GUIDANCE DOCUMENT: Health Visiting Programme: Pathway to support professional practice and deliver new service offer
Maternal mental health pathway 3.

Context

This pathway is guidance to support professionals to develop indicators and ways of measuring outcomes to assess improvement. It outlines our aspirations for service delivery. Local services will be at differing points of development and can use the pathway to benchmark their progress. The pathway builds on good practice and evidence drawn from the professions.

This document sets out the rationale for the pathway and outlines the challenges and potential opportunities. The pathway focuses on the role of the health visitor and the third sector, but recognises the essential contributions of partners in midwifery, mental health and general practice. This document endorses the practice of joint working and encourages an integrated approach to service delivery. Key principles and core components required to enhance outcomes including options for service delivery are detailed together with a suggested timeline.

Why do we need a pathway?

The pathway sets out the benefits and principles for health visitors, midwives, specialist mental health services and GPs working together in pregnancy and the first postnatal year, as the basis for the detailed, local pathway to meet the physical, mental health and wellbeing needs of parents, babies and families.

The pathway provides a structured approach to addressing the common issues associated with the journey mothers experience in relation to their emotional and mental wellbeing from midwifery to health visiting services. The pathway is not policy, but guidance for staff that builds on good practice as identified by professional consensus, the Healthy Child Programme, NICE Guidance, the Frank Field report all provide a systematic solution-focused approach on which to base local practice.

Rationale

The overarching rationale for the pathway is to strengthen consistent, seamless support and care and to recognise that enhanced partnership working will support the delivery of the Healthy Child Programme and achieve quality outcomes for children and parents. Underpinning this:

- Anecdotal evidence from the children's workforce indicates that there is no single profession or organisation involved in ensuring best outcomes for children and families in relation to the wide spectrum of maternal mental health - this reinforces the need to have joined-up services and strong multi agency working.
- Recognition of the specialist public health role needed for health visitors and midwives in their assessment of maternal mental health in order to promote skills for parenting.These professionals are knowledgeable leaders in promoting mental health & wellbeing during pregnancy and the postnatal period.
- There is now a better understanding of the importance of pregnancy and infancy on a baby's neural development, thus laying the blueprint for a baby's future health. Early maternal mental health support and intervention by health visitors and their colleagues can not only make a difference to the families but also to the wider community.

Examples of Anticipated Outcomes

Public Health Community – Outcomes:

- Increase public awareness of maternal mental health issues and promote inclusion and reduce stigma.
- Reduce inequalities in parents accessing mental health services.
- All babies are born healthy, especially those to mothers with long term conditions.
- All parents and children achieve positive physical and emotional development milestones.
- All parents have access to support for emotional health and wellbeing and all children are supported to reach their full potential.

Indicators of success:

- Reduction in maternal and children's deaths relating to mental health issues.
- Strategic plan (JSNA) to deliver family focused services for those that are vulnerable, hard to engage, with English as a second language, at high risk or with complex needs.
- Universal Services, universal plus, partnership plus & safeguarding – Quarterly client satisfaction surveys.
- Universal implementation of the HCP 0-5, i.e. a progressive, stepped approach with specific short term outcome focused interventions.
- Evidence of training and development of staff in relation to maternal and infant mental health and a good understanding of how to work with other agencies to deliver most appropriate services.
- All mothers will be seen by a health visitor for mental health screening assessments at set times.
- All children will be reviewed at set times.

Performance Measures:

- Service users reporting a high level of satisfaction with services provided.
- Data collection on HCP KPIs e.g. ASQ, GAD 7 PQH, HAD.
- Evaluation of effectiveness of staff training. i.e. evidence of implementation of knowledge and skills and did it make a difference.

Addressing the Challenges

There are challenges that cannot be addressed solely by a high-level pathway, including local variation in service configuration, delivery and resourcing. Such issues require local collaboration in the form of a clinical perinatal network which includes service leads, commissioners and health and social care practitioners to adopt the partnership pathway principles. The pathway can be adapted to meet the needs of local women, babies and families taking account of local health priorities, health needs and resource deployment. The use of a pathway will support delivery and contribute to addressing key themes including:

1. **Workforce issues – training opportunities.** Addressed through identification of joint training opportunities for health/development i.e. Healthy Child Programme e-learning Programme, case analysis. LSCB multi agency, Safeguarding, training greater visibility of health visiting as a career.
2. **Commissioning – A joint approach to commissioning services which span this issue and offers improved outcomes across the board.** Addressed through the identification of clear service specification, standards and outcome measures and the JSNA and HWB Strategy.
3. **Potential service fragmentation during pregnancy and 0-5 years - lack of specific leadership role and service definition.** Addressed through clear identification and coordination of the contribution of all service providers throughout the pathway and transition timeline.
4. **Utilising growing evidence base.** Addressed through the identification and implementation of supporting policy and evidence and the development of clear protocols and guidelines.
5. **Communication systems – fragmented within health and partner organisations.** Addressed through sharing of learning and best practice, enhanced records, seamless sign posting between professions and clear referral routes. Standardisation of procedures for handover of records from midwifery to health visitor services and other service providers. This must include how to consistently transfer information.
6. **Partnership working - variation in quality of maternal mental health services across England.** Addressed through enhanced partnership working, formalised liaison, joint training, joint delivery of the Pregnancy, Birth and Beyond programme, HCP 0-5 and implementation of NICE antenatal and postnatal mental health guidelines through regular meetings and improved service specification.
7. **Inadequate training –** addressed through ensuring specific training is available on post natal depression for all health visitors.
8. **Barriers to women disclosing their feelings –** addressed by training for staff in respect of communication style, non-judgemental approach and training on working effectively with others.

Opportunities Setting out an agreed framework can help identify where there are new opportunities.

Quality

- Increased equality and quality of service for all outcomes.
- Improved clinical indicators and measures of effectiveness and risk management.
- Explicit and well-defined operating standards for care provided.
- Improved service user/client satisfaction
- Family/individual issues or problems identified and addressed as soon as possible.
- Improved use of shared documentation.
- Implementation of evidence-based care and use of clinical guidelines.
- Baseline for future initiatives building on what works and good practice examples.
- Improved use of specialist skills and clinical judgement, building on right person, right place, right time.
- Ensure all midwives and health visitors are appropriately trained in relation to assessing mental health.

Innovation

- Implementation of the stepped approach to care delivery outlined in the HV Implementation Plan, HCP and NICE guidance e.g. outcome led short term interventions.
- Supported opportunities for delivering care in new ways e.g .through "Any Qualified Provider".
- Increased opportunities to focus on enhanced provision for mothers, babies and families with complex needs.
- Identified framework to support flexibility to adapt quickly to changing circumstances, cultural circumstances and new priorities.

Productivity

- All pregnant women receive co-ordinated and continuous care across different clinical disciplines and sectors.
- Improved multidisciplinary communication, teamwork and care planning.
- Supported peers and inter-agency training between professionals.
- Identified opportunities for joint clinical supervision and shared resources.
- Clear measures for clinical effectiveness.

Prevention

- Jointly delivered public health outcomes through implementation of the Healthy Child Programme 0-5.
- Improved seamless services which would address the full public health agenda, i.e.,obesity, smoking cessation, mental health, substance misuse.
- Improved parenting skills and family resilience, with relapse prevention and mental health wellbeing woven into service delivery.

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Suggested collaborative timeline for Midwifery and Health Visiting Services*

*It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline e.g. the information needs and emotional experiences of first time parents differ to those of experienced parents (for further information follow this link)

*GPs are very important partners through out this timeline when a mothers mental health is compromised

	ANTENATAL Please note that NICE guidelines relate only to subsections of the work described.				
When	**Booking in (8-12 weeks)**		**16-28 weeks**		**32-36 weeks**
Who*	Midwife (MW)	Health Visitor (HV)	MW	MW/HV	MW/HV
Where	Home, Health Centre, Children's Centre (CC), GP Surgery - (dependant on family need and local provision)				
Action Proposals you may wish to consider developing	Midwifery team to notify health visiting team of pregnancy (admin task). Notification to include assessment of maternal mental health using three WHO questions and clinical judgement, including needs of father and referrals to other agencies and action plan; this should be a particular consideration for women and fathers with complex social factors (NICE 110). 12 weeks health needs assessment. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps. A supplementary mental health assessment may also be used e.g. HADS, EPDS and other risk assessment tools. Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period. Child safeguarding concerns to be shared with Children's Social Care.	Health visiting or Family Nurse Partnership team to inform midwife of named health visiting team for every woman. NB: Where there is an identified mental health issue, it is recommended that an individual health visitor and midwife is allocated to the woman. Importance of Adult services working closely with Children's services which must be informed of potential child safeguarding concerns, GPs to be involved in all cases where there is a past history of mental health issues and mental health team if mother known to them. (GP should be consulted to provide necessary background if the mother has an identified issue.) Children's social care (CSC) should also be involved.	Ongoing review of action plan and the midwife to communicate any change in the pregnancy status and/or changes in risk to the family or child to the named health visitor/family nurse partnership team and CSC. Health promotion review. Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period.	Possible further health needs assessment, including the fathers needs and vulnerability factors e.g. relationship with partner. Where there is an identified mental health issue the midwife should work collaboratively with the Health Visitor, Family Nurse, GP, specialist mental health services, CSC and the woman and her family to assess need and ensure informed choices are made regarding future planning and medication management. (NICE 110).	All women not receiving family nurse partnership to receive contact from the health visiting service and offered mental health promotion advice and information. A review /repeat of the 3 WHO questions to be carried out by the health visitor. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps. A supplementary mental health assessment may also be used e.g. HADS, EPDS. Women with an identified vulnerability (e.g. maternal mental health, learning disability, fetal developmental issue, obstetric issue, domestic violence etc.) or need to have received an 'individualised postnatal care plan' prepared in conjunction with midwife and health visitor (NICE 37). Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period. Importance of Adult services working closely with Children's services which must be informed of potential child safeguarding concerns.
HCP Key Messages and Actions	• Promoting positive mental health and wellbeing of mother. • Promoting Healthy Start for all women. • Preparing families for parenthood. • Promoting breastfeeding and the support available. • Promoting the importance of the involvement of the father. • Promoting the neurological development of child, the negative impact of stress and the importance of attachment. • The Healthy Child Programme promotes good liaison between MW and HV to benefit early intervention. • Promoting positive mother and father relationships.		• Promoting positive mental health and wellbeing of mother. • Providing information re local Children's Centre services and consent to contact. • Providing smoking cessation support, • Promoting breastfeeding and the support available. • Providing information re screening/immunisations, child development, maternal nutrition e.g. folic acid and other dietary or lifestyle advice as required. • Preparing families for parenthood. • Promoting the importance of the involvement of father.		• Promoting positive mental health and wellbeing of mother. • Preparing families for parenthood. • Promoting the importance of parent and baby mental health/attachment. • Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Signposting parents to Parent Education. • Promoting the importance of the involvement of the father. • Delivering the Pregnancy, Birth and Beyond programme in partnership.

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Your Community	Targeted to meet the identified needs of the community, Your Community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwifes work together to develop and promote community based support for expectant and new parents such as preparation for parenthood groups and activities that meet the needs of local families.		
Universal Services	Universal Services are for all families. Health visitors deliver the Healthy Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services/resources.		
Universal Plus	Targeted according to assessed or expressed need, universal plus gives a rapid response from the HV team when families need specific expert help, for example, all women identified with a mild to moderate mental health issue to be offered a range of support, e.g. wellbeing advice, short term guided self help such as solution focused approaches, motivational interviewing, CBT and medication and baby massage.		
Universal Partnership Plus	Targeted according to identified need, Universal Partnership Plus provides ongoing support from the team or family nurse partnership plus a range of local services working together with families to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, the third sector, specialist mental health services, GP, housing, welfare and social care.		

Key messages from partners

- Assessment is not in itself an outcome, nor is it necessarily reliable. Its success depends on the honesty of, and trust felt by, the informant and this depends on non-judgemental attitudes, empathy, and good continuity of care on the part of the care provider. New mothers need a champion, not a judge. They need the opportunity to develop a relationship with their HV. Ideally, all women should always see the same Health Visitor and information about post-natal depression should be widely disseminated.
- Health visitors are crucial lynch pins of care given to women at risk of or experiencing post natal depression, but need new structures that provide much better continuity of care, and specialised training in post natal depression which must also be child-centred.
- Mothers and their health visitors need to know the alternative forms of support open to them, from assessment to recovery from postnatal depression.
- Where barriers exist to effective working, these issues need highlighting and addressing to ensure successful partnerships.

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Suggested collaborative timeline for Midwifery and Health Visiting Services*

*It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline e.g. the information needs and emotional experiences of first time parents are likely to differ to those of experienced parents (for further information follow this link)

*GPs are very important partners through out this timeline when a mothers mental health is compromised.

	Postnatal Please note that NICE guidelines relate to subsections of the work described only.				
When	**Birth visit to 10-14 days**		6 -8 weeks	3-4 months	8 months-12 months
Who*	Midwife (MW)	Health Visitor (HV)	Health Visitor	Health Visitor	Health Visitor
Where	Obstetric/Midwifery unit/Home/CC	Home, Health Centre, Children's Centre (CC), GP Surgery - (dependent on family need and local provision)			
Action Proposals you may wish to consider developing	MW to update the HV on the health and emotional and social status of both mother and baby. Ask NICE recommended predication questions (only asked again if answers 'no' at midwife booking appoint) - evidence from audits say women disclose more with repeated asking. Prompt referral to Perinatal Psychiatry Services (puerperal psychosis). Adult services to work with children's services in the event of child safeguarding concerns	All women to have a new baby review with the health visitor where there is a comprehensive assessment of the physical and emotional health of mother and baby. Assessment to include 3 WHO questions and clinical judgement to assess maternal mood. A supplementary mental health assessment may also be used e.g. HADS, EPDS. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps and appropriate intervention or referral. Prompt referral to Perinatal Psychiatry Services (puerperal psychosis) Adult services to work with children's services in the event of child safeguarding concerns	All women to have contact with the health visitor where there is a comprehensive assessment of the physical and emotional health of mother and baby. Assessment to include 3 WHO questions and clinical judgement to assess maternal mood. A supplementary mental health assessment may also be used e.g. HADS, EPDS. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps and appropriate intervention or referral. Adult services to work with children's services in the event of child safeguarding concerns Reference local referral pathway to specialist services – inform GP	All women to have contact with the health visitor team where there is a comprehensive assessment of the physical and emotional health and wellbeing of baby. To include a review of the mothers' mental wellbeing to include 3 WHO questions and clinical judgement to assess maternal mood. A supplementary mental health assessment may also be used e.g. HADS, EPDS. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps and appropriate intervention or referral. Adult services to work with children's services in the event of child safeguarding concerns Reference local referral pathway to specialist services – inform GP	All women to have contact with the health visitor where there is a comprehensive assessment of the physical and emotional health of the child. To include a review of the mothers' mental health; to include 3 WHO questions and clinical judgement to assess maternal mood. A supplementary mental health assessment may also be used e.g. HADS, EPDS. Clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps and appropriate intervention or referral. Adult services to work with children's services in the event of child safeguarding concerns Reference local referral pathway to specialist services – inform GP
HCP Key Messages and Actions	• Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Promoting the importance of parent and baby mental health/attachment. • Supporting mothers with postnatal exercise. • Promoting home safety. • Promoting steps to take to prevent Sudden Infant Death Syndrome (SIDS). • Providing information on smoking cessation, development and growth. • Promoting attuned, sensitive parenting that supports baby's early development. • Promoting importance of father and wider family (involvement.)		• Assessing maternal mental health. • Promoting breastfeeding and the support available. • Promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports baby's early development. • Promoting importance of father involvement. • Providing information on, and registration with, local Children's Centres. • Delivering the Pregnancy, Birth and Beyond programme in partnership.	• Reviewing maternal mental health. • Promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports baby's early development. • Promoting importance of father involvement. • Health visiting leadership in shaping and informing the delivery of Children's Centre programmes based on local health need. • Working in partnership with local IAPT services to promote delivery of perinatal guidance.	• Reviewing maternal mental health. • Promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports infant mental health & development. • Promoting importance of father involvement. • Health visiting leadership in shaping and informing the delivery of Children's Centre programmes based on local health need. • Working in partnership with local IAPT services to promote delivery perinatal guidance.

	• Providing information on, and registration with, local Children's Centres. • Assessing maternal mental health. • Delivering the Pregnancy, Birth and Beyond programme in partnership.	• Health visiting leadership in shaping the delivery of Children's Centre family support services.		
Your Community	Targeted to meet the identified needs of the community, Your Community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwifes work together to develop and promote community based support for expectant and new parents such as preparation for parenthood groups and activities that meet the needs of local families.			
Universal Services	Universal Services are for all families. Health visitors deliver the Healthy Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services/resources.			
Universal Plus	Targeted according to assessed or expressed need, Universal Plus gives a rapid response from the HV team when families need specific expert help, for example, all women identified with a mild to moderate mental health issue to be offered a range of support, e.g. group support, wellbeing advice, short term guided self help such as solution focussed approaches, motivational interviewing, CBT and medication and baby massage.			
Universal Partnership Plus	Targeted according to identified need, Universal Partnership Plus provides ongoing support from the team plus a range of local services working together with families to deal with more complex issues over a period of time. The health visiting team to contribute to a care package led by specialist mental health services, this might include services from Sure Start Children's Centres, the third sector, GP, housing, welfare and social care.			

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High-level core principles

- Health and wellbeing of mother, baby and family.
- Baby and parent-centred approach to care and support.
- Fathers/partners to be fully included.
- Sensitive to needs of different communities e.g. those who have English as a second language.
- Partnership working within the changing health and social care agenda and recognising core values of the family service.
- Pregnancy and infancy are critical to setting out a child's life trajectory for physical and emotional health, learning and development.
- Local service provision taken into account in designing a collaborative shared pathway to identify the optimum points for partnership working.

Key principles and components

Figure 1 illustrates the key issues and core principles that professionals need to address to provide a seamless transition and readiness for parenthood.

Achieving a seamless journey for the mother and child

Essential service components;

- Working in partnership;
- Respecting diversity;
- Practising ethically;
- Challenging inequality;
- Promoting recovery;
- Identifying mothers needs and strengths;
- Providing FAMILY centred care;
- Making a difference; and,
- Promoting safety and positive risk taking.

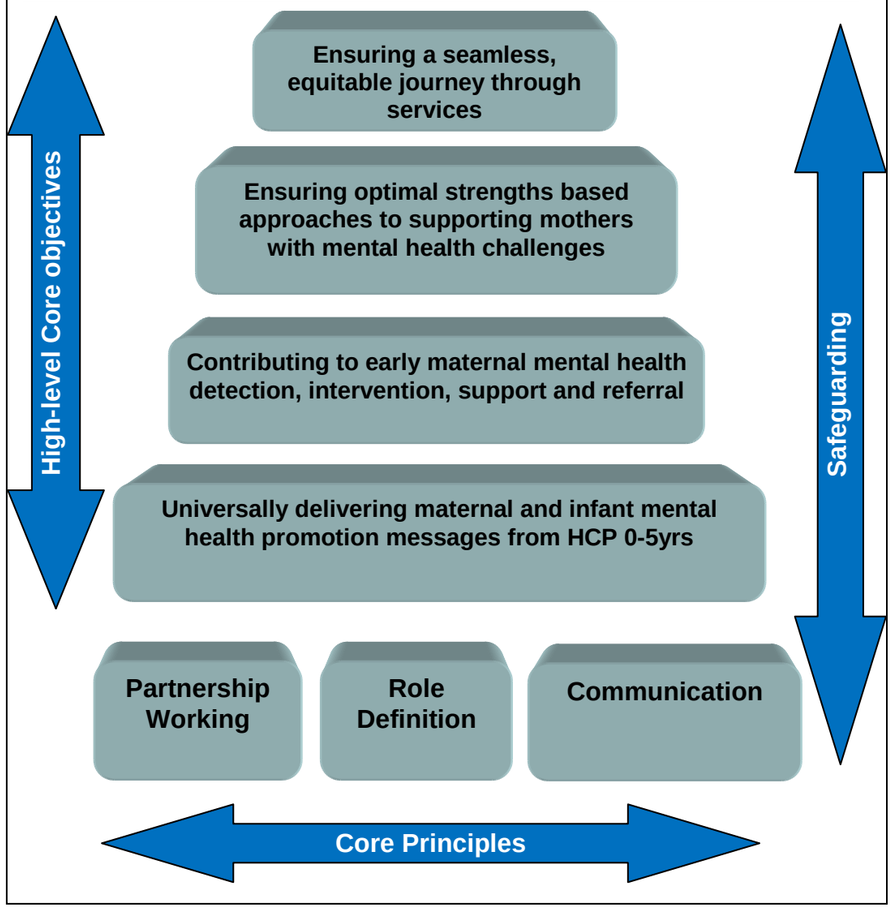
Partnership working

Partnership working between health visitors and all other professionals involved will ensure that the antenatal and postnatal maternal mental health care is coordinated, systematic and documented, thus ensuring children and families received coordinated, consistent and seamless care.

Proposed objectives for delivery

- Develop a local perinatal mental health network to ensure coordination and cooperation of stakeholder planning of service delivery.
- Develop joint caseload review meetings organised to underpin continuous flow of information about vulnerable families throughout pregnancy.
- Offer joint clinics/preparation for being a parent sessions for parents to build relationships with health visitor; breastfeeding support, relationship building and health promotion/social and emotional assessment.
- Share evaluation/use of the Common and shared assessment processes, such as, the Common Assessment Framework (CAF).
- Pool resources and engagement in joint commissioning.
- Offer joint home visits between health visitor and other involved health professionals for families with complex needs.
- Enhance joint working by joint training and sharing of information to improve outcomes for families.

Figure 1: Improved mental health outcomes for mothers and infants.



Safeguarding is of paramount importance and local areas need to ensure there are clear protocols in place, which offer clarity regarding the roles and responsibilities of health visitors and midwives.

Communication and information

Good communication is essential throughout the whole of the pathway. It is essential that mothers and other family members are offered the appropriate information at the right time and pace for them; this is in itself a challenge. The development of a strengthened pathway provides an opportunity to evaluate outcomes that measure quality and undertake audits using information about the impact for users/clients rather than the impact of processes.

Proposed suggestions for improved communications:

- Share learning and best practice.
- Improve use of technology and systems to ease access to records and assist recording.
- Develop a seamless approach to signposting and messaging about the roles and services from midwifery to health visiting.
- Standardise procedures for handover of records from midwifery services to health visiting services.
- Build on learning from mobile working pilot and roll out good practice.
- Standardise computer systems to ease access to records and assist recording.
- Ensure awareness of cultural sensitivities to mental health and the use of appropriately trained interpreters and materials e.g. How are you feeling? Booklets.
- Use educational tools e.g. literature, DVDs, groups etc.

Role definition

Throughout the timeline the expectations of mothers and families will need to be managed. It is therefore important to understand the role of the health visitor and all other health professionals involved to ensure that families seeks expert advice from the appropriately trained professional.

Proposed suggestions for delivery

- Clarify the roles and responsibilities of health visiting, midwifery and adult mental health service teams in the delivery of maternal mental health care and their responsibilities towards child safeguarding.
- Provide clear information for parents, families and other health and social care professionals and partners.

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Supporting Policy

- The Healthy Child Programme (2009), is the preventive programme for all children and includes schedules for screening, immunisation and assessment. The HCP supports health, and learning and development outcomes for children, and recognises that some will need higher levels of input to reach their potential. The HCP is led by health visitors and commences in pregnancy.
- The Health Visitor Implementation Plan: A Call to Action (2011), sets out the revitalised universal offer of health visiting support for all children and their parents and challenges midwives and health visitors to articulate and recognise their different professional perspectives and collaborative contributions to ensure quality outcomes for children and parents.
- The Supporting Families in the Foundation Years (2011), document underlined and emphasised the importance of the foundations years, (from pregnancy to age five) and the value of offering parents support, advice, and information antenatally and after birth.
- Midwifery 2020: Delivering Expectations (2010), set the direction for midwifery and outlined that timely communication is crucial to the success of such partnership working.
- Maternity and Early Years: Making a good start to Family Life (2010), sets out the Governments ambition for better integrated care in response to feedback from families that they would like 'stronger continuity of care after birth'.
- Good partnership working is seen as one of the key elements in responding to the recommendations of the Allen (2011), Munro (2010), Tickell (2011) and Field (2010) reviews.
- Public Health White Paper Update and Way Forward: (2011), Professionals such as health visitors and midwives will have a role in helping to develop local approaches to public health, by providing links between public health and the NHS and displaying leadership in promoting good health and addressing inequalities.
- NICE Clinical Guideline 37. Routine postnatal care of women and their babies (2006).
- NICE Clinical Guideline 6. Antenatal Care: Routine care for the healthy pregnant woman (2008).
- NICE Clinical Guideline 110. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (2010).
- NICE Clinical Guideline 45. Antenatal and postnatal mental health: Clinical management and service guidance (2007).
- Supporting Families in the Foundation Years (2011).
- Parents' views on the maternity journey and early parenthood (2011), this can be used in conjunction with the suggested timeline for advice as to how to deliver the messages to ensure a family and baby-centred approach.
- NHS Future Forum
- Frank Fields review, The Foundation Years: preventing poor children becoming poor adults (2010).

Acknowledgements

This pathway has been developed in partnership with a range of stakeholders across the NHS and other organisations. Thanks are extended to all contributors, specifically the following: MIND, the Department for Education and the Royal College of GPs.

Task and Finish Group members

Members all have extensive experience in working in inter-professional partnerships and were nominated by their professional bodies; the Royal College of Midwives and Community Practitioner Health Visitors Association/Unite.

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DH INFORMATION READER BOX

Policy	**Clinical**	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	17968
Title	Maternal Mental Health Pathway
Author	Department of Health
Publication Date	**August 2012'**
Target Audience	published on DH website - no direct mailing. For Nursing Audience
Circulation List	The draft document has been circulated widely for comment.
Description	This pathway is a guidance document to support professional practice and provides a structured approach to addressing the common issues associatesd with maternal mental health and wellbeing, from pregnancy through the early months after the birth. It sets out the benefits and principles of integrated working. It focuses on the role of the health visitor but also recognises the essential contributions of patners in midwifery, mental health,general practice and third sector.
Cross Ref	Health Visitor Implementaion Plan published February 2011
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	