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Antenatal and postnatal mental health: clinical management and service guidance

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Contents

Introduction

This guideline updates and replaces NICE clinical guideline 45. See about this guideline for details.

In pregnancy and the postnatal period, many mental health problems have a similar nature, course and potential for relapse as at other times. However, there can be differences; for example, bipolar disorder shows an increased rate of relapse and first presentation in the postnatal period. Some changes in mental health state and functioning (such as appetite) may represent normal pregnancy changes, but they may be a symptom of a mental health problem.

The management of mental health problems during pregnancy and the postnatal period differs from at other times because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby. There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding and risks of stopping medication taken for an existing mental health problem. There is also an increased risk of postpartum psychosis.

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth. During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history.

Changes to body shape, including weight gain, in pregnancy and after childbirth may be a concern for women with an eating disorder. Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher. Smoking and the use of illicit drugs and alcohol in pregnancy are common, and prematurity, intrauterine growth restriction and fetal compromise are more common in women who use these substances, particularly women who smoke.

Between 2006 and 2008 there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK as a result of mental health problems. Although response to treatment for mental health problems is good, these problems frequently go unrecognised and untreated in pregnancy and the postnatal period. If untreated, women can continue to have symptoms, sometimes for many years, and these can also affect their babies and other family members.

This guideline makes recommendations for the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth) and in women who are planning a pregnancy. The guideline covers depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness (such as psychosis, bipolar disorder, schizophrenia and severe depression). It covers subthreshold symptoms as well as mild, moderate and severe mental health problems. However, the guideline focuses on aspects of expression, risks and management that are of special relevance in pregnancy and the postnatal period.

The recommendations are relevant to all healthcare professionals who recognise, assess and refer for or provide interventions for mental health problems in pregnancy and the postnatal period. It will also be relevant to non-NHS services, such as social services and the voluntary and private sectors, but does not make specific recommendations for these. The guideline also makes recommendations about the primary and secondary care services needed to support the effective identification and treatment of most mental health problems in pregnancy and the postnatal period. This guideline should be read in conjunction with other NICE guidelines on the treatment and management of specific mental health problems. The guideline indicates where modifications to treatment and management are needed in pregnancy and the postnatal period.

The guideline draws on the best available evidence. However, there are significant limitations to the evidence base, including limited data on the risks of psychotropic medication in pregnancy and during breastfeeding.

Medicines

No psychotropic medication has a UK marketing authorisation specifically for women who are pregnant or breastfeeding. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The woman (or those with authority to give consent on her behalf) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further

information. Where recommendations have been made for the use of medicines outside their licensed indications ('off-label use'), these medicines are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the recognition, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth). It also offers advice on the care of women with an existing mental health problem who are planning a pregnancy.

Women and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the service user is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have the capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All healthcare professionals and social care practitioners working with people using adult NHS mental health services should follow the recommendations in service user experience in adult mental health.

If a young person is moving between child and adolescent mental health services and adult mental health services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult, neonatal and child healthcare teams should work jointly to provide assessment and services during pregnancy and the postnatal period for women with mental health problems and their babies. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

Considerations for women of childbearing potential

- Discuss with all women of childbearing potential who have a new, existing or past mental health problem:
  - the use of contraception and any plans for a pregnancy
  - how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
  - how a mental health problem and its treatment might affect the woman, the fetus and baby
  - how a mental health problem and its treatment might affect parenting. [new 2014]
- Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential. **[new 2014]**

Principles of care in pregnancy and the postnatal period

Coordinated care

- Develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:
  - the care and treatment for the mental health problem
  - the roles of all healthcare professionals, including who is responsible for:
    - coordinating the integrated care plan
    - the schedule of monitoring
    - providing the interventions and agreeing the outcomes with the woman. **[new 2014]**

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

Information and advice

- Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include discussion of the following, depending on individual circumstances:
    - the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
    - the likely benefits of each treatment, taking into account the severity of the mental health problem
    - the woman's response to any previous treatment
    - the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
    - the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
    - the risks or harms to the woman and the fetus or baby associated with each treatment option
    - the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
    - the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. **[new 2014]**

Starting, using and stopping treatment

- Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing

risk-benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. **[new 2014]**

- If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:
  - confirm the pregnancy as soon as possible
  - explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
  - offer screening for fetal abnormalities and counselling about continuing the pregnancy
  - explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

    Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. **[new 2014]**

TCAs, SSRIs, (S)NRIs

- When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI][1], take into account:
  - the woman's previous response to these drugs
  - the stage of pregnancy
  - what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
  - the uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors
  - the risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine. **[new 2014]**

Recognising mental health problems in pregnancy and the postnatal period and referral

- At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:
  - During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - During the past month, have you often been bothered by having little interest or pleasure in doing things?

    Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
  - During the past month, have you been feeling nervous, anxious or on edge?[2]
  - During the past month have you not been able to stop or control worrying?[2]**[new 2014]**

Providing interventions in pregnancy and the postnatal period

- All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services). **[new 2014]**

Considerations for women and their babies in the postnatal period

Traumatic birth, stillbirth and miscarriage

- Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following:

- seeing a photograph of the baby
- having mementos of the baby
- seeing the baby
- holding the baby.

This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery if needed. **[new 2014]**

The organisation of services

- Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:
  - a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
  - access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
  - clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
  - pathways of care for service users, with defined roles and competencies for all professional groups involved. **[2007]**

[1] Although this use is common in UK clinical practice, at the time of publication (December 2014]), TCAs, SSRIs and (S)NRIs did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General

Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[2] An answer of 'Not at all' scores 0; 'Several days' scores 1; 'More than half the days' scores 2; 'Nearly every day' scores 3.

1 Recommendations

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

Terms used in this guideline

Anxiety disorders These include generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, phobias, post-traumatic stress disorder and social anxiety disorder.

Baby refers to an infant aged between 0 and 12 months.

High-intensity intervention A formal psychological intervention usually delivered face to face (either in a group or individually) by a qualified therapist who has specific training in the delivery of the intervention.

Low-intensity intervention A psychological or psychosocial intervention delivered by a trained coach or facilitator (rather than a therapist) to enable use of self-help materials.

Postnatal period This is defined in this guideline as up to 1 year after childbirth.

Postpartum psychosis Psychosis often with mania and/or depressive symptoms in the immediate postnatal period, which can become very severe extremely quickly.

Psychotropic medication This is defined in this guideline as all medication used to treat mental health problems.

Severe mental illness This is defined in this guideline as severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder and postpartum psychosis.

Traumatic birth includes births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward.

Valproate Refers to 3 formulations of valproate available in the UK: sodium valproate and valproic acid (licensed for the treatment of epilepsy) and semi-sodium valproate (licensed for the treatment of acute mania and continuation treatment in people whose mania responds to treatment). Both semi-sodium and sodium valproate are metabolised to valproic acid (also known as valproate), which is the pharmacologically active component.

Woman/women refer(s) to female(s) of childbearing potential, including girls and young women under 18 years.

1.1 Using this guideline in conjunction with other NICE guidelines

Improving the experience of care

1.1.1 Use this guideline in conjunction with the guidance on service user experience in adult mental health (NICE guideline CG136) and patient experience in adult NHS services (NICE guideline CG138) to improve the experience of care for women with a mental health problem in pregnancy or the postnatal period. **[new 2014]**

Assessment and treatment in pregnancy and the postnatal period

1.1.2 Use this guideline in conjunction with the NICE guideline for a specific mental health problem (see the related NICE guidance in section 3.2) to inform assessment and treatment decisions in pregnancy and the postnatal period, and take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period
- the setting for assessment and treatment (for example, primary or secondary care services or in the community, the home or remotely by phone or computer)
- recommendations 1.6.1 to 1.6.6 in this guideline on assessment in pregnancy and the postnatal period

- recommendations 1.4.10 to 1.4.37 in this guideline on starting, using and stopping treatment in pregnancy and the postnatal period
- recommendations 1.8.1 to 1.8.23 in this guideline on treating specific mental health problems in pregnancy and the postnatal period. **[new 2014]**

1.2 Considerations for women of childbearing potential

1.2.1 Discuss with all women of childbearing potential who have a new, existing or past mental health problem:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- how a mental health problem and its treatment might affect the woman, the fetus and baby
- how a mental health problem and its treatment might affect parenting. **[new 2014]**

1.2.2 When prescribing psychotropic medication for women of childbearing potential, take account of the latest data on the risks to the fetus and baby. **[new 2014]**

1.2.3 Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential. **[new 2014]**

1.3 Principles of care in pregnancy and the postnatal period

Supporting women and their partners, families and carers

1.3.1 Acknowledge the woman's role in caring for her baby and support her to do this in a non-judgmental and compassionate way. **[new 2014]**

1.3.2 Involve the woman and, if she agrees, her partner, family or carer, in all decisions about her care and the care of her baby. **[new 2014]**

1.3.3 When working with girls and young women with a mental health problem in pregnancy or the postnatal period:

- be familiar with local and national guidelines on confidentiality and the rights of the child
- be aware of the recommendations in section 1.4 of the guideline on pregnancy and complex social factors (NICE guideline CG110)
- ensure continuity of care for the mental health problem if care is transferred from adolescent to adult services. **[new 2014]**

1.3.4 Take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period. These include:

- the welfare of the baby and other dependent children and adults
- the role of the partner, family or carer in providing support
- the potential effect of any mental health problem on the woman's relationship with her partner, family or carer. **[new 2014]**

Coordinated care

1.3.5 Develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
  - coordinating the integrated care plan
  - the schedule of monitoring
- providing the interventions and agreeing the outcomes with the woman. **[new 2014]**

1.3.6 The healthcare professional responsible for coordinating the integrated care plan should ensure that:

- everyone involved in a woman's care is aware of their responsibilities
- there is effective sharing of information with all services involved and with the woman herself
- mental health (including mental wellbeing) is taken into account as part of all care plans
- all interventions for mental health problems are delivered in a timely manner, taking into account the stage of the pregnancy or age of the baby. **[new 2014]**

1.4 Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

Information and advice

1.4.1 Provide culturally relevant information on mental health problems in pregnancy and the postnatal period to the woman and, if she agrees, her partner, family or carer. Ensure that the woman understands that mental health problems are not uncommon during these periods and instil hope about treatment. **[new 2014]**

1.4.2 Consider referring a woman to a secondary mental health service (preferably a specialist perinatal mental health service) for preconception counselling if she has a current or past severe mental health problem and is planning a pregnancy. **[new 2014]**

1.4.3 Discuss treatment and prevention options and any particular concerns the woman has about the pregnancy or the fetus or baby. Provide information to the woman and, if she agrees, her partner, family or carer, about:

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment

- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly. **[new 2014]**

1.4.4 Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. Explain to them the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed. **[new 2014]**

1.4.5 If needed, seek more detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period from a secondary mental health service (preferably a specialist perinatal mental health service). This might include advice on the risks and possible harms of taking psychotropic medication while breastfeeding and how medication might affect a woman's ability to care for her baby (for example, sedation). **[new 2014]**

1.4.6 Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include discussion of the following, depending on individual circumstances:

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment

- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. **[new 2014]**

1.4.7 When discussing likely benefits and risks of treatment with the woman and, if she agrees, her partner, family or carer:

- acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice
- use absolute values based on a common denominator (that is, numbers out of 100 or 1000)
- acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit
- use high-quality decision aids in a variety of numerical and pictorial formats that focus on a personalised view of the risks and benefits, in line with the guidance on patient experience in adult NHS services (NICE guideline CG138)
- consider providing records of the consultation, in a variety of visual, verbal or audio formats. **[new 2014]**

Monitoring and increased contact

1.4.8 Healthcare professionals working in universal services and those caring for women in mental health services should:

- assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one

- agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem
- monitor regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth. **[new 2014]**

1.4.9 Discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires, such as the Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire [PHQ-9] or the 7-item Generalized Anxiety Disorder scale [GAD-7]). **[new 2014]**

Starting, using and stopping treatment

General advice

1.4.10 Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. **[new 2014]**

1.4.11 If the optimal treatment for a woman with a mental health problem is psychotropic medication combined with a psychological intervention, but she declines or stops taking psychotropic medication in pregnancy or the postnatal period, ensure that:

- she is adequately supported and
- has the opportunity to discuss the risk associated with stopping psychotropic medication and
- is offered, or can continue with, a psychological intervention. **[new 2014]**

1.4.12 When psychotropic medication is started in pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health, and:

- choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication

- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to 2 or more drugs
- take into account that dosages may need to be adjusted in pregnancy. **[2014]**

1.4.13 When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
  - restarting the medication
  - switching to other medication
  - having a psychological intervention
- increasing the level of monitoring and support.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication. **[new 2014]**

1.4.14 When a woman with depression or an anxiety disorder decides to stop taking psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
  - having a psychological intervention
  - restarting the medication if the depression or anxiety disorder is or has been severe and there has been a previous good response to treatment
  - switching to other medication

- increasing the level of monitoring and support while she is not taking any medication.

  Ensure she knows about any risks to herself, the fetus or baby when stopping medication. **[new 2014]**

1.4.15 If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:

- confirm the pregnancy as soon as possible
- explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- offer screening for fetal abnormalities and counselling about continuing the pregnancy
- explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

  Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. **[new 2014]**

TCAs, SSRIs, (S)NRIs

1.4.16 When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI][3], take into account:

- the woman's previous response to these drugs
- the stage of pregnancy
- what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)

- the uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors
- the risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine. **[new 2014]**

1.4.17 When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs[3] for a woman who is considering breastfeeding, take into account:

- the benefits of breastfeeding for the woman and baby
- the uncertainty about the safety of these drugs for the breastfeeding baby
- the risks associated with switching from or stopping a previously effective medication.

Seek advice from a specialist (preferably from a specialist perinatal mental health service) if there is uncertainty about specific drugs. **[new 2014]**

Benzodiazepines

1.4.18 Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of severe anxiety and agitation. **[2014]**

1.4.19 Consider gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding. **[2014]**

Antipsychotic medication

1.4.20 When assessing the risks and benefits of antipsychotic medication[4] for a pregnant woman, take into account risk factors for gestational diabetes and excessive weight gain. **[new 2014]**

1.4.21 When choosing an antipsychotic, take into account that there are limited data on the safety of these drugs in pregnancy and the postnatal period. **[new 2014]**

1.4.22 Measure prolactin levels in women who are taking prolactin-raising antipsychotic medication and planning a pregnancy, because raised prolactin levels reduce the chances of conception. If prolactin levels are raised, consider a prolactin-sparing antipsychotic. **[2014]**

1.4.23 If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic. **[new 2014]**

1.4.24 Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain, in line with the guideline on weight management before, during and after pregnancy (NICE guideline PH27). **[new 2014]**

1.4.25 Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE guideline CG63) and offer an oral glucose tolerance test. **[new 2014]**

1.4.26 Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication. **[new 2014]**

Anticonvulsants for mental health problems (valproate, carbamazepine and lamotrigine)

1.4.27 Do not offer valproate for acute or long-term treatment of a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding. **[new 2014]**

1.4.28 If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy. **[2014]**

1.4.29 If a woman is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes. **[2014]**

1.4.30 Do not offer carbamazepine to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding. **[new 2014]**

1.4.31 If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, discuss with the woman the possibility of stopping the drug (because of the risk of adverse drug interactions and fetal malformations). **[new 2014]**

1.4.32 If a woman is taking lamotrigine[5] during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times. **[new 2014]**

Lithium

1.4.33 Do not offer lithium[6] to women who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective. **[new 2014]**

1.4.34 If antipsychotic medication has not been effective and lithium is offered to a woman who is planning a pregnancy or pregnant, ensure:

- the woman knows that there is a risk of fetal heart malformations when lithium is taken in the first trimester, but the size of the risk is uncertain
- the woman knows that lithium levels may be high in breast milk with a risk of toxicity for the baby
- lithium levels are monitored more frequently throughout pregnancy and the postnatal period. **[new 2014]**

1.4.35 If a woman taking lithium becomes pregnant, consider stopping the drug gradually over 4 weeks if she is well. Explain to her that:

- stopping medication may not remove the risk of fetal heart malformations
- there is a risk of relapse, particularly in the postnatal period, if she has bipolar disorder. **[2014]**

1.4.36 If a woman taking lithium becomes pregnant and is not well or is at high risk of relapse, consider:

- switching gradually to an antipsychotic or
- stopping lithium and restarting it in the second trimester (if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past) or
- continuing with lithium if she is at high risk of relapse and an antipsychotic is unlikely to be effective. **[new 2014]**

1.4.37 If a woman continues taking lithium during pregnancy:

- check plasma lithium levels every 4 weeks, then weekly from the 36th week
- adjust the dose to keep plasma lithium levels in the woman's therapeutic range
- ensure the woman maintains an adequate fluid balance
- ensure the woman gives birth in hospital
- ensure monitoring by the obstetric team when labour starts, including checking plasma lithium levels and fluid balance because of the risk of dehydration and lithium toxicity
- stop lithium during labour and check plasma lithium levels 12 hours after her last dose. **[2014]**

1.5 Recognising mental health problems in pregnancy and the postnatal period and referral

1.5.1 Recognise that women who have a mental health problem (or are worried that they might have) may be:

- unwilling to disclose or discuss their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care

- reluctant to engage, or have difficulty in engaging, in treatment because of avoidance associated with their mental health problem or dependence on alcohol or drugs. **[new 2014]**

1.5.2 All healthcare professionals referring a woman to a maternity service should ensure that communications with that service (including those relating to initial referral) share information on any past and present mental health problem. **[2014]**

Depression and anxiety disorders

1.5.3 Recognise that the range and prevalence of anxiety disorders (including generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, phobias, post-traumatic stress disorder and social anxiety disorder) and depression are under-recognised throughout pregnancy and the postnatal period. **[new 2014]**

1.5.4 At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?[7]
- During the past month have you not been able to stop or control worrying?[7] **[new 2014]**

1.5.5 If a woman responds positively to either of the depression identification questions in recommendation 1.5.4, is at risk of developing a mental health problem, or there is clinical concern, consider:

- using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) as part of a full assessment or
- referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. **[new 2014]**

1.5.6 If a woman scores 3 or more on the GAD-2 scale, consider:

- using the GAD-7 scale for further assessment or
- referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. **[new 2014]**

1.5.7 If a woman scores less than 3 on the GAD-2 scale, but you are still concerned she may have an anxiety disorder, ask the following question:

- Do you find yourself avoiding places or activities and does this cause you problems?

  If she responds positively, consider:

- using the GAD-7 scale for further assessment or
- referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. **[new 2014]**

1.5.8 At all contacts after the first contact with primary care or the booking visit, the health visitor, and other healthcare professionals who have regular contact with a woman in pregnancy and the postnatal period (first year after birth), should consider:

- asking the 2 depression identification questions and the GAD-2 (see recommendation 1.5.4) as part of a general discussion about her mental health and wellbeing and

- using the EPDS or the PHQ-9 as part of monitoring. **[new 2014]**

Severe mental illness

1.5.9 At a woman's first contact with services in pregnancy and the postnatal period, ask about:

- any past or present severe mental illness
- past or present treatment by a specialist mental health service, including inpatient care
- any severe perinatal mental illness in a first-degree relative (mother, sister or daughter). **[2014]**

1.5.10 Refer to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during pregnancy or the postnatal period or at any other time).

Ensure that the woman's GP knows about the referral. **[new 2014]**

1.5.11 If a woman has any past or present severe mental illness or there is a family history of severe perinatal mental illness in a first-degree relative, be alert for possible symptoms of postpartum psychosis in the first 2 weeks after childbirth. **[new 2014]**

1.5.12 If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral). **[new 2014]**

Alcohol and drug misuse

1.5.13 If alcohol misuse is suspected, use the Alcohol Use Disorders Identification Test (AUDIT) as an identification tool in line with recommendation 1.2.1.4 of the guideline on alcohol-use disorders (NICE guideline CG115). **[new 2014]**

1.5.14 If drug misuse is suspected, follow the recommendations on identification and assessment in section 1.2 of the guideline on drug misuse – psychosocial interventions (NICE guideline CG51). **[new 2014]**

1.6 Assessment and care planning in pregnancy and the postnatal period

1.6.1 Assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include:

- history of any mental health problem, including in pregnancy or the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- the woman's attitude towards the pregnancy, including denial of pregnancy
- the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby
- the mother–baby relationship
- any past or present treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first-degree relative) of mental health problems

- domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
- housing, employment, economic and immigration status
- responsibilities as a carer for other children and young people or other adults. **[new 2014]**

1.6.2 When assessing or treating a mental health problem in pregnancy or the postnatal period, take account of any learning disabilities or acquired cognitive impairments, and assess the need to consult with a specialist when developing care plans. **[new 2014]**

1.6.3 Carry out a risk assessment in conjunction with the woman and, if she agrees, her partner, family or carer. Focus on areas that are likely to present possible risk such as self-neglect, self-harm, suicidal thoughts and intent, risks to others (including the baby), smoking, drug or alcohol misuse and domestic violence and abuse. **[new 2014]**

1.6.4 If there is a risk of, or there are concerns about, suspected child maltreatment, follow local safeguarding protocols. **[new 2014]**

1.6.5 If there is a risk of self-harm or suicide:

- assess whether the woman has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk
- inform all relevant healthcare professionals (including the GP and those identified in the care plan [see recommendation 1.6.6])
- advise the woman, and her partner, family or carer, to seek further help if the situation deteriorates. **[new 2014]**

1.6.6 Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer should also be involved. The plan should

cover pregnancy, childbirth and the postnatal period (including the potential impact of the illness on the baby) and should include:

- a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored
- increased contact with and referral to specialist perinatal mental health services
- the names and contact details of key professionals.

The care plan should be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and a copy given to the woman and all involved professionals. **[new 2014]**

1.7 Providing interventions in pregnancy and the postnatal period

1.7.1 All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services). **[new 2014]**

1.7.2 All interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions practitioners should:

- receive regular high-quality supervision
- use routine outcome measures and ensure that the woman is involved in reviewing the efficacy of the treatment

- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate. **[new 2014]**[8]

1.7.3 When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assess for treatment within 2 weeks of referral and provide psychological interventions within 1 month of initial assessment. **[new 2014]**

1.7.4 When offering psychotropic medication during pregnancy and the postnatal period, follow the principles in recommendations 1.4.10 to 1.4.37. **[new 2014]**

1.7.5 Provide interventions for mental health problems in pregnancy and the postnatal period within a stepped-care model of service delivery in line with recommendation 1.5.1.3 of the guideline on common mental health disorders (NICE guideline CG123). **[new 2014]**

1.8 Treating specific mental health problems in pregnancy and the postnatal period

Interventions for depression

1.8.1 For a woman with persistent subthreshold depressive symptoms, or mild to moderate depression, in pregnancy or the postnatal period, consider facilitated self-help (delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults [NICE guideline CG90]). **[new 2014]**

1.8.2 For a woman with a history of severe depression who initially presents with mild depression in pregnancy or the postnatal period, consider a TCA, SSRI or (S)NRI. **[new 2014]**

1.8.3 For a woman with moderate or severe depression in pregnancy or the postnatal period, consider the following options:

- a high-intensity psychological intervention (for example, CBT)

- a TCA, SSRI or (S)NRI if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and:
  - she has expressed a preference for medication or
  - she declines psychological interventions or
  - her symptoms have not responded to psychological interventions
- a high-intensity psychological intervention in combination with medication if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and there is no response, or a limited response, to a high-intensity psychological intervention or medication alone. **[new 2014]**

1.8.4 If a woman who is taking a TCA, SSRI or (S)NRI for mild to moderate depression becomes pregnant, discuss stopping the medication gradually and consider facilitated self-help (delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults [NICE guideline CG90]). **[new 2014]**

1.8.5 If a pregnant woman is taking a TCA, SSRI or (S)NRI for moderate depression and wants to stop her medication, take into account previous response to treatment, stage of pregnancy, risk of relapse, risk associated with medication and her preference, and discuss with her the following options:

- switching to a high-intensity psychological intervention (for example, CBT)
- changing medication if there is a drug that is effective for her with a lower risk of adverse effects. **[new 2014]**

1.8.6 If a pregnant woman is taking a TCA, SSRI or (S)NRI for severe depression, take into account previous response to treatment, stage of pregnancy, risk of relapse, risk associated with medication and her preference, and discuss with her the following options:

- continuing with the current medication

- changing medication if there is a drug that is effective for her with a lower risk of adverse effects
- combining medication with a high-intensity psychological intervention (for example, CBT)
- switching to a high-intensity psychological intervention (for example, CBT) if she decides to stop taking medication. **[new 2014]**

Interventions for anxiety disorders

1.8.7 For a woman with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss her fears with a healthcare professional with expertise in providing perinatal mental health support in line with section 1.2.9 of the guideline on caesarean section (NICE guideline CG132). **[new 2014]**

1.8.8 For a woman with persistent subthreshold symptoms of anxiety in pregnancy or the postnatal period, consider facilitated self-help. This should consist of use of CBT-based self-help materials over 2-3 months with support (either face to face or by telephone) for a total of 2-3 hours over 6 sessions. **[new 2014]**

1.8.9 For a woman with an anxiety disorder in pregnancy or the postnatal period, offer a low-intensity psychological intervention (for example, facilitated self-help) or a high-intensity psychological intervention (for example, CBT) as initial treatment in line with the recommendations set out in the NICE guideline for the specific mental health problem and be aware that:

- only high-intensity psychological interventions are recommended for post-traumatic stress disorder
- high-intensity psychological interventions are recommended for the initial treatment of social anxiety disorder
- progress should be closely monitored and a high-intensity psychological intervention offered within 2 weeks if symptoms have not improved. **[new 2014]**

1.8.10 If a woman who is taking a TCA, SSRI or (S)NRI for an anxiety disorder becomes pregnant, discuss with her the following options:

- stopping the medication gradually and switching to a high-intensity psychological intervention (for example, CBT)
- continuing with medication if she understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and:
  - has expressed a preference for medication or
  - declines psychological interventions or
  - her symptoms have not responded to psychological interventions
- changing medication if there is a drug that is effective for her with a lower risk of adverse effects
- combining medication with a high-intensity psychological intervention (for example, CBT) if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and there is no response, or a limited response, to a high-intensity psychological intervention alone. **[new 2014]**

Psychological interventions for eating disorders

1.8.11 For a woman with an eating disorder in pregnancy or the postnatal period:

- offer a psychological intervention in line with the guideline on eating disorders (NICE guideline CG9)
- monitor the woman's condition carefully throughout pregnancy and the postnatal period
- assess the need for fetal growth scans
- discuss the importance of healthy eating during pregnancy and the postnatal period in line with the guideline on maternal and child nutrition (NICE guideline PH11)
- advise her about feeding the baby in line with the guideline on maternal and child nutrition (NICE guideline PH11) and support her with this. **[new 2014]**

Interventions for alcohol and drug misuse

1.8.12 If hazardous drug or alcohol misuse is identified in pregnancy or the postnatal period, refer or offer brief interventions in line with section 1.3.1 of the guideline on drug misuse - psychosocial interventions (NICE guideline CG51) or the guideline on alcohol-use disorders: preventing harmful drinking (NICE guideline PH24). **[new 2014]**

1.8.13 If harmful or dependent drug or alcohol misuse is identified in pregnancy or the postnatal period, refer the woman to a specialist substance misuse service for advice and treatment. **[new 2014]**

1.8.14 Offer assisted alcohol withdrawal in collaboration with specialist mental health and alcohol services (preferably in an inpatient setting) to pregnant women who are dependent on alcohol. Work with a woman who does not want assisted alcohol withdrawal to help her reduce her alcohol intake. **[new 2014]**

1.8.15 Offer detoxification in collaboration with specialist mental health and substance misuse services to pregnant women who are dependent on opioids. Monitor closely after completion of detoxification. Work with a woman who does not want detoxification to help her reduce her opioid intake. Recognise the risk of accidental overdose in women who stop or reduce drug misuse in pregnancy but start misusing again after childbirth. **[new 2014]**

Interventions for severe mental illness

1.8.16 Consider psychological interventions for women with bipolar disorder. This includes:

- CBT, IPT and behavioural couples therapy for bipolar depression
- structured individual, group and family interventions designed for bipolar disorder to reduce the risk of relapse, particularly when medication is changed or stopped. **[new 2014]**

1.8.17 If a pregnant woman develops mania or psychosis and is not taking psychotropic medication, offer an antipsychotic. **[new 2014]**

1.8.18 Consider psychological interventions (CBT or family intervention) delivered as described in section 1.3.7 of the guideline on psychosis and schizophrenia in adults (NICE guideline CG178) for a woman with psychosis or schizophrenia who becomes pregnant and is at risk of relapse arising from:

- stress associated with pregnancy or the postnatal period
- a change in medication, including stopping antipsychotic medication. **[new 2014]**

1.8.19 Offer an antipsychotic in line with recommendations 1.5.3 and 1.5.4 of the guideline on bipolar disorder (NICE guideline CG185) as prophylactic medication if a woman with bipolar disorder:

- becomes pregnant and is stopping lithium, or
- plans to breastfeed. **[new 2014]**

1.8.20 If a pregnant woman with bipolar disorder develops mania while taking prophylactic medication:

- check the dose of the prophylactic medication and adherence
- increase the dose if the prophylactic medication is an antipsychotic
- suggest changing to an antipsychotic if she is taking another type of prophylactic medication
- consider lithium if there is no response to an increase in dose or change of drug and the woman has severe mania
- consider electroconvulsive therapy (ECT) if there has been no response to lithium. **[new 2014]**

Interventions for sleep problems

1.8.21 Advise pregnant women who have a sleep problem about sleep hygiene (including having a healthy bedtime routine, avoiding caffeine and reducing activity before sleep). For women with a severe or chronic sleep problem, consider promethazine[9]. **[new 2014]**

Electroconvulsive therapy

1.8.22 Consider electroconvulsive therapy (ECT) for pregnant women with severe depression, severe mixed affective states or mania, or catatonia, whose physical health or that of the fetus is at serious risk. **[2014]**

Rapid tranquillisation

1.8.23 A pregnant woman requiring rapid tranquillisation should be treated according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder (see the related NICE guidance in section 3.2 for details), except that:

- she should not be secluded after rapid tranquillisation
- restraint procedures should be adapted to avoid possible harm to the fetus
- when choosing an agent for rapid tranquillisation in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account
- during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist. **[2007]**

1.9 Considerations for women and their babies in the postnatal period

Reviewing treatment for women with severe mental illness

1.9.1 After childbirth, review and assess the need for starting, restarting or adjusting psychotropic medication as soon as a woman with a past or present severe mental illness is medically stable. **[new 2014]**

Monitoring babies for effects of psychotropic medication taken in pregnancy

1.9.2 If a woman has taken psychotropic medication during pregnancy, carry out a full neonatal assessment of the newborn baby, bearing in mind:

- the variation in the onset of adverse effects of psychotropic medication
- the need for further monitoring
- the need to inform relevant healthcare professionals and the woman and her partner, family or carer of any further monitoring, particularly if the woman has been discharged early. **[new 2014]**

Care of women and their babies if there has been alcohol or drug misuse in pregnancy

1.9.3 If there has been alcohol or drug misuse in pregnancy, offer treatment and support after childbirth to both the woman and the baby, including:

- a full neonatal assessment for any congenital abnormalities or neonatal adaptation syndrome
- continuing psychological treatment and support for the woman
- monitoring of the baby. **[new 2014]**

Traumatic birth, stillbirth and miscarriage

1.9.4 Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends. **[new 2014]**

1.9.5 Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline on post-traumatic stress disorder (PTSD) (NICE guideline CG26). **[new 2014]**

1.9.6 Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth. **[new 2014]**

1.9.7 Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following:

- seeing a photograph of the baby
- having mementos of the baby
- seeing the baby
- holding the baby.

This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery if needed. **[new 2014]**

Psychotropic medication and breastfeeding

1.9.8 Encourage women with a mental health problem to breastfeed, unless they are taking carbamazepine, clozapine or lithium (valproate is not recommended to treat a mental health problem in women of childbearing potential). However, support each woman in the choice of feeding method that best suits her and her family. **[new 2014]**

1.9.9 When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs for women who are breastfeeding, take into account:

- the limited data about the safety of these drugs and
- the risks associated with switching from a previously effective medication.

Seek advice from a specialist (preferably from a specialist perinatal mental health service) if needed for specific drugs. **[new 2014]**

1.9.10 When assessing the risks and benefits of antipsychotic medication for women who are breastfeeding, take into account:

- the limited data on the safety of these drugs and
- the level of antipsychotic medication in breast milk depends on the drug. **[new 2014]**

1.9.11 If a woman is taking psychotropic medication while breastfeeding, monitor the baby for adverse effects. **[2014]**

The mother–baby relationship

1.9.12 Recognise that some women with a mental health problem may experience difficulties with the mother–baby relationship. Assess the nature of this relationship, including verbal interaction, emotional sensitivity and physical care, at all postnatal contacts. Discuss any concerns that the woman has about her relationship with her baby and provide information and treatment for the mental health problem. **[new 2014]**

1.9.13 Consider further intervention to improve the mother–baby relationship if any problems in the relationship have not resolved. **[new 2014]**

1.10 The organisation of services

1.10.1 Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. **[2007]**

1.10.2 Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that:

- there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment

- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways. **[2007]**

1.10.3 Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved. **[2007]**

1.10.4 Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates. **[2007]**

1.10.5 Specialist perinatal inpatient services should:

- provide facilities designed specifically for mothers and babies (typically with 6-12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for babies
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services

- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay. **[2007]**

[3] Although this use is common in UK clinical practice, at the time of publication (December 2014]), TCAs, SSRIs and (S)NRIs did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[4] Although this use is common in UK clinical practice, at the time of publication (December 2014]), antipsychotic medication did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[5] At the time of publication (December 2014), lamotrigine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[6] Although this use is common in UK clinical practice, at the time of publication (December 2014), lithium did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[7] An answer of 'Not at all' scores 0; 'Several days' scores 1; 'More than half the days' scores 2; 'Nearly every day' scores 3.

[8] Adapted from the guideline on depression in adults (NICE guideline CG90).

[9] At the time of publication (December 2014), promethazine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance,

taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

2.1 Preventing postpartum psychosis

What methods can improve the identification of women at high risk of postpartum psychosis and reduce this risk?

Why this is important

Postpartum psychosis is a severe mental illness with a rapid onset and a major impact on the woman and her ability to care for her baby. It is associated with an increased risk of mortality in both the woman and her baby. Prophylactic treatment can be effective for women who are known to be at high risk, but for some women postpartum psychosis may be their first episode of severe mental illness. Better identification of women at high risk and a greater understanding of prophylactic and acute treatment would have a significant impact on maternal and child welfare, and on service costs.

The question should be addressed by a programme of research into the prevention, treatment and management of postpartum psychosis comprising:

- The development of a tool for routine clinical use to improve the identification of women at high risk of developing postpartum psychosis. This should be tested in a prospective cohort study.
- The development of a set of interventions intended to prevent the onset of postpartum psychosis and a method for their effective and efficient delivery.
- The testing of the clinical and cost effectiveness of the interventions in a large scale randomised controlled trial.
- The development and testing of a programme for the implementation of an effective strategy for preventing and identifying postpartum psychosis.

2.2 The safety of drugs for bipolar disorder in pregnancy and the postnatal period

How safe are drugs used to treat bipolar disorder in pregnancy and the postnatal period?

Why this is important

Drugs are effective for the acute treatment of bipolar disorder and for preventing relapse. All drugs used to treat mental health problems may carry some risk for the woman, fetus and baby. For some drugs such as sodium valproate these risks are well described, but the data are drawn from epilepsy case registers. For others such as lithium, the data are very limited. In addition, the prevalence of adverse outcomes for the woman, fetus or baby in untreated bipolar disorder is not well described.

The question should be addressed by establishing a long-term register of women with bipolar disorder to provide data on:

- the drugs used for treating bipolar disorder in pregnancy
- the following outcomes (by drug type and for women who had no treatment for bipolar disorder in pregnancy):
    - maternal outcomes (for example, episodes of mood disorder in pregnancy and the postnatal period, miscarriage, preterm delivery)
    - congenital malformations (for example, spinal cord and cardiac malformation)
    - baby outcomes (for example, mortality, birthweight)
    - childhood outcomes (for example, cognitive development).

2.3 Psychological interventions focused on the mother-baby relationship

Are interventions designed to improve the quality of the mother–baby relationship in the first year after childbirth effective in women with a diagnosed mental health problem?

Why this is important

Problems in the mother–baby relationship in the first year after childbirth may increase maternal mental health problems and are associated with a range of problems for the baby, including delayed cognitive and emotional development. A number of interventions are effective in improving the interaction between women and their babies, but it is not known if these are effective in women with a diagnosed mental health problem.

The question should be addressed in a randomised controlled trial comparing an intervention (proven to be effective in improving the quality of mother–baby interactions in women without a diagnosed mental health problem) against standard care. The trial should report the following outcomes, with a follow-up period of at least 2 years:

- the mental health of the woman
- the emotional and cognitive development of the baby
- the quality of the interaction.

The trial should also examine the cost effectiveness of the intervention.

2.4 Structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period

Is structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period effective at improving outcomes for women and their babies?

Why this is important

Personality disorders are associated with poor engagement with maternity services and perinatal mental health services and this leads to poor mental and physical health outcomes for the woman, fetus and baby. The complex psychological interventions that are effective for treating personality disorder may present problems for engagement even in those motivated to seek treatment. Structured clinical management is a psychologically informed model of case management, which is effective for treating personality disorder and may have greater flexibility and capacity to engage women with personality disorder in pregnancy and the postnatal period.

The question should be addressed in a randomised controlled trial comparing structured clinical management of personality disorder in pregnancy and the postnatal period against standard care. The trial should report the following outcomes, with a follow-up period of at least 2 years:

- the mental and physical health of the woman
- the physical health of the fetus
- the mental and physical health of the baby
- the quality of the mother–baby relationship.

The trial should also examine the cost effectiveness of the intervention.

2.5 Psychological interventions for moderate to severe anxiety disorders in pregnancy

Are psychological interventions effective for treating moderate to severe anxiety disorders (including obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder and social anxiety disorder) in pregnancy?

Why this is important

Anxiety disorders are often not identified or treated in pregnancy. In addition, many women who are taking medication for such problems stop taking it when they are pregnant. The development of effective psychological interventions is therefore important. Although there are effective psychological interventions for anxiety disorders, there is limited evidence about their effectiveness in pregnancy and how these interventions might be adapted for use in pregnant women.

The question should be addressed by a programme of research evaluating psychological interventions (including individual and group approaches) for moderate to severe anxiety disorders in pregnancy, comprising:

- a development programme to establish the adaptations to effective interventions (for example, mode of delivery, duration, content, and intensity of treatment) that are needed for use in pregnancy

- the testing of the adapted interventions in a series of pilot studies
- the testing of the clinical and cost effectiveness of the adapted interventions in large-scale randomised controlled trials
- the development and testing of a programme for the implementation of psychological interventions for moderate to severe anxiety disorders.

3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in the guidelines manual.

3.2 Related NICE guidance

Details are correct at the time of publication of the guideline (December 2014). Further information is available on the NICE website.

Published

General

- Patient experience in adult NHS services (2012) NICE guideline CG138
- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

Condition-specific

- Intrapartum care (2014) NICE guideline CG190
- Postnatal care (2014) NICE guideline CG37
- Bipolar disorder (2014) NICE guideline CG185
- Psychosis and schizophrenia in adults (2014) NICE guideline CG178

- Smoking cessation in secondary care: acute, maternity and mental health services (2013) NICE guideline PH48
- Social anxiety disorder (2013) NICE guideline CG159
- Psychosis and schizophrenia in children and young people (2013) NICE guideline CG155
- Ectopic pregnancy and miscarriage (2012) NICE guideline CG154
- The epilepsies (2012) NICE guideline CG137
- Caesarean section (2011) NICE guideline CG132
- Multiple pregnancy (2011) NICE guideline CG129
- Common mental health disorders (2011) NICE guideline CG123
- Alcohol dependence and harmful alcohol use (2011) NICE guideline CG115
- Anxiety (2011) NICE guideline CG113
- Aripiprazole for the treatment of schizophrenia in people aged 15 to 17 years (2011) NICE technology appraisal guidance 213
- Pregnancy and complex social factors (2010) NICE guideline CG110
- Hypertension in pregnancy (2010) NICE guideline CG107
- Weight management before, during and after pregnancy (2010) NICE guideline PH27
- Quitting smoking in pregnancy and following childbirth (2010) NICE guideline PH26
- Alcohol-use disorders: preventing harmful drinking (2010) NICE guideline PH24
- Alcohol-use disorders: physical complications (2010) NICE guideline CG100
- Depression in adults (2009) NICE guideline CG90
- When to suspect child maltreatment (2009) NICE guideline CG89
- Borderline personality disorder (2009) NICE guideline CG78
- Antisocial personality disorder (2009) NICE guideline CG77

- Diabetes in pregnancy (2008) NICE guideline CG63
- Antenatal care (2008) NICE guideline CG62
- Maternal and child nutrition (2008) NICE guideline PH11
- Drug misuse: psychosocial interventions (2007) NICE guideline CG51
- Computerised cognitive behaviour therapy for depression and anxiety (2006) NICE technology appraisal guidance 97
- Obsessive-compulsive disorder (2005) NICE guideline CG31
- Depression in children and young people (2005) NICE guideline CG28
- Post-traumatic stress disorder (2005) NICE guideline CG26
- Violence (2005) NICE guideline CG25
- Eating disorders (2004) NICE guideline CG9
- Guidance on the use of electroconvulsive therapy (2003) NICE technology appraisal guidance 59

Under development

NICE is developing the following guidance (details available from the NICE website):

- Diabetes in pregnancy (update). NICE clinical guideline. Publication expected February 2015.
- Challenging behaviour and learning disabilities. NICE clinical guideline. Publication expected May 2015.
- Children's attachment. NICE clinical guideline. Publication expected October 2015.
- Preterm labour and birth. NICE clinical guideline. Publication expected June 2016.

4 The Guideline Development Group, National Collaborating Centre and NICE project team

4.1 Guideline Development Group

The Guideline Development Group members listed are those for the 2014 update. For the composition of the previous Guideline Development Group, see the full guideline.

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4.2 National Collaborating Centre for Mental Health

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

This guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in the guidelines manual.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

This guideline updates and replaces NICE guideline CG45 (published February 2007).

Recommendations are marked as **[new 2014]**, **[2014]** or **[2007]**:

- **[new 2014]** indicates that the evidence has been reviewed and the recommendation has been added or updated
- **[2014]** indicates that the evidence has been reviewed but no change has been made to the recommended action
- **[2007]** indicates that the evidence has not been reviewed since 2007.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also patient-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations ending **[2007]** (see 'Update information' above for details about how recommendations are labelled). In particular, for recommendations labelled **[2007]** the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Other versions of this guideline

The full guideline, 'Antenatal and postnatal mental health – clinical management and service guidance' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

The recommendations from this guideline have been incorporated into a NICE pathway.

We have produced information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual

responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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