Maternal Mental Health Service Guideline				
MHASPPM/8027				
Approved:	General Manager – Mental Health & Addiction	**First Issued:**	September 2012	HE KAUANUANU RESPECT ĀKINA IMPROVEMENT RARANGATETIRA PARTNERSHIP TAUWHIRO CARE
Signature:	David Warrington	**Review Date:**	January 2022	
		Next Review:	January 2025	

Purpose

The purpose of this document is to provide a clear understanding of the pathway through the Maternal Mental Health Service from referral to discharge.

The Maternal Mental Health Service comes under the umbrella of Te Ara Manapou.

This document is to be used in conjunction with MHASPPM/8953 – Mental Health Service Policy which outlines the shared vision and expectations for the direction, values, principles, attitudes and ways of working to deliver a values based service.

Scope

Woman that may require mental health assessment and intervention due to moderate to severe mental illness during their pregnancy or up to one year post-natal.

All DHB and Primary Care Health Care Professionals.

Definitions

Refer to the Mental Health Service Definitions Glossary \\FS3\share\Public\All Users\MHS Policy review\DEFINITIONS FOR WORDS AND TERMS IN USE WITHIN THE MENTAL HEALTH SERVICE.docx.

Roles and Responsibilities

Role	Responsibility
Referrer	With consent of the client, the referring agency will contact Te Ara Manapou and provide the relevant documentation which will be triaged by the Te Ara Manapou team.
Clinical Manager	Will be responsible for the operational delivery of the service. Will receive referrals, review and consult with the team on appropriateness for the service. Referrals will be discussed at daily team meetings. Outcome of referral will be communicated to the referrer as soon as possible. Manage governance issues such as key performance indicators, orientation, training needs, risk management procedures, audit, staffing levels, roster, clinical practice standards, complaints, staff and Tangata Whaiora experience. Coordinate and chair the Multi-Disciplinary Team Meetings (MDT) and risk review meetings and delegate this task in his/ her absence Attend the Multi-Disciplinary Team meetings with Key Stakeholders/consumers to maintain the profile of the service within the community. Support staff in maintaining their agreed level of supervision and development for ongoing registration for their relevant professional organization

Role	Responsibility
Registered Health Practitioner	Will directly report to the Clinical Manager. On allocation, the Practitioner will contact the referrer, person/tangata Whaiora, family/ whānau to arrange a time for the first face to face meeting. Will update referral and assessment plan and begin appropriate interventions. Will start planning for the Comprehensive Assessment at first point of contact, formulating the risk plan as a priority. Will attend a daily morning meeting to review risk plans and case discussions with colleagues as required. Will have relevant documentation completed to review clients at weekly MDT review meetings. Provides Mental Health related education to, whaiora, whanau and wider community. Offer therapeutic treatment interventions which include attachment-based parenting programmes. Will employ a range of practice tools to facilitate the identification of strengths with the client and whānau in order to formulate a treatment/ go to plan. Will review the go to plan at each meeting with the client and whānau to review progress and identify any difficulties. Will support the client and whānau to engage with appropriate community resources. Will work collaboratively with health, education and social service providers engaging with Tangata whaiora and whanau to strengthen their connections to relevant other services. Will support Client and whānau in transitioning from the service to other agencies, ensuring that there is a robust discharge plan in place with the agreement of the TAM team. Before closure of the case to the service the Health Practitioner will, when possible, discuss closure with client, then present the case to MDT to discuss the rational for closure.
Clinical Specialty Nurse	Utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. Will work in partnership with patients, families/whānau and collaborate with the multidisciplinary team to provide quality nursing care that is safe and in accordance with professional and organisational standards, policies and procedures. Will provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. The SCN is accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. The SCN will provide a range of services; including specialist assessment, treatment intervention, care management and clinical guidance for services for women with moderate to severe mental illnesses coupled with pregnancy. Developing relationships is paramount to maximising health outcomes. Secondary care responsibilities include specialist consultation, liaison nursing care, training/education and early intervention services for community mental health clinicians and other health providers in the community.

Role	Responsibility
MMH Psychiatrist	Provides; Client assessment and pharmacological interventions (as needed) for clients not involved with mental health services including referral for those who need mental health services. Consultation for Clinicians Support/expertise with regards to team reviews of client risk and treatment. Consultation with mental health services.

Guideline

Maternal Mental Health Service Staffing

Maternal Mental Health Service operates:
Monday to Friday 08:00 – 16:30

The team consists of:

- 0.8 Specialty Clinical Nurse
- 0.8 Registered Health Practitioner
- 0.2 Consultant Psychiatrist.

Objectives

The objectives of the Service are:

to provide a timely specialist mental health service to women who are pregnant or in the first year postpartum
AND
who are most severely affected by a mental health disorder or have a history of or are suspected of serious mental health problems, risking disruption of the mother infant relationship
AND
are a primary carer of the infant or are likely to become a primary carer of the infant.
OR
provide a consultation service to women with a major mental illness who are considering pregnancy.

For most women with an identified or suspected mental health disorder during the antenatal or postnatal period, assessment and treatment will take place in primary care, coordinated by the General Practitioner

Referrals

Who can be Referred to the Service

Women who are pregnant or in the first year postpartum and experiencing moderate to severe mental distress, not related to social stressors and with or without disruption within the mother infant relationship.

Women seen by Maternal Mental Health are required to either have the care of their infant or will have the care of their infant following delivery.

We can provide a consultation service to women with a major mental illness who are considering pregnancy.

If the infant dies in utero or after birth or is moved away from the parents, care will need to be humanely transitioned to another service and the woman not discharged precipitously.

Women who are seen by Community Mental Health can be referred for MMH specialist assessment and treatment alongside community keyworker input, co-working is encouraged.

How to make a Referral

Referral can be sent via email: maternalmentalhealth@hbdhb.govt.nz

Screening tools (for example Edinburgh Postnatal Depression Scale) and any relevant maternity and or mental health information is useful.

Contact can also be made to progress or query a referral on 0800 234 556, we encourage discussion with our referrers so that if the client is not able to be accepted we are able to make other suggestions for care.

Maternal Mental Health Clinical Care Pathway

Refer to Appendix 1 - Maternal Mental Health Clinical Care Pathway

Additional Contacts

Immediate Crisis

For concerns regarding immediate significant risk to self or others due to mental illness, please refer directly to the Emergency Mental Health Service 0800 112 334 or, if necessary, the Police.

After Hours

For urgent mental health support and referrals out of business hours, please contact the Emergency Mental Health Service (0800 112334).

Risks and Hazards to Staff

Risks/Hazards	Control
Home Visits	Risk assessment completed at referral and first visits always in pairs. Staff are registered with the Get Home Safe app and Panic button.
Abusive behaviour by client	All staff to attend De-escalation and Breakaway Training

Measurable Outcomes

Clients are progressed through the pathway successfully, with no events or complaints received in relation to the service

Regular MDTs and case reviews conducted by the Clinical Manager

Related Documents

MHASPPM/8953 – Mental Health Service Policy

References

New Zealand Guidelines Group. Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline. Published by New Zealand Guidelines Group; Wellington: 2008.

Ministry of Health. 2012. Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand. Wellington: Ministry of Health.

Harvey, S., Fisher, L., & Green, V. (2012). Evaluating the clinical efficacy of a primary care-focussed, nurse-led, consultation liaison model for perinatal mental health. Journal of Mental Health Nursing, 21, 75-81.

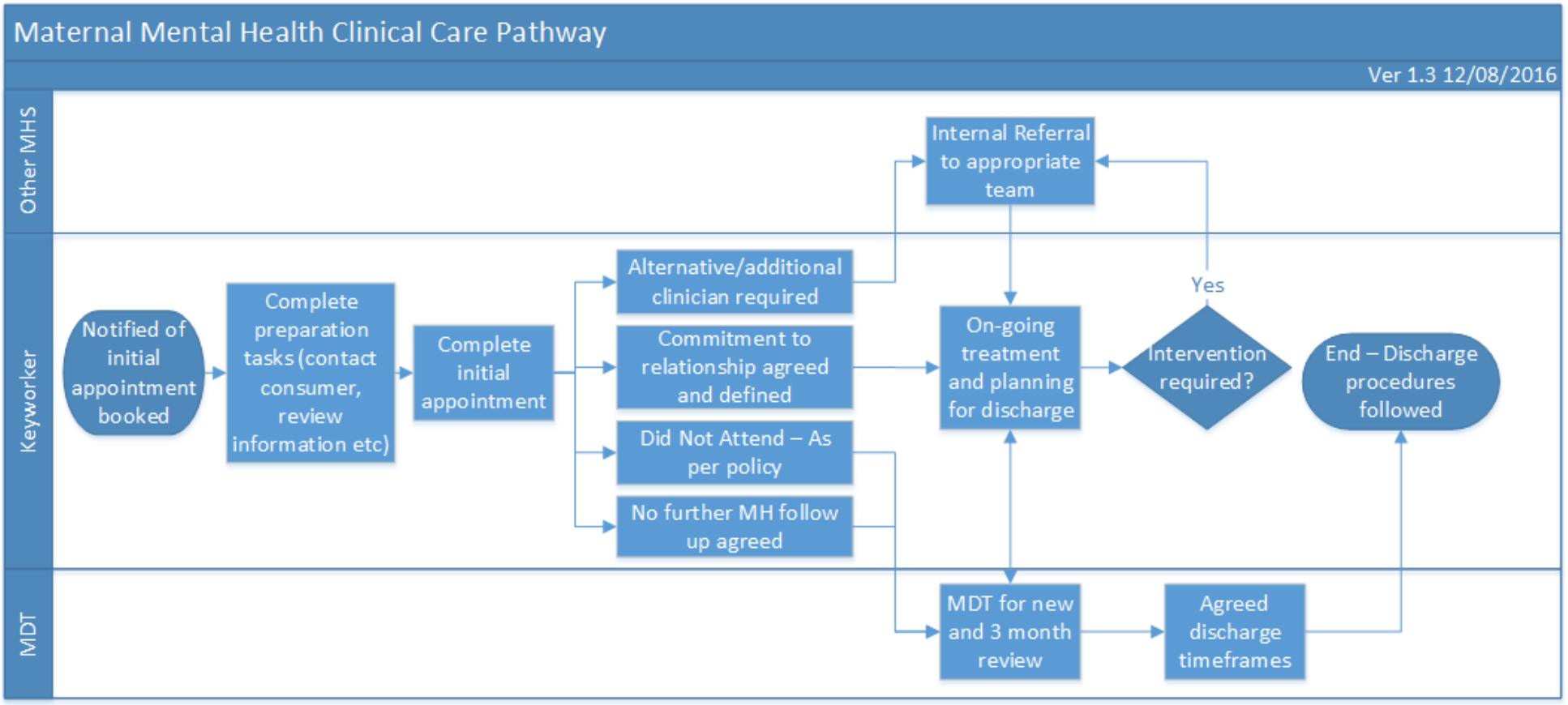
Keywords

Maternal
Mental Health
Pathway

For further information please contact the Specialty Clinical Nurse - Maternal Mental Health or the Clinical Manager - Maternal Mental Health on 0800 234 556

APPENDIX 1

Maternal Mental Health Clinical Care Pathway



APPENDIX 2

Practice Principles - based in the first instance on the principles of Te Tiriti o Waitangi

- **Tino rangatiratanga**: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Equity**: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection**: The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.
- Aligning with and implementing the principles of Te Tiriti o Waitangi, requiring that Maori remain able to protect their cultural practices and their Tikanga, and participate fully in New Zealand society, as Maori. This can only occur if Maori remain able to exercise Tino Rangatiratanga in relation to their values and cultural practices.
    - providing services in a flexible, non-judgemental and client focused way
    - supporting parents and whānau self-efficacy, empowerment and recovery
    - using a harm reduction approach
    - utilizing a strength/resilience-based model
    - practising from a social justice perspective and working within a bio/psycho/spiritual model
    - improving outcomes for the unborn child and children
    - Culturally inclusive, consulting with and using existing community and other cultural networks.
    - Cultural relevance – the design and delivery of prevention and harm minimization must be able to meet the needs of people from diverse ethno-cultural backgrounds, including but not limited to, subpopulations, such as youth, refugees and migrant communities.
    - helping parents form supportive relationships within their community
    - helping parents to strengthen connection with health and social services