NICE National Institute for Health and Care Excellence

NICE Pathways

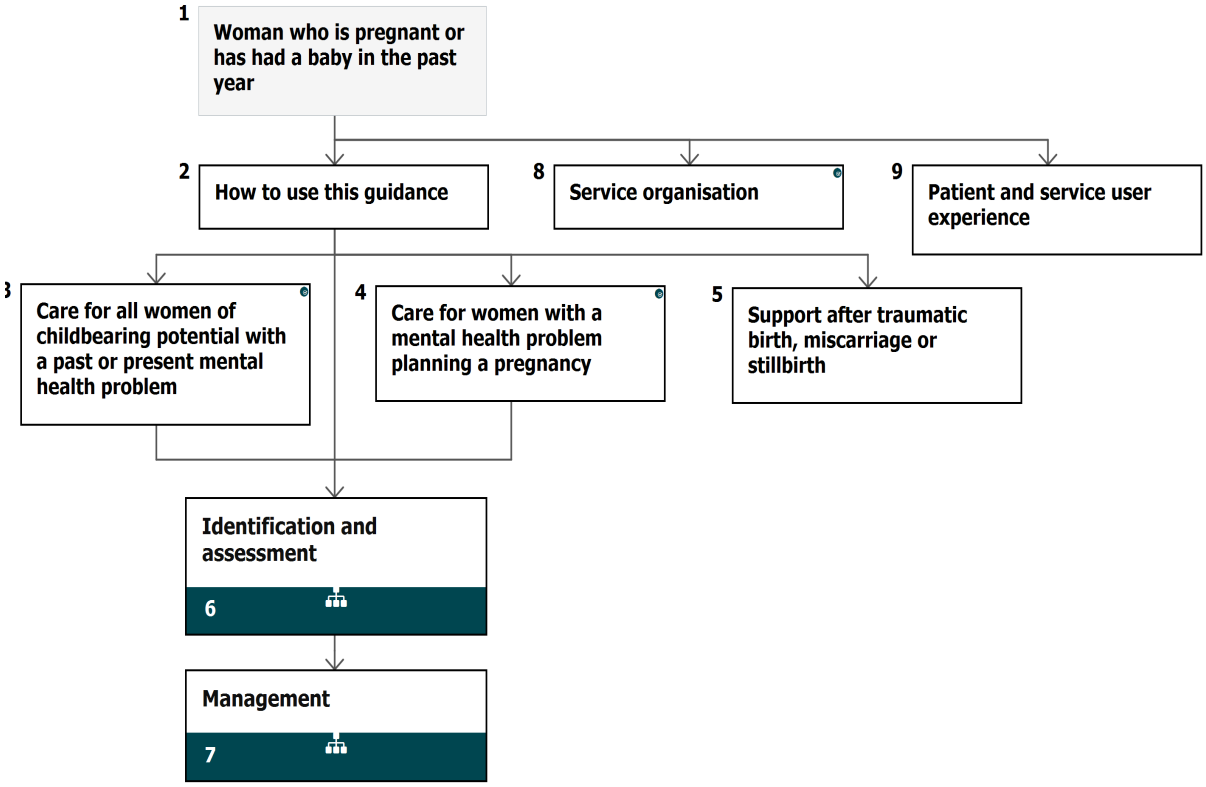
Antenatal and postnatal mental health overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/antenatal-and-postnatal-mental-health
Pathway last updated: 17 November 2017

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 Woman who is pregnant or has had a baby in the past year

No additional information

2 How to use this guidance

Use this guidance in conjunction with the NICE guidance on specific mental health problems (links are provided at relevant places) to inform assessment and treatment decisions in pregnancy and the postnatal period, and take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period
- the setting for assessment and treatment (for example, primary or secondary care services or in the community, the home or remotely by phone or computer)
- the recommendations on
  - assessment
  - pharmacological treatments
  - treating specific mental health problems.

3 Care for all women of childbearing potential with a past or present mental health problem

Discussion and advice

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
- how a mental health problem and its treatment might affect the woman, the fetus and baby
- how a mental health problem and its treatment might affect parenting.

Psychotropic medication

When prescribing psychotropic medication for women of childbearing potential, take account of the latest data on the risks to the fetus and baby.

Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential.

See also the MHRA toolkit on the risks of valproate medicines in female patients.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Antenatal and postnatal mental health quality standard

1. Valproate

2. Pre-conception information

4 Care for women with a mental health problem planning a pregnancy

Preconception counselling

Consider referring a woman to a secondary mental health service (preferably a specialist perinatal mental health service) for preconception counselling if she has a current or past severe mental health problem and is planning a pregnancy.

Psychotropic medication

When prescribing psychotropic medication for women of childbearing potential, take account of the latest data on the risks to the fetus and baby.

Benzodiazepines

Consider gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding.

Anticonvulsants

Do not offer valproate for acute or long-term treatment of a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding.

If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy.

Do not offer carbamazepine to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding.

If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, discuss with the woman the possibility of stopping the drug (because of the risk of adverse drug interactions and fetal malformations).

Antipsychotics

When choosing an antipsychotic, take into account that there are limited data on the safety of these drugs in pregnancy and the postnatal period.

Measure prolactin levels in women who are taking prolactin-raising antipsychotic medication and planning a pregnancy, because raised prolactin levels reduce the chances of conception. If prolactin levels are raised, consider a prolactin-sparing antipsychotic.

Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication.

Lithium

Do not offer lithium[1] to women who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective.

If antipsychotic medication has not been effective and lithium is offered to a woman who is planning a pregnancy or pregnant, ensure:

- the woman knows that there is a risk of fetal heart malformations when lithium is taken in the first trimester, but the size of the risk is uncertain
- the woman knows that lithium levels may be high in breast milk with a risk of toxicity for the baby
- lithium levels are monitored more frequently throughout pregnancy and the postnatal period.

See also balancing risks and benefits of psychotropic medication.

[1] Although this use is common in UK clinical practice, at the time of publication (December 2014), lithium did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal and postnatal mental health quality standard

1. Valproate

5 Support after traumatic birth, miscarriage or stillbirth

Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends.

Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following:

- seeing a photograph of the baby
- having mementos of the baby
- seeing the baby
- holding the baby.

This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery if needed.

For recommendations on treating post-traumatic stress disorder after a traumatic birth, miscarriage or stillbirth see anxiety disorders.

6 Identification and assessment

See Antenatal and postnatal mental health / Identifying and assessing mental health problems in pregnancy and the postnatal period

7 Management

See Antenatal and postnatal mental health / Managing mental health problems in pregnancy and the postnatal period

8 Service organisation

Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so.

Inpatient care

Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates.

Specialist perinatal inpatient services should:

- provide facilities designed specifically for mothers and babies (typically with 6–12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for babies
- 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 length of stay.

Care pathways and clinical networks

Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that:

- there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways.

Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved.

Safe midwifery staffing

See what NICE says on safe midwifery staffing for maternity settings.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal and postnatal mental health quality standard

7. Specialist multidisciplinary perinatal mental health services (developmental)

9 Patient and service user experience

Use this guidance in conjunction with the NICE guidance on service user experience in adult mental health services and patient experience in adult NHS services to improve the experience of care for women with a mental health problem in pregnancy or the postnatal period.

AUDIT

alcohol use disorders identification test

CBT

cognitive behavioural therapy

EPDS

Edinburgh postnatal depression scale

GAD

generalised anxiety disorder

PHQ

patient health questionnaire

Severe mental illness

severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder and postpartum psychosis

High-intensity psychological intervention

a formal psychological intervention usually delivered face to face (either in a group or individually) by a qualified therapist who has specific training in the delivery of the intervention

(S)NRI

(serotonin-) noradrenaline reuptake inhibitor

SSRI

selective serotonin reuptake inhibitor

TCA

tricyclic antidepressant

Sources

Antenatal and postnatal mental health: clinical management and service guidance (2014 updated 2017) NICE guideline CG192

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Contact NICE

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester
M1 4BT

www.nice.org.uk

nice@nice.org.uk

0845 003 7781