MATERNAL MENTAL HEALTH REPORT 2022

The photos throughout this report are of the planting of 30 trees in Kelmarna Community Gardens to represent the number of women who had died to suicide since the PMMRC recommendations in 2007. These trees were planted alongside the 8000 flowers we planted in the Spring of 2017 which represent the 8000 women who experience delayed diagnosis and treatment for PNDA every year, and the number of women who do not meet the criteria for funded Maternal Mental Health services. Members of the public, community agencies and politicians attended the **planting of the 8000 flowers**. In 2021, a call went out to ministers, the Ministry of Health, clinicians, community agencies and political parties in Government to donate a tree to honour women that have died to suicide during the perinatal stages since 2007. The following responded with a donation (some of whom attended the tree planting event): Maternal Care Action Group NZ, Mothers Helpers, Plunket, Mental Health Foundation, PADA (Perinatal Anxiety & Depression Aotearoa), Mind Body Trust, The Royal College of General Practitioners, Ministry of Health, Women's Health Action Trust, Matrescense, Beth-Shean Trust, Refugees as Survivors – New Zealand, Brooke van Veldon from the Act Party and a representative for Chloe Swarbrick from the Green Party.

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WHY MATERNAL HEALTH MATTERS

Mental health issues during pregnancy and following childbirth are common in all parts of the world and adversely impact on maternal morbidity, mortality and ultimately the survival and development of children (WHO, 2021). The impact of mental illness at this critical time can be far reaching, affecting not only the mother but also her baby, family and the community. When a woman experiences untreated perinatal depression/anxiety, her baby is more likely to develop emotional, cognitive and behavioural issues and there is an increased risk of learning difficulties, mental health issues, trouble with the law and suicide (Foreman, 1998; Stewart, Robertson, Dennis, Grace, & Wallington, 2003).

In Aotearoa, the largest cause of maternal death is suicide. In the period 2006-2018, suicide accounted for 30 maternal deaths and Māori women are 3.35 times more likely to die by suicide according to the 2021 report from the Perinatal and Maternal Mortality Review Committee (PMMRC). The report highlights that even though the rates of maternal death in Aotearoa are higher than those in the UK, there is significantly less investment in maternal and perinatal mental health in NZ than in the UK (PMMRC, 2021).

Feedback from women as well as research studies have shown that many women do not seek help for their depressive symptoms and as many as 50% do not even ask family and friends for help (Small et al. 1994).

DR CELIA DEVENISH, CHAIR OF THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"It is disheartening that of the PMMRC recommendations since 2007, fewer than half have been implemented… There is still an alarming lack of maternal mental health resources in Aotearoa… The health sector needs to step up."

INTRODUCTION

ABOUT MATERNAL CARE ACTION GROUP NZ

Maternal Care Action Group NZ (MCAGNZ) was formed in 2017 out of a concern for the ongoing gaps in Maternal Health, and specifically Maternal Mental Health. Members of MCAGNZ include midwives, well child nurses, clinicians, women who have experienced perinatal depression/anxiety (PNDA) and their families. There are nearly 200 members that make up Maternal Care Action Group. Find out more at their **website.**

PMMRC RECOMMENDATIONS

In 2007-2019, the Perinatal and Maternal Mortality Review Committee (who is appointed by the Health Quality and Safety Commission) made a series of recommendations in Maternal Mental Health to reduce the number of maternal mortalities since the leading cause of maternal deaths is suicide. Those **recommendations** were marked as URGENT and include:

- Antenatal maternal mental health screening
- A stocktake of current mental health services across New Zealand for pregnant and recently pregnant women to identify strengths and gaps, inequity and skills in the workforce
- A national pathway for accessing maternal mental health services including cultural appropriateness, appropriate screening, care for women with a history of mental illness, communication and co-ordination
- That a Perinatal and Infant Mental Health Network be established to provide an interdisciplinary and national forum to discuss perinatal mental health issues
- A comprehensive perinatal and infant mental health service should include screening and assessment, timely interventions including case management, transition planning and referrals, access to respite care and specialist inpatient care for mothers and babies, consultation and liaison services within the health system and agencies
- Improved awareness and responsiveness to the increased risk for Maori women

In 2021, the PMMRC reported that these recommendations were yet to be implemented. Later that same year they reported that some of the more urgent recommendations as well as a stocktake had been completed. They delayed their next report by six months – their announcement can be viewed here: **Update from the PMMRC September 2021**

2021

GAPS IN MATERNAL MENTAL HEALTH

In 2015, a Mothers Helpers Survey found two-thirds of women with Perinatal Depression/Anxiety had experienced significant delays in diagnosis and treatment due to poor education and low screening rates for PNDA. In 2019, Mothers Helpers repeated the survey and found that the delays in diagnosis had not changed and there had been no improvement in screening or education since the previous survey. This delay in diagnosis and treatment affects an estimated 8,000 New Zealand women and their children every year. Some of the stories of these women can be found on the home page of the Maternal Care Action Group website. 2019-2021 Survey Results are now available.

11,000 women are estimated to experience Perinatal Depression/Anxiety in New Zealand every year. An average of 75% of these women will not meet the criteria for Maternal Mental Health due to their symptoms not being "severe enough." In some DHB areas, it is as much as 95% not meeting the criteria simply because the service is flooded with women experiencing severe symptoms, and a budget that does not allow them to accept more (Scoop, 2015). Maternal Care Action Group NZ is currently waiting on Official Information Act Results from every District Health Board in New Zealand on an update on this situation and will update this report when they come through in late May 2022.

EXPERIENCING PERINATAL/DEPRESSION IN NEW ZEALAND 2019-2021 SURVEY RESULTS BY MOTHERS HELPERS

201 women participated in the survey. Of these, 81% were NZ European/Pakeha, 9% were Maori, 3% were Pasifika, 5% were Asian and 11% were 'Other' - a mix of British, European, American, Middle Eastern, Latin American, Australian and African or South African. 41% were aged between 30 and 35, 31% between 35-40 and 17% between 25-30. The remainder fell into the 20-25 or 40-45 age group. No one was under the age of 20. Location-wise, this was spread throughout all DHB catchment areas with the exception of South Canterbury. The areas most represented were Waitemata

(21%), Auckland (17%), Waikato (9%), Canterbury (9%), Counties Manukau (7%), Hutt Valley (7%), Bay of Plenty (6%), Capital and Coast (5%), Mid Central (4%) and Northland (4%).

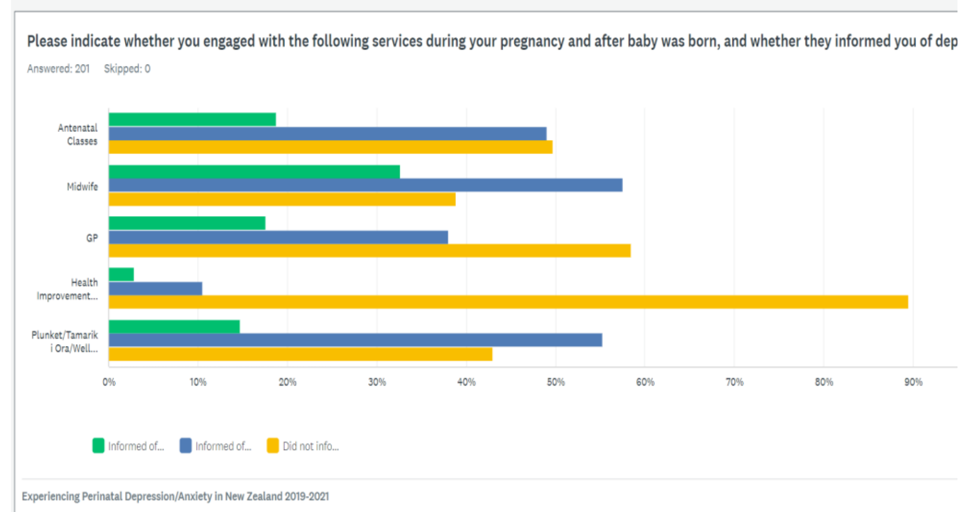
Due to the under-representation of Maori, Pasifika, Asian and other ethnicities, Mothers Helpers chose to share all comments on services offered by these ethnicities and created a service rating comparison between Tangata Whenua and the overall rating of a service. This was for the purpose of giving them a greater voice since Maori, Pasifika and Asian communities are less likely to access health or mental health services, Asian and new migrant communities experience a higher rate of Perinatal Depression/Anxiety and Maori experience a higher rate of maternal suicide than any other ethnicity.

<u>Summary of Survey Results</u>

This survey combined with previous surveys spanning 11 years explores the experiences of women who have had perinatal depression/anxiety in Aotearoa New Zealand. These surveys have consistently identified gaps in education, screening/assessment and funded therapeutic treatment.

1. Education

Participants were asked to detail if they engaged with any of the following services and whether they informed them of antenatal depression/anxiety or postnatal depression/anxiety or neither. Green indicated informed of antenatal depression/anxiety, blue indicated informed of postnatal depression/anxiety and yellow indicates neither informed of antenatal nor postnatal depression/anxiety.



Participants were than asked to indicate *when* they were informed:

Information about Perinatal Depression/Anxiety

We asked when women were given information about Perinatal Depression/Anxiety.

Time they were informed	% Given information about PNDA in 2015	% Given information about PNDA in 2019	% Given information about ANDA in 2019	% Given information about ANDA in 2022	% Given information about PNDA in 2022
Never	N/A	11	69	54	13
During Pregnancy	58	45	19	32	49
Post-partum	38	35	4	7	36
At the time they went for help	50	62	14	19	54

Participants were then asked about the quality of the information. Of those that were given information, just 23% found it to be very informative, 37% felt the information was OK, 21% found it was only a little informative and 10% felt it was not at all adequate.

2. Screening/Assessment

Assessment comparisons:

Assessed by	% in 2015 post-partum	% in 2019 during pregnancy	% in 2019 post-partum	% in 2022 during pregnancy	% in 2022 post-partum
Never assessed	34	61	41	49	36
Midwife	28	25	39	35	42
Plunket	21		27	-	24
GP	43	18	24	20	23
MMH		15	16	10	17
Mothers Helpers	-	1	1	3	3
Health Improvement Practitioner				2	1
Other		10	13	8	6

Gaps in information and screening/assessment has led to delays in diagnosis and treatment:

Delay of Diagnosis following onset of Sx	%
Within 1 month	22
Within 2 months	10
Within 3 months	13
Between 4 and 6 months	14
Between 7 and 9 months	6
Between 10 and 12 months	7
Between 12 and 18 months	5
More than 18 months	6
I was never diagnosed or received help	17

Mothers Helpers writes "It's difficult to put a number on what would be considered a "reasonable timeframe" before a woman is picked up for perinatal depression/anxiety. For those that experience it without help or treatment, one month feels like a long time. Some clinicians would argue that symptoms need to be experienced for two months before a diagnosis is warranted."

What we can see from this table is that two-thirds of women (68%) are experiencing delays in diagnosis beyond that two-month mark and more than 50% are experiencing significant delays with 17% never diagnosed or receiving of help/treatment.

In response to the feedback of participants, Mothers Helpers recommends:

- Training clinicians in perinatal depression/anxiety – particularly Midwives, Plunket, Health Improvement Practitioners and Health Coaches specifically on the onset, symptoms, screening, assessment, best practice for treatment of PNDA and referral pathways for help
- Standardised education on PNDA delivered to mothers in antenatal classes and midwifery care.
- Universal/routine screening for depression/anxiety of women during the perinatal stage by midwives and Health Improvement Practitioners.
- Funded therapeutic services tailored towards Maternal Mental Health (rather than being lumped in with generic mental health services) are made available to all women experiencing perinatal depression/anxiety alongside clear pathways communicated to both clinicians and consumers alike.

These recommendations have been made in response to the survey results of women's experiences of PNDA over the last 11 years and it is the view of Mothers Helpers that these are still the main priorities for Maternal Mental Health to address existing gaps that have been there for 11 years or more.

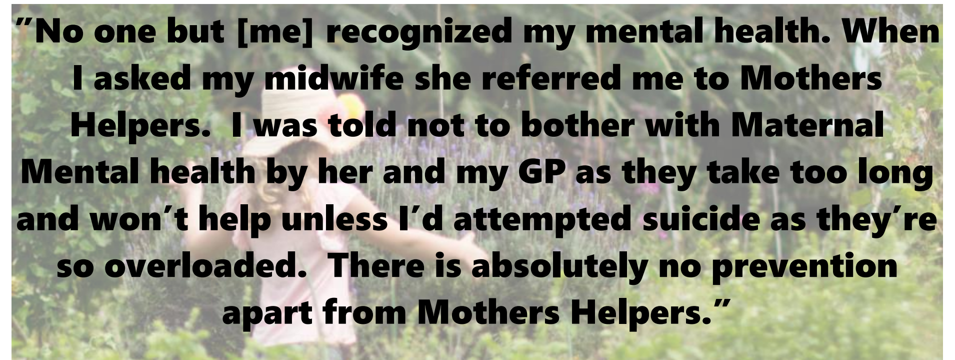
There has been a low number of participants (24 of the 201) who indicated they accessed the service of the Health Improvement Practitioner – part of newly Government funded community mental health service. A lack of promotion of the newly funded mental health service or the slow rollout of availability has likely contributed to the low access, but unless gaps around information of PNDA and screening/assessment for PNDA is addressed, there will still be low access to this service by women experiencing perinatal depression/anxiety.

Participants have also indicated that their experience of a service has the ability to greatly impact their mental health. They rated their experience of community services including Child Birth Educators, Midwives, GP's and Plunket as "good," Health Improvement Practitioners and Health Coaches as "fair" or "poor" and the Mothers Helpers service as "very good." They rated Hospital Staff at time of delivery and Maternal Mental Health as "good" or "fair" and Community Mental Health and the Crisis Team as "fair." Ratings from Tangata Whenua were lower than overall scores when rating their experience of GP's, Hospital Staff at the time of delivery, Maternal Mental

Health, Community Mental Health, the Crisis Team, Health Improvement Practitioners and Health Coaches.

Participants said their mental health is supported when they experience a service that they can access easily with a short wait-time, that genuinely listens to their concerns, treats them non-judgmentally with warmth, kindness and understanding, is attentive and informative. They want a mental health service that is consistent and reliable, a service that is sensitive and focused on their needs - checking in with them regularly. They want a service that helps them to identify contributing factors to their depression/anxiety and gives them tools to manage it, a service that helps them to make small, realistic, practical steps towards their goals. They want a service that is relevant, inclusive, current and up-to-date that provides or can access practical help/respite.

A full report of these latest Survey Results are available **here** and data **here**



EFFECTS OF COVID-19

Presentation to the Epidemic Response Committee by Rebekah Burgess

Global Research on the effects of Covid-19 on mothers:

Pregnancy During Covid-19 Lockdown: How the Pandemic Has Affected New Mothers – 2021

Women's Mental Health Deteriorated More in Covid Pandemic: Study - 2021

Covid-19 Pandemic Increased Stillbirth and Maternal Death Rates, Study Says - 2021

In 2020 "Out of the Fog" released the New Zealand based survey results for the **"Psychological Effects of Covid-19 and Lockdown in NZ on New/Expectant Mothers."**

The most significant findings of this survey was the impact on mothers' mental health: 32% said they had a diagnosis of depression/anxiety prior to

the Covid-19 pandemic and lockdown yet 49% had an Edinburgh score that was 11 or greater (indicating mild perinatal distress or depression/anxiety).

Those that had been diagnosed with depression/anxiety prior to the Covid-19 pandemic and lockdown, 51% said it had become worse since the pandemic and lockdown.

While there was a small number of mothers that enjoyed lockdown, 95% experienced stressors (high-risk pregnancy, health problems, complications during labour, breastfeeding issues, traumatic birth experience, reduced support by their partner, midwife or family or felt anxious to go out), 78% reported distress and nearly half experiencing anxiety since the first Level 4 lockdown. There was also some mention of financial strain and income loss.

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Increase in Demand for Mental Health Services

Along with other mental health providers, Mothers Helpers reported a huge increase in demand for their service since the Covid-19 pandemic and subsequent lockdowns. In 2020, demand had grown from 293 to 432 requests for support and in 2021 from 432 to 633. Organisations such as Mothers Helpers put the increase in demand down to the significant reduction in support experienced by women during pregnancy and post-partum during Levels 2-4. This included reduced in-person with midwives, well child and other clinicians as well as a loss of family support due to restrictions.

"In summary the anxiety in our mothers has skyrocketed and mothers have been presenting with so many more issues to do with Covid on top of their anxiety brought about by hormones and transitioning to motherhood. The mothers are more isolated than ever which compounds their feelings of anxiety and depression, as loneliness can be an unforgiving state of mind which breeds negativity. There has also been a large presentation of trauma by mothers over the last years, which is not something that this organisation has got time or money to deal with. Due to Covid, wait lists for health provided treating mental health and trauma have closed or been up to 6 months, so we have been having to hold these mothers. Due to this the workload at Perinatal Support Nelson has doubled with a wait list of up to 3 months. There has been the job for the Clinical Manager to support these mothers by phone regularly while they wait. It has not been an ideal situation at all but it has been the only way recently with lack of funding and staff."

- Harriet Denham,
  Clinical Manager of Perinatal Support Nelson

"There certainly has been an increase in birth trauma and birth-related distress due to the pandemic - staff shortages meaning less support for birthing and new parents; fewer services/support service opportunities, for example lactation consultants; decreased familial/friends support due to travel restrictions & lockdowns means new parents have less support; restrictions on numbers in the birth space/post-birth space (in hospital/birthing centre)….There is, generally, huge gaps in specialised care for those who have experienced birth-related trauma or distress. Many health care professionals do not know enough about birth trauma to appropriately diagnose and refer, and many support professionals do not understand the uniqueness of birth trauma and how to best support birth givers/parents."

- Kate Hicks
  Founder Birth Trauma Aotearoa

Birth Trauma Aotearoa state what is needed in New Zealand is:
- increased knowledge and understandings around birth trauma (both physical and psychological);
- improved referral systems and support systems - streamlining of systems and options for care (e.g. improved ACC cover for physical injury/diversity of healing modalities);
- improved numbers of support staff, e.g. counsellors/psychologists and increased skill of those staff, specifically around birth trauma;
- improved access to culturally appropriate and safe care (e.g. for whānau Māori; Pacifica families), including diverse options for healing (e.g. Rongoa);

- improved access for rural communities and other marginalised groups (e.g Rainbow communities);
- improved information for birthing parents, pre-birth, in order to help prevent trauma/distress.

Mothers Helpers Board member plants a tree at Kalmarni Gardens

2021 MENTAL HEALTH REPORTS

Please click on the following report titles (underlined) to access each report in its entirety:

Te Huringa: Change and Transformation 2022 Mental Health & Addiction Service Monitoring Report

This report has been released by the Mental Health and Wellbeing Commission. Its intention is to monitor the Government response to the Mental Health Report He Ara Oranga. In summary this report:

- Acknowledges the $1.9 billion invested into mental health by the Government in 2019
- Urges the Government to keep it as a priority
- Acknowledges Maori are not well served by the mental health and addiction system and therefore they would like to see a range of health services that reflects the aspirations of whanau, hapu and iwi, an interconnection with Maori healing and treatment options and resources developed by Maori, and culturally and spiritually safe services for Maori

- Would like to see further investment and development in peer services, youth services, and other community-based specialist services particularly for those with mild-moderate and moderate-severe mental health needs: "the measures… show access to specialist services has not changed since the beginning of the Covid-19 pandemic. However, these measures do not necessarily reflect the need (or demand) for support. The Ministry of Health has reported many people have experienced increased distress during the Covid-19 pandemic, particularly during lockdowns. The workforce is feeling this pressure too, with recent data showing 45% psychiatrists would leave their job if they could. We have also heard from tangata whaiora that accessing support has been a challenge due to the pandemic."
- Acknowledges the rollout of the "Access and Choice" mental health primary care approach across the country but mentioned that they would like to see services for Maori, Pasifika and Youth accelerated.
- Wants to see the effectiveness of interventions measured by reduced symptoms or severity of symptoms and broader wellbeing outcomes.
- There was no specific mention of Maternal Mental Health nor any connection made between Maternal Mental Health and Youth Mental Health despite accumulating research which connects the two.

Access and Choice Programme: Report on the First Two Years

This reports reflects on the first two years (2019-2021) of the Access and Choice Mental Health rollout through Primary Care services. In summary this report:

- Acknowledges the $516.4 million invested into Integrated Primary Mental Health and Addiction Services (IPMHA services): services provided in general practices that are accessible to everyone enrolled in those practices (ie. Health Improvement Practitioners (HIPs) and Health Coaches), Kaupapa Maori, Pacific and Youth Services
- Acknowledges there have been some concerns that local communities were not involved in the design of the IPMHA service and there have been concerns about funding allocation for the services eg. Practices that might have a higher population of Maori or high needs
- Reports the rollout is ahead of schedule and is available across 16 DHB's and 237 general practices with the number of people using services "on track"
- Recruiting and training the workforce for the new roles of HIPs and Health Coaches has been challenging but the gap between funding versus workforce employed is decreasing
- Most frequently recorded presenting issues as of June 2021: lifestyle choices 10.8%, anxiety/panic 9.3%, stress 7.4%, long term condition 5.1%, depression 5%, family/whanau/parenting/relationships 2.8%, self management of long term condition 2.6%, sleep 2.2%, grief 1.6%, emotional wellbeing 1.1%
- Kaupapa Maori services are behind what was expected by this time, Kaupapa Maori services were co-designed, with $62 million targeted spending over 4 years. 12 Kaupapa Maori services have been contracted over 11 districts. There are also some workforce issues in these services.

- Pacific services implemention is behind what was expected by this time, Pacific services were co-designed, with $25 million targeted spending over 4 years. 9 Pacific services have been contracted across 7 districts. Workforce recruitment is also a challenge.
- Youth services (aimed at 12-24 years) receives more than $60 million over 4 years. Youth services went through a consultation process before setting up. It is behind schedule and there are workforce challenges. 18 youth services have been contracted across 15 districts.
- Again, Maternal Mental Health has not been specifically included in targeted funding. Rather, women can access Kaupapa Maori or Pacific services or they can access their Health Improvement Practitioner/Health Coach through their General Practice despite Maternal Mental Health having unique gaps and unique needs. There is no acknowledged connection between Maternal Mental Health and youth mental health in this report despite the wealth of research connecting the two.

Maternal Care Action Group NZ asks that the Mental Health and Wellbeing Commission:
- connect the wellbeing of mother and parents with the wellbeing of children and youth
- acknowledge the link between Maternal Mental Health and child attachment and youth mental health
- begin to make specific reports about Maternal Mental Health in the context of IPMHA, Kaupapa Maori, Pacific and Youth Services in terms of how these are being addressed and what gaps remain

Ahurutia Te Rito – It Takes A Village by the Helen Clark Foundation

This report by Holly Walker of the Helen Clark Foundation was released in April 2022. In summary, this report:

- Focuses on what contributes to perinatal distress

Attempts to answer the question "*What are the stress factors contributing to poor mental health among 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?"*

- Acknowledges better support for perinatal mental health would be transformational for whanau and communities in Aotearoa. Concludes that the responsibility for reducing parental distress should not fall on individuals, nor over-stretched community-led or Kaupapa Maori organisations. States it is a critical public policy challenge that requires urgent prioritization.
- Makes the point that perinatal distress is widespread, complex and linked to systemic inequities
- Points to parents and whanau having access to support is the best way to protect perinatal mental health and whanau wellbeing: "support works best when it comes from sources that parents already know and trust, and that collaborative, strengths-based initiatives, including community-led and kaupapa Māori-driven initiatives, are best placed to reach those in most need of support. Current supports available in Aotearoa New Zealand are not adequate to meet current

needs, and specialist perinatal mental health support in particular is inadequate, uneven, and may be inequitable."

- Recommendations of the report address policies and funding around systemic and social issues including housing, income/poverty, resourcing maternity services, extending parental leave, funding Kaupapa Maori services, training and upskilling those who work with parents/caregivers during the perinatal stages to identify perinatal depression/anxiety. The Report suggests that this could include workforce development, mandating universal screening and clear referral pathways. The Report also recommends hands-on practical support for parents/whanau in their daily life and suggests increasing funding and support to antenatal (culturally relevant and inclusive) education, parenting education. The final recommendation focuses on providing 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.
- The Report then looked at Opportunities for change and therefore the following recommendations were made:
- Ensure perinatal mental wellbeing is included as a key focus area in the interim Health Plan (due out on 1st July 2022)
- Develop a perinatal mental wellbeing plan in partnership with Māori, midwives, WCTO providers, clinicians, and parents with lived experience of distress. It should set specific, measurable, achievable, realistic, and time-bound goals that are resourced and designated to a specific agency that reports publicly on progress.
- Amend the ACC (Maternal Birth Injury and Other Matters) Amendment Bill to ensure mental injuries from birth trauma are covered
- That the Productivity Commission currently investigating the "dynamics and drivers of persistent disadvantage" makes perinatal mental health a priority in its preliminary recommendations to Government in August 2022, and its final report in March 2023.
-

A summary of this report is available here
The report in its entirety is available here

Maternal Care Action Group NZ wholeheartedly supports this robust Report and its above recommendations and thanks Holly Walker for this important piece of work.

Maternal Mental Health Service Provision in New Zealand: Stocktake of District Health Board Services, by MOH 2021

This stocktake was carried out by the Ministry of Health in 2021 as per the recommendation of the PMMRC. The key findings of the stocktake are as follows:

- There is an increasing complexity of need and unmet need and concern that delivery is inequitable
- Cultural models of care need to be strengthened
- There are gaps in the continuum of care

- We need to support and grow the wider maternal mental health workforce
- Eligibility criteria to access DHB maternal mental health services require a live child

"DHB specialist maternal mental health services are seeing a higher proportion of the population than is usual for specialist services. They believe this is likely at least partly because of a lack of support in the community and primary health care sector, for example, in the areas of psychological therapy, systematic and effective screening, and early intervention in primary health care."

Their stocktake is as follows:

Table 1: Number of DHBs reporting availability of perinatal maternal mental health inpatient services, by region

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	0	1	5
Postnatal	4	0	1	5

Notes:

Some DHBs may not have reported availability because the service may be provided regionally by a different DHB, while some DHBs may have reported availability despite the service being accessed through another DHB in the region. However, all regions do have a perinatal mental health inpatient service available.

Some mental health services will admit a mother but do not have facilities for the baby to be in the inpatient service as well.

Table 2: Number of DHBs reporting availability of perinatal respite services, by region

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	0	2	0
Postnatal	4	1	1	0

Notes:

The services referenced in Table 2 are those that can host both mother and baby and exclude adult respite services that can accept a pregnant or postpartum woman without her child.

While only DHBs in the Northern region specifically reported offering perinatal respite services, some DHBs in other regions, such as in Te Manawa Taki region, described offering respite type services through different models. For example, Waikato DHB described using flexible funding to support the ongoing needs for māmā and pēpi, including respite and in-home care.

Table 3: Number of DHBs reporting availability of perinatal specialist community services, by region

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	5	6	3
Postnatal	4	5	6	3

Note: Services that do not have a specialist maternal/perinatal mental health service usually provide some services for this population through the general mental health service.

There are six current sites: one in Waitematā DHB (the original site, which has been running for over 15 years), three sites that were funded through Budget 2016 in Tairāwhiti, Hawke's Bay and Northland DHBs and two sites that were funded through Budget 2019 in Whanganui and Bay of Plenty DHBs.

Table 4: Number of DHBs reporting availability of pregnancy and parenting services, by region

	Northern	Te Manawa Taki	Central	Southern
Pregnant	4	2	2	0
Postnatal	4	2	2	0

Table 5: Number of DHBs reporting availability of maternal mental health clinics, by setting and region

		Northern	Te Manawa Taki	Central	Southern
Hospital campus	Pregnant	3	5	6	1
	Postnatal	3	5	6	1
GP practice	Pregnant	0	0	1	0
	Postnatal	1	0	1	0
Community organisation	Pregnant	2	2	1	2
	Postnatal	2	2	1	2
Virtually	Pregnant	3	2	5	0
	Postnatal	3	2	5	2

Table 6: Number of DHBs reporting availability of counselling for women experiencing distress, by region

	Northern	Te Manawa Taki	Central	Southern
Pregnant	2	2	6	3
Postnatal	2	2	6	3

Table 7: Number of DHBs reporting availability of telephone consultation services, by region

		Northern	Te Manawa Taki	Central	Southern
GPs	Pregnant	4	2	5	3
	Postnatal	4	2	5	3
LMCs	Pregnant	3	2	4	2
	Postnatal	3	2	4	2

With regards to the community mental health services rolling out across the country: "Expanding access and choice of primary mental health and addiction support was a key focus of Budget 2019. This five-year programme is building a missing component in the mental health and addiction system for people with mild to moderate mental wellbeing needs. While it is not specifically targeted at maternal mental health (or any other type of mental health issue), it is accessible and suitable for addressing maternal mental health issues."

A CASE STUDY ON HOW ACCESS & CHOICE CAN PROVIDE EFFECTIVE THERAPEUTIC INTERVENTION

Mothers Helpers is a nationwide holistic therapeutic community agency specializing in Maternal Mental Health. More than 640 women access their service with steady growth year on year. Statistics show that they are reaching Maori as well as Pakeha women with the percentage of Maori accessing the service at 26% (17% of population are Maori), but Pasifika and Asian communities lower than population comparison.

In 2021 Mothers Helpers signed a contract with Manawatu's 'Think Hauora' Access and Choice (Te Ara Rau) as a Speciality Service providing a therapeutic package of care to women experiencing perinatal distress.

Over the last 10 months, their agreement had been revised multiple times. Initially, funding was provided to cover four counselling sessions and their nine-week group therapy **'Out of the Fog' programme** for each woman that was referred to them. Eventually, an initial assessment was also funded as well as their six-week **'Preparing for Parenthood' programme** for expecting parents. On rare occasions, several extra counselling sessions were funded for an individual if required.

- Mothers Helpers provided a full-day seminar on perinatal depression/anxiety hosted by MidCentral DHB and Think Hauora. GP's, midwives, Health Improvement Practitioners, Health Coaches and other clinicians were invited. Local iwi were also invited to present in partnership with Mothers Helpers. The seminar included information on the symptoms, risk-factors, onset and best-practice treatment of perinatal depression/anxiety as well as assessment and screening. Clear pathways for referral were communicated.
- Think Hauora Service Managers triaged referrals either to Mothers Helpers or Maternal Mental Health appropriately.
- Referrals to Mothers Helpers were picked up by the Service Manager, allocated to a clinician (counsellor or social worker) who in turn reached out to the client via text or phonecall within 48 hours
- An appointment was offered to the client within one week
- Mothers Helpers was given five months to complete the service with the referred client, allowing for time to attend any or both of the courses alongside counselling sessions

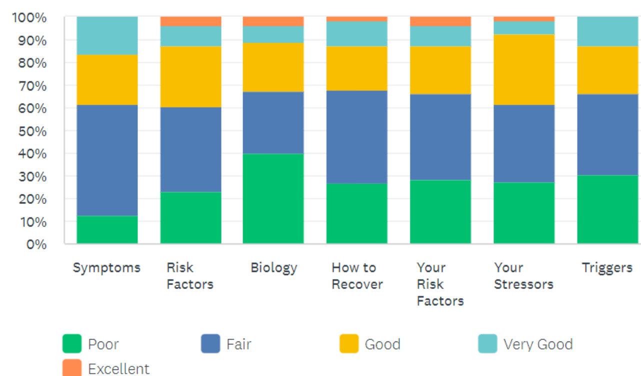
Over 10 months, Mothers Helpers received 57 referrals from Think Hauora Access & Choice. Of these, we engaged with 47 women with 10 either not attending appointments, not contactable or declining the service. All 47 received an initial assessment with one of our clinicians. One hour is given to each of the women not including follow up paperwork. In that time, her story is heard and strengths and resources acknowledged alongside risk factors and other issues. Edinburgh scores are carried out as well as an Impact Event Score (if she describes a traumatic birth experience) to pick up signs of PTSD

and a Hua Oranga score as per the contract (based on Te Whare Tapa Wha values). A history is taken including medication and together client and clinician decide on next steps. Together, she and the clinician will identify any need for a medication review with her GP, or whether a referral is needed to Maternal Mental Health or the Crisis Team if her symptoms are severe or she is at-risk. The clinician may make other referrals to address contributing factors such as family violence, housing needs, sexual assault. She has the opportunity to attend four funded counselling sessions. She has the opportunity to join the six-week "Preparing for Parenthood" psycho-educational group for expecting parents to help them with the psychological transition to parenthood. This covers expectations, adjusting, communication, stress management, self-esteem and self care, building resilience, coping with change, diet and exercise and risk-factors, signs/symptoms of perinatal depression/anxiety and where to go for help.

She has the opportunity to join the 9-week "Out of the Fog" programme focusing on understanding Perinatal Depression/Anxiety and learning holistic tools towards wellness combining Peer Support, CBT, Mindfulness, ACT and Solution-focused approaches.

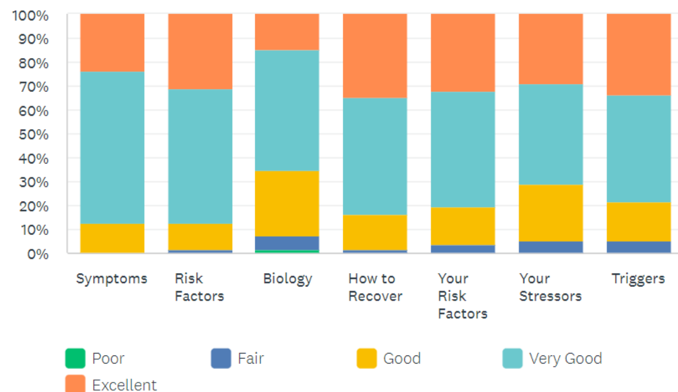
What Was Your Knowledge Like Prior to the PND Recovery Course?

Answered: 56 Skipped: 0



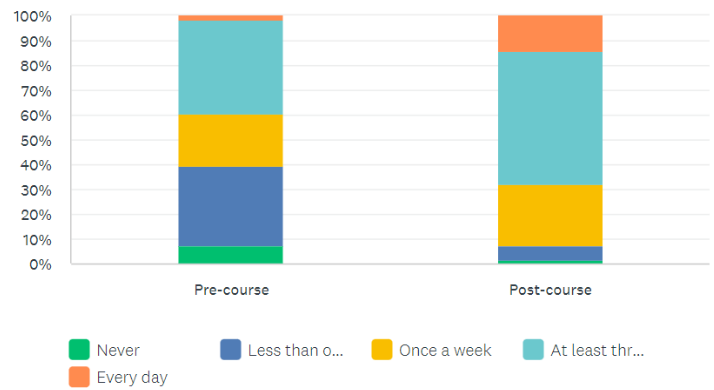
What Was Your Knowledge Like After the PND Recovery Course?

Answered: 56 Skipped: 0



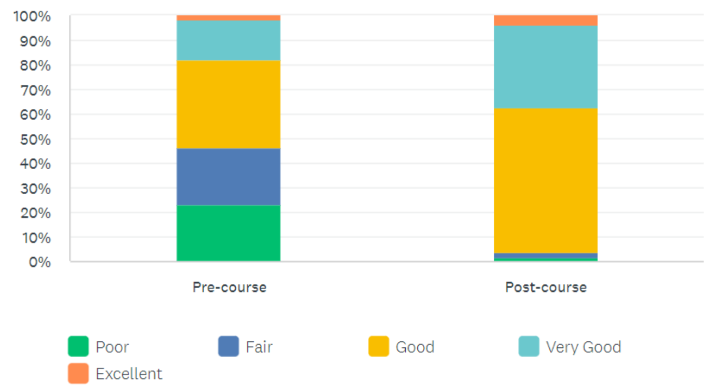
What Was Your Exercise Like?

Answered: 56 Skipped: 0



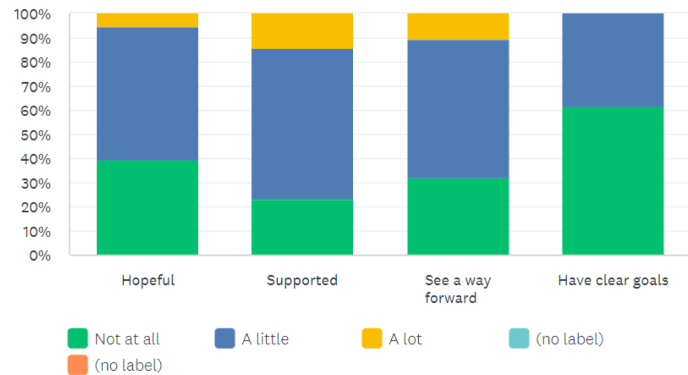
What was your diet like?

Answered: 56 Skipped: 0



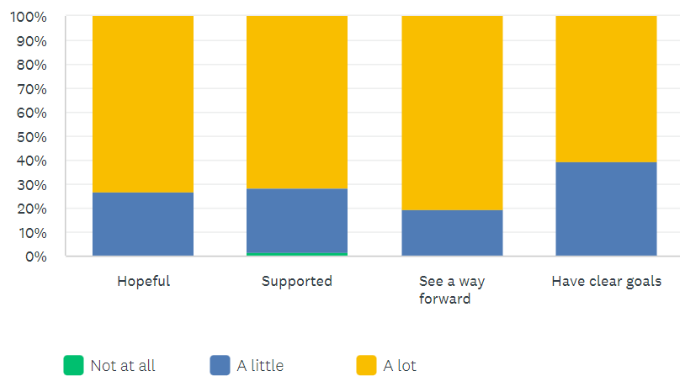
How Did You Feel Pre-Course?

Answered: 56 Skipped: 0



How Did You Feel Post-Course?

Answered: 56 Skipped: 0



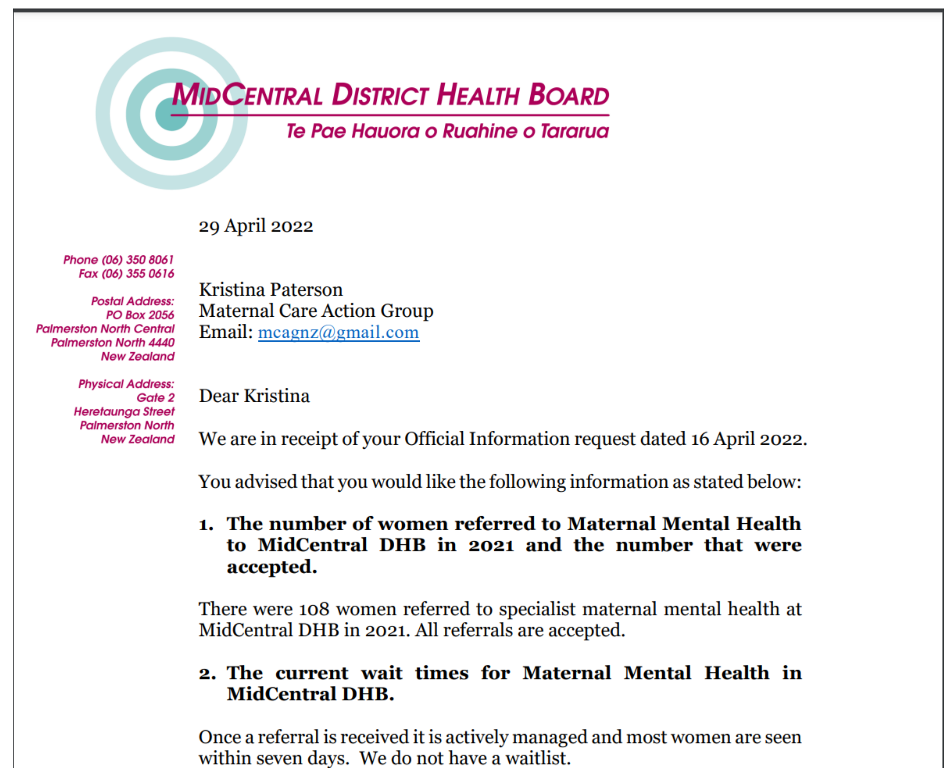
Outcome: All Hua Oranga assessments Mothers Helpers were able to obtain following completion of package of care had improved with the exception of one whose package of care had been extended to add in a further two counselling sessions. All Edinburgh scores were between 11-22 (indicating mild-severe depression/anxiety) prior to therapeutic intervention by Mothers Helpers and all were <11 at completion of package of care with the exception of one which was 12 (down from 17). This meets the requirements of the Mental Health and Wellbeing Commission and the He Ara Oranga report in that there is measurable improvement in symptoms as well as evidence of increased wellbeing.

"I found it extremely helpful being heard. [Alice] gave great advice and relevant exercises and examples given. I was made to feel I can be honest and open"
~ Ashley

"I only had one goal and that was to be able to try and find a way to help myself and cope better than what I was. My experience was amazing I wish the course didn't have to end…but overall I loved it! I love my course facilitator, she was amazing, made me feel heard. I think she made all of us feel heard. She helped me the best she could, it wasn't awkward or anything it was amazing! Everything Gena did was so helpful. I don't think she needed to do anything more to have improved my experience."

~ Annonymous

An Official Information Act Request to MidCentral DHB showed that by providing a community-based Maternal Mental Health service, this reduced pressure on Maternal Mental Health services so that they were able to accept referrals without a wait time:



MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

29 April 2022

Kristina Paterson
Maternal Care Action Group
Email: mcagnz@gmail.com

Dear Kristina

We are in receipt of your Official Information request dated 16 April 2022.

You advised that you would like the following information as stated below:

1. **The number of women referred to Maternal Mental Health to MidCentral DHB in 2021 and the number that were accepted.**

There were 108 women referred to specialist maternal mental health at MidCentral DHB in 2021. All referrals are accepted.

2. **The current wait times for Maternal Mental Health in MidCentral DHB.**

Once a referral is received it is actively managed and most women are seen within seven days. We do not have a waitlist.

With the current Access and Choice model, we have the opportunity to provide this kind of service across the nation – whether it's contracting with Mothers Helpers (a nationwide service) or another service providing effective perinatal mental health therapy. However, this is at the discretion of the Primary Health Organisation as to whether they decide to contract anyone to deliver a perinatal mental health therapy service or whether they are lumped in with all mental health service. If there is a requirement that PHO's contract a service that specializes in maternal mental health, then this is one simple

way in which we can begin to address the gaps for those experiencing mild-moderate perinatal depression/anxiety – especially if that service is given the opportunity to educate referring clinicians on screening, assessing and referring.

2021 RESEARCH ON MATERNAL MENTAL HEALTH

Exploring How the "Mothers Helpers" Organization Supports Maternal Mental Health in New Zealand: A Qualitative Case Study by Qing Fang, August 2021

Abstract

Background

In New Zealand, suicide has become the leading cause of maternal deaths as the result of severe perinatal depression. The Ministry of Health estimates that 14% of mothers in New Zealand suffer from maternal mental health issues and more than 50% of them have never been identified and treated within the current system. These mothers are part of the so-called "missing middle" group of mental health patients who cannot access any support from the specialist services they require. This situation, especially in light of the often overwhelmed, public health system have intensified calls for a transition from the costly and arguably inefficient "psychiatry focus" mental health services, to the low cost and multidisciplinary approach that characterises preventive community-based interventions.

Aims and Research Questions

The aim of this study is to explore how Mothers Helpers, a non-government organization, supports maternal mental health in New Zealand. The two research questions associated with this aim are 1) what degree of sustainability and replicability exists for Mothers Helpers as an NGO? 2) what **can be learned** from Mothers Helpers' strengths, experience and vision to inform future health policy and mental health practice?

Methodology and Methods

This study used a case study methodology based on single case qualitative source of data involving semi-structured interviews and examination of some of the organization's archival records. The data analysis was conducted using the reflexive thematic analysis method and an inductive coding approach. The researcher played a key role in both aspects of the data collecting and the analysis. Additionally, NVivo software was utilized for the data management, sorting and storage of the qualitative data to be analysed.

Findings

Five key findings emerged from the qualitative data obtained in this case study, and they have been characterised as 1) "bridging the service gap" 2) "survival and historical development" 3) "Barriers for growth" 4) "system

integration" and 5) "effective maternal mental health promotion". Inherent in all of the interviewee responses was the conviction that, not only did promotion of effective maternal mental health needed a re-focusing from "pathology and dysfunction" to the active promotion of positive experiences and emotions, but also that the maternal mental health itself needed to re-invent itself to achieve universal screening and collaboration between different level or "steps" of care.

Conclusion

The forceful views of the participants notwithstanding, there are obvious limits to what can be established of from this small scale, exploratory case study. Nonetheless, several aspects of the Mothers Helpers model appear to be backed up by the findings of previous and current studies and these quite possibly deserve a more in-depth investigation as to their workability and replicability within a larger system. Foremost among these are Mothers Helpers innovative use of the group "Solution Focused Brief Therapy" based holistic interventions, which they utilize to meet changeable needs in the community. Of at least equal importance is their use of the "5S" paradigm, which consists of self-care, social support, stepped collaborative care, system integration and smartphone enabled digital care. These evidence-based approaches are best seen as a response to the negative experiences which the experienced social worker-clinicians at Mothers Helpers see as arising from both the "lack of system integration" and the service gap that exists for the "missing middle" group of mild-to-moderate perinatal depression and anxiety mothers.   And multidsplinary preventive approach of addressing such issues are exactly what could potentially inform future health policy and mental health practice.

You can read the full dissertation here

“We spoke to 17 mama across Aotearoa with a particular focus on wahine Maori mums…

“We learnt a lot about the realities and challenges of motherhood, including the following eight key insights..

1.Becoming a mother amplifies existing anxieties, stress, and past trauma
2. Assumptions – from self and others – stop mums from asking for or accepting help
3. Reliable support people are key, but who that is can be different for everyone
4. Loneliness can have many faces
5. Mums can be deeply afraid of formal support services and spaces
6. The invisible line between what is and isn’t normal means mums don’t know when to ask for help
7. Seeking formal support can fundamentally challenge mothers’ identity as Maori.”

Report: Mai te Whai-Ao Ki Te Ao Marama

Innovation Unit and Health Promotion Agency

Early Onset and Recurrent Depression in Parents Increases Risk of Intergenerational Transmission to Adolescent Offspring – 2021

BACKGROUND: To assess whether the age-of-onset or the recurrence of parents' major depressive disorder (MDD), measured prospectively in a longitudinal birth cohort study, predicted offspring depression at age 15. METHODS: A two-generation study of New Zealanders, with prospective, longitudinal data in the parents' generation (n = 375) and cross-sectional data from their adolescent offspring (n = 612). Parent and offspring depression was measured with structured clinical interviews. Parent depression was measured at six time points from age 11 to 38 years. Adolescent offspring depression was measured at age 15. RESULTS: Compared to adolescents whose parents were never depressed, those whose parents met criteria for MDD more than once and those whose parents first met criteria before adulthood had more symptoms of depression. The combination of early-onset and recurrent depression in parents made adolescents particularly vulnerable; their odds of meeting criteria for MDD were 4.21 times greater (95% CI = 1.57-11.26) than adolescents whose parents were never depressed. The strength of the intergenerational effect did not vary as a function of parent or offspring sex. The prevalence of adolescent depression was 2.5 times higher in the offspring than at age 15 in the parents' generation.

CONCLUSIONS: Recurrent depression in both fathers and mothers increases offspring risk for depression, particularly when it starts in childhood or adolescence, but a single lifetime episode does not. Health practitioners should be aware of age-of-onset and course of depression in both parents when assessing their children's risk for depression.

Maternal Mental Health Mediates the Effects of Pandemic-related Stressors on Adolescent Psychopathology during Covid-19 - 2022

A B S T R A C T

B A C K G R O U N D

This study examined whether COVID-19-related maternal mental health changes contributed to changes in adolescent psychopathology.

M E T H O D S

New Zealand's rate of maternal suicide is 7x that of the UK

A community sample of 226 adolescents (12 years old before COVID-19) and their mothers were asked to complete COVID-19 surveys early in the pandemic (April–May 2020, adolescents 14 years) and approximately 6 months later (November 2020–January 2021). Surveys assessed pandemic-related stressors (health, financial, social, school, environment) and mental health.

R E S U L T S

Lower pre-pandemic family income-to-needs ratio was associated with higher pre-pandemic maternal mental health symptoms (anxiety, depression) and adolescent internalizing and externalizing problems, and with experiencing more pandemic-related stressors. Pandemic-related stressors predicted increases in maternal mental health symptoms, but not adolescent symptoms when other variables were covaried. Higher maternal mental health symptoms predicted concurrent increases in adolescent internalizing and externalizing. Maternal mental health mediated the effects of pre-pandemic income and pandemic-related stressors on adolescent internalizing and externalizing problems.

C O N C L U S I O N S

Results indicate that adolescent mental health is closely tied to maternal mental health during community-level stressors such as COVID-19, and that pre-existing family economic context and adolescent symptoms increase risk for elevations in symptoms of psychopathology.

Risk Factors Associated with Postpartum Depressive Symptoms: A Multinational Study - 2022

A B S T R A C T

Objective: To evaluate the association between maternal age, parity, gestational number (singleton vs twin), newborn gender and self-reported postpartum depressive symptoms (PDS) in a large multinational sample using survey data from a digital telephone application.

Results: Over a million women from 138 countries participated. Of all respondents, 9.4% endorsed PDS. The weighted mean prevalence of PDS was 11%. We found that PDS decreased with advancing age. First-time mothers reported higher rates of PDS. Twin births were associated with a higher symptom burden than singleton births and mothers of twins in the oldest age group reported the greatest burden. We did not find a clinically significant difference in rates of PDS between mothers of singleton girls and boys.

"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and that they can grow up in peace."

- Kofi Annan, United Nations

Helping families is helping children, and helping children is helping the future of this beautiful country. (Service provider)

A strong theme from submissions was that prevention must engage more fully with life-course theory and that child-centred, early intervention service delivery is insufficiently embedded into current mental health and addiction services. The role trauma plays in mental health and addiction challenges and the need for adequate and appropriate responses were emphasised.

Submitters highlighted the toxic environment in which many children and young people live, affected by multigenerational trauma, family violence, poverty, abuse and neglect. Reversing this situation – intervening to prevent adverse childhood experiences among today's infants, children and young people and supporting whānau to nurture them – was described as the best medium- to long-term investment in mental wellbeing.

Prevention! Prevention! Prevention! We need to focus on early childhood. Attachment. Parenting. Love. Pregnancy. A system that enables parents. (Provider and researcher)

Maternal mental health is a major public health issue, not just because of the adverse impact on the mother, but also because mental health issues have been shown to compromise the health, emotional, cognitive and physical development of the child with serious long-term consequences. (NGO provider)

Despite a huge number of submissions, this was the only mention of Maternal Mental Health in the He Ara Oranga Mental Health Report

DR JOHN TAIT, CHAIR OF PMMRC

"One of the feelings we have is that maternity always appears to be at the bottom of the heap, and the only time District Health Boards really get worried about maternity services is when they hit the front page of the paper."

2021-22 ARTICLES ON MATERNAL MENTAL HEALTH

Mothers Reveal the Darker Symptoms of Postnatal Depression: 'I Became Really Scared of Myself' – NZ Herald, April 2021

Postnatal Depression was TWICE as Common Among Mothers Caring for New Babies During Lockdowns, Study Claims – Mail Online, May 2021

Pasifika Journalist Speaks Out on Having Perinatal Depression: 'It Got So Bad' – RNZ, May 2021

No Baby, No Help: Depressed, Grieving Mum Told She's Not Eligible for Help – RNZ, April 2021

'There's No Shame': Pasifika Mums Urged to Get Help for Depression – RNZ, May 2021

Ministry of Health Orders Urgent Review of Maternal Mental Health, Amid Growing Concern About Women Being Turned Away – Stuff, June 2021

Gaps, Inequities and Staff Shortages in Maternal

Mental Health Services – Stuff, November 2021

Investment to Support Maternal Mental Health - Beehive Press Release, November 2021

New Zealand Lockdown Babies Turn One – NZ Herald, December 2021

Why NZ Needs a Women's Health Strategy – Newsroom, December 2021

A Conversation About Postnatal Depression with Sarah Wynter – RNZ, February 2022

WHO Prioritises Maternal Mental Health in New Global Postnatal Care Guidelines – WHO, March 2022

More Conversations Needed on Maternal Mental Health Advocates Say – 1 News, April 2022

Maternal Mental Health in 'Very Dire' State as Need for Help Increases – Stuff, April 2022

Maternal Suicide: Leading Cause of Deaths of Pregnant Women, New Mothers, Report Reveals – NZ Herald, April 2022

Plunket Whanau Awhina to Exit Parenting Education Programme (PEPE) – Press Release, April 2022

Mothers Are Being Sidelined in the Conversation About Maternal Mental Illness – The Spinoff, May 2022

Maternal Care Action Group NZ Spokesperson Kristina Paterson makes a wish/prayer at the newly planted wishing tree (key lime) to honour women who have died to suicide during the perinatal stages at Kelmarna Gardens.

GOVERNMENT & MINISTRY OF HEALTH RESPONSE TO MATERNAL MENTAL HEALTH GAPS 2021

INVESTMENT TO SUPPORT MATERNAL MENTAL HEALTH

HON DR AYESHA VERRALL

Associate Minister of Health Dr Ayesha Verrall has announced an investment to help expand maternal mental health services in five District Health Boards.

“Supporting parent’s mental wellbeing during their child’s first 1000 days, from conception to two years of age, is critical to the long-term emotional, mental and physical wellbeing of their tamariki,” Ayesha Verrall said.

“Pregnancy and early parenting is a time of enormous change and often big challenges for parents and whānau - and maternal mental health is a foundation of strong families and communities.”

The Ministry of Health estimates around 12 to 18 percent of New Zealand mothers will develop depression, anxiety or other mental health issues during the perinatal period. These figures are higher in some population groups, including Māori and Pacific peoples.

“I asked the Ministry of Health to carry out a stocktake of maternal mental health services provided by district health boards. A key finding in their report, which is being

released today, was that we need to do more to improve equity and ensure cultural models of care are available," Ayesha Verrall said.

"This funding of $500,000 per year under the Maternity Action Plan, will be used to enhance early intervention initiatives for women with mild-to-moderate maternal mental health needs, and their whānau. Māori and Pacific women in rural and isolated areas will be prioritised.

"This year, we're investing across Lakes, Northland, Waitemata, Counties Manukau and Hawkes Bay DHBs.

"From July 2022, Northland and Lakes DHBs will receive an additional $500,000 per year for service expansion. They were chosen as they provide maternal mental health services with support from local community providers, and this funding will allow them to immediately extend their services to help more mothers and whānau in these priority communities.

"It is important people have access to consistent and appropriate support, when and where they need it. The findings of the Maternal Mental Health Stocktake will be used as we reform the health system," Ayesha Verrall said.

The stocktake also found a need to provide an environment that better supports whānau who experience the loss of a child. Work is already progressing on a bereavement pathway to support people through this tragic time.

And the Ministry of Health is also working with the Health Reform Transition Unit on developing a national pathway for accessing maternal mental health services.

"This was a recommendation from the Perinatal Maternal Mortality Review Committee. The national pathway will ensure our future health system supports services which better meet the Crown's Te Tiriti o Waitangi obligations. And it will provide more equitable health outcomes for whānau Māori, Pacific peoples and other populations that are disadvantaged.

"Mental health and child wellbeing are key priorities for this Government, and I am committed to ensuring women receive the support they need during pregnancy, birth and in the post-natal period," Ayesha Verrall said.

Ko te wāhine te kaitiaki o te whare tangata

Women are the guardians of the house of humanity; guardians of the past, present and future.

WHAT'S NEXT

Based on the themes presented in this Report and the 2021 Report by Maternal Care Action Group NZ and all the petitions, submissions, articles, research, and recommendations by PMMRC spanning the last 15 years, we ask for:

- A Professional Development training of midwives and Health Improvement Practitioners in the onset, prevalence, identification, screening, treatment and intervention of PNDA and when and whom to refer
- A requirement that Primary Health Organisations have in place a Specialties Service contract with a community service providing therapy specialized in Maternal Mental Health as opposed to a generic mental health service

We also support the "Next Steps" recommendations by Holly Walker (The Helen Clark Foundation):

- Ensure perinatal mental wellbeing is included as a key focus area in the interim Health Plan (due out on 1st July 2022)
- Develop a perinatal mental wellbeing plan in partnership with Māori, midwives, WCTO providers, clinicians, and parents with lived experience of distress. It should set specific, measurable, achievable, realistic, and time-bound goals that are resourced and designated to a specific agency that reports publicly on progress.
- Amend the ACC (Maternal Birth Injury and Other Matters) Amendment Bill to ensure mental injuries from birth trauma are covered
- That the Productivity Commission currently investigating the "dynamics and drivers of persistent disadvantage" makes perinatal mental health a priority in its preliminary recommendations to Government in August 2022, and its final report in March 2023.

ARTICLE 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and ***medical care and necessary social services,*** and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. ***Motherhood and childhood are entitled to special care and assistance*****.** All children, whether born in or out of wedlock, shall enjoy the same social protection.

Universal Declaration of Human Rights signed by New Zealand in 1948

Maternal Care Action Group NZ plants a “wishing tree” (key lime) where attendees tie a wish or prayer to the tree for

Baby booties are placed in a pair of shoes to represent new mums who die by suicide in a 2017 demonstration raising awareness of NZ's high suicide rates. There have been 30 maternal deaths between 2006-2018.

This document has been sent to:

Prime Minister Jacinda Ardern
Minister of Health Andrew Little
Dr Ayesha Verrall (Associate Minister of Health)
Deputy Director-General, Mental Health & Addiction
PMMRC Chair John Tait
Health Select Committee Members
Mental Health Cross-Party Members
Platform NZ
The College of Midwives
Perinatal Anxiety & Depression Aotearoa (PADA)
Manager of Maternity, Ministry of Health Nicky Smith
Principal Advisor of Maternity, Ministry of Health Heather Raeburn
Senior Advisor of Maternity, Ministry of Health Amanda Rouse
Plunket Chairperson Dame Fran Wilde
The Royal New Zealand College of General Practitioners
Minister for Women Jan Tinetti
The Helen Clark Foundation (Holly Walker)
Mental Health and Wellbeing Commission
District Health Boards Maternal Mental Health Managers
Primary Health Organisations Access & Choice Managers

It is publicly available on our website: www.mcagnz.com

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