National Institute for Health and Care Excellence

Antenatal and postnatal mental health (update)
Guideline Consultation Table
16th July – 27th August 2014

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Association for Post Natal Illness	1	NICE	1.7.14	44	Most mothers are aware that there may be problems with the mother-baby relationship. Mothers should be encouraged to discuss their relationship with the baby and any problems with it. The statement, "Any problems with the relationship are likely to improve with effective treatment of the mental health problem" does not fit the experience of all our mothers. There are mothers who confess that they have no feelings at all for their babies, except hostility, and it is time this was recognized, so that they can get the help they need. This should be handled in such a way that the mother does not feel threatened, but feels able to express her feelings frankly. The most important point is that, even if antidepressants fail, appropriate psychological treatment (which may require a specialist mother & baby facility) can help almost all these mothers to love their babies in a normal way.	Thank you for your comment. In response to your, and other stakeholders', comments this recommendation has been amended.
Association for Post Natal Illness	2	NICE	1.8.5	46	This section lists what specialist perinatal inpatient services should do. APNI would wish that it includes links with specialist voluntary agencies, and (somewhere in this Guideline) includes a list of them. They are a major source	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					of support for mothers when they are unwell, and can be important allies for the services.	
Bipolar UK	1	Full	6.4.1.1	201	We welcome this recommendation as currently few young women diagnosed with BD are informed of the implications of pregnancy	Thank you for your comment.
Bipolar UK	2	Full	6.4.1.3	202	We welcome this emphasis on treating women suffering from a mental illness in a 'non-judgemental way'	Thank you for your comment.
Bipolar UK	3	Full	6.4.1.11	204	We welcome the emphasis on the central role of the woman and her loved ones in reaching treatment decisions and the clarification of the professional's role as 'informing that decision with balanced and up-to-date information and advice': this is a significant improvement on the suggestion the professional 'should discuss with the woman'...	Thank you for your comment.
Bipolar UK	4	Full	8.9.1.2	717	We welcome that previous advice highlighting the risk of prescribing Valproate to women of childbearing age has been clarified and strengthened in the new guideline. In our experience, many women have been put on this drug without information on its serious risks in pregnancy, and have subsequently had a longer wait before trying for a baby because of the need to change medication. Alternative medications exist and should be offered first.	Thank you for your comment.
Bipolar UK	5	Full	8.9.1.6-7	718	We welcome the greater emphasis on the usefulness of psychological interventions	Thank you for your comment.
Bipolar UK	6	Full	8.9.1.29-34	722	We welcome the greater clarity on the treatment of women on lithium	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Bipolar UK	7	NICE	1.7.9	43	Though we welcome the suggestion that women should be 'supported' in their choice of feeding method, we would like to see it strengthened, perhaps 'support and offer assistance in the choice of feeding method that best suits her and her family" as many women who choose to bottle-feed because of their medication receive no help and indeed suffer extreme stigma from healthcare workers, which adds significantly to their stress and feelings of inadequacy as mothers.	Thank you for your comment. The GDG believe that the recommendation and wording used here sufficiently covers this point.
Bipolar UK	8	NICE	general	0	Bipolar UK commends the Guideline Update group for greatly improving the Antenatal and Postnatal Guideline; the advice has been generally clarified and strengthened and we hope it will lead to a significant improvement in the treatment of women with mental illness in the perinatal period.	Thank you for your comment.
Breastfeeding Network	1	NICE	Introduction	4	BfN welcomes the opportunity to comment on this guideline. In particular the recognition that we are all supporting mothers in the context of 'significant limitations to the evidence base, including limited data on the risks of psychotropic medication in pregnancy and during breastfeeding.' P4. The Breastfeeding Network works in some of the most socially and economically deprived areas of the UK, focussing on young parents and communities where breastfeeding rates are at their lowest and with high incidence of anxiety	Thank you for your comment and for highlighting the work undertaken by the Breastfeeding Network.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and depression. We run 17 breastfeeding peer support projects offering a range of independent support to Mums and families from antenatal through to post birth and beyond. We also support Mums through our helplines including National Breastfeeding Helpline in association with ABM, Drugs in Breastmilk Line and a number of minority language lines. Providing a vital link for Mums and communities and compliment services run by health professionals, we work with many breastfeeding Mums and their families who have additional mental health needs and challenges. BfN offers a Drugs in Breastmilk service (DIBM) to provide counselling and drug information. The second highest number of calls to Drugs in Breastmilk Helplines concern antidepressant medication for breastfeeding women with postnatal depression reflecting the need for this unfunded service.	
Breastfeeding Network	2	NICE	Patient centred care	5	Could person-centred care be used rather than patient-centred? Involving mothers in decision making and give her sufficient information to be aware of what adverse effects might be likely so she can note	Thank you for your comment. This is set text from NICE, which we are unable to change. The postnatal period was set at one year in the scope as this is the period that defines most specialist perinatal mental health services.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					these in her baby. Be aware that mother may be non compliant with medicines and prefer to breastfeed. We welcome the recognition that the service should extend through the whole of the first year. Building on the work of the Family Nurse Practitioner and the Healthy Child programme should consideration be given to extending this further until 2 or 2 ½ years in recognition of the vulnerability of the family?	
Breastfeeding Network	3	NICE	1.1.2	16	We welcome this addition of this section "When prescribing for women of present and future childbearing potential, take account of the latest data on the risks to the fetus and baby associated with psychotropic medication." This requires specialist knowledge and dissemination. Could this be coordinated nationally? See later comment about using the yellow card system for building knowledge.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Breastfeeding Network	4	NICE	1.2.2	17	1.2.2, 1.2.3 & 1.2.5 Support and decision making We welcome this additional section. There is no mention of fathers becoming depressed in the postnatal period and the impact of both partners being depressed. This may not be the best section to consider the implications but it is important to consider the impact of this on the family.	Thank you for your comment. This guideline has reviewed the role of the family, the carers and partners in the treatment and the support of women with mental health problems but it was beyond the scope's remit to assess the fathers or partners mental health on the mother.
Breastfeeding	5	NICE	1.2.6	18	We agree that "All interventions delivered in a	Thank you for your comment. The guideline

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Network					timely manner." This should be seen in association with 1.8 which is greyed out so we are unable to comment but this is critical to the management of acute mental disorders. 1.8 P45. 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 We are aware of many barriers to ensuring mothers and their babies being kept together and urge the needs of the family to be given priority.	development group agrees that it is of paramount importance that mother and babies are kept together, and overcoming any barriers will be a matter for implementation, and has been passed on to the NICE implementation support team.
Breastfeeding Network	6	NICE	1.7.9 – 1.7.13	43	1.79-1.7.13 Psychotropic medication and breastfeeding We welcome this section and ask that the text from recommendation 15 of PH11 is both summarised and linked in the final document. Link to PH11 recommendation 15 Ensure health professionals and pharmacists who prescribe or dispense drugs to a breastfeeding mother consult supplementary sources (for example, the Drugs and Lactation Database [LactMed] or seek guidance from the UK Drugs in Lactation Advisory Service. Health professionals should discuss the benefits and risks associated with the prescribed medication and encourage the mother to	Thank you for your comment. The guideline development group considers that its advice reflects what is in recommendation 15 of Public Health guidance 11 but is more relevant to the mental health context. Therefore the guideline development group did not think that a summary of the Public Health guidance 11 would be necessary but the guidance is referenced in the related guidance section of the NICE guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					continue breastfeeding, if reasonable to do so. In most cases, it should be possible to identify a suitable medication which is safe to take during breastfeeding by analysing pharmokinetic and study data. Appendix 5 of the 'British national formulary' should only be used as a guide as it does not contain quantitative data on which to base individual decisions. Health professionals should recognise that there may be adverse health consequences for both mother and baby if the mother does not breastfeed. They should also recognise that it may not be easy for the mother to stop breastfeeding abruptly – and that it is difficult to reverse. It would be worth mentioning the yellow card system for reporting adverse events. These should be reported back to a national body reviewing treatments for pregnant and breastfeeding women Urge practitioners not rely solely on manufacturers data on use in breastfeeding. BfN DIBM service even has a recent example of a mother being denied CBT because "negative emotions released within therapy would be detrimental to the baby's developing brain".	
Breastfeeding Network	7	NICE	General	0	Consider a role for commissioned peer support services	Thank you for your comment. The GDG did not feel the evidence for peer support was strong

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						enough to make such a recommendation
Breastfeeding Network	8	NICE	General	0	As part of the care of pregnant women with depression consideration of changing the antidepressant in late pregnancy to one less likely to cause drowsiness in the newborn infant, particularly if breastfeeding is being considered.	Thank you for your comment. The GDG felt it was necessary to have comprehensive recommendations for women postnatally regarding her treatment and the possible effects on breastfeeding, please see recommendations 1.9.8- 1.9.11.
British Association for Counselling and Psychotherapy	1	NICE	General	0	BACP welcomes the development of updated guidance on antenatal and postnatal mental health and is grateful of the opportunity to comment upon the draft update.	Thank you for your comment.
British Association for Counselling and Psychotherapy	2	NICE	1.4.3	29	This section sets out the questions practitioners should ask of mothers to help identify depression and anxiety: "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?" "During the past month, have you been feeling nervous, anxious or on edge?" "During the past month have you not been able to stop or control worrying?" These are among the standard questions asked to place patients within diagnostic scales, and as such are commonly used to monitor patients with known or self-presented mental ill health However, given that section 1.4.1 highlights the	Thank you for your comment. As your comment, and recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health and wellbeing) is the primary component and the healthcare professional should consider asking these specific depression and anxiety identification questions as part of this general discussion.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					need to "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", these questions do not feel well designed to elicit admissions of mental distress among those who have not yet disclosed psychological difficulty. BACP would suggest that asking less formal, less specific and more conversational questions would bring greater success in identifying potential depression and anxiety among mothers. Once this subject has been breached, more formal questions could then be asked.	
British Association for Counselling and Psychotherapy	3	NICE	1.6.2	34	BACP agrees that "all interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners". However, it is frequently not known to healthcare practitioners that the Department of Health, through the Centre for Workforce Intelligence, has developed a set of required standards for counsellors and other psychological therapists in the NHS, namely: • "to have completed one-year of recognised full-time (or equivalent part-time) psychological	Thank you for this comment. This is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					therapy or counselling training leading to a qualification, certification or accreditation recognised by a relevant professional or regulatory body • "to have achieved a competency level that fulfils the requirements of the regulatory, accrediting or professional body • "to be a member of a relevant professional or regulatory body, and continue to fulfil any accreditation or membership criteria, including meeting requirements for continuing professional and personal development, regular supervision and codes of practice • "to have gained the supervised therapy experience required by the regulatory or professional body encompassing assessment, formulation, engagement, developing the therapeutic relationship, using relevant therapeutic interventions, working collaboratively with clients, and working to end therapy" (BACP is among the professional bodies recognised by the Department of Health in relation to these standards, which all BACP Registered Members and BACP Accredited Members meet.)	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					We therefore suggest that the guidance should make practitioners aware that such a definition exists, and signpost them to it – it can be found in Improving Workforce Planning for the Psychological Therapies Workforce (Centre for Workforce Intelligence, 2013) at http://www.cfwi.org.uk/publications/improving-workforce-planning-for-the-psychological-therapies-workforce/.	
British Association for Counselling and Psychotherapy	4	NICE	1.6.3	35	While we are pleased to see that the guidance suggests target times from referral to assessment and assessment to treatment, we are concerned that these target times are unambitious, particularly in the context of the effect of poor maternal mental health for unborn children and new babies. Allowing 2 weeks from referral to assessment and a further month from assessment to treatment means a mother in distress might have to wait six-and-a-half weeks for treatment, in addition to the time in which the mental health problem may have built up prior to the mother seeking help as well as the gap between the mother's contact with her healthcare practitioners and a referral for further assessment being made. We would recommend a single target of a maximum of 28 days between a request for a referral and first treatment appointment, with	Thank you for your comment. The GDG considered this recommendation and felt that further restriction of the timescales would not be realistic. It is important to note that this recommendation is already a strengthened version of the 2007 guidance where only the time scale between assessment and treatment was specified (and not between referral and assessment) with the unintended consequence that women may have been placed on waiting lists for assessment so that waiting times for treatment may have been considerably longer than the 1-3 month time period recommended. It is also important to note that for women with sudden onset of possible symptoms of postpartum psychosis a referral to a secondary mental health service for immediate assessment (within 4 hours) is recommended.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					an appropriately faster response for a mother experiencing a mental health crisis.	
British Association for Counselling and Psychotherapy	5	NICE	1.7.7	43	The draft update advises practitioners to: "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...in line with the guideline on post-traumatic stress disorder." We suggest that the guidance be amended such that all women who have had a traumatic birth or miscarriage, not just those who have already been diagnosed with PTSD, are offered counselling or a similar psychological intervention, and also made aware that they can take up this offer at any point.	Thank you for your comment. The evidence search did not identify any high quality evidence for the effectiveness of high-intensity psychological interventions for women who have had a traumatic birth or miscarriage and do not have PTSD. There was evidence for large effects associated with post-traumatic birth counselling on depression and anxiety symptomatology. However, there was also evidence for harms associated with post-traumatic birth counselling with a large effect favouring treatment as usual for a continuous measure of feelings of self-blame. These inconsistent effects may be indicative of the need for individualized information and support following a miscarriage or a traumatic birth and this was also a theme which emerged from the qualitative review of service user experience (Chapter 6). Based on the quantitative and qualitative evidence, and GDG consensus opinion, the GDG recommended that women who have had a traumatic birth or miscarriage and wish to talk about their experience should be offered advice and support.
British Medical Association	1	Full	General	2	We are disappointed that primary care is not represented proportionately within the Guideline Development Group. The emphasis is on secondary care expertise.	Thank you for your comment. The membership of the GDG was consulted on during the scoping and deemed to be appropriate. Primary care expertise was included with GP, midwifery and health visitor representation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
British Medical Association	2	NICE	General	0	Resources required to implement the guidance should be identified. Although access to psychological therapies is highlighted, this will be challenging due to low levels of community psychiatric nurses and counsellors.	Thank you for your comment, your concern has been passed on to the NICE implementation support team.
British Medical Association	3	NICE	General	0	We would require more information as to how the guidance should be implemented on a local level. The requirement to form multidisciplinary working groups and stakeholders may be considered too resource intensive, and may lead to varying levels of implementation.	Thank you for your comment, your concern has been passed on to the NICE implementation support team.
British Medical Association	4	NICE	General	0	The role of Social Services is not mentioned within the document. They have an important role in providing maternal support, and assessments of child protection.	Thank you for your comment. In light of your comment a new recommendation has been added to address the important role of health visitors, and health and social care professionals have in recognising and monitoring the woman's mental health. Where there are concerns about suspected child maltreatment, the advice is to follow local safeguarding protocols.
British Medical Association	5	NICE	General	0	The summary is currently 76 pages long, which is too lengthy to be user friendly. The aim of the document is to assist clinicians and service users to make decisions about appropriate treatments, but this will be difficult as the guidance is dense, and the layout is confusing. A number of different mental health issues are mixed together, which is also confusing.	Thank you for your comment. The guideline covers a wide range of mental health problems, and a number of different clinical scenarios, therefore the guideline is perhaps longer than other NICE guidelines. The guideline covers the decisions about starting and stopping a particular treatment in 1.3 (now 1.4.), because for some women these decisions will be of paramount importance. Where the recommendations were disorder-specific (for example, which specific treatments to offer a

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						pregnant woman with depression), the recommendations are contained in section 1.6 (now 1.8) The GDG realises that this might not have been immediately obvious and to address your concerns, the guideline has undergone some restructuring in order to make it clear how to navigate the document (see recommendation 1.1.2, which has been moved to the front of the guideline). Also, there will be a NICE Pathway for this topic, which will be launched at the same as the guideline, which provide ease of navigation.
British Medical Association	6	NICE	General	0	It would be useful to include the incidences of illnesses and risk of relapse in a clear manner – this would help clinicians to place the recommendations in context. The document could then link each condition to the pages where clinical advice and recommendations are found. In the context of a ten minute consultation, this would provide a valuable 'working document'.	Thank you for your comment. The guideline development group very much hopes that guideline will prove to be valuable to GPs and other professionals. The NICE guideline specifically lists the recommendations only, but the NICE Pathway, which will be published at the same time as the guideline, will be a more user-friendly version which will enable users to find the information they require as quickly as possible, including recommendations for specific mental health problems.
British Medical Association	7	Full	2.5.4	32	Step 3 of (Figure 1) illustrates that GPs should be caring for severely depressed patients in the community. This is beyond normal general practice in the use of the medicines involved, and pregnancy.	Thank you for your comment. Step 4 of figure 1 refers to severe depression and step 3 to moderate to severe depression. The GDG, which included a GP, is aware that GPs often care for patients with moderate to severe depression but this will vary according to GPs' experience and competencies. It will also be more relevant for a woman who the GP knows

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						well, who responds well to treatment and can therefore be restarted on treatment, compared with a woman with a new severe presentation, who would usually be referred to secondary care.
British Medical Association	8	Full	General	0	The recommendations for medication use and for whom is clearer within the main document, and this should be used within the NICE document.	Thank you for your comment. The content of the recommendations in the NICE and full guideline are the same, although the structure is different. Because the guideline covers a wide range of mental health problems, some of which may be treated by the same drug, the decision was made to cover the decisions about starting and stopping a particular treatment in section 1.4, because for some women these decisions will be of paramount importance. Where the recommendations were disorder-specific (for example, which specific treatments to offer a pregnant woman with depression), the recommendations are contained in section 1.8. The GDG realises that this might not have been immediately obvious and to address your concerns, the guideline has undergone some restructuring in order to make it clear how to navigate the document (see recommendation 1.1.2, which has been moved to the front of the guideline). Also, in the NICE Pathway for this topic, which will be launched at the same as the guideline, the linkage between sections will be clearer and the ability to navigate easier.
British Medical Association	9	Full	General	0	Young mothers to-be under the age of 16 need to be considered in greater detail. These	Thank you for your comment. A cross reference to recommendations in section 1.4 of the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					children are very vulnerable, particularly in the context of mental health issues, and are like to need complex care arrangements.	guideline on pregnancy and complex social factors (NICE clinical guideline 110) to ensure greater awareness for pregnant young women under 20 has been added to the recommendation 1.3.3.
British Medical Association	10	Full	General	0	Social influences are touched upon, and further expansion may be outside the remit of the guidance, but lack of social support, financial poverty and social isolation have a major impact of the well being of these women.	Thank you for your comment, but the guideline development group considers that it has covered social factors in so far as it can within the scope of the guideline (see the recommendations on assessment in section 1.6 of the NICE guideline).
British Medical Association	11	Full	General	0	GPs should normally not be expected to initiate or supervise prescribing of drugs not licensed for use during pregnancy and breast feeding.	Thank you for this comment. The clinicians on the GDG are aware that many GPs do regularly initiate antidepressant medication during pregnancy and will monitor such medication even when initiated by others. Other GPs will not, as they will not have the relevant experience, training and/or competence. Recommendations in the 'Providing assessment and interventions for mental health problems in pregnancy and the postnatal period' section make it clear that practitioners should understand the variations in the presentation and course of mental health problems in pregnancy and the postnatal period and how these variations impact on treatment, and that all interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners
British Medical Association	12	Full	6.2.1	153	General: Patients from ethnic backgrounds and have communication problems due to lack of	Thank you for your comment. The experience of care for women from black and minority ethnic

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					English or learning difficulties need to be considered. These women are extremely vulnerable and may be experiencing undeclared abuse and coercion. A formal recommendation proposing that support workers and interpreters must be included in the proposed pathways of care.	groups, socioeconomic groups or asylum seekers and refugees was given special consideration due to the recognition that these women may be particularly vulnerable (see sub-question in review protocol, section 6.2.1). Indeed, emerging themes from the qualitative evidence review found that cultural differences were perceived to create barriers to accessing help and support, women from BME communities described information and support in the form of leaflets and insufficient face-to-face communication in pregnancy and South Asian women suggested a number of service improvements, including verbal and written information about depression in pregnancy, information about services available and culturally-specific support. The GDG wished to ensure that culturally relevant information is given to all women about mental health problems in pregnancy and the postnatal period and this led to recommendation 1.4.1. In addition, this guideline should be used in conjunction with NICE clinical guidance on service user experience in adult NHS services (CG 136) that has recommendations to include an interpreter in the care pathway where required
British Medical Association	13	Full	3.5.1	44	The methodology states that no foreign language research papers were reviewed. This is a concern as it may cause a bias in the proposed management pathways. With other long terms	Thank you for your comment. The GDG recognised that this approach had limitations but due to time and resource constraints it was not possible to include non-English language

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					conditions there is variability in the effectiveness and metabolism of medicines between different genetic groups. It is also less acceptable in many cultures to access talking therapies.	articles
British Medical Association	14	NICE	Patient centred care	6	The transfer from child and adolescent mental health services and adult mental health services care is high risk. The risk of a pregnant teenager with mental health issues falling between services is high. We would suggest that the recommendation is amended to state that child and adolescent mental health services or adult services assumes full responsibility for the duration of the pregnancy and postnatally until the patient is stable.	Thank you we have amended rec 1.3.3 in response to your comment
British Medical Association	15	Full	General	0	Commissioners must ensure that patients who need medication during pregnancy must have rapid access on early referral to secondary or tertiary care, and must remain under the care of mental health consultants throughout pregnancy and post natal periods. NICE must be clear that this is not a role for GPs. Alerting all clinicians to medications which should be avoided is valuable.	Thank you for this comment. We agree that it is for commissioners to ensure that high quality services are provided. However, we do not agree that all prescribing or more generally the treatment of all women should remain under the care of mental health consultants. Many women with mild to moderate common mental health problems can and should be managed predominantly in primary care
British Pregnancy Advisory Service	1	Full	6.2.5	198	We welcome the emphasis placed on the importance of individualised treatment for women who have experienced stillbirth, miscarriage and termination for fetal abnormality (TOPFA) and recognition of the mixed experience of seeing and/or holding the fetus/baby. The possibility of holding the fetus	Thank you for your comment. The choice of a medical or surgical method of termination is outside the scope of this guideline, although the emphasis on the importance of individualised treatment is captured by the recommendations

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					for women undergoing TOPFA will also be linked to whether a woman has chosen a medical or surgical method of abortion. In 2011, a qualitative study by Kerns et al of women terminating a pregnancy for fetal or maternal complications found that decisions to undergo surgical or medical abortion were highly personal and could affect how women recover after ending a desired pregnancy. They recommended that women should be offered counselling about and access to both methods. Choice of a medical or surgical method of termination for TOPFA is advocated in national guidelines however research published by Fisher et al in 2014 found just 8% of women in England undergoing TOPFA were offered choice of method.	
British Pregnancy Advisory Service	2	Full	7.7.1.9	554	We welcome the recommendation that women with tokophobia should be offered the opportunity to discuss their fears with a trained medical professional. However, for women with tokophobia, the ability to choose the right birth method and pain relief for them can also be valuable, and it is important that their choices are not restricted on the basis of cost, particularly in the case of elective caesarean sections. Consequently, we would welcome the recognition of the importance of choice of birth method for women with tokophobia as part of this guidance.	Thank you for your comment. Consideration of delivery methods is outside the scope of this guideline. However, a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
British Pregnancy	3	Full	8.9.1.2	717	We support the aim of this recommendation to	Thank you for your comment. The GDG were

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Advisory Service					provide suitable medical treatment according to women's reproductive needs. However, we are concerned that restricting valproate to all women of future or current reproductive age does not adequately support women's individual choices. For women for whom valproate would be the most effective treatment option, bpas believes that this medication should not be excluded from her treatment options. If after a discussion of the risks and benefits of valproate and alternative medications, a female patient decides to take valproate, this decision should be supported and the patient should be offered suitable contraception. The decision whether or not to continue or start this treatment should ultimately rest with the individual woman, providing she gives informed consent. It would also be helpful if NICE could provide further explanation for the change in policy from the 2007 guidance which stated 'Valproate should not be routinely prescribed to women of child-bearing potential. If there is no effective alternative, the risks of taking valproate during pregnancy, and the importance of using adequate contraception, should be explained.' (Section number 1.4.1.14)	concerned that prescribing practices of sodium valproate for women of childbearing age remained higher than would be expected if existing NICE guidance was being followed. Based on GDG concerns about the potential for harm, the consensus judgement was that there were grounds to strengthen the valproate recommendations that were made in the previous 2007 guideline. This was also consistent with recommendations made in the bipolar guidance (for both acute and long-term treatment). The MHRA are also currently leading a review on valproate due to new safety data.
British Psychological	1	NICE	General	0	There are two major key points of feedback- detailed further below:	Thank you for your comment. We agree that all health professionals should tailor to client need;

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Society					1) For complexity of issues in perinatal mental health care highly trained psychological therapists with the capacity to tailor interventions to client need and across presenting difficulties are required. This is a level beyond high intensity protocol driven psychological therapy. 2) Post traumatic stress disorder information is underestimated and based on old figures. The scale of the issue and the lack of good quality studies make research recommendations for assessment and intervention methods in this area imperative.	this is the case irrespective of the setting or disorder being treated. We do not accept that the use of manuals or protocols would get in the way of tailoring recommendations or that the proper treatment of problems in this area is at a level beyond 'protocol driven interventions'. We have drawn attention in recs 1.71. 1.7.2 for staff to be aware of variations in the presentation and the course of the disorder and the need for effective support and supervision. In response to your comments regarding PTSD, where possible we have used systematic reviews as a source for epidemiological data discussed in the introduction of the full guideline (Chapter 2). However, Grekin and O'Hara (2014) which provides a more recent prevalence figure was published after submission of the guideline. We have now added the estimate from that meta-analysis to chapter 2 of the full guideline. The GDG did not feel that assessment of PTSD should be prioritised for further research as the limited data available did not suggest that there were likely to be significant differences in the performance of case identification measures from that in the wider population on which previous NICE recommendations were based. There is however a research recommendation for psychological interventions for moderate to

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						severe anxiety disorders in pregnancy, which includes PTSD.
British Psychological Society	2	NICE	General	0	All the references to psychological treatment refer to self-directed interventions or manualised high intensity interventions. High intensity psychological therapists do not typically work with women with complex comorbid psychological conditions which require multimodal, individually tailored psychological approaches. In addition, the narrow assessment and manualised approach adopted by high intensity workers has on occasion resulted in misdiagnosis e.g. Postpartum psychosis being misdiagnosed as birth trauma, severe OCD being misdiagnosed as PTSD, severe bonding disorders going undetected because high intensity workers never see the mothers together with their babies etc. This is picked up further with reference to 1.6.2.	Thank you for your comment. The recommendations for psychological interventions in this guideline are based on a careful consideration by the GDG of the relevant evidence. In some cases this draws on evidence direct from high intensity interventions in pregnancy where there was evidence of effectiveness and in other cases the expert opinion of the GDG that it was appropriate to draw on evidence from non-pregnant populations. We also offer advice on assessment and diagnosis which we think directly address the concerns you raise.
British Psychological Society	3	NICE	General	0	Time limited CBT as delivered by High Intensity workers has not been shown to be effective in a perinatal population of women from diverse cultures with complex co-morbid psychological conditions complicated by family dynamics as presenting in inner city services. The NICE version appears to overstate the applicability. In addition, High Intensity CBT for severe maternal bonding disorders, as opposed to attachment disorders, has not been demonstrated to be effective of CBT to populations where it has not	Thank you for your comment. The evidence identified and reviewed found large to moderate benefits of structured psychological interventions (CBT or IPT) on depression diagnosis, depression symptomatology and depression mean symptoms, and there was no suggestion of differential effects for black and minority ethnic groups in the evidence reviewed. As no reference is provided for the evidence statements in your comment it is difficult to comment directly on the issues you

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					been fully evaluated.	raise. We did not find any high quality evidence for maternal bonding disorders and no recommendations are made for these disorders.
British Psychological Society	4	NICE	General	0	Overall, the Society believes that this version does not fully address the perinatal population being seen by Clinical Psychologists in community and inpatient setting across the UK. We are concerned that in its current form this will result in the most risky and distressed women being denied or given inappropriate psychological treatment.	Thank you for this comment. We disagree and think that the guideline does point to the best evidence for effective psychological interventions across the range of disorders and the need to tailor the interventions to the needs of the women, the nature of the disorder and the context in which she is treated. (see recommendation 1.7.1)
British Psychological Society	5	NICE	1.3.11	11	Starting using and stopping treatment. The Society believes that it should be made clear that when a treatment is initiated in pregnancy and there are interventions with equivalent effectiveness then psychological rather than pharmacological interventions should be advised to minimise the risk to the foetus. For example O'Hara's work is clear that psychological treatments rather than antidepressants should be available and recommended. If pharmacological treatment is already ongoing then the issue is more complex. The Society, therefore recommends disaggregating this recommendation to deal with these two different scenarios.	Thank you for your comment. The GDG considered this recommendation and felt that it did capture the higher threshold for starting pharmacological treatments in pregnancy. The advice for pharmacological treatment that is established pre-pregnancy is covered under the individual drug sections
British Psychological Society	6	NICE	Key prioritie s	13	The third diagnostic question has been deleted. We believe that this potentially was a means of establishing anxieties that mothers were keen to keep hidden, and therefore admitting to	Thank you for your comment. As your comment, and recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					psychological problems might lead to the involvement of social services and perhaps their child being taken into care. This fear remains an influence, as does shame and guilt. We believe that it is essential that mothers trust the person asking the questions and be reassured that any disclosed illness will not result in their child being taken away. We cited a reference in the last consultation. A suggestion for a third question: "Would you appreciate any further support or advice to help you feel better at this time?" A general question, not asking directly about symptoms, might optimally result in a useful discussion and identify 'hidden' causes of distress. Consider also the stigma against mental illness. A general question avoids this. The stigma and difficulty of disclosure is well evidenced by panel members themselves: Reference: Jones, I and Shakespeare, J (2014). Postnatal depression. BMJ, 349:g45000. doi:10.1136/bmj.g4500	consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. Evidence reviewed in the full guideline (see chapter 5) did not find that the additional question added to the depression identification questions ('Whooley questions') about the need for help had conclusive benefit, and resulted in poor discrimination between true-negative and false-negative cases which may lead to an increased risk of depression being missed or lost to follow-up.
British Psychological Society	7	NICE	1.7.8	43	The title includes traumatic birth but the recommendation covers only stillbirth and miscarriage- The literature is clear that objective measures or complications or outcome are not a reliable assessment of experienced trauma and that negative appraisal issues are key and normal birth can be	Thank you for your comment. The recommendations on traumatic birth are intended to apply to both women who have experienced a traumatic delivery due to physical birth complications but also women with an obstetrically-normal delivery who experience it as psychologically traumatic.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					experienced as traumatic. (See O' Donovan et al, 2014). This issue is not currently covered. Simple questioning about birth experience needs to be routine with follow up tailored to responses. Reference: O' Donovan, Alcorn, Patrick, Creedy, Dawe and Devilly (2014) Predicting post traumatic stress disorder after childbirth. Midwifery http://dx.doi.org/10.1016/j.midw.2014.03.011	However, to make this more explicit a definition of traumatic birth has been added to the guideline. The recommendation that women who have had a traumatic birth and wish to talk about their experience should be offered advice and support applies to both groups of women. Recommendation 1.6.1 also recommends that 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 and the postnatal period, the woman's attitude towards the pregnancy, the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby and trauma. The paper referenced in the comment, O'Donovan et al. (2014), would not have been identified by the search as it was published post-consultation. It would also not have been included as prediction of mental health problems in pregnancy or the postnatal period was outside the scope of this guideline.
British Psychological Society	8	NICE	1.1.2	16	When prescribing for women of present and future childbearing potential, take account of the latest data on the risks to the fetus and baby associated with psychotropic medication. The Society believes that this should be amended. The guidance is written with an acceptance of pharmacological treatment as	Thank you for your comment with which we agree. Please see NICE recommendation 1.2.2 for the change.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					the norm and minimising risk from this. We believe that the most effective way to minimise risk is for the guidance to promote a major shift in thinking to recognise that where women are of childbearing age and where there are interventions with equivalent effectiveness then psychological rather than pharmacological interventions must be advised to minimise the risk to the foetus.	
British Psychological Society	9	NICE	1.3.3	18	The Society recommends that a qualifier could be added to the end of the first bullet point to read: "Discuss treatment and prevention options, any particular concerns the woman has about the pregnancy or the baby and provide information to the woman, and if she agrees her partner, family or carer, about: • _the likely benefits of psychological interventions and psychotropic medication for mother and unborn child or baby."	Thank you for the comment. Your suggestion has been added to the recommendation.
British Psychological Society	10	NICE	1.3.5	19	We would recommend adding 'or specialist parent-infant mental health services'. In some areas of the country expertise lies within CAMHS services for early intervention with maternal mental health particularly in the absence of perinatal services and this may not be self-evident.	Thank you for your comment. The GDG felt it's important not to be too prescriptive and perinatal specialists would have breadth of expertise.
British Psychological Society	11	NICE	1.3.2.1	25	There have been major advances in incorporating psychological methods into interventions for psychosis- see the NICE	Thank you for your comment. We agree and this is reflected in recommendation 1.8.19

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					guidance on this. We would recommend that these be incorporated into perinatal care for women with psychotic difficulties.	
British Psychological Society	12	NICE	1.5.1	32	The Society believes that assessment needs to include whether a birth has been experienced as traumatic and whether this is continuing to affect a woman.	Thank you for this comment. This recommendation includes trauma (see bullet point 11).
British Psychological Society	13	NICE	1.62	34	The Society welcomes that all personnel completing these assessments should know about the range of presentations but it may be helpful to operationalise how this may be achieved. We believe that it should be specified that they should have received a minimum of training of a day per year and demonstrated contemporary knowledge through use of an online assessment.	Thank you for this comment. This is a matter for local determination and implementation which is outside of the scope of the guideline. This has been passed on to the NICE implementation support team.
British Psychological Society	14	NICE	1.6.2	34	The Society believes that interventions need to be formulation driven so that they are tailored to the individual on the basis of a shared understanding of why this woman is having these difficulties at this point in time. With more information regarding a woman's predisposing, precipitating and maintaining factors, the therapist with psychological expertise can work with a in a flexible way. Clinical psychologists have knowledge of psychological theory and intervention and can tailor to the needs of women and their families in a creative way. This may mean having the ability to use cognitive methods with	Thank you for this comment. The recommendation suggests using manual(s) to guide practice this is what we would expect all competent practitioners to do. It should however be guided by the best available evidence on what is known to be effective.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					mindfulness or attachment elements or eye movement desensitisation reprocessing but linked with some compassionate mind work. We believe that rigid protocols are unlikely to be the best way of facilitating the engagement so critical in this sort of work. For example, at some points, a woman may not have the focus to engage with CBT or the approach may not fit with her beliefs about aetiology thereby reducing the potential for effective engagement. In addition psychological treatment for women with complex psychological presentations (e.g. birth trauma, OCD and depression and a bonding disorder occurring in the context of historical or current abuse) have not yet been annualised therefore clinical psychologists working with these women are unlikely to work to a manual in the manner suggested in this statement. Treatment adherence to manuals when working with complex presentation is not appropriate. One way of addressing this issue is to include in research recommendations to examine the effectiveness and costs and service user feedback of a flexible formulation driven approach with women across the diagnostic spectrum including anxiety, depression eating disorders, PTSD against protocol driven services.	
British	15	NICE	1.6.7	37	In pregnancy psychological interventions need	Thank you for this comment. As set out in our

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Psychological Society					to be the first line of intervention not pharmacology because of foetal health risks	recommendations priority has been given to psychological interventions but given the evidence of the effectiveness of pharmacological interventions it would not be appropriate to adopt your suggestion
British Psychological Society	16	NICE	1.6.24	40	General sleep hygiene is important; however it may be helpful to include psychological interventions that have demonstrated effectiveness with sleep difficulties. See also point 28 below	Thank you for your comment. The literature search did not identify any high quality studies assessing the efficacy of psychosocial interventions for sleep problems and insomnia in pregnant women.
British Psychological Society	17	NICE	1.7.5	43	The Society welcomes the fact that the impacts of traumatic births are highlighted. However, we believe that there needs to be a process for identification and ongoing monitoring and intervention for traumatic symptoms during pregnancy (See O' Donovan et al, 2014) from previous traumatic deliveries. This may have implication for raising awareness and training for midwives to enquire and/or notice such symptoms and for the provision of intervention. Reference: O' Donovan, Alcorn, Patrick, Creedy, Dawe and Devilly 2014) Predicting post traumatic stress disorder after childbirth. Midwifery http://dx.doi.org/10.1016/j.midw.2014.03.011	Thank you for your comment. The GDG took the view that trauma symptoms during pregnancy as a result of a previous traumatic delivery should be conceptualised as part of a presentation of post-traumatic stress disorder (PTSD) and therefore treatment should be informed by existing NICE guidance on PTSD. There was no evidence for the validation of specific identification instruments for PTSD or trauma in pregnancy, and the PTSD guideline does not recommend any specific screening instrument. Therefore the GDG judged that the use of the GAD-2 questions was a reasonable extrapolation for pregnancy and the postnatal period. In addition, a recommendation has been added (1.5.3) to: 'Be aware of the range, prevalence and under-recognition of anxiety disorders (including GAD, OCD, panic disorder, phobia, PTSD and social anxiety)…'. Recommendation 1.6.1 also recommends that assessment and diagnosis of a suspected

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						mental health problem in pregnancy and the postnatal period should include history of any mental health problem including in pregnancy and the postnatal period, the woman's attitude towards the pregnancy, the women's experience of pregnancy and any problems experienced by her, the fetus or the baby, and trauma. The paper referenced in the comment, O'Donovan et al. (2014), would not have been identified by the search as it was published post-consultation. It would also not have been included as prediction of mental health problems in pregnancy or the postnatal period was outside the scope of this guideline.
British Psychological Society	18	NICE	1.7.7	43	We believe that the following should be added for clarity: "Interventions need to be provided by specialist staff that have specific knowledge of the maternity context."	Thank you for this comment. We have addressed this issue in recommendation 1.7.1
British Psychological Society	19	NICE	1.7.14	45	The Society believes that blanket reassurance may not be appropriate. For example, in cases where mental health problems occur within the context of broader based marital relationship problems such as domestic violence. Mother-baby relationship difficulties may arise and be stark or hidden in pregnancy or postnatally when the pregnancy was unplanned, conceived in the context of DV etc, or otherwise is untimely. Blanket advice to reassure that the mother-infant relationship will improve following treatment for mental health problems is not accurate and should be amended	Thank you for your comment. In response to your, and other stakeholders', comments, this recommendation has been amended.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					accordingly.	
British Psychological Society	20	Full	2.3.2	25	These comments in this box all relate to post traumatic stress and so have been collated for ease of use. The information on post traumatic stress disorder included is now outdated being based on Olde, 2006's review. There are now much better large sample longitudinal studies. The estimate of 1.5% PTSD relating to childbirth at 6 months is likely to be incorrect e.g. see Alcorn et al (2010) in a large sample high quality study who found 3.6% full PTSD related to childbirth at 6 months . Equally a recent metanalytic review in Clin Psy Review estimates rates of 3.1% across community samples(ie non targeted postnatal women) in studies considering rates 1- 18 months postnatally where symptoms relate specifically to childbirth (Grekin and O'Hara, 2014) . Therefore the figures and the extent of the problem that is utilised in this review are outdated. PTSD after childbirth is 36 times more common than for example puerperal psychosis. References: Olde, E; van der Hart, O; Kleber, R; et al. (2006) Posttraumatic stress following childbirth: A review. Clinical Psychology Review. 26(1), 1-16. Grekin, R. & O'Hara, M.W. (2014) Prevalence	Thank you for your comment. Where possible, we have used systematic reviews as a source for epidemiological data discussed in the introduction of the full guideline (Chapter 2). However, the Grekin and O'Hara review was published after submission of the guideline. We have now added the estimate from that meta-analysis to the full guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and Risk Factors of Postpartum Posttraumatic Stress Disorder: A Meta-Analysis, Clinical Psychology Review, doi: 10.1016/j.cpr.2014.05.003 K. L. Alcorn, A. O'Donovan, J. C. Patrick, D. Creedy and G. J. Devilly (2010). A prospective longitudinal study of the prevalence of posttraumatic stress disorder resulting from childbirth events. Psychological Medicine, 40, 18491859; doi:10.1017/S0033291709992224	
British Psychological Society	21	Full	5.3.8.	140	p140-149 5.3.8 And 5.4.8.4- Assessment of suspected mental health problems in pregnancy and postnatal recommendations need to routinely incorporate assessment of response to childbirth in terms of experience of trauma and then provide follow-up.	Thank you for your comment. See the glossary in the NICE guideline p. 17for the definition of trauma which includes the experience of childbirth.
British Psychological Society	22	NICE	2,5	50	We believe that information is needed on effective systems for doing this and this should to be urgently included in the research recommendations.	Thank you for your comment
British Psychological Society	23	Full	7.5.15	458	The Society believes that interventions for depression after traumatic childbirth is very limited and of low quality. Therefore further work may change recommendations (one included of low quality). This is the same for interventions for PTSD which indicates improvement in symptoms and in quality of life but increase in self blame. The quality of evidence is low and clear recommendations	Thank you for your comment. As you correctly identify, the evidence for post-traumatic birth counselling is limited, of low quality and reveals inconsistent effects. These inconsistent effects may be indicative of the need for individualized information and support following a miscarriage or a traumatic birth and this was also a theme which emerged from the qualitative review of service user experience. Based on the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					cannot be made but we urgently need research on this.	quantitative and qualitative evidence, GDG consensus opinion, and existing NICE guidance on PTSD (CG 26), the GDG recommended that women who have had a traumatic birth or miscarriage and wish to talk about their experience should be offered advice and support
British Psychological Society	24	NICE	2.5	50	Research studies to develop reliable systems to identify women at risk of post traumatic stress following childbirth and test prevention and if required interventions are urgently needed. This should be incorporated into research recommendations.	Thank you for this comment. We have included PTSD in the list of anxiety disorders in the recommendation
British Psychological Society	25	NICE	1.7.14	44	Improvements in the mother-baby relationship have not been shown to follow as a matter of course from improvements in MMH following treatment of the mother's MH problem. (Centre on the Developing Child at Harvard, 2009) Prevention in Mind,2013 comment that general adult MH services may not have the time, resources or expertise to support the mother-infant relationship, hence the key role of specialist perinatal services or parent-infant mental health services, sometimes linked to CAMHS. Reference: Center on the Developing Child at Harvard University (2009). Maternal Depression Can Undermine the Development of Young Children:	Thank you for your comment. The GDG agree that the evidence does not support that the mother-baby relationship will automatically or always improve with the treatment of the maternal mental health problem and the recommendation has been amended in response to stakeholder comments.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Working Paper No. 8. http://www.developingchild.harvard.edu	
British Psychological Society	26	NICE	1.7.15	45	This is quite a big ask of the sort of local services that are currently configured. To have practical value, this recommendation would need to give guidance on the sort of tools/approaches that midwives, HVs and others should employ eg. Minding the Baby programme (Sadler, Slade and Mayes, 2005) Reference: Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., Mayes, L (2005) Minding the baby - A reflective parenting program, Psychoanalytic Study of the Child, 60, 74-100	Thank you for your comment. Recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services. The paper you reference would not have been identified by our search as it does not meet study design criteria (RCT or SR for intervention efficacy) or date restriction (post-2006 as this guideline is an update)
British Psychological Society	27	Full	8.9.1.49	726	There are limited recommendations for interventions re sleep i.e. lack of sleep has significant impact on mental health and well being and there is research by Colin Espie re sleep interventions require more than sleep hygiene i.e. CBT. Espie C.A (2009) "Stepped care": A health technology solution for delivering Cognitive Behavioral Therapy as a first line insomnia treatment. 32(12):1549-1558.	Thank you for your comment. The literature search did not identify any high quality studies assessing the efficacy of psychosocial interventions for sleep problems and insomnia in pregnant women. Espie (2009) would not meet the study design eligibility criteria for this review. Therefore, the GDG did not feel able to make any more specific recommendation for psychosocial interventions aimed at sleep problems
Central & North West London NHS Foundation Trust	1	NICE	1.1.1	16	Currently bullet point: "how a mental health problem and its treatment might affect the woman and the foetus or baby. [new 2014] [1.1.1]"	Thank you. In this context the GDG means treatment (or lack of) more generally not specifically pharmacological interventions.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					please amend to : "how a mental health problem and its pharmacological treatment might affect the woman and the foetus or baby. [new 2014] [1.1.1]"	
Central & North West London NHS Foundation Trust	2	NICE	Key prioritie s	10	Key priorities & 1.2 (p16ff) "Considerations" but i cannot see any reference made here, or elsewhere in the guidance as to written support material to give to patients. Or the fact that we should give them such material in order to carefully decide and make informed decisions. Would be good to see reference made to UKTIS http://www.uktis.org/ and the BUMPS (Best Use of Medicines in Pregnancy) website which is specifically for patients http://www.medicinesinpregnancy.org/ .	Thank you for the information but we have not verified or reviewed sources of advice.
Central & North West London NHS Foundation Trust	3	NICE	Key prioritie s	10	Key priorities and 1.1.3 (p.16) Currently: "Do not offer valproate to treat a mental health problem in women of present and future childbearing potential. [new 2014] [1.1.3]" This is worded too strongly to be realistic, or to give clinicians or patients the choice. And is not in keeping with BAP guidelines or the draft BPAD NICE guidelines. There are times when valproate is the only viable option, or the only acceptable option to the patient. And some pts would rather accept these risks than the far greater likelihood of other risks or side effects with olanzapine (weight gain) and lithium. So when a fully informed pt understands and accepts the	Thank you for your comment. The GDG were concerned that prescribing practices of sodium valproate for women of childbearing age remained higher than would be expected if existing NICE guidance was being followed. Based on GDG concerns about the potential for harm, the consensus judgement was that there were grounds to strengthen the valproate recommendations that were made in the previous 2007 guideline. This was also consistent with recommendations made in the bipolar guidance (for both acute and long-term treatment).

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					teratogenic risk, or currently has no intention of getting pregnant (eg on contraceptive depot), then clinicians should be allowed to prescribe valproate. There are other times when valproate may be used acutely – eg during an admission for mania. The decision to continue this (or not) is then made at a later date. But to explicitly tell prescribers that they cannot use valproate in women of child bearing potential, entirely removes one very effective antimanic treatment form the options for admitted mania women, this is not in the interest of this population, is not evidence based, or consistent with other guidelines and bout the acute treatment of mania.	
Central & North West London NHS Foundation Trust	4	NICE	1.2	16	No general introduction about the rates of miscarriages of malformations in the general population, this is necessary if you then start talking about increased risks. As baseline is required in order to be meaning full. Eg. "The risk of malformations is increased by some psychotropic drugs, but the difficulties in assessing the risk with medication in pregnancy for psychiatric illness include the paucity of data and interpretation of exposures are often complicated by other confounders such as concurrent medication, lifestyle (e.g. diet, smoking, illicit substances) use as well as the illness itself." "There is a background risk of major	Thank you for this comment. This level of detail is too much to be incorporated into a recommendation. The harm data is reviewed in chapter 8 of the full guideline where the baseline risk is considered (relative risk effect estimates [OR] and absolute risk difference between exposed and unexposed groups) and the limitations of this evidence in terms of potential confounders and the level of uncertainty has been discussed in some detail in the linking evidence to recommendations section of this chapter in the full guideline (see section 8.8.2)

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					malformations of between 2 and 4 in 100 and a risk of spontaneous miscarriage between 10 and 20 in 100 in the general population even without drug treatment. This background risk may be increased by the presence of a mental disorder. Treatment can reduce the risk, but some psychotropics may increase it. Other factors other than drug treatment may also increase the risk of malformations e.g. blood relations marriages. • The potential risks associated with the specific medication(s) prescribed. • The risk of malformations is increased by some psychotropic drugs, but is often difficult to quantify because of the limited data1. The prescriber should acknowledge the uncertainty surrounding the risks with drug treatments. • Data for many drugs in pregnancy and breast-feeding are derived from small studies, case reports, case series or from preclinical studies in animals (where extrapolation of such studies into human pregnancy is difficult).For more established drugs sometimes larger studies are available, lending to more confidence in the risk assessment, e.g. certain tricyclic antidepressants (TCAs) for depression. • It is impossible to be sure that any drug is 'safe' in pregnancy because it is unethical to conduct the randomised placebo-controlled trials that would be necessary to prove the point.	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					The data available to support prescribing decisions in pregnancy are usually of limited quantity and quality. Data regarding the neurodevelopmental effects of psychotropic medication in pregnancy and breast-feeding are lacking."	
Central & North West London NHS Foundation Trust	5	NICE	1.2	16	There's no/very little general introduction about the general principles of balancing the decision and what to tell the mother. Please add the following: "Treatment decisions during pregnancy and breast feeding should always be made on a case-by-case assessment. Treatment decision should be made using the most up-to-date evidence. The potential risks of the maternal medication on the fetus/infant should be balanced against the risks of leaving the psychiatric illness untreated or inadequately treated when making this decision."	Thank you for your comment. However, the GDG felt that these points were captured by existing recommendations (see 1.2.2, 1.4.2-1.4.7, 1.4.10-1.4.17)
Central & North West London NHS Foundation Trust	6	NICE	1.2	16	I cannot see prescribers responsibilities explicitly stated i would have thought this is important, please add: "The final decision regarding treatment for an individual patient remains the clinical responsibility of the prescriber." And: "Prescribers should establish a clear indication for medication treatment during pregnancy and breast feeding. The severity of the mental	Thank you for your comment. The coordinated care recommendations have been amended in response to stakeholder comments and recommendation 1.3.5 now recommends that an integrated care plan is developed 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 and the roles of all healthcare professionals (including who is responsible for

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					health illness is an important parameter to take this clinical decision."	coordinating the integrated care plan, the schedule of monitoring, providing the interventions and agreeing the outcomes).
Central & North West London NHS Foundation Trust	7	NICE	1.2	16	I cannot see any general principles about the physiological changes in pregnancy. This understanding is necessary as it informs the treatment decisions. Please add: "Physiological changes during pregnancy include increased glomerular filtration rate and expansion of plasma volume, which subsequently return to pre-pregnancy states soon after delivery. The physiological changes will be even greater in twin pregnancies. These changes can affect the clearance of many drugs. This may introduce the need for dose increases in the third trimester (usually around week 27 of gestation). Any increases made during pregnancy should be reduced again either near to term, or soon after delivery. Dose changes where possible, should be guided by maternal therapeutic drug monitoring."	Thank you for your comment. Recommendation 1.7.1 outlines the general principle that 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 impact on treatment, and the context in which they are assessed and treated. There are also specific recommendations to check lamotrigine (1.4.32) and lithium (1.4.34, 1.4.37) levels during pregnancy and into the postnatal period
Central & North West London NHS Foundation Trust	8	NICE	1.2	16	General advice re teratogenicity would be helpful in guiding prescribers in what to do and what to tell the mothers: eg. "Drugs can potentially cause adverse effects at any stage in pregnancy. Exposure to a teratogen in the first 3 months is more likely to cause structural Malformations, exposure after the first trimester is more likely to cause growth defects.	Thank you for your comment. The GDG considered providing more detail regarding teratogenicity in the NICE guideline, but decided that it would not be helpful to do so. The GDG felt that given the uncertainty inherent in the data, in particular problems with confounding variables, it is more important for prescribing healthcare professionals to keep up-to-date with the evidence on harms rather than

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					The embryo is most vulnerable to teratogens during the embryonic phase from days 18 to 55 when the cells differentiate and the major organs are formed The risk of exposure to a teratogen can differ among individuals. Not all fetus' will be affected. During the fetal period, from day 56 until birth, organs such as the cerebral cortex and the renal glomeruli continue to develop and remain particularly susceptible to damage. Functional abnormalities such as deafness may also occur. Teratogenic effects are usually dose-dependent and the dose response curve is steep i.e. a small increment in dose can result in a large increase in fetal toxicity. For example the incidence of neural tube defects with sodium valproate may be dose-related".	rely on what may become outdated estimates of risk. Recommendations 1.2.2, 1.4.2-1.4.7 and 1.4.10-1.4.17, 1.4.20-1.4.21, and 1.4.34 are concerned with considering and discussing risk. Recommendation 1.2.3 recommends that valproate should not be offered for acute or long-term treatment of a mental health problem in women of childbearing potential. This 'do not' offer recommendation was made on the basis of concerns about harms so outlining dose-response curves for this drug were not considered necessary or appropriate.
Central & North West London NHS Foundation Trust	9	NICE	1.3	18	p18-29 1.3 and 1.6 (p34-40) Re drug treatment. In general I did not find this document easy to navigate. Mostly because 1.3 and 1.6 did not seem to be distinct enough from each other, yet were separated. Meaning the reader had to keep going back and forth. It appears that 1.3 was intended to be a more general section (which makes sense) then 1.6 should give the more detail advice. However currently 1.3 goes into a lot of specific detail i.e. the whole of 1.3.16 – 1.3.39. This would better sit in 1.6, with further details added.	Thank you for your comment. Because the guideline covers a wide range of mental health problems, some of which may be treated by the same drug, the decision was made to cover the decisions about starting and stopping a particular treatment in 1.3 (now 1.4.), because for some women these decisions will be of paramount importance. Where the recommendations were disorder-specific (for example, which specific treatments to offer a pregnant woman with depression), the recommendations are contained in section 1.6 (now 1.8) The GDG realises that this might not have been immediately obvious and to address

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						your concerns, the guideline has undergone some restructuring in order to make it clear how to navigate the document (see recommendation 1.1.2, which has been moved to the front of the guideline). Also, in the NICE Pathway for this topic, which will be launched at the same as the guideline, the linkage between the two sections will be clearer and the ability to navigate easier.
Central & North West London NHS Foundation Trust	10	NICE	1.3.13	22	2nd bullet point currently says: "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" agreed, but please amend to: "use the lowest effective dose to achieve remission of maternal psychiatric symptoms. This is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related. However, doses so low as to constitute ineffective treatment (i.e. sub-therapeutic) may also needlessly expose the fetus to risks"	Thank you for your comment. The recommendation has been revised to say 'note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively', which the guideline development group thinks is clearer.
Central & North West London NHS Foundation Trust	11	NICE	1.3.13	22	1.3.13, 1.6.6,1.6.7, 1.6.8- 2nd bullet point, 1.6.9 Both here and numerous places further on in the document it uses the phrase "in pregnancy and the postnatal period". Obviously the "postnatal" period may include breastfeeding, but it would be better to make this explicit. The use of medicines in a	Thank you for your comment. We have now made this explicit in 1.4.5.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					postpartum breastfeeding mother is a very different scenario to the use of medicines in a postpartum mother who is not breastfeeding. And the situations need very different consideration and action.	
Central & North West London NHS Foundation Trust	12	NICE	1.3.19	25	1.3.19 and 1.3.20 Then 1.6.24 There are just 2 points about benzodiazepines. But no mention at all here about other hypnotics. And the only section about sleep (1.6.24)doesn't talk about benzodiazepines. These don't fit well together, aren't consistent and do not reflect other national guidance (eg BAP).	Thank you for your comment. We don't have any efficacy data on benzodiazepines to treat sleep disorders or insomnia in pregnancy so there are no grounds for including sleep as an exception to the 'do not offer benzodiazepines...' recommendation. In response to your comment regarding the recommendation for interventions for sleep problems, no evidence was found for z-hypnotics (or benzodiazepines) for the treatment of sleep disorders or insomnia in pregnancy
Central & North West London NHS Foundation Trust	13	NICE	1.3.19	25	1.3.19 and 1.3.20 These two points make no differentiation between the odd occasional use of a single dose of benzodiazepine eg temazepam to assist sleep, vs chronic regular doses of long acting benzodiazepines. These need to be given a distinction, as they are very different clinical scenarios and require different management plans.	Thank you for your comment. The recommendation does make a distinction between long-term and acute treatment as 'the short-term treatment of extreme anxiety and agitation' is added as an exception to the 'Do not offer benzodiazepines…' recommendation. There was no efficacy data on benzodiazepines to treat sleep disorders or insomnia in pregnancy so there are no grounds for including sleep as an exception in this recommendation
Central & North West London NHS Foundation Trust	14	NICE	1.3.23	26	"....offer a different antipsychotic." Please change to "....offer a prolactin sparing antipsychotic."	Thank you we have made specific reference to prolactin sparing medication in recommendation 1.4.22.
Central & North	15	NICE	1.3.29	27	And 1.3.30	Thank you for your comment, but the guideline

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
West London NHS Foundation Trust					"advise her to gradually stop". Again there is no sense of balancing risks in this instructive. What if is best that she should stay on valproate in order to stay well? What if any other drugs are less acceptable to her, or she will refuse to take? Please also see comment above re Key priorities on page 10 and 1.13 on page 16 No acknowledgement that teratogenic effects are dose related, and advice about how to use valproate when necessary eg twice daily dosing use Modified Release preps to avoid peaks and troughs etc. There no text to show prescribers that they need to balance of the chance or relapse (and the impact that has on a foetus) versus the chances of teratogenicity. Furthermore 1.3.30is not consistent within itself. It tells prescribers "to stop2 the valproate. And "take into account the risks and benefits of other drugs". If other drugs are not effective/can't be tried/haven't worked previously. We have then left the patient without any drug. I doubt this is what you intended this section to mean.	development group wished to be robust about valproate because poor neurodevelopmental outcomes result from exposure to valproate throughout pregnancy.
Central & North West London NHS Foundation Trust	16	NICE	1.3.32	27	Please qualify that the lamotrigine being discussed here is "for a mood disorder".	Thank you for your comment, but in the context of a guideline on mental disorders this was not considered necessary.
Central & North West London NHS Foundation Trust	17	NICE	1.3.35	28	This section on lithium is phrased nicely and realistically. Could we please have the same approach with valproate? Both are teratogenic,	Thank you for your comment. The GDG were concerned that prescribing practices of sodium valproate for women of childbearing age

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					both should equally be avoided in pregnancy and breastfeeding, and both have additional (separate and different) postpartum complications.	remained higher than would be expected if existing NICE guidance was being followed. Based on GDG concerns about the potential for harm, the consensus judgement was that there were grounds to strengthen the valproate recommendations that were made in the previous 2007 guideline. This was also consistent with recommendations made in the bipolar guidance (for both acute and long-term treatment).
Central & North West London NHS Foundation Trust	18	NICE	1.6.18ff	38	This section needs some general principles added. ie to balance the realistic immediate needs of both the mother and unborn child in order to stay safe, versus technical longer term potential risks of using medicines. And to add that in principle a pregnant woman with an acute episode fo mental health illness should be treated as per the principles of NICE guidelines. The exact details will be dependent on the patients history of response to medicines, the severity of her current situation and the risks to the baby incurred by her current mental state.	Thank you for your comment. The points that you raise are covered in other sections of the guideline, notably in sections 1.1 and 1.4. The NICE guideline has undergone some minor restructuring to make it clear that healthcare professionals should consult specific mental health guidelines, and modify them according to the advice set out in the Antenatal and Postnatal Mental Health guideline.
Central & North West London NHS Foundation Trust	19	NICE	1.6.19	39	In addition this point needs to be realistic and add that if a pregnant woman with BPAD becomes manic she should also be treated as per the principles of the BPAD NICE guidelines. Ie she should also be offered a mood stabiliser (even as a short term measure) and this may include valproate if she is not in the first	Thank you for your comment. The NICE guideline has undergone some restructuring to make it clear from the outset that healthcare professionals should consult specific mental health guidelines, and modify them according to the advice set out in the Antenatal and Postnatal Mental Health guideline. But it should

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					trimester, a/or a benzodiazepine (as a short term measure). The exact choice of medicine will be dependent on the patient's history of response to medicines, the severity of her current situation and the risks to the baby incurred by her current mental state.	be noted that both the Antenatal and Postnatal Mental Health guideline and the Bipolar Disorder guideline do not recommend valproate for pregnant women or women of childbearing potential.
Central & North West London NHS Foundation Trust	20	NICE	1.6.21	39	Start the same sentence with "Where possible....."	Thank you for your comment, however the guideline development group did not judge that this change was needed given that it is clear from the recommendation that the action only applies to women already taking medication for bipolar disorder.
Central & North West London NHS Foundation Trust	21	NICE	1.6.21	39	This is an example of this guidance being hard to follow as it doesn't flow well. I would have thought that this point sit in the breast feeding section. Ie 1.7.9-13 or at least to be mirrored there.	Thank you for your comment, but this recommendation is specific to women with bipolar disorder so is best placed in the section on specific mental health problems. The guideline has, however, been restructured elsewhere to improve the flow and the links between sections. Also, in the NICE Pathway for this topic, which will be launched at the same as the guideline, the linkage and distinction between recommendations in each section will be clearer and the ability to navigate easier.
Central & North West London NHS Foundation Trust	22	NICE	1.6.22	39	Please acknowledge that this plan is an ideal. And that the prescriber need to balance the desire and preference for the mother to breast feed versus the need to keep her mentally well and stable such that she can deliver and keep the baby in her care.	Thank you for your comment. There are a number of recommendations which relate to discussing with the woman the risks and benefits of taking medication versus potential harms to the fetus or the baby; specially if no other drug has an effect on the mother.
Central & North West London NHS	23	NICE	1.6.23	39	3rd bullet point As above (1.6.19): In addition this point needs	Thank you for your comment. The recommendations in this guideline are

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Foundation Trust					to be realistic and add that if a pregnant woman with BPAD becomes manic she should also be treated as per the principles of the BPAD NICE guidelines. Ie she should also be offered a mood stabiliser (even as a short term measure) and this may include valproate if she is not in the first trimester, a/or a benzodiazepine (as a short term measure). The exact choice of medicine will be dependent on the patient's history of response to medicines, the severity of her current situation and the risks to the baby incurred by her current mental state.	consistent with the most recent bipolar guidance
Central & North West London NHS Foundation Trust	24	NICE	1.6.24	39	Needs to read consistently with 1.3.19. which only spoke about benzodiazepines. And neither section even mention "z-hypnotics". Would be preferable if these two sections where together and if they more comprehensively addressed the topic of hypnotics as this is a very frequent issue in pregnancy.	Thank you or your comment. We don't have any efficacy data on benzodiazepines to treat sleep disorders or insomnia in pregnancy so there are no grounds for including sleep as an exception to the 'do not offer benzodiazepines...' recommendation. In response to your comment regarding the recommendation for interventions for sleep problems, no evidence was found for z-hypnotics (or benzodiazepines) for the treatment of sleep disorders or insomnia in pregnancy
Central & North West London NHS Foundation Trust	25	NICE	1.6.26	40	Second bullet point says "She shodul not be secludes after RT" again such definite statements are not realistic. It is probably safer for someone to be constantly observed under the very tight restrictions required for practising seclusion, that it is to leave a manic pregnant person unattended. Furthermore the use of seclusion is intended in part to be another	Thank you for your comment. As evidence was not reviewed for rapid tranquilisation for this update (outside the scope of this update) this recommendation was directly taken from the previous 2007 APMH guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					method for addressing disturbance other than medicines (ie RT), therefore the use of seclusion may diminish the need for further RT and restraint. What is the evidence base and rational for this instruction? It would be preferable to instead emphasise that the MDT should do everything possible to avoid the use of restraint. But this doesn't seem to be addressed.	
Central & North West London NHS Foundation Trust	26	NICE	1.7.2	41	And 1.7.3 This seems a very short section given the title " Monitoring babies for effects of psychotropic medication taken in pregnancy". There is so much more to be said. There is no mention here about the medium term and follow up to establish if there is any neurodevelopmental delay, or not. And there should be specific details about the follow up required for babies who are born to mothers taking lithium (ie to monitor levels and to check for cardiac abnormalities), or those taking valproate.	Thank you for this comment. This recommendation has been amended in response to stakeholder's comments and the need for further monitoring has been added as a bullet point to recommendation 1.9.2. More specific detail is outside the scope of this guideline and is an implementation issue and has been passed on to the NICE implementation support team.
Central & North West London NHS Foundation Trust	27	NICE	1.7.9.	43	Need to add that although this is true, this need shodul be balanced against the need of the mother to say mentally well enough so that she can actually care for the child and retain custody.	Thank you for your comment. The GDG agree that this is important and feel that it is covered by recommendation 1.4.4
Central & North West London NHS Foundation Trust	28	NICE	1.7.12	44	Please rephrase the opening line to: "Women who need to continue to take the following medicines should be strongly advised and encouraged not to breastfeed, for the safety of the baby:"	Thank you for your comment. The recommendation has been revised in light of your and other stakeholders' comments to say 'Do not advise breastfeeding in women taking...' and then lists carbamazepine,

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Then bullet points to continue as currently written/.	clozapine and lithium.
Central & North West London NHS Foundation Trust	29	NICE	General	0	omission : No reference to UKTIS and their resources, and the need to inform them of the out come post partum in order to established a greater understanding of the medicines use in pregnancy. "The UK Teratology Information Service (UKTIS) collate data on medicines use during pregnancy. Please contact UKTIS on [redacted] to inform them of any pregnancy where exposure to medicine (especially where data is limited) has occurred during pregnancy."	Thank you for the information but we have not verified or reviewed sources of advice.
Children and Young People's Mental Health Coalition	1	Full	7.7.1.20	556	And NICE version 1.7.14 respectively (it is the same text in both documents) p 44 The relationship between mother and child is a delicate and complex thing, and improvements in mothers' symptoms alone will not help improve the child's development - file:///C:/Users/plavis.FOUNDATION/Downloads/WP8%20(1).pdf We know that maternal mental health problems can have a negative impact on the child's mental health and on the ability of the mother to form a secure attachment with her child. With this in mind it is important to reassure mothers who have a mental health problem that they will be able to form a good relationship with their child, but they will	Thank you for your comment. In light of your, and other stakeholders', comments the recommendation has been amended.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					probably help to do this. We are concerned that the statement in the guidance is too simplistic.	
Children and Young People's Mental Health Coalition	2	Full	7.7.1.21	556	Whilst we agree with the statement in principle, we are concerned about who will be carrying out this assessment, as this is not clear in the statement. Ideally it should be a health visitor or a midwife, or GP, who has built up a good relationship with the mother, but we are concerned whether they would have time and the skills/support in order to do this. In order for this to be effective in practice, more thought needs to be given to the practicalities of how this will be achieved.	Thank you for your comment. Please see the amended recommendation in light of your comment.
College of Mental Health Pharmacy	1	Full	5.4.8.1	148	Principles of care for women with a mental health problem…… Would it be worth adding something here about reviewing any medication currently being taken (or prescribed but not taken) to reduce the risk to the foetus while best protecting the mother. 5.4.8.1 might not be exactly the right place to mention this, so perhaps somewhere else in this brief section.	Thank you for your comment, but the guideline development group considers that the points you have raised are adequately covered in other recommendations - see section 1.4 of the NICE guideline.
College of Mental Health Pharmacy	2	Full	6.4.1.11	204	The part of this recommendation that includes the use of decision aids is very sensible but not particularly practical. Developing such aids is a skilled task that is likely to be beyond the resources of most service providers. If such an aid could be developed by NICE, or signposting to an existing aid provided, this would provide clinicians with the tools to do a good job and make it easier to implement the guideline. To	Thank you for your comment. This recommendation provides general principles about how to assist a woman in the treatment decision. Your concern has been passed on to the NICE implementation support team who will look into how best to translate these recommendations into practice.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					give an example of this, the ADHD guideline recommends the use of centile charts to document BP when stimulant drugs are prescribed, but such charts are very difficult to locate and can't be embedded in electronic patient records. Therefore in practice, very few patients have their BP monitored in the way that is recommended. Clinicians see the recommendation as impractical and this undermines the guideline.	
College of Mental Health Pharmacy	3	Full	7.7.1.10	554	At this point, the foetus has already been exposed to medication and the benefits of stopping medication may be limited. There needs to be some acknowledgement here that the risk/benefit of stopping medication may be greater than in a woman who is yet to conceive.	Thank you for your comment. The point that you have made is of course a valid one, and one which the guideline development group discussed at length. The GDG considers that the risks of stopping medication are adequately covered in section 1.4 of the NICE guideline.
College of Mental Health Pharmacy	4	Full	7.7.1.12	554	Changing to a medication with a lower risk of adverse effects …..this may potentially benefit the mother but may not benefit the foetus (now exposed to multiple medications). See also the comment related to table 321 below. If depression is/was severe in the mother, the risks of switching may also be considerable for the woman herself.	Thank you for your comment. In response to your and the comments of other stakeholders this recommendation has been redrafted to be more cautious and to make it clear that medication should only be switched if a drug that is effective for the woman is available. As outlined in the recommendation, this decision will be informed by the woman's previous response to treatment, stage of pregnancy, risk of relapse, risk associated with medication and the woman's preference
College of Mental Health Pharmacy	5	Full	8.1	558	The introduction to this section is very thoughtful and well written. If read (unlikely when embedded in the full guideline), it would be very helpful to doctors (perhaps particularly	Thank you for your positive comment about the introduction to 8.1. The NICE guideline introduction is purposefully short, but the guideline development group feels that it has

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					in primary care) who often seek a simple safe/less safe list of medicines. If it were possible to make this text available in the NICE guidance this may facilitate more thoughtful care.	covered most of the issues from 8.1 either in the NICE guideline introduction or in the recommendations.
College of Mental Health Pharmacy	6	Full	8.2	569	Calcium v placebo: The text mentions selenium (n-247), when the study in the table involves calcium	Thank you for your comment. The text has been changed from selenium to calcium
College of Mental Health Pharmacy	7	Full	8.4	651	Table 321: This table is helpful but could be interpreted very concretely (that a medication with a risk of 4 more per thousand was safer than one with 7 more per thousand) and switching may take place which then exposes the foetus to 2 medicines, The truth is that the studies that form the meta-analysis differ in design and this may partially explain the apparently different risks, albeit usually small, associated with similar medicines.	Thank you for your comment. The reason for including both statistics is that where the actual event rate is low in the general population, an effect may be statistically significant, however lead to an over-interpretation of the effect size if the absolute risk difference is actually very low. However the GDG did feel that greater clarification was needed on interpreting the absolute values, therefore further explanation has been added to the section on statistical analysis in the full guideline
College of Mental Health Pharmacy	8	Full	8.8.2	709	The set of principles to guide prescribing is very welcome. One of these principles (which we agree with) is that considerable caution should be exercised when changing or stopping antidepressant drugs in pregnancy. See comments for 7.7.1.12 that seems to support switching.	Thank you for your comment. We agree with this point and have changed the recommendation to include 'discussing continuing the current medication' as one of the following options, and have amended the option about switching medication to 'changing medication if a drug with a lower risk of adverse effects is available'.
College of Mental Health Pharmacy	9	Full	8.9.1.1	717	In the last few years the number of studies that have examined the effects of psychotropic drug use during pregnancy has increased hugely. The quality of such studies has also improved. The	Thank you for your comment. As you point out this recommendation covers the individual prescriber's responsibility to keep themselves up to date with the evidence base on harms

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					evidence base is moving on quite rapidly so we agree absolutely that the latest data should always be used and welcome this recommendation. Is it possible to go further and recommend that those who prescribe psychotropics for pregnant women have a responsibility to keep up to date themselves with this evidence base (this would apply to specialists) or to seek case-specific advice (generalists, particularly GPs for whom such prescribing may be infrequent)?	associated with psychotropic medication. The recommendation for a pregnant woman who has taken psychotropic medication with known teratogenic risk at any time in the first trimester (1.4.15) also includes that healthcare professionals should 'seek advice from a specialist if there is uncertainty about the risks associated with specific drugs '
College of Mental Health Pharmacy	10	Full	8.9.1.2	717	Observation only ……While we agree that this is desirable, a 'do not offer' recommendation may be very difficult to implement, particularly when treating acute episodes of mania. We agree that awareness of the teratogenic potential of valproate and converting that awareness into prescribing decisions is very much poorer than it should be. Child-bearing potential has probably been carefully chosen over child-bearing age but it leads to all sorts of assumptions (patient not at risk because not in a relationship, religious beliefs or simply didn't think this would be an issue – all explored in a study published in the Journal of Mental Health a number of years ago- James L et al). Child-bearing age might be better as that places the onus on the prescriber to actively defend/document why they are prescribing outside a recommendation, rather than assume the patient's GP is prescribing contraception	Thank you for your comment. This recommendation is consistent with the bipolar guidance (for both acute and long-term treatment). The GDG considered using the term childbearing age relative to childbearing potential in recognition of the valid points you highlight. However, the decision was taken to use childbearing potential as it is consistent with other NICE guidance and the age range that you would have to specify would be so wide as to be meaningless but without specification could also be open to misinterpretation

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					thus removing the child-bearing potential issue from the prescribing decision.	
College of Mental Health Pharmacy	11	Full	8.9.1.9	719	Might it be worth adding that discussing the potential harms of psychotropic medication to the foetus may help the mother make a more informed decision (it is possible she hugely over-estimates the risks).	Thank you for your comment. The GDG did not feel the evidence in the qualitative review was strong enough to make such a claim and amending the recommendation would be misleading.
College of Mental Health Pharmacy	12	Full	8.9.1.12	720	The stem here is about risks to the foetus or pregnant woman. The last point about FTI is absolutely true but doesn't quite belong here. In clinical practice, women often find that TCAs compound constipation, sedation and dizziness (postural hypotension). This may be useful practical advice.	Thank you for your comment. This recommendation has been amended and the final bullet point has been removed. Given the lack of evidence reviewed for an association between TCAs and constipation, sedation and dizziness the GDG did not feel it was appropriate to add this point to the recommendation
College of Mental Health Pharmacy	13	Full	8.9.1.23	721	Do not offer carbamazepine appears here. We may have missed reference to this 'do not offer' statement earlier.	Thank you for your comment, but the guideline development group wished to highlight the particular harms associated with valproate for women of childbearing potential.
College of Mental Health Pharmacy	14	Full	8.9.1.25	722	At this point the harm may be done. Is it worth considering whether an early high resolution ultrasound scan to detect neural tube defects may help inform the care plan. A woman may elect to terminate such a pregnancy particularly if it is in the early stages.	Thank you for your comment. Recommendation 1.4.15 recommends that if a pregnant woman has taken psychotropic medication with known teratogenic risk at any time during the first trimester they should be offered screening for fetal abnormalities and counselling about continuing the pregnancy
College of Mental Health Pharmacy	15	Full	8.9.1.28	722	Pre-conception folate may not protect against anticonvulsant-associated neural tube defects (there is some literature on this) and high-dose folic acid is associated with having twins. This information should be shared with the woman.	Thank you for your comment. This recommendation has been removed based on your, and other stakeholder's, comments that an unintended consequence of this recommendation may be to imply that pre-

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						conception high dose folic acid will protect against harms. Given that we have not reviewed the evidence for the efficacy of folic acid in preventing congenital malformations (or any evidence for the association between folic acid and the incidence of twins), the GDG agreed that this recommendation was going beyond the data.
College of Mental Health Pharmacy	16	Full	8.9.1.29	722	Among the alternatives to lithium are valproate and carbamazepine. If read in isolation this recommendation could direct clinicians towards less desirable treatments.	Thank you for your comment, the guideline development group has made it clear that it means antipsychotics.
College of Mental Health Pharmacy	17	Full	8.9.1.34	723	Is it worth adding a recommendation about not stopping lithium abruptly at the point of delivery because this increases the risk of manic relapse at a time that a woman with bipolar disorder is perhaps most vulnerable.	Thank you for your comment. The recommendation has been amended in light of your comment.
College of Mental Health Pharmacy	18	Full	8.9.1.51	726	Floppy baby syndrome seems an odd thing to mention here when the woman is pregnant and is receiving very short-term treatment for disturbed behaviour. If she is in labour at this time, this is reasonable but there is no evidence to suggest that such effects on the foetus/neonate are long-lasting.	Thank you for your comment. The evidence for this recommendation has not been reviewed for this update, therefore we are unable to make changes to the recommendation.
College of Mental Health Pharmacy	19	Full	8.9.1.54	727	Assess for…..and then do what?	Thank you for your comment. The recommendations has been amended in light of your comment.
College of Mental Health Pharmacy	20	Full	8.9.1.59	728	Depot antipsychotics….this doesn't quite make sense as the depot is in the mother, not the baby. The foetus is exposed via the placenta and the neonate via breastmilk. So a mother	Thank you for your comment. Depot antipsychotics have been removed from this recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					who stops her depot will certainly have medication in her breast-milk for some time afterwards but she would also have medication in her milk if she took an oral antipsychotic and this could also cause EPS in the neonate. The neonate will cease to be exposed immediately breast-feeding stops (depot or oral).	
Department of Health	1	General	General	General	The Department of Health has no substantive comments to make regarding this consultation.	Thank you for your comment
Elective Cesarean	1	General	General	General	While there are evidently many positive statements and recommendations in this guideline, my organisation is concerned by a few specific areas in these draft NICE documents, and hopes that the comments below will be useful for the GDG. Please note that where comments appear related to the Appendices, they may also refer back to related areas in the NICE and FULL versions of the guidance. Type of Support This guideline appears to assume that in all cases of tokophobia - because it is considered a 'mental health' issue,- it only warrants mental health interventions/ psychological treatment. However, one of the most common presentations of tokophobia in women is a request for elective caesarean birth, which does not necessarily require any mental health	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation. In response to the specific phrases mentioned in the full guideline. The following amendment has been made: "Similarly fear of childbirth in pregnancy has been associated with an increased risk of costly emergency ~~or elective~~ Caesarean sections." It is not possible to respond to comments on other NICE guidance referred to, for instance, 'National costing report: Caesarean section (November 2011)' or the caesarean section (CG 132) guidance, as it is outside the scope of this guideline. In response to the comments on the caesarean delivery rates being considered as a 'harm' in

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					intervention or support, but rather the promise of a surgical one. Indeed in cases where the woman is fully informed of the risks and benefits of surgery, and is very clear in her mind that this would be the overriding factor in reducing or even eradicating entirely her symptoms of birth anxiety and fear, having to attend 'mental health' sessions aimed at avoiding a caesarean birth can often exacerbate her stress and anxiety instead. Repeated Negative Reference to 'ALL' Caesarean Types This concern comes under 'Potential inconsistencies or any disagreement with the Guideline'. Both versions of this guideline are littered with phrases similar to, "There was some evidence for an increased risk of caesarean delivery", but without specifying whether the caesarean delivery was an emergency or planned one, and whether it was wanted or unwanted by the women. Of course neither may indeed always be known, but when this is the case, NICE guidance should take care to note the fact somewhere prominent in each guideline version. Otherwise it encourages the	section 8.4.9 of the full guideline. The subheading for this section is 'course of pregnancy, obstetric and neonatal complications' and includes other outcomes that would not necessarily be considered as a harm in themselves but might be considered to be adverse events if an association was found with psychotropic medication, in this instance benzodiazepines, for example, birth weight or gestational age.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					misconception that a caesarean is a caesarean is a caesarean, and any caesarean is a negative outcome. This is not true, and also the risks and costs of an emergency caesarean far outweigh those of an elective caesarean – in particular one that is performed at 39+ gestational weeks. Until all of NICE guidance is fully consistent, and separates these two very distinct delivery types with very different physical and psychological health outcomes, the confusion, misunderstanding and bias that surround the subject of caesarean birth will only continue. CG132 and QS32 are particularly useful to look at in this respect. For example, my organisation would like to see the statement below deleted or at the very least revised (it appears on page 36 of the FULL guideline; in lines 7-9): "Similarly fear of childbirth in pregnancy has been associated with an increased risk of costly emergency or elective Caesarean sections." It expresses an attitude that this association is a negative one, and a situation that should be avoided wherever possible. But while this may be perfectly reasonable to state in regard to an emergency CS, the same cannot and should not be said of an elective CS. Especially when you	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					consider that for many women with a fear of childbirth, the availability and comparative safety of a more controlled elective caesarean birth is exactly what they want. It is as though the guideline has been written with an elective caesarean in mind as a 'last resort only' (or even not in mind at all in certain areas), and therefore not properly addressed and discussed. This would fall under 'Points or areas that are not covered, but which appear to fall within the scope of the guideline', which Stakeholders have been asked to comment on. Inconsistent Message on Caesarean Rates 3.5.4 on page 30 of the NICE document 'National costing report: Caesarean section (November 2011)' reads: "Improved provision of mental health support could lead to improved psychological outcomes for women with anxiety about childbirth, and a potential reduction in caesarean section rates for such women." Given that NICE has elsewhere repeatedly assured the public that it "has not sought to define acceptable caesarean section rates", the statement above can be interpreted as support for reducing them. NICE may not be proposing a	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					specific number but it is presenting a reduction as a good thing. The question is whether the statement refers only to reducing rates of emergency CS, or reducing all CS, and if it is the latter, then NICE is not only contradicting itself both across different guidelines and within related documents of a single (CG132) guideline, but it is feeding the idea that one of the expected outcomes of offering mental health support to women is to reduce rates of CS. As such, this could certainly have an effect on the 'Development Group's interpretation of the evidence.' Furthermore, it is highly questionable whether such a focus on reducing CS rates would result in "improved psychological outcomes" for the tokophobic women who want a caesarean, as discussed in the Hofberg study (see note. 60), and as evidenced in communication from women with my organisation over the past decade. And again, on page 672 of the FULL guideline, caesarean delivery is listed under the heading "harm". My organisation wouldn't disagree with this for an emergency CS, but for an elective CS, and particularly one that was welcomed by the mother, the two birth types should either be	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					listed separately or NICE should include a note in each table to the effect of: "Outcomes are only known for 'all' caesareans, emergency and elective combined, which makes it difficult to draw any precise conclusions." Unfortunately, even the current NICE Quality Standard on caesareans QS32 contains the QS9 Outcome, "Rates of complications in women who have had a caesarean section." For this information to be fully useful in future research, it's essential that type of caesarean is always recorded. Inconsistent Message on Caesarean Cost In contrast to the example above that reads, "Similarly fear of childbirth in pregnancy has been associated with an increased risk of costly emergency or elective Caesarean sections.", it is worth the GDG looking at the extracts below, which appear in NICE's 'National costing report: Caesarean section (November 2011)': The '2011 NICE. Caesarean Section (Update). Costing report. Implementing NICE guidance' states that in fact it is the provision of mental health support that is more costly than an elective caesarean:	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					"1.4.5 The care of women who request a caesarean section, including the provision of mental health support for women with anxiety about childbirth, is likely to lead to a resource impact for many NHS organisations." Furthermore: "3.3.4 Costs for providing mental health support to women with anxiety about childbirth are based on the assumption (from a range of clinical opinions) that 92% of women with anxiety about childbirth have low-level anxiety and will receive one or two hour-long sessions with a midwife, costing £52 per hour (1.5 hours assumed). It is assumed that the remaining 8% will have higher-level anxiety and will receive one hour-long session with a midwife, and a further three hour-long sessions with a clinical psychologist, costing £81 per hour." In summary, the "Cost of offering mental health support to women with anxiety about childbirth - £1080". Given the choice, most women requesting a caesarean birth would prefer that this NHS money is spent directly on their preferred planned caesarean surgery.	
Elective Cesarean	2	Full	3.7	58	Page 58 (3.7) discusses "USING NICE EVIDENCE REVIEWS AND RECOMMENDATIONS FROM	Thank you for your comment. As a result of yours, and other stakeholder comments, a

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					EXISTING NICE CLINICAL GUIDELINES - When review questions overlap and evidence from another guideline applies to a question in the current guideline, it might be desirable and practical to incorporate or adapt recommendations published in NICE guidelines." My organisation would like to suggest incorporation or adaptation of the following statements from CG132 in relation to women who request a caesarean: "For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS." "An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS." CG132 also states: "When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner." Unfortunately, my organisation is aware of	cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					cases where both tokophobic and non-tokophobic women are being refused a planned caesarean in UK hospitals, despite NICE CG132 and QS32, and also, where women with anxiety about childbirth are being forced to undergo mental health assessments against their will, and to provide psychological 'proof' of their mental health condition, regardless of the CG132 recommendations to "offer [mental health] referral", and to also "offer a planned CS". Could NICE please include something concrete in both versions of this guideline to ensure that it is completely clear what the CG132 maternal request recommendation says about women being offered a planned CS – including women with anxiety about vaginal birth. Tokophobia as a Mental Health 'Disorder' This guidance reads, "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."	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					My organisation has often questioned whether it should be considered abnormal, irrational or inappropriate to fear the very real and unpredictable events that can occur during and after childbirth. For example, a very high proportion of women will end up with an instrumental or emergency caesarean delivery, and women with fear or anxiety have been shown to have an even greater risk of experiencing these. Historically, and still in developing world settings, maternal and neonatal mortality is high during childbirth, making it one of the riskiest things a woman will do. My organisation appears not to be alone in this view. A quick check found that while tokophobia is referred to throughout this guideline, the word itself does not appear in NICE's CG132, but more interestingly, it does not appear on the UK's Mental Health Foundation's website under its A-Z of mental health conditions ('fear of birth' does not appear either; and I confirmed this via phone). http://www.mentalhealth.org.uk/help-information/mental-health-a-z/ Tokophobia/ fear of birth also doesn't appear in a similar American website that summarises "Symptoms and Treatments of Mental Health Disorders" by John M Grohol on June 25, 2014. http://psychcentral.com/disorders/	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					That said, my organisation is simultaneously reluctant to see tokophobia removed from its home in 'mental health' guidance because in hospitals where there are blanket policies against supporting maternal request caesareans (regardless of NICE CG132 guidance and QS32), 'proving' tokophobia can often be a woman's only chance of arranging the birth of her choice. And where that woman does not have the financial means to schedule her preferred caesarean birth at a private hospital or through a private obstetrician, this can directly affect the 'quality of opportunity' for women without these means – and also without the ability to articulate and properly 'present their [tokophobia] case'. Here is an example of what one hospital is writing to pregnant women: "where there are neither medical nor proven psychological grounds, we are not in a position to provide the choice of a caesarean section".	
Elective Cesarean	3	Full	App 1		*(l) Mental health disorders during pregnancy and the postnatal period can be associated with, or aggravated by, a number of factors, including:* *- psychosocial factors, such as the demands and expectations of being a mother in addition to the psychological effects of a traumatic delivery*	Thank you for your comment. You are quoting the Epidemiology of the scope, which is to set the background scene of the reviews undertaken in this guideline. We do not underestimate the physical effects that can lead to mental health disorders but this was outside of our remit.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					But what about the physical effects that can also lead to mental health disorders? For example, when a woman is incontinent of urine or faeces, unable to have sex or needs surgical reconstruction of her pelvic floor region due to prolapse or similar, this can destroy her self-confidence, self-esteem, and in some cases ruin her career when she is unable to return to work. *- social isolation* *Again, this can occur where physical trauma is so severe that the woman avoids leaving her home.*	
Elective Cesarean	4	Full	App 1		*(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.* The mother-infant relationship of women can sometimes be adversely affected following a traumatic (including emergency caesarean or instrumental) birth or a birth that is very different to the one they wanted, and women who request a caesarean are often trying to remove the risk of these outcomes as far as possible.	Thank you for your comment, which relates to the epidemiology in the scope of this guideline update. This section of the scope is to highlight the importance of mother infant interaction, hence it's inclusion in our review.
Elective Cesarean	5	Full	App 1		"2.2 Current practice"	Thank you for your comment. Reference has

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					One of the problems with the current practice of tokophobia treatment is that it is very often leaned towards 'convincing' the woman to have a vaginal birth – instead of exploring, understanding, respecting and supporting her preference for a planned caesarean. The idea that a caesarean is inherently 'bad' for a woman often permeates current knowledge and practice to such an extent that discussions are not always sufficiently 'informed' or 'individualised'.	been made to the Caesarean Section guideline.
Elective Cesarean	6	Full	App 1		"3.1. Population - b) Specific consideration will be given to the needs of black and minority ethnic groups, socioeconomic groups, asylum seekers, women who are victims of trafficking, and women with learning and physical disabilities." These women are particularly vulnerable if they are tokophobic and want to request a caesarean birth. Even the most articulate, literate, educated and confident women can face an immense battle when trying to arrange a caesarean birth, and again, it is only those with the financial means that can fall back on private maternity care if their NHS hospital refuses to follow NICE guidance. The women in group b) above have virtually no chance, leaving the promise of 'choice' in the UK's maternity services a very often narrow and	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					prescriptive one. Home birth? Yes. Water birth? Yes. VBAC? Yes. Epidural? If you need it and if one is available, yes. Caesarean? Very often, no. The current situation surrounding maternal request and tokophobia is actually very similar to that of the history of mental health and abortion. The 1938 Dr Alec Bourne case set a legal precedent for performing an abortion to preserve a woman's mental health, and so between the Bourne ruling and the 1967 Abortion Act some women were able to arrange abortions with the consent of a psychiatrist, to protect their mental health. Wealthier women were more likely to be able to pay to see a psychiatrist who could agree to a safe abortion, but women from lower socio economic groups would have had no option but to seek illegal (and more dangerous) methods for ending a pregnancy – or to have no abortion choice at all. Ironically, given the controversy that surrounds the subject of abortion, in 2014 it is easier for a woman to plan a pregnancy termination that it is for her to schedule a prophylactic planned caesarean delivery. This needs to change.	
Elective Cesarean	7	Full	App 1		*3.3 Clinical management* *3.3.1 Key clinical issues that will be covered* *a) The prevention of mental health disorders in pregnancy and the postnatal period.*	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					A planned caesarean birth really needs to be recognised in this guidance as one aspect of clinical management that really can help prevent disorders for many tokophobic women, both during pregnancy and during the postnatal period.	
Elective Cesarean	8	Full	App 1		"3.4 Main outcomes - c) Quality of life." With all the criticism surrounding collective caesarean birth rates, it can be very difficult for some medical professionals to understand how, for some women, a caesarean birth can provide a better quality of life. My organisation hopes that this GDG will recognise this.	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
Elective Cesarean	9	Full	App 1		"3.5 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." Again, it would be beneficial if this guideline recognised here that one possible, extremely beneficial intervention for some tokophobic women is an elective caesarean birth. Perhaps an assessment of patient experience following this birth method could be included by NICE?	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
Elective Cesarean	10	Full	App 1		"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	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					quality of the mother–infant interaction?" My organisation would like to see planned caesarean birth included here as an intervention for tokophobic women who request it.	added to the recommendation.
Elective Cesarean	11	Full	App 1		"3.6 Economic aspects - Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions." Given that the NICE CG132 (see 'Health Economics' section of the FULL guideline) found just an £84 cost difference between a planned CS and a planned VD once urinary incontinence was factored in (as just one downstream adverse effect to be considered postpartum), and given the estimated cost of mental health counselling estimated in the NICE (see note. 1 above) National costing report: Caesarean section (November 2011), offering a planned caesarean remains a cost effective intervention, contrary to common perception.	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
Elective Cesarean	12	Full	App 1		*"4.1.2 Other related NICE guidance - Caesarean section. NICE clinical guideline 132 (2011)"* CG132 is clearly included here, which is excellent. Unfortunately however, instead of just being 'offered' referral to a mental health specialist, the experience of women who have contacted my organization has been far more	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					pressured. Some women have expressed that they do not feel they have a mental health disorder that needs 'fixing' or 'treating' at all; they just want a caesarean, and it is only the thought of not being able to plan ahead for a caesarean that is causing their anxiety.	
Elective Cesarean	13	Full	App 1		"Review questions. Experience of care - 1.3 What modifications to services improve the experience of using services for women with a mental health problem who are antenatal or postnatal?" Suggested answer for inclusion – the availability of and support for caesarean birth.	Thank you for your comment. We are unable to make changes to the review questions at this stage of the process.
Elective Cesarean	14	NICE	Introduction	3	For some women, a planned caesarean offers relief from their fear of childbirth; it makes them feel more in control and less vulnerable. Yet very often the midwives, doctors and obstetricians that they encounter communicate their own personal and professional aversion to, and even 'fear' of, caesarean birth. Some midwives, largely as a result of their education and training but also sometimes because of an ideological viewpoint, do not fully understand the benefits of surgery or why a woman might choose it. Obstetricians meanwhile, can be under considerable pressure to keep their overall caesarean rate low, and fear professional peer or management criticism if they are seen to 'give in' to caesarean requests too readily. And for mental health professionals, they may see it as their	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					responsibility and role to try and 'fix' birth phobia, and perceiving a caesarean outcome as somehow failing in this effort. It's similar to the sense of personal and professional achievement that midwives can sometimes express when vaginal delivery is achieved, but the problem is that it places birth method at centre stage and can get in the way of the "person-centred approach to provision of services [NICE says] is fundamental…".	
Elective Cesarean	15	NICE	Patient centred care	5	*Paragraph 2- Patient-centred care - "Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals."* This is very welcome, and chimes with the NICE Quality Standard statement quoted above. Unfortunately, my organization has growing evidence that in the case of a maternal request CS, no matter how informed the woman's decision (and that of her husband/partner) is, the planned CS is still refused.	Thank you for your comment. It is beyond the scope of the guideline to address childbirth delivery services.
Elective Cesarean	16	NICE	Strength of	7	Strength of recommendations - "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." As referred to above, in terms of the "offer" of perinatal mental health support, the reality is that for many women, if they don't accept this	Thank you for your comment. It is beyond the brief of the scope to address childbirth delivery methods. The recommendation on tokophobia has been revised and now references the Caesarean Section guideline CG132.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					offer of intervention, they will have absolutely NO chance of having their caesarean request supported. Going through with it essentially becomes compulsory for them. For truly tokophobic women who desperately want a caesarean, this process can feel like a 'test' that they must pass – and that they dread they will fail. Will they be deemed 'tokophobic enough'? My organisation is aware of one woman who went through this process but says she wasn't truly tokophobic at all – she simply knew that it would be the only way to get the hospital to agree to her maternal request. This latter example is included here with extreme caution due to the awareness that it could negatively impact on true tokophobic cases (who may not be believed). Again, the 'offer' of counselling intervention/ treatment, if women are effectively forced to accept it, can become the source of another layer of pregnancy stress and anxiety for some. This is wholly unhelpful and doesn't seem to reflect the spirit of this NICE guidance.	
Elective Cesarean	17	NICE	Key prioritie s	10	Coordinated care -"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." The expected intervention for a tokophobic	Thank you for your comment. Reference is now made to CG132, Caesarean Section.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					woman is perinatal mental health support, but the intervention many women are seeking is a scheduled caesarean, and a huge part of alleviating their stress and anxiety is having their caesarean agreed to in a timely manner. If, as the pregnancy progresses, the woman changes her mind about the caesarean, this is far a less traumatic than being refused a caesarean. My organisation is aware of a number of cases where a tokophobic woman has terminated her much-wanted pregnancy when a caesarean was not agreed to early in the pregnancy (this is important given the statutory limits on abortion dates), but since the November 2011 publication of NICE CG132, this should not be happening. Maternal request CS by an informed woman who has discussed the risks and benefits of surgery should be supported. And this is why it's so important for this guidance to reinforce the CG132 and QS32 recommendations, and ensure that the most vulnerable women requesting a caesarean do not face a lengthy and distressing battle. Many tokophobic women simply cannot cope with this. Note - the above also fits in with (pg. 11): "the need for prompt treatment because of the potential effect of an untreated mental health	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					problem on the fetus or baby".	
Elective Cesarean	18	NICE	1.4.3	29	"Recognising mental health problems and referral" For tokophobic women who want a caesarean birth (i.e. not all tokophobic women), the issues described here can be very quickly, easily, and cost-effectively alleviated. If they are reassured that a caesarean is possible following a risk/benefit discussion about their own individual case, this can offer important relief in the interim. The sooner this discussion with a consultant obstetrician can be arranged (if this is the final decision-maker), the better for these women. In reality however, very often when a tokophobic woman first mentions a caesarean preference, they are presented with a mix of shock, criticism and resistance, or platitudes and reassurances that this feeling can and will pass. This can increase the woman's anxiety, adding conflict and distrust into the mix of emotions and concerns. My organization is aware of cases where women have sought help from their own GP, presenting with depression and anxiety directly related to refusal of a caesarean birth, and this adds to the pressure on NHS services, and impacts on total overall cost of the pregnancy. It is important that "referral" in this context includes referral to a consultant	We have now cross referenced the CG132 guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					obstetrician who can discuss the woman's cesarean request.	
Elective Cesarean	19	NICE	1.7.8	43	Suggested additional wording in bold: Traumatic birth, stillbirth and miscarriage - …the woman and her partner and family should be offered a follow-up appointment in primary or secondary care so that they can fully understand what has happened and whether anything might have prevented it." My organisation feels that the above wording, or similar, is important to add here because very often the focus in the aftermath of stillbirth can be on bereavement counselling, and for some parents whose babies have died at full term, they may also feel very angry about something specific that has happened and feel that something could have been done differently. They may also want reassurance about whether this could happen again in the future or what could be done to reduce the risk. It may be that nothing could have prevented it, but as my organisation has commented in past NICE publication drafts, there is a concern that women are not always fully informed about the increased risk of stillbirth after 38/39 weeks' gestation for example (even though the risk is not exponential, there remains a peak period of risk during which different obstetric and maternal decisions may be made), and it is	Thank you for your comment, but the GDG did not feel that adding the text you have suggested would be advisable because of potential legal repercussions. The GDG saw this follow-up appointment in terms of the psychological management of trauma; to say anything further would be beyond the scope of the guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					often only in a pregnancy subsequent to a late-term stillbirth that this information is shared with women.	
Elective Cesarean	20	NICE	1.2.3	17	"Involve the woman, and if she agrees her partner, family or carer, in all decisions about her care and the care of her baby." My organisation welcomes this recommendation, particularly as it relates to decisions during the antenatal and intrapartum period, but remains concerned that in the context of decisions related to tokophobia and a caesarean birth, NICE recommendations such as this are not being followed. It's important for this updated guidance to reinforce the recommendations on CS in CG132 and QS32.	Thank you for your comment.
Elective Cesarean	21	NICE	1.2.6	18	*"Ensure that… 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."* My organisation welcomes these recommendations, for the same reasons as cited in the notes above.	Thank you for your comment.
Elective Cesarean	22	NICE	1.3.1	18	"Provide culturally relevant information on mental health problems in pregnancy and the postnatal period. Ensure that the woman understands that mental health problems are not uncommon during these periods and instil hope about treatment."	Thank you for your comment. It is beyond the brief of the scope to address preferred childbirth delivery methods. The recommendations go as far as they can to support women who fear childbirth and we do now make reference to CG132.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					My organisation is concerned about the different interpretations of this recommendation in the context of tokophobic women requesting a caesarean birth. What would "instil hope" in the case of many of these woman is the knowledge and assurance that a caesarean will ultimately be supported, following a discussion to first determine that this is an informed decision, and to establish whether the woman is interested in the offer of mental health support to explore her fears and possibly overcome them. If the woman declines this offer, or following counselling still wants a caesarean, then it is this surgical 'treatment' that would be most successful in removing her anxiety and possibly depression.	
Elective Cesarean	23	NICE	1.3.3	18	This section demonstrates one of the problems with discussions and guidance about how to 'treat' tokophobia. Because it is classified by NICE as a "mental health" problem, the proposed treatment is understandably psychological and not physical. However, for tokophobic women who only fear one type of birth (vaginal birth) and who feel very comfortable with and reassured by another (planned caesarean birth), the answer can be a physical rather than psychological one. CG132 refers to this, but again, it would be helpful to include it here too. My organisation is comforted by the fact that there are psychiatrists, psychologists, midwives	We have now cross referenced the CG132 guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and doctors who absolutely agree with this, and are very supportive of a tokophobic woman's caesarean request, but it is not yet universal, and this is where NICE guidance can help.	
Elective Cesarean	24	NICE	1.3.7	20	*"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"* This is an excellent recommendation.	Thank you
Elective Cesarean	25	NICE	1.3.9	21	*"If a pregnant woman with a mental health problem chooses not to have treatment or stops treatment… discuss and plan how symptoms will be monitored"* This is potentially problematic in the context of a tokophobic woman requesting a caesarean who either wants to decline the offer of mental health support or who decides she wants to stop this support after one or more sessions. If she has provided lucid reasons for her caesarean birth preference, and explained that scheduling a caesarean will greatly alleviate her anxiety and distress during the pregnancy (for many women, some level of anxiety always remains, e.g. fear of going into labour earlier than the scheduled caesarean), it won't suffice to instead discuss and plan how her tokophobic symptoms will be "monitored" or to have "increased contact and support".	We have now cross referenced the Caesarean Section CG132 guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					What she needs is support for a scheduled caesarean – unless of course there are exceptional circumstances outside the scope of risks and benefits covered under maternal request in CG132. Suggested additional line of text here: *"If a pregnant woman with tokophobia chooses not to have treatment or not to complete treatment because she wants a caesarean birth, this should be offered."*	
Elective Cesarean	26	NICE	1.4.2	29	"Ensure that all communications with maternity services (including those relating to initial referral) include sharing of information on any past and present mental health problem." This is an excellent recommendation, though it is unclear precisely who must be responsible for the "sharing of information". It can be particularly distressing for women to have to repeat their reasons for wanting a caesarean if these reasons include past trauma of any kind; is it NICE's intention here that the woman fully communicates her reasons once, and this background information is then shared with others ahead of future meetings? Also, there is an important distinction to made here between sharing information that will help the maternity team care for a pregnant woman	Thank you for your comment. The recommendation has been amended to make it clear that "All health and social care 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." The need for psychological treatment would be covered in the woman's care plan.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					with mental health problems, and better understand her needs, and insisting that information from past medical records is shared in order to provide concrete 'evidence' to support a maternal caesarean request (the latter does sometimes happen). Suggest adding wording: "…present mental health problem where this is needed for psychological treatment."	
Elective Cesarean	27	NICE	1.6.7 &	35	And 1.6.8 In the case of a tokophobic woman who is requesting a caesarean and this request is not being supported, but who is experiencing depression as a result, my organisation is not aware of any evidence that the interventions described here will best alleviate the woman's symptoms in all cases. My organisation is aware of a case where medicine with known side effects were suggested as treatment for a tokophobic pregnant woman (who did not want to take it) rather than agreeing to her caesarean request – even though she made clear that her onset of anxiety and depression was a direct result of being refused a caesarean.	Thank you for your comment, a cross-reference to the caesarean section guidance (CG 132) has been added to recommendation 1.8.5.
Elective Cesarean	28	NICE	1.6.10	36	"For women with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss their fears with a healthcare professional with expertise in providing perinatal mental health support."	Thank you for your comment. A cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation. As outlined in the introduction of the full guideline (chapter 2), the GDG took the view that fear of childbirth secondary to traumatic childbirth

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					There will be some multiparous women who request a caesarean too, and whose tokophobia is a result of a previous traumatic birth. Again, there is the option of counselling, and reassurance that this second experience will be 'different and improved', but ultimately, if the woman is convinced that a caesarean is her birth choice preference, this should be supported. Suggest adding: "If a pregnant woman with tokophobia chooses not to have treatment or not to complete treatment because she wants a caesarean birth, this should be offered."	(sometimes referred to as 'secondary' tokophobia) may be more helpfully conceptualised as a trauma symptom or as part of a presentation of post-traumatic stress disorder (PTSD) and therefore treatment should be informed by existing NICE guidance on PTSD, and where appropriate the caesarean section guidance.
Elective Cesarean	29	NICE	1.7.5	43	Suggested addition to text in bold: "If the woman wishes, refer her for a specialist mental health assessment or counselling."	Thank you for your comment. Please see the revised recommendation in light of other stakeholders' comments.
Elective Cesarean	30	NICE	1.7.9	43	"Encourage women with a mental health problem to breastfeed, except in rare circumstances. However, support each woman in the choice of feeding method that best suits her and her family." This is a good example of the kind of balanced wording that my organisation would like to see more of in relation to birth plan choices. By all means encourage a tokophobic woman to consider giving birth vaginally, but equally, support each woman in the choice of birth	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					method (including a caesarean) that best suits her and her family.	
Elective Cesarean	31	NICE	1.7.14	44	"Recognise that mental health problems may affect the mother–baby relationship, but reassure the woman that any problems with the relationship are likely to improve with effective treatment of the mental health problem." This is ironic in cases where the mother knows herself that effective treatment (i.e. agreeing to a caesarean birth plan) will improve her mental wellbeing, but the hospital is refusing to comply.	Thank you for your comment. This recommendation has been amended in light of stakeholder comments. Mode of delivery as an intervention is outside the scope of this guideline.
Elective Cesarean	32	NICE	2.1	47	"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." A planned caesarean on maternal request is also referred to as a prophylactic caesarean, which is interesting in his context.	Thank you for your comment.
Elective Cesarean	33	NICE	App A	59	*1.1.1.2* *Healthcare professionals should work to develop a trusting relationship with the woman… explore the woman's ideas, concerns and expectations… [1.1.1.2]* *Is it possible to keep this helpful 2007 text in?*	Thank you for your comment. While this recommendation was described as 'deleted' it was in fact superseded by several other new recommendations based on a review if the experience of care undertaken for the updated guideline. Exploration of the woman's ideas and concerns is still covered in the new guideline (for example, in recommendation 1.4.3) and developing trusting relationships is covered in the Service User Experience in Mental Health guidance, which is referenced in the first

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						recommendation in the new guideline.
Elective Cesarean	34	NICE	App A	60	*1.2.1.3* *Is this something you feel you need or want help with? [1.2.1.3]* *Is it possible to keep this 2007 text in?*	Thank you for your comment. Evidence reviewed in the full guideline (see chapter 5) did not find that the additional question added to the depression identification questions ('Whooley questions') about the need for help had conclusive benefit, and resulted in poor discrimination between true-negative and false-negative cases which may lead to an increased risk of depression being missed or lost to follow-up.
Elective Cesarean	35	Full	2	15	L28-30- The optimisation of psychological wellbeing, as opposed to the management of mental health problems, is not covered in this guideline, however, the importance of this is implicit. This is a good point.	Thank you.
Elective Cesarean	36	Full	2	16	L 15-16- Women might not want to tell anyone about their feelings because of the stigma of mental health problems This is a particular concern for some women who are tokophobic, but who don't view themselves as having a 'mental health' problem and don't want it recorded in their medical records as such. On a practical level, life insurance companies for example will often ask questions about any referral to psychiatric care, and women have communicated to my organisation that they feel under pressure to go down the 'mental health' route in maternity	We agree stigma is a significant problem for women with a range of mental health problems and have therefore included this issue in the full guideline, section 2.5. Recommendation 1.8.7 cross-refers to the caesarean section guidance (NICE clinical guideline 132) that provides guidance on maternal requests for caesarean sections

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					wards or else face no caesarean agreement at all. L 17-18 Similarly, women who have such high levels of anxiety about giving birth vaginally that they have (even fleetingly) considered terminating their pregnancy may fear being stigmatised as a non-maternal or 'unnatural' mother. I personally recall a midwife at a conference in the U.S. (in response to my recounting a tokophobic woman in the UK who terminated her pregnancy after being refused a CS) whose less than sympathetic response inferred that perhaps this woman was not really going to be a good mother anyway since she was willing to abort her baby for this reason.	
Elective Cesarean	37	Full	2	16	L 25-28 The impact of any mental health problem may often require more urgent intervention than would usually be the case because of its potential effect on the fetus/baby and on the woman's physical health and care, and her ability to function and care for her family. This is precisely why it's unhelpful to make tokophobic women wait until a late gestation age before scheduling their caesarean. My organisation is concerned that some psychologists may recommend waiting until very late in the third trimester – to allow time for the woman to overcome her fear of childbirth – before confirming support for her	Thank you for your comment. It is however difficult to comment on individual variations of treatment and there was no evidence identified that explored when such referrals for caesareans should be made from a mental health perspective.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					caesarean request, and this can make for a very unsettling and stressful pregnancy experience.	
Elective Cesarean	38	Full	2	19	L14-17-*There is evidence that mental health problems in pregnancy and the postnatal period are associated with adverse outcomes for the fetus and the baby as well as for the woman herself.* *See research in note 60 below.*	Thank you for your comment. We agree and have reviewed this evidence in the full guideline.
Elective Cesarean	39	Full	2	20	*L*4-5: Postnatal mental health problems in women, if chronic, can be associated with adverse cognitive outcomes for their children and mental health problems PTSD is more common following emergency CS than planned CS. See research in note 60 below.	Thank you for your comment. We agree and have reviewed this evidence in the full guideline.
Elective Cesarean	40	Full	2	24	L41-44 Other specific phobias of relevance to pregnancy include needle phobia, which can restrict pain relief options (such as an epidural during labour) for these women and lead to them refusing blood tests -- as a result medical conditions might go undetected, with potentially serious consequences (Cantwell et al., 2011). It is evident that not all tokophobic women will request a caesarean, as there are aspects of this birth type that they fear too; my organisation is aware of cases where the woman's fear of needles, related to the spinal injection, led to her requesting general anaesthesia instead. Effectively, these women want the exact opposite of a 'birth experience' – wanting no experience of the birth at all. My organisation is	Thank you. We agree other phobias are important and included these in our searches and our anxiety recommendations. We have referred to the issue of the consequences of needle phobia in the full guideline and have cited the same reference.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					not advocating this choice, but adding the comment to demonstrate how it may restrict anaesthetic options in an elective or emergency surgery too.	
Elective Cesarean	41	Full	2	34	*l25: £3,647 – roughly £54 million annually (range £52 to £65 million). It was acknowledged that this value might in reality be a conservative estimate, given that the condition was likely to have longer-term consequences in terms of health status and health service utilisation over the woman's and her child's lifetime* *The cost of PND described here is important, especially given that women who experience a traumatic, instrumental or emergency caesarean birth, or who do not get the birth they want, are more prone to PND.*	Thank you for your comment. In this section existing evidence on the financial implications of the presence of mental health problems in pregnancy or in the first postnatal year was reviewed. It is very likely that women who experience a traumatic, instrumental or emergency caesarean birth, or who do not get the birth they want, are more prone to PND; however this wasn't discussed in Petrou et al (2002).
Elective Cesarean	42	Full	2	36	L 4 and L 7-9 Again, in the context of an "economic burden", and given the Health Economics section of the NICE CG132, which states, "On balance, this model does not provide strong evidence to refuse a woman's request for CS on cost effectiveness grounds", my organisation feels that the sentence below should be removed or altered please: "Similarly fear of childbirth in pregnancy has been associated with an increased risk of costly emergency or elective Caesarean sections." The cost of these very different types of surgery are vastly different and it would be remiss of this NICE guidance to lump them together as a collectively "costly" birth method after the	Thank you for your comment. As suggested "elective" was removed and the sentence now reads "Similarly fear of childbirth in pregnancy has been associated with an increased risk of costly emergency Caesarean sections".

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					efforts of the CG132 GDG and Stakeholders to distinguish between the two.	
Elective Cesarean	43	Full	3.4	41	*l 11 What is really important for the service user?* *This PICO outcome here is crucial with a caesarean request.*	Thank you for your comment. This section of the guideline is methodological (with this sub-section detailing factors the GDG consider in defining critical outcomes) and is not concerned with specific interventions
Elective Cesarean	44	Full	3.7	58	See note 2 above re: 3.7	Thank you for your comment. As a result of yours, and other stakeholder comments, a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation
Elective Cesarean	45	Full	3.8	60	L 10-12 3.8 the GDG took into account the trade-off between the benefits and harms of the intervention/instrument, as well as other important factors, such as economic considerations, My organisation is not fully convinced that this was achieved in the case of a planned caesarean intervention, given the statement included on page 36, referred to in note 1 above.	Thank you for your comment. This section of the guideline is methodological (with this sub-section outlining the approach used to move from the evidence to recommendations) and is not concerned with specific interventions or mode of delivery
Elective Cesarean	46	Full	5.3.8	140	L 33-35 Suggested additional text here: 5.3.8.2 Ensure that all communications with maternity services (including those relating to	Thank you for your comment, the recommendation has been amended in light of your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					initial referral) include sharing of information on any past and present mental health problem so that the woman does not have to repeatedly communicate her situation.	
Elective Cesarean	47	Full	5.4.	144	L16- 5.4.4 "the needs of and concerns for the fetus or baby" An elective CS at 39+ weeks' gestation is statistically very safe, and certainly safer than an instrumental or emergency CS delivery. Therefore concerns about the health of the baby should not influence decisions about supporting a cesarean, as per CG132.	Thank you for your comment. This section of the guideline is concerned with assessment and is not concerned with specific interventions or mode of delivery
Elective Cesarean	48	Full	5.4.7	146	L8-9 5.4.7 Linking evidence to recommendations "an accurate assessment of a woman's needs and identification of the best available treatment or care option" My organisation supports this statement and trust that it extends to a caesarean birth maternal request being supported.	Thank you.
Elective Cesarean	49	Full	5.4.7	147	L33- *Trade-off between net health benefits and resource use* Again, as per CG132, "On balance, this [planned caesarean on maternal request] model does not provide strong evidence to refuse a woman's request for CS on cost effectiveness grounds".	Thank you for your comment. In this section the cost effectiveness of assessment systems for women with a mental health problem in pregnancy or the postnatal period was discussed. This section hasn't covered evidence on the cost effectiveness of CS.
Elective Cesarean	50	Full	6.2.5	180	*L 8- 6.2.5 Unmet needs: specific intervention needs* The BMJ letters below from doctors and	Thank you for your comment. As a result of yours, and other stakeholder comments, a cross-reference to the caesarean section guidance (CG 132) has been added to the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					midwives, and my organisation's responses to them, highlight the fact that NICE recommendations on maternal request caesareans (including those from tokophobic women) are currently unmet, and that there are maternity health care professionals who do not understand the NICE CG132 guidance, maintaining that a caesarean request should not be supported as a standard level of care. My organisation would appreciate if some or all members of the GDG could read these letters and my organisation's responses, as they help inform other comments submitted about this guideline update. Thank you. August 7, 2013 Re: NICE promises on infertility and caesarean section are unmet http://www.bmj.com/content/346/bmj.f3814/rr/656821 August 7, 2013 Re: NICE says caesarean section is not available on demand unless clinically indicated http://www.bmj.com/content/347/bmj.f4649/rr/656733	recommendation
Elective Cesarean	51	Full	7.5.4	390	*L 11-12 Summary of findings table for effects of music therapy during birth compared with treatment as usual on depression outcomes* Approximately one quarter of women in the UK each year have a caesarean birth, but whereas	Thank you for your comment. Mode of delivery (as an intervention) is outside the scope of this guideline and could not therefore be prioritised for further research

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					there are sufficient numbers of studies to produce a whole table of findings in this guideline update on "music therapy during birth", there is no such table of findings and evidence on the different types of caesareans experienced by women with mental health problems, or whether there are different outcomes in their short- and long-term psychological wellbeing following each. The lack of research into planned caesareans (and specifically maternal request caesareans) versus other modes of delivery for tokophobic women, demonstrates that more needs to be done. If more was known about which groups of women are more likely to end up needing an emergency CS, and if there was more research into the patient experience of women who have an elective CS, this would be extremely useful.	
Elective Cesarean	52	Full	7.5.9	417	7.5.9 Clinical evidence for effects on fear of childbirth outcomes (by intervention) There was no evidence for clinically or statistically significant benefits of pre- delivery discussion/psychoeducation on mode of delivery (elective caesarean [p=0.76]; choosing vaginal delivery [p=0.69]; vaginal delivery [p=0.21]) or for pre- delivery fear of, or preparedness for, childbirth (p=0.13-0.53) or satisfaction with childbirth (p=0.14). This is interesting. It's concerning that the message here appears to infer that one such	Thank you for your comment. The intervention outcomes are guided by the target of the intervention and for these trials the primary goal was to evaluate the possibility of reducing requests for caesarean by reducing fear, therefore a smaller number of elective caesareans was a positive intervention outcome. The offer of an opportunity to discuss fears is recommended, and the evidence reviewed here is consistent with the recommendations made by the C-section guideline (cross-reference to this guideline has

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					'benefit' might have been fewer elective caesareans, but it's also of interest to recognise that it may not be an effective use of NHS resources to force women to have mental health counselling when they request a caesarean, if the woman is adamant that a caesarean is her preferred birth plan choice.	been added to the recommendation)
Elective Cesarean	53	Full	7.5.26	528	L38-40 7.5.26 Health economics evidence The expected incremental cost (relative to standard care) per woman 38 over 12 months was £792 for structured psychological therapy and £947 for listening 39 visits in 2006-2007 prices. These figures again reflect that there is a cost involved in mental health support, just as there is in the childbirth delivery method itself, and this should not be ignored when considering a woman's request for a caesarean.	Thank you for your comment. The guideline development group has considered the costs associated with mental health counselling and agreed that women with tokophobia should be offered an opportunity to discuss fears; it's not advocating mental health counselling over a method of delivery. A delivery method as an intervention is outside the scope of this guideline, but as a result of yours, and other stakeholder comments, a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
Elective Cesarean	54	Full	7.6	549	7.6 LINKING EVIDENCE TO RECOMMENDATIONS …The economic evidence review did not find any studies assessing the cost-effectiveness of pre-delivery interventions. Although the evidence for large and appreciable benefits was not found, the GDG agreed by consensus judgement, that it is important for women with tokophobia to have the opportunity to discuss these fears during the pre-delivery period and they should have access to a healthcare professional with expertise in providing	Thank you for your comment. The guideline development group has considered the costs associated with mental health counselling and agreed that women with tokophobia should be offered an opportunity to discuss fears; it's not advocating mental health counselling over a method of delivery. A delivery method as an intervention is outside the scope of this guideline, but as a result of yours, and other stakeholder comments, a cross-reference to the caesarean section guidance (CG 132) has been

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					perinatal mental health support. Moreover, the GDG judged that the cost of such interventions would be small relative to the reduction in women's burden, potential for developing mental health problems and other health vulnerabilities which may be costly to other parts of the NHS." Key words above are "the opportunity" (i.e. offer)… Also, regarding "cost-effectiveness of pre-delivery interventions", did the GDG consider the cost estimates contained within '2011 NICE. Caesarean Section (Update). Costing report. Implementing NICE guidance', noted above?	added to the recommendation.
Elective Cesarean	55	Full	7.7.1.9	554	Request that text in bold is added: 7.7.1.9 For women with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss their fears with a healthcare professional with expertise in providing perinatal mental health support. **If after discussion and offer of support, a vaginal birth is still not an acceptable option, offer a planned CS in a timely manner**. [new 2014]	Thank you for your comment. As a result of yours, and other stakeholder comments, a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.
Elective Cesarean	56	Full	7.7.1.16	556	Request that text in bold is added to: Traumatic birth, still birth and miscarriage "If the woman wishes, refer her for a specialist mental health assessment. **Support the woman's choice of delivery method in any**	Thank you for your comment. However, the suggested addition cannot be added as it is outside the scope of this guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					subsequent pregnancy. [new 2014]	
Elective Cesarean	57	Full	7.7.2	556	7.7.2 Research Recommendation Suggestion: Could women at high risk for an emergency CS birth or traumatic instrumental delivery be identified, and what can be done to alter the long-term unchanged caesarean ratio that exists (i.e. a much higher emergency CS rate than elective CS rate), which is unhelpful for reducing the most adverse physical and psychological health outcomes for women and babies?	Thank you for your comment. The suggested research recommendation could not be added as it is outside the scope of this guideline
Elective Cesarean	58	General	General	General	3.4.7 Any assumed increase in the number of planned vaginal births could also potentially lead to an increase in the number of unplanned caesarean sections carried out. Therefore if an increase in the number of planned vaginal births is expected, an increase in the number of unplanned caesarean sections should also be anticipated. This is an important point that is raised in '2011 NICE. Caesarean Section (Update). Costing report. Implementing NICE guidance', and is precisely why my organisation is concerned about efforts to convince tokophobic women to have a vaginal delivery against their will.	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation
Elective Cesarean	59	General	General	General	*Do you think this guidance could be changed to better promote equality of opportunity relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socio-economic status?* *Yes – as descried above with women's ability to*	Thank you for your comment. Delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					argue their case for a caesarean request when perhaps language education and/or cultural understanding of how the NHS maternity care system works and what NICE guidance even is, are all potential barriers.	
Elective Cesarean	60	General	General	General	Relevant research to support statements made above: Tokophobia: an unreasoning dread of childbirth. A series of 26 cases. KRISTINA HOFBERG, MRCPsych. I. F. BROCKINGTON, FRCP "Pregnant women with tokophobia who were refused their choice of delivery method suffered higher rates of psychological morbidity than those who achieved their desired delivery method. Conclusions. Tokophobia is a specific and harrowing condition that needs acknowledging. Close liaison between the obstetrician and the psychiatrist in order to assess the balance between surgical and psychiatric morbidity is imperative with tokophobia." Mode of birth and women's psychological and physical wellbeing in the postnatal period. Rowlands IJ1, Redshaw M. BMC Pregnancy Childbirth. 2012 Nov 28;12:138. doi: 10.1186/1471-2393-12-138. "Women who had forceps-assisted vaginal births and unplanned caesarean section births reported the poorest health and wellbeing,	Thank you for your comment. The referenced papers would not meet the eligibility criteria for intervention efficacy review, i.e. they are not RCTs and delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					while those of women who had unassisted vaginal births and planned caesarean section births were less affected by the birth process. Most women's physical and emotional health appeared to improve with time, however, those who had a forceps-assisted vaginal birth were more likely to report ongoing posttraumatic-type symptoms several months after the birth." Prevalence and risk factors of childbirth-related post-traumatic stress symptoms. Modarres M1, Afrasiabi S, Rahnama P, Montazeri A. BMC Pregnancy Childbirth. 2012 Sep 3;12:88. doi: 10.1186/1471-2393-12-88. "The findings from present study indicated that more than half of women experienced a traumatic delivery. In addition we found that post-partum PTSD was associated with low educational level, premature labor, inadequate prenatal care visits, having complications due to pregnancy, pregnancy intervals less than 2 years, labor duration, and emergency cesarean section." Post-traumatic stress disorder after childbirth in Nigerian women: prevalence and risk factors. Adewuya AO1, Ologun YA, Ibigbami OS. BJOG. 2006 Mar;113(3):284-8. "The prevalence of PTSD was 5.9%. The factors independently associated with PTSD after childbirth include hospital admission due to	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					pregnancy complications (OR 11.86, 95% CI 6.36-22.10), instrumental delivery (OR 7.94, 95% CI 3.91-16.15), emergency caesarean section (OR 7.31, 95% CI 3.53-15.10), manual removal of placenta (OR 4.96, 95% CI 2.43-10.14) and poor maternal experience of control during childbirth (OR 5.05, 95% CI 2.69-9.48)." The prevalence of enduring postnatal perineal morbidity and its relationship to type of birth and birth risk factors. Williams A1, Herron-Marx S, Knibb R. J Clin Nurs.2007 Mar;16(3):549-61. "The study concludes that enduring perineal morbidity in women following childbirth is common, especially with women following a forceps birth and certain birth risk factors (i.e. age, ethnic origin, length of labour and birth weight)." Obstetric complications in women with schizophrenia B.E Bennedsen et al. Denmark Schizophrenia Research Volume 47, Issues 2-3, Pages 167–175, March 1, 2001 Schizophrenic women were at increased risk of interventions such as Cesarean section, vaginal assisted delivery, amniotomy, and pharmacological stimulation of labor.	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Fear of childbirth and duration of labour: a study of 2206 women with intended vaginal delivery. Adams S, Eberhard-Gran M, Eskild A.BJOG 2012; DOI: 10.1111/j.1471-0528.2012.03433.x. The study also found that women with fear of childbirth more often delivered by instrumental vaginal delivery (17.0% versus 10.6%) or emergency caesarean delivery (10.9% versus 6.8%) as compared to women without fear of childbirth. In total, 25.5% (42 women) of women with fear of childbirth and 44.4% (906 women) of women without fear of childbirth had a vaginal delivery without any obstetric interventions. However, it is important to note that a large proportion of women with a fear of childbirth successfully had a vaginal delivery and therefore elective caesarean delivery should not be routinely recommended." Regarding this last line, my organization is not suggesting the routine 'recommendation' of elective caesarean delivery, but rather the offer of support for this birth choice if it is what the woman requests.	
Elective Cesarean	61	General	General	General	The review paper below outlines some of the problems that exist even where research in the area of tokophobia and mode of birth is happening. A comprehensive systematic review of the impact of planned interventions offered to	Thank you for your comment. We are not able to comment on a systematic review that was not included in the review of evidence for this guideline and delivery method as an intervention is outside the scope of this guideline, but a cross-reference to the caesarean section guidance (CG 132) has been

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					pregnant women who have requested a caesarean section as a result of tokophobia (fear of childbirth). Weaver J, Browne J, Aras-Payne A, Magill-Cuerden J. JBI Library of Systematic Reviews 2013; 11(1): 70-122. For example, one of the review objectives is to: "synthesise the best available quantitative evidence relating to the effectiveness of planned interventions (intervention vs. standard care or intervention vs. intervention) in reducing fear and/or anxiety in women who present with tokophobia, and in reducing the number of planned Caesarean section (CS) deliveries in these women," Why? Why the obsession with the number of planned caesareans from the outset? And with reducing that number? Why not an objective to reduce the number of emergency caesareans? Or to ensure that women are fully informed about the risks and benefits of surgery? Patient satisfaction following different types of caesarean surgery? The answer comes swiftly: "In the UK, the rate has risen from around 3% in the 1960s 4 to 24.8% in 2009-10. This is considerably higher than the maximum medically justified rate of 15%, as defined by	added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					the World Health Organisation (WHO). A number of authorities have expressed concern at this trend, especially when there are no medical indications for CS, as surgical intervention in childbirth may result in adverse maternal or infant outcomes." My organisation presented a great deal of evidence in response to the problem with birth politics, and an unhealthy obsession with a 1985 WHO recommended rate that had no basis in empirical evidence. In fact the WHO has admitted that there is 'no known optimum rate', and the NICE CG132 and QS32 would not have been published if there was evidence that maternal request caesareans would lead to "adverse maternal or infant outcomes" (or rather, any greater adverse maternal or infant outcomes than a planned vaginal delivery). When any research review takes place with the starting point that "high CS rates are bad, low CS rates are good", this can colour the whole exercise, and take away from a 'patient-centred' approach. It can also mean that there may be missed opportunities for finding effective solutions (e.g. increasing the planned CS rate and reducing the emergency CS rate). Finally, it's worth noting that none of the listed "Planned interventions" cited in this review	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					include 'agreeing to the CS request', and this is why it is so important that this intervention is recognised by NICE here.	
Expert Reviewer 1	1	Full	5	85	General: As acknowledged, the Guideline continues to suffer from an over emphasis on depression and the postnatal period. While this is understandable given the limited research available, it is disappointing that further progress has not been prompted by the NICE (2007) emphasis on the need to recognise mental health problems other than depression and also the occurrence of mental health problems during the antenatal period.	Thank you for your comment. As acknowledged, by your comments and in the guideline text, the research literature is dominated by postnatal depression. However, recommendations are also included for recognising anxiety disorders, severe mental illness, and alcohol and drug misuse, and for recognising depression in pregnancy as well as in the postnatal period. In addition, a new recommendation has been added that recommends that healthcare professionals be aware of the range, prevalence and under-recognition of anxiety disorders (including GAD, OCD, panic disorder, phobia, PTSD and social anxiety) and depression throughout pregnancy and the postnatal period.
Expert Reviewer 1	2	Full	5.3.4	114	It is welcome that there has been an attempt to address anxiety within the confines of the available research evidence. Although Table 20 includes the use of different EPDS cut offs in pregnancy there is no comment or summary on anxiety on p 114. This would be helpful in giving a context / cross reference for the GDG recommendation of GAD-2 questions (p 139). While the rationale given on p 118 is helpful it is not readily accessible	Thank you for this comment. We agree that the section was unclear. The clinical evidence summary for identification of anxiety disorders has been amended in the chapter to give a more comprehensive summary of the clinical evidence review (included in Table 20). A cross-reference to the GAD-2 questions has also been inserted into this section in order to make this rationale clearer
Expert Reviewer 1	3	Full	5.3.5	117	The GDG decision to favour sensitivity over	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					specificity is welcome as a means of improving detection of those women who have sub-threshold symptoms of depression and who may otherwise be missed. This is in keeping with the principle of including the full spectrum of severity of depression.	
Expert Reviewer 1	4	Full	5.3.6	123	The economic modelling incorporates pharmacological treatment with Sertraline for 8 weeks. Standard advice to patients is usually to continue antidepressant medication for 6 months following an improvement in mood in order to reduce the risk of relapse. There appears to be some question around the application of this shorter period.	Thank you for your comment. This has been amended.
Expert Reviewer 1	5	Full	5.3.6	136	p. 136-138 I strongly support the reservations and concerns of the GDG regarding the economic analysis. In particular I welcome their emphasis on the use of clinical judgement and the importance of the relationship between the patient and the professional in optimising the accuracy of identification. An over emphasis on the time needed to administer test instruments in a clinical setting risks undervaluing the relationship and the style of administration and ultimately the accuracy of results.	Thank you for your comment.
Expert Reviewer 1	6	Full	5.3.8.3 to	140	p140-15.3.8.3- 5.3.8.6 These recommendations are appropriate and the specific timings are important for standardised screening purposes. However, specifying a single time for screening in pregnancy also carries a risk for mental	Thank you for your comment. The guideline development group has added a further recommendation that at all subsequent contacts during pregnancy and in the postnatal period women should be asked the Whooley

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					health problems with onset during pregnancy but after booking to be missed. The long standing trend to overlook mental health problems in the antenatal period adds to this concern. It is suggested that an additional recommendation should prompt repetition of the screening questions if a health professional has concerns at any stage later in pregnancy.	questions and the GAD-2 and the specificity with regards to the timepoints have been removed from full guideline recommendation 5.3.8.3.
Expert Reviewer 1	7	Full	5.3.8.7 &	141	p141-2 5.3.8.7&.8Women with a history of, or current, severe mental illness are likely to be known to community mental health services. Some will already be attending services and may have taken advice on getting pregnant. There is advantage in these women maintaining contact with the service where their history is known. It is suggested that recommendations should be clear that the service where the woman is already known should always at least be made aware of the pregnancy following booking. Referral to that service may be considered and, when available, the additional expertise of specialist perinatal mental health professionals should be sought to complement the core service. On-going involvement of the core mental health services will facilitate continuity of care through and beyond the perinatal period.	Thank you for your comment. The GDG agrees and think that this point has been covered by an overarching principle about coordination of care (recommendation 1.3.6).
Expert Reviewer 1	8	Full	5.4	142	p141-2 The clarification provided in this section related to specifics of the perinatal period is very welcome and helpful. In particular it is	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					useful to have highlighted "the recognition that assessment is not a single, time-limited intervention but a continuing process throughout any period of care" (5.4.4). The suggested addition to recommendations in 5.3.8 is in keeping with this view (Comment 6).	
Expert Reviewer 1	9	Full	5.4	142	p141-2 It is useful to have it formally recognised that women make different choices related to treatment in the perinatal period. This acknowledgement enables open discussion, effective sharing of information between the woman/couple and professionals, on-going monitoring and adherence.	Thank you for your comment.
Expert Reviewer 1	10	Full	5.4.8.4	149	This guidance on relevant topics to be included when making an assessment of a suspected mental health problem is very helpful, especially for health professionals with limited mental health training. It is suggested that perinatal specific experience which may contribute to the risk of developing a mental health problem should also be included e.g. assisted or delayed conception, history of or current diagnosis of foetal anomaly, history of perinatal loss, history of traumatic birth.	Thank you for your comment. The recommendation has been amended to include "the women's experience of pregnancy and any problems experienced by her, the fetus or the baby".
Expert Reviewer 1	11	Full	6	151	p151-204 This chapter on experience of care adds significantly to the Guideline. The content is consistent with clinical experience of working with many women in the perinatal period. It includes important perinatal specific issues	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					which are inadequately addressed elsewhere in the document but where attention to psychological well-being and mental health is essential.	
Expert Reviewer 1	12	Full	6	198	The complexity of judging what is helpful in the highly sensitive and challenging circumstances around perinatal loss is well portrayed and hence the necessity of individual care planning taking the preferences and choices of the woman fully into account along with those of her partner, when appropriate.	Thank you for your comment
Expert Reviewer 1	13	Full	6.2.5	198	The timing of offering options related to perinatal loss to women/couples is important as pointed out by some women (e.g. p198; lines 24-26); also allowing ample time to consider choices. Clinical experience of working with women and partners who have been advised of a foetal diagnosis and are aware that their baby will die in utero, at birth or soon after, indicates that it is helpful to prompt consideration of their options and wishes during pregnancy. This includes planning for delivery, the immediate postnatal period and disposal. This reduces the stress of making difficult decisions immediately after birth. Particularly for women who choose to allow the pregnancy to run its course as long as possible, this time to consider and discuss options is valued. It increases the probability of couples making decisions they will continue to be	Thank you for your comment. The GDG agree that it is important to incorporate the opportunity for planning and preparation for women who have been advised of a fetal diagnosis, and as a result of your comment the recommendation has been amended

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					content with into the future; reduces the likelihood of regrets and facilitates the grieving process.	
Expert Reviewer 1	14	Full	6.2.5	191	191-194 It is welcome to see consideration of traumatic birth. This section captures the psychological impact of traumatic delivery with birth complications involving physical trauma. However there is a danger of overlooking those women who experience an apparently normal delivery as psychologically traumatising, often due to a history of exposure to trauma. These women are easily overlooked as there are no obstetric risk factors to alert maternity staff or primary care staff following up in the early postnatal period. As with PTSD following other experiences, it is safe to assume that there is risk for a negative impact on relationships, adjustment and developing comorbid mental health problems.	Thank you for your comment. The GDG agree that it is important not to overlook this group of women. The recommendations on traumatic birth are intended to apply to both women who have experienced a traumatic delivery due to physical birth complications but also women with an obstetrically-normal delivery who experience it as psychologically traumatic. However, to make this more explicit a definition of traumatic birth has been added to the guideline
Expert Reviewer 1	15	Full	6	151	p151-204 While this chapter usefully addresses some important challenges specific to perinatal experience, others have received little or no consideration i.e. intrauterine death, foetal diagnosis and termination of pregnancy. While there are some similarities it is considered that such complex topics do not lend themselves to joint consideration or generalisation.	Thank you for your comment. Experiences of post-miscarriage or post-stillbirth information and support and experiences of seeing and/or holding the dead baby after stillbirth or termination of pregnancy following diagnosis of fetal abnormalities are included in the summary of themes from the qualitative analysis of service user experience (section 6.2.5)
Expert Reviewer 1	16	Full	7	205	205-557 The selection of therapeutic approaches to be	Thank you for your comment. The type of therapeutic approach was not restricted prior

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					included in the evaluation of outcomes is a matter for concern. The majority are low level interventions applied by staff with very limited training in mental health. This excludes more severe and complex mental health problems which require individualised assessment and intervention delivered by a fully trained mental health professional. While such cases may be covered in another NICE Guideline on a particular mental illness, this Guideline will not inform, and may mislead, commissioners considering staffing needs for perinatal mental health services.	to the evidence search. Rather, this list reflects the interventions for which there is evidence. The guideline includes recommendations for interventions for severe mental illness which were largely adaptations of existing NICE guidance to pregnancy and the postnatal period as informed by expert consensus judgement and evidence reviewed for this guideline where available
Expert Reviewer 1	17	Full	7	425	p425,458 & 550 The limited research evaluating post traumatic birth counselling in the research setting has produced mixed results. Clinical experience indicates that such follow up by obstetricians and midwives is highly valued by women and usually also by their partners. It can be very helpful. However there is considerable variation in how such counselling is delivered in terms of timing and the counselling skills of the professional. The difference between counselling and debriefing is often poorly understood. Such variables can make the difference between being helpful and adding to post trauma response severity. The comments related to clarifying the difference are welcome and much needed. It seems particularly important to discourage the	Thank you for your comment. Recommendations under the 'Traumatic birth, stillbirth and miscarriage' sub-heading capture these points.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					practice of an obstetrician or midwife taking a woman through her traumatic birth experience step by step in the early days after delivery. A recommendation to this effect would be helpful. To be prepared to answer any questions she may have at this stage and providing the option of a later opportunity for fuller consideration of the details is appropriate.	
Expert Reviewer 1	18	Full	7	549	In my opinion fear of childbirth is highly variable in terms of presentation, origin and complexity. There is a danger of overlooking the necessity for detailed assessment in order to guide appropriate intervention. I welcome the GDG view that women with this difficulty should have the "opportunity to discuss fears before delivery and to have access to a healthcare professional with expertise in providing perinatal support." More complex cases will however require individualised psychological therapy delivered by a mental health professional, preferably in the maternity setting.	Thank you for your comment. However, as there is no evidence identified or reviewed for individualised psychological therapy (delivered by a mental health professional) for the treatment of tokophobia or for the identification of a 'complex' case, the GDG judged that such a recommendation would be going beyond the data
Expert Reviewer 1	19	NICE	Introduction	4	It is welcome and appropriate to emphasise that "recommendations are relevant to all healthcare professionals providing intervention for mental health problems". However this statement does not recognise the essential role of midwives, in particular, and others in maternity services and primary care, in implementation. Midwives do not usually provide intervention	Thank you for your comment. The guideline development group agrees and has amended the statement in the introduction to include professionals who are involved in recognition and assessment, as well as providing interventions.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					for mental health problems but it is they who provide the universal elements of antenatal care and who will carry out screening in pregnancy. It is essential to recognise that the guideline is relevant to healthcare staff who provide standard perinatal care if the aims of the guidance are to be realised. On this basis it is suggested that the statement above is amended.	
Expert Reviewer 1	20	NICE	1.3.14	22	When a woman with severe mental illness decides to stop psychotropic medication in pregnancy it is suggested that discussion with her should also include the possibility of introducing psychological intervention if it is not already in place. As recognised in other recommendations (e.g. 1.6.18) psychotherapy can be beneficial for women with severe mental illness.	Thank you for your comment. The recommendation has been amended to add psychological interventions.
Expert Reviewer 1	21	NICE	1.4.3	29	While supportive of the recommendation related to screening for depression and anxiety disorders it is important that the prescribed times are not exclusive. An additional recommendation is needed to cover new onset or recurrence of anxiety or depression later in pregnancy. (See also comment 6)	Thank you for your comment. In light of your, and other stakeholders', comments the timing specificity has been removed from the recommendation. In addition, a new recommendation has been added that at subsequent contacts in pregnancy and the postnatal period the health visitor (and other health and social care professionals who have regular contact with the woman) should discuss mental health and consider asking the depression and anxiety identification questions and consider using a formal tool as part of ongoing assessment and monitoring (1.5.8).

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Expert Reviewer 1	22	NICE	1.4.4	30	There appears to be an error in the reference to 1.4.4. It seems this should be 1.4.3.	Thank you. The recommendation has been amended.
Expert Reviewer 1	23	NICE	1.4.2	29	Recognising mental health problems and referral: This new recommendation to share information on past and present mental health problems with maternity services is very welcome. Such information is valuable for maternity staff providing standard care and particularly in stressful situations which can arise during the course of pregnancy and childbirth. With this information and a better understanding staff can support a woman more effectively and are better prepared to recognise when it is necessary to involve specialist mental health support.	Thank you for your comment.
Expert Reviewer 1	24	NICE	1.4.3	29	1.4.3-.10 (p29-31) Midwives will be dependent on clear information in order to determine whether it is appropriate to follow guidance on depression and anxiety disorders (1.4.3 to 1.4.6) or that on severe mental illness (1.4.7 to 1.4.8). In the absence of adequate information on past and current mental health problems it will be helpful to advise seeking clarification by asking the woman about any previous treatment for a mental health problem and details of who provided care. This will give useful information to facilitate timely and appropriate referral and sharing information.	Thank you for your comment. The GDG agree that assessment and diagnosis of a suspected mental health problem should include history of any mental health problem, any current or past treatment for a mental health problem, and response to any treatment, and feel that these points are captured by recommendation 1.6.1.
Expert Reviewer 1	25	NICE	1.4.8	31	This recommendation needs to recognise that	Thank you for this comment. Amended

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					some women with severe mental illness will already be in the care of a mental health service but may have infrequent contact. Where this is the case the mental health service should be made aware of the pregnancy even if the woman is referred to a specialist perinatal mental health service. (See also comment 7)	recommendations on coordinated care (1.3.5-1.3.6) recommend that all women with a mental health problem in pregnancy and the postnatal period should have an integrated care plan developed that sets out the care and treatment for the mental health problem and the roles of all healthcare professionals, and that the healthcare professional responsible for coordinating the care plan should ensure that there is an effective sharing of information with all services involved and with the woman herself.
Expert Reviewer 1	26	NICE	1.5.1	32	This new information on relevant historical and contextual factors to be considered at assessment is welcome and will be particularly helpful to those who are not mental health professionals but who will be involved in assessment of suspected mental health problems. Professionals with mental health training will be familiar with the topics listed but they are less likely to consider specific perinatal experiences, which may increase the risk of developing a mental health problem. (See also comment 10)	Thank you for this comment.
Expert Reviewer 1	27	NICE	1.5.5	33	'If there is a risk of self-harm or suicide.' If this should arises at initial assessment or later in the perinatal period in the maternity setting and there is no indication that the GP is already aware it would seem useful to emphasise immediate communication to inform the GP and mental health services rather than waiting	Thank you for this comment. We have amended the recommendation in light of your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					for referral, further assessment and the development of a full care plan.	
Expert Reviewer 1	28	NICE	1.6.3	35	I welcome this GDG review of 2007 guidance, stressing the importance of prompt service delivery with a shorter time to assessment and intervention being necessary in the perinatal period. It may be helpful to replicate the specific meaning of 'timely' on page 10 and at 1.2.6., page 18 or at least to cross reference to 1.6.3. It should also be made clear that a much earlier response is necessary for assessment of maternity in-patients.	Thank you for your comment, but the meaning of 'timely' does not quite equate to the 2 week referral for and 1 month provision of psychological interventions – some treatments (for example for postpartum psychosis) will need to be delivered more quickly.
Expert Reviewer 1	29	NICE	1.6.24	40	Intervention for infant sleep problems – when basic advice on sleep hygiene is not sufficient it seems that psychological therapies should be offered before the initiation of medication.	Thank you for your comment. To clarify this section is concerned with interventions for maternal sleep problems not infant sleep problems. The literature search did not identify any high quality studies assessing the efficacy of psychosocial interventions for sleep problems and insomnia in pregnant women, and in the absence of any evidence for benefits or harms the GDG were unable to recommend any specific psychosocial intervention
Expert Reviewer 1	30	NICE	1.7.5	43	The change to this recommendation is very welcome as is the prioritisation. It acknowledges the range of responses by women, their partners and families to the death of a baby, as illustrated in chapter 6 and in keeping with clinical experience.	Thank you.
Expert Reviewer 1	31	NICE	1.7.8	43	It is suggested that discussion of disposal of remains should be included in the support and	Thank you for your comment. While the GDG appreciates that this is important, the GDG was

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					facilitation provided by the practitioner.	concerned with the immediate psychological management of trauma. Disposal of remains would be covered by local protocols and common law.
Expert Reviewer 1	32	NICE	1.7.5 to 1.7.8	41	It is fully appreciated that miscarriage and stillbirth often involve psychological trauma but it must also be appreciated that perinatal loss and psychological trauma can also occur independently of one another and they are very different experiences. The combined heading on page 14 is confusing without the detail of 1.7.5 through to 1.7.8. Greater clarity may be achieved by separating those recommendations related to perinatal loss, where psychological trauma may be a factor and related to complex grief, and those recommendations where psychological trauma is the primary problem. It seems by subsuming psychological trauma in this way the presentation of this problem in the perinatal period has been inadequately addressed.	Thank you for your comment. The headings are not intended to be read without the detail of the recommendations, therefore the GDG did not consider it appropriate to separate out or restructure these recommendations. Also, in the NICE Pathway for this topic, which will be launched at the same as the guideline, the linkage and distinction between recommendations in each section will be clearer and the ability to navigate easier.
Expert Reviewer 1	33	NICE	1.7.7	43	This recommendation is fully appropriate for PTSD in the circumstances cited and it is helpful to add direction to the NICE post-traumatic stress disorder guideline. It is also important to recognise that psychological trauma can be triggered by a normal delivery and where the baby is alive and healthy. Combining loss and trauma risks incomplete understanding and missing cases.	Thank you for your comment. The recommendations on traumatic birth are intended to apply to both women who have experienced a traumatic delivery due to physical birth complications but also women with an obstetrically-normal delivery who experience it as psychologically traumatic. However, to make this more explicit a definition of traumatic birth has been added to the guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					This section also fails to recognise post trauma responses, including PTSD, during pregnancy. A proportion of women with PTSD following childbirth are not new cases (Ayers & Pickering, 2001). Direction to the PTSD guideline will not be sufficient in relation to the antenatal context as it does not address the specifics of the antenatal period. Exacerbation or recurrence of psychological trauma responses related to earlier experiences can be triggered during pregnancy and particularly as the delivery date draws closer. This requires timely assessment and intervention in the maternity setting, including consideration of the implications for childbirth and parenting. With appropriate intervention women can have much more positive birth experiences than they anticipated whether a first delivery, or subsequent to previous deliveries which were experienced a psychologically traumatising. It is important to address this gap in the guideline for the benefit of women and also as it is relevant to policy on birth choices and reducing the number of caesarean sections. When an expressed preference for operative delivery is dictated by fear, women can be relieved to have real choice restored through psychological intervention along with psychology involvement with midwives in planning delivery. To quote one example: "[redacted]	As outlined in the introduction of the full guideline (chapter 2), the GDG took the view that fear of childbirth secondary to traumatic childbirth (sometimes referred to as 'secondary' tokophobia) may be more helpfully conceptualised as a trauma symptom or as part of a presentation of post-traumatic stress disorder (PTSD) and therefore treatment should be informed by existing NICE guidance on PTSD, and where appropriate the caesarean section guidance. The importance of timely assessment and intervention in pregnancy and the postnatal period is captured in recommendation 1.3.6.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					[redacted]." Decisions around proceed with and pacing of trauma work is more complex in the perinatal period as the existing distress must be balanced against the distress which is inevitable in therapy, while bearing in mind the demands of the key milestones during this period.	
Expert Reviewer 1	34	NICE	1.7.14	44	1.7.14 & 1.7.15 This recognition of the potential impact of maternal mental health problems on the mother-baby relationship is welcome. The guidance to reassure women on this subject is important. Growing awareness of bonding with limited understanding of the concept and how it relates to the long term attachment relationship often leads to disproportionate worry for women when initial interaction with their baby is interrupted or disrupted, even briefly, by physical health issues in either mother or baby.	Thank you for your comment.
Expert Reviewer 1	35	NICE	1.8.5	46	The guideline recognises that specialist perinatal inpatient services must be staffed to provide appropriate care for the baby, however this alone is not sufficient. It is also imperative that in patient units have formal arrangements in place to ensure timely access to a professional with expertise in attachment and infant mental health to provide consultation, assessment and direct work with mothers and babies.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Expert Reviewer 1	36	Full	General	0	The GDG are to be congratulated on their	Thank you for your comment. This is an

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					review of the APMH Guideline. The revised version has much to recommend it with the benefit of important additions and appropriate revisions of earlier recommendations. The attention given across the full range of severity in mental health problems fits with the vision of effective universal screening and early intervention to benefit women, their children and families. Given that the opportunity for universal screening falls within maternity care it is important to fully recognise the essential role of maternity and primary care staff in the implementation of the guideline. In addition to fully acknowledging this within the guideline it will be important for commissioners to consider the implications for staffing levels and training needs to make implementation possible and effective.	implementation issue and has been passed on to the NICE implementation support team. Implications for staffing levels are not part of our remit and NICE have a separate safe staffing programme.
Expert Reviewer 1	37	Full	General	0	Denial of pregnancy, also known as concealed pregnancy, is a complex mental health issue which is difficult to assess but does not seem to have been mentioned at all. Such women may book late in pregnancy or not at all. They may come to the maternity hospital in labour, or just after, or not at all. A proportion of cases is readily explained by absence of usual signs of pregnancy leading to a woman being genuinely unaware that she was pregnant, or by fear of telling about the pregnancy. The maternal response to the baby in these circumstances can be warm and accepting, especially if there is	Thank you for your comment. We agree that denial of pregnancy may be an issue for some women, although it is not included in diagnostic classification systems, we recognise that it may be a complication associated with mental health problems. In response to your, and other stakeholder's, comments, we have added a woman's attitude towards the pregnancy including denial of pregnancy, to the first recommendation in the 'Assessing mental health problems in pregnancy and the postnatal period and care planning' section, which lists the components that should be included in an

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					good family support but it does need to be assessed and monitored. More challenging cases involve longer lasting denial of the pregnancy and in some cases lack of recognition or acceptance of the baby. These cases have very serious child protection implications. In one case where I was directly involved [redacted]. Denial of pregnancy has long been recognised in case studies in the literature (Brockington, 1996) but there does not appear to be any more sophisticated research. Nonetheless the implications are so serious in the worst cases it is suggested that the topic should be acknowledged in the guideline. Brockington, I. (1996) Motherhood and Mental Illness. Oxford University Press.	assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period.
Expert Reviewer 1	38	Full	General	0	While there is an acknowledgement of the importance of cultural variation in the guideline it may merit further emphasis, not least in awareness of those determining the content of the guideline, to avoid missing relevant guidance. As example, the law surrounding termination of pregnancy is more restrictive in Northern Ireland than in GB and it is regrettable that some women are forced to continue with their pregnancy or that others must travel to England, if termination is their choice.	Thank you for this comment. Some of the issues you raise are outside of the scope of the guideline, others concerning for example, still birth, are dealt with in the guideline (see rec 1.5.9) or in other mental health guidance (see CG136, Service User Experience Guideline).

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					However.it is important that eagerness to challenge the law does not blind professionals to the different choices women and their partners make when faced with a serious foetal diagnosis where life after birth is unlikely. Working with several families in this situation I have found that many wish to continue the pregnancy to extend their time with their baby. They value this time when they create memories, prepare their other children and prepare for the birth and funeral of their baby. This has proven to be very therapeutic for couples, similarly when one foetus in a multiple pregnancy is affected. This is just one example, but may serve to emphasise the value and importance of cultural diversity within the GDG and the advisors to the GDG to ensure that the guideline is fully inclusive.	
Expert Reviewer 2	1	Full	2.3.3	25	There could have been a broader review, there are more papers than those cited, for example Knoph et al, 2013 focuses on eating disorders in the postnatal period	Thank you. We have now added this study's findings in our review.
Expert Reviewer 2	2	NICE	1.6.14	37	"Monitor the woman's condition carefully throughout pregnancy and the postnatal period" THIS SHOULD BE REWORDED TO SAY: "Monitor the woman's condition AND WEIGHT carefully throughout pregnancy and the postnatal period"	Thank you. We have now added a bullet point to this recommendation to consider a fetal growth scan for these women. The evidence on optimal weight gain through pregnancy is unclear and assessment by obstetricians of underweight women would include the progress of the pregnancy and where indicated fetal growth scans

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Expert Reviewer 2	3	NICE	2	46	I notice there are no research recommendations for eating disorders, it is one of the few disorders where there is a lack of treatment studies. Should this be a research recommendation?	Thank you for this comment. The GDG considered your comment carefully and agreed that recommendations on eating disorders were desirable. However, the GDG felt it would be premature to move to treatment trails when methods for identifying women with eating disorders in the perinatal period were not well developed. The GDG felt that it would be better to address both issues. This would necessitate two recommendations which would present problems in incorporating them with in the current NICE guideline. These two recommendations have therefore been included in the full guideline only; please see section 7.7.2.5 and 7.7.2.6.
Expert Reviewer 3	1	Full	General	0	This is an excellent document, which clearly reflects a huge amount of work by the GDG. It should have a significant and positive influence on clinical practice well beyond the geographical scope of NICE. My specific comments are given below.	Thank you for your comment
Expert Reviewer 3	2	Full	2	18	L41 I think it would be more appropriate to reference the Confidential Enquiries here and thereafter by the relevant chapter (Chapter 11) as Oates M & Cantwell R, [chapter 11]…in CMACE (2011)…	Thank you. We have made the requested change.
Expert Reviewer 3	3	Full	2	29	L36 2.4 It would perhaps be relevant to allude to pregnancy and childbirth as major life events which may have aetiological significance for some pregnancy-related and postpartum disorders	Thank you. We feel that the sentence "The variation in the presentation, course and outcomes of mental health problems in pregnancy and the postnatal period is reflected in the breadth of theoretical explanations for

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						their aetiology, including genetic, biochemical and endocrine, psychological and social factors" encompasses this important point.
Expert Reviewer 3	4	Full	4	67	L15-18 I seem to remember that [redacted] did not confine study to first episode psychosis admissions as this seems to suggest. The statement here referring to the rate of 'first presentation severe mental illness' is at odds with what is recognised in the shorter version of the guideline as including postpartum recurrences of pre-existing disorders (page 3).	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Expert Reviewer 3	5	Full	4	67	L29-32 It would be better to use birth numbers as the denominator	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Expert Reviewer 3	6	Full	4	67	L36 These figures are now out of date	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Expert Reviewer 3	7	Full	4	71	The stepped-care model does not take into account the more reflective discussion in Chapter 2 about the need to accept that women with significant risk, or those with current illness, may require entry into assessment and treatment at a higher level. It seems to suggest that women are first referred to general services. There should be a reminder of how pregnancy and childbirth may be modifying factors both in the presentation of mental illness and the need for intervention.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Expert Reviewer 3	8	Full	5	86	L11 Correct 'antenatal pregnant'	Thank you, the change has been made.
Expert Reviewer 3	9	Full	5	138	L38 Remove one 'that'	Thank you, the change has been made.
Expert Reviewer 3	10	Full	5	141	REC5.3.8.4 The recommendation for referral to a specialist mental health practitioner for assessment may result in significant increased workload with high numbers of false positives referred. I would suggest that GPs have a role in assessing cases here. · Same is true for 5.3.8.5 and 5.3.8.6	Thank you for your comment. We have revised the recommendations to specify that GPs have a role in assessment.
Expert Reviewer 3	11	Full	7	327	L1 Correct 'none…were' to 'none…was'	Thank you for your comment. In modern English, the phrase 'none of these studies' can take either a singular or a plural verb and the plural, which we have used, is probably more common. Accordingly, we have left 'were' in this sentence.
Expert Reviewer 3	12	Full	7.7.1.5	553	Assessment within 2 weeks is a very ambitious target. If the referral originates from primary care/maternity services, and is to secondary care mental health services then such a rapid assessment is unlikely in many, if not most, services, unless the condition or risk is regarded as significant. If the referral is made specifically to IAPT services, then it is more likely to be met, but this would only be appropriate for milder conditions. There may be a group with mid-level severity for whom services will struggle to meet this target. If the aim of the guideline is to draw attention to the need for improved access to services, then that is laudable but there needs to be some recognition of the challenges in achieving such a standard.	Thank you for this comment. We accept that the target may be ambitious for some current services but the GDG , in view of the need for early intervention, thought it right to set a target of 2 weeks.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Expert Reviewer 3	13	Full	7.7.1.10	554	& REC7.7.1.11 The wording is a little confusing with regard to anxiety. Both recommendations seem to refer to any anxiety disorder. I am assuming that the first refers to mild/moderate anxiety and the second to moderate/severe anxiety? If so, the wording should be changed to 'for mild to moderate depression or anxiety disorder…' (i.e, removing the definite article) and similarly in the next recommendation.	Thank you for your comment. The guideline development group agrees that the recommendations on anxiety and depression were not clear and have therefore drafted separate recommendations for the anxiety disorders.
Expert Reviewer 3	14	Full	7.7.1.13	554	Consider adding a recommendation that eating disorders should be managed in conjunction with specialist eating disorders services (as is stated with substance use disorders)	Thank you for this comment. We did consider your suggestion but the GDG were of the view that a significant number of women with eating disorders could be properly managed either in primary care or secondary care mental health services.
Expert Reviewer 3	15	Full	7.7.1.19	556	REC7.7.1.19 This recommendation needs to reflect better the uncertainty in the literature. If anything is to be taken from the studies reviewed, it is that, in the absence of clearer evidence, the woman's (and her family's) wishes should be the deciding factor. The current wording may be interpreted as suggesting that exposure to the baby is the optimal course of action, and may lead maternity staff to make strong recommendations in that direction.	Thank you for your comments. However, the GDG consider the language used in the recommendation to 'Discuss with a woman...the options…' sufficiently nuanced to capture the importance of individualised treatment and reflect the mixed evidence
Expert Reviewer 3	16	Full	8	558	Overall: There should be a definition of congenital and major congenital malformation in the glossary	Thank you for your comment. A definition has been added to chapter 8 (section 8.4.2) of the full guideline
Expert Reviewer 3	17	Full	8.3.3	622	P622 L4 Change 'less' to 'fewer'	Thank you for your comment. This has been changed in the text

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Expert Reviewer 3	18	Full	8.4.7	668	P668 L5-7 It would be helpful to give rates for valproate	Thank you for your comment. The study (CHRISTENSEN2013) which reported the outcomes in the line referenced this 'did not have information on the actual dose of valproate or on whether the dose was changed during pregnancy, which may limit the validity of the analyses'. Risks were similar for 183 children of women who used a high valproate dose (>750 mg/d) for autism spectrum disorder and childhood autism compared with those for 325 children of women who used a low valproate dose (<750 mg/d). The GDG did not feel there was enough information here to warrant highlighting this in the chapter
Expert Reviewer 3	19	Full	8.8.2	710	P710 L16 The first part of this sentence needs clarification, i.e., what sort of monitoring, and by whom?	Thank you for your comment. This is a list of general principles and the GDG considered it appropriate to leave the content and provider of such assessments to clinical judgement. However, recommendation 1.9.2 has been amended post-consultation in order to provide clearer guidance on what healthcare professionals should be aware of when conducting a full neonatal assessment of the newborn baby
Expert Reviewer 3	20	Full	8.9.1.2	717	P717 REC8.9.1.2 The reasons behind this recommendation are entirely understandable. However, there may be cases where valproate is the only effective drug. For non-pregnant women, who are not planning a pregnancy, the GDG might consider the possibility of recommending the use of LARC in such	Thank you for your comment. The GDG were concerned that prescribing practices of sodium valproate for women of childbearing age remained higher than would be expected if existing NICE guidance was being followed. Based on GDG concerns about the potential for harm, the consensus judgement was that there

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					circumstances. I would entirely agree with the unqualified recommendation not to prescribe in pregnancy or where a pregnancy is being planned.	were grounds to strengthen the valproate recommendations that were made in the previous 2007 guideline. This was also consistent with recommendations made in the bipolar guidance (for both acute and long-term treatment). The GDG did not consider it appropriate to recommend prescribing valproate together with use of a LARC for non-pregnant women as no contraception is 100% effective and because of the concerns about implementation highlighted by the GDG.
Expert Reviewer 3	21	Full	8.9.1.3	718	This is very broad and would result in high numbers of women on e.g., antidepressants being referred to perinatal mental health services. Good information, and access to advice from specialist services, for primary care professionals is more appropriate in such cases. Referral for pre-conceptual advice should be recommended for women on complex psychotropic regimes and/or those identified as being at high risk for pregnancy or postpartum major mental illness.	Thank you for your comment. In light of your, and other stakeholders', comments the recommendation has been amended to 'Consider referring a woman with a current or past history of a severe mental health problem who is planning a pregnancy and is established on psychotropic medication…' in order to capture that a referral might not be necessary in all cases
Expert Reviewer 3	22	Full	8.9.1.36	723	In the main, practice would be to suggest greater monitoring and psychological intervention in pregnancy, with a low threshold for antidepressants if evidence of worsening symptoms. This is very dependent on past history/illness profile and the wording of the recommendation as it stands may be a bit prescriptive.	Thank you for your comment. Note that the recommendations is to 'consider' a TCA, SSRI or (S)NRI. In section 1.4 of the NICE guideline there is guidance on starting, using and stopping treatment which states '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

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						of a psychological intervention'. The recommendation should be read in conjunction with this advice.
Expert Reviewer 3	23	Full	8.9.1.52	727	Unclear if this refers only to women with current significant symptoms or also includes those with a diagnosis of bipolar disorder but who are well and at high risk. In those cases, a decision should already have been made and a treatment plan drawn up. I have significant concern that this (and possibly REC8.9.1.46) is the only recommendation which says anything about postpartum management of high risk women. Earlier recommendations suggest monitoring in the early postpartum (P142 REC5.3.8.9 and 5.3.8.10 – both in themselves quite appropriate) but the overall impression is that the emphasis is on watchful waiting, rather than active intervention. Chapter 2 refers to the very high risks associated with a past history of bipolar disorder and postpartum psychosis, increased further in the presence of a similar family history. The evidence for early postpartum prophylaxis in well but high risk women does not seem to have been reviewed, albeit there is little recent evidence and what exists is of poor quality. However, the GDG has made frequent decisions elsewhere to provide recommendations based on consensus expert opinion. It is widely accepted and uncontroversial practice in the UK amongst all perinatal professionals to offer postpartum	Thank you for your comment. The recommendation has been revised to make it clear that we mean current and previous illness.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					reinstatement of previously effective mood stabilising/antipsychotic treatments for high risk women. This should be reflected in the guideline, which, if anything, has less to say on this than the previous version. This is a significant omission with potential clinical implications, as accepted practice may not be widely recognised where specialist services do not exist.	
Expert Reviewer 4	1	Full	5.3.8	142	Recommendations seem reasonable to me. I do have some concerns about the whole concept of identification of mental health problems using the Whooley questions and/ or the EPDS and/ or any other instruments. I believe if this is done on every woman i.e. at a population level, then there is no getting away from the fact that this is screening by any other name. Therefore, I think this would benefit from being referred to the National Screening Committee for further advice.	Thank you for your comment. Due to several other comments about this issue, the recommendation has been revised to say 'consider asking' rather than 'ask', which implies it should be done in all women.
Expert Reviewer 4	2	Full	5.4.8	148	I think recommendations 5.4.8.4, .6, .10, .11 are entirely reasonable. In terms of treatment ie. 5.4.8.10, I wondered about a research recommendation about investigating the effectiveness of alcohol and drug treatment specifically during pregnancy and the postpartum period in RCTS in a UK setting?	Thank you for your comment we agree that the issue of drug and alcohol treatment during pregnancy are important and that further work is need in this area. However the GDG felt in the absence of good information about the extent of the problem and the feasibility of engaging women in clinical trials it would be premature to set out a series of clinical trials in the area as you suggest in the NICE guideline. The GDG did however decide to include a series of recommendations in the full guideline; See

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						section 8.9.2.2.
Expert Reviewer 4	3	Full	7	205	General: This section seems fine to me, I have nothing to add.	Thank you.
Expert Reviewer 4	4	Full	8	558	General:I think what is proposed here is entirely reasonable.	Thank you.
Family Links	1	NICE	Introduction	3	p 3-4 and general : Considering the points being well made about depression and anxiety being the most common mental health probs in pregnancy with further recognition that mental health problems frequently go unrecognised and untreated in pregnancy and postnatally, there appears to be no real substantial case being made for universal antenatal/postnatal relationship/parenting/mindfulness group interventions/programmes. Emphasis is on clinical treatment rather than on how to provide women/partners/family information on potential mental issues and where to go to for support if it is needed. More research needs to be prioritised to demonstrate positive/cost effective impact of preventative interventions using pre and post measures ,eg, Warwick and Edinburgh Mental Wellbeing Scale	Thank you for your comment. Evidence for the effectiveness of psychosocial interventions in preventing mental health problems is reviewed in section 7.4 of the full guideline. However, there was insufficient evidence for significant benefits or harms associated with these preventative interventions to warrant a recommendation. A research recommendation (2.1) is made on the prevention of post-partum psychosis as there was a research gap and the GDG felt that 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.
Family Links	2	NICE	Patient centred care	5	Evidence shows that many women feel unable to admit anxiety or depression to their Midwife or Health visitor as they have less consistent/continuous MW or HV contact in order to build effective partnership relationships in which they would feel safe to share anxiety and be signposted earlier.	Thank you for your comment. We feel we address the issue of unwilling to disclose or discuss a problem in the 'recognition' recommendations.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Children centre/Health support staff are being increasingly trained to deliver low intensity interventions within their proactive role as part of integrated care teams in which trusting helping relationships flourish and sign posting can be made. Unfortunately evidence of effectiveness is limited at this time.	
Family Links	3	NICE	Key prioritie s	10	Good to see that mental wellbeing is stated in brackets along with mental health, in being taken into account as part of all care plans.	Thank you.
Family Links	4	NICE	Recom mendati ons	15	As well as booking, Pre/ post measures and implementation data should be used to measure universal/low intensity group intervention impact.	Thank you for your comment. The approach taken in this guideline was to list critical outcomes (rather than the specific outcome measurement tools) and these are outlined in the review protocols (see Appendix 9) and include: maternal outcomes (symptom-based, diagnosis of mental disorder, symptomatology, relapse); service utilisation (hospitalisation for mental health problems, retention in services); experience of care; quality of life; harm; quality of mother-infant interaction and infant care; fetal/infant outcomes (cognitive, physical and emotional development, side effects, service use)
Family Links	5	NICE	1.2.2	17	Multiagency staff supporting pregnant women ,partners, family , carers would benefit from multiagency partnership model working/ emotional health team training in order to break down professional boundaries and improve communication/coordinated care amongst agencies.	Thank you for your comment. We have recommended an integrated care plan which we believe goes some way to addressing your concerns, please see NICE recommendations 1.3.5-1.3.6.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Family Links	6	NICE	1.4.1	29	Evidence shows that many women feel unable to admit anxiety or depression to their Midwife or Health visitor. They have less consistent/continuous MW or HV contact in order to build effective partnership relationships in which they would feel safe to share anxiety and be signposted earlier. Children centre/Health support staff are being increasingly trained to deliver low intensity interventions within their proactive role as part of integrated care teams in which trusting helping relationships flourish and sign posting can be made under qualified supervision. Unfortunately evidence of effectiveness is limited at this time.	Thank you for your comment. As your comment, and recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. As pointed out there is no high quality evidence for the efficacy of low intensity interventions delivered by children centre/health support staff and therefore the GDG did not consider it appropriate to recommend such interventions
Family Links	7	NICE	1.4.3	29	As well as first contact, booking, or early post natal period, pre and post measures should be used to measure universal/low intensity group/couple intervention impact. eg, Warwick and Edinburgh Mental Wellbeing Scale	Thank you for your comment. The approach taken in this guideline was to list critical outcomes (rather than the specific outcome measurement tools) and these are outlined in the review protocols (see Appendix 9) and include: maternal outcomes (symptom-based, diagnosis of mental disorder, symptomatology,

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						relapse); service utilisation (hospitalisation for mental health problems, retention in services); experience of care; quality of life; harm; quality of mother-infant interaction and infant care; fetal/infant outcomes (cognitive, physical and emotional development, side effects, service use)
Family Links	8	NICE	1.6.1	34	Children centre/Health support staff are being increasingly trained to deliver low intensity interventions within their proactive role as part of integrated care teams in which trusting helping relationships flourish and sign posting can be made under qualified supervision. Training, support and supervision of universal staff is essential. Monitoring and evaluation strategy needs to be in place. Unfortunately evidence of effectiveness is limited at this time.	Thank you for your comment.
Family Links	9	NICE	1.8.3	45	Perinatal Mental health and wellbeing clinical networks/services/groups need a strong preventative focus and representation	Thank you for your comment. The evidence on organisation of services has not been reviewed and we are therefore unable to consider any changes to the recommendations
Family Links	10	NICE	2.3	48	Good to see psychological interventions focused on the mother –baby relationship is included in research recommendations. Interested to ask if an RCT would be the only method to be considered as equal attention needs to be paid to the challenges of real world implementation to know whether/how an intervention can be implemented in a variety of different settings and still be effective?	Thank you for your comment. RCTs provide the greatest degree of certainty that can be attributed to the conclusions drawn from the study. An RCT requirement does not preclude examination of an intervention in different settings
Institute of Health	1	General	General	General	Contact [redacted] for the letter sent from IHiV	Thank you.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Visiting						
Institute of Health Visiting	2	General	General	General	Supported by the Department of Health, over the past year the Institute of Health Visiting has provided 400 senior health visitors and academic health visitors with evidence based training to case find and manage mild to moderate perinatal mental health issues in their clients. Furthermore to cascade the training onto all working and student health visitors and to act as a local resources for maintaining the quality of perinatal mental health services for local mothers. The training set out to: 'address the fundamental requirements that are necessary for health visitors to manage anxiety, mild to moderate depression and other perinatal mental health disorders in the mother and their impact on the infant, family and society and to know when to refer on'. This highly successful project has led to around 3500 health visitors already being trained and very many reports of improved services. What has been particularly heartening has been the local leadership by these Champions who have gone on to instigate multi-professional care pathways, develop benchmarking and	Thank you for your comments. The GDG recognised the importance of effective case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations in section 1.5). Recommendation 1.5.1 is informed by the qualitative evidence review that revealed that women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. In response to your, and other stakeholders', concerns that the Whooley questions may still fail to identify depression for

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					auditing tools and generally improve local services by all those with a responsibility to the 'sick' mother and her family significantly. Indeed to become local leaders at the primary care level. We can provide you with the survey evidence for this. To give a few examples though: [redacted] Whilst the training makes reference to the Whooley questions and existing NICE guidance the consistent feedback has been that since the last NICE guidance - 2007, where health visitors have been told by managers to follow that guidance and to abandon use of the EPDS, a tool that was specifically designed and validated for use by health visitors, case finding has gone down significantly with some therapeutic groups for mothers being closed due to lack of need being identified. This evidence based training could only be funded as a 2 day training so incorporated non-directive counselling (listening visits) as the counselling intervention although it encouraged the use of other interventions such as CPT, Solution Focused Therapy and so on being use where health visitors had received training in these. We immediately shared the draft NICE update guidance with out Champions and have been	some women, recommendation 1.5.5 has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are recommended to consider using a formal tool such as the EPDS as part of a full assessment. The role the health visitor (and other health and social care professionals who have regular contact with the woman) have in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8). In response to your comments regarding listening visits, there was evidence for moderate clinical benefits of facilitated self-help on depression symptomatology (scoring above threshold on a depression rating scale) and mean depression symptoms for women with sub-threshold to moderate symptoms of depression in pregnancy or the postnatal period. The economic analysis conducted for this guideline also found facilitated self-help to be dominant when compared with listening visits. Cost-effectiveness results were driven by the superior efficacy of facilitated self-help and

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					receiving very significant concerns coming back from them with managers saying that local services should be changed to reflect the new NICE guidance rather than continue in the format we have prescribed which has led to significant improvements in the quality and consistency of local health visiting services and increased case finding and management. This is frankly 'bonkers', when the original NICE guidance came out it was followed by a taking part of existing and effective local health visiting services as the evidence for them was not reflected in the NICE guidance. We had understood that this was one of the reasons for revisiting the guidance, so for the committee to come back with the guidance it has, again promoting the very limited and so far not evidence based assessment by health visitors with Whooley, and now GAD, is only going to lead to much poorer primary preventative services by health visitors at a time when there is huge government commitment from Dan Poulter MP, health minister, the Maternal Mental Health Alliance, the 1001 days manifesto, 6 High Impact Outcome areas and the Public Health England mandate to improve such health visiting services. This guidance is totally out of step with current policy.	the relatively low intervention costs. The GDG considered this evidence together with what is known about the clinical and cost effectiveness of facilitated self-help for the treatment of depression in non-pregnant women, and recommended that facilitated self-help should be considered for women with persistent sub-threshold depressive symptoms, or mild to moderate depression (recommendation 1.8.1). There was no high quality evidence to make a recommendation for listening visits.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					[redacted] We have a significant concern with these draft guidelines which seem to reflect a very bio-medical model which whilst appropriate for use with the severely ill is inappropriate for use at a whole population level where health visitors can make a huge difference to women's outcomes if they have the time and tools to work with them early. We suspect that many of those on the guideline development group have no experience of working with whole populations, only experience of working with the more severely ill. Rather than improving care for all women the guidance relating to whole population assessment when applied by health visitors will devastate the quality services we have been able to introduce over the past year, totally destabilising a Department of Health funded initiative. No other professional group in primary care i.e GPs or midwives have the level of training, experience or opportunity that the health visiting profession has for early detection and management of mild to moderate perinatal mental illness. Health visitors are not only trained to case find	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and manage this, they also have significant training in related areas such as domestic violence and will be receiving new training in supporting couple relationships following the announcement last week by the Prime Minister. These are both areas which may underpin the development of depression and anxiety and where early detection and support to the family may reduce their impact. We are well aware of the short-comings of the EPDS but it will pick up depression, anxiety and suicidal ideation if used properly as a framework for a much wider assessment which also incorporates the clinical interview and this is how we train health visitors to use it. Non-directive counselling is one of a range of interventions including group interventions and the support of the voluntary and statutory sector that health visitors can call on. The so-called 'Health Visitor listening visit' is much more sophisticated than it is given credit for, it addresses not only the needs of the mother, but also considers those of her wider family group, especially the infant. This does not happen in secondary services where counselling	
Institute of Health Visiting	3	NICE	Key prioritie s	13	iHV Perinatal Champions, (iHV:PMHC), have expressed concern that the EPDS has been removed. However is cited to be used in section 1.4.4	Thank you for your comment. This section of the guideline identifies the key priorities for implementation and the GDG prioritised the case identification questions over the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					We would request it is put back into page 13.	recommendation for full assessment as the guideline economic analysis suggested that the strategies utilising a brief case identification tool (that is, the Whooley questions) are preferred to the strategies not utilising a brief case identification tool, however little can be said about which tool should be used for a more formal assessment (that is, the EPDS or PHQ-9)
Institute of Health Visiting	4	NICE	1.2.5	17	iHV:PMHC welcome the recommendation that professionals should consider the impact of perinatal mental illness on the partner, other family members and children, however, feel it should also refer to any potential impact on the unborn baby.	The impact of perinatal mental illness on the unborn baby is covered in other NICE recommendations 1.4.6, 1.6.1, 1.6.3, and 1.6.6
Institute of Health Visiting	5	NICE	1.3.1	18	iHV:PMHC are delighted to see the guideline recommends the use of culturally relevant information relating to mental health problems. However, believe that there is a need to develop good quality literature to support professionals in this area. iHV:PMHC also suggest that the term 'culturally competent' replaces culturally relevant. Before working with other cultures a professional must be culturally competent, they then require culturally relevant tools.	Thank you for your comment. The term 'culturally competent' is not a term that can be used when talking about information. The guideline also refers the reader to the Service user experience guideline where this is covered.
Institute of Health Visiting	6	NICE	1.3.2	18	The guideline recommendation is welcomed, however, commissioners would be required to review the service specification for specialist mental health services locally in order to implement this recommendation in full. There are many gaps in national service provision	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					where specialist perinatal mental health services are not available (as identified by the Maternal Mental Health Alliance) and hence services could not therefore be accessed as the guideline suggests in many parts of the country.	
Institute of Health Visiting	7	NICE	1.3.9	21	We welcome this new addition/amendment	Thank you.
Institute of Health Visiting	8	NICE	1.4.1	29	We welcome this new addition but would also like to inform NICE of the work done by Health Visitors at the antenatal stage with clients this includes using the 'Boots Trust' wellbeing plan and assessing their current mental health as well as risks to their future mental health as part of the health visitor promotional interview at 36 weeks of pregnancy. The wellbeing plan was funded by Boots Family Trust and developed by experts from Netmums, Institute of Health Visiting, Royal College of Midwives and charity Tommy's to help mums prepare for the birth and support they might need to look after their mental health. It is a tool which was developed following evidence from Netmums of the reluctance of mothers to disclose their mental health issues. It allows the professional to guide the mother into planning her own postnatal emotional support framework. Although not formally validated it has through testing and use been found to facilitate such discussions and planning. As based on the evidence alluded to in point 1.4.1 it might be included as one possible	Thank you for your comment. As pointed out this tool has not been formally validated and therefore the GDG did not consider it appropriate to make the suggested recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					intervention to be used by midwives and health visitors with all mothers.	
Institute of Health Visiting	9	NICE	1.4.2	29	iHV:PMHC support the consultation guideline recommendation relating to the sharing of information with maternity services when there is a past or present mental health problem. However consideration should be given to extending this recommendation to include the health visiting service as the "Healthy Child Programme" (2009), the "National Health Visiting Service Specification 2014/2015" (2014) and the Framework for Personalised Care and Population for Nurses, Midwives, Health Visitors and Allied Heath Professionals (2014), clearly states that health visitors are responsible for delivering the Healthy Child Programme and this includes maternal mental health in full which includes a universal offer in the antenatal as well as the postnatal period. By not mentioning health visitors by name their contribution could be diluted as commissioning of their services is moved to local authorities. Already we have been informed of an area where it was felt mothers could be assessed for PND by children's centre workers with no professional health training.	Thank you for your comment. In light of your, and other stakeholders', comments a new recommendation has added that explicitly recognises the role of health visitors (and other health and social care professionals who have regular contact with the woman) in the ongoing assessment and monitoring of women in pregnancy and the postnatal period (1.5.8)
Institute of Health Visiting	10	NICE	1.4.3	29	Perinatal mental health assessments in the postnatal period form part of the universal service offered by health visitors. However when reviewing the consultation guideline it is	Thank you for your comments. In light of your, and other stakeholders', comments the timing specificity has been removed from the recommendation. The GDG recognised the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					disappointing that the timescales for assessment do not coincide with those referred to in the DH Maternal Mental Health Pathway (2012). iHV:PMH are disappointed that an assessment at 8-12 months has been omitted as this is a universal contact for the health visiting service when mothers will often be identified to be experiencing mental ill health or report that they had experienced mental ill health but did not report it. iHV:PHC suggest that if an assessment is not recommended universally that best practice should recommend that women with a past history of mental ill health are offered a further assessment at this point. Health visitors have found the Whooley Questions, which have no evidence for use in the community by health visitors, (as is the case with GAD 2) to be totally inadequate for the full assessments of the mental health needs of the whole family as should be done at each of their formal contacts prescribed by the Healthy Child Programme (HCP) and to be mandated when their commissioning moves to Local Authorities next year. As described above in our introduction we have introduced training across the UK for standardised assessment using the	importance of effective case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations in section 1.5). Recommendation 1.5.1 is informed by the qualitative evidence review that revealed that women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. The GDG felt that it was important to point out that these case identification tools have been validated for use in primary care so the distinction of which primary healthcare professional administers

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					EPDS as the framework but also based on the clinical interview questions. This allows for discussion of not only depression but anxiety and suicidal ideation, something we know is commonest in the postnatal year. iHV:PMHC welcomes that the inclusion of GAD 2 identification questions and further assessment using GAD 7 for general use but not for specific use by health visitors. iHV:PMHC welcome the recommendation that further assessment if women answer positively to either of the "Whooley" questions rather than asking the third question "is this something you feel you need or want help with for general use but not for health visitors who need to perform a much more detailed assessment. As recently announced by the Prime Minister the health visitor assessment should include not only the mental health of the mother, but include an assessment of the couple relationship and of the attachment relationships with the baby. Health visitors are in a unique place, through delivery of their universal services to identify any of these issues for the emotional wellbeing of families early in all families and this unique role requires formal recognition by NICE so that it is not out of step with the other national guidance and requirements already quoted.	them is not meaningful. In response to your, and other stakeholders', concerns that the Whooley questions may still fail to identify depression for some women, recommendation 1.5.5 has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are recommended to consider using a formal tool such as the EPDS as part of a full assessment. The role the health visitor (and other health and social care professionals who have regular contact with the woman) have in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8). In addition, recommendation 1.6.1 has been amended with a new bullet point added that assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include the mother-baby relationship. Moreover, recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					We support the suggestion that further assessment should also be recommended if there is a lack of congruence between a woman's' verbal responses to the identification questions and her presentation when these questions are being asked by non health visitors but as stated we call for a much more comprehensive assessment by health visitors to be expected by NICE as by others.	care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services.
Institute of Health Visiting	11	NICE	1.4.4	30	In principle we welcome the introduction of the statement advising referral to a specialist mental health practitioner for full assessment and treatment. However, this is expensive and ignores the fact that there is a very significant number of quite highly trained health visitors who are best placed to provide immediate interventions for low to moderate perinatal mental health. All have some training to do so. The aspiration of the iHV and the government is that all health visitors will have the training to do this. Many of these women are lonely or anxious and quite simple interventions led by health visitors will quickly improve their mental wellbeing. Health visitors have access to a very wide range of interventions including referral to mental health services via GPs (or directly), therapeutic groups, support groups, involvement of voluntary organisations such as HomeStart, use	Thank you for your comment. This recommendation does not advise that all women should be referred to a specialist mental health practitioner but rather that a formal tool (such as the EPDS or PHQ-9) could be considered 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 (see recommendation 1.5.5). NICE guidance does not generally specify the healthcare professional who should deliver recommended interventions but rather outlines key components. For women with persistent subthreshold depressive symptoms, or mild to moderate depression, or persistent subthreshold symptoms of anxiety, facilitated self-help is the recommended intervention, therefore, referral to and engagement with mental health services would not necessarily be

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					of Children's Centre activities, use of parent support from online groups such as Netmums as well as most health visitors being trained in some counselling approaches. iHV:PMHC welcomes the continued use of the EPDS by health visitors to further explore symptoms of depression but are concerned that the GDG perceives that the health visitor's role relates only to detection, further assessment and subsequent referral. This is not what mothers would want, is out of step with the evidence and with policy for the service. iHV:PMHC suggest that the guideline fails to acknowledge and address the management of those women who refuse to access GPs and mental health services and the potential impact that their mental illness may have on their relationships and on the cognitive, emotional, physical and behavioural development of their infant. This is where the health visitor focuses her activities. It is inadequate to only consider illness in the mother.	required. Facilitated self-help should include the provision of written materials, supported by a trained practitioner (face-to-face or by telephone) which in this context could include a health visitor.
Institute of Health Visiting	12	NICE	1.5.1	32	iHV:PMHC are delighted that the consultation guideline recommends a holistic assessment of the woman and that psychosocial factors that can impact on mental health and wellbeing are incorporated. iHV:PMHC would also welcome clarification of	Thank you for your comment. The GDG did not consider it appropriate to specify who should ask the initial case identification questions as it will be dependent on the woman's contact with services. However, greater specificity about professional roles in identification and assessment of depression and anxiety disorders

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					which professional group/s undertakes this assessment. In a complex environment there are many groups (who do not have a nursing/medical/social work background) but who feel that they are able to assess this vulnerable group Health visitors universally access all pregnant and postnatal women and this information is routinely collated and subsequent support / referral offered when necessary. iHV:PMHC feel that clarification and the identification of the role of the health visitor is therefore required when assessment of psychosocial factors impacting on mental health are recommended. This clarification will reduce the need for women to have multiple assessments and will confirm the health visitor's responsibilities in a stepped care model as required by the Healthy Child Programme.	has been added to other recommendations. For instance, recommendations 1.55-1.5.6 have been amended to include the option of referring the woman to her GP or (if a severe mental health problem is suspected) to a mental health professional. An additional recommendation has also been added in response to stakeholder comments that explicitly recognises the role of health visitors (and other health and social care professionals who have regular contact with the woman) in the ongoing assessment and monitoring of women in pregnancy and the postnatal period (1.5.8).
Institute of Health Visiting	13	NICE	1.5.3	32	We welcome this important addition but wonder whether a lack of family or other support should also be included here as well as in 1.5.5.	Thank you for this comment. We note your comment but think this is covered in recommendation 1.6.1
Institute of Health Visiting	14	NICE	1.5.4	33	and 1.5.5 We welcome this important addition and its formal recognition of the issue of safeguarding	Thank you.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Institute of Health Visiting	15	NICE	1.5.6	33	We welcome the consultation guideline recommendation of the development of a written care plan but feel that this should include desirable timescales. The care plan should, where appropriate also include the potential impact on the baby, unborn and in the post natal period and what protection is in place for the infant. iHV:PMHC feel that communication would be enhanced if when referring to "all involved professionals" a further statement was added "to include GP, midwife and health visitor i.e. those professionals offering women a universal service in the perinatal period who may have the most knowledge about her and her family. This would promote and encourage all involved professionals to participate in the Care Programme Approach.	Thank you for your comment. A new recommendation has been drafted to take into account some of your concerns, such as schedule of monitoring. However, the GDG felt it would not be appropriate to state which professional should be involved but rather the health plan should state who is involved and who is responsible for coordinating the care plan (see recommendations 1.3.5-1.3.6)
Institute of Health Visiting	16	NICE	1.6.2	34	This states that all interventions for mental health problems in pregnancy and the postnatal period should be carried out by competent practitioners. Health visitors are competent practitioners and offer up to 6 sessions of non-directive counselling or other psychological interventions they are trained in. However this statement appears only to refer to psychological services and does not acknowledge the important role of the health	Thank you for your comment. This recommendation does not only refer to psychological services but applies to any healthcare professional who is delivering an intervention for mental health problems in pregnancy and the postnatal period. High quality clinical supervision, monitoring and adherence mechanisms are implementation issues and have been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					visitor which in most instances has the potential to contain the illness and prevent it requiring secondary support – something that NICE should surely welcome as the government does. There is plenty of research to demonstrate the health visitor's contribution, certainly to postnatal depression but this seems not to have been acknowledged by this statement. Currently clinical supervision and certainly high quality clinical supervision is patcy for health visitors working in this area and health visitors do not have access to the the monitoring and adherence mechanisms suggested.	
Institute of Health Visiting	17	NICE	1.6.3	35	iHV:PMHC welcome the consultation guideline recommends reducing the timescales for assessment and subsequent treatment but feels this statement is a bit nebulous. Health visitors would never keep a mother in distress waiting a month for support and the range of psychological interventions they can provide. Should it say is referred to GP or secondary services…. We would suggest setting a time scale of within a week for health visitor services! iHV:PMHC Consideration must also be given to those women who refuse to be referred or to engage with mental health services as the consequences of maternal mental illness will potentially remain untreated affecting not only the woman but other family members, the	Thank you for your comments. NICE do not usually specify which healthcare professional delivers the recommended intervention but rather recommends key components and in this case, the required time scale for assessment, referral and delivery. It is also important to note that for women with sudden onset of possible symptoms of postpartum psychosis a referral to a secondary mental health service for immediate assessment (within 4 hours) is recommended. For women with persistent subthreshold depressive symptoms, or mild to moderate depression, or persistent subthreshold symptoms of anxiety, facilitated self-help is the recommended intervention, therefore, referral to and engagement with mental health services

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					infant and any other children. Women who have an established therapeutic relationship with their health visitor often find it more acceptable to engage in the universal plus component of the service than to access mental health services. This relationship needs to be acknowledged and valued as stigma, and the perceived consequences of admitting to having a perinatal mental illness still prevent women from accessing psychological therapy. Health visitors often, therefore, have a role in terms of engaging women through home listening visits in the therapeutic process, which we believe requires further consideration. The consultation guideline fails to address the management of women who refuse to access psychological services and the impact untreated maternal mental illness can have on the cognitive, emotional and behavioural development of the infant and child as well as the other relationships within the family.	would not necessarily be required. Facilitated self-help should include the provision of written materials, supported by a trained practitioner (face-to-face or by telephone) which in this context could include a health visitor. In response to your comments regarding listening visits, there was no high quality evidence to make a recommendation for listening visits. The economic analysis conducted for this guideline found facilitated self-help to be dominant when compared with listening visits. Cost-effectiveness results were driven by the superior efficacy of facilitated self-help and the relatively low intervention costs. The GDG considered this evidence together with what is known about the clinical and cost effectiveness of facilitated self-help for the treatment of depression in non-pregnant women, and recommended that facilitated self-help should be considered for women with persistent sub-threshold depressive symptoms, or mild to moderate depression.
Institute of Health Visiting	18	NICE	1.6.6	35	Once again the contribution of the health visitor, which will be with the majority of depressed mothers who may not need any other intervention, is ignored here. This guidance refers to the NICE guidelines 90 – This relies heavily on CBT. Whilst CBT has its	Thank you for your comment. There was evidence for moderate clinical benefits of facilitated self-help on depression symptomatology (scoring above threshold on a depression rating scale) and mean depression symptoms for women with sub-threshold to moderate symptoms of depression in

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					importance and the other options are also useful it only suits some women and this is not acknowledged. We question why the contribution of health visitors through their additional support and non-directive counselling, (listening visits) has been removed. This guidance is in danger of increasing not decreasing the mobidity of women in the perinatal period – indeed its very very worrying and something that could take another 7 years to turn around. Why would you ignore such an important service especially as there is an evidence base for health visitors work in this area. As well as the evidence base in the UK we wonder if you have considered the recent RCT led by Glavin K through public health nurses (health visitors) working in Norway? This demonstrated that not only the mother but also the baby did better as a result of the health visitor intervention. iHV:PMHC would like to advise that the Listening Visit contact may include a variety of methodologies including: • Non-directive counselling • Solution focused therapy • Motivational and Promotional interviewing • Mindfulness • Sleep hygiene • Infant attachment	pregnancy or the postnatal period. The economic analysis conducted for this guideline also found facilitated self-help to be dominant when compared with listening visits. Cost-effectiveness results were driven by the superior efficacy of facilitated self-help and the relatively low intervention costs. The GDG considered this evidence together with what is known about the clinical and cost effectiveness of facilitated self-help for the treatment of depression in non-pregnant women, and recommended that facilitated self-help should be considered for women with persistent sub-threshold depressive symptoms, or mild to moderate depression, and delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults (NICE clinical guideline 90), including the provision of written materials, supported by a trained practitioner (face-to-face or by telephone) which in this context could include a health visitor and typically consisting of six to eight sessions over nine to twelve weeks. The only Glavin reference that was identified by the evidence search was Glavin et al. (2010). "Redesigned community postpartum care to prevent and treat postpartum depression in women--A one-year follow-up study. [References]." Journal of Clinical Nursing 19(21-22): 3051-3062. This paper was excluded (based on title and abstract) as it was not an RCT (quasi-

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					These home contacts/listening visits are usually essential to get women into facilitated groups or accepting other interventions.	experimental design).
Institute of Health Visiting	19	NICE	1.6.10	36	iHV:PNHC are delighted that the consultation guideline incorporates tokophobia and this will need to be considered when service specifications are being agreed and mental health services commissioned.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Institute of Health Visiting	20	NICE	1.7.2	41	iHV:PMHC welcome this recommendation. We are assuming that this refers to the examination that all babies have within 72 hours of delivery. Members report that this examination is undertaken by GPs on discharge into the community and that mothers are required to visit their GP for the examination. Will GPs have the training in the case of babies who may be affected by their mother's substance misuse?	Thank you for this comment. Training to support implementation for the guideline is important but is outside the scope of the guideline. This has been passed on to the NICE implementation support team.
Institute of Health Visiting	21	NICE	1.7.3	41	It is also essential that there is good communication of such potential effects to the HV and midwive.	Thank you for your comment. See NICE recommendation which enforces good communication in a coordinated care plan.
Institute of Health Visiting	22	NICE	1.7.5	43	iHV:PMHC welcome that the consultation guideline recommends additional support and advice for women who have experienced a traumatic birth, stillbirth or miscarriage. However specialist mental health assessment provided by perinatal services requires further consideration as women who have experienced a miscarriage or stillbirth may decline to engage in a parent and baby service. Alternative	Thank you. The recommendation "offer support and advice to women who have had a traumatic birth…" has been revised in light of your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					services therefore need to be considered. iHV:PMHC are delighted that the consultation guideline requires professionals to consider the impact of perinatal mental illness on the mother infant relationship.	
Institute of Health Visiting	23	NICE	1.7.14	44	We welcome this section. Health Visitors have long known the effect of mental health issues and their impact on attachment However, further detail relating to suggested assessment tools and recommended interventions would be welcomed in order to ensure best practice is developed. iHV:PMHC acknowledge that another GDG are looking at Children's attachment but as this guideline is not expected until October 2015 professionals will require additional guidance in the interim.	Thank you for your comment. Recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services. The evidence for interventions which directly targeted the mother-infant relationship was mixed, but largely non-significant. This inconclusive evidence prompted the GDG to recommend a definitive trial of a mother-infant relationship intervention that examines clinical and cost effectiveness and reports on the mental health of the woman, the emotional and cognitive development of the baby, and the quality of the interaction with a follow-up period of at least 2 years.
Institute of Health Visiting	24	NICE	1.7.15	45	iHV:PMHC report that infant mental health services are not available nationally, therefore, if problems with the mother infant relationships remain unresolved commissioning	Thank you we have revised the recommendation and adopted a more general approach to this topic as we did not feel, following consultation, that the evidence

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					arrangements need to be reviewed or the GDG needs to consider alternative timely yet appropriate referrals and interventions.	available supported the previous recommendations.
Institute of Health Visiting	25	NICE	2.3	48	We welcome this section, however, we would also welcome some up-to-date and robust research on the impact of health visiting, given the recent investment – Call to Action. We would also welcome research on the current listening visit/contact - the contact, its content and outcomes for mothers and babies. There needs to be a re-evaluation as there has been considerable investment made. iHV:PMHC report that most Health Visitors feel confident and competent in completing perinatal mental health care.	Thank you for your comment. There is data on listening visits including a definitive trial which are reviewed in chapter 7 of the full guideline and therefore the GDG did not consider this a priority for further research
Institute of Health Visiting	26	NICE	App A	60	Point 4 iHV:PMHC report that the 3-4month contact is not commissioned in all areas in England; therefore a vital universal, evidence-based opportunity to assess, identify and support women with perinatal mental illness and her baby is not offered. The Whooley questions are made preferable to the EPDS despite the Whooley questions not being validated for routine use as a screening tool with postnatal women in the UK. We understand that its use is not endorsed by the National Screening Committee. The EPDS is a very good tool when properly by health visitors	Thank you for your comments. The evidence reviewed for the guideline on case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations under 'Recognising mental health problems in pregnancy and the postnatal period and referral'). However, based on your and other stakeholders' comments, these recommendations have been revised. The

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					used hence our national training of health visitors. We understand the need to include a process of quick inquiry that can be used by all those working with women who may have perinatal mental illness but adherence by all to Whooley will weaken not strengthen these mother's outcomes. We would respectfully like to suggest that you need to make a special case of health visiting interventions as they are difference as are those of secondary and tertiary services. iHV:PMHC have been unable to identify the evidence that the GAD 2 item scale is a valid tool for screening and detecting of Perinatal Mental Illness. Historically, the EPDS has been endorsed as the tool of choice; by Health Visiting along with a clinical interview to facilitate the recognition for the mother and the professional that depression &/or anxiety may exist. The National Screening Committee accept the use of the EPDS as a framework for assessment when used by health visitors but not as a generalizable screening tool. The iHV: PMHC training reinforces the use of the EPDS as a recognised tool and this knowledge is being disseminated nationally to all HV's. This will ensure that this approach is	recommendation advocating use of the Whooley questions and the GAD-2 has now been revised to say 'consider asking' rather than 'ask' and the 3-4 month timepoint has been removed. In addition, the role the health visitor (and other health and social care professionals who have regular contact with the woman) has in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation to say that at all subsequent contacts in pregnancy and the first postnatal year, the health visitor (and other healthcare professionals who have regular contact with the woman), should consider using the EPSD and the PHQ-9 along with the Whooley questions and GAD-2.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					embedded within practice nationally.	
Institute of Health Visiting	27	NICE	App A	61	Point 1: The iHV:PMHC training reaffirmed the EPDS as a reliable tool. It also acknowledged the unique access and contribution that Health Visitors offer to women with PMI, in strengthening the maternal / infant attachment. The early assessment, identification and support offered by HV, has been evidenced as an effective contribution in responding to a mild episode of depression and anxiety and possibly avoiding a further deterioration in the woman's mental health. Historically, and currently, Health Visitors are recognised within local health populations as providing a service for women with PMI, e.g. H.V.'s receive referrals from General Practitioners, Midwives, Community Adult Mental Health teams, Sure Start Children's Centres, Community Adult Substance Mis-use Teams, Home Start as well as women themselves, requesting health-needs support for perinatal mental illness symptoms.	Thank you for your comments. The guideline development group recognises and supports the important contribution of health visitors and has revised and added to the recommendations accordingly to say that at all subsequent contacts in pregnancy (after booking) and the first postnatal year, the health visitor (and other healthcare professionals who have regular contact with the woman), should consider using the EPSD and the PHQ-9 along with the Whooley questions and GAD-2.
Institute of Health Visiting	28	NICE	App A	62	Point 2: iHV: PMHC express concern that the guidance suggests women can access computerised CBT self-help tools, assumes that women have access to computers, are literate and have no learning disabilities, language or cultural barriers impeding their access to computer help. Potentially this further disadvantages those women, whose children	Thank you for your comment, but in the new guideline the format of the facilitated self-help that is recommended is face to face or via telephone.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					have the poorest outcomes. To delete the option of a face to face psycho-social intervention, e.g. group education / support, designed specifically for women with perinatal mental illness or at risk of developing perinatal mental illness is a serious concern.	
Institute of Health Visiting	29	NICE	App A	62	Point 3: iHV: PMHC are astounded with the lack of insight into the core competencies' and daily workload undertaken by Health Visitors, nationally. The Family Health Needs model, practiced by H.V.'s each and every day, includes assessments of the psychological and social resilience at every family contact and is especially promoted when a H.V. makes an assessment to identify and support mothers with perinatal mental illness.	Thank you for your comment. The guideline development group recognises and supports the important contribution of health visitors, and has revised and added to the recommendations accordingly. The role the health visitor (and other health and social care professionals who have regular contact with the woman) has in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8).
Institute of Health Visiting	30	NICE	App A	63	Point 2: iHV: PMHC feel that as a health visiting service, we are already meeting the time frame & offering evidence-based support. However, the tone of the draft guidance appears to suggest that the H.V.'s support is out dated or of no value to women in the ante or postnatal period, with perinatal mental illness. Our experience of response times from the Community Adult Mental Health services, in the current climate, leads us to believe that the draft guidance is unrealistic & that this	Thank you for your comment. The guideline development group recognises and supports the important contribution of health visitors, and has revised and added to the recommendations accordingly. The role the health visitor (and other health and social care professionals who have regular contact with the woman) has in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8).

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					proposed change will result in many vulnerable women left unsupported, with their infants vulnerable to safeguarding concerns.	
Institute of Health Visiting	31	NICE	App 1	70	Point 60 In some areas iHV:PMHC have adopted the Milgrom CBT programme for women with mild to moderate depression. This programme incorporates a mental health well-being tool kit including exercises to empower women to recognise & support their own emotional & psychological health, facilitated by the group facilitator & the peer participants.	Thank you for your comment. The Milgrom CBT programme was included in the review of psychological interventions conducted for this guideline (see chapter 7) and is a facilitated self-help model consistent with the facilitated self-help for women with persistent subthreshold depressive symptoms or mild to moderate depression recommended in the guideline.
Institute of Health Visiting	32	NICE	General	0	Whist the guidance, in the main, is focused on antenatal and postnatal mental health we cannot disregard the fact that mothers still play a central role in family life and are directly affected and bombarded with determinates that will either positively or negatively effect them. These may not impact on their mental health but may have a negative impact on the child, such as attachment issues, growth and development and safeguarding issues. We welcome the fact that the guidance has in part taken this into account. A welcome addition would be acknowledgement of the effects of perinatal mental illness on the couple relationship. Health Visitors are trained to take all these	Thank you for your comment. The scope of this guideline was to review the role of the family, carers and peers in the treatment and support of women with mental health disorders in pregnancy and the postnatal period. Which we believe has been covered amply throughout the recommendations. It is beyond the guideline's remit to review perinatal mental illness on the couple's relationship.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					issues into consideration when developing a package of care for mothers/families. Health Visitors are one of very few professional groups who maintain a relationship with families until the youngest child is 5 years of age via the Healthy Child Programme which can be supported by a number of other guidance's/packages such as this guidance.	
Institute of Health Visiting	33	NICE	General	0	Whooley Questions. Some professional groups prefer to use the Whooley questions due to time constraints as they can be asked quickly, however, mothers have issues with understanding them. Each question has to be broken down, which makes the time argument incongruous, so you may as well use a more appropriate tool. The questions also pose a major problem if mothers have issues with literacy or if English is not the first language.	Thank you for your comment. Based on GDG consensus, the recommendation reads, the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. In response to your, and other stakeholder's, concerns that the Whooley questions may still fail to identify depression for some women, the next recommendation has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						recommended to consider using a formal tool such as the EPDS as part of a full assessment. This guideline is to be read in conjunction with the service user experience in adult mental health (CG136), see recommendation 1.1.3 which address communication needs. However, the group feels the administration of the screening questions is an implementation issue and this has been passed on to the NICE implementation support team.
Institute of Health Visiting	34	NICE	General	0	Healthy Child Programme The programme sets of a national set of targets/contacts for health visitors. The programme ideally places Health visitors to be the first line of screening and treatment, (low to moderate mood), or referral. There is no need for additional cost for other professionals to be involved at this stage.	Thank you for this information.
Institute of Health Visiting	35	NICE	General	0	A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals Launched on 1st July 2014 states that 'Beginning of life' is a priority area of high impact. Maternal mental health is addressed and Health Visiting highlighted.	Thank you for this information.
Institute of Health Visiting	36	NICE	General	0	Listening Visits Omitted from the updated guidance – see above. They could be viewed/implied as part of Low	Thank you for your comment. A new recommendation has been drafted to specify the role of health visitors. However, it should be noted that a range of psychological services do provide services at home and by telephone.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					intensity interventions as described in the supporting document, (adult mental health NICE guidance) but are not explicit. However, if and when this guidance, adult mental health, is reviewed it may potentially impact on this, antenatal and postnatal mental health, guidance. Some other psychological interventions are already provided by health visitors - (via the listening contact/visit and support groups) Training that has already been implemented to ensure that these contacts are effective and have positive outcomes for both mother and baby. iHV:PMHC are reporting that unless they are stipulated as 'listening visits/contacts by the Health Visiting service they will not be commissioned as such. With the move to local authority commissioning this puts the early identification of women with Perinatal mental illness at significant risk. iHV:PHMC are asking for listening visits, undertaken by health visitors, to be written back into the guidance.	
Institute of Health Visiting	37	NICE	General	0	Added Value of the Health Visitor Listening Visits and the wider determinates of health	Thank you for your comment. A new recommendation has been drafted to specify the role of health visitors.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Interventions provided by other professional groups will not pick up the wider determinates of health and their impact for the mother or her family. iHV:PMHC report that Health visiting does not just see the mother as a separate 'person': Heath visitors view the whole picture and there is not a drive to provide a fixed amount of sessions/contacts. If health visitors are unable to provide the right service they will refer appropriately. Other services can only provide a fixed number of sessions to mums exclusively e.g. IAPT. HOWEVER, what the added value that health visiting brings to the debate and the most vulnerable of families is that the health visitor is the only professional group that will contact these mothers and families until the youngest child is 5years old. The other health visitor is also very experienced at working with marginalised groups such as those who have English as a second language who might otherwise receive no services. Contacts are brokered through link workers or interpreters.	
Institute of Health Visiting	38	NICE	General	0	Attachment and Early Years Development Health visitors receive training in	Thank you for your comment and references. Recommendations were made regarding mother baby interaction however 'attachment'

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					secure/insecure attachment and how to support mothers via programmes such as Solihull Approach and Brazelton and the iHV will shortly be rolling out Champions training in infant mental health to specialist health visitors who will then cascade this training on to all health visitors. This is recognized by 1001 Critical Days http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf [redacted]	was beyond the scope of this guideline. A specific guidance is under development and will be published in October 2015 covering Children's Attachment needs.
Institute of Health Visiting	39	NICE	General	0	Safeguarding The nature of health visiting and having a holistic approach to mothers, children and the wider family means this professional group is the most trusted by families and has access to provide support to the most vulnerable in society. Health visitors are able to use their skills to identify issues of safeguarding and refer appropriately.	Thank you for your comment. The GDG felt it appropriate to follow local safeguarding protocols if there is a risk of or there are concerns about suspected child maltreatment.
Institute of Health Visiting	40	NICE	General	0	Health Visitor Implementation Plan: Call to Action: Increase numbers in the workforce, building capacity. Up to date information: Health visitors in the past had reported that they did not feel confident in managing low to	Thank you for your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					moderate mood. However, 400 iHV PMH Champions have completed Perinatal Mental Health training. Each Champion who was sponsored by their organization made a commitment that each Champion would cascade training to 30 more health visitors. This has a potential for over 11,000 of the health visiting workforce to be trained in providing low intensity interventions (the listening visit/contact). No other workforce can boast this. Across the country we now have 25% (over 3000, and growing daily), of the workforce trained.	
Institute of Health Visiting	41	NICE	General	0	Our members are the only professional group that has a Universal Package of care to women and children that can be stepped up as required. Health Visitors will have continued contact with families until the youngest child is 5 years of age.	Thank you for your comment.
Institute of Health Visiting	42	NICE	2	46	Research Recommendations iHV:PMHC welcome the areas for research as identified. However, we also feel that the outcome of the research could have made a very significant contribution to the	Thank you for your comment. The GDG agree that were the research recommendations to be implemented and trials run, results collected and analysed, and included in the guideline review, they would inevitably have an impact

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					reformulated guidance currently proposed.	upon the recommendations made and that is in fact why they are research recommendations
Institute of Health Visiting	43	NICE	General	0	The tone of the guidance, in our opinion, discounts and underestimates the needs of many women who suffer mild to moderate symptoms perinatal mental illness. Without early intervention these will become severely ill and require expensive secondary services. The iHV:PMHC feel that the draft guidance unfortunately appears predicated on an overtly medical, psychiatric, and medication model, focussed on the minority of women with severe perinatal mental illness.	Thank you for your comment. The guideline is concerned with a broad range of mental health problems, including depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness (such as psychosis, bipolar disorder, schizophrenia and severe depression). This includes women with subthreshold symptoms and those with mild, moderate and severe mental health problems. However, the guideline focuses on the aspects of their expression, risks and management that are of special relevance in pregnancy and the postnatal period. Thus, the guidelines should be used in conjunction with other NICE guidance about specific mental health problems (see recommendation 1.1.2). The GDG do not agree that the needs of women with mild to moderate mental health problems are not captured by the recommendations. For a woman with persistent subthreshold depressive symptoms, or mild to moderate depression, or persistent subthreshold anxiety symptoms, in pregnancy or the postnatal period, the guideline recommends that facilitated self-help is considered, and for women with moderate depression or an anxiety disorder in pregnancy or the postnatal period high-intensity psychological interventions (for example, CBT) are recommended as a treatment option alone

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						or in combination with medication.
Institute of Health Visiting	44	NICE	General	0	iHV:PMHC tell us that referrals to the Community Adult Mental Health services are rarely accepted as the women's symptoms do not meet the mental health services threshold for support. This is increasingly evident as midwives are now referring these women to us, in part because the service offers visits during the antenatal period as standard practice. Therefore potentially health visiting will be identifying more women.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Maternal OCD	1	Full	7.5.8	414	p414-16 Making an assumption that this is about the Timpano study - it is not a clinical study, so the heading here is a bit misleading. Also it has been rated as very low quality and we would request clarification regarding this rating.	Thank you for your comment. The single study in the review in this section is the TIMPANO2011 study. This study was categorised under treatment for sub-threshold symptoms of OCD. Given the inconsistency across studies in how disorders in pregnancy or the postnatal period are characterized and how researchers define their trials as preventative or as treatment, the GDG took the decision that for the purposes of clarity and transparency inclusion criteria and/or baseline mean symptom scores were used to make the distinction between prevention and treatment studies (see 7.2.1 and 7.2.2 for outline of this review strategy). The GDG took the view that it was preferable to be over-inclusive and include women with sub-threshold symptoms in the treatment review. Where there was available data (which unfortunately was not the case for this comparison or outcome), sub-analyses

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						were conducted to evaluate any differences based on baseline diagnostic status. The confidence in the effect estimates from this study were rated using GRADE as very low (please see the footnotes of Table 174 for reasons for the quality ratings). A GRADE rating of very low means that we are very uncertain about the estimates, and in the case of this study that is due to imprecision (the total population size is less than 400 [a threshold rule-of-thumb] and for some outcomes the 95% confidence interval crosses both the line of no effect and measure of appreciable benefit or harm) and the paper omits data (data not reported for EPDS, OBQ, SCID and PTBC)
Maternal OCD	2	Full	2.3	21	p21-29 We can't find a mention of emetophobia - not well understood but does have a direct impact in relation to very low fertility rates and high abortion rates as people so fearful of vomiting during pregnancy. [redacted] has survey data highlighting this - this can be sourced if requested. It is often mistaken for OCD/eating disorder so worth including.	Thank you for your comment. The literature search did not find any evidence on emetophobia.
Maternal OCD	3	Full	General	0	There is not very much about OCD at all - it seems that all anxiety disorders are grouped together in terms of treatment - the last guideline broke it down a bit more.	Thank you for your comment. The decision was made by the GDG that only recommendations which differ from specific existing mental health recommendations will be included in this guideline for the sake of clarity and precision. This is mentioned in NICE recommendation 1.1.2. We do however acknowledge your

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						concern and have gone further to include new recommendations on anxiety.
Maternal OCD	4	Full	General	0	It is true that there is a real dearth of evidence, particularly regarding postnatal anxiety disorders but this could be more explicit. Especially as anxiety disorders can be very different in terms of particular effects on parenting and stigma regarding help-seeking.	Thank you for your comment. The GDG felt we have made recommendations to go some way to assessing a variety of mental health problems; notably anxiety disorders, which in the glossary defines the anxiety disorder and includes OCD. We do however acknowledge your concern and have gone further to include new recommendations on anxiety.
Maternal OCD	5	Full	General	0	There is not much about diagnosis/misdiagnosis - there is a mention of the fact that normal levels of anxiety are not well understood but this could be more prominent in assessing the evidence base for anxiety.	Thank you for this point. We agree that this is important and hence have now included recommendations about identification of anxiety. In addition in the full guidance we now make reference to under identification of depression and anxiety. Also, please see changes in the introduction of the full guideline Chapter 2, section 2.5, which highlights the consequences of under detection.
Mellow Parenting	1	NICE	1.7.4	41	Women using drugs or alcohol during pregnancy as well as other vulnerable women should have access to personal support and an introduction to infant mental health during pregnancy. This is helpful in itself and likely to promote the welfare of the mother and baby, but also establishes the sort of trusting relationships likely to promote engagement with appropriate services after delivery. Programme such as mellow Bumps, an attachment based stress-reduction programme offered to vulnerable women in pregnancy have	Thank you for your comment. The Puckering (2011) paper referenced was not identified by the evidence search and cannot be found now, a Puckering et al. (2010) study on intervention efficacy of mellow babies was identified by the search but was excluded (see Appendix 18) as data could not be extracted for analysis (the N on which outcome data were based is not reported)

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					been shown to reduce anxiety depression and irritability in pregnancy and lead to longer gestation and better birth weights for the babies. Puckering, C. (2011) Mellow Bumps: an antenatal programme for families under stress. Children in Scotland, 119, 18-19	
Mellow Parenting	2	NICE	1.7.14	44	The evidence does not support that the mother-baby relationship will automatically improve with the treatment of the mother's mental health problem. Cooper et al (2003) and Murray et al (2003) show that while maternal depression can be improved with a variety of appropriate interventions, there is no commensurate improvement in the mother-baby relationship of the baby's later outcome. In a small waiting list RCT Mellow Babies has been shown both to improve maternal mental health and the quality of the mother-baby interaction. Cooper, Peter J., et al. "Controlled trial of the short-and long-term effect of psychological treatment of post-partum depression 1. Impact on maternal mood." The British Journal of Psychiatry 182.5 (2003): 412-419. Murray, Lynne, et al. "Controlled trial of the short-and long-term effect of psychological treatment of post-partum depression 2. Impact	Thank you for your comment. The Puckering et al. (2010) study on intervention efficacy of mellow babies was identified by the search but was excluded (see Appendix 18) as data could not be extracted for analysis (the N on which outcome data were based is not reported). The Cooper et al. (2003) and Murray et al. (2003) papers which report on the same trial were included and reviewed here and provide evidence that a structured psychological intervention (IPT) aimed at maternal depression can significantly reduce mother-infant attachment problems at endpoint (see section 7.5.12 in full guideline). However, the GDG agree that the evidence does not support that the mother-baby relationship will automatically or always improve with the treatment of the maternal mental health problem and the recommendation has been amended in response to stakeholder comments.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					on the mother—child relationship and child outcome." The British Journal of Psychiatry 182.5 (2003): 420-427. Puckering , C., McIntosh, E. and Hickey A. (2010) Mellow Babies: A group intervention for infants and mothers experiencing postnatal depression. Counselling Psychology Review, 25(1), pp 28-40	
Mellow Parenting	3	NICE	1.7.15	45	Health visitors themselves do not feel they have the time or the skills to assess the relationship between the mother and child. Health visitors require more training in structured assessments of the relationship and then the opportunity to specialist infant mental health services where they are required. Wilson, P., Barbour, R.S., Graham, C., Currie, M., Puckering, C., and Minnis, H., (2007) "Are they holding it like this?" Health visitors' assessments of parent- child relationships. International Journal of Nursing Studies, 45 (8), 1137-1147	Thank you for your comment. Recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
National Childbirth Trust	1	NICE	General	0	NCT welcomes this guidance and feels that it generally reads very well. What struck us is that many of the recommendations made in 2007 have still not been implemented (e.g. specialist perinatal mental health services accessible to all) and it is imperative that NICE, the NHS (NHS England, CCGs) Public Health England and local authorities should be concentrating their efforts to achieve these goals.	Thank you for your comment. This is an implementation issue, and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					NCT recently conducted a survey, which highlighted that the vast majority of CCGs within England do not currently have a perinatal mental health strategy in place. Freedom of Information requests were sent to 194 CCGs in England. Out of the 186 CCGs that replied, only 3% said they currently had a perinatal mental health strategy. Out of the 97% with no strategy, 60% have no plans to put one in place. Fifteen percent of CCGs were unable to offer any information and directed the charity to local NHS trusts or NHS England, suggesting a lack of clarity about who is responsible for commissioning and providing services. NCT also contacted 193 NHS trusts to ask if they were able to provide a perinatal mental health service with trained specialists. Over half of all trusts (54%) said that they do not provide any perinatal mental health service. Thirty-three trusts (17%) did not respond to the FOI request. Only 26% of the trusts contacted provide a dedicated perinatal mental health service. However, just 13% of trusts contacted have a full team in place. Fourteen percent are employing only one specialist perinatal mental health midwife or doctor, frequently on a part-time basis	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
National Childbirth Trust	2	Full	General	0	NCT recommends that more from the full guideline is included in the NICE guideline. NCT felt that there was a wealth of information in the full version of the guidance that did not translate well into the NICE version. The sections and recommendations included in the NICE guideline do not always link clearly to those in the Full version. We are concerned that this will have detrimental implications for the extent to which the guideline is implemented. In particular, the Introduction is important and in the NICE version is currently not as well structured and clearly written as we feel it should be. In parts it is positively misleading (see below).The introduction of the full guideline is, in contrast, very much clearer and well structured. We suggest including more from the full guideline. As a minimum, we suggest including the following paragraphs from the full version word-for-word in the NICE version (the last para of this section from the full version might also usefully be included): This guideline covers the mental healthcare of women who have, or are at risk of mental health problems in the perinatal period, which comprises pregnancy (the 'antenatal period')	Thank you for this comment. We have made some changes to the introduction to the NICE guideline to improve the structure and we have added the paragraph you have quoted from the full guideline about the broad range of mental health problems experienced by women in pregnancy and the postnatal period. However it should be noted that the purpose of the introduction to the NICE guideline is to give a brief overview of the topic. Also, the NICE guideline and full guidelines are purposefully structured in different ways – the NICE guideline follows a woman's journey through health services, whereas the full guideline is structured according to the evidence reviews and all of the recommendations in the full guideline are linked to the evidence reviews via the 'Linking evidence to recommendations' sections.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and the 'postnatal period' (from childbirth to the end of the first postnatal year) – the period that defines most specialist perinatal mental health services. The guideline is concerned with a broad range of mental health problems, including depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness (such as psychosis, bipolar disorder, schizophrenia and severe depression). This includes women with subthreshold symptoms and those with mild, moderate and severe mental health problems. However, the guideline focuses on the aspects of their expression, risks and management that are of special relevance in pregnancy and the postnatal period. Thus, the guidelines should be used in conjunction with other NICE guidance about specific mental health problems (see http://www.nice.org.uk/guidance/index.jsp?action = bytopic&o = 19 7281). The guideline also makes recommendations about the services required to support the delivery of effective identification and treatment of most mental health problems in pregnancy and the postnatal period in primary and secondary care. It will also be relevant to (but not make specific recommendations for) non-NHS services such as social services and the	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					independent sector. The optimisation of psychological wellbeing, as opposed to the management of mental health problems, is not covered in this guideline, however, the importance of this is implicit. The mental health needs of fathers, partners, other carers and children, whose health and functioning will inevitably be affected by mental health problems in women, are also important and should not be neglected, and their needs have been considered in developing the recommendations in this guideline. In relevant places, the phrase 'partner, family or carer' has been used to remind readers of the continued importance of thinking about mental health problems within the context of the family.	
National Childbirth Trust	3	Full	2.5.3	31	p31-32 It would be helpful if the full guideline made a more positive statement about the potential benefits of pharmacological treatment when first introducing and (rightly) discussing the (known and unknown) risks associated with pharmacological treatments during pregnancy and while breastfeeding. Getting the balance right on this point is both important and challenging. As the public have open access to clinical guidelines through the internet, it is especially important that messages are carefully drafted to inform and support decision-making and to avoid language that might mislead or	Thank you for your comment. We feel the statement that "As with psychological interventions, there is little evidence to suggest that pharmacological treatments (the mainstay of treatment of mental health problems in the NHS) have any differential benefit in pregnancy or the postnatal period from their use in other adult populations" makes this point and hope the guideline achieves the right balance in its revised recommendations which now highlight the importance of pharmacological treatment for many women

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					undermine informed decision-making.	
National Childbirth Trust	4	NICE	Introduction	4	It is unclear from paragraph four on page four of the introduction whether the guideline is intended for those providing maternity care as well as healthcare professionals providing specific intervention. We suggest amending as follows to include the underlined text: "The recommendations are relevant to all healthcare professionals providing interventions and maternity care for women with mental health problems."	Thank you for your comment. The guideline development group agrees that it is not clear that the guideline encompasses other professionals not directly involved in providing specific interventions for mental health problems. The statement has been amended in the introduction to the NICE guideline.
National Childbirth Trust	5	General	General	General	This guidance needs to be written in a way that staff who are not mental health specialists (e.g. GPs, midwives and health visitors) can understand it, as well as providing useful guidance for specialists.	Thank you. The GDG felt the language used would be easily understood by a wider range of professionals and where greater clarity on certain terms was required a glossary can be found in the NICE guideline see, 'Terms used in this guideline'.
National Childbirth Trust	6	Full	2.5.4	33	The NICE summary paper is unclear on who is responsible for carrying out mental health assessments at various points on a woman's pregnancy and postnatal journey. Midwives do not always feel equipped to carry out mental health assessments (see reference below). In order to increase the chances of these guidelines being implemented, it may be necessary to specify which health disciplines need to carry out these assessments, and which NHS staff are suitably trained and experienced. Many of the community health services will require extra support to provide appropriate	Thank you for your comment. We have added more detail on examples of professionals who may be carrying out certain tasks. However as a general rule NICE guidance avoids over specifying which professionals should do which task as roles change over time and the guidance needs to be relevant whatever the changes in policies and organisational changes to the NHS. We have emphasised the need for professionals to be suitably trained and competent in recommendations.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					diagnosis, support and care. We found figure 1 in this section quite helpful; it needs to be formatted so that all the information can be seen clearly and consideration given to including this in the summary doc, with links to the full guidance, in order to emphasise the need for full integration of CCGs, Public Health England and mental health services in order to provide a wrap round service. With the changes in the organisation of the NHS in England and the respective roles of DH, NHS England, Public Health England, CCGs, and health and wellbeing boards, we are very concerned that responsibility for implementing guidance and developing fully integrated and responsive services is unclear. A consequence of this is that people in need of services are missing out. Any guidance which NICE can give is very important in assisting these processes. This will help to ensure that staff are suitably trained and experienced to implement this guidance, or at least make it easier for organising bodies to identify areas where more specialist mental health training is needed. Reference: Hamilton, S.K.D. (2014) Improving the Identification of Perinatal Mental Illness through an Evaluation of Midwifery Education in England Unpublished poster presentation at: Royal College of Psychiatrists General Adult Conference, May 9 2014, Perthshire, Scotland	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
National Childbirth Trust	7	General	General	General	Use of the term 'psychotropic' seems less helpful than 'mental health medications' used by the National Institute of Mental Health (http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml) who state these are 'Sometimes called psychotropic or psychotherapeutic medications'. If you do decide to keep the term 'psychotropic', please provide a clear accessible explanation in the NICE guideline, such as 'This includes all medications used in the treatment of depression and anxiety disorders as well as those for conditions such as psychosis and bi-polar.'	Thank you for your comment. The term 'psychotropic medication' has been used for consistency with other NICE guidelines on mental health topics, but we have added a definition to the NICE guideline as you have suggested.
National Childbirth Trust	8	NICE	1.8	45	We welcome the recommendations 1.8.2 and 1.8.3 (pg. 46) from the 2007 guidance; however we feel greater steps towards implementing this recommendation need to be made. We are strongly in favour of recent government proposals to ensure that there is a specialist mental health midwife post in each maternity unit by 2017. We propose that there is a strong need for equivalent provision for women after completion of midwifery care, with the health visitor or GP as first point of call, plus good lines of communication between the different sections of the service, where all those providing care must have had adequate training in perinatal mental health	Thank you for your comment. The previous 2007 guideline recommendation concerning clinical networks has been added to the key priorities for implementation.
National Childbirth	9	Full	General	0	Mental health is a field in which the voluntary	Thank you for your comment. The contribution

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					sector/ private sector provides a significant level of service. 'Some guidance on the interaction between NHS and other services would be helpful to encourage best practice and joint working. We suggest this: • To avoid mental health professionals working in silos, and to encourage and enable the sharing of good practice • As the reality of waiting lists means that sometimes alternative support is appropriate and could be recommended. Some women may seek it out themselves. • So that all parties caring for women with mental health issues and their families can work together to provide support specifically for those at risk of suicide.	of the voluntary and independent sectors is referred to in the 'Organisation of perinatal mental health services', section 2.5.4 in the introduction of the full guideline. Poor communication has often been identified as the reason for poor-quality care and was behind the development of the care programme approach in the UK healthcare system. The Experience of Care chapter in the full guideline (section 6.25) explains 'It is, however, important to note that although some women had positive experiences of integrated care, a recurring theme experienced across the care pathway was an unmet need for the sharing of information and treatment planning between professionals and a fragmented care plan.' A number of recommendations in the guideline update advise on care planning, see Section 1.6 Assessing mental health problems in pregnancy and the postnatal period and care planning of the NICE guideline.
National Childbirth Trust	10	General	General	General	Whilst we understand that this is a NICE decision rather than the GDG, NCT feels very strongly that the strength of evidence for the recommendations should be re-instated. We have found it difficult to establish the strength of evidence supporting a recommendation from the wording being used. We find the GRADE and WHO way of presenting this information (giving the strength of a recommendation and the quality of the	Thank you for your comment. Please note that GRADE was used to rate the quality of all clinical efficacy evidence and the GRADE rating is included in the clinical evidence sections throughout the full guideline. The strength of each recommendation is reflected in the wording of the recommendation (see guidance at the beginning of the NICE guideline). The 'linking evidence to recommendation' sections of the guideline make clear the distinction

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					evidence on which there recommendation is based) much easier to follow. We particularly would like to see the Good Practice Point (GPP) reinstated as we feel it is critical for the reader to be able to differentiate between GPP and evidence based recommendations.	between evidence-based and expert consensus recommendations
National Childbirth Trust	11	Full	3.8	60	All pages P60 lines 30&31 We find using wording to represent the strength of evidence very difficult to grasp, and we feel it does not give the reader the information he/she needs. We much prefer the suggestions made in Grade, and used by WHO in its guidelines, where a recommendation is labelled as either a strong or weak recommendation with the quality of the evidence which supports the recommendation also given (ranging from high to very low). Grade software and guidance manual: http://tech.cochrane.org/revman/other-resources/gradepro/download	Thank you for your comment. Please note that GRADE was used to rate the quality of all clinical efficacy evidence and the GRADE rating is included in the clinical evidence sections throughout the full guideline. Please see the NICE guidelines manual for further detail on how the approach taken by NICE differs from the standard GRADE approach (section 6.2.1) and for further detail on how the wording of recommendations reflects the strength of the recommendation (section 9.3.3)
National Childbirth Trust	12	General	General	General	We recommend that in the NICE version there is a link relating to the page in the Full Guideline and to pages in any relevant appendices. We recommend that in the NICE version there is a link relating to the page in the Full Guideline	Thank you for your comment. We are currently unable to make links between the Full and NICE guideline but NICE are aware of these concerns and are exploring options to improve the situation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and to pages in any relevant appendices. We have found it very time consuming to track down the evidence behind some of the recommendations due to lack of such links. It is extremely confusing to have different numbering in the full guideline and the NICE version. We assumed that the NICE version would have the same chapters as the full guideline but just list the recommendations – this appears not to be the case. We felt there was a wealth of useful information (to a wider audience) in the full guideline. It is very difficult to find the evidence behind the recommendations.	
National Childbirth Trust	13	NICE	General	0	We would welcome an Index in the NICE version as there is in the Full Guideline.	Thank you for your comment. We do not produce Indexes for either the NICE or the Full version of the guidelines.
National Childbirth Trust	14	Full	2.2.2	17	We suggest that the following comment from the full guideline is included in the NICE version; we have added the second clause as a clear rationale. 'The focus on the needs of the baby by both the mother and healthcare professionals should not obscure the needs of the mother, as the mother's health and wellbeing is important both in its own right and for the baby and the wider family.'	Thank you for your comment. The GDG feels that it has got the balance right in the NICE guideline regarding the needs of the mother and the baby. NICE recommendations do not usually have a rationale unless the recommendation will lead to significant changes in practice.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
National Childbirth Trust	15	Full	2.2.2	17	The following text is unclear: "The context of the discussion (maternal mental health problems being causally related to problems in/for the fetus/baby) suggests that there may be a causal relationship between women's mental health and their partner's mental health." Is this the case? Is there also an independent relationship? i.e. that women with mental health problems are more likely than women in general to have a partner with a mental health problem. If the relationship is unclear, it would be helpful to say so. 'However, there is evidence of increased risk of adverse outcomes for the fetus/baby, and subsequently in childhood (see Chapter 6, Case identification and assessment) and an increased risk of mental health problems in the partners of women with mental health problems in pregnancy and the postnatal period (Lovestone & Kumar, 1993).	Thank you for your comment. The first paragraph you have quoted is not from the guideline, therefore we are unable to address whether this is unclear. In the second paragraph you have quoted, reference is made to there being some evidence (from Lovelace & Kumar, 1993) for an increased risk of mental health problems in the partners of women experiencing a mental health problem in pregnancy and after childbirth.
National Childbirth Trust	16	Full	2.2.4	20	The following passage is unclear and seems contradictory. We suggest that the following underlined sections are clearer and more accurate: 'Although there is an increased risk of adverse outcomes in the children of mothers with mental health problems, these are not inevitable and the effect sizes are moderate or	Thank you for your comment. We have edited this section to remove "and the effect sizes are moderate or small" from the quoted paragraph as this may have led to some confusion and hope this clarifies the point being made here.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					small. It is difficult to establish whether many of the associations are causal because large sample sizes are needed to disentangle the effect of mental health problems in pregnancy and the postnatal period from other risk factors. There is growing evidence, for example, that socioeconomic adversity, higher socioeconomic status and higher levels of education modify the association between depression in the postnatal period and child outcomes; that is, poor outcomes occur only predominantly in families living in socioeconomic difficulties (Pearson et al., 2013; Lovejoy et al., 2000).	
National Childbirth Trust	17	Full	2.3.1	22	The following two studies seem to have very similar findings, providing useful reinforcement of evidence that both diagnosed depression and women's self reporting of depressive symptoms is higher in pregnancy than in the early postnatal weeks. Why do you say that the findings 'contrast' and emphasise 'variation in rates'? 'Gavin and colleagues calculated the period prevalence (that is, the rate over a period of time) as 12.7% in pregnancy, 5.7% from birth to 2 months postnatally, 6.5% at 6 months and 21.9% at 12 months. However, for most of these estimates, only a single study was found. The estimates contrast with a large-scale community prospective study of around 8,300 women (based on the Avon Longitudinal Study	Thank you for your comment. These findings differ because the period prevalence is for depression over the whole of pregnancy (the point prevalence for the third trimester is included and is 3.1%) whereas the Evans study reports 13.5% at one point in pregnancy (the pregnancy period prevalence would therefore be much higher).

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					of Parents and Children [ALSPAC; O'Connor et al., 2003; Heron et al., 2004]), which measured depressive symptoms in pregnancy and the postnatal period (from 18 weeks' gestation to 8 months postnatally), and found that depression scores were higher at 32 weeks' gestation than at 8 weeks postnatally, with 13.5% scoring above threshold for probable depression at 32 weeks and 9.1% at 8 weeks postnatally (Evans et al., 2001). The study used self-report measures (Edinburgh Postnatal Depression Scale [EPDS] 4 and Crown-Crisp Experiential Index [CCEI]) and did not confirm diagnoses of depression. The variation in rates found is probably a result of different populations studied. It should be noted that Gavin and colleagues (2005) used only studies where depression had been diagnosed according to recognised criteria rather than self-report measures.	
National Childbirth Trust	18	Full	2.3.1	23	The following does not seem to make sense. Why link the two findings with 'however'? they seem to be mutually reinforcing: There has been some debate over the putative increased incidence of depression in the postnatal period with early research reporting incidence to be raised approximately threefold in the first 5 weeks postnatally (Cox 20 et al., 1993). However, recent longitudinal population-based studies have observed increased	Thank you, the text has been amended and the word 'however' removed.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					incidence during the postnatal period (Ban et al., 2012; Munk-Olsen et al., 22 2006).	
National Childbirth Trust	19	NICE	Key prioritie s	10	Key priorities for implementation (NICE, p10-14) NCT welcomes the inclusion of principles of co-ordinated care (point 1.2.6 in the NICE summary) in this section. We note that it refers to mental wellbeing, as well as mental health, and feel it is important that strategies to manage this are included in this guideline. Mental wellbeing may be covered by other guidelines, but if so this document needs to contain the link to such guidance. Consideration should also be given to the specific needs of pregnant women or mothers with babies, who may not be physically able to join general exercise programmes designed for those with low mood, or need to be able to take their baby when attending support programmes.	Thank you for your comment. Please see Chapter 7, Section 4 of the full guideline for the review conducted on prevention of mental health disorders in pregnancy and the postnatal period. The optimisation of psychological wellbeing, as opposed to the management of mental health problems, is not covered in this guideline, however, the importance of this is implicit. There are no guidelines that we could link to for mental wellbeing, but the GDG did not feel this was entirely necessary. In regards to the third point, the NICE recommendation 1.7.1 does stress all healthcare professional providing assessment and interventions to women in pregnancy and postnatally should understand the variations of the mental health, the impact on treatment and the context in which they are assessed; this includes acknowledging that the woman may not be able to leave the house or keep to a booking visit time.
National Childbirth Trust	20	NICE	Key prioritie s	10	NCT suggests that an additional key priority for implementation should be included to help ensure implementation of the 2007 guidance regarding adequate clearly specified care pathways and adequate training and supervision. For example, we recommend including the	Thank you for your comment. The GDG agreed and the Organisation of Services recommendation on what the clinical networks should provide, now NICE recommendation 1.10.3, can be found under key priorities for implementation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					following in the key priorities for implementation (taken from section 1.8.3 page 45/46 of the NICE version): 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]	
National Childbirth Trust	21	NICE	1.1.1	16	Considerations for women of childbearing potential (NICE, p15) The term 'present and future childbearing	Thank you for your comment with which we agree. We have deleted 'present and future' and revised the recommendation, see NICE

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					potential' is confusing. (The only way in which 'present potential' can be distinct from 'future potential' is if the latter refers to pre-pubescent girls.) We suggest instead: Considerations for girls and women who might become pregnant • Discuss with all girls and women who might become pregnant who have a new, existing or past mental health problem:	recommendation 1.2.1.
National Childbirth Trust	22	NICE	1.1.3	16	We suggest instead: Do not offer valproate to treat a mental health problem in girls and women who might become pregnant. [new 2014] [1.1.3]	Thank you for your comment. We have revised the recommendation but the GDG judged that child bearing potential was the most clinically useful term in this context and was consistent with other guidance in this area.
National Childbirth Trust	23	NICE	1.2.2	17	Principles of care for women with a mental health problem (NICE p16-18) While the recommendation to 'Acknowledge and reinforce the woman's role in caring for her baby' is generally good advice, there will be situations where in fact a baby is likely to be taken into the care of social services, with little or no role for the mother. In other circumstances, simply 'reinforcing' the responsibilities associated with parenthood may increase levels of anxiety. This recommendation needs some clarification with awareness because of these different situations. We suggest changing the wording to include: Acknowledge and support the woman's role in	Thank you for your comment. We have acknowledged your suggestion and amended the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					caring for her baby and do so in a non-judgmental and compassionate way.	
National Childbirth Trust	24	NICE	1.2.3	17	We feel that the phrasing 'Involve the woman, and if she agrees her partner, family or carer,' is ambiguous owing to the mis-use of punctuation. We suggest instead: 'Involve the woman and, if she agrees, her partner, family or carer,'	Thank you this has been corrected.
National Childbirth Trust	25	NICE	1.2.5	17	NCT welcomes the new recommendation to consider the impact for a woman's relationship with her partner, family or carer. We would recommend including a further point to acknowledge potential 'carer burden' and appropriate support for those caring for women with any mental illness during the perinatal period.	Thank you for your comment, the scope of this guideline was to consider the role of the family, carers and peers in the treatment and support of women with mental health problems but not the needs of infants, other children and partners.
National Childbirth Trust	26	NICE	1.2.6	18	NCT is pleased to see this included in the key priorities for implementation (see also comment number 1). Greater emphasis and expansion of this point would also cover our comments 5 and 6 on joint working.	Thank you for your comment. The guideline development group agrees and has expanded the recommendations around coordination and an integrated care plan (new recommendations 1.3.5 and 1.3.6).
National Childbirth Trust	27	NICE	1.3.18	25	1.3.18-1.3.27 Treatment decisions, advice and monitoring for women with a mental health problem (NICE p18-29) Antipsychotic Medication: We would suggest inclusion of the following within this section of the guidance:	Thank you for your comment. Please see the revised NICE recommendation 1.4.4 and 1.4.5 which has been amended to provide clearer guidance on taking psychotropic medication and breastfeeding.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					When considering prescribing antidepressants which would necessitate cessation of breastfeeding, physicians should be aware that many mothers with depression report that it is the only part of their life which they feel is under their control and at which they can succeed. This needs be considered when evaluating the risk-benefits of recommending antidepressant drugs that would require cessation of breastfeeding. Reference: Jones W. Breastfeeding and Medication. Routledge 2013.	
National Childbirth Trust	28	NICE	1.3.18	25	1.3.18-1.3.27 When considering the risk-benefits of mental health medication for women considering breastfeeding, we suggest adding a comment to this section to also consider the direct effect of breastfeeding on a woman's emotional state from the action of oxytocin. For example: With nursing (breastfeeding), blood pressure decreases, and the level of the stress hormone cortisol in the blood drops.' K.U Moberg 2003 'The Oxytocin factor' p97	Thank you for your comment. We did not review the evidence on potential benefits associated with breastfeeding as it is outside the scope of this guideline.
National Childbirth Trust	29	Full	4	62	We understand that only minimal changes have been made to this important chapter. It would be helpful to make this explicit, and provide the date when the: 'surveys of mental health	Thank you. See section 4.2, the date of publication has been added to when the surveys were published for the purpose of clarity.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					services for pregnant and postnatal women currently provided by PCTs and secondary care mental health services' were carried out. (see also point 48 under research recommendations).	
National Childbirth Trust	30	NICE	1.3	18	Overall the balanced approach taken in this section, the recognition that treatment decisions are difficult and risks are unclear, is welcomed by NCT. The emphasis on the autonomy of the woman and her need for (specialist) support is also good. The emphasis on availability of psychological treatment both as an alternative and as an adjunct to medication is valued.	Thank you.
National Childbirth Trust	31	NICE	1.3.1	18	NCT feels there needs to be greater clarity regarding what 'culturally relevant' information on mental health would be. For example, how should midwives and health visitors, who are not specialists in mental health, discuss their needs with women who have no words for mental illness in their first language? See reference - Wittkowski , Zumla , Glendenning & Fox (2011). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study, Journal of Reproductive and Infant Psychology, 29:5, 480-492 The injunction to 'instil hope about treatment' is a curious phrase – we presume this means	Thank you for your comment. The GDG did not feel the evidence in the qualitative review was strong enough to make such a claim and amending the recommendation would be misleading.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					being positive about prospects for recovery, yet the context of inadequate services presents a challenge to assumption. We think this should be rephrased to read: Ensure that the woman understands that mental health problems are not uncommon during these periods and that with treatment the chances of recovery are very good.	
National Childbirth Trust	32	NICE	1.3.4	19	NCT welcomes this recommendation but suggests adding: "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 and up-to-date evidence on any risks associated with taking psychotropic medication while breastfeeding, or with stopping medication in order to breastfeed. Discuss treatment options that would enable her to breastfeed if she wishes and support women who choose to breastfeed and also those who choose not to breastfeed. [new 2014]"	Thank you for your comment. Discussion about up to date evidence about risks is covered in section 1.4 and 1.9.
National Childbirth Trust	33	NICE	1.3.9	21	NCT welcomes and is pleased to see the option of increased contact as an alternative to drugs. We would recommend specifying whether the guidance is specifically referring to social contact or contact with health services.	Thank you, the recommendation has been clarified to state healthcare professional. Please see NICE recommendation 1.4.8.
National Childbirth Trust	34	NICE	1.3.17	24	The quoted risks of antidepressants in the NICE version do not seem to relate in a clear way to	Thank you for your comment. The GDG considered quantifying the risks in the NICE

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					tables in section 8.4 of the full version. There is little attempt to quantify the risks in the NICE version and we would suggest more information is provided to allow adequate consideration of the associated risks.	guideline, but decided that it would not be helpful to do so given that the exact estimates are likely to change with each new study and the view that it is more important for prescribing healthcare professionals to keep up-to-date with the evidence on harms rather than rely on what may become outdated estimates of risk
National Childbirth Trust	35	NICE	1.3.30	27	The phrase 'stop the drug' gives the woman no choice in the matter. NCT would prefer to see this point phrased as '**advise stopping'** in conjunction with a discussion of risk and benefits of other treatments.	Thank you for your comment. The GDG disagreed because neurodevelopmental outcomes result from exposure to valproate throughout pregnancy.
National Childbirth Trust	36	NICE	1.4.1	29	Recognising mental health problems and referral (NICE p29-32, Full p) NCT feels this point should be expanded to include social and cultural issues. A recent systematic review suggests that one of the major barriers to accessing treatment among South Asian women with PND was 'lack of attention to mental health and cultural factors by health care providers' We suggest the following amendment: 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, lack of awareness/ sympathy for emotional distress	Thank you for your comment. The GDG did not feel that it was necessary to make this addition to the recommendation as it is covered by 'fear of stigma' in recommendation 1.5.1.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					in their family and/ or cultural group, or fear that their baby might be taken into care. Reference: Nilaweera, I., Doran, F., & Fisher, J. (2014). Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: A systematic review of the evidence. Journal of Affective Disorders, 166, 213-226.	
National Childbirth Trust	37	Full	5.3.8	141	We would like to see more importance given to specific types of anxiety rather than general anxiety as an umbrella term. A recent study found that 50% of women reported symptoms that indicate some aspect of their childbirth experience was 'traumatic', and at least 3.1% meet diagnosis for PTSD six months post-partum. Therefore we feel that trauma and PTSD warrants more attention within the guidelines on recognising mental health problems. Reference: O'Donovan A, Alcorn KL, Patrick JC, et al. Predicting posttraumatic stress disorder after childbirth. Midwifery 2014;30(8):935-41.	Thank you for your comment. The GDG acknowledged that there are different types of anxiety disorders, including PTSD and trauma. In response to this comment the recommendation has been changed to include a definition of all types of anxiety disorder (including PTSD) rather than general anxiety as an umbrella term. There was no evidence for the validation of specific identification instruments for PTSD or trauma in the perinatal population, and the PTSD guideline does not recommend any specific screening instrument. Therefore the GDG judged that the use of the GAD-2 questions was a reasonable extrapolation for pregnancy and the postnatal period. In addition, a recommendation has been added to the section on recognising mental health problems in the NICE guideline: 'Be aware of the range, prevalence and under-recognition of anxiety disorders (including GAD, OCD, panic disorder, phobia, PTSD and social

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						anxiety) and depression throughout pregnancy and the postnatal period' in order to reflect this point.
National Childbirth Trust	38	NICE	1.5.1	32	Assessment and initial care of mental health problems (NICE p32-34) NCT welcomes the comprehensiveness of this section. We suggest amending the eighth bullet point to 'domestic abuse' rather than 'domestic violence' so as to recognise the frequency and adverse consequences of emotional abuse and controlling behaviour. We would also like to see some mention of discussion of self help strategies with women, such as exercise, in this section. The 2006 RCOG statement on Exercise in Pregnancy (http://www.rcog.org.uk/womens-health/clinical-guidance/exercise-pregnancy) states that "active women experience less insomnia, stress, anxiety and depression". Given that some women may experience a significant wait for treatment which is acceptable to them, especially if they are judged to be at low risk of serious mental illness or suicide, advice about easily accessible strategies which give a woman some sense of control over her life may be welcomed.	Thank you for your comment. We have amended to domestic violence and abuse as this is the terminology used by NICE. The evidence for physical interventions was limited and the quality of evidence low. In reviewing the available data there appeared to be some beneficial effects of physical activity on preventing depression. However the GDG did not feel the evidence was strong enough to make any specific recommendations about exercise. We do, however, recommend facilitated self-help for women with persistent subthreshold depressive or anxiety symptoms, or mild to moderate depression (see recommendation 1.8.1 and 1.8.8-1.8.9)
National Childbirth Trust	39	NICE	1.5.7	34	Does this point of the guideline cover smoking and smoking cessation services? The prevalence	Thank you for this comment. This is important, we do identify it as a risk factor and this is

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					of smoking is higher among women with mental illness during pregnancy. Given that smoking is one of the main preventable causes of adverse fetal outcomes in the UK the guidance should make clear recommendations for the initial assessment of smoking during pregnancy and referral to smoking cessation services.	covered in specific NICE guidance on smoking cessation, see CG26.
National Childbirth Trust	40	NICE	1.6.5	35	Treating specific mental health problems (NICE p34-40, Full p) "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 in the guideline on common mental health disorders (NICE clinical guideline 123). [new 2014]" When referring to something in another NICE guideline, it will help to quote that recommendation specifically in this guideline but making clear this is from another guideline. Readers don't really want to have to access other documents; they want all the recommendations here. We also feel this point should be added to the 'Priorities for implementation' section.	Thank you for your comment. As far as we can identify precise recommendations from other mental health related guidance, we do so. The NICE pathway which will be available online will link directly to other guidelines mentioned; this should go some way to making the issue of cross referencing recommendations more user friendly.
National Childbirth Trust	41	NICE	1.6.6.	35	"For a woman with persistent sub-threshold 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	Thank you for your comment. As far as we can identify precise recommendations from other mental health related guidance, we do so. The NICE pathway which will be available online will link directly to other guidelines mentioned; this

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					guideline on depression in adults [NICE clinical guideline 90]). [new 2014]" Same as above: When referring to something in another NICE guideline it will help to quote that recommendation specifically in this guideline. There are also others throughout the document eg 1.6.11	should go some way to making the issue of cross referencing recommendations more user friendly.
National Childbirth Trust	42	NICE	1.6.18	38	A midwife or health visitor may not have the expertise necessary to be able to make this judgment. We feel this point needs to be more specific about who would make that decision; alternatively, there should be more guidance about what level of expertise is expected when treating specific mental health problems at the beginning of this section. Reference: Hamilton, S.K.D. (2014) Improving the Identification of Perinatal Mental Illness through an Evaluation of Midwifery Education in England Unpublished poster presentation at: Royal College of Psychiatrists General Adult Conference, May 9 2014, Perthshire, Scotland	Thank you for your comment. A new recommendation has been drafted that specifies that the roles of professionals should be part of the care plan (1.3.5).
National Childbirth Trust	43	NICE	1.7.1	41	Considerations for women and their babies in the postnatal period (NICE p41-45, Full p) NCT welcomes this point, and would like to see more general guidance in this document about coming off medication – both antenatally and postnatally.	Thank you for this comment. Recommendations 1.4.10-1.4.37 provide guidance on starting, using and stopping treatment in pregnancy and the postnatal period
National Childbirth	44	NICE	1.7.9	43	NCT welcomes this recommendation.	Thank you for your comment. The

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					We would like to see added: When considering prescribing antidepressants which would necessitate cessation of breastfeeding, physicians should be aware that many mothers with depression report that it is the only part of their life which they feel is under their control and at which they can succeed. Suggesting that a mother stop breastfeeding in order to administer anti-depressant drugs should only be considered as a last resort. Reference: Jones W. Breastfeeding and Medication. Routledge 2013.	recommendation does not suggest cessation of breastfeeding with antidepressants, instead encourages women to breastfeed, except in rare circumstances. Therefore we feel the recommendation is in support of your comments and do not normally include the level of detail you suggest.
National Childbirth Trust	45	NICE	1.7.14	44	NCT welcomes this recommendation. We would like to see the phrase "effective treatment" expanded to include the positive role of social support. For example: Reassure the woman that any problems with the relationship are likely to improve with effective treatment, including good social support, of the mental health problem. Reference: Dennis CL, Dowswell T. Psychosocial and psychological interventions for preventing postpartum depression. Cochrane Database of Systematic Reviews 2013, Issue 2.	Thank you for your comment. The evidence for social support was reviewed in this guideline and given the absence of high quality and consistent evidence for benefits associated with such interventions, the GDG did not consider it appropriate to make the suggested amendment
National Childbirth	46	NICE	2.3	21	We do not agree that "whether or not the	Thank you for your comment. We have

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					woman is breastfeeding" is likely to be a false belief. (line 27) A recent review of 49 studies found that breastfeeding protects maternal mental health and lowers risk of depression (Dennis & McQueen, 2009). Breastfeeding helps because it down regulates the stress response. Unfortunately, depressed women are often advised to stop breastfeeding in order to give themselves ''a break'.' This advice may prolong their depression. Dennis, C.-L., & McQueen, K. (2009). The relationship between infant-feeding outcomes and postpartum depression: A qualitative systematic review. Pediatrics, 123, e736–e751. Recent research reports "For mothers who were not depressed during pregnancy, the lowest risk of PPD was found among women who had planned to breastfeed, and who had actually breastfed their babies, while the highest risk was found among women who had planned to breastfeed and had not gone on to breastfeed. We conclude that the effect of breastfeeding on maternal depression is extremely heterogeneous, being mediated both by breastfeeding intentions during pregnancy and by mothers' mental health during pregnancy."	deleted this statement as we agree it is misleading.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Borra, C, Iacovou M, Sevilla, A. New Evidence on Breastfeeding and Postpartum Depression: The Importance of Understanding Women's Intentions. Matern Child Health Journal, 20 Aug 2014. DOI 10.1007/s10995-014-1591-z	
National Childbirth Trust	47	NICE	2	46	Research recommendations (NICE p46-50, Full p) A number of non-pharmacological interventions (hypnosis; acupuncture; massage; bright-light therapy; omega 3 oils; imagery; yoga; autogenic training; home-visits; peer-based support; psychotherapy; etc) have been proposed to reduce the incidence of postnatal depression, and sometimes antenatal depression, but for which there is insufficient evidence to be able to say whether they are effective or not (Dennis 2013a&b; Marc 2011; Dennis 2007). We would like to see further research on some of these proposed interventions to gather data to confirm whether they are effective or not. A careful examination of the Cochrane reviews would indicate which interventions show the most promise. We feel this research is particularly important because of the concerns women have about taking medication for mental problems in pregnancy due to the uncertainty around potential adverse effects, particularly on the baby. References	Thank you for your comment. The evidence for many of these interventions has been reviewed in chapters 7 and 8 of the full guideline and initial results do not look promising. Therefore, the GDG did not feel it appropriate to recommend further research in this area.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					• Dennis CL, Dowswell T. Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression. Cochrane Database of Systematic Reviews 2013, Issue 7. • Marc I, Toureche N, Ernst E, Hodnett ED, Blanchet C, Dodin S, Njoya MM. Mind-body interventions during pregnancy for preventing or treating women's anxiety. Cochrane Database of Systematic Reviews 2011, Issue 7. • Dennis CL, Dowswell T. Psychosocial and psychological interventions for preventing postpartum depression. Cochrane Database of Systematic Reviews 2013, Issue 2. • Dennis CL, Ross LE, Grigoriadis S. Psychosocial and psychological interventions for treating antenatal depression. Cochrane Database of Systematic Reviews 2007, Issue 3.	
National Childbirth Trust	48	NICE	2.2	47	NCT welcomes this research recommendation. The guidance highlights that this important research on the adverse effects of drugs used to treat bipolar in pregnant women is strongly needed. These drugs are being recommended for clinical practice and it is clear there is insufficient data on adverse effects	Thank you for your comment.
National Childbirth Trust	49	NICE	2.3	48	This is also a very important research question on "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?"	Thank you for your comment

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					which could improve the lives of babies born to mothers with mental health problems.	
National Childbirth Trust	50	NICE	2	46	NCT feels strongly that a further recommendation should be added: Further surveys are needed to ascertain the extent to which the NICE 2007 recommendations have been implemented by commissioning groups and services and the main opportunities and barriers perceived by commissioners and services for implementation.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
National Childbirth Trust	51	NICE	2	46	We would welcome further research (with a qualitative focus) into the feasibility and acceptability of screening for mental illness in antenatal settings for parents and midwives.	Thank you for your comment. The GDG did not consider this to be a priority, given that qualitative evidence was reviewed for experiences of screening with the EPDS (see Chapter 6)
National Childbirth Trust	52	Full	2.5	30	Based on the following statement of evidence, we call for another recommendation: 'Of the 130 depressed people per 1000 population, only 80 will consult their GP. Of these 80 people, 49 are not recognised as depressed, mainly because most such patients are consulting for a somatic symptom and do not consider themselves mentally unwell, despite the presence of symptoms of depression (Kisely et al., 1995). This group also has milder illnesses (Goldberg et al., 1998; Thompson et al., 2001). GPs and other non-mental health specialists vary in their ability to	Thank you for your comment. The GDG recognised the importance of effective case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations in section 1.5). The role the health visitor (and other health and social care professionals who have regular contact with the woman) have in the ongoing individualized monitoring of the woman throughout pregnancy and the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					recognise depressive illnesses, with some recognising the vast majority of the patients found to be depressed at independent research interview and others recognising very few (Goldberg & Huxley, 1992; Üstün & Sartorius, 1995).' Recommendation: 'During the pregnancy and the postnatal year, women should be encouraged by primary healthcare professionals, family support workers and antenatal teachers, their partners and family members, to visit their GP if they feel unwell, experience persistent low mood or have difficulty sleeping and to seek a second opinion if their symptoms persist. (cf Full guideline, p30 31-40)'	postnatal period is recognised by the addition of a new recommendation (1.5.8). In addition, recommendation 1.5.1 highlights the importance that healthcare professionals 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 fears of stigma or loss of custody.
National Childbirth Trust	53	NICE	2	46	Given the apparent paucity of research evidence on the risk-benefits of cessation of medication during the perinatal period we would like to see more research done in this area.	Thank you for your comment, however, the GDG did not feel that this would be a plausible proposal for a research programme
National Perinatal Epidemiology Unit, University of Oxford	1	NICE	Introduction	3	This section doesn't read particularly well. Many of the facts and figures that are presented that related to perinatal mental health seem to have just been dropped into a section without much explanation of each, detail of the relevance, or even a logical flow from one point to the next. To increase the potential impact on the reader, it might be beneficial to re-organise and	Thank you for your comment. The introduction to the NICE guideline has been expanded and reorganised to address your points, however the purpose of the introduction is to present a very brief overview of the scope of and need for the guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					to elaborate some of these points.	
National Perinatal Epidemiology Unit, University of Oxford	2	NICE	Introduction	3	the term "tokophobia" is used. This term is not that common, and may not be well understood. We would suggest providing a brief explanation of this term, as is done in subsequent uses of the term throughout of the document.	Thank you for your comment. A definition of tokophobia has been added to the introduction to the NICE guideline.
National Perinatal Epidemiology Unit, University of Oxford	3	NICE	Patient centred care	5	In reference to service users under the age of 16, health care professionals are referred to the NICE Guidance on working with children. However, as the context of the service users in this care are pregnant women and new mothers, it seems (at face value) to be somewhat inappropriate to be referring to the service users as "children". Could there potentially be a different document drafted or set of guidelines developed for females in maternity services under the age of 16?	Thank you for your comment. The recommendation 1.3.3 advises all professionals 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 the NICE guideline on pregnancy and complex social factors • ensure continuity of care for the mental health problem during transfer between adolescent and adult services
National Perinatal Epidemiology Unit, University of Oxford	4	NICE	1.1.1.	16	"How a mental health problem and its treatment might affect the woman and the fetus or baby": I would recommend that the wording also include details about the short-term and longer-term effects on the woman and the child.	Thank you for your comment, but there was not evidence for the long-term effects of mental health problems to allow the guideline development group to make this statement.
National Perinatal Epidemiology Unit, University of Oxford	5	NICE	1.4.3.	29	"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	Thank you for your comments. Based on considerations from the qualitative review about barriers to disclosure the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					doing things?" Are these questions to be asked of ALL women? Or only those with previous history of mental illness? What about later in the pregnancy and in the postnatal year? My view is that women should be asked these in reference to how they normally feel, and if they have experienced a change from their norm. Also I think they should be asked if they want help with how they are feeling. I also believe that these questions (or a form of them) should be asked at each contact throughout the woman's perinatal care (in light of later onset perinatal mental illness, and acknowledgement of mental health issues retrospectively).	as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. In addition and in response to stakeholder concerns that the Whooley questions may still fail to identify depression for some women, recommendation 1.5.5 has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are recommended to consider using a formal tool such as the EPDS as part of a full assessment. A new recommendation has also been added that the health visitor (and other health and social care professionals who have regular contact with the woman) should consider asking the depression and anxiety identification questions as part of a general discussion about a woman's mental health and wellbeing and consider the use of a formal tool (as part of the monitoring plan) at all subsequent contacts with a woman in

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						pregnancy and the first postnatal year (1.5.8). Evidence reviewed in the full guideline (see chapter 5) did not find that the additional question added to the depression identification questions ('Whooley questions') about the need for help had conclusive benefit, and resulted in poor discrimination between true-negative and false-negative cases which may lead to an increased risk of depression being missed or lost to follow-up.
National Perinatal Epidemiology Unit, University of Oxford	6	NICE	1.2.4.	17	"supporting girls and young women": is there an age range as a guide for practitioners?	Thank you this is defined in "terms used in this guideline" in the NICE guideline.
National Perinatal Epidemiology Unit, University of Oxford	7	NICE	1.3.1	18	"provide culturally relevant information..." Will such documents be produced?	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
National Perinatal Epidemiology Unit, University of Oxford	8	NICE	1.3.8.	21	"Monitoring and increased contact": How is this going to happen? By whom?	Thank you. The recommendation has been amended in light of your comment.
National Perinatal Epidemiology Unit, University of Oxford	9	NICE	1.6.23	39	Should there be a separate section earlier in the document about ECT risks to mother and fetus? I would recommend revising the section on page 40 (1.6.25) to include risks, place it earlier in the document with other treatment considerations and risks. If so, this point should have a reference to that section.	Thank you for your comment. No studies were found that matched the inclusion criteria for the updated review of ECT. Therefore the recommendation from the previous 2007 guideline remains unchanged, other than to use current NICE style for recommendations.
National Perinatal Epidemiology Unit,	10	NICE	1.6.24	40	Sleep problems: This section doesn't seem to fit at all within the context of the rest of the	Thank you for your comment. The GDG considered it important to retain this

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
University of Oxford					document. I would suggest removing it.	recommendation given that some women experience severe or chronic sleep problems in pregnancy, and in the absence of existing NICE guidance on insomnia or sleep problems it was considered important that the needs of this group of women were not overlooked
National Perinatal Epidemiology Unit, University of Oxford	11	NICE	1.7.2.	41	recommendation of full neonatal assessment by neonatologist: Should there be timing guidance for this point to ensure timely provision of care for the infant?	Thank you for this comment. We have revised the recommendation but greater specificity with regards to timing has not been added as we expect that these are covered by local protocols for assessment.
National Perinatal Epidemiology Unit, University of Oxford	12	NICE	1.7.9	43	There needs to be an explicit reference to mother's medication use in this point. It feels too much like a blanket statement recommending that women should breastfeed.	Thank you for your comment. The GDG considered breastfeeding, reviewed the previous recommendations, and drawing on expert experience took the view that given the uncertainty of data, it would be inappropriate for the group to make specific recommendations, apart from those previously existing, other than to raise awareness of the potential risks, and that pharmacological treatments should not be a reason for not breastfeeding. However, recommendation (1.9.8) does explicitly state which specific mediation should not be routinely offered to women who are breastfeeding.
National Perinatal Epidemiology Unit, University of Oxford	13	NICE	1.7.14	44	In reference to the mother-baby relationship, I think there should be some explicit mention of involvement of the mother in promoting mother-infant relationship. Also there ought to mention something about offering resources to the mother for self-help, as well as encouraging	Thank you for your comment. This recommendation has been amended in light of stakeholder comments. Recommendation 1.3.1 recommends that the woman's role in caring for her baby is acknowledged and that the woman is supported in this caring role in a non-

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					the mother to take an active role in her relationship with her baby.	judgemental and compassionate way. The GDG did not feel it appropriate to recommend self-help targeted at the mother-baby relationship as no evidence was reviewed for this. The evidence for interventions which directly targeted the mother-infant relationship was mixed, but largely non-significant. This inconclusive evidence prompted the GDG to recommend a definitive trial of a mother-infant relationship intervention that examines clinical and cost effectiveness and reports on the mental health of the woman, the emotional and cognitive development of the baby, and the quality of the interaction with a follow-up period of at least 2 years.
National Perinatal Epidemiology Unit, University of Oxford	14	NICE	App A	59	Deletion of 2007 1.1.1.2 I disagree with the deletion that has been suggested, due to the fact that the replacement point doesn't adequately address the same issues to the same extent, with the same nuanced detail as the older point. I would recommend reverting back to the 2007 version and simply updating that.	Thank you for your comment. While this recommendation was described as 'deleted' it was in fact superseded by several other new recommendations based on a review if the experience of care undertaken for the updated guideline. Exploration of the woman's ideas and concerns is still covered in the new guideline (for example, in recommendation 1.4.3) and developing trusting relationships is covered in the Service User Experience in Mental Health guidance, which is referenced in the first recommendation in the new guideline.
National Perinatal Epidemiology Unit, University of Oxford	15	NICE	App A	61	Deletion of 2007 1.2.1.6 I don't completely agree with the proposed deletion of this point. I think that the woman's mental state should be asked at each point of contact throughout the	Thank you for your comments. The guideline development group agrees and has added a further recommendation to say that at all subsequent contacts with a woman in

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					perinatal period, not just at first point of contact. While this may seem repetitive, at the first point of contact/booking, the mother may not feel ready to divulge details of her mental health history. It may only be after repeated contact with a health care professional that such information can be shared.	pregnancy and the first postnatal year, the health visitor, and other healthcare professionals who have regular contact with the woman, should consider asking the Whooley questions and the GAD-2 as part of a general discussion about a her mental health and wellbeing and consider using the EPDS and the PHQ-9 as part of monitoring.
National Society for the Prevention of Cruelty to Children	1	NICE	General	0	We welcome this revised guidance and support many of the new recommendations. Our most significant concerns are about section 1.7, described at point 7 below.	Thank you.
National Society for the Prevention of Cruelty to Children	2	NICE	General	0	We believe that it would be valuable for the guidance to acknowledge the work that can be done to reduce the incidence of perinatal mental health problems. Social and economic factors, and experiences in the perinatal period can influence the likelihood of perinatal mental illness and we would like to see more on what can be done to influence these factors.	Thank you for your comment. Chapters 7 (section 7.4) and Chapter 8 (section 8.2) of the full guideline present the evidence for prevention of mental health problems. Also please see the Assessment recommendation, which lists the main factors to identify a woman who may have a mental health problem.
National Society for the Prevention of Cruelty to Children	3	NICE	1.3	18	p.18-20 We believe this section should recommend that a woman's partner, family or carer be given information about perinatal mental illness; about how they can support their partner is she is ill and reduce risks to her and the baby, and what help is available for them during this time.	Thank you for your comment. The guideline development group has added that families and carers should be given information about mental health problems in pregnancy and the postnatal period.
National Society for the Prevention of Cruelty to Children	4	NICE	1.4	29	Research shows us that many women do not feel comfortable disclosing mental health problems in response to questions asked in the booking appointment. The general approach	Thank you for your comment. As recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					and sensitivity of midwives, the way in which these questions are asked, and the responses give to any answers are all critically important. We believe that the guidance must acknowledge that simply asking these questions will not be sufficient to recognise mental health problems – the way in which they are asked will determined their value.	Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion.
National Society for the Prevention of Cruelty to Children	5	NICE	1.5.1	32	We believe it would be useful to have more clarity about the responsibilities of different professionals in assessing a woman's mental health.	Thank you for your comment. The GDG did not consider it appropriate to specify who should ask the initial case identification questions as it will be dependent on the woman's contact with services. However, greater specificity about professional roles in identification and assessment of depression and anxiety disorders has been added to other recommendations. For instance, recommendations 1.5.5-1.5.6 have been amended to include the option of referring the woman to her GP or (if a severe mental health problem is suspected) to a mental health professional. An additional recommendation has also been added in response to stakeholder comments that explicitly recognises the role of health visitors (and other health and social care professionals

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						who have regular contact with the woman) in the ongoing assessment and monitoring of women in pregnancy and the postnatal period (1.5.8)
National Society for the Prevention of Cruelty to Children	6	NICE	1.5.4	33	We think that this section should be expanded to give professionals more detail about when a woman's mental health problems should trigger safeguarding concerns. Evidence shows that children are particularly at risk if parents experience psychotic beliefs about the child, if mental health problems result in parental conflict or isolation; if mental health problems significantly impair parents' ability to function and/or if mental health problems occur in the presence of other risk factors such as substance use and domestic abuse.	Thank you for your comment. The GDG did not consider it appropriate to specify triggers for safeguarding concerns as the risk factor evidence has not been reviewed
National Society for the Prevention of Cruelty to Children	7	NICE	1.7.14 and 15	44	We have particular concerns about this part of the guidance. 1. The guidance says that professionals should "reassure the woman that any problems in the relationship are likely to improve with effective treatment of the mental health problem." This is incorrect. The mother-infant relationship is complex, and actions to address a factor that has affected the relationship do not necessarily resolve problems in the relationship. Lynne Murray's research, amongst others, shows that treatments have improved mothers' depressive symptoms have not had measurable effects on children's developments . 2. The guidance recommends that professionals	Thank you for your comment. The evidence reviewed here (including Murray et al., 2003 and Cooper et al., 2003, papers which report on the same trial) provide evidence that a structured psychological intervention (IPT) aimed at maternal depression can significantly reduce mother-infant attachment problems at endpoint (see section 7.5.12 in full guideline). However, the GDG agree that the evidence does not support that the mother-baby relationship will automatically or always improve with the treatment of the maternal mental health problem and the recommendation has been amended in response to stakeholder comments.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					should assess the nature of the mother-baby relationship. We believe more clarity is required on who should do this and when and how it should be done (ie. what tools should be used). 3. The recommendation states that professionals should only make a referral to an infant mental health service if problems are detected. This fails to acknowledge the value of preventative interventions – it is likely to be far more effective to support the mother-infant relationship straight away, rather than to wait until problems are identified and a referral made. 4. Evidence shows that the impact of antenatal anxiety and depression on infant development can be mitigated if a baby has sensitive and responsive early care. The guidance does not acknowledge the value of work to support the mother-infant relationship in order to reduce the impacts of antenatal mental illness. [1] Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: I. Impact on maternal mood. British Journal of Psychiatry, 182, 412-419. Forman, D. R., O'Hara, M. W., Stuart, S., Gorman, L. L., Larsen, K., & Coy, K. C. (2007). Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship. Development and	Recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services. The evidence for interventions which directly targeted the mother-infant relationship was mixed, but largely non-significant (see Chapter 7 in full guideline). This inconclusive evidence prompted the GDG to recommend a definitive trial of a mother-infant relationship intervention that examines clinical and cost effectiveness and reports on the mental health of the woman, the emotional and cognitive development of the baby, and the quality of the interaction with a follow-up period of at least 2 years. In reference to the specific papers you cite, Murray et al. (2003) and Cooper et al. (2003) are referred to above. Forman et al. (2007) was identified by the search but was excluded from the analysis as data could not be extracted because the number of participants in each arm for outcomes was not reported (see Appendix

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Psychopathology, 19, 585-602. Murray, L., Cooper, P. J., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: II. Impact on the mother-child relationship and child out-come. British Journal of Psychiatry, 182, 420-427. [1] Bergman, K., Sarkar, P., Glover, V., & O'Connor, T. G. (2010). Maternal prenatal cortisol and infant cognitive development: Moderation by infant–mother attachment. Biological psychiatry, 67(11), 1026-1032.	18). Bergman et al. (2010) would not have been identified by our search as it is outside the scope of this guideline.
NHS Choices (Digital Assessment Service)	1	Full	General	0	DAS welcome the update and have no comments as part of the consultation.	Thank you for your comment
NHS England	1	General	General	General	NHS England has no substantive comments to make regarding this consultation.	Thank you for your comment.
OCD Action	1	NICE	1.4.1	29	Some people with Obsessive Compulsive Disorder (OCD) experience intrusive thoughts which are sexual or threatening in nature and focus on fears of them harming their family members. Health care professionals need to be sensitive to the possible reluctance of a woman to disclose such intrusive thoughts in case they are misinterpreted.	Thank you for your comment. The GDG felt that this point was captured by the recommendation.
OCD Action	2	NICE	1.4.2	29	Health care professionals also need to be very sensitive to the reporting and sharing of such disclosures.	Thank you for your comment. The GDG felt the Coordinated Care Plan recommendation sets out the need for 'effective' sharing of information. Professionals should be aware of

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						issues around confidentiality and sensitivity in writing reports.
OCD Action	3	NICE	1.5.3	32	For the individual with intrusive thoughts these thoughts are extremely distressing and they may struggle to accept them as merely thoughts rather than intentions. The individual experiencing such thoughts does not present a risk to those around them as there is no evidence that those thoughts are ever acted upon. However we are aware of some tragic cases where mental health professionals have not recognised this form of OCD with the result that children have been removed from families unnecessarily. We would urge that all health and social care professionals working with perinatal women receive training on this much misunderstood but fairly common symptom of OCD. The following article was written by clinical specialists working in OCD to highlight the lack of risk people with intrusive thoughts present:	Thank you for this comment. This is an implementation issue and has been passed on to the NICE implementation support team.
OCD Action	4	NICE	General	0	The separation of depression and anxiety disorders from severe mental illness does not take into account how severe and life limiting OCD can be.	Thank you for your comment. The definition of 'Severe mental illness' in this guideline primarily includes psychotic illness. The guideline development group does not think that it has underestimated the severity of anxiety disorders, and has recommended high-intensity psychological interventions, medication and combined treatment for those more severe presentations.
Oxford Health NHS	1	NICE	1.6.3	35	Can any guidance be provided on the time	Thank you for your comment. The GDG did not

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Foundation Trust					scales for assessment and treatment when the referral is made within a month of the estimated due date?	consider it appropriate to add this level of specificity here. However, recommendation 1.3.6 recommends that the healthcare professional responsible for coordinating the integrated care plan should ensure that 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
Oxford Health NHS Foundation Trust	2	NICE	1.6.3	35	Is it possible to add something about clinical judgement being used to determine appropriateness of starting psychological treatment in close proximity to estimated due date?	Thank you for your comment. We do not think it would be appropriate to make a recommendation because as you suggest and is the case for all guidelines this is properly an issue for clinical judgement
Oxford Health NHS Foundation Trust	3	NICE	1.7.14	44	Research contradicts this advice; it is important not to unduly worry a mother but unethical to mislead too. Lynne Murray's research among others shows definitively that the impact on an infant is likely to persist whether or not a mother's depression is successfully treated; it is usually the case that the infant-parent relationship needs assessing post treatment of PND and often treating alongside or after PND treatment.	Thank you for your comment. The evidence reviewed here (including Murray et al., 2003) provide evidence that a structured psychological intervention (IPT) aimed at maternal depression can significantly reduce mother-infant attachment problems at endpoint (see section 7.5.12 in full guideline). However, the GDG agree that the evidence does not support that the mother-baby relationship will automatically or always improve with the treatment of the maternal mental health problem and the recommendation has been amended in response to stakeholder comments.
Oxford Health NHS Foundation Trust	4	NICE	1.7.15	45	There needs to be tiered assessments for mother-infant relationship with clear defined measures/skills used at different levels; that is;	Thank you for your comment. Recommendation 1.6.1 has been amended with a new bullet point added that assessment and diagnosis of a

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					what a midwife can do to identify gross problems post delivery for instance; what a health visitor can use to identify difficulties that will persist post treatment of depression/m.h. difficulty; plus guide to treatment programmes that are effective.	suspected mental health problem in pregnancy and the postnatal period should include the mother-baby relationship. Moreover, recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services. The evidence for interventions which directly targeted the mother-infant relationship was mixed, but largely non-significant. This inconclusive evidence prompted the GDG to recommend a definitive trial of a mother-infant relationship intervention that examines clinical and cost effectiveness and reports on the mental health of the woman, the emotional and cognitive development of the baby, and the quality of the interaction with a follow-up period of at least 2 years.
Oxford Health NHS Foundation Trust	5	NICE	1.7.15	45	The recommendations need to acknowledge the value of preventative interventions – it is likely to be far more effective to support the mother-infant relationship straight away, rather than to wait until problems are identified later in treatment.	Thank you for your comment. The review did not find any high quality evidence for clinically or statistically significant benefits of mother-infant relationship interventions on preventing mother-infant attachment problems for women with identified risk factors. However, the need for the ongoing assessment and monitoring of the mother-baby relationship and to consider

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						further intervention where problems in the relationship are not resolved is recognised and captured by recommendations
Pandas Foundation	1	Full	General	0	The use of the term 'mental health problem'. Problem needs to be changed to illness. Definition of illness according to Oxford Dictionaries is 'a disease or period of sickness affecting the body or mind'.	Thank you for your comment. The GDG considered the issue of terminology at some length and were concerned that other terms such as 'mental illness' and 'mental disorder' were potentially stigmatising.
Royal College of General Practitioners	1	Full	General	0	The mental health services do not have capacity at the moment to respond in the ways recommended. The GP relationship and continuity can be crucial even though they may not feel trained. I absolutely agree with the principle of networking, but GPs need protected time to do this.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of General Practitioners	2	Full	General	0	This is a very impressive collation of research. The GDG deserve congratulations on all this work and their following recommendations.	Thank you.
Royal College of General Practitioners	3	Full	8.9	717	The recommendations should also include something about service user feedback and development of the service in response. I really like the service user guidelines and they are sadly not heeded in present services.	Thank you for your comment, your concern has been passed on to the NICE implementation support team..
Royal College of Midwives	1	General	General	General	The introduction to the updated guideline is very useful in providing information about current incidence of these mental health problems.	Thank you for your comment.
Royal College of Midwives	2	General	General	General	It is very unclear in this update exactly which professionals this guideline is aimed at - in the previous version this was clearly and repeatedly stated.	Thank you for your comment. The guideline is for all professionals who are in contact or work with women whilst they are pregnant and in the postnatal women. In light of your and several

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						other stakeholder comments there is a recommendation saying that women with a mental health problem should have an integrated care plan which sets out the roles of all healthcare professionals and who is responsible for coordinating the care plan.
Royal College of Midwives	3	General	General	General	In the above context it is unlikely that midwives will readily identify recommendations that are relevant to their practice - this is of serious concern and will impact on effective implementation. Given that midwives have the ability to develop the important trusting relationship that can enable women to reveal concerns about their mental health, the importance of their role should be highlighted along with the recommendations that will support their practice and appropriate information giving.	Thank you for your comment. The coordinated care recommendations have been amended in response to stakeholder comments and recommendation 1.3.5 now recommends that an integrated care plan is developed 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 and 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). In addition, the role the health visitor and other health and social care professionals who have regular contact with the woman (including the midwife) have in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8). The implementation concerns you raise have been passed on to the NICE implementation support team.
Royal College of Midwives	4	General	General	General	The guideline has a focus on pharmacological interventions and generally refers to other	Thank you for your comment. It is an evitable consequence of the topic and evidence

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					guidance when recommending psychosocial interventions which are often more acceptable to women as a primary intervention. We think that the value of these interventions should be more prominent in this guideline.	reviewed that there will be more of a focus on pharmacological interventions. However, the guideline development group strove to ensure that there was balance where possible, and believes it has achieved this within the constraints of the evidence.
Royal College of Midwives	5	NICE	1.2.6	18	Ensure that: - the woman's care is fully coordinated when different professional groups and agencies are involved - mental health (including mental wellbeing) is taken into account as part of all care plans, including those for women with physical health problems - there is effective sharing of information with all services involved and the woman herself -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. This is a very important recommendation and we presume this will be incorporated into a quality standard to facilitate its implementation.	Thank you for your comment.
Royal College of Midwives	6	NICE	1.3.11	22	Discussing the' risk-benefit for psychotropic medication' It should be made clear who is the appropriate health professional to have this discussion, as this should not be undertaken by someone without the up to date knowledge.	Thank you for your comment. The recommendation has not been changed as the group felt the healthcare professional will be competent to have this conversation.
Royal College of	7	NICE	1.3.13	22	When psychotropic medication is started in	Thank you for your comment. We feel that

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Midwives					pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health. The recommendation should be stronger than 'consider' here.	'consider' is the most appropriate word here. Not all professionals will need to seek specialist advice.
Royal College of Midwives	8	NICE	1.4.2	29	Ensure that all communications with maternity services (including those relating to initial referral) include sharing of information on any past and present mental health problem. This is an important recommendation about sharing information - but it would be more useful to be explicit about between whom eg midwives, GPs and health visitors.	Thank you for your comment. The recommendation has been amended so that the onus is on all healthcare professionals referring a woman to a maternity service should ensure that communications with that service share information on any past and present mental health problem.
Royal College of Midwives	9	NICE	1.6.10	34	For women with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss their fears with a healthcare professional with expertise in providing perinatal mental health support. We are very pleased to see this new recommendation in the update.	Thank you.
Royal College of Midwives	10	NICE	1.7.14	44	Recognise that mental health problems may affect the mother–baby relationship, but reassure the woman that any problems with the relationship are likely to improve with effective treatment of the mental health problem. This important recommendation comes very late in the document. It would be more useful to include it in one of the key priorities for implementation.	Thank you for your comment. This recommendation has been subsequently amended and the GDG did not feel it appropriate to include as a key priority
Royal College of Midwives	11	Full	5.3.8.1	140	Recognise that women who have a mental health problem (or are worried that they might have) may be unwilling to disclose or discuss	Thank you for your comment. We have an overarching recommendation which advises to take cultural differences into consideration and

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care. It is important to include 'cultural barriers' to disclosing mental health concerns here.	to ensure information is delivered according.
Royal College of Midwives	12	Full	5.3.8.3	140	The evidence behind the move to losing the third question (below) after the Whooley questions in this version of the guideline is unclear. A third question should be considered if the woman answers 'yes' to either of the initial questions. Is this something you feel you need or want help with? We think this is a more useful and sensitive question to ask rather than moving directly to using the GAD scale, when we know woman are anxious about the implications of being graded on such scales, and may not be honest in responding to the questions. Midwives, who are key to this initial discussion, will need specific training in the use of these scales.	Thank you for your comment. As your comment, and recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. Evidence reviewed in the full guideline (see chapter 5) did not find that the additional question added to the depression identification questions ('Whooley questions') about the need for help had conclusive benefit, and resulted in poor discrimination between true-negative and false-negative cases which may lead to an increased

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						risk of depression being missed or lost to follow-up. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Midwives	13	Full	5.3.8.5	141	*If a woman scores 3 or more on the GAD-2 scale, consider:* *- using the GAD-7 scale for further assessment, or providing, or referring to a specialist mental health practitioner for, full assessment and treatment.* It is again unclear who should be using the GAD 7 scale here. It would be more appropriate to simply recommend direct referral to a specialist mental health practitioner.	Thank you for your comment. Unless the evidence or consensus points to a particular professional, NICE recommendations do not specify the individuals who could carry out the recommended actions. The GAD-7 can be used in primary care and is not restricted to specialist mental health practitioners.
Royal College of Nursing	1	NICE	General	0	The RCN feel the guidelines are very clear and comprehensive and women and their families will benefit from the comprehensive update provided.	Thank you for your comment
Royal College of Nursing	2	NICE	General	0	We also remain concerned about the inequitable and inconsistent access to appropriate services.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	1	Full	General	0	The additional sections and recommendations in this updated guideline are excellent. In particular we welcome the recommendations relating to 'Principles of care for women with a mental health problem' (section 5.4.8.1)	Thank you.
Royal College of Obstetricians and Gynaecologists	2	Full	General	0	There is a need to consider in the NICE guideline the training and support needs of professionals in order to develop better services.	Thank you for your comment. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Obstetricians and Gynaecologists	3	Full	General	0	We need to consider whether we recruit trainees who have an interest in this area of practice. We also need to ensure that those who do have the skill/interest have the opportunities to gain appropriate training.	Thank you for your comment. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	4	Full	General	0	The curriculum and assessments of training need to be developed to highlight the importance of communication skills in domains of mental health/drug misuse	Thank you for your comment. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	6	Full	1.2.2	13	Line 16 – Please put a capital 'T' for Trust	Thank you for your comment, the change has been made.
Royal College of Obstetricians and Gynaecologists	7	Full	1.2.3	13	Lines 29-30 - The importance of detecting those at risk is highlighted. Do we have the systems in place to do this? Do we have the training to ask the relevant questions? We need to be able to document and store the information in antenatal records/on-line systems	Thank you for your comment. The training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	8	Full	1	9	Lines 18-29 - The system of antenatal care is described in great detail. What is challenging is how the maternity service will develop such a service and who will be the lead professional. If it is an obstetrician we need to develop training packages at the appropriate level. We need to decide if obstetricians will take on these roles or midwifery practitioners.	Thank you for your comment. It is unclear which section of the full guideline is being referred to. However, the coordinated care recommendations have been amended in response to stakeholder comments and recommendation 1.3.5 now recommends that an integrated care plan is developed 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 and the roles of all healthcare professionals (including who is responsible for coordinating the integrated care plan, the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						schedule of monitoring, providing the interventions and agreeing the outcomes).In addition, the training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	9	NICE	1.6.1	34	These statements are interesting. The use of the word 'all practitioners'. We need to define what we expect of generalists and if delivering this level of mental health service is not generalism then this does not need to be in the core curriculum. We need to increase the emphasis and highlight the issues within the core curriculum but not to the level described here. We need to develop advanced training or ATSMs for this level of expertise – either as a mental health ATSM or within an advanced antenatal care ATSM	Thank you for your comment, the recommendation actually refers to 'all healthcare professionals' but with the important caveat 'providing assessment and interventions for mental health problems in pregnancy and the postnatal period'. Nevertheless this encompasses a wide range of professional roles, some of whom may be 'generalists'. But the guideline development group considered that it was of some importance that any professional involved in assessment and treatment of mental health problems in pregnancy and the postnatal period should be aware of variations in presentation and course so that disorders such as depression, anxiety and postpartum psychosis did not go unrecognised. Your concerns have been passed on to the NICE implementation support team.
Royal College of Obstetricians and Gynaecologists	10	NICE	1.6.2	34	These statements are interesting. The use of the word 'all practitioners'. We need to define what we expect of generalists and if delivering this level of mental health service is not generalism then this does not need to be in the core curriculum. We need to increase the	Thank you for this comment. We believe this is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					emphasis and highlight the issues within the core curriculum but not to the level described here. We need to develop advanced training or ATSMs for this level of expertise – either as a mental health ATSM or within an advanced antenatal care ATSM	
Royal College of Obstetricians and Gynaecologists	11	Full	2.2.4	14	Line 19-20 - What are placental abnormalities – can you be more specific?	Thank you for your comment. The following examples have been added to section 2.2.4 of the full guideline: abruption of the placenta, placenta previa.
Royal College of Obstetricians and Gynaecologists	12	Full	5.3.7	138	As there is little evidence/poor diagnostic test accuracy for the use of case identification tools for depression/anxiety/alcohol misuse, could this paragraph be shortened.	Thank you for your comment. The GDG feel that all the details provided in this paragraph are necessary and crucial in terms of linking the evidence to recommendations. This is particularly important where there is poor or little diagnostic test accuracy, as it provides the rationale as to how the GDG arrived at the recommendations.
Royal College of Obstetricians and Gynaecologists	13	Full	5.3.8.10	142	Page 142 - Can you detail "psychotic" symptoms for the general obstetrician?	Thank you for your comment. We have added a definition of psychotic symptoms in the introduction
Royal College of Obstetricians and Gynaecologists	14	Full	5.3.8.10	142	Page 142 - Could you give a time in which "urgent" assessment needs to take place? In my experience my urgent assessment is not necessarily the same as the mental health services urgent assessment e.g. within 4 hours, within 12 hours or within 24	Thank you for your comment the recommendation has been amended so that the referral for assessment is 'immediate' and no longer than 4 hours.
Royal College of Obstetricians and Gynaecologists	15	Full	5.3.8.11 & 5.3.8.12	142	Page – 142 - Could both tools be placed in the text or in an easy to refer to place (appendix) rather than having to trawl other guidelines?	Thank you for your comment. As these tool are readily available online, it was felt by the GDG that having extra appendices would not necessarily facilitate the reader.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Obstetricians and Gynaecologists	16	Full	5.3.8.3	141	Page 141 - Has the 2-item Generalized Anxiety Disorder scale been validated in pregnancy? One of the questions in this scale is: 'during the past month, have you been feeling nervous, anxious or on edge?' Most women feel some anxiety or nervousness in early pregnancy, especially before their first ultrasound scan.	Thank you for this comment. The GAD-2 has not been validated in pregnancy, therefore the GDG also considered the evidence on the use of the questionnaire in non-pregnant populations which was reviewed in other NICE guidance and took the view that it was an appropriate instrument to recommend in this guideline despite the potential for more false positives. We should also point out that it is recommended for use only as a case recognition instrument, that the item you refer to above is one of two questions and that before any interventions are offered (if the score on the GAD-2 is positive) a further assessment is recommended (see recommendations 1.5.6 – 1.5.7). This consideration has also been included in the full guideline chapter as follows: 'the GDG felt it important that clinicians should also bear in mind that some changes in mental state and functioning are a normal part of the pregnancy and postnatal experience and should, therefore pay careful consideration to the context. '
Royal College of Obstetricians and Gynaecologists	17	Full	5.4.8.2	148	Page 148 - "Monitor regularly" – this is difficult and depends on the degree of risk but who should monitor, how frequently should they monitor, how should they monitor (presumably using the scoring system) and what training should they have (for GPs, midwives, HVs and doctors)? A table here would help or mention that "women should have an individualised care	Thank you for your comment. The guideline development group has revised this recommendation and also added a further recommendation specifying the need for an integrated care plan, that has a schedule for monitoring.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					plan put in place in the antenatal period."	
Royal College of Obstetricians and Gynaecologists	18	Full	5.4.8.4	149	Page 149 - This recommendation states that assessment of a suspected mental health problem in pregnancy and the postnatal period should include the woman's responsibilities as a carer for other children and young people or other adults. Does this mean 'Does the woman have children and/or dependents at home?'	Thank you for your comment, but the wording is purposefully broad to cover, for example, caring for an elderly relative who lives in their own home.
Royal College of Obstetricians and Gynaecologists	19	Full	7.7.1.10	554	Page 554 - Is this recommendation intended for the 'generalist' obstetrician? We see many women who book for antenatal care who are taking anti-depressant medication. I am not sure that we would be able to determine whether a woman's depression or anxiety disorder is mild, moderate or severe. Should these women be seen by a perinatal mental health specialist, or would it be possible to give definitions of mild, moderate and severe in the guideline?	Thank you for this comment. The applicable categorisations are in the relevant NICE guidelines to which we refer. We accept this may present problems to those not familiar with that guidance.
Royal College of Obstetricians and Gynaecologists	20	Full	8.8.2	712	Page 712- Lines 16-17 - Babies should be monitored for the effects of medication taken in pregnancy and a drug offered that enables the woman to breastfeed if she chooses.	Thank you for your comment. The GDG considered breastfeeding, reviewed the previous recommendations, and drawing on expert experience took the view that given the uncertainty of data, it would be inappropriate for the group to make specific recommendations, apart from those previously existing, other than to raise awareness of the potential risks, and that pharmacological treatments should not be a reason not to breastfeed
Royal College of	21	Full	8.8.2	708	Line 31 – 'pregnancy' should be 'pregnant'	Thank you for your comment. The use of

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Obstetricians and Gynaecologists						'pregnancy' cannot be located in the quoted page and line
Royal College of Obstetricians and Gynaecologists	22	Full	8.9.1.11	719	Inset bullet point into last item on list on list	Thank you for your comment. The GDG felt the sentence starting with "seek specialist advice…" is an overarching principle of the bullet points above and it was agreed to leave the recommendation as it is.
Royal College of Obstetricians and Gynaecologists	23	Full	8.9.1.12	720	Page 720 - Certain drugs have a higher significant risk namely paroxetine and fluoxetine and citaloptam for CHD in varying degrees. Should a recommendation be made that the fetuses should have a formal fetal echocardiogram?	Thank you for this comment. The GDG considered your comment but decided not to take up your suggestion as they were not convinced that the identification of particular drugs was supported by the evidence reviewed. We have recommended fetal screening but in the absence of clear evidence for the association between antidepressants and cardiac defects, we have left it to maternity units to choose how to do this
Royal College of Obstetricians and Gynaecologists	24	Full	8.9.1.13	720	Bullet point for last recommendation	Thank you for your comment. The GDG felt the sentence starting with "seek specialist advice…" is an overarching principle of the bullet points above. It was agreed to leave the recommendation item.
Royal College of Obstetricians and Gynaecologists	25	Full	8.9.1.51	726	Page 726 - It would be useful to say where women who require rapid tranquillisation during the perinatal period should be managed – in a specialist perinatal inpatient service (see section 4.6.1.3), a maternity unit adjacent to a specialist perinatal inpatient service or any consultant-led maternity unit?	Thank you for your comment. The evidence for this recommendation has not been reviewed for this update, therefore we are unable to make changes to the recommendation.
Royal College of	26	Full	8.9.1.52	727	Once fluid balance is established? Do they mean	Thank you for your comment. The phrase 'once

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Obstetricians and Gynaecologists					'once fluid balance has equilibriated' or 'once a steady fluid balance state has been achieved'?	the fluid balance is established' has been removed from the recommendation.
Royal College of Obstetricians and Gynaecologists	27	Full	8.9.1.57	727	Formatting. Needs bullet point	Thank you for your comment. If you are referring to the final sentence of the recommendation, this is intentionally not bulleted text as it is separate action but linked to the previous action.
Royal College of Obstetricians and Gynaecologists	28	Full	8.9.1.21	721	Page 721 - "Monitor" for GDM as per NICE guideline – I would suggest "screen" to avoid confusion	Thank you for your comment. 'Screen' has a particular meaning in the context of NICE guidelines and in this instance we mean 'monitor'.
Royal College of Obstetricians and Gynaecologists	29	Full	8.9.1.27	722	Page 722 - There is no evidence to perform this for epilepsy in pregnancy – it is the subject of an ongoing study (EMPIRE) – I think one should be specific that this is for other mental health conditions – and what is the frequency of monitoring – possibly monthly?	Thank you for your comment. As the guideline relates specifically to mental health problems, the GDG did not feel this needed to be spelt out. Regarding the frequency of monitoring, the GDG felt that due to the paucity of evidence, they could be specific about this and that it would be dependent on the individual and rely on clinical judgement. Also note that the recommendation has been amended to cover the timeframe 'during pregnancy and into the postnatal period'
Royal College of Obstetricians and Gynaecologists	30	Full	9	729	The description of antenatal care with key priorities is clear. However the team structures required to deliver this service and who may be responsible within such a team for each priority need some explanation. The description of a 'team' in this setting would be helpful	Thank you for your comment. It is unclear what your comment is precisely referring to. We have tried to put the onus in most of the recommendation for all professionals who work with women during their pregnancy and the postnatal period. This is explained in the introduction of the NICE guideline.
Royal College of Paediatrics and	1	General	General	General	No comments.	Thank you.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Child Health						
Royal College of Psychiatrists	1	General	General	General	We welcome that the close relationship between childbirth and bipolar disorder is more emphasized throughout the documents than in the previous guidelines. However, we feel that this has led to some imbalance with the consideration of other disorders that may affect more women, are associated with significant risks and suffering for the mother and baby and are under-researched. There are a number of inconsistencies between the different sections in the documents. This is between evidence and summaries/ recommendations, levels of scientific rigour, and the clarity and quality of the tables and we have highlighted this in the following. We feel that chapter 4 requires more consideration and editing.	Thank you for your comment. In the absence of specific examples of other disorders which have not, but should have been, included in this review it is not possible to adequately address this comment or to make any changes to the guideline. As evidence was not reviewed for the organisation of care for this update (outside the scope of this update) chapter 4 was directly taken from the previous 2007 APMH guideline.
Royal College of Psychiatrists	2	Full	General	0	We could not locate appendices 1-16 on the website	Thank you for your comment. Appendices 1-16 were on the website.
Royal College of Psychiatrists	3	Full	2.3	21	We welcome the section on the misuse of the term postnatal depression	Thank you.
Royal College of Psychiatrists	4	Full	2.3.1.	22	It is not clear from the text that the figures '6.5 % at 6 months and 21.9 % at 12 months' refer to point prevalence rather than period prevalence	These figures are for period prevalence (see Gavin et al 2005). The text reads "The same review estimated the postnatal point prevalence at between 1 and 5.7% in the first postnatal year, with the highest rates at 2 months (5.7%) and 6 months (5.6%) postnatally. Gavin and colleagues calculated the period

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						prevalence (that is, the rate over a period of time) as 12.7% in pregnancy, 5.7% from birth to 2 months postnatally, 6.5% at 6 months and 21.9% at 12 months"
Royal College of Psychiatrists	5	Full	2.3.2	25	It is not clear whether any comparative studies of the prevalence or incidence rates of PTSD in pregnant/ postnatal women and non-childbearing women were identified.	We have cited reviews (and have now added a more recent systematic review - Grekin and O'Hara - published since the guideline was published for consultation) and to our knowledge studies have focused on the prevalence and incidence in perinatal women rather than comparing with non-childbearing women
Royal College of Psychiatrists	6	Full	2.3	21	p21-29 Full guideline 2.3 & 2.4 And the NICE guideline Introduction The NICE version (page 3) states that 'In pregnancy and the postnatal period, women are vulnerable to the same range of mental health problems as at other times. These usually have the same nature, course and potential for relapse (although bipolar disorder shows an increased rate of relapse and first presentation in pregnancy and the postnatal period)' and Comment: Could the GDG please check for consistency in this issue ? We noted discrepancies in: • the statement in the FULL version in section 2.4 page 29: 'The variation in the presentation, course and outcomes of mental health	Thank you for your comment. In the context of a brief introduction in the NICE guideline (ie not the full version) we now state that "In pregnancy and the postnatal period, mental health problems usually 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." In the full guideline we review evidence on the epidemiology which is beyond the scope of the summary guidance. We have added a sentence

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					problems in pregnancy and the postnatal period is reflected in the breadth of theoretical explanations for their aetiology, including genetic, biochemical and endocrine, psychological and social factors.' • The guideline in NICE page 13:'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….' We also noted inconsistencies with a) other sections of the FULL version where individual conditions are discussed or with b) available evidence on individual disorders, for example : 1. Regarding OCD: The FULL guideline states that 'it appears reasonable to conclude that the risk of OCD is greater when women are pregnant or postnatal (Russell et al., 2013)' 2. Regarding eating disorders - section 2.3.3. page 25: The full guidelines state: 'Anorexia nervosa is less common in pregnant women than in the general population' 3. Regarding depression: While we agree that there is no consistent evidence from cross-sectional, cohort or epidemiological studies of an effect of childbearing on the overall prevalence or incidence of depression, we feel that evidence to suggest that childbearing has a significant effect on particularly recurrent or severe depression has not been given sufficient	in the introductory section stating that "There are also some other differences in epidemiology which are reviewed for the specific disorders below" as these are discussed in the relevant sections. We have highlighted the Munk-Olsen findings and the study by Ban et al regarding increased incidence of depression postnatally. Similarly we do highlight the increased risk of relapse postnatally in the postnatal period for women with schizophrenia and have now also added the 2009 reference.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					attention. For example, in a large epidemiological study (Munk-Olsen et al, 2006) first admissions to hospital for the treatment of depression were significantly increased in the first 5 months postpartum. A small subgroup of women experience severe depression which may explain the lack of finding when the whole severity spectrum is considered. However, the risks and cost implications for an increased risk of severe depression are large so that it should not be neglected. In addition, a recent study examining the lifetime course of illness in women with recurrent major depression found that they had a significantly increased rate of episodes in pregnancy and the first postpartum month compared to other times in their lives (Di Florio et al 2014). 4. In regard to schizophrenia: in two large epidemiological studies, significantly more women were admitted to hospital for the treatment of schizophrenia in the first 1-2 months after childbirth (first and subsequent admissions, Munk-Olsen et al, 2006 and 2009). We are aware that it has been argued that these only represent a difficult adjustment to motherhood, however we do not feel that there is as yet sufficient evidence to support this. The FULL version only references the 2006 study and says ' women with schizophrenia are at an increased risk, but of lower magnitude,	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					throughout the first postnatal year'. We do not feel that the finding was accurately reported and that the effects found in the two papers have been omitted. 5. We are aware of one large epidemiological study (Vesga-Lopez et al 2008) which did not find any differences in broad categories of psychiatric disorder in pregnant and postnatal women compared to non-childbearing women (except for an increase in the rates of depression in the early postnatal period). This study using community interviews contradicted existing larger epidemiological studies of severe mental illness (eg Kendell et al, 1987, Munk-Olsen et al 2006, Munk-Olsen 2009) that have used recorded hospital admissions and are likely to be more reliable for capturing severe mental illness. 6. Regarding anxiety disorders: This section is not well structured in the FULL guideline (with the exception of OCD) and difficult to comment on. It also contains repetition (eg on study by Vesga-Lopez et al, 2008). We would recommend that it is revised. Conclusion: We agree with the NICE version statement about (largely) the same range and nature of mental health problems, but not that they	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					'usually' have the same course and potential for relapse. The evidence suggests that there are several differences. We feel that 2.3. is an important section. Given their prominent role, the NICE guidelines are frequently used not only by clinicians advising their patients in clinical practice, cut also for the development of business cases and cases for research funding. A general statement that most mental health problems have the same course (eg are as common) in pregnancy and the postnatal period as at other times, is not only giving an inadequate view of the evidence but is also likely to hinder service development and research in perinatal mental illness. We consider that a statement such as 'current evidence does strongly suggest that women with bipolar disorder have a high risk of suffering a postnatal episode. There is also evidence that several other groups of women may be at higher risk of being mentally unwell in pregnancy and/or the postnatal period than non-childbearing women' could be suitable.	
Royal College of Psychiatrists	7	Full	8.4	630	General: It would be helpful if the GDG could let the reader know what definition of prospective and retrospective has been used for the selected studies. On page 631 it is stated that only unadjusted	Thank you for your comments. 1. Regarding the general comment, retrospective and prospective study definitions have been added to the full guideline 2. We agree that the relationship is difficult to interpret. We have added further explanation

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					data were used for analysis but no further explanations were given. Having noticed that the odds ratios between the odds ratios and the absolute risk calculations in the tables, we asked a medical statistician helping us to understand this relationship. It would be helpful if a brief explanation could be added to the section of statistical analysis on page 631 how absolute exposed risk and difference relate to the odds ratios Presentation of tables: • It would be helpful if K could be explained • It would be helpful if the studies referred to could be listed with author name and year • It would be helpful for the reader if the numbers exposed to the psychotropic drugs could be separated from the numbers of unexposed for all types of studies. • Footnote numbers or footnote texts are not given consistently	to the section on statistical analysis in the full guideline 3. • Thank you- we have added (K) and (N) in brackets to the table heading columns • In some cases K is a very large number, therefore it would be too long to list each individual study- the forest plots in appendix (21) have the study IDs relating to each outcome • Thank you- we have been through the footnotes and ensured that the footnote numbers and are consistent
Royal College of Psychiatrists	8	Full	8.4.2	630	Timing of exposure: We feel that the timing of exposure is an important part of the methodology in the reproductive safety context. Could the GDG give an estimate as to how the precision of the results is altered by including studies where the timing of the exposure is uncertain ?	The timing of exposure is detailed in the study characteristics table (most studies specified at least first trimester exposure or all trimesters exposure) and was considered by the GDG in linking the evidence to the recommendations. There was not enough information from the individual studies to conduct a separate analysis for timing of exposure
Royal College of Psychiatrists	9	Full	8.4.4	632	We would request that the GDG considers the inclusion of some studies with single outcomes	Thank you for your comment. Given the limited evidence available on antipsychotics, and in

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					since clinicians are often asked by patients about them, such as for example the study by Peng et al, 2013 regarding the intra-uterine exposure to antipsychotic medication. We note that there is a precedent for not excluding one other study (eg El Marroun et al 2014).	response to your comment, the GDG felt that studies reporting on single outcomes could be included in the meta-analysis for this class of drugs. These outcomes have been added to the chapter.
Royal College of Psychiatrists	10	Full	8.4.4	636	The heading of the tables calls the studies trials – could this please be altered	Thank you for your comment. This has been changed in the text
Royal College of Psychiatrists	11	Full	8.4.4	637	The publication year for El Marroun et al is 2014	Thank you for your comment. This has been changed in the table
Royal College of Psychiatrists	12	Full	8.4.4	638	The study by Ramos2008 was excluded from analysis and should be removed from the table	Thank you for your comment. This has been removed in the table
Royal College of Psychiatrists	13	Full	8.4.5	648	Line 19: 'major congenital malformations' should read 'all malformations'	Thank you for your comment. This has been changed in the text
Royal College of Psychiatrists	14	Full	8.4.5	652	Re effects of exposure to TCAs in the first trimester on cardiac defects: we are uncertain whether the results of the meta-analysis described here are correct or the statement in the NICE version, 1.3.7 Although in the FULL table on page 652 the result is described as not significant, the NICE version states that there may be a small risk associated with TCAs. We would recommend to clarify this.	Thank you for your comment. The results of the meta-analysis described in the full guideline are correct. The recommendation has been amended (in the full and NICE guidelines) to reflect the evidence reviewed for this guideline, existing NICE guidance, and GDG consensus judgement about potential harms given what is known about mechanisms for action and adopting a cautious approach as appropriate given the uncertainties inherent in the data
Royal College of Psychiatrists	15	Full	8.4.5	656	L 13, 24 We are not aware that there are any studies comparing the severity or incidence of poor neonatal adaptation among infants exposed to venlafaxine and would suggest to change the wording slightly in the NICE version	Thank you for your comment. The recommendation has been amended (in the full and NICE guidelines) to reflect the evidence reviewed for this guideline, existing NICE guidance, and GDG consensus judgement about potential harms given what is known about mechanisms for action and adopting a cautious

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						approach as appropriate given the uncertainties inherent in the data.
Royal College of Psychiatrists	16	Full	8.4.	648	On page 648 it is stated: 'although the statistical association was not significant, the absolute risk difference was substantially higher than seen with the other SSRIs…..' We do not consider this an appropriate comment for a result that is not significant (or nearing significance) or where no scientific comparisons have been made between drugs. The reader not familiar with statistics may think that it is a true finding that there will be, for example, 17 cases more affected after citalopram exposure. Similar statements appear in other places. We would recommend to remove such statements from the text that relate to this or other non-significant results. We would recommend the same for the presentation of the tables.	Thank you for your comment. We agree that this statement could be misleading and reflects the difficulty in interpreting both the effect size and the absolute risk difference. The reason this association was not statistically significant was due to wide confidence intervals, variation in the data and high heterogeneity. The GDG decided not to single out citalopram or make any specific recommendations, therefore the statement has been removed from the text. Other similar statements have also been removed.
Royal College of Psychiatrists	17	Full	8.4.5	648	Line 19: 'major congenital malformations' should read 'all malformations'	Thank you for your comment. This has been changed in the text
Royal College of Psychiatrists	18	Full	8.4.5	662	The text 'table 328' should be replaced with 'table 327 and 328'.	Thank you for your comment. We refer to both table 327 (in line above) and table 238
Royal College of Psychiatrists	19	Full	8.4.5	662	The significant effect of valproate on cleft lip and palate and neural tube defects should be described also in the text	Thank you for your comment this has been made clearer in the text. The significant effect of valproate and carbamazepine and cleft lip and/or palate has been described with the absolute risk differences noted. The significant effect of valproate on neural tube defects has also been added to the text.
Royal College of	20	Full	8.4.5	667	Line 4 and line 8: we think that the	Thank you for your comment. We agree that

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Psychiatrists					complications discussed are not 'obstetric'	not all these complications are 'obstetric', the text has been changed to 'course of pregnancy, obstetric and neonatal complications' to describe the range of outcomes that are referred to and discussed
Royal College of Psychiatrists	21	Full	8.8.2	708	We welcome this section and feel that it is well written and informed by clinical practice	Thank you.
Royal College of Psychiatrists	22	Full	8.8.2	711	The risk of not taking medication should not only be pointed out to the women with bipolar disorder but also for women with schizophrenia or current or past depression since the risks of recurrences and the risks to the children are also very high	Thank you for your comment. The GDG agreed that this statement should be referring to women not only with bipolar disorder. In light of this comment, we have replaced 'bipolar disorder' with 'severe mental illness'
Royal College of Psychiatrists	23	Full	8.8.2	712	Line 25 – replace antipsychotic with anticonvulsant	Thank you for your comment. This has been changed in the text
Royal College of Psychiatrists	24	Full	8.8.2	713	Line 41-42: we feel that this also applies to schizophrenia and severe depression	Thank you for your comment. The GDG agreed that this statement should be referring to women not only with bipolar disorder. In light of this comment, we have replaced 'bipolar disorder' with 'severe mental illness'
Royal College of Psychiatrists	25	Full	8.8.2	713	We feel that too much emphasis has been placed on quetiapine in line 10 and 44	Thank you for your comment. The example of quetiapine has been removed from the text in both cases. The bipolar guideline recommends the choice of four different drugs, one of which is quetiapine. In the NICE guideline quetiapine has been removed and replaced with a cross-reference to the NICE bipolar guideline
Royal College of Psychiatrists	26	Full	8.8.2	714	And the NICE guideline p.40 We think that the following statement is worded too strongly: 'did not consider there to be sufficient evidence of clinical benefit to	Thank you for your comment. The exceptions specified in the recommendation (short-term treatment of severe anxiety and agitation) address much of your point. We don't have any

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					justify their use in pregnancy and the postnatal period'. There are clinical situations where benzodiazepines are an important aspect of short-term treatment. This applies to acute and severe psychotic states and severe depression, where women can be so agitated that parenteral antipsychotic medication is not sufficient to manage the risk of the woman to herself, the fetus and others. Benzodiazepines have in our view also a role in the treatment of severe anxiety and severe insomnia where other treatments, including other medications, have not been effective. We agree that benzodiazepines should be avoided in subacute or chronic conditions. We consider that the chosen wording will put clinicians, who have no alternative to use benzodiazepines in the described situations in a difficult medico-legal position and will undermine the trust that the patients partners or carers may have in them. We would like to highlight that the wording is not consistent with the NICE version page 40	efficacy data on benzodiazepines to treat sleep disorders or insomnia in pregnancy so there are no grounds for including sleep as an exception in the recommendation
Royal College of Psychiatrists	27	Full	8.8.2	716	Line 8-10: we feel that quetiapine has been given too much prominence by only mentioning this agent as 'suitable' for a pregnant woman. Readers are likely to interpret this as meaning that other antipsychotics are not, or significantly less, suitable in bipolar disorder. However, there is a significant proportion of	Thank you for your comment. The example of quetiapine has been removed. The bipolar guideline recommends the choice of four different drugs, one of which is quetiapine. In the NICE guideline quetiapine has been removed and replaced with a cross-reference to the NICE bipolar guideline

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					women with bipolar disorder who have responded well to other antipsychotic drugs, such as olanzapine or risperidone without detrimental side-effects, where a switch to quetiapine may cause a destabilization of illness. Rewording of this sentence would be helpful	
Royal College of Psychiatrists	28	NICE	Introduction	3	Bulimia nervosa is said to be less frequent in pregnancy but this is not reflected in the discussion of the evidence in the full guideline	Thank you for your comment. The introduction in the full guideline does not state that bulimia nervosa is less frequent in pregnancy. Instead the reverse is stated, i.e. that pregnancy is more common in women with bulimia compared to women with anorexia nervosa
Royal College of Psychiatrists	29	NICE	Introduction	3	The statement on binge eating disorder is not backed up by stated evidence in the FULL guideline	Thank you for your comment. The introduction in the full guideline does not state that bulimia nervosa is less frequent in pregnancy. Conversely, pregnancy is more common in women with bulimia compared to women with anorexia nervosa
Royal College of Psychiatrists	30	NICE	Key priorities	10	The second heading should read 'care for pregnant or postnatal women'	Thank you for your comment. This has been amended.
Royal College of Psychiatrists	31	NICE	Key priorities	12	TCAs have not been associated with PPHN in the full guidelines	Thank you for your comment. The recommendation has been amended to reflect the evidence reviewed for this guideline, existing NICE guidance, and GDG consensus judgement about potential harms given what is known about mechanisms for action and adopting a cautious approach as appropriate given the uncertainties inherent in the data
Royal College of	32	NICE	1.3	18	We welcome the wording of this section	Thank you.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Psychiatrists						
Royal College of Psychiatrists	33	NICE	1.3.13	22	This is a difficult area. Recommending that clinicians have increased awareness implies that there are consequences of the changes in pharmacokinetics in pregnancy that need to be recognized by the clinician and that action should be taken. There is to our knowledge little evidence of changing drug levels (except for lithium and lamotrigine) and their impact on the course of mental illnesses in pregnancy. We feel that the situation is highly complex because it is not only the parent compound that may change but also potential active metabolites and because the pharmacological net effect is difficult to predict. Our preferred option would be not to include this issue at this point because of the lack of evidence but rather in the text referring specifically to lithium and lamotrigine	Thank you for the comment. Please see the re-drafted recommendation 1.4.12.
Royal College of Psychiatrists	34	NICE	1.3.17	24	And NICE guideline p26 We would like to draw the attention of the GDG to the FULL version where no association of TCAs with heart defects after exposure in the first trimester has been highlighted.	Thank you for your comment. The recommendation has been amended to reflect the evidence reviewed for this guideline, existing NICE guidance, and GDG consensus judgement about potential harms given what is known about mechanisms for action and adopting a cautious approach as appropriate given the uncertainties inherent in the data
Royal College of Psychiatrists	35	NICE	1.3.19	25	We would recommend to add severe sleeplessness	Thank you for your comment, the GDG have made a recommendation for sleep problems and did not judge that benzodiazepine had a role to play in managing sleep problems in pregnant or breastfeeding women.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Psychiatrists	36	Full	8.9.1.18	721	And NICE guideline 1.3.23 p26 We would welcome more specific guidance from the GDG. In women of childbearing age we would recommend that measurement of prolactin levels should be done before antipsychotics with prolactin elevating potential are commenced. We would also like to ask the GDG to consider the interpretation of different magnitudes of prolactin level increases, for example unspecific increases at 2-3 fold above normal, which could be checked in second sample under standard conditions. If the second level is normal, then this would avoid changes in antipsychotic medication and potential recurrences. If a second sample is still raised, and the relationship to the offending medication is unclear, and the woman has had a good therapeutic response to the drug, then a referral for an endocrinological opinion would be appropriate, to assess the ovulatory state and the presence of any space-occupying lesions.	Thank you for your comment. The interpretation of prolactin levels goes beyond the scope of a NICE recommendation and should be within the competence of the healthcare professional ordering the test.
Royal College of Psychiatrists	37	Full	8.9.1.22	26	Both the NICE(1.3.27) and FULL versions state in regard to depot antipsychotics '…babies may show extrapyramidal symptoms several months after administration of the depot'. We are not aware of evidence for this. On a theoretical basis this is unlikely. The antipsychotic depot in oil is in the maternal muscle, the drug is released without its oil into the maternal circulation and the drug is not stored in the	Thank you for your comment; the guideline development group has removed the phrase 'babies may show extrapyramidal symptoms several months after administration of the depot'.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					infant to any greater degree than medication that the mother has ingested by mouth.	
Royal College of Psychiatrists	38	NICE	1.3.28	26	We feel that the wording should be stronger for valproate and say 'must not be used'. This is because we feel that its detrimental effects on the development of the child are widespread and severe and because there are alternatives for this agent. In the case of carbamazepine, the effects are less widespread and frequent and we feel that wording of 'do not offer' would be appropriate, also in consideration of the fact that its role in the treatment of bipolar disorder is less well established.	Thank you for your comment. Please see NICE recommendation 1.2.3 which clearly states that Valproate should not be prescribed to women of childbearing potential for long-term or acute treatment of a mental health problem.
Royal College of Psychiatrists	39	NICE	1.3.29	27	The first sentence should read 'if a woman is already taking valproate for a mood disorder' (because it does not apply for the indication of epilepsy)	Thank you for your comment; the GDG has made it clear in the heading for this section that in the context of this guideline anticonvulsants are for use in mental health problems.
Royal College of Psychiatrists	40	NICE	1.3.29,	27	And 1.3.30 and 1.3.31We feel that the following should be deleted :'for example, quetiapine for treating a bipolar disorder' for the reasons above	Thank you for your comment, the phrase about quetiapine has been deleted from these recommendations.
Royal College of Psychiatrists	41	NICE	1.3.32	27	We would recommend not only to check the lamotrigine level in pregnancy, but also in the early postnatal period since substantial changes are to be expected during this time	Thank you we have amended the recommendation to include the postnatal period
Royal College of Psychiatrists	42	NICE	1.3.33	27	There is a widespread belief that folate can protect from some malformations. This applies to the general population but not necessarily true to women taking anticonvulsant medication. We would recommend to add: 'Be aware that it is uncertain whether or to what	Thank you for your comment. This recommendation has been deleted.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					degree folic acid protects the infant from congenital malformations or neurodevelopmental impairments'.	
Royal College of Psychiatrists	43	NICE	1.3.33-1.3.38	28	It would be helpful if the GDG could make recommendations in regard to prescribing lithium during labour or that it is difficult to make recommendations in this area due to current evidence. This would be helpful for clinicians and their patients.	Thank you for your comment. In light of your, and other stakeholders', comments the GDG has revised the recommendation to indicate that lithium should be stopped in labour
Royal College of Psychiatrists	44	NICE	1.3.37	28	It would be helpful if the GDG could clarify whether lithium could be restarted in the second trimester for women where there is a strong preferential response to lithium	Thank you for this comment. We have amended the recommendation and stated lithium could be re-started in the 2nd trimester
Royal College of Psychiatrists	45	NICE	1.7.3	41	It would be helpful if the GDG could be more specific about: 1. Does the recommendation to monitor babies for discontinuation symptoms for 14 days also apply to those who have had PNAS and are asymptomatic from day 3 or so and to those who do not develop symptoms by 72 hours postnatal ? 2. How often should the baby be checked within the first 14 days and who should carry these checks out ? Community midwives frequently stop daily visits at day 10 postnatal. 3. How long does the monitoring should the monitoring be for in hospital ? 4. What does monitoring mean - would it include alerting the family to adverse symptoms? 5. What do the paediatricians have to do about	Thank you for this comment. We have revised the recommendation but greater specificity has not been added as we expect that these are covered by local protocols for assessment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					it? 6. How likely are severe adverse events such as seizures and have any of them ever required specific intervention? 7. Is there any evidence for any long term issues that could be attributed to the withdrawal/toxicity? Given that this is currently causing some uncertainties between paediatricians and psychiatrists, we would like clearer guidance for the benefit of women who are planning a birth, where the neonatologist has a view but is not at the planning meeting. Many maternity units now recommend an observation period of 48-72 hours on the maternity ward. We also refer to a recent expert review discussing management guidelines which we found helpful (Kieviet et al, 2013, Neuropsychiatric Disease and Treatment, 9, 9 1257–1266)	
Royal College of Psychiatrists	46	Full	8.9.1.27	722	Re: 'If a woman is taking lamotrigine during pregnancy, check lamotrigine levels frequently because they vary substantially at this time' It would be helpful to have clearer guidance from the GDG. At what stage of pregnancy should measurement begin and what should be the resulting action be if it changes ? Noting that there are large inter-individual variations in how lamotrigine clearance is altered in pregnancy, should the levels be measured either in the preconception period or	Thank you for your comment. Whilst we appreciate that this is difficult, due to the paucity of evidence, the GDG did not feel they could be specific about this and that it will be dependent on the individual and rely on clinical judgement. Also note that the recommendation has been amended to cover the timeframe 'during pregnancy and into the postnatal period'

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					early on in pregnancy so that it is established what level the woman needs in order to maintain clinical response ? Should the woman keep a diary so that it is established whether any changes in mental state occur after any fall in the level and whether she improves after any dose increases ?	
Royal College of Psychiatrists	47	Full	4	62	Page 62-84 It is felt that this chapter would benefit from a fuller update of the 2007 version and more editing. Much has changed in the last 7 years. There is additional information now available from the CCQI Perinatal Network and also from the Maternal Mental Health Alliance	Thank you for your comment. Any decision to update a guideline must balance the need to reflect changes in the evidence against the need for stability, because frequent changes to guideline recommendations would make implementation difficult. The Organisation of Services chapter was not prioritised for update in the review process and as a result we are unable to make your suggested changes to the chapter.
Royal College of Psychiatrists	48	Full	4.2	62	p62-63We do not feel that this survey justifies the prominence it has been given in this chapter. • It was conducted in 2006 and is now out of date. PCTs are no longer in existence. • The methodology of the study was problematic at the time and the response rate low. • The list of bullet point percentages is not helpful as a way of expressing the numbers of services who are engaged in certain activities but it is also likely to have changed in the time since it was conducted.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of	49	Full	4.2	64	line 7-17 This is no longer relevant due to	Thank you for your comment. As the evidence

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Psychiatrists					changes in commissioning.	has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	50	Full	4.2.2	63	p63-66 The expression of the survey in percentages is difficult to understand given the low response rate. It is over-wordy and particularly with reference to community perinatal mental health teams likely to be out of date. To summarise, this survey and its findings could be easily summarised in one short paragraph making it clear that it was conducted some 8 years ago and perhaps referencing more recent surveys including one led by the same author for the Maternity Alliance, the Royal College of Psychiatrists CCQI Network for community perinatal mental health teams.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	51	Full	4.3	66	Lines 5-11: This is now out of date	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	52	Full	4.3.2	67	1st paragraph Line 19 There is confusion between the administrative incidence of admission to psychiatric hospital within a year of childbirth (2 per 1000) and the incidence of a specific disorder (how defined?) within a defined period of childbirth. 1 per 1000 refers to postpartum onset psychosis	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					within 6 months of childbirth. This does not therefore include women with a postpartum recurrence of a previous illness or all admissions to mother and baby units whatever the diagnosis. In a chapter entitled "Estimating the need for services" it is critically important that this distinction is made between the incidence of admission and the incidence of a particular defined condition.	
Royal College of Psychiatrists	53	Full	4.3.2	67	Line 27: It is difficult to know what is meant. The denominator used by the author for presentation was the numbers of deliveries. It therefore should be 18 to 30 per 1000 deliveries. The author did not use the general population size as the denominator. This must be rewritten.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	54	Full	4.3.2	67	Line 39: We do not think that there are any longer psychiatric units in England who admit the occasional mother and baby to an adult psychiatric ward since it is unlikely that they would be commissioned.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	55	Full	4.3.2	67	p67-68 We consider this as now out of date. There is frequent mention of PCTs and there are references to unpublished findings in the Hampshire Service from some years ago.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	56	Full	4.3.2	67	Up to 80 % of beds in some MBUs are for parenting assessments. We do not believe that this is still the case, it would also require a reference	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of	57	Full	4.3.2	68	Line 29: We do not believe that the	Thank you for your comment. As the evidence

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Psychiatrists					denominator of 100,000 is correct. In all published work on service provision, CR88 and the National Service Specifications etc, the denominator is 1000 deliveries. The "current statistics" referred to here are 9 years old. We are uncertain about the origin of the figures of 0.13 and 0.51 beds per 100,000. If the denominator is incorrect, the publication of these figures could, in the first instance, of 0.13 beds per 1000 deliveries lead to a serious under-provision nationally and of 0.51, over-provision. We would recommend that a simple formula is being used for calculating need based on the numbers of admissions per 1000 deliveries and the length of stay.	has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	58	Full	4.4.1	71	Figure 3: Stepped care model. It is disappointing to see this again. It was in the 2007 document. There is a problem with the term stepped care which is generally taken to mean the patients will go through each of the steps in turn. Almost all of the clinical pathways in existence would try to determine that the patient arrives at the right place for the right treatment in a timely manner. It is also concerning that this stepped care model implies that referrals to the specialised perinatal mental health services only come from the community mental health service. In practice the overwhelming majority of perinatal services accept direct referrals from GPs, obstetricians and midwives as well as their psychiatric colleagues.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Psychiatrists	59	Full	4.4.1	71	line 5: This is now out of date- there has been an expansion in in Health Visiting services and they will now see women during the pregnancy as well as post-natally	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	60	Full	4.4.4	73	lines 21-30: This does not make any mention of pregnant women and where they are admitted to. This information is now available from the CCQI.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	61	Full	4.4.4	74	line 29: It would be useful to include Jess Heron's study looking at the longer term impact on mothers separated from the babies v those admitted to an MBU using the APP data.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	62	Full	4.5.3	76	p76-83 This whole section is now out of date. All existing managed clinical networks were subsumed under the umbrella of the Strategic Clinical Networks. Their type and functions are clearly distinguished between strategic and operational. Neither type of network has money, therefore they cannot be said to "provide" services as it says in this section. They can recommend, guide, educate and train, they have no power. They can ensure the development of common pathways and consistent service specifications across large areas. This whole section needs to be rewritten.	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.
Royal College of Psychiatrists	63	Full	5.3.8.4	141	And 5.3.8.5 & 5.3.8.7 What is "a specialist mental health practitioner" – is this a specialist midwife, CPN, CMHT or perinatal mental health service?	The recommendation has been revised to say that referral should be to a mental health professional. There are a range of professionals who could undertake the assessment and it is up to local services to make the decision.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Psychiatrists	64	Full	5.3.8.7	141	With which services does it mean? Is it maternity services and therefore question is by the booking in midwife, or just primary care in which case question is by the GP?	Thank you for your comment. This recommendation is relevant to all services, including maternity, primary care and secondary mental health.
Royal College of Psychiatrists	65	Full	5.3.8.7	141	Line 30 May be useful to have a clear definition of what is meant by "severe" if it is midwives who are going to be asking this question.	Thank you for your comment. Please see the NICE guideline for the definition of "severe mental illness" p.17, section 1 or the introduction of the full guideline, Chapter 2, paragraph 2.
Royal College of Psychiatrists	66	Full	5.3.8.9	142	line 4-5 "be alert for possible symptoms" – seems a bit vague might be better with "have a low threshold for seeking advice and further assessment with any change in behaviour or presentation"	Thank you for your comment, but the guideline development group considers the current wording to be clear.
Royal College of Psychiatrists	67	Full	5.4.8	148	P148 5.4.8 Recommendations We miss the mention of Child Safeguarding	Thank you for your comment. In the assessment section of 5.4.8 in the full guideline, there is a safeguarding recommendation; if there is a risk or concerns about child maltreatment follow local safeguarding protocols.
Royal College of Psychiatrists	68	Full	5.4.8.7	149	line 27-29 It's not just about maltreatment and active harm to the child but also neglect, emotional harm and accidental harm, by not prioritising their needs.	Thank you for your comment. The recommendation does include an assessment of the mother-baby relationship which should capture issues such as neglect, emotional harm etc.
Royal College of Psychiatrists	69	Full	5.4.8.8	149	lines 30-36 With suicidal mothers there is a need to consider safety of the child	Thank you for your comment. There is a recommendation which advises, if there is a risk of or there are concerns about suspected child maltreatment, follow local safeguarding protocols.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Psychiatrists	70	Full	5.4.8.4	149	line 17 Social services involvement needs to be recorded along with the names and dates of birth of all children in contact with the service user in case a social services referral is needed at a later date (an outcome of several serious case reviews following child deaths)	Thank you for this comment. Although the GDG feel this is important background information this is not the right place to include this level of detail in a recommendation.
Royal College of Psychiatrists	71	Full	6.4.1.1	201	lines 28-34 Is this beyond the scope of this guideline – would need to be in each specific illness guideline. We won't be able to measure this recommendation in an audit	Thank you for your comment. The GDG were aware that this guidance would be included in the guidelines for the specific mental health problems. However, the potential for harm was considered to warrant duplication. The GDG were particularly concerned that at the time when a fetus may be most susceptible to harm the woman may well not know she is pregnant.
Royal College of Psychiatrists	72	Full	6.4.1.6	202	line 25 Every single care plan including those with physical health problems – is that achievable?	Thank you for your comment. The guideline development group has removed physical health problems.
Royal College of Psychiatrists	73	Full	7.3.12	211	lines 13-26 Peer mediated support is also being done via Action on Post Partum Psychosis (APP) as well as for depression. This support can be provided on line via a support forum as well as individual and group.	Thank you for your comment. This section of the guideline defines peer-mediated support and support groups in general terms and is not specific to mental health problem, provider or mode of delivery
Royal College of Psychiatrists	74	Full	7.6	548	end of 1st paragraph "the GDG recommended time scales for assessment (assess for treatment within 2 weeks of referral) and treatment initiation (provide psychological interventions within 1 month of initial assessment)	Thank you for your comment. There is no evidence for the clinical or cost effectiveness of these time scales for assessment and treatment initiation. However, as outlined in section 7.6, this recommendation was a modified version of the recommendation in the 2007 guidance. The GDG reviewed the previous 2007

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Is this evidence base? Who ought to be doing this assessment? GP, counsellor, IAPT worker, specialist services?	recommendation which specified that psychological treatment should be initiated within 1-3 months post-assessment and expressed concerns that women may be placed on waiting lists for assessment so that waiting times for treatment may be considerably longer than the 1-3 month time period outlined. In order to remove this potential ambiguity and ensure prompt delivery, the GDG recommended time scales for assessment. Recommendations for assessment do not specify who should be doing the assessment as the GDG believe this will be dependent on the individual and on clinical judgement
Royal College of Psychiatrists	75	Full	7.7	551	p.551-553 Is this not a normal event and are we in danger of pathologising a normal bereavement reaction by placing guidelines on what to do in a mental health guideline? These sections seem to miss the point about perinatal services Psychological services should be delivered by individuals who understand the normal/typical changes which occur during the perinatal period. These recommendations are an over-simplification and make it look as though psychological treatment at this time is no different than the psychological treatment of these disorders at any other time. There is no mention of the treatment/management of personality	Thank you for your comments. The recommendations concerning stillbirth are included in this guideline as stillbirth is not a normal or routine event for most women (as reflected in the qualitative review of service user experience) and the management that women receive at this time can have repercussions for their mental health. As reflected by recommendation 1.1.2 the key methodological principle underpinning the development of this guideline was the assumption that much of the assessment and treatment of mental health problems in the antenatal and postnatal period is not different from that at other times of a woman's life, albeit with the important caveat that there are

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					disorders? There is no mention of women who decline psychological treatment.	factors that might require the development of new recommendations or changes to existing recommendations and these include: where we have evidence for variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period; where the setting in which interventions are delivered needs to be considered/adjusted; where the health of the fetus/infant requires new recommendations or modifications to existing recommendations; where evidence is identified and supports a recommendation for an intervention which is unique to the antenatal or postnatal period. In response to your comments about personality disorder, the GDG agree that the treatment/management of personality disorder is an important issue and it was discussed in GDG meetings. However, the lack of evidence and continued uncertainty about what should be recommended led to the GDG making a research recommendation. Finally, recommendation 1.4.8 covers women who decline psychological or pharmacological treatment
Royal College of Psychiatrists	76	Full	7.7.1.17	556	Normal treatment of PTSD advocated, however also need to consider impact on mother-infant relationship and therefore specialist services would be preferable rather than generic PTSD	Thank you for your comment. Assessment of the mother-baby relationship is covered as a general principle under considerations for women and their babies in the postnatal period

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					services	and this recommendation has been further elaborated as a result of stakeholder comments
Royal College of Psychiatrists	77	Full	7.7.2.4	556	We have extrapolated across from all guidelines to form the recommendations so why are we specifically questioning whether this is possible for OCD, panic disorder and social anxiety?	Thank you for your comment, but the GDG considered the higher risks associated with some anxiety disorders in pregnancy and the postnatal period and the corresponding lack of perinatal data for effectiveness of psychological interventions warranted a research recommendation that focused specifically on moderate to severe anxiety disorders
Royal College of Psychiatrists	78	Full	7.7.2.3	556	This is the only mention of personality disorder	Thank you for your comment. The GDG agree that the treatment/management of personality disorder is an important issue and it was discussed in GDG meetings. However, the lack of evidence and continued uncertainty about what should be recommended led to the GDG making a research recommendation.
Royal College of Psychiatrists	79	Full	7.7.1.4	552	p552 7.7.1.4 "psychological and psychosocial interventions should be based on the relevant treatment manual(s)" – are we saying that all psychological treatments can be manualised? This seems to be ignoring more complex presentations.	Thank you for this comment. As with all guidance manuals, they are a guide to best evidence based practice. Of course there will be circumstances where variation from the manual will be advised but this may be the case for 15% or so of patients and even then, elements of the manual may still inform practice.
Royal College of Psychiatrists	80	Full	8.8.2	712	line 16-18 Choose medication to enable breast feeding – but no advice as to which drugs could be used for nursing mothers – would be useful to have a link out to a website, or a table with current data on it.	Thank you for your comment. The GDG considered breastfeeding, reviewed the previous recommendations, and drawing on expert experience took the view that given the uncertainty of data, it would be inappropriate for the group to make specific recommendations, apart from those previously

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						existing, other than to raise awareness of the potential risks, and that pharmacological treatments should not be a reason not to breastfeeding
Royal College of Psychiatrists	81	Full	8.9.1.13	720	Need to balance the risks of medication against the benefits of breast feeding. Non-specialist psychiatrists won't know much about the benefits of breast feeding at all and so it may be worth spelling this out in more detail.	Thank you for this comment. We have made a number of amendments to the recommendations on breastfeeding. Importantly in recommendation 1.9.9 we stress the importance of seeking specialist advice.
Royal College of Psychiatrists	82	NICE	2.1	46	We welcome the projects considered in this section but would have liked a wider range of conditions being considered, given the risks or increased incidence/prevalence in childbearing women, such as OCD, schizophrenia, prevention of depressive recurrences, the uncertainty of the role of confounding factors for interpreting reproductive safety findings of antidepressants, and the effectiveness of specialist community services versus standard care.	Thank you for your comment. The existing research recommendation 2.5 includes psychological interventions for anxiety disorders (including OCD). Evidence for the prevention of depression is reviewed in chapters 7 and 8 and was not considered by the GDG to be a priority for further research. The GDG did not consider the uncertainty of the role of confounding factors for interpreting harms associated with antidepressants to be a suitable research recommendation, given that a lot of data exists in this area and the uncertainty is often associated either with problems with analysis or with the impossibility/implausibility of separating out these confounding factors. Organisation of care was outside the scope of this guideline update
Royal College of Psychiatrists	83	NICE	1.5.1	29	It would be helpful if the assessment could include questions about the womans feeling about her pregnancy and becoming a parent, such as for example, what was it like when her other children were born, how long did it take	Thank you for your comment. In response to your, and other stakeholders' comments, recommendation 1.6.1 has been amended with a new bullet point added that assessment and diagnosis of a suspected mental health problem

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					to bond with them, how does the father feel about pregnancy and parenthood	in pregnancy and the postnatal period should include the woman's attitude towards the pregnancy and the woman's experience of pregnancy.
Royal College of Psychiatrists	84	NICE	1.6.8	35	We would recommend that the woman, if she is not bonding or has a severe disturbance in her relationship with the fetus or baby, to consider treating the depression via psychotherapy by perinatal and parent-infant psychotherapists depending on the local provision. If she is presenting with a long-standing complex psychological disturbance , perhaps related to her own upbringing, which has triggered the depression on becoming a parent, also consider these services. It would be useful for professionals to consider other specialist treatments for depression in a wider range of mental health services, depending on the presentation of the woman on assessment. If there is high conflict in the couple relationship, consider couple therapy. If she is worried about her other children, consider family therapy in a Child and Adolescent Mental Health Service.	Thank you for your comment. The GDG reviewed the clinical and cost-effectiveness of psychosocial interventions in pregnancy and the postnatal period and there was no evidence to support recommending couple or family therapy. It is also important to note that NICE guidance does not usually specify the professional or service who will provide interventions but rather outlines key components that any recommended intervention should include
Royal College of Psychiatrists	85	NICE	1.6.4	35	Consider referral to a specialist perinatal and parent-infant psychotherapy service if you have concerns about how the woman may be relating to her baby, both emotionally and in the feeding relationship. Advice may not be enough.	Thank you for your comment the recommendation has been revised as to assess the nature of the mother- baby relationship, including verbal interaction, emotional sensitivity and physical care, at all postnatal contacts. If there are safeguarding issues, the recommendations advise to refer to local safeguarding protocols.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Psychiatrists	86	NICE	1.7.14	44	Consider referral to a parent-infant mental health service	Thank you. We have revised the recommendation but given the limited evidence on interventions we are not able to take up your suggestion.
Royal College of Psychiatrists	87	NICE	2.3 RCT	48	The quality of the relationship between the mother and her partner and between the mother and her other children should also be considered as key outcomes in this trial	Thank you for your comment. However, the suggested amendment cannot be made as this is outside the scope of this guideline
Royal College of Psychiatrists	88	NICE	2.4.	49	Personality disorder: Comparing the model of structured clinical management with standard clinical care sounds useful. This study would be even more informative if a third arm of the study was included: to randomize women to a personality disorder psychotherapy service (see Fonagy/Bateman research and clinical practice)	The GDG did consider a three arm trial of the kind you describe but were mindful of the problems of attendance for specified therapeutic sessions over an extended period of time which women who are pregnant or in the immediate postpartum period in receipt of MBCT (Bateman and Fonagy) or DBT (Linehan) would be required to do. As a result they favoured a trial of structured clinical management because of its greater flexibility in delivery.
South London & Maudsley NHS Trust	1	NICE	General	0	Overall these updated guidelines provide a lot of useful new information. The guidelines are generally readable and easy to follow.	Thank you for your comment.
South London & Maudsley NHS Trust	2	NICE	General	0	The guidelines are heavily written in the language of IAPT – symptoms, manuals, outcomes, high intensity vs low-intensity interventions. The latter is particularly deskilling as it lumps all qualified therapists of whatever level, experience or professional group together as the conduits of 'high intensity' therapy, which typically means a 12-20 once-weekly input rather than anything	Thank you for your comment. We disagree that the approach has been simply from IAPT, rather it is an approach adopted in a number of NICE guidelines and is used in this guideline to be consistent with other NICE guidance. We think it will lead to improvements in care and will not be de-skilling.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					longer term or more intense. This is also consistent with the 'recovery' paradigm which does not appear to recognise the persistence of severe and enduring mental illness. Any research based guidelines will of necessity take on some of these aspects, but the retention of more clinically based descriptors in places would be helpful.	
South London & Maudsley NHS Trust	3	General	General	General	Therapy for the mother: The guidelines make a point of considering the context within which services are delivered, by which I understand is meant the location. There is another important context, which is the emotional turmoil of childbirth, affecting not just the patient but also family and especially the infant. Whilst this is stated, it is to some extent negated by taking a symptom-focussed approach to the recommendations of therapy, rather than a whole person, systemic approach. It is well-recognised that RCTs do not reflect the complexity of real clinical practice and there is insufficient acknowledgement of this. This is particularly true in the perinatal period, where there are relatively fewer RCTS for diagnostic groups, and reasons for believing that a greater leeway is needed due to the complexity of the period. For example, someone with depression in the perinatal period may be struggling with any number of role changes, loss of identity as a working woman, stressful marital and family	Thank you for your comment. RCTs provide the greatest degree of certainty that can be attributed to the conclusions drawn from the study. This review did consider RCTs with pregnant women or women in the postnatal period and where these revealed evidence that adaptations were needed to existing NICE guidance, or examined unique interventions for this period, recommendations were made/amended as necessary. The qualitative review of service user experience (chapter 6) also provided a wider view of women's experiences of treatment and management and informed the recommendations made.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					relationships etc etc, and so warrants assessment as to the most suitable psychological therapeutic approach to the 'depression'. This may well be CBT / IPT but could equally be mother-infant, psychodynamic [brief or longer term] or couple/ family work. Psychodynamic Psychotherapy is all but obliterated as a treatment in these guidelines, despite it still widespread use and its principles underlying many of the newer approached. Couple Therapy is also underrepresented compared to how clinically relevant and useful – [one could argue that it is an accident of criteria that the Leff and Asen trial showing that couple therapy is effective in depression was removed from the general guidelines on depression]. The depression could also be in the context of a personality disorder, which would need consideration in its own right, and in which case there is at least a discussion to be had about whether the NICE guidelines for PD should apply. I do not agree that there is a general perception that therapy is not helpful in the perinatal period [Full guidelines], rather the reverse has been beamed at us and there are cases where caution is needed. Despite the statement on page 5, there is insufficient emphasis on patient choice.	
South London & Maudsley NHS	4	NICE	0	2	Contents page and section 1.3 p.18-19It may useful to separate this section out so that	Thank you for the comment. The NICE guideline has been restructured.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					sections 1.3.1 to 1.3.16 (the more general advice) forms one section and sections 1.3.17 onwards (relating to specific medications) are another. It is not easy to identify from the contents page where information about specific medications can be found.	
South London & Maudsley NHS Trust	5	NICE	1.3.2	18	Do we want everyone who is taking an SSRI in primary care to be referred to perinatal services for preconception counselling? Would it be better to make some general points about advice for women taking antidepressants and to suggest referral only for women with severe/complex disorders ?	Thank you. The guideline development group agrees with your comment and has amended the recommendation to say that women should be referred to a secondary mental health service (preferably a specialist perinatal mental health service).
South London & Maudsley NHS Trust	6	NICE	1.3.13	22	Again is it realistic to expect perinatal services to be asked about prescribing in every case?	Thank you for your comment. The recommendation says "consider seeking advice…", precisely as to avoid it being every case.
South London & Maudsley NHS Trust	7	NICE	1.3.16	24	"Seek specialist advice if there is uncertainty about the risks associated with specific drugs". Would it be useful to suggest that one source of this advice could be from UKTIS (www.uktis.org)?	Thank you for the information but we have not verified or reviewed sources of advice.
South London & Maudsley NHS Trust	8	NICE	1.4.4	30	Midwives do the majority of the mental health screening antenatally. It may not be realistic for them to use rating scales (e.g. GAD-7/EPDS/PHQ9) given everything they need to fit into antenatal booking appointments. It is also unlikely that specialist mental health services will have the capacity to assess everyone who responds positively to the Whooley/ GAD-2 questions. Could the recommendation be that	Thank you for your comment. The guideline recommends that at a pregnant woman's first contact with primary care or her booking visit, the healthcare professional should consider asking brief case identification questions as part of a general discussion about a woman's mental health and wellbeing. As highlighted by your comment, the benefit of using a brief case-finding approach in clinical settings where

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					the GP, or possibly the specialist mental health midwife (given the recent recommendation about specialist midwife posts in all maternity services) has a role in the "further assessment" using these questionnaires? Health visitors may still be able to take on this role in the postnatal period.	routine perinatal care takes place is not necessarily to diagnose anxiety or depression per se, but to reduce the number of women who need extensive assessment or evaluation with longer questionnaires such as the EPDS. Recommendation 1.5.5 has been amended in light of your, and other stakeholders', comments so that the healthcare professional can consider using a formal tool as part of a full assessment or refer the woman to her GP or (if a severe mental health problem is suspected) to a mental health professional. In addition, a new recommendation has been added that recommends that at subsequent contacts in pregnancy and the postnatal period the health visitor (and other health and social care professionals who have regular contact with the woman) should consider asking case identification questions and consider use of a formal tool as part of ongoing assessment and monitoring (1.5.8).
South London & Maudsley NHS Trust	9	NICE	1.4.10	31	It may be useful to define "urgent" and suggest a time frame within which women need to be assessed and suggest that if CMHT/Perinatal service cannot see the woman within this time frame she should attend A&E.	Thank you for your comment. The recommendation has been amended in light of your comment. We now recommend that a woman who has sudden onset of symptoms suggestive of postpartum psychosis is assessed within 4 hours of referral. See revised recommendation 1.5.12.
South London & Maudsley NHS Trust	10	NICE	1.6.21	39	Is there evidence that Quetiapine is better than e.g. Olanzapine? In the postpartum period, Quetiapine requires	Thank you for your comment. In response to your, and other stakeholders', comments, the example of quetiapine has been removed from

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					titration and is clinically less effective in treating mania, which usually requires rapid sedation. A drug such as Olanzapine (although there are side effects of weight gain, glucose metabolism) is faster in action to treat an emerging psychosis .	the recommendation and replaced by a reference to the NICE guideline on bipolar disorder. The GDG agreed that there was an unnecessary emphasis on quetiapine drug which was not supported by the evidence reviewed.
South London & Maudsley NHS Trust	11	NICE	1.7.1-.13	43	1.7.1-1.7.13 Regarding breast feeding, it would be worth including some information about 'Relative Infant Dose' Thomas Hale data – Medication and Mother's Milk. If psychotropic less than 10 % maternal dose (weight adjusted), then reasonable safe to breast feed unless drug is toxic or baby very premature. Some drugs e.g. Lithium very high relative infant dose therefore dangerous to breast feed baby as likelihood of neonatal toxicity.	Thank you for your comment. The GDG considered breastfeeding, reviewed the previous recommendations, and drawing on expert experience took the view that given the uncertainty of data, it would be inappropriate for the group to make specific recommendations, apart from those previously existing, other than to raise awareness of the potential risks. Where there was existing evidence for specific drugs, these have been singled out (see recommendation 1.9.8). Thank you for the information you provide but we have not verified or reviewed sources of advice.
South London & Maudsley NHS Trust	12	NICE	1.7.14	44	…"reassure the mother that any problems with the relationship are likely to improve with effective treatment of the mental health problem." This needs qualification – it may be true in some cases, but certainly not all e.g. not uncommonly where there is a disturbance in mother's relationship with her own mother this may well manifest in a non-symptomatic way which is nevertheless inimical to the infant.	Thank you for your comment. In response to your, and other stakeholders', comments, this recommendation has been amended.
South London & Maudsley NHS	13	NICE	1.7.15	45	The recommendation to consider referral to an infant mental health services in the event of a	Thank you we have revised the recommendation and adopted a more general

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					disturbance emerging in the mother-infant attachment I think misses the dyadic nature of this, despite apparently highlighting it. Nomenclature is important in opinion formation. These disturbances need to be addressed in a mother-infant context. In our experience in over 14 years of treating this population in a secondary care adult mental health service that one focuses primarily on the infant at the risk of mother dropping out of therapy. There needs to be some recognition that when the mother is the referred patient, any such therapy should also encompass mother's issues, with flexibility as to attendance of the infant at sessions. Such services are best located within the general provision rather than split off. The emphasis may be different when the infant is the referred patient and such services are typically located in CAMHS. As there is apparently a lack of robust research in this area, clinical opinion needs to be reflected.	approach to this topic as we did not feel, following consultation, that the evidence available supported the previous recommendations.
South London & Maudsley NHS Trust	14	NICE	1.7.14	44	1.7.14-.15 It would be worth mentioning that admission to a Psychiatric Mother and Baby Unit does improve outcomes for mothers and babies and should be considered as per national guideline for admission to MBU – see Service Spec from MBUs' NHS England Supported by paper : Mother-infant interaction in mother and baby unit patients: Before and after treatment.Kenny, M., Pariante, C., Conroy, S., Seneviratne, G. & Pawlby, S. Sep 2013 In :	Thank you for this comment. This issue was outside the scope of this update of the guideline.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Journal of Psychiatric Research. 47, 9, p. 1192-1198. An important paper evidencing outcomes on an MBU	
South London & Maudsley NHS Trust	15	NICE	2.3	48	The recommendation for further research in mother-infant therapy: There could be ethical problems in randomising a mother-infant with demonstrable attachment problems to 'standard' care. To quote [redacted] and clinicians do tend to believe in the efficacy of mother-infant interventions even without robust RCTs. In fact medicine generally operates on a basis of older tried medications which have not been through RCTs but which no-one would suggest testing against a non-specific comparator e.g. steroids. Two years is insufficient follow-up time to know if these interventions have been effective [in the research sense] as effects of infant deprivation are known to show up e.g. in adolescence and early motherhood. The prohibitive nature of mounting a 'proper' trial with long-term follow-up has been a factor in the lack of existing RCTs.	Thank you for this comment. We do think it important that the effectiveness of these interventions are properly tested and we think that the RCT is the best method to do this. We agree that it might be appropriate to seek longer-term outcome data than the 2 years initially suggested in the recommendation (note we say for "at least 2 years') but did not feel it appropriate to specify a longer term follow if there is no data to support effectiveness at 2 years. We have therefore decided not to change the recommendation.
St Mary's Hospital (CNWL)	1	NICE	General	0	The guidelines are easy to read and offer a good deal of new evidence; they are informative but not too prescriptive; this allows the right degree of flexibility in day to day clinical practice when one has to develop tailored individual-centred care plan using the evidence from population-based studies.	Thank you for your comment.
St Mary's Hospital (CNWL)	2	NICE	1.7.5-1.7.8	43	It is helpful to highlight that women experiencing a foetal loss should be offered the	Thank you for your comment. The group have shared your concern and it has been passed on

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					appropriate management, however this is primarily maternity service responsibility (bereavement midwife, maternity counsellor, signposting to the relevant NGOs) and it would be helpful to make it clear; maternity service provisions for foetal losses are underfunded, primary care e.g. IAPT usually does not have sufficient resources or expertise to manage these women and there is a risk that a proportion of this population will be referred inappropriately to Specialist Perinatal Mental Health Services or other secondary services. Women who develop psychiatric complications above the expected adjustment reaction (e.g. depression or PTSD) should be referred for further assessment and management to secondary	to the NICE implementation support team.
St Mary's Hospital (CNWL)	3	NICE	1.1.1	16	Child bearing women at risk of developing or affected by a mental illness receiving preconception advice may well have other children; highlighting the impact of an increased risk of relapse and of the psychiatric management during pregnancy and postpartum on the rest of the family should be part of the process of facilitating patient's choice	Thank you for your comment. The guideline development group agrees that highlighting increased risk of relapse and of treatment for any mental health problem in pregnancy and the postnatal period is crucial. A number of recommendations in sections 1.2, 1.3 and 1.4 highlight the increased risk of women of relapsing and how to support a women in her decision making process if she wishes to involve her partner, family or carer.
St Mary's Hospital (CNWL)	4	NICE	1.2.6	18	(2nd bullet point) In psychiatry there is a lack of clarity in the terminology and mental health is often interpreted as a synonym of mental illness – this does not happen in the realm of	Thank you. A new recommendation has been drafted in light of yours and other stakeholders' comments; please see NICE recommendation 1.3.5 and 1.3.6.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					physical health – making it difficult to make sense of generic terms like mental well being. Would it be possible to suggest a coordinated approach based on a care plan where physical and mental health management are fully integrated? In the same way in which women in maternity are counselled about promoting good physical health, screened for medical and obstetric complications and stepped up accordingly, they should be counselled about promoting positive mental health, screened and referred to specialist mental health services accordingly.	
St Mary's Hospital (CNWL)	5	NICE	1.3.12	22	1.3.12 and General- Some psychological interventions are effective in the management of a proportion of psychiatric conditions, usually not of severe degree, but one should be cautious in recommending them as an "alternative" to psychotropic medication when this is the first line of treatment. If a woman opts to discontinue or declines psychotropic medication it should be made clear that this will increase the risk of relapse and psychological intervention and general "supportive" measures may be insufficient to contain the risk; in addition women who are symptomatic may not be able to engage constructively in psychotherapy. Would it be possible to introduce the notion that assessment for suitability for psychological interventions should be incorporated in specialist perinatal mental	Thank you for your comment. Please see NICE recommendation 1.4.11 for the amendment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					health management to reflect the reality that some women may well benefit form psychological input but are not able to engage, commit or tolerate it.	
St Mary's Hospital (CNWL)	6	NICE	1.4.4 - 1.4.6	30	Midwives do the majority of the mental health screening antenatally and it may not be realistic for them to use rating scales (e.g. GAD-7/EPDS/PHQ9) in the limited time of the antenatal booking appointments. It is also unlikely that specialist mental health services will have the capacity to assess everyone who responds positively to the Whooley/ GAD-2 questions. Could the recommendation be that the GP, or the specialist mental health midwife – if available - or the Health Visitor play a role in evaluating the need for further assessment?	Thank you for your comment. The guideline recommends that at a pregnant woman's first contact with primary care or her booking visit, the healthcare professional should consider asking brief case identification questions as part of a general discussion about a woman's mental health and wellbeing. As highlighted by your comment, the benefit of using a brief case-finding approach in clinical settings where routine perinatal care takes place is not necessarily to diagnose anxiety or depression per se, but to reduce the number of women who need extensive assessment or evaluation with longer questionnaires such as the EPDS. Recommendation 1.5.5 has been amended in light of your, and other stakeholders', comments so that the healthcare professional can consider using a formal tool as part of a full assessment or refer the woman to her GP or (if a severe mental health problem is suspected) to a mental health professional. In addition, a new recommendation has been added that recommends that at subsequent contacts in pregnancy and the postnatal period the health visitor (and other health and social care professionals who have regular contact with the woman) should consider asking case

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						identification questions and consider use of a formal tool as part of ongoing assessment and monitoring (1.5.8).
St Mary's Hospital (CNWL)	7	NICE	General	0	Would it be useful to suggest UKTIS (www.uktis.org) and Thomas Hale data – Medication and Mother's Milk as a source of information in the relevant sections?	Thank you for the information but we have not verified or reviewed sources of advice.
St Mary's Hospital (CNWL)	8	NICE	1.6.21	39	1.6.21 and general: Is there evidence that Quetiapine is better than e.g. Olanzapine? There seems to be a general preference for Quetiapine over Olanzapine in the guidelines.	Thank you for your comment. In response to your, and other stakeholders', comments, the example of quetiapine has been removed from the recommendation and replaced by a reference to the NICE guideline on bipolar disorder. The GDG agreed that there was an unnecessary emphasis on quetiapine drug which was not supported by the evidence reviewed.
Staffordshire and Stoke on Trent Partnership NHS Trust	1	NICE	1.2.5	17	We approve that the consultation guideline recommends that professionals should consider the impact of perinatal mental illness on the partner, other family members and children but feel it should also refer to any potential impact on the unborn baby.	The impact of perinatal mental illness on the unborn baby is covered in other NICE recommendations 1.4.6, 1.6.1, 1.6.3, and 1.6.6
Staffordshire and Stoke on Trent Partnership NHS Trust	2	NICE	1.3.1	18	We approve that the consultation guideline recommends the use of culturally relevant information relating to mental health problems but believe that there is a need to develop good quality literature to support professionals in this area.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Staffordshire and Stoke on Trent Partnership NHS	3	NICE	1.3.2	18	We support the guideline recommendation however commissioners would be required to review the service specification for specialist	Thank you for your comment. The recommendation has been broadened so that a woman is seen by a specialist, however the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					mental health services locally in order to implement this recommendation in full. There are gaps in national service provision where specialist perinatal mental health services are not available and could not therefore be accessed as the guideline suggests.	GDG maintain where possible, preferably a perinatal mental health specialist.
Staffordshire and Stoke on Trent Partnership NHS Trust	4	NICE	1.3.5	19	Multiagency staff supporting pregnant women ,partners, family , carers would benefit from multiagency partnership model working/ emotional health team training in order to break down professional boundaries and improve communication/coordinated care among	Thank you for your comment. The guideline does make several recommendations enforcing the need for good communication between health and social care professionals. However providing the necessary support to enable good communication is an implementation issue and has been passed on to the NICE implementation support team.
Staffordshire and Stoke on Trent Partnership NHS Trust	5	NICE	1.4.2	29	We support the consultation guideline recommendation relating to the sharing of information with maternity services when there is a past or present mental health problem. However consideration should be given to extending this recommendation to include the health visiting service as the "Healthy Child Programme" (2009) and the "National Health Visiting Service Specification 2014/2015" (2014) clearly states that health visitors are responsible for delivering the Healthy Child Programme in full which includes a universal offer in the antenatal as well as the postnatal period.	Thank you for your comment. In light of your, and other stakeholders', comments a new recommendation has added that explicitly recognises the role of health visitors (and other health and social care professionals who have regular contact with the woman) in the ongoing assessment and monitoring of women in pregnancy and the postnatal period
Staffordshire and Stoke on Trent Partnership NHS Trust	6	NICE	1.4.3	29	Perinatal mental health assessments in the postnatal period form part of the universal service offered by health visitors. However when reviewing the consultation guideline it is	Thank you for your comments. In light of your, and other stakeholder's, comments the timing specificity has been removed from the recommendation. The GDG recognised the

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					disappointing that the timescales for assessment do not coincide with those referred to in the DOH Maternal Mental Health Pathway (2012). Furthermore we are disappointed that an assessment at 8-12 months has been omitted as this is a universal contact for the health visiting service when mothers will often be identified to be experiencing mental ill health. We suggest that if an assessment is not recommended universally that best practice should recommend that women with a past history of mental ill health are offered a further assessment at this point. We approve that the consultation guideline recommends the inclusion of GAD 2 identification questions and further assessment using GAD 7. We approve that the consultation guideline recommends further assessment if women answer positively to either of the "Whooley" questions rather than asking the third question "is this something you feel you need or want help with. Additionally we suggest that further assessment should also be recommended if there is a lack of congruence between a woman's' verbal responses to the identification questions and her presentation.	importance of effective case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations under 'Recognising mental health problems in pregnancy and the postnatal period and referral'). The first recommendation in this section is informed by the qualitative evidence review that revealed that women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in the recommendations that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. The GDG felt that it was important to point out that these case identification tools have been validated for use

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						in primary care so the distinction of which primary healthcare professional administers them is not meaningful. In response to your, and other stakeholder's, concerns that the Whooley questions may still fail to identify depression for some women, the next recommendation has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are recommended to consider using a formal tool such as the EPDS as part of a full assessment. The role the health visitor (and other health and social care professionals who have regular contact with the woman) have in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation. In addition, the first recommendation in the 'Assessing mental health problems in pregnancy and the postnatal period and care planning' section has been amended with a new bullet point added that assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include the mother-baby relationship. Moreover,

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						recommendations in the 'Considerations for women with mental health problems and their babies in the postnatal period' section, under 'The mother-baby relationship' sub-heading, have been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). However, specifying who should complete this assessment was not considered appropriate as it will depend on the individual and their contact with services.
Staffordshire and Stoke on Trent Partnership NHS Trust	7	NICE	1.4.4	30	We approve that the consultation guideline permits health visitors to use the Edinburgh Postnatal Depression Scale to further explore symptoms of depression but are concerned that the GDG perceives that the health visitor's role relates only to detection, further assessment and subsequent referral. The guideline fails to acknowledge and address the management of those women who refuse to access mental health services and the potential impact that their mental illness may have on their relationships and on the cognitive, emotional and behavioural development of their infant	Thank you for your comment. NICE guidance does not generally specify the healthcare professional who should deliver recommended interventions but rather outlines key components. For women with persistent subthreshold depressive symptoms, or mild to moderate depression, or persistent subthreshold symptoms of anxiety, facilitated self-help is the recommended intervention, therefore, referral to and engagement with mental health services would not necessarily be required. Facilitated self-help should include the provision of written materials, supported by a trained practitioner (face-to-face or by telephone) which in this context could include a health visitor.
Staffordshire and Stoke on Trent Partnership NHS	8	NICE	1.5.1	32	We approve that the consultation guideline recommends a holistic assessment of the woman and that psychosocial factors that can	Thank you for your comment. Please see a new recommendation 1.5.8 for further clarity and specificity on the role of health visitors

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trust					impact on mental health and wellbeing are incorporated. As health visitors universally access all pregnant and postnatal women this information is routinely collated and subsequent support / referral offered when necessary. Clarification of the role of the health visitor is therefore required when psychosocial factors impacting on mental health are identified. Clarification will reduce the need for women to have multiple assessments and will clarify the health visitor's responsibilities in a stepped care model.	
Staffordshire and Stoke on Trent Partnership NHS Trust	9	NICE	1.5.3	32	We approve that the consultation guideline has extended guidance around risk assessment which now includes alcohol and substance misuse and domestic violence.	Thank you.
Staffordshire and Stoke on Trent Partnership NHS Trust	10	NICE	1.5.6	33	We approve that the consultation guideline recommends the development of a written care plan but would prefer to see desirable timescales included. We believe that the care plan should where appropriate also include the potential impact on the unborn baby. We believe that communication would be enhanced if when referring to "all involved professionals" a further statement was added "to include GP, midwife and health visitor i.e. those professionals offering women a universal service in the perinatal period. This would	Thank you for your comment. A new recommendation has been drafted to take into account some of your concerns, such as schedule of monitoring. However, the GDG felt it would not be appropriate to state which professional should be involved but rather the health plan should state who is involved and who is responsible for coordinating the care plan (see recommendations 1.3.5-1.3.6)

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					promote and encourage all involved professionals to participate in the Care Programme Approach.	
Staffordshire and Stoke on Trent Partnership NHS Trust	11	NICE	1.6.6	35	We acknowledge the recommendations in 1.6.1. and 1.6.2 but believe it is not immediately apparent when reading the guideline that it is no longer recommending home listening visits from health visitors. Consideration must be given therefore to those women who refuse to be referred or to engage with mental health services as the consequences of maternal mental illness will potentially remain untreated affecting not only the woman but other family members, the infant and any other children. Women who have an established therapeutic relationship with their health visitor often find it more acceptable to engage in the universal plus component of the service than to access mental health services. This relationship needs to be acknowledged and valued as stigma, and the perceived consequences of admitting to having a perinatal mental illness still prevent women from accessing psychological therapy. . Health visitors often therefore have a role in terms of engaging women through home listening visits in the therapeutic process which we believe requires further consideration. The consultation guideline fails to address the	Thank you for your comments. NICE do not usually specify which healthcare professional delivers the recommended intervention but rather recommends key components. For women with persistent subthreshold depressive symptoms, or mild to moderate depression, or persistent subthreshold symptoms of anxiety, facilitated self-help is the recommended intervention, therefore, referral to and engagement with mental health services would not necessarily be required. Facilitated self-help should include the provision of written materials, supported by a trained practitioner (face-to-face or by telephone) which in this context could include a health visitor. In response to your comments regarding listening visits, there was no high quality evidence to make a recommendation for listening visits. The economic analysis conducted for this guideline found facilitated self-help to be dominant when compared with listening visits. Cost-effectiveness results were driven by the superior efficacy of facilitated self-help and the relatively low intervention costs. The GDG considered this evidence together with what is known about the clinical and cost effectiveness of facilitated self-help for

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					management of women who refuse to access psychological services and the impact untreated maternal mental illness can have on the cognitive, emotional and behavioural development of the infant and child.	the treatment of depression in non-pregnant women, and recommended that facilitated self-help should be considered for women with persistent sub-threshold depressive symptoms, or mild to moderate depression.
Staffordshire and Stoke on Trent Partnership NHS Trust	12	NICE	1.6.3	35	We approve that the consultation guideline recommends reducing the timescales for assessment and subsequent treatment. However this needs to be considered when service specifications are being agreed and mental health services commissioned.	Thank you for your comment. This refers to the implementation of the guideline and has been passed on to the NICE implementation support team.
Staffordshire and Stoke on Trent Partnership NHS Trust	13	NICE	1.6.10	36	We approve that the consultation guideline incorporates tokophobia, however this needs to be considered when service specifications are being agreed and mental health services commissioned.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Staffordshire and Stoke on Trent Partnership NHS Trust	14	NICE	1.6.14	37	We approve that the consultation guideline refers to specific psychological interventions for eating disorders. However these services are not nationally available and gaps in service provision would need to be addressed in order to implement the guidance.	Thank you for your comment. This is an implementation issue and has been passed on to the NICE implementation support team.
Staffordshire and Stoke on Trent Partnership NHS Trust	15	NICE	1.7.2	41	We presume that this could refer to the examination that all babies have within 72 hours of delivery. Despite a local commissioning agreement stating that all new-born infants will have this examination prior to discharge home from hospital babies are still frequently required to visit their GP for the examination. Timescales inevitably lapse and if therefore an examination is recommended by a	Thank you for this comment. Training to support implementation for the guideline is important but is outside the scope of the guideline. This has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					neonatologist, acute services would need to review staffing and skill mix especially at busy times and weekend's etc. in order to implement this guidance.	
Staffordshire and Stoke on Trent Partnership NHS Trust	16	NICE	1.7.5	43	We approve that the consultation guideline recommends additional support and advice for women who have experienced a traumatic birth, stillbirth or miscarriage. However a specialist mental health assessment provided by perinatal services requires further consideration as women who have experienced a miscarriage or stillbirth may decline to engage in a parent and baby service. Alternative services therefore need to be considered.	Thank you. The recommendation has been revised in light of your comment.
Staffordshire and Stoke on Trent Partnership NHS Trust	17	NICE	1.7.14	44	We approve that the consultation guideline requires professionals to consider the impact of perinatal mental illness on the mother infant relationship.	Thank you for your support.
Staffordshire and Stoke on Trent Partnership NHS Trust	18	NICE	1.7.15	45	We approve that the consultation guideline recommends assessment of the mother / infant relationship. However we believe that further detail relating to suggested assessment tools and recommended interventions is required in order to ensure best practice is developed. We acknowledge that there is a GDG looking at Children's attachment but as this guideline is not expected until October 15 professionals will require additional guidance in the interim. Infant mental health services are not available nationally therefore if problems with the	Thank you for your comment. Recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). The evidence for interventions which directly targeted the mother-infant relationship was mixed, but largely non-significant (see Chapter 7 in full guideline). This inconclusive evidence prompted the GDG to recommend a definitive trial of a mother-infant relationship

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					mother infant relationships remain unresolved commissioning arrangements need to be reviewed or the GDG needs to consider alternative timely yet appropriate referrals and interventions.	intervention that examines clinical and cost effectiveness and reports on the mental health of the woman, the emotional and cognitive development of the baby, and the quality of the interaction with a follow-up period of at least 2 years. Recommendation 1.9.13 has been revised, the 'referral to infant mental health services' has been removed and a more general approach to this topic has been adopted as the GDG did not feel, following consultation, that the evidence available supported the previous recommendations.
Swansea University	1	Full	2	15	The introduction is very useful and well written.	Thank you.
Swansea University	2	Full	6	151	General: Quotations are used extensively. Many of these are interesting and work as illustration, but readers need to know how representative they are before they can be seen as encapsulating the evidence. Simple proportions would be helpful.	Thank you for the comment. The GDG did not consider it appropriate to attach proportions to the emerging themes as this was a qualitative rather than quantitative analysis. However, all papers have been double-coded to ensure that themes have been reliably coded and selected participant quotes accurately reflect the themes identified.
Swansea University	3	Full	8	558	General: This was hard to follow in places. Scores on a range of measures are quoted as study outcomes, but there is little information as to their provenance or clinical utility.	Thank you for your comment. It is difficult to give estimates on the clinical utility of individual scores on a scale. Whilst there are no agreed cut-offs, the GDG used clinical judgement and expert opinion to consider the clinical utility of scores on the different measures when making recommendations. However due to the absence of agreed clinical cut-off points it is not possible

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						to give specific information as to their provenance or clinical utility of these scores.
Swansea University	4	Full	7.5.16	475	Table 212. The first outcome has 'high level of evidence' but only 1 study.	Thank you for your comment. This outcome is rated as high quality as although it is single study data, the study was considered to be at low risk of bias, the effect estimate was precise (total population size over the threshold rule of thumb [N>400] and small confidence interval) and there was no reason to suspect publication bias. It is worth noting that for the case of this outcome the effect estimate is consistent with 'no effect' (SMD=0.08)
Swansea University	5	Full	8.21	561	Mode of delivery should be included in the critical outcomes.	Thank you for your comment. This has been added to the list of critical outcomes
Swansea University	6	Full	8.4.4	636	Table 314 is headed 'trials' but describes cohort studies.	Thank you for your comment. This has been changed in the text
Swansea University	7	Full	8.4.5	648	The discussion of congenital anomalies makes no mention of folic acid use. IUGR and birth weight are also important considerations.	Thank you for your comment. The GDG considered folic acid use, however in the absence of evidence and uncertainty around its use, they did not feel it was appropriate to make any specific guidance. There was limited evidence available for IUGR or birth weight therefore the GDG felt it was not appropriate to make any specific guidance
Swansea University	8	Full	8.9.1.24	722	There is a recommendation to discontinue valproate in the first trimester. This would be too late to prevent major congenital anomalies and might increase the risks or relapse.	Thank you for your comment, but the NICE guideline does not recommend that valproate is discontinued in the first trimester, rather it recommends that valproate is categorically not offered to women of childbearing potential or pregnant and breastfeeding women.
Swansea University	9	Full	8.9.1.26	722	Jentink et al (2010) indicate a relatively low risk	Thank you for your comment. The paper you

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					of anomalies for carbamazepine. This paper is in the reference list. Jentink J, Loane MA, Dolk H, Barisic I, Garne E, Morris JK, de Jong-van den Berg LT; EUROCAT Antiepileptic Study Working Group. Valproic acid monotherapy in pregnancy and major congenital malformations. N Engl J Med. 2010 Jun 10;362(23):2185-93. doi: 10.1056/NEJMoa0907328.	cite reports on risk of congenital abnormalities associated with use of valproate, and includes a case-control study which reports enough data to be included in the meta-analysis for congenital malformations. There is an additional paper, which you may be referring to: Jentink J, Dolk H, Loane MA, Morris JK, Wellesley D, Game E. Intrauterine exposure to carbamazepine and specific congenital malformations: systematic review and case-control study. British Medical Journal. 2010;341:c6581. This paper also reports on a case control study for carbamazepine, however did not report enough data to include in the meta-analysis. In light of your comment the reference to this paper been added to the excluded studies list in, found in Appendix 18. The meta-analysis in the guideline included more data than is reported in the Jentink et al. 2010 paper. The actual event rate for major congenital malformations from the guideline meta-analysis was 3.5%, which consistent with the figure 3.3%, reported in the Jentink paper. The Odds Ratio suggests that there is a small, but statistically significant association between carbamazepine and major congenital malformations. The GDG considered this finding, in particular the evidence for the increased risk of Spina Bifida (which Jentink2010 highlights), and whilst acknowledging the limitations of the studies

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						included and uncertainty surrounding the risks, they feel that the decision not to recommend carbamazepine in pregnancy is justified.
Swansea University	10	NICE	Introduction	3	Is the term 'Intrauterine growth retardation' the correct term to use? Should it instead read 'Intrauterine growth restriction'?	Thank you for your comment. We have replaced with Intrauterine growth restriction as suggested
Swansea University	11	NICE	Introduction	4	Is the term 'Fetal distress' the correct term to use? Should it instead read 'Fetal compromise'?	Thank you for your comment .We have replaced fetal distress with fetal compromise as suggested.
Swansea University	12	NICE	Introduction	4	At the top of the page it should read 'particularly women who smoke, than **in** those who do not.'	Thank you for your comment. This has been amended.
Swansea University	13	NICE	Introduction	3	Is the term 'Booking visit' the correct term to use? Should it instead read 'Initial consultation'?	Thank you for your comment, but the guideline development group favoured the term 'booking visit' which they felt would be best understood by the intended audience.
Swansea University	14	NICE	1.4.8	31	Should the woman also be made aware of the referral?	Thank you for this comment. We agree this should be the case and would expect this to be part of routine care for all referrals in the NHS. As a consequence we have not included this in the recommendation. Amended recommendations on coordinated care (1.3.5-1.3.6) recommend that all women with a mental health problem in pregnancy and the postnatal period should have an integrated care plan developed that sets out the care and treatment for the mental health problem and the roles of all healthcare professionals, and that the healthcare professional responsible for coordinating the care plan should ensure that

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						there is an effective sharing of information with all services involved and with the woman herself.
The Marce Society	1	General	General	General	The review of the NICE Guidelines is very welcome and has provided a comprehensive account of the management of antenatal and postnatal mental health The main points of concern are the screening /assessment process Whooley Questions The dismissal of the use of the EPDS is concerning, although unsurprising given the lack of written evidence to sanction its continued usage. However, the committee are urged to reconsider this decision based on anecdotal evidence both of the use of the EPDS, the Whooley questions and the reality of Commissioning services. In these times of austerity, Health Commissioners are often charged to reduce costs and the simplicity of the Whooley Questions offer an excellent 'op out' clause. This is born out of discourse with some health professionals whose managers have sanctioned minimal interventions. The understanding of the introduction of the Whooley questions was based on parity with the General Practitioners who used this method when during the clinical interview.	Thank you for your comments. The GDG recognised the importance of effective case identification and the economic model outlined in chapter 5 suggested that the use of a brief case identification tool followed by the use of a more formal method (such as the EPDS or PHQ-9), appears to be the most cost-effective approach in the identification of depression in the postnatal period (see recommendations in section 1.5). Recommendation 1.5.1 is informed by the qualitative evidence review that revealed that women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion. In response to

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Practitioners (Health Visitors) are well aware that the EPDS is not a screening tool and are versed in using this to assess maternal mood. It offers a succinct guide to the practitioner and is able to highlight the source of anxiety, depression and / or self harm or suicide. The simplicity of the questions should allow practitioners to investigate the mood of the mother, the following points might be added: In primary care, at least one hour is spent assessing physical needs, yet without the use of the EPDS mothers are confined to a mere 5 minutes or whatever the estimated time to ask 3 questions Inexperienced practitioners found the questions nebulous – because they are closed questions and contravene their investigative skills Several practitioners discussed the noticeable increase in the rate of detection of depression and anxiety once they reverted to use of the EPDS from the Whooley Questions. The needs of men and women during pregnancy are inter-related and not worlds apart. If applied sensitively, the same set of clinical skills e.g., empathy, active listening, problem solving, information giving can support expectant mothers (O'Hara 1985) Added to the discussion on the Marce listserve,, as I am sure you are aware, have been several emails supporting assessment, but summarised by the comments from Dr Alan Gemmill:	stakeholder comments, the timing specificity has been removed from this recommendation. In response to your, and other stakeholders', concerns that the Whooley questions may still fail to identify depression for some women, recommendation 1.5.5 has also been amended so that even in the absence of a positive response to the depression identification questions, but where a woman is perceived to be at risk of a mental health problem or there is clinical concern, healthcare professionals are recommended to consider using a formal tool such as the EPDS as part of a full assessment. The role the health visitor (and other health and social care professionals who have regular contact with the woman) have in the ongoing individualized monitoring of the woman throughout pregnancy and the postnatal period is recognised by the addition of a new recommendation (1.5.8). In response to your technical comments, separate analyses were done for antenatal or postnatal administration, but it was not possible to consider the exact timing of the administration. There was much heterogeneity between the studies, and a long list of factors which could have contributed to this, so we were unable to do separate sub-analyses for all of these. Some of the reviews which you

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					This question is very specific in terms of timing (10 to 14 days) and very general in terms of what type of evidence is sought in relation to the use of a screening tool. On the purely technical side to do with test performance there is certainly evidence that psychometric test properties of screening tools change at different timepoints postpartum: 1. Hewitt, C., Gilbody, S., Brealey, S., Paulden, M., Palmer, S., Mann, R., . . . Richards, D. (2009). Methods to identify postnatal depression in primary care: an integrated evidence synthesis and value of information analysis. Health Technology Assessment 13(36), 1-145, 147-230). 2. Gaynes, B. N., Gavin, N., Meltzer-Brody, S., Lohr, K. N., Swinson, T., Gartlehner, G., . . . Miller, W. C. (2005). Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evidence Report: Technology Assessment (Summary)(119), 1-8. However, the absolute difference in performance of screening tools used in the "early" (<6weeks) and later postnatal periods is likely to be relatively small: 3. Myers, E., Aubuchon-Endsley N, Bastian LA, Gierisch JM, Kemper AR, Swamy GK, . . . GD., S. (2013). Efficacy and Safety of Screening for	mention do consider timing, however all seem to be in agreement that there are many factors which may influence the diagnostic performance (hence the high heterogeneity), and to our knowledge none have found conclusive evidence that timing significantly effected this. In response to the specific papers you mention: 1. Hewitt et al. (2009) was identified by the search, but as it is a HTA report with no primary data, it was used to help identify the papers rather than being included in meta-analysis 2. Gaynes et al. (2005) was also identified by the search but was a HTA report providing no primary data for the meta-analysis 3. Myers et al. (2013) was identified by the search but was a review paper providing no primary data for the meta-analysis 4. Armstrong et al. (1999) is an intervention RCT and is reviewed in chapter 7 of the full guideline 5. Crotty & Sheehan (2004) was identified by the search but was not included as it does not report validation data (ie. sensitivity and specificity) for the EPDS. However, this study was missing from the list of excluded studies so we have

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Postpartum Depression. Comparative Effectiveness Review 106. Rockville, MD: Agency for Healthcare Research and Quality. Next, there have been some studies looking at prevention that have screened very early and have been successful at cutting subsequent depression symptoms: 4. Armstrong KL, Fraser JA, Dadds MR, et al. A randomized, controlled trial of nurse home visiting to vulnerable families with newborns. J Paediatr Child Health 1999; 35(3):237-44. Last, there are various papers looking at validating screening in the "early" postnatal period e.g. 5. Crotty F, Sheehan J. Prevalence and detection of postnatal depression in an Irish community sample. Ir J Psychol Med. 2004;21(4):117-21. PMID: 2004-22274-003. 6. Jardri R, Pelta J, Maron M, et al. Predictive validation study of the Edinburgh Postnatal Depression Scale in the first week after delivery and risk analysis for postnatal depression. J Affect Disord. 2006;93(1-3):169-76. PMID: 16644021. 7. Ji S, Long Q, Newport DJ, et al. Validity of depression rating scales during pregnancy and the postpartum period: impact of trimester and parity. J Psychiatr Res. 2011;45(2):213-9. PMID:	added it to Appendix 18 6. Jardri et al. (2006) is referenced in the chapter as meeting inclusion criteria but could not be included in the meta-analysis because the data could not be extracted. This study is listed in the excluded studies table (Appendix 18) 7. Ji et al. (2011) is referenced in the chapter as meeting inclusion criteria but could not be included in the meta-analysis because the data could not be extracted. This study is listed in the excluded studies table (Appendix 18) 8. Gibson et al. (2009) was a systematic review identified by the search and was used as a source of studies and referenced in the chapter 9. The 'Identifying Perinatal Depression and Anxiety: Evidence-based Practice in Screening, Psychosocial Assessment and Management' reference was not identified by the search as it does not meet study design criteria (book)

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					20542520. The reviews above numbered 1] and 3] are good sources of tables showing (among other things) the timing of postnatal screening in the bulk of the published literature. Also see tables in: 8. Gibson, J., McKenzie-McHarg, K., Shakespeare, J., Price, J., & Gray, R. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. Acta Psychiatrica Scandinavica, 119(5), 350-364. Identifying Perinatal Depression and Anxiety: Evidence-based Practice in Screening, Psychosocial Assessment and Management" (published by Wiley-Blackwell).	
Tommy's The Baby Charity	1	NICE	General	0	We welcome the revised update and support the recommendations proposed. We are especially pleased to see more detail about the use of psychotrophic drugs, the use of psychological interventions, inclusion of self-help, the need for continuity of care and the involvement of wider professionals and a women's network in planning her care with her.	Thank you for your comment.
Tommy's The Baby Charity	2	NICE	General	0	We think it would be useful to be more specific across the document about the health professionals involved and which HCPS might be responsible with regard to certain actions.	Thank you for your comment. As a result of your, and several other stakeholders, suggestion to be more explicit about who and how responsibility will get picked up in a

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					These are picked up below. At the moment there is some risk that actions may be deemed as 'some else's job'. However we welcome the point made on page 10 that healthcare teams should be working together and continuity of care be ensured through the clarification of a lead clinician. This lead contact needs to be highlighted further in the document.	woman's care plan, recommendation 1.3.5 now recommends that an integrated care plan is developed 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 and 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).
Tommy's The Baby Charity	3	NICE	1.1.1	16	We would like to see included in this section the need for discussion about the implications of a sudden halt to any medication being used and that women should be encouraged to speak to the prescribing practitioner following a positive pregnancy result to discuss the options available. (to prevent possibility of relapse or decline with cessation of medication without consultation). As described in section 1.3. Can a reference be made in section 1.1.1. to Section 1.3?	Thank you for your comment. Section 1.1 (now 1.2). is specifically for women of childbearing potential, whereas section 1.3 (now 1.4) is for women who are pregnant, planning a pregnancy or in the postnatal period. The issues you have raised about suddenly stopping medication are most pertinent to women who are planning a pregnancy or pregnancy, and therefore did not see that a cross-reference in section 1.1 was necessary.
Tommy's The Baby Charity	4	NICE	1.3	18	p.18-20 We would like to see the role of any partner, wider family or carer be acknowledged further through the recommendation that these persons be provided with information regarding their role in supporting a woman, information about perinatal illness and also where they too can seek help and advice about perinatal illness.	Thank you for your comment. The guideline development group has added that families and carers should be given information about mental health problems in pregnancy and the postnatal period.
Tommy's The Baby Charity	5	NICE	1.3.8	21	Regarding the monitoring of women during pregnancy and beyond, we are pleased to see	Thank you. The recommendation has been amended in light of your comment.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					regularity of monitoring highlighted, however who will be doing this? Should it be made clearer that all HCPs involved in her care should be alert to her mental health needs? It is not just the role of any prescribing practitioner or psychological interventionist but that of the whole healthcare team.	
Tommy's The Baby Charity	6	NICE	1.3.11	22	We are pleased to see the use of psychological as well we pharmacological treatments recognised more clearly in this update.	Thank you
Tommy's The Baby Charity	7	NICE	1.3.17-.37	24	We welcome the increased information regarding specific psychotrophic medication during the perinatal period and also the recommendation to seek specialist advice from a specialist perinatal team. We hope this will aid decision making for women and the different practitioners she encounters within the perinatal journey and prevent mixed messages within her care.	Thank you for your comment.
Tommy's The Baby Charity	8	NICE	1.4	29	We are pleased to see it recognised that many women are reluctant to discuss their mental health with HCPs. We feel it should be recognised within this section that simply asking the assessment questions is not necessarily enough and that time, the manner in which the questions are asked and the general approach of the HCP are all important in supporting a trusting relationship in which a woman feels comfortable to discuss her feelings.	Thank you for your comment. As your comment, and recommendation 1.5.1 highlights, women may be reluctant to disclose problems due to stigma and fears about the consequences of disclosure. Based on these considerations the GDG included in recommendation 1.5.4 that the depression and anxiety identification questions should be asked as part of a general discussion about a woman's mental health, and as a result of stakeholder comments and a reappraisal of the evidence, the emphasis and strength of this

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						recommendation has been amended so that the general discussion (about a woman's mental health *and* wellbeing) is the primary component and the healthcare professional should *consider* asking these specific depression and anxiety identification questions as part of this general discussion.
Tommy's The Baby Charity	9	NICE	1.4.1	29	1.4.1-.6We are pleased to see the recognition of other tools beyond the existing Whooley questions in assessing anxiety and the importance these can add to identifying women's needs. We also welcome the recommendation to consider referral to a specialist mental health practitioner where positive responses are found. However we believe more information is needed on the responsibility of different HCPs in assessing a woman's mental health needs.	Thank you for your comment. The GDG did not consider it appropriate to specify who should ask the initial case identification questions as it will be dependent on the woman's contact with primary care services. However, greater specificity about professional roles in identification and assessment has been added to other recommendations. For instance, referral to a GP has been added to recommendations 1.5.5-1.5.6. An additional recommendation has also been added in response to stakeholder comments that explicitly recognises the role of health visitors (and other health and social care professionals who have regular contact with the woman) in the ongoing assessment and monitoring of women in pregnancy and the postnatal period (1.5.8).
Tommy's The Baby Charity	10	NICE	1.4.8	31	We are pleased to see the recommendation that any severe mental illness or history is also highlighted to the GP. However as in the point above, further clarity on the responsibilities of HCPs in assessment and treatment is warranted to assist in cohesive care plans and also	Thank you for this comment. Amended recommendations on coordinated care (1.3.5-1.3.6) recommend that all women with a mental health problem in pregnancy and the postnatal period should have an integrated care plan developed that sets out the care and

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					continuity of care in women regardless of severity.	treatment for the mental health problem and the roles of all healthcare professionals, and that the healthcare professional responsible for coordinating the care plan should ensure that there is an effective sharing of information with all services involved and with the woman herself.
Tommy's The Baby Charity	11	NICE	1.7	43	We welcome the recognition of the needs of women following a traumatic birth, miscarriage or stillbirth and the guidance provided on supporting women and their partner/family at this time. We would also include premature delivery in this section, especially where a very early delivery has occurred or the infant requires specialist care for related health needs. This can also be a time of enhanced anxiety and stress. We would also like to see it recommended that any of the experiences listed are clearly noted in a woman's continuation notes to prevent repeated disclosure as she moves through the postnatal changes to healthcare i.e. midwifery to health visiting.	Thank you for your comment. In response to your, and other stakeholders', comments a definition of traumatic birth as used in the guideline has been added to the NICE guideline and makes clear that traumatic birth includes physically traumatic deliveries and psychologically traumatic deliveries (even when the delivery is obstetrically straightforward) and that preterm delivery is included in this definition if it falls into one of these two categories. The GDG also agree that it is important that all women receive coordinated care and feel that this point is captured by recommendations 1.3.5-1.3.6
Tommy's The Baby Charity	12	NICE	2	46	p.46-50 We welcome the additional research recommendations, especially those relating to management of women with severe mental illness in pregnancy.	Thank you for your comment.
University of Birmingham	1	NICE	Introduction	3	(Pages, e.g. 3-4, 11) The work of the GDG has been focused mainly on treatment trials. But diagnosis is fundamental, and however good	This comment appears to be incomplete, we are therefore unable to make a response.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					the service, its effectiveness depends on the acumen of clinicians, and their ability to diagnose and treat a broad range of disorders. This guideline still reflects the narrow range of concepts that were current in the early 1990s. It should be expanded to include:	
University of Birmingham	2	NICE	1.4.2	29	Pre Birth Planning This needs to be strengthened. If a mother with a history of severe mental illness becomes pregnant, a multidisciplinary pre-birth planning meeting should be convened as soon as possible, to share information and coordinate management. The interval between the diagnosis of pregnancy (which may be delayed) and birth (which may be premature) can be short. The meeting should include the GP, representation from the obstetric team, and the mental health team, and (if possible) the expectant mother and family members. A child and family social worker may need to be involved where necessary. There are many issues to be addressed – pharmaceutical treatment, antenatal care, early signs of a recurrence, the management of the puerperium and the care of the infant. It is essential that the mental health team is alerted as soon as the mother goes into labour. Psychiatry of pregnancy. There is little mention of psychological processes taking place during pregnancy, and how these might be of relevance to outcomes for parent and child.	Thank you for this comment. We have revised the recommendations about care planning and clarified the responsibilities that rest on individual health and social care practitioners. We have not taken up your suggestions regarding various diagnoses you suggest. This is because we think that some of the matters you raise are dealt with elsewhere in the guideline (e.g. fear of child being removed- rec 15.1) and we have used the current diagnostic groupings in diagnostic manuals. We have reviewed the evidence on mother-infant interaction and include recommendations and research recommendations on this.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					There are a number of disorders of pregnancy adjustment (denial, rejection, impaired prepartum affiliation and fetal abuse). There is also obstetric factitious disorder, and prepartum psychosis. Dysmorphophobia can occur without a history of an eating disorder. Anxiety during pregnancy has specific themes, for example the fear of inadequacy as a mother leading to removal of the child, not just tokophobia. There is also a psychopathology of parturition. Psychiatry of the postpartum period. 'Panic' and 'generalized anxiety' are not the only way to classify anxiety disorders. There is also the focus of anxiety that indicates specific psychological treatments. Some mothers' fear is centred on the infant (e.g. phobic avoidance of the infant) and some for the infant's safety. Obsessive-compulsive disorder includes the common forms found in adult women (which have increased frequency) and obsessions of infanticide, which is an important differential diagnosis for anger-based impulses to harm a child. PTSD is not the only consequence of parturient stress; there are also complaining reactions, which require specific psychological treatment. There are about 20 varieties of postpartum psychosis: most of these psychoses are rare, but this guideline is not only written for general practitioners, maternity health care professionals and general psychiatrists, but also	

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					for specialist teams and it would be appropriate to devote a sentence or two to rarer disorders, at least indicating where information can be found about them, should they occur. Disorders of the mother-infant relationship. As in the 2007 guidelines, the introduction makes no mention of these severe 'bonding disorders', which are in the first rank of severity in the psychiatry of motherhood. They are much commoner than psychoses and have long-term effects on the child. It used to be thought that they belonged to the syndrome of postpartum depression, but this is untenable, because some of the mothers are not depressed, and, when they are, the severity and course of the two disorders differ; their treatments and to some extent their causes are different. Their frequency in mothers referred to these services is about 10% for established rejection, 15% for threatened rejection and 25-30% for various degrees of pathological anger against the infant. There is an extensive literature, none of which has been cited in the bibliography. In the last ten years at least four rating scales have been published, one of which (PBQ) has been validated and translated into many languages. Although these disorders came to attention after consultations for ICD-10 were completed, they are recognized by the World Psychiatric Association (World Psychiatry 2011, 10: 96).	
University of	3	NICE	1.4	29	The first section is focused entirely on	Thank you for your comment, our focus in this

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Birmingham					depression and anxiety, using narrowly focused questions. They omit enquiry into the expectant mother's attitude to the pregnancy. It is necessary to ask, "How do you feel about the pregnancy?" because unwanted pregnancies (approximately 10%) are an important factor in depression, fetal & child abuse, and infanticide. There is a large literature on prenatal 'affiliation' (not referenced in the bibliography). If there is any evidence of a negative attitude to the pregnancy, a prenatal bonding questionnaire should be completed. In the postpartum period a general question about the mother's emotional response to her baby is essential, such as "Have you felt disappointed with your feelings for (name of baby)?" or "How are things going with (name of baby)?"	section of the guideline was on the identification of depression and anxiety disorder. In response to your, and other stakeholders' comments, recommendation 1.6.1 has been amended with new bullet points added that assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include the woman's attitude towards the pregnancy, the woman's experience of pregnancy, or the mother-baby relationship. Moreover, recommendation 1.9.12 has been amended to provide greater specificity around what an assessment of the mother-baby relationship should include (verbal interaction, emotional sensitivity and physical care). The issue of affiliation was outside of the scope of the guideline.
University of Birmingham	4	NICE	1.4.3	29	The guideline does not suggest who should complete the assessment during the postnatal period, nor does it specify why 3-4 months has been chosen as a time of particular importance.	Thank you for your comment. The GDG did not consider it appropriate to specify who should complete this initial assessment as it will be dependent on the woman's contact with primary care services. However, a new recommendation has been added that at subsequent contacts in pregnancy and the postnatal period the health visitor (and other health and social care professionals who have regular contact with the woman) should consider asking these questions and consider use of a formal tool as part of ongoing

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						assessment and monitoring (1.5.8). In light of your, and other stakeholders', comments the timing specificity (including the 3-4 month reference) has been removed from the recommendation
University of Birmingham	5	NICE	1.4.8	31	The recommendation suggests referring to psychiatry anyone 'having a suspected severe mental illness'. There needs to be a specific recommendation about how a primary care professional such as a midwife would make this decision on such a limited basis.	Thank you for your comment. The decision would be made on the basis of information provided by the women or an informant who knows her well. Given the potentially serious nature of postpartum psychosis we would expect as part of their core training all health care professionals, including midwives to be sufficiently aware to make or to alert colleagues to the need to make a referral
University of Birmingham	6	NICE	1.5.1	32	The assessment should include: · the circumstances of the pregnancy– its social and family context, planning, the mother's reaction to becoming pregnant, and (if this is negative), ideas of termination · Under 'social networks and quality of relationships', the reaction of the husband, or the baby's father, and the wider family, to the pregnancy is important · It is essential to explore the expectant mother's interaction with the unborn child. "How do you respond to the presence of the baby inside you?" (or to fetal movements, quickening). "Do you spend a lot of time imagining what it will be like after the birth?" "What arrangements have you made?"	Thank you for your comment. In response to your, and other stakeholders', comments an additional bullet point has been added to the recommendation to include 'the woman's attitude towards the pregnancy' which captures many of the points your comment addresses. The GDG believed that with this addition the list of factors that an assessment should include would capture all of the questions which you highlight.
University of	7	NICE	1.5.3	33	1.5.3- .5 Child protection (as in 2007) is rarely	Thank you for your comment. The

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Birmingham					mentioned in this Guideline. Child abuse and neglect (including emotional neglect and abuse) are among the most serious consequences of maternal mental illness. Responsibility for preventing it, by diagnosing and treating severe disorders – depression, bonding, psychosis – cannot be shifted to the child protection services; it is a vital part of the work of mother-infant (perinatal) psychiatric teams. NICE clinical guideline 89 (Child Maltreatment) indicates that "Risk factors for child maltreatment" and "parental or carer mental health problems" are outside the scope of that guideline. There is a risk that parent-infant relational difficulties become missed between different sets of guidance. The questions put to a mother who dislikes or is hostile to her baby should include, "Have you lost control when you felt angry with (name of baby?)". 'What is the worst thing you felt an impulse to do?" If there is a suicidal risk, it is essential to explore the risk of filicide, for example by asking, "Did it ever cross your mind that you would have to take the baby (or children) with you?"	recommendation has been redrafted, so that where there are concerns of suspected child maltreatment, follow local safeguarding protocols
University of Birmingham	8	NICE	1.6.10	36	There have been attempts to deal with tokophobia by psychological treatment, but there is always the alternative of referring to a sympathetic obstetrician or consultant midwife, who may advise a Caesarean section by maternal request.	Thank you for your comment. A cross-reference to the caesarean section guidance (CG 132) has been added to the recommendation.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
University of Birmingham	9	NICE	1.6.26	40	Mothers with acute postpartum psychosis are highly susceptible to side effects from neuroleptics, and there have been cases of neuroleptic malignant syndrome including one fatality.	Thank you for your comment. Rapid tranquilisation has not been reviewed as part of this guideline update. Other than minor changes to the language to fit NICE's style of writing recommendations no further changes can be made.
University of Birmingham	10	NICE	1.7.5	43	1.7.5-.8 It is unclear why these three are in the same section as they have quite different foci from a psychological perspective	Thank you for your comment. The headings are not intended to be read without the detail of the recommendations, therefore the GDG did not consider it appropriate to separate out or restructure these recommendations. Also, in the NICE Pathway for this topic, which will be launched at the same as the guideline, the linkage and distinction between recommendations in each section will be clearer and the ability to navigate easier.
University of Birmingham	11	NICE	1.7.5	43	1.7.5-.8 'Traumatic birth' has a different meaning in an obstetric context and a mental health context. In obstetrics it might mean a bad tear of the perineum, but in mental health it usually means excessive pain or loss of control. This requires clarification if the guidelines are to be meaningful to both obstetric and mental health professionals.	Thank you for your comment. The recommendations on traumatic birth are intended to apply to both women who have experienced a traumatic delivery due to physical birth complications but also women with an obstetrically-normal delivery who experience it as psychologically traumatic. However, to make this more explicit a definition of traumatic birth has been added to the guideline
University of Birmingham	12	NICE	1.7.8	43	Bereavement after a stillbirth commonly involves a normal grieving process and does not require specialist mental health support (unless perhaps there is an impact on a subsequent pregnancy). This is predominantly a matter for	Thank you for your comment, the guideline development group has removed the reference to specialist mental health.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					obstetrics and gynaecology), and there are already good practice procedures in place from this perspective.	
University of Birmingham	13	NICE	1.7.14	44	Our group had concern that this recommendation was paternalistic in tone, seeming to assume that mothers could not tolerate the anxiety of discussing their relationship with the baby. It risks minimising the problem, invalidating her concern (and therefore the likelihood that these difficulties will be reported) and thereby reducing professionals' awareness of difficulties. It is reasonable to indicate that a degree of ambivalence is a very common experience for new parents. It is not true that "any problems with the (mother infant) relationship are likely to improve with effective treatment of the mental health problem". This sometimes happens. In other cases, the relationship disorder is the problem and requires focused psychological treatment. Mothers should be reassured that disclosing these feelings does not imply critical scrutiny of their mothering, but will lead to skilled help in overcoming the problem. Reassurance can be based on the fact that, once the problem is recognized and handled by a skilled therapist, almost all these mothers develop a normal mother-infant relationship.	Thank you for your comment. In response to your, and other stakeholders', comments, this recommendation has been amended.
University of Birmingham	14	NICE	1.7.15	45	This suggests referral of resistant mother-infant relationship disorders to an infant mental	Thank you for your comment. Recommendation 1.9.13 has been revised, the 'referral to infant

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					health service. But there are very few specific infant mental health services in UK. There needs to be more clarity about what degree of parent-infant work should be provided by mother-infant (perinatal) mental health services (who have previously managed this work successfully) and/or what an Infant Mental Health Service should look like as an alternative.	mental health services' has been removed and a more general approach to this topic has been adopted as the GDG did not feel, following consultation, that the evidence available supported the previous recommendations.
University of Birmingham	15	NICE	2.1	46	The first recommendation should be the objective evaluation of specialist mother infant services (especially mother & baby units), including a full economic costing. In the West Midlands we had a protocol comparing the Birmingham unit (with in-patient, day-patient and community care) with the Stoke unit (based on a day-hospital), and units in Dudley and Shrewsbury that lacked specialist components. It is important to measure severity as well as diagnosis and study the process of assessment and care. This has yet to be funded, but the protocol exists and can be adapted for other localities.	Thank you for your comment. The organisation of care was outside the scope of this guideline update
University of Birmingham	16	NICE	1.8.3	45	· Psychiatrists, with appropriate training · Nursing staff of several kinds (in-patient, community, nursery nurses, play therapists) · Clinical Psychologists, who have the principal role in the treatment of anxiety and obsessional disorders, PTSD and complaining disorders, · At least one social worker, not only to provide social casework for the mothers, but	Thank you for your comment. The evidence on organisation of services has not been reviewed and we are therefore unable to consider any changes to the recommendations

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					also to liaise with the multitudinous social service teams in the localities servedThe guideline should recommend staffing on these services; 'multi-disciplinary' is not enough. The specialist staff should include:	
University of Birmingham	17	NICE	1.8.5	45	Additional functions include: • The full clinical assessment of mothers referred, including the social, psychological and obstetric context of the pregnancy and puerperium and the mother-infant relationship • The training of all the disciplines listed above • The organization of services in the locality served • An obstetric liaison service • Research, especially clinical observations, which require no funding • Medico-legal work, especially in residence disputes • Liaison with voluntary agencies, which give much effective support to mothers. • It is also useful to keep a register of (consenting) mothers with particular disorders, as another means of mutual support.	Thank you for your comment. The evidence on organisation of services has not been reviewed and we are therefore unable to consider any changes to the recommendations
University of Birmingham	18	NICE	1.8.5	45	The range of resources should include: • Day care, which is effective for all but the most severe and dangerous disorders, and is much less expensive and disruptive to the families than conjoint admission • Community outreach. Rather than 'close integration with community-based mental health services', the best mother-infant	Thank you for your comment. The evidence on organisation of services has not been reviewed and we are therefore unable to consider any changes to the recommendations

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					psychiatric services are themselves community-based.	
University of Birmingham	19	NICE	2.2	48	Recommendation for a register of women with bipolar disorder to understand the safety of medications used in women "who were pregnant" is narrow in focus and precludes examination of the safety of drug classes (e.g. those used in women with bipolar disorder or other psychoses). A national, prospective registry associated with Public Health England (e.g. UKTISS) that focuses on safety of medications used in women with mental health problems would provide stronger evidence than retrospective, disorder specific data.	Thank you for this comment . We agree that the register should be prospective and that means that it should include all women of child bearing potential, only some of whom may go on to become pregnant. We have removed the term 'who have been pregnant' from the recommendation.
University of Birmingham	20	NICE	2.3	48	We were glad to see this research recommendation. Together with the attention given in the Full Version to interventions targeting the mother-infant relationship (over 50 pages), it suggests that the GDG now recognizes that these disorders are the responsibility of mother infant (perinatal) psychiatric teams. The recommendation remains unhelpfully vague, however and appears to assume that 'mothers with a diagnosed mental health problem' are a coherent group, (distinct from 'mothers with PND' with whom much of the maternal sensitivity research has been conducted) for whom mother-infant intervention will have a consistent focus and outcome.	Thank you for this comment. The GDG did discuss whether to focus the recommendation on one or more specific disorders but given the broad range of disorders in which problems in the mother infant relationship are seen and the possibility of intervention(s) which span diagnostic groups, the GDG did not think it appropriate to specify any particular diagnostic group at this stage. This will be better dealt with by the funding bodies when they draw up a more detailed specification for any research study.
University of	21	NICE	3.2	51	Epilepsy NICE guidance is not referred to but it	Thank you. The epilepsy guideline has been

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Birmingham					seems important to have consistent guidance not least because women with epilepsy may also experience mental health issues and so seek information from both. Early years guidance also warrants reference.	added to the list of related guidelines.
University of Birmingham	22	Full	General	5	The GDG has no paediatrician and no social worker. This may have influenced the limited focus on child protection?	Thank you for your comment. The membership of the GDG was consulted on during the scoping and deemed to be appropriate.
University of Birmingham	23	Full	3.5.1	42	This section describes the 'systematic search strategy'. Their bibliography comprises about 650 articles (excluding those not specifically related to disorders of childbearing). We estimate that this 'comprehensive coverage' includes about 10% of the literature. We have checked this by comparing, for eight topics (the long-term effect of prepartum anxiety, parenting difficulties in chronic psychosis, anxiety disorders, obsessive compulsive disorder, PTSD, eating disorders, postpartum psychosis and the prevention of child maltreatment) the cited references with the literature known to us; the ratio is about 1 to 10. The explanation is not a restriction of citations to the most important articles, because, for example, on postpartum psychosis, a review by Kumar (1989) is cited; this had 22 relevant publications (1% of the literature published by that time); since 1990 there have been over 80 reviews of this subject, one of which had over 500 references. The guideline therefore appears to reflect no more than a	Thank you for your comment. Electronic databases were systematically searched, and full details of the search strategies can be found in Appendix 10 and 11. In addition to filters applied at the searching stage, papers were also excluded if they failed to meet the criteria for inclusion detailed in the review protocol (Appendix 9). A full list of the references of excluded studies and reasons for exclusion can be found in Appendix 18. We do not believe that our search will have missed any studies that will change recommendations, and would hypothesise that 'missing' papers may have been excluded due to search restrictions or inclusion criteria.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					sample of the literature on the psychiatry of childbearing and motherhood. Much pioneering and seminal work has been ignored.	
University of Birmingham	24	Full	General	65	p 65, 67,68,83,84These units are among the most expensive in the psychiatric services, and expose infants to risk from their own as well as other mothers. Their cost-effectiveness has never been established. Following the publication of the 2007 guidance Mr Pilling acknowledged (British Medical Journal, July 6th 2007) "that funding should be made available to undertake research into their effectiveness". This should be included as a recommendation here. In an estimate done in the late 1990s South Birmingham (at that time 6,500 births/year, 400,000 inhabitants) had 28 admissions/year (average of 7 years), with a mean length of stay of 33 days. Applied to the UK (813,000 births, 63 million inhabitants) the requirement would therefore be 316-393 beds (at least 5/million). We recently mapped the distribution of 142 beds in 19 units with at least 4 beds (copy sent to the Chair). This is 2.2/million, and a marked reduction from the 294 beds found by Aston & Thomas in 1985/6. There are still large areas unserved, for example a broad swathe of Central and Eastern England, Merseyside and North Wales, and Ireland (with no beds in Ulster or Eire). There has been no improvement since 2007, and the reason for a sluggish response may be the lack of research	Thank you for your comment. As the evidence has not been reviewed as part of this guideline update, no further changes can be made to this chapter.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					into the cost-effectiveness of these units.	
University of Birmingham	25	Full	7.4.4	225	(Page e.g. 225) TABLE 38 and similar tables used throughout the full version (making up most of its content) are difficult to use because the table itself does not identify the article analysed.	Thank you for your comment. The tables in the guideline are evidence profiles outputted by GRADE. The evidence profiles do not include study IDs as evidence is assessed at the outcome rather than study level. For a list of the studies included for each outcome please see the full forest plots in Appendix 19.
University of Birmingham	26	Full	7.4.7	248	Some of this infant / relationship data is presented in a misleading way. For example, the study analysed on page 247 is reported to show no impact, but the paper itself indicates that the intervention had an impact on the relationship (its primary target), albeit not on maternal depression.	Thank you for your comment. The outcomes reported on page 247-248 are general mental health outcomes (as measured by the General Health Questionnaire [GHQ-28]) rather than mother-infant attachment outcomes or maternal depression outcome
University of Birmingham	27	Full	7.4.9	249	The limited evidence on infant outcomes appears to relate to the fact that only studies that showed a longitudinal relationship between interventions for parental mental health and medium term child outcomes were included. Most of the available evidence can be divided into two groups – evidence showing a link between maternal mental health and maternal sensitivity, and evidence showing a link between maternal sensitivity and child outcomes. Studies in the latter group provide evidence for a far larger and more robust group of interventions than those cited in 7.3.9, for example Video Interaction Guidance (e.g. Kennedy, Landor & Todd, 2010), Watch Wait Wonder (e.g. Cohen et al, 1999), Mellow	Thank you for your comment. Studies were not selected on the basis of findings but on the basis of pre-specified eligibility criteria as outlined in the review protocols (see section 7.5.2 and Appendix 9). In reference to the specific papers mentioned, we are not aware of the Puckering et al. (2013) reference referred to and without a full bibliographic reference we are not able to comment on why it was not identified by the evidence search, there is a Breustedt & Puckering (2013) paper that is included in the qualitative evidence review in chapter 6 and a Puckering et al. (2010) study on intervention efficacy of mellow babies. The Puckering et al. (2010) study was identified by the search but was excluded (see Appendix 18)

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Parenting (e.g. Puckering et al, 2013), which demonstrate a clear impact on parental sensitivity, parent-infant relationships and child outcomes. These are not mentioned in the bibliography.	as data could not be extracted for analysis (the N on which outcome data were based is not reported). The Cohen study does not meet the date restriction criteria applied to the search (post-2006). The Kennedy, Landor & Todd (2010) paper was also not picked up by the search as it does not meet study design criteria for intervention effectiveness review (due to non-randomised allocation to groups)
University of Birmingham	28	Full	8.9.1.8	719	The guideline states "this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related" however there is scant detail of well-established dose-response relationships between prenatal anti-convulsant exposure and malformations or poor neurodevelopmental outcomes. For example, Tomson 2011 (Lancet Neurol 2011; 10: 609–17) is the largest report from EURAP on risks associated with monotherapy, not included in lists of included or excluded literature (but is EURAP's latest update), illustrates this clearly. It also highlights rates of malformations associated with LTG, which is dose-dependent, yet is not referred to in the new guidance. A number of other papers in the literature appear not to have been identified by the group. With regards to the safety of medication use during pregnancy, the trimester of exposure is not addressed and mention of the potential risk associated with exposure later in pregnancy (i.e. not just	Thank you for your comment. The paper you refer to (Tomson et al., 2011) did not meet the eligibility criteria for this review as the paper did not include an unexposed comparison group (but would also not have been included in the list of excluded studies as it could have been excluded on the basis of title and abstract and only papers for which the full text was reviewed are included in the list of included and excluded studies). Clarification of the inclusion criteria has been added to section 8.4.2. The unspecified papers missing from this review were probably excluded for failing to meet this or other eligibility criteria as outlined in section 8.4.2, however, as references are not provided for these papers it is not possible to check this. The recommendation referred to is not about a specific drug or drug class (e.g. anticonvulsants) but is general advice that where there are known dose-related responses the use of the lowest effective dose is particularly important. The timing of exposure is reported in the study

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Trimester 1) seems warranted.	information table in chapter 8, in general there was insufficient data to make timing of exposure comparisons, there was evidence for long-term neurodevelopmental harms associated with valproate supporting the recommendation to not offer valproate at anytime in pregnancy or to women of childbearing potential.
University of Reading/ Royal Berkshire Hospital	1	Full	7.5.12	430	General: When reviewing effects of intervention on infant attachment (and indeed other infant outcomes), it is important that a distinction is made between maternal reports of the mother-infant relationship, and objective measures of infant development, with more caution being required in relation to the former, especially when mothers have received an intervention which they will know is aimed at improving their relationship with their infant.	Thank you for your comment. The blinding of the outcome assessor was considered in the risk of bias judgement as part of the GRADE quality rating, and so this distinction between maternal reports and objective/blinded measurements would be captured by the confidence in the effect estimate rating.
University of Reading/ Royal Berkshire Hospital	2	Full	7.6	551	The guidelines recommend that assessment and monitoring of the mother-baby relationships should be routine. At present, midwives and health visitors are unable to fulfil this remit of assessing mother infant relationships, since they are not routinely trained to undertake such assessments. Furthermore, there is an urgent need for tools to assess the mother-infant relationship in primary care that are reliable and well-validated, and for training of primary care workers in such measures to be included as part of standard training. These assessment measures should be evidence-based objective	Thank you for your comment. In light of your, and other stakeholders', comments the recommendation has been expanded to include aspects of the mother-baby relationship that should be assessed (verbal interaction, emotional sensitivity and physical care). Furthermore, the training needs of healthcare professionals is an implementation issue and has been passed on to the NICE implementation support team.

Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					observations of parenting, rather than questionnaires, since the latter are of limited validity.	
University of Reading/ Royal Berkshire Hospital	3	Full	7.6	551	There was not enough evidence from the review to say that women should be reassured that effective treatment of their mental health problem will bring about improvement in problems in the mother-infant relationship	Thank you for your comment. In light yours, and other, stakeholders' comments this recommendation has been amended

These organisations were approached but did not respond:

2gether NHS Foundation Trust
5 Borough Partnership NHS Foundation Trust
Academic Division of Midwifery, University of Nottingham
Action on Postpartum Psychosis
Action on Pre Eclampsia
All Wales Birth Centre Group
Allocate Software PLC
American Medical Systems Inc.
Approachable Parenting
Assocation of NHS Occupational Physicians
Association for Family Therapy and Systemic Practice in the UK
Association for Improvements in the Maternity Services
Association for Psychoanalytic Psychotherapy in the NHS
Association of Anaesthetists of Great Britain and Ireland
Association of Breastfeeding Mothers
Association of Child Psychotherapists, the
Association of Directors of Children's Services
Association of Radical Midwives
Astrazeneca UK Ltd
Baby Lifeline
Barking, Havering and Redbridge Hospitals NHS Trust
Barnardo's
Barnsley Hospital NHS Foundation Trust
Belfast Health and Social Care Trust
Betsi Cadwaladr University Health Board

BHR University hospital NHS trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham City Council
Birmingham Women's Health Care NHS Trust
Birth Trauma Association
BirthChoice UK
Black and Ethnic Minority Diabetes Association
Bliss
Bolton Hospitals NHS Trust
Bolton NHS Foundation Trust
Bonpharma Ltd
Bradford District Care Trust
Bristol Health Services Plan
British Association for Music Therapy
British Association for Psychopharmacology
British Association of Art Therapists
British Association of Behavioural and Cognitive Psychotherapies
British Association of Dramatherapists
British Association of Perinatal Medicine
British Association of Play Therapists
British Association of Psychodrama and Sociodrama
British Association of Social Workers
British Dietetic Association
British Maternal & Fetal Medicine Society
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Paediatric Mental Health Group
British Red Cross
Buckinghamshire Healthcare NHS Trust
Calderdale and Huddersfield NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire & Peterborough Mental Health Trust
Camden Link
Capsulation PPS
Capsulation PPS
Cardiff and Vale University Health Board
Care Quality Commission

Central London Community Health Care NHS Trust
Central Manchester and Manchester Children's Hospital NHS Trust
Centre for Mental Health
Centrepoint
Chartered Physiotherapists in Mental Health
Chartered Physiotherapists Promoting Continence
Chartered Society of Physiotherapy
Child Bereavement Charity
Childhood Bereavement Network
Children, Young People and Families NHS Network
Children's HIV Association
Christian Medical Fellowship
Chroma
CIS' ters
City Hospitals Sunderland NHS Foundation Trust
City University
Clarity Informatics Ltd
Cleft Lip and Palate Association
Cochrane Pregnancy & Childbirth Group
College of Occupational Therapists
Community District Nurses Association
Community Practitioners' & Health Visitors Association
Counselling and Psychotherapy Trust
Coverage Care Services Ltd
Critical Psychiatry Network
Croydon Clinical Commissioning Group
Croydon Health Services NHS Trust
Croydon University Hospital
csections.org
Cumbria Partnership NHS Trust
CWHHE Collaborative CCGs
Department for Education
Department of Health, Social Services and Public Safety Northern Ireland
Derbyshire County Council
Det Norske Veritas NHSLA Schemes
Devon Partnership NHS Trust
Diverse Cymru
Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Doncaster and South Humber Healthcare NHS Trust
Dorset Mental Health Forum
Doula UK
Drinksense
Ealing Public Health
East and North Hertfordshire NHS Trust
East Kent Hospitals University NHS Foundation Trust
Eastbourne District General Hospital
Eaton Foundation
Economic and Social Research Council
Eli Lilly and Company
Empowerment Matters
English National Forum of LSA Midwifery Officers
Epilepsy Action
Equalities National Council
Essex County Council
Ethical Medicines Industry Group
Evidence based Midwifery Network
Faculty of Public Health
Fair Play for Children
Fatherhood Institute
FBA and Brook
Fibroid Network Charity
Five Boroughs Partnership NHS Trust
Food for the Brain Foundation
Foundation Trust Network
GE Healthcare
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire LINk
GP update / Red Whale
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hafal Wales
Hampshire Partnership NHS Trust
Health & Social Care Information Centre
Health and Care Professions Council

Healthcare Improvement Scotland
Healthcare Infection Society
Healthcare Inspectorate Wales
Healthcare Quality Improvement Partnership
Healthwatch East Sussex
Hertfordshire Partnership NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Herts Valleys Clinical Commissioning Group
Hindu Council UK
Hockley Medical Practice
Homerton Hospital NHS Foundation Trust
HQT Diagnostics
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
Independent Midwives Association
Infertility Network UK
Information Centre for Health and Social Care
Institute for Womens Health
Kent and Medway NHS and Social Care Partnership Trust
Kingston University and St Georges, University of London
La Leche League GB
Lactation Consultants of Great Britain
Lancashire Care NHS Foundation Trust
Lanes Health
Leeds and York Partnership Foundation Trust
Leeds Teaching Hospitals NHS Trust and Leeds Radiology Academy
Leicestershire Partnership NHS Trust
Lilly UK
Liverpool Women's NHS Foundation Trust
Local Government Association
London and the South Perinatal Psychiatry Clinical Network
London Labour Ward Leads Group
London Metropolitan Police
Lundbeck UK
Maidstone and Tunbridge Wells NHS Trust
Maternal Mental Health Alliance
Maternity Action
Maternity and Mental Health Network

McDonald Obstetric Medicine Society
Medicines and Healthcare products Regulatory Agency
Medway NHS Foundation Trust
Mental Health Act Commission
Mental Health Foundation
Mental Health Group British Dietetic Association
Mental Health Nurses Association
Mental Health Providers Forum
Meriden Family Programme
Mersey Care NHS Trust
Mid and West Regional Maternity Service Liasion Committee
midwifeexpert.com
Midwifery Studies Research Unit
Midwives Information and Resource Service
Mind
Mind Wise New Vision
Ministry of Defence (MOD)
Multiple Births Foundation
Mumsnet
National Association of Primary Care
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Deaf Children's Society
National Federation of Women's Institutes
National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Institute for Mental Health in England
National Obesity Forum
National Organisation on Fetal Alcohol Syndrome UK
National Patient Safety Agency
National Public Health Service for Wales
Netmums
Newcastle, North Tyneside and Northumberland Mental Health NHS Trust
NHS Barnsley Clinical Commissioning Group
NHS Clinical Knowledge Summaries
NHS Confederation

NHS Connecting for Health
NHS County Durham and Darlington
NHS Cumbria Clinical Commissioning Group
NHS Devon
NHS Dudley
NHS Halton CCG
NHS Hardwick CCG
NHS Health at Work
NHS Herefordshire
NHS Improvement
NHS Medway Clinical Commissioning Group
NHS Midlands and East
NHS Milton Keynes
NHS North Somerset
NHS Plus
NHS Sheffield
NHS South Central
NHS South Cheshire CCG
NHS South of England
NHS Wakefield CCG
NHS Warwickshire North CCG
North Cumbria Maternal MH Alliance
North East Essex Clinical Comissioning Group
NORTH EAST LONDON FOUNDATION TRUST
North Essex Mental Health Partnership Trust
North of England Commissioning Support
North Staffordshire Combined Healthcare NHS Trust
North Tees and Hartlepool NHS Foundation Trust
North West London Hospitals NHS Trust
North West London Perinatal Network
Northamptonshire county council
Northern Health and Social Care Trust
Northumberland, Tyne & Wear NHS Trust
Northumbria Healthcare NHS Foundation Trust
Nottingham City Council
Nottingham City Hospital
Nottingham Healthcare NHS Trust
Nottinghamshire Acute Trust

Nottinghamshire Healthcare NHS Trust
Nursing and Midwifery Council
Nutrition Society
Obstetric Anaesthetists' Association
One Plus One
One to One
Oxford University Hospitals NHS Trust
Oxfordshire Clinical Commissioning Group
Oxleas NHS Foundation Trust
Partneriaeth Prifysgol Abertawe
Patient Assembly
Pelvic Obstetric and Gynaecological Physiotherapy
Peninsula Primary Care Psychology & Counselling Services
PERIGON Healthcare Ltd
Perinatal Institute
Pharmacosmos
PHE Alcohol and Drugs, Health & Wellbeing Directorate
Pilgrim Projects
PNI ORG UK
PrescQIPP NHS Programme
Primary Care Child Safeguarding Forum
Primary Care Pharmacists Association
Primary Care Women's Health Forum
Primrose Bank Medical Centre
Public Health Agency
Public Health England
Public Health Wales NHS Trust
Queen Mary's Hospital NHS Trust
Regional Maternity Survey Office
Rethink Mental Illness
ROCK Medical Communications
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners in Wales
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists in Scotland
Royal College of Radiologists

Royal College of Surgeons of England
Royal Cornwall Hospitals NHS Trust
Royal Free London NHS Foundation Trust
Royal Society of Medicine
RSPH health visitor steering group
Safeline
Sandwell and West Birmingham Hospitals NHS Trust
SANE
Scarborough and North Yorkshire Healthcare NHS Trust
Scottish Intercollegiate Guidelines Network
SEE BETSI CADWALADR North Wales NHS Trust
Self Help Services
Servier Laboratories Ltd
Sheffield Care Trust Sheffield Birth Centres group
Sheffield Perinatal Mental health service
Sheffield Teaching Hospitals NHS Foundation Trust
SNDRi
Social Care Institute for Excellence
Society for Academic Primary Care
Society for Existential Analysis
Society for the Protection of Unborn Children
Soldiers, Sailors, Airmen and Families Association
South Asian Health Foundation
South Devon Healthcare NHS Foundation Trust
South Eastern Health and Social Care Trust
South Essex Partnership NHS Foundation Trust
South Essex Partnership University Foundation Trust
South West London and St George's Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southend on Sea Borough Council
Southern Health & Social Care Trust
Southport and Ormskirk Hospital NHS Trust
Spacelabs Healthcare
St Andrews Healthcare
Stockport Clinical Commissioning Group
Stockport Clinical Commissioning Pathfinder
Sure Start Ashfield
Sure Start Tamworth

Sussex Partnership NHS Foundation Trust
Tavistock Centre for Couple Relationships
Tees, Esk and Wear Valleys NHS Trust
Tees, Esk and Wear Valleys NHS Trust
The African Eye Trust
The Association for Infant Mental Health
The Bowlby Centre
The Cedar House Support Group
The College of Social Work
The For All Healthy Living Centre
The Hindu Forum of Britain
The Independent Fetal Anti Convulsant Trust
The Lullaby Trust
The Miscarriage Association
The Pelvic Partnership
The Princess Alexandra Hospital NHS Trust
The Rotherham NHS Foundation Trust
The Samaritans
The Stefanou Foundation
Therapy in Praxis
Towards Tomorrow Together
Twins and Multiple Births Association
UCL/UCLH
Institute for Women's Health
UK Clinical Pharmacy Association
UK National Screening Committee
UK Newborn Screening Programme Centre
UK Specialised Services Public Health Network
Ultrasis plc
Unison
Unite the Union
United Kingdom Council for Psychotherapy
United Lincolnshire Hospitals NHS
University College London Hospital NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham
University Hospitals Bristol NHS Foundation Trust
University of Hertfordshire

University of Huddersfield
University of Salford
University of West England
VBAC Information and Support
Virgin Care
Walsall Local Involvement Network
Warrington and Halton Hospitals NHS Foundation Trust
Welsh Government
Welsh Scientific Advisory Committee
West Hertfordshire Hospital Trust
West London Mental Health NHS Trust
West Middlesex Hospital
West Middlesex University Hospital NHS Trust
Western Health and Social Care Trust
Wigan Borough Clinical Commissioning Group
Wirral University Teaching Hospital NHS Foundation Trust
WISH A voice for women's mental health
Worcestershire Acute Hospitals Trust
Worcestershire Health and Care NHS Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
Wye Valley NHS Trust
York Hospitals NHS Foundation Trust
Yorkshire and Humber Strategic Clinical Network
Yorkshire and The Humber Maternity Network