Antenatal and postnatal mental health

NICE quality standard

Draft for consultation

May 2015

Introduction

This quality standard covers the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth). It also includes the care of women with an existing mental health problem who are planning a pregnancy, and the organisation of mental health services needed in pregnancy and the postnatal period. For more information see the antenatal and postnatal mental health topic overview.

Why this quality standard is needed

In pregnancy and the postnatal period, women are vulnerable to having or developing the same range of mental health problems as other women, such as depression, anxiety disorders, eating disorders, drug and alcohol use disorders and severe mental illness (including psychosis, bipolar disorder, schizophrenia and severe depression). 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.

Depression and anxiety are the most common mental health problems occurring during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point, and many women experiencing both. Depression and anxiety also affect 15–20% of women in the first year after childbirth. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth. Women with pre-existing bipolar type 1 disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history.

Mental health problems occurring in pregnancy and the postnatal period are often similar to those occurring at other times in their nature, course and potential for

relapse, but there can be differences, for example women with bipolar disorder have an increased risk of developing an episode during the early postnatal period.

The majority of mental health problems during pregnancy and the postnatal period are mild to moderate, and are treated in primary care. Other settings where women with mental health problems during pregnancy and the postnatal period may be treated include obstetric and gynaecological services, general mental health services and specialist secondary care mental health services.

Mental health problems in pregnancy and the postnatal period may often require more urgent intervention than they would at other times because of their potential effect on the baby and on the woman's physical health and care, and her ability to function and care for her family. However, problems frequently go unrecognised and untreated in pregnancy and the postnatal period. Some women do not seek help because of fear of stigma, or fear of intervention by social services. The perinatal period can also present practical barriers to treatment, for example, the demands associated with the care of an infant may interfere with a woman's ability to regularly attend treatment. If mental health problems are left untreated, women can continue to have symptoms, sometimes for many years, which can also affect their children and other family members.

There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding, and with stopping medication taken for an existing mental health problem without professional advice, because of the potential to trigger or worsen an episode.

Between 2006 and 2008 there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK as a result of mental health problems (Centre for Maternal and Childhood Enquiries 2011 Saving mothers' lives).

The quality standard is expected to contribute to improvements in the following outcomes:

- maternal wellbeing
- service user experience of mental health services
- quality of life for women with severe mental illness

- neonatal health and wellbeing
- suicide rate.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- The Adult Social Care Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare i Adults ***Improvement areas*** **Reducing premature mortality in people with mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** (ASCOF 1A) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness** (ASCOF 1F & PHOF 1.8)
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11) ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures ii Psychological therapies
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care 4b Patient experience of hospital care 4c Friends and family test ***Improvement areas*** **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **Improving women and their families' experience of maternity services** 4.5 Women's experiences of maternity services **Improving experience of healthcare for people with a mental illness** 4.7 Patient experience of community mental health services **Improving people's experience of integrated care** 4.9 People's experience of integrated care** (ASCOF 3E)
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicator*** 5c Deaths attributable to problems in healthcare **Improvement area** **Improving the safety of maternity services** 5.5 Admission of full-term babies to neonatal care
Alignment across the health and social care system * Indicator is shared ** Indicator is complementary	

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* (NHSOF2) ***Outcome measures*** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1F Proportion of adults in contact with secondary mental health services in paid employment* (PHOF 1.8, NHSOF 2.5) 1H Proportion of adults in contact with secondary mental health services living independently, with or without support** (PHOF 1.6) 1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like** (PHOF 1.18)
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support Placeholder 3E The effectiveness of integrated care* (NHSOF 4.9))

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe* (PHOF 1.19) ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation* (ASCOF 1G and 1H) 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services* (NHSOF 2.2) ** (ASCOF 1E) ** (NHSOF 2.5) ** (ASCOF 1F) 1.9 Sickness absence rate 1.18 Social isolation* (ASCOF 1I)

2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.1 Low birth weight of term babies 2.5 Child development at 2–2½ years 2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years 2.10 Self-harm 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable** (NHSOF 1.1) 4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5) 4.10 Suicide rate 4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)
Alignment across the health and social care system * Indicator shared with the NHS Outcomes Framework ** Complimentary indicators in the NHS Outcomes Framework	

Service user experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to antenatal and postnatal mental health.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathway on patient experience in adult NHS services/service user experience in adult mental health services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements

on these aspects of patient/service user experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on patient/service user experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for antenatal and postnatal mental health specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole antenatal and postnatal mental health care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women with a mental health problem in pregnancy and the postnatal period.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing high-quality services for antenatal and postnatal mental health are listed in Related quality standards. [Link to section in web version]

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in antenatal and postnatal mental health should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting women with a mental health problem in pregnancy and the postnatal period. If

appropriate, healthcare professionals, public health professionals and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Women of childbearing potential are not prescribed valproate to treat a mental health problem.

Statement 2. Women with a past or existing mental health problem, who are seeking pre-conception advice or are pregnant, are given information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Statement 3. Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact.

Statement 4. Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.

Statement 5. Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.

Statement 6 (developmental). Specialist community and inpatient multidisciplinary perinatal mental health services are available to support women with a mental health problem in pregnancy or the postnatal period.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Questions about the individual quality statements

Question 4 For draft quality statement 4: How would this quality statement be measured in practice?

Question 5 For draft quality statement 4: When should a comprehensive assessment take place?

Question 6 For draft developmental statement 6: Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services or new equipment? Can you provide any examples of current practice in this area?

Quality statement 1: Valproate

Quality statement

Women of childbearing potential are not prescribed valproate to treat a mental health problem.

Rationale

Valproate can harm unborn babies when taken during pregnancy. Babies exposed to valproate in the womb are at a high risk of serious developmental disorders (approximately 30-40% of babies) and congenital malformations (approximately 10% of babies). Valproate should not be prescribed to women of childbearing potential.

Quality measures

Structure

a) Evidence of practice arrangements and written clinical protocols to ensure that women of childbearing potential are not prescribed valproate to treat a mental health problem.

Data source: Local data collection.

Process

a) Proportion of women of childbearing potential prescribed valproate to treat a mental health problem.

Numerator – the number in the denominator prescribed valproate to treat a mental health problem.

Denominator – the number of women of childbearing potential with a mental health problem.

Data source: Local data collection.

Outcome

a) Valproate prescribing rates among women of childbearing potential for treatment of a mental health problem.

Data source: Local data collection.

b) Children with serious developmental disorders or congenital malformations born to mothers who took valproate in pregnancy for treatment of a mental health problem.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices, community health services, mental health services and hospitals) ensure that there are practice arrangements and written clinical protocols to ensure that women of childbearing potential are not prescribed valproate to treat a mental health problem.

Healthcare professionals do not prescribe valproate to women of childbearing potential to treat a mental health problem.

Commissioners (such as NHS England area teams and clinical commissioning groups) specify within contracts that women (of childbearing potential) are not prescribed valproate to treat a mental health problem.

What the quality statement means for service users and carers

Women who may become pregnant or who are pregnant should not be prescribed a medication called valproate to treat a mental health problem. Valproate can harm unborn babies.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendations 1.2.3 and 1.4.27

Equality and diversity considerations

Childbearing potential should be determined for women on an individual basis. It should not be determined solely by age because childbearing potential is also dependent on factors other than age.

Quality statement 2: Information for women with a past or existing mental health problem

Quality statement

Women with a past or existing mental health problem, who are seeking pre-conception advice or are pregnant, are given information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Rationale

It is important that women with a past or existing mental health problem understand how their mental health problem might affect them during and after pregnancy, and how pregnancy and childbirth might affect their condition, including the risk of relapse. These issues should be discussed if the woman is planning a pregnancy or is pregnant. In particular, it is important that the potential risks of using some medications to treat mental health problems during pregnancy and while breastfeeding are discussed to help women to make informed decisions about managing their condition.

Quality measures

Structure

Evidence of local arrangements to ensure that women with a past or existing mental health problem, who are seeking pre-conception advice or are pregnant, are given information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Data source: Local data collection.

Process

a) Proportion of women with a past or existing mental health problem, who are seeking pre-conception advice, who are given information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Numerator – the number in the denominator who have received information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Denominator – the number of women with a past or existing mental health problem who are seeking-preconception advice.

b) Proportion of first contacts with a healthcare professional in pregnancy within which pregnant women with a past or existing mental health problem are given information at their appointment about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Numerator – the number in the denominator in which the woman receives information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Denominator – the number of first contacts with a healthcare professional in pregnancy, of women with a past or existing mental health problem.

Data source: a) and b) Local data collection. The following indicator is included on the NICE menu for the quality and outcomes framework: The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 12 months. NM78 (2014).

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care services, general mental health services, specialist secondary care mental health services, family planning and sexual health services) ensure that systems are in place for women with a past or existing mental health problem who are seeking preconception advice, or are pregnant, to receive information about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Healthcare professionals ensure that they provide information to women with a previous mental health problem who are seeking preconception advice, or are pregnant, about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

Commissioners (NHS England and commissioners of specialist and general mental health services (clinical commissioning groups)) ensure that they commission services that give information to women with a past or existing mental health problem who are seeking preconception advice, or are pregnant, about how a mental health problem and its treatment might affect them or their baby during pregnancy, the postnatal period and while breastfeeding.

What the quality statement means for patients, service users and carers

Women with a current or past mental health problem who want to become pregnant or are pregnant, are given information about how a mental health problem might affect them or their baby during pregnancy and after their baby is born, and the possible benefits and harms of any treatment they might have for their mental health problem during this time and while breastfeeding if they choose to breastfeed. This will help them to make decisions about pregnancy and their treatment.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendations 1.2.1 (key priority for implementation), 1.4.4 and 1.4.6 (key priority for implementation).

Definitions of terms used in this quality statement

Information

NICE guideline CG192 recommendation 1.2.1 includes the following information that should be discussed with 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.

NICE guideline CG192 recommendation 1.4.6 recommends that 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.

Recommendation 1.4.4 recommends that healthcare professionals discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. This should include an explanation of the benefits of breastfeeding, the potential risks associated with taking psychotropic

medication when breastfeeding and with stopping some medications in order to breastfeed. Healthcare professionals should discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

Postnatal period

Up to 1 year after childbirth.

Equality and diversity considerations

When information is provided, there must be equal access to information for all women, including those with additional needs, such as physical or learning disabilities, and those who do not speak or read English. Women receiving information should have access to an interpreter or advocate if needed.

Quality statement 3: Routine assessment of emotional wellbeing

Quality statement

Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact.

Rationale

Routine antenatal and postnatal appointments are an opportunity for regular monitoring of women's emotional wellbeing. Women should be actively asked about their emotional wellbeing at each routine contact to support them to discuss any concerns. This will enable identification of symptoms of potential mental health problems.

Quality measures

Structure

Evidence of arrangements for healthcare professionals to ask women about their emotional wellbeing at all routine antenatal and postnatal contacts.

Data source: Local data collection.

Process

The proportion of routine antenatal and postnatal contacts at which woman are asked about their emotional wellbeing.

Numerator – the number in the denominator at which women were asked about their emotional wellbeing.

Denominator – the number of routine antenatal and postnatal contacts.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (antenatal care service providers in primary and secondary care) ensure that there are procedures and protocols in place to ask women about their emotional wellbeing at each routine antenatal and postnatal contact.

Healthcare professionals ask women about their emotional wellbeing at each routine antenatal and postnatal contact to support identification and discussion of mental health problems.

Commissioners (commissioners of maternity care (including antenatal care) (clinical commissioning groups)) ensure that they commission services that make sure women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.

What the quality statement means for patients, service users and carers

Women who are pregnant are asked how they are feeling at every routine appointment during pregnancy and in the first year after giving birth so that they can talk to their healthcare professional about any concerns they have, and any problems can be identified.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendations 1.5.4 (key priority for implementation) and 1.5.8.

Definitions of terms used in this quality statement

Assessment of emotional wellbeing

NICE guideline CG192 recommendations 1.5.4 and 1.5.8 set out questions that healthcare professionals should consider asking a woman at her booking visit and regular contacts in pregnancy, as part of a general discussion about her mental health and wellbeing:

- Depression identification questions:

  - 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?
- Asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
  - During the past month, have you been feeling nervous, anxious or on edge?
  - During the past month have you not been able to stop or control worrying?

Recommendations 1.5.5–1.5.7 set out additional questions to ask if initial questioning indicates the need for further investigation.

Routine antenatal contacts

Routine antenatal contacts include a pregnant woman's first contact with a midwife or doctor to discuss their pregnancy, the booking appointment (between 8 and 12 weeks of pregnancy), dating scan (between 8 and 14 weeks of pregnancy), 16-week check, anomaly scan (between 18 and 20 weeks of pregnancy), and further routine scheduled checks (the frequency of these will vary depending on whether it is the woman's first pregnancy). (NHS Choices)

Routine postnatal contacts

Women should receive the number of postnatal contacts that are appropriate to their care needs. A routine postnatal contact is a scheduled postnatal appointment that may occur in the woman or baby's home or another setting such as a GP practice, children's centre or a hospital setting if the woman and/or the baby requires extended inpatient care. All women should have a postnatal check about 6 weeks after their baby's birth to make sure that they feel well and are recovering properly.

Postnatal period

Up to 1 year after childbirth.

Equality and diversity considerations

Pregnant women include women with complex social needs who may be less likely to access or maintain contact with antenatal care services. Examples of women with complex social needs include, but are not limited to, women who:

- have a history of substance misuse (alcohol and/or drugs)
- have recently arrived as a migrant, asylum seeker or refugee
- have difficulty speaking or understanding English
- are aged under 20
- have experienced domestic abuse
- are living in poverty
- are homeless.

It is therefore appropriate that localities give special consideration to these groups of women. NICE clinical guideline 110 has recommendations about how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Quality statement 4: Comprehensive assessment

Quality statement

Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.

Rationale

A comprehensive assessment can support accurate diagnosis of a mental health problem in pregnancy or the postnatal period, and can ensure that women are offered the most appropriate treatment at the earliest opportunity. A comprehensive assessment will also consider wider factors influencing the woman's mental health problem, and her physical wellbeing, so that additional needs and support can be identified.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.

Data source: Local data collection.

Process

Proportion of women with a suspected mental health problem in pregnancy or the postnatal period who receive a comprehensive assessment.

Numerator – the number in the denominator who receive a comprehensive assessment.

Denominator – the number of women who have a suspected mental health problem who are pregnant or have given birth within the last 12 months.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care, obstetric and gynaecological services, general mental health services and specialist secondary care mental health services) ensure that systems are in place for women with a suspected mental health problem in pregnancy or the postnatal period to receive a comprehensive assessment so that the mental health problem can be accurately diagnosed, any additional factors influencing emotional wellbeing can be identified and appropriate support can be provided.

Healthcare professionals ensure that women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment that enables them to diagnose the mental health problem, identify additional factors influencing their emotional wellbeing and provide appropriate support.

Commissioners (such as commissioners of primary care services, maternity services and mental health services (NHS England and CCGs) ensure that they commission services that provide women with a suspected mental health problem in pregnancy or the postnatal period with a comprehensive assessment that enables accurate diagnosis and consideration of wider factors affecting emotional wellbeing.

What the quality statement means for patients, service users and carers

Women who may have a mental health problem in pregnancy or within a year after giving birth to their baby have a full assessment to find out what the problem is and whether they need extra support.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendation 1.6.1.

Definitions of terms used in this quality statement

Comprehensive assessment

NICE guideline CG192, recommendation 1.6.1 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 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.

Postnatal period

Up to 1 year after childbirth.

Suspected mental health problem

Women might be suspected to have a mental health problem if they have a history of a mental health problem, possible symptoms (such as mood difficulties or detachment from their pregnancy or baby) or have recently experienced a trauma, such as a traumatic birth.

Equality and diversity considerations

Healthcare professionals should ensure that, in comprehensive assessments with all women, they understand variations in the presentation of mental health problems, and are sensitive to any potential concerns about disclosing mental health problems. This includes ensuring that they are culturally competent in their discussions with women from black, Asian and minority ethnic groups to support full and meaningful discussion. An independent interpreter should be provided if required to support women in discussions.

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

Questions for consultation

How would this quality statement be measured in practice?

When should a comprehensive assessment take place?

Quality statement 5: Psychological interventions

Quality statement

Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.

Rationale

It is important that women with a mental health problem in pregnancy or the postnatal period receive prompt treatment to manage their condition and prevent worsening of symptoms. More urgent intervention may be needed at these times because of the potential effect of the untreated mental health problem on the baby and on the woman's physical health and care, and her ability to function and care for her family.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that women with a mental health problem in pregnancy or the postnatal period, who are referred for psychological interventions, start treatment within 6 weeks of referral.

Data source: Local data collection.

Process

a) Proportion of women with a mental health problem in pregnancy or the postnatal period, who are referred for psychological interventions, who are assessed for treatment within 2 weeks of referral.

Numerator – number of women in the denominator who are assessed for treatment within 2 weeks of referral.

Denominator – the number of women with a mental health problem in pregnancy or the postnatal period who are referred for psychological interventions.

Data source: Local data collection.

b) Proportion of women with a mental health problem in pregnancy or the postnatal period, who are assessed for psychological interventions, who start psychological interventions within 4 weeks of assessment.

Numerator - number of women in the denominator who start psychological interventions within 4 weeks of assessment.

Denominator – number of women who are referred for psychological interventions and have an assessment.

Outcome

Women's satisfaction with psychological interventions.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (general mental health services, primary care psychological therapy services and specialist secondary care mental health services) ensure that women with a mental health problem in pregnancy or the postnatal period who are referred for psychological interventions start treatment within 6 weeks of referral.

Healthcare professionals ensure that women with a mental health problem in pregnancy or the postnatal period who are referred for psychological interventions start treatment within 6 weeks of referral.

Commissioners (such as commissioners of specialist and general mental health services) ensure that they commission services that provide psychological interventions to women with a mental health problem in pregnancy or the postnatal period within 6 weeks of referral.

What the quality statement means for patients, service users and carers

Women who are pregnant, or have had a baby in the past year, who have a mental health problem start psychological interventions within 6 weeks of being

referred by their healthcare professional, so they can receive the treatment they need as soon as possible.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendation 1.7.3.

Definitions of terms used in this quality statement

Psychological interventions

Psychological interventions should be tailored to the (sometimes highly specialist) needs of women in pregnancy and the postnatal period, and to support the child's development, attachment and mental health. 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).

Quality statement 6 (developmental): Specialist multidisciplinary perinatal mental health services

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Developmental quality statement

Specialist community and inpatient multidisciplinary perinatal mental health services are available to support women with a mental health problem in pregnancy or the postnatal period.

Rationale

The management of mental health problems during pregnancy and the postnatal period differs from at other times because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby. Access to specialist community and inpatient services (including mother and baby units) can ensure that the most appropriate assessment, monitoring and treatment is provided. Access to specialist multidisciplinary perinatal community and inpatient services varies considerably, as services are not available in each locality.

Women with severe mental health problems require specialist perinatal support to ensure that their condition is monitored appropriately, and that they can access the most suitable treatment. This is because severe mental health problems can be associated with significant impairment in social and personal functioning, which might have a detrimental effect on the woman's ability to care effectively for herself and her children. Psychiatric causes of maternal death, particularly suicide, continue to be a significant cause of maternal mortality in the UK.

Quality measures

Structure

a) Evidence of local arrangements to provide specialist community and inpatient multidisciplinary perinatal mental health services.

b) Evidence of local arrangements to ensure women needing inpatient care for a mental health problem within 12 months of childbirth can be admitted to a mother and baby unit.

c) Evidence of referral arrangements for women with a severe mental health problem to be referred to specialist community and inpatient multidisciplinary perinatal mental health services.

Data source: Local data collection.

Outcome

Suicide rates (reduction).

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care services, obstetric and gynaecological services, general mental health services and specialist secondary care mental health services) ensure that systems are in place for women with a mental health problem in pregnancy or the postnatal period to have access to specialist community and inpatient perinatal mental health services.

Healthcare professionals ensure that they are aware of local referral pathways for women with a mental health problem in pregnancy or the postnatal period to ensure that women receive support from specialist community and inpatient perinatal mental health services.

Commissioners of specialist services (NHS England specialist commissioning teams) should ensure that perinatal mental health services are commissioned for women with a mental health problem in pregnancy or the postnatal period. Commissioners of primary and secondary care services (NHS England and clinical commissioning groups) should ensure that providers in primary and secondary care services refer women with a mental health problem in pregnancy or the postnatal period to receive support from specialist community and inpatient perinatal mental health services when appropriate.

What the quality statement means for patients, service users and carers

Women who have a mental health problem during pregnancy or in the year after having a baby receive support from services that are specially designed for women with a mental health problem during these times and can give them the support they need.

Source guidance

- Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendations 1.5.10, 1.10.1 and 1.10.3 (key priority for implementation).

Definitions of terms used in this quality statement

Specialist multidisciplinary perinatal mental health service

A specialist multidisciplinary perinatal mental health service should be available 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. [Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendation 1.10.3]

Status of this quality standard

This is the draft quality standard released for consultation from 29 May to 26 June 2015. It is not NICE's final quality standard on antenatal and postnatal mental health. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 26 June. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from October 2015.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something

should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources [Link to section in web version].

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and women with a mental health problem planning or during pregnancy and in the year after giving birth is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women with a mental health problem planning or during pregnancy and in the year after giving birth should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Antenatal and postnatal mental health (2014) NICE guideline CG192.

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Maternal Mental Health Alliance (2014) UK specialist community perinatal mental health teams (current provision)
- Royal College of Midwives (2014) Maternal mental health: improving emotional wellbeing in postnatal care
- National Audit Office (2013) Maternity services in England
- NHS England (2013) NHS standard contract for specialised perinatal mental health services (in patient mother and baby units and linked outreach teams) Schedule 2 The Services A Service Specifications
- Department of Health (2012) Maternal mental health pathway
- Public Health Agency (2012) Integrated perinatal mental health care pathway
- Centre for Maternal and Childhood Enquiries (2011) Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–2008

Definitions and data sources for the quality measures

- NHS Choices (2015) Your antenatal appointments.
  NICE quality and outcomes framework (QOF) menu indicator NM78 (2014).

Related NICE quality standards

Published

- Psychosis and schizophrenia in adults (2015) NICE quality standard 80
- Ectopic pregnancy and miscarriage (2014) NICE quality standard 69
- Anxiety disorders (2014) NICE quality standard 53

- Depression in children and young people (2013) NICE quality standard 48
- Multiple pregnancy (2013) NICE quality standard 46
- Postnatal care (2013) NICE quality standard 37
- Self-harm (2013) NICE quality standard 34
- Caesarean section (2013) NICE quality standard 32
- Antenatal care (2012) NICE quality standard 22
- Service user experience in adult mental health (2011) NICE quality standard 14
- Alcohol dependence and harmful alcohol use (2011) NICE quality standard 11
- Depression in adults (2011) NICE quality standard 8

In development

- Personality disorders (borderline and antisocial). Publication expected May 2015
- Bipolar disorder in adults. Publication expected June 2015
- Intrapartum care. Publication expected December 2015

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Maternal health: promoting maternal health through community based strategies
- Medicines optimisation (covering medicines adherence and safe prescribing)
- Mental well-being: life course, settings and subgroups
- Parenteral nutrition in neonates
- Premature birth
- Premature labour
- Provision of termination of pregnancy services
- Suicide prevention

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on Antenatal and postnatal mental health.

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

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