NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report

Indicator area: Antenatal and postnatal mental health

Consultation period: 8 February – 8 March 2017

Date of Indicator Advisory Committee meeting: 6 June 2017

Contents

Summary of indicators included in the consultation

ID	Indicator	Evidence source
GP11	The percentage of women who have given birth in the preceding 12 months who have had an enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.	Antenatal and postnatal mental health (2016) NICE QS115 statement 4
CCG12	The proportion of pregnant women who were asked about their mental health at their first booking appointment	Antenatal and postnatal mental health (2016) NICE QS115 statement 4
CCG13	The proportion of women referred for psychological interventions in pregnancy or the postnatal period who start treatment within 6 weeks of referral	Antenatal and postnatal mental health (2016) NICE QS115 statement 6

GP11: Postnatal enquiry

The percentage of women who have given birth in the preceding 12 months who have had an enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.

Rationale

Mental health problems occurring in pregnancy and the postnatal period are often similar to those occurring at other times in their nature, course and potential for relapse, but there can be differences. For example, women have an increased risk of relapse or developing a first episode of bipolar disorder during the early postnatal period than at other times. Some changes in mental health state and functioning (such as appetite) may represent normal pregnancy changes, but they may be symptoms of a mental health problem.

Routine postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems.

Summary of consultation comments

Stakeholders welcomed an indicator recognising the importance of assessing postnatal mental health in women.

Stakeholders raised concerns about awareness, resource and capacity issues within GP practices. They specifically mentioned time, skills and ability to have a meaningful and sensitive conversation about maternal mental health. Stakeholders suggested that midwives or health visitors are better placed than GPs to carry out this assessment because of the convenience for the mother and potentially closer relationship with her.

Stakeholders suggested that mental health checks should be carried out at each point of contact, not just 4 – 10 weeks postpartum. They raised concerns that the importance of regular checks would be lost if the indicator is implemented in its current form.

Stakeholders highlighted that the indicator is limited to the enquiry but does not address the actions required once needs are identified. They also suggested that resources and suitable support need to be available for women once mental health issues are identified.

Data quality and reliability was questioned by some stakeholders who are concerned that mothers may not be truthful when talking about their mental health due to fear of health professionals involving social services if they have concerns. They also

highlighted the discrepancy in reporting having had the conversation about mental health between women and healthcare professionals.

Stakeholders raised multiple concerns about using screening tools and highlighted that the Whooley and GAD-2 questions were not supposed to be used in isolation but be used as part of general discussion about emotional wellbeing. They also highlighted that the guideline only recommends considering using these tools due to the evidence supporting them being less certain. Some stakeholders believe that using the tools may have a negative impact on open, individualised conversation and may result in missing other conditions such as PTSD or eating disorders.

Considerations for the advisory committee

The committee is asked to consider:

- who should carry out this enquiry
- whether the enquiries should be made at additional timepoints
- the appropriateness of using the Whooley and GAD-2 questions.

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CCG12: First booking appointment

The proportion of pregnant women who were asked about their mental health at their first booking appointment

Rationale

In pregnancy and in the postnatal period, women are vulnerable to having or developing the same range of mental health problems as at other times. However, the management of mental health problems during pregnancy differs because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby.

The first booking appointment allows healthcare professionals to discuss emotional wellbeing with women and identify potential mental health problems. This will help health professionals provide appropriate support.

Summary of consultation comments

Stakeholders welcome and support the principle behind the indicator. However, stakeholders raised concerns about the scope of the indicator being too narrow as they believe that questions about mental health should be asked routinely at every appointment not just at the first booking appointment.

Stakeholders raised concerns about skills among midwives to facilitate an open and meaningful conversation. They also highlighted that the rationale outlined in the consultation document only refers to exacerbation of psychosis in pregnancy and excludes other mental health conditions.

Stakeholders suggested that including an additional indicator about asking women about history of mental health problems is important.

Considerations for the advisory committee

The committee is asked to consider:

- if the first booking appointment is the correct focus
- if an additional indicator on historical mental health problems should be explored.

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CCG13: Access to psychological services

The proportion of women referred for psychological interventions in pregnancy or the postnatal period who start treatment within 6 weeks of referral

Rationale

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

Summary of consultation comments

Stakeholders support the principles behind the indicator.

Stakeholders raised concerns about lack of awareness of IAPT services among healthcare professionals. They also suggested that to effectively support women in perinatal period, IAPT services need to prioritise perinatal mental health, address capacity issues, improve waiting times and staff training.

Stakeholders proposed an alternative indicator which would look at CCGs commissioning a specialist community perinatal mental health service, to make sure that there is adequate investment and sustainability built in.

Stakeholders suggest that extra vulnerability in the postnatal period and mothers' parenting role means that 6 weeks is too long a period to wait for specialist treatment.

Considerations for the advisory committee

The committee is asked to consider if starting treatment within 6 weeks is an appropriate timescale.

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Appendix A: Consultation comments

ID	Consultation question ID	Organisation name - stakeholder	Comment
Question 11.1 Do you think there are any barriers to implementing the care described by this indicator?			
GP11	11.1	Bliss	One in nine babies are born requiring neonatal care (77,262 babies were discharged from neonatal care in England in 2013: Neonatal Data Analysis Unit (2013) NDAU Report, Imperial College London. This equates to 11.6 per cent, or one in nine, of the 664,517 live births in England in 2013: Office for National Statistics (2013) Birth Summary Tables, England and Wales). For some of these babies, their care will be lifesaving and last many weeks or months, and will often be delivered at a neonatal unit far from the family home. For mothers, this means the majority of their time is spent with their baby on the neonatal unit, and it may be difficult for them to attend GP appointments and the post-natal check, especially if this requires them to attend a clinic far from the neonatal unit. This could mean some mothers failing to receive the appropriate mental health assessments at the earliest opportunity.
GP11	11.1	British Psychological Society Perinatal Faculty	GPs need support in increasing awareness of the issues of postnatal mental health and training in how to address the issues as many women have fears around disclosure.
GP11	11.1	Crossfell Health Centre - GP	Who will do this? As a GP practice we have had to stop doing postnatal 6 weeks checks as we no longer have the capacity to do them. Patients struggle to come in for appointments as it is and to do so with a young baby is extremely difficult. This should be done by the Health Visitor who reviews the children at home and has time and access to the mother as well.
GP11	11.1	Maternal OCD	Time restriction and knowledge of perinatal mental health by the HCP asking

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GP11	11.1	National Perinatal Epidemiology Unit	A particular barrier to this indicator will be the quality and reliability of the data collected. It is well-established that there is reluctance on the part of the mother to disclose details of her feelings and symptoms relating to mental health concerns. This can be attributed to a number of issues relating to: e.g. lack of continuity of care, lack of relationship with healthcare provider, and lack of comfort disclosing sensitive feelings; how the mental health questions are asked of the woman – tone of voice, leading questioning, etc.; fear of involvement of social services. In addition, studies have documented a discrepancy between women and health professionals as to whether they feel they have been asked about their mental health (see Boots report, 2013). For example, their work indicated that during the antenatal booking appointment, 96% of healthcare professionals reported asking about mental health, while only 11% of their patients reported being asked. I'm concerned that an indicator such as this will become little more than a 'tick box' exercise. I'm also concerned that the scope of this indicator isn't broad enough to provide an accurate illustration of the scale of the problem. As read, the indicator is not sensitive to the number of different contacts with perinatal women. As indicated in guidance, the Whooley or GAD questions ought to be asked at EACH point of contact with the woman – as written, this indicator will miss the richness of this standard of care. While it is understood that most women will attend a postnatal appointment with their GP at around 6 weeks postpartum, this is only one point in the whole maternity journey for the woman. It is also still relatively early after the birth of the baby for any significant concerns to arise in those mothers who may be experiencing some of the milder to moderate symptoms, and may not yet be at the point of talking about how they are feeling. In the development of perinatal mental health indicators for the NHSOF and the PHOF, our advisory group considered the 9-12 month time point as another key period in which to

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			ask about mother's mental health. It is a time when many mothers are starting to return to work, which can lead to an increase in difficulty coping with life changes. We were advised to consider an indicator at around this time point to ensure that healthcare professionals were asking mothers meaningful questions around this time with regards to their mental health. It is my belief that there ought to be an indicator metric that reliably measures whether mental health is asked about at every point of contact with the mother.
GP11	11.1	NCT	NCT is aware that GPs often do not have time for a meaningful discussion on emotional wellbeing in the 6-week check in its current form.* It is often ignored altogether or squeezed in at the end of an appointment, especially if the doctor has to fit in baby checks as well as maternal postnatal checks.** To address this barrier we recommend that the indicator should specify the following components: - a maternal postnatal check appointment at about 6-8 weeks, just to cover maternal health and wellbeing, with baby checks done in a separate appointment - postnatal check appointment to include an enquiry on general and emotional wellbeing early in the appointment and for emotional wellbeing to be given equal emphasis to physical. * Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 15 http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Perinatal-Mental-Health/RCGP-Exec-Summary-Falling-through-the-gaps-PMH-and-general-practice-Mar-2015.ashx **NCT (2015) Minding the Gap- Perinatal mental health service provision. Page 3 https://www.nct.org.uk/sites/default/files/related_documents/328-NCT-mindTheGap-shortReport-loRes.pdf
GP11	11.1	NHS Medway Clinical Commissioning Group	Is this not what Health Visitors already do?
GP11	11.1	Royal College of Nursing	No

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GP11	11.1	The Royal College of Midwives (RCM)	A significant barrier to implementing the care described here is the known lack of GP time to undertake this sensitive enquiry. This is an important indicator to use but it is vital to include the role of the other relevant professionals. Midwives and health visitors are the most likely professionals to be in contact with post-natal women classified as low risk. Many women are now reporting that they do not have a 6 week postnatal check which was previously considered an appropriate time for this enquiry.
GP11	11.1	The Royal College of General Practitioners	• This may be seen to be a tick box exercise which risks less meaningful conversations happening. An alternative would be an indicator such as "the percentage of women who have given birth in the preceding 12months who have had an enquiry about their mental health and documented discussion" • Screening questions can interfere with a natural conversation about mental wellbeing. • This needs to be done by midwives and health visits as GP may not see them • Staffing and resourcing issues for the additional workload in primary care • The NSC did not recommend screening for postnatal depression, although the evidence is now out of date (https://legacyscreening.phe.org.uk/postnataldepression) • In NICE CG192 the strength of the evidence reviewed for asking the Whooley questions was phrased as "could consider". In NICE this means: "We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective". • There is a lack of evidence for using the Woolley and GAD-2 questions in this way. There is some evidence in general adult populations in primary care from Bosanquet et al. Diagnostic accuracy of the Whooley questions for the identification of depression: a diagnostic meta-analysis. (BMJ Open 2015;5:e008913. doi:10.1136/bmjopen-2015-008913) This shows that the Whooley questions demonstrate discriminatory power at ruling out depression: few people who answer "no" to both questions are depressed according to gold standard diagnostic interview. However it does lead to a large number of false positives and does not help with the diagnosis of other common disorders in postnatal women • There is currently a trial looking at the utility of the Whooley questions for screening:

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			Littlewood et al - Identification of depression in women during pregnancy and the early postnatal period using the Whooley questions and the Edinburgh Postnatal Depression Scale: protocol for the Born and Bred in Yorkshire: Perinatal Depression Diagnostic Accuracy (BaBY PaNDA) study. Identification of depression in women during pregnancy and the early postnatal period using the Whooley questions and the Edinburgh Postnatal Depression Scale: protocol for the Born and Bred in Yorkshire: Perinatal Depression Diagnostic Accuracy (BaBY PaNDA) study. (BMJ Open 2016;6:e011223. doi:10.1136/ bmjopen-2016-011223) This trial has not reported yet • Service provision and funding: A postnatal check by GPs is not currently funded within the NHS England standard GP contract. (See page 50, 9.7 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/06/gms-2015-16.pdf) • We have no idea how many GPs are carrying out this check, despite lack of funding. Thus, GPs have no routine contact with postnatal women. • The indicator is vague about who does the test and in what circumstances. Health visitors have a statutory contact at 6-8 weeks as part of the '6 high impact areas' for early years, although there is currently a consultation taking place about whether this is to continue. https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children • The role of the visit is to give on-going advice about breast-feeding and to assess maternal mental health (perinatal depression) according to NICE guidelines. • It is unclear from the indicator whether GPs will be able to ask Health visitors if they have done this work and to use their results as part of the indicator. In addition this names only postnatal depression not other causes of PMI Barriers for women and professionals to disclosing PMI are discussed in Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: a systematic review and meta-synthesis of qualitative research. (Megnin-Viggars et al. Arch Womens Ment Health. 2015 Dec;18(6):745-59. doi: 10.1007/s00737-015-0548-6. Epub 2015 Jul 17.) • Falling through the gaps and Perinatal mental health: Women's and health professionals' experiences

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			• For women this includes stigma, fear of losing their child and failure to recognise their symptoms: for professionals a lack of time, training, lack of services to refer to. Asking the Whooley and GAD-2 questions will not get round these human factors. • It is not certain that the GP is necessarily the best person to make this assessment. Usually midwives and health visitors are involved in supporting women at this stage, and may be best positioned to make this assessment. It is easier for a midwife / health visitor to enquire about a patient's mental health without overmedicalising the 'baby blues'. Should they identify any concerns, then it would be appropriate for the patient to be seen and treated by the GP. The GP is not the person best placed to screen for postnatal depression. • This indicator is very ill informed. The major problem of identifying women with postnatal depression is that it can occur at any time, but that the peak incidence is at 3-6 months postpartum. • It recommends screening at a particular time convenient to practitioners, but which would necessarily miss most of those suffering from postnatal depression. It could argued that it wouldn't matter, if it resulted in picking up some mothers with depression who would otherwise be missed. The counter argument is that it might encourage doctors to think that this is the important time, and reduce their willingness to diagnose depression in those who present later. In other words reduce identification, not increase it. • It recommends two scales that have not been widely used in the postnatal period. Why does it not recommend the more widely used EPDS? • A paper published some years ago (author Judy Shakespeare, BJGP) based on women's reports about their completion of the EPDS. Overall they said that they did not fill it in honestly. For instance, women who were depressed were so worried that diagnosis might lead to children being taken from them that they pretended to be much less depressed than they were. • This indicator is recommending a screening programme where there is no evidence to support it, using the wrong scale at the wrong time and which women are unlikely to complete correctly. • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet

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			the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to implementation clinicians.
Question 11.2 Do you think there are potential unintended consequences to implementing / using this indicator?			
GP11	11.2	Bliss	As above, potentially, some mothers may not receive the appropriate mental health assessments at the earliest opportunity due to being with their baby in neonatal care.
GP11	11.2	British Medical Association	It is important that an assessment of mental health is performed in the post-partum period but this does not require the administration of a questionnaire. Sensitive open questioning, particularly where there exists an established relationship would be more appropriate.
GP11	11.2	British Psychological Society Perinatal Faculty	We broadly support the use of these but without specific training it is very easy for questions to be asked in a way that does not facilitate openness and leads to erroneous information. The second issue is that if women are identified as suffering from distress then there needs to be access to staff well trained in perinatal mental health issues to provide psychological therapies as this is what postnatal women want.
GP11	11.2	Maternal OCD	Only comments about enquiry NOT what happens next e.g. rapid referral to specialist perinatal mental health services or IAPTS (specialist perinatal mental health)
GP11	11.2	National Perinatal Epidemiology Unit	If this indicator is implemented as written, I believe there is a significant risk that the importance of mental health checks at each point of contact will be lost. I believe that it is also important to learn more of those women who may present with symptoms beyond 10 weeks postpartum may not be identified.

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GP11	11.2	NCT	1) The Whooley 2 and GAD2 scales are assessment tools not enquiry tools. Evidence is clear that they are a poor way of enquiring about mental health and although they may well be relevant in some cases, we know that using assessment scales can be counterproductive in the case of perinatal mental health as they often lead to women closing down rather than opening up.* This can lead to mental health problems being missed. From conversations with GPs, we also know that using scales such as these encourages a tick-box approach to questioning and puts a barrier between doctor and patient. Furthermore, by only including scales that assess anxiety and depression, this ignores the multitude of other mental health problems that can appear in the perinatal period (for example OCD, PTSD, puerperal psychosis) and may also miss problems of mild severity that require supervision and low-level interventions but not specialist care. It is important that practitioners begin with general questions that start a conversation on emotional wellbeing, before drilling down into specific assessment tools. Moreover, the Whooley 2 has been validated with a postnatal population in very few studies, and has been shown to have a low positive predictive value.** Therefore, we suggest that the reference to the Whooley 2 and GAD 2 as the method of enquiry should be removed from the indicator. The practitioner should be encouraged to use his or her judgement about whether the GAD or Whooley would be useful in a particular case. To address these unintended consequences, we strongly recommend deletion of the words “using the Whooley 2 depression questions and the GAD-2” Additionally, we would recommend that the indicator should specify that mental health is asked about using open supportive questioning and a sympathetic manner that encourages the woman to talk openly about her emotional well-being. This could be added to the Rationale if it is not appropriate in the indicator itself.

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			(2) We are concerned that specifying the 4-10 week postpartum period could encourage practitioners to ignore mental wellbeing at other times. We therefore recommend that the words "between 4-10 weeks postpartum" are replaced with the words "at the routine postnatal check between 4-10 weeks postpartum and at all other contacts during the postnatal period" so that practitioners are similarly encouraged to ask women about their mental health at any other postnatal appointment. * Boots Family Trust Alliance et al (2013) Perinatal mental health experiences of women and health professionals. Page 11 ** Bick, D., & Howard, L. (2010). When should women be screened for postnatal depression? Expert review of neurotherapeutics, 10(2), 151-154
GP11	11.1	Royal College of Nursing	No
GP11	11.1	The Royal College of Midwives (RCM)	A potential unintended consequence here is the creation of unnecessary anxiety in women when asking these questions. This conversation has to be handled with skill and the advantage of continuity of carer is key here. The practitioner who knows the woman's history well is the most likely to have the woman's confidence and identify any worrying changes in her mental state.

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GP11	11.2	The Royal College of General Practitioners	• Yes, it takes time up in the consultation that could be used to ask more individualised open questions that allow the woman to open up and disclose feelings of mental health problems including depression and anxiety, but also many other conditions that these questions would miss – OCD, PTSD, substance misuse, eating disorders. • Screening questions are not as good as open questions about mental well-being. Can make the consultation feel 'robotic' and that 'boxes' are being ticked. • Increase in demand for solutions that may not exist • Allocated length of time for routine postnatal checks in primary care will need to be increased which will need to be funded • The Whooley and GAD-2 questions were never intended to be seen in isolation. In NICE 192 it says • "Healthcare professionals should consider asking the following questions at a woman's booking appointment and at regular contacts in pregnancy, as part of a general discussion about her mental health and wellbeing". • Neither does QS 115 specifically use the Whooley and GAD-2 questions • Statement 4. Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact • This indicator could lead to a lack of adequate clinical assessment for women who fail to score positively and no improvement in the clinical detection of illness. There could be harms from the over-diagnosis or incorrect diagnosis • Lack of services. Even though NHS England is in a process of transforming specialist services for women it will be many years before they are available universally. Introducing this QOF indicator now is jumping the gun • This indicator is a pure process indicator with no link to outcomes and no consideration of the human factors critical to improving outcomes • There are concerns that there would be over diagnosis of postnatal depression as a result of the introduction of this indicator. • False positives

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Question 11.3 Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP11	11.3	British Medical Association	We would need reassurance that the questionnaire proposed are applicable to people of all cultures.
GP11	11.3	National Perinatal Epidemiology Unit	Research has shown that there are ethnic and socioeconomic group differences with respect to accessing mental health services, responding to the questions asked of their mental health, and to disclosing their feelings of mental ill-health. It would be worthwhile verifying that the recommended questions are suitable to various populations
GP11	11.3	NCT	Women in the perinatal period often express concerns that disclosing emotional difficulties may lead to their child being taken into care.* For this reason, it is especially important that questioning is open and non-judgemental. * Boots Family Trust Alliance et al (2013) Perinatal mental health experiences of women and health professionals. Page 3
GP11	11.3	Royal College of Nursing	No
GP11	11.3	The Royal College of Midwives (RCM)	There is great potential for differential negative impact in the context of women who's first language is not English. Access to interpreting services for the discussion could also have difficult impact in the context of gender and race.
GP11	11.3	The Royal College of General Practitioners	• Vulnerable women who are most at risk of committing suicide are hard to engage in services and treatment • Most of these women have had pre-existing mental illness and are high risk for recurrence postnatally. They should not be managed as low risk women. The impact would be negative • Women with language and cultural issues will be negatively impacted because translation services are inadequate

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Question 11.4 Do you have any general comments on this indicator?			
GP11	11.4	Bliss	Mothers whose baby is born requiring care in a neonatal unit are far more likely to experience post-natal mental health problems than the general population. One study found that 40 per cent of mothers of a premature baby were affected by post-natal depression (Vigod et al (2010), Prevalence and risk factors for postpartum depression among women with preterm and low-birthweight infants: a systematic review, BJOG, 117(5), pp.540-50). Some babies will require neonatal care for many weeks or months, and it is vital that mothers are able to access psychological support on the neonatal unit as soon as their baby is admitted. However, Bliss research shows that 41 per cent of neonatal units in England have no access to a trained mental health worker, and one third of neonatal intensive care units, where the most critically ill babies are cared for, could not offer parents the support of a trained mental health worker (Cleland (2015), Bliss baby report 2015: hanging in the balance, p.22). It is important for General Practitioners to be aware of mothers who have given birth to babies who have received neonatal care, so they can assess whether any psychological support was given while the baby was admitted on to the unit.
GP11	11.4	British Medical Association	We agree that the 6 week post-natal check is an important time to enquire about the mental state of the mother. However we do not agree that the administration of a questionnaire is
GP11	11.4	National Perinatal Epidemiology Unit	To reiterate, I think that focussing on only one time point so early in the postnatal period risks sending the wrong message and by identifying this one time point, there is a risk that the full extent of the issue is not going to be captured. It would be my opinion that the indicator (or other indicators be developed) to reflect these questions being asked at multiple time points.

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GP11	11.4	NCT	We welcome wholeheartedly the inclusion of an indicator that recognises the importance of postnatal mental health and the crucial role that GPs can play in identification and management of perinatal mental health conditions. We recommend that the indicator (or information in the Rationale accompanying the indicator) should specify the following ingredients: - a maternal postnatal check appointment at about 6-8 weeks, to cover maternal health and wellbeing only, with baby checks done separately - postnatal check appointment to start with an enquiry on mental health - using open supportive questioning and a sympathetic manner that encourages the woman to talk openly about her emotional wellbeing
GP11	11.4	Royal College of Nursing	A positive indicator.
GP11	11.4	The Royal College of Midwives (RCM)	There is no mention of the vital role of midwives and health visitors here. They are the most likely professionals to have good contact at the most relevant times.
GP11	11.4	The Royal College of General Practitioners	• A more general indicator asking about mental health ANTENATALLY and POSTNATALLY would be preferable • It is a very important area – enquiring about mental well-being is essential in the perinatal period, but NICE should not mandate a tool to use for this • Once identified, the reality is that no service is provided • This should be undertaken by the health visiting service. They also undertake a comprehensive assessment and would be a more cost efficient screening service • The GP is not necessarily the best person to make this assessment. Usually midwives and health visitors are involved in supporting women at this stage, and they may be best positioned to carry out this assessment. It is easier for a midwife / health visitor to enquire about a patient's mental health without over-medicalising the 'baby blues'. Should any concerns be identified, it would be appropriate for the patient to be seen and treated by a GP

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Question 23.1 Do you think there are any barriers to implementing the care described by this indicator?			
CCG12	23.1	British Psychological Society Perinatal Faculty	The principle is excellent. However it is not whether but how such questions are asked that matters. Midwifery staff need to be trained to do this in a way that enables openness so that results are meaningful. There are no adequate ways of assessing fear of childbirth that have been tested in a UK population. Fear of childbirth is not synonymous with anxiety. Simple psychometrically sound and acceptable tools are in the process of development (FOCUS study Slade et al) at University of Liverpool but are not yet in existence.
CCG12	23.1	Caesarean Birth	Re: "This will help health professionals provide appropriate support". A recent RCOG report highlighted problems with women accessing support in this area, and NHS resources are clearly an issue. https://www.rcog.org.uk/en/news/only-7-of-women-with-mental-health-problems-during-or-after-pregnancy-referred-to-specialist-care/ However, my organization has been contacted by a number of women over the years who have been pressured to meet with mental health/psychological support staff (often against their will) when all they want is to have their informed choice of a caesarean birth supported as per NICE CG132 (this states that an "offer" of support should be made, but if, after a discussion of the risks and benefits, a woman still wants to plan a caesarean birth, she should be supported). If women who don't want or need access to mental health support, but are made to access it in order to have their caesarean request supported, this can inevitably create a barrier to other women accessing these services.
CCG12	23.1	Maternal OCD	Only states they were asked NOT how they were asked and what happens next (and if there was anyone else in the room it may impact the mother's answer)

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CCG12	23.1	National Perinatal Epidemiology Unit	One of the primary barriers to implementing this indicator would be at the level of the health care professionals. As reported in the Boots Report (2013), there is a large discrepancy between whether healthcare professionals report having asked about a woman's mental health (96%), and whether the woman reports having been asked (11%). The cause of this is still unclear, but suggestions have pointed towards the lack of time available in appointments to ask the questions in a meaningful way, and the lack of rapport between the HCP and the patient as a result of the lack of continuity of care from multiple HCPs.
CCG12	23.1	NCT	Time pressures at the first booking appointment are a barrier. We suggest that this barrier is addressed by replacing the words "at their first booking appointment" with the words "at any antenatal appointment" so that practitioners are encouraged to ask women about their mental health at every appointment, not just the first booking appointment.
CCG12	23.1	Royal College of Nursing	No
CCG12	23.1	The Royal College of Midwives (RCM)	The lack of midwives' time and competing priorities as to what takes place at the first booking appointment The lack of ongoing mental health training for professionals (recognition and assessment) More time is necessary to provide the clinical and emotional support for women identified with any mental health problems which includes effective partnership working across the professional groups – obstetricians, psychiatrists, psychologists, midwives, health visitors and other agencies. Safeguarding issues are often related to mental health, and this is time consuming in terms of ensuring a good care plan is in place.
CCG12	23.1	The Royal College of General Practitioners	• No

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Question 23.2 Do you think there are potential unintended consequences to implementing / using this indicator?			
CCG12	23.2	Caesarean Birth	Yes. The focus on tokophobia (an extreme fear of childbirth as a mental health issue can be problematic, especially in cases where the pregnant woman is seeking support for a maternal request caesarean. As stated in 23.1 there are women being referred to mental health support services who maintain that it is not necessary for them. Tokophobia is often defined as an "irrational fear of childbirth" but when rates of mortality, morbidity and unpredictability are considered, fear is not irrational; it is rational. Evidently, there are risks and benefits with any birth plan, but assessing these two and making an informed decision should not automatically be considered a 'mental health problem' that requires treatment. Another unintended consequence is a waste of NHS resources. I am aware of women who have felt it necessary to go along the mental health assessment route in order to secure a planned caesarean birth. They could see that this was the only way a caesarean would be agreed and went along with it, but would have happily had the caesarean birth minus the mental health treatments. Finally, there are women who do not want to be treated for a mental health problem due to concerns about future repercussions related to health or life insurance. They do not want 'mental health' treatment recorded in their medical files when they are adamant that a caesarean request is not a mental health issue.
CCG12	23.2	Maternal OCD	Why only first booking? Needs to be as consistently asked as routine physical i.e. urine check

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CCG12	23.2	NCT	NCT is concerned that specifying that women should be asked about mental health at their first booking appointment may lead to women not being asked about mental health at other time points during their pregnancy. We are concerned that this could cause symptoms to be missed and could lead to escalation of problems if they are not identified, as the evidence suggests.* Therefore, we would propose that women should be asked about their mental health at every contact with a health professional during pregnancy and the postnatal period, including the first booking appointment. We therefore recommend replacing the words "at their first booking appointment" with the words "at any antenatal appointment" *Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Gray, R., & Kurinczuk, J. J. (2015). Saving Lives, Improving Mothers' Care—Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13. National Perinatal Epidemiology Unit. University of Oxford. Page 30. https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf
CCG12	23.2	Royal College of Nursing	No
CCG12	23.2	The Royal College of Midwives (RCM)	As above there is the potential for creation of unnecessary anxiety in women when asking these questions.
CCG12	23.2	The Royal College of General Practitioners	• No, provided the professional explains why it is important.

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Question 23.3 Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
CCG12	23.3	Caesarean Birth	One of the key differences in terms of adverse or positive impact can be a woman's level of education, if I may suggest adding this to the list. As a positive, these women can be stronger advocates for themselves, and are able to research and/or afford different treatments related to their situation. Maternal satisfaction in the context of birth plans and outcomes can have a very strong and lasting impact postnatal mental health.
CCG12	23.3	NCT	As pregnancy and maternity are recognised as a period of risk and vulnerability for women's physical and mental health, we strongly support the inclusion of this indicator.
CCG12	23.3	Royal College of Nursing	No
CCG12	23.3	The Royal College of Midwives (RCM)	As above, there is great potential for differential negative impact in the context of women who's first language is not English. Access to interpreting services for the discussion could also have difficult impact in the context of gender and race.
CCG12	23.3	The Royal College of General Practitioners	• No
Question 23.4 Do you have any general comments on this indicator?			
CCG12	23.4	Caesarean Birth	My organisation has been contacted by numerous women over the years who only develop anxiety and/or mental health problems as a result of their request for a planned caesarean birth being refused. Essentially, a mental health problem is created when NICE CG132 and QS32 are not followed, and then health professionals seek to treat it. This is not only unfair to women but it is also a waste of NHS resources. The NICE CG132 Costing Report estimated £1,053 for the mental health support of women who request a caesarean, while a planned caesarean was estimated to cost just £84 more than a planned vaginal delivery (when just urinary incontinence was factored in as a downstream cost). This was an issue discussed by the Guideline Development Group too:

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			"The GDG also felt that women's mental health was an important outcome to consider… It was acknowledged that not agreeing to a request for a CS could have a negative impact on a woman's mental health and potentially lead to a long-term need for psychological support postnatally… GDG members agreed that it was important to recognise the increased cost and resources required associated with CS." CG132 reads: "On balance, this model does not provide strong evidence to refuse a woman's request for CS on cost effectiveness grounds." And yet the practice of refusing to support maternal request caesareans, and/or insisting on mental health support prior to agreeing the request, persists in many NHS Trusts around the country. Unfortunately, there remains the idea that in most cases, women need to 'treated' or 'helped' in some way if they are requesting a caesarean, since such a request is 'not normal'. Even the GDG Chair, after CG132 was published, discussed caesarean maternal request and women in the context of being "misunderstood… they have been misinformed… misconceived some of the risks" (https://www.nice.org.uk/guidance/cg132/resources/transcript-184805678). This is problematic because it may encourage GPs, who may not be as up-to-date on evidence and debate in obstetric practice, to view maternal request as an irrational mental health problem.
CCG12	23.4	Maternal OCD	Concerning that only mentions psychosis can be exacerbated by pregnancy – OCD can also be exacerbated and is often a misdiagnosed perinatal mental health problem so is vital that this is overtly stated. A tweet from Maternal OCD stating: 'Perinatal OCD can also be exacerbated by pregnancy - this needs to be included in this consultation with a hyperlink to the consultation' was liked 22 times and retweeted 28 times and included prolific OCD clinicians including Professor Paul Salkovskis, Dr Fiona Challacombe and Dr Rob Willson

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CCG12	23.4	National Perinatal Epidemiology Unit	As with the proposed indicator GP11, I believe that the scope of this indicator is too narrow. The mental health of women during pregnancy ought to be checked at each contact, not just at the booking appointment. The booking appointment often happens around 12 weeks gestation, which for many women who may experience mild to moderate mental ill-health, may not develop until later in the pregnancy. It would be my recommendation that the indicator be revised to encompass the multiple contacts made with women during pregnancy, ensuring that they are asked about their mental health each time, and that the indicator reflect this accordingly. With respect to mental health at the booking appointment, I believe that an additional indicator asking about history of mental health would be meaningful. Past history of mental health issues is a very strong predictor of recurrence of mental ill-health in pregnancy, and subsequently in the postnatal year.
CCG12	23.4	NCT	We welcome wholeheartedly the inclusion of this indicator and the recognition of the importance of perinatal mental health problems, which can often begin to emerge during the antenatal period. Whilst we agree that women should be asked about their mental health at the booking appointment, we also think they should be asked at all other contact with health professionals during their pregnancy and postnatal period and appropriate action taken. Furthermore, we are keen to know how they will be asked about their mental health, as this is not specified. We know that open sensitive questions are more likely to help a woman open up about any difficulties she is experiencing. We recommend a statement be added to the indicator or the Rationale section to this effect. Despite our concerns around how this indicator would be implemented and its potential to dis-incentivise asking about mental health at other time points, we very much welcome the inclusion of an indicator.
CCG12	23.4	Royal College of Nursing	A much needed indicator.

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CCG12	23.4	The Royal College of Midwives (RCM)	There is a key need for a perinatal mental health care pathway with local leadership in including 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. The review of existing medications for the treatment of mental health problems should take place preconception, rather than at the first booking appointment.
CCG12	23.4	The Royal College of General Practitioners	• It is very important for GPs to be able to identify those women at risk of mental health problems to allow the delivery of good care
Question 24.1 Do you think there are any barriers to implementing the care described by this indicator?			
CCG13	24.1	Bliss	As mentioned in response to indicator GP11, a baby's admission to the neonatal unit, particularly if the care required is long-term, may be a barrier to mothers receiving appropriate interventions at the earliest opportunity. Further, if her own mental health care is located at a clinic away from the hospital where her baby is receiving treatment, this could make it more difficult for her to attend and receive the support she requires.
CCG13	24.1	Caesarean Birth	Some women may find it difficult to admit that they are struggling, or see it as a 'failure' to admit this.
CCG13	24.1	Maternal OCD	Lack of trained workforce needs to be prioritised – this should NOT mean that this indicator is removed, it should mean that further focus on perinatal mental health IAPTs services need to be prioritised
CCG13	24.1	NCT	NCT welcomes this indicator, however we are concerned that there are two substantial barriers to its implementation - Lack of appropriate specialist services to refer women to, and Lack of knowledge amongst health professionals of the services that do exist.

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CCG13	24.1	Royal College of Nursing	No
CCG13	24.1	The Royal College of Midwives (RCM)	The lack of ongoing mental health training for professionals (recognition and assessment) Recommending the start of treatment within 6 weeks is too long a time gap. A comprehensive assessment and treatment needs to take place within 2 weeks during pregnancy and within a week postnatally depending on the severity of the problem. Pregnant and postnatal women with a severe or a complex/enduring moderate mental health problem should be assessed at secondary mental health service level, preferably a specialist perinatal mental health service.
CCG13	24.1	The Royal College of General Practitioners	• There is widespread variation in waiting times and service provision across the country that requires improvement • Workforce issues within IAPT services - training is needed to manage perinatal women • CCGs must bid for monies to set up specialist perinatal community teams and those that are least prepared/able to bid will not be able to offer the care. • The lack of ring-fencing of the extra money after 2017-18 may prevent the provision of the specialist services
Question 24.2 Do you think there are potential unintended consequences to implementing / using this indicator?			
CCG13	24.2	Caesarean Birth	Very often women are experiencing physical problems (i.e. pelvic floor trauma) that are impacting their daily life. Some are unable to go out easily, are in pain or may be struggling to resume their sex lives. GPs, midwives, friends and family may tell them that this is a 'normal' outcome of childbirth, and they may not want to be referred for a 'mental health' problem when they themselves see it as a physical one. It is vitally important that the impact of physical personal/private pain on mental health is fully recognised or it may be missed.
CCG13	24.2	Maternal OCD	As long as the person referring is clear where on the mild/moderate/severe part of the spectrum the mum is – and that some mothers need specialist community perinatal mental health team / MBUs

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CCG13	24.2	NCT	There is a risk that severe cases requiring more urgent treatment could be de-prioritised in favour of referrals within the 6 week period. We suggest that, the maximum referral period should be reduced substantially to reflect the fact that the perinatal period is such a critical and vulnerable time. Six weeks is much too long a period to wait for treatment as conditions can escalate significantly during that time. We know from consultations with GPs that even for women with more mild depression and anxiety, six weeks can be a long time to wait, particularly at a time when they are coping with the demands of a new baby and the stresses this involves; symptoms often have to be managed by GPs whilst women wait for treatment. Furthermore, evidence from Confidential Enquiries into Maternal Deaths* show that some women who went on to die from mental health related causes were identified as having symptoms of 'anxiety' at first presentation and if they had been seen earlier, this may have prevented problems from escalating. *Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Gray, R., & Kurinczuk, J. J. (2015). Saving Lives, Improving Mothers' Care—Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13. National Perinatal Epidemiology Unit. University of Oxford. Page 30. https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf
CCG13	24.2	Royal College of Nursing	No
Question 24.3 Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
CCG13	24.3	Caesarean Birth	One of the key differences in terms of adverse or positive impact can be a woman's level of education, if I may suggest adding this to the list. As a positive, these women can be stronger advocates for themselves, and are able to research and/or afford different treatments related to their situation. As a negative, they may feel as though they 'should' be able to cope and may be better at covering up what they are feeling deep down (mentally and/or physically).

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CCG13	24.3	NCT	Extra vulnerability in the postnatal period and mothers' parenting role means that 6 weeks is too long a period to wait for specialist treatment.
CCG13	24.3	Royal College of Nursing	No
CCG13	24.3	The Royal College of Midwives (RCM)	As above, there is great potential for differential negative impact in the context of women who's first language is not English. Access to interpreting services for the discussion could also have difficult impact in the context of gender and race.
CCG13	24.3	The Royal College of General Practitioners	• Yes - the inability to provide adequate, culturally appropriate translation services and offer domiciliary services to disabled patients
Question 24.4 Do you have any general comments on this indicator?			
CCG13	24.4	Caesarean Birth	Re: "More urgent intervention may be needed at these times (and women with acute mental health problems will need to be seen as quickly as possible) because of the potential effect of the untreated mental health problem on the baby and on the woman's physical health and care, and her ability to function and care for her family." This explains the impact that mental health problems may have on a woman's physical health and care, but it is important to recognise and identify cases where the exact opposite is also true. Some doctors are not looking for/ asking about physical issues such as levator ani avulsion (LAM), obstetrical anal sphincter injuries OASI, sexual health dysfunction, prolapse or even minor tears that are causing discomfort - any of which may be specifically impacting on a woman's postnatal mental health, and all of which we know women can suffer in silence with for years (let alone weeks/months). Sometimes a combination of psychological and physical treatments will be necessary to help the woman, and one without the other is not sufficient. There is a growing body of research now looking at the impact of physical birth trauma on women's mental health, and I can send links/information if NICE would find this helpful. In particular, midwife Elizabeth Mary Skinner and Professor Hans Peter Dietz at the

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			University of Sydney have published evidence on this, and are currently researching screening tools to identify women who may be at higher risk for adverse postnatal mental health outcomes. Again, my organisation would like to emphasise that maternal satisfaction in the context of birth plans and outcomes can have a very strong and lasting impact on women's postnatal mental health. Thank you very much for this opportunity to comment on these indicators.
CCG13	24.4	Maternal OCD	We have mums with perinatal OCD repeatedly approaching us wanting support to access services promptly – please apply the necessary resources to make this happen and indeed faster than 6 weeks
CCG13	24.4	National Perinatal Epidemiology Unit	As a preliminary marker of the length of time a woman has to wait for referral, I think this indicator would be fine. However, it would be helpful to learn more about what this indicator will entail and how it will be measured. It's not possible to give an accurate review of this without key information such as: How is the indicator going to be measured? What will the numerator and denominator be? What will the thresholds be? For example, will a referral be deemed successful if the woman attends only 1 appointment? In the work that we have undertaken on the development of perinatal mental health indicators for the NHSOF and PHOF, our advisory group indicated there were other associated issues that are important to consider: - Which services will be included in the tabulation; - Whether there has been meaningful improvement in the woman's scores on a validated measure of mental health; - What will the interpretation of low referral rates mean – lack of services, the wrong services available, or lack of uptake on the part of the mother Another important point of consideration for this indicator is the data quality that will be used to populate it. From our work, we were advised that data for such an indicator was not complete, and may not be fully representative of the service.
CCG13	24.4	NCT	NCT welcomes the inclusion of this indicator as it recognises the importance of maternal mental health in the perinatal period.

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CCG13	24.4	Royal College of Nursing	A positive indicator.
CCG13	24.4	The Royal College of Midwives (RCM)	As above, there is a key need for a perinatal mental health care pathway with local leadership
CCG13	24.4	The Royal College of General Practitioners	• It may be better to hold CCGs to account by asking if they have a specialist community perinatal mental health service, to make sure that there is adequate investment and sustainability built in

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Appendix B: Equality impact assessment

Protected characteristics		
• Age • Disability • Gender reassignment	• Pregnancy and maternity • Race • Religion or belief	• Sex • Sexual orientation
Note: 1) The characteristic of marriage and civil partnership is protected only from unlawful discrimination. There is no legal requirement to consider the need to advance equality and foster good relations. 2) The definition of direct discrimination includes less favourable treatment of someone associated with a person with a protected characteristic, such as the carer of a disabled person.		
Socioeconomic factors		
The relevance and nature of socioeconomic factors will vary according to the quality standard topic. They may include deprivation and disadvantage associated with particular geographical areas, or other geographical distinctions (for example, urban versus rural).		
Other definable characteristics		
Certain groups in the population experience poor health because of circumstances distinct from – though often affected by – sharing a protected characteristic or socioeconomic factors. The defining characteristics of groups of this sort will emerge from the evidence (although a quality standard topic will sometimes explicitly cover such a group). Examples of groups identified are: • looked-after children • people who are homeless • prisoners and young offenders.		

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Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Antenatal and post-natal mental health

1.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
Stakeholders commented that mothers with pre-existing mental illness are high risk for recurrence postnatally.

1.2 Have any population groups, treatments or settings been excluded from coverage by the indicators at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?
No population groups, treatments or settings have been excluded from coverage at this stage.

1.3 Do any of the indicators make it more difficult in practice for a specific group to access services compared with another group? If so, what are the barriers to, or the difficulties with, access for the specific group?
Indicator GP11, CCG12, CCG13 - consultation comments suggest that women who do not have English as their first language may not receive appropriate support due to inadequate translation services. Stakeholders also highlighted that the questionnaires proposed might not be appropriate for women from all cultures.

1.4 Is there potential for the indicators to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No – comments from consultation do not suggest that the indicator will have an adverse impact on people with disabilities.

Completed by lead technical analyst: Ania Wasielewska

Date 30/03/2017

Approved by NICE quality assurance lead: Julie Kennedy

Date 06/04/2017