BMJ 2014;349:g7394 doi: 10.1136/bmj.g7394 (Published 18 December 2014)

PRACTICE

GUIDELINES

Antenatal and postnatal mental health: summary of updated NICE guidance

Louise M Howard *professor, consultant perinatal psychiatrist*[1], Odette Megnin-Viggars *systematic reviewer*[2], Iona Symington *research assistant*[3 4], Stephen Pilling *director, professor*[3 4], On behalf of the Guideline Development Group

[1]Section of Women's Mental Health, Health Service and Population Research Department, King's College London, London, UK; [2]National Collaborating Centre for Mental Health, Royal College of Psychiatrists, London, UK; [3]Centre for Outcomes Research and Effectiveness, University College London, London, UK; [4]National Collaborating Centre for Mental Health, University College London, London, UK

This is one of a series of *BMJ* summaries of new guidelines based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

This guideline is an update of the 2007 National Institute for Health and Care Excellence (NICE) guideline on antenatal and postnatal mental health.[1] It covers a broad range of mental disorders, including depression, anxiety disorders, eating disorders, drug and alcohol use disorders, and severe mental illness (such as psychosis, bipolar disorder, schizophrenia, and severe depression), which can all occur in the antenatal and postnatal periods. The guidance focuses on aspects of the identification and management of these disorders that are specific to this context. For example, women with bipolar disorder are at increased risk of a relapse in the early postpartum period, and postpartum psychoses (whether in women with bipolar disorder or not) are particularly rapid in onset and severe.[2] These problems are managed differently during the antenatal and postnatal periods than at other times because of the impact that the mental disorder and its treatment (for example, the use of psychotropic drugs) can have on the fetus or baby.[3 4]

This article summarises the most recent recommendations from NICE on the clinical management of antenatal and postnatal mental health (Clinical Guideline CG192).[5]

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group's experience and opinion of what constitutes good practice. Evidence levels for the recommendations are given in italic in square brackets.

Considerations for women of childbearing potential

- Discuss with all women of childbearing potential who have a new, existing, or past mental health problem:
  -The use of contraception and any plans for a pregnancy
  -How pregnancy and childbirth might affect a mental health problem, including the risk of relapse (for example, at least a fifth of women with bipolar disorder have a severe recurrence after childbirth)
  -How a mental health problem and its treatment might affect the woman, the fetus, or baby and have an impact on parenting.
- (New recommendation.) [*Based on the experience and opinion of the Guideline Development Group (GDG)*]
- Do not offer valproate for acute or long term treatment of a mental health problem in women of childbearing potential because of the increased risk of major congenital malformations (event rate 7-10% relative to a baseline risk of about 3% in the general population) and adverse neurodevelopmental outcomes (average decrease in IQ of 9 points). (New recommendation.) [*Based on moderate quality observational study evidence and the experience and opinion of the GDG*]

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

- At a woman's first contact with primary care or her booking visit, and during the early postnatal period, all health professionals should consider asking the following

Correspondence to: S Pilling s.pilling@ucl.ac.uk

The bottom line

- Do not offer valproate for acute or long term treatment of mental health problems in women of childbearing potential
- Assess women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period for treatment within two weeks of referral; provide psychological interventions within one month of initial assessment
- At a pregnant woman's first contact with services, ask about any past or present severe mental illness, previous or current treatment, and any severe postpartum mental illness in a first degree relative
- Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment

depression identification questions as part of a general discussion about mental health and wellbeing:

-During the past month have you often been bothered by feeling down, depressed, or hopeless?

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

- (New recommendation.) [*Based on meta-analysis, an economic model, and on evidence reviewed in a NICE guideline on common mental health disorders (CG123)*] [6]
- Also consider asking about anxiety using the two item generalized anxiety disorder scale (GAD-2):

-During the past month have you been feeling nervous, anxious, or on edge?

-During the past month have you not been able to stop or control worrying?

- (New recommendation.) [*Based on the experience and opinion of the GDG and on evidence reviewed in a NICE guideline on common mental health disorders (CG123)*] [6]
- If the woman answers yes to any of the above questions, or where there is clinical concern, further assessment is needed. Consider using formal measures such as the patient health questionnaire (PHQ-9),[7] the Edinburgh postnatal depression scale (EPDS),[8] or GAD-7[9] and referral to a general practitioner or mental health professional, depending on the severity of the presenting problem. (New recommendation.) [*Based on a meta-analysis, an economic model, the experience and opinion of the GDG, and on evidence reviewed in a NICE guideline on common mental health disorders (CG123)*] [6]
- Assess all women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period for treatment within two weeks of referral and provide psychological interventions within one month of initial assessment. (New recommendation.) [*Based on the experience and opinion of the GDG*]
- At all subsequent contacts during pregnancy and the first year after birth, the health visitor and other healthcare professionals who have regular contact with the woman should consider asking the two depression questions and using GAD-2 as well as the EPDS or the PHQ-9 as part of monitoring. (New recommendation.) [*Based on the experience and opinion of the GDG*]
- If alcohol misuse is suspected, use the alcohol use disorders identification test (AUDIT) as an identification tool in line with the guideline on alcohol use disorders. (New recommendation.) [*Based on the experience and opinion of the GDG and on evidence reviewed in a NICE guideline on alcohol use disorders (CG115)*] [10]
- If drug misuse is suspected, follow the recommendations on identification and assessment in the guideline on drug misuse—psychosocial interventions. (New recommendation.) [*Based on the experience and opinion of the GDG and on evidence reviewed in a NICE guideline on drug misuse (CG51)*] [11]
- At a woman's first contact with services, ask about any past or present severe mental illness, previous or current treatment, and any severe postpartum mental illness in a first degree relative. Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, and ensure that the woman's GP knows about the referral. (New recommendation.) [*Based on the experience and opinion of the GDG*]
- If a woman has any past or present severe mental illness or there is a family history of severe antenatal or postnatal mental illness in a first degree relative, be alert for possible symptoms of postpartum psychosis in the first two weeks after childbirth. (New recommendation.) [*Based on the experience and opinion of the GDG*]
- If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within four hours). (New recommendation.) [*Based on the experience and opinion of the GDG*]

Principles of care

Coordinated care

- Develop an integrated care plan for a woman with a mental health problem that sets out:

-The care and treatment for the mental health problem

-The roles of all healthcare professionals, including who is responsible for:

Coordinating the integrated care plan

The schedule of monitoring

Providing the interventions and agreeing the outcomes.

- (New recommendation.) [*Based on moderate to high quality qualitative study evidence and the experience and opinion of the GDG*]

Assessment

- Assessment and diagnosis of a suspected mental health problem should include:

-A history or family history of any mental health problem

-Physical wellbeing and history of any physical health problem

-Alcohol and drug misuse

-The woman's attitude to and experience of the pregnancy

-The mother-baby relationship

-Any current or past treatment for a mental health problem and response to any treatment

-Social networks, living conditions, and social isolation

-Domestic violence and abuse, sexual abuse, trauma, or childhood maltreatment

-Housing, employment, economic and immigration status

-Responsibilities as a carer for other children and young people or other adults.

- (New recommendation.) [*Based on the experience and opinion of the GDG*]

Advice on treatment for women with mental health problems in pregnancy and the postnatal period or who are planning a pregnancy

- Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment should discuss the following, depending on individual circumstances:
  -The uncertainty about the benefits, risks, and harms of treatments for mental health problems during pregnancy and the postnatal period

  -The likely benefits of each treatment, and the woman's response to any previous treatment

  -The background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk associated with no treatment

  -The risks or harms to the woman and the fetus or baby associated with each treatment option

  -The possibility of the sudden onset of mental health symptoms, particularly in the first few weeks after childbirth (for example, in bipolar disorder)

  -The need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby

  -The risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment.
- (New recommendation.) [*Based on epidemiological evidence, low to moderate quality observational study evidence, and the experience and opinion of the GDG*]

Starting, using, and stopping treatment

- Before starting any treatment in pregnancy and the postnatal period discuss with the woman the higher threshold for starting psychotropic drugs because of the risk-benefit ratio at this time (the impact on the fetus or baby and the mother) and the likely benefits of a psychological intervention. (New recommendation.) [*Based on RCTs of psychological and pharmacological interventions and the experience and opinion of the GDG*]
- If a pregnant woman has taken psychotropic drug(s) with known teratogenic risk at any time in the first trimester:
  -Confirm the pregnancy as soon as possible

  -Explain that stopping or switching the drug after pregnancy is confirmed may not remove the risk of fetal malformations

  -Offer screening for fetal abnormalities and counselling about continuing the pregnancy

  -Explain the need for additional monitoring and the risks to the fetus if she continues to take the drug.
- (New recommendation.) [*Based on low and moderate quality observational study evidence and on the experience and opinion of the GDG*]
- Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. (New recommendation.) [*Based on the experience and opinion of the GDG*]

Tricyclic antidepressants, selective serotonin reuptake inhibitors, (serotonin)-noradrenaline reuptake inhibitors

- Take the following into account when choosing antidepressant drugs:
  -The woman's previous response to treatment with these drugs

  -The stage of pregnancy

  -What is known about the reproductive safety profile (for example, any risk of cardiac fetal abnormalities and persistent pulmonary hypertension in the newborn baby)

  -The uncertainty about whether any increased risk of fetal abnormalities and other problems for the woman or baby can be attributed to these drugs or may be caused by other factors

  -The risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby (usually mild and self limiting adverse neurobehavioral effects such as irritability, sleep disturbance, or hypoglycaemia) with most antidepressants, in particular paroxetine and venlafaxine.
- (New recommendation.) [*Based on low and moderate quality observational study evidence and the experience and opinion of the GDG*]

Considerations for women who experience traumatic birth, stillbirth, or miscarriage

- Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby, or holding the baby. This should be facilitated by an experienced healthcare professional and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If the baby is known to be dead in utero, this discussion should take place before the delivery. (New recommendation.) [*Based on low quality cohort study evidence, moderate to high quality qualitative study evidence, and the experience and opinion of the GDG*]

Overcoming barriers

The guideline emphasises recognition of mental health problems by all healthcare professionals during both the antenatal and postnatal periods.[12] It also emphasises the need to include anxiety disorders as well as depression,[13] and to promptly identify severe mental disorders, as well as understand their nature and rapid onset. Improved recognition will come from staff training and revision of routine care pathways to provide prompt access to further assessment, including that by specialist perinatal mental health services. In addition, easily available public health information is needed to:

- Promote recognition

- Rectify women's misplaced but understandable concerns that disclosure of a mental disorder may lead to their baby being taken into care[14]
- Prevent the risks associated with women deciding to stop psychotropic drugs (without consulting a healthcare professional) when they discover they are pregnant.[15]

Barriers to providing effective care include a lack of knowledge and skills. For example, many services fail to follow previous NICE advice against prescribing sodium valproate to women of childbearing potential,[16] and coordination between primary care, maternity services, social care, and specialist mental health services can be poor. The guideline recommends a raised threshold for using psychotropic drugs for some disorders (such as mild or moderate depression or anxiety) and more emphasis on providing psychological therapies. This requires greater and faster availability of psychological interventions that meet the needs of pregnant women and those with newborn babies.

The members of the Guideline Development Group were Louise M Howard (chair), Stephen Pilling (facilitator), Odette Megnin-Viggars, Eric Slade, Helen Adams, Jane Barlow, Maria Bavetta, Sonji Clarke, Asha Day, Jill Demilew, Karen Grayson, Alain Gregoire, Ian Jones, Liz McDonald, Kirstie McKenzie-McHarg, Maryla Moulin, Heather O'Mahen, Sally Russell, Judith Shakespeare, Sarah Stockton, Iona Symington, Clare Taylor, and Amina Yesufu-Udechuku.

Contributors: All authors helped in the conception and drafting of this article and in revising it critically. They have all approved this version. SP is guarantor.

Funding: SP, OM-V, and IS had support from the National Collaborating Centre for Mental Health, which was in receipt of funding from the National Institute for Health and Care Excellence, for the submitted work; LMH received support from a National Institute for Health Research (NIHR) research professorship (RP-R3-12-011) and an NIHR programme grant for applied research on the effectiveness of perinatal mental health services (RP-DG-1108-10012.)

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following interests: None. The authors' full statements can be viewed at www.bmj.com/content/bmj/349/bmj.g7394/related#datasupp.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance. (Clinical Guideline 45.) 2007. http://guidance.nice.org.uk/CG45
2 Jones I, Chandra PS, Dazzan P, Howard LM. Perinatal mental health 2: bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet* 2014;384:1789-99.
3 Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, et al. Perinatal mental health 3: effects of perinatal mental disorders on the fetus and child. *Lancet* 2014;384:1800-19.
4 Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. Perinatal mental health 1: non-psychotic mental disorders in the perinatal period. *Lancet* 2014;384:1775-88.
5 National Institute for Health and Care Excellence. Antenatal and postnatal mental health: Clinical management and service guidance (update). (Clinical Guideline 192.) 2014. http://guidance.nice.org.uk/CG192.
6 National Institute for Health and Care Excellence. Common mental health disorders: identification and pathways to care. (Clinical Guideline 123.) 2011. http://guidance.nice.org.uk/CG123.
7 Spitzer RL, Kroenke K, Williams JBW; for the Patient Health Questionnaire Primary Care Study Group. Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. *JAMA* 1999;282:1737-44.
8 Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. *Br J Psychiatry* 1987;150:782-6.
9 Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med* 2006;166:1092-7.
10 National Institute for Health and Care Excellence. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. (Clinical Guideline 115.) 2011. http://guidance.nice.org.uk/CG115.
11 National Institute for Health and Care Excellence. Drug misuse: opioid detoxification. (Clinical Guideline 52.) 2007. http://guidance.nice.org.uk/CG52.
12 Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet *Gynecol* 2005;106:1071-83.
13 Vesga-López O, Blanco C, Keyes K, Olfson M, Grant BF, Hasin DS. Psychiatric disorders in pregnant and postpartum women in the United States. *Arch Gen Psychiatry* 2008;65:805-15.
14 Dolman C, Jones I, Howard LM. A systematic review and meta-synthesis of the experience of motherhood in women with severe mental illness. *Arch Womens Ment Health* 2013;16:173-96.
15 Petersen I, Gilbert RE, Evans SJW, Man SL, Nazareth I. Pregnancy as a major determinant for discontinuation of antidepressants: an analysis of data from the health improvement network. *J Clin Psychiatry* 2011;72:979-85.
16 Jones SC, Melville J, McDonald L. Prescribing sodium valproate to women of childbearing age. Royal College of Psychiatrist's International Congress 24-27 June 2014; London, UK.

Cite this as: *BMJ* 2014;349:g7394

Further information on the guidance

The update of this guideline covers several areas in which considerable uncertainty remained or where implementation of the previous guideline had been poor. For mild to moderate disorders, psychological interventions are effective and are prioritised in the guideline. For more severe disorders, drugs may be more beneficial, and the guideline focuses on the principles for their use in the antenatal and postnatal periods. The recommendations on the potential harms associated with psychotropic drugs have shifted from a focus on specific drugs to principles that should guide the prescriber. The extent and nature of possible adverse risks associated with taking psychotropic drugs are uncertain; data are limited and the causal nature of such associations, which may be due to factors associated with the disorder itself, are unclear. This is particularly complex when the needs of the mother and the fetus or baby potentially conflict. In the case of valproate, however, the guideline re-emphasised the recommendation not to prescribe because the associated risks are well established and audit data made available to the Guideline Development Group (GDG) suggest that current prescribing practices are not consistent with National Institute for Health and Care Excellence (NICE) guidance. Recommendations for the organisation of services were not reviewed because there was no new evidence and it was therefore outside the scope of the guideline. Recommendations to cover the recognition of anxiety disorders were developed because of the concern that these disorders tended to be overshadowed by depression.

Methods

This guideline, which is an update of NICE clinical guideline 45,[1] was developed by the National Collaborating Centre for Mental Health using NICE guideline methods (www.nice.org.uk/guidelinesmanual). The guideline review process involved comprehensive and systematic literature searches to identify relevant evidence for the clinical and economic reviews, with critical appraisal of the quality of the identified evidence. Results of intervention studies were compared using meta-analysis. Results of the meta-analysis were used to inform an economic model. The GDG, which comprised a multidisciplinary team of healthcare professionals from psychiatry, psychology, general practice, nursing, and health visiting as well as service user representatives, was established to review the evidence and develop the subsequent recommendations. The guideline then went through an external consultation with stakeholders. The GDG considered the stakeholders' comments, reanalysed the data where necessary, and modified the guideline as appropriate.

NICE has produced three different versions of the guideline: a full version; a summary version known as the "NICE guideline;" and a version for women with antenatal and postnatal mental health problems and the public (www.nice.org.uk/guidance/cg192/informationforpublic). All these versions, as well as a pathway, are available from the NICE website. Further updates of the guideline will be produced as part of NICE's guideline development programme.

Areas for future research

- What methods can improve the identification of women at high risk of postpartum psychosis and reduce this risk?
- How safe are drugs used to treat bipolar disorder in pregnancy and the postnatal period?
- Are interventions designed to improve the quality of the mother-baby relationship in the first year after childbirth effective in women with a diagnosed mental health problem?
- Is structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period effective at improving outcomes for women and their babies?
- Are psychological interventions effective for treating moderate to severe anxiety disorders (including obsessive-compulsive disorder, panic disorder, and social anxiety disorder) in pregnancy?