somewhat piecemeal. No DHB currently provides the full range of perinatal and infant mental health and AOD services that as documented in *Healthy Beginnings*. Comprehensive perinatal and infant mental health services 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.

Developing perinatal and infant mental health services, including specialist inpatient facilities for mothers and babies in the North Island, will take time and requires regional and national funding, planning and co-ordination.

Approach	<p>The approach will include the following processes:</p> <ul style="list-style-type: none">• Approval of the project scope and the proposed content of the report• Consulting with key stakeholder groups using developed stocktake template• Collecting, analysing and presenting the information to stakeholder group• Report writing and editing• Ongoing checking processes to ensure that the information, and the way it is
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³ The term **perinatal** means relating to the period immediately before and after birth. The internationally accepted timeframe is from pregnancy to one year postpartum.

⁴ 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.

	<p>presented is going to be useful to stakeholders</p> <ul style="list-style-type: none"> • Monthly progress reporting to the project sponsor • Submitting the final draft report to sponsor
Options Considered	<p><i>1. Do nothing</i></p> <p>This piece of work requires a regional approach that is aligned to the Ministry of Health's expectations re effective and efficient services. Doing nothing runs the risk of Midland not having an informed picture of where services sit for this vulnerable client group.</p> <p><i>2. Each Midland DHB gather its own information as required</i></p> <p>This would not be acceptable to the MoH as does not provide a regional picture</p> <p><i>3. Undertake a Midland Project</i></p> <p>This option is seen by the region to be as the most efficient way to achieve the MoH expectations regarding a regional response to benchmarking.</p> <p>Option 1 would result in not meeting the expectations of the Ministry of Health. Option 2 would result in high cost to individual DHBs and could result in inconsistent decision making across the region. Option 3 is a cost effective way to carry out this work.</p>
The project will include	<p>Key areas to be covered in the report include <i>(this is subject to discussion with the key stakeholder groups)</i>:</p> <ul style="list-style-type: none"> • Literature scan • A review of current secondary 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
The project will not include	<p>The report will not, include information about DHBs from outside the region.</p> <p>The project will exclude doing original research.</p> <p>The project will not conduct a prioritisation process based on the information.</p>
Completion Criteria	<p>The project will be completed once the final report is signed off by the Midland Planning and Funding-Alliance Leadership Team (PF-ALT).</p>
Internal Stakeholders	<p>Project Sponsor, Eseta Nonu-Reid</p> <p>Midland Clinical Governance Network</p> <p>Midland Portfolio Managers</p>

External Stakeholders	<p>Midland region has a number of existing regional groups representing key stakeholders who will be consulted as part of the project:</p> <ul style="list-style-type: none"> • He Tipuana Nga Kakano "Growing the Seeds". The Midland Regional Consumer Leadership Network • The Midland Regional Māori Leadership Network. Newly established early in 2013 this network meets four times a year • The Midland Whānau Leadership Network. A forum to provide peer support and mentorship to Family advisors, advocates and peer support workers working in the sector • The Midland regional Addiction Leadership Network • Midland Region Workforce Leadership Network • Others as identified during the process. <p>Relevant key stakeholders will be invited to identify, from their knowledge and experience, the gaps, needs, priorities and risks for the region and for their particular DHBs.</p>
Implications for Māori	Māori are over-represented in prevalence data and in mental health and addictions services. This project will ensure that good information is provided to support planning to meet the needs of Māori in the Midland region.
IM Implications	The regional network meetings, email and Midland website will be utilised to convey information about the project to the sector.
Resources and Project Structure	<p>The project will be led by a project consultant who will be responsible for carrying out the work, consultation, communication and writing the report. The project consultant will report directly to the Midland Region Director, Mental Health and Addiction Service Development.</p> <p>Midland staff to be involved in this project are:</p> <p>A expert Reference Group will be established to support the project consultant. The Reference Group will comprise of the Clinical Governance Network and the Regional Portfolio Managers Group who are key to the process and provision of information, quality monitoring and input to reports.</p>

Key milestones and timeline	Date	Deliverable
	1 May 2013	Draft project scope completed
	9 May 2013	Plan signed off by Clinical Governance and Regional Portfolio Managers
	13 May 2013	Project Consultant contracted
	12 July 2013	Stocktake completed
	19 July 2013	Regional Meeting completed
	Monthly	Progress reports to project sponsor
	1 August 2013	Final draft report completed for regional consultation
	1 September 2013	Final report signed off by GMs Planning and Funding and Māori Health

Project relationships and linkages

Other projects or initiatives that this project relates to and key contact people that provide liaison:

Project	Contact
Link with other individual DHB or regional projects relevant to this project	Midland Portfolio Managers
Midland Region Services Plan 2013 -2014	Midland Regional Director

Financial Summary

Budget (one-off costs)

The project consultant will be contracted for up to 50 hours. A total amount of \$6,250.00 has been allocated for this project.

In addition disbursement of \$5,000 will be include in the contract to cover the costs below:

Costing Activity	Indicative Costs
Travel	\$2,000
Meeting costs	\$2,000 (nil if the project uses existing meetings)
Printing/Publication	\$1,000 (nil if the project uses electronic distribution only)

Ongoing cost: **Nil**

Cost Savings: The cost of carrying out this project as a regional project will be significantly less than the cost of all four DHBs carrying out their own project.

Risk management	<p>Risks associated with the project.</p> <p>Stakeholder meetings do not match up with project timeframe - Medium</p> <p>Delays in receiving information from the various information sources – Medium</p> <p>Information about workforce may be difficult to access or not available – Medium</p> <p>Risk that cannot get regional agreement on gaps Medium</p> <p>Risk of poor alignment with national Infant and Maternal strategy High</p> <p>Risks the region is exposed to if the project does not proceed.</p> <p>The Midland DHBs will not gain sign off from the Ministry of Health if this piece of work is not completed and the Midland region is likely to miss out on funding allocation if any.</p>	<p>Risk Mitigation</p> <p>Build timeframes for project around stakeholder meeting times</p> <p>Build sufficient time into project plan or renegotiate timeframes with project sponsor</p> <p>Start collecting workforce information early in the project</p> <p>Consultation throughout the project key to ensure that this objective is achieved.</p> <p>Advocacy at a national level is undertaken by Midland representatives</p>
Quality	<p>Quality will be facilitated through</p> <p>Use of an expert Reference Group will provide clinical guidance to the project</p> <p>Use of regional Clinical Governance Network and Portfolio Managers to provide guidance to the project</p> <p>Sector involvement throughout the project</p> <p>The project Consultant needs to have credibility within the mental health and addiction sector</p> <p>A signoff process for both the project scope and the final document following final consultation</p>	
Assumptions	<p>The following assumptions have been made:</p> <p>The project will be funded by Midland Regional Network, Mental Health and Addictions</p> <p>The project will be sponsored by Midland Regional Director, Mental Health and Addiction Service Development</p> <p>The project is supported by the Midland Clinical Governance Network and Regional Portfolio Managers Group</p> <p>The Midland regional networks will actively participate in and support the project</p>	
Constraints	None known	

Communication Plan	There will be at least two written communications with stakeholders, one at the start of the project, outlining the project and its objectives and another at the end of the project, thanking stakeholders for their contribution to the project and providing the final report.
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During the project, stakeholders will be consulted at their scheduled meetings on gaps, needs, priorities and risks. Monthly project updates will be circulated to the regional stakeholder forums and posted on the Midland website.

Some of the key messages to be included in communications with stakeholders will be:

The purpose of this project

We want this to be a report that is well used and contributes to meeting the identified needs in the region

Consultation will occur across the Midland region in each of the four participating DHB areas.

Sign-off (signatures required)	
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Project Consultant: Roz Sorensen

Project Sponsor: Eseta Nonu-Reid

GM Planning & Funding Lakes DHB: Mary Smith

Date:

8.2 Regional Data from Ministry of Health

Maternal and Infant Mental Health Services

Midland Region⁵

Service Utilisation of Specialist Maternal Mental Health⁶

	2010	2011	2012
Number of referrals	592	703	569
Number of contacts	5,394	6,395	5,649
Number of clients seen	547	652	523

Service Utilisation of Specialist Infant Mental Health Services⁷

	2010	2011	2012
Number of referrals	15	15	28
Number of contacts	135	179	302
Number of clients seen	14	13	28

Note: infants aged 0-1 years

⁵ Midland region: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB, Waikato DHB

⁶ Source: PRIMHD 25 Nov 2013. Team type = 15.

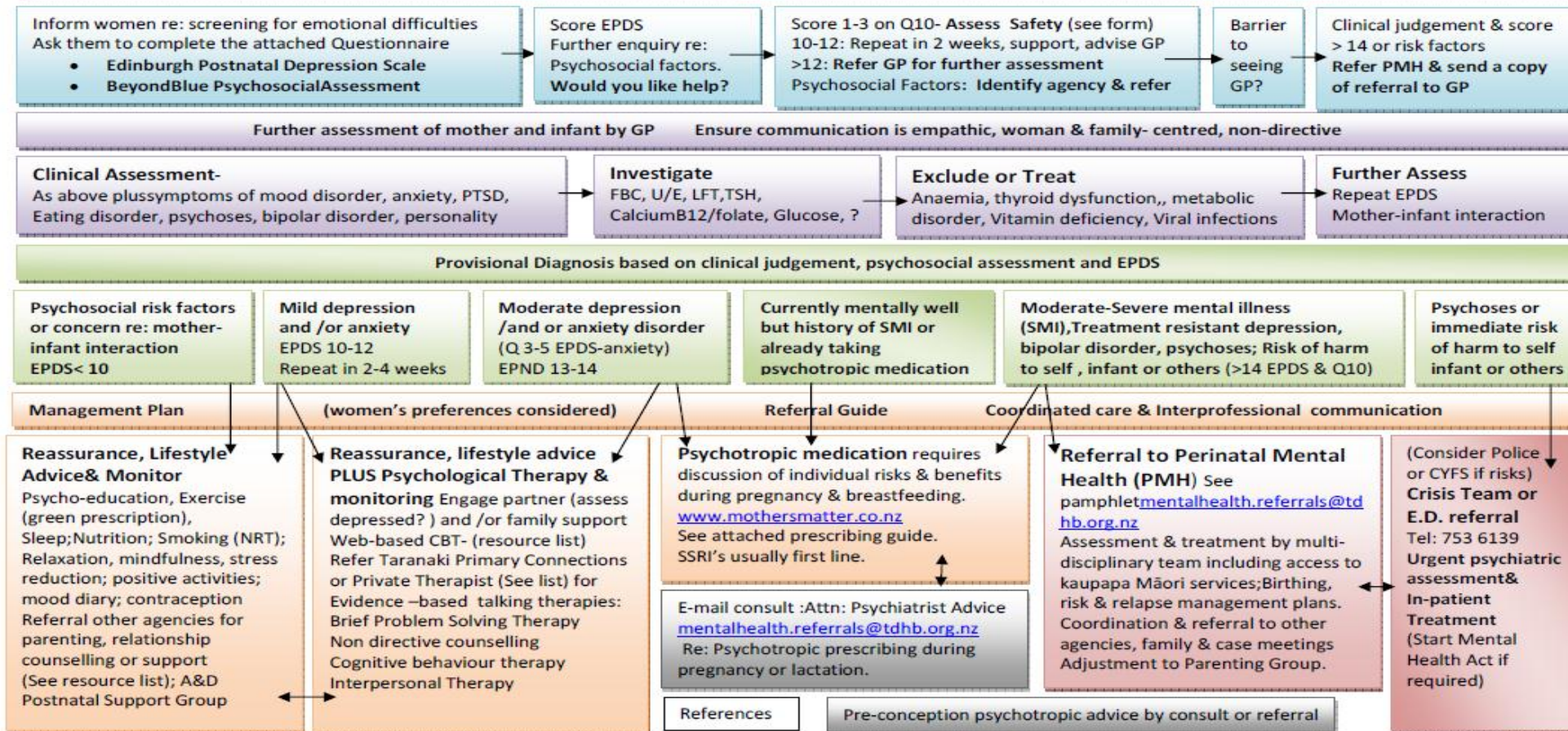
⁷ Source: PRIMHD 25 Nov 2013. Team type inlist 04,21,22,14 and age 0-1 years.

8.3 Taranaki Draft Pathway

EPND, Risk assessment, Resource List & Prescribing Guide, accompany this Pathway

DRAFT Perinatal Mental Health TDHB: Local Referral Pathway October 2011

All Health Professionals(midwife, Well Child Providers, social worker, psychologist, obstetrician etc)assessing a woman during pregnancy and up to 1 year postnatally have the opportunity for screening for perinatal mental health problems. This should occur at least once in the ante and post-natal periods, preferably twice.



Austin M-P, Hight N & the Guidelines Expert Advisory Committee (2011) Clinical Practice guidelines for depression and related disorders-anxiety, bipolar disorder & puerperal psychosis –in the perinatal period, A guideline for primary care health professionals. Melbourne: Beyond Blue: the national depression initiative; NZGG (2008) Identification of common mental disorders and management of depression in Primary Care, Evidence-based best practice guideline; NICE (2007) guideline on clinical management and service guidance antenatal and postnatal mental health, British Psychological Society & Royal College of Psychiatrists

8.4 Future Data Collection Opportunities

The following is a summary of current service provision in Waikato DHB showing demand and utilisation. More specifically, access and referral rates. It has been suggested that other DHBs within the Midland region would also benefit from the collection and analysis of similar data requirements.

Summary of current providers of specialist perinatal mental health community services.

1 October 2011 to 30 September 2012.

Providers name	Health Waikato (Provider arm services)	Hauora Waikato Māori Mental Health Services
a brief description of the services delivered	As above	As above – this service provides a comprehensive bio-psycho-social assessment and treatment from kaupapa Māori, bi-cultural, pan cultural and mainstream perspective.
The geographical population served	Throughout the whole of the Waikato DHB	Greater Hamilton area
Service volume (e.g. FTE numbers for community services and bed numbers for inpatient or residential services)	MHM90A senior medical 0.50 FTE MHM90C clinical 4.20 FTE Total FTEs 4.7	MHM90A senior medical 0.1 FTE MHM90C clinical 1 FTE Total FTEs 1.1
The number of pregnant and postpartum women who have accessed this service in the last 12 months	256	65

Summary of wrap around services used to support women and their infants supported by specialist perinatal mental health community services

Type of wrap round service provided	Number of referrals made by Health Waikato	Number of referrals made by Hauora Waikato
Mother Craft unit (mother and infant admission)	18	
Acute Home based treatment	No statistics available	4
Crisis respite (both mother and infant)	No statistics available	3
Packages of care	6	21
Mahoe day crisis facility (Hauora Waikato services only for mother and infant and other pre-school children)		23
Parenting classes	No statistics available	11
ICAMHS	8	13
Inpatient bed at Henry Bennett Centre (mother only)	No statistics available	1
Home based support	No statistics available	34