Antenatal and postnatal mental health:
clinical management and service guidance

NICE guideline

Draft for consultation, July 2006

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.
Contents

Introduction.............................................................................................................3

Patient-centred care ..........................................................................................4

Key priorities for implementation ....................................................................5

1 Guidance .........................................................................................................8
   1.1 Common aspects of care for all women with mental disorders during the antenatal and postnatal period 8
   1.2 The prediction and detection of mental disorders 9
   1.3 Care of women during the perinatal period 13
   1.4 The organisation of services 32

2 Notes on the scope of the guidance ............................................................34

3 Implementation in the NHS ..........................................................................34

4 Research recommendations ............................................................................35

5 Other versions of this guideline ....................................................................35
   5.1 Full guideline 35
   5.2 Quick reference guide 35
   5.3 Understanding NICE guidance; information for patients and carers 36

6 Related NICE guidance ..................................................................................36

7 Review date ......................................................................................................37

Appendix A: The Guideline Development Group .............................................38

Appendix B: The Guideline Review Panel .........................................................40

Appendix C: Perinatal clinical network ..............................................................41
Introduction

This guideline makes recommendations for the prediction and detection, and treatment and management of mental disorder in women during pregnancy and the postnatal period. It includes advice on the care of women with existing mental disorder who are planning a pregnancy, and advice on the configuration of mental health services. Mental disorder during pregnancy and the postpartum period can have serious consequences for the health and well-being of a mother and her baby, as well as for other family members, including her partner. The guideline covers the care of women with anxiety disorders, depression and psychotic disorders including bipolar disorder and schizophrenia. Psychotic disorders during this period are often referred to as puerperal psychoses but the diagnostic terms of schizophrenia and bipolar disorder are preferred in this guideline as there is little evidence to support the use of puerperal psychosis as a separate diagnostic entity. Similarly the term postnatal depression is avoided as it is not supported as a separate diagnostic entity, and it is can be inappropriately used as a general term for perinatal mental disorders as a group.

The guideline includes advice on the teratogenic risk of psychotropic medication and of risks during breastfeeding, and the need to balance these risks against the risks of untreated or inadequately treated disorder for the individual woman.

The guideline draws on the best available evidence. However, there are significant limitations to the evidence base, including limited data on the risks of psychotropic medication during pregnancy and breastfeeding, for example, with more recently introduced drugs.
Patient-centred care

This guideline offers best practice advice on the care of women with mental disorders during pregnancy or up to one year after the birth of their baby.

Treatment and care should take into account patient’s individual needs and preferences. Women with mental disorders during the antenatal or postnatal period should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – *Reference guide to consent for examination or treatment* (2001) (available from [www.dh.gov.uk](http://www.dh.gov.uk)).

From April 2007 healthcare professionals will need to follow a code of practice accompanying the Mental Capacity Act (summary available from [www.dca.gov.uk/menincap/bill-summary.htm](http://www.dca.gov.uk/menincap/bill-summary.htm)).

Good communication between healthcare professionals and patients, and their partners, families and carers, is essential. It should be supported by evidence-based information tailored to the patient’s needs. The treatment and care, and information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Carers and relatives should have the opportunity to be involved in decisions about the patient’s care and treatment, unless the patient specifically excludes them.

Carers and relatives should also be provided with the information and support they need.
Key priorities for implementation

The following recommendations have been identified as recommendations for implementation:

- Healthcare professionals (including midwives, health visitors and general practitioners) should be aware of the importance of mental well-being in pregnancy and the postnatal period, and the potential importance of any mental disorder (not just depression). They should routinely ask women about their mental health at first contact with primary care services, booking with maternity services, and postnatally (usually between 4 to 6 weeks and 3 to 4 months after delivery), including the following.
  - At first contact: specific questions about past or present severe psychiatric illness including schizophrenia, bipolar disorder, puerperal psychosis and previous severe depression (postnatal or other) along with questions about previous treatment by a psychiatrist/specialist mental health team including inpatient care.
  - On each of these occasions: two questions to identify possible depression (During the last month, have you often been bothered by feeling down, depressed or hopeless? During the last month have you often been bothered by having little interest or pleasure in doing things?) and consider adding a third question (Is this something you feel you need or want help with?).

- The following are not recommended for the routine prediction and detection of psychiatric disorder in pregnant or postnatal women:
  - the use of specific predictors, such as poor relationships, except previous psychiatric history
  - the use of paper and pencil self-report measures such as the Edinburgh Postnatal Depression Scale as the primary means of assessing mental state.

- The lower threshold for access to psychological therapies in the antenatal and postnatal periods requires that services should provide prompt access
to psychological therapies so that the negative impact on the mother and fetus/infant can be minimised.

- Healthcare professionals should discuss with women the absolute risks (generally the preferred metric) and relative risks associated with both treating and not treating their disorder during pregnancy and the postnatal period before treatment decisions are made. They should acknowledge the uncertainty surrounding the risks and should also:
  - work to develop a trusting relationship with women and be willing to explore the ideas, concerns and expectations of patients and regularly check the women’s understanding of the issues discussed
  - negotiate with women and, where appropriate their family members/carers, about the level of involvement of family members/carers in the discussion of risk
  - use decision aids, which focus on a personalised view of the risks, in a variety of verbal and visual formats, where possible
  - use written material summarising the risk (individualised if possible) or where possible audio-taped records or notes of the consultation which should be made available to the women.

- For women with mild or moderate depression, either antenatally or postnatally, consider the following options in order of priority:
  - self-help strategies (guided self-help, computerised cognitive behavioural therapy [C-CBT], exercise)
  - non-directive counselling delivered at home (listening visits)
  - brief CBT
  - antidepressant medication if the depression is persistent or if the women declines the offer of psychological interventions but also understands the potential risks associated with the use of antidepressant medication.

- Managed clinical networks for the delivery of perinatal mental health services should be established throughout England and Wales, comprising:
  - a coordinating board composed of relevant clinicians, commissioners, managers and service users and carers
DRAFT FOR CONSULTATION

- specialist perinatal services in each locality served by the network – such services may be part of general mental health or liaison services or particularly in areas of higher morbidity separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services at all levels of the stepped care framework
- clearly defined pathways of care for service users, with clearly defined roles and competencies for all professional groups involved in the pathway.
1 Guidance

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance (see section 5 for details).

1.1 Common aspects of care for all women with mental disorders during the antenatal and postnatal period

1.1.1 Providing good information, informed consent and mutual support

The provision of information about the nature, course, and treatment of mental disorder during the antenatal and postnatal periods is important in facilitating access to services and understanding and collaboration between patients, close family members, carers and healthcare professionals.

1.1.1.1 Healthcare professionals should provide both women with existing mental disorder who are considering pregnancy or who become pregnant, and women who develop a mental disorder during pregnancy or the postnatal period, with information about the impact of their disorder and its treatment on their health and that of the fetus/infant at every stage of assessment, diagnosis, course and treatment (including the proper use and likely side-effect profile of medication) of the disorder.

1.1.2 Supporting families and carers

1.1.2.1 Healthcare professionals should assess and, where appropriate address, the needs of the family members/carers of a woman experiencing mental disorder during pregnancy and the postnatal periods, including the following:

- the welfare of the infant, and other dependent children and adults
• the impact of mental disorder on relationships with family members and carers.

1.1.3 Additional considerations for adolescents

1.1.3.1 Healthcare professionals working with adolescents experiencing a mental disorder during pregnancy or the postnatal period should:

• be familiar with local and national guidelines on confidentiality and the rights of the child
• ensure appropriate consent is obtained, considering the adolescent’s position (including Gillick competence), parental consent and responsibilities, child protection matters, and the use of the Mental Health Act and of the Children Act (1989).

1.2 The prediction and detection of mental disorders

Pregnancy and the postnatal period are times of considerable psychological adjustment for women, and there is evidence that a woman’s mental state during this time can influence both obstetric outcomes and the development of the fetus/child, as well as affecting other family members, including the woman’s partner, if appropriate. Therefore, accurate identification of both those at risk of developing, and those currently suffering from, mental illness during this time is desirable. The routine contact with a range of healthcare professionals that women typically have at this time provides an important opportunity to identify those at risk of developing, or currently suffering from, mental disorders.

The guideline uses the terms prediction and detection to describe these processes. Prediction refers to the identification of risk factors, either current or past, which increase the probability of developing mental disorder, or the probability of relapse of a previous mental disorder at some point in the future. Detection is used to refer to the identification of current disorder.

1.2.1.1 Healthcare professionals (including midwives, health visitors and general practitioners) should be aware of the importance of mental
well-being in pregnancy and the postnatal period, and the potential importance of any mental disorder (not just depression). They should routinely ask women about their mental health at first contact with primary care services, booking with maternity services, and postnatally (usually between 4 to 6 weeks and 3 to 4 months after delivery), including the following.

- At first contact: specific questions about past or present severe psychiatric illness including schizophrenia, bipolar disorder, puerperal psychosis and previous severe depression (postnatal or other) along with questions about previous treatment by a psychiatrist/specialist mental health team including inpatient care.
- On each of these occasions: two questions to identify possible depression (During the last month, have you often been bothered by feeling down, depressed or hopeless? During the last month have you often been bothered by having little interest or pleasure in doing things?) and consider adding a third question, (Is this something you feel you need or want help with?).

1.2.1.2 Following identification of a possible mental health problem in women in the antenatal or postnatal period, a healthcare professional should consider further assessment, where appropriate in consultation with colleagues. If there is significant concern on the part of the healthcare professional or the woman a referral for further assessment should be made. This may be to the GP or a specialist mental health service but in the case of a current or a past history of severe mental illness (such as severe depression, schizophrenia and bipolar disorder) the referral should be to a specialist mental health service after discussion with the woman and at least informing, or preferably discussion with the GP.
1.2.1.3 In all cases, where a current possible mental disorder or a history of significant mental disorder is detected, even where no further detailed assessment or referral is made, the GP should be informed.

1.2.1.4 When a possible current mental health problem, or a past history of severe mental disorder has been identified in women in the antenatal or postnatal period further enquiries as to mental well-being and any emerging mental health problems should be made as a routine part of all subsequent contacts.

1.2.1.5 When referring pregnant women to maternity services GPs should include information on any relevant history of mental health problems.

1.2.1.6 The following are not recommended for the routine prediction and detection of psychiatric disorder in pregnant or postnatal women:

- the use of specific predictors, such as poor relationships, except previous psychiatric history
- the use of paper and pencil self-report measures such as the Edinburgh Postnatal Depression Scale as the primary means of assessing mental state.

1.2.1.7 Managers and senior clinicians responsible for perinatal mental health services should ensure that:

- clearly specified care pathways are in place so all primary and secondary healthcare professionals involved in the care of women in the antenatal and postnatal periods are aware how to access appropriate assessment and treatment
- staff have appropriate training and supervision to allow them to follow such pathways, including appropriate knowledge of mental disorders, assessment methods and referral routes.
1.2.2 Prevention of mental health problems

Interventions for all pregnant women

There is no evidence to support the use of psychosocial interventions in routine care specifically aimed at preventing the development of mental health disorders in the antenatal and postnatal periods.

1.2.2.1 Psychosocial interventions designed specifically to reduce the likelihood of developing mental health problems in the perinatal period should not be provided as part of routine antenatal and postnatal care.

Interventions for all pregnant women with significant psychological distress

There is evidence to support the use of psychosocial and psychological interventions for women with significant psychological distress, but which does not meet threshold for formal diagnosis of a mental disorder.

1.2.2.2 For pregnant women who have psychological distress that interferes with personal and social functioning, but does not meet diagnostic criteria for a mental disorder, consideration should be given to the provision of social support during the antenatal and postnatal period. Such support may consist of informal, but regular, individual or group-based support.

1.2.2.3 For pregnant women who have psychological distress that interferes with personal and social functioning, and who have had a previous episode of depression or anxiety consideration should be given to the provision of individual psychological treatment during the perinatal period. This treatment should involve brief (4 to 6 sessions), structured psychological interventions such as interpersonal psychotherapy (IPT) or cognitive behavioural therapy (CBT).
1.3 Care of women during the perinatal period

The specifics of treatment of women with mental disorder during pregnancy and the postnatal period should be the same as for anyone experiencing a mental disorder at any time, except that the risks posed by some psychotropic drugs for the developing fetus and for breastfed babies need to be balanced against the risks posed by untreated disorder. This may mean that the threshold for non-pharmacological treatments, in particular psychological therapies is reduced, and requires prompt and timely access if the interventions are to be of benefit. It should be noted that the background risk of malformations is between 2% and 4% in the general population and that, although this is increased by some psychotropic drugs, the precise increase in risk is often difficult to quantify because of limited data.

1.3.1 Discussing and explaining the risk of treatments

When considering treatment choices for mental disorder during pregnancy and breastfeeding, and when planning a pregnancy, it is important to place the absolute risk of problems from pharmacological treatment in the context of the individual woman’s illness, and to consider a range of factors such as the risk of relapse or deterioration in symptoms, and her ability to cope with untreated or subthreshold symptoms. In order to do this it is important that she understands the risks fully.

1.3.1.1 Healthcare professionals should discuss with women the absolute risks (generally the preferred metric) and relative risks associated with both treating and not treating their disorder during pregnancy and the postnatal period before treatment decisions are made. They should acknowledge the uncertainty surrounding the risks and should also:

- work to develop a trusting relationship with women and be willing to explore the ideas, concerns and expectations of patients and regularly check the women’s understanding of the issues discussed
• negotiate with women and, where appropriate their family members/carers, about the level of involvement of family members/carers in the discussion of risk
• use decision aids, which focus on a personalised view of the risks, in a variety of verbal and visual formats, where possible
• use written material summarising the risk (individualised if possible) or where possible audio-taped records or notes of the consultation which should be made available to the women.

1.3.2 Principles of care

Medication should be prescribed cautiously for women who are considering pregnancy, or who are pregnant or breastfeeding. The threshold for considering psychological treatments is lowered at this time.

1.3.2.1 When discussing treatment choices for a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding consider:

• treatment options that would enable women to breastfeed if they wish rather than recommending avoidance of breastfeeding
• the history of previous treatment response to help guide future treatment decisions
• the increased risk of harm associated with pharmacological interventions in pregnancy and the postnatal period and the consequent lowering of the threshold for the use of psychological interventions
• the need for timely access to any treatment because of the potential impact of a mental disorder during pregnancy or the postnatal period on the fetus, and/or the infant.

1.3.2.2 When initiating drug treatment in a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding consider:

• the use of drugs with lower risk profiles for mother and fetus/infant
• the use of the lowest effective dose whilst maintaining a therapeutic effect, and slow titration up of the dose. This is particularly important where identified risks are potentially dose-related
• the use of monotherapy in preference to combination treatment.

1.3.2.3 The lower threshold for access to psychological therapies in the antenatal and postnatal periods requires that services should provide prompt access to psychological therapies so that the negative impact on the mother and fetus/infant can be minimised.

1.3.3 Severe mental illness during pregnancy and the postnatal period

1.3.3.1 Pregnant women and those in the immediate postnatal period with severe mental illness should receive increased contact from specialist mental health services (including, where appropriate specialist perinatal mental health services) and there should be close liaison between mental health and maternity services.

1.3.3.2 A written management plan for the mental healthcare of women in pregnancy, delivery and postnatal period should be developed for all pregnant women with severe mental illness as early as possible. This should be developed in collaboration with the woman and significant others, and shared with her obstetrician, midwife, general practitioner and health visitor. A detailed record of the plan should be recorded in all versions of the patient's notes (woman's own records, maternity, primary care and mental health notes).

1.3.4 Prescribing psychotropic medication to women of childbearing potential

The teratogenic risk of some psychotropic medication early in the first trimester of pregnancy and the fact that many pregnancies are not confirmed until after the 28th day (when the neural tube closes) mean that care is
needed when prescribing to women of childbearing potential regardless of whether they are currently pregnant or even planning a pregnancy. Women should understand the risks of becoming pregnant whilst taking psychotropic medication together with the risks of untreated disorder and of stopping medication abruptly without discussion with their doctor.

1.3.4.1 Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing of medication) should be discussed with all women of child-bearing potential with an existing mental illness and/or who are taking psychotropic medication. They should be encouraged to discuss pregnancy plans with their doctor.

1.3.4.2 Valproate should not be prescribed routinely for women of child-bearing potential. If no effective alternative to valproate can be identified, adequate contraception should be used, and the risks of taking valproate during pregnancy should be explained.

1.3.4.3 Valproate should not be prescribed for young women who are younger than 18 years because of the risk of polycystic ovary syndrome and increased rate of unplanned pregnancy in this age group.

1.3.5 **Women with an unplanned pregnancy**

Due to the risks of neural tube and other defects posed by some psychotropic medication early in pregnancy, women with an unplanned pregnancy whilst taking such medication should be offered appropriate advice.

1.3.5.1 If a woman taking carbamazepine, lamotrigine, lithium, paroxetine or valproate has an unplanned pregnancy:

- the pregnancy should be confirmed as quickly as possible
- the woman should be advised to stop taking valproate, carbamazepine, lamotrigine and paroxetine
• if the pregnancy is confirmed in the first trimester, and the woman is stable, lithium should be stopped gradually over 4 weeks, and the woman informed that this may not remove the risk of cardiac defects in the fetus
• if the woman remains on lithium during pregnancy serum lithium levels should be checked every 4 weeks, then weekly from the 36th week, and less than 24 hours after childbirth; the dose should be adjusted to keep serum levels within the therapeutic range, and the woman should maintain adequate fluid intake
• offer appropriate screening and counselling about the continuation of the pregnancy, the need for additional monitoring and the risks to the fetus if the woman stays on medication.

1.3.5.2 If a woman with serious mental disorder taking potentially harmful medication and an unplanned pregnancy continues with the pregnancy, a full paediatric assessment of the new-born baby is required with appropriate social and medical help being provided for mother and child.

1.3.6 Women planning pregnancy

1.3.6.1 Women taking antipsychotics who are planning a pregnancy should be advised that the raised prolactin levels associated with some antipsychotics reduce the chances of conception. If prolactin levels are raised, an alternative drug should be considered.

1.3.6.2 Women who are considering pregnancy should normally be advised to stop taking valproate, carbamazepine, lithium and lamotrigine, and alternative drugs (such as an antipsychotic) should be considered.

1.3.7 Women who are pregnant

1.3.7.1 The following drugs should not be routinely prescribed for pregnant women:
• valproate because of risk to the fetus and subsequent child intellectual development. If valproate is used it should be limited to a maximum of 1 gram per day, administered in divided doses and in the slow release form, with 5 mg/day folic acid
• carbamazepine because of its limited efficacy and risk of harm to the fetus
• lamotrigine because of its limited efficacy and the possible risk to the fetus
• paroxetine because of the risk of cardiovascular malformations in the fetus
• long-term treatment with benzodiazepines because of risks during pregnancy (for example cleft palate) and the immediate postnatal period (for example floppy baby syndrome).

1.3.8  Sleep problems

Sleep problems are an issue in the management of most mental disorders, and may be a particular issue in pregnancy. Some of the drugs commonly prescribed are not safe for longer term use in pregnancy, notably benzodiazepines. Alternatives may include chlorpromazine or amitriptyline which can be effective at low-dose for sleep problems.

1.3.8.1 For patients with sleep problems first consider providing general advice about sleep hygiene. For women with serious and chronic problems consideration may be given to the use of low-dose chlorpromazine or low-dose amitriptyline.

1.3.9  Care of the infant

1.3.9.1 Any child born to a mother prescribed a psychotropic drug during pregnancy should be monitored for adverse drug effects, drug toxicity or withdrawal (for example, floppy baby syndrome, irritability, constant crying, shivering, tremor, restlessness, increased tone, feeding and sleeping difficulties and rarely seizures) in the first few weeks after delivery. If the mother was prescribed antidepressants in
the last trimester, such symptoms may be a serotonergic toxicity syndrome rather than withdrawal, and the neonate should be monitored.

1.3.10 Women who are breastfeeding

1.3.10.1 Prescribers should note that the following drugs should not be routinely prescribed for women who are breastfeeding:

- lithium because of high levels in breast milk
- lamotrigine because of the potential risk of dermatological problems
- clozapine because of high levels in breast milk and the risk of agranulocytosis in infants
- citalopram and fluoxetine because of high levels in breast milk.

1.3.11 Use of electroconvulsive therapy in any mental disorder

1.3.11.1 For women with severe depression, severe mixed affective states and mania in the context of bipolar disorder, or catatonia, and whose physical health/or that of the fetus is at serious risk, a course of electroconvulsive therapy (ECT) should be considered.

1.3.12 Additional guidance for specific disorders

This section considers how existing NICE guidance should be adapted for women planning a pregnancy, or who are pregnant or breastfeeding. It should be read in conjunction with the general advice above.

Bipolar disorder

Whilst the risk of relapse of treated and untreated bipolar disorder is no different during pregnancy, the likelihood of treatment discontinuation due to the pregnancy is much higher and is often unplanned and abrupt. In addition there is a significant increase in risk of 50% or more postnatally.
General principles of management for pregnant women with bipolar disorder

1.3.12.1 If a pregnant woman with bipolar disorder is stable on an antipsychotic and likely to relapse without medication, she should be maintained on the antipsychotic, and monitored for weight gain and diabetes.

Women with bipolar disorder planning a pregnancy

1.3.12.2 If a woman who needs antimanic medication plans to become pregnant, a low-dose typical or atypical antipsychotic should be considered, because they are of least known risk.

1.3.12.3 If a woman taking lithium plans to become pregnant, the following options should be considered:

- if the patient is well and not at high risk of relapse – gradually stopping lithium
- if the patient is not well or is at high risk of relapse:
  - switching gradually to an antipsychotic, or
  - stopping lithium and restarting it in the second trimester if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past, or
  - continuing with lithium, after full discussion of the risks, while trying to conceive and throughout the pregnancy, if manic episodes have complicated the woman’s previous pregnancies, and her symptoms have responded well to lithium.

1.3.12.4 If a woman remains on lithium during pregnancy, serum lithium levels should be monitored every 4 weeks, then weekly from the 36th week, and less than 24 hours after childbirth. The dose should be adjusted to keep serum levels within the therapeutic range. The woman should maintain adequate fluid intake.

1.3.12.5 If a woman with bipolar disorder planning a pregnancy becomes depressed after stopping prophylactic medication, psychological
therapy (CBT) should be offered in preference to an antidepressant because of the risk of switching associated with antidepressants. If an antidepressant is used, it should usually be a selective serotonin reuptake inhibitor (SSRI; but not paroxetine because of the risk of cardiovascular malformations in the fetus) and the woman should be monitored closely.

Women with an unplanned pregnancy
1.3.12.6 If a woman with bipolar disorder has an unplanned pregnancy follow the advice above. If stopping lithium as prophylactic medication, an antipsychotic should be offered.

Pregnant women with acute mania or bipolar depression
Acute mania
1.3.12.7 If a pregnant women who is not taking medication develops acute mania, an atypical or a typical antipsychotic should be considered. The dose should be kept as low as possible and the woman monitored carefully.

1.3.12.8 If a pregnant woman develops acute mania while taking prophylactic medication prescribers should:

- check the dose of the prophylactic agent and adherence
- increase the dose if the woman is taking an antipsychotic, or consider changing to an antipsychotic if she is not
- if there is no response to changes in dose or drug and the patient has severe mania, consider the use of ECT, lithium and, rarely, valproate.

1.3.12.9 If there is no alternative to valproate the woman should be informed of the increased risk to the fetus and the child’s intellectual development. The lowest possible effective dose should be used and augmenting it with additional antimanic medication (but not carbamazepine) considered. The maximum dosage should be
1 gram per day, in divided doses and in the slow-release form, with 5 mg/day folic acid.

**Depressive symptoms**

1.3.12.10 For mild depressive symptoms in pregnant women with bipolar disorder the following should be considered:

- self-help approaches such as guided self-help and computerised CBT (C-CBT)
- brief psychological interventions
- antidepressant medication.

1.3.12.11 For moderate to severe depressive symptoms in pregnant women with bipolar disorder the following should be considered:

- psychological treatment (CBT) for moderate depression
- combined medication and structured psychological interventions for severe depression.

1.3.12.12 For moderate to severe depressive symptoms in pregnant women with bipolar disorder, quetiapine alone, or SSRIs (but not paroxetine) in combination with prophylactic medication should be preferred because SSRIs are less likely to be associated with switching than the tricyclic antidepressants (TCAs). Monitor closely for signs of switching and stop the SSRI if patients start to develop manic or hypomanic symptoms.

**Care in the perinatal period**

1.3.12.13 Women taking lithium should deliver in hospital, and be monitored during labour by the obstetric medical team, in addition to usual midwife care. Monitoring should include fluid balance, because of the risk of dehydration and lithium toxicity.

1.3.12.14 After delivery, if a woman with bipolar disorder who is not on medication is at high risk of developing an acute episode, prescribers should consider establishing or reinstating medication as
soon as the patient is medically stable (once the fluid balance is established).

1.3.12.15 If a woman maintained on lithium is at high risk of a manic relapse in the immediate postnatal period, augmenting treatment with an antipsychotic should be considered.

1.3.12.16 If a woman with bipolar disorder develops severe manic or psychotic symptoms and behavioural disturbance in the intrapartum period rapid tranquillisation with an antipsychotic should be considered in preference to a benzodiazepine because of the risk of floppy baby syndrome. Treatment should be in collaboration with an anaesthetist.

**Women with bipolar disorder who with to breastfeed**

1.3.12.17 Women with bipolar disorder who are taking psychotropic medication and wish to breastfeed should be offered a prophylactic agent that can be used when breastfeeding – an antipsychotic should be the first choice.

**Depression**

This section should be read in conjunction with the NICE clinical guideline on the treatment and management of depression in primary and secondary care (see section 6 for details).

The risks associated with antidepressant treatment during pregnancy and breastfeeding include spontaneous abortion, heart defects in the fetus (particularly with paroxetine), and the possibility of serotonergic syndrome or serotonin withdrawal syndrome in the neonate. These risks alter the threshold for psychological treatments. In addition, risks are better established in older drugs and a cautious approach would be to avoid newer drugs.

**For women currently being treated for depression who are planning a pregnancy or with an unplanned pregnancy**

1.3.12.18 For women being treated for mild depression who are currently taking an antidepressant, withdraw the medication gradually and...
consider monitoring (‘watchful waiting’). If intervention is required consider:

- self-help strategies (guided self-help, C-CBT, exercise) or
- brief psychological therapy.

1.3.12.19 For women taking an antidepressant who initially presented with moderate depression consider the following options in discussion with the patient, taking into account previous response to treatment, patient preference, and risk:

- switching to psychological therapy (CBT/IPT)
- switching to an antidepressant with lower risk unless clinical history shows that woman does not respond to alternative antidepressants.

1.3.12.20 For women taking an antidepressant who initially presented with severe depression consider the following options in discussion with the patient, taking into account previous response to treatment, patient preference, and risk:

- combining with psychological treatment and switching to an antidepressant with lower risk unless clinical history shows that woman does not respond to alternative antidepressants
- switching to psychological treatment (CBT/IPT).

For pregnant or breastfeeding women experiencing a new episode of depression

1.3.12.21 For women with mild or moderate depression, either antenatally or postnatally, consider the following options in order of priority:

- self-help strategies (guided self-help, C-CBT, exercise)
- non-directive counselling delivered at home (listening visits)
- brief CBT
- antidepressant medication if the depression is persistent or if the women declines the offer of psychological interventions but also
understands the potential risks associated with the use of antidepressant medication.

1.3.12.22 For women with moderate or severe depression, either antenatally or postnatally:

- consider a structured psychological treatment developed specifically for the treatment of depression (CBT/IPT)
- consider the provision of antidepressant treatment where a woman has expressed a preference for antidepressant medication
- if there is no, or a limited response, to either psychological or pharmacological treatment alone consider combination treatment provided the woman understands the potential risks associated with the use of antidepressant medication.

Treatment-resistant depression
1.3.12.23 Healthcare professionals should consider a further trial of a single drug or ECT before considering combination pharmacological treatment in women with treatment-resistant depression.

Choice of antidepressant
1.3.12.24 When choosing an antidepressant for pregnant or breastfeeding women with depression take into account previous response to treatment, patient preference, risk and continuity of treatment. The choice of individual drugs may be influenced by the following factors.

- The balance of known risks favours TCAs over other antidepressants during pregnancy and breastfeeding compared with other times
- The TCA with relatively low cardiotoxicity and relative safety in overdose compared with other antidepressants is lofepramine
- The drugs with the lowest levels in breast milk are nortriptyline and sertraline.
Eating disorders
This section should be read in conjunction with the NICE clinical guideline on the treatment and management of eating disorders (see section 6 for details).

Although anorexia nervosa reduces a woman’s fertility, women with this disorder can become pregnant as can those with bulimia nervosa, who are prone to unplanned pregnancy in part due to vomiting oral contraceptives.

Women with anorexia nervosa
1.3.12.25 For women with anorexia nervosa who are planning a pregnancy, who have an unplanned pregnancy or who are breastfeeding follow the existing NICE guideline.

Women with binge eating disorder
1.3.12.26 For women with binge-eating disorder who are planning a pregnancy, who have an unplanned pregnancy or who are breastfeeding and who are taking an antidepressant follow the section on the treatment of depression.

Women with existing bulimia nervosa or binge-eating disorder
1.3.12.27 For a woman with bulimia nervosa who is considering a pregnancy or pregnant and who is taking medication, consider gradually stopping the medication following discussion with the woman. If the problem persists consider referral to specialist treatment.

For women experiencing an episode of bulimia nervosa whilst breastfeeding
1.3.12.28 For a woman who is breastfeeding whilst experiencing an episode of bulimia nervosa initiate psychological treatments rather than initiating fluoxetine at 60 mg. If there is no alternative to fluoxetine at 60 mg, advise the patient not to breastfeed.
Generalised anxiety disorder (GAD)
This section should be read in conjunction with the NICE clinical guideline on the treatment and management of anxiety in primary, secondary and community care (see section 6 for details).

For women with existing GAD who are considering a pregnancy or who are pregnant
1.3.12.29 For women considering pregnancy or who become pregnant whilst being treated for generalised anxiety disorder consider:

- stopping medication (gradually over 4 weeks) and starting psychological therapy (CBT/IPT) if this treatment option has not already been tried
- if the decision is to maintain medication consider switching (by cross-tapering) to a TCA (for example, imipramine) or sertraline if the woman is not already on one of these drugs
- Consider stopping benzodiazepines and sedating antihistamines if these are being used.

For women experiencing a new episode of GAD
1.3.12.30 For women who experience a new episode of GAD during pregnancy follow the existing NICE guideline and initiate appropriate psychological treatments (CBT/IPT), but do not routinely prescribe benzodiazepines, sedating antihistamines, paroxetine or venlafaxine.

Panic Disorder
This section should be read in conjunction with the NICE clinical guideline on the treatment and management of anxiety in primary, secondary and community care (see section 6 for details).

For women with existing panic disorder who are considering a pregnancy or who are pregnant
1.3.12.31 For women considering pregnancy or who become pregnant whilst being treated for panic disorder:
- consider stopping medication (gradually over 4 weeks) and starting psychological therapy (CBT/IPT) if this treatment option has not already been tried
- if the decision is to maintain medication consider switching (by cross-tapering) to a TCA (for example, imipramine) or sertraline if the woman is not already on one of these drugs.

1.3.12.32 For other treatment decisions women considering pregnancy or who become pregnant whilst being treated for panic disorder follow the existing NICE guideline.

For women experiencing a new episode of panic disorder

1.3.12.33 For women who experience a new episode of panic disorder during pregnancy consider psychological therapy (CBT/IPT), self-help or CCBT before initiating a pharmacological treatment.

1.3.12.34 When considering pharmacological therapy in women who experience a new episode of panic disorder during pregnancy do not initiate paroxetine but use another drug such as sertraline.

1.3.12.35 For a woman who experiences a new episode of panic disorder whilst breastfeeding follow the existing guideline except do not initiate venlafaxine or benzodiazepines.

Obsessive compulsive disorder

This section should be read in conjunction with the NICE clinical guideline on the treatment and management of obsessive compulsive disorder (OCD) (see section 6 for details).

Severe OCD in pregnant and postnatal women can present a serious challenge for both mother and her fetus/baby, and also to her family. Whilst in common with the treatment of other disorders during this time, there should be a shift in threshold towards favouring initial treatment with psychological interventions, the impact on functioning of severe OCD on mother and
fetus/infant suggests that effective pharmacological treatment must be considered.

**For women with OCD planning a pregnancy or who are pregnant**

1.3.12.36 When treating a woman with OCD who is planning a pregnancy or who is pregnant, follow the existing NICE guideline except:

- consider initiating psychological therapy before pharmacological treatment
- for a woman taking paroxetine stop the drug and consider switching (by cross-tapering) to an alternative antidepressant (such as, imipramine and sertraline).

1.3.12.37 For women with OCD who are pregnant and wish to breastfeed but who do not respond adequately to treatment, follow the existing NICE guideline except avoid the use of combination pharmacological treatments where possible.

**For women experiencing a new episode of OCD during pregnancy**

1.3.12.38 When treating a woman with a new episode of OCD during pregnancy, follow the existing NICE guideline except:

- consider initiating psychological therapy before pharmacological treatment provided rapid access to such treatment can be assured.
- when initiating pharmacological treatment, consider an alternative antidepressant (for example, amitriptyline, imipramine or sertraline) and provide in combination with psychological therapy.

**For women experiencing a new episode of OCD whilst breastfeeding**

1.3.12.39 For women with OCD who are breastfeeding follow the existing NICE guideline except do not prescribe a combination of clomipramine and citalopram because of high levels in breast milk.
**Post-traumatic stress disorder**
This section should be read in conjunction with the NICE clinical guideline on the treatment and management of post-traumatic stress disorder (PTSD) (see section 6 for details).

There is no convincing evidence for the pharmacological treatment of PTSD regardless of pregnancy status and, therefore, psychological interventions are preferred. If there are significant difficulties with sleep, follow the advice in recommendation 1.3.8.1.

*For women with PTSD planning a pregnancy or who are pregnant*

1.3.12.40 Follow existing NICE guideline. For a woman taking paroxetine, stop the drug, and provide trauma-focused psychological therapy (eg CBT).

1.3.12.41 For women with existing PTSD planning a pregnancy or who are pregnant do not prescribe adjunctive olanzapine.

*For women with PTSD who are breastfeeding*

1.3.12.42 For women with PTSD who are breastfeeding follow the existing NICE guideline.

*Formal debriefing following traumatic birth*

1.3.12.43 Single session formal debriefing focused on women’s experience of traumatic birth should not be routinely provided to women who have experienced a traumatic birth. However, this should not preclude maternity staff and other healthcare professionals from encouraging the women to talk about their experience and in particular the natural support systems available from family, friends and also the effect of the birth on the partner.

**Schizophrenia**
This section should be read in conjunction with the NICE clinical guideline the treatment and management of schizophrenia (see section 6 for details).
For women with existing schizophrenia planning a pregnancy or who are pregnant

1.3.12.44 For pregnant women requiring treatment for schizophrenia, follow the existing NICE guideline except consider the following issues.

- That the emphasis of treatment is to restore and maintain functioning at a level high enough to cope with pregnancy, delivery and parenting.
- For women currently taking an atypical antipsychotic, consider switching to low-dose haloperidol or other typical antipsychotic, such as chlorpromazine or trifluoperazine, unless the clinical history shows that the current drug is the only one which is effective and tolerated.
- When considering prescribing olanzapine consider risk factors for the precipitation of gestational diabetes and weight gain, including family history, existing weight, ethnicity.
- For women already on clozapine consider switching to another drug.
- For women receiving medication via depots, continue with the medication.
- For women taking anticholinergic drugs for the side effects of medication, reduce the dose with the aim of stopping regular use of this medication and as necessary reduce the antipsychotic to the minimum effective dose or using p.r.n. at the lowest dose and lowest frequency.
- For women with treatment-resistant schizophrenia, avoid the initiation of clozapine during pregnancy due to the theoretical risk of agranulocytosis in the fetus but consider at an early stage postnatally when the women is not breastfeeding in order to optimise symptom control and functioning.

For women with schizophrenia who are breastfeeding

1.3.12.45 For women who are breastfeeding and require treatment for schizophrenia, follow the existing NICE guideline except advise
women receiving medication via depots that their baby may show EPS symptoms several months after administration of the depot. These symptoms are usually self-limiting.

1.3.12.46 Do not prescribe clozapine in breastfeeding women because of the high levels in breast milk.

**Rapid tranquillisation**

1.3.12.47 For pregnant women requiring rapid tranquillisation in the context of a diagnosis of schizophrenia, follow the existing NICE guideline except:

- do not seclude a pregnant woman following rapid tranquillisation
- adapt restraint procedures to avoid possible harm to the baby.
- when choosing an agent for rapid tranquillisation in a pregnant woman, choose an antipsychotic in preference to a benzodiazepine because of the risk of floppy baby syndrome. If rapid tranquillisation is required during the perinatal period, the woman should be managed in close collaboration with an anaesthetist.

### 1.4 The organisation of services

Since the precise structure of services varies in different parts of the country based on local factors including the organisation of existing mental health services, the demographic profile of the local population, and geographical issues, the provision of services needs to be seen in terms of standard features which can be adopted by any service and adapted to meet local need in order to deliver integrated care. This is conceptualised by a managed network model, defined as linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and service boundaries. This will help to ensure equitable provision of high quality clinically effective services. A model is provided in Appendix D.
1.4.1.1 Managed clinical networks for the delivery of perinatal mental health services should be established throughout England and Wales, comprising:

- a coordinating board composed of relevant clinicians, commissioners, managers and service users and carers
- specialist perinatal services in each locality served by the network – such services may be part of general mental health or liaison services or particularly in areas of higher morbidity separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services at all levels of the stepped care framework
- clearly defined pathways of care for service users, with clearly defined roles and competencies for all professional groups involved in the pathway.

1.4.1.2 Each managed perinatal mental health network should have designated specialist inpatient services and typically provide for a population of between 2 million and 4 million.

1.4.1.3 Each specialist perinatal inpatient services normally providing between 6 to 12 beds should:

- provide facilities designed specifically for mother and infants
- be staffed by specialist perinatal mental health staff
- be staffed so as to provided appropriate care for infants
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services
- be closely integrated with community based mental health services to ensure continuity of care and minimum necessary length of stay.
2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from [www.nice.org.uk/page.aspx?o=232805](www.nice.org.uk/page.aspx?o=232805).

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: ‘The guideline development process: an overview for stakeholders, the public and the NHS’ (second edition, published April 2006), which is available from [www.nice.org.uk/guidelinesprocess](www.nice.org.uk/guidelinesprocess) or by telephoning 0870 1555 455 (quote reference N0472).

3 Implementation in the NHS

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in ‘Standards for better health’, issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website ([www.nice.org.uk/CGXXX](www.nice.org.uk/CGXXX)).

[NICE to amend list as needed at time of publication]

- Slides highlighting key messages for local discussion.
• Costing tools
  – Costing report to estimate the national savings and costs associated with implementation.
  – Costing template to estimate the local costs and savings involved.
• Implementation advice on how to put the guidance into practice and national initiatives which support this locally.
• Audit criteria to monitor local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. [To be completed after consultation]

5 Other versions of this guideline

5.1 Full guideline

The full guideline, ‘Antenatal and postnatal mental health: clinical management and service guidance’ contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from www.nccmh.org.uk, our website (www.nice.org.uk/CGXXXfullguideline) and the National Library for Health (www.nlh.nhs.uk). [Note: these details will apply to the published full guideline.]

5.2 Quick reference guide

A quick reference guide for health professionals is also available from our website (www.nice.org/CGXXXquickrefguide) and the NHS Response Line (telephone 0870 1555 455; quote reference number NXXXX). [Note: these details will apply when the guideline is published.]
5.3 Understanding NICE guidance; information for patients and carers

A version of this guideline for women and their partners/carers is available from our website (www.nice.org.uk/CGXXXpublicinfo) and the NHS Response Line (0870 1555 455); quote reference number NXXXX). [Note: these details will apply when the guideline is published.]

6 Related NICE guidance


- Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline no. 22 (2004). Available from www.nice.org.uk/CG022


DRAFT FOR CONSULTATION


NICE is developing the following guidance (details available from [www.nice.org.uk](http://www.nice.org.uk)):

- Postnatal care: routine postnatal care of women and their babies. NICE clinical guideline. (Publication expected July 2006.)

7 Review date

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.
Appendix A: The Guideline Development Group

Dr Dave Tomson
Guideline Development Group Chair
GP and Consultant inpatient centred primary care
North Shields

Mr Stephen Pilling
Facilitator, Guideline Development Group; Joint Director, National Collaborating Centre for Mental Health; Director, Centre for Outcomes Research and Effectiveness; Consultant Clinical Psychologist, Camden and Islington Mental Health and Social Care Trust

Dr Fiona Blake
Consultant Psychiatrist
Cambridge University Hospitals NHS Foundation Trust

Ms Rachel Burbeck
Systematic Reviewer, from July 2005
National Collaborating Centre for Mental Health

Dr Sandra Elliott
Consultant Clinical Psychologist
South London & Maudsley NHS Trust

Dr Pauline Evans
Service User Representative, Guideline Development Group
Senior Lecturer in health and social care
University of Gloucestershire

Ms Josephine Foggo
Project Manager, until August 2005
National Collaborating Centre for Mental Health

Dr Alain Gregoire
Consultant Perinatal Psychiatrist
Hampshire Partnership NHS Trust & University of Southampton

Dr Jane Hamilton
Consultant Psychiatrist in Maternal Health
Sheffield Care Trust

Mrs Claire Hesketh
Primary Care Mental Health Manager
Northumberland, Tyne & Wear NHS Trust

Ms Rebecca King
Project Manager, from August 2005
National Collaborating Centre for Mental Health

Dr Elizabeth McDonald
Consultant Perinatal Psychiatrist
East London and the City NHS Mental Health Trust
Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The Panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

Dr Graham Archard
GP

Dr Jo Cox,
Clinical Research Physician, Eli Lily

Ms Karen Cowley,
Practice Development Nurse, York Health Services NHS Trust

Mr Barry Stables
Patient/Lay Representative
Appendix C: Perinatal clinical network

Key
- Patient flow
- Information and education flow

Coordinating Centre
- Coordinate associated inpatient unit(s)
- Coordinating board
- Network manager
- Local specialist service provision
- Protocol development and monitoring

Specialist perinatal services
- Local specialist provision
- Managing admissions
- Consultancy and training to primary and secondary care
- May be separate service or part of specialist MH service

Specialist mental health services
- Local service provision
- Assessment and referral
- Consultancy and advice

Primary care services
- Local service provision
- Assessment and referral

Maternity services
- Local service provision
- Assessment and referral