National Institute for Health and Care Excellence

Surveillance programme

Surveillance proposal consultation document

Antenatal and postnatal mental health: clinical management and service guidance

NICE guideline CG192 – 4-year surveillance review

Background information

Guideline issue date: December 2014

NICE guideline CG192 is a partial update of antenatal and postnatal mental health (NICE guideline CG45). There have been no surveillance reviews of NICE guideline CG192 since publication in 2014.

Surveillance proposal for consultation

We propose to not update the guideline on antenatal and postnatal mental health at this time.

During surveillance editorial or factual corrections were identified:

- We propose to add a footnote with a link to the MHRA toolkit to recommendations 1.2.3 and 1.4.27–1.4.29 relating to the risks of taking valproate medicines during pregnancy.

Full details are included in appendix A: summary of evidence from surveillance.

Reason for the proposal

Assessing the evidence

We found 23 relevant studies in a search for randomised controlled trials and systematic reviews published between 01 April 2014 and 16 January 2017.

We also included 6 relevant studies from a total of 37 identified by members of the guideline committee who originally worked on this guideline.

From all sources, we considered 29 studies to be relevant to the guideline.

This included evidence to support current recommendations on case identification and assessment, experience of care and pharmacological and non-pharmacological interventions.

We also identified evidence that was not consistent with current recommendations on access to services and exercise interventions. This evidence was considered to be insufficient in volume and conclusive results to change recommendations in these areas at this time. Topic expert opinion was sought as to whether this evidence would affect current recommendations. Generally, the topic experts agreed that the new evidence would not impact recommendations in these areas.

We did not find any evidence related to the organisation of perinatal mental health services. We also did not find any new evidence on postnatal post-traumatic stress disorder, which was an area considered to be important during post-publication correspondence.

We did not find any evidence in areas not covered by the original guideline.

Additionally, we identified relevant ongoing research due to be published in the next 3 to 5 years. There are 4 ongoing trials investigating the effectiveness of pharmacological treatments for postpartum depression and are due to publish results end of 2017. Three studies investigating psychological or psychosocial treatments have completed recruitment at this time. One study has investigated strategies for postnatal depression screening and is currently in press. A further 3 studies are investigating the effectiveness of perinatal mental health service delivery. The progress of the ongoing studies will be monitored and they will be considered at the next surveillance review when results publish.

Research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, progress is assessed against prioritised research recommendations. See the research recommendations section of appendix A for further information.

For this surveillance review we assessed 5 prioritised research recommendations, and proposed that all 5 should be retained in the NICE version of the guideline and the NICE database for research recommendations.

Equalities

No equalities issues were identified during the surveillance process.

Overall proposed decision

After considering all the evidence and views of topic experts, we proposed not to update this guideline. However, we propose to add a footnote with a link to the MHRA toolkit to recommendations 1.2.3 and 1.4.27–1.4.29 relating to the risks of taking valproate medicines during pregnancy.

Further information

See appendix A: summary of evidence from surveillance below for further information.

For details of the process and update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Appendix A: summary of evidence from surveillance

Case identification and assessment

192 – 01 What concerns and behaviours (as expressed by the woman, carer and family, or exhibited by the woman) should prompt any professional who comes into contact with woman who is antenatal or postnatal to consider referral or further assessment for the presence of mental health problems?

192 – 02 What are the most appropriate methods/instruments for the identification of mental health problems in women who are antenatal or postnatal?

192 – 03 For women who are antenatal or postnatal, what are the key components of, and the most appropriate structure for a comprehensive diagnostic assessment (including diagnosis)?

Consider:

- **the nature and content of the interview and observation**
- **formal diagnostic methods/ psychological instruments for the assessment of core features mental health problems**
- **the assessment of risk to self and others**
- **the assessment of need of self and others**
- **the setting(s) in which the assessment takes place**
- **the role of the any informants**
- **gathering of independent and accurate information from informants**

192 – 04 What strategies should be adopted to minimise potential harm to the women or fetus/infant of these assessments?

Recommendations derived from these review questions

Using this guideline in conjunction with other NICE guidelines

1.1.2 Use this guideline in conjunction with the NICE guideline for a specific mental health problem (see our web pages on pregnancy and mental health and wellbeing) to inform assessment and treatment decisions in pregnancy and the postnatal period, and take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period
- the setting for assessment and treatment (for example, primary or secondary care services or in the community, the home or remotely by phone or computer)
- recommendations 1.6.1 to 1.6.6 in this guideline on assessment in pregnancy and the postnatal period
- recommendations 1.4.10 to 1.4.37 in this guideline on starting, using and stopping treatment in pregnancy and the postnatal period

- recommendations 1.8.1 to 1.8.23 in this guideline on treating specific mental health problems in pregnancy and the postnatal period.

Principles of care in pregnancy and the postnatal period

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

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

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

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

- assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one
- agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem
- monitor regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth.

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

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

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

- unwilling to disclose or discuss their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care
- reluctant to engage, or have difficulty in engaging, in treatment because of avoidance associated with their mental health problem or dependence on alcohol or drugs.

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

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

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

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

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

- Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?*

- Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?*

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

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

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

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

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

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

  If she responds positively, consider:

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

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

- asking the 2 depression identification questions and the GAD-2 (see recommendation 1.5.4) as part of a general discussion about her mental health and wellbeing and
- using the EPDS or the PHQ-9 as part of monitoring.

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

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

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

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

  Ensure that the woman's GP knows about the referral.

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

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

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

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

Assessment and care planning in pregnancy and the postnatal period

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

- history of any mental health problem, including in pregnancy or the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- the woman's attitude towards the pregnancy, including denial of pregnancy
- the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby
- the mother–baby relationship
- any past or present treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first-degree relative) of mental health problems
- domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
- housing, employment, economic and immigration status
- responsibilities as a carer for other children and young people or other adults.

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

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

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

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

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

1.6.6 Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer should also be involved. The plan should cover pregnancy, childbirth and the postnatal period (including the potential impact of the illness on the baby) and should include:

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

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

Providing interventions in pregnancy and the postnatal period

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

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

Treating specific mental health problems in pregnancy and the postnatal period

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

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

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

Surveillance decision

These review questions should not be updated.

Factors prompting further assessment

Surveillance summary (2017)

A meta-analysis[1] of 12 studies found significantly higher depression and anxiety symptom scores for women with hyperemesis gravidarum (nausea and vomiting) compared to women without during pregnancy.

A meta-analysis[2] of a total 55 studies found significantly increased risks of depression and anxiety during antenatal and postnatal periods for women who were obese or overweight during pregnancy.

Topic expert feedback

Feedback highlighted new studies on the impact of mental disorders pre-conception and in pregnancy which highlight the need to identify disorders in addition to depression in perinatal period.

A cohort study[3] (n=244) found significantly increased risks of antenatal anxiety in women with a pre-conception diagnosis of personality disorder. Although an increased risk of antenatal depression was also found, this was no longer significant when adjusted for background factors.

During the development of NICE guideline CG192, topic experts commented that postpartum post-traumatic stress disorder (PTSD) is not covered in the PTSD NICE guideline CG26. Feedback suggested that postpartum PTSD should instead be covered in NICE guideline CG192. This 2017 surveillance review of CG192 did not find any relevant evidence on postpartum PTSD.

Impact statement

The evidence identified at the surveillance review and feedback from topic experts indicates a need for the assessment of current physical and mental health problems.

This evidence is in line with current recommendations to assess these factors when considering the need for further mental health assessment and case identification.

No evidence was found relating to the issue of postpartum PTSD to impact recommendations. The current CG26 guideline on PTSD is undergoing an update on the sections for interventions which may be applicable to postpartum PTSD.

New evidence is unlikely to change guideline recommendations.

Depression screening

Surveillance summary (2017)

A systematic review[4] did not find RCT evidence sufficient enough to determine whether depression screening is more effective when conducted during pregnancy or at postpartum.

Topic expert feedback

Feedback indicated that there are currently ongoing studies on the identification of depression and other disorders in pregnancy.

A topic expert highlighted the inappropriate use of the Hospital Anxiety and Depression Scale as a diagnostic tool in this population. The expert suggested further clarity is required about the use of inappropriate tools.

A topic expert suggested there is a real drive to also provide screening and treatment for fathers.

Impact statement

The evidence identified at the surveillance review is inconclusive at determining the optimal time for conducting a screening assessment.

Evidence from topic experts indicates the need to identify appropriate diagnostic tools and potentially include fathers in the assessment process.

The current recommendations identify the most appropriate tools for diagnosis.

Ongoing studies will be considered at the next surveillance review when their results publish.

New evidence is unlikely to change guideline recommendations.

Experience of care

192 – 05 What factors prevent women with a mental health problem who are antenatal or postnatal accessing mental healthcare services?

192 – 06 What factors improve or diminish the experience of services for women with a mental health problem who are antenatal or postnatal?

192 – 07 What modifications to services improve the experience of using services for women with a mental health problem who are antenatal or postnatal?

Recommendations derived from these review questions

Using this guideline in conjunction with other NICE guidelines

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

Considerations for women of childbearing potential

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

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse

- how a mental health problem and its treatment might affect the woman, the fetus and baby
- how a mental health problem and its treatment might affect parenting.

Principles of care in pregnancy and the postnatal period

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

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

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

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

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

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

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

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

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

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

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

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly.

1.4.5 If needed, seek more detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period from a secondary mental health service (preferably a specialist perinatal mental health service). This might include advice on the risks and possible harms of taking psychotropic medication while

breastfeeding and how medication might affect a woman's ability to care for her baby (for example, sedation).

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

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment.

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

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

Surveillance decision

These review questions should not be updated.

Mental health services

Surveillance summary (2017)

No relevant evidence was identified.

Topic expert feedback

Feedback highlighted a report into maternal deaths and perinatal mental health recommendations:

- Confidential enquiry and maternal report

Topic experts highlighted ongoing studies relating to the effectiveness and cost-effectiveness of perinatal mental health services which may inform issues relating to the quality of service delivery in the future. This includes a comparison of mother and baby

units with other forms of acute care for postnatal mental disorders.

A topic expert suggested that there is currently no evidence that services are linguistically or culturally sensitive.

Furthermore, there was a suggestion that access to services remain variable even with the additional funds.

Impact statement

Topic experts highlighted limitations of access to services and a lack of evidence that inclusive mental health services are being provided.

No relevant evidence was identified at the surveillance review to impact on the guideline recommendations. Ongoing studies in this area will be considered at the next surveillance review when their results publish.

New evidence is unlikely to change guideline recommendations.

Psychological and psychosocial interventions for the prevention or treatment of mental health problems

192 – 08 What is the effectiveness of selective prevention interventions (for women with no risk factors) in reducing the likelihood of developing mental health problems in pregnancy or the postnatal period?

192 – 09 What is the effectiveness of indicated preventative interventions (for women with identified risk factors present) in reducing the likelihood of developing mental health problems in pregnancy or the postnatal period?

192 – 10 What strategies should be adopted to minimise potential harm to the women or the fetus/infant of these interventions?

192 – 11 For women with mental disorders who are antenatal or postnatal, what are the benefits and/or potential harms of psychosocial interventions to treat mental health problems?

192 – 12 For women with mental disorders who are antenatal or postnatal, what are the benefits and/or potential harms of interventions targeted at improving the quality of the mother-child interaction?

192 – 13 What is 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?

Recommendations derived from these review questions

Using this guideline in conjunction with other NICE guidelines

1.1.2 Use this guideline in conjunction with the NICE guideline for a specific mental health problem (see our web pages on pregnancy and mental health and wellbeing) to inform assessment and treatment decisions in pregnancy and the postnatal period, and take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period

- the setting for assessment and treatment (for example, primary or secondary care services or in the community, the home or remotely by phone or computer)
- recommendations 1.6.1 to 1.6.6 in this guideline on assessment in pregnancy and the postnatal period
- recommendations 1.4.10 to 1.4.37 in this guideline on starting, using and stopping treatment in pregnancy and the postnatal period
- recommendations 1.8.1 to 1.8.23 in this guideline on treating specific mental health problems in pregnancy and the postnatal period.

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

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

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

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

Providing interventions in pregnancy and the postnatal period

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

- receive regular high-quality supervision
- use routine outcome measures and ensure that the woman is involved in reviewing the efficacy of the treatment
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate.**

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

Treating specific mental health problems in pregnancy and the postnatal period

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

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

- a high-intensity psychological intervention (for example, CBT)
- a TCA, SSRI or (S)NRI if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and:
  - she has expressed a preference for medication or
  - she declines psychological interventions or
  - her symptoms have not responded to psychological interventions

- a high-intensity psychological intervention in combination with medication if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and there is no response, or a limited response, to a high-intensity psychological intervention or medication alone.

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

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

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

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

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

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

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

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

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

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

- stopping the medication gradually and switching to a high-intensity psychological intervention (for example, CBT)
- continuing with medication if she understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and:
  - has expressed a preference for medication or

  - declines psychological interventions or
  - her symptoms have not responded to psychological interventions
- changing medication if there is a drug that is effective for her with a lower risk of adverse effects
- combining medication with a high-intensity psychological intervention (for example, CBT) if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and there is no response, or a limited response, to a high-intensity psychological intervention alone.

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

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

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

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

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

- stress associated with pregnancy or the postnatal period
- a change in medication, including stopping antipsychotic medication.

Considerations for women and their babies in the postnatal period

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

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

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

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

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

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

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

1.9.13 Consider further intervention to improve the mother–baby relationship if any problems in the relationship have not resolved.

** Adapted from the guideline on depression in adults (NICE guideline CG90).

Surveillance decision

These review questions should not be updated.

Indicated preventative interventions

Surveillance summary (2017)

A meta-analysis[5] of a total of 7 trials found no significant effect of a debriefing intervention designed to reduce the risk of psychological trauma following childbirth. No differences were found in the prevalence of psychological trauma between the debriefing intervention and standard care at up to 6 months postpartum.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

Evidence from the surveillance review found no benefit of adding a debriefing intervention to reduce the risk of psychological trauma following childbirth.

This evidence is unlikely to impact on current recommendations.

New evidence is unlikely to change guideline recommendations.

Treatment interventions

Surveillance summary (2017)

Interventions for depression

An RCT[6] (n=397) found significant improvements in depression EPDS scores for telephone-based CBT compared to standard care for postnatal depression measured at 6 weeks postpartum. However, the significant difference was only maintained at 6 months in a subgroup with minor depression.

A meta-analysis[7] of a total 10 studies found significant improvements in postnatal depression symptoms up to 6 months follow-up for psychological interventions compared with controls. No significant differences were found between different types of psychological therapy.

Interventions for anxiety

An RCT[8] (n=364) found significant improvements in anxiety and self-rated health scores for a psychoeducational programme for couples compared with usual care. However, the primary outcome to prevent postpartum common mental disorders among unselected populations was only significant when the full programme of 3 components (care from a trained nurse, printed materials and a face-to-face seminar) was used.

Interventions for mixed depression and anxiety

An RCT[9] (n=189) found significant improvements in depression and anxiety scores for a lifestyle-based education intervention compared with controls during pregnancy. A larger effect was found for the intervention when it included both women and their husbands.

An RCT[10] (n=163) found significant improvements in symptoms of depression, anxiety and stress for behavioural activation compared with usual care for pregnant women.

Interventions for psychological distress

A secondary analysis[11] of a cluster RCT (n=6275) found no significant differences in reducing postpartum psychological distress between attendance at women's health groups and usual care as reported with the Self

Reporting Questionnaire (SRQ-20) up to 52 weeks after childbirth.

An RCT[12] (n=280) found significant improvements in psychological distress scores, as measured by the General Health Questionnaire and Beck Depression Inventory, for supportive counselling compared to routine care after miscarriage. However, these effects were only significantly different for the subgroup of women with more severe baseline scores.

Interventions for stress

A secondary analysis[13] of the above RCT (n=397) found significant improvements in parenting stress scores at both 6 weeks and 6 months for the CBT group compared to standard care.

A meta-analysis[14] of a total 13 studies found significant improvements in postpartum stress for psychosocial interventions compared with usual care. A larger effect was found particularly for supportive stress management programmes.

Topic expert feedback

Feedback indicated that there is currently ongoing research investigating the effects of exercise, yoga and psychological interventions that include partners of pregnant women. There is also an ongoing trial investigating CBT for postpartum obsessive compulsive disorder.

A topic expert indicated that some psychological therapies could be more harmful to black and minority ethnic (BME) groups.

Impact statement

The evidence identified at the surveillance review indicates a general trend towards the beneficial effects of psychological and psychosocial interventions. These effects appear to be present at various stages of antenatal and postnatal periods.

This evidence is generally in line with current recommendations which advise on the use of individual, group and family interventions for this population.

The evidence also suggests that the beneficial effects of psychosocial interventions are present across various mental health problems.

No relevant evidence was found for the effects of psychosocial interventions in women from BME groups.

As the new evidence does not conclusively indicate a particular form or structure of psychological and psychosocial intervention being most beneficial, it is unlikely to change the recommendations.

Ongoing studies will be considered at the next surveillance review when their results publish.

New evidence is unlikely to change guideline recommendations.

Improving the mother-child interaction

Surveillance summary (2017)

An RCT[15] (n=1324) found a significant improvement in mother-to-infant bonding following assignment to a Pregnancy Outreach Worker service compared to standard care. No significant differences were found for the rates of antenatal visits attended, depression scores, maternal or neonatal birth outcomes, maternal self-efficacy, child development, breastfeeding, and immunisation uptake.

Topic expert feedback

Feedback indicated that there is an ongoing trial investigating the mother-infant interaction for women with postpartum depression.

Impact statement

Evidence from the surveillance review indicates a beneficial effect of a Pregnancy Outreach Worker service on the mother-to-infant bond. However, results for most of the outcomes were not significant; in particular, for depression scores and breastfeeding which were listed as important outcomes in the guideline. As evidence is currently limited in this area it is unlikely to impact on recommendations.

Ongoing studies will be considered at the next surveillance review when their results publish.

New evidence is unlikely to change guideline recommendations.

Pharmacological and physical interventions

192 – 14 **What is the effectiveness of selective prevention interventions (for women with no risk factors) in reducing the likelihood of developing mental health problems in pregnancy or the postnatal period?**

192 – 15 **What is the effectiveness of indicated preventative interventions (for women with identified risk factors present) in reducing the likelihood of developing mental health problems in pregnancy or the postnatal period?**

192 – 16 **What strategies should be adopted to minimise potential harm to the women or the fetus/infant of these interventions?**

192 – 17 **For women with mental disorders who are antenatal or postnatal, what are the benefits and/or potential harms of pharmacological interventions to treat mental health problems?**

192 – 18 **For women with mental disorders who are antenatal or postnatal, what are the benefits and/or potential harms of combined pharmacological and psychosocial treatment interventions to treat mental health problems?**

192 – 19 **For women with mental health problems in pregnancy or the postnatal period, what are the benefits and/or potential harms of physical interventions to treat mental health problems?**

192 – 20 **For women with mental disorders who are antenatal or postnatal, what are the benefits and/or potential harms of electroconvulsive therapy to treat mental health problems?**

Recommendations derived from these review questions

Using this guideline in conjunction with other NICE guidelines

1.1.2 Use this guideline in conjunction with the NICE guideline for a specific mental health problem (see our web pages on pregnancy and mental health and wellbeing) to inform assessment and treatment decisions in pregnancy and the postnatal period, and take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period
- the setting for assessment and treatment (for example, primary or secondary care services or in the community, the home or remotely by phone or computer)
- recommendations 1.6.1 to 1.6.6 in this guideline on assessment in pregnancy and the postnatal period
- recommendations 1.4.10 to 1.4.37 in this guideline on starting, using and stopping treatment in pregnancy and the postnatal period
- recommendations 1.8.1 to 1.8.23 in this guideline on treating specific mental health problems in pregnancy and the postnatal period.

Considerations for women of childbearing potential

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

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

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

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

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

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

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

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

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

- choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication
- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to 2 or more drugs
- take into account that dosages may need to be adjusted in pregnancy.

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

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

  Ensure she knows about any risks to herself, the fetus or baby when stopping medication.

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

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

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

Ensure she knows about any risks to herself, the fetus or baby when stopping medication.

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

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

Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs.

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

- the woman's previous response to these drugs
- the stage of pregnancy
- what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
- the uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors
- the risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine.

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

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

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

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

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

1.4.20 When assessing the risks and benefits of antipsychotic medication†† for a pregnant woman, take into account risk factors for gestational diabetes and excessive weight gain.

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

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

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

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

1.4.25 Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the NICE guideline on diabetes in pregnancy and offer an oral glucose tolerance test.

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

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

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

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

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

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

1.4.32 If a woman is taking lamotrigine‡ during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times.

1.4.33 Do not offer lithium‡‡ to women who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective.

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

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

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

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

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

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

1.4.37 If a woman continues taking lithium during pregnancy:

- check plasma lithium levels every 4 weeks, then weekly from the 36th week
- adjust the dose to keep plasma lithium levels in the woman's therapeutic range
- ensure the woman maintains an adequate fluid balance
- ensure the woman gives birth in hospital

- ensure monitoring by the obstetric team when labour starts, including checking plasma lithium levels and fluid balance because of the risk of dehydration and lithium toxicity
- stop lithium during labour and check plasma lithium levels 12 hours after her last dose.

Providing interventions in pregnancy and the postnatal period

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

Treating specific mental health problems in pregnancy and the postnatal period

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

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

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

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

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

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

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

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

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

- stopping the medication gradually and switching to a high-intensity psychological intervention (for example, CBT)
- continuing with medication if she understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and:
  - has expressed a preference for medication or

  - declines psychological interventions or
  - her symptoms have not responded to psychological interventions
- changing medication if there is a drug that is effective for her with a lower risk of adverse effects
- combining medication with a high-intensity psychological intervention (for example, CBT) if the woman understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and there is no response, or a limited response, to a high-intensity psychological intervention alone.

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

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

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

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

- becomes pregnant and is stopping lithium, or
- plans to breastfeed.

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

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

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

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

1.8.23 A pregnant woman requiring rapid tranquillisation should be treated according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder (see our web pages on mental health and wellbeing for details), except that:

- she should not be secluded after rapid tranquillisation
- restraint procedures should be adapted to avoid possible harm to the fetus
- when choosing an agent for rapid tranquillisation in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account

- during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist.

Considerations for women and their babies in the postnatal period

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

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

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

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

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

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

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

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

  Seek advice from a specialist (preferably from a specialist perinatal mental health service) if needed for specific drugs.

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

- the limited data on the safety of these drugs and
- the level of antipsychotic medication in breast milk depends on the drug.

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

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

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

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

‡‡ Although this use is common in UK clinical practice, at the time of publication (December 2014), lithium did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance,

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

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

Surveillance decision

These review questions should not be updated.

Recommendations relating to valproate (1.2.3 and 1.4.27 – 1.4.29) will be amended to include a footnote with a link to the MHRA toolkit.

Pharmacological interventions

Surveillance summary (2017)

Three systematic reviews and meta-analyses[16-18] found significantly higher risks of preterm birth and low birth weight in women using antidepressants during pregnancy compared to controls without exposure to antidepressants.

An update of a Cochrane systematic review[19] compared antidepressant treatment with any other treatment, placebo or treatment as usual in women with depression up to 6 months postpartum. A total of 6 trials found inconclusive evidence for the effectiveness of antidepressants, whether they are more effective for particular subgroups or risks of adverse effects.

A meta-analysis[20] including 12 studies found significantly increased risks of major congenital malformations and preterm births in women using second-generation antipsychotics during the first trimester of pregnancy. No significant differences were found for risks of miscarriage, stillbirths or gestational size, age or weight.

Topic expert feedback

Feedback highlighted a cohort study[21] (n=1, 341 715) which found no significant increase in congenital or cardiac malformations in women using antipsychotics during the first trimester of pregnancy compared to women without exposure to antipsychotics.

A cohort study[22] (n=319 520) found no significant increase in rates of caesarean section, gestational diabetes, premature birth, low birthweight or congenital malformations in women using antipsychotics during pregnancy compared to those discontinuing treatment during pregnancy and those with no history of treatment. These effects were not significant once adjustments were made for health, lifestyle and concomitant medication factors.

Data from a national pregnancy registry[23] (n=303) found no significant increase in the risk of major congenital malformations in women using second generation antipsychotics during the first trimester of pregnancy compared with controls without exposure to antipsychotics.

A retrospective cohort study[24] (n=30 198) found a significantly increased risk of postpartum haemorrhage in women using antidepressants during late gestation compared with women without exposure to antidepressants.

A prospective cohort study[25] (n=56 340) found a significantly increased risk for speech and language disorders in children of women exposed to selective serotonin reuptake inhibitors (SSRIs) during pregnancy.

Feedback indicated that there is currently ongoing research investigating drug interventions for this population.

Further feedback highlighted that there is an MHRA toolkit on the risks associated with valproate medicines.

Impact statement

Evidence from the surveillance review found inconsistent results regarding the adverse effects of antipsychotic use during pregnancy. Some of the data trends towards an increased risk of adverse events with the use of antidepressants during pregnancy.

However, much of the evidence is derived from non-randomised studies and the results should be taken with caution.

The new evidence is in line with current recommendations which advise of the risks associated with pharmacological treatment and the varying adverse effects that may occur.

Ongoing studies will be considered at the next surveillance review when their results publish.

Recommendations relating to valproate (1.2.3 and 1.4.27 – 1.4.29) will be amended to include a footnote with a link to the MHRA toolkit.

New evidence is unlikely to change guideline recommendations.

Selective prevention interventions

Surveillance summary (2017)

An RCT[26] (n=167) found significant improvements in depression scores in healthy pregnant women for a supervised exercise programme compared with a control group.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

Evidence from the surveillance review suggests a beneficial effect of exercise as a preventative intervention for women not currently at risk of mental health problems.

Although exercise may form part of facilitated self-help interventions as recommended in the guideline, there is currently not enough evidence for this population to impact the recommendations.

New evidence is unlikely to change guideline recommendations.

Physical interventions

Surveillance summary (2017)

An RCT[27] (n=94) found significant improvements in Edinburgh Postnatal Depression Scale (EPDS) scores for a facilitated exercise intervention compared with usual care. However, the effects were only significant when adjusted for demographic variables and it is unclear at which follow-up time point after childbirth this effect occurs.

A meta-analysis[28] including 6 trials found a significant improvement in depression scores during the antenatal period for exercise interventions compared with controls. However, the authors noted that the low quality of the trials and significant heterogeneity reduce the strength of the evidence.

A meta-analysis[29] of 6 trials found a significant improvement in prenatal depression scores for yoga interventions compared with standard care.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

Evidence from the surveillance review indicates some benefit of physical activity in reducing depression symptoms. However, the strength of the evidence is limited due to low quality and evidence of heterogeneity. The evidence reviewed during development of the guideline was also considered not strong enough to make any specific recommendations about physical interventions. The current evidence base is too premature to consider for inclusion in the guideline at this time.

New evidence is unlikely to change guideline recommendations.

The organisation of perinatal mental services

Service delivery and coordination of care

Recommendations derived from this question (no questions made in guideline)

The organisation of services

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

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

- there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways.

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

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

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

1.10.5 Specialist perinatal inpatient services should:

- provide facilities designed specifically for mothers and babies (typically with 6-12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for babies
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

Editorial and factual corrections

During surveillance of the guideline we identified the following issues with the NICE version of the guideline that should be corrected:

- Recommendations relating to valproate (1.2.3, 1.4.27-29) should include a footnote with a link to the MHRA toolkit.
- Recommendations cross-referring to other specific guideline recommendations may need updating when the related guideline update is published:
  - Recommendations 1.8.1 and 1.8.4 in NICE guideline CG192 antenatal and postnatal mental health cross-refer to recommendation 1.4.2.2 of NICE guideline CG90 depression in adults for delivery of facilitated self-help.
  - Recommendation 1.8.7 in NICE guideline CG192 antenatal and postnatal mental health cross-refers to section 1.2.9 of NICE guideline CG132 caesarean section for the management of tokophobia.
- Recommendations cross-referring to related guidelines to be updated with new guideline numbers:
  - Recommendation 1.8.23 in NICE guideline CG192 antenatal and postnatal mental health cross-refers to NICE guideline CG25 violence. The link should be updated to NICE guideline NG10 violence and aggression.

Research recommendations

Prioritised research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. We may then propose to remove research recommendations from the NICE version of the guideline and the NICE database for research recommendations. The research recommendations will remain in the full versions of the guideline. See NICE's research recommendations process and methods guide 2015 for more information.

These research recommendations were deemed priority areas for research by the Guideline Committee; therefore, at this 4-year surveillance review time point a decision **will** be taken on whether to retain the research recommendations or stand them down.

We applied the following approach:

- New evidence relevant to the research recommendation was found and an update of the related review question is planned.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database. If needed, a new research recommendation may be made as part of the update process.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.
  - The research recommendation will be retained because there is evidence of research activity in this area.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database because further research is unlikely to impact on the guideline.
- Ongoing research relevant to the research recommendation was found.
  - The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.
- No new evidence relevant to the research recommendation was found and no ongoing studies were identified.
  - The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.
- The research recommendation would be answered by a study design that was not included in the search (usually systematic reviews or randomised controlled trials).
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.
- The new research recommendation was made during a recent update of the guideline.
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 01 What methods can improve the identification of women at high risk of postpartum psychosis and reduce this risk?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence was found for the screening and identification of depression and included under questions 01-04. However, this evidence would not be directly relevant to the research question.

Surveillance decision

The new research recommendation was made during a recent update of the guideline. The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 02 How safe are drugs used to treat bipolar disorder in pregnancy and the postnatal period?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified. New evidence was found for the pharmacological treatment of depression and psychotic disorders and included under questions 14-20. However, this evidence would not be directly relevant to the research question.

Surveillance decision

The new research recommendation was made during a recent update of the guideline. The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 03 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?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations. Additionally, ongoing research relevant to the research recommendation was found and included in question 12.

Surveillance decision

The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.

RR – 04 Is structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period effective at improving outcomes for women and their babies?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

The new research recommendation was made during a recent update of the guideline. The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 05 Are psychological interventions effective for treating moderate to severe anxiety disorders (including obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder and social anxiety disorder) in pregnancy?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations. Additionally, ongoing research relevant to the research recommendation was found and included under questions 08-13.

Surveillance decision

The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.

Other research recommendations

The following research recommendations were not deemed as priority areas for research by the guideline committee.

RR – 06 An evaluation of managed perinatal networks should be undertaken to compare the effectiveness of different network models in delivering care. It should cover the degree of integration of services, the establishment of common protocols, the impact on patients' access to specified services and the quality of care, and staff views on the delivery of care.

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 07 What screening tools are effective in identifying the range of eating disorders (including anorexia nervosa, bulimia, binge eating disorder and eating disorders not otherwise specified) in pregnancy?

No new evidence relevant to the research recommendation was found.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 08 What adaptations to current effective psychological interventions (for example, mode of delivery, duration, content, and intensity of treatment) are needed for use in the perinatal period to treat eating disorders?

No new evidence relevant to the research recommendation was found.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

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