

# NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

## SCOPE

### 1 Guideline title

Antenatal and postnatal mental health: clinical management and service guidance

#### 1.1 *Short title*

Antenatal and postnatal mental health

### 2 The remit

This is a partial update of [Antenatal and postnatal mental health](#) (NICE clinical guideline 45). See section 4.3.1 for details of which sections will be updated. We will also carry out an editorial review of all recommendations to ensure that they comply with NICE's duties under equalities legislation.

This update is being undertaken as part of the guideline review cycle.

### 3 Clinical need for the guideline

#### 3.1 *Epidemiology*

- a) Women in the antenatal and postnatal period are vulnerable to the same mental health disorders as other adults. Pregnancy is not protective and does not affect the probability of relapse, particularly if women stop taking psychotropic medication. There is a high risk of puerperal psychosis postpartum in women with bipolar disorder and women with a history of puerperal psychosis.

- b) The management of mental health disorders in the antenatal and postnatal periods can differ from management of mental health disorders in adults at other times. This is because of:
- the impact of abruptly stopping medication
  - the increased risk of developing an episode of a psychotic disorder in the postpartum period
  - the rapid onset and severity of puerperal psychosis
  - the risk–benefit ratio of psychotropic drugs during pregnancy and breastfeeding
  - the impact of illness on the baby.<sup>1</sup>
- c) There is concern that misuse of the term ‘postnatal depression’ to describe any mental health disorder occurring in the postnatal period has led to a failure to identify other mental health disorders that occur at this time. In addition to depression and psychosis, anxiety disorders, substance misuse and eating disorders can also occur in the postnatal and antenatal periods.
- d) At least half of women who have a baby experience low mood, either at some point in their pregnancy, or in the initial days or weeks following the birth. Symptoms include feeling tearful, overwhelmed and irritable, but these usually pass with rest, support and reassurance.
- e) If low mood persists during pregnancy, a diagnosis of antenatal depression may be appropriate. Antenatal depression is thought to affect around 12% of pregnant women, which is similar to the prevalence of postnatal depression. However, despite high prevalence rates, antenatal depression and anxiety disorders are often a neglected aspect of pregnancy. Early detection and management could prevent the development of postnatal problems and improve the mother’s quality of life during pregnancy.

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<sup>1</sup> In this document ‘baby’ refers to single and multiple births

- f) If, during the postnatal period, low mood persists or occurs for the first time, the mother may be diagnosed with postnatal depression. Diagnostic features include:
- irritability
  - difficulty sleeping even when the baby is sleeping
  - lack of appetite
  - anxiety
  - poor mother–infant interaction (for example, lack of interest in the child or lack of sensitivity to the infant’s needs)
  - anxieties about the child (possibly including thoughts of harming the child)
  - lack of motivation or enjoyment
  - panic attacks
  - feelings of isolation
  - a sense of being overwhelmed
  - physical signs of tension such as headaches or gastrointestinal symptoms.

Thoughts of self-harm and suicide can also be present, and these may or may not lead to self-harming behaviour.

- g) Anxiety disorders, characterised by abnormal or inappropriate anxiety, occur on their own but can also occur with depressive disorders. Anxiety disorders can include panic disorder, generalised anxiety disorder, obsessive-compulsive disorder, tokophobia (fear of childbirth or pregnancy) and post-traumatic stress disorder. Prevalence rates vary according to the type of anxiety disorder.
- h) A personality disorder causes persistent difficulties in the way a person manages their day-to-day life and interacts with others. Approximately 3% of women in the UK are thought to have a personality disorder: the most prevalent are schizoid personality disorder, avoidant personality disorder, obsessive-compulsive

personality disorder and borderline personality disorder. Pregnancy and childbirth in women with personality disorders (particularly borderline personality disorder) can evoke many issues relating to trauma in their past, which in turn can affect their ability to cope with being a mother and caring for their baby.

- i) A more severe illness, with acute onset, is puerperal psychosis, a relatively rare disorder characterised by psychotic depression, mania or atypical psychosis. It affects between 1 and 2 in every 1000 women who give birth. Characteristic features in those with mania include excitability, disinhibition and intense over-activity. Pregnancy, childbirth and the postnatal period can be associated with the re-emergence or exacerbation of a previous psychotic illness, such as schizophrenia or bipolar disorder. For some women, there can be an increased risk of danger to themselves or others, including the baby.
- j) Changes to body shape, including weight gain, during pregnancy and the postnatal period can be of particular concern to women with an eating disorder. Eating disorders are characterised by significant disturbances in normal eating patterns, body image and normal weight gain. They include anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified, including binge eating disorder. The prevalence of eating disorders in the general population is approximately 4%. The prevalence of anorexia nervosa and bulimia nervosa during pregnancy is lower than at other times, but pregnant women with a history of an eating disorder can have some subthreshold eating disorder symptoms.
- k) The misuse of drugs, alcohol and nicotine during pregnancy is thought to be common: 15% of pregnant women in inner cities screen positive for drug use, most of which is cannabis; 10% of pregnant women binge drink; and 13% of pregnant women smoke throughout pregnancy (self-reported data collected at delivery). The misuse of drugs and alcohol during pregnancy is known to have

significant harmful effects on pregnancy and infant outcomes, with smoking thought to be the main contributor to adverse fetal outcomes even in women with other substance misuse. Complications during pregnancy, for example prematurity, intrauterine growth retardation and fetal distress, are more common in women who misuse drugs than those who do not. Drug misuse in pregnancy can also result in neonatal abstinence syndrome and negative effects on the growth and development of the infant.

l) Mental health disorders during pregnancy and the postnatal period can be associated with, or aggravated by, a number of factors, including:

- psychological factors, such as the demands and expectations of being a mother in addition to the psychological effects of a traumatic delivery
- social factors, including social isolation, economic status, ethnicity, cultural issues and housing
- family factors, including the relationship with the baby's father and the support received from family and friends
- biological factors, including genetic factors and the hormonal changes that occur during pregnancy, childbirth and following childbirth
- personal history (including lifestyle factors, domestic violence, childhood sexual and physical abuse, past psychiatric history and previous maternal history) and family history
- the infant's general health.

m) The UK Confidential Enquiry into Maternal Deaths (CMACE) reports that between 2006 and 2008, 1.27 per 100,000 maternal deaths in the UK were a result of psychiatric disorders. Although response to treatment is good, mental health disorders can go unrecognised and untreated in pregnancy and postpartum. If untreated, women can continue to have symptoms, sometimes for

many years, with the negative impact affecting not only the mother, but also other family members.

- n) All mental health disorders in the antenatal and postnatal period can have a significant effect on the mother–infant relationship, and as a result, there may be longer-term consequences for all areas of the infant’s development.

### **3.2 Current practice**

- a) Women with antenatal and postnatal mental health disorders are treated in a variety of NHS settings, including primary care services, obstetric and gynaecological services, general mental health services and specialist secondary care mental health services. Most mental health disorders that arise during pregnancy and the postnatal period will be mild to moderate, and treated and managed in primary care.
- b) The provision and uptake of services varies across England and Wales. In part this reflects variation in the recognition of disorders, but also the presence or absence of specialist multidisciplinary and multi-agency services, particularly for women with more severe illness.

## **4 The guideline**

The guideline development process is described in detail on the NICE website (see section 6, ‘Further information’).

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

## **4.1 Population**

### **4.1.1 Groups that will be covered**

- a) Women who have, or are at risk of, mental health disorders during pregnancy and the postnatal period. This will include women with sub threshold symptoms and women with mild, moderate and severe disorders.
- b) Families and carers involved in the care and support of women who have mental health disorders.
- c) Specific consideration will be given to the needs of black and minority ethnic groups, socioeconomic groups, and women with learning and physical disabilities.

## **4.2 Healthcare setting**

- a) Care and shared care provided in primary, secondary and tertiary healthcare services in the NHS and NHS-funded services, including care provided by healthcare professionals and others working in healthcare settings, who have contact with, and make decisions concerning, the mental healthcare of women in pregnancy and the postnatal period. This update covers the same healthcare settings as the original NICE guideline (CG45).

## **4.3 Clinical management**

### **4.3.1 Key clinical issues that will be covered**

- a) The prevention of mental health disorders in pregnancy and the postnatal period.
- b) Case identification, diagnosis and assessment of mental health disorders in women during pregnancy and the postnatal period.
- c) Psychosocial interventions (including type, form and duration) and the balance of risk and benefit for the mother, fetus and baby.

- d) Pharmacological interventions (including type, dose and duration) and the balance of risk and benefit for the mother, fetus and baby.

Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

- e) Appropriate use of combined pharmacological and psychological treatments.
- f) Electroconvulsive therapy.
- g) The role of the family and carers in the treatment and support of women with mental health disorders in pregnancy and the postnatal period.
- h) Identification and management of risk to self and others, including the baby.
- i) The impact of the mother's mental health on the quality of the mother–baby interaction.

#### **4.3.2 Clinical issues that will not be covered**

##### **Areas not covered by the original guideline or the update**

- a) The needs of infants, other children and partners of women who have developed mental health disorders in pregnancy and the postnatal period.
- b) Consideration of the need for specialist inpatient services (for example, mother and baby units).

### **Areas from the original guideline that will not be updated**

The guideline will not update the configuration of services for the provision of effective care for women and their children.

#### **4.4 *Main outcomes***

- a) Diagnosis of a mental disorder.
- b) Symptomatology.
- c) Quality of life.
- d) Relapse.
- e) Hospitalisation.
- f) Attrition.
- g) Side effects.
- h) Quality of mother–infant interaction.
- i) Fetal and infant development, including congenital malformations.

#### **4.5 *Review questions***

Review questions guide a systematic review of the literature. They address only the key clinical issues covered in the scope, and usually relate to interventions, diagnosis, prognosis, service delivery or patient experience. Please note that these review questions are draft versions and will be finalised with the Guideline Development Group.

##### **4.5.1 Case identification and assessment of mental health disorders during pregnancy and the postnatal period**

- a) What tools or methods have been developed that reliably predict the development or recurrence of mental health disorders in women during pregnancy and the postnatal period?

- Subsidiary questions: repeat for depression, puerperal psychosis; and anxiety disorders, personality disorders, substance misuse and eating disorders.
  - Does the benefit of using these tools or methods outweigh the harm?
- b) What tools or methods have been developed that reliably detect and assess mental health disorders in women during pregnancy and the postnatal period?
- Subsidiary questions: repeat for depression, puerperal psychosis; and anxiety disorders, personality disorders, substance misuse and eating disorders.
  - Does the benefit of using these tools or methods outweigh the harm?

#### **4.5.2 Treatment**

- a) For women with mental health disorders during pregnancy and the postnatal period, what interventions are associated with a reduction in symptomatology, improved quality of life and increased remission rates?
- Subsidiary questions: repeat for depression, puerperal psychosis; and anxiety disorders, personality disorders, substance misuse and eating disorders
  - Subsidiary question: repeat for psychological, pharmacological, ECT and combined interventions
- b) For women with mental health disorders during pregnancy and the postnatal period, what interventions are associated with an increase in harm to the mother, fetus or baby (measures might include relapse, hospitalisation, increased attrition or side effects)?.
- Subsidiary questions: repeat for depression, puerperal psychosis; and anxiety disorders, personality disorders, substance misuse and eating disorders

- Subsidiary question: repeat for psychological, pharmacological, ECT and combined interventions
- c) For women with mental health disorders during pregnancy and the postnatal period, what interventions (beyond those targeting the mental health disorder) help to improve the quality of the mother–infant interaction?
- d) What are the needs of family and carers in the treatment and support of women with mental health disorders during pregnancy and the postnatal period?

## **4.6      *Economic aspects***

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see 'Further information').

## **4.7      *Status***

### **4.7.1      *Scope***

This is the consultation draft of the scope. The consultation dates are 10 October to 7 November 2012.

### **4.7.2      *Timing***

The development of the guideline recommendations will begin in March 2013.

## 5 Related NICE guidance

### 5.1 *Published guidance*

#### 5.1.1 NICE guidance to be updated

This guideline will partially update and will replace the following NICE guidance:

- [Antenatal and postnatal mental health](#). NICE clinical guideline 45 (2007).

#### 5.1.2 Other related NICE guidance

- [Patient experience in adult NHS services](#). NICE clinical guideline 138 (2012)
- [Antenatal care](#). NICE quality standard 22 (2012).
- [Service user experience in adult mental health](#). NICE clinical guideline 136 (2011)
- [Caesarean section](#). NICE clinical guideline 132 (2011)
- [Multiple pregnancy](#). NICE clinical guideline 129 (2011)
- [Common mental health disorders](#). NICE clinical guideline 123 (2011)
- [Alcohol dependence and harmful alcohol use](#). NICE clinical guideline 115 (2011)
- [Alcohol dependence and harmful alcohol use](#). NICE quality standard 11 (2011)
- [Anxiety](#). NICE clinical guideline 113 (2011)
- [Aripiprazole for the treatment of schizophrenia in people aged 15 to 17 years](#). NICE technology appraisal guidance 213 (2011)
- [Pregnancy and complex social factors](#). NICE clinical guideline 110 (2010)
- [Hypertension in pregnancy](#). NICE clinical guideline 107 (2011)
- [Weight management before, during and after pregnancy](#). NICE public health guidance 27 (2010)
- [Quitting smoking in pregnancy and following childbirth](#). NICE public health guidance 26 (2010)
- [Depression in adults](#). NICE clinical guideline 90 (2009)
- [Schizophrenia](#). NICE clinical guideline 82 (2009)

- [Borderline personality disorder](#). NICE clinical guideline 78 (2009)
- [Antisocial personality disorder](#). NICE clinical guideline 77 (2009)
- [Diabetes in pregnancy](#). NICE clinical guideline 63 (2008)
- [Maternal and child nutrition](#). NICE public health guidance 11 (2008)
- [Intrapartum care](#). NICE clinical guideline 55 (2007)
- [Drug misuse: psychosocial interventions](#). NICE clinical guideline 51 (2007)
- [Computerised cognitive behaviour therapy for depression and anxiety](#). NICE technology appraisal guidance 97 (2006)
- [Bipolar disorder](#). NICE clinical guideline 38 (2006)
- [Eating disorders](#). NICE clinical guideline 9 (2004)
- [Guidance on the use of electroconvulsive therapy](#). NICE technology appraisal guidance 59 (2003)

### 5.1.3 Guidance under development

NICE is currently developing the following related guidance (details available from the NICE [website](#)):

- [Antenatal care](#). NICE clinical guideline. Publication expected September 2012.
- [Postnatal care](#). NICE clinical guideline. Publication expected July 2013.
- [Diabetes in pregnancy](#). NICE clinical guideline update. Publication expected June 2014.
- [Psychosis and schizophrenia](#). NICE clinical guideline update. Publication date to be confirmed.
- [Bipolar disorder](#). NICE clinical guideline update. Publication date to be confirmed.

## 6 Further information

Information on the guideline development process is provided in the following documents, available from the NICE [website](#):

- [How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS](#)
- [The guidelines manual](#)

Information on the progress of the guideline will also be available from the [NICE website](#).