New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

11th December 2019

Mental Health and Wellbeing Commission Bill

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. Our members are employed and self-employed and collectively represent over 90% of the practising midwives in this country. There are approximately 3,000 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 followed by a first year of practice program that includes full mentoring by senior midwives. 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
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

11th December 2019

Committee Secretariat
Committee Secretariat
Health Committee
Parliament Buildings
Wellington

he@parliament.govt.nz

Mental Health and Wellbeing Commission Bill

The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the Mental Health and Wellbeing Commission Bill and we feel encouraged to hear statements from the Hon Dr David Clark, Minister of Health, stating that this Government is taking mental health seriously. The reestablishment of a Mental Health Commission is a very positive move which backs up this statement. The College also notes the recent opening of the first Suicide Prevention Office and the $12 million Māori and Pacific suicide prevention community fund which are positive initiatives to start seriously addressing the high suicide rates in Aotearoa New Zealand.[1]

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.

The College understands that transforming mental health and wellbeing systems in Aotearoa New Zealand will take time and alignment across sectors, and between Government and non-Government players. In terms of a whole of system view we support the inclusion of maternal mental health and wellbeing as an integral part of any strategy for positive change. With the establishment of a Mental Health Commission in mind we submit the following key points for consideration.

[1] Government opens New Zealand's first Suicide Prevention Office. Stuff, Nov 27, 2019. Thomas Coughlan. https://www.stuff.co.nz/national/117738791/pm-jacinda-ardern-and-david-clark-open-suicide-prevention-office

1. Midwives are 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 and that all efforts to support perinatal mental health and well-being are critically important for not only women but for infants, children and whānau.

2. A project examining the costs of perinatal mental health problems in the UK found that perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.[2] The Chair of the Mental Health Alliance, Dr Alain George, states in the foreword, *"We hope this shocking statistic will motivate policy makers, commissioners and providers to act urgently."* The report also notes that to bring the full pathway of perinatal health care up to national recommended guidelines in the UK would be £280 million per year and suggests, *"This is a case for investment that cannot be ignored."* Perinatal mental health in Aotearoa New Zealand also requires significant investment and cannot be ignored. The College recommends this compelling report be taken into account by the Mental Health Commission.

3. As reported by the Perinatal and Maternal Mortality Review Committee (PMMRC) the single largest cause of maternal death in Aotearoa/New Zealand is suicide. The 2019 PMMRC report describes 66 direct maternal and 44 indirect maternal deaths over the period from 2006–2017 inclusive, with suicide accounting for 30 deaths during this time (45%). [3]

4. In 2018 the PMMRC recommended that the Ministry of Health should fund a maternal and infant mental health network to review current mental health services available across Aotearoa New Zealand for pregnant and recently pregnant women. They also recommended the establishment of a national pathway for accessing culturally appropriate maternal mental health services. [4] Now, in 2019, the PMMRC again draw attention to the issue of maternal mental health and suicide, and recommend comprehensive action is taken. [5]

---

[2] Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., and Adelaja, B. (2014). *The costs of perinatal mental health problems*. Personal Social Services Research Unit (PSSRU), London, Centre for Mental Health and London School of Economics.
[3] Perinatal and Maternal Mortality Review Committee. (2019). Whakarāpopototanga Matua o te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki | Executive Summary of the 13th Annual Report of the Perinatal and Maternal Mortality Review Committee. Wellington, PMMRC.
[4] Perinatal and Maternal Mortality Review Committee. (2018) Annual Report: Frequently asked questions https://www.hqsc.govt.nz/assets/PMMRC/NEMR-images-files-/PMMRC12thReport2018_FAQs.pdf
[5] Perinatal and Maternal Mortality Review Committee. (2019). Whakarāpopototanga Matua o te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki | Executive Summary of the 13th Annual Report of the Perinatal and Maternal Mortality Review Committee. Wellington, PMMRC.

5. One of the issues identified by the PMMRC was the variability of maternal mental health service provision and the limited resources available for women with mild to moderate illnesses in terms of access to services. [6] With suicide as the leading cause of maternal death in Aotearoa New Zealand and the limited resources available for maternal mental health, the College would like to see the PMMRC recommendations urgently addressed.

6. Pregnancy, childbirth and mothering are times of great significance in the lives of women. 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.

7. The Australian Government developed a document focussed on the social and emotional development and wellbeing of infants in pregnancy and the first year of life. Home visiting interventions were found to be of benefit starting before birth and in the first year of life.[7] Support for maternal mental health is significantly important to the wellbeing of infants.

8. 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. These challenging situations have an effect on midwives as well as women and their whānau.

9. Some issues that arise for midwifery care are related to a lack of support services, or specialist services to refer women to, in situations where additional needs have been identified. 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. These conditions add extra challenges for midwives in terms of the degree and intensity of their workloads.

10. As well as poverty and deprivation, the College recognises there are a range of factors which may increase the likelihood of depression arising during the pregnancy, childbirth and the postnatal period and these include; abnormal results from foetal screening; the birth of a

[6] Perinatal and Maternal Mortality Review Committee. (2019). Whakarāpopototanga Matua o te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki | Executive Summary of the 13th Annual Report of the Perinatal and Maternal Mortality Review Committee. Wellington, PMMRC.

[7] Australian Government / National Health and Medical Research Council. (2017). *NHMRC Report on the evidence: Promoting social and emotional development and wellbeing of infants in pregnancy and the first year of life*. https://aifs.gov.au/cfca/2017/05/08/report-evidence-promoting-social-and-emotional-development-and-wellbeing-infants

preterm, sick infant or an infant with congenital abnormalities, the loss of a pregnancy, ectopic pregnancy, stillbirth or neonatal death, or separation of the mother and infant due to adoption, care and protection, custody or incarceration issues.

11. Midwives are a primary workforce and in positions where they can identify perinatal mental health challenges early, support women during these times, and refer to specialist support when needed. However, sustainable, accessible, culturally appropriate services need to be developed 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, midwifery services and Well Child Services.

12. Midwives often become aware of mental health issues through history taking, as well as through relationship building 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 the midwifery scope of practice does not include mental health diagnoses their significant role as referrers to general practice or specialist services, is critical and should be supported.

13. Midwives are autonomous health professionals and practice on their own professional responsibility in New Zealand. 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. The College would like to see midwives enabled to make direct referrals to all non-acute mental health services in order to reduce barriers to accessing these services.

14. The College considers that it may be optimal to undertake a review and map 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. The development of a single point of entry referral systems for women with mental health concerns during pregnancy or postpartum would assist a seamless referral process, rather than expecting practitioners to keep abreast of continually changing services.

15. Racial and ethnic inequities contribute to poor health outcomes. Discrimination and its effects on health and wellbeing were 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.[8]

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

17. As described by Curtis et al., eliminating indigenous and ethnic health inequalities requires addressing the social determinants of health which include institutionalised racism. [9] A shift to an approach based on a transformative concept of cultural safety, which involves a critique of power imbalances and critical self-reflection, is described as being necessary to improve health inequities. Evidence of cultural safety as a requirement for accreditation of services is recommended.

18. Cormack et al., in a secondary analysis of Te Kupenga 2013 (the first Māori Social Survey) found that racial and other forms of discrimination are pervasive and experienced in multiple domains across the life course. [10] Cormack et al., reaffirmed the urgency with which the Government, its agencies and agents need to identify and take action to eliminate discrimination towards Māori.

19. 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

20. 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 and consistency can be achieved and this is paramount in mental health services. 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 services would also be a pre-requisite before any mental health screening programme

[8] 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).
[9] Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, 18(174): https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3
[10] Cormack, D., Harris, R., & Stanley, J. (2019). Māori experiences of multiple forms of discrimination: findings from Te Kupenga 2013. *Kotuitui New Zealand Journal of Social Sciences Online*, DOI: 10.1080/1177083X.2019.1657472

could be implemented. Setting up screening services without referral support options being developed first is unacceptable.

21. 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.[11]

22. 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%.[12] 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.[13]

23. The New Zealand College of Midwives has been providing family violence education for midwives since 2002, and this work has supported midwives to safely and effectively ask questions, respond, and refer appropriately when abuse is disclosed. Midwives work in partnership with women and are therefore well positioned to screen for family violence. Midwives do require ongoing support to address the issue of abuse against women and children within the national family violence strategy/framework.

24. The College strongly supports a significant investment in the first 1000 days of life, which requires a dedicated focus on health and wellbeing in pregnancy, and early childhood. There is a growing body of evidence showing maternity care is a critical building block for the foundation of health. Giving every infant the very best start in life is crucial to preventative health care and to reducing health inequalities across the life course.

25. Maternal wellbeing is essential to child wellbeing, and needs to be at the centre of decision making at policy level across all sectors such as health, mental health, social services and education. A healthy confident mother provides the essential environment for a healthy

[11] 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.

[12]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

[13] 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

nurtured infant. Midwives and midwifery care have the potential to reduce inequities that continue to threaten maternal and infant mental health and wellbeing.

Conclusion

The College recognises the importance of good mental health for the wellbeing of women who become mothers, as well as for their babies and members of their whānau. The College also 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 mental health services across Aotearoa New Zealand.

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 or any maternal mental health service development. College involvement directly with the Mental Health Commission would be desirable and an effective way forward.

The College is grateful to have the opportunity to provide a submission to the Mental Health and Wellbeing Commission Bill, specifically with the establishment of a Mental Health Commission in mind, and we look forward to the development of, robust, free, accessible, equitable and culturally appropriate services for women and their whānau.

Ngā mihi

Carol Bartle

Policy Analyst

New Zealand College of Midwives