NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION SUMMARY REPORT

1 Quality standard title

Antenatal and postnatal mental health

Date of Quality Standards Advisory Committee post-consultation meeting:
15 July 2015.

2 Introduction

The draft quality standard for antenatal and postnatal mental health was made available on the NICE website for a 4-week public consultation period between 29 May and 26 June 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 28 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

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

Stakeholders were also invited to respond to the following statement specific questions:

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

2. For draft quality statement 4: When should a comprehensive assessment take place?

3. For draft quality 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?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Risk factors for mental health problems should be addressed in the quality standard.
- Multiple pregnancies should feature as a risk factor in the quality standard, as they are potentially more complicated, and there is an association between complicated pregnancies and births and postnatal depression.
- The link between mental health and sudden infant death syndrome (SIDS) should be highlighted.
- Concern was expressed over limited resources to support implementation of the quality statements.

Consultation comments on data collection

- It was considered that data collection is achievable if each statement has a clear set of outcomes, e.g. number of prescriptions for valproate, level of knowledge following information-giving and wellbeing status post-delivery for women who have received a comprehensive assessment.
- Comments were received to suggest that it might be difficult to collect adequate data in relation to women receiving pre-conception advice because this information is not easily available.
- Concern was expressed about the time needed to collect the volume of data required, and the potential impact on the quality of care.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- There was support for this statement because of the potential risks to the unborn child.
- Stakeholders highlighted that in certain circumstances women might need to be prescribed valproate, e.g. if other medication is ineffective. It was suggested that measures can be put in place to ensure this is the best option for the woman and to minimise risk, e.g:
  - a second opinion is sought, preferably from a specialist affective disorders clinic or a perinatal psychiatry clinic
  - highly effective and safe contraception is realistic and being used, such as an oestrogen implant or depot progestin injections
  - the woman has been given sufficient information, including written material and has capacity to give informed consent
- “Child-bearing potential” was flagged as difficult to define, and concern was expressed about trying to apply it as a blanket term.

5.2 Draft 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.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders commented that pre-conception care should be proactive, and that appropriate pre-conception and contraception advice should become part of routine care for women of childbearing potential who have a mental health problem. It was highlighted that health inequalities could be further exacerbated if women need to request preconception advice.
- It was suggested that women with risk factors for mental health problems should be given information and advice on how to spot the early signs of mental health problems and when and where to seek help.
- It was highlighted that women may resent being considered to have had a mental health problem when they have experienced what they regard as a normal and understandable reaction to life events. It was suggested that it might not be reasonable or appropriate to apply the quality statement in such cases, especially if there is no other history or risk factor for mental health problems.
- It was suggested that women with severe mental health problems may benefit from discussions that empower them to make choices in the event that they need acute care.
- Stakeholders commented that accurate advice on medication whilst breastfeeding is needed. It was suggested that the quality statement detail should be revised to highlight that alternative medications may be an option.

5.3 Draft statement 3

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- One stakeholder considered that re-wording of the statement could make it clearer that it applies to all women, and at all contacts.
- Stakeholders suggested that there should be a clear definition of emotional and mental wellbeing, and clarification that this includes the first year after birth as well as pregnancy.
- Stakeholders highlighted that the grief of a woman whose baby has died should not be confused with depression and that the statement will not cover the needs of mothers experiencing loss of a child after routine appointments have ceased.
- One stakeholder suggested that use of the term “assessment” in both statement 4 and 5 could be confusing and queried whether different terminology should be used in each to differentiate.
- Stakeholders expressed concern that there is not always sufficient time for women to discuss concerns especially for women having consultant-led care or with a multiple pregnancy.
- It was highlighted that women have reported fear of disclosure due to concern that they will be referred to social services.
- It was noted that healthcare professionals have been critical of the Whooley questions as inadequate to pick up symptoms.
- Stakeholders expressed concern that the statement may imply that women should be routinely screened at each appointment for a mental health problem.
- Concerns were raised about the potential for the statement to become a tickbox-exercise, and the potential adverse consequence that women do not have the opportunity to ask any questions about anything else that they wish to.

5.4 Draft statement 4

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Various suggestions were given for the timing of the comprehensive assessment. It was generally considered to be dependent on the type and presentation of the mental health problem: ranging from 24 hours to a number of weeks.
- A suggestion was made that an assessment should be offered rather than compulsory, to avoid women feeling stigmatised.
- It was suggested that stillbirths, neonatal deaths or death of one or more babies during a multiple birth pregnancy should be included in the list of indicators for a suspected mental health problem.
- Stakeholders considered that in the postnatal period this should be extended to services that provide postnatal contraception care such as primary care and sexual and reproductive health services.
- It was suggested that parents who have lost a baby should be offered an assessment proactively and sensitively, and that healthcare professionals should be made aware how grief differs from depression.
- Stakeholders indicated that for women with PTSD from previous births, questioning or treatment can provoke flashback and stress.
- One stakeholder expressed the importance of appropriate cross-cultural training in cases where a comprehensive assessment is carried out with women from an ethnic minority.
- One stakeholder noted that women who have requested a caesarean based on informed choice may find a comprehensive assessment insulting and unnecessary. Concerns were also raised about potential for the quality statement to increase unnecessary referrals to mental health services for women requesting a caesarean section.

5.5 Draft statement 5

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- It was noted that some women will need to be seen sooner than 6 weeks.
- It was suggested that the target of 6 weeks from referral to treatment might require either new investment or re-prioritisation of services for some areas, meaning some other groups may have to wait longer.
- It was considered that the assessment of mother-infant attachment should be included in the quality statement.
- It was suggested that tokophobia (fear of childbirth) should be considered in the quality statement.
- A query was raised about which service / professional would lead on coordinating care.
- Concerns were raised that if psychotherapy approaches are not targeted to the specific needs of women with mental health problems they do not help and may do harm, e.g. there is a great need for specialist care for those with birth trauma and post-partum PTSD.
- Comments were made on the outcome measures, with a suggestion that they should include women's self-rated ability and confidence in coping, and data about children whose parent receives a psychological intervention.

5.6 Draft statement 6

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.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Overall, strong support was expressed for this quality statement, and it was considered that this should be part of practice.
- It was noted that this statement covers an area where significant investment in services will be required, due to disparity in the provision of services.
- Stakeholders highlighted a need for collaborative working between specialist mental health services and other services such as public health and the voluntary sector to implement the quality statement.
- It was suggested that women and their infants who require specialist services should have access to them in a timely way.
- Stakeholders considered that the need for provision of specialist mother and baby units is not made clear enough in the quality statement. It was suggested that the term “in-patient provision” should be amended to specify mother and baby units.
- One stakeholder considered that provision of specialist bereavement services for families following the death of a baby should be included because general bereavement services (e.g. non-specialist counselling) may not be appropriate for the needs of bereaved parents.
- Additional outcomes were suggested, including self-harm, poor infant bonding, poor mental health in offspring, ability to cope, well-being, and confidence in parenting.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Assessment of the well-being of the infant and the mother-infant relationship
- Continuity of carer, i.e. women seeing the same midwife or consultant throughout their care.
- Provision of a planned caesarean birth for women who request one because they have a fear of the unpredictability and/or overall experience of a vaginal birth.
- Support for women who have experienced the loss of their baby.
- Prescribing of selective serotonin re-uptake inhibitors (SSRIs) in pregnancy for women with mild to moderate mental health problems.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
003	The Twins and Multiple Birth Association	General	Complicated pregnancy and births are more likely to be at risk of PND it was interesting that multiple birth pregnancies tick both those boxes yet these types of pregnancies were not mentioned at all in this quality standard.
004	Faculty of Sexual and Reproductive Healthcare	General	The standard covered the pre-natal and antenatal periods of women with exiting or past history of mental health problems but it does not address women with risk factors for mental ill-health . Furthermore , it does not strengthen the role of specialist mental health services in preventing perinatal mental health problems and the role services could play in collaboration with other players in the system such as public health and the voluntary sector to strengthen the prevention agenda
010	The Lullaby Trust	General	Maternal mental health and Sudden Infant Death Syndrome (SIDS) are closely associated in a multifactorial way. Antenatal depression (Howard 2007) or any mental illness (King-Hele et al 2009) has been found to increase the chance of SIDS, and maternal alcohol or drug use is strongly associated (Webb 2010). Admission to hospital for any mental illness has been found to double the risk of SIDS (King-Hele et al 2007), and an elevated risk persists for as long as five years after inpatient care (Webb 2010). The reasons for this association can be seen to be the overrepresentation of SIDS risk factors in mothers with mental illness: smoking, social disadvantage, low birthweight and maternal age of less than 20 (Webb 2010). Nearly 300 babies die every year from SIDS, due to these largely modifiable risk factors. If mothers with mental illness receive support during the antenatal and postnatal period as set out in this draft quality standard, it is quite possible that the rates of SIDS in this group would decline. It is not only in prevention of SIDS that this quality standard would address: the emotional consequences of losing a baby suddenly and unexpectedly can be devastating and wide-ranging. Depression and anxiety have been found to be more prevalent in mothers who lost a baby to SIDS that any other type of infant death, for up to 30 months after the bereavement (Boyle 1996). SIDS can also lead to 'complicated grief' reactions in the long term, as well as the development of post-traumatic stress disorder (Turton 2001). Therefore it is key that mothers are able to access high-quality psychological care following a sudden and unexpected death.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
010	The Lullaby Trust	General	Knowledge of infant care, and in particular safer sleep practices, is key to reducing the risk of SIDS from modifiable risk factors. Depression is also thought to contribute to SIDS by making mothers less responsive to infant needs. Therefore if women with poor mental health are targeted to receive this information from service providers either in the antenatal or postnatal period, this could make an impact on infant mortality and prevent SIDS.
011	British Medical Association	General	We believe this is a sensible document in general, which explains the importance of good mental health provision in the antenatal and postnatal period.
011	British Medical Association	General	Overall, the six specific quality standards with regards to General Practice seem reasonable.
011	British Medical Association	General	Yes – We believe that this draft quality standard accurately reflects the appropriate areas for quality improvement.
012	The Royal College of General Practitioners	General	I welcome the Quality Standard
012	The Royal College of General Practitioners	General	Yes
016	Royal College of Obstetricians and Gynaecologists	General	Regarding Training & competencies (page 8), the Curriculum Committee of the RCOG is working with The Faculty of Perinatal Health at the Royal College of Psychiatrists. We are rewriting the Curriculum for all trainees and will in time rewrite the Curriculum for advanced training in antenatal care as related to perinatal mental health.
017	The Royal College of Midwives	General	RCM welcomes this quality standard which covers several of the key areas that need quality improvement.
024	Home-Start UK	General	Home-Start is pleased that NICE is consulting on this important topic. Mental health problems including postnatal depression are the main reason for referral to Home-Start's 288 schemes. Mental health problems can have a profound impact in the short and long term on a woman, her partner and her children. Through experience, Home-Start knows that mental health problems can affect a woman's confidence and ability to take care of her child/children.
004	Faculty of Sexual and Reproductive Healthcare	Implementation	See answers above Also staff in SRH services may need more training on antenatal and post natal mental health services
011	British Medical Association	Implementation	Regarding what could be done for each quality statement to support improvement and overcome barriers: Quality Statement 1: Reiterate advice regarding valproate; place warnings on electronic prescribing systems; work jointly with pharmacists to look out for potential prescriptions. Quality Statement 2: As this already happens, there should not be any barriers to it. Quality Statement 3: As this already happens, there should not be any barriers to it. Quality Statement 4: The term 'comprehensive assessment' is quite vague allowing the assessment to be done both in primary or secondary care, where appropriate, and thus avoids raising unnecessary barriers.

ID	Stakeholder	Statement number	Comments[1]
			Quality Statement 5: We believe this would be a major challenge to the psychology services, as in many areas 6 weeks is not even close to being met for access. For such areas, getting access to psychology within 6 weeks, would require either new investment or re-prioritisation of services, meaning some other groups may have to wait longer. Quality Statement 6: Similar to 5, in many areas this doesn't exist, and would require either new investment or reallocation to facilitate it. However, as a quality aspiration, we do not object to it.
013	The Royal College of Psychiatrists	Implementation	*Statement 1. Women of childbearing potential are not prescribed valproate to treat a mental health problem.* Given that Na Valproate continues to be prescribed to women of childbearing potential (as highlighted in several audits nationally) without due recording of consent/capacity/contraception etc, there need to be barriers to prescribing, such as requiring the completion of a proforma outlining the discussions with the patient, the need for such treatment, and that the problems associated with its use are communicated clearly and at a level that the patient understands. There will always be a small group of women for whom this drug is required, most likely on a temporary basis, and the use of reliable contraception needs to be planned for on these occasions. Continued education of professionals and in particular of prescribers is required. Primary care and pharmacists as well as psychiatrists needs to be at the forefront in this. *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.* Women need to be advised and reminded that they should seek pre-conception advice. Primary care needs to know when to refer women for pre-conception advice. In relation to the use of the words “given” and “provided with” there is concern that this will result in the majority of cases with women being given information leaflets. The advice given to women on the impact of their illness on pregnancy and childbirth and vice a versa is highly individualised and requires knowledge and skills on the part of the person giving the information about perinatal psychiatry. The statement should say – *discussed with* in addition to providing written information and that the person should have the requisite skills and knowledge to undertake this task. *Statement 3. Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact.* Continued education of midwives. Obstetricians to acknowledge and accept that they also require education in this

ID	Stakeholder	Statement number	Comments[1]
			area. *Statement 4. Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.* Provision of specialist services. *Statement 5. Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.* Care pathways developed across IAPtTand secondary psychological services to reflect this requirement. *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.* Commissioning is the single most important factor here.
015	Maternal OCD	Implementation	HCPs need to understand that normalising plays a huge part in the care of women specifically with perinatal OCD and the intrusive thoughts they experience – we all have intrusive thoughts and knowing that is helpful in the first instance.
017	The Royal College of Midwives	Implementation	Better mental health training for professionals (recognition and assessment) Partnership working across the professional groups – obstetricians, psychiatrists, psychologists, midwives, health visitors and other agencies. Additional resources to provide a better service, so it is not an add on. More time is necessary to provide the clinical and emotional support for these women. Safeguarding issues are often related to mental health, so time consuming in terms of ensuring a good care plan is in place. Local leadership – need for specialists or champions who can act as a resource. The existence of a specialist mental health midwife in each trust would support the appropriate care planning and delivery of a continuous pathway of care. For draft quality statement 4: A tool briefly summarising the assessment needs to be developed so that proportion of women where assessment has been done can be measured
021	electivecesarean.com	Implementation	Re: "*Question 3 For each quality statement what do you think could be done to support improvement and help*

ID	Stakeholder	Statement number	Comments[1]
			overcome barriers? *Questions about the individual quality statements*" Ironically, one of the barriers to maternal request women receiving the mental health support they need is their being forced into assessments and treatment that they do not want to attend.
012	The Royal College of General Practitioners	Implementation	Support improvement: training, not just a "tick box" response Overcome barriers: QS6 DH needs to make provision mandatory or it will never happen in a time of austerity. See recommendation in: Falling through the gaps: perinatal mental health and general practice 2015 http://www.rcgp.org.uk/clinical-and-research/clinical-news/~/media/Files/CIRC/Perinatal%20Mental%20Health/RCGP-Report%20-Falling-through-the-gaps-PMH-and-general-practice-March-2015.ashx "The Government should commission a taskforce to examine how to ensure that NICE guidance on perinatal mental health is implemented in full during the next Parliament"
005	Swansea University	Introduction	Health improvement indicators. Low birth weight is included, but premature birth and congenital anomalies should be added.
009	East and North Hertfordshire NHS trust	Introduction	Please add recent statistics for maternal mortality from EMBRRACE report which was launched in Dec 2014.
016	Royal College of Obstetricians and Gynaecologists	Introduction	Could reference to Maternal Deaths be updated to MBRRACE 2014 figures?
021	electivecesarean.com	Introduction	Comment re: "*recognition, assessment, care and treatment of mental health problems in women during pregnancy*" Since tokophobia is considered a 'mental health problem', this statement, in the absence of an important qualification by NICE regarding the maternal request recommendations of CG132, has the potential to have a significantly adverse effect on the mental health of many women (and indeed the health and wellbeing of their baby; see next comment). This is because there is a misconception among some professionals, and especially midwives, that women who request a caesarean 'must' have mental health support first, before the request can be agreed, when in fact only the 'offer' of support is recommended by NICE. Look at this correspondence in the BMJ in July 2013 for example:

ID	Stakeholder	Statement number	Comments[1]
			A group of six authors, including professors and midwifery lecturers, wrote a letter titled, "*NICE says caesarean section is not available on demand unless clinically indicated*" (http://www.bmj.com/content/347/bmj.f4649). And on the specific issue of mental health support for women with a fear of birth, Scamell et al wrote: "*The recommendation is that a caesarean section should be offered only if this fails*" [and] "*clinical guidelines hold that surgical interventions, such as caesarean section, are not available on demand unless clinically indicated.*" Both of these assertions are incorrect, as the CG132 recommendations cited above attest. A woman is at liberty to decline the offer of support, and more importantly, their use of the word "*fails*" (which certainly does not appear in the CG132 in this context) betrays a belief that only by changing a woman's birth plan to vaginal delivery would the referral 'support' be considered a success. Concerns were raised about the potential for this type of interpretation during the development of CG132, and in response, NICE specifically clarified that it "*was not the intention of the guideline development group to suggest women should be talked out of a CS… [but rather] strived to place women at the centre of decision-making*". But then incredibly, once CG132 was published in November 2011, *NICE's own newsroom* published a podcast interview with the CG132 GDG Chair, **consultant obstetrician and gynaecologist Malcolm Griffiths who said it was "***most important*" to attempt to identify "*women who have some particular reason for wanting a caesarean… as early as possible*" and "*put in place any support that's necessary that hopefully will allow the majority of these women to opt for a vaginal birth rather than pressing for a caesarean section.*" **And when asked why he thought** women might request a caesarean, Mr. Griffiths said, it's "*because they have misunderstood, they have been misinformed, for cultural reasons why they have latched onto vaginal birth being a bad thing… There are other women who have perhaps misconceived some of the risks, particularly where we are able to debunk myths then that may be where we can turn things around and allow women to make an informed choice to have a vaginal delivery… my understanding is that with appropriate support these women will generally be able to continue and have a normal labour and a vaginal delivery.*" Conversely, when talking about the CG132 recommendations to allow vaginal birth choice for women who have had multiple caesarean sections or are HIV positive, Mr. Griffiths described them as "*now going to be empowered to choose a vaginal birth over a repeat caesarean section.*" And while he did state, "*But ultimately if a woman has gone through those various processes and still has a strong, clearly expressed need for a caesarean section then we should not be denying her that choice*", this still contradicted NICE CG132, which makes it clear that only the *offer* of

ID	Stakeholder	Statement number	Comments[1]
			support is recommended. Women don't *have* to go through 'various processes' first. In August 2013, I made a formal complaint about this podcast but in October 2013, it resulted in just two words being removed from the podcast ("*debunk myths*"). Nothing else was changed because NICE told me (extract): "The purpose of the podcast was to support the communication of the following key messages from the guideline: *…ensure that women give birth in the way that is most appropriate for them and for their babies… help a woman to avoid having a caesarean section (CS) if it is not appropriate for her and her baby. Equally, it will help to ensure that a woman can have a CS if that is the most appropriate mode of delivery for her and her baby. The guideline does not recommend that all women should be offered the option of a CS.*" This is one of a number of examples where there can be contradictions within NICE publications, and since many mental health professionals may only read this Quality Standard and not CG132 or QS32 (on caesareans), it's really important that it clarifies the recommendations for women presenting with tokophobia or fear and anxiety about vaginal birth.
021	electivecesarean.com	Introduction	Comment re: "*The quality standard is expected to contribute to improvements in the following outcomes:* *- maternal wellbeing* *- neonatal health and wellbeing*" Importantly, women have expressed to my organisation that they do not feel they have a mental health disorder that needs 'fixing' or 'treating' at all. They simply want to schedule a caesarean (following discussion of their reasons, and understanding of the risks and benefits), and it is only the thought of *not* being able to plan ahead for a caesarean that is causing their anxiety. Anxiety can also arise from forced visits to psychologists and counsellors and not knowing whether their caesarean will be approved; one specialist even advised me that in her view, it's unnecessary for women to have confirmation of their request approval until around the 36th week of pregnancy…! But while it's true that as a woman's pregnancy progresses, there is always the possibility that she may change her mind about requesting a caesarean (this is not unheard of), there is also a very strong possibility that she won't – and if she is refused her much wanted caesarean early on this can be extremely traumatic. My organisation is aware of a number of cases where a tokophobic woman has terminated her much-wanted pregnancy when a caesarean was not agreed to early in the pregnancy (this is important given the statutory limits on abortion dates).

ID	Stakeholder	Statement number	Comments[1]
			This is relevant in the context of "*the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby*" (CG192 Full version pg. 208). And also: "*The optimisation of psychological wellbeing, as opposed to the management of mental health problems, is not covered in this guideline, however, the importance of this is implicit."* (CG192 Full version pg. 16) This is why it's so important for this guidance to reinforce the CG132 and QS32 recommendations, and to ensure that the most vulnerable women requesting a caesarean do not face a lengthy and distressing battle. Many tokophobic women simply cannot cope with this.
021	electivecesarean.com	Introduction	Re: "*Table 1 NHS Outcomes Framework 2015–16* *4 Ensuring that people have a positive experience of care*" If a woman requests a caesarean and provides legitimate reasons for making an informed choice, but is made to endure unwanted mental help therapies and/or ultimately refused her request, she will not have a positive experience of care.
023	Sands	Introduction	In the first sentence, posttraumatic stress disorder should be included in the list of mental health problems that may affect women in pregnancy or the postnatal period.
023	Sands	Introduction	In the section that discusses mental health problems going unrecognised in the postnatal period, it is important to highlight the barriers that some mothers face in receiving postnatal and follow up care after the death of their baby. The NPEU's *Listening to Parents* (2014) report found that only 56% of women whose baby was stillborn and 62% of women whose babies died in the neonatal received a postnatal check after the death of their baby.
024	Home-Start UK	Introduction	Home-Start would like to see an inclusion of parenting in the paragraph that speaks of the urgency of intervention due to the potential impact on the baby. While mental health problems may have an impact on a woman's ability to function and care for her family, this does not consider the much wider role of parenting all children in a family. Caring, and being a carer, is generally defined as a role a person has in caring for someone who needs extra support due to illness, disability or health problems. Parenting is inclusive of the various roles a parent has in their child's life, including responsibility for their physical, mental and emotional well-being.
004	Faculty of Sexual and Reproductive Healthcare	Measures	Yes this could easily be achieved if each standard has clear set of outcomes ; e.g a. monitor the levels of valproate prescriptions and maternal and child outcomes . b. Assess the level of mental health and wellbeing knowledge following advice giving or using a before and after evaluation model c. Link the results of antenatal and post natal assessment with to mental wellbeing status of women 3 and 6 and 9 months post delivery .
004	Faculty of Sexual and	Measures	See section Q2 C

ID	Stakeholder	Statement number	Comments[1]
	Reproductive Healthcare		This data would probably need to be collected prospectively as women as seen and referred on for assessment.
010	The Lullaby Trust	Measures	General - Yes, for most of the proposed measures.
011	British Medical Association	Measures	Even though the collection of data is always possible, the amount of data to be collected, particularly for the first 3 quality statements, could potentially affect the delivery of care.
012	The Royal College of General Practitioners	Measures	Probably, but see response to QS 2 because at the moment the information is not easily available and it needs commissioning.
013	The Royal College of Psychiatrists	Measures	It is certainly hoped that this would be feasible. However one would suspect that *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*….would be difficult to evaluate in relation to seeking pre-conception advice if there was not adequate recording of such a request. Also the underlying issue of *whether a woman knows she is entitled to and that it is appropriate for her to ask for this advice* needs to be ascertained to make the data collected of value.
017	The Royal College of Midwives	Measures	If the systems and structures were available it would be possible to collect the data for the proposed quality measures.
008	British Maternal and Fetal Medicine Society	1	Involvement of pharmacy in both primary and secondary care is vital to success in this area Suggest re-word, as there may be some women who will need to or chose to take Valproate – add' except in exceptional circumstances'; add 'unless using reliable contraception, ideally a long acting reversible option'
009	East and North Hertfordshire NHS trust	1	No comments
016	Royal College of Obstetricians and Gynaecologists	1	Question 1 – does this draft quality standard accurately reflect a key area for quality improvement? *Yes – this does reflect a key area 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 measure? *It should be possible to collect the data. I have some reservations about the term 'women of childbearing potential'. As it says in the section 'Equality and diversity considerations' (page 12 of 39) this should not be determined solely by age, other factors such as use of long term contraceptives (eg sterilization), previous hysterectomy, and same sex relationship, might mean that fertility is not an issue. These factors may impact on data collection.* Question 3 – for each quality statement what do you think could be done to support improvement and help overcome

ID	Stakeholder	Statement number	Comments[1]
			barriers? *Better education of healthcare professionals on the risks of valproate in pregnancy is required*
017	The Royal College of Midwives	1	This relates to a wider issue of medication for mental health issues and the confusion about what is safe experienced by women planning a pregnancy, women in early pregnancy, breastfeeding mothers and health care professionals. It would be useful to have a centralised pharmaceutical helpline that women and professionals could access to discuss individual conditions and alternatives. Even when women are advised to see their GP, their GPs are often no wiser. For women of childbearing potential who are not pregnant: Valproate should only be prescribed in exceptional cases (if there is no alternative effective antipsychotic or mood stabilizing therapy) to women of childbearing potential if a: a second opinion is sought, preferably from a specialist affective disorders clinic or a perinatal psychiatry clinic and b: if highly effective and safe contraception is realistic and being used, such as an oestrogen implant or depot progestin injections, and c: if the woman has been given sufficient information, including written material and informed consent. In all other routine cases valproate should not be prescribed to women of childbearing potential. This could be achieved by red alerts being set up at pharmacies and the presentation of a letter from the psychiatrist explaining in exceptional circumstances (as described above) why valproate is recommended and a reassurance that highly reliable contraception is in place For pregnant women: A warning to be included in the booking form, that if a pregnant woman presents at booking and is still taking valproate, that the midwife makes an emergency appointment with the psychiatrist or GP requesting to stop valproate or replace it with another drug.
018	Association for Improvements in the Maternity Services	1	We agree with the statement that women of childbearing potential should not be prescribed valproate.
018	Association for Improvements in the Maternity Services	1	Since, despite the known risks, it continues to be so prescribed, we suggest that pharmacists should be asked to query prescriptions if the patient seems to come in this category, adding another layer of safety., However, use of other anti-depressants prior to pregnancy is not without problems, as a number of women trying to reduce or stop dosage when they become pregnant report, nor are they completely safe.
018	Association for Improvements in the Maternity Services	1	We continue to receive complaints that both ante and post-natally, GPs reach for the prescription pad rather than suggesting or supporting women's requests for talking therapies (admittedly hampered by waiting lists and shortage of supply). *We therefore suggest that this advice should be extended to preference for talking therapies if appropriate for women of reproductive potential or breastfeeding*
022	National Childbirth Trust	1	NCT welcomes this quality statement and agrees that the standard accurately reflect the key areas for quality improvement.

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027	South West Yorkshire Partnership Foundation Trust	1	Women of childbearing potential are not prescribed valproate to treat a mental health problem. Not "normally" prescribed would be better. There are always exclusions and some people may be very well treated with valproate, who do not respond well to other drugs. If they are prescribed valproate, there should be documented evidence that the professional has discussed the teratogenic risks of this drug, ensured that the woman has got capacity to understand the risks and agreed to them. In a previous trust-wide medication review audit I performed, none of the women sampled of child-bearing age who were prescribed valproate had any discussion of teratogenesis discussed / documented.
004	Faculty of Sexual and Reproductive Healthcare	2	We suggest including women with risk factors of mental ill-health such as history of self harm, drugs and alcohol are to be given information and advice on how to spot the early signs of mental health problems , when and where to seek help. Child bearing "potential" is quite difficult to define and should be discussed with each woman on an individual basis. It is difficult to make "blanket rules" for this
005	Swansea University	2	Suggest define the medium for information. Will this be a leaflet? Will there be a free choice of language?
007	Surrey and Borders Foundation NHS Trust	2	• Welcome recognition of the fact that a mental health problem and it's treatment might affect the woman, the fetus and the baby • Pleased that there is recognition that this might also affect parenting. Would want to add that this is in relation to both the physical and psychological care of the baby.
008	British Maternal and Fetal Medicine Society	2	***"who are seeking pre- conception advice"*** Pre-conception care should be PROACTIVE rather than REACTIVE Women of childbearing potential who have a mental health problem should be given pre-conception care as part of ROUTINE care by healthcare professionals throughout their patient journey Women with mental health problems may not seek out pre-conception care [due to lack of awareness, language difficulties, lack of knowledge of where to ask etc.] Health inequalities would be further exacerbated if women need to "seek" pre-conception advice, rather than it becoming a part of standard mental health care for women of childbearing potential
008	British Maternal and Fetal Medicine Society	2	**"These issues should be discussed if the woman is planning a pregnancy or is pregnant."** Many pregnancies are not planned – so that all women get appropriate pre-conception advice it must become part of routine care given by all healthcare practitioners caring for women of childbearing age who have mental health problems

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			Contraception must be discussed as well – the fact that a woman is not planning a pregnancy does not mean she is actively taking steps to avoid conception.
009	East and North Hertfordshire NHS trust	2	This statement accurately reflects the areas of improvement. However time pressures and inadequate training could be a barrier for this. For pregnant women, this discussion (especially for women who are not on medication for mental health problem) should possibly happen at the booking visit. However, we are not sure if the midwives conducting the booking are adequately trained or have sufficient time for a detailed discussion. This could be partly overcome by enhancing training (for example incorporating training on mental health problems in pregnancy on mandatory training days for doctors and midwives) and developing local patient information leaflets. Part of his information could possibly be incorporated in perinatal institute notes. There is already a small paragraph in these notes, it could be expanded further. Pregnant women who are on medication are likely to be seen by obstetrician in antenatal clinic and/or psychiatrist. In our experience these discussions are already happening in specialist clinics. However discussions and documentation in routine obstetrics antenatal clinics may not be as detailed as set out in NICE guidance. This could possibly be overcome by allocating more time for these women in clinics and enhancing training for all obstetricians. Also, we have to consider whether or not to exclude women who required one-off treatment or psychological therapy following a significant life event; e.g. loss of a child in the past. We are not sure if it is entirely reasonable/ appropriate to have detailed discussion with these women about of “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” especially if there is no other history or risk factor for mental health problems.
010	The Lullaby Trust	2	Knowledge of SIDS risk factors and prevention measures amongst practitioners is important to supporting improvement in this standard. It is generally high amongst health visitors and midwives but other service providers in primary care and mental health services would benefit from knowing about the link between mental illness and SIDS, and how to prevent it or at least who they can refer women to for this information.
012	The Royal College of General Practitioners	2	I think it would be really helpful for NICE to commission written guidance to fulfil this QS, with translation into languages as necessary. I do not think this information currently exists in an accessible form and suitable for women and professionals. This might be commissioned from UKTIS (http://www.uktis.org/), as they hold the majority of the information, but maybe it needs to be written according to the points raised in CG192 and maybe it needs to be a decision support tool for women. This is such an important area that some body needs to take responsibility for making sure it is accurate, evidence-based, flexible so it can be tailored to a specific woman’s need or the quality could be questionable and inaccurate.
015	Maternal OCD	2	The section 'What does this mean for Healthcare Professionals' - there is a pre-supposition that all HCP will know all about the varied perinatal mental health problems there are and the reality is that isn't the case. There needs to be some training to underpin their knowledge of all perinatal mental health problems including perinatal OCD. Also there

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			may need to be more clarification regarding the history of mental health problems as different professionals may have a different understanding of what this means.
016	Royal College of Obstetricians and Gynaecologists	2	Question 1 – does this draft quality standard accurately reflect a key area for quality improvement? *Yes – this does reflect a key area for quality improvement. It is a key priority for implementation in the NICE guideline.* Question 2 – if the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measure? *It should be possible to collect the data* Question 3 – for each quality statement what do you think could be done to support improvement and help overcome barriers? *This could be incorporated in to the routine care for all pregnant women* Page 14 - Why is the cut off age 45? For example, what happens if you're 46?
017	The Royal College of Midwives	2	All members of the primary care team need to be aware of the importance of this discussion. This is particularly relevant for GPs who should know of existing mental health problems before the woman encounters the maternity services All women with severe or enduring or complex moderate mental illness should be seen by a specialist in perinatal mental health. In areas where there is no such service or an insufficient service this needs to be established. Women with mild to moderate mental health problems should receive this service by specialist mental health midwives or their GP. Since there are hardly any maternity services in the country that would be able to cope with case numbers, more midwives need to be trained in mental health according to local need.
018	Association for Improvements in the Maternity Services	2	Women with prior or existing mental health problem seeking preconception advice or are pregnant should be given information about how it may affect them or their baby. Please note that a number of women with long term mental conditions are not always in a condition to control use of their bodies by others, and that support and empowerment in their care rather than the disempowerment so many report, may better protect them against unwanted pregnancies.
018	Association for Improvements in the Maternity Services	2	Already we have received a number of complaints about inappropriate and damaging enquiries and attitudes to "prior mental problems", as a result of concerns about reducing suicides. As many have pointed out, there has been too little understanding and differentiation here. A past "mental health" problem may have been caused by break up of a relationship, or one or more bereavements close together. Often this past grief has been inappropriately dealt with anyway. Women bitterly resent being labelled as potentially "mentally ill" and potentially unsafe mothers when they have been through what they regard as a normal and understandable reaction to life events.
018	Association for	2	Bipolar disorder, with the substantial risk of recurrence, is entirely different. However, much depends on the

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	Improvements in the Maternity Services		approach. Once again, women report feeling that they are seen primarily as "risks". We would recommend that *if such discussions are approached from the point of view of empowering the woman, and enabling her to make choices in the event that she may need acute care,* her reaction would be different. For example, she may choose to enquire about the availability of a place in a mother-and-baby psychiatric unit if she were to need it, and try to get an out of area referral planned if there is no local unit. She might also decide which relatives could care for the baby and/or other children is she and the father are unable to do so temporarily.
018	Association for Improvements in the Maternity Services	2	The same applies to those with other long term conditions like schizophrenia.
018	Association for Improvements in the Maternity Services	2	We would remind NICE that the first two reports of Confidential Enquiries into Maternal Deaths which covered psychiatric deaths, found that in a number of cases of suicide, a surprisingly large number of the women were health care professionals who had concealed serious mental illness. If they, and their families, felt it necessary to conceal serious mental illness, we may well ask why.
018	Association for Improvements in the Maternity Services	2	Accurate advice on medication whilst breastfeeding is needed. We have received numerous complaints about vague, conflicting and inaccurate advice from professionals who are not well-informed, and sadly there is a shortage of breastfeeding counsellors within the NHS. *We suggest direct access to a telephone advice service on pregnancy/breastfeeding medication (including herbal preparations) with expert advisers.*
018	Association for Improvements in the Maternity Services	2	Ticking boxes to show what percentage of women have been advised tells us nothing about whether more harm than good has been done. At a time when confidential health care for pregnant women and mothers no longer exists, only those support groups who promise confidentiality are hearing many parents' stories.
019	LCGB	2	This quality standard discusses providing pregnant woman or women planning a pregnancy with information about their condition and the treatment. Specifically it states 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" This specific phrase is repeated several times throughout the discussion of this standard. Each of them should be revised to reflect the fact that a more compatible drug may be an option. The vast majority of medications are considered to be compatible with breastfeeding *(Breastfeeding and Maternal Medication: Recommendations for Drugs in the Eleventh WHO Model List of Essential Drugs from the Department of Child and Adolescent Health and Development, World Health Organization, 2002)* Whilst I (on behalf of LCGB) do not disagree with this statement, could the reviewing panel consider altering the wording to reflect the fact that many medications used in mental health conditions have a safer alternative in breastfeeding. The LACTMED database is an excellent source of up to date pharmacological information on safer alternatives in breastfeeding. *http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm*

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			It is also important to note that many medications are considered safe for continued use throughout breastfeeding, and this is very reassuring and encouraging for women. It is important that there are no perceived barriers to initiating breastfeeding, as successful breastfeeding is associated with improved maternal mental health outcomes *(Oddy WH, Kendall GE, Li J et al (2009) The Long-Term Effects of Breastfeeding on Child and Adolescent Mental Health: A Pregnancy Cohort Study Followed for 14 Years. Jpeds. Vol 156, Issue 4, 568-574)*
019	LCGB	2	There are a number of bullet points detailing the areas which healthcare professionals should consider when counselling women about their mental health condition. Breastfeeding intention should be a discussion point as a more compatible medication may be prescribed. The risks to the infant being exposed to a negligible amount of medication should be weighed against the risks to the infant of not being breastfed. The pharmacokinetics and pharmacodynamics of the drug can be evaluated to assess the degree of drug transfer into human milk. The amount of drug excreted into milk depends on a number of kinetic factors: 1) the lipid solubility of the drug, 2) the molecular size of the drug, 3) the blood level attained in the maternal circulation, 4) protein binding in the maternal circulation, 5) oral bioavailability in the infant, and the mother, and 6) the half-life in the maternal and infant's plasma compartments. - See more at: *http://www.infantrisk.com/content/drug-entry-human-milk#sthash.ud9rfRBw.dpuf (Thomas Hale)* *Hale T, Rowe H (2014) Medications & Mothers' Milk. Hale Publishing*
		2	NCT welcomes this quality standard. However there is a challenge in measuring the quality of information women receive. Several pieces of research have now indicated that maternity staff, health visitors and GP's can feel ill equipped to offer women support and information about perinatal mental illness. There is a risk that this quality standard will measure whether or not women received information, but not whether it was accurate or sufficient to guide their decision making. We recommend that the quality standard should further qualify that the type of information should be evidence-based and up-to-date to reflect the often complex nature of the information surrounding treatment and the evidence base is constantly evolving. In order to help overcome barriers to healthcare professionals providing evidence based information on perinatal mental illness there is a need for national training programmes (such as the Perinatal mental health champions

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			training) to be more widely implemented to all maternity staff and general practitioners to improve knowledge, skills and awareness of perinatal mental health issues.
022	National Childbirth Trust	2	NCT would encourage a focus on women-centred and individualised care be added to quality statement 2, to recognise that decision making regarding the risks and benefits of treatment during pregnancy and during the postnatal period are often highly individualised and women will require tailored support.
024	Home-Start UK	2	Home-Start would like this section to be expanded to ensure that women are informed of how a mental health problem might affect them, their baby and other children in the family. A mental health problem can have a long-term impact on a woman's confidence and ability to parent and this will influence all children in a family.
027	South West Yorkshire Partnership Foundation Trust	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. Practitioners need to have a baseline of knowledge with the ability to ask for expert advice. All prescribers (including primary and secondary care) should be able to access specialist medical / pharmaceutical advice. There should be clear pathways in place when specialist mother and baby unit advice is required, including during pregnancy. Therefore all trusts need to have ongoing perinatal awareness training for qualified staff, we are aiming to do this on a 3-yearly rolling programme in our area. This won't happen nationally unless mandated.
028	NHS England (Central Midlands)	2	I am concerned about the use of the words "given" and "provided with". I think this will result in the majority of cases with women being given information leaflets. The advice given to women on the impact of their illness on pregnancy and childbirth and vice a versa is highly individualised and requires knowledge and skills on the part of the person giving the information about perinatal psychiatry. I think that this statement should say – discussed with in addition to providing written information and that the person should have the requisite skills and knowledge to undertake this task. Measure – Case record audit
003	The Twins and Multiple Birth Association	3	Routine Assessment of Emotional Wellbeing. Women should be actively asked about their emotional wellbeing at each routine contact to support them to discuss their concerns. Many of our mums have consultant led care only and may not either a) feel that they can address their concerns with the consultant or b) may not have time in the appointment to discuss them especially as one of the listed 'routine contacts' is the 20 week anomaly scan which many women already say is compromised as they do not get a double slot for careful assessment of both babies but get crammed into the same time slot as a single pregnancy. The NICE GUIDELINE 129 states all units to have a named specialist midwife for multiples yet research shows that there is suboptimal adoption (only 18% across the country). If all units had a named specialist midwife for multiples then the risk of PND in multiple birth mums might be

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			reduced. • Also of note in the supporting briefing paper on page 16 is comment that an NCT survey showed that 22% of mums put on a brave face & did not tell the truth about how they were feeling in their post-natal 6 week check. Again multiple birth mums may more at risk if the multiple birth angle is not highlighted in this quality standard as many multiple birth mums struggle with the huge challenges of more than one baby and often have limited physical & emotional support.
004	Faculty of Sexual and Reproductive Healthcare	3	There is a need for developing a clear definition of emotional and mental wellbeing
005	Swansea University	3	A definition of poverty (or a reference for this) would be useful.
007	Surrey and Borders Foundation NHS Trust	3	If the use of GAD 2, GAD 7. PHQ 9 or EPDS is discretionary this should be clear. The recommendations a re confusing and there is a danger that women and clinicians get overloaded with paper tasks.
008	British Maternal and Fetal Medicine Society	3	Reword statement to emphasise that is applies to all women [not just those with mental health problems] and at all contacts [emergency or unscheduled contacts may be a symptom of, or provoke deterioration in mental health]. This will help to ensure that enquiring about mental health issues becomes an automatic and routine part of all care. 'ALL women have their emotional wellbeing assessed at EVERY antenatal and postnatal contact'
009	East and North Hertfordshire NHS trust	3	This statement reflects an area of improvement. However, limited time allocated to healthcare professionals for reviewing women can potentially act as a barrier and it may not be feasible to ask all these questions at every appointment.
010	The Lullaby Trust	3	Asking about emotional wellbeing in routine antenatal appointments will be especially important for women who have previously lost a baby, as they are likely to have strong feelings of anxiety. This may also provide an opportunity to trigger referral to the Care of the Next Infant programme, which provides much-needed support during pregnancy and in the postnatal period through intensive health visiting.
010	The Lullaby Trust	3	However, if postnatal visits are not required to continue beyond six weeks there is somewhat of a gap through which mothers whose babies die after this time may slip. SIDS is most likely to occur between 2–4 months, so they would miss out on routine enquiries about their emotional wellbeing, despite still being classed as 'postnatal' in the standard. To counter this it is key to have efficient inter-agency working, to allow mothers to access mental health services through channels other than postnatal contact.
010	The Lullaby Trust	3	We welcome the special consideration that women living in poverty and/or are under 20 would receive due to their more complex social needs, as both of these are risk factors for SIDS.
010	The Lullaby Trust	3	Within the established protocol and procedures, it will be important for service providers to receive guidance on *how*

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			to ask about general wellbeing as much as the asking itself, to support non-judgemental and open communication.
012	The Royal College of General Practitioners	3	Under definitions, assessment of emotional wellbeing: needs to include and in the first year after birth as well as pregnancy
012	The Royal College of General Practitioners	3	The provision of a routine postnatal check about 6 weeks is not specified in the current GP contract. I think this is an error in the drafting and I have brought it to the attention of the DH, and I think it is to be considered in the Maternity Review. http://www.england.nhs.uk/wp-content/uploads/2014/05/gms-contract-04-14.pdf **P 35** **"Maternity medical services** 9.7.1. The Contractor shall- (a) provide to female patients who have been diagnosed as pregnant all necessary *maternity medical services* throughout the antenatal period; (b) provide to female patients and their babies all necessary *maternity medical services* throughout the postnatal period other than neonatal checks; (c) provide all necessary *maternity medical services* to female patients whose pregnancy has terminated as a result of miscarriage or abortion or, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services, who does not have such conscientious objections. 9.7.2. In clause 9.7.1 - "antenatal period" means the period from the start of the pregnancy to the onset of labour, "maternity medical services" means- (i) in relation to female patients (other than babies) all primary medical services relating to pregnancy, excluding intra partum care, and (ii) in relation to babies, any primary medical services necessary in their first 14 days of life, and "postnatal period" means the period starting from the conclusion of delivery of the baby or the patient's discharge from secondary care services, whichever is the later, and ending on the fourteenth day after the birth".
016	Royal College of Obstetricians and Gynaecologists	3	Question 1 – does this draft quality standard accurately reflect a key area for quality improvement? *Yes – this does reflect a key area for quality improvement. It is a key priority for implementation in the NICE guideline.* Question 2 – if the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measure? *It should be possible to collect the data*

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			Question 3 – for each quality statement what do you think could be done to support improvement and help overcome barriers? *This could be incorporated in to the routine care for all pregnant women*
017	The Royal College of Midwives	3	This statement would be better implemented if there was a standard somewhere else about continuity of carer, if midwives had more time for caring and if there was more time for education and training. This could be achieved if there was adequate time for 1. Midwives continuing to ask the NICE screening questions in those women who have not previously been identified as having a mental health problem before delivery, and midwives, GPs or health visitors after delivery 2. In those who have been already identified to have a severe or enduring moderate mental health problem, that the involved midwife ensures that she is still in contact with the specialist service 3. In those who have an identified mild – moderate mental health problem, that the midwife organizes and checks that the woman is receiving appropriate support at primary care level.
018	Association for Improvements in the Maternity Services	3	Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact *We strongly object to the inclusion of this statement.* We think it will be counter-productive, and may well discourage those women who may be most in need of help It will lead to yet another box-ticking exercise where professionals will record that women were asked about their mental state, but the women themselves may be unaware of it. (This amounts to screening without consent). If they are aware of it, many will continue to conceal mental health problems for well known reasons (fear of having their baby removed by social services) Midwives will continue to "cover their backs" by referring women to social services – not for the woman's benefit, but to avoid risk to the child. (a process for which no evidence of benefit exists). Women's response to probing of this kind will depend on two things (a) trust in the person who is asking (b) the institution which employs them, and (c) confidence that beneficial, rather than harmful, actions will follow. We suggest that at present the conditions for success do not exist. Mention of mental illness carries a high risk of being referred to social workers In assessing pregnant women (and expectant fathers) SWs will routinely search for other "risk factors"(to the baby, not the woman) and women who are depressed, or have PTSD, are statistically more likely to come from deprived backgrounds, and the risk factors SWs seek are invariably associated with poverty and deprivation. We have seen so many cases of mental illness being exacerbated, and serious suicide attempts following such referrals, that we can well understand why women lie. In addition, we now have a substantial collection of cases where social services referral has been used solely as a punitive and controlling measure by health care professionals when women exercised their right to refuse intervention or to birth at home. We would point out that in the last Confidential Enquiry into Maternal Deaths which covered psychiatric illness, a

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			highlighted learning point was that "referral to safeguarding teams should not be routine" and that "referral to social services may otherwise result in avoidance of care and necessary treatment and may increase the risk of deterioration in the mother's mental health and suicide." *(2011. Saving Mothers' Lives. Reviewing maternal deaths to make motherhood safer 2006-8. BJOG Vol 118 Supplement 1. page 138)* This "screening" does not reach a standard or use diagnostic tools acceptable to the UK National Screening Committee *(UK National Screening Committee Policy Review Postnatal Depression Screening Position Statement 17 November 2011)* certainly will not result in women having the feeling that they are cared for, or cared about, and will detract even more from the time available in the consultation for the woman to raise issues which are top of *her* priorities,.(commonly mentioned in our complaints calls) Already the first antenatal visit is so crowded with essential information-gathering that women complain their questions are never even voiced. In the recent Tommy's NetMums survey *(2013 Tommy's Netmums Royal College of Midwives Boots Family Trust Perinatal Mental Health Experiences of Women and Health Professionals)* http://www.tommys.org/file/Perinatal_Mental_Health_2013.pdf healthcare professionals said that lack of time in appointments and lack of continuity meant that they were unable to build up a relationship where women would open up. Fewer than half the community midwives saw the same woman throughout her care. They were also critical of the Whooley questions as inadequate to pick up symptoms. This survey also found that 34% of women gave as their reason for concealment as fear of the baby being taken by social services. The report says that this "myth" must be dispelled. But it is not a myth; we have cases where the mother's mental health has been the primary reason for removal and setting out on the path to adoption.when there are no other adequate grounds. At a time when it is still government policy to increase adoptions, and babies are the most desired adoptees, the social and political context of such enquiries cannot be ignored. In our case work, we are continually pointing out to local authorities, that their social workers are ignorant of NICE guidelines, and that their post-graduate education INFORM booklet on antenatal care (written by a social worker) was regarded as risible by three professors of midwifery whom we asked to read it. It has created a "crime" which they call antenatal neglect, and expectant mothers can already be found guilty before the birth. We know that referral to social workers hugely increases stress in mothers, with proven adverse long term effects on the child. Whilst this happens, screening (even if it were effective) is likely to do more harm than good.
021	electivecesarean.com	3	Re: "*Quality statement 3: Routine assessment of emotional wellbeing* *Quality statement* *Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact.*" My organisation agrees that routinely assessing a woman's emotional wellbeing is an excellent goal, but the outcome

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			of this statement appears to measure simply '*was the woman asked?*' It's possible that that perhaps the statement could have more value as a measure of patient care or quality standard if a response from the woman was collected at the same time – to indicate whether or not she felt listened to and/or helped. Perhaps the more important measure is whether there was any benefit or positive outcome of the woman being asked? For example, in one RCM Maternal Mental Health survey response (January 2014), a mother responded: "*I was asked how I was... but it was a tick box exercise only*" https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Mental%20Health%20-%20Final.pdf
022	National Childbirth Trust	3	A audit conducted by the Royal College of Midwifes (2010) found that although a high proportion of midwifes enquired about mental illness during booking, only half use the two screening questions recommended in NICE guidance in 2007. The report concluded that midwifes were often reluctant to explore issues around domestic violence and mental health and found these difficult subjects to discuss with women. We recommend that this quality standard is updated or an additional quality statement is included to assess whether the recommended screening questions are being used as part of this routine assessment – to ensure optimal identification of antenatal and postnatal mental illness is.
023	Sands	3	A note should be added that the grief of a woman whose baby has died should not be confused with depression and that this should be considered when asking bereaved women depression identification questions.
024	Home-Start UK	3	Home-Start would like to see training on perinatal mental health for every health care professional involved in a woman's care, both during pregnancy and during her child's first year, and perinatal mental health teams available to support women and their families living in every area. Specialist mental health midwives would assist healthcare professionals in accurately assessing emotional wellbeing at antenatal and postnatal appointments and be appropriately positioned to ensure that women receive a more comprehensive assessment, appropriate support and treatment.
026	UK national screening committee	3	The UKNSC would like to highlight that quality statement 3 could be mistakenly appear to conflict with the recommendation made by the UKNSC on screening for post-natal depression. It is clear that the statement is based on the recommendation in clinical guideline 192 – which lists 4 questions which could be considered during routine clinical assessment. The wording of the standard implies that these questions now must be part of routine care, which is somewhat different from direction of the source recommendation. We believe that the recommendation in clinical guideline 192 is correct and at risk women should be identified in this manner. However, the quality standard should also acknowledge that this is not a screening programme, nor a

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			recommendation to screen. The UKNSC screening review found that there is no adequately accurate test for depression in pregnancy and the post-test management options offer limited effective benefit – therefore a formal screening strategy is not appropriate.
027	South West Yorkshire Partnership Foundation Trust	3	Women have their emotional wellbeing assessed at each routine antenatal and postnatal contact. Agree, but forms have to be nationally standardised and have the sensitivity to pick up severe mental health disorders
012	The Royal College of General Practitioners	3 & 4	The use of the term "assessment" in both could be confusing. Should the terminology be different in each one to clarify this?
022	National Childbirth Trust	3 & 4	As with quality statement 2 one of the main barriers to implementation of these quality standards is lack of knowledge, skills and awareness of perinatal mental illness, and confidence to discuss such issues with women, among maternity staff, health visitors and GP's. To overcome this barrier national perinatal mental health awareness programmes delivered to healthcare professionals are needed.
003	The Twins and Multiple Birth Association	4	Women with suspected mental health problem in pregnancy or the post-natal period receive a comprehensive assessment. In the briefing paper on page 28-30/90 they mention still births and neonatal deaths but they do not then mention it in the quality standard 4 page 24/39. See the bottom paragraph on page 24 of quality standard. It says 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. • It is the opinion of Tamba that it should go on to say still birth, neonatal death or death of one or more babies during a multiple birth pregnancy. • We know from our Bereavement Support Group that many women who lose either one or more babies find it hard to access bereavement support and this can lead to mental health problems such as PND and general anxiety disorder. Also on page 24 they provide a comprehensive list of consideration for this assessment including 'the women's experience of pregnancy and any problems experienced by her, the fetus or baby'. • Multiple birth pregnancy be listed as a consideration as it is high risk, more likely to have complications and the incidence of PND is higher post multiple births.
003	The Twins and Multiple Birth Association	4	A question that they ask on page 25 in Questions for Consultation - 'When should a comprehensive assessment take place?' It is our opinion at Tamba that every multiple birth mum have a comprehensive assessment as they are high risk pregnancies and have a higher incidence of PND
004	Faculty of Sexual and Reproductive	4	There is a need to extend the role of undertaking comprehensive assessment in the postnatal period to services that provide post natal contraception care such as primary care and Sexual and Reproductive Health services

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	Healthcare		
004	Faculty of Sexual and Reproductive Healthcare	4	See section Q2 C the suggested timeframe is a pragmatic choice based on the likelihood of developing different mental health diseases post delivery Comprehensive assessment should take place asap but could be guided by the presentation, eg those mild symptoms would not need such urgent assessment as those with suicidal ideation
008	British Maternal and Fetal Medicine Society	4	A timescale should be included. Acute problem – within 24 hours Urgent problem – within 1 week Routine assessment – within 4 weeks A guide regarding who should do the comprehensive assessment should be included
009	East and North Hertfordshire NHS trust	4	No comments
010	The Lullaby Trust	4	The draft standard is helpful by specifying that women who have “recently experienced a trauma” can be seen as having a suspected mental health problem which warrants a comprehensive assessment on their emotional wellbeing. Losing a baby suddenly and unexpectedly is undoubtedly traumatic, and it would be helpful for some parents to be offered an assessment proactively. This is not to pathologise grief however: it is widely accepted that feelings such as depression and anxiety are a normal response to loss. Instead, receiving a sensitive contact from a mental health professional after an appropriate interval could help to intervene before more long-term and damaging mental health issues develop, and would help them to access specialist counselling if required.
010	The Lullaby Trust	4	Due to the fact that women are more likely to lose a baby to SIDS after being discharged from postnatal care, it may be difficult to truly ascertain the number of women who have a suspected mental health problem (which would include a recent trauma) and are in need of an assessment.
010	The Lullaby Trust	4	It is important that the emotional wellbeing assessment should be offered rather than compulsory, to avoid women feeling stigmatised. As mentioned above feelings of depression and anxiety are a normal part of grief, and women should not feel that this means they have a mental illness or that they need treatment. Instead it should be offered as a way in for mothers to access psychological services, when there may be other barriers in place to stop them, such as social circumstances.
010	The Lullaby Trust	4	For bereaved mothers referred for assessment, the length of time between bereavement and the assessment should be down to individual circumstance. It should not take place too soon as the mother would be grieving, but it should take place before long-term mental health issues may take root. In an ideal world, it would be helpful to have a protocol in place that triggers a contact from mental health services not long after the bereavement to let them know that an assessment and/or counselling is possible, and followed up some months later.

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011	British Medical Association	4	Rather than having to assess a patient using a specific template which may get in the way of the consultation, we believe a retrospective audit of notes to assess the standard of assessment would be more appropriate
011	British Medical Association	4	We believe a comprehensive assessment should take place whenever someone has a suspected mental health problem during pregnancy. We believe that stating particular weeks would not be appropriate, as these problems may arise at different stages in different patients.
012	The Royal College of General Practitioners	4	When the initial assessment (see comment above) demonstrates a problem and it should happen as soon as possible afterwards by an appropriately trained person. This may not be on just one occasion.
013	The Royal College of Psychiatrists	4	As soon as the problem is identified the woman should be referred to both her GP and a local specialist team. For pregnant women, assessment needs to take place in the first trimester or as soon after detection as possible, in order to allow for a timely management and care plan to be developed that meets the need of the woman and her infant. Primary care needs to carry out an assessment as soon after referral as possible. Secondary services may have to work around resources and other targets. Women with SMI need to be assessed as soon as possible, however.
016	Royal College of Obstetricians and Gynaecologists	4	Question 1 – does this draft quality standard accurately reflect a key area for quality improvement? *Yes – this does reflect a key area 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 measure? *It should be possible to collect the data. It would have to be documented that every woman in pregnancy or the postnatal period is assessed to determine whether she has a suspected mental health problem.* Question 3 – for each quality statement what do you think could be done to support improvement and help overcome barriers? *Incorporate monitoring for mental health problems at every maternity contact.* Question 4 - how would this quality statement be measured in practice? *Local data collection showing that all pregnant women are monitored at each antenatal and postnatal contact for mental health issues – those who 'screen positive' should receive the comprehensive assessment.* Question 5 – when should a comprehensive assessment take place? *Some women may be well during pregnancy and only develop the mental health problem postnatally. Women would therefore need to assessed both in pregnancy and in the postnatal period.*
017	The Royal College of Midwives	4	A comprehensive assessment needs to take place within 2 weeks during pregnancy and within a week postnatally depending on the severity of the problem. Having to care for a baby and family will put additional stress on the mother with mental health issues and therefore an assessment needs to be very timely. Pregnant and postnatal women with a severe, or a complex/enduring moderate mental health problem should be

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			assessed at secondary mental health service level, preferably a specialist perinatal mental health service. This should also include women with a past history of these disorders. This is because experience shows that women who are currently well but have a high risk of recurrence will not be seen by a general psychiatry service. Pregnant women with other moderate and mild conditions should be screened by community midwives using the NICE screening questions and a screening tool (to be developed) to measure functioning. Positive cases should be referred by community midwives for specialist midwifery assessment. After childbirth, screening questions and a measurement of functioning in the community should be repeated by community midwives and health visitors
018	Association for Improvements in the Maternity Services	4	Women with a mental health problem receive a comprehensive assessment We would like this amended to "are offered" a comprehensive assessment, and that this is an assessment from someone with adequate training – preferably a perinatal psychiatrist. Where the women is from an ethnic minority, this should be someone with appropriate cross-cultural training. Many women now see the construction of mental health records on them as further instruments of surveillance and control (especially as they may be widely disseminated) – because that is the way in which they have been used on many in the past. Only when these are genuinely linked to networks of support (of a kind which the women find supportive) will this change. We would also mention that for women with PTSD from previous births, questioning or treatment at this time is highly stressful as it provokes flashbacks and stress to the woman and the foetus. Their primary need at this stage is usually is assurance they will get the kind of birth care they want, and treatment to follow. A good birth in such cases is often therapeutic.
021	electivecesarean.com	4	Re: "*Statement 4. Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.*" Again, this is problematic in the context of all of the above. Maternal request caesareans where the mother mentions fear of vaginal birth and preference for surgery can be considered 'abnormal' and 'unhealthy'. Jenni Murray, presenter of BBC Radio 4's Woman's Hour reacted to CG132 recommendations with an article titled "*The madness of Caesareans on demand*" and called it "*a potentially terminal blow to those of us who have campaigned for years for women to be given the proper support to give birth to our children as nature intended.*" The current situation is very similar to that of the history of mental health and abortion. The 1938 Dr Alec Bourne case set a legal precedent for performing an abortion to preserve a woman's mental health, and so between the Bourne ruling and the 1967 Abortion Act some women were able to arrange abortions with the consent of a psychiatrist, to protect their mental health. *Wealthier women* (and this is important to note in terms of equality and more vulnerable women covered by this Quality Standard) were more likely to be able to pay to see a psychiatrist who could agree to

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			a safe abortion, whereas women from lower socio economic groups would have had no option but to seek illegal (and more dangerous) methods for ending a pregnancy – or to have no abortion choice at all. Ironically, given the controversy that surrounds the subject of abortion, in 2015 it is still easier for a woman to plan a pregnancy termination that it is for her to schedule a prophylactic planned caesarean delivery. *Statement 4* is also problematic in the context of maternal request for a caesarean because midwives are usually the first point of contact in a woman's antenatal care, and they can refer woman for consultant care/communication – or suggest mental health support. Where there is an ingrained belief (by some, not all) that in order for a woman to 'request surgery' she must therefore have a 'mental health problem', this can mean that more women are referred for mental health support than need it, and that many find the 'comprehensive assessment' insulting and unnecessary. A negative attitude towards women who request caesareans is very unhelpful; and only continued (and consistently) evidence-based NICE guidance and quality standards can help ensure that these women receive equal and appropriate care during pregnancy – in order to avoid causing or worsening their anxiety about whether their birth plan choice will be respected. Disparaging remarks and attitudes are rife, and the World Health Organization doesn't help with its ideological statements on maternal request caesareans and caesarean rates, for which it openly admits it has no empirical evidence to support. An RCM comment in response to the CG132 draft guideline read: This "*seems to be simply encouraging CS. Many of our members have commented on this as very unhelpful in their quest to reduce CS rate".* It then said on its website in November 2011, "*in cases where women ask for a caesarean section for 'purely social convenience' the RCM does not think the procedure is appropriate*" (though in the past decade of correspondence with women, my organisation has yet to come across a woman for whom this was the reason behind her request); and Jenni Murray, again: "*it seems the 'too posh to push' brigade has won itself something of a triumph*". Without reinforcing CG132 in the context of Section 1.2.9 recommendations, this Quality Standard could be used to defend the practice of highly inappropriate mental health 'care' for women requesting a caesarean.
021	electivecesarean.com	4	Re: "*Question 5 For draft quality statement 4: When should a comprehensive assessment take place?*" "*Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.*" For women with severe tokophobia requesting a caesarean, waiting up to six weeks for a referral can be too long, as cited above with cases of abortion when a caesarean could not be scheduled. My organisation would just like to

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			emphasise again how it would be far better for the mental health of women requesting a caesarean if CG132 and QS32 recommendations were appropriately followed first, and women given the further option of mental health support for trying to change their birth plan – *IF* that is something they would like to do.
021	electivecesarean.com	4	Re: "*Quality statement 4: Comprehensive assessment* *Quality statement* *Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment.*" As above, it is very important, and would be much appreciated by the women my organisation represents, for NICE to include a sentence here that ensures women who request a caesarean can have a discussion about the risks and benefits of surgery in order to convince the midwife and obstetrician that she is making a truly informed and prophylactic choice, with no expectation that she should still subsequently be assessed and/or treated for a 'mental health problem'.
021	electivecesarean.com	4	Re: "*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.*" Again, this is where there has been conflicting advice and guidance even from NICE itself. In the event that a woman requesting a caesarean *does* cite fear and anxiety (or tokophobia), this doesn't necessarily equate to a 'mental health problem' and in fact for many of these women, the anxiety and fear disappears the instance their caesarean request is approved. There is also the inappropriate and costly issue of women 'going through the motions' of a tokophobia assessment because they fear (or calculate) this may be their only chance of arranging a planned caesarean in the NHS. My organisation was forwarded a hospital letter by a woman who had requested a caesarean there, which said: "*where there are neither medical nor proven psychological grounds, we are not in a position to provide the choice of a caesarean section"*.
021	electivecesarean.com	4	Re: "*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.*"

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			Again, on its own, there is a danger that this will be interpreted by some care givers as meaning they 'must' refer all women requesting a caesarean for a comprehensive mental health assessment, since they 'suspect' a mental health problem. The basis for this viewpoint is often that no one of normal or sound mind would ever request surgery. My organisation is also concerned that the numerator and denominator process outcome here could be an incentive for assessments to be carried out that are not actually necessary, and again, this also costs the NHS money. If we look at the extracts below, which appear in NICE's '*National costing report: Caesarean section (November 2011)*', it becomes clear that the provision of mental health support that is more costly than scheduling a planned caesarean: "*1.4.5 The care of women who request a caesarean section, including the provision of mental health support for women with anxiety about childbirth, is likely to lead to a resource impact for many NHS organisations.*" "*3.3.4 Costs for providing mental health support to women with anxiety about childbirth are based on the assumption (from a range of clinical opinions) that 92% of women with anxiety about childbirth have low-level anxiety and will receive one or two hour-long sessions with a midwife, costing £52 per hour (1.5 hours assumed). It is assumed that the remaining 8% will have higher-level anxiety and will receive one hour-long session with a midwife, and a further three hour-long sessions with a clinical psychologist, costing £81 per hour*." In summary, the "*Cost of offering mental health support to women with anxiety about childbirth - £1080"*. Given the choice, most women requesting a caesarean birth would prefer that this NHS money is spent directly on their preferred planned caesarean surgery (CG132 'Health Economics' section calculated an increased cost of just £84 for a planned caesarean versus a planned vaginal delivery, and this only included *one* downstream cost – urinary incontinence).
022	National Childbirth Trust	4	NCT would welcome further clarification of the term 'comprehensive assessment' in this quality statement. Comprehensive is a subjective term and therefore difficult to measure. We recommend replacing with an objective statement.
022	National Childbirth Trust	4	In response to the question: How would this quality statement be measured in practice? A 'comprehensive assessment' should include all of the components of an assessment listed in the NICE guideline for antenatal and postnatal mental health, and outlined on page 24 of the quality standard. Therefore a comprehensive assessment should include all of these components i.e. how many women were asked the recommended screening questions, how many women were asked about previous or current mental illness or

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			treatment and severe postpartum mental illness in first degree relatives, etc.
022	National Childbirth Trust	4	In response to the question: When should the comprehensive assessment take place? NCT recommend routine assessment of women during pregnancy and following the birth of their baby. As a minimum all women should receive a comprehensive assessment at their booking appointment with their midwife and during their first postnatal visit with their health visitor. (any other times/occasions??) NCT also recommends a more comprehensive assessment of mental health take place during the routine six week check with GPs. Findings of recent research from NCT (Mind the Gap http://www.nct.org.uk/sites/default/files/related_documents/328-NCT-mindTheGap-shortReport-loRes.pdf) found that 3 out of ten women (29%) said their GP did not ask them about any emotional or mental health issues during their six week check 7% of women wanted to talk about how they were feeling but felt there wasn't time and 22% of women admitted they were not truthful during the appointment, but put a brave face on to hide how they really felt. These findings emphasise a greater need for new mothers mental health to be routinely assess by GPs in the postnatal period.
023	Sands	4	Healthcare professionals should also be aware of grief and how it differs from depression, particularly when engaging in comprehensive assessments of bereaved women following the death of their baby.
023	Sands	4	The bullet point that highlights the need to assess "the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby" should be expanded to explicitly include an assessment of whether a woman has experienced the death of a baby.
024	Home-Start UK	4	How would this quality statement be measured in practice? Home-Start suggests local data collection with a denominator of all women referred for a comprehensive assessment and a numerator of all women receiving support within 28 days of referral.
027	South West Yorkshire Partnership Foundation Trust	4	Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive assessment. Does this mean a comprehensive mental health assessment? It needs to be specified which services can provide this. Could it be done by GP / IAPT services, or would this have to be done by secondary services? – this would have a huge effect on workload if this had to be done by secondary care services.
004	Faculty of Sexual and Reproductive Healthcare	5	There is a need to develop referral protocols between maternity, primary care and psychological services
005	Swansea University	5	For distressed women, a 6 week wait for treatment may seem excessive. Such delays may prompt prescription of SSRIs.

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008	British Maternal and Fetal Medicine Society	5	No comments
009	East and North Hertfordshire NHS trust	5	No comments
010	The Lullaby Trust	5	We welcome the fact that counselling may need to be highly specialised, as bereaved parents from SIDS often report feeling 'different' from other bereaved parents, due to the fact that their child's death was unexplained. Although The Lullaby Trust offers long-term bereavement support through our Befriending service, some parents may also benefit from face-to-face and specialist bereavement counselling.
015	Maternal OCD	5	Generally there is a recommended timescale of 6 weeks for access to treatment, but we can't find a recommended timescale for the initial assessment, it would be helpful if the recommendations offered some guidance on which service or professional would take a leadership/coordinator role in care – appreciate this might be in the guidelines but may need to appear in the quality standard too.
016	Royal College of Obstetricians and Gynaecologists	5	Question 1 – does this draft quality standard accurately reflect a key area for quality improvement? *Yes – this is important and reflects a key area 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 measure? *It should be possible to collect the data* Question 3 – for each quality statement what do you think could be done to support improvement and help overcome barriers? *There would need to be an investment in perinatal mental health services to ensure that this timeframe is met.* Page 27 - Suggest adding 'and' as in 'women who are pregnancy or have had a baby in the past year AND who have a mental health problem'. This makes it clear and explicit.
018	Association for Improvements in the Maternity Services	5	Women referred for psychological treatments start treatment within 6 weeks. We welcome this statement, since the delay has been damaging for many women who are under great stress, and these services have been under-provided. However, there is a great need for specialist care for those with birth trauma and post-partum PTSD, and inappropriate psychotherapy approaches do not help and may do harm.
022	National Childbirth Trust	5	NCT welcomes a quality statement regarding the number of women both being referred for psychological treatment and the proportion of those that actually go on to receive treatment. There are currently several barriers that prevent women from receiving treatment. We are aware of women being turned away from IAPT services after referral because they do not meet the criteria for the service. Women are also

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			often unable to attend psychological appointments during work hours, in part due to stigma associated with mental illness many women do not feel comfortable sharing letters from psychological or psychiatric services with their employers. Furthermore, some women have expressed difficulty in attending perinatal mental health treatment due to a lack of childcare for siblings during the time of appointments. NCT is concerned that mental health services are failing to meet the needs of these women during the perinatal period and it is essential to capture information on why women are not receiving psychological treatment and support following a referral.
024	Home-Start UK	5	Home-Start is concerned that a wait time of 6 weeks between identification of a mental health problem and treatment is too long. Babies make incredible physical, emotional and mental developments across their first year of life and require as much support as possible from their caregiver during this time. Home-Start recommends reducing the wait time for treatment to 28 days.
024	Home-Start UK	5	Home-Start asks that in addition to women's satisfaction with psychological interventions, women's self-rated ability and confidence in coping be used as an outcome. We also recommend that in order to support improvement, data should be collected on children whose parent receives a psychological intervention.
027	South West Yorkshire Partnership Foundation Trust	5	Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral. Agree, but is this for IAPT only, or does it include APTS? Calderdale has been reported to have a 3 year wait for routine treatment
013	The Royal College of Psychiatrists	General, 5 & 6	This document is a good summary of the standards required and will be well received. The assessment of mother infant attachment is mentioned and should be included directly in the statement on psychological care as this is a vital part of psychological treatment and could be a reason for referral. Tokophobia and lack of attachment to the unborn also need to be considered. Under psychological care. The term Mother and Baby Unit seems to be replaced with 'multidisciplinary inpatient service'. There is concern that this could be construed by some to mean acute adult wards.
004	Faculty of Sexual and Reproductive Healthcare	6	There is a need for collaborative working between specialist mental health services and other services such as Public Health and Voluntary sector to champion the prevention agenda
004	Faculty of Sexual and Reproductive Healthcare	6	The answer is no; there is a need for collaboration and system wide approach between specialist services and other players in the system such as Public Health, maternity services , primary care, the voluntary sector and social care support services such as troubled family programme in order to be able to address the whole care pathway from prevention in high risk groups to tertiary care in a sustainable and cost effective fashions. In Scotland, local services vary. There is v good support for clients involved in the family nurse partnership (mother's

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			aged under 19) but perhaps less so for the general population.
007	Surrey and Borders Foundation NHS Trust	6	The role of a specialist perinatal service seems to be developing in this part of the document This is important for women, families, services and commissioners.
008	British Maternal and Fetal Medicine Society	6	Suicide is only one outcome associated with poor mental health. Other more frequent poor outcomes that might be impacted by having specialist multidisciplinary teams are self harm, poor infant bonding, poor mental health in offspring
009	East and North Hertfordshire NHS trust	6	This statement accurately reflects the areas of improvement. Does it reflect an emergent area of cutting edge service delivery? In our opinion, all women with mental health problem in pregnancy and postnatal period **must** have access to specialist perinatal mental health services tailored to pregnancy and postnatal period. Sadly the resources are limited and not all women have access to these specialist services and "outstanding performance" is only carried out by minority providers. More resources should be invested into this.
011	British Medical Association	6	We believe that statement 6 would be a significant development on current practice in many areas, and as detailed above is likely to require new investment.
012	The Royal College of General Practitioners	6	See comment above. This should not be seen as cutting edge service delivery as it was recommended in the previous NICE guideline and implementation has not taken place except in a few areas. On the contrary areas that do not have a service should be regarded as poorly performing and letting down the women, children and families in these areas. The service specification for such services is very clear and the RCPsych has quality standards.
013	The Royal College of Psychiatrists	6	All women and their infants who require specialist services should have access to them in a timely way. The current situation where there is a postcode lottery goes against all the principles of equality that underpins the NHS. Each CCG needs to commission a perinatal mental health service that provides a comprehensive, effective, equitable service for all women and their infants who need it. Excellent examples include services in North East London – within ELFT and NELFT.
016	Royal College of Obstetricians and Gynaecologists	6	Does this reflect an emergent area of cutting-edge service delivery? *Yes – this is crucially important. A successful model has been developed in the West of Scotland: http://www.nhsggc.org.uk/your-health/health-services/mental-health-services/services/other-services/west-of-scotland-mother-baby-unit/*
017	The Royal College of Midwives	6	A key area that is missing however, is a statement about the provision of specialist mother and baby units when access is currently so difficult http://everyonesbusiness.org.uk/?page_id=349
017	The Royal College of Midwives	6	This vital statement will need significant redesign of services in most areas. Examples of current practice are documented here http://everyonesbusiness.org.uk/?page_id=349

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			This could be achieved by each psychological service at primary and secondary care level prioritizing pregnant and postnatal women. This service should be available for women with severe or complex or enduring moderate mental health problems. Where a service does not exist, it should be developed and consist of perinatal mental health CPNs, support workers, occupational therapists and psychologists.
018	Association for Improvements in the Maternity Services	6	Specialist community and inpatient multidisciplinary services to support women with perinatal mental health problems. We greatly welcome this, though we recognize it will take time to develop. The availability of supportive community and inpatient services would encourage women to share problems. Only recently we had yet another report from a woman who had been terrified by violent male patients in an acute psychiatric ward, so, like many other clients, she discharged herself early. The quality of services previously received is an important factor in women feeling safe to disclose mental illnesses
022	National Childbirth Trust	6	NCT strongly welcomes this quality standard to ensure that specialist community and inpatient perinatal mental health services.
022	National Childbirth Trust	6	Question to be answered in response. 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?
023	Sands	6	The provision of specialist bereavement services for families following the death of a baby should be included in this Quality Statement. The inclusion of such specialist mental health services is particularly important as general bereavement services (e.g. non-specialist counselling) may not be appropriate for the needs of bereaved parents. It is important that healthcare professionals providing specialist perinatal mental health care to bereaved parents have an understanding of the unique nature of grief and bereavement following the death of a baby.
024	Home-Start UK	6	Home-Start suggests that outcomes are expanded beyond a reduction in suicide rates, to ensure that support is received for women identified as having less severe mental health problems. We suggest including outcomes related to ability to cope, well-being, and confidence in parenting.
025	London and South Perinatal Consultants Psychiatric Association	6	Comment about quality statement 6. Would it be possible to specifically mention mother and baby units each time specialist community and in-patient perinatal mental health services are referred to? It has been suggested that the in-patient provision could otherwise be taken to mean another type of ward/unit where facilities do not exist for admission of babies. (There is a women's

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			crisis house in London where babies are accepted from the age of 6 months, but this is not an accreditable MBU).
027	South West Yorkshire Partnership Foundation Trust	6	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. Only 0.2% of pregnancies result in a puerperal psychosis that is likely to require specialist inpatient care. 10% of pregnancies result in significant post natal depression/anxiety. Therefore the vast majority of postnatal mental health provision takes place in the community and that is clearly where funding should be targeted. The government has announced funding for community perinatal services, but this is ear-marked for IAPT level services, which will not be able to provide a service to people with persistent or moderate-severe mood disorders which require secondary care. There is no ring-fenced funding for perinatal mental health from local CCG's. The fact that perinatal mental health occurs across all clusters means that in many trusts it will continue to be a "forgotten difficulty" by services. It should be seen as a specialist service with separate funding arrangements, with national funds devoted to trusts based on their annual birth rates. The current model for community perinatal mental health care is based on "perinatal outreach" run out of M&B units. However these specialist services only provide outreach within their own trust boundaries. Therefore SUs of trusts without their own M&B unit are clearly disadvantaged to those which have M&B units. Some English counties have no specialist perinatal service at all. A target to achieve would be that all mental health trusts should have their own specialist community perinatal mental health service, which can refer to regional M&B inpatient units. It is only by providing such services that perinatal networks and local pathways of care can be developed, which are key targets in NICE guidance. This should not be a developmental statement.
028	NHS England (Central Midlands)	6	This should include a specific statement about women being admitted with the baby to a specialist mother and baby unit unless there are specific reasons not to do so. Measure – Deviancy reporting, Mental Health Trusts to Commissioners. All women admitted to adult mental health wards in late pregnancy/post-delivery. MH Trust Patient Information Systems.
017	The Royal College of Midwives	4, 5 & 6	All these statements are absolutely dependant on increased resources for perinatal mental health and have not got a hope of being implemented at the moment given the appalling shortage of services.
021	electivecesarean.com	EQIA	Re: "*NICE has a duty to have due regard to the need to eliminate… advance equality of opportunity…*" Some women are particularly vulnerable if they are tokophobic and want to request a caesarean birth; for example women who have less education than others, women who have immigrated recently or who may not have English as a first language. Even the most articulate, literate, educated and confident women can face an immense battle when

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			trying to arrange a caesarean birth, and of course it is only those with the financial means that can fall back on private maternity care if their NHS hospital refuses to follow NICE CG132 and QS32 guidance.
001	The Royal College of Surgeons of England	None	No comments
002	Digital Assessment Service, NHS Choices	None	We welcome the guidance and have no comments as part of the consultation
006	Royal College of Paediatrics and Child Health	None	No comments
007	Surrey and Borders Foundation NHS Trust	None	• Acknowledgment of engaging in a therapeutic relationship that is non judgemental, compassionate. • That women should be involved in all the decisions about her care and the care of her baby. • Continuity of care from adolescent to adult service These statements would ensure that the principles of any engagement with individuals and their families an carers are embedded within this area of specialism.
007	Surrey and Borders Foundation NHS Trust	None	• It is agreed that it is Important to take into account the mental health needs of partners and families including the welfare of the baby and the role of the partner and the potential effects of any mental health on the woman's relationship with her partner, family or carers. Growing evidence that indicates fathers often suffer with post natal depression in the post natal period. **However it would have been hoped that there would have been a stronger statement given the clear evidence that the psychological state of the mother impacts on the psychological state of the baby.** Allen, G. Early Intervention: The Next Steps" (2011) Barlow, J. et al ' Health led interventions in the early years to enhance Infant and Maternal Mental health Child & Adolescent Mental Health (2010) Field, T. The Foundation Years (December 2010)
007	Surrey and Borders Foundation NHS Trust	None	Appreciate the importance that services develop an integrated care plan for a woman with a mental health problem in pregnancy and the post natal period that is agreed with the woman

ID	Stakeholder	Statement number	Comments[1]
007	Surrey and Borders Foundation NHS Trust	None	Helpful to have clear Guidance about co ordination between professionals so that all interventions are appropriate. **However it would be helpful to have a definition of ' Mental well being'**.
007	Surrey and Borders Foundation NHS Trust	None	Welcome the recognition that mental health problems are not uncommon during the perinatal period.
007	Surrey and Borders Foundation NHS Trust	None	Depression and anxiety disorders: Helpful to acknowledge that anxiety disorders and depression are under recognised throughout pregnancy and the post natal period.
007	Surrey and Borders Foundation NHS Trust	None	It would have been helpful to include in the assessment template issues of loss of previous children, namely those who have been taken into Care by Social services as unresolved issues linked with this can impact upon the mother's capacity to form a healthy attachment to a subsequent baby.
007	Surrey and Borders Foundation NHS Trust	None	Important to highlight the importance of thinking about any learning disabilities and liaising with specialist when developing are plans.
007	Surrey and Borders Foundation NHS Trust	None	It is appreciated that risk to the infant is included in the risk assessment during both the ante natal and post natal period.
007	Surrey and Borders Foundation NHS Trust	None	<u>Considerations for women and their babies in the post natal period.</u> Young women who are in the Care system or leaving the Care system are highly vulnerable to significant mental health problems and difficulties with their babies. This group is currently omitted from this section.
007	Surrey and Borders Foundation NHS Trust	None	There is no recognition given to the importance of parent- infant psychotherapy in providing positive outcomes for mothers and babies who have difficulties in their relationship. The importance of Baby massage is also absent from this document.
014	Royal College of Nursing	None	No comments to make
020	Department of Health	None	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.

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015	Maternal OCD	Related quality standards	Is there an OCD Quality Standard that could be added to the list of related NICE Quality Standards?
021	electivecesarean.com	Related quality standards	Re: "*Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?*" No, not without clarity regarding its relationship to CG132. Here is another example of how NICE CG132 can be misinterpreted and misrepresented in the context of the Antenatal and Postnatal Health Quality Standard: The November 2011 NICE Costing Report for CG132 (published WITHOUT *STAKEHOLDER INPUT*) reads: "*Improved provision of mental health support could lead to improved psychological outcomes for women with anxiety about childbirth, and a potential reduction in caesarean section rates for such women.*" As explained above, the NICE GDG said this was *not* an intended outcome of mental health support, and CG132 (WITH *STAKEHOLDER INPUT*) reads: "*The guideline has not sought to define acceptable caesarean section rates. Rather the purpose of the guideline is to enable healthcare professionals to give appropriate research-based advice to women and their families. This will enable women to make properly informed decisions.*"
		Related quality standards	The recommendation that mental health support should only be *offered* to women requesting a caesarean (whatever the reason for their request) is reinforced in CG192 too (extract from pg. 642): "*There was limited evidence for the effectiveness of a pre-delivery psychoeducational discussion on fear of childbirth (symptoms of tokophobia). There were no clinically or statistically significant effects on mode of delivery. However, there was single study evidence for small and statistically significant benefits of pre-delivery discussions on continuous measures of feeling safe during childbirth, the experience of fear during childbirth, and maternal attitude to motherhood. The economic evidence review did not find any studies assessing the cost-effectiveness of predelivery interventions for tokophobia. Although the evidence for large and appreciable benefits was not found, the GDG agreed by consensus judgement, that it is important for women with tokophobia to have the opportunity to discuss these fears during the pre-delivery period and they should have access to a healthcare professional with expertise in providing perinatal mental health support. Moreover, the GDG judged that the cost of such interventions would be small relative to the reduction in women's potential for developing mental health problems and other health vulnerabilities which may be costly to other parts of the NHS. Moreover, this recommendation is in line with NICE guidance on caesarean section (NICE, 2011e).*

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			Interventions for anxiety disorders *7.7.1.11 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 clinical guideline 132). [new 2014]*" https://www.nice.org.uk/guidance/cg192/evidence/cg192-antenatal-and-postnatal-mental-health-full-guideline3
021	electivecesarean.com	Related quality standards	Re: "*Related NICE quality standards*" QS32 on Caesarean Section is listed here, but my organisation has evidence that its recommendations are not consistently followed.
013	The Royal College of Psychiatrists	Additional areas for consideration	The NICE guidelines on antenatal and postnatal mental health (published in 2014) recommend that all women of *childbearing potential* need to be considered - their needs, the implications of their conditions and treatments on pregnancy, the postnatal period and parenting - all borne in mind throughout their contact with services, not merely when they are actually pregnant or voicing a desire to become pregnant. A very high proportion if not the majority of pregnancies are unplanned. In light of this, a quality standard in relation to clinicians holding in mind the potential that an individual woman may become pregnant should be developed and included. This might mean saying that at CPA reviews a woman's thoughts on her fertility/contraception/plans for parenthood are reviewed the impact that her prescribed medication may have on her fertility/the fetus/breastfeeding and parenting are made clear to the woman, her family and clinical team. There should be a quality standard that states that women should be admitted to a mother and baby unit unless there are exceptional reasons not to do so. There is no standard relating to quantifying the well-being of the infant and the mother-infant relationship This is of course a major issue within perinatal mental health services. Should there be a standard around this?
018	Association for Improvements in the Maternity Services	Additional areas for consideration	Increased data collection will absorb precious time in clinics and will not create a single extra perinatal psychiatrist or mother-and-baby psychiatric unit in the many areas where there are none. However, gathering information about how the mother is feeling within the context of continuity of trusted carer, where a personal relationship has been established, could have quite different outcomes.Fruitful possibilities are offered by: 1. *Providing continuity of midwifery carer: Continuous care by the same midwife for antenatal, intrapartum and postnatal care Priority should be given to higher risk populations. We would support this being introduced in the context of a randomised trial, with mental health being one of the outcomes measured. This enables*

ID	Stakeholder	Statement number	Comments[1]
			professional and woman to establish a relationship, know each other well, and midwives who know their clients well can assess mood often without asking, but the trust established gives women the confidence to talk about their problems 2. *Using the Family Nurse Partnership system for expectant and new mothers at risk, since an evidence base of benefit exists, with a 20 year follow up.* *A study in Scotland has shown that their continuous contact from pregnancy onwards made it easier to discuss mental health and wellbeing, and there were many benefits to health behaviours (Evaluation of the Family Nurse Partnership Prgramme ijn NHS Lothian Scotland 2nd Report – Late pregnancy and postpartum Scottish Goverment 2012)* http://www.gov.scot/Publications/2012/06/1551/0 A randomised trial of FNP style home visiting in pregnancy to a deprived population in the USA, although not addressing mental health, reduced pregnancy hypertension and had many beneficial outcomes for children. (*Kitzman H et al. Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries and repeated childbearing. 1997 JAMA vol 278 644-652)* http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/visit_5.authcheckdam.pdf A follow up after 12 years, showed that home-visited mothers reported longer term relationships, a greater sense of mastery, and less drug and alcohol use, outcomes which are strongly suggestive of better mental health *(2010 Olds D. et al.. Enduring Effects of prenatal and infancy home visits by nurses on maternal life course and government spending. Arch.Pediatr.Adolesc.Med 164(5) 4119-424).)* *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3249758/* A 20 year follow up to this trial, showed that in those who had the home visitation programme, maternal deaths were also reduced, particularly external causes of death including suicide, drug overdose, accident etc. *(2014. Olds D et al. Effect of Home visiting by nurses on maternal and child mortality. JAMA Paediatr. 168(9) 800-808)* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235164/ The essence of the Family Nurse Partnership approach demonstrated in many publications by David Olds and colleagues, is that it is an empowering and respectful approach, which has been shown in randomised trials to bring beneficial results to mothers, children and families where monitoring, and surveillance approaches fail. Race and risk of mental illness: we have received a number of disturbing reports from women that racist behaviour contributed to their mental state, and that they were further discriminated in their contacts with health care professionals, thereby exacerbating their distress, and making them reluctant to seek further help. Yet women are not

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			asked about this, or other discrimination they may encounter which creates stress in their lives. , Cultural misconceptions were frequent. Despite NICE recommendations that cultural education is necessary, healthcare professionals in the Tommy's survey quoted above highlighted their lack of training in this area.
021	electivecesarean.com	Additional areas for consideration	Comment re: "*important areas of care or service provision that are not included*" as per http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards One very important area of care and service provision that is noticeably absent from this Quality Standard draft is the provision of a planned caesarean birth for women who request one because they have a fear of the unpredictability and/or overall experience of a vaginal birth. This is a serious omission, as my organisation continues to be aware of cases, almost four years after CG132 was published, where women with (and without) tokophobia are being refused a maternal request caesarean, and where women with a fear of birth are being forced against their will to undergo psychological assessments and attend appointments with psychologists and/or mental health counsellors during their pregnancy – echoing the early legal abortion process. This is done in order to 'treat' their 'mental health problem' – instead of respecting their informed choice, scheduling surgery in a timely manner, and immediately alleviating the main source of their anxiety, which is the fear that their caesarean request will be refused. Crucially, the accompanying guideline to this Quality Standard, NICE CG192, reads: "*Interventions for anxiety disorders* *1.8.7 For a woman with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss her fears with a healthcare professional with expertise in providing perinatal mental health support in line with section 1.2.9 of the guideline on caesarean section (NICE guideline CG132)."* http://www.nice.org.uk/guidance/cg192/resources/guidance-antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf Section 1.2.9 of CG132 reads: "*1.2.9.5 When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner.* *1.2.9.5 For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS.* *1.2.9.6 An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS.*" There is no NICE guidance that prescribes women must accept the offer of referral to a perinatal mental health

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			support specialist, or that compliance with any support offered is a necessary prerequisite to agreeing to their caesarean request. And yet this is precisely what can transpire – and when forced, attendance at 'mental health' sessions aimed at avoiding a caesarean birth can actually introduce anxiety or exacerbate a woman's stress and anxiety even further. As submitted in my organisation's comments for CG192, one of the most common presentations of tokophobia in women is a request for elective caesarean birth, which does not necessarily require any mental health intervention or support, but rather the promise of a surgical one. Yet there is often an assumption that in all cases of tokophobia, because it is considered a 'mental health' issue, only mental health interventions or psychological treatments are warranted – when for many women, a planned caesarean offers relief from their fear of childbirth and makes them feel more in control, and less vulnerable.
021	electivecesarean.com	Additional areas for consideration	RE: "*What the quality statement means for service providers, healthcare professionals and commissioners*" It needs to be remembered that these statements will be read in the context of an environment of maternity policy that often actively seeks to reduce caesarean rates (see RCM statement above re: maternal request impacting on its members' '*quest*' to reduce rates). In August 2012, the RCOG, RCM and NCT circulated (much criticised*) guidance to CCGs encouraging them to reduce their caesarean rates to 20% and increase the number of 'normal' births. The CQC continues to use a hospital's 'caesarean rates' as a measure of quality care, and hospitals are criticised in CQC investigations where caesarean rates are deemed to be too high. Within the confines of these pressures, my organisation does not have full confidence that antenatal decisions and care will always ultimately be made and given in the best interests of women's mental health. *New RCOG guidance urges CCGs to increase births without epidurals and reduce caesarean rates to 20%. 23 August 2012 http://www.prlog.org/11953412-new-rcog-guidance-urges-ccgs-to-increase-births-without-epidurals-and-reduce-caesarean-rates-to-20.html Some midwives, largely as a result of their education and training but also sometimes because of an ideological viewpoint, do not fully understand the benefits of surgery or why a woman might choose it. Obstetricians meanwhile, can be under considerable pressure to keep their overall caesarean rate low, and fear professional peer or management criticism if they are seen to 'give in' to caesarean requests too readily. And for mental health professionals, they may see it as their responsibility and role to try and 'fix' birth phobia, and perceiving a caesarean

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			outcome as somehow failing in this effort. It's similar to the sense of personal and professional achievement that midwives can sometimes express when vaginal delivery *is* achieved, but the problem is that it places birth method at centre stage and can get in the way of the "*person-centred approach* to *provision of services* [NICE says] *is fundamental*…".
021	electivecesarean.com	Additional areas for consideration	Re: "*Policy context* *It is important that the quality standard is considered alongside current policy documents, including:*" 1) *Maternal Mental Health Alliance (2014) UK specialist community perinatal mental health teams (current provision)* This document appears to shows limited provision in many areas. My organisation would question here, with such seemingly limited resources, how hospitals can defend the enforced provision of mental health support – with the specific aim of talking women out of having a caesarean, against their will – when actually allowing the caesarean would be better value for money? 2) *National Audit Office (2013) Maternity services in England – "The Department's main aims for maternity services are … for mothers to report a good experience; to encourage normality in births by reducing unnecessary interventions;*" This document highlights incompatible aims in the context of women who request a planned caesarean birth. Women's satisfaction rates are very high following maternal request caesarean (Stephen Robson et al. Elective caesarean delivery at maternal request: a preliminary study of motivations influencing women's decision-making. 2008 Aust NZJ Obstet Gynaecol), so they could "*report a good experience*". Except in a policy culture of 'encouraging normality' my organization hears about women's requests being refused and/or women enduring a long, protracted process of fighting to secure agreement – an altogether 'bad antenatal experience'. Also cited in this document is: "*The Department outlined its strategy for maternity services in 2007 in Maternity Matters. It intended to achieve its aims by: offering choice in where and how women have their baby;* Except the 2007 document itself doesn't include the choice of '*how*' a woman has her baby – only '*where*' she has it: *"Department of Health, Maternity Matters: Choice, access and continuity of care in a safe service, April 2007.*

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			The national choice guarantees described in this document are: *1. Choice of how to access maternity care* *2. Choice of type of antenatal care* *3. Choice of place of birth"* Also irony for maternal request at that time (when the NICE 2004 CG13 then said maternal request was not on its own an indication for a caesarean…): "*Policy commitment to maternity services* *1.2 The aim of health reform in England is "to develop a patient-led NHS…*"
021	electivecesarean.com	Additional areas for consideration	Re: "*A NICE pathway brings together all NICE guidance, quality standards and materials to support implementation on a specific topic area. The pathways are interactive and designed to be used online. This pdf version gives you a single pathway diagram and uses numbering to link the boxes in the diagram to the associated recommendations. http://pathways.nice.org.uk/pathways/antenatal-care June 22, 2015*" In this pathway, there is no mention of maternal request caesarean at all – and that's despite the fact that more than double the percentage of women would choose surgery than choose a home birth. There is a section on "*planning place of birth*" but not planning *type* of birth. Even CG132 does not appear to be included in the Pathway, even though overall almost a quarter of women who receive antenatal care will have a caesarean birth. One of my organisation's main concerns as a Stakeholder during the development of CG190 was the focus on planned place versus planned mode of delivery and with many of my comments, NICE's response was '*this is covered in CG132*'. That is, caesarean delivery is 'separate' and 'distinct' from 'normal' antenatal care. Except that's surely not the case given caesarean maternal request. How can we ensure satisfaction and respect for women who request a caesarean when their antenatal care doesn't even appear on the NICE Pathway? And when they make their request, they are considered to have a 'mental health problem' – except the NICE Quality Standard on Antenatal and Postnatal Mental Health does not include maternal request or tokophobia either. This apparently inconsistent and fragmented approach to delivering guidance and standards in antenatal and postnatal care does not help communicate NICE recommendations in the most effective way, and my organisation

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			hopes that this can be remedied somewhat in this QS at least in relation to maternal request and the 'offer' of mental health support as per CG132 and QS32.
021	electivecesarean.com	Additional areas for consideration	Comment re: "*Table 4 Summary of suggested quality improvement areas* *Additional suggestions not meeting technical criteria for statement development:* *- Support for women requesting a caesarean section* *4.8statement development:* *Support for women requesting a caesarean section* *One stakeholder highlighted that perinatal mental health services should be able to support maternity services in cases where women do not have a medical indication for caesarean section but request elective caesarean.* *The NICE quality standard for caesarean section (QS32) includes 2 quality statements on maternal request for caesarean section:* • *QSt1: Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.* • *QSt2: Pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.* *The quality standard for antenatal and postnatal mental health should be used in conjunction with other relevant guidance, including NICE QS32.*" My organisation understands that consideration was given to including maternal request in this Quality Standard, but it was felt that this issue is sufficiently covered within QS32. I hope that the information above has helped to encourage NICE to reconsider its response here, with the understanding of the practical adverse impact the absence of a specific explanatory line or paragragh could have on women requesting caesareans. Even when CG132 and QS32 *are* read in conjunction (and they are not always), there is misunderstanding about the recommendations on maternal request. Further clarification and reinforcement is urgently needed. Caesareans are an important aspect of antenatal care and the provision of mental health care, but they remain often inextricably linked with 'negative outcomes'. Even in the Stakeholder response for this Quality Standard beow, it is clear that CG132 has not been properly understood in relation to 'offering' support and allowing women to make their own informed choices – the emphasis is instead on rising caesarean rates, and aspirations to better match the arbitrary percentages suggested by the W.H.O.

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			"*Appendix 3: Suggestions from stakeholder engagement exercise* *Stakeholder* *SCM3* *Area for improvement* *Support for women requesting a caesarean section* *Key area for quality improvement* *Key area for quality improvement 3* *Why is this important?* *Perinatal mental health services should be able to support maternity services with women requesting elective caesarean section in the absence of any medical indication* *Why is this a key area for quality improvement?* *Caesarean section rates are rising, and are generally well above the levels recommended as most appropriate by the WHO. Part of this increase is driven by maternal request for caesareans. Although the NICE Caesarean Section guideline highlights the need for referral of these women to perinatal mental health specialists, these do not exist in many areas within the UK* *Supporting information* *NICE Caesarean Section guideline*"
021	electivecesarean.com	Additional areas for consideration	I'd like to give the last word to Lady Hale, taken from a recent (March 2015) Supreme Court Judgment, which I hope might carry some weight in the context of maternal request and forced mental health 'support': *"the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body…* *"A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the "natural" and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby…* *"The medical profession must respect her choice, unless she lacks the legal capacity to decide…* "*Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.*" https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf

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023	Sands	Additional areas for consideration	Women who have had a baby that has died should be explicitly included in this quality standard for antenatal and postnatal mental health as some perinatal mental health services do not offer mental health care to women if their baby has died. The NPEU's *Listening to Parents* (2014) report found that women whose babies were stillborn or died in the neonatal period experienced high rates of depression (24% in both groups) and anxiety (30% of women whose baby was stillborn and 24% whose baby died neonatally). While grief in itself is not a mental health problem, some women may also experience depression, anxiety, PTSD or other mental health problems following the death of a baby and they may not be receiving appropriate care and support for these problems. The inclusion of women whose babies have died is also important as the death of a baby affects the whole family (including any current or future siblings) and potentially causes the life expectancy of bereaved parents to be shortened (Harper et al 2011, *British Medical Journal Supportive and Palliative Care* doi:10.1136/bmjspcare-2011-000025). This is in line with Domain 1 in the NHS Outcomes Framework 2015-2016 that is described in Table 1 (page 3) of this Quality Standard.
024	Home-Start UK	Additional areas for consideration	Does this draft quality standard accurately reflect the key areas for quality improvement? The quality standard would be enhanced with the inclusion of information on treatment and support for women and families.
027	South West Yorkshire Partnership Foundation Trust	Additional areas for consideration	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? No. There needs to be much stronger emphasis on development of local and regional perinatal networks. It is only by achieving these that services can be developed, improved and SU voices heard. This is especially important because staff are involved from multiple disciplines and trusts – MH trust, Acute trust, community providers eg Locala, CCGs, social services/child protection. Only networks can enable these staff and SUs to communicate and co-produce
005	Swansea University	Additional areas for consideration	Key areas for quality improvement. This document focuses on those with severe mental illness. It does not fully address the needs of women with less severe illness who are receiving medicines from their GPs. Some 5% women in the UK are prescribed an SSRI during pregnancy, a much higher prevalence than elsewhere in Europe (Charlton et al 2015). Given the potential impact of SSRIs on infants, this issue warrants further attention.

Registered stakeholders who submitted comments at consultation

Association for Improvements in the Maternity Services
British Maternal and Fetal Medicine Society
British Medical Association
Department of Health
Digital Assessment Service, NHS Choices
East and North Hertfordshire NHS trust
Electivecesarean.com
Faculty of Sexual and Reproductive Healthcare
Home-Start UK
LCGB
London and South Perinatal Consultants Psychiatric Association
Maternal OCD
National Childbirth Trust
NHS England (Central Midlands)
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Sands
South West Yorkshire Partnership Foundation Trust
Surrey and Borders Foundation NHS Trust
Swansea University
The Lullaby Trust
The Royal College of General Practitioners
The Royal College of Midwives
The Royal College of Psychiatrists
The Royal College of Surgeons of England
The Twins and Multiple Birth Association
UK national screening committee