

Matiro whakamua. Over the horizon. Making effective, culturally meaningful change a sustained reality.

Mahuru 2022

Hinemoa Elder

Mihi

**Ko te whaea te takere o te waka.**

Mothers are the most critical part of our whānau.

We work at Haumaru Ōrite, the Mother Baby Unit, at Starship Hospital. A four bed whānau-friendly place for wāhine and their pēpi, for hapū wāhine and their whānau, who are experiencing severe mental illness from around Tāmaki Makaurau and Te Tai Tokerau. Our place for Māmā and their pēpi is part of a larger intergenerational setting where we look after rangatahi experiencing severe and complex challenges to their oranga, in particular their hinengaro and wairua, and of course including tinana and whānau, up to the age of 18, with their whānau from the upper North Island. We are continuing to work towards our goals, of more than the last 20 years, to become bilingual, Kaupapa Māori, bringing together our cultural approaches, including kāhui of kaumātua, kāhui Māmā and rangatahi, and offering rongoā Māori. Alongside access to the best of hospital level care from our wider Starship specialists to keep our whānau safe and help them on their recovery journey, Māori and non-Māori alike.

I am tasked with 15 minutes of provocation around putting our collective plans for perinatal mental health into action. Ko te whaea te takere o te waka. Mothers are the hull, the most critical part of the structures of our waka, waka being a metaphor for our whānau. On the waka theme, the phrase mātiro whakamua is also fitting for us today.

Whaea Moe Milne taught us about this concept of “mātiro whakamua” looking over the horizon, when we were establishing a first attempt at a kaupapa Māori Child and Adolescent Mental Health Service, “He Kākano” in South Auckland in 2006, in what was then Counties Manukau DHB. Sadly, He Kākano was dis-established in 2018.

Mātiro whakamua is what we need to do now. Look beyond our horizon and bring that future, forward into today’s reality. In our waka tradition our tūpuna fished up islands out of the ocean from beyond the horizon, within the mātauranga of knowing the islands were already there. And we know, from our childhood play, that we can pull on water and bring objects towards us.

So what is this future destination we are creating? A community that values and continues to bring to life actions reflecting the critical importance of women’s mental health in pregnancy and after delivering babies as a major determinant of whakapapa oranga. Of intergenerational wellbeing.

This is clear to us, we are all here because we don’t need to be convinced. We want change, we know it needs to happen urgently. We know the evidence. We want that evidence informed future right now. Now we need to work on the who and the how to make it real.

At the end of today we must have a manifesto of how to bring to life the best of oranga hinengaro in what is called in English perinatal mental health, a co-ordinated programme with concrete actions, people to call, meetings to hold to move actions forward, of who will do what. What are the tangible actions we can take and galvanise others to take to make this future real now?

Knowing the real life experiences, knowing the human costs being paid right now means we hold the responsibility to ensure there is meaningful structural change that in the end does not rely on any one of us or any of us. Time for another whakatauki: **e kore a muri e hokia, there is no going back.**

**A few key issues for us as we move into action.**

1. **Ehara i te aurukōwhao, he takerehāia! Not a leak in the upper lashings but a rent in the hull.** Perinatal mental ill health is not a minor problem. Half of all people who give birth will experience some perinatal mental health difficulties. And as I have emphasised mothers are the hull of our waka, so cannot be treated as individuals, rather as part of the waka, part of the whānau. Our efforts must make the right difference across the spectrum of our whānau needs.

Building general population awareness, normalising, destigmatising across our whole community, all the way from increasing resilience, prevention of progression of difficulties, responses to experiences of those who are experiencing symptoms sub-threshold for diagnosis, and for those with diagnosed conditions, through to their recovery journeys. These aspects must all be addressed with culturally relevant responses and with timely availability of local, trusted and long-term supports. Our systems must not leave anyone behind. We need to think strategically about how to partner with others with similar goals, with related health messages and actions. Māori, Pacific, Asian, Refugee, parents with disabilities, with pēpi with disabilities and their whānau and supporters, must feel at the centre of this, feel seen and heard, be seen and heard.

I am reminded of the salutary lessons from early health promotion for the cervical screening programme. For many years it presented a Pākehā face and so was not relatable for those of us who are outside that parameter. So Māori and Pacific access and uptake rates were low and outcomes poor. The introduction of the Māori and Pacifica messaging with collective groups of women seen getting their smear tests, along with Smear your Mea campaign, which grew from the tragic preventable death of Talei Morrison, have helped to reduce the inequities of access to screening and therefore to better outcomes. Let's remember those hard lessons and not repeat those mistakes. Normalising entry into culturally meaningful supports must be robust and sustained. The evidence is clear, trust is not consistently experienced. Is often missing. Localised safe and trusted places, marae, GP practices, church meeting halls, all need to feel equipped to walk alongside our whānau who need that support.

Another salutary lesson, is in the recently published guidelines for primary mental health, showing we haven't got it right (page 13 and 14).

[https://www.gen2040.co.nz/files/ugd/2a6483\\_d85bea3a28db41deafe9a6014c5584ef.pdf](https://www.gen2040.co.nz/files/ugd/2a6483_d85bea3a28db41deafe9a6014c5584ef.pdf)

Simply asking a woman if she has ever had a mental illness or a mental illness in the perinatal period is tick box. It ignores the stigma, and relies on so many factors that make answering these questions honestly very difficult. There will be many women who will not feel safe to say yes to such questions. And they are right to be wary. Even for those who do acknowledge previous challenges, the next stage of the algorithm is also not fit for purpose. Health questionnaires, GAD-2, PHQ-2, then if positive, Edinburgh Postnatal Depression Scale (EPDS), PHQ-9, GAD-7, not validated for Māori, Pacifica or Asian whānau, not even translated into Māori or any Pasifica languages, are recommended, which rely on speaking and understanding english. This also relies on trusting that the documents and who ever sees them with some of our most sensitive and private information are kept confidential. Research published in 2020 regarding the EPDS raised serious questions about its validity for indigenous peoples. And yet it continues to be included in our screening. This approach risks opening up fears and trauma about what the consequences of saying yes to such questions might be. That might include having your child or other children removed. These are very real issues for many whānau. The primary care triaging systems must be based on developing relationships, and must be culturally lead, designed, governed and measured in terms that resonate with those communities in the first instance.

One additional red flag experience I have had in this domain was a stakeholder review in South Auckland in 2006/7 exploring needs related to what was called "infant mental health". Unsurprisingly, it was not and is not a phrase that resonates with Māori, Pacifica or Asian whānau. The community voice from the stakeholder hui said very clearly, we do not want a specialist infant mental health service. But, MOH ignored the community voice. In doing so, an Infant Mental Health Service was created. This took away time, space and resource from existing culturally informed and trusted community solutions. It sent a message that those existing cultural approaches were not valid. And the bitter irony was that the Pākehā model that the service was predicated on was not even evidence based by Pākehā research standards itself.

2. This leads me to a second point. Measures. **Ehara taku toa i te toa takitahi, engari he toa takitini.** Our success in perinatal mental health is measured with impacts with the whānau, with collective groups. We must put in place ways to measure what works, how and why it works in order to continue to refine what we do. I spent the later part of my doctoral research and 4 years of my post doc developing measures for cultural needs of whānau with Traumatic Brain Injury, based on the whakaaro from marae wānanga. I knew I needed to develop measures that could withstand critique first from our kaumātua and next from conventional academic analysis. It is a process that takes a very long time. If COVID has taught us anything it is that we

can move more swiftly if we have to. How can we learn from the last few years and put into practice accelerated ways of developing and deploying meaningful measuring tools?

We must identify ways to develop and utilise measures for at least three key aspects. First, we need whānau, collective measures. This is something many of us have been discussing for some time now. Individual data points are necessary but not sufficient. We need to apply smart thinking to the development of meaningful whānau measures in order to better understand what works and what doesn't work so well for our whānau experiencing perinatal mental health problems.

Second, locally meaningful sets of measures are needed. Third, measures that are used by all, across Aotearoa. We must develop some overarching measures that show us the broad parameters. We have some now. Suicide rates. Admission to hospital units, length of stay, referral rates. These tell part of the story. What are the additional overarching measures we need, and what are some thoughts about how local measures could be developed?

Māori measures must be developed by Māori. Pacifica measures by Pacifica and Asian measures by Asian peoples. LGBTQIA+ by LGBTQIA+. Whānau with disabilities similarly are the experts in developing measures that are meaningful to them. Recognising the heterogeneity in all groups.

Collecting measures means they must be reported and those collecting them need to know that collecting and communicating these is useful and is being actioned. Another salutary lesson. I hark back to the early days when measures such as the HoNOSCA and HoNOS, required by MOH, were difficult to get colleagues to complete. That was 15 years ago. At that time, the sense was the numbers were sent of and they did not have any effect on the work of people on the front lines. There was no feedback loop. It made us feel like the form filling was not of any real value and being scolded for not doing it felt hōhā. Let's not do that. Measures must feel important and intrinsic to the best quality of care. The feedback about what that information does and how it supports what is happening to continue to improve is a critical piece. And one technology can help us with.

3. **Me aro koe ki te hā o Hineahuone.** Heed the mana of Hineahuone, the first person., a woman Infusing the oranga of perinatal mental health and wellbeing intelligence into all the work being done on the broader ecological determinants of perinatal mental health outcomes is a critical challenge for us. We all need to be breathing the same air. We must find ways to continue to most effectively identify and implement solutions to these broad ecological aspects, as key determinants of outcomes, and at the same time we have to sort out the services' factors. Ecological aspects first. By these I mean, awareness and shaping of our approaches based on the impact of local, national and global histories, intergenerational experiences, racism, the socio-economic factors, whānau experiences of illness and injury, community supports, iwi structures and functions. Vigilant systems and cultures are needed to check that perinatal mental health efforts are required in policies related to housing,

employment, poverty, policing, care and protection, corrections, pay equity legislation in ways that are effective. This cannot rest on one person, department or Ministry. This requires a culture change, such that all who work in all these areas come to value playing their part in ensuring we maintain cycles where progress is fostered and monitored, as well as analysis of any barriers and blocks to momentum and working collectively to change these. Finding the key people, decision makers and implementers is crucial. Treasury being one important area, those who can implement and maintain collaborative cross-Ministry performance indicators are another.

4. **He manako te kōura i kore ai.** We won't get there by wishing. Lets talk about the services part. Services are not going to solve this alone. And at the same time we need services to be the best we can be. We must be perinatal mental health focussed not illness focussed. This future service provision must embrace and manifest that whānau are experts about themselves and have a range of resources and strengths. We have mātauranga specific to the whare tangata, fertility, consideration of pregnancy, pregnancy itself and birthing and the role of parents. Recognising the continuum of services needed in maintaining wellbeing, of oranga hinengaro all the way across to mate hinengaro, severe illness.

I have a couple of red flag experiences to add here. I am reminded of the work done and delivered by Atawhaingia Te Pā Harakeke. It started as a pilot developed by Huhana Roxx, initially in the context of the Domestic Violence Act, it grew and became part of Early Childhood Education, which is why no one in mental health knew about it. In 2007, when we were the fledging kaupapa Māori team I mentioned at Counties Manukau, my cousin told me about Atawhaingia te Pā Harakeke, and so we did the training. It was brilliant. Practical. Great resources. Expert relational work. Culturally rich and real. Nationwide. Meeting the needs locally and nationally. And then, after 10 years, funding was cut, despite positive evaluations. So the learning point here is: culture specific approaches are often funded by pilots and or for short periods then shut down and disappear with all that great work lost. We cannot let that happen again.

5. **He kuaka marangaranga, kotahi manu i tau ki te tahuna tau atu tau atu tau atu.** A famous saying from home in the far north. Our ūkaipō, our iwi, are a critical part of this future. Our iwi are a site of real transformation and must play a lead role as source of trust, a source of whakapapa relationships and tikanga. Marae are the central and fitting place for validating the strengths of whānau and also for early recognition of any challenges. Iwi structures also the source of local rangahau and development of meaningful measures of wellbeing, data collection, data sovereignty and cultural expertise.

I see a role for specific work that supports our iwi in what ever form works best for iwi, to place this aspect, and however they wish to frame it, front and centre. Recognising iwi partnership board frameworks may not be the only place for centring this work. To develop systems recognising local hapūtanga, including measures, workforce development, mātauranga, enhancing awareness, education,

prevention, treatment and healing. Many of our marae remain a relatively untapped site of transformation in our communities. Utilising existing centres of cultural energy, activity, language vitalisation and commitment provides a natural, trusted environment for centring such work in this area. This ensures culturally meaningful options and solutions will be woven through every experience.

Who are the right people to ensure Iwi prioritise oranga hapūtanga or “perinatal mental health” and wellbeing and support them as those endeavours are set up for success?

6. **Ko te manu e kai ana i te mātauranga, nōna te ao.** The bird that feeds on knowledge theirs is the world. The healthy future of addressing these aspects of oranga hinengaro also requires working with the Ministry of Education. The school curriculum must include developmentally tailored content, about our concepts of roles as parents and caregivers, about mental wellbeing in these contexts. This must be a key target in addressing social and emotional literacy at key ages and stages. This can be an area where existing curriculum can be adapted and enhanced with sophisticated and creative approaches as to how we address these aspects throughout our tamariki mokopuna school life. Liaison with those involved with Te Aho Matua, the curriculum of Kura Kaupapa Māori is also needed. Te Aho Matua already encompasses a deliberately holistic approach to learning, honours genders and gender differences, roles and responsibilities, recognising that these synergies are essential for the wellbeing of whānau and whakapapa. It asserts that learning is “caught” rather than “taught”. Wānanga content related to oranga hapūtanga in this area can be further supported for development.
7. A few last thoughts. No advisory boards. No. We know that doesn't work. Māori, Pacific peoples, Asian, refugee groups, whānau with disabilities and LGBTQIA+ need to design and oversee their budget lines, need to be leading design, delivery and in governance, to be part of systems that can retain some flexibility in contract development to actually make sure the parts that really make the difference are funded, with one eye always looking over the horizon.

Ka whakakapi māku, the range of evidence before us is clear, this is the way to ensure best outcomes, and to actively address the spectrum of needs. So let's be specific. Who are the key people who can make this happen, who determine budgets, contracting, commissioning? How will we continue to invigorate meaningful channels and mechanisms of action to bring this future forward? Where are the synergies with other kaupapa and action plans?

Recognising the life-saving and intergenerational life-span values of the changes. We must take responsibility to work through all necessary steps to ensure practical, meaningful changes happen, starting now, and are maintained and grow to meet future needs. Some of these changes can begin to happen today. Because this is not theoretical, these are life and death issues that we can make a difference to right now. Ko te Whaea te takere o te waka.