Āhurutia Te Rito | It takes a village

How better support for perinatal mental health could transform the future for whānau and communities in Aotearoa New Zealand.

A report by Holly Walker, May 2022

Contents

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About Mahi a Rongo | The Helen Clark Foundation

Mahi a Rongo | The Helen Clark Foundation is an independent public policy think tank based in Tāmaki Makaurau Auckland, at the Auckland University of Technology. It is funded by members and donations. We advocate for ideas and encourage debate; we do not campaign for political parties or candidates. Launched in March 2019, the Foundation issues research and discussion papers on a broad range of economic, social, and environmental issues.

Our philosophy

New problems confront our society and our environment, both in New Zealand and internationally. Unacceptable levels of inequality persist. Women's interests remain underrepresented. Through new technology we are more connected than ever, yet loneliness is increasing, and civic engagement is declining. Environmental neglect continues despite greater awareness. We aim to address these issues in a manner consistent with the values of former New Zealand Prime Minister Helen Clark, who serves as our patron.

Our name

The ingoa/name Mahi a Rongo was gifted to us by Dr Haare Williams (Te Aitanga-a-Mahaki, Rongowhakaata, Ngāi Tūhoe) in early 2022. It literally translates as 'Work of Peace', with both mahi and rongo embodying multiple meanings and associations in te ao Māori. Mahi a Rongo is both what we aim to produce – public policy research that promotes peace, environmental stewardship, and care for all people – and how we aim to do it – by listening, collaborating, facilitating consensus, and supporting women and members of diverse communities to lead.

Our purpose

The Foundation publishes research that aims to contribute to a more just, sustainable, and peaceful society. Our goal is to gather, interpret, and communicate evidence in order to both diagnose the problems we face and propose new solutions to tackle them. We welcome your support: please see our website www.helenclark.foundation for more information about getting involved.

About The Tindall Foundation

The Tindall Foundation is a private philanthropic family foundation working throughout Aotearoa New Zealand. Our aim is to contribute to a stronger, more sustainable nation so that families, communities, and our environment thrive now and in the future. Our work is driven by a belief that all Kiwis should have the chance to achieve their full potential and contribute to a healthy, equitable, and inclusive society.

He oriori, he pūrākau, me he whakataukī: Epigraphs

A lullaby, a legend, and a proverb

Pō! Pō! E tangi ana Tama ki te kai māna!
Waiho me tiki ake ki te Pou-a-hao-kai,
Hei ā mai te pakake ki uta rā. Hei waiū mō Tama!

Baby! Pōtiki! The boy is crying for food!
Let it be fetched from the pile of netted seafood,
And the whale be driven ashore. As mother's food to make milk for the boy!

– *From* Pō! Pō! Pō! *an oriori from Te Aitanga-A-Mahaki, Ngati Porou, by Enoka Te Pakaru.*[1]

I was in awe with what had preceded me, with what had ensured my creation. Overwhelmed with responsibility, I felt the guiding hand of Papatūānuku in my prayers, in my blood and in my body. I felt the spirit of Ranginui in my mind and the breath of Tāne in my lungs. These things helped me understand. […]. I am Hineahuone, the creator of people.

– *'Hineahuone', from* Māori Myths, Legends and Contemporary Stories: A Trilogy of Wahine Toa*, by Wiremu Grace.*[2]

It takes a village to raise a child.

– *International proverb, origin unknown.*

About the project name *Āhurutia Te Rito*

The ingoa/name for this project was developed with the help of Dr Haare Williams (Te Aitanga-a-Mahaki, Rongowhakaata, Ngāi Tūhoe) in March and April 2022.

One meaning of the verb 'uru' is to enter, join, or be included – appropriate for a kaupapa surrounding birth and the moment when a pēpi enters Te Ao Mārama/the world of light. Building on this, 'āhuru' is to be warm, comfortable, or cosy, and when the suffix 'tia' is added, it conveys a change of state. Hence 'āhurutia' is to make something comfortable and cosy, or prepare a soft space, as a mother bird feathers her nest in preparation for her chicks.

'Te Rito' refers to the tender centre shoot of the harakeke/flax bush. As the new shoot grows, it is protected by the next layer of leaves that surround it, known as the Awhi Rito or the mātua/parents. These are in turn protected by the mature outer leaves. This image of harakeke sheltering the precious new growth is a common metaphor for the collective importance of whānau caring for tamariki/mokopuna in te ao Māori, and a fitting description of what this report advocates. In the words of Dr Williams, "there is no greater investment than in whenua, moana, ngahere, and the child – the jewel of heart, soul, and future."

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[1] Kuni Jenkins and Helen Mountain Harte, *Traditional Māori Parenting: An Historical Review of Literature of Traditional Māori Child Rearing Practices in Pre-European Times*, Te Kahui Mana Ririki and the Office of the Children's Commissioner, 2011.

[2] Wiremu Grace, 'Māori Myths, Legends and Contemporary Stories: A Trilogy of Wahine Toa', *Te Kete Ipurangi,* Ministry of Education, n.d..

He mihi: Acknowledgements

I am incredibly grateful to the following people and organisations who have assisted with the production of this report:

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Dr Haare Williams for the privileged opportunity to listen and converse with him to settle on the perfect image and ingoa for this project.

Elizabeth Emere Harte, Dr Hinemoa Elder, and the woman we have called Nazia for sharing their wisdom, experience, and aroha in their insightful Q&A contributions.

The many knowledgeable experts who kindly reviewed and improved the draft – even when it turned out to be three times longer than promised! – including: Dr Felicia Low from Koi Tū, Paulien Fa'atafa from Te Hiringa Hauora Health Promotion Agency, Olivia Stapleton and Chloe Shaw from the Mental Health Foundation, Treena Cooper and Leigh Bredenkamp from Perinatal Anxiety and Depression Aotearoa, Kelly Feng from Asian Family Services, Natalie Horspool, and Julie Fry.

Everyone I've just listed also generously shared resources, contacts, and time to kōrero about the project, as did Professor Sir Peter Gluckman from Koi Tū, Tanya Radford from Te Hiringa Hauora, Jane O'Malley (before her retirement) and more recently Karen Magrath from Whānau Āwhina Plunket, Maree Brown and Penny Gault from the Child Wellbeing Unit at the Department of Prime Minister and Cabinet, Heather LaDell and Rachel Noble from Capital and Coast District Health Board, Angela Demarais from Disabled Persons Assemby New Zealand, Lily Chalmers from Tākai, and Raewyn Stone from the National Council of Women New Zealand.

A professional editor, Madeleine Collinge, provided a detailed and sensitive proofread of the final draft at very short notice – huge thanks Madeleine!

My colleagues at Mahi a Rongo | The Helen Clark Foundation for practical and moral support: Kathy Errington, Tom James, Matt Shand, Paul Smith, Soraiya Daud, Grace Sinclair, and Ciaran Riddell.

Author’s note

In my experience as a policy analyst and researcher, it is not often someone offers you the opportunity and time to research and write about any topic you like, and when they do, you had better say yes. That’s what happened to me at the end of 2021 when I was preparing to finish up after two amazing years as the WSP Fellow at Mahi a Rongo | The Helen Clark Foundation. The Foundation’s Director, Kathy Errington, suggested I stay on for one more project on a topic of my choice. Was there a significant public policy challenge I had been burning to write about but hadn’t yet had a chance?

As it happened, there was. My own experience of perinatal distress is some years ago now, and I have written about it elsewhere, so I won’t recount it here. I am privileged (in more ways than one) that my family and I are now all well and have been for some time, but my personal reckoning with anxiety, rage, and self-harm after the birth of my first daughter eight years ago left me with many questions about exactly how mothers and birthing parents are supposed to cope with the myriad stresses and challenges that can accompany the birth of a new baby in contemporary Aotearoa.

Then, a few years ago in 2019, when I was working as an advisor to the then Children’s Commissioner Judge Andrew Becroft, I accompanied him to a meeting with Professor Sir Peter Gluckman. Sir Peter was there to share early findings from some ground-breaking international research into the long term determinants of child and family wellbeing. I was both staggered, and yet somehow immediately unsurprised, when he told us that maternal mental health (particularly during pregnancy) was emerging as perhaps the single biggest factor in determining long term child health and wellbeing. Wait, so we need to support mothers and birthing parents better? I thought. Well, blow me down with a feather.

Of course, Māori and Pacific peoples (and many other cultures for that matter) have long understood the importance of supporting birthing parents during the perinatal period (from conception until the baby’s first birthday). In te ao Māori, māmā and pēpi have special status, and tikanga and cultural practices around pregnancy and birth are intended to uphold them, enhance their mana, and surround them with collective support and aroha.

My tūpuna were from England and Scotland, and even in Celtic and Anglo-Saxon traditions you can find many rituals and cultural practices intended to support new mothers and protect new babies (chiefly from being stolen away by fairies). But in most modern, English-speaking, so-called ‘Western’ nations like Aotearoa New Zealand, healthcare and maternity policies and services have come to be strongly dominated by a focus on the baby, sometimes at the exclusion of the birthing parent. It’s as if we think the baby’s interests and needs can somehow be separated from those of their whānau.

This can lead to the early signs of maternal distress going unnoticed, or parents missing out on support with things like feeding, sleep, and domestic work that would make a huge difference to their recovery. At the extreme end, it can lead to babies being removed from their whānau, pregnant people or new parents dying by suicide, or new parents struggling with addiction or psychosis.

In reality, of course, what a baby needs, and what their parents and whānau need, are one and the same, as the research Sir Peter shared with Judge Becroft clearly demonstrated (this research has subsequently been published and is cited extensively here).

I left that meeting in 2019 thinking about how if we could identify what is contributing to perinatal and maternal distress, and then prioritise public policy and investment to alleviate those stressors, we would be a long way towards addressing the inequity, intergenerational disadvantage, and poor outcomes that can sometimes seem so entrenched and immovable for those who work on child and whānau wellbeing.

Supporting birthing parents – and the whole whānau that loves a new baby – *is* what's best for that baby. It's also what's best for us all. How to do this, and do it *well*, is a significant public policy challenge for Aotearoa New Zealand. With huge gratitude to the Foundation for the opportunity, and to the many experts who helped with the research, this report is my attempt to answer that challenge.

– Holly Walker, April 2022

Specialist terms defined

Perinatal period	The period from conception until the baby's first birthday
First 1000 Days	It is common to see references to the First 1000 Days in government policy and academic literature related to perinatal wellbeing. The First 1000 Days overlaps with the perinatal period, starting with conception but extending to a child's second birthday. During this time, a baby's brain develops more quickly than at any other time of life. The events and environments (both positive and negative) that a baby experiences during this period have a major influence on their long term wellbeing.
Perinatal distress, including definitions of ante- and postnatal anxiety, depression, and psychosis	Perinatal distress is an umbrella term used to describe the symptoms and experience of depression, anxiety, and stress during the perinatal period. It usually refers to mothers/birthing parents, but can also be experienced by fathers/non-birthing parents. These conditions can be experienced antenatally (during pregnancy) postnatally (after birth; also known as post-partum), or both. Conditions under the perinatal distress umbrella include: **Perinatal depression**: persistent low mood and/or loss of interest during the perinatal period. Symptoms include feeling sad, empty, or hopeless; crying for no apparent reason, loss of interest or pleasure in life, physical symptoms such as changes in appetite, headaches, changes in sleep patterns, racing heart, or sweaty palms; loss of energy/fatigue; difficulty concentrating or making decisions; thoughts of or attempts at self-harm or suicide. **Perinatal anxiety**: overwhelming feelings of worry or fear during the perinatal period that interfere with daily life. Symptoms include difficulty concentrating or focussing, restlessness, excessive and generalised worry, irritability, panic attacks, muscle tension, sleep disturbance, appetite changes, and other physical symptoms like heart palpitations, sweaty palms, and stomach complaints. **Perinatal Obsessive-Compulsive Disorder (OCD)**: repetitive thoughts or images causing anxiety and stress, often followed by repetitive actions to reduce the anxiety, often (but not always) revolving around baby's safety. Thoughts may include fears about baby being harmed, worries about parental action/inaction in relation to baby's safety, and distressing thoughts or images of harm to baby. Behaviours in response can include repetitive and

	unnecessary washing, frequently checking that baby is breathing, seeking repeated assurance from others, counting, praying, or repeating words, and avoiding certain situations or activities. A smaller number of birthing parents experience **postnatal or post-partum psychosis**. This is a severe illness that can start suddenly in the days or weeks after having a baby and is considered an emergency. Symptoms include mania, depression, rapid mood changes, confusion, loss of inhibitions, hallucinations, paranoia, and delusions. Postnatal psychosis is much less common than other forms of perinatal distress.
Mental health/wellbeing	The Ministry of Health's Long term Pathway to Mental Wellbeing defines 'Mental wellbeing' as "one component of broader wellbeing, and more than simply the absence of mental illness. Positive mental wellbeing is most likely when people feel safe, connected, valued, worthy and accepted and have a sense of belonging, identity and hope for the future. Mental wellbeing means being able to adapt and cope with life and life's challenges and feeling that your life has meaning, as well as experiencing feelings of contentment or general happiness."[3]
Social support	Social support is generally defined as "perception or experience that one is cared for, esteemed, and part of a mutually supportive social network"[4]
Instrumental support	Instrumental support refers to the "provision of concrete resources or assistance, such as lending money, providing childcare, or driving a sick friend or family member to the doctor."[5]
Birthing parent	Throughout this report we use the inclusive term 'birthing parent' in place of mother and/or women, in recognition of the fact that not everyone who is pregnant or gives birth is a woman, and that not all mothers are birthing parents. Sometimes though, when quoting or paraphrasing others' research, we use women and/or mother in that context. We recognise that the majority of birthing parents *are* women, and that the particular social and cultural

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[3] Ministry of Health, *Kia Manawanui Aotearoa: Long term Pathway to Mental Wellbeing*, 2021.

[4] Marçal, 'Perceived Instrumental Support', 2021.

[5] Marçal, 'Perceived Instrumental Support', 2021.

	expectations placed on mothers can be a source of perinatal stress. Our use of inclusive language does not diminish the feminist lens with which we have approached this work.

Te reo Māori terms defined

Āhurutia	*To make something comfortable and cosy, or prepare a soft space, as a mother bird feathers her nest in preparation for her chick*
Hapū	*Pregnant; also, a kinship group, clan, tribe, subtribe – section of a large kinship group and the primary political unit in traditional Māori society*
Iwi	*Extended kinship group, tribe, nation, people – often refers to a large group descended from a common ancestor and associated with a distinct territory*
Karakia	*Incantation, ritual chant, prayer – a set form of words to state or make effective a ritual activity*
Kaupapa Māori	*A Māori approach, Māori principles; a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society*
Māmā	*Mother, or mothers*
Matua	*Parents*
Mokopuna	*Grandchildren, grandchild - child or grandchild of a son, daughter, nephew, niece; descendent*
Oriori	*A lullaby or song composed for or sung to a child about their ancestry and tribal history*
Pēpi	*Baby, or babies*
Pito	*The stump of the umbilical cord*
Pūrākau	*Myth, legend, or oral history*
Takatāpui	*A traditional term meaning 'intimate companion of the same sex,' more recently reclaimed to embrace all Māori who identify with diverse sexes, genders and sexualities.*
Tamariki	*Children*

Tapu	*Sacred, restricted, set apart, under protection*
Tauiwi	*Someone who is non-Māori*
Te ao Māori	*The Māori world*
Te Rito	*The tender centre shoot of the harakeke/flax bush. As the new shoot grows, it is protected by the next layer of leaves that surround it; metaphor for a baby being cared for by whānau*
Te Tiriti o Waitangi	*The Treaty of Waitangi (Māori version)*
Tūpuna	*Ancestors, grandparents*
Whakapapa	*Genealogy, genealogical table, lineage, descent*
Whakawhanaungatanga	*Process of establishing relationships*
Whānau	*Extended family – the primary economic unit of traditional Māori society*
Whanaungatanga	*Relationship, kinship, family connection; a relationship through shared experiences and working together which provides a sense of belonging*
Whenua	*Placenta; also land, ground, territory*

Executive summary

Every birthing parent, newborn pēpi, and their whānau should be surrounded with aroha and support during the joyful, challenging, and sometimes overwhelming period at the start of a baby's life. This is the vision that sits behind this report. If realised, it would give parents and pēpi the best possible chance of staying well and contribute significantly to improved whānau, community, and intergenerational wellbeing.

Pregnancy, birth, and the postnatal period have always been times of huge transition for birthing parents and their whānau. While the perinatal period (from conception until a baby's first birthday) can be a time of joy and celebration, it can also be one of the most physically and emotionally vulnerable experiences of someone's life, even for parents with good access to mitigating factors like adequate financial resources, secure housing, and strong support networks. For the many whānau whose access to these protective factors is thin or fraying, the risks are even greater, both of experiencing distress during the perinatal period, and of suffering additional harm as a result of that distress.

Māori and Pacific cultures have long understood the importance of adequately supporting birthing parents and babies during the crucial perinatal period. In te ao Māori, Pacific cultures, and many other cultural traditions, birthing parents and new babies are accorded special status, and rituals and traditions during and after pregnancy uphold and surround new parents and babies with collective support. It is widely understood that the strong bonds between parents and babies, safe, secure home environments, and access to practical and emotional support are vital for new parents and important for long term whānau and family wellbeing.

A growing body of scientific and academic research is now catching up with these cultural practices, illustrating the physiological significance of parental mental health, and incorporating cultural practices and Indigenous knowledge systems into the academy. There is a clear convergence of many kinds of evidence that parental distress during the perinatal period can have severe consequences for both parents themselves, and for their babies. This is especially concerning right now, at a time when District Health Boards (DHBs) are reporting increasingly complex maternal mental health needs and high unmet need for support.

This enhanced knowledge of the impact of perinatal distress presents an important opportunity. If we can understand what contributes to this distress and put in place policies to actively remove or alleviate it, we can not only support parents who are struggling right now, but also significantly improve intergenerational outcomes. This is a critical public policy challenge, and the subject of a current Productivity Commission inquiry.

This Report addresses the following question:

What are the stress factors contributing to poor mental health amongt new and expectant parents in Aotearoa New Zealand, and how can we use good public policy to alleviate these and surround parents with the support they need?

To answer this question, we considered tikanga and mātauranga Māori, voices of lived experience, evidence of best practice in clinical and public health settings, the expertise of community-led, kaupapa Māori and culture-based family/whānau support organisations, and the latest academic and scientific research, including academic research led by Māori that foregrounds mātauranga. From this analysis, we have distilled three key insights:

1. Better support for perinatal mental health would be transformational for whānau and communities in Aotearoa New Zealand.
2. Perinatal distress in Aotearoa is widespread, complex, and linked to systemic inequities.
3. Making sure parents and whānau have access to support is the best way to protect perinatal mental health, and contributes directly to wider whānau wellbeing.

This report summarises the evidence and key findings that led us to each of these insights. Taken together, they make the case that if we are serious about addressing intergenerational wellbeing in Aotearoa New Zealand, we will need to prioritise perinatal mental health in our newly reformed health system.

Unfortunately, our current policies and services are insufficient to meet current and likely future perinatal and maternal mental health needs. With the right policy settings, though, we could change this trajectory, and there are important opportunities for change right now.

We conclude by suggesting that political leaders and those designing the new health system should prioritise policies that:

- alleviate or remove background stress for new and expectant parents by making sure they have warm, secure, affordable housing, adequate food, and that they are safe from violence and abuse
- make it easier for whānau/families to spend time with and support new parents and pēpi
- ensure birthing parents have access to continuous, holistic maternity care, supportive birth environments, and tailored assistance to mitigate the increased risk of distress for some groups
- resource and empower kaupapa Māori and community-led initiatives to better support new parents, babies, and their whānau
- assist all who work with new and expectant parents and their babies, as well as their whānau, to develop the skills to recognise when parents are at risk of distress, identify what kind of support they need, and move quicky to provide it
- provide parents with hands-on practical support for aspects of parenting and daily life when required
- provide fast access to affordable, culturally appropriate therapeutic services for parents at risk of distress and with mild to moderate clinical need
- guarantee immediate access to specialist clinical support when parents become seriously unwell

At the time this report is being published, in mid-2022, there are some particularly pertinent opportunities to embed a strong future focus on perinatal mental health and wellbeing. Major reforms are underway in both the wider health system, and the mental health sector in particular, while the government is likely to act on the recommendations of a major inquiry by the Productivity Commission into the prevention and reversal of intergenerational disadvantage.

Within that context, we have identified four immediate opportunities to strongly embed the approach outlined above:

- Prioritise perinatal and maternal health in the reformed health system.
- Develop a perinatal mental wellbeing action plan for Aotearoa New Zealand.
- Amend the Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill to ensure mental injuries from birth trauma are covered.

- Encourage the Productivity Commission to emphasise the potentially transformative role of supporting perinatal mental health for addressing intergenerational disadvantage.

This report is partly intended as a conversation starter. Now it has been published, we hope Mahi a Rongo | The Helen Clark Foundation can play a facilitative role to encourage concrete progress on some of these opportunities. Our next steps will be to:

- hold a public webinar to disseminate our findings and invite feedback
- discuss our insights and suggestions with experts, clinicians, and key decision-makers
- facilitate a roundtable event with key stakeholders to progress concrete action
- publish a final report summarising the outcomes of this project

Insight 1: Better support for perinatal mental health could be transformational for whānau and communities

Many cultural traditions accord special status to parents and new babies, and surround them with support, for good reason

Support for māmā and pēpi in te ao Māori

Māori and Pacific cultures have long understood the importance of adequately supporting birthing parents and babies during the crucial perinatal period (the period from conception until a baby's first birthday). In te ao Māori and many Pacific cultures, māmā/birthing parents and pēpi are accorded special status, and tikanga and cultural practices uphold and surround new parents and babies with collective support.

This is the idea encapsulated in the title of this report – Āhurutia meaning to make something warm, comfortable, or cosy (like a mother bird who prepares a soft nest for her baby), and Te Rito meaning the tender centre shoot of the harakeke, or flax bush. The image of the Rito being sheltered and protected by the Awhi Rito (also known as the mātua, or parents), in turn protected by the outer leaves of the harakeke, is a common metaphor for the collective importance of whānau caring for their tamariki/mokopuna.

> *In te ao Māori, Māmā and pēpi are accorded special status, and tikanga and cultural practices uplift and surround them with collective support.*

For Māori, these practices date back to before the arrival of European settlers in Aotearoa. Waiata, karakia, pūrakau, and oriori reveal the importance of what is now called by some 'the perinatal period' for collective wellbeing in the pre-colonial period. Pregnant wāhine ate special health-giving foods gathered for them by others, and gave birth while incantations were chanted to protect them and guide their pēpi into te ao Mārama – the world of light. Birthing rituals included roles for many members of the wider whānau and hapū, and, following the birth, special blessings and lullabies were recited to pēpi to connect them to their whakapapa and invoke the gifts, abilities, or roles they would contribute to the collective.

Even the words used to describe to these practices reveals the central importance of pregnancy/birth rituals to the wellbeing of the collective in te ao Māori. The kupu 'hapū' refers both to the state of being pregnant, and to extended kinship networks of whānau descended from a common ancestor. The kupu 'whenua' refers both to land – intrinsically important and inseparable from people in te ao Māori – and to the placenta, which is always returned to the whenua and buried after birth.

Pre-contact Māori practices relating to pregnancy and birth revolved around what whānau advocate, educator, and facilitator Deb Rewiri (Ngāpuhi, Ngāti Awa,Te Whānau-ā-Apanui) has called "holistic nurturing." Rewiri notes that care and time was devoted to whanaungatanga – establishing and strengthening connections between people – before and after a birth. In modern physiological terms, we know that practices like this reduce the stress response in the brain and body and help to put mothers, babies, and whānau members at ease.[6]

In te ao Māori, the key units of economic and social life are collective – whānau, hapū, and iwi. In pre-colonial times, kainga/home communities consisted of small units of 30 to 45 people where "everyone helped with the children and were committed to raising the next generation."[7] These groupings included grandparents, uncles and aunts, older cousins and siblings who all shared in the work of childrearing, in the model of the 'primal whānau' in Māori cosmology: Ranginui, Papatūānuku, and their various offspring and mokopuna.

Pēpi were also considered tapu, or sacred, and were thought to be the closest human beings could be to the atua/gods, born with inherent mana. Waiata, karakia, and oriori imparted to pēpi and tamariki ensured they were surrounded by positive messages and showed how they were valued and loved by their parents and whānau. Adults, too, were constantly reminded of the special nature of children.[8]

Many of these beliefs, practices, and values from pre-colonial times have been maintained and continue to be upheld and practised in te ao Māori today, and some have even been adopted by tauiwi, such as the increasing popularity of retaining and burying the placenta/whenua after birth. Unfortunately, though, for generations of Māori experiencing the ongoing negative impacts of colonisation, many connections with traditional birthing and parenting practices have been severed. Advocates like Tūpuna Parenting founder Elizabeth Emere Harte (featured on page 17) are working to repair this breach by restoring the status of traditional Māori parenting practices and educating whānau Māori and the people who work with them about how to apply this knowledge in contemporary Aotearoa.

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[6] Deb Rewiri, 'Pregnancy and Childbirth, Traditional Knowledge Practices and Keys for Successful Support, presentation at a DPMC-hosted wānanga on early brain development, 2021 (notes taken by DPMC staff and appended to The Workshop's Report *Talking about Early Brain Development in Aotearoa New Zealand*, 2021).

[7] Jenkins and Harte, *Traditional Māori Parenting*, 2011.

[8] Jenkins and Harte, *Traditional Māori Parenting*, 2011.

‘What kind of tūpuna do I want to be?’ Q&A with Elizabeth Emere Harte of Tūpuna Parenting

Elizabeth Emere Harte (Ngāpuhi, Ngāti Porou) is the co-founder of Tūpuna Parenting, a movement to reclaim traditional Māori parenting ways and share this knowledge with whānau and the people who work with them. With Whānau Āwhina Plunket, she is currently working to train Plunket’s kaiāwhina workforce in Māori parenting knowledge and practice. Her professional background was as a software developer and roboticist, before moving into leadership and planning roles. She learnt about tūpuna parenting from her Mum, Helen Mountain Harte, a leading scholar on traditional Māori birthing and parenting practices. Elizabeth and Helen founded Pēpi Penapena (Cherish Babies) together in 2018, before Helen sadly passed away in 2019. In 2020, Elizabeth’s cousin, Dr Hirini Kaa, joined Pēpi Penapena as Chair, and they founded the Tūpuna Parenting movement in 2021. Elizabeth’s other mahi is as māmā to three young tamariki, whom she treasures and adores.

Tēnā koe e Liz. Let's start with some whakawhanaungatanga. Ko wai koe? What should we know about you and your whānau?

Tēna koutou katoa. He uri tēnei nō Ngāpuhi, nō Ngāti Porou. Ko Walter Clapham Mountain raua ko Emere Makere Waiwaha Kaa ōku tūpuna. Ko Michael raua ko Helen Mountain Harte ōku mātua. Ko Elizabeth Emere Harte tōku ingoa.

In your working life, you’ve gone from being a software developer and roboticist to helping Māori parents and the people who support them learn to decolonise their parenting. That’s quite a journey! How did it come about?

I was always very interested in computers and technology as a kid, and did well with maths, so getting into computer science was an obvious career path for me. But as my career evolved, I became less interested in the technology and more interested in supporting my team and helping them succeed. Then I got into product strategy, planning, and user experience design, focusing on what the customer needed – the people-oriented stuff. The big perspective shift came, of course, once I had my first pēpi in 2016. Suddenly, the tūpuna parenting work my Mum had been doing for almost 20 years was important and completely relevant.

In 2018, Mum and I decided to start working together to share tūpuna parenting ways online. Our skills were a great mesh for this kaupapa. I learnt so much about tūpuna parenting ways from Mum during that year before she passed away, and I am so proud to be continuing her work.

What do we know about how Māori parented in pre-colonial times, and how have these practices continued or changed in the two hundred or so years since? What does it mean to talk about decolonising parenting?

Tūpuna Māori had these beautiful and fundamental beliefs about pēpi and tamariki. They believed pēpi were born tapu, sacred and protected, and were born with mana. They believed all pēpi inherited tapu and mana from their whakapapa and from the atua (spirit world).

By being tapu, this meant our tūpuna would protect pēpi and tamariki from all harm, including yelling, insults, and smacking. With their mana, this meant our tūpuna would respect pēpi and tamariki right from birth. It was embarrassing for our tūpuna if pēpi cried for any reason, and they would listen and respond to their tamariki, even at large hui. They wanted pēpi and tamariki to be bold, brave, and independent when they were young, so they would have these qualities when they grew up.

European parenting at the time was a stark contrast. Women and children were effectively the property of their husbands and fathers. Children were to be seen and not heard, and physical punishment was used by parents and teachers to ‘teach children a lesson’, as were insults and humiliation.

Colonisation undid much of Māori culture, including our parenting and whānau relationships. When we talk about decolonising parenting, we’re talking about reclaiming our whakapapa, re-Indigenising our parenting ways, and reflecting on our whānau relationships in a way that’s informed by our tūpuna.

What are the stories from your own whānau that inform how you think about these things?

This kaupapa is grounded in mātauranga (Māori knowledge) and central to that is mātauranga-a-whānau (whānau knowledge). Our whānau pūrākau (oral histories) are an insight into how our tūpuna did things, looking into the past using the voices of our elders. Tapu and mana are such intangible values to describe that sometimes they are best described through lived experience.

For example, our whānau all bury the whenua (placenta) and pito (cord stump) of our pēpi at ‘home’, wherever that may be. Some of my cousins have buried theirs down in Rangitukia, mine are at Te Rawhiti, and Nanny and Grandpa’s were in Kaikohe and Kawakawa where their pēpi were born.

Another whānau story is about my Mum’s parents, Emere Makere Waiwaha Kaa (1901–1996), and Walter Clapham Mountain (1908–2000). They had three tamariki, and they never smacked them or raised their voices in anger – and they were raising their whānau in the 1940s, when getting a hiding was pretty common. But they knew their whānau was tapu, and they protected them in many ways.

My third whānau story goes back another generation, and is about my great grandfather, Nanny's Dad, Panikena Kaa (1872–1948). He used to bury their whenua and pito of their whānau under a particular tree behind the house, all 16 or so. One day after a big storm, the tree fell down the bank and died. To him this tree was so tapu, so sacred, that he held a three-day tangi for the tree and grieved its loss. He showed the tree the respect it deserved as a tapu place, a tapu object. And our pēpi and tamariki should also be respected, acknowledging their tapu every day in many ways.

These stories are lessons from our past, and we’re pulling them into our future. They make me think about ‘what kind of tūpuna do I want to be’ for my whānau and whakapapa? What stories do I want to be remembered for? What lessons do I want to share through my actions? This guides the kaupapa as it guides how I live my life.

This report is about parents’ mental health during and after pregnancy, and how our public policies can support and protect this. Of course, we need to look at much more than just the presence or absence of a diagnosis. How would you define wellbeing for whānau with new pēpi, or who are getting ready to welcome new pēpi?

Whānau wellbeing all depends on the definition of whānau. For Māori, it is important to remember that whānau is not just the nuclear whānau but also the wider whānau and even the community that supports them. That’s perhaps the crux from tūpuna Māori: it was the whānau who helped with a new pēpi.

For example, when a pēpi was born, māmā wouldn't cook or work until the pito fell off, so they could have dedicated time with pēpi. The whānau would do the work and look after any other tamariki during this time. In te reo Māori, 'whaea' means both mother and aunty, and 'matua' means both father and uncle. This is significant because it's another example of whānau support. The whole whānau shared in the upbringing of pēpi and tamariki, so when you called out 'Whaea' you were interchangeably speaking to either your Mum or your Aunty. Both would nurture you and provide you with care. Early explorers also noted if māmā couldn't exclusively breastfeed for some reason, other whānau might breastfeed their pēpi too.

So the question is, really, what does wellbeing look like for whānau? From a tūpuna standpoint, it's about acknowledging the tapu and the mana of your pēpi and everyone in the whānau. This means the whole whānau are teaching and raising a person, a rangatira (chief) of tomorrow. It's not just the parents – grandparents, aunties, uncles, and siblings will all help raise the next generation together.

How will you measure the success of your mahi? What do you hope for?

The dream is that we break that awful Once Were Warriors stereotype that has created a bias against our people and tarnished the memories of our tūpuna. Everyone knows our tūpuna were great warriors – women and men – and some know they were explorers, farmers, philosophers, and much more too. But not everyone remembers that those warriors were raised gently and respectfully, without smacking or shouting, and that they in turn raised their pēpi and tamariki gently too. By not punishing tamariki when they were young, they encouraged bravery and independence. Our tūpuna absolutely believed that.

The dream is that all whānau know that pēpi are born tapu and with mana, and that this meant our tūpuna didn't smack or shout at their whānau. Then those whānau members can become the inspiring tūpuna their mokopuna will remember fondly. They'll become the Nan and Koro in the whānau pūrākau, remembered for passing on tūpuna parenting ways and raising their whānau gently. Wouldn't that be the most beautiful thing? It'll take time, but I know we'll get there.

Support for mothers and babies in Pacific cultures

'Pacific peoples' is a collective term for diverse ethnic and cultural groups with heritage links to Pacific island countries. The seven largest Pacific ethnic groups in New Zealand are Samoan, Cook Islands Māori, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan.[9]

When we talk about Pacific peoples we are talking about a diverse range of cultures. There are many island nations in Te Moana Nui a Kiwa (the Pacific Ocean) and many ethnicities, cultures, and languages that originate from those islands. Today in the early 21st century, many Pacific peoples in Aotearoa are of mixed Pacific ethnicity, whakapapa Māori, or have European heritage – frequently all three. Many were born here, as were many of their parents and grandparents, and some have never visited their 'home' islands.

For these reasons, we need to be careful not to generalise about the role of mothers and babies or the significance of the perinatal period in Pacific cultures. However, there are some core tenets that are common among Pacific communities. Some of these are encapsulated in the Fonofale model of health, a system of wellbeing developed by Samoan-born academic Fuimaono Karl Polotu-Endemann that acknowledges and embraces elements of Samoan, Cook Islands, Niuean, Fijian, Tokelauan and Tongan culture.

In this model, built around the idea of a Samoan fale or house, the floor or foundation is the aiga or extended family network, including links formed by partnership or agreement. The roof is culture – beliefs and values systems that provide shelter. The foundation and roof are linked and supported by four pou representing holistic aspects of wellbeing.[10]

> *Many traditional beliefs and practices in Pacific cultures resonate with what we now understand about the importance of the perinatal period and early brain development. – Dr Teuila Percival (paediatrician)*

Invoking this model, paediatrician Dr Teuila Percival has noted that many traditional beliefs and practices in Pacific cultures resonate with what we now understand about the importance of the perinatal period and early brain development. Caring for and raising children was traditionally and is still seen as a collective responsibility, and childcare is commonly shared by all members of the aiga, including grandparents, easing the burden of stress on parents. Family stories are shared and passed down between generations to establish and maintain links of connection and belonging, and children and babies are celebrated including (in Samoan culture) on Lotu Tamaiti (White Sunday), a national holiday and day of religious observance dedicated to honouring children.[11]

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[9] Health Quality and Safety Commission New Zealand, *Bula Sautu - A Window on Quality 2021: Pacific Health in the Year of COVID-19*, 2021.

[10] 'A Resilient Home: The Fonofale Model of Health' (https://www.springboardtrust.org.nz/news/a-resilient-home-the-fonofale-model-of-health).

[11] Dr Teuila Percival, 'Pacific Child Health and Wellbeing - Knowledge and Practices', presentation at a DPMC-hosted wānanga on early brain development, 2021 (notes taken by DPMC staff and appended to The Workshop's Report *Talking about Early Brain Development in Aotearoa New Zealand*, 2021.

Support for new babies and birthing parents in other cultural traditions

Similar beliefs about the special status of new babies and birthing parents during and after pregnancy are found in many cultures, including in many tauiwi groups now well-established in Aotearoa.

In many Asian cultures, for example, it is common for birthing parents to spend time in confinement after childbirth. During this time, which can last between three weeks and several months, they may eat traditional foods to assist with their recovery from pregnancy and birth and observe certain restrictions such as no heavy lifting, bathing, or hair washing. New parents are often supported to observe this period of confinement by extended family, and it is not unusual for a birthing parent's own parents or in-laws to live with the family either permanently or for the period of confinement to help with childcare, meals, and domestic work.

Many cultures observe specific rituals following the birth of a baby to support birthing parents and help them stay well.

More generally, systematic academic studies of traditional postpartum care around the world reveal that many cultures observe specific rituals following the birth of a baby to support birthing parents and help them stay well. Common themes include organised support, periods of rest, prescribed or prohibited foods to promote recovery, particular hygiene practices, and rituals related to infant care and breastfeeding. As the authors of one study noted, "these rituals allow the mother to be 'mothered' for a period of time after the birth [and] may have beneficial health effects as well as facilitate the transition to motherhood."[12]

While similar traditions to keep mothers and babies safe date back hundreds of years in Aotearoa's Pākehā settler cultures, including in Anglo-Saxon and Celtic traditions, in contemporary English-speaking societies, standard postnatal care tends to have a strong focus on the baby, sometimes at the expense of the birthing parent.[13] While many midwives practise holistically and attend to the wellbeing of both birthing parents and babies in the postnatal period, this is not a standardised expectation. Especially in hospital settings, over-stretched staff may only have capacity to attend to the immediate physical needs of birthing parents, missing an important opportunity to assess and prioritise their mental wellbeing.

Scientific research is catching up with the importance of perinatal mental wellbeing

In recent decades, though, a growing body of scientific and academic research has emerged that illustrates what traditional cultural practices have long inferred about the importance of perinatal wellbeing for long term child outcomes and extended family wellbeing, both by demonstrating the physiological and psychological consequences of parental distress during the perinatal period, and by expanding the definition of academic knowledge to incorporate Indigenous and traditional knowledge systems.

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[12] Cindy-Lee Dennis et al., 'Traditional Postpartum Practices and Rituals: A Qualitative Systematic Review', *Women's Health*, 3.4, 2007.

[13] Dennis et al., 'Traditional Postpartum Practices and Rituals', 2007.

It is now well understood that the environments and experiences we are exposed to in childhood play a powerful role in shaping both our socioeconomic status and our wellbeing as adults. In one recent British study based on two longitudinal studies, researchers concluded that "the effect of childhood and family does not then fade away over time. […] it is childhood emotional health that is the strongest predictor of adult life satisfaction."[14]

> *The environments and experiences we are exposed to in childhood play a powerful role in shaping our wellbeing as adults.*

Researchers here in Aotearoa have spearheaded important longitudinal research highlighting the importance of early childhood experiences. Studies like the Dunedin Multidisciplinary Health and Development Study, the Christchurch Health and Development Study, and more recently, Growing Up in New Zealand, have been instrumental in highlighting the critical importance of these earlier experiences for long term child and family wellbeing.

Now in its fourth decade, the Dunedin Study is intergenerational, involving many of the children of original participants. One workstream focuses on the parenting experiences of study members and in 2005 found that "mothers who experienced more supportive rearing throughout their own childhoods provided more such care when interacting with their young children."[15] Findings like this highlight that if we get our policy settings right to support today's parents and their wellbeing, we will also be supporting their children and even their children's children.

In recent decades, Indigenous leaders have developed holistic models of health and wellbeing using traditional knowledge, such as Te Whare Tapa Wha, a Māori model of a unified theory of health developed by Tā Mason Durie,[16] and the Fonofale model of Pacific wellbeing developed by Fuimaono Karl Polotu-Endemann.[17] These models are increasingly used and understood in academic and clinical settings, expanding definitions of science and research to encompass Indigenous knowledge systems, and encouraging clinicians and public health professionals to take an increasingly holistic and collective approach to health and wellbeing. While evidence of their influence is also beginning to be seen in policy development, they are yet to be translated effectively into the kind of fundamental shifts in investment and service delivery their full implementation would require.

Perinatal distress can have severe consequences

Building on these now established findings about the importance of early childhood experiences and holistic wellbeing, in recent years, researchers have begun to pay closer attention to the role and consequences of perinatal distress and mental illness in shaping individual and family outcomes.

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[14] Sarah Flèche, et al., 'The Long-Lasting Effects of Family and Childhood on Adult Wellbeing: Evidence from British Cohort Data', *Journal of Economic Behavior & Organization*, 2021.

[15] Jay Belsky et al., 'Intergenerational Transmission of Warm-Sensitive-Stimulating Parenting: A Prospective Study of Mothers and Fathers of 3-Year-Olds', *Child Development*, 76.2, 2005.

[16] Tim Rochford, 'Whare Tapa Wha: A Māori Model of a Unified Theory of Health', *Journal of Primary Prevention*, 25.1, 2004.

[17] 'A Resilient Home: The Fonofale Model of Health'.

Perinatal distress creates suffering and stress for parents

> *I couldn't laugh, watch TV, or read. All the things that I knew used to make me laugh and feel good were gone. It felt like looking at one of those music videos where everything rushes past except for the singer who is moving in slow motion and the video is shot in black and white. I felt nothing. The energy I normally got from looking at colour was gone. My joy at seeing a sunrise or sunset vanished. Then one awful day, I lay on the couch for hours and hours, staring up and out the window at the sky and knew I wanted to die. This out of control, panicked, incredibly sad pain was unbearable.*
>
> *– Kathryn (story shared with Perinatal Depression and Anxiety Aotearoa (PADA) and reproduced with permission)*

Perinatal distress causes significant pain, anguish, guilt, and grief for those who experience it. At a time that is expected to be one of joy and celebration, distressed parents can instead find themselves feeling – on the one hand – numb, isolated, disconnected, and tearful, or – on the other – agitated, manic, fearful, or panicked – sometimes both.

Perinatal distress can significantly disrupt parent-child bonding and attachment, leaving some parents feeling as though they have no meaningful connection with their baby. This in turn can become a source of considerable distress and guilt. It can get in the way of important opportunities for social connection, and over time it can chip away at supportive relationships and erode social networks, leaving parents even more vulnerable and isolated. It can also result in self harm.

Not surprisingly, then, perinatal mental disorders are associated with an alarming array of negative outcomes for parents who experience them.

Suicide is the leading cause of death for pregnant women and new mothers in Aotearoa New Zealand. No child should start their life bereaved.

At the most severe end, this includes death. Suicide is the leading cause of death for pregnant women and new mothers in Aotearoa New Zealand, a shameful fact that is both unacceptable and preventable. No child should start their life bereaved. Our maternal suicide rate is seven times that of the United Kingdom, but there are no other statistically significant differences between the two countries in terms of maternal mortality.[18] This suggests there is considerable scope for improved intervention here.

Such interventions need to urgently focus particularly on the needs of Māori mothers. According to the Perinatal and Maternal Mortality Review Committee, which reviews the deaths of mothers and babies during pregnancy or within six weeks of birth, more than half of pregnant of new mothers who have died by suicide since 2006 have been Māori, and wāhine Māori are more than three times

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[18] Health Quality and Safety Commission, *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee*, 2021.

more likely to die by suicide than Pākehā.[19] This is an egregious inequity and, arguably, a breach of the Crown's responsibilities under Te Tiriti o Waitangi.

Perinatal distress can also contribute to preventable maternal deaths from methods other than suicide. In the UK, recent enquiries have highlighted an increasing prevalence of substance misuse among women who died in the perinatal period, and have observed that women with substance misuse issues who died during the perinatal period had often received poor maternity and mental health care prior to their death. Perinatal distress can also contribute to preventable maternal deaths when the physical symptoms of life-threatening complications like pulmonary embolisms are wrongly attributed to the patient's mental health condition and are left untreated.[20] This is known as 'diagnostic overshadowing' and has been identified as a major barrier to physical health equity for those who experience mental illness and substance use/addictions in Aotearoa New Zealand.

Perinatal distress is strongly associated with wider systemic disadvantages like poor housing, low-income, food insecurity, and domestic abuse.

Perinatal distress can have myriad other severe consequences. It can impede emotional and physical wellbeing, healthy parenting, family functioning, employment status, and household financial wellbeing.[21] It is strongly associated with wider systemic disadvantages like poor housing, low income, food insecurity, and domestic abuse. For most of these factors, the relationship is bi-directional or two-way, meaning that not only does perinatal distress increase someone's likelihood of experiencing these outcomes, but experiencing any of these things during the perinatal period also increases someone's likelihood of developing perinatal distress. This creates a vicious and negatively reinforcing cycle from which the effects can be felt for many years. One longitudinal US study found that maternal depression in the first year was associated with increased likelihood of housing insecurity two and three years later, and even by the time children were entering adolescence it remained "a crucial factor in predicting risk for housing instability."[22]

Perinatal distress can have negative impacts for babies and hinder their development

> *I had frequent panic attacks, which would grip me in the stomach mainly and cause me to shake. I dreaded the sound of my baby's cries thinking I had no idea what to do to help her. I had no connection emotionally with my baby. – Kathryn*

Having a parent experiencing perinatal distress can also have lifelong implications for babies, even from before they are born. The first 1000 days – critical for early brain development, in which the brain grows faster than at any other time and in which essential neural connections and patterns are established – begins at conception.

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[19] *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee,* 2021.

[20] Louise M. Howard and Hind Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', *World Psychiatry*, 19.3, 2020.

[21] Katherine E. Marçal, 'Perceived Instrumental Support as a Mediator between Maternal Mental Health and Housing Insecurity', *Journal of Child and Family Studies*, 30.12, 2021.

[22] Marçal, 'Perceived Instrumental Support', 2021.

Having a parent experience perinatal distress – even before they are born – can have lifelong implications for babies.

Ground-breaking new research, including research being led here in Aotearoa, has revealed that symptoms of maternal distress during pregnancy can have a significant negative impact on child brain development. Antenatal distress can impede both the structure and connectivity of a child's brain, and functional outcomes for that child, like working memory, attention, and sensory processing. As a recent evidence brief published by Koi Tū: The Centre for Informed Futures notes, "all of these aspects affect school readiness and the child's subsequent journey through school and society."[23]

During pregnancy, the transmission of risk from perinatal distress from parent to child is biological, probably related to the physiological impacts of stress. After the child is born, the mechanism of transfer may differ, becoming more environmental and psychological, but parental distress in the postnatal period can still have long term detrimental consequences for children.

Because it produces low mood, makes motivation difficult, and gets in the way of the enjoyment of daily life, postnatal distress (especially depression) can disrupt critical attachment bonds between parents and children. In both mothers and fathers, it is associated with a reduction in positive enrichment activities like reading, talking, smiling, and telling stories to their babies, all of which are essential to early brain development.[24]

These effects appear to be universal across different cultures and socioeconomic groups. Caregiving activities like feeding (especially breastfeeding), establishing sleep routines, attending well-child visits, getting children vaccinated, and safety practices like supervision are all negatively impacted by postnatal parental distress, leading the author of one systematic review to conclude that "these data highlight the need for universal screening of maternal and paternal depression during the postpartum period."[25]

The combined result can lock in intergenerational disadvantage

Impaired executive functioning, sub-optimal brain development, insecure attachments with caregivers, and early health disadvantages all have lifelong consequences. While these impacts can be managed with good support, they are still likely to have long term implications, and the cost of mitigating them later in life is significantly greater (and less effective) than intervening to support parental mental wellbeing during the perinatal period.

These combined effects impact future generations. With reference to distress experienced during pregnancy, the authors of Koi Tū's recent evidence brief observe:

> *Taken collectively, the existing and emerging research demonstrates that children born to mothers who are stressed and have suboptimal mental health are at risk of impaired*

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[23] Felicia Low, Peter Gluckman, and Richie Poulton, *Intergenerational Disadvantage: Why Maternal Mental Health Matters*, Koi Tū: The Centre for Informed Futures, May 2021).

[24] James F. Paulson et al., 'Individual and Combined Effects of Postpartum Depression in Mothers and Fathers on Parenting Behavior', *Pediatrics*, 118.2, 2006.

[25] Tiffany Field, 'Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review', *Infant Behavior & Development*, 33.1, 2010.

> *executive function and lower psychological resilience. If these children in turn become pregnant later in life [this] may manifest as greater stress in pregnancy. In turn, their child's neurodevelopment is also likely to be adversely affected, potentially to a greater extent than what they had experienced themselves. Thus, a self-reinforcing feedback loop is created, and over time intergenerational disadvantage leads to greater adversity and worse community outcomes.*[26]

Warm, supportive, and attentive parenting is strongly protective of lifelong health and wellbeing.

Postnatally, warm, supportive, and attentive parenting is strongly protective of lifelong health and wellbeing. As the Dunedin Study's parenting project research cited earlier demonstrated, those who have experienced warm, engaged parenting are more likely to parent their own children this way. Conversely, children who have been parented by parents in distress may struggle to parent their own future children in engaged and protective ways, driving further intergenerational disadvantage.

This is a major public policy challenge we are actively trying to solve right now

'Breaking the cycle' of intergenerational disadvantage has long been a buzzword in policy circles, but intergenerational problems require intergenerational solutions, and these have proved stubbornly difficult to identify and implement, from both a political and practical perspective.

Most recently, the government has asked the Productivity Commission to investigate the "dynamics and drivers of persistent disadvantage" and make recommendations to help "break or mitigate the cycle of disadvantage within people's lifetimes and across generations". The Terms of Reference for the resulting 'A fair chance for all' inquiry require the Commission to "promote a strengths-based approach, looking to make recommendations that would help individuals, families, whānau and communities realise their potential, and enhance their mana and wellbeing."[27]

In view of the number of people affected, interventions and prevention strategies for perinatal mental health should be a public health priority. – The Lancet

In light of the growing body of evidence about the importance of the perinatal period for lifelong wellbeing and the potential intergenerational consequences of perinatal distress, it is hard to look past Koi Tū's conclusion that "Improving maternal mental health is, arguably, the most logically, morally and economically sound way of breaking the cycle of intergenerational disadvantage and advancing society."[28]

This echoes many other studies in recent years, including a review of the known impacts of perinatal distress on babies and children published in *The Lancet* in 2014, which argued that "in view of […]

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[26] Low et al., *Intergenerational Disadvantage*, 2021.

[27] New Zealand Productivity Commission, 'A Fair Chance for All: Breaking the Disadvantage Cycle'.

[28] Low et al., *Intergenerational Disadvantage*, 2021.

the number of people affected, interventions and prevention strategies [for perinatal mental health] should be a public health priority."[29] We think this should be a major focus for both the Productivity Commission's inquiry, and the Health System Transformation currently underway.

Responsibility for reducing perinatal distress should not fall on individuals

Through no fault of their own, perinatal distress can get in the way of parents interacting with their babies and parenting in ways that support brain development, early learning, and emotional resilience. Many parents know this is happening, but struggle to reverse it without the right support. In a cruel irony, this knowledge can itself drive feelings of guilt and catastrophic thinking that deepen parental distress.

The feeling that everything is simultaneously your fault but also your job to fix will be familiar to many mothers and birthing parents, since this is what most cultural representations of motherhood, at least in the 'Western' tradition, seem to reinforce. As British cultural critic Jacqueline Rose has noted, "motherhood is […] the ultimate scapegoat for our personal and political failings, for everything that is wrong with the world, which it becomes the task – unrealisable of course – of mothers to repair."[30]

In highlighting the importance of perinatal mental health for long term child and family outcomes in this report we are acutely aware of two risks:

a) that parents with lived experience of perinatal distress may be left with feelings of guilt and worry about the impacts of that distress on their children; and

b) that stress becomes one more thing added the long list of things mothers and birthing parents are supposed to 'avoid' during pregnancy, leaving it up to individuals to try to mitigate the risk of transmitting intergenerational trauma and disadvantage to their babies, when we should instead be working towards structural solutions.

The authors of a recent review of international evidence about perinatal mental health suggest this concern is well-placed, noting that "there is a risk of 'blaming' mothers for the health of future generations, when the need for family and system level interventions is clear."[31] The same researchers concluded that, since the drivers of perinatal distress are systemic, so must be the solutions: "social determinants of mental health – poverty, racism, gender disadvantage and other structural inequalities, food insecurity, gender-based violence, poor housing, limited education and social networks – are all of critical importance for women in the perinatal period."[32]

There is a risk of 'blaming' mothers for the health of future generations, when the need for family and system level interventions is clear.

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[29] Alan Stein and others, 'Effects of Perinatal Mental Disorders on the Fetus and Child', *The Lancet*, 384.9956 (2014), 1800–1819 <https://doi.org/10.1016/S0140-6736(14)61277-0>.

[30] Jacqueline Rose, *Mothers: An Essay on Love and Cruelty* (London: Faber and Faber, 2018).

[31] Howard and Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', 2020.

[32] Howard and Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', 2020.

This conclusion is in keeping with Indigenous and cultural models of health such as Te Whare Tapa Wha and the Fonofale model, which emphasise the role of the collective in protecting, sheltering, and nurturing whānau and aiga, and aligns with traditional birthing and parenting practices aimed at surrounding new parents and babies with support to uphold their special status. Leaving it to individual parents to manage the health and wellbeing risks to themselves and their babies at this crucial time would be anathema in these cultural traditions and holistic models. Nor should it characterise public policy or service delivery of perinatal care.

In a report about joined-up social services commissioned by the Productivity Commission as part of its 'A Fair Chance for All' inquiry, economist Julie Fry recently concluded that successfully addressing intergenerational and complex disadvantage requires the government to collaborate effectively with kaupapa Māori and community-led organisations to build individual, whānau, and community capabilities. For this to happen, Fry emphasises that "deep-seated causes of disadvantage such as colonisation, racism, patriarchy and ableism [will] need to be addressed."[33]

The same report also notes that when collaborative initiatives begin to work effectively to extend culturally appropriate, community-led support to whānau, they often uncover huge volumes of unmet need. This can threaten to overwhelm service providers and community organisations under-resourced to deal with such high demand, and can lead to serious health and safety risks to both the kaimahi/staff of these organisations and the people they work with. Just as it should not be left up to individual parents to manage the risks of perinatal distress, nor should the burden fall to overburdened, under-resourced community leaders and kaimahi at risk of burnout.

In the next section, we look at the prevalence of perinatal distress among different population groups in Aotearoa New Zealand, what drives it, how this is linked to wider forms of systemic disadvantage, and the impact of the COVID-19 pandemic.

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[33] Julie Fry, *Together Alone: A Review of Joined-up Social Services*, New Zealand Productivity Commission, 2022.

Insight 2: Perinatal distress is widespread, complex, and linked to systemic inequities

Up to half of all birthing parents may experience perinatal distress

There is a lack of robust data about the prevalence of perinatal distress in Aotearoa New Zealand, but it is estimated that 10–20% of birthing parents may experience significant distress – enough to meet clinical definitions of mental illness – during the perinatal period.[34] New Zealand studies suggest 12–18% of birthing parents may be clinically depressed during pregnancy,[35] while in the Growing Up in New Zealand cohort study, 11% reported similar symptoms when their babies were nine months old.[36] In one study, 25% of Māori and 20% of non-Māori reported symptoms of anxiety in late pregnancy.[37]

An even larger group is thought to experience distress that is still serious, and, while outside the clinical range, may confer some impairment in the short and/or long term. Again, there is a shortage of robust data, but researchers have extrapolated from similar studies in Australia and Singapore that this could include as many as 30% of all birthing parents.[38] This is in addition to the 10–20% with clinical symptoms, meaning that, in total, almost half of all birthing parents may experience some form of perinatal distress. Supporting this hypothesis, in the study cited earlier, 55% of Māori participants and 30% of non-Māori reported experiencing “significant life stress” in late pregnancy.[39]

In one study, 55% of Māori and 30% of non-Māori reported significant life stress in late pregnancy.

There is reason to be concerned about this larger group with less severe symptoms as well as those meeting clinical criteria; not only is this group at risk of developing more serious distress without adequate support, but there may be flow-on implications for whānau wellbeing even from less severe symptoms. Recent studies indicate that even so-called ‘mild to moderate’ stress during pregnancy can impact a baby’s early brain development, while any low mood after birth can interfere with parents’ ability to respond to their babies’ physical and emotional needs.

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[34] Health and Disability Commissioner, *Monitoring and Advocacy Report of the Mental Health Commissioner,* 2020.

[35] Low et al., *Intergenerational Disadvantage*, 2021.

[36] Susan Morton et al., *Growing Up in New Zealand: A Longitudinal Study of New Zealand Children and Their Families. Report 2: Now We Are Born*, Growing up in New Zealand (Auckland: University of Auckland, March 2012).

[37] T. Leigh Signal et al., ‘The Prevalence of Symptoms of Depression and Anxiety, and the Level of Life Stress and Worry in New Zealand Māori and Non-Māori Women in Late Pregnancy’, *The Australian and New Zealand Journal of Psychiatry*, 51.2, 2017.

[38] Low et al., *Intergenerational Disadvantage*, 2021.

[39] Signal et al., 'The Prevalence of Symptoms of Depression and Anxiety', 2017.

The role of previous pregnancy loss and birth trauma

While many of the risk factors for perinatal distress are systemic and linked to wider structural disadvantage, some birthing parents are at greater risk through the sheer bad luck of having experienced previous pregnancy loss or a traumatic birth.

Previous prenatal loss (i.e. the death of a baby through miscarriage or stillbirth) is strongly associated with increased risk of depression and anxiety in subsequent pregnancies. This is the case even when the subsequent pregnancy is uneventful, and it does not resolve with the birth of a subsequent healthy child. In fact, previous pregnancy loss can cause symptoms of depression and anxiety well after the standard postnatal period. The lingering effects of pregnancy loss can impact on parenting styles and behaviours, especially in relation to perceived health and safety risk, and may have an adverse impact on parent–child attachment.[40]

Having a traumatic birth experience can also increase the risk of developing postnatal distress. Birth trauma can trigger ongoing psychological symptoms, including anxiety, depression, and PTSD. Like other forms of perinatal distress, it can interfere with parent–child attachment. Many people who have experienced traumatic births develop tokophobia, or a fear of childbirth. This can impact future fertility decisions, as some parents decide not to try for a subsequent pregnancy due to a fear of repeated trauma, despite having previously hoped to have a larger family.[41]

In the case of both previous pregnancy loss and birth trauma, researchers have suggested the association with perinatal distress is significant enough to warrant targeted interventions to specifically support mental wellbeing for parents who have experienced these challenging events. There is also a need for policy interventions to reduce the risk of traumatic birth and pregnancy loss, such as improving access to maternity care and increasing provision and choice of safe birthing environments

Fathers and non-birthing parents can experience perinatal distress

Perinatal distress is not only experienced by mothers/birthing parents. Postnatal depression in fathers/non-birthing parents is less understood and discussed, but is also thought to affect a significant number of families. In the Growing Up in New Zealand cohort, 2.3% of fathers experienced depression during their partner's pregnancy, and 4.3% reported symptoms of depression nine months after their child was born. International studies suggest the rate of paternal depression is even higher and could be up to 10%.

According to the advocacy organisation PADA, factors that contribute to anxiety and depression in non-birthing parents include having a family or personal history of mental illness, unemployment, lack of social support, financial history, and a history of abuse. It can manifest as constant tiredness

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[40] Emma Robertson Blackmore et al., 'Previous Prenatal Loss as a Predictor of Perinatal Depression and Anxiety', *The British Journal of Psychiatry*, 198.5, 2011.

[41] Kristy Watson et al., 'Women's Experiences of Birth Trauma: A Scoping Review', *Women and Birth*, 34.5, 2021.

or exhaustion, high physical stress such as muscle tension and headaches, emotional withdrawal from partner, baby, friends, and whānau, and using alcohol or drugs to 'escape' or cope.[42]

Non-birthing parents can also be affected indirectly when their partner becomes unwell. Common issues include not knowing how to help their partner, becoming frustrated when their attempts at support are met with evasion or anger, disappointment that the postnatal period is not the joyful time of celebration they expected, feeling overwhelmed by new or additional responsibilities, and internalising some of their partner's anxiety and/or low mood. Without adequate support, non-birthing parents in this situation are at risk of developing clinical levels of distress themselves.

> *Without adequate support, non-birthing parents supporting a distressed partner are themselves at risk of developing clinical symptoms.*

Like maternal/birthing parent distress, distress among fathers/non-birthing parents can also have detrimental impacts on long term whānau wellbeing. Paternal postnatal depression is associated with reduced parenting warmth and sensitivity, increased parental conflict, and poorer long term emotional and behavioural outcomes for children. In international studies, fathers who experienced depression in the first year of their baby's life were less likely to report reading to their children, and more likely to report spanking them.[43]

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[42] Perinatal Anxiety and Depression Aotearoa, 'Dads and Postnatal Depression', 2021 (https://pada.nz/wp-content/uploads/2021/04/Dads-and-postnatal-depression-2019.pdf).

[43] Tova B. Walsh, et.al. , 'A Call to Action: Screening Fathers for Perinatal Depression', *Pediatrics*, 145.1, 2020.

What about sole parents?

On the topic of partners, it seems pertinent to address the question of sole parents. While it has sometimes been posited that parenting alone may increase the risk of developing perinatal distress, there is little evidence to support this. A recent Swedish study used longitudinal data to investigate the effects of young maternal age (20 or younger at the time of birth) and single parent status on maternal and child mental health outcomes. The researchers found that young maternal age was associated with symptoms of postnatal depression, but single parent status was not.[44]

In an earlier Australian study, researchers compared the influence of single parent status and the level of partner support on women's emotional wellbeing during pregnancy. While single women were slightly more likely to have experienced symptoms of depression than the total partnered group, their symptoms of perinatal distress were considerably less severe than for those with unsupportive partners. Controlling for other variables subsequently suggested the initial correlation between single parent status and depressive symptoms was explained by women with a previous history of depression, rather than by single status.[45]

Findings like this would seem to suggest that, in and of itself, sole parent status has little to no bearing on perinatal mental health. However, because being a sole parent tends to be correlated with other risk factors like low income, insecure housing, and young maternal age, it may be that in practice, a disproportionate number of sole parents do experience perinatal distress.

Perinatal distress can affect anyone, but some groups are at greater risk

While perinatal distress can affect anyone, and is experienced by birthing parents of all ethnicities, ages, and socioeconomic backgrounds, some groups face disproportionate risk of both experiencing distress, and of this distress manifesting severely. There is relatively good data showing that Māori, Pacific, and Asian parents are more likely than Pākehā birthing parents to experience perinatal distress.

For other groups known to be at higher risk of poor outcomes, such as takatāpui/LGBTQI+ people and disabled people, there are big gaps in available data about both mental wellbeing in general, and perinatal mental health specifically. Encouragingly, though, some recent research is beginning to address these gaps.

Perinatal distress is more common for Māori, Pacific, and Asian birthing parents

One of the most comprehensive New Zealand studies to date compared the experiences of Māori and non-Māori birthing parents in 2017. Researchers found a high incidence of distress in both groups, but in all cases, Māori were more likely to experience symptoms than non-Māori.[46]

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[44] Sara Agnafors et al., 'Mental Health in Young Mothers, Single Mothers and Their Children', *BMC Psychiatry*, 19.1, 2019.

[45] Justin L.C. Bilszta et al., 'Single Motherhood Versus Poor Partner Relationship: Outcomes for Antenatal Mental Health', *Australian & New Zealand Journal of Psychiatry*, 42.1, 2008.

[46] Signal et al., 'The Prevalence of Symptoms of Depression and Anxiety', 2017.

Type of distress	Percentage of Māori participants affected	Percentage of non-Māori participants affected
Depressive symptoms	22%	15%
Anxiety symptoms	25%	20%
Significant life stress	55%	30%
Poor mood during pregnancy	18%	14%

In general, birthing parents from non-European ethnicities are more likely to experience perinatal distress.[47] Pacific and Asian birthing parents in particular are more likely than Pākehā to experience perinatal depression and/or bear a greater emotional burden during pregnancy.[48] In an analysis of Growing up in New Zealand data, mothers who identified as Pacific or Asian were more likely than Pākehā mothers to record a high score on the Edinburgh Postnatal Depression Scale (a widely used screening tool to identify parents in distress both during and after pregnancy). In total, Pacific or Asian women accounted for 26% of the study's cohort, but 37% of those who experienced ante- and/or postnatal depression.[49]

Māori and Pacific women also have the highest maternal death rates of any ethnicity.[50] As noted earlier, most of these deaths are by suicide.

Migrant parents may be particularly at risk

There is limited specific data about the perinatal experiences of migrant parents, but the research that is available indicates that they may be at particular risk of perinatal distress. As noted above, Pacific and Asian parents in general have a greater risk of experiencing perinatal distress, but the risk factors and policy solutions are likely to be different for New Zealand citizens and permanent residents from these ethnic backgrounds than for recent migrants from these and other countries of origin.

There may be numerous additional challenges for migrant parents who have been in Aotearoa New Zealand for just a short time when they become pregnant or give birth. These include language difficulties, inadequate knowledge and awareness of existing services, and lack of culturally appropriate mental health and social support services. For families living far away from their social and familial support networks, the perinatal period can be particularly challenging since they don't have ready or frequent access to the kinds of practical, emotional, in-person support family members can provide.

These challenges may be particularly pronounced for birthing parents wishing to observe cultural birthing and postnatal traditions, such as observing a period of confinement and only eating certain foods. While these practices can be strongly supportive of mental wellbeing, they are challenging to observe without significant family support. Struggling to uphold these traditions by oneself, or with only a partner for support, and feelings of guilt or disappointment if this proves too hard, may actually contribute to increased distress in some cases. Similarly, mainstream maternity and early

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[47] Mental Health Foundation, *Perinatal Mental Health*, 2021.

[48] Low et al., *Intergenerational Disadvantage*, 2021.

[49] Morton et al., *Growing Up in New Zealand: Report 2*, 2012.

[50] Health Quality and Safety Commission, *Bula Sautu - A Window on Quality*, 2021.

childhood service providers may have limited or no knowledge of these practices, may lack policies and strategies to respond to diverse populations, or may not have invested in ongoing cultural competency training for their workforces. Combined with language barriers, all of these factors can lead to lower engagement, miscommunication, and missed opportunities to support migrant parents to have culturally safe birth and recovery experiences.

Many of these factors were highlighted in a 2002 study of the mental health experiences of Asian people in New Zealand, including new migrants. More recent research about the perinatal experiences of Asian women suggests that these barriers are very much still in place 20 years later.[51] For Pacific migrants too, there is evidence that Pacific mothers who retain strong linguistic and cultural ties to their home islands may find it more difficult to access and/or feel comfortable with mainstream maternity and Well Child/Tamariki Ora (WCTO) providers, and perhaps as a result, these women report higher psychological distress than Pacific mothers who are more strongly "aligned" with the dominant New Zealand culture.[52]

Finally, the COVID-19 pandemic is likely to have significantly exacerbated the risk of perinatal distress for migrant parents by cutting off access to familial support networks for a prolonged period due to the closure of the border. This is supported by a finding from our 2021 research about loneliness in Aotearoa New Zealand during the pandemic, which found that new migrants were one of the groups most likely to report feeling lonely most or all of the time.[53]

There is probably a high incidence of perinatal distress and unmet need for support among disabled birthing parents and parents of babies with impairments

Not enough is known about the relationship between disability and perinatal wellbeing, but the data we do have suggest experiencing disability increases someone's risk of developing perinatal distress. Disabled people are among those most likely to report low levels of positive mental wellbeing in Aotearoa New Zealand.[54] For example, as we reported in our series about loneliness, in 2020, disabled people were four times more likely than non-disabled people to report feeling lonely most or all of the time.[55] More than a quarter of disabled adults reported experiencing psychological distress in the 2020/21 New Zealand Health Survey, compared to 7.9% of non-disabled adults.[56] With specific regard to perinatal mental health, in the Growing up in New Zealand study, mothers who reported an existing disability prior to pregnancy were more likely to report a high score on the Edinburgh Postnatal Depression Scale.[57]

A recent report commissioned by the three Wellington regional DHBs sheds further light on the relationship between disability and perinatal mental health. Researchers examined the maternity

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[51] Ho et al. *Supporting Equitable Perinatal Mental Health Outcomes for Asian Women: A Report for the Northern District Health Boards*, Asian Family Services, 2021.

[52] Janis Paterson and others, 'Pacific Islands Families Study: Psychological Distress among Mothers of Pacific Children Living in New Zealand', *Australian and New Zealand Journal of Public Health*, 40.2, 2016.

[53] Holly Walker, *Still Alone Together: How Loneliness Changed in Aotearoa New Zealand in 2020 and What It Means for Public Policy*, The Helen Clark Foundation and WSP, 2021.

[54] Mental Health and Wellbeing Commission, *Te Rau Tira: Wellbeing Outcomes Report*, 2021.

[55] Holly Walker, *Still Alone Together*, 2021.

[56] Ministry of Health, 'New Zealand Health Survey: Annual Update of Key Results 2020/21'.

[57] Morton et al., *Growing Up in New Zealand: Report 2*, 2012.

experiences of both disabled mothers and mothers of children born with impairments in the region. They found that disabled women faced multiple barriers in accessing appropriate maternity care and, as a consequence, felt ill-prepared and unsupported to manage their pregnancies and births. Disabled women reported discrimination, negative attitudes, and a lack of knowledge about disability among healthcare professionals, and described how this created a significant emotional burden for them in addition to the usual upheaval of becoming a parent.

> *Disabled women face multiple barriers to appropriate maternity care and many feel ill-prepared and unsupported to manage their pregnancies and births.*

Women whose babies were born with impairments also described receiving inappropriate care and encountering discriminatory attitudes from health professionals. There were significant mental health impacts for these women at critical points in their maternity journey, such when they received their baby's diagnosis or when their babies were in specialist care units, but they found it difficult to access the support they needed at these times.

Many participants from both groups said they felt they had required mental health care during or after their pregnancies, but most had found this nearly impossible to access unless they were at critical risk. As one participant starkly put it, "you basically have to be saying you're going to kill yourself or harm your baby before they will see you."[58]

In a relatively small sample size of 20, several of the study's participants had experienced postnatal depression, and three had developed postnatal psychosis.[59]

There is probably also a high incidence of perinatal distress and unmet need for support among Takatāpui and LGBTQI+ birthing parents

Again, little is known about the specific perinatal mental health experiences of rainbow families, but in general, people identifying as LGBTQI+ are more likely to experience discrimination, find it hard to be themselves, feel lonely, and report overall lower levels of positive mental wellbeing.[60]

International research suggests that some LGBTQI+ parents may face increased risk of perinatal distress. One US study, for example, found that perinatal depression and increased stress may be more prevalent in same-sex female couples than heterosexual couples.[61]

A recent international review of research related to the parenting experiences of trans and nonbinary parents found that to date, no studies had focused specifically on traumatic birth or perinatal mental health for this group, although there were common themes of dysphoria, lack of

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[58] Carey-Ann Morrison, *Creating Enabling Maternity Care, Dismantling Disability Barriers: Mums and Babies' Experiences at the 3DHB - Research Report* (Imagine Better and DPA, April 2021).

[59] Carey-Ann Morrison, *Creating Enabling Maternity Care, Dismantling Disability Barriers,* 2021.

[60] Mental Health and Wellbeing Commission, *Te Rau Tira*, 2021.

[61] Yana Sigal, 'Perinatal Mental Health in Same-Sex Female Couples', *Journal of Student Nursing Research*, 2.1, 2009.

visibility, and isolation in more general research about the experiences of trans and nonbinary parents, suggesting significant mental health challenges were present.[62]

> *International evidence shows maternity care is often unsafe and inadequate for trans and nonbinary people.*

Here in Aotearoa, a research project funded by the Health Research Council is currently investigating the need for trans, nonbinary, and takatāpui inclusive perinatal and maternity care. Announcing the project in 2021, lead researcher George Parker said international evidence showed maternity care was often unsafe and inadequate for trans and nonbinary people. They cited a lack of gender-inclusive language, lack of gender-inclusive facilities, data systems that make it difficult or impossible to capture gender identity, and unwelcoming and transphobic attitudes from maternity providers as significant issues.[63] Hopefully this research will soon begin to address the current knowledge gap about perinatal mental wellbeing for trans and nonbinary birthing parents.

The stressors that drive perinatal distress are systemic

As noted earlier, after a recent systematic review of international evidence about the impacts of perinatal distress, researchers in the UK firmly concluded that the drivers are systemic and require systemic interventions. Among the list of structural factors they found contribute to an increased risk of perinatal distress were: poverty, racism, gender disadvantage, food insecurity, gender-based violence, poor housing, limited education, and weak social networks. The authors noted that these "are all of critical importance for women in the perinatal period."[64]

Structural factors that can contribute to perinatal distress:

- Poverty
- Racism
- Gender disadvantage
- Food insecurity
- Gender-based violence
- Poor housing
- Limited education
- Weak social networks

Source: Louise M. Howard et al., 'Domestic Violence and Perinatal Mental Disorders: A Systematic Review and Meta-Analysis', *PLOS Medicine*, 10.5, 2013

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[62] Mari Greenfield and Zoe Darwin, 'Trans and Non-Binary Pregnancy, Traumatic Birth, and Perinatal Mental Health: A Scoping Review', *International Journal of Transgender Health*, 22.1–2, 2021.

[63] Victoria University of Wellington, 'School of Health Lecturer to Lead Research on Trans, Non-Binary and Takatāpui-Inclusive Maternity Care', 2021 (https://www.wgtn.ac.nz/health/about/news/a-te-herenga-waka-victoria-university-of-wellington-researcher-is-the-lead-on-a-project-granted-almost-$180,000-to-research-trans,-non-binary-and-takatapui-inclusive-maternity-care).

[64] Howard and Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', 2020.

The relationships between these factors and increased risk and severity of perinatal distress have been well documented both here in Aotearoa and internationally. For example, analysis of the perinatal experiences of the Growing up in New Zealand cohort found in 2012 that if a family's financial situation had deteriorated or if the family had experienced hardship or increased financial stress during the perinatal period, "maternal mental health was likely to have deteriorated."[65]

A recent US study found that maternal mental health was a crucial factor in predicting mothers' risk of housing instability (defined as being unable to make a rent or mortgage payment, having to borrow money to pay for rent or utilities, moving in with others, being evicted, or spending at least one night homeless). Using longitudinal data, researchers determined that, even after adjusting for other variables, maternal depression in the first year of a baby's life was a key predictor of housing instability two and three years later, and was associated with a 40% increase in the risk of experiencing homelessness. Even many years later, as children were entering adolescence, maternal depression early in life continued to have an impact on families' housing outcomes."[66]

> *If a family's financial situation had deteriorated during the perinatal period, maternal mental health was also likely to have deteriorated. – Growing Up in New Zealand*

Not surprisingly, having a history of domestic abuse and/or intimate partner violence is strongly associated with depression, anxiety, and post-traumatic stress disorder in the perinatal period. [67] Researchers have calculated that, internationally, women with symptoms of perinatal distress were 3-5 times more likely to have experienced domestic violence during pregnancy or the previous year than those with no symptoms. This association is thought to be two-way, meaning both that showing symptoms of distress can increase someone's vulnerability to domestic violence, and that having experienced domestic violence can increase their likelihood of developing perinatal distress.[68] In the US, the national death reporting system found that interpersonal violence had been present for nearly half of mothers who died by suicide.[69] Similarly, here in Aotearoa the Perinatal and Maternal Mortality Review Committee also identified that a history of mental distress and intimate partner violence were frequent experiences reported in a review of mothers who died by suicide.

Food insecurity can also be a driver of poor perinatal mental health. Defined as not having adequate food, access to food, or variation in food, food insecurity contributes to household stress and has been found to have persistent negative effects on the mental health of household members, even after controlling for income. International studies have found a strong association between food insecurity and both postnatal depression and antenatal anxiety. As with violence, the relationship between food insecurity and perinatal mental health is two-way, so that not only does experiencing

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[65] Morton et al., *Growing Up in New Zealand: Report 2*, 2012.

[66] Marçal, 'Perceived Instrumental Support', 2021.

[67] Christina Laurenzi et al., 'Food Insecurity, Maternal Mental Health, and Domestic Violence: A Call for a Syndemic Approach to Research and Interventions', *Maternal and Child Health Journal*, 24.4, 2020.

[68] Louise M. Howard et al., 'Domestic Violence and Perinatal Mental Disorders: A Systematic Review and Meta-Analysis', *PLOS Medicine*, 10.5, 2013.

[69] Howard and Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', 2020.

food insecurity increases someone’s risk of developing perinatal distress, but experiencing perinatal distress separately increases their risk of experiencing food insecurity. In low-income families in the US, researchers have used longitudinal data to estimate that having a mother experiencing moderate-to-severe symptoms of depression may increase the odds of her family experiencing food insecurity by between 50 and 80%.”[70]

A range of other factors can also increase someone’s likelihood of developing symptoms of perinatal distress. In the Growing up in New Zealand study, participants’ scores on the Edinburgh Scale tended to be higher (and thus more concerning) for mothers who:

- had an unplanned pregnancy
- were under the age of 30
- had a previous diagnosis of depression or anxiety
- reported poor self-rated health or an existing disability prior to pregnancy
- were not employed during pregnancy
- consumed alcohol during pregnancy
- smoked (or had only given up in pregnancy)
- were not physically active during the first trimester of pregnancy
- reported high levels of family stress.

Tracking changes in participants’ self-reported mental wellbeing over time, researchers noted that a planned pregnancy, physical activity before and during pregnancy, and family support could all help to reduce a previously high score on the Edinburgh scale.[71]

Chronic, overlapping stressors combine to drive both perinatal distress and wider disadvantage

Not only are there two-way relationships between perinatal distress and systemic factors like violence, food insecurity, and poor housing, but very often there are multiple, intersecting, and mutually reinforcing relationships between three or more. The combination of these risk factors, or ‘co-morbiditities’ as they are sometimes referred to, can interfere with day-to-day functioning, as well as parents’ abilities to plan and manage problems. Researchers have posited, for example, a three-way relationship between food insecurity, intimate partner violence, and perinatal distress.[72] In practice, such a relationship might look something like this:

> *A shortage of food in the house, and a set of gendered assumptions about domestic roles, triggers an abusive male partner to lash out at his pregnant partner, complaining that there is ‘nothing to eat’. This not only physically hurts her, but causes her considerable emotional distress, and the next day, unable to stop crying, she struggles to leave the house to source additional food or prepare the food they do have. This leads to a repeat of the previous day’s violence. Over time, this pattern contributes to the emergence of full-blown and severe antenatal depression. In this state, she struggles to get out of bed, and her apparent lack of motivation frustrates her partner and triggers further violence. The mother suffers significant*

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[70] Laurenzi et al., ‘Food Insecurity, Maternal Mental Health, and Domestic Violence', 2020.

[71] Morton et al., *Growing Up in New Zealand: Report 2*, 2012.

[72] Laurenzi et al., ‘Food Insecurity, Maternal Mental Health, and Domestic Violence', 2020.

> *psychological harm, and her baby is at risk of physical from the violence and functional impairment from the biological transmission of her stress response during pregnancy.*

In short, chronic, overlapping household stressors – all of which are known to be key drivers of structural disadvantage and sources of inequity – can combine during the perinatal period to render some parents more susceptible to poor physical and mental health. This in turn reduces their household capacity to respond to these challenges, and can deepen their vulnerability to poverty, food insecurity, violence, and unstable housing, among other things.

A broader approach is needed that acknowledges that these issues are interrelated, co-occurring, and continuous.

As the authors of the study linking perinatal mental health, domestic violence, and food insecurity noted, "a broader approach is needed that acknowledges that these issues are interrelated, co-occurring, and continuous."[73]

The COVID-19 pandemic is exacerbating the challenge

Evidence of the detrimental impact of the COVID-19 pandemic on the already significant issue of poor perinatal mental health is beginning to amass, both here and overseas. From early in the pandemic, anecdotal reports suggested it was having a significant negative impact on maternal mental wellbeing, and this is now being borne out by clinical evidence.

In 2020, an early review of the likely impact of the pandemic on perinatal mental health noted that women and birthing parents were likely to experience increased distress related to a range of factors during the pandemic, including:

- having their movements and opportunities to socialise restricted by lockdowns
- being concerned about the risk of infection to themselves and their families
- having reduced access to in-person antenatal care
- being unable to have their partner with them at antenatal clinics, birthing facilities, or postnatal wards
- worrying about giving birth in a hospital setting where COVID-19 was present
- having reduced access to their usual support networks during pregnancy and after birth

These factors led the authors to conclude that the COVID-19 pandemic was highly likely to increase perinatal distress.[74] All of these factors are likely to have applied in the Aotearoa New Zealand context, and for Pacific, Asian, and migrant women in particular, the lengthy border closure is likely to have had a significant impact on their access to support networks.

More recently, researchers surveyed expectant mothers in the UK in 2020 and 2021 about their experiences of anxiety, depression, and stress related to the pandemic, and the impact it was having on their perceived access to social support. The results indicated an extremely high prevalence of

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[73] Laurenzi et al., 'Food Insecurity, Maternal Mental Health, and Domestic Violence', 2020.

[74] Karen Matvienko-Sikar, et al., 'Perinatal Mental Health during the COVID-19 Pandemic', *Women and Birth*, 33.4, 2020.

perinatal distress among participants (especially those who became pregnant during the pandemic, compared to those who were already pregnant when it started).

Overall, 47% percent of participants reported symptoms consistent with a clinical diagnosis of depression, 60% reported symptoms of anxiety, and a startling 40% reported symptoms associated with post-traumatic stress disorder. While these figures were not directly comparable with pre-pandemic measures, perinatal distress is generally thought to affect between 10 and 20% of birthing parents in the UK, as it is here, so the proportion of study participants who experienced distress during the pandemic was exceptionally high.[75]

In a UK study of pregnant mothers during the COVID-19 pandemic:

- 47% reported symptoms of depression
- 60% reported symptoms of anxiety
- 40% reported symptoms associated with PTSD

Pre-pandemic, the incidence of perinatal distress was estimated at 10–20%.

Source: Maria Laura Filippetti, et al., ‘The Mental Health Crisis of Expectant Women in the UK: Effects of the COVID-19 Pandemic on Prenatal Mental Health, Antenatal Attachment and Social Support’, *BMC Pregnancy and Childbirth*, 22.1, 2022.

Researchers concluded that the experience of pregnancy and birth during the COVID-19 pandemic could be considered a prenatal trauma, and noted that it was likely to be having a significant impact on the ability for new mothers to form positive relationships with their babies. They called for urgent intervention strategies aimed at fostering support for pregnant women during the pandemic.[76]

Closer to home, in study by Ipsos commissioned by the Mental Health Foundation at the end of 2020, 25% of those surveyed reported poor levels of mental and emotional wellbeing. The proportion of women with poor wellbeing was higher, at almost one third, with women on incomes of less than $50,000 most affected.[77] The 2020/21 New Zealand Health Survey revealed a smaller general increase in the incidence of psychological distress among adults in Aotearoa New Zealand from 7.5% pre-pandemic in 2019/20 to nearly 10% in 2020/21.[78]

A study of breastfeeding women in Australia and New Zealand during the pandemic surveyed participants about their mental wellbeing, challenges, and any positive experiences associated with having a new baby during the pandemic. As in the UK survey, women who had spent more time pregnant during the pandemic were more likely to report low mental wellbeing, as were those living in areas with high rates of COVID-19 infection. Those who reported reduced mental wellbeing also reported poor family functioning.

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[75] Maria Laura Filippetti, et al., ‘The Mental Health Crisis of Expectant Women in the UK: Effects of the COVID-19 Pandemic on Prenatal Mental Health, Antenatal Attachment and Social Support’, *BMC Pregnancy and Childbirth*, 22.1, 2022.

[76] Filippetti et al., 'The Mental Health Crisis of Expectant Women in the UK', 2022.

[77] Ipsos for the Mental Health Commission, *Wellbeing Amongst New Zealanders*, 2021.

[78] Ministry of Health, ‘New Zealand Health Survey: Annual Update of Key Results 2020/21’.

While there were some positive impacts associated with the pandemic, such as more time for family bonding, it had also created significant health and parenting challenges. Overall, researchers concluded COVID-19 had exacerbated mental health concerns, and highlighted “a critical need for access to mental health and broader family support.”[79]

Most studies published to date about the impact of the COVID-19 pandemic on perinatal mental health concern the early phase of the pandemic in 2020 and 2021, and the specific impacts of lockdowns and social isolation measures. As the Omicron outbreak has demonstrated, the COVID-19 pandemic continues to evolve, both in terms of the nature of the virus, and in the policy measures and restrictions variously imposed and/or lifted by governments in response.

Research and experiences to date suggest that the major mental health impacts of the COVID-19 pandemic will be cumulative, and there is a lot we still don’t know about their long term impact on perinatal wellbeing. Whatever that impact turns out to be, it is clear the pandemic is already adding new and compounding sources of stress and trauma for many new parents at an already challenging time.

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[79] Vanessa S. Sakalidis et al., ‘Wellbeing of Breastfeeding Women in Australia and New Zealand during the COVID-19 Pandemic: A Cross-Sectional Study’, *Nutrients*, 13.6, 2021.

'Parents of the future face an increasingly complex world': A Q&A with Dr Hinemoa Elder

Dr Hinemoa Elder (Te Aupouri, Ngāti Kurī, Te Rarawa and Ngāpuhi) is a Fellow of the Royal Australia and New Zealand College of Psychiatrists and is a consultant child and adolescent psychiatrist working in community and inpatient, youth forensic and neuropsychiatry fields. She is also the bestselling author of *Aroha: Māori wisdom for a contented life lived in harmony with our planet*, and a former television presenter. She sits on the board of Mahi a Rongo | The Helen Clark Foundation.

Tēnā koe e Hinemoa. Many of our readers will know you as the author of Aroha*, or from your TV career, but may not know about your clinical and academic research, or other aspects of your background. So, in the spirit of whakawhanaungatanga, what would you like readers of this report to know about who you are and where you come from?*

Nō Muriwhenua ahau, Ko Parengarenga te moana, ko Tawhitirahi te maunga, ko Awapoka te awa, Ko Kurahaupō te waka, Ko Potahi te marae, ko te Aupōuri te iwi. I am a psychiatrist, and I work at Starship Hospital's Mother and Baby and Child and Family Units. I have a long-standing concern about the unmet wellbeing needs of our parents and future parents and their whānau.

One of your areas of expertise is tikanga-based approaches to the treatment and care of traumatic brain injuries among young people. What led you to this topic, and how significant is the problem of traumatic brain injury among young people in general, and rangatahi Māori in particular?

I saw many tamariki mokopuna with traumatic brain injuries during my early career and I wondered why mātauranga Māori was not offered and included in their care and rehabilitation. I was aware of some of the basic whakaaro from our culture such as 'he tapu te upoko,' 'he taonga te mokopuna.' I saw a great need to bring forward our mātauranga to support whānau affected by traumatic brain injury. This is a serious health issue which is largely unrecognised. Once any evidence of external injury has healed, the longer-term impact on thinking, feeling, interpreting the world, learning and behaviour and their links to the injury can go unrecognised. Māori rates are greater than non-Māori rates of Traumatic Brain Injury (TBI). Many people believe incorrectly that children 'just bounce back' after traumatic brain injuries. We have significant evidence from the Christchurch Health and Development longitudinal study that so called 'mild' traumatic brain injuries can have significant long term effects.

What are the relationships and connections between traumatic brain injuries, neurodiverse conditions like ADHD, and mental health issues like depression, anxiety, and PTSD?

There are myriad connections between traumatic brain injuries, ADHD, and depression and anxiety. Traumatic brain injuries can lead to an ADHD-like syndrome and to mood and anxiety disorders such as PTSD. Tamariki with ADHD are also at increased risk of TBI.

Are these challenges more significant for the current generation of children and young people, or do we just have new ways of conceptualising and talking about them now?

The challenges for current generations are complex given the need to navigate both the online and face-to-face worlds. We are also getting better at recognising the effects of traumatic brain injuries.

Thinking about the children and young people who will become parents in the next 5–10 years, are you concerned they may be at heightened risk of developing perinatal distress, given what we know about the incidence of brain injury, neurodiversity, and mental health challenges among this group?

Our parents of the future face an increasingly complex world with increasing risks of distress in the perinatal period. The issues of housing, income, financial safety, and security are paramount in alleviating the risks of perinatal distress they will face. And they will need supporters who are culturally responsive, skilled, and knowledgeable to help them.

What can we do now – both in whānau and communities, and at the policy level – to ease the transition to parenthood for this coming generation of new parents and make sure it is supportive and healing?

There is a danger in focusing solely on service improvement. Services alone cannot address the complex perpetuating factors of perinatal distress. Tackling the tough socio-economic factors that drive vulnerability must be a central focus of any policy that seeks to truly address this critical issue affecting intergenerational lifelong health and wellbeing.

Do the kaupapa Māori models you have developed for whānau-based recovery from traumatic brain injuries have the potential to be applied in other settings, such as the treatment of perinatal distress?

The approaches developed for whānau affected by traumatic brain injury have been found useful in a wider range of settings already, as well as in TBI rehabilitation. These ways of working have been developed from marae wānanga in urban, rural, and remote areas and so reflect a range of experiences of being Māori. The cultural needs assessment tool 'Te Waka Kuaka' and the activity guide 'Te Waka Oranga' could both be used in situations where whānau are affected by perinatal distress.

Insight 3: Making sure parents and whānau have access to support is the best way to protect perinatal mental wellbeing

One of my overwhelming feelings was one of wishing to be looked after, just as my baby was being cared for – in a cot, asleep, with all my needs met. – Kathryn

Access to support is the key protective factor for perinatal mental health

As noted at the beginning of this report, traditional practices from te ao Māori, Te Moana nui a Kiwa, and many cultures around the world reinforce the idea that the perinatal period is a vital time during which communities should work together to ensure birthing parents, new babies, and their wider families/whānau are surrounded with collective support.

Almost every academic study accessed in the research for this report reaches a similar conclusion: access to support is *the* key protective factor for perinatal mental health.

In the same way tikanga Māori practices of whanaungatanga and holistic care surrounding pregnancy and birth are now understood to reduce the physiological stress response in the body and put people at ease,[80] clinical researchers have observed that having access to social support during the perinatal period reduces the impact of stress on pregnant and birthing parents and decreases their symptoms of distress.[81]

Study after study concludes with some version of the same recommendation:

- "Health services should prioritise interventions and strategies aimed at fostering support for pregnant women."[82]
- "Interventions aimed at improving social support should be considered for the prevention and treatment of prenatal depressive symptoms."[83]
- "Stronger policies and actions that enable mothers to access their immediate support networks remain essential."[84]
- "Interventions that bolster social networks and improve availability of instrumental support may be an important tool."[85]
- "Therapeutic interventions directly addressing mothers' needs for consistent, interpersonal contact and support can effectively reduce the risk [of perinatal distress]."[86]
- And so on.

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[80] Deb Rewiri, 'Pregnancy and Childbirth, Traditional Knowledge Practices and Keys for Successful Support, 2021.

[81] Pengsheng Li et al., 'Association Between Perceived Stress and Prenatal Depressive Symptoms: Moderating Effect of Social Support', *Journal of Multidisciplinary Healthcare*, 14, 2021.

[82] Filippetti et al., 'The Mental Health Crisis of Expectant Women in the UK', 2022.

[83] Li et al., 'Association Between Perceived Stress and Prenatal Depressive Symptoms', 2021.

[84] Sakalidis et al., 'Wellbeing of Breastfeeding Women in Australia and New Zealand during the COVID-19 Pandemic, 2021.

[85] Marçal, 'Perceived Instrumental Support', 2021.

[86] Eszter Lefkovics et al., 'Effect of Maternal Depression and Anxiety on Mother's Perception of Child and the Protective Role of Social Support', *Journal of Reproductive and Infant Psychology*, 36.4, 2018.

Various studies have investigated *why* support is such a key factor in determining perinatal mental wellbeing.

In many ways, the reasons are intuitive: supportive relationships make us feel good, or "enhance feelings of well-being, personal control and positive affect."[87] This helps new parents to feel less isolated or alone, relieves symptoms of low mood, improves their perception of their babies, facilitates stronger parent–child attachments, increases parents' responsiveness to babies' emotional and physical needs, and increases their self-confidence in their parenting abilities. This can create a mutually reinforcing cycle of positive mood, increased self-confidence, and warm, engaged parenting.

Support works best when it comes from sources parents already know and trust

While the importance of addressing the structural drivers of perinatal distress such as low income, poor housing, and domestic abuse cannot be overstated, the presence of supportive relationships and the perceived ability to access practical support can be strongly protective of parental mental health even in situations where those other risk factors are present.

> *Strong relationships in the immediate environment, such as those with family members, friends, or neighbours, significantly enhance the ability of low-income households to withstand crises and avoid catastrophic outcomes. – Journal of Child and Family Studies*

Knowing that they could access support from a friend or family member to provide an emergency loan, babysit at short-notice, or help with transport to an appointment reduced both the severity and duration of maternal distress, and the relationship between that distress and an increased risk of poor housing outcomes in one US study.[88] In another, while unemployment was found to increase the risk of perinatal distress, social support was found to reduce the risk of depressive symptoms, regardless of employment status.[89]

Strong relationships in the immediate environment, such as those with family members, friends, or neighbours, have been found to significantly enhance the ability of low-income households to withstand crises and avoid catastrophic outcomes. They are most likely doing so by "filling in gaps that could otherwise be filled with adequate income", and, as such, should not be used as a reason not to invest in improving incomes and reducing whānau poverty. Even so, we should prioritise public policy solutions and investments that can bolster parents' existing support networks. This is because "strategies that mobilise existing safety nets have the benefit of being tailored to specific client population, and are typically more accessible and enduring."[90]

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[87] Lefkovics et al., 'Effect of Maternal Depression and Anxiety on Mother's Perception of Child and the Protective Role of Social Support', 2018.

[88] Marçal, 'Perceived Instrumental Support', 2021.

[89] Dwenda Gjerdingen et al., 'Maternal Depressive Symptoms, Employment, and Social Support', *The Journal of the American Board of Family Medicine*, 27.1, 2014.

[90] Marçal, 'Perceived Instrumental Support', 2021.

Collaborative, strengths-based initiatives can reach those most in need of support

In 2015, a Productivity Commission inquiry into the need for more effective social services concluded that services funded and delivered by a single agency often perform poorly for people with multiple and complex needs. Parents who are currently experiencing the cumulative impacts of perinatal distress and other systemic disadvantages like low income, unstable housing, food insecurity, and domestic abuse would probably agree. Many people in this situation will have had long histories of negative interactions with the state, which could include having been removed from their whānau as a child, having had their own children removed, having loved ones incarcerated, having encountered racist or discriminatory attitudes from government employees, having been denied access to their full entitlement to financial support from Work and Income, or having been discriminated against or bullied at school. As a result, government agencies or government-funded services aimed at supporting improved perinatal wellbeing, no matter how well-intentioned or designed, are unlikely to successfully identify, reach, or appeal to those who may be most in need of support.

In recent years, many government agencies have been working towards funding and delivering more 'joined-up' social services, often partnering with kaupapa Māori or community-led initiatives with the aim of delivering flexible, strengths-based, culturally appropriate supports. The most successful of these are often whānau-centred initiatives that aim to build on the existing strengths and capabilities of the collective and address core needs like housing, income, and employment alongside the target outcomes like drug harm reduction or improved mental health. This is the core philosophy underpinning the Whānau Ora approach, and is the basis of successful pilots like the Te Ara Oranga methamphetamine harm reduction pilot in Te Tai Tokerau, or the Whāngaia Ngā Pā Harakeke family violence programme in Tairāwhiti.[91]

In a recent review of these 'joined-up' social services commissioned by the Productivity Commission to inform its current 'A Fair Chance for All' inquiry, author Julie Fry noted that recipients of collaborative services like these often view them positively, appreciating the access to flexible, holistic services that "meet them where they are" and support them to be "the architects of their own solutions."[92]

But current supports for new parents and babies are not meeting current needs

Aotearoa New Zealand's maternity system has often been internationally feted for its provision of continuous care from the same lead carer (most often a midwife, but sometimes an obstetrician or GP) throughout pregnancy and for the first six weeks after birth. While our model has long been considered world-leading, there are concerning signs that its sustainability and effectiveness are currently under threat, mainly from a severe shortage of midwives.

After the birthing parent and baby are discharged from their lead maternity carer at six weeks postpartum, parents can register with a WCTO provider, who will provide a series of health assessments, support services, and health promotion activities for children and families from six weeks post-birth to five years. The largest and most well-known WCTO provider is Whānau Āwhina Plunket, which offers a parenting helpline and a range of local services in addition to its WCTO service (although, concerningly, in April 2022, it discontinued its PEPE parenting education

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[91] Fry, Together Alone, 2022.

[92] Fry, *Together Alone*, 2022.

programme, citing a lack of funding.)[93]. In some locations, parents hve the option to register with a specialist Māori or Pacific WCTO provider instead of Whānau Āwhina Plunket, although these specialist services are not available everywhere.

There is much to celebrate about New Zealand's free perinatal and early childhood wellbeing services. The *Creating Enabling Maternity Care, Dismantling Barriers* study of the experiences of disabled mothers in the three Wellington regional DHBs, for example, concluded that midwives provided supportive, holistic care and worked to ensure disabled women's rights were upheld. Study participants reported trusting their midwives and feeling safe in their care. Yet midwives themselves reported time restraints and lack of training in disability issues as barriers to delivering good maternity care to disabled women and women who have babies born with impairments.[94]

More generally, many parts of the country are currently experiencing chronic midwifery shortages, and many DHBs report being unable to fill critical vacancies. Anecdotal reports from midwives themselves suggest many are leaving the profession, citing stress and burnout. The net result is that, while our maternity system offers holistic, continuous care in theory, in practice many birthing parents are unable to find a midwife, and are relying on hospital-based teams for their antenatal care, where they might see a different person each time.

There are also considerable ethnic disparities in access to maternity care. For example, in 2018, less than half of pregnant Pacific women were registered with a lead maternity carer in the first trimester, compared with 81% of non- Māori, non-Pacific women.[95]

Similarly, Pacific families are also more likely to miss out on accessing WCTO support. In 2018 and 2019, Pacific families were nearly 10 percentage points less likely than non-Māori, non-Pacific families to have received their first WCTO contact on time, with flow-on effects for subsequent contacts with the programme. There was a 22% gap between Pacific families and non-Māori, non-Pacific families for receiving WCTO contacts in the first year, and more than 700 Pacific families did not receive all the recommended core contacts.[96]

Neither the maternity care system, nor the WCTO programme, are specifically designed to screen for or support parents experiencing perinatal distress. While, in practice, many providers follow a holistic mode of care and are familiar with the risks and early warning signs of perinatal distress, there is no universal screening. Nor is there universal training for the maternity and WCTO workforces in how to respond to a parent in distress. While many LMC midwives and WCTO providers support birthing parents in distress by referring them for specialist support, this support is in many cases extremely difficult to access.

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[93] 'Media Release: Whānau Āwhina Plunket to Exist Parenting Education Programme PEPE', 8 April 2022 (https://www.plunket.org.nz/assets/media-releases/MEDIA-RELEASE-Whanau-Awhina-Plunket-to-exit-parenting-education-programme-PEPE-.pdf).

[94] Carey-Ann Morrison, *Creating Enabling Maternity Care, Dismantling Disability Barriers*, 2021.

[95] Health Quality and Safety Commission*, Bula Sautu - A Window on Quality,* 2021.

[96] Health Quality and Safety Commission*, Bula Sautu - A Window on Quality,* 2021.

“I just needed a circuit-breaker” – Nazia’s story of postnatal distress and recovery*

Kia ora Nazia. Before we get into your story, let’s start with a bit of whakawhanaungatanga. Can you tell us a bit about yourself and your life before your daughter was born?

I am originally from Auckland, from a family of five, and I live in Wellington. My parents are both of Indian origin, and from a Muslim background. My dad came here as a student and my mum was born in New Zealand, so we very much have a sort of mixed cultural identity. My husband is the same – he was born in Fiji, but he was mostly brought up here. I went to university after leaving school, and I’ve done all sorts of interesting work.

Had you always wanted and expected to have children? What did you imagine it would be like?

Yeah, I did always want to have children. I didn’t know how many, I didn’t know who with, but I definitely wanted them; it was part of my ‘plan’. I knew I wanted a partner who wanted to have children, and a big appeal about my husband was that he was very family-oriented and really good with children. He’s wonderful like that. I knew kids would be part of my path, but it was all very abstract. I’m the eldest, so I didn’t have any siblings with children, and I didn’t have a really close understanding of what it would be like, particularly with a newborn.

What about your mental wellbeing before your pregnancy? Did you have any previous experience with depression or anxiety?

I have had anxiety and depression since I was at high school, though it was undiagnosed back then - it was diagnosed when I was at university. I’ve been on a long journey of understanding the root causes of that anxiety and what it’s about, but it is something that’s always there. Sometimes it presents more as depression or low mood, and sometimes it is much more about fear and anxiety. It was very much a part of my life before my pregnancy, and still is. I know it’s a situation I have to manage. I have had some bad times with it in the past; just this sense of overwhelm and anxiety, and feeling hopeless about particular challenges and not knowing how to work through them. That feeling has led to some quite dangerous situations, and I’ve done some destructive things because of it.

There’s an interesting paradox with having a history of depression or anxiety. On the one hand, it can increase the risk of developing perinatal distress, but on the other hand, it can be easier to recognise the warning signs and ask for help if you know what to look out for. What was your experience?

I got pregnant not long after I’d lost someone who was really close to me. I’d just had this really sad thing happen, so when I got pregnant, it was this really happy thing, it felt wonderful. I had quite a beautiful pregnancy. It was during the first COVID-19 lockdown, so I really got to run my own schedule and look after myself. Finding a midwife was very stressful, but that probably was the only real stress. There were no health issues, and my mood was really good. I don’t know if it was hormones or what, but whatever it was – and I think this quite often happens to people – I was feeling so good that I actually chose to come off antidepressants, and I didn’t look into a replacement.

I moved back to Auckland temporarily to have my baby near my family. By the time I was birthing my daughter, I wasn’t on any medication, and I wasn’t having any therapy either because that had stopped because of the COVID-19 lockdown, and I didn't feel like I needed it. If you had talked to my family just before the baby was born, I think they were quite surprised with how well I had coped. When you’ve got a family member with mental health issues you’re always a little bit alert, you know? I think they would have said, "wow, what’s going on with her? She's doing wonderfully."

Then I gave birth and things got really hard. I had a lot of ideas about the sort of natural birth I wanted, and none of them ended up happening. I needed to be induced, and that led to a lot of intervention. Even so, the birth was a positive experience – I felt quite empowered by it – but the physical aftermath was really difficult. I had to stay in hospital for a week, and I found that hard, because I couldn't go anywhere. During that week we had a lot of feeding and health issues, that I was finding really challenging. My mood started to decline, my anxiety started to increase, and I got into what I would call a state of distress, just from being so overwhelmed. Unfortunately, it didn't get picked up by the hospital, maybe because I had my daughter later in the week, and there weren’t many staff on over the weekend. But I had a really awesome midwife who checked in on me, and she basically was like, "I think you need to just get referred into maternal mental health." And she did all the work.

What happened after the initial referral?

When I was in hospital, I never actually got a visit from anybody, but I did get a couple of calls when I talked to an assessment-type person and a specialist psychiatrist. In those phone calls, I think because I had had this previous experience of mental health, I was able to articulate my situation quite well. I was able to just tell them exactly what was happening, and explain it in language that I knew they would understand. Then while the referral was being processed, I went home, and was very up and down in terms of mood. We had a lot of sleep issues and feeding issues and I was feeling a lot of pressure, some of it real, some of it perceived. I was observing a 40 day confinement that’s a cultural tradition in my family, and while I found that to be practically supportive, especially around food and company, it also created a sense of social pressure and expectation that triggered some of my anxiety. Sleep was also very, very difficult, and it really impacted on me.

Sometime in that whole process the referral came through and I was allocated a psychologist who was like my caseworker. I remember one thing she said to me was that lack of sleep is a form of torture. That really put it in context. The scariest point, I'd say, in the whole thing, was when I said in a meeting with her and some of my family members that I didn’t feel like bonding with my daughter, that I wanted to sort of push her away because I didn’t feel like I was good enough for her. I couldn't feed her properly, I couldn't do right by her, and so many people were giving me advice that I thought – well, if they’re giving advice, maybe they’re better off looking after her. I think it was really scary for my family to hear me say that. You know, they can't believe it because they know who you are, right? They know the type of person that you are, and that you would never say something like that, and yet you're behaving like a very different person.

I felt horrible after that, and I felt many of the same things I’d felt in the past when I had experienced self-harm. The interesting thing is, I didn’t do anything to myself in that moment. I knew that in the past, the reason I would do those things is because I needed a circuit-breaker. So when I next spoke to the psychologist caseworker I said, "I just need a circuit-breaker." And she basically said, “yes, given your record, and given what you're saying to me, we need to get you a circuit-breaker. And I have got a good circuit-breaker for you.”

So you spent some time at He Kākano Ora, which is a residential maternal mental health service for mothers and babies in Auckland. The idea of being admitted to an in-patient unit might sound quite serious and maybe a bit scary for some people. What was it like for you?

What they do there is so incredible. It was a place I could go – with my baby – and just kind of be for a few days. The rooms are beautiful. They've all got ensuites. If you want your baby with you, your baby will be with you. If not, they'll settle her, feed her, help her sleep. They make dinner for you. They have all these activities and classes to help you learn some skills and centre yourself and connect with your baby – things like baby massage. They were pretty good about supporting the traditions of my confinement, though they probably could have been more rigorous around halal options for food storage and cooking. I was quite relaxed about that though. It's just a really beautiful place. When I was there, there was almost no-one else there, it was really quiet, and I got to stay for four days, which I think is actually longer than the usual stay. It was just a complete game-changer.

It was the circuit-breaker that you needed.

Yeah. It was the circuit-breaker. I wouldn't say that coming out of it, everything was fine. There were still some pretty challenging situations. But when I think about my time there, I feel really positive, and I wish that kind of experience was available for other people.

What happened next?

While I was still being looked after by the maternal mental health team in Auckland, they helped me to get back onto some medication that worked, and that was important. Not long after that I came back to Wellington, and got referred into the system here. They didn't have the same kind of residential care, but they did refer me to the Family Start programme, and they had a social worker who came and saw me every week. Some of what they cover is child development, and they observed me with my daughter and told me, "Your daughter has very good attachment." Given that I'd had this experience feeling like I wasn't able to bond with her at the beginning, that was so reassuring, and lifted a big burden off me. Then we would just talk, and they would help me problem-solve about things I was finding challenging. One of the things that was a real struggle for me was thinking about childcare, and they really helped me break that down. I didn't actually need this, but the social worker even offered to come with me to visit different ECE centres to choose one.

You can be under the care of maternal mental health for up to 12 months – which I don't think is long enough by the way – but in the end, I didn't need to do the whole year. I got to the point at about eight months where I was like, "I don't need someone to come visit me every week. In fact, it's kind of becoming a bit of an inconvenience. And I'm actually all right." Which is amazing, given how distressed I was after the birth. A lot of it was just that really practical support, both in HKO, and with the social worker. I think with mental health issues, some of that problem-solving cognitive stuff can just become so overwhelming. You just need someone to sit with you and help you work through it. In a funny way, just knowing that there was someone who would help me do these hard things with me almost gave me the ability to do it myself.

* Name changed at Nazia's request to preserve her anonymity

Specialist perinatal mental health support is inadequate, uneven, and may be inequitable

The Ministry of Health recently undertook a stocktake of maternal health service provision across the country, in preparation for the coming transition to the new health system, and in response to repeated recommendations from the Perinatal and Maternal Mortality Review Committee.

In the stocktake, DHBs reported experiencing increasingly complex perinatal mental health needs, and estimated that there was a high degree of unmet need in their communities. Some expressed concern that service delivery is inequitable, citing as evidence the fact that they were not seeing as many Māori, Pacific, and Asian women as the estimated prevalence of perinatal distress among these groups would indicate. In only around half of DHBs could wāhine Māori access care through a kaupapa Māori service or provider, and very few DHBs had a specific focus on Pacific or Asian women.

DHBs noted that specialist maternal mental health services seem to be seeing a higher proportion of the population than is usual for specialist services and suggested that this was at least partly due to a lack of community-based and primary care support. They suggested an urgent need to grow and support the wider maternal mental health workforce, including a need for more psychiatrists and psychologists, other kinds of professionals like peer support workers and a larger community support workforce, and specialist training for primary health care workers including midwives, GPs, and WCTO providers. DHBs also noted that a lack of staff was sometimes preventing them from providing additional supports in the community.

Finally, they suggested that criteria to access specialist maternal mental health support should be extended to include parents who have lost a baby, parents who no longer have their baby in their care, and parents suffering birth traumas.[97]

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[97] Ministry of Health, *Maternal Mental Health Service Provision in New Zealand: Stocktake of District Health Board Services*, 2021.

Conclusion: We have an opportunity to turn things around

As this report has outlined, there is a powerful convergence of evidence that experiencing good mental health during and after pregnancy is critical for the long term wellbeing not only of parents themselves, but of their babies, whānau and families, and communities.

We think most people in Aotearoa New Zealand instinctively understand that pregnancy and the period at the start of a baby's life are crucial times. For some, this knowledge comes from deep and rich cultural traditions, although this knowledge is not available to all. For others, it is passed down from generation to generation as a set of practical skills. For still others, it is hard won from the knowledge of what it is like to miss out on that support, either at the start of their own lives, or at the start of their parenting journey. As a result, most people know that the perinatal period can be challenging for new parents, and our impulse is to treat them with respect, try to make things easier for them, and affirm their mana and abilities as parents.

However, things go awry when the right practical, financial, policy, and community supports are not in place to enable this. At the moment, the priority we accord perinatal and maternal health in our health and social policy does not reflect this collective understanding of the importance of the parent and child wellbeing. This lack of policy priority combines with broader structural issues like poverty, insecure housing, and violence, and current challenges like the COVID-19 pandemic and general shortage of mental health support, to create an increasingly concerning picture. It is clear we are getting things very wrong when the leading cause of maternal death in Aotearoa New Zealand is suicide, and more than half of these deaths are wāhine Māori. This is an intolerable situation.

Clinical researchers are at pains to emphasise that the well-documented association between parental distress and adverse child outcomes doesn't mean these outcomes are inevitable. In fact, their research illustrates the critical importance of systemic factors like low income, insecure housing, and lack of support. When these things are present alongside parental distress, the risk of adverse outcomes for children increases, but when they are absent, and the parent's distress is of short duration, "the risks to the child are generally low."[98]

This is a critical finding from a policy perspective. Public policy decisions and investments will never be able to completely prevent perinatal distress, but they can have a powerful impact on external factors like income, housing, and access to support that contribute significantly to its incidence, risk, duration, and severity. As the authors of a major review in *The Lancet* concluded in 2014, "In view of increasing evidence that experiences in the early years of life are crucial for healthy development and productivity later in life and the number of people affected, interventions and prevention strategies [for perinatal mental health] should be a public health priority."[99]

Such strategies need to come at the challenge from both sides. There is strong evidence that prevention strategies to protect mental wellbeing from the very beginning of the perinatal period – including pre-conception – are highly cost-efficient and effective at positively influencing public health at the population level. Shifting the focus of mental health policy and investment from a sole focus on specialist intervention and treatment to a population-wide focus on promotion, prevention, and early intervention is clearly warranted, and is reflected in current work to transform the mental health system such as the *Kia Manawanui Aotearoa – Long term pathway to mental wellbeing*. At

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[98] Alan Stein et al., 'Effects of Perinatal Mental Disorders on the Fetus and Child', *The Lancet*, 384.9956, 2014.

[99] Stein et al., 'Effects of Perinatal Mental Disorders on the Fetus and Child', 2014.

the same time, though, we also need to address the critical lack of specialist support for parents in severe distress, and expand access to the right kinds of support for the large number experiencing mild to moderate need. Such investment is likely to reduce suffering for women and positively impact on their families.[100] As much as investment in perinatal mental health support is required at all levels – promotion, prevention, early intervention, and specialist treatment – it also won't be effective if it is not also accompanied by significant investment to address the wider structural and systemic drivers, like unstable housing, low income, food insecurity, and domestic violence.

We need our political leaders, policy-makers, and the stewards of the new health system to understand the evidence, champion the needs and rights of pēpi and whānau in their decision-making, and adopt policies that restore and enhance the mana and special status of parents, pēpi, and whānau to promote individual, whānau, and community wellbeing.

We will know we have succeeded when…

- Every birthing parent (and newborn pēpi) in Aotearoa New Zealand is surrounded with aroha and support during the perinatal period.
- Whānau themselves know the early warning signs of distress and have trusted people and places to go where they receive meaningful help.
- The full range of health professionals, social service providers, kaupapa Māori initiatives, and community organisations that may provide help also know the early signs of distress and can quickly provide or connect parents with the extra supports they need. This might take the form of temporary hands-on assistance, or support for the wider whānau with adequate resources to care for their own. Or it might mean timely access to affordable, culturally appropriate therapy, even if the birthing parent is presenting with seemingly 'mild to moderate' distress.
- Community groups and organisations already have strong, reciprocal relationships with parents and whānau, so parents should not feel threatened or vulnerable when discussing their mental health, and are comfortable to receive support or further assessment. If an organisation or community group can't directly provide the support someone needs, they will know where to go and how to access the resources that can.
- The relatively few parents who still become unwell will be able to access intensive specialist support, and most will make a full recovery. Whānau will determine which ongoing supports they need. No matter what their situation, all parents will have the opportunity to parent their babies and stay connected with their whānau.

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[100] Howard and Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', 2020.

Recommended policy priorities

We recommend political leaders, policy-makers, and those designing the new health system prioritise policies that:

Alleviate or remove background stress for new parents by making sure they have warm, secure, affordable housing, adequate food, and that they are safe from violence and abuse.

This could include:

- expanding the provision of social housing and prioritising placements for whānau with young children or expecting new babies
- developing referral pathways between lead maternity carers, WCTO providers, social housing agencies, and Māori housing providers to identify new parents at risk of housing instability and collaborate to find them appropriate, stable accommodation
- guaranteeing adequate food to new parents and whānau, by reducing the cost of fresh food, making it freely available to low-income households, and facilitating partnerships between food-based community initiatives and those who work with new parents
- accelerating work to realise the vision and deliver the shifts for change in *Te Aorerekura*, the National Strategy to Eliminate Family Violence and Sexual Violence.

Make it easier for whānau/family to spend time with and support new parents and pēpi.

This could include:

- extending paid parental leave entitlements to support all parents (i.e. fathers/non-birthing parents as well as mothers/birthing parents) to spend time bonding with their baby and focusing on their whānau
- ensuring everyone in Aotearoa has adequate income and enough time to support new parents and babies in their whānau and support networks, through a combination of sufficient core benefits, a liveable minimum wage, Working for Families support, and enhanced leave and employment provisions.

Ensure birthing parents have access to continuous, holistic maternity care, supportive birth environments, and tailored assistance, to reduce the risk of birth trauma and resulting distress.

This could include:

- increasing funding for midwives and partnering with the sector to develop a strategy to fill urgent vacancies and address long term skill shortages (such as attracting and retaining more Māori, Pacific, and Asian midwives)
- providing sustainable funding for more community birthing centres and primary birthing units (including kaupapa Māori-based environments), so that all birthing parents have a meaningful choice within a reasonable distance of where they live
- commissioning and funding additional antenatal support tailored for groups that may be at increased risk of distress, including Māori, Pacific, and Asian ethnicities, disabled birthing parents, takatāpui and LGBTQI+ people, people who have had a previous pregnancy loss, and people with a prior history of mental illness.

Resource and empower kaupapa Māori and community-led initiatives to better support new parents, babies, and their whānau.

This could include:

- developing meaningful Te Tiriti o Waitangi partnerships to support whānau, hapū, and iwi to provide tailored support to their own new parents and pēpi
- funding the new Māori Health Authority to commission additional and expanded kaupapa Māori initiatives for whānau wellbeing, with a particular focus on reducing high rates of perinatal distress and maternal suicide among wāhine Māori
- ensuring greater decision-making power and flexibility for kaupapa Māori and community-led initiatives so they can respond more effectively to the needs of the new parents, babies, and whānau they work with
- commissioning and funding appropriate support services for Pacific and Asian birthing parents and their babies, disabled birthing parents and their babies, and takatāpui/LGBTQI+ birthing parents and their babies
- changing the internal policies and accountability requirements of government funding agencies to enable more flexible reporting and genuine collaboration between community organisations and government agencies
- equitably resourcing kaupapa Māori and community-led initiatives that support new parents, babies, and their whānau to meet current and likely future need. This is likely to require significant investment.

Assist all who work with new parents and babies to develop the skills to recognise when parents are at risk of distress, identify what kind of support they need, and move quicky to provide it.

This could include:

- supporting workforce development for those who work with new parents, babies, and their whānau to better understand perinatal mental health in general, and the specific needs of Māori, Pacific, Asian, disabled, and takatāpui and LGBTQI+ parents and whānau
- mandating universal screening for perinatal distress during and after pregnancy, investigating culturally safe and appropriate ways to deliver this, and resourcing midwives and WCTO providers to roll it out
- developing agreed referral pathways between those who work with new parents and babies and a range of community and clinical mental health supports.

Provide parents with hands-on practical support for aspects of parenting and daily life when required.

This could include:

- increasing funding and support for antenatal education, and working with providers to develop content specific to the needs of Pacific and Asian birthing parents, disabled birthing parents, takatāpui and LGBTQI+ birthing parents, parents with a history of mental illness, distress, and/or substance abuse, and parents of babies with impairments or rare disorders identified during pregnancy.

- increasing funding and support for breastfeeding support services, and increasing the provision of specialist lactation consultants in hospitals and primary birthing units
- extending ACC coverage for birth injuries to include mental injuries from birth trauma, expanding affected parents' access to support during their recovery
- increasing funding and support for parenting education services, and providing training and support for communities to share practical, culturally appropriate parenting support in their daily interactions with whānau.

Provide fast access to affordable, culturally appropriate therapeutic support to parents with early signs of distress, and guarantee immediate access to best practice specialist help if they become unwell

This could include:

- using the findings of the Ministry of Health's stocktake of maternal mental health service provision as a guide for Health New Zealand to develop nationally consistent, culturally informed, community-based perinatal mental health supports, including best-practice specialist and residential care for those who become unwell, and making these changes a key performance indicator for Health New Zealand and the new Māori Health Authority.

Current opportunities for change

At the time this report is being published, in mid-2022, there are some particularly pertinent opportunities to embed a strong future focus on perinatal mental health and wellbeing. Major reforms are underway in both the wider health system, and the mental health sector in particular, while the government is likely to act on the recommendations of a major inquiry by the Productivity Commission into the prevention and reversal of intergenerational disadvantage.

Within that context, we have identified some immediate opportunities to strongly embed the approach outlined above.

Prioritise perinatal and maternal mental health in the reformed health system

In April 2021, in response to the final report of a major Health and Disability System Review commissioned in 2018, the government released a white paper outlining its plan to disestablish DHBs and merge their functions into a single entity called Health New Zealand to lead the day-to-day running of the health system. The reforms will also create a new Māori Health Authority with the ability to directly commission tailored health services for Māori, a new Public Health Agency within the Ministry of Health, and a national public health service within Health New Zealand. The Ministry of Health will take on a refocused role as the chief steward of the health system and lead advisor to government.

Legislation formalising these changes is currently being considered by a select committee and is expected to come into force in July 2022. When it does, it will require a regular planning cycle. The Minister of Health will produce a national Health Strategy (and specific Māori, Pacific, and Disability health strategies) covering the key priorities and opportunities in the health system on a 5–10-year horizon. Drawing from these, the Minister will also produce a Government Policy Statement (GPS) on health that sets specific priorities for the next three years. Health New Zealand and the Māori Health Authority will then use the health strategies and the GPS to jointly develop a three-year costed plan for the delivery of publicly funded health services.

In anticipation of the formal creation of Health New Zealand in July 2022, interim agencies are working to facilitate the transition to the new model. As part of this, an Interim New Zealand Health Plan is currently being developed. This interim health plan will be finalised before 1 July and will create the first set of formal performance expectations for the new health system. It is expected to apply for two years, while the first GPS, 10-year strategies, and 3-year costed plans are developed.

There is therefore a vital and timely window of opportunity right now (in May and June of 2022) to ensure perinatal mental wellbeing is included as a key focus area in the interim Health Plan, as well as an equally important medium-term priority to ensure it is also given prominence in the first full cycle of strategic planning once the new system is in place.

Develop a perinatal mental wellbeing action plan for Aotearoa New Zealand

There are several existing government strategies and plans that relate to perinatal mental wellbeing. For example, the Child and Youth Wellbeing Strategy includes an initiative to redesign maternity and early years support.[101] The resulting Maternity Action Plan, developed by the Ministry of Health, led the Ministry to undertake the stocktake of maternal mental health services referred to earlier, and

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[101] Department of Prime Minister and Cabinet, ‘Child and Youth Wellbeing Strategy’ (https://childyouthwellbeing.govt.nz/).

this in turn is intended to drive improvements in "provision of equity and evidence-based care for women and whānau with mental health needs leading to improved maternal and infant outcomes for Māori, Pacific and Asian women and babies."[102] There is also a National Breastfeeding Strategy, although it makes no specific mention of the known links between perinatal distress and poor breastfeeding outcomes.[103]

While these existing strategies and plans touch on some of the issues and solutions identified in this report, in our view they do not give sufficient weight to the critical challenge of preventing, alleviating, and treating perinatal distress, given the many significant ways it can impact adult, child, whānau, and intergenerational wellbeing. Given these impacts, and the fact that up to half of all birthing parents may be affected, we think the challenge of improving perinatal mental health warrants its own plan, with specific actions attached to each of the policy priorities identified above.

This plan could sit under the broader Child and Youth Wellbeing Strategy when it is refreshed later this year, or alternatively could be pursued under the umbrella of the Kia Manawanui long term pathway to mental wellbeing administered by the Ministry of Health. Either way, it should be developed in partnership with communities, Māori, midwives, WCTO providers, clinicians, and parents with lived experience of distress. It should set specific, measurable, achievable, realistic, and time-bound goals to improve perinatal mental wellbeing in Aotearoa, allocate sufficient resources to enable these to be achieved, and designate an agency or agencies to monitor progress, report publicly, and advocate for greater investment or effort directly to decision-makers, if and when we do not see the progress required.

Amend the Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill to ensure mental injuries from birth trauma are covered

Recently the government announced the welcome decision that it would extend the ACC scheme to specifically cover birth injuries, after a recent review of existing criteria had led the agency to stop covering such injuries.

The resulting Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill is currently before a select committee, and presents an important opportunity to specifically ensure that mental injuries caused by birth trauma are also covered.

Numerous submitters on the Bill have argued for this, including the Mental Health Foundation and PADA, pointing out the known links between birth trauma and poor mental health, and illustrating how conditions like PTSD can impact on someone's daily functioning. Extending ACC coverage to specifically include mental injury from birth trauma is one important way to help ensure parents in distress can access the supports they need to recover fully. There is a window of opportunity right now for the select committee to recommend this change before it reports back to the House on 14 June 2022.

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[102] Ministry of Health, 'Maternity Action Plan' (https://www.health.govt.nz/our-work/life-stages/maternity-services/maternity-action-plan).

[103] Ministry of Health, 'National Breastfeeding Strategy for New Zealand Aotearoa | Rautaki Whakamana Whāngote' (https://www.health.govt.nz/our-work/life-stages/breastfeeding/national-breastfeeding-strategy-new-zealand-aotearoa-rautaki-whakamana-whangote).

Encourage the Productivity Commission to emphasise the potentially transformative role of supporting perinatal mental health for addressing intergenerational disadvantage

As noted earlier, the Productivity Commission is currently investigating the “dynamics and drivers of persistent disadvantage” and has been asked by the government to make recommendations that will help “break or mitigate the cycle of disadvantage within people’s lifetimes and across generations.”[104] The Commission is due to make preliminary recommendations in August 2022, and to deliver its final report by March 2023. In the coming months, then, there is an important opportunity to encourage the Commission to make perinatal mental health a significant priority in its interim and final reports, and to make recommendations that align with the policy priorities we have identified in this report. While public submissions are not currently being sought for the Commission’s inquiry, we will share this report and its findings and recommendations with the Commission, and we encourage others working in this space to do the same.

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[104] New Zealand Productivity Commission, ‘A Fair Chance for All: Breaking the Disadvantage Cycle’.

Where to get help

Some readers of this report may have experienced – or be currently experiencing – perinatal distress. If this report has brought up feelings of distress or concern, whether current or historical, please know that you are not alone.

The Edinburgh Postnatal Depression Scale is a useful indicator of possible perinatal distress and can be accessed on the PADA website: https://pada.nz/screening-tools/

PADA suggests the following services if you would like to talk to someone. You can also access help via your GP.

- 1737, Need to talk? – Free call or text 1737 to talk to a trained counsellor
- Lifeline – 0800 543 354 or (09) 5222 999 within Auckland
- Suicide Crisis Helpline – 0508 828 865 (0508 TAUTOKO)
- Anxiety New Zealand – 0800 ANXIETY (0800 269 4389)
- Healthline – 0800 611 116
- Rural Support Trust – 0800 787 254
- Samaritans – 0800 726 666

Little Shadow (https://www.littleshadow.org.nz/) for volunteer counsellors specialising in support for parents.

A further list of support services and ways to get help is also available on the PADA website: https://pada.nz/national-helplines/