NEW ZEALAND COLLEGE OF MIDWIVES (INC)

5th June 2018

Mental Health and Addiction

FEEDBACK FROM New Zealand College of Midwives

PO Box 21 206

Christchurch 8143

Tel (03) 377 2732

The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent 90% of the practising midwives in this country. There are around 2,900 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to, on average, 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby.

Midwives undertake a four year equivalent undergraduate degree to become registered. The undergraduate curriculum meets all international regulatory and education standards. Midwives are authorised prescribers in relation to their Scope of Practice as determined by the Midwifery Council.

Midwives provide an accessible and primary health care service for women in the community within a continuity of carer model as Lead Maternity Carers. Midwives can also choose to work within secondary and tertiary maternity facilities, providing essential care to women with complex maternity needs.

The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and wellbeing.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

5th June 2018

Mental Health and Addiction Inquiry
PO Box 27396
Marion Square
Wellington 6141
mentalhealth@inquiry.govt.nz

Mental Health and Addiction

The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the 'Government Inquiry into Mental Health and Addiction: Oranga Tāngata, Oranga Whānau.'

Introduction

Midwives in New Zealand work in partnership with women to give women the necessary skilled support, care and advice, during pregnancy, birth, labour, and the post-birth period. Partnership is a key concept for the midwifery profession and midwives engage with women and their families in relationships of trust, shared decision making and responsibility, negotiation and shared understanding. It is this quality relationship that supports the midwife-woman connection and which fosters trust and meaningful dialogue about a range of concerns and issues. It is in the context of midwifery care and women's health that we are making this submission. Midwives are well aware of the mental health concerns that arise for some women during their pregnancies, their labours and births, and during the adjustment period of becoming a new mother and all that this entails, including sleep deprivation and relationship changes. These issues can overshadow both pregnancy and the postnatal period.

The College considers that supporting mothering and parenting is an investment for New Zealand and that all efforts to support perinatal mental health and well-being is critically important for not only the woman but for her infant, children and whānau. Pregnancy, childbirth and mothering are times of great significance in the lives of women, and

376 Manchester Street / PO Box 21106 Edgeware Christchurch / Telephone (03) 377 2732 / Facsimile (03) 377 5662 / Email nzcom@nzcom.org.nz

represent a time of potential vulnerability. Midwives are well placed as the primary workforce who can recognise when there may be issues to address, help women with their mental health challenges early, support them during these times, and refer to specialist or other support services when needed.

The issues that arise for midwifery care are related to a lack of support or specialist referral services to refer women to in situations where additional needs have been identified. In addition to this midwifery services are underfunded and this can create time pressures on midwife-mother quality engagements. Barriers to accessing support for mental health or addiction services are many and include geographical difficulties for rural women, inequity, financial pressures, unavailability of timely culturally appropriate services for women, and the overwhelmingly difficult lives that women in poverty or deprivation experience. There are challenges for midwives in terms of the degree and intensity of their workloads and the services available for support and referral. This is addressed in the points below.

1.0 The needs of women, and workload issues for midwives

1.1 When women are pregnant they may experience anxiety, depression and a worsening of any existing mental health issues. They may also face major social challenges related to work, family and home life that having a baby entails. Frequently these emotional challenges result in an increased workload for midwives due to the need to spend more time with women to identify appropriate supports, referrals and care plans individualised to each woman's needs. This can prevent minor mental health concerns from becoming major issues.

1.2 Lead maternity carer midwives have noted that a significant proportion of the women they care for have depression and anxiety, and one midwife recently reported that 34% of the women she cared for in one year had a range of issues such as depression (treated and untreated), anxiety, post-traumatic stress and trauma (some related to a previous birth), and relationship breakdowns. In these situations midwifery appointments generally need to be more frequent and of a longer length. Anxious women also contact their midwives more often, and these contacts may be during the evening, night or weekend. Hence these issues increase the workload of midwives substantially, yet this is not currently recognised or appropriately funded. Core midwives working in maternity facilities are also experiencing barriers to having the time

376 Manchester Street / PO Box 21106 Edgeware Christchurch / Telephone (03) 377 2732 / Facsimile (03) 377 5662 / Email nzcom@nzcom.org.nz

required to provide sufficient care for women, due to inadequate numbers of midwives on staff, and recruitment retention and funding issues that have not yet been satisfactorily addressed.

1.3 Midwives currently undertake a wide range of screening, diagnostic and public health services. The Primary Maternity Services Notice 2007 (Section 88 of the NZ Public Health and Disability Act 2000) requires LMCs (mostly midwives), as part of their duty to the woman they provide care, to provide information and advice on a wide range of health issues. These include screening for HIV, sexually transmitted diseases, foetal anomalies, family violence, smoking, drug / alcohol use, MRSA, hepatitis, TB, diabetes, diet, nutrition, physical activity, obesity, blood tests (e.g. anaemia, rubella, antibodies), and general health, as well as newborn screening – hearing, sight, full physical check, and metabolic screening.

1.4 Midwives also currently discuss/assess maternal mental health and assess each woman as she transitions from pregnancy through her maternity journey to parenting. However, we are concerned that any additional screening requirements are fully acknowledged, supported and appropriately funded.

1.5 A recent media report about 'Growing Up in New Zealand' findings stated that 13% of pregnant women experience depressive symptoms in late pregnancy and while this drops to 8%, in the postnatal period half of those are new cases. Symptoms were more likely in young women and/or those facing high levels of financial or relationship stress.[1]

1.6 The College notes that there are a range of factors which may increase the likelihood of depression arising during the maternity episode and these include; abnormal results from foetal screening; the birth of a preterm, sick baby or a baby with congenital abnormalities, the loss of a pregnancy or baby by miscarriage, ectopic pregnancy, blighted ovum, stillbirth or neonatal death, or separation of the mother and baby due to adoption, care and protection, custody or incarceration issues.

1.7 The loss of an expected birth process or outcome can leave women feeling disempowered and may exacerbate symptoms of depression. Pregnant

---

[1] *Growing up in NZ: Fascinating finds about Kiwi kids*. 20 May 2018. http://www.newstalkzb.co.nz/news/national/growing-up-in-nz-fascinating-finds-about-kiwi-kids/

women and women with new babies are also negatively affected by isolation (not necessarily geographical) from family, neighbours, friends and peer groups. Poverty, socioeconomic deprivation, and inadequate, insecure accommodation may also increase the likelihood of depression.

1.8 The College considers that when a woman has perinatal mental health issues she requires full discussion of the risks and benefits of all treatment options and the risks of untreated depression. We also consider that the uncertain state of the evidence should be acknowledged and discussed.

1.9 As noted in the introduction midwives are the primary workforce who can identify perinatal mental health challenges early, support women during these times, and refer to specialist support when needed, but the development of sustainable, accessible, culturally appropriate services is required to meet the needs of a diverse group of women, including Māori, Pasifika, young women, refugee and migrant women, alongside a significant investment in midwives and midwifery services and Well Child Services. Providers of mental health support services need to be culturally fit for purpose and the College would like to see a move away from a 'one-size-fits-all' approach to enable better support midwives to refer appropriately when necessary.

2.0 Screening issues

2.1 The College strongly supports lead maternity carer/core midwives' discussions with women about mental health issues as part of the on-going assessment of the woman's health during her maternity journey. We do, however, have several issues of concern in relation to routine screening initiatives for pregnant and post-partum women.

2.2 For screening programmes to be introduced there needs to be reliability, effective treatment and the process must cause minimal harm. The College is uncertain that these pre-requisites have currently been met but consider this review a timely opportunity to raise these issues.

2.3 We have concerns about funding, sustainability and a potential lack of resources which would inhibit the success of any mental health service being developed. The College strongly recommend that midwives be included as an integral part of any maternal mental health service and recommend further consultation with the

midwifery workforce, via the College, prior to the development of any programmes involving routine screening of pregnant or post-birth women.

2.4 Noonan et al. examined midwives' perceptions and experiences of caring for women who experience perinatal mental health problems and concluded that educational and training support for midwives in the absence of appropriate referral pathways and support systems would have little benefit. [2]

2.5 Thought also needs to be given to the resources which will need to be developed and made available to address any needs identified as a result of mental health screening.

3.0 Referral

3.1 In many areas of New Zealand midwives are unable to refer directly to non-acute mental health services but must refer first to a general practitioner. Midwives are autonomous health professionals and practice autonomously on their own professional responsibility in New Zealand. Many women do not have a general practitioner or they may not wish to see their general practitioner for various reasons, plus this system can incur financial costs to the women and her family which may be impossible to meet, and create time barriers which can contribute to worsening situations. This situation also places the midwife in the position of identifying a need for additional support for the woman, yet not being able to access and refer to appropriate supportive services for women under her care.

3.2 Midwives often become aware of mental health issues through history taking, as well as through close association with the woman and her family (in the home and in clinic settings). Women may disclose their concerns, signs and symptoms to their midwives but as midwives are not skilled in mental health diagnosis their role as referrers to both general practice or specialist services is critical and should be supported.

3.3 Non-acute services for individuals who have mild to moderate mental health needs have been developed in many regions without discussion/consultation with the maternity workforce so many midwives may be unaware of some of the newer services available. The College considers that it may be optimal to undertake a

[2] Noonan, M., Doody, O., Jomeen, J., & Galvin, R. (2017). Midwives perceptions and experiences of caring for women who experience perinatal mental health issues: An integrative review. Midwifery, 45:56-71.

review and map the regional non-acute mental health services to identify what is available for women in each region and determine their referral requirements. This would provide a more comprehensive understanding of service availability and accessibility and would help practitioners identify the appropriate services in each region. At the same time this mapping will identify the gaps in support services.

3.4 As previously stated, some women choose not to take up the referral the midwife makes to the GP. There needs to be consideration of other referral options provided for LMC midwives, and readily available and accessible services to carry out this function (free of charge) for women who require it.

3.5 The College would like to see midwives enabled to make direct referrals to all non-acute mental health services.

3.6 In the interests of collaborative working and continuity of care the College would like to see improved communication between practitioners. There is currently no requirement for GPs to provide referral information to midwives once a woman has chosen the midwife as her LMC. Midwives may receive little no information about the woman's history or even test results from GPs who have provided early pregnancy care. There needs to be a clear mechanism for communicating actions undertaken and test results to other professionals involved in the women's care.

3.7 The College suggest a specific requirement for GPs to provide mental health history information to midwives once they have been chosen as a woman's LMC. Standardised access to relevant health history information would be highly valuable for LMC midwives and would support earlier identification of a woman's needs.

4.0 Support and support services

4.1 The College is aware of the lack of suitable support services for women to access, and the inequity of access to services around New Zealand.

4.2 When non-pharmacological interventions such as enhanced social support and/or a psychological intervention are indicated the College has some concerns due to the lack of appropriate and accessible support services. The College considers

that social support in the form of funded groups and other non-pharmacological interventions could be considered, with the informed consent of the woman, before medication is prescribed for perinatal depression, especially for a woman with mild symptoms, or when she is in very early pregnancy.

4.3 The College is concerned about the lack of funded support services in New Zealand and feels that community support groups run by volunteers provide a very valuable service, but that these groups and roles should be adequately funded. Funding is the only means by which sustainability can be achieved and this is paramount in mental health services. We note that many breastfeeding support groups also provide significant mental health support for new mothers. Anecdotal accounts from women stating that these groups were 'their post-natal prevention strategy' should be considered pertinent to this inquiry as prevention is a significant prong of maternal mental health services. These breastfeeding groups are largely run by volunteers and significantly underfunded as groups in terms of buildings, people and resources.

4.4 On the topic of breastfeeding, research in 2014 highlighted the importance of women's infant feeding intentions to the development of postnatal depression.[3] Data from a British survey, the Avon Longitudinal Study of Parents and Children was used. The effect of breastfeeding on women's mental health was measured and the estimated effects of breastfeeding on PND differed according to women's intentions. For women who were not depressed during pregnancy the lowest risk of PND was found among women who had planned to breastfeed and who had actually breastfed their babies. The highest risk of PND was found among women who had planned to breastfeed but had not gone on to breastfeed. In New Zealand data indicates that 96-98% of women plan to breastfeed and initiate breastfeeding. The results of the study by Borra et al. underline the importance of providing a range of breastfeeding support services to women who plan to breastfeed and the provision of compassionate support to women who intended to breastfeed but who were unable to achieve this for a range of reasons. Midwives provide support for women for all aspects of infant feeding, both breastfeeding and formula feeding, but recognise that some women require additional support services. These additional services are not always available and accessible to all women, and the College recommends that adequate funding for breastfeeding support services is necessary to ensure their continuation and sustainability.

---

[3] Borra, C., Lacovou, M., & Sevilla, A. (2015). New evidence on breastfeeding and postpartum depression: the importance of understanding women's intentions. *Matern Child Health J*, 19:897-907.

4.5 Access to mental health services varies around the country and many rural communities often have no access to this support which may leave rural women with no option apart from medication. This can place an additional burden on practitioners providing care to women in these areas. Given that support and psychological intervention may be less expensive than pharmacological therapy, and provide an effective way of supporting women the College thinks that this is worthy of funding support and provision of more diverse groups around the country will address some inequity issues.

4.6 Dedicated support services, which midwives could refer women to for access to supportive counselling, would work well for both women and midwives. The establishment of such a service would also be a pre-requisite before any mental health screening programme could be implemented. Setting up screening services without referral support options being developed first is unacceptable

4.7 The College considers that antidepressants could be considered as first line treatment for a perinatal woman with moderate to severe depression, provided she has expressed a preference for this treatment and is well informed about known risks and benefits and about the limitations of the evidence. We support pregnant women being offered consultation with maternal mental health services before initiation of antidepressant treatment.

4.8 If a woman who is pregnant or planning pregnancy is being treated with an antidepressant, her treatment preference, previous history and risk should be reviewed. If appropriate, attempts should be made to withdraw the antidepressant and substitute an alternative treatment and/or ensure that the antidepressant with the lowest risk profile is used.

4.9 For a minority of women support services in the community are insufficient and in-patient services are necessary. The College is concerned about the lack of dedicated mother and baby facilities for women with serious perinatal mental health issues. These services are unavailable in most centres. As described by Poinso et al. (2002) a residential mother-baby unit *"enables a mother to obtain care for psychiatric disorders and simultaneously receive support in developing her identity as a mother. This care is meant to prevent attachment disorders and*

376 Manchester Street / PO Box 21106 Edgeware Christchurch / Telephone (03) 377 2732 / Facsimile (03) 377 5662 / Email nzcom@nzcom.org.nz

mother-baby separation." [4] The College supports initiatives that protect the mother-baby relationship and which avoid separation of the dyad. Research does indicate that mother-baby units positively impact on maternal mental health and the mother–infant relationship. [5]

4.10 Although maternal deaths are fortunately rare, suicide is the leading cause of indirect maternal deaths within a year of childbirth in New Zealand. The Perinatal and Maternal Mortality Review Committee (PMMRC) (2017) reported twenty-seven maternal deaths by suicide in the years 2006-2015.[6] The PMMRC report in 2016 reviewed maternal suicide deaths in more detail and reported the results from a maternal mental health survey of 398 Lead Maternity Carers. Respondents were midwives (89.6 percent), obstetricians (9.3 percent) and paediatricians (1.1 percent). Three-quarters of respondents stated they routinely screened pregnant women for depression using specific questions, and 61 percent said there was a specific referral pathway for women identified as being at risk of developing mental health problems during or after pregnancy. 46 percent felt completely comfortable asking women about their mental health history, and 84 percent felt they would benefit from more training. 32 percent of respondents felt that services for maternal mental health were overwhelmed, poorly coordinated or insufficient.[7]

4.11 Although the screening of all women for perinatal mental health disorders is being debated, the College considers, as previously discussed, that the setting up of screening services without support referral options and adequate, appropriate, accessible services being developed first is unacceptable. As described in 4.9 some respondents to the maternal health survey felt that services were overwhelmed, poorly coordinated or insufficient. Development of accessible maternal mental health services throughout New Zealand is an urgent issue.

5.0 The needs of fathers and partners

5.1 The College has concerns about a lack of support services for fathers as research indicates that fathers also experience perinatal mental health issues. The Growing

[4] Poinso, F., Gay., Glangeaud-Freudenthal, N. M-C., & Rufo, M. (2002). Care in a mother-baby psychiatric unit: analysis of separation at discharge. *Arch Womens Mental Health*, 5(2):49-58.
[5] Gillham, R.,& Wittkowski, A. (2015). Outcomes for women admitted to a mother and baby unit: a systematic review. *International Journal of Women's Health,* 7:459-476.
[6] Perinatal and Maternal Mortality Review Committee. (2017). *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission.
[7] Perinatal and Maternal Mortality Review Committee. (2016). *Tenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission.

Up in New Zealand study found that expectant fathers were at risk of depression symptoms if they felt stressed or were in poor health.[8] As with women, a similar range of factors can contribute to mental health issues such as isolation, a lack of support networks and socioeconomic stressors.

6.0 Mental health and family violence

6.1 There is a link between family violence and depression, and research indicates that abuse may begin or escalate during pregnancy. A recent study from Australia by Dahlen et al. with a cohort of 33,542 women giving birth in a major health facility in Western Sydney, found that a report of intimate partner violence at the first antenatal booking visit was associated with a higher level of reporting on all psychosocial risks, and higher antenatal admissions, especially for threatened preterm labour.[9]

6.2 The Dahlen et al. research reported on a meta-analysis of risk factors for domestic violence during pregnancy. This meta-analysis found across 92 studies that the average prevalence of emotional abuse during pregnancy was 28.4%, physical abuse 13.8% and sexual abuse 8%.[10] Another systematic review of domestic violence and perinatal mental health disorders referenced in the Dahlen et al. study found a three-fold increase in the odds of high-level depressive symptoms in the postnatal period after having experienced domestic violence during pregnancy.[11]

6.3 Midwives are already screening for family violence and they are are the primary workforce engaging with around 600,000 pregnant women each year in New Zealand the College recommends that more support for midwives is necessary to enable them to respond more appropriately to women's needs. This support needs to take the form of development of a broad range of accessible perinatal mental health services, and investment in midwives and midwifery services.

---

[8] Underwood, L., Waldie, K. E., Peterson, E., D'Souza, S., Verbiest, M., McDaid, F., & Morton, S. (2017). Paternal depression symptoms during pregnancy and after childbirth among participants in the Growing Up in New Zealand Study. *JAMA Psychiatry*, 74(4), 360–410. http://doi.org/10.1001/jamapsychiatry.2016.4234

[9] Dahlen, H. G., Munoz, A. M., Schmied, V., & Thornton, C. (2018).The relationship between intimate partner violence reported at the first antenatal booking visit and obstetric and perinatal outcomes in an ethnically diverse group of Australian pregnant women: a population-based study over 10 years. *BMJ Open*, 8(4):e019566.

[10]James, L., Brody, D., Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence Vict,* 28:359–80.doi:10.1891/0886-6708.VV-D-12-00034

[11] Howard, L. M., Oram, S.,Galley, H., Trevillion, K., & Feder, G. (2013). Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLoS Med*;10:e1001452.doi:10.1371/journal.pmed.1001452

7.0 Economics and mental health

7.1 Bauer et al. (2016) examined the potential costs and potential economic benefits of early interventions that can prevent or reduce perinatal mental illness and the long-term impacts on mothers and their children. This was to examine the economic case for investing in early interventions that reflect best practice in England.[12]

7.2 Costs included a *"range of public sector costs (health and social care, education, criminal justice), health-related quality of life and productivity losses linked to a range of adverse, partly overlapping child outcomes. Adverse child outcomes included pre-term birth, infant death, emotional and conduct problems, special educational needs, and leaving school without qualifications."*

7.3 Results from the Bauer et al. economic analysis suggested that investment in a comprehensive range of interventions during the perinatal period is likely to *"offer good value for money."* Suggested interventions included collaborative care to identify and refer women, with a particular role for midwives.

7.4 In a 2014 report Bauer et al. found that perinatal depression, anxiety and psychosis carried a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the UK.[13]

7.5 Bauer et al estimated the cost of extra provision for perinatal mental health was equivalent to about £400 per average birth. Perinatal mental health problems were estimated as imposing costs of around £10,000 per birth for society as a whole, with costs of around £2,100 per birth falling on the public sector. Bauer et al. concluded that because *"the costs of perinatal mental health problems indicate the potential benefits of intervention, even a relatively modest improvement in outcomes as a result of better services would be sufficient to justify the additional spending on value for money grounds."*

---

[12] Bauer, A., Knapp, M., & Adelaja, B. (2017). *Best practice for perinatal mental health care: the economic case*. Personal Social Services Research Unit PSSRU Discussion Paper DP2913. London School of Economics, www.pssru.ac.uk

[13] Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. Personal Social Services Research Unit, PSSRU, Centre for Mental Health and London School of Economics.

7.6 Bauer et al also described the current provision of services in the UK as patchy, with significant variations in coverage and quality around the country. As previously noted, this is the same situation as in New Zealand.

.

8.0 Separation of mothers/fathers and their babies, and mental health

8.1 Meeting the needs of parents of infants who have been admitted to a neonatal intensive care unit is significantly important. Separation impacts on bonding and attachment. Support for parents and parenting needs to start in the NICU and continue into the community with home support, continued breastfeeding support and early intervention support.

8.2 The College supports equitable free access to clinical psychologists and ongoing counselling support for parents of babies admitted to NICU.

8.3 The mental health needs of all parents separated from their children requires attention, regardless of the reason for the separation. Recent Canadian research has found that mothers who have had a child taken into care had significantly higher rates of suicide attempts and completions. The researchers suggested that when children are taken into care, attention should be paid to appropriate mental health follow-up and screening for maternal suicidal behaviour.[14] [15]

11. Discrimination

11.1 As previously noted some population groups experience greater inequity, suffer more material hardship and deprivation, and are less likely to have their mental health and health needs met. Racial and ethnic inequities contribute to poor health outcomes. Discrimination and its effects on health and wellbeing was examined by Cormack et al. who found that exposure to racial discrimination was associated with poorer self-rated health, poorer mental health and greater life dissatisfaction. [16]

11.2 Cormack et al. found that Maori, Pacific and Asian ethnic groups reported much higher levels of discrimination, and experienced multiple forms of discrimination, and the researchers

[14] Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N., Chateau, D., & Singal, D. (2017). Suicide Attempts and Completions among Mothers Whose Children Were Taken into Care by Child Protection Services: A Cohort Study Using Linkable Administrative Data. *The Canadian Journal of Psychiatry*, 63(3):170-177.
[15] Wall-Wieler, E., Roos, L. L., Nickel, N. C., Chateau, D., & Brownell, M (2018). Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. *American Journal of Epidemiology*, kwy062, https://doi.org/10.1093/aje/kwy062
[16] Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health*, 17(26).

suggested a need for research and interventions that more fully account for the multiple ways in which discrimination impacts on health.

11.3 The development of more kaupapa Māori mental health services that are well-funded and sustainable is necessary. The ability to be responsive to whānau needs requires a different approach to service delivery and a strong community focus is needed.

11.4 About to be published work by Wilkinson and Pickett suggests that inequality and low social status are linked to elevated levels of stress, anxiety and depression. Wilkinson and Pickett's work proposes that equal societies generate higher levels of wellbeing.[17]

Feedback from the College related to midwifery and maternity issues and the specific inquiry questions is below.

1. **What's currently working well?**

- Continuity of midwifery care for pregnant, birthing and post-natal women.

2. **What isn't working well at the moment?**

- Inadequate service coverage, inequity of access, rural access issues, midwives recognising perinatal mental health needs but having limited services and referral pathways available.
- Not enough support for parents, infants and children – poverty, housing issues.
- Recruitment and retention of midwives.
- Collaboration and the sharing of mental health information between health professionals.

3. **What could be done better?**

- Equitable access to support services
- A range of consistently available support services that meet the needs of less severe to severe perinatal mental health problems.
- Integrated care pathways, local strategic plans to meet the needs of the local population.
- Les reliance on medication and more counselling services and services to address discrimination and social issues that lead to loss of wellbeing and quality of life.

[17] Wilkinson, R., & Pickett, K. (2018). *The Inner Level: How more equal societies reduce stress, restore sanity and improve everyone's well-being*. London, Penguin.

- Further work to reduce the stigma associated with perinatal mental health problems.
- Collection of, and access to, comprehensive data on the prevalence, incidence and treatment of perinatal mental health issues.
- Pregnant women and new mothers with mild or moderate perinatal mental health illnesses must be able to access timely services.
- Services should meet the needs of women but also understand the impact on other family members – whānau services are needed.

4. What sort of society would be best for the mental health of all our people

- One that addresses health inequity, including gender equity, racism and discrimination.
- Attention to deprivation, poverty, lack of housing, and access to health care.
- Support for all mothers, mothering and parenting – local, affordable, accessible, appropriate health and social services care.

Conclusion and summary

- The College do support increasing the range of diverse, free, accessible, culturally appropriate support services nationally for perinatal and mental health with attention being paid to equity of access to these services.
- The College support opportunities for discussion with women about their perinatal mental health, clear and open communication with women, and between health professionals about care.
- The College highlights the vital role played by midwives in terms of perinatal mental health support for women, which is well supported by the continuity of care model, and we recommend that appropriate funding and recognition of the increased workload for midwives be addressed.
- When appropriate the College supports the use of the least interventionist management as a first option.
- The College does not support mandatory mental health screening for all women.
- The College has considerable concerns that resources and funds for supporting any care plan, including the services to make referrals to, are not freely accessible to all women, or parents, to the level that they will be required when mental health services are reviewed and further developed.

- The College feel strongly that building capacity and capabilities within services and the development of new services is paramount, and this requires evidence, planning, assessment, implementation and also evaluation and review.
- Cultural competence and the ability to be responsive to cultural needs are essential. Well - funded sustainable kaupapa Māori mental health services are needed.
- The College recognises the potential economic benefits of early intervention to prevent or reduce perinatal mental illness, the importance of investment in early intervention services and midwifery, and the need for well-funded non-acute and acute, sustainable services across New Zealand regionally.

The College is grateful to have the opportunity to provide a submission to this mental health and addiction inquiry and we wait with interest to hear the results of this critical and overdue national conversation about mental health, and to the development of, robust, free, accessible, equitable and culturally appropriate services for women and their whānau, and for increased support for midwifery care.

Yours sincerely

New Zealand College of Midwives

376 Manchester Street / PO Box 21106 Edgeware Christchurch / Telephone (03) 377 2732 / Facsimile (03) 377 5662 / Email nzcom@nzcom.org.nz